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Infusing Integrated Behavioral Health in an MSW Program: Curricula, Field, and Interprofessional Educational Activities

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ABSTRACT

An essential aspect of integrated care is the coordination of medical and behavioral health needs concurrently. This has sparked renewed emphasis on interprofessional (IP) education and practice. The impetus for IP efforts was crystalized in large part because of health care reforms, and federal funding to expand the behavioral health work force. Using an ecological systems perspective, this article describes how one school is preparing a new generation of MSW students to work in integrated behavioral health care using a three-pronged approach involving curricula, field education, and IP activities. Social work education must ensure that new and experienced professionals can (a) understand the profession's role in IP health care settings, and (b) navigate an evolving and complex health care environment.

ARTICLE HISTORY

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The Patient Protection and Affordable Care Act (PPACA) brought a focus on prevention and curbing exorbitant health care costs that has led to renewed emphasis on integrated care (Council on Social Work Education [CSWE], 2014; Heath, Wise Romero, & Reynolds, 2013; Hoge et al., 2014). However, the term *integrated care* has been used in various ways to refer to various approaches, thus necessitating a standardized definition. To provide a working definition of the term, the World Health Organization (2008, p. 1) defines integrated care as “the 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.” An essential aspect of integrated care is the coordination of services to address medical and behavioral health needs concurrently (Hoge et al., 2014). This approach requires providers to collaborate to coordinate the assessment, treatment, and follow-up of consumers' needs, which has sparked renewed emphasis on interprofessional (IP) education and practice (CSWE, 2014; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

The impetus for IP efforts involving social work has been bolstered in part to the Patient Protection and Affordable Care Act (also known as the ACA) (2010) and other reforms in health care (Fraher & Ricketts, 2016) to achieve the triple aim of healthcare—improved care, reduced costs and improved population health (Brandt, Lutfiyya, King, & Chioreso, 2014). Federal funding from the Health Resources and Services Administration (HRSA) to expand and train the behavioral health workforce (U.S. Department of Health and Human Services [DHHS], 2014a) has also been a catalyst for promoting the role of social work in integrated care settings. In 2014 HRSA awarded more than \$26 million to 62 social work programs around the country to prepare MSW students to work in integrated health care settings (CSWE, 2014). An additional \$54 million was awarded to community health centers and earmarked for hiring mental health professionals (DHHS, 2014a). These funding streams reflect important policy changes under the PPACA that promote a move away from the fragmentation and separation of physical and mental health care toward a model of health care that provides coordinated, prevention-focused, integrated physical and behavioral health care (Manderscheid & Kathol, 2014). This paradigm shift has significant implications for the way social work is practiced and taught, particularly given that the PPACA is relatively new and remains

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an evolving “work in progress” (Gorin, 2011, p. 83). Based on the 2016 election results, the fate of the PPACA and related health provisions remains unknown.

Expansion of the social work workforce—A macro overview

Since the passage of the PPACA in 2010, more than 20 million Americans have become insured and now have access to health care (Andrews & Brown, 2015; DHHS, 2014b; Wachino, Artiga, & Rudowitz, 2014). Many of the newly insured have complex needs that include acute and chronic medical problems as well as behavioral health disorders. Currently, more than 25% of the U.S. population reports having multiple chronic health conditions (Falci, Shi, & Greenlee, 2016; DHHS, 2016). This sector of the population also has high rates of behavioral health issues that can contribute to worsening outcomes and higher costs if these physical and behavioral problems are not addressed concurrently (Manderscheid & Kathol, 2014). The prevalence of multiple chronic health conditions not only affects population health outcomes generally but also exacerbates health disparities for already marginalized groups (Adrian et al., 2014; Alegria, Vallas, & Pumariega, 2010; National Institute of Mental Health, 2011). To address this problem, the PPACA offers incentives to encourage the development of integrated systems of care that are designed to improve access to services, enhance quality of care, and by doing so, lower costs (Andrews & Brown, 2015).

