

# The Evolving Practice of Social Work within Integrated Care

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William J. Spitzer, PhD/DCSW  
Editor

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*Glossary*

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## Preface

The health care environment is constantly evolving and with it comes perpetual change. Propelled by advances in scientific knowledge, breakthroughs in medical technology and innovations in practice techniques, the environment is also plagued by escalating costs arising from an ever-more sophisticated health care delivery system. The most prominent challenge is to orchestrate a means to engage the knowledge, tools and practices that result in optimized health outcomes while constraining costs and not bankrupting individuals and the nation. The quest for efficiency and effectiveness has taken on unprecedented importance with our recognition that the United States has the most advanced health care services available in the world, but also has a burgeoning percent of the population who cannot avail themselves of these services because they are unaffordable. Inequitable cost-shifting of indigent and other non-reimbursed expenses to those parties who can pay ultimately compounds the problem, posing moral and ethical issues while promulgating hostilities across socioeconomic lines.

In the midst of this already churning, tumultuous environment were research findings that determined the deaths of many individuals with serious and persistent mental illnesses were actually attributable to preventable and treatable chronic physical illnesses. Uncoordinated or absent linkages of otherwise available health and mental health interventions were found to have needlessly jeopardized patients' lives. The increasing efforts to integrate health and mental health care services can be regarded in large part as a reaction to these findings. Widespread barriers to the employment of integrated care, however, persist in nearly all states.

Our fifteen contributing authors examine a broad array of crucial issues associated with delivery of integrated health care and its signature emphasis on interdisciplinary or transdisciplinary patient care. *Little* states the general concept of integrated care as well as the catalysts for its evolution. *Leone* presents integrated care from a community mental health perspective, identifying integrated mental health care models, initial concerns and continuing operations issues that exist between primary health care providers and their mental health counterparts. The extensive work conducted within the US Department of Veterans' Affairs to promulgate an integrated model for patient care is the focus of *Amdur*, *Sheets* and *Lynch*. Given the unique demands of delivering health care in low population and frequently poor rural areas, *Perone* and *Aguiniga* focus on how integrated care can maximize the utilization of already limited resources while placing social workers in particularly utilitarian roles of both facilitating and providing care. They address the use of telehealth and telecare as well as social networking as mediums for increasing service accessibility. At the other end of the continuum, *Shier*, *Rooney* and *Golden* discuss the social-work driven, telephone-based Enhanced Discharge Planning Program of a major Chicago hospital system and its beneficial, integrative role in providing transitional care to patients returning home after inpatient hospital stays. Considering the evolutionary path of integrated care and transdisciplinary service models, *Gilbert*, *Trachtenberg*, *Davidson*, *O'Donnell* and *Perone* examine the implications for social work education and the skill needs requisite for future professional practice in our ever-changing health care environment.

Readers will find this text particularly stimulating as it presents the dilemmas and shortcomings of current practices, outlines new alternative modalities and offers insight into how individual professionals should prepare for the future challenge of patient care service delivery.

William J. Spitzer, PhD/DCSW  
Editor

## EDITOR'S NOTE

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# **The Evolving Practice of Social Work within Integrated Care**

## **OVERALL DESCRIPTION:**

This text identifies issues and techniques of social work practice in health care settings that use or are developing integrated care as an overall approach to patient services. It identifies factors influencing the evolution of this approach, distinguishes the associated nomenclature, highlights the efforts and outcomes of social work personnel in utilizing integrated care and provides recommendations for expanded use of this approach. The implications for social work education and effective practice in integrated care settings are also presented.

## **LEARNING OBJECTIVES:**

Upon completion of this publication, readers will be able to:

1. Describe the catalysts to the evolution of integrated care in the United States, the health care impacts of trans-disciplinary patient care and the issues that must be addressed by social work and other professionals in designing future patient care.
2. Understand the principles and operational components of the “*Patient Aligned Care Team (PACT)*” model of integrated care, including the determinants of its associated high risk acuity system for prioritizing care and the impacts on service delivery.
3. Understand the operational basis of an “*Enhanced Discharge Planning Program (EDDP)*”, the differences of EDDP social work roles versus discharge planners and the benefits derived from this social work-driven, telephone-based model for providing transitional care to patients returning home after inpatient hospital stays.
4. Recognize the dilemmas, challenges and opportunities experienced by social workers and other health care providers as they provide integrated health care services to patient populations in rural communities.
5. Distinguish the factors impacting on development of integrated models for delivering mental health care services along with changes to social work roles, collaboration, documentation, communication and coordination of care in such models.
6. To identify issues associated with educating social workers for future practice within integrated practice settings.

# INTEGRATED CARE: WHERE WE'VE BEEN AND WHERE WE NEED TO GO

*Virna Little, PsyD, LCSW-r, SAP*

## **Introduction**

The concept of integrated care, specifically the integration of health and mental health services has been the focus of much discussion and national attention (*Center for Health Care Strategies, 2009*) rapidly escalating over the past decade. While many have referred to this “movement” as the “rediscovery of the neck” - a seemingly sudden realization that our minds and bodies are connected, it defies logic that we should have to rediscover the need to treat patients in their entirety at all.

While both health and mental health providers on a cognitive level would acknowledge a mind-body connection, providers in both disciplines have essentially developed their practices in “silos.” Most county health and mental health departments seldom collaborate; many states have completely separate offices of health and mental health with completely separate mandates and frequently separate licensing. Organizations providing both health and mental health services often provide them in separate units, floors or even buildings. Training programs for social workers seldom included chronic disease management or health information, and primary care providers receive little to no training on the provision of mental health services or the provision of primary care to individuals with serious mental illnesses (*Cummings, Cummings & Johnston, 1997*). As a result, delivery of health and mental health services transitioned into separate care systems with few opportunities for comprehensive care delivery.

Although healthcare social workers have advocated for team based service delivery, it seldom effectively occurred in healthcare organizations where social work or mental health services were seen as secondary and ancillary services. Providers in different disciplines did not speak the same “language”, measure the same outcomes and seldom reinforced shared goals. Fortunately over the past several years primary care and mental health providers have begun examining these practices, seeking ways in which to transform and transition current practices. For the first time providers in both disciplines are committing to examine practices with the intent of integrating care, a practice both supported by research and inspiring new research. The development of integrated care has and will continue to be the most important factor transforming the delivery of social work services in health care in years. With the formation of patient centered medical homes, clinical homes and behavioral health homes there is continued expansion of the concept of “no wrong door” for consumers of services, meaning that social workers practicing in either medical or mental health settings will soon all be practicing in some version of an integrated model of care. Accountable care organizations and clinical homes are going to shape the service delivery landscape for medical, mental health and even substance abuse providers who will all need to collaborate

in order to meet the requirements to move towards systems that improve access, the patient experience, quality and care outcomes.

## **Catalysts to the Evolution of Integrated Care**

A crucial catalyst encouraging movement toward integrated care was the revelation that patients with severe mental illnesses were dying 25 to 30 years sooner than the general population (*National Association of State Mental Health Program Directors, 2006*). Professionals historically assumed the reasons for premature death rates in this population were either para-suicidal or directly suicidal behaviors. More recently, research findings determined that the deaths of many individuals with serious and persistent mental illnesses were actually attributable to preventable and treatable chronic illnesses such as diabetes and hypertension (*National Association of State Mental Health Program Directors, 2006*). The implication was that the inability of primary care and mental health to collaborate cost lives. Additional research by Gaynes et al (2004) revealed that many patients with completed suicides had actually visited their primary care provider within the month of their death, suggesting we were not doing such a good job of identifying and treating mental illness in primary care settings.

The take-home message to the provider community was two-fold. First, serious attention needed to be directed toward bringing the two worlds of primary and mental health care together. The second message was that further thought was needed regarding where patients sought care. Arising from these two premises was the idea of integrated patient care and the concept of “no wrong door,” meaning that individuals should have both primary and mental health care made available regardless of whether they entered a health or mental health setting. For many years the term “integrated care” was used interchangeably with “co-located,” “multidisciplinary” and “interdisciplinary care.” Provider communities have since realized considerable differences between the terms and have continued to develop the premise of integrated care into comprehensive team based models of care that can and do occur in a myriad of health and mental health settings.

At an earlier point, consideration had been given to research and models supporting the provision of comprehensive care. One such model, one of the first in integrated care, is Project IMPACT. Project IMPACT was the first time that model was introduced into a primary care setting to identify and treat a mental health disorder. Using a randomized control trial that included over 1800 patients and 400 primary care providers from across the country, Project IMPACT was the first to introduce a proven model of integrated care (*Unutzer et al, 2002*). While the study focused on the identification and treatment of depression in seniors in a primary care setting, it was the first time that team-based care was introduced. The study was instrumental in promoting collaborative care, especially in primary care settings. Equally important, it introduced the use of the phq9 depression tool, an internationally known tool to help identify depression and track depression outcomes (*Spitzer, Kroenke & Williams, 1999*) in community settings. Utilization of such tools created a forum where, for the first time, professionals from varied disciplines could speak the same

language. This ability to share the same language facilitated shared goals and decision making, thereby changing the face of service delivery and building the foundation of integrated care. While the IMPACT project introduced a model for collaborative care, collaborative care is more often viewed as a concept than a model for promoting integrated models team-based care. Gilbody et al (2006) notes consistent, solid research continues to drive the concept of collaborative care.

As a result of research on collaborative care and initiation of Project IMPACT, increased attention became focused on development of co-located services. Healthcare organizations increasingly sought to partner with community mental health organizations in an effort to provide mental services in their centers. It rapidly became apparent that simply mingling various disciplines together in one location did not necessarily promote collaboration or improved client outcomes. Not infrequently a health organization would have a psychiatrist come into their practices one day a week and see patients, but there was limited case discussion with the primary care providers and it often was unclear as to how or why patients were selected to see a psychiatrist. New means were needed to foster communication and collaborative, team-based care among co-located service providers.

Organizations began to focus on the development of interdisciplinary or multidisciplinary teams creating expanded opportunities for different disciplines to work side by side. Discussion initially focused on how to share information and the importance of having varied disciplines in the same physical space. Health and mental health records began to be shared, discounting earlier notions that mental health records could not be revealed to other professionals. As organizations began to review their physical space in an effort to bring the various disciplines together, primary care providers learned how to periodically see patients *without* an exam table while mental health providers learned it was “okay” to provide care in a room *with* an exam table. Progression down the integration road and interdisciplinary team development did not, however, necessarily mean that individual professionals on care teams ended their “silo” practices. Often they continued to practice as they always had, frequently inhibiting both team functioning and patient outcomes. Social workers in primary care settings continued to see patients for ongoing sessions for extended periods of time. This left little time for team collaboration and limited their accessibility to team members for new patient referrals. Primary care providers would infrequently refer patients for mental health services and often knew little about the scope of services available by social workers. It became apparent that in order to achieve truly integrated care, additional modifications had to be made to the team-based integrated care model.

Organizational partnering with community health or mental health organizations also increased in an effort to expand core lines of business associated with health and mental health services. Organizations such as the National Council for Community Behavioral Healthcare (NCCBH) developed sample agreements and memorandums to help develop and formalize these relationships. Reynolds, Chesney and Capobianco (2006) note that a “Four Quadrant Model” was developed by integration leaders in Michigan to help organizations examine patient populations and develop algorithms for working with them. The four patient population quadrants identified were: patients with high primary care/low behavioral health

needs; low primary care and low behavioral health needs; high mental health and low primary care needs, and; high primary and high mental health needs. This model aided organizations experimenting with integrated care by prompting them to consider the processes necessary to develop their service models and processes for initiating referrals for patients with varying clinical needs.

## **Transdisciplinary Care and Health Care Impacts**

In order to provide truly integrated care that promoted both better patient outcomes and professional team satisfaction, several things needed to happen. First, each of the disciplines on the patient care team needed basic training on the scope and nature of services offered by other disciplines. A social worker on the team needed to have expanded information on chronic diseases such as diabetes and a primary care provider needed to know about mental health. There was also a realization that a truly integrated transdisciplinary team could not be comprised of just health and behavioral health providers, but needed other disciplines such as nutrition, dental, rehabilitation specialties as well as community health workers and the patients. Increasingly, team members have come to understand that involving the patient in both the team and their care directly relate to both patient engagement and improved outcomes. In a true transdisciplinary team model all team members have an equal voice on the team, and all members reinforce goals. In order to assist in training providers to work as part of transdisciplinary teams and develop shared care plans I developed the notion of the three “E”s: *every* discipline, *every* problem, *every* time as an encouraged standard of practice.

The evolution of integrated care from co-location to transdisciplinary team models has not only transformed care delivery systems, but challenged provider training and practices. Research supporting integrated care has helped shape modern service delivery, health care reform and even payment structures. The foundations for becoming a clinical home require both electronic health records and integrated care. Organizations that successfully become clinical homes are often eligible for special recognition and higher reimbursement rates. The ability to examine where individuals receive care and then ensure they receive all necessary care regardless of the setting has contributed to improved intervention outcomes, particularly with patients who present with serious, co-morbid health and mental health conditions. As we continue to move forward, it is imperative to consider individuals with substance abuse diagnoses and/or triple-diagnoses. While specific mental health outcomes were omitted in the original patient-centered medical home requirements, there are corrective initiatives currently under consideration that would address this concern.

## **Current Practice Needs and Future Directions**

It is critical that social workers in the field be educated about integration and transdisciplinary care models and that training for students takes place in both the classroom

and field placement. Given current reform measures and continued transition of care to community health settings, these settings are predicted to not only deliver two thirds of the country's mental health services but become the largest employer of social workers over the next ten years (*Sterney, 2009*). We should consequently review our roles and practice to foster adoption of transdisciplinary care in our own practice settings. Social workers need to recognize the necessary skill sets to effectively practice in integrated settings and develop their competencies accordingly. Initially it was thought that being active on a service delivery team would be sufficient. Over the past few years, however, shorter term, more symptom-based treatment is increasingly being encouraged. Evidence-based models specifically for behavioral health in primary care have now evolved such as Problem Solving Treatment in Primary Care (PST-PC) for treating depression and Behavioral Activation (BA) (*Townsend et al, 2001*). In addition to training in such interventions, social workers need to be oriented not just to provision of individual patient care, but to population management, including serious review and tracking of outcomes for both individual and groups of patients.

As practitioners began to experiment with open access and patient centered care, specialized job descriptions were developed for integrated settings. A general consensus evolved that behavioral health providers in such settings needed to be flexible and have skills more like those found in community-based organizations or emergency rooms, rather than traditional mental health, such as behaviorists. Primary care staff realized a greater need for training to treat mental health diagnoses as part of routine care, but also to afford comprehensive primary care to individuals with serious and persistent mental health problems. While there is a continuing recognition of the need for provider training, there are still significant barriers to provision of integrated care in both medical and mental health arenas.

As social workers, it is imperative we advocate for regulatory changes that promote integrated and transdisciplinary models of care. Barriers to integrated care exist in nearly all states, including the failure to recognize the importance of integrated care with separate licensing and regulatory systems. Most payers do not provide for care management or case conferencing reimbursement. Many have not recognized mental health parity and, most importantly, will often not reimburse for primary care codes in mental health settings or mental health diagnosis in primary care settings. That many integration projects continue to be grant funded not just for start-up and training costs but for ongoing support is a reflection of the difficulty in creating viable, sustainable financial models for integrated care. As federally qualified health centers (FQHC's) are federally mandated to offer a full complement of services, they have often been sites of more mature integrated care models. FQHCs receive higher reimbursement rates and have been front runners in achieving medical/clinical home status. A growing demand exists for social workers in the FQHC's. With many states developing behavioral health homes or clinical homes, professionals will be needed for work in fast paced, diverse, team-based settings. These professionals have the prospect for receiving higher reimbursement rates. The National Association of Community Health Centers (NACHC) advocated for the billing for social work services in FQHC's at the beginning of integration work almost a decade ago. The NCCBH has also created active and national integration learning communities. The need remains for community health center

social workers to systematically collaborate with physical health providers and address physical health in their settings.

