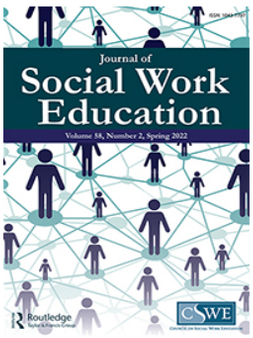

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Research Note—Integrated Care Training and Preparedness: Evidence From 5-Years of Postgraduation Data

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ABSTRACT

Social work has seen significant federal investment through the Behavioral Health Workforce Education and Training (BHWET) for Professionals grants. This research note examined differences between BHWET trainees and general MSW graduates regarding self-reported knowledge of integrated behavioral health competencies, job placement, and starting salaries. A survey was administered 10 months after graduation (N=288) for five graduating classes (2014-2018). Bivariate two-tailed t-tests and Fisher's exact tests examined group differences. BHWET participants rated interprofessional abilities and integrated care skills significantly higher; were significantly more likely to secure employment quicker; work on interprofessional teams; and earn higher salaries, compared to counterparts. Demonstrating the effectiveness of workforce initiatives is necessary to document best practices and continue federal investment in the social work workforce.

ARTICLE HISTORY
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Changes in healthcare policy and service delivery have driven the expansion of integrated health services (Butler et al., 2008; Druss & Mauer, 2010). This expansion is replacing fragmented healthcare delivery with integrated care models that rely on interprofessional health teams to meet patients' needs holistically (Croft & Parish, 2013; Crowley & Kirschner, 2015). As such, integrated care involves the coordinated treatment of physical health concerns, behavioral health issues (including substance use and mental health), and psychosocial needs (Peek & National Integration Academy Council, 2013). Integrated care requires a trained workforce who understand key components of integration, such as the importance of team communication, shared informatics, and knowledge of the complementing roles of a team of providers (Heath et al., 2013). Educating and training behavioral healthcare providers is paramount to advancing integrated models of care and broadly transforming the current health systems (Kepley & Streeter, 2018).

To this end, the Health Resources and Service Administration (HRSA) and Substance Use Mental Health Services Administration (SAMHSA) have invested in the Behavioral Health Workforce Education and Training (BHWET) program "to help those in need of high-quality behavioral health care by supporting the training of new behavioral health providers" (Kepley & Streeter, 2018, p. 190). To scale up the behavioral health workforce and invest in social work practitioners working in integrated care, in 2014 HRSA awarded BHWET grants to 62 MSW programs (HRSA, 2018). In 2017, HRSA reaffirmed this commitment to developing an integrated care workforce, awarding BHWET grants to 58 MSW programs (Council on Social Work Education [CSWE], 2017).

Recent literature has articulated the role of social work in integrated settings (Stanhope et al., 2015) and described how social work competencies align with integrated care delivery (Horevitz & Manoleas, 2013). Further, emerging evidence supports models of integrated care that include the roles of social workers (Fraser et al., 2018) and demonstrated cost-effectiveness of including social workers on integrated teams (Steketee et al., 2017). Encouragingly, due to changing healthcare policies

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and funding initiatives toward behavioral health workforce development like the BHWET mechanism, social work education has increasingly incorporated new skills and content necessary to train graduates for integrated care settings and interprofessional practice (Mancini et al., 2019; Rishel & Hartnett, 2015, 2017; Rubin et al., 2018; Zerden et al., 2017, 2021).

Integrated behavioral health training overview

This article discusses one integrated care BHWET funding program at one school of social work. A detailed description and some evaluative components of this specific program have been published elsewhere (see Zerden et al., 2017, 2018, 2021). In accordance with the HRSA funding mechanism's purpose, this school's BHWET training was designed to enhance Master of Social Work (MSW) students' knowledge of behavioral healthcare and develop their ability to use assessments, brief evidence-based treatments, and interventions appropriate for integrated settings. Trainees are required to complete field placements in integrated settings as a member of an interprofessional healthcare team treating rural and underserved groups. A required course titled Integrated Behavioral Health Care With Underserved Populations and 15 hours of supplemental seminars reinforce the core competencies of integrated care (Hoge et al., 2014). Evidence-based interventions taught in this coursework include motivational interviewing, screening brief intervention referral to treatment, problem-solving therapy in primary care, behavioral activation, and cognitive behavioral therapy.

