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Social workers on the interprofessional integrated team: Elements of team integration and barriers to practice

Lisa D. Zerden[a,*], Brianna M. Lombardi[b], Erica L. Richman[c]

[a] University of North Carolina at Chapel Hill, School of Social Work, United States
[b] University of Pittsburgh, School of Social Work, United States
[c] University of North Carolina at Chapel Hill, Cecil G. Sheps Center for Health Services Research, United States

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ABSTRACT

Roles for social workers on integrated health teams are growing, yet more information is needed to understand the workings of interprofessional teams and their practice settings. Even less is known about the barriers to practice social workers encounter or the system-level factors that promote or inhibit social workers' success as members of interprofessional, integrated teams. This article presents findings from a study of 395 social workers who are members of interprofessional teams in integrated health care settings across the country. Discussion includes the characteristics, clinic types, and populations served are explored. Additionally, the discussion includes the common elements of team integration and clinic- or system-level barriers that affect social work practice in integrated, interprofessional settings. We offer recommendations for educational, practice, and policy efforts to better support integrated care, interprofessional teams, and integration across health systems.

The roles of social workers are increasingly expanding, particularly for social workers practicing as members of integrated health care teams.[21] These new roles are responsible for an increasing number of social workers in health care settings, a workforce that is expected to grow by 20% over the next 10 years.[26] Primary factors spurring the growth of social work in integrated health include the shift in health systems toward prioritizing patients' behavioral health and increased understanding of the ways in which the social determinants of health affect physical health outcomes.[21] To meet these changing needs, the social work workforce brings unique knowledge and skills to integrated health settings that make social workers valuable members of interprofessional teams.[9,27] For example, as members of interprofessional teams, social workers bring an understanding of psychosocial risk and protective factors, behavioral health screening, assessment and intervention, and the skills to adapt services to be culturally inclusive.[28] Although the literature supports the expanding roles of social workers on integrated health teams,[9] only limited literature has examined the interprofessional teams and characterized the integrated practice settings in which social workers are employed. Further, little is known regarding the barriers to practice that social workers might encounter when working as members of interprofessional teams in integrated health settings.

The addition of social workers to integrated health teams has required health systems to include members not traditionally considered as members of the health care team. Expanding the idea of who "belongs" on an integrated health team can occur through interprofessional efforts in educational and practice settings. IPE is commonly defined as an educational approach in which students or providers from "two or more professions learn with, about, and from each other to enable effective collaboration and improve health outcomes"[25]; p.7). Interprofessional practice (IPP) involves more than a mix of professionals working together; IPP represents a fundamental rethinking of health care in which providers from different disciplines work collaboratively and partner with the patient (and the patient's family) to achieve best outcomes. IPP is distinct from the older concept of multidisciplinary teams in which providers from different medical specialties focused on the same patient but tended to work in parallel and independently (Institute of Medicine, 1972; Grumbach & Bodenheimer, 2004; Schuetz Mann & Everett, 2010). In contrast, a critical aspect of IPP centers on the collaboration being a "negotiated agreement between professionals, which values the expertise and contributions that various healthcare professionals bring to patient care"[30]; p.2). The expansion of integrated care has focused efforts on using an interprofessional perspective in health care education and training so that providers are better able to holistically meet the complex needs of patients and better prepared for the realities of team-based care.

The definition of integrated care has been explained by many health entities, including the[24]; which describes this approach as "the

* Corresponding author. 325 Pittsboro Street, CB#3550, Chapel Hill, NC, 27599-3550, United States.
E-mail address: lzerden@email.unc.edu (L.D. Zerden).