## Conclusion

Both the mental health and medical professions have made progress in recognizing the value of integrated care and most states are examining their ability to support such care through regulatory and fiscal changes. There is considerably more work to be done however as many providers continue to practice in silos. Often there is pushback from mental health providers about changing practices or sharing records. Pushback also occurs from primary care providers about incorporating mental health treatment. Social workers must be poised in our practice settings and professional organizations to vigorously promote integrated and transdisciplinary care.

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# **Integrated Care from a Community Mental Health Perspective**

*Laura A. Leone, MSSW, LMSW*

## **Introduction**

The concept of integrated care and integrated care models was originally perceived as a primary care initiative before it impacted community mental health. As integrated care evolved, many primary care providers sought relationships with community mental health centers, as they felt unable to provide specialized mental health services. As integrated models in primary care settings developed, it became apparent to community mental health providers that there was a substantial difference in mental health service delivery in primary care settings in comparison to those services in mental health settings. This realization was coupled with a changing landscape requiring quantifiable outcomes from all service delivery systems as well as cost saving models that supported a “no wrong door” policy. Mental health centers began to examine their service delivery systems and models, following some of the work that had started in integration where outcomes were tracked from inception.

The last few years have seen rapid changes in the mental health community as those providers seek to create behavioral health or clinical homes and add primary care to their spectrum of in-house services. Community mental health centers are now compelled to interact with primary care organizations and providers, regardless of the setting. As these partnerships expanded and traditional mental health organizations built primary care services, there was a realization that mental health service delivery in these settings needed to be markedly different from traditional mental health services, including the utilization of tools; outcome and population management; new modalities being introduced; and shorter term treatment. While many mental health providers touted these changes as the “medicalization” of mental health services, others realized that these changes, being formalized by health reform, were going to change the landscape of mental health service delivery in the country for years to come.

This chapter examines the changes that integration has had on community mental health including the considerations for models of care, the social work role, team composition, documentation, communication, coordination of care, and educational needs.

## **Integrated Mental Health Care Models**

Multiple models of care have evolved seeking to optimize integration for mental health providers. The different models include solo community mental health and primary care centers, which partner with each other through community referrals; primary care delivery in mental health day programs; mental health services embedded in primary care centers, and; co-located licensed physical health and mental health centers. The co-location

of two separate licensed facilities is not without challenges, particularly for the mental health providers in these centers. Since the centers have different regulatory compliance needs, it is necessary for providers to be very clear regarding what is procedurally needed, including documentation procedures. The referral process, which is seemingly simple, can get more tedious when a patient “moves” from one facility to the next, even if the reality is that the facilities are only separated by an office wall.

For the first time, community mental health providers have been encouraged to reconfigure their documentation to support these new models, one example being psychiatric consultation. There is a frequent need in primary care settings for consulting psychiatry visits, either a “curbside” consult or one or two stabilization visits and then a transfer back to the primary care provider for ongoing medication management. The regulatory and documentation requirements of community health centers do not support the provision of consulting psychiatry services. This often results in restricted utilization of psychiatry services in these co-located models, a very frustrating outcome for primary care providers without access to psychiatry providers within their own walls. Many state mental health agencies are reviewing this policy in order to allow consultation services in community mental health settings. The idea of consultation psychiatry has also taxed many psychiatry providers accustomed to traditional mental health service delivery; they are not used to transferring patients out to primary care providers and many share a belief that primary care providers should “not be in the mental health business”.

With the creation of new models and Evidence-Based Practices (EBP), including Open Access Care, Wellness Self-Management, Problem Solving Therapy and Behavioral Activation, patients are able to improve their mental health in shorter amounts of time. These new integration models and EBPs have inspired the mental health system to re-examine practices of community mental health as payers began to realize that services were being provided in shorter time frames. As a result, payers now require shorter term treatment models of care and no longer pay for patients to be in treatment indefinitely. Community mental health centers have had to make changes in their practices in order to ensure their services are reimbursed, while simultaneously attending to the treatment needs of patients.

## **Changes to the Social Work Role and Team Collaboration**

It well known that a patient’s mental health is greatly impacted by their physical health. Traditionally, a clinical social worker in a mental health setting would make numerous outreach attempts to a patient’s primary care provider in order to coordinate collateral involvement and then work collaboratively with the provider for the benefit of improving the patient’s outcomes. The ease of access in collaborating with other providers in an integrated care setting is what makes integrated care so preferred and ultimately best for achieving desirable results for patients. Unlike the historical “silos” of care from the past, integrated care establishments function smoothly, since all members of the patient’s care team are typically located in the same building, making collaboration easier and direct. As more primary care providers and support staff join community mental health centers, the

patient's care team may well encompass a psychiatrist, primary care provider, nurse, and medical assistant as well as one or more social workers in the roles of mental health clinician, outreach worker, care manager, and/or case manager. Other possible members on the patient's team include a medical specialist, nutritionist, and consulting attorney.

The role of the clinical social worker in a community mental health setting has been changed by integration. Social workers in "siloes" community mental health settings were accustomed to a primary role in the patient's mental health treatment, often making the majority of non-medication clinical decisions. When the two settings become joined as an integrated care setting, team members have to readjust their understanding of the importance and value of each of the other members, as well as understand the changes to their own role and practices.

With integrated care, there has been a shift towards more preventative care, continuity of care, and care management for mental health concerns (*Mutschler, 1990*). This shift requires the expertise of social workers who can integrate the family, community, medical and mental health systems. Social workers contribute greatly to the overall health of patients in integrated settings through effective interactions with patients, families, and community resources as well as the utilization of information technology to generate more accurate, efficient, and comprehensive patient records. Shared computerized databases and electronic health records (EHRs) improve coordination of care between health care disciplines. *Mutschler (1990)* emphasizes that computerized systems must be adopted if integrated health care teams are to work efficiently, effectively and accurately share information about patients in a timely manner.

## **Changes in Documentation and Communication**

### *Progress Note versus Psychotherapy Note*

One of the greatest challenges for the mental health community has been the sharing of records and mental health information. Early integration efforts began to differentiate the progress note from the psychotherapy note, with the progress note being shared while the psychotherapy note continued to be constrained by additional confidentiality requirements. Despite the shift in notation style, many mental health providers struggle with the idea that information gained from confidential therapy sessions will be viewed freely among all of the integrated team members. What can be even more jarring to the providers is the patient-centered notion that in an integrated approach, *the patient* has the same viewing access to their notes and medical record as would a member of their care team. This trend, which started with community primary care providers then transitioned to community mental health, placed considerable pressure on mental health providers. There was a general lack of desire and initiative for mental health providers to use or share their electronic health record. This ultimately precluded the mental health providers from benefitting from the Medicare "meaningful use" dollars and other initiatives.

Although the practice that both patients and other providers would have access to traditionally segregated mental health notes has been met with some resistance by mental health providers in many organizations, research and general practice have ultimately shown that sharing records and patient involvement is considered the most patient-centered approach to documentation. It is empowering to the patient, which in turn serves to help improve their health outcome as the patient becomes more invested in their own care (Conway, Johnson, Edgman-Levitan, Schlucter, Ford, Sodomka, & Simmons, 2006).

### *Electronic Documentation and Communication*

One of the quickest ways for a community mental health center to share its documentation with other staff and even with patients is to use some form of an electronic health record (EHR) or behavioral health record. Frequently though, the mental health center is without an EHR and has no desire to have one, especially if they have no connection to a medical facility. The community health center, however, is placed at a disadvantage by being “behind the times” as integration-minded facilities are particularly prone to migrating their records to an EHR system.

EHR system use is optimal for operating vast integrated systems of care. Through the ongoing advancement of both EHRs and integrated care systems, EHRs have transformed mental health care and are capable of many uses in addition to general documentation of progress notes. The EHR allows all providers to communicate with each other immediately. As an illustration, if a clinical social worker identifies a patient as “high risk”, all of the patient care team members can view that information in “real time”, simultaneously access the record and thereby vastly decrease response time for urgent situations; something paper charts could never do. The creation of mental health user groups to share tools and development strategies, along with the development of electronic intake and assessment tools within the EHR, increases efficiency and ease of use of the tools for mental health providers. Utilizing measures in the EHR such as the PHQ9 depression screening tool or the GAD7 anxiety tool creates quantifiable ways to communicate mental health information to primary care providers and in a numeric language to which primary care providers are accustomed. The result of each measure, which is entered in the EHR as a lab value, gives mental health providers the capability to track patient success in treatment and can be used as a way to “flag” results to other members of an integrated care team (Little, 2009).

An EHR enhances the capability for a community mental health center to manage schedules, providers and programs, measure outcomes, monitor quality and revenue, and extract data for proposals and reports. “In an integrated care model, it is imperative that the EHR encompass reporting, financial, and registration systems. This will not only promote a more seamless operation, but will also allow the accurate reporting and tracking of service delivery centers, programs, and providers” (Little, 2009, p.55). As more community mental health centers realize the immense capabilities integration has for mental health care, the need, desire, and ultimately utilization of an EHR will surely increase.

### *Changes to the Referral Process*

For those community mental health centers that are more progressive in their integration and already connected to primary care, the patient referral process has been dramatically altered by integration and the use of an EHR. A patient can enter into an integrated care system through a variety of different service portals, whether it is through mental health or other services. Regardless of how they enter the system, however, patients have equal access to all available services. If the patient, for example, enters through the community mental health center and during some point in the intake process is determined to be in need of chronic disease care management, staff can elect to make a formal referral in the EHR system. The referring provider may then directly message a provider electronically, or even preferably escort the patient directly to the appropriate provider. This patient exchange from one provider to the next is often called “the warm handoff” or “hallway handoff” approach. By using the “hallway handoff” approach in an integrated care system, 85-90% of referred patients can enter treatment immediately, compared to the 10% of patients referred by traditional referral systems (*Cummings, O’Donohue, & Cummings, 2009*). Patients who therefore require chronic disease care management in addition to mental health treatment are more likely to receive needed care in a community mental health center that is integrated with primary care and auxiliary services. This improves patients’ physical health outcomes, which in turn improves patients’ mental health outcomes, as opposed to the experience of those who enter non-integrated community mental health centers with traditional referral processes.

Research shows that in an integrated mental health care setting with “warm handoffs” occurring between the primary care providers and the clinician social workers, primary care providers are 80% more likely to feel there is better communication between themselves and clinical social workers. Research has also revealed there can be fewer stigmas for older adults accessing mental health care if it is integrated in the primary care setting, where the primary care clinicians were involved in the direct referral, counseling and management of medications (*Gallo, et. al., 2004*). To make handoff communications successful, consideration must be afforded to the physical setting, social setting, language used, and communication medium. Rather than just mentioning that a coworker exists, a “warm handoff” statement offered is, “I have a coworker here. It is important that you talk to them. Let me walk you over to their office,” (*Tai-Seale, Kunik, Sheperd, Kirchner, & Gottumukkala, 2010*). Handoffs should have a “closed-loop” communication system, with “readback/hearback” information exchanges which allow for the confirmation of information received and understood, whether verbal or electronic (*Dunn & Murphy, 2008*). There should be opportunities for questions and answers between the referring staff and staff receiver about such factors as patient condition, treatment, and any current or possible changes (*Patton, 2007*). Even if the setting is strictly a mental health setting, warm handoffs should occur between providers such as therapists and psychiatrists to facilitate integration in the center.

## Coordination of Care

Historically, mental health care became more medicalized with a push towards medication as a preferred mental health treatment, possibly replacing psychotherapy. With that notion was the idea that two “silos of care” have been created, one for physical health, which gets about 95% of reimbursement and funding, and the other smaller “perpetually underfunded” silo for behavioral health (*Cummings, O’Donohue, & Cummings, 2009*). Research suggests that underfunding can be related to stigma, quality concerns, lack of access, and insistence of providers on private practice due to the separation of the two types of care. In truth, a patient should be treated as a whole and not in parts. Integrated care attends to all of the different needs of a patient. It does not discern between the mind and body and therefore represents full integration into healthcare settings, not just collaboration among providers. Integration requires administrators to understand the complexity of the system and that it cannot just simply happen – much training for both mental health and primary care providers is required for integrative models to work successfully.

Joining primary care to a community mental health setting has facilitated improved patient health outcomes, in turn decreasing overall costs a center might incur for care of a particular patient. In a retrospective cohort study by Reiss-Brennan, Briot, Savitz, Cannon, & Staheli (2010), a sample of patients was identified from a depression registry, restricted by age, no pre-diagnosis mental health condition and no medical co-morbidity in post-diagnosis period. These patients were also within the same group insurance. The sample of 1,229 patients included 797 in a mental health integration cohort and 432 in the usual-care group. Examining associated care and costs of care for the different patient groups, it was determined that allowed charges in the one year period following initial diagnosis for depression increased only by 73% (\$640) for the mental health integration group, while charges increased by 100% (\$1,045) for the usual-care clinic group. Patients with one co-morbidity in the mental health integration group had only an 8% increase in charges while patients in the usual-care group had a 90% increase in average per-patient allowed charges. For all levels of patient complexity, it was less expensive to treat patients newly diagnosed with depression for a twelve month period in the mental health integrated clinics than in non-mental health integrated clinics. The researchers concluded that integrated clinics not only allow for enhanced access to coordinated, higher quality integrated mental health and medical care, but do so with a resulting decrease in treatment cost to payers.

With increasing numbers of mental health patients being seen in integrated care settings or being managed by just their primary care provider, fewer patients are being cared for solely by a community mental health center for mental health concerns. Patients who are more severely and persistently mentally ill no longer need to be restricted to mental health centers to receive needed treatment. The implication is that community mental health centers will be deprived of revenue as well as lose control over their patient populations if they remain segregated or un-integrated.

## **Educational Considerations**

Integration has changed the training needs of social workers today. Social workers need to have a more thorough understanding of other professionals' roles on integrated care teams. They need to be multi-tasking collaborators and "hands on" liaisons that navigate the patients as they received care for their health needs. The education social workers receive today must prepare them for effective, efficient functioning in integrated care settings.

### *Models, Evidence-Based Practices, and Research*

Social workers particularly need training on the use of Evidenced-Based Practices (EBPs) which afford the cultural shift necessary to fully integrate services (*Reiss-Brennan, Briot, Savitz, Cannon, & Staheli, 2010*). As previously discussed, EBPs are evolving into the only acceptable types of practice used in community mental health settings. A growing number of grant funders and payers will only pay for services that are evidence-based and they require proof that EBPs are being utilized. Without supportive research, a regular clinical practice will not be regarded as "evidence-based" and will be excluded from an integrated practice. Social workers determined to practice in the integrated care arena should anticipate knowing more about EBPs and research than perhaps ever before.

### *Health Information Technology*

Training must also focus on health information technology and the use of an EHR, particularly with regard to the means by which integrated teams communicate and document patient interactions. For mental health clinic social workers, this entails learning how to write progress notes rather than the superfluously detailed psychotherapy notes of the past. Social workers must be schooled in concurrent documentation as a patient-centered approach necessary for the fast-pasted atmosphere of integrated community mental health centers. Concurrent documentation, the process for documenting the session collaboratively with the patient present, is considered a patient-centered treatment approach as the patient is directly involved with their chart documentation. Therapy is accordingly not done *to* patients, but *with* them. Research findings point to this technique as increasing engagement, session adherence, understanding of therapy, and treatment outcomes. Also beneficial to staff, this process reduces documentation time after completed patient sessions. In one study, 85.4% of the patients reported that they liked the way their provider used the computer during the visit, while only 6.2% of the patients reported the computer was a distraction (*Hsu, Huang, Fung, Robertson, Jimison, & Frankel, 2005*). Since integration efforts have encouraged that concurrent documentation practices and models be used in community mental health settings, it is crucial that social workers receive training on utilization of concurrent documentation.