Despite this program's tailored integrated care curriculum, little is known about how this specialized education and training grant affected students' job placement and readiness post-MSW graduation. Although many BHWET grantees have described innovative ways to enhance field placements, adapt curricula (e.g., Mancini et al., 2019; Rishel & Hartnett, 2017; Zerden et al., 2017), and assess interprofessional knowledge, values, and skills across student cohorts from three BHWET-funded schools (Acquavita et al., 2020), to our knowledge this is the first article to assess the effect of a BHWET-funded curriculum on the job placement and salaries of MSW trainees postgraduation. This research note presents data from five cohorts of graduating MSW students at one BHWET-funded school to answer two research questions:

(1) Do MSW students who received the integrated BHWET program training report differences in competence and educational preparedness to work as members of integrated, interprofessional teams compared to those MSW students who did not receive the specialized training?
(2) Are there significant differences between the employment and salaries of MSW students who participated in the specialized integrated BHWET program and those MSW students who did not receive the specialized training?

Methods

Data collection and study sample

This study took place at a school of social work at a large, research-intensive public institution as classified by the Carnegie Classification of Institutions of Higher Education (n.d.). The institution is located in the Southeastern United States and has sustained a BHWET program for the past 6 years. The human subjects' protocol was deemed exempt after a review by the University of North Carolina at Chapel Hill's Institutional Review Board. A longitudinal and repeated cross-section design was used to collect data from a new cohort of students each year, using the same survey instrument (Sanders & Ward, 2007). Likewise, observational design (Lavrakas, 2008) allowed us to compare outcomes of graduates who received the specialized BHWET program with outcomes of the general direct practice MSW graduates. The sample comprised MSW graduates from five graduating classes between 2013 and 2014 and 2017 and 2018, with data gathered at 10 months postgraduation.

A brief online survey was administered via Qualtrics to graduates using a nonschool-based e-mail address obtained prior to graduation. The original survey invitation and a reminder e-mail were sent to encourage participation. The survey included 17 items and was organized across the following five areas: (a) graduates' demographics, (b) graduates' program concentration (e.g., micro versus macro), (c) population or area of practice since graduation, (d) self-reported preparedness, and (e) competence based on their clinical skill development in the core competencies of integrated care identified by SAMHSA and HRSA (Heath et al., 2013). Participants self-reported to what extent they felt their MSW education prepared them for the ability across the following skill areas based on a 4-point Likert scale: 0 (*much less*), 1 (*less*), 2 (*more*), and 3 (*much more*). The survey took between 10 and 15 minutes to complete, and participants received a $10 incentive.

The overall 5-year response rate was 65% (403 of 618). However, just direct practice (i.e., micro) MSW students were included in the analysis because BHWET only allowed these students to participate in the workforce training program. Therefore, to ensure equivalence between the two groups of students assessed, macro students ($n = 115$) were excluded from all analyses. After removing macro graduates, a total of 288 MSW graduates responded to the survey. Among these, 63 of 99 (64%) graduates specialized in the BHWET integrated behavioral health training program responded to the survey. There were no significant differences in response rates between MSW graduates in the general program and those who participated in the specialized integrated BHWET program.

Data analysis

Data were downloaded and the mean, frequency distribution, and percentages of each variable were calculated. We conducted an independent group two tailed *t*-test to examine differences between the two groups of MSW students (i.e., those who completed the specialized BHWET training compared to those who completed the general MSW program with a focus on direct practice). We used Fisher's exact tests to examine differences between groups for each categorical variable. The statistical significance level was set to ≤.05 for all analyses, which were performed using Stata 16 software (StataCorp, 2019).

Results

Table 1 details the demographic information of the study sample, including the graduates who participated in the specialized integrated BHWET program ($n = 63$) and MSW graduates who did not ($n = 225$). We found no significant differences in age, gender, or race between the two groups. The BHWET training subsample averaged 31 years of age and the majority identified as White (89%) and female (92%). Similarly, the general MSW direct practice graduates (those not in the BHWET program) averaged 31 years of age and the majority identified as White (82%) and female (91%). We surveyed program participants 10 months after graduation and found that 41% of respondents who participated in the BHWET program were working as part of interprofessional teams. Over that same period, 23% of non-BHWET MSW graduates reported that they were working in interprofessional teams ($p < .01$). Additionally, a comparison of the outcome measures of BHWET trainees between the cohorts, there were no statistically significant differences between groups on any outcome measure.