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management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system" (p. 1). Care integration occurs when multiple services, including primary care, mental health, and substance use services are provided in a comprehensive, coordinated way to produce beneficial and cost-effective delivery of care for people with multiple needs (SAMHSA-HRSA, n.d.). In integrated care practices, patients receive comprehensive, personalized, and patient-centered care that not only encompasses mental, physical, and behavioral health conditions but also considers the impact of social factors to improve outcomes and increase access to holistic health services.[21,28] Moreover, the evolution of integrated care models has been supported by increased understanding of the social determinants of health. An ever-growing body of evidence has shown that social factors and experiences such as income, employment, discrimination, and educational attainment influence mental, physical, and behavioral health outcomes.[3,4,16] Given these complex, interrelationships, integrated health care is understood as a transformative model of care that breaks down the traditional siloed, fractured systems to better address co-occurring chronic disorders[10] and can be adapted specifically to the social work profession.[29] The integrated care approach requires an interprofessional team of providers who can coordinate treatment plans and collaborate to comprehensively treat individual consumers and address their multiple needs holistically.

Social work, one of the largest groups of clinically trained providers in the United States,[17] are trained in a systems-perspective predicated on serving society's most vulnerable, marginalized, and underserved groups. Social workers can provide a crucial perspective for interprofessional teams that want to improve health equity, address the social determinants of health, and adapt behavioral health care methods (e.g., screening, assessment, and treatment) to meet consumers' needs in traditional primary care settings.[9] Although social workers are increasingly part of integrated healthcare teams,[9,12] little information is available to explain how adding social workers to interprofessional teams can affect team functioning.[18] Even less is known about the individual- and system-level factors that promote or inhibit social workers' success as members of interprofessional, integrated teams.

To address these gaps in the literature, we conducted a study of 395 social workers who are members of interprofessional teams in integrated health care settings located across the country). The study had three aims. Study Aim 1 was to characterize interprofessional teams that routinely included social workers, identifying the providers with whom social workers collaborated with most frequently, and describing both the clinic types and patient populations served by care teams that included a social worker. Study Aim 2 focused on examining interprofessional teams to identify common elements of team integration (as defined by[19] elements of integrated practice.[10]; Study Aim 3 was to identify the impact of clinic- and system-level barriers on social work practice in integrated, interprofessional settings.

1. Method

1.1. Sample and participant recruitment

A convenience sample was recruited from a list of schools of social work that received funding in 2014 from the Health Resources and Service Administration (HRSA) under the Behavioral Health Workforce Education and Training (BHWET) initiative. (For information on the BHWET HRSA-funding mechanism, see Ref. 14. To recruit potential respondents, our team contacted BHWET project directors with a request that they forward a pre-scripted e-mail to masters of social work (MSW) students and field instructors in their programs. If project directors were unavailable, the research team contacted administrators of the identified BHWET schools. The scripted e-mail explained the study's purpose, included an invitation to participate in a survey of their BHWET program, and provided a link to the online survey. As a participation incentive, the invitation informed recipients a $100 gift card would be awarded to respondents randomly selected from those who completed the survey.

Of the 62 HRSA-funded BHWET schools, more than 50% of the project directors forwarded the recruitment e-mail. However, given this recruitment strategy, the exact number of invitation e-mails forwarded is unknown. This study was reviewed and approved by the Institutional Review Board at both the University of Michigan and the University of North Carolina at Chapel Hill.

1.1.1. Survey

An electronic survey was developed using Qualtrics and administered to MSW students and field instructors ($N = 395$). The survey gathered respondents' sociodemographic information and included questions on the respondent's role on the integrated health team, team composition, and barriers and facilitators of interprofessional practice. Additionally, the survey collected data regarding on the patient population, setting type (outpatient/inpatient), location (rural/urban), and elements of team integration (defined as team co-location, communication, access to and use of the electronic health record, collaboration and team culture, and team composition) based on the levels of integration established by SAMHSA-HRSA.[10] The survey took approximately 35 min to complete.

1.1.2. Survey development

The survey was developed using current literature, practitioner expertise, cognitive interviewing, and feedback from pilot data. Prior to this study, the survey was pilot tested with a small sample of MSW students and their field instructors ($N = 42$; 21 BHWET-funded MSW students and their 21 field instructors.[7]; After pilot testing, the survey tool was refined through cognitive interviewing with four MSW student interns working in integrated care settings to better understand how respondents interpreted each survey item. The instrument was then reviewed by social workers and nurses with active practices in integrated settings. Survey items about the level of practice integration were drawn from SAMHSA-HRSA Center for Integrated Health Solutions Standard Framework for Levels of Integrated Healthcare,[10] core competencies of integrated care[11]; and the Integrated Practice Assessment Tool, version 2.0[23]).