### *Engagement and Open Access*

With the evolution of patient care teams and transdisciplinary teams including the patient, patient-centered care has become the focus of much discussion. The mental health community reviewed policies such as scheduling and patient engagement and new models

were developed utilizing concurrent documentation as well as the Open Access scheduling model. In supporting the Open Access model, Cole, Pomerantz, Watts, & Weeks (2008) note it provides "...unscheduled or same-day appointments on request and has been shown to improve treatment engagement and outcomes" (p. 547). With Open Access service in place, patients are seen for a visit on the same day of referral. Same day service helps patients at imminent risk find proper treatment at the time of need. Face-to-face contact ensures patients leave the clinic with a mental health plan intact and the "warm handoff" approach to Open Access makes certain of that.

## **A New Workforce**

New social workers entering the workforce armed with the educational preparation previously outlined will prove perfect candidates for employment in integrated care settings. Among those social workers who have been in the mental health field longer, change and adaptation to new integrated ways of functioning and treating patients may prove harder. The cost for organizations to retrain staff is much greater than if they hired new staff already knowledgeable and trained in the tools necessary for integrated care. More jobs in integrated centers are becoming available and those who want to continue working or find new jobs to advance in their career will need to be savvy regarding integrated care to remain desirable to prospective employers.

## **Summary**

Integrated care in community mental health centers has the potential to increase patients' overall mental health, while simultaneously enhancing their physical health. The clinical social worker in an integrated community mental health setting, once acclimated to a team mentality and the changes in documentation and engagement practices, will be able to quickly navigate patients' needs and assess the next steps to be taken with patient care team members for the optimal intervention. Inability to acknowledge the progressive shift toward integrated care will put social work at a disadvantage and increase its risk for exclusion from the integrated care conversation.

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# **Social Work Case Management Model in the Veterans' Affairs Patient Aligned Care Team (PACT)**

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## **Introduction**

The Department of Veterans' Affairs (VA) is the largest integrated health care system in the United States, serving over 6 million Veterans each year. Enrolled Veterans receive a continuum of health care services at 1,597 sites ranging from medical centers and outpatient clinics to community living centers, residential rehabilitation programs and readjustment counseling centers. Professional social workers are an integral and vital part of the Department of Veterans' Affairs health care system. They support and advance the mission of the Department of Veterans' Affairs by providing high quality psychosocial services to Veterans, their families and caregivers. These services can assist Veterans, families and caregivers in maximizing their potential and support them in meeting their emotional, social, mental and spiritual needs.

This chapter focuses on an innovative model of care known as the Patient Aligned Care Team (PACT) and discusses the subsequent transformation of primary care services following its introduction in the VA. It highlights how social workers provide case management services in the PACT, the framework and opportunities associated with implementation of the new practice model and the outcome measurements proposed for evaluation of the model.

## **Background: Social Work in the Department of Veterans Affairs**

The Veterans' Bureau General Order dated June 16, 1926, established the social work program in the Veterans' Bureau, outlining its organization and functions. The first year staffing consisted of fourteen social workers placed in psychiatric hospitals and twenty-two located in regional offices throughout the country. Early social work involvement was centered exclusively on psychiatric and tuberculosis patients. A small but efficient social work services program was directed by Mrs. Irene Grant Dalymple from 1926 to 1946, a pioneer in providing social work in medical settings. Her foresight was instrumental in structurally incorporating the social work program within the VA rather than having social services contracted by outside organizations as had been the practice following World War I.

From this modest beginning, social work in the VA has evolved into a professional resource with treatment responsibilities in all patient care areas, helping patients and families to achieve their highest level of functioning, adjustment and coping in society while promoting vocational and psychosocial rehabilitation. The VA is the single largest employer of masters-level social workers in the United States, with approximately 9,000 such

personnel assigned to VA facilities and Readjustment Counseling Centers across the nation. Professional social workers are licensed independent practitioners who provide a wide range of services designed to best meet the identified needs of Veteran patients, their families and caregivers.

To assure the best possible care, social workers collaborate regularly with other disciplines involved in providing care. Social workers are key members of interdisciplinary treatment teams, regularly conferring and consulting with other team members on treatment issues, provision of health care services and psychosocial issues that impact the Veterans' ability to gain maximum benefit toward their health care. The exchange of information and recognition of the unique contributions provided by each team member are vital to optimal patient outcomes.

Social workers often facilitate team meetings and patient/family/caregiver conferences, using their systems training and group process skills. Social workers provide care, support and treatment in all clinical programs including, but not limited to, Emergency Departments, inpatient units, outpatient treatment, extended and community care to treat both physical and mental illness. They coordinate care for specialized populations of Veterans such as returning combat Veterans from our current wars in Iraq and Afghanistan, female Veterans, frail elderly, those with serious physical and mental disabilities, poly-trauma, spinal cord injury, visual impairments, infectious diseases, substance abuse and the homeless.

Social workers develop and implement treatment approaches which address individual bio-psychosocial problems and work with acute/chronic medical or mental health conditions, dying patients, and bereaved families. VA social workers are responsible for ensuring continuity of care through the admission, evaluation, treatment, and follow-up processes. This includes coordinating discharge planning and providing case management services based on patients' clinical needs and community resources. Over time, social work staff have addressed the needs of distinct Veteran populations from all conflicts and wars, i.e., the homeless, the aged, HIV/AIDS patients, spinal cord injury, ex-POWs, Viet Nam and Persian Gulf Veterans, returning combat Veterans from the wars in Iraq and Afghanistan as well as their families and caregivers.

## **The VA Evolution and Role in Health Care Reform**

President Hoover signed the executive order establishing the VA on July 21, 1930. This new agency became responsible for the medical services of war Veterans; life insurance; bonus certificates; retirement payments for emergency officers; Army and Navy pensions; and retirement payments for civilian employees. During the next decade, from 1931 to 1941, the number of VA hospitals increased from 64 to 91 (*VA History in Brief, Department of Veterans Affairs* (see [www.va.gov/opa/publications/archives/docs/history\\_in\\_brief.pdf](http://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf)).

Demand for hospital care grew dramatically in the Depression years, with tuberculosis being the predominate condition treated in VA hospitals. By the middle 1930's,

tuberculosis patients had dropped to only 13 percent of the overall patient population, largely associated with the significant efforts of VA research and treatments. A growing focus, neuropsychiatric conditions then accounted for more than half of the patients (*VA History in Brief, Department of Veterans Affairs*, see: [www.va.gov/opa/publications/archives/docs/history\\_in\\_brief.pdf](http://www.va.gov/opa/publications/archives/docs/history_in_brief.pdf)).

President Reagan signed legislation to elevate VA to Cabinet status in 1988 and on March 15, 1989, the Veterans Administration became the Department of Veterans' Affairs. The VA was the largest independent federal agency in terms of budget and was second only to the Department of Defense in staff. Proponents for Cabinet-level status of the VA agreed the agency should be represented by a cabinet secretary having direct access to the president given that one-third of the US population was eligible for Veteran benefits.

The Veterans' Health Administration is funded through the federal budget. In a 1995 response to changes in health care delivery, the VA hospitals were grouped into twenty-two Veterans Integrated Service Networks using a capitated model. Critical elements of this transformation included population-based planning, decentralization, universal availability of primary care, a shift to outpatient care from inpatient care, and an emphasis on measuring health-care performance on the outcome of patient treatment. Each VA health care facility receives annual funding based upon the number of Veterans enrolled in the system. Additional funding is provided for the needs of Veterans with extraordinary medical needs, such as the spinal cord injured and those needing dialysis.

During the late 1990's the focus of health care was transformed from acute inpatient care to outpatient care emphasizing chronic disease management as well as health promotion and disease prevention. While VA social work practice had focused on inpatients and discharge planning as well as specialized population care, the new outpatient focus thrust social workers into community planning, coordination, and integration of services at federal, state, county and local levels.

The VA initiated hiring outpatient primary care social workers in 2000. Working with interdisciplinary teams, they concentrated on chronic disease management, health promotion and disease prevention, motivating patients toward these goals and identifying psychosocial and environmental barriers. It became clear patients were often unwilling or unable to fully participate in health promotion activities when they experienced significant stress. A person, for example, might not be able to quit smoking if they were facing eviction or other serious psychosocial stressors. Insufficient funds for transportation to medical appointments or to comply with recommended diets detracted from patient treatment plan compliance. Careful assessment of the underlying causes of psychosocial stressors became crucial along with viable recommendations for sustained patient improvement. With reduced stress, patients were able to more productively focus on chronic disease management, health promotion and disease prevention efforts.

## **A New Model of Health Care Delivery – Patient Aligned Care Team**

The Department of Veterans' Affairs has several major initiatives underway to transform VA into a 21<sup>st</sup> century organization. One particularly important transformational change occurred with the introduction of a new model of primary care known as the Patient Aligned Care Team or *PACT*. The catalyst for PACT occurred in 2009, when the Universal Health Care Services Task Force was charged by the Principal Deputy Under Secretary for Health and the Deputy Under Secretary for Health for Operations and Management to define a comprehensive set of health care services that VA provide all enrolled Veterans in a more patient-centered way and without respect to location, facility, or provider (*Department of Veterans Affairs, 2009*).

The PACT delivers Veteran-centered, team-based healthcare services that are comprehensive, collaborative, coordinated and continuous. Five goals were identified in fully transforming primary care into a patient-centered service delivery model:

- Provide superb access
- Redesign primary care practices
- Improve care coordination
- Develop measurement and evaluation tools
- Restructure the organizational structure

The PACT typically includes a primary care practitioner (Physician, Nurse Practitioner or Physician Assistant), an RN Care Manager, a Clinical Associate, and a Clerical Associate. The team establishes patients' health care plans, provides primary care services and care management that facilitate comprehensive, effective care delivery. The interdisciplinary PACT has a key role in identifying patients who may benefit from case management.

Every patient requiring case management services is assigned to either a registered nurse or social work case manager. Nurses and social workers collaborate when both complex medical and psychosocial factors are identified that may place a Veteran at risk for decline. This collaborative relationship between nursing and social work case managers provides a comprehensive approach to case management services that minimizes duplication of services and unnecessary handoffs. Each discipline brings their unique perspective to ensure that all the Veteran's bio-psychosocial needs are identified and met.

While nursing case management focuses on the medical needs of Veterans to enable their return to an optimal level of function, social work case management addresses individuals' bio-psychosocial status, social system and resources. Interventions occur at the Veteran, family and systems levels. Social workers develop and maintain therapeutic relationships with Veterans, which may include linking them with systems that provide needed services, resources and opportunities. They demonstrate their expertise by navigating complex health and social service systems and, combined with their unique psychosocial perspective, help Veterans and their families/caregivers access resources needed to maximize patient independence, health and well being.

## **Social Work Case Management in Patient Aligned Care Teams (PACT)**

PACT focuses on health promotion, prevention and management of chronic disease. Preventive care and successful management of many conditions are dependent on behavioral changes that patients are willing and able to make as well as environmental factors. The role of a PACT social work case manager is to assess and treat psychosocial and environmental factors that impact the patient's ability to achieve maximum health and wellness.

Patients' psychological and emotional adjustments to illnesses are assessed within the context of medical diagnosis, prognosis, and treatment options. Environmental assessments include a review of the dynamics of patients' support systems, functional status and the vocational, economic, housing, spiritual, cultural and legal factors that influence patients adhering to medical recommendations and their management of self. Social workers assess the underlying factors that contribute to the presenting concerns. They then develop interventions to promote lasting positive change by decreasing stress, promoting health and wellness and removing barriers to care. Psychosocial treatment options are reviewed with the patient, family and PACT team. A treatment plan based on the patient's identified concerns and goals is established. Patients are given supportive assistance and referrals to appropriate resources to lessen the acuity of psychosocial stressors.

### *Functional Assessments and Patient Acuity Determination*

In the social work model used with the PACT, patients are assessed in six domains: access to care, economics, housing, psychological status, social support, and functional status. One of four possible levels of acuity is assigned for each domain. *Level 1* represents patients whose basic needs are met, *Level 2* is assigned to patients with minor concerns in one or more of the domains, *Level 3* reflects patients with major concerns in one or more of the domains and *Level 4* patients are in crisis in one or more domains (i.e. have no income, no social support or are homeless). For each level, possible interventions are listed. The ultimate goal of any intervention is to lessen acuity and move the patient toward Level 1.

### **ACUITY LEVEL 1 - *Patients essentially have all personal needs met***

***Access to Care:*** Patients have access to needed care and have transportation

***Economics:*** Patients have sufficient income for their needs

***Housing:*** Patients have adequate housing for their needs

***Psychological Status:*** Stable mood and behavior

***Social Support:*** Patients have supportive relationships

***Functional Status:*** Patients are functionally independent

### **Associated Intervention:**

- 1) Inquiries to establish the patient/family status, questions and issues regarding the cost of health care in and outside the VA (including available use of Medicare, Medicaid, private health insurance, and supplemental insurance policies).
- 2) Inquiries of patient and family regarding Veterans benefits (including health care, pensions/compensation, burial benefits, Veterans homes, vocational rehab, etc).

- 3) Provide information and assistance in preparing patient advance directives.
- 4) Schedule or reschedule appointments, ensure that ordered equipment/services are received, and provide information and assistance with transportation arrangements.
- 5) Provide supportive counseling to assist patient and family with their adjustment to a diagnosis or disability.
- 6) Provide patient/family education about health promotion, prevention and patient self-management.
- 7) Initiate referrals as warranted/requested for competency exams (neuropsychological assessments, payee, guardianship, fiduciary, etc).

**ACUITY LEVEL 2 - *Patients with minor concerns with access to care, economics, housing, psychological status, social support or functional status.***

**Access to Care:** Patients may have access issues and/or questions, including requiring assistance with the means test/eligibility for care or arrangement of transportation to the VA. Appointments may need to be rescheduled due to transportation problems.

**Economics:** Patients have limited income and may warrant financial counseling to manage within their means. This may include assistance to increase income and/or decrease expenses.

**Housing:** Current patient housing arrangements may not be adequate for their needs.

**Psychological Status:** Patients may have minor mood or behavioral disturbances that intermittently interfere with daily functioning.

**Social Support:** Patients have supportive relationships, but are not receiving sufficient support or assistance to meet their current and/or anticipated needs.

**Functional Status:** Patients may have issues with independent activities of daily living.

**Associated Intervention (*beyond Level 1 Interventions*):**

**Access to Care:**

- 1) Assist patients as needed to get updated means tests to determine co-payment.
- 2) Schedule/reschedule appointments resulting from patient no-shows.
- 3) Prepare handicapped parking applications.
- 4) Prepare applications for reduced fare public transportation programs.
- 5) Arrange for temporary lodging.
- 6) Provide bus tickets and other transportation assistance.

**Patient Finances/Budgeting:**

- 1) Initiate financial counseling referrals.
- 2) Provide assistance with pension, benefit and Social Security applications.
- 3) Initiate vocational rehabilitation program referrals as warranted.
- 4) Provide assistance with subsidized housing or mortgage refinancing referrals and applications for property tax reductions and energy assistance programs.

**Housing:**

- 1) Refer to home maintenance assistance programs, including weatherization and loans.
- 2) Assist patient to maintain uninterrupted home utilities.
- 3) Initiate referrals for assistance with rodent/insect infestations.

**Psychological Issues:**

- 1) Provide supportive counseling that facilitates patients asking for/receiving assistance.
- 2) Refer to the mental health or substance abuse treatment programs.

***Social Support:***

- 1) Identify and address family relationship issues.
- 2) Initiate referrals to senior centers for meals and socialization.
- 3) Arrange for respite care to assist patient caregivers.
- 4) Initiate referrals to peer support groups as warranted.

