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RESEARCH ARTICLE

Social Work Student and Practitioner Roles in Integrated Care Settings

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Introduction: Social workers are increasingly being deployed in integrated medical and behavioral healthcare settings but information about the roles they fill in these settings is not well understood. This study sought to identify the functions that social workers perform in integrated settings and identify where they acquired the necessary skills to perform them.

Methods: Master of social work students (n=21) and their field supervisors (n=21) who were part of a Health Resources and Services Administration–funded program to train and expand the behavioral health workforce in integrated settings were asked how often they engaged in 28 functions, where they learned to perform those functions, and the degree to which their roles overlapped with others on the healthcare team.

Results: The most frequent functions included employing cultural competency, documenting in the electronic health record, addressing patient social determinants of health, and participating in team-based care. Respondents were least likely to engage in case conferences; use Screening, Brief Intervention and Referral to Treatment; use stepped care to determine necessary level of treatment; conduct functional assessments of daily living skills; use behavioral activation; and use problem-solving therapy. A total of 80% of respondents reported that their roles occasionally, often, very often, or always overlapped with others on the healthcare team. Students reported learning the majority of skills (76%) in their Master of Social Work programs. Supervisors attributed the majority (65%) of their skill development to on-the-job training.

Conclusions: Study findings suggest the need to redesign education, regulatory, and payment to better support the deployment of social workers in integrated care settings.

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INTRODUCTION

Individuals with co-occurring physical and behavioral health conditions experience poorer health outcomes, have increased risk of mortality, and incur greater costs to the health system.[1–5] Increasingly, intervention trials are testing models of integrated care in which interprofessional healthcare teams screen and treat behavioral health symptoms for patients with comorbid health issues, such as diabetes and cardiovascular disease.[6] Evidence suggests that simultaneously

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addressing patients' behavioral and physical health needs improves patient health outcomes, reduces hospitalizations, and decreases specialty and outpatient visits.[7–10]

Integrated behavioral and physical healthcare models are of increased interest to employers as the healthcare system shifts from paying for volume to rewarding value. Because of social workers' expertise in assessing and treating behavioral health disorders and addressing the social determinants of health,[11,12] they are increasingly being hired by health systems, hospitals, and in ambulatory care settings. Social workers are working alongside physicians, nurses, pharmacists, and other health professionals to screen and assess patients, provide brief mental health interventions, monitor symptoms and care plans, facilitate communication among members of the healthcare team, and connect patients and families to needed resources in the community.[12,13] A recent systematic review of RCTs of interprofessional teams found that social workers are functioning in three primary roles in integrated primary care settings—acting as behavioral health specialists, care managers, and community engagement specialists.[14]

Although nearly 160,000 healthcare social workers are employed in health care in the U.S.[15] and the workforce is expected to increase by nearly 20% by 2024,[16] social workers have not typically been included in health workforce planning efforts. As Stanhope et al.[12] have noted, "while nursing has played a major role in the research and forecasting of health care workforce needs, social work has largely been absent from the planning table." The lack of recognition by health workforce researchers of social work as a health profession has resulted in a paucity of information about the number, scope, and functions of social workers employed in healthcare settings.

Researchers have called for more studies on how social workers function on interprofessional healthcare teams[17,18] to help educators modify the curriculum and expand clinical placements to better prepare students for practice. Although social workers' educational preparation and scope of practice are well aligned with integrated care models,[19] many social work students exit training with a limited understanding of the healthcare system. Recognizing this need, in 2014 the Health Resources and Services Administration (HRSA) awarded more than $26 million to 62 Master of Social Work (MSW) programs to better prepare students to work in integrated behavioral health and primary care settings. This funding—the behavioral health workforce expansion training grant (BHWET)—is the largest of its kind targeted at social work education.