1.1.3. Analysis

The survey analysis was completed using Stata 15. Given the exploratory nature of the study aims and the data collected, we conducted both descriptive and bivariate (*t*-test and Pearson chi-square) analyses.

2. Results

Of the 395 respondents (64% MSW students, 36% field instructors), the majority were women, and 75% self-identified as White, 10% as Black, 6.5% as Latinx, and 8.5% as other or multiracial. Sample demographics were consistent with reports of the national population of MSW students that indicate 80% of MSW students are female[5]). However, in this national census of MSW students, only 54% identified as White as compared with 79% in our sample. Most field instructors in our sample (77%) were licensed clinical social workers (LCSW), with an additional 8% working toward LCSW licensure. Most field instructors graduated from an MSW program in 2009 (mean = 2001; $SD = 10.3$; range = 1971–2015). Over one-third of MSW student respondents (36%) reported having a bachelor's of social work degree. Not surprisingly, MSW students (M = 27.35 years, SD = 15.88) were statistically significantly younger than the field instructors (M = 42.69, SD = 16.79), $t(391) = 9.0082$, $p < .001$). See Table 1 for sample description.

Study Aim 1 focused on characterizing the interprofessional, integrated settings and types of providers and composition of the teams

Table 1
Sample description (N = 395).

	MSW Student		Field Instructor		Total Sample	
	n	n (%) or *Mean* (*SD*)	n	n (%) or Mean (*SD*)	n	n (%) or Mean (*SD*)
Total	251		142		395	
Gender	246		137		383	
Male		24 (9.76%)		15 (11%)		39 (10%)
Female		219 (89%)		122 (89%)		341 (89%)
Other		3 (1%)		0		3 (0.8%)
Age* **	251	*27 (17)*	142	*43* (16)	393	*34* (12)
Highest Degree	251		142		393	
Undergraduate		217 (86%)		5 (4%)		222 (56%)
Masters		34 (14%)		129 (91%)		163 (41%)
Doctorate (MD or PhD)		0		8 (6%)		8 (2%)
Race	249		142		391	
Black (non-Hispanic)		183 (74%)		113 (80%)		296 (76%)
White (non-Hispanic)		26 (10%)		13 (9%)		39 (10%)
Hispanic		15 (6%)		4 (3%)		19 (5%)
Other/Multiracial		25 (10%)		12 (8%)		37 (9%)
Setting	208		98		306	
Academic hospital system		46 (22%)		23 (23%)		69 (23%)
Non-academic health system		68 (33%)		44 (45%)		110 (36%)
Community setting		94 (45%)		31 (32%)		125 (41%)

Note. T-test and Pearson χ^2 statistic were used to compare differences across groups.
***$t(391) = 9.01$, $p < .0.001$).

on which social workers are most frequently included.

2.1. Setting type

Most respondents reported working in outpatient settings (57%) followed by inpatient settings (16%), whereas 12% worked across both outpatient and inpatient settings. In addition, respondents indicated working in other types of settings that included school-based (13%); residential-inpatient (2%); and care settings for justice-involved patients (2%). Respondents were also asked to identify the type of health system they worked within. More than half of the respondents (58%) worked within a hospital system (university-affiliated, private, or other hospital) and 42% worked in community-based agencies. Less than one-fifth of respondents (17%) reported working in a rural health location.

2.2. Patient populations

Respondents reported working with patient populations that represented a mix of insurance statuses. Whereas 82% of respondents reported their patient populations were *most likely* to be insured, 73% indicated some portion of their caseload was uninsured. Among insured patients, 66% of respondents indicated Medicaid was the most frequent insurance type. Respondents identified serving a variety of patients with health and behavioral health conditions. For example, respondents most frequently reported that *most or all* of their patients experienced psychosocial stressors (73%), mental illness (64%), depression (48%), victimization (52%), and co-occurring health conditions (37%). Some respondents worked with patient populations in which *most or all* were patients with substance-use disorders (21%), chronic medical conditions (19%), and acute medical conditions (13%). Among our sample, respondents infrequently reported working with patient populations in which *most or all* patients had physical disabilities (5%), neurological conditions (4%), and developmental disabilities (3%).