***Functional Status:***

Initiate referrals for meals on wheels, homemaker/home health and rehabilitation services.

***ACUITY LEVEL 3 - Patients with major concerns with access to care, economics, housing, psychological status, social support or functional status.***

***Access to Care:*** Patients may have limited or cost prohibited transportation to the VA. They may need to have many appointments scheduled for the same day, or schedule overnight accommodations due to transportation problems.

***Economic:*** Patients have too little income to support basic human needs. Their expenses exceed their income. Patients need immediate assistance to either increase their income or decrease their expenses.

***Housing:*** Patients have housing that is inadequate for their needs.

***Psychological Status:*** Patients may have a major mood or behavioral disturbance that interferes with daily functioning.

***Social Support:*** Caregiver is overwhelmed and stressed by patient care needs. Patients have strained relationships and do not receive adequate assistance. Patient is isolated without adequate social supports.

***Functional Status:*** Patients may be at risk for falls or other injuries. Patients may need assistance with activities of daily living/independent activities of daily living (ADLs/IADLs).

***Associated Intervention (beyond Level 1 and 2 Interventions):***

***Access to Care:***

- 1) If patient is not eligible for all VA health care and has no health insurance, initiate Medicaid referral.
- 2) Determine if patient needs to pay privately for an ambulance to access care and coordinate appointments as warranted.
- 3) Apply for wheelchair van service and check community transportation resources.
- 4) Explore availability of other transportation options with patient support system.

***Patient Finances/Budgeting:***

- 1) Initiate patient referrals for VA and temporary welfare benefits.
- 2) Initiate referrals to community programs or legal assistance to prevent eviction.
- 3) Initiate referrals to community financial aid and employment programs.

***Housing:***

- 1) Initiate referrals to programs for renovations to make home handicapped accessible.
- 2) Assist patient in maintaining home utilities.
- 3) Initiate group homes/assisted living/nursing home referrals as warranted.

***Psychological Issues:***

Coordinate transition to mental health, substance abuse and/or day program providers.

***Social Support:***

- 1) Provide supportive counseling to improve relationships with family and friends.
- 2) Initiate referrals for respite care or adult day health care.

***Functional Status:***

- 1) Initiate referrals for inpatient or home rehabilitation to improve functional ability and address any existing/potential safety concerns.
- 2) Initiate referrals for home health aides to assist with ADLs and IADLs.
- 3) Initiate referrals to Adult Protective Services if warranted.

***ACUITY LEVEL 4 - Patients having a crisis with access to care, economics, housing, psychological status, social support or functional status.***

***Access to Care:*** Patients may be unable to afford or find transportation. Patients may lack understanding how to manage scheduling appointments.

***Economic:*** Patients have no income. Patients need immediate assistance to either find work or receive benefits.

***Housing:*** Patients have no home.

***Psychological Status:*** Patient requires inpatient psychiatric admission.

***Social Support:*** Patients lack social supports.

***Functional Status:*** Patients are functionally dependent.

***Associated Intervention (beyond Level 1, 2, and 3 Interventions):***

***Access to Care:*** Provide bus tickets and arrange other transportation as necessary. Work with Veteran to gain understanding of the appointment scheduling process and ensure that needed appointments are scheduled.

***Patient Finances/Budgeting:*** (assistance in levels 2 & 3, but with increased advocacy)

- 1) Initiate referral for employment resource
- 2) Initiate referrals for financial assistance (pension/benefits; temp. welfare; Medicaid)

***Housing:***

- 1) Initiate referral to homeless shelters, public housing, Veterans Home, group homes, assisted living facilities or nursing home as appropriate.
- 2) Identify in-home supports that allow the Veteran to remain in the community despite deficits.

***Psychological Status:*** Refer to inpatient psychiatric unit to improve functioning and safety.

***Social Support:*** Provide supportive counseling to improve relationships with family/friends.

***Functional Status:***

- 1) Initiate referral for inpatient rehabilitation to enhance functional ability and safety.
- 2) Initiate referral for nursing home placement as warranted.

## **Levels of Case Management**

The Social Work Case Management model was designed with primary domains of assessment and interventions as well as acuity measurement. A four-point acuity measurement is established to measure the severity of the psychosocial stressor in the most common domains of assessment (access to care, economics, housing, psychological status,

social support and functional status). The extent and nature of case management is determined by clinical assessment and acuity scoring as well as the severity and urgency of the presenting problem(s). Veterans with an acuity level of 2, 3, or 4 will receive case management services. Those at level 1 will receive episodic care.

- **Episodic – Level 1**

Patient typically has all personal needs met with low psychosocial acuity rating. Generally one to two contacts are required.

- **Supportive – Level 2**

Patient expresses minor concerns with access to care, economics, housing, psychological status, social support or functional status. Monthly-quarterly contact as clinically indicated to ensure sufficient support to meet case management goals.

- **Progressive – Level 3**

Patient has major concerns with access to care, economics, housing, psychological status, social support or functional status. Weekly-monthly contact as clinically indicated to ensure sufficient support to meet case management goals.

- **Intensive – Level 4**

Patient has a crisis with access to care, economics, housing, psychological status, social support or functional status. Daily-weekly contact as clinically indicated to meet case management goals.

Standardized progress notes for a triage assessment, comprehensive assessment and a follow-up note are put in place to evaluate outcome measures for the effectiveness of case management within PACT. When completing the comprehensive assessment and follow-up notes, social workers will rate the acuity of the psychosocial need in each of the six domains at the initial assessment and at each follow-up visit. If psychosocial interventions are effective patients will show a decrease in psychosocial acuity, the rating will change for example from level 3 or 4 to level 1 or 2. In addition to rating psychosocial acuity, the social workers will also determine a level of case management that is the frequency of future visits based upon the severity and urgency of the need. This level of case management will often correlate with the level of severity, however there may be circumstances when a person has a high acuity, such as no income, and the social worker will not need to see them often because the appropriate interventions have already been used, such as an application for social security disability is pending and the patient applied to temporary aid agencies.

When implementing the social work model into the Patient Aligned Care Team the role of social work is expanded and more clearly defined. Social workers will support the members of the health care team, providing assistance and guidance in dealing with challenging patient care situations, seeking to eliminate barriers to health care interventions. Social workers will identify Veterans at high risk for psychosocial complications and proactively reach out to offer case management services, proposing strategies to resolve underlying causal factors that lead to psychosocial complications while building upon the strengths and abilities of patients and their families/caregivers. They will educate and

motivate Veterans and families toward health promotion, disease management and management of self. Social workers also link Veterans with needed services and resources based on their needs in collaboration with interdisciplinary team members, the Veteran and family/caregiver.

## **Computerized Patient Record System (CPRS)**

VA primary care teams utilize a computerized medical record system (CPRS) developed in the 1990s to identify high-risk patients for targeted interventions. Patients, for example, with elevated blood pressure, blood sugar levels, and chronic congestive heart failure with frequent exacerbations are offered appointments where they are seen by a multidisciplinary team that teaches best practices for health improvement and provides monitors between primary care provider visits. Some patients are monitored in their homes through “Telehealth” devices and will soon have the ability to communicate with their health care team through secured electronic messaging. Social workers leveraging technologies such as “Telehealth” may provide services more efficiently to Veterans living in rural communities.

CPRS is regarded as having transformed patient care. The system is password protected and is accessible to VA health care professionals from any computer terminal throughout the VA health care system. It allows VA providers access to medical records stemming from injuries that occurred on the battlefield and enables patient information access at any site along the continuum of care.

CPRS holds information related to patient demographics, diagnoses, progress notes, lab and test results and hospital discharge summaries. It is regarded as improving the quality of patient care and medical outcomes by providing legible and accurate information at the site of care. It improves safety by alerting providers to patient-specific safety information. Patient care is standardized through the use of template progress notes and clinical reminders for preventive medicine screenings. CPRS helps to eliminate duplication of service by allowing other providers access to previously ordered test results; an emergency room physician can view progress notes by the primary care provider (PCP) and results of previously ordered tests. Care is coordinated by adding additional signers to progress notes. Veteran patients can access portions of their health record through VA’s MyHealthVet (<http://www.myhealth.va.gov/>).

## **PACT Social Work Role: Case Illustration**

A recent *New Yorker* article, “The Hot Spotters”, illustrated a strategy of contacting high users of health care services and then identifying environmental and psychosocial risk factors contributing to emergency room visits and hospital admissions (*Gawande, 2011*). These patients were more closely followed by a health care team to better manage chronic conditions. Health coaches were utilized to encourage health promotion. While health care

utilization initially increased from better coordinated care, a significant cost decrease was seen within several years.

In a similar fashion, VA primary care teams use CPRS to identify high-risk patients for targeted intervention. As an example, patients with elevated blood pressure, blood sugar levels, and chronic congestive heart failure with frequent exacerbations are offered appointments with a multidisciplinary team that teaches best practices for health improvement and provides monitors between primary care provider visits. Some patients are monitored in their homes through Telehealth devices and will soon have the ability to communicate with their health care team through secured electronic messaging. Social workers leveraging technologies such as Telehealth may provide services more efficiently to Veterans living in rural communities.

The following illustrates the role of a PACT social worker:

A patient, a 48 year old veteran, who works 6 days per week at the Post Office as a letter carrier, visits the primary care provider (PCP) with complaints of back pain and requesting to have the PCP complete a Family Medical Leave Act form to authorize 1-3 days off work per month as needed. The PCP suggests that the patient have a physical therapy evaluation but the patient refuses, citing a fear of losing his job if he takes too much time off work. The primary care provider brings the patient to see the social worker. The Veteran has been working for the U.S. Post Office for the past 14 years; he sustained a back injury while in the military that still causes chronic back pain. This injury was known to the Post Office at the time of his employment. As a letter carrier, he delivers mail to houses six days per week, walking many miles each day while carrying a heavy bag. The patient reported he was unable to go to work on some occasions due to back strain from the preceding day. He brought a Family Medical Leave Act form to be completed, seeking permission from the physician to take off work 1-3 days per month as needed.

The social worker explores patient's fear of being off work too much for treatment and explains that the physical therapist could complete the evaluation in one visit and give a home exercise program that the patient can follow. Additionally, the appointment can be scheduled at the beginning or the end of the work day or at another time most convenient. Subsequent visits would evaluate the effectiveness of the home exercise program and offer further treatment options as needed. They agreed upon a plan with the patient and the health care team to "tune up" the patient with the intent of optimizing his level of functioning. The primary care physician ordered physical therapy consultations with the goal of strengthening the muscle systems that support the patient's back and to teach proper body mechanics. A patient referral to the pain clinic was also ordered to enhance the patient's pain management. The social worker additionally discussed the possibility of the patient's medical retirement from the Post Office if these interventions proved insufficient in facilitating the patient's Post Office employment until the usual

retirement age. The patient was reluctant about this prospect, citing the excellent pay and benefits he received from this job. They discussed the possibility of using vocational rehabilitation to train him for a new career that would be less stressful on his body. This dialogue set the tone for future interventions, letting the patient know that the team will provide ongoing support as his physical condition changes over time.

The PCP has limited time with each patient and appreciates the assistance of the social worker to engage the patient in the treatment process. When the patient arrived in physical therapy, he readily engaged in treatment and was adherent with the home exercise program. The social worker discussed other options should the outcomes of physical therapy and the pain clinic not allow the patient to continue working in his present job. The patient was encouraged to return to the clinic for additional assistance as needed.

## **Outcome Measurements**

The scoring of psychosocial acuity at the initial and subsequent visits will be tracked in the social work progress notes in CPRS. This data can be extrapolated into reports that can show changes in acuity over time, i.e. which interventions are most effective in lowering psychosocial acuity. Conversely, social workers will be able to determine which outcomes could be improved by streamlining referral processes. The reports can correlate psychosocial acuity and environmental factors with data pertaining to medical diagnosis and health status. This could provide knowledge as to which social work interventions have the most significant impacts on health care outcome and by doing so contribute to evidence-based practice. The reports will additionally allow comparison of outcome measurements to various social work staffing ratios. Further research studies may reveal, in an era of limited resources, where social work positions can be most effectively utilized and identify reasonable case management ratios. Current experience has already demonstrated social workers have an integral role in the Patient Aligned Care Team, facilitating access to health and psychosocial services that improve health outcomes.

## **Summary**

PACT is a partnership between the Veteran and his/her health care team to ensure the Veteran is receiving holistic care. PACT offers personalized care to meet the individual health care goals of each Veteran with emphasis on prevention and health promotion. Care is coordinated through collaboration with all members of the health care team with a focus in helping the Veteran achieve his or her health care goals. Social work case managers are key to assisting the Veteran to achieve these goals.

Social workers participated in regional interdisciplinary educational collaboratives and learning colleges during a national rollout of this new model of health care delivery. This provided an opportunity to educate other disciplines on the role of the social work case

manager in PACT. Additionally, the National VA Social Work Program, Care Management and Social Work Service has provided national trainings to promote the rollout of the new case management model for the VA social work community. The personalized focus of the PACT, its combined acuity system and associated intervention levels, coupled with identified outcome measures make it a valuable redesign of patient care and one whose principles and structure may prove useful in other health settings.

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# Contemporary Issues in Rural Health Care Practice

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## Introduction

Increasingly, discussions about the practice of health care social work and integrated care are giving greater attention to the arena of rural health care. Rural health care introduces specific challenges that social work practitioners need to be cognizant of and prepared to address. These challenges include reduced availability of health care practitioners, reduced or restricted access to hospital and emergency services and the potential impact of patients' cultural attitudes on their use of health care services.

Discussion of rural health care issues should be a required component of social work education. This chapter examines common issues in rural health care, the roles and necessary communication skills of a rural health care social worker, and the state of mental health services in rural environments. An exploration of the use of technology, including the addition of telecare and social networking as treatment tools, is provided. Lastly, a discussion of the challenges and opportunities of rural health care provides an opportunity for final reflection upon the integrated role of health care social workers in rural settings. Settings such as physician offices, mental health clinics, hospitals and public health clinics empower rural social workers to integrate nontraditional roles. Taking leadership in innovative integration of health care delivery expands the rural health care social worker's responsibilities and provides for diverse challenges and opportunities unique to the rural environment.

## Defining Rural Health Care

In order to understand the context of rural health care, it is critical to understand what is meant by rural. Ecological definitions of the term, from which most official definitions are based, focus on the characteristics of small population size, low population density and isolated populations (*Ashley & Maxwell, 2001*). The most prominent official definition of rural is that of the United States Census Bureau. The Census Bureau measures urban as settled areas with high population density. Urban areas (settlements of at least 50,000 people) and urban clusters (settlements of at least 2,500) consist of census tracts with a population density of at least 1,000 people per square mile and the adjacent census tracts with a population density of at least 500 residents per square mile (*United States Census Bureau [UCSB], 2007*). By default, anything that is not classified as urban is deemed rural. Using the Census definitions, approximately twenty-one percent of the United States population lived in rural areas in 2000 (*UCSB, 2011*).

Definitions of rural are arbitrary and, as such, have no inherent meaning beyond what is prescribed at that moment. Is a community with 2,501 residents measurably less rural than one with 2,500? Communities that are determined to be adjacent to an urban area, and as

such have lost their rural designation, may still perceive themselves as rural communities and continue to struggle with rural issues. For example, rural health care social workers may work with patients who hold traditional attitudes towards health and mental health treatment. Awareness of these attitudes and their impact on help-seeking behaviors for health and mental health concerns would be critical for a social worker to be effective in practice.