Studies that better elucidate social workers' roles in the evolving healthcare system will help the profession claim its identity as a health profession.[12] Key to these efforts is the need to disseminate evidence about social workers' roles outside of the social work community. Many of the existing studies on social workers' functions in new models of care are published in social work journals[11,12,18] that are not often read by workforce researchers, policy makers, or other health professionals. In this exploratory study, both MSW students and their supervisors in one BHWET program are surveyed to identify how often social work students and their supervisors performed certain functions in integrated healthcare settings and where they acquired the necessary skills to perform them. A review of the literature did not reveal any previous studies that focused on both practitioners and students to provide both a training and practitioner perspective of social workers' roles in integrated settings. The ultimate goal of this work is to help health workforce researchers and policy makers develop a deeper understanding of social worker activities on integrated care teams and identify the implications of their changing roles for education, regulation, and payment policy.

METHODS

In 2016, an electronic survey was administered to a cohort of 21 MSW students at the University of North Carolina at Chapel Hill who were part of the HRSA-funded BHWET program and their field instructors (n=21). The survey asked about student/supervisor demographics and their roles in the integrated setting (i.e., care manager, care coordinator, or behavioral health specialist). Information about their field placement and work location was also collected, including type of setting (academic health center, hospital or health system, community health center, free clinic, school-based clinic or other setting). The survey examined whether and to what extent respondents performed 28 functions in their integrated setting (Table 1). The functions were chosen and defined based on seminal work done by Horevitz and Manoleas[13] that identified the competencies and educational needs of social workers in integrated settings; findings that emerged from a recent systematic review on social work in integrated primary care (Fraser et al., University of North Carolina at Chapel Hill, unpublished observations, 2017)[14]; HRSA's Core Competencies for Integrated Behavioral Health and Primary Care[20]; and expert clinical input from practicing social workers and nurses.

For each of the 28 functions, students and supervisors were asked how often they engage in the function (*daily*, *2–3 times a week*, *once a week*, *2–3 times a month*, *once a month*, *rarely or never*). The survey also gathered data on the workforce development needs of social workers in integrated settings related to each of the functions by asking where they learned most about performing the function (*I have not learned about this*, *MSW program*, *other graduate program*, *on the job*, *attended training unaffiliated with work or school*, *self-taught*).

The survey was piloted with five social workers and revised to improve clarity and construct validity. Supervisors were offered a $20 gift card and lunch for survey completion. MSW students did not receive incentives because, as part of their stipend for participating in the BHWET program, they were expected to participate in these types of programmatic activities. The survey had a 100% response rate, with 21 MSW students and 21 field instructors responding. Data were exported from Qualtrics, and descriptive analyses including means, SDs, and percentages were