2.3. Team composition

As illustrated in Fig. 1, survey respondents worked on interdisciplinary teams that included a variety of health professionals. The survey listed 18 types of health professionals identified in the literature as members of some interprofessional care teams: On average, respondents selected seven professions (SD = 3.6) representing the composition of their interprofessional care team. Most respondents worked with physicians, specifically identifying primary care physicians (45%), psychiatrists (61%), and specialty physicians (8%). Beyond working on a team with other social workers (91%), respondents most often worked with registered nurses (RNs; 62%) and nurse practitioners (NPs; 60%). In addition, an open-ended item allowed respondents to specify team constituents beyond the 18 options on the survey; 13% identified other professionals on teams, including child protective services workers, speech pathologists, teachers or school administrators, recreation and vocational specialists, and peer-support specialists.

Team composition was significantly influenced by setting type and co-location of team members. Social workers working in co-located settings (i.e., two or more services located in the same clinic or building, although those services might not be fully integrated) were significantly more likely to work with physician assistants (PA) (χ^2 $(1) = 5.73$, $p < .05$), NPs (χ^2 $(1) = 16.65$, $p < .001$), RNs (χ^2 $(1) = 5.35$, $p < .05$), nutritionists (χ^2 $(1) = 8.48$, $p < .01$), and pharmacists (χ^2 $(1) = 5.13$, $p < .05$). Social workers in settings without co-located services were significantly more likely to work with community health workers (χ^2 $(2) = 14.44$, $p < .01$). Respondents who worked in co-located settings ($t(319) = 2.50$, $p < .05$) and hospital systems ($t(361) = 3.76$, $p < .01$) worked with a significantly greater number of types of team members.

2.4. Team integration

Study Aim 2 focused on elements of team integration established by SAMHSA-HRSA's levels of integrated health care.[10] Respondents were asked to describe the extent to which their practices met the six characteristics of integration: team co-location, communication, EHR use, collaboration and team culture, and team composition.[10]

2.4.1. Team co-location

Most often respondents were co-located in the same unit or clinic with their integrated care team (62%), whereas almost another 15% were co-located in the same building as other members of their team, but located in separate units. In contrast, nearly a quarter of respondents (23%) worked in separate practices in separate buildings from the other providers on their team, indicating a lower level of integration. Social workers who worked in hospital systems (academic