One strategy used in the integrated health care approach is the patient medical home model, which encompasses a model of care delivery and a philosophy of integrated care characterized as patient centered, comprehensive, team based, coordinated, accessible, and focused on quality and safety (Agency for Healthcare Research and Quality, n.d.). Moreover, the medical home model is designed to coordinate care through the primary care provider as a way of ensuring that patients receive the level of care they need when and where needed. Thus, implementing the patient medical home model in integrated care necessitates that provider’s work in IP teams, many of which include social workers. Indeed, the Department of Labor has projected that by 2022, the demands of integrated health care will need a workforce bolstered by an additional 39,200 health care social workers and 26,000 mental health and substance abuse social workers (Bureau of Labor Statistics, 2014). Social workers serve critical roles on IP health teams because social work’s systems and biopsychosocial perspectives makes these professionals especially well prepared to recognize the impact of social and environmental factors (e.g., income, education, and employment) on health outcomes. Historically, social work has focused on vulnerable populations and sought to remedy health disparities. However, today’s changing landscape of health and mental health delivery systems requires social workers to use a prevention-focused approach to develop increased competency in working in medical teams (Horevitz & Manoleas, 2013; Zerden, Jones, Lanier, & Fraser, 2016). Given this evolution of care and systems, the social work profession must ensure that students and practitioners are competent in using evidence-informed practices that involve IP teams in fast-paced medical settings (Brandt et al., 2014).

Because physical and mental health are influenced by a largely common set of risk and protective factors, good quality health care requires a holistic approach that considers the social and physical determinants of health (Adrian et al., 2014). Social workers are particularly well equipped to use a systems perspective to understand the social context affecting health and health behaviors. Understanding these social factors provides social workers with insight into helping patients modify their health behaviors to improve personal health as well as to achieve population health goals (Zerden et al., 2016).

This article describes how one school of social work, as part of a public university in the southeastern United States and the state’s flagship university, is preparing a new generation of MSW students to work in integrated behavioral health care settings. This school is using a three-pronged approach that involves curricula, field education, and IP activities. As workforce demands increase to promote the role of social work in integrated behavioral health settings, schools of social work must meet the imperative to ensure that new and experienced professionals can (a) understand the social work role in IP health care settings (Brandt et al., 2014) and (b) navigate an evolving and complex integrated health care environment (Fraher & Ricketts, 2016).

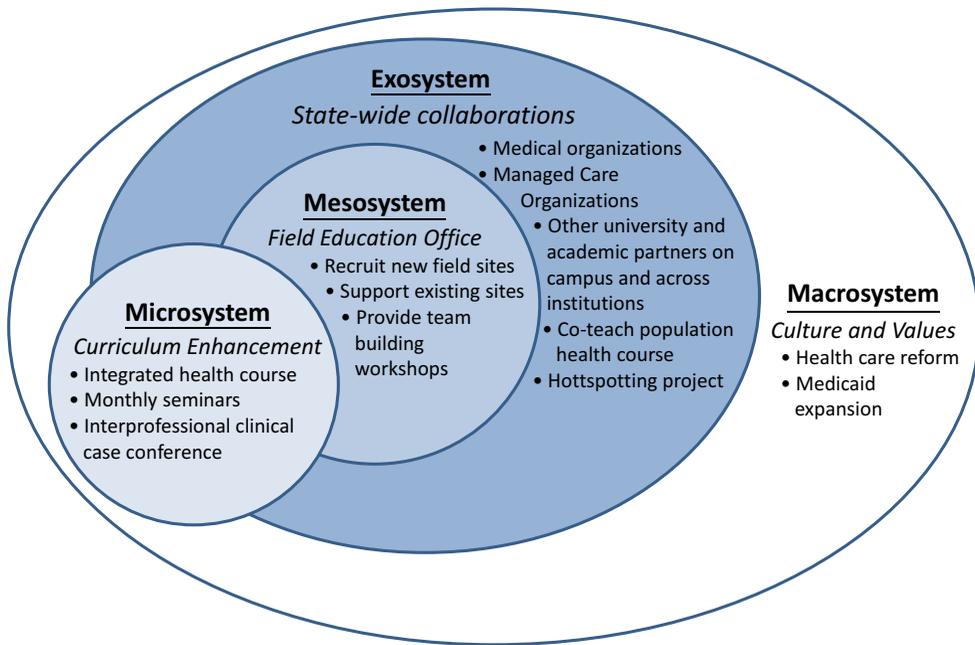


Figure 1. Levels of integrated behavioral health care in an MSW curriculum.

Conceptual framework for preparing students to work in integrated care

The UNC-PrimeCare Program is informed by the multisystems perspective of ecological theory (Bronfenbrenner, 1986) and by social learning theory (Bandura, 1977), frameworks seminal to social work practice in general and how social workers understand individuals, groups, and systems. Ecological systems theory suggests that individuals are shaped by the strong influences of their surrounding social environment and that an ongoing, interactive relationship exists between individuals and the systems they live with (Siporin, 1980). This perspective—that human behavior is the product of the interplay between individual and context, or the person in environment—forms the basis of the social work profession. Similarly, social learning theory conceptualizes learning as an interactive reciprocal process that involves behavior, cognitions, and the environment. Additionally, learning theory states that intentional learning requires attention, motivation, modeling, and replication (Bandura, 1977). Together, these theories suggest that a comprehensive program in which students are expected to acquire a range of knowledge and practical skills should include a multisystem and experiential approach.