Table 1. Social Worker Activities in Integrated Settings

Activities	Definition
Standardized assessment	A standardized assessment uses validated measures, scales or instruments to evaluate health or behavioral health status (such as the Patient Health Questionnaire for Depression [PHQ-9]; Short Form Health Survey–36 item [SF-36]).
Patient navigation	Patient navigation refers to the assistance offered to patients by guiding them through complex healthcare and community service systems to overcome barriers in accessing quality care and treatment (e.g., insurance issues, scheduling or coordinating appointments).
Contribute to the care plan	Contributing to the care plan refers to providing input to a patient plan of care composed of treatment needs, assessments, goals, and intervention strategies.
Linking with community resources	Linking with community resources includes connecting patients to services to address the social determinants of health; this may include assisting clients in finding housing, food, transportation, or employment. May also include establishing eligibility for social programs.
Patient education	Patient education refers to providing information and training regarding health conditions or health risk behaviors to improve health literacy.
Facilitated communication among team members	May include coordinating discussions or sharing information in a treatment team meeting or through brief consultations.
SBIRT	SBIRT (Screening Brief Intervention Referral and Treatment) is used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
Huddle	The team huddle is an organizational platform for team building, communication, and process improvement. The huddle prepares the treatment team for the day by planning for patients scheduled to receive care.
Case conferences	A case conference bridges the patient and all of her or his social service, behavioral health, and physical health providers.
Electronic health records	Electronic health records are an electronic version of a patient's medical history. Electronic health records consolidate patient information across providers and may be accessed by all members of the interprofessional team.
Functional assessment	A functional assessment is used to assess current level of functioning including both strengths and functional impairments in a patient's activities of daily life (ADLs; e.g., walking, making meals).
Functional assessment of problem behavior	Functional assessment of problem behavior is a process by which the variables influencing problem behavior are identified; awareness of these factors allows the provider to identify an effective treatment for severe problem behavior.
Warm handoff	The warm handoff is an approach in which the medical provider does a face-to-face introduction of a patient to another health provider to which he or she is being referred. The reason behind the "warm handoff" is to establish an initial face-to-face contact between the client and the new health provider and to confer the trust and rapport the client has developed with the medical provider to the new health provider.
Behavioral activation	Behavioral activation is an intervention for depression that focuses on activation of behavioral responses and on processes that inhibit activation, such as escape and avoidance behaviors and ruminative thinking. It is a method that involves identifying activities associated with positive mood, client self-recording of engagement in pleasant activities, and setting weekly, small goals and setting longer-term goals to gradually increase the frequency and duration of pleasant activities.
Motivational interviewing	Motivational interviewing is a treatment that addresses a patient's ambivalence to change and uses conversational techniques designed to help people identify their readiness, willingness, and ability to change and to make use of their own change-talk. Motivational interviewing upholds four principles: expressing empathy, developing discrepancy, rolling with resistance, and support self-efficacy.
Problem-solving therapy (PST)	Problem-solving therapy is a cognitive–behavioral intervention that teaches patients to solve psychosocial problems in a distinct stepwise fashion (problem definition, goal formulation, plan development, implementation, and evaluation). PST is an adaptive problem-solving training to help individuals cope more effectively with stressful problems in living.
Brief cognitive–behavioral therapy	Brief cognitive–behavioral therapy is based on the traditional foundations of cognitive–behavioral therapy (CBT) combining behavioral and cognitive techniques but is modified to be used in as few as 4–8 sessions. In primary care settings, it is sometimes referred to as CBT-PC (cognitive–behavioral therapy in primary care).
Relaxation training	Relaxation training refers to a variety of techniques including teaching diaphragmatic breathing, mindfulness, and visualizations.

(continued on next page)

Table 1. Social Worker Activities in Integrated Settings *(continued)*

Activities	Definition
Team-based care	Team-based care is a method of providing health care by employing a team that includes physicians, nurse practitioners, physician assistants, nurses, oral health providers, midwives, social workers, health educators, and many others to holistically address patient needs for care.
Social determinants of health	The social determinants of health are factors that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature.
Medication management	Medication management is the comprehensive management of medications by the interprofessional treatment team to identify, resolve, and prevent medication-related problems (e.g., reducing risk of adverse events). Social workers may contribute to the patient's plan of medication management by working with the patient or the patient's family to address barriers of medication use as prescribed.
Psychoeducation	Psychoeducation refers to a systematic method of teaching patients and their relatives about a behavioral health disorder and providing strategies to improve coping (e.g., information about the nature of diagnosis; development of communication skills; prevention of symptom relapse).
Informal provider consultation	Informal provider consultation, sometimes called curbside consultation, refers to the practice of brief, impromptu consultation with a patient's medical provider to help inform patient care.
Risk stratification	Risk stratification uses standardized assessments to identify patients who may need an increased level of intervention.
Stepped-care	Stepped care is a system of delivering and monitoring treatments, so that the most effective yet least resource-intensive, treatment is delivered to patients first, only "stepping up" to intensive/specialist services as clinically required.
Care management	Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.
Cultural competence	Cultural and linguistic competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables them to work effectively cross-culturally. Cultural competence includes the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.
Adaption of services to be culturally inclusive	Adaption of services to the language and cultural norms of healthcare patients and their family members.

calculated using Stata, version 14.0. This research was approved by the IRB at the University of North Carolina at Chapel Hill.