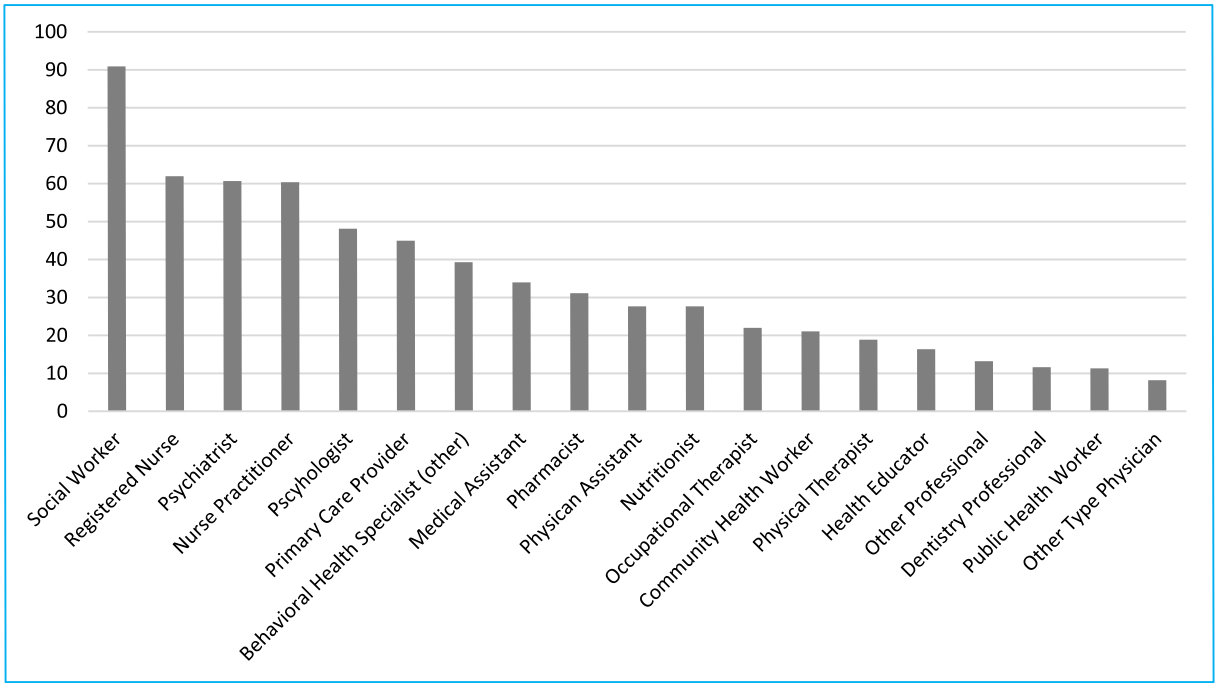

Fig. 1. Types of professionals most likely to work on teams with social worker respondents.

and non-academic hospitals) were significantly more likely to be co-located with other providers on an interprofessional team than were social workers who worked in community-based agencies ($\chi^2(2) = 9.66$, $p < .001$). Similarly, respondents who worked in in-patient, outpatient, and combined settings also were more likely to be co-located with their team members than with respondents in schools or settings in the other category (χ^2 $(4) = 10.39$, $p < .05$).

2.4.2. Communication

About 80% of respondents interacted face-to-face with their integrated care team at least weekly, with more than 42% of respondents reporting daily interactions with members of the care team. Respondents also indicated they had regular communication (i.e., at least weekly) with the interprofessional team via e-mail (63%) and phone (44%). In addition, a majority of respondents reported frequently meeting as a whole team (68%) and/or frequent meeting with portions of the team (86%). However, the frequency and type of team communications differed substantially across respondent type, setting type, and co-location status. For example, respondents working in either co-located settings (χ^2 $(2) = 53.28$, $p < .001$) or inpatient settings (χ^2 $(4) = 24.91$, $p < .001$) were more likely to report in-person communication with team members that occurred *daily or several times a week*. Frequent communication by phone (i.e., daily or several times a week) with the integrated care team was most often reported by respondents who were field instructors (χ^2 $(1) = 8.55$, $p < .01$), those working in hospital systems (χ^2 $(1) = 9.03$, $p < .01$), or those working in inpatient settings (χ^2 $(4) = 23.09$, $p < .001$).

2.4.3. Electronic health record use

Respondents were asked if all members of the integrated care team had access to the same electronic health record (EHR). About 53% responded affirmatively, although 15% said team members *never* used the same EHR. As compared with respondents who worked in school settings or "other" settings, respondents who worked in co-located settings ($\chi^2(1) = 37.78$, $p < .001$), within hospital systems (χ^2 $(1) = 17.18$, $p < .001$), and in both inpatient and outpatient settings (χ^2 $(4) = 18.28$, $p < .01$) were significantly more likely to have access to the same patient EHR as other team members. Notably, some respondents working within hospital systems indicated that not all team members had access to the same EHR. We found no difference in EHR use by respondent type (i.e., MSW student vs. field instructor).

2.4.4. Collaboration and team culture

More than 60% of respondents reported that all members of the integrated team collaborated on patients' plan of care *most or all* of the time whereas less than 4% reported *never* collaborating as a team on patient care plans. The level of collaboration was significantly associated with both setting and co-location type. As compared with respondents who worked in community-based agencies, schools, or "other" setting types, respondents who worked in a hospital system (χ^2 $(2) = 9.71$, $p < .05$) or on a co-located team (χ^2 $(2) = 24.03$ $p < .05$) were significantly more likely to report full team collaboration *most or all* of the time. Responses to items that asked participants to indicate the extent to which team members understood each other's roles indicated that 38% of teams had an in-depth understanding of each member's role whereas 46% had only a basic understanding of other team members' roles and functions.

