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Health Workforce Policy Brief

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Toward a Better Understanding of Social Workers on Integrated Care Teams

Brianna M. Lombardi, MSW, Lisa de Saxe Zerden, MSW, PhD, School of Social Work, University of North Carolina at Chapel Hill & Erica L. Richman, MSW, PhD, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

BACKGROUND

Social workers' training and knowledge of psychosocial risk factors, behavioral health screening, assessment and intervention, and focus on the adaption of services to be culturally inclusive makes the profession uniquely positioned to assist in the treatment of the "whole person" in integrated care settings.[1,2] Literature describes how social work education prepares the workforce to serve as behavioral health specialists, patient navigators, and care managers[1,3] but there is limited understanding as to what roles actively practicing social workers are performing in integrated settings. Until now, work exploring social worker roles in integrated settings has been theoretical in nature and limited by sample size or geographical reach. This study used a national sample of Masters of Social Work (MSW) students in integrated field placement settings and their field instructors to clarify how this workforce, not traditionally captured in workforce research, contributes to integrated healthcare.

METHODS

An electronic survey was developed and administered in partnership with the University of Michigan's Behavioral Health Workforce Research Center to HRSA-funded Behavioral Health Workforce Expansion and Training Grant (BHWET) MSW students and their field instructors. The survey focused on understanding the roles and functions of social workers in integrated health care, setting type, level of integration, patient population, where they learned tasks, barriers and facilitators to practice, and compositions of interprofessional teams. The survey asked about 28 social worker tasks identified from SAMSHA-HRSA's core competencies and previous literature.[4,5] Descriptive and bivariate (t-test, chi-square) analyses were conducted.

KEY FINDINGS

Sample and Settings

Participants included 395 respondents from all nine HRSA regions and over half of all BHWET funded schools. Respondents worked mostly in outpatient care (57%), inpatient care (16%), or across both settings (12%). The majority

CONCLUSIONS AND POLICY IMPLICATIONS

Social workers are an extremely flexible workforce with skills that can be adapted to patient and administrative needs in all healthcare settings. Findings from this study suggest social worker field instructors and MSW students are learning the skills necessary for integrated care both on the job and in MSW programs.

Social workers perform many job functions that are not directly reimbursable. As they continue employment in integrated settings, systems must prioritize employing payment structures and billing codes that facilitate new social work roles.

Some skills regularly used by social workers in integrated settings, like addressing patient social determinants of health, provide value that is intrinsic and is therefore hard to measure. This type of indirect value renders the return on investment of the work of social workers integrated settings difficult to define. Further evidence is needed to quantify social work's value in integrated healthcare.

[1] Andrews, C. M., Darnell, J. S., McBride, T. D., & Gehlert, S. (2013). Social work and implementation of the Affordable Care Act. *Health & Social Work*, *38*(2), 67-71.
[2] Stanhope, V., Videka, L., Thorning, H., & McKay, M. (2015). Moving toward integrated health: An opportunity for social work. *Social work in health care*, *54*(5), 383-407.
[3] Zerden, L. D. S., Jones, A., Brigham, R., Kanfer, M., & Zomorodi, M. (2017). Infusing integrated behavioral Health in an MSW program: Curricula, field, and interprofessional educational activities. *Journal of Social Work Education*, 1-13.
[4] Hoge, M. A., Morris, J. A., Laraia, M., Pomerantz, A., & Farley, T. (2014). Core competencies for integrated behavioral health and primary care. *Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions*.
[5] Horevitz, E., & Manoleas, P. (2013). Professional competencies and training needs of professional social workers in integrated behavioral health in primary care. *Social Work in Health Care*, *52*(8), 752-787.

worked within hospital systems (58%), including academic, private, or other hospital types; and 17% identified working in rural locations.

Tasks Used in Integrated Practice

Respondents performed an average of 15 out of 25 tasks at least weekly. The most commonly used skills were: team-based care; motivational interviewing; psychoeducation; using the social determinants of health; and adapting services to be culturally inclusive. The least used skills were medication management; SBIRT (screening, brief intervention, and referral to treatment); warm hand-offs; functional assessment of daily living skills; and behavioral activation (Table 1).

Table 1. Participant-Identified Most and Least Used Skills in Weekly Practice

Task	MSW Students		Field Instructors		All Respondents	
	n	%	*n*	%	*n*	%
Most Used Tasks						
Team Based Care**	*195*	*80%*	*116*	*91%*	*311*	*83%*
Motivational Interviewing**	*174*	*77%*	*107*	*91%*	*281*	*82%*
Psychoeducation	*187*	*82%*	*93*	*79%*	*280*	*81%*
Use Social Determinants of Health	*181*	*81%*	*90*	*78%*	*271*	*80%*
Adapt Services to Be Culturally Inclusive	*174*	*77%*	*95*	*84%*	*269*	*80%*
Least Used Tasks						
Behavioral Activation	*117*	*52%*	*62*	*54%*	*179*	*52%*
Functional Assessment of Daily Living	*97*	*40%*	*57*	*45%*	*154*	*42%*
Warm Hand-Off***	*67*	*30%*	*62*	*52%*	*129*	*37%*
Medication Management**	*63*	*28%*	*53*	*45%*	*116*	*34%*
SBIRT	*34*	*15%*	*25*	*22%*	*59*	*18%*

Note. Not all respondents answered every question due to skip patterns, survey fatigue and/or other reasons. SBIRT= screening, brief intervention, and referral to treatment. *p<0.05; **p<0.01; ***p<0.001.