RESULTS

The majority of students were female (n=16, 76%) and white (n=18, 86%), with an average age of 31 years (SD=8.67; Table 2). Sample demographics were consistent with the national population of social workers in which 80% of MSW students are female and between the ages of 25 and 34 years.[21] Only 54% of MSW students nationally identified as white compared with 86% in the sample. One third (n=7) of students held a Bachelor of Social Work degree. Most supervisors were female (n=17, 76%); white (n=17, 85%); and on average were aged 46 years (SD=11.22). National statistics of field instructor demographics are unknown.

The largest percentage of students reported that their primary role was working as a behavioral health specialist (57%, n=12) and secondary role was a care manager (43%, n=9; Table 1). Supervisors indicated their primary and secondary roles were best defined as other (43%, n=9 and 57%, n=12, respectively). A total of 80% of respondents reported that their roles occasionally, often, very often, or always overlapped with others on the healthcare team (data not shown).

The majority (67%) of social worker students and supervisors in the study were working in large health systems. Only 7% were in rural communities and 17% were in small towns; the rest practiced in suburban and urban communities (Table 3). Students reported that their caseloads were more often made up of Medicaid or uninsured patients compared with supervisors. A total of 48% of students reported that more than half of patients were on Medicaid and 30% reported that more than half their caseload was insured. Student and supervisor caseloads included patients from diverse backgrounds, with only 29% of the sample indicating that >50% of their caseload was from white, non-Hispanic descent (data not shown).

Of the 28 functions, the six most frequently used skills among supervisors and students were employing cultural competency, engaging in patient electronic health records (EHRs), exploring and responding to patient's social

Table 2. Characteristics of Students and Supervisors

Characteristics	MSW students	Supervisors	Total
n	21	21	42
Age, years, M (SD)	31 (9)	46 (11)	38 (12)
Percent female, *n* (%)	16 (76)	16 (76)	32 (76)
Race/ethnicity, *n* (%)			
White	18 (86)	17 (85)	35 (83)
Black	0 (0)	2 (10)	2 (5)
Native American	1 (5)	0 (0)	1 (2)
Hispanic/Latino	0 (0)	0 (0)	0 (0)
Asian	1 (5)	0 (0)	1 (2)
Other	1 (5)	1 (5)	2 (5)
Missing	0 (0)	1 (5)	1 (2)
Primary role, *n* (%)			
Care manager	3 (14)	5 (24)	8 (19)
Care coordinator	2 (10)	2 (10)	4 (10)
Behavioral health specialist	12 (57)	5 (24)	17 (40)
Other	4 (19)	9 (43)	13 (31)
Secondary role, *n* (%)			
Care manager	9 (43)	6 (29)	15 (36)
Care coordinator	3 (14)	2 (10)	5 (12)
Behavioral health specialist	4 (19)	1 (5)	5 (12)
Other	5 (24)	12 (57)	17 (40)

MSW, Master of Social Work.

determinants of health, participating in team-based care, providing patient education, and facilitating communication among team members (Table 4). Supervisors were more likely than students to engage in all functions, except students were more likely to report acting as care managers and be involved in team-based care.

Respondents were least likely to engage in case conferences; use Screening, Brief Intervention and Referral to Treatment (SBIRT); use stepped care to determine necessary level of treatment; conduct functional assessments of daily living skills; use behavioral activation; and use problem-solving therapy. The largest differences

Table 3. Characteristics of Settings and Patients

Characteristics	MSW students, *n* (%)	Supervisors, *n* (%)	Total, *n* (%)
n	21	21	42
Setting type			
Health system	16 (76)	15 (71)	31 (74)
Community health clinic	5 (24)	6 (29)	11 (26)
Rurality			
Rural (<2,500 residents)	1 (5)	2 (10)	3 (7)
Small town (2,500–10,000 residents)	4 (19)	3 (14)	7 (17)
Suburban (>10,000–50,000 residents)	3 (14)	8 (38)	11 (26)
Urban (>50,000 residents)	13 (62)	8 (38)	21 (50)
Patient insurance			
Medicaid			
>50% of caseload	10 (48)	7 (39)	17 (40)
Missing	0 (0)	3 (14)	3 (7)
No insurance			
>50% of caseload	6 (30)	4 (21)	10 (12)
Missing	1 (5)	2 (10)	3 (7)

MSW, Master of Social Work.