2.5. Barriers to respondents job or field placement

Last, Study Aim 3 focused on identifying barriers to respondents' job or field placement settings. Responses to these items were captured using the same 5-point Likert scale (*never, occasionally, often, very often, always*) to measure impact of barriers or facilitators to respondents fulfilling the roles and functions of their positions. For the remainder of this section, all percentages indicate an answer of *often, very often* or *always*. Notably, the vast majority of respondents (85%) reported feeling supported in their work or field placement. Most respondents reported feeling the organizational climate was supportive of social worker roles in general (80%), social worker roles on the interprofessional team (78%), and considered social workers as a valued member of the team (85%). Although 77% of social workers reported having a clearly defined role on their team, 37% reported that their role overlapped with other team members.

Despite favorable indicators of positive organizational environments, respondents reported barriers to their working effectively on the

Table 2
Frequency of Reported Barriers to Social Work Practice on Interprofessional Care Teams in Integrated Settings.

	Never	Occasionally	Often, Very Often, Always
	%	%	%
No reimbursement for consultation between medical providers and social workers	59	20	22
Differences in professional culture/terminology between medical providers and social workers	34	42	24
Practice insufficiently informed by social determinants of health	32	37	31
Medical providers lack training in behavioral health	30	33	37
No designated office space for social worker	50	24	26
Team interactions negatively influenced by hierarchal salary system	35	41	23
Social worker's caseload is too high	19	37	44
Social worker's role overlaps with roles of other team members	23	39	37
Social worker has clearly defined role on interprofessional team	6	17	77
Organizational climate supports social workers on an interprofessional team	3	18	78
Organizational climate promotes social worker's role and social work interventions	5	15	80
Social worker role is valued on the interprofessional team	3	12	85
Data collected by the social worker is entered into electronic health record and is accessible to all team members	26	13	61

interprofessional team (see Table 2). For example, 24% reported professional cultural or terminology differences between medical providers and social workers that negatively affected the social workers' ability to function on the team. Almost 31% of respondents indicated that their work setting was insufficiently informed regarding the social determinants of health, and 37% of respondents reported that medical providers on their team lacked adequate training in behavioral health. Nearly 25% of all respondents reported a hierarchal salary system had a negatively impact on equitable team interactions.

Respondents identified structural barriers in their work settings that negatively affected their ability to fulfill their roles on interprofessional teams. For example, billing was described as an issue that negatively affected the social workers' practice, with than 22% of respondents indicating their work setting lacked a reimbursement mechanism for consultation between social workers and medical providers. Physical space was also a reported barrier, with more than a quarter of respondents indicating their work setting had no designated office space for the social worker. Relatedly, the lack of computer access availability of technology impacted social work practice, with less than two-thirds of social workers reporting they routinely entered information into patients' EHR for all team members to review. It is unknown if this was a limitation due to not having an office or computer, or if the social workers didn't have privileges for using EHR. Last, almost half of respondents (44%) indicated social work caseloads were too large for social workers to carry out their expanded roles on interprofessional teams.

Surprisingly, few of the reported barriers differed by student versus instructor status, setting type, or co-location. MSW students were significantly less likely to report barriers stemming from professional culture or terminology differences between social workers and medical providers ($\chi^2(2) = 9.2$, $p < .05$). Both student and field instructors in co-located settings were less likely than other respondents to report barriers to their practice related to reimbursement for consultation ($\chi^2(2) = 6.49$, $p < .05$). Last, social workers in community-based agencies or in settings without co-located services were less likely than all other respondents to report collecting information that would be included in patients' medical records (72% in hospital system setting vs. 48% in community settings; $\chi^2(2) = 19.72$, $p < .05$).

3. Discussion and implications

This study represented one of the largest surveys of social workers in the United States who are working in integrated settings. The study aimed to more fully describe the various settings and compositions of interprofessional teams on which social workers are working. Additionally, this study examined the components of integration and barriers to practice in integrated models of care as described by social workers. Study findings highlight the extent to which social workers work in interprofessional, integrated services across the United States.