Different definitions of rural may also have a larger impact on service provision for rural residents and communities (*Isserman, 2005*). Depending upon the definition, estimates of the United States population who are rural can range from 17 to 49 percent (*Cromartie & Bucholtz, 2008*). Because the percentage of Americans residing in rural settings changes depending upon the definition used, it is possible that fewer people are classified as rural (than in actuality are rural) and subsequently the government may reduce overall funding for rural communities. Rural communities are more dependent than their urban counterparts upon government funding for mental health care (*Office of Rural Health Policy, 2005*). The allocation of resources to rural communities has important ramifications for the ability of communities to provide adequate health care services for their population. The allocation of resources to increase the availability of medical services subsequently affects the services provided by the rural social worker and creates the need for integrated care. Integrated care such as the addition of social work services into rural primary care practice, technology based health care and integrated social work education are a few opportunities to consider for the rural population.

## **Rural Health Care Issues**

Although many health care issues are universal, a rural setting often exacerbates or complicates these issues. Rural populations tend to have higher unemployment and higher percentages of poverty, uninsured and underinsured community residents than urban areas (*Hart, Larson, & Lishner, 2005*). Economics, coupled with the traditional values and geographic isolation of rural life, have created an environment where residents are oftentimes unable to get their health care needs adequately served. A useful framework for exploring rural health care needs is to think in terms of availability, accessibility, and acceptability (*Bushy, 2005*).

### *Availability of health care services*

The availability of health care services refers to the presence, or lack thereof, of health care practitioners and services. The number of primary care physicians in rural areas is decreasing and recruiting and retaining primary care providers is of utmost importance for rural health care (*Seshamani, Van Nostrand, Kennedy, & Cochran, 2009; Gamm, Castillo & Pittman, 2003*). Positions in rural clinics are more likely than those in urban areas to have long-term vacancies and trouble filling open positions (*Rosenblatt, Andrilla, Curtin, & Hart, 2006*). Many rural family practitioners are retiring and are not being replaced in rural areas. The need to balance family life and medical practice, child care issues and social isolation are a few of the barriers for practitioners in the rural setting (*Wainer, 2004*). Additional factors such as geographic and professional isolation, the lack of recreational opportunities, and

limited employment and educational options for family members all contribute to the rural health practitioner shortage.

The availability of services at rural hospitals is declining. Rural hospitals face severe economic challenges and many have incurred significant budgetary deficits. Far too many rural hospitals have out-dated medical equipment and are not equipped with the latest technology for patient services. The Medicare Rural Hospital Flexibility Program (Flex) was designed to assist states in maintaining rural health care service by improving collaborative health care services, with an emphasis on emergency services and increasing the designated number of critical access hospitals in rural areas (*State Office of Rural Health, 2010*). A growing number of small rural hospitals have closed or changed their classification to become a critical access hospital. A critical access hospital “must be more than 35 highway miles or 15 secondary road miles from another full service hospital. The number of beds and length of stay must be limited and 24 hour emergency care must be available” (*Capalbo, Kruzich, & Heggem, 2002, p. 27*). However, a consequence of this program is that services available to the patient are limited.

Critical access hospitals may choose to not provide obstetric services or other vital medical services which would be available at an urban hospital. A person experiencing a cardiac event in a rural setting will usually need to be transported by air or ground to a hospital specializing in cardiac care. Patients can die en route if inclement weather, traffic, or other delays prolong transit. For example, a twenty minute helicopter ride to a cardiac care hospital may take two hours by ambulance if weather grounds the helicopter. When time to treatment matters, residents of rural communities are at a disadvantage.

#### *Accessibility of health care*

A second critical issue in rural health care is access to services. Residents of rural communities are less able to access health care services because of cost and transportation needs. Residents of rural communities are more likely to be living in poverty than those in urban areas and 88 percent of counties with high, long-term poverty in the United States are rural (*Joliffe, 2004; Kusmin, 2007*). According to *Bolin & Gamm (2003)*, the high poverty found in rural areas negatively impacts the availability of employer-based health insurance programs and premium costs. With the high costs of health care, high levels of poverty, and lack of health insurance, basic health care often suffers. People who lack health insurance coverage are more likely not to use preventive services such as mammograms, and not seek care for chronic diseases such as diabetes (*Bolin & Gamm, 2003*).

Limited transportation options also hinder access to services needed by rural patients. Rural areas frequently have no or limited mass transit options available. *Chan, Hart and Goodman (2006)* found patients in rural areas will seek treatment from their general practitioners rather than travel to see a recommended specialist. Nonmetropolitan residents have also been found to face significantly longer travel times to the closest physical health physicians and have fewer physicians within 30 minutes of their home (*Fortney, Rost, and Warren, 2000*). The major mode of transportation in rural areas is a personal vehicle. The

increasing cost of fuel has created a new barrier for residents to seeking appropriate medical attention outside of the rural area.

### *Acceptability of health care*

Acceptability refers to the attitudes and beliefs of people towards health care. Rural residents oftentimes hold traditional values, including self-sufficiency and independence, and are likely to want to conform to group norms (*Office of Rural Health Policy, 2005*). In part because of these attitudes, residents who are unable to pay for services are less likely to seek health care services (*Mueller, Patil, & Ullrich, 1997*). Attitudes towards self-sufficiency also mean that rural residents are less likely to use preventative services. Health promotion and disease prevention in general is not a high priority in the rural environment. Rural residents seek care when care is needed. Many rural areas lack integrated health services such as support groups and educational resources for diseases and disease prevention. Examples include Alzheimer's resources, caregiving resources, and specific disease resources such as heart disease, stroke or cancer information. Changing the rural culture to include preventative health care is an issue which needs to be addressed.

## **Roles of a Rural Health Care Social Worker**

The roles of rural health care social workers are similar to their urban counterparts; the difference lies in the breadth and depth of services social workers may need to provide. Dubois & Miley (*2011*) discuss the roles of social workers, including those of resource broker, advocate, and community outreach worker. The rural health care social worker roles include all of the above, but extend to all populations within a community. For example, in the rural hospital setting, the medical social worker visits patients who represent the entire life span. The social worker may begin the day in obstetrics visiting a teen mom who has chosen adoption and end the day working with the family of a 78-year-old male in intensive care.

A rural health care social worker's role demands a greater emphasis on acting as a resource broker to better connect patients with the relatively limited resources and educational opportunities in the community. The rural social worker will need to identify and investigate both formal and informal community resources and services (*Haxton & Boelk, 2010*). Resource limitations may include the lack of transportation for patients and their families, community services such as meal delivery to homebound patients and educational support groups such as caregiver support groups. Due to limited resources, the rural health care social worker must, even more than urban social workers, be aware of informal support networks, such as church groups, neighbors and other family members, as possible means to meet the patient's care needs.

In the hospital setting, patients frequently view the social worker as an extension of the nurse and may in fact call the social worker "the nurse I saw yesterday." By identifying his or her health care roles, the social worker is defining the importance of those roles. Educating a patient on advance directives options, for example, allows the social worker to

promote the roles of educator and advocate. The social worker provides the patient specific information about advance directives in simple patient-focused language and provides written material to supplement verbal communication. Allowing sufficient time to discuss material and answer patient questions creates a supportive environment for the patient. The social worker advocates the patient's advance directive wishes throughout the continuum of care. The patient sees the social worker as a person who listens and will be a voice during hospitalization and beyond.

The rural health care social worker has a key role in community outreach, leadership and advocacy. Community outreach and education is an important role of the rural health care social work professional. There is oftentimes limited understanding among community residents about the purpose of social workers. What knowledge does exist may be tinged with stereotypes, perpetuated in film and television, of social workers as adversarial to families. This lack of clear understanding makes it imperative for a health care social worker to be a part of the community. The social worker should participate in community-based activities outside of work. Forging community ties will help residents know that the health care social worker is an advocate for the community. Because of poverty often found in rural communities and the subsequent reliance on outside funding sources, the health care social worker must oftentimes advocate for continued or new funding from public and private sources. This advocacy role has ramifications beyond the local community. Rural health care social workers should also advocate for additional training and education about rural social work practice in the social work education curriculum (*Riebschleger, 2007*).

Integrated care expands the rural health care social worker's role. The rural health care social worker functions as an interdisciplinary team member, utilizing social work skills and competent practice behaviors to address the patient's goals and outcomes. The social worker works in conjunction with other health team professionals to coordinate a treatment plan for the patient. Although the interdisciplinary team approach also applies to urban settings, the rural setting provides for an increased familiarity amongst team members with each other outside of the professional setting. Team members may attend the same church, utilize the same banking institution or have other links between their social networks. This familiarity may be an asset in developing professional ties that allow for better coordination of integrated care for clients.

Finally, rural perspectives on health integration extend to health professional education. One example comes from the University of New Mexico Health Sciences Center, where a rural health interdisciplinary educational program has been developed. The program integrates coursework from various health professionals into the curriculum and allows health professional students to gain knowledge about various health fields. Students from diverse health professions, including nursing, physicians, and social workers, engage in professional trainings to better understand other health care perspectives (*Geller & et al, 2002*). This type of programming has promise in helping improve the relationships among rural health providers and may serve to decrease professional isolation by creating an integrated network of colleagues.

## **Requisite Communication Skills**

Communication is the foundation of social work practice, particularly in the rural health care setting. When a person's health is compromised, the person is likely to experience anxiety and concern regarding him/her and family. Listening and providing empathy to the person will lessen the person's level of anxiety. The use of simple language and avoidance of medical jargon, which the patient or family does not understand is especially important. The social worker should use non-verbal communication as appropriate and watch for patient non-verbal cues.

When working with larger systems, rural health care social workers must also be aware of (often unstated) communication dynamics. They must take time to become familiar with the dynamics of the rural community and its people before they can be effective (*Ginsberg, 1998*). Rural communities oftentimes have underlying power and social structures that may not be apparent. It is not uncommon for certain individuals and groups, whether because of tradition, economics, or social connections, to exercise power behind the scenes. Assessing the "structure of local power" is necessary to understand how change occurs in rural communities (*Flora, Flora, & Fey, 2004, p. 129*). Identifying the leaders within these structures is critical. The use of community leaders in a rural setting to initiate dialogue for new ideas is a crucial step in promoting initiatives (*Haxton & Boelk, 2010*). Community leaders such as political officials, clergy, educators and business owners will enhance ownership when integrating rural health care improvement. The rural health care social worker also has the unique opportunity to listen to community members at local businesses and restaurants. These local establishments serve as communication outlets for people to vent their frustrations on issues important to them and can be an important way for a social worker to learn about the needs and wishes of the community.

## **Rural Health Care and Mental Health**

Parallel to the concerns about physical health in rural areas are issues concerning access and treatment for mental health issues. Those living in rural areas have a greater risk of not receiving mental health care when needed. Non-metropolitan counties are four times more likely than metropolitan counties to not have mental health services (*Gamm, Stone, & Pittman, 2003*). More than 85% of the mental health professional shortage areas designated by the federal government are found in rural areas (*Bird, Dempsey, & Hartley, 2001*).

Mental health services that do exist in rural areas are often piecemeal and uncoordinated. Estimates place the number of rural citizens showing indications of mental illness who fail to receive any care as high as two-thirds (*Office of Rural Health Policy, 2005*). Reiger and colleagues (as cited in the *Office of Rural Health Policy, 2005*) found that for those who do obtain treatment, only 40 percent receive that care from mental health specialists. A significant portion of individuals who do receive mental health care in rural settings utilize a general practitioner rather than a mental health professional. While use of a general practitioner for mental health is also found in urban areas, Rost, Williams, Wherry and Smith (*1995*) found that rural doctors were 50 percent less likely to detect depression in

their patients. High rural poverty means that a significant number of residents are unable to afford the cost of services and, if the services are located in outside one's home community, the expense is increased due to travel costs. Even those rural residents who have purchased small group or individual health insurance oftentimes cannot afford behavioral health coverage (*McDonnell & Fronstin, 1999*). The cost of treatment may then keep people from receiving treatment until a crisis point is reached or the mental health issues negatively impact multiple arenas of a person's life (e.g., family and work).

The integration of mental health professionals into the primary care physician's office has been studied in the urban areas with positive outcomes. In this integrated model, mental health professionals collaborate on the treatment plan of the patient. The physician seeks guidance from the mental health professional and the mental health professional has the opportunity to work in an environment familiar to the patient. The patient, by virtue of being seen by the mental health professional in the physician's office, is more comfortable with the interaction. This model can also be utilized in the rural health care setting to increase the use of mental health services and reduce mental health stigma (*Aitken & Curtis, 2004; Badger, Ackerson, Buttell & Rand, 1997*)

The realities of a rural lifestyle and the traditional attitudes and values in a community can have a negative impact on the mental health of rural individuals. The nature of farming, and the reliance on unpredictable weather, can elevate stress. Frequently, rural residents may view asking for help as a sign of weakness. The impact of acceptability of services is even more powerful when discussing mental health treatment. The small size of rural communities means that recipients of treatment cannot be guaranteed their privacy. Even though confidentiality is maintained by the social work professionals, communities may know when a community member is seeking mental health assistance. The rural health care social worker must collaborate with community members to eliminate the stigma by developing community in-service mental health presentations, strengthening the mental health support system through group work, and network with other rural health care professionals on innovative programs which focus on the mental health stigma in society.

## **Technology Use in Rural Health Care Settings**

The integration of technology in the rural health care setting has created innovative programs in telehealth, telecare and social networking.

### *Telehealth*

Telehealth or telemedicine is becoming more widely used in the rural health care setting. Telemedicine is defined as "the use of electronic information and communication technologies to provide and support health care when distance separates the participants. A telemedicine network "connects distant 'spoke' sites, often located in rural communities with one and another and also with a 'hub' site, which is usually a larger urban center" (*Capalbo & Heggem, 1999, p. 8*). While the term telemedicine is more commonly used, the term telehealth is more comprehensive and is becoming the term used more often in the health-

technology vocabulary (*McCarty & Clancy, 2002*). Telehealth provides a rural health care setting an opportunity to offer additional services and improve the cost-efficiency of existing services (*Capalbo, Kruzich, & Heggem, 2002; Whitacre, Harman, Boggs & Schott, 2009*). The advent of telehealth technology means that rural health professionals, including rural health care social workers, are now able to collaborate with colleagues and better integrate services for their patients.

Telehealth alternatives reduce the need for costly trips by both patients and professionals. Telehealth allows the patient to stay in the community for health services such as medical tests and can be used for (but not limited to) services such as radiology, mental health, home health, hospice, cardiology, oncology and pediatrics (*Whitacre, Harman, Boggs & Schott, 2008*). Patients utilizing telehealth alternatives do not have to take time off work to travel to a distant health care facility. A patient may miss an entire day's work when traveling to an alternative location for a medical test. Rural health care professionals can also take advantage of telehealth to access to continuing education (*Williams & Cutchin, 2002*). Health care professionals can interact with colleagues in a learning environment necessary for professional and personal growth, while saving on transportation expenses and reducing their time spent away from practice.

The use of telehealth technology is widely used in the mental health field and is increasing in degree of practice (*Surface, 2007*). The integration of video conferencing with mental health sessions is popular with many social work professionals. Video teleconferencing involves a patient or patients at one location and a mental health professional at a different location communicating with each other through the use of a monitor or screen. A team approach can also be utilized with video conferencing. Another health care professional (e.g. nurse) is in the room with the patient and can observe and communicate non-verbal cues the mental health professional may not see during the session (*Surface, 2007*). One key advantage of utilizing this technology is that it allows the patient access to the same mental health professional even if the professional has relocated to a different community. This allows the rural patient the continuity so important in the patient/professional relationship (*Surface, 2007*).

The home health field has used telehealth for home health visits in some rural settings. Although telehealth has been used primarily with home health nurses, home health social workers can also utilize telehealth for subsequent social visits (*McCarty & Clancy, 2002*). In remote geographical locations such as Alaska, where weather may hamper a visit, an online visit may be useful to provide emotional support and avoiding patient isolation.