Table 4. Functions Performed Most and Least Frequently by Social Workers in Integrated Primary Care Settings

Most versus least frequently performed functions	Students who performed function daily, % (n=21)	Supervisors who performed function daily, % (n=21)	Percent difference (supervisors − students), %	All respondents, % (n=42)
Most frequent functions of social workers				
Employing cultural competency	90	100	10	95
Engaging[a] in patient EHR	86	95	10	90
Social determinants of health	86	90	5	88
Team-based care	90	86	−5	88
Patient education	76	90	14	83
Facilitating communication on team	67	86	19	76
Provide informal consultations	67	86	19	76
Care managers	76	71	−5	74
Least frequent functions of social workers				
Engage in case conferences	0	10	10	5
SBIRT	19	19	0	19
Stepped care	10	43	33	26
Functional assessments of daily living skills	29	38	10	33
Behavioral activation	33	43	10	38
Problem-solving therapy	29	57	29	43
Medications management	33	67	33	50
Risk stratification	52	81	29	67

[a]The term "Engaging in patient EHR" is used to capture a range of functions, including entering notes into the EHR; extracting information for panel management, care management, and risk stratification; and using the EHR as a means to communicate about the patient with other healthcare professionals on the team.
EHR, electronic health record; SBIRT, Screening Brief Intervention Referral and Treatment.

between student and supervisor roles were that supervisors were much more likely than students to provide stepped care (10% vs 43%, respectively); medication management (33% vs 67%); use risk stratification to determine level of care (52% vs 81%); and engage in problem-solving therapy (29% vs 57%).

Respondents were most likely to work on healthcare teams with registered nurses, nurse practitioners, other social workers, and primary care physicians (data not shown). Other frequent collaborators were physician assistants, medical assistants, psychiatrists, and nutritionists. Social workers were least likely to work with public health workers, occupational therapists, and health educators. No one in the sample reported working with oral health providers.

More than 60% of respondents had been trained to do all 28 functions included in the survey (data not shown). Students reported learning 76% of the surveyed skills in their MSW programs, 12% on the job, and the remaining 12% were learned via other avenues. Supervisors attributed the majority (65%) of their skill development to on-the-job training. Every respondent had been trained to employ cultural competency, engage with patient EHRs, address patient social determinants of health, provide team-based care, provide patient education, facilitate communication among team members, and perform care management responsibilities. Respondents were least likely to have been trained in stepped care (40% had not learned this skill); problem-solving therapy (26% had not learned this skill); and behavioral activation (19% had not learned this skill). All the students had learned how to conduct SBIRT, whereas 33% of supervisors had not; this was the largest discrepancy between students and supervisors.

DISCUSSION

Skills used most often (employing cultural competency, team-based care, utilizing the patient EHRs, social determinants of health, patient education, facilitating communication on the team) were consistent with the skills Stanhope and colleagues[12] identified as needed in integrated behavioral health settings. Surprisingly, some of the least used skills (SBIRT, behavioral activation, and

problem-based therapy) are evidence-based, brief mental health interventions that social workers should be deploying when working with patients with high psychosocial stressors and complex needs. This latter finding suggests social workers may not be working to the top of their education because they are not regularly employing evidence-based interventions in which they have training. Findings also suggest a potential mismatch between roles and functions as almost 60% of students reported behavioral health specialist as their primary role (Table 1), but most reported infrequently providing behavioral health interventions (Table 4). One of the biggest differences in training between students and field instructors was around SBIRT, an evidence-based practice used to identify, reduce, and prevent substance use disorders. All the students in the sample had learned how to conduct SBIRT, whereas 33% of supervisors had not. This likely reflects a generational difference as only recently did the National Academy of Medicine recommend this type of screening for behavioral health risks.[22]