Regarding research question one, we found that graduates who participated in the specialized integrated BHWET program were significantly more likely to rate their competence in integrated care higher than their counterparts (Figure 1). Students who participated in the specialized integrated BHWET program scored themselves significantly higher across five of the behavioral health core competencies defined by HRSA and SAMHSA (Heath et al., 2013): ability to use information technology to support and improve delivered services ($p < .01$); ability to function effectively within the organizational and financial structures of the local system of healthcare ($p < .01$); ability to provide a range of brief, focused prevention, treatment, and recovery services ($p < .05$); ability to create and

Table 1. Demographic characteristics of participants (assessed 10 months postgraduation).

	Total Direct Practice MSW Grads (n = 288)		BHWET-Funded MSW Grads (n = 63)		Non-BHWET MSW Grads (n = 225)	
Characteristic	*n*	%	*n*	%	*n*	%
Gender						
Female	257	90.81	56	91.80	201	90.54
Male	25	8.83	5	8.20	20	9.01
Other gender	1	0.35	0	0	1	0.45
Race and ethnicity						
African American	25	9.80	4	7.02	21	10.61
White	214	83.92	51	89.47	163	82.32
Latinx	9	3.53	1	1.75	8	4.04
Other race(s)	7	2.75	1	1.75	6	3.03
Part of interprofessional team						
Yes	85	29.51	26	41.27*	44	22.68
	Mean	*SD*	Mean	*SD*	Mean	*SD*
Age (years)	31.00	8.45	30.97	8.64	31.01	8.42

*p < .01.
BHWET = Behavioral Health Workforce Education and Training; MSW = Master of Social Work

implement integrated care plans, ensuring access to an array of linked services (p < .01); and ability to function as members of an interprofessional team that includes healthcare providers and consumers (p < .01). Additionally, there were four other competencies in which both groups of graduates did not differ (i.e., ability to assess and continually improve services as an individual provider, ability to provide culturally relevant services to consumer and their family, ability to conduct brief evidence-based screening, and ability to establish rapport and communicate effectively with consumers).

Research question two asked if there were significant differences in the employment and salary outcomes of MSW students who participated in the specialized integrated BHWET program versus students who did not receive this specialized training. Among our sample, we found a statistically

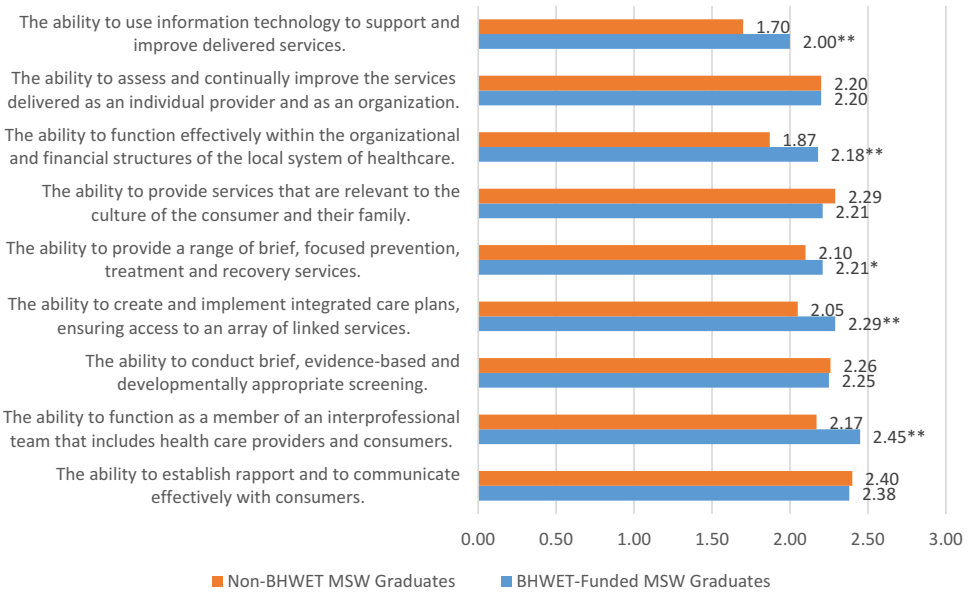

Figure 1. Comparison of Master of Social Work (MSW) competence and educational preparation for Behavioral Health Workforce Education and Training (BHWET)–funded MSW graduates and non-BHWET MSW graduates.
*p < .05, **p < .01.