There is resistance among health care professionals, including social workers, about using telehealth technology. Health care professionals are more willing to accept the use of telehealth when they see the advantage to access to care and the openness of patients to communicate and share personal information (*Surface, 2007*). The expansion of payment for telehealth services has also impacted the usage of telemedicine. As technology continues to develop, new opportunities for telehealth may increase its use. For example, the use of smartphones as a tool in telehealth is just beginning to be recognized (*Jensen, 2011*). Rural health care social workers will also have a role in educating and advocating for the use of

new technologies in providing services. Rural health care social workers may serve as the liaison between agencies and patients and educate the patient, family members and health professionals on adjusting to new innovations in health care.

### *Telecare*

Telecare is a service that utilizes technological assistive devices such as alarms and medication monitoring systems to support activities of daily living (Rowney, 2007; Smith, 2008). The use of telecare is increasing in the health care arena. Telecare is primarily used for homebound older adults, veterans or rural residents (Hersh et al., 2001). Telecare education and usage has primarily focused on the nursing profession but the concept is certainly applicable to social work practice. Software to promote patient relaxation, especially in the use of pain management, is one example of social work integration to telecare. While telehealth is used primarily for communication between health care providers, telecare is concept which allows a person with impaired health the opportunity to maintain independence in the home.

### *Social Networking*

Another innovative use of technology in rural health care is utilizing modern, technology- based forms of social networking. “A social network is a configuration of people connected to one another through interpersonal means, such as friendship, common interests, or shared ideas” (Coyle & Vaughn 2008, p. 13). By this definition, society has utilized social networking for centuries. In today’s technological society, social networking refers to online social networks that integrate communication and technology through various tools. The use of social networking in health care includes the creation of support groups for diseases such as diabetes and cancer (Kamel Boulos, & Wheeler, 2007). These support groups provide collaborative support and disease education to members. Social networks have the flexibility to be open to anyone interested in the shared interest or be private and accessible to members only. For the rural population, social networking is a bridge linking everyone to a common interest. Within a social networking site, the consumer can blog, announce upcoming events, initiate a discussion forum and develop educational links for educational purposes.

## **Challenges and Opportunities in Rural Health Care Settings**

### *Challenges*

Challenges in the rural health care setting involve many of the health care issues presented in this chapter. Recruiting medical and mental health physicians to practice in rural areas continues to be a challenge. The closing or consolidation of rural hospitals creates physical and emotional barriers to residents in a rural community. The lack of health insurance or higher premiums with health insurance access creates additional challenges to community residents already struggling with ongoing loss of jobs and higher unemployment. The lack of services, especially transportation, builds geographical and psychological barriers which can lead to social isolation in a community. The lack of mental health access in rural

communities not only affects residents now, but will have lasting effects across generations.

Rural residents are still less likely than their urban counterparts to have high-speed Internet access (*Whitacre & Mills, 2007*). While it is possible that this is due in part to failure to adopt available technology by rural residents, analysis of Internet use by resident income and general population characteristics provides evidence that availability is limited in some rural settings (*Stenberg, Morehart, Vogel, Cromartie, Breneman, & Brown, 2009*). In order to best capitalize on telehealth and social networking opportunities afforded by new technologies, rural health care social workers need to work with their communities to advocate for and invest in high-speed Internet access.

Rural health care social workers will also need to be aware of the ethical challenges of practicing in rural communities. “Ethical issues are often more acute in rural or isolated health care settings primarily because usual practices to ensure ethical conduct are narrowed by the scarcity of health care resources” (*Roberts, Battaglia, & Epstein, 1999, p. 499*). Ethical considerations include managing dual relationships, privacy and confidentiality, boundary issues, and competency concerns created by professional isolation.

Within the role of the rural health care social worker, dual relationships constitute a major area of concern. Managing dual relationships is a challenge for all health care social workers, but is especially difficult in a rural area due to the smaller populations. Because of the heightened likelihood of dual relationships in rural settings, it is important to include a discussion of dual relationships during the patient’s initial assessment process. It is also important to consider how to address existing dual relations with the patient (*Galambos, Watt, Anderson & Danis, 2006; Reamer, 2004*). When possible, the patient should be reassigned to a different social worker; however, in a rural social work setting, referral may not be an option. If the nature of the dual relationship does not automatically preclude the social worker from treating the patient (e.g. an intimate relationship), a social worker who treats a client with whom there is a dual relationship should actively seek out opportunities for consultation and be forthright with the patient about the need for professional boundaries.

Patient confidentiality and privacy can be more difficult to maintain in rural settings. Rural areas often have strong ties between community members, through work, family, religious, and social outlets, that foster a sense of ownership in others’ personal lives. People may recognize who is receiving treatment from the cars in the parking lot or have heard through the community grapevine. Once people believe they know who is receiving services, a social worker may find themselves inundated with questions or advice about the patient. Although the specific purpose of the health care social worker may not be known, the public perception that the social worker “needs to take care of the situation” is widespread in a rural community. Because community members will know the social worker, many may feel comfortable in offering advice or dictating directions for intervention. For example, an elderly patient’s neighbor tells the social worker, at a local establishment, that he saw the elderly patient’s son take furniture out of the patient’s home. The neighbor wants to know “what’s going to do about it.” A rural health care social worker will need to take preventative steps to protect patients’ privacy and educate the community about the need for confidentiality and the limits of service.

Finally, it is important to recognize professional isolation and its impact on competent social work practice in a rural setting. There may be only one health care social worker in the entire community. The nearest social worker may be 200 miles away or farther depending on geographical location. The professional isolation may drive social workers to offer services outside the scope of their training because there are few to no feasible options for patient referrals. However, even with the best of intentions, rural social workers must recognize the limits of competency and the potential harm they may be doing. Rural health care social workers must explore networking opportunities which are available, take advantage of continuing education trainings, and, possibly, utilize telehealth as a means to both reduce their professional isolation and increase their knowledge and skill set.

### *Opportunities*

Just as there are challenges, there are a wide range of opportunities in rural health care. A variety of innovative programs have been created to better prepare rural communities to meet the health care needs of their residents.

As previously reviewed, one of the most pressing needs in rural health and mental health is the recruitment and retention of practitioners. Several programs have had some success in attracting qualified health care professionals to rural communities. Recruitment of rural practitioners has also proven successful when economic and professional incentives such as loan forgiveness programs and promotion opportunities are provided (*Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007*). One loan forgiveness program is the National Health Service Corp (NHSC). The NHSC works to increase the number of health and mental health practitioners in underserved, oftentimes rural, areas. As part of the NHSC program, licensed clinical social workers are eligible for loan repayment upon fulfilling a commitment to serve in these areas (*Health Resources and Service Administration, 2010*). Professional education and training opportunities which focus on the advantages of rural practice have also proven successful. Medical educators' curricula which focus on the advantages of generalist medicine and rural practice have proven to be valuable tools in recruiting rural primary care physicians. Another successful technique has been to recruit practitioners with past ties to rural communities (*Balance, Kornegay & Evans, 2009*). Social work education programs that emphasize the recruitment of rural community members, such as the one at Eastern New Mexico University, represent an important way that social work can help train new practitioners for rural communities.

The Southeast Kentucky Community Access Program (SKYCAP) was developed to improve availability to health care which includes emergency medication access, dental care, eye care, primary providers, home visits, education, transportation and eligibility for pharmaceutical programs for the indigent (*Bolin & Gamm, 2003*). This program serves residents in the Appalachian region. Family health navigators (FHNs) are being utilized in this program to assist clients with medical/social health care needs. While most patient navigators are nurses, social workers can serve as navigators based on the needs of the patient. Patient navigators serve as facilitators, service coordinators, patient liaisons, and advocates (*Darnell, 2007*). Through social work education and practice competence, health

care social workers have been trained to provide these services in the health care setting. The rural health care social worker has the opportunity to serve as a leader in patient navigation.

A rural West Virginia community action agency, in collaboration with other health care organizations and institutions, established The CHANGE Inc. Health Care Center which serves residents without employer-sponsored health insurance who are in need of health care services. A rural transportation program which is part of this agency, allows patients without access to cars, the opportunity to utilize this program to travel to local and regional hospitals as needed (*Friedman, 2003*).

Rural health care social workers have an opportunity to participate in research projects addressing rural health care issues. Integrating evidence-based practice with research enables the health care social worker to address key rural health care issues and be an active change agent. It is imperative that rural social workers remain knowledgeable about health care issues, innovations and integration of services by reading journal articles, attending conferences and webinars, and taking continuing education courses (*Cohen, 2003*).

Integrating technology into the social work arena is an opportunity social workers must explore. Given the literature on the future use of technology in health care, rural social workers can serve as leaders in promoting technology without jeopardizing the ethical responsibilities to the clients, colleagues and society.

## Summary

Health care delivery in rural areas poses unique challenges. Social work services are an integral component of rural health care. Availability, accessibility, and acceptability of services are key factors for evaluating integrated care. Physical as well as mental health care delivery issues underscore the logic of integrated programs in rural settings. Evolving roles of rural health care social workers and their valuable communication skills represent crucial elements in the integration of care.

While many challenges exist for rural health care social workers, numerous opportunities also exist to develop and lead health care community programs. Collaboration with colleagues is clearly vital for successful health care program integration. Social workers should recognize these opportunities and maintain significant roles advancing health care practice in rural settings.

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## **Rush Enhanced Discharge Planning Program: A Model for Social Work-Based Transitional Care**

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### **Introduction**

The Enhanced Discharge Planning Program (EDPP) at Rush University Medical Center is a social work-driven, telephone-based model for providing transitional care to patients returning home after an inpatient hospital stay. EDPP is designed to address the nonmedical factors contributing to poor transitions, particularly for patients deemed “at risk” for re-hospitalization due to complicated psychosocial situations. Following EDPP protocols, trained social workers engage patients and their caregivers, assess their post-discharge needs, and intervene to ensure the patient is safe and well supported at home. After nonmedical barriers are addressed by the EDPP social worker, patients and caregivers are better able to address the medical plan of care, which in turn allows patients to avoid preventable readmissions and mortality. EDPP is a promising model for transitional care built upon social work skills and abilities, creating a vital role for social work within the nation’s health care delivery system.

### **Background**

Over the past several years care transitions have emerged as a topic of interest for those working to improve health care quality and safety. The interest is driven by a simple fact: poor transitions are dangerous and costly. Moving from one health care setting to another leaves patients vulnerable to negative outcomes resulting from gaps in service, incomplete transfer of information, and transition from one team of providers to another. Negative outcomes can be exacerbated by changes in the care plan, patient function, and diagnosis that can accompany a hospital stay. Heightened risk due to psychosocial factors such as low health literacy, difficulty coping, and limited self-management skills can create even more opportunity for adverse events post-discharge, particularly if medical complexity is also present.

Poor transitions are particularly dangerous and expensive for older adults and people with chronic conditions, some of health care’s top users. Nineteen percent of patients experience an adverse event within three weeks of discharge (*Forster, A., Murff, H., Peterson, J., Gandhi, T., and Bates, D., 2003*), and 18% of Medicare beneficiaries are readmitted to the hospital within thirty days (*Commonwealth Fund Commission on a High Performance Health System, 2008; Friedman, B., & Basu, J. 2004*). In 2005 alone, Medicare spent \$15 billion on hospital readmissions (*Commonwealth Fund Commission on a High Performance Health System, 2008*). Thirteen percent of those readmissions are thought to be preventable, according to the Medicare Payment Advisory Commission (*Medicare Payment Advisory Commission, 2007*). More importantly, many of those re-hospitalizations have little

to do with medically related complications: 40% to 50% can be linked back to social or nonmedical reasons (*Proctor, E.K, Morrow-Howell, N., Li, H., and Dore, P., 2000*).

For these reasons, transitional care models have been created to support patients as they move across care settings. These models operate with the goal of preventing unnecessary re-hospitalizations by educating on medical issues, supporting patient self-management, and engaging patients in their own care (often referred to as “patient activation”). While these models have shown success in preventing re-hospitalization, they are often not designed to specifically address the nonmedical factors contributing to adverse events.

Further, the rise of research on social determinates of health and the role of psychosocial and environmental factors in health outcomes yield a growing interest in determining approaches to address these issues. Factors such as stress, social exclusion, work, social support, food, and transportation drive patient outcomes, particularly for older adults and people with chronic conditions (*Wilkinson, R. & Marmot, M., 2003*). These factors contribute to how well patients and their caregivers can attend to health needs, as these social factors often conflict with the ability to adhere to medical care plans.

## **The Enhanced Discharge Planning Program: The Pilot**

The Enhanced Discharge Planning Program (EDPP) exists at the intersection between the medical and the social and between the hospital and the community. EDPP started in 2007 as a collaborative effort between Rush University Medical Center’s Older Adult Programs and Department of Case Management in response to a need perceived by inpatient staff. Hospital discharge planners reported feeling concerned about their inability to know what happened to patients after they returned home from an inpatient stay. The discharge planners worked to create the best possible plan in the time available before a patient was discharged, but they would often have concerns about patients with complex situations. Due to the parameters of their position, the discharge planners did not have the capacity to follow up with patients in the community. As a result of these concerns and to ensure patient safety, outpatient social workers in Rush’s Older Adult Programs department began contacting patients post-discharge.

At the program’s inception, discharge planners would refer patients to EDPP by telephone or email. While there was no formal referral criteria, patients tended to be over 60 with a complicated psychosocial situation anticipated post-discharge. The EDPP social worker would call the patient or their caregiver within 2 working days of discharge. The social worker would evaluate the patient’s situation, identify gaps in service, and intervene until the patient was stable at home. The intervention’s goals were to ensure the patient’s safety and ability to adhere to the plan of care and to prevent any complications from becoming catastrophes post-discharge. While the process for receiving referrals changed after this initial pilot period, the goals remain the same.

## **The Enhanced Discharge Planning Program: The Model**

After the first two years as an informal pilot, official protocols were built for the EDPP intervention. The four step process is detailed below.

### ***Step 1: Referral***

#### ***Main Task: Identification***

During this step, patients are identified and referred for assessment and intervention. The hospital's electronic medical record facilitates this process. An automatic daily report identifies at risk patients discharged the day prior based upon inpatient nursing and discharge planning documentation in Epic, the hospital's electronic record system. The use of an electronic risk report removes the subjectivity of referrals and enables the screening of all admitted patients for post-discharge risk.

Factors included in EDPP's risk screen were determined through a thorough literature review, interviews with discharge planners, and analysis of two years of pilot data. The screen places emphasis on psychosocial risk factors and issues social workers are particularly skilled at addressing, such as systems, benefits and access, and emotional and coping issues.

To be eligible for EDPP, patients must meet three baseline requirements: 1) be 65 years of age or more at the point of discharge; 2) have seven or more medications prescribed, and; 3) be returning to a home rather than institution after discharge. Once baseline eligibility is achieved, patients must also have one additional risk criteria present. High risk considerations include:

- patients living alone
- no known source of emotional support
- no known support system for care in place
- discharges with a service referral
- patient high falls risk
- inpatient hospitalizations in past 12 months
- identified in-depth psychosocial needs, and
- high-risk medications prescribed

“In-depth psychological need” is a special category documented by discharge planners. It includes, but is not limited to an array of potential issues such as:

- Patient or family conflict or concerns
- Difficulty adjusting to an illness or diagnosis
- Safety issues or risk of harm in the home
- Mental health concerns
- Issues with the teaching or learning of new treatments or regimens
- Issues relating to the patients' support system
- Financial constraints
- Substance and/or alcohol abuse
- Legal issues
- Suspected compliance issues

## ***Step 2: Pre-Assessment***

### ***Main Task: Research***

During this step of the model, the EDPP social worker reviews the patient's hospital chart in the electronic medical record. The goal of the review is to understand what happened while the patient was in the hospital and to anticipate complications that may emerge once the patient is at home based upon that information. The social worker seeks to answer several specific questions:

- Why was the patient admitted to the hospital?
- What happened during their inpatient hospitalization?
- Were there any major changes while the patient was in the hospital relating to diagnosis, function, or other area?
- Does the patient have an identified caregiver? What is the status of the patient's social support system?
- Who is part of the patient's care team, including any services already received in the home and the patient's primary care physician?
- Does the patient have any known deficits in capacity for self-management, health literacy, or ability to follow up with the medical care plan?
- Are there any gaps in knowledge about the patient's social or medical situation that could benefit medical care if filled?