Drawing from Bronfenbrenner's (1979) model of interlocking systems or *nested structures*, the developers of the UNC-PrimeCare Program considered how best to infuse content on the integrated behavioral health care approach into the existing systems in and surrounding the school's MSW program. The overview of the macrosystem warranting policy and workforce expansion described earlier is a backdrop for the micro-, mezzo-, and exosystems described in detail next. In addition, we discuss the ways these systems were able to adapt to this new program, including the challenges and opportunities that arose (see Figure 1).

The microsystem refers to an individual's most immediate system of people and places; for the UNC-PrimeCare Program, the microsystems level included the people and places involving the school of social work or the UNC-PrimeCare Program, the students' courses, and their peer group. At this systems level, the primary focus of the UNC-PrimeCare Program was three pronged, that is, (a) curriculum enhancement through creating a new course on integrated behavioral health care, (b) developing a series of monthly seminars based on the integrated care competencies as set by SAMHSA-HRSA (Hoge et al., 2014), and (c) codeveloping an IP course on population health in the school of nursing.

The next level of the mesosystem, as defined by Bronfenbrenner (1979), consists of the relationship and interactions between two microsystems. In general, the stronger the relationship, the more an individual will feel supported. With the UNC-PrimeCare Program, the Field Education Office serves as a bridge between the academic microsystem (i.e., courses and supplemental seminars) and the experiential learning microsystem (i.e., student field placements). Furthermore, the Field Education Office has been responsible for identifying and cultivating new field sites in integrated care settings to provide the students with the necessary learning experiences. Fortunately, the school's Field Education Office has faculty dedicated to field education and has developed a strong base of placement sites in health- and medical-related settings. This foundation was a key factor in the Field Education Office's ability to use existing positive relationships in the community to forge new collaborative relationships with health care organizations that were in the process of moving toward integrated care.

Whereas in microsystems and mesosystems individuals directly interact with others, exosystems and macrosystems comprise setting, situations, and larger systems in which an individual does not play a direct role but nevertheless has an impact on those settings or situations. Exosystems in the UNC-PrimeCare Program include a wide range of IP activities in which the program's two codirectors have been involved across their university and in the wider community. The macrosystem, the culture, ideologies, and values imbedded in a society surround and have an impact on exosystems and are reflected in social forces such as political, economic, and health care systems; laws; and public policies. Although macrosystems are clearly broader than programs, the PPACA (2010) and resulting changes described at the beginning of this article exemplify how the larger culture shapes the development of programs and ultimately individuals.

The UNC-PrimeCare Program's focus on curriculum enhancement was a special challenge given the increasing complexity of social work education. Social work curricula must be responsive to constantly changing national and global environments as well as to the needs of the local community. Additionally, MSW programs must include content and competencies required to meet accreditation standards. Thus, like most other MSW programs, our school made incremental changes to the social work curriculum to add new content related to integrated behavioral health and to infuse IP content throughout relevant courses.

Curriculum enhancement: Microlevel

One of the most substantial changes to the school's curriculum was the development and addition of a new course titled Social Work Practice in Integrated Health Care. This course is open to all students but is a required course for the trainees funded under the HRSA grant. The course is offered in a nontraditional format and can be taken either during the summer session or on three Saturdays in early fall. This unique format was purposely developed to provide trainees with a foundational base before they started their field placements in integrated care settings.

The developers of Social Work Practice in Integrated Health Care worked throughout 2015 to design a course that would provide students with the practical skills and knowledge required to select and deliver evidence-informed interventions when working with a diverse population in a fast-paced primary care primary health care setting. Within this broad spectrum, the course focuses on the following four areas: health promotion, prevention and early intervention of social or emotional challenges, assessment of and intervention with patients who have mild to moderate behavioral health issues, and provision of services to address the social and behavioral challenges that can compromise care and treatment of patients with chronic health problems. The objectives of the course are for students to gain mastery in using a variety of brief screening tools, functional assessments, and interventions; these objectives are accomplished using various pedagogical techniques, including role plays, case studies, and team projects.