3.1. Health in communities

Although the majority of respondents worked within a hospital system setting, study findings reflect that integrated and interprofessional care is expanding far beyond hospital systems. Indeed, close to half of social workers in this study worked in community settings. This finding likely reflects that health care now includes community context as well as increasing collaborative efforts of community agencies and health systems in new and innovative ways.[7] Moving care from hospitals to communities is a priority in population health.[6] However, this move requires innovative models of care that depend on a trained and flexible workforce to not only be present in communities but also be inclusive and reflect the diversity of community context. Certainly, social workers constitute one workforce with the training, flexibility, and experience to work across created "walls" in health systems while having the capacity to collaborate with other providers such as community health workers, peer-support specialists, and public health workers to transform health care.

3.2. The spectrum of integration

This study further reflects the significant variation in the components of integration, and that such variation is more the rule than the exception. Indeed, respondents indicated considerable differences in characteristics of service integration, including co-location, team communication, EHR use, collaboration between team members, and team culture. Extensive variation was seen in both types of hospital-based health systems and within community-based agencies. For example, even within hospital-based health systems, not all members of the interprofessional team had access to the same EHR. Without a shared EHR, team communication and coordination might be limited and less effective. Moreover, without a shared EHR, understanding what social workers document and how they contribute to patient care is likely to remain poorly understood among other members of interprofessional treatment teams.

As compared with respondents working in hospital-based health systems, respondents working in community-based agencies identified significantly fewer components of integration in place on their interprofessional team. In addition, respondents in community-based agencies were far less likely to be co-located with other providers on their interprofessional team, and in turn, communicated with other members of the team less frequently and were less likely to share EHR records. As health care shifts from hospital-based acute or inpatient settings to ambulatory and community-based approaches,[8] the level of team

integration will be an important indicator to focus on in order to best meet population health within community contexts. As our study findings illustrate, integration occurs on a spectrum across the different components of integration. This variation makes it challenging to distill a clear picture of integrated practice and social workers' roles on teams.

3.3. Interprofessional team-based care

Data from this current study underscores how practices among interprofessional, integrated teams varies based on elements of integration. This study offers a picture of social workers' perspectives of their practice in various settings to better understand the way social work is currently incorporated on interprofessional teams in integrated settings. This study offers a current and accurate perspective of social workers on interprofessional teams as health settings move toward integrated service delivery. The components of integration highlighted within these results can also serve as beneficial starting points for efforts to ensure quality health care continues as health settings move closer toward fully integrated services. This study highlights several areas in which education, practice, and policy recommendations can be strengthened to further clarify and expand the role of social workers in integrated, interprofessional settings.

3.4. Identified barriers

Although social workers on integrated care teams reported feeling supported by their team, several barriers to effective team practice were identified. Of primary concern were barriers related to structural and administrative systems. For example, the lack of a designated workspace for the social worker would clearly compromise effective practice. Similarly, the proportion of social workers who reported their team did not share electronic health records not only hinders the social workers' practice but also creates a troublesome team dynamic. Integrated care requires not only a focus on working collaboratively; it also mandates that health systems put in the structure to support team functions. Further, social workers reported that the lack of reimbursement mechanisms for social work consultation impacted practice. Health systems need to identify ways to create sustainable models of integration—with a priority on payment and creating time for the necessary components of care.

3.5. Role clarity

Similarly, role confusion and lack of clearly defined roles on integrated teams were commonly reported obstacles. Role confusion can lead to suboptimal functioning among team members, which in turn, can contribute to inefficient practices.[2] Further, role confusion can lead to duplication of services or underuse of the skills of team members[22]). Underuse of skills of particular team members is a particularly salient issue for teams that include social workers because the scope of social work practice is often poorly understood by other disciplines.[7] Similarly, social workers' role clarity was also identified as a crucial challenge in Ref. 1 qualitative study of challenges encountered among health care social workers. To address this challenge, integrated care teams must work to clearly define each member's role and task responsibilities as well as develop an understanding of each other's roles and skill sets.