Study findings suggest that social workers fill a variety of functions on interprofessional teams and that role overlap exists, with 80% of respondents reporting regular overlaps. The profession's ability to dynamically adapt their roles to meet the needs of different patient populations, employment settings, and interprofessional teams is important in a rapidly changing system, but this flexibility may contribute to role confusion. Other studies have documented how physicians and nurses do not fully understand the roles of social workers[18,23,24] and found that the lack of clarity about roles can lead to fragmentation in patient care.[25] Previous work on the changing roles of health professionals in rapidly transforming primary care practices suggests that each discipline must understand the roles, functions, and training of the others to efficiently and effectively delegate tasks among team members.[26] Role ambiguity will likely remain a challenge for social workers in the future as Ricketts and Fraher[27] note: "roles continuously shift in response to internal and external forces, including patient expectations; policy and payment changes; organizational factors; geographic proximity of other providers; and professional regulation, training, and attitudes." Together, these forces will continue to reshape social workers' roles and require closer collaborations between employers and educators so that academic institutions can modify the curriculum to respond to the needs of the rapidly changing healthcare system.[27] Educators and employers will also need to collaborate to provide more interprofessional training and practice opportunities for social workers and other care providers on integrated care teams.

Surveying both students and actively practicing social workers was critical to identify what changes are needed to the curriculum for students in training as well as the continuing education opportunities needed for the workforce already in practice. Although it is tempting to focus efforts on simply redesigning the curriculum for social work students in the workforce pipeline, it is social workers actively practicing in integrated settings who need to gain new skills and competencies to optimally function in integrated behavioral health settings.

Most respondents were employed by health systems, but 24% of students and 29% of supervisors were employed in community health clinics. As health care shifts from inpatient to outpatient and community settings, the workforce will also shift.[28] Although there is an evolving literature on the roles of social workers in hospital settings,[29–31] more studies are needed to investigate social worker roles in outpatient settings. Educators will also need to identify community-based practices where social work students can be placed to acquire the skills needed in ambulatory settings outside of academic health centers.

Social work scopes of practice vary between states, and there is considerable heterogeneity in the practice and supervision hour requirements for licensure.[32] In general, state licensure boards have been slow to respond to the workforce needs of the rapidly changing healthcare system.[33] State social work practice acts tend to focus on the provision of psychotherapy as opposed to the emerging roles that social workers are filling in health care. In their roles as behavioral health specialists, social workers are less likely to provide psychotherapy, which is currently required for licensure. States' narrow definitions of what qualifies as clinical experience may not help students earn hours toward licensure. Without licensure, social workers are less likely to be hired by health systems and may not be able to bill for their services because many insurers require a clinical license (i.e., Licensed Clinical Social Worker) for reimbursement.

Studies, such as this one, are important to help public and private payers develop a better understanding of the roles and functions that social workers play on integrated care teams. Many of the activities that social workers indicated they were most likely to engage in daily are not reimbursable interventions. In the future, lack of reimbursement for social work functions may be partially resolved as the system moves from fee-for-service to value-based payments. However, even in such a system, policy makers and payers will require a clearer understanding of the business case for paying for social worker services.

Limitations

The study has a number of important limitations. The small sample size and use of convenience sampling limits generalizability of results. The study was conducted in a

single setting in one state and there is considerable variation in social work scope of practice between states.[34] The study relies on self-reported data that may be influenced by recency and response biases. Although all social worker respondents were deployed in integrated care settings, the level of integration was not objectively measured. Findings report on functions surveyed; social workers may have been engaged in other roles that were not measured.

CONCLUSIONS

This exploratory study sought to identify the roles and functions of social workers on integrated care teams and the educational, regulatory, and payment changes needed to better support their deployment in new models of care. Future research needs to go beyond describing social work functions to identify their unique contributions to patient outcomes and the return on investment for including social workers on care teams. As with nursing, quantifying social workers' contributions to patient outcomes is difficult because many social work interventions are not systematically collected in EHRs. An important area of future research is to determine the degree to which EHRs could be used to extract information about the characteristics of social work practice, including frequency, procedures, practice settings, and encounter types for patients with different demographics and conditions. This information is needed to help the profession, health workforce researchers, and policy makers identify how to better support social workers' emerging roles in the rapidly changing healthcare system.

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