A second enhancement of the MSW curriculum was the development of a series of eight monthly seminars for the students in the HRSA behavioral health workforce expansion training program. These seminars were developed to supplement the traditional MSW curriculum by providing enhanced content related to integrated health care. Each seminar topic was linked to at least two of the core SAMHSA-HRSA competencies described in a report by Hoge et al. (2014). Seminar topics covered during the 2015–2016 academic year included use of psychotropic medication with children and adolescents, brief interventions

with parents, the role of culture in shaping health attitudes and behavior, and ethical issues in health informatics. Seminars were conducted by lecturers recruited from other health professional schools in the university or from nearby health care organizations. Depending on the topic, lectures were accompanied by role plays or discussion (see [Table 1](#)).

In addition to these two direct enhancements to the social work curriculum, the school of social work was also involved in codeveloping a foundation course in IP and integrated systems for the school of nursing. The creation of a population health course, Population Health: Interprofessional Management in a Changing Healthcare System, was initiated by a faculty member of the school of nursing who pulled together faculty from medicine, public health, pharmacy, and social work to create and pilot the course in fall 2015. The shared goal of all the schools represented by this diverse group of faculty was to design a course that would provide graduate students in health-related fields with foundational knowledge enabling them to effectively collaborate and coordinate care in population health management. This goal was accomplished through the course design, which mixed online instruction and classroom sessions. The course includes a series of six online modules (see [Table 2](#)), which uses a team approach for activities and assignments. In addition to the online modules, the students convene on campus for five in-person sessions. Although the course was geared toward macro-oriented students, two of the HRSA-funded social work students participated in this course. Overall, 23 IP graduate students enrolled in the course; in preliminary feedback, the course has received outstanding evaluations, with a mean score of 4.7 on a 5-point scale. Although continued course evaluation is needed, preliminary results indicate IP success beyond the social work curricula.

Expansion of field education sites and training of field teams: Mezzolevel

The Field Education Office began recruiting new field placement sites focused on integrated care in anticipation of the HRSA grant funding, and those efforts have continued since the grant award. This expansion of field education sites and the associated training of field teams to supervise MSW students

Table 1. Overview of integrated behavioral health supplemental seminars.

Seminar Topic and Corresponding Integrated Behavioral Health Core Competencies	Seminar Speaker or Facilitator
Roles and Functions of an Interprofessional Team Core Competencies I, II, VIII	Interprofessional panel consisting of social worker, medical doctor, nurse practitioner, home-health administrator, and speech pathologist
Psychotropic Medications for Children and Adolescents Core Competency V	UNC university hospital psychiatric pharmacy resident
High Risk Situations: Screening, Assessment & Evidence-Based Interventions Core Competencies III, V, VIII	MSW or PhD assistant professor at UNC School of Social Work MSW or PhD clinician at large private university hospital
Engaging Parents and Using Brief Parenting Interventions Core Competencies I, IV, V	Licensed clinical social worker from an integrated pediatric clinic
Recognizing and Intervening with Co-occurring Developmental Disabilities and Behavioral Health Issues Core Competencies I, II, III, V, VI	Two MSWs; one of whom has a master's in public administration and is the director of the Family Support Program; both are parents of children with needs and they also spoke as consumers
Innovations and Ethical Issues in the Use of Health Informatics Core Competencies I, IX	PhD professor in school of health sciences and director of UNC University Health Informatics Program
Cultural Competence: The Role of Culture in Shaping Health Attitudes and Beliefs Core Competencies I, III, VI	Registered nurse, PhD, on faculty at UNC-University's School of Nursing and a community practitioner
Ethical Challenges for Social Workers in Behavioral Health Care Settings Core Competencies I, II, III, V, VI,	Led by a licensed clinical social worker from an integrated pediatric clinic

Note. All competencies are based on Hoge et al. (2014). The competencies are I, interpersonal communication; II, Collaboration and Teamwork; III, Screening and Assessment; IV, Care Planning and Care Coordination; V, Intervention; VI, Cultural Competence and Adaptation; VII, Systems-Oriented Practice; VIII, Practice-Based Learning and Quality Improvement; IX, Informatics.

Table 2. Outline of population health: Interprofessional education management in a changing health care system.

Module and Topic Area	Key Content
Module 1: What is Population Health?	Overview of the Patient Protection and Affordable Care Act and the increased focus on population health Patient care delivery models and the need for team-based care Understanding each team members' role in population health
Module 2: Overview of Quality	Overview of dashboards, registries, and metrics The impact of quality on care delivery
Module 3: How to Identify Clinical Problems and Make Change	Community and clinical needs assessment Quality improvement processes Change management processes
Module 4: Care Coordination	Overview of care coordination and high-functioning teams Electronic medical records Health information technology
Module 5: Patient and Community Engagement	The need for patient and community engagement Motivational interviewing techniques Strategies for engagement as an interprofessional team
Module 6: Health Care Costs and Risks	Impact of cost on the health care system Risk assessment scores Using registries and surveys for population health

occurred through various strategies. First, the initial recruitment for field sites began through contacting the existing network of field placement agencies that we understood were in the process of implementing integrated behavioral health in their organizations ($N = 18$). All these agencies provide physical and mental health services in outpatient clinics.