4. Educational, practice and policy recommendations

4.1. Ongoing need for interprofessional education

Social workers are working on interprofessional teams with a multitude of providers from a variety of disciplines. On average, social workers in this study reported working on interprofessional teams that included seven provider specialties in addition to social work. Prior research on interprofessional care team identified a clear understanding of each member's roles and functions as a key element on which the success of health care teams hinges.[15,20,22] As demonstrated in our study, social workers' roles are flexible and vary significantly by setting; however, this extent of variation likely contributes to role confusion or ambiguity among other team members, increasing some providers' difficulty with understanding the social work role on their team.[7] To address this barrier for social workers as well as other provider specialties, more opportunities for ongoing IPE to better acculturate future providers to the functions and skills of all professionals on the team is needed. However, creating opportunities for IPE must move beyond shared classroom time to extend to the clinical learning environment and practice settings. Further, although graduate programs are increasing opportunities for IPE, both health systems and the existing workforce can benefit immediately from interprofessional training that promotes team culture and improves understanding of the roles and functions of the members on health care teams. Alternatively, health systems can foster interprofessional culture by requiring the existing workforce, including front desk staff and administration, to complete IPE trainings or continuing education courses.

4.2. Supporting integration in health systems

As reflected in our study findings, social workers are deployed in settings with varying extents and components of integration. To deploy social workers in their fullest capacity, health systems will need continued support to implement elements of integration in both hospital-health settings and across coordinated settings such as collaborations with community-based agencies. Increasing integrated services requires improving administrative structures to better facilitate team communication, shared use of EHRs, and billing structures to account for team-based models of care. As U.S. health systems move to value-based models of care, researchers will need to develop better measures of the value of social work functions as part of interprofessional teams across settings. To date, this type of analysis remains nascent.

The heterogeneity of social work practice in integrated behavioral health settings observed in this study—both with whom social workers work and by setting—is mirrored by commentaries and theoretical work in the field, which highlight the natural fit of social workers in integrated models of health care.[7,21] However, this heterogeneous nature is often not well understood within other disciplines, and teams or health systems that have a narrow understanding of the profession can severely limit social workers' ability to practice in dynamic ways on integrated care teams. The flexibility of social work as a health workforce is beneficial when health systems face labor shortages or maldistribution of providers. However, although this flexibility is a strength of the social work profession it might also contribute to role confusion among other health professionals.[1,13,18] For example, only 38% of our sample reported their team had an in-depth understanding of each other's roles and functions. Similarly, the scope of social work practice, licensure, payment, and job descriptions vary by state, likely exacerbating the role confusion not only within the interprofessional team but also across health care systems.

4.3. Limitations

Although the current study gathered data from a large sample of social workers located across the United States, the sample was not nationally representative of all social workers in integrated care settings. Additionally, all data were self-reported descriptions and might be biased. Therefore, we caution readers that the generalizability of the findings is limited. Further, the sample was drawn from schools receiving HRSA BHWET funding, and schools selected for the BHWET program might have training standards and protocols that differ significantly from those of non-BHWET funded schools, particularly regarding field placements that involve MSW students as part of

interprofessional teams.

5. Conclusions

Social workers' knowledge of psychosocial needs; methods of behavioral health screening, assessment, and intervention; and training in adapting services to ensure services are culturally inclusive uniquely positions social workers to assist in treating the "whole person" in integrated care settings. Overall, this study found that social workers are deployed across a variety of settings, work with a multitude of interdisciplinary providers, and work within varied models of integrated care. However, study findings also showed that with whom social workers work, where they work, and other barriers to practice are significantly impacted by team and health system factors. The complex challenge of adopting and supporting interprofessional teams in integrated health care systems requires changes at micro, mezzo, and macro levels. Ongoing development of IPE and clinical learning is needed to promote new models of integrated care at both the education and practice levels. Health system administrators should be mindful of factors that affect interprofessional practice for social workers as members of integrated teams.

JIEP: TCBY IPE conflict of interest statement

All authors on the manuscript titled: *Social Workers on the Interprofessional Integrated Team: Elements of Team Integration and Barriers to Practice* have no conflicts of interest to disclose.

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Appendix A. Supplementary data

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