Task Education

Respondents had knowledge of or education related to most tasks. Skills most widely learned were: linking patients to services; psychosocial assessment; motivational interviewing; standardized assessment; and team-based care (all were learned by 98-100% of respondents). SBIRT was least likely to have been learned, followed by behavioral activation; problem-solving therapy; huddles; and warm hand-offs. Students most often reported learning skills in their MSW programs whereas field instructors learned them on the job (*p<0.05*).

Elements of Integration

Participants reported on elements of integration within their practice settings. Most were co-located with the rest of the integrated care team (62%). About 80% talked with the team in person at least weekly, with more than 42% doing so daily. Frequency of communication significantly varied by setting type and co-location status. Most respondents (60%) felt their team collaborated *most or all of the time* on patient cases and treatment plans. Participants who were co-located or worked in inpatient settings were more likely to communicate with team members in person (*p<0.001*). Over 53% reported that team members *always* have access to the same electronic health record (EHR), but 15% indicated team members *never* use the same EHR. Participants who worked in co-located settings, within hospital

systems, and in inpatient and outpatient settings (compared to school or "other") were significantly more likely to work on teams that all used the same EHR. More than 46% of participants reported the team had a *basic* understanding of other members' roles.

Team Compositions

Participants worked on interdisciplinary teams that included a variety of professionals (See table 2). Team composition was significantly influenced by setting type and co-location of team members. Social workers working in co-located settings were significantly more likely to work with NPs, RNs, PAs, nutritionists, and pharmacists ($p<0.05$). Social workers in non-co-located settings were significantly more likely to work with community health workers ($p<0.05$). Participants working in co-located settings and hospital systems worked with more types of professionals overall ($p<0.05$) (Table 2).

Table 2. Types of Professionals Most Likely to Work on Teams with Respondents

Professional	n	%	Professional	n	%
Social Worker	289	91	Nutritionist	88	28
Registered Nurse	197	62	Occupational Therapist	70	22
Psychiatrist	193	61	Community Health Worker	67	21
Nurse Practitioner	192	60	Physical Therapist	60	19
Psychologist	153	48	Health Educator	52	16
Primary Care Provider	143	45	Other Professional	42	13
Behavioral Health Specialist (other)	125	39	Dentistry Professional	37	12
Medical Assistant	108	34	Public Health Worker	36	11
Pharmacist	99	31	Other Type Physician	26	8
Physician Assistant	88	28			

CONCLUSIONS

Respondents performed a variety of roles and activities in many healthcare settings with diverse patient populations who have a range of health needs. In short, social workers are an extremely flexible workforce with a skill mix that can be adapted to patient and administrative needs in all healthcare settings. Findings suggest social worker field instructors and MSW students are learning these flexible integrated care skills on the job and in MSW programs.

In this study, social workers performed activities that supported team-functions such as team-based care, facilitation of team communication, and the regular provision of informal consultation to medical providers. They also assessed patients using standardized measures, and utilized evidence-based interventions such as motivational interviewing and cognitive behavioral therapy. Social workers acted as care managers and contributed to care coordination through use of EHRs. As is central to the social work profession, respondents performed functions in ways that were culturally inclusive and addressed patient social determinants of health. Many of these functions are not directly reimbursable. As social workers continue to conduct interventions in integrated settings, systems must prioritize employing appropriate payment structures and billing codes (like CMS CPT Behavioral Health Care Management codes) that facilitate social work roles. Some skills regularly used by social workers in integrated settings, like addressing patient social determinants of health, provide value that is intrinsic and is therefore hard to measure. This type of indirect

value renders the return on investment of the work of social workers integrated settings, difficult to define. Further evidence is needed to better quantify social work's value in integrated healthcare.

The flexibility and variability of roles filled by social workers on integrated care teams is a strength of the profession but may also contribute to role confusion by other professionals who do not understand the full scope of social work practice.[6][7] Many studies have identified success of integration to be dependent on team understanding of roles and functions of each member. This finding highlights the importance of interprofessional education to acculturate future providers to the functions and skills of social work within integrated settings. It suggests that when a social worker is on a team, other providers may not be aware of their full scope of practice, which limits the types of tasks they are likely to do. Current providers may benefit from continued education efforts related to interprofessional team-based care.

A standard level of integration cannot be assumed because a practice reports to be integrated; this study supports related literature asserting that integrated care exists on a continuum.[8] Community-based agencies, which not unexpectedly, are the least integrated, use fewer skills and exhibit less team collaboration than hospital settings. Measures aimed at increasing integration should target community-based settings and focus on strengthening partnerships between health and behavioral health providers. Efforts should also promote administrative structures that facilitate team communication, shared use of EHRs, and billing structures that will support community-based models of integrated care.

Findings from this study support federal funding of programs to train and deploy social workers in integrated settings, as MSW students appear to be learning the necessary skills needed to work in integrated care. However, social workers currently in practice still require retooling and training. This education gap provides an opportunity for MSW educators to develop continuing education curriculums to support and re-tool the current social work workforce.

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[6] Keefe, B., Geron, S. M., & Enguidanos, S. (2009). Integrating social workers into primary care: Physician and nurse perceptions of roles, benefits, and challenges. *Social Work in Health Care*, *48*(6), 579-596.
[7] Netting, F. E., & Williams, F. G. (1996). Case manager-physician collaboration: Implications for professional identity, roles, and relationships. *Health & Social Work*, *21*(3), 216-224.

[8] Heath, B., Wise Romero, P., & Reynolds, K. (2013). A standard framework for levels of integrated healthcare. *Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions*.