After receiving the HRSA grant, the Field Education Office began reaching out to a broader audience. Specifically, an agency assessment tool and application instrument was developed and sent to a pool of existing field placement agencies that provide services in health care, child mental health, and adult mental health care. The field site application described the UNC-PrimeCare Program, including the benefits and expectations for participation, and asked agency directors to indicate interest. Using the framework outlined in a SAMHSA-HRSA (Heath et al., 2013) report, the agency assessment instrument asked the agency directors to classify their services as being coordinated, colocated, or integrated (see Table 3). We received responses from 15 of the 18 sites whose level of integration ranged from Level 3 (basic collaboration on site) to Level 6 (full collaboration and integration practice). Agency administrators were asked what percentage of their clients were 25 years or younger (the age range targeted by HRSA to mitigate behavioral health conditions before they worsen into adulthood), and of the 15 sites that responded, the average percentage reported was 52%. However, this proved to be a difficult question given that some settings were clearly pediatric in nature. This skewed the responses, which ranged from 10% to 100%. The survey also asked if there was a plan to move toward either integrated services or higher levels of integration in the future, and 100% said yes. Finally, when asked to rate how interested they were in being a field placement site on a scale of 1 to 10 (1 = *least interested*, 10 = *most interested*), the average rating was 9.2, indicating strong collaboration from our field sites.

Directors of all agencies who returned the application were interviewed either in person or by telephone by the assistant dean for field education or the field faculty responsible for health-related placements. Many agencies wanted to be identified as integrated health care sites for our students. For some agencies, the designation was a goal, but the actual implementation of integrated care was not yet in place. Although an agency might be a good field site for a student, we developed the following criteria for agencies to be considered as an integrated care field site for HRSA-funded trainees: The agency had to have a mission of helping patients achieve positive health outcomes by integrating physical and behavioral health care, and a practice of providing health care through IP teams, at least some of the time.

Integrated behavioral health occurs on a spectrum. The results of this survey showed that many directors rated their agencies quite highly in terms of their level of integration and that they wanted to participate in the UNC-PrimeCare training program. Notably, this outreach strategy as well as social media announcements about the HRSA funding resulted in the field office being contacted by a number

Table 3. PrimeCare brief agency assessment.

Please type or print your responses to the following questions. We recognize these questions may not be answered simply and that identifying your agency's level of integration can be complicated. There are no right or wrong answers. We are aware integrated care occurs on a continuum so there is no need to overstate where your agency currently lies on this scale. Based on the chart, would you classify the services you provide at your agency as coordinated, colocated or integrated? Please specify a Level (1–6) based on:
 What percentage of your caseload is serving individuals age 25 or younger and their families?
 What are the e most typical symptoms or issues you see?
 Does your agency currently have a plan or strategy to move toward integration in the future? Please briefly explain:
 Based on a scale of 1 to 10 (1 = *least interested* and 10 = *most interested*), how would you rate your interest in being a PrimeCare site for MSW students?

COORDINATED		COLOCATED		INTEGRATED	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal collaboration	Basic collaboration at a distance	Basic collaboration on Site	Close collaboration on site with some system integration	Close collaboration approaching integrated care	Full collaboration and integrated practice
In separate facilities where:	In separate facilities where:	In same facility, not always same office:	In same facility, similar space or near one another:	In same space within the same facility:	In same space within same facility:
Have separate systems	Have separate systems	Have separate systems	Share some systems (i.e., scheduling or records)	Actively seek system solutions together to develop plans	Have resolved most or all of the system issues, function as one system
Communication is rare and for compelling cases	Communicate sporadically about patients	Communicate regularly about shared patients by phone or email	Communicate in person as needed	Communicate frequently in person	Communicate consistently at all the system, team and individual levels
Communication driven by provider needs	Communication driven by patient issues	Collaboration driven by need for other's services and more reliable referral	Collaboration driven by need for consultation and coordination for difficult patients	Collaboration drive by desire to be a member of team	Collaboration driven by concept of team care
Have limited understanding of other's roles and resources	May meet as part of larger community	Meet occasionally to discuss cases	Have regular face-to-face interactions about some clients	Have regular meetings to discuss overall and specific patient care	Have formal and informal meetings, support integrated model of care
May never meet as part of a team	Appreciate each other's resources	Feel part of larger yet poorly defined team	Have a basic understanding of culture and roles	Have an in-depth understanding of roles and culture	Have roles and cultures blend