The information gathered during the pre-assessment informs the work done during the assessment phase and lays the groundwork for the EDPP intervention.

## ***Step 3: Assessment***

### ***Main Task: Engagement***

During the assessment phase, the EDPP social worker calls the patient and their caregiver, if appropriate, within two working days of discharge. The goal of this phase is to engage the patient and/or caregiver and begin to identify any complications or gaps in care happening at home. The EDPP intervention begins with standard questions about the patient's follow-up medical care plan and their support system. The questions touch on common logistical and emotional issues many patients face when returning home.

Logistical questions address issues such as the understanding of the discharge plan of care, the plan for obtaining medications, the status of services used in the home, the presence of a plan for follow-up medical appointments, and the awareness of what to do in the event of complications. Questions about the patient's and caregiver's emotional and social situation focus on identifying strengths and weaknesses in personal coping abilities and support network. These logistical and support questions identify areas needing intervention and serve as a tool for building rapport.

After these initial questions are answered, the EDPP social worker uses information gathered in the pre-assessment phase to ask targeted questions about specific issues a particular patient may be facing. Common problem areas addressed include:

- *Transition/Discharge Plan:* Relate to the actual transition; typically time limited, and may include dissatisfaction with the discharge plan or a lack of clarity on the plan, issues with coordination between care providers, difficulty obtaining services in the discharge plan, or difficulty with information received in the plan.
- *Home Health Care:* Relate directly to home health care; may include systems issues like delay in service, scheduling conflict, or an agency unable to provide services from the plan, but may also relate to patient concerns such as dissatisfaction with the care provided or language barriers.
- *Follow-up Medical Care:* Relate to patient awareness of the need for medical follow-up and the plan for accessing services; may include transportation issues for getting back to an appointment, issues scheduling an appointment, no primary care physician available or presence of insurance/financial issues.
- *Medication Management:* Relate to medication troubles; may include missing medications, medication reconciliation, problems understanding instructions, or side effects.
- *Self-management:* Relate to the patient's ability to care for themselves; may include issues like pain, functional and cognitive limitations, and health literacy
- *Psychosocial:* Relate to non-medical issues impacting the ability to adhere to the discharge plan of care; may include caregiver burden, socialization needs, spiritual needs, and grief and bereavement.

#### ***Step 4: Intervention***

##### *Main Task: Stabilization*

After the main barriers are identified, the EPDP social worker intervenes until all issues identified during the assessment phase are stabilized, the patient has a plan for ongoing care, and no gaps in service remain. To achieve this, the EDPP social worker may facilitate communication among care providers, assist with linkage to community services, and provide short-term counseling, among many other services. The goal of the EDPP intervention is not to provide long term care management, but rather to link to resources in the community that can provide services on a long-term, ongoing basis. The EDPP social worker concludes the intervention by ensuring the patient and caregiver know how to re-contact the program should new needs arise.

## **The Enhanced Discharge Planning Program: The Research**

### *Structure*

EDPP was studied in a randomized controlled trial with 740 participants from June 2010 to March 2011. Eligible participants were randomized into two groups: an “intervention group” received the full EDPP intervention coupled with a baseline survey, while a “usual care group” received the normal care a patient can expect when discharged from the hospital. Both groups received a follow-up survey thirty days after discharge.

### *Quantitative Findings*

The EDPP social workers identified barriers for 83% of intervention group participants. These problems did not emerge until after discharge for 74% of participants with barriers. The average intervention lasted 5.8 days and required 5.4 calls to resolve. Seventy-one percent of participants needed more than one call to resolve their issue, indicating their need required some intervention from the EDPP social worker. Problems encountered by patients post-discharge most commonly related to self-management, coping, educational needs, and required services. In response, the social worker most commonly provided emotional support, educated, and facilitated communication.

Early findings revealed that EDPP participants experienced significant improvement in understanding why they were taking their medications as well as in patient and caregiver stress. The intervention group and the usual care group also showed differences in understanding of responsibilities for managing care, as well as differences in post-discharge utilization of medical care. Patients in the intervention group were significantly more likely to communicate with their physician, schedule an appointment, and keep that appointment. This is thought to relate to the EDPP social worker's ability to aid scheduling, eliminate barriers like transportation, and educate on the importance of post-discharge medical follow-up.

A review of readmissions to Rush University Medical Center revealed that while there was no significant difference in readmissions to Rush within 30 days of discharge, a statistically significant difference occurred when the readmission timeframe was extended. Intervention group participants experienced statistically lower rates of readmission to Rush within 60 and 90 days of their original re-hospitalization. Additionally, intervention group participants (2.2%) showed lower mortality rates at 30 days when compared to usual care group participants (5.3%).

Twenty-nine percent of intervention group participants recontacted the EDPP social worker after their case was closed. This suggests EDPP intervention is having a lasting impact on participants, perhaps by connecting them to long-term supports in the community and providing them with a consistent and trusted point of access to health care information.

### *Qualitative Findings*

A qualitative analysis of clinical notes from the EDPP intervention and interviews with the EDPP social workers supplement quantitative findings about the program. The goal of the qualitative analysis was to identify the impact of social workers with geriatric training on improving services for older adults across transitions. Three major themes emerged during qualitative analysis: surprises; an expanded view of the client system, and; relationships.

#### Surprises:

Findings from EDPP show that even the best discharge planning cannot entirely anticipate the reality of discharge. Often, reality does not match expectations: new issues arise, levels of ability or support change, and self-management may be more difficult than

anticipated. EDPP social workers are able intervene around these issues to identify new and emerging issues and resolved them quickly before they turn into larger conflicts.

#### Client System:

Social workers approach their work using a broad definition of “client” which encompasses both the target client system (the focus of the change) and the action system (the resources and people who can help reach goals). As a result of this broader approach informed by systems theory learned during social work training, EDPP social workers are able to stabilize the patient within the reality of their situation using all the available resources.

#### Relationship Building:

One key to EDPP’s success is the ability to engage patients and caregivers in a trusting, helping relationship, rather than just providing “help”. As a result of this trusting relationship, EDPP social workers are able encourage patients to express the truth of their post-discharge situation without fear of repercussion or a “noncompliant” label. This realistic view of the patients’ situations and resources can lead to more effective interventions based upon patients’ needs and abilities.

## **EDPP and Social Work**

### *Discussion*

Findings from analysis of the model highlight the value of EDPP’s use of master’s prepared social workers experienced in health and aging. This helps to ensure the psychosocial and environmental factors influencing health outcomes are addressed in concurrence with medical and physical needs. Social workers are trained to assess people in their environment and are able to identify and intervene around personal, social, and systemic barriers. Social workers are also able to tap into a network of community resources using their extensive knowledge of available services. Lastly, expertise in navigating complex systems and an understanding of care coordination enable social workers to build a bridge between the hospital and the community. As a result, patients are able to understand their care plan, ask questions, get help navigating the system, have their providers communicate with each other, and connect to community resources.

Additionally, EDPP social workers benefit from an interdisciplinary team. The model allows for communication and consultation with numerous different disciplines in the hospital and community, including physicians, nurses, pharmacists, physical and occupational therapists, and other professionals. The EDPP social worker is able to address the non-medical issues impacting patient outcomes, allowing the other members of the team to focus on their areas of expertise. The social worker can tap into the knowledge of the care team when they identify medical needs while helping members of the team learn to identify non-medical barriers for their patients.

### *The Interface between Discharge Planners and EDPP Social Workers*

It is important to understand how the role of EDPP social workers differs from that of discharge planners. EDPP social workers interface with the inpatient clinical team but are *not* directly responsible for coordinating inpatient treatment or the discharge plan of care. They are viewed as extensions of the inpatient team post-discharge to ensure the medical plan of care does not get lost and the patient and caregiver can cope with the demands of care once home. Additionally, while discharge planners make referrals to medical and community-based providers before discharge, their focus is not necessarily to connect those providers to one another. EDPP social workers are able to take that discharge plan and work to connect those providers, bridging the gaps in communication and making new referrals for unmet needs, with the patient and caregiver as the focus of care.

The EDPP model is different from discharge planning contextually, as well. Discharge planners interface with patients and caregivers in the hospital within the context of illness. EDPP social workers interface with patients and caregivers in their living environment with a focus on self-management, recovery, and reintegration into the community. With ever-shorter lengths of stay, discharge planners work with patients for brief and task-specific interventions, such as to determine which service referrals are needed post-discharge. EDPP social workers have the opportunity to ask different questions from discharge planners or the same questions in more depth. Less constrained assessments and interventions help EDPP social workers identify the information patients do not always disclose in the hospital, whether because they were not asked or due to guilt, shame, lack of understanding of the information's importance, or fear of not being a "good patient." EDPP social workers have the luxury of being able to intervene for a much longer time with the duration of intervention driven by the outcome of the post-discharge assessment and needs, rather than the length of the hospital stay. This greater flexibility and time allows for assessments and interventions that are broader in scope, including both task and process oriented interventions.

### *Integration into Health Care: A New Role for Social Work in Health Care Reform*

The successes and challenges of the EDPP model will serve as a guide as hospitals and community providers seeking to meet the requirements of the Accountable Care Act, specifically the demand for greater partnerships between the hospital and the community. An example of EDPP's success in the front is found in the development of a new pilot involving home health care agencies.

During the EDPP RCT, discharge with home health care was found to be a risk factor, particularly relating to the impact of psychosocial factors on home health provision. In response to this finding, Rush University Medical Center created a pilot with several frequently utilized home health care agencies, establishing agreed upon standards for service provision and communication. Greater accountability around these issues has been enforced through the use of an enhanced feedback mechanism between the hospital and these agencies. *Importantly, each agency is expected to have social work services available for patients with high psychosocial needs.* This expectation has resulted in a number of the

agencies hiring master's level social workers to serve Rush patients, acknowledging the important role social workers have on the team in addressing complex social situations. EDPP social workers are able to act as a resource for these home health agencies and their social workers, as well.

The Community Based Care Transitions Program (Section 3026) of the Affordable Care Act represents another opportunity for the expansion of social work's role in health care reform through the use of the EDPP model. In addition to the work done with home health agencies, EDPP social workers have been integrated into an innovative pilot at Rush that uses daily interdisciplinary rounds to focus on identifying and intervening on risk factors, both medical and psychosocial, that impact outcomes for discharged patients. EDPP social workers serve as team members, providing consultation about anticipated complications, system issues, or other outcomes that are both general and patient specific to help with care planning.

In addition, the EDPP model has implications on another component of the Affordable Care Act: Patient Centered Medical Homes. During the EDPP pre-assessment phase, contact is made with primary care physicians in outpatient practices to notify them about the potential for a post-discharge intervention and to inquire about the care needs for each patient. EDPP social workers use this information in their assessments and provide feedback to each physician about intervention outcomes. Once the post-discharge situation is stable, patients needing more intensive care coordination are connected to The Aging Resource Center at Rush or other community services. As more primary care physicians gain exposure to the EDPP model, its potential impact on Accountable Care Organizations, another component of health care reform, increases, as well.

EDPP's meaningful role in both inpatient and outpatient care provision shows how social work can be integrated into health care in a meaningful and valuable role as part of health care reform. Growing attention is focused on care transitions and care coordination, particularly in how they relate to reducing health care costs and readmissions within 30 days. EDPP shows how these activities can be accomplished effectively by social workers.

## **Summary**

The Enhanced Discharge Planning Program is a model for care coordination across settings and providers. The program is built upon a foundation of social work education and theory, making it widely generalizable to multiple hospital and community-based settings where social workers practice. EDPP analysis contributes to an evidence base for care coordination, strengthening the case for its integration into medical care and outlining a process by which it can be provided.

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# **Educating Social Workers for Transdisciplinary Practice**

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## **Introduction**

Previous chapters have afforded excellent examples of integrated care coordination as it has evolved from the early decades of the 21<sup>st</sup> century. For many readers, however, the terms and models are not all that new. They have been part of social work vocabulary and practice for years. What is new is the context in which they are used and the nature of currently needed professional skills.

The concept “everything old is new again” holds much merit and, hopefully, comfort. The practices considered essential to providing benchmark physical and behavioral health care to patients are well known. “Person-in-environment”, “strengths-based” social work, clarifying who the “client” is, and collaborative transdisciplinary practice are all long-standing social work tenets.

It has long been true that to be timely and effective, health care social workers need to be proactive, creating systems to identify patients likely to need help, rather than waiting for referrals from physicians or nurses (*Rehr & Berkman, 1973*). Further emphasis is given to this approach today in integrated and transdisciplinary care programs. Clarke (*1990*) notes that Hyman Weiner’s long-standing idea of using systems and population approaches based on diagnosis or social factors to identify patient groups needing specific services takes on particular importance. In current health care environments, it is vital for social workers and fieldwork students placed with them to be cognizant of outcomes for particular patient groups. Rapidly evolving practice contexts have brought both challenges and opportunities for the education and training of health care social workers.

This chapter focuses on unfolding educational opportunities within the classroom and field. Important questions arise. What is appropriate and necessary education for social work students working in contemporary health care settings? What assignments are warranted and which ones may no longer be most effective for learning? What skills and competencies must students have upon graduation that can readily be put into practice? Where do opportunities exist to impact on the effectiveness and efficiency of client systems? A clear challenge for the social work profession is to fully comprehend the changes in health care delivery and what makes these changes significant. It becomes crucial that health care social workers be alert to innovations and make creative contributions to their assessment, development and implementation so as to enhance positive patient and community outcomes.

This chapter highlights educational imperatives for social work as health care continues to broaden its focus from working with the acutely ill to addressing patients and families experiencing chronic conditions such as diabetes, asthma, autism, dual diagnoses and epidemics such as influenza or HIV/AIDS. The shift from inpatient hospitalization to

community-based primary and preventative care is recognized, particularly in light of how modern technologies profoundly impact on patient care practices.

It is of fundamental importance that social work students, whether at the undergraduate, master, or doctoral levels, understand the economic and medical factors driving contemporary practice changes. Advances in diagnoses, treatment and rehabilitation enable patients to consider an ever-broadening range of care options. As life-spans increase, the concepts of “chronically ill” and “older adult” take on greater significance. War-wounded patients rightfully demand that all known interventions be used to enable them to fully live life. Expanding health care needs bring potentially unsustainable increases in individual and national health care costs if there are not major enhancements to efficient, effective practice. As political rhetoric heats up about such concerns, it is imperative that educators in both classrooms and agencies cultivate social work graduates capable of offering micro, mezzo, and macro interventions that are practical, cost-effective and forward thinking.

The needed skill sets in this environment must be clear. Practitioners must not only proficiently interact with patients and families, but constructively engage in collegial teamwork. Such integrated practice requires critical thinking, conflict management, interagency negotiation, advocacy, care coordination, leadership and competent use of technologies that promote rapid communication. Social workers must promote dialogue within teams about ethical decision making, role perceptions and differing professional values. How do team members introduce patients and families to each other? How is work explained and managed? These are questions that must be addressed with candor and thoughtfully brought forward with social work faculty and students.

## **Social Work Education**

“Assessing social work competence is essential to ensuring that graduates will be effective practitioners” (*Regehr, Bogo, Regehr & Power, 2007, p.327*). It is the responsibility of social work educators, health care agencies, field instructors and students to determine the processes necessary to achieve competency in field education. Health care social work constantly evolves and social work competency reflects that evolution.