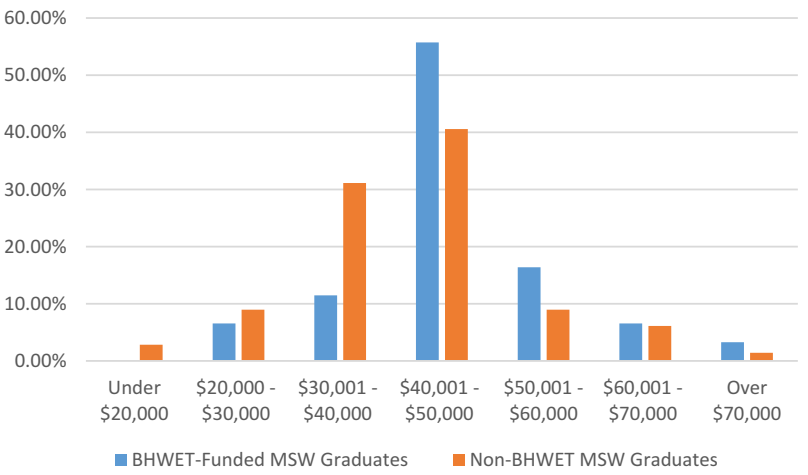

Figure 2. Comparison of current salary for Behavioral Health Workforce Education and Training (BHWET)–funded Master of Social Work (MSW) graduates and non-BHWET MSW graduates.
Fisher's Exact Test, $p = .012$.

significant difference in rates of employment at 10 months postgraduation: just 2% of the BHWET-funded students were unemployed versus 12% of the general MSW sample. We also found differences regarding who was employed in-state: 87% of the BHWET-trained subsample were employed in [North Carolina] compared to 74% of the general MSW sample ($p < .01$). Further, we performed a Fisher's exact test of independence to examine differences between the salaries of the two groups. The relation between these variables was significant: X^2 [1, $N = 273$]=14.7515, $p = .012$. Results showed that the current salaries of graduates who participated in the specialized integrated behavioral health curriculum were on average significantly higher than the salaries of their counterparts who graduated with a general direct practice MSW degree (Figure 2). Salary data that were captured via ordinal responses revealed that 55.8% of students who participated in the specialized integrated BHWET program reported earning $40,001 to $50,000, versus 40.6% of direct practice students who did not participate in the BHWET program. Likewise, 16.4% of the BHWET program students reported an income between $50,001 and $60,000, compared to 8.8% of MSW graduates who did not participate in the BHWET program. While the greatest numbers of students from both groups fell into one of the two salary ranges, Figure 2 shows that, in general, the salaries of BHWET program students skewed higher than those of their counterparts.

Discussion and implications

Social workers currently constitute one of the largest behavioral health workforces in the country (CSWE, 2014; HRSA, 2019) and national estimates suggest that this field will continue to grow (HRSA, 2019). Furthermore, the Bureau of Labor Statistics, U.S. Department of Labor (2020) predicted a 17% increase in social work jobs across the behavioral health sector by 2029. This increase is expected to occur primarily in the health and behavioral health sectors, signaling the urgent need for a workforce who can address behavioral health needs and psychosocial factors affecting health (Bureau of Labor Statistics, U.S. Department of Labor, 2020; Salsberg et al., 2017).

Findings from our study of five graduating MSW cohorts align with the National Academies of Science Engineering and Medicine (NASEM)'s (2019) recent recommendation to prepare and expand the behavioral health and social care workforce. This seminal report suggests integrating social workers—among other social care providers—into the delivery of healthcare is imperative to improving health outcomes and addressing inequities within the U.S. healthcare system (NASEM, 2019).

Achieving this objective requires a workforce appropriately trained to address the complexities of providing care in integrated settings. As such, findings from this study provide a demonstration on how one workforce training program is attempting to prepare future behavioral health providers to function competently as members of integrated, interprofessional teams. The federal investment of HRSA to expand the social work workforce holds promise for meeting the behavioral health demands our society faces (HRSA, 2019; Kepley & Streeter, 2018). Our findings capture how five cohorts of BHWET trainees have met the competencies required for integrated care delivery and the behavioral health demands postgraduation.