Source. Adapted from HRSA (2013): http://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf

of agencies the school had not worked with before. Several of these contacts were from physicians and administrators in health care settings who had never before employed a social worker. They were, however, moving toward an integrated model of care and indicated interest in adding a social worker as a member of their IP teams. These contacts were especially advantageous as they represented large networks of outpatient care clinics and therefore involve potentially many new field placements.

In Year 1 of the PrimeCare project, the school worked with eight separate agencies, all of which had been involved in prior field education partnerships with the school. These agencies included six health care placements and two mental health care placements. The mental health placements were adding physical health care to their behavioral health care services, which is termed *reverse colocation*. In Year 2, our project expanded to 23 placements, and in Year 3 to 39 placements. For example, new agency field placements included county public health departments, Federally Qualified Health Centers, public and privately owned pediatric and family medicine outpatient clinics, substance use treatment centers, and campus health clinics at our university.

Finally, the UNC-PrimeCare Program staff worked closely with the field office to provide two interactive workshops a year (one each semester) for field instructors, members of their team, and

their students. The goal of these workshops is to increase knowledge and skills necessary for work in integrated care among field instructors and to reward them for their time and effort in participating in this program. Topics have included solution-focused therapy in integrated health care, inter-professional practice and education, the role of social work in new models of care, and implicit bias in health care.

Successes and challenges

After working with two cohorts of HRSA-funded students, we note the following successes and challenges with the project thus far. The most significant success has been the extent to which the field office was able to expand the cadre of available health care and mental health care placements for MSW students. The implementation of the integrated health care project occurred parallel to the loss of placements in traditional, hospital-based settings that were making the transition from clinical roles for social workers to case management roles for social workers. This change in the social work role left some field supervisors temporarily uncertain about the social worker's function in the setting and, therefore, were either not interested or were unavailable to work with students interested in traditional medical social work.

Field placements are also related to one of the program's greatest challenges. For some field placements, agencies were implementing a new model of care and becoming a field placement site for the first time. These two parallel goals meant the social work field instructor had the triple responsibility of developing organizational structures to deliver behavioral health care services, providing direct patient care, and teaching their field students the SAMHSA-HRSA core competencies for integrated behavioral health and primary care at the same time that the instructors might have also been familiarizing themselves with this content themselves (Hoge et al., 2014). Although students in these field placements were provided with the opportunity to learn about the implementation of a new service delivery structure, at times students expressed concerns about their clinical skills development. In these circumstances, a consultation approach was used with the agency to ensure that students' learning goals were being met. This approach ranged from meeting with physicians and medical students to teach them the vast array of services that social workers are trained to provide to working individually with field instructors and students. It should be noted that students who appeared to function best in these settings tended to be highly flexible, motivated, mature, and assertive.

IP activity development: Exosystem level

At the exosystem level, a concerted effort was made to develop collaborations with other health care professions across the university and around the state. These activities included planning and teaching an IP course on population health in the school of nursing, developing a IP case conference, and participating in a primary care and hospital-based hotspotting project. Hotspotting is defined as a "data driven process for the timely identification of extreme patterns in a defined region of the healthcare system" (Camden Coalition, 2015). In this context, hotspotting refers to identifying patients who have been inordinately high users of health care resources and who appear to require a more targeted intervention and follow-up to better address the patients' needs and reduce costs.

The hotspotting project was initiated by a physician in the UNC internal medicine department. The project was funded by a health education grant for the purpose of (a) teaching students how to work in IP teams while working with patients who are high users of hospital services (e.g., frequent emergency room visits, repeated hospital admissions), (b) reducing individual and environmental problems that affect a patient's ability to maintain good health, and (c) decreasing cost of care. Three MSW students participated in the project, which has been refunded for another year. Student learners and their faculty mentor came from schools of medicine, nursing, public health, and social work. After patients were identified, students were paired with another learner from a different discipline and were assigned to the case together. The pair then saw the patient and family in the hospital, clinic, or in the patient's home. They

conducted an assessment using a questionnaire and standardized measures and worked together to address the patient's needs, which were psychological or social in nature. Team meetings to discuss cases and share information were held weekly. All three of the first-year MSW students participating in this initiative applied for and will be part of the HRSA funded training program in the 2017–2018 academic year.