To our knowledge, our study provides the first longitudinal data of the HRSA-funded BHWET mechanism's effect on students' professional trajectories postgraduation. Encouragingly, data from this BHWET-funded school of social work suggest that the specialized training program is having its intended outcome. The MSW students who participated in the specialized integrated behavioral health training program at this school of social work were more likely to work on interprofessional teams and exhibited higher levels of integrated care competence, especially in areas including information technology, healthcare financial structures, care plan development and implementation, and serving as a member of an interprofessional team. However, it is important to note that while the BHWET students rated themselves significantly higher across five of the behavioral health core competencies defined by HRSA and SAMHSA (Heath et al., 2013), there were four competencies in which both groups of graduates did not differ. This may suggest the overall MSW curriculum produced high levels of competence in these specific areas irrespective of the BHWET training intervention, yet further assessment of the MSW curriculum is needed to identify overlap and areas of specialization.

In addition to some statistically significant self-reported competency ratings, BHWET trainees were also more likely to remain in the state where the school of social work was located, increasing the state's capacity to meet its residents' behavioral health needs. This outcome is particularly important in [North Carolina], where 84 of the state's 100 counties are designated a geographic or population health professions shortage area for mental health services ([North Carolina] Department of Health and Human Services, 2022).

The study yielded positive findings while also pointing the way for future efforts. Although this BHWET program aimed to prepare students for integrated behavioral health settings, we also found—unexpectedly— statistically significant differences in the postgraduation salaries and employment rates of BHWET-trained graduates versus those who did not participate in this specialized program. More information is needed about graduates' employment settings to identify other factors that may be contributing to these differences. For instance, our findings do not consider licensure or regional differences (e.g., rural versus urban areas; different state policies), which may affect our findings related to salaries and rates of employment. As the 2017 report on the social work workforce identified, MSWs in health settings earn, on average, more than their counterparts. For example, MSWs in individual and family services are estimated to earn average salaries of $45,000 versus $56,000 for those in health-related settings (Salsberg et al., 2017).

Data related to job tasks, functions, and longevity will help determine the long-term outcomes of these HRSA- and BHWET-funded curricula. Likewise, data from postgraduation follow-ups with BHWET-funded students will be needed to demonstrate the long-term outcomes of this funding mechanism, and hopefully help close current behavioral health shortage gaps. Future research could also create additional data points for assessing training effect at additional intervals postgraduation, rather than at just one timepoint.

It is also worth noting that we excluded 115 macro MSW graduates from the original sample. Although this exclusion was necessary to allow for more equivalence across the two surveyed groups of direct practice students, it may also have excluded data pertaining to other types of social work jobs (e.g., health system administration) obtained by MSW graduates. Although findings suggest that the BHWET funding had its intended effect on trainees in this specific program, opportunities for macro participation could further contribute to social work's future involvement and leadership in integrated settings.

Limitations

Our findings from one school of social work show the promise of the BHWET mechanism for growing the future integrated health workforce, but they may not be generalizable to other programs that may have designed their integrated training in different ways. Additionally, this study relied on students' self-report ratings of their integrated care competencies, which were not verified by an employer or supervisor, meaning that our data may have been affected by respondent bias. Finally, given that integrated care occurs on a spectrum from coordinated to full integration, field experiences may vary from site to site.

Conclusion

Given the increased attention to integrated services in healthcare systems' current transformation, the federal investment in the BHWET program, and the projected growth of social work jobs in the health and behavioral health sectors (Bureau of Labor Statistics, U.S. Department of Labor, 2020), integrated health is undoubtedly here to stay. It is paramount to train and involve social workers in building the United States's future integrated care workforce in light of evolving political policies and scientific evidence. As healthcare systems continue to transition to value-based care models, job opportunities will certainly expand for BHWET-trained social work students. The specialized training they receive in team-based care, prevention, screenings, assessments, brief treatments, and referrals will make them invaluable members of any interprofessional team (Coyle, 2019). Practice, education, and research must continue to demonstrate the effectiveness of workforce initiatives to promote the social work profession in growing sectors, such as behavior health. Our finding that the BHWET training grants are producing their intended effect on the behavioral health workforce and integrated care delivery further evinces the promise of this initiative and social work's role within it.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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