Another example of IP activities used to develop and expand collaborations with health care professions across the university and around the state included the implementation of two separate case conferences for graduate students in nutrition, social work, medicine, and rehabilitation sciences. In the first case conference, which took place in the fall over two afternoons, graduate students were placed in IP teams that shared a vignette about an older adult in need of health and social services. Working as a team, the students discussed the case from the perspective of their professional discipline and then collaborated on developing a care plan for the patient. In between the student discussions, which were set up to resemble practice team meetings in a clinical encounter, faculty from the collaborating schools and departments discussed professional roles and the scope of IP practice in didactic lectures.

Similarly, a second IP case conference was conducted in the spring semester focusing on transitional-age youths using standardized patients and providers. Funded through a small grant from the Area North Carolina Area Health Education Centers (AHEC) Program, the project team and the Family Support Resource Program (i.e., an externally funded program in our school) created an interactive video using standardized patients to spur an IP half-day training opportunity for the HRSA-funded students and other graduate students in the allied health professions on campus. This video presents the case of an 18-year-old transitional-age youth with a developmental disability, attention-deficit/hyperactivity disorder, and a history of anxiety. The case depicts the young woman, her mother, and her care team—consisting of a doctor, nurse, dietician, and social worker—interacting in a primary care setting. The video was designed to help the care team work together to address the patient's presenting problem in the context of her co-occurring developmental disability and mental health challenges. The video was recorded in segments, allowing interactive audience participation after viewing each segment.

This experiential IP program enabled participants to identify and discuss the benefits of IP collaboration, to see how concepts such as people-first language and patient-centered care are carried out in practice, and to consider the unique needs of transitional-age youths, which is the core focus of the HRSA-funded behavioral health workforce expansion grant. Moreover, it was important to videotape this case so that the case conference could be replicated in various training opportunities beyond the HRSA-funded project as well as in other practice settings.

Broader systemic efforts to support integrated behavioral health: Macrolevel

Although an overview of changes in health care reforms, reimbursement, and focus on prevention is presented at the beginning of this article, the UNC-PrimeCare project has been involved in some specific macro-related activities to reinforce the impact of this direct training initiative on a broader level. For example, the project personnel and dean of the school of social work set up two meetings with the state's clinical licensure board to discuss how the role and functions of social workers in integrated behavioral health should be able to count their brief clinical interventions as part of their clinical hours toward licensure. Members of the North Carolina chapter of the National Association of Social Workers (NASW-NC) were also present at these meetings to help with advocacy and an expanded definition of clinical social work. Although no changes have been made through legislative policy, conversations and advocacy toward this aim are currently under way.

Another example of our efforts to expand the role of social workers in integrated behavioral health was led by the state NASW chapter to allow licensed clinical social work associates (LCSWA, the state's title for social workers working toward full licensure) to directly enroll in Medicaid. This allowed LCSWAs, many of whom are graduates of our school, to treat clients receiving Medicaid under the signature of a physician or with special permission of billing codes. This important change had implications for how the Centers for Medicare & Medicaid Services recognized the services provided

by associate-level MSWs, many of whom provide behavioral health services in conjunction with physical health care (NASW-NC, 2015). UNC-PrimeCare project personnel were involved with this change by working with NASW-NC and educating HRSA-funded trainees on this new change as they graduated and entered their first jobs. We also made sure to inform the field placement sites and those working toward integration so agency personnel would know about the new billing capability of LCSWAs, which could help with the employability of MSWs before full licensure was achieved.

Lessons learned

Over the past couple of years of providing this new training program in integrated behavioral health care, a number of lessons have been learned along the way. One lesson was that because integrated behavioral health is still in its infancy and can take place in different ways, it may differ substantially across settings and contexts. For example, some of our field sites provided coordinated physical medicine and behavioral health care services. Other had colocated services, and a few had reverse colocated physical medicine services in established behavioral health agencies. Some were close to being fully integrated health care agencies. For this reason, field sites differed widely in the composition of IP teams, how well they functioned, and the role assigned to social workers. Some MSW students had limited opportunities to participate alongside IP teams (e.g., half day or 1 day per week), whereas students placed in other sites were involved in an IP team on all 3 field days. On days when students were not working alongside IP teams, they worked with clients, conducted group meetings, identified resources, attended meetings, and participated in other activities assigned by their field supervisor. All students, regardless of the site, successfully completed field and met the CSWE requirements for field education, and were not specifically tested on the integrated core competencies formally.

A second lesson, was that the HRSA-funded UNC-PrimeCare's part-time field education development coordinator, although initially hired to recruit new field sites and provide some MSW supervision when needed, was essential in helping to troubleshoot some of the preceding issues. This position was filled by a licensed clinical social worker with extensive clinical experience in an academic medical setting. In addition to providing supervision to students working in agencies without an MSW (which made it possible to add many more field sites), the coordinator also worked with students and providers to educate them about the role of social workers on integrated care teams. The field education coordinator also served as a consultant to agencies that needed guidance and support in designing an integrated care training model for the MSW students. Thus this role was especially important given the high number of first-time placement sites participating in the UNC-PrimeCare project. Overall, this field coordinator position substantially increased the program's ability to recruit, engage, and sustain partnerships with busy primary care settings.

A third lesson was that even though students had varying experiences as trainees, and some encountered many systemic and interpersonal challenges inherent in settings where there is organizational change (e.g. moving to an integrated care model), they nevertheless appeared to recognize and appreciate their role as seed planters. That is, they realized that even though they were perhaps doing more care management, they were part of an important and historic change in health care delivery, an analogue Fraher and Ricketts (2016) refer to as "the road map being redrawn as we drive" (p. 94). Other students, whom we considered more as germinators, were in placements that were further along the integrated health care spectrum, were able to participate more fully in IP teams, and were relied on to provide brief assessment and treatment as well as care coordination. Whether seed planter or germinator, both groups of trainees are on their way to expanding their skills and expertise as integrated care providers and contributing to the local and national movement.

Another lesson or realization is that in many ways, these HRSA-funded MSW students are prepared for practice in an integrated behavioral health care environment, but this environment or practice does not yet fully exist. In this respect, some students may be better trained in integrated care than their supervisors and IP team members who have been practicing under other models and have not had the same exposure to formal integrated behavioral health care education. This cart-before-the-horse

phenomenon came up as a common theme from students and field instructors. Although our expanded curricula infused integrated behavioral health theory and practice content into MSW course work, practitioners did not always have this same level of concentrated training. Given this reality, it may be helpful to include content in the integrated care enhanced curriculum on ways that social workers can help to educate members of IP teams on issues such as implementation of integrated care and how it can contribute to cost savings, cultural competency and humility, and motivational interviewing.

This will clearly require excellent communication, leadership capabilities, and holistic MSWs who understand how micro-, mezzo-, exo-, and macrosystems intersect and affect practice in integrated settings. This also demonstrates the need for skills in measuring outcomes for social workers and IP practice specifically.

Finally, a most important lesson involved the myriad logistical constraints associated with IP education. Although in theory, when taught consistently, IP education can challenge students to problem solve collaboratively, impart attitudinal changes, and reduce stereotypes among health professionals (Reeves et al., 2013); however, scheduling these opportunities were far more complex than anticipated. This is largely because each professional school in our university has very different course and internship rotational schedules. Thus finding common times for students to meet in teams for initiatives like the population health IP course and the hotspotting project was very challenging. Hiring an IPE coordinator at the university may help as well as increasing acceptance from deans across health professional schools. Also, given how an academic workload is calculated at most universities, graduate school directors will also have to grapple with how to value and support IP efforts for faculty involved in these kinds of initiatives.

For social work educators, it is promising that the CSWE (2016) was accepted as an institutional member of the Interprofessional Education Collaborative, which was established in 2009 by six organizations committed to advancing IP learning experiences and promoting team-based care. These organizations represent higher education in allopathic and osteopathic medicine, dentistry, nursing, pharmacy, and public health. With the CSWE as a new member, the role of social work on IP teams should become that much more prominent.

Conclusion

As these IP examples demonstrate, social work education is paramount in the participation and contribution of the future training of health care professionals in the changing and evolving context of health care. Meaningful health care reform requires transformation of the current health care delivery system and demands a workforce that is educated, prepared, and skilled to respond to the needs of new systems and their patients (Fraher & Ricketts, 2016). Social workers are well positioned to take leading roles in advancing these reforms and helping to transform systems of care; however, other health professionals are not always aware of the depth and breadth of the contributions that social workers can bring to IP teams. Therefore, those in social work education and in research need to demonstrate the effectiveness of social work services on population health outcomes and to inform policy on the role and benefits of social workers in these settings. This moment in the evolution of health care represents a critical time for social work to take a leadership role in creating and developing solutions to improve health care delivery. By infusing integrated behavioral health in MSW education, curricula, and the field, with and among other health professions, we're one step closer to keeping pace with a rapidly evolving health care system.

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