The Council on Social Work Education (CSWE), as the accreditation body for social work schools, identifies ten core competencies deemed necessary in social work students’ educational development. This approach measures the integration of knowledge, values, and skills as demonstrated in students’ practice with individuals, families, groups, organizations, and communities (*Council on Social Work Education, 2010*). Classroom based courses and field instruction alike must include content designed to meet core competencies which expect students to:

- identify as a professional and conduct oneself accordingly
- apply social work ethical principles to guide professional practice
- apply critical thinking to inform and communicate professional judgments
- engage diversity and difference in practice

- advance human rights and social and economic justice
- engage in research-informed practice and practice-informed research
- apply knowledge of human behavior and the social environment
- engage in policy practice to advance social and economic well-being and deliver effective social work services
- respond to contexts that shape practice
- engage, assess, intervene, and evaluate with individuals, families, groups, organizations and communities.

### *Classroom education*

Many if not all of the ten core competencies required by CSWE can be included in health care specializations and courses. In the most recently published study of accredited graduate schools of social work, approximately one-third (36%) of 128 schools surveyed in 1996-1997 offered specializations in health care (Volland, Berkman, Stein, & Vaghy, 2000). Regardless of existing specializations, a 1995 survey by Kadushin and Egan (1997) found that 68% of 94 respondents in a study of 121 graduate social work schools offered health care courses. The contrasting rates in the studies likely reflect differences between specializations versus single courses and perhaps movement towards generalist curricula.

In the classroom, health care students are expected to master the theoretical foundations for clinical and policy practice. In clinical health care courses, students focus on identification of “high-risk” patients, case management, clinical interventions for patients, families, and groups, education regarding health promotion and disease prevention, recognition and elimination of health disparities, culturally competent care, transitions among levels of care, coordination with community providers, advance directives, end-of-life care, ethical issues, and professional writing. Perceptions endure, however, of a disconnect between what is taught in the classroom and experienced in internships (Volland, Berkman, Stein, & Vaghy, 2000). Transdisciplinary teamwork and time-effective treatments are the focus of this present discussion because of their relevance to integrated care in cost-conscious practice environments.

*Interprofessional/transdisciplinary education.* Kadushin and Egan (1997) determined that collaboration and team work was the most frequently taught unit in health care courses, being present in 67% of 94 sampled social work programs. Despite this finding, preparing students for work on transdisciplinary teams remains a major curriculum improvement recommendation of CSWE health track members (M. C. Gilbert, personal communication, October 15, 2010), echoing earlier findings of the New York Academy of Medicine (Volland, Berkman, Stein, & Vaghy, 2000). To effectively work on transdisciplinary teams, students must acquire the knowledge, values and skills necessary to assess ecological and mental health factors affecting patients’ physical conditions. Students must also learn sufficient content about physical health and illness, understand the roles and functions of other team members (Little, 2010) and recognize the effects of current medications and treatments.

Students must further master not only the development of their own professional identity and self-directed practice, but acquire an awareness of, and appreciation for, the professional identities of other health practitioners. An important first step in this process is to understand the basis or underpinnings for each profession's identity. Students can learn about inter-professional identities by attending core courses in which different units are taught by members of different professions, listen to inter-professional guest speakers, read pertinent literature such as that of Clark (1997), and apply transdisciplinary course content to field learning objectives through networking and shadowing staff of other disciplines.

Brownstein (2003) noted the influence of professional roles, structure, history of collaboration, and personal characteristics on team functioning. Group dynamics can have powerful effects on team functioning. Clarity regarding the purpose of the team becomes essential and should drive decisions about the nature of the team. Brownstein (2003) emphasizes collective ownership of patient-centered goals that involve shared decision making and cultivation of specific, realistic, well defined goals. Group dynamics are affected by size, with small groups of five to seven members tending to have increased cohesion, decision-making consensus and pressure to conform ("group think"). Enduring personal characteristics of team members such as age, race, gender, ethnicity, spiritual beliefs, sexual orientation, and socioeconomic class also affect their behaviors. Teams that experience frequent changes in membership often have difficulty moving beyond beginning stages of group development. Constant and significant changes in membership prompt health care team members to expend considerable time in meetings clarifying their purpose, introducing members and identifying roles. Conflicts may be difficult to resolve and team members may fail to bring up sensitive issues in the absence of trusting relationships. Social work students need to become proficient in resolving conflicts so their teams remain productive, harmonious and supportive with shared goals, norms, bonds and professional roles.

*Time-effective treatment.* A number of factors support the use of time-effective treatment, which has inaccurately been earlier referred to as "brief" treatment. Use of this intervention has been prompted by shortened lengths of inpatient hospital stays and time-limited clinic visits. The consequences of reduced contact time include practitioners' attempting to prematurely conduct interviews when patients are very ill and having to cope with professional schedules made tight from accommodating the needs of other treatment team members. Time-effective therapies can be traced to Sigmund Freud and particularly his colleague Sandor Ferenczi (Bauer & Kobos, 1993). Although they were not created in response to the cost containment emphasis of managed care, time-effective treatments have been appreciated as a good fit with managed care because they are efficient and effective.

Because brief therapies are defined by clear goals, explicit interventions and measurable outcomes, they are highly compatible with the empirical and philosophical base of evidence-based practice (Dziegielewski & Roberts, 2004). New graduates entering integrated care settings find practice requires the use of short-term, evidence-based treatment models and concurrent documentation. This requires that students become adept in conducting rapid assessments, establishing working alliances, setting modest yet achievable goals, specifying treatment foci, using time flexibly and judiciously, collaborating with clients, emphasizing strengths and hopefulness, employing integrative techniques, and

developing outcome measures. The benefit of brief interventions has been well-documented, with Bloom (1997) for example reviewing a series of studies by Cummings (1967, 1968, 1977) and colleagues who found that after only a single psychotherapy session for emotional concerns, sampled patients reduced their medical care usage *by 60%* for the following five years. Whether clinicians use a single-subject design based on one patient or participate in randomized controlled trials, evidence-based practice is increasingly regarded as an effective means to minimize inappropriate use of services, unnecessary suffering of patients and otherwise avoidable readmissions.

Practitioners faced with time constraints can employ Rapid Assessment Tools (RAT) for initial screenings of patients who may warrant more comprehensive assessment. Standardized Health-Related Quality of Life instruments such as the SF-36v2 can be used with general populations to identify the burdens and benefits of health care treatment. Developed by the Rand Corporation to measure quality of life and medical outcomes, the SF-36v2 has thirty-six questions and can be self-administered (*Health Measurement Research Group, 2011*). A RAT can also be population specific such as the Geriatric Depression Scale (*Yesavage et al., 1983*), the Edinburgh Postnatal Depression Scale (*Cox, Holden, & Sagovsky, 1987; Wisner, Parry, & Piontek, 2002*), or alcohol and drug screening instruments including the CAGE, MAST, AUDIT, SASSI and ASI. These instruments are listed, evaluated, and linked at the University of Washington Alcohol and Drug Abuse Institute (See: <http://lib.adai.washington.edu/instrumentsearch.htm>).

The selection of a particular time-effective approach is influenced by many factors. These may include how clients' problems are conceptualized; theoretical orientations and associated techniques of an intervention such as cognitive-behavioral treatment, psychodynamic or solution-focused approaches; missions and philosophies of practice settings; definitions of client systems (individual, family, or group); unique client characteristics, and/or; the nature of professional relationships, roles and limitations on time and resources.

Widely prevalent approaches such as problem-solving therapy in primary care (PST-PC) (*Townsend et al, 2001*), solution-focused treatment (*De Jong & Berg, 2002*), and motivational interviewing (*Rollnick, Miller & Butler, 2008*) may be taught in the classroom and then experienced in the field. Corwin (2002) introduced the "Levels of Intervention" model to assist practitioners in establishing a rational fit among the cause and severity of clients' problems, their individual strengths and support systems, and the clinician's selected strategy of intervention. In *Level I*, patients present with severe problems such as substance-related or severe psychiatric disorders. They may have experienced traumatic events, be dangerousness to themselves or others, and/or harbor life-threatening diagnoses. Level I patients generally require clinicians to be active and directive, typically using brief treatments such as crisis intervention, problem-solving, case management and education to provide medical care, social support and resource needs.

Presenting with less acute and grave issues, *Level II* patients characteristically experience difficult interpersonal relationships, boundary issues among family members, depression or anxiety associated with illness, or grief and bereavement issues. For these

clients, task-centered, cognitive-behavioral, solution-focused, family or brief psychodynamic therapies or grief counseling supplemented with education and medication, often prove beneficial. When patients seek help with issues such as age-related psychosocial crises (i.e.: identity formation or difficulties with intimate relations), *Level III* interventions of brief psychodynamic psychotherapy or narrative therapy are often helpful in prompting insight. With the levels of intervention being more cyclical than linear, clients may move among the three levels of assessment and associated treatment interventions as their situations change.

### ***Field education***

Field education is social work's signature pedagogy, *the* critical form of professional education in which students are socialized regarding the norms, roles, and functions of practice. The intent of field education is to unite the theoretical and conceptual content of classroom instruction with the realities of the practice setting. Students learn practice skills in their field placements and depend on field instructors to assist in translating classroom and theoretical learning into practice. The centrality of field education to social work education is widely recognized (*Hendricks, Finch & Franks, 2005*).

It is in the field that students try out their newly acquired knowledge from the classroom and reading, sometimes making errors as they do so. It can be particularly challenging, however, for field instructors in fast-paced health care settings to help students learn through reflection and questioning, while allowing sufficient time to contend with doubts and uncertainties. Although students often have different learning styles and practice styles from those of their field instructors, students' initial professional identities are characteristically acquired in large part through modeling by the field instructor and colleagues in settings that establish norms and expectations for the student. Field instructors who themselves have relevant knowledge and skills are best able to prepare social work students for practice in integrated, transdisciplinary care settings. Yet even in more traditional settings, if field instructors recognize the changing, economically driven health care environment and evolving emphasis on community based care, they can impart skills essential for integrated and transdisciplinary practice. Health care students can be universally exposed in field placements to learning the short-term, time-effective, episodic interventions and advocacy so fundamental to community-based service.

“Field education is systematically designed, supervised, coordinated, and evaluated based on criteria by which students demonstrate the achievement of program competencies” (excerpted from the *Compliance, Concern, and Noncompliance Statements for the 2008 Educational Policy and Accreditation Standards, 10.17.2008*). Within ten core competencies are measurable practice behaviors for each competency. Agency field instructors evaluate social work students on each practice behavior. Competencies are developed through generalist practice at the Bachelor of Social Work (BSW) level or advanced practice at the Master of Social Work (MSW) level.

Although social work students must acquire proficiency in all competencies, two specific areas that social work educators, students, and agency personnel identify as essential for competent health care practice are *advocacy* (*Council on Social Work Education, 2010*;

*Rocha, 2000; Russell & White, 2002*) and *written communication*, specifically documentation (*Council on Social Work Education, 2010*).

Advocating for patients at the micro, mezzo and macro levels of practice constitutes a vital part of health care social work. Health care social workers face the challenge of growing patient caseloads, a changing health care system and demands imposed by organizational structures. Student social workers must learn to advocate for patients and families, be prepared to advocate at the macro-level with legislators and lobbyists and anticipate the prospect of preparing policy programs as crucial components in dynamic economic, social and political climates.

Moving beyond immediate patient care intervention, health care social workers can mentor fieldwork students considering health care in the areas of “policy, research and practice for...(the purpose of effecting)...positive change” (*Rowan & Honeycutt, 2010, p.73*). NASW health care standards emphasize that “...social workers have a responsibility to advocate for the needs and interests of clients and client systems in health care, including advocating for larger system change to improve access to care and improved delivery of services” (*NASW Health Care Standards, 2005, p.24*). NASW interpretation of this standard specifically mentions this as a key area, including mentorship of new professionals. The presence of advocacy in both CSWE and NASW standards underscores its level of importance in social work practice.

Incorporating experiential learning in the classroom prior to field placement and active participation in advocacy during field education will assist in students’ comfort level advocating for health care issues and reform (*Rocha, 2000*). Examples of assignments which help teach and evaluate practice behaviors include providing staff training on national, state or local health care policy changes, organizing a task force, using the internet to locate information regarding policy issues such as health care reform, contacting public officials regarding health care issues, attending legislative sessions, organizing “Health Care Advocacy Days”, or attending hospital board meetings (*Rocha, 2000*). To establish competency as an advocate during the field experience, the student must become cognizant of the political culture of the health care organization, particularly in recognizing the extent to which the health care organization *is receptive to social work advocacy*.

Competency in written communication is a fundamental skill in all social work settings (*Bogo, Regehr, Woodford, Hughes, Power & Regehr, 2006*). While documentation may be viewed by some health care social workers as “a necessary evil”, it is and should be “an integral part of clinical practice” (*Cumming, Fitzpatrick, McAuliffe, McKain, Martin & Tonge, 2007, p.254*). Documentation provides the means to demonstrate professional competence by recording service delivery outcomes and justification for health services (*Kagle & Kopels, 2008*). Managed health care requires proficient documentation including “information about the client-need-situation and service process in a form that is accessible and useful to reviewers” (*Kagle & Kopels, 2008, p.195*). Although documentation is important in all arenas of social work practice, it is especially crucial in today’s health care culture, which emphasizes safety, liability and risk management (*Reamer, 2005*).

Incorporating documentation in student field learning plans is a first step toward achieving practice competency. Insight into how much or how little to document is initially gained from field instructors and then refined through repeated practice. In integrated care, social work assessments are presumed to focus on clients' current clinical symptoms and functioning, with less attention to family and behavioral history than found in traditional in-patient settings. Practicum students' abilities to observe their field instructors' expertise in documentation, to document with the field instructor's oversight, and to receive field instructors' constructive criticism and positive reinforcement promotes student mastery of this crucial practice skill.

Providing documentation that contributes to treatment plan formulation is best facilitated when electronic health records (EHR) are uniformly available to all team members (*Little, 2010*). Using this method of recording during meetings with patients may, however, be a new skill for both field instructor and student. Notwithstanding the importance of EHR documentation to the team functioning, many faculty advisors and classroom teachers are unfamiliar with transdisciplinary care and EHRs. This raises concerns about simultaneous documentation methods interfering with the traditional social work focus on helping clients "tell their stories". Traditional practices and even the emphasis on confidentiality must be reconsidered in light of health care practitioners in transdisciplinary teams *routinely* sharing patient information. This occurs by design not only through EHR use, but in conjunction with direct and immediate introductions of team members preparing to initiate additional patient care service following what is commonly referred to as the "warm hand-off."

Field instructors must *themselves* learn about non-traditional practices associated with integrated health care models before they can effectively impart them to students. At the same time, practitioners with competencies in evolving contemporary models may need to interpret practice shifts to social work school faculty less connected with rapidly changing service environments. Field instruction seminars and workshops for field instructors offer valuable training opportunities for faculty and experienced practitioners to share and deliberate on new models of care that effectively influence the shape of professional practice.

## **Interprofessional / Transdisciplinary Teams**

By the early 1950s interdisciplinary teams had been organized as an effort to meet the needs of children suffering from developmental disabilities (*Chamberlain, 1980*). The passage of Public Law 88-164 in 1963 led to funding construction of facilities for children and adults with mental retardation that provided clinical services, research, and interdisciplinary training of professionals and paraprofessionals. This health care delivery model resurfaces "new again" within the context of the Affordable Care Act of 2010, which promotes the provision of care through interdisciplinary teams in the form of "medical homes" intended to promote shared accountability for patient care and cost containment for defined populations (*Collins, 2010*). Depending upon patient needs, these interdisciplinary teams provide care either directly or virtually and may be composed of physicians, nurses, physician assistants, social workers, pharmacists, paraprofessionals, and other allied health professionals.

Transdisciplinary collaboration aids patients, health care professionals, and paraprofessionals enhance the quality of care while reducing costs. Recognizing that no one profession possesses complete knowledge about a phenomenon, it instead maximizes interdisciplinary dialogue and, in turn, promotes coordinated care. The various disciplines interact in such a manner as to be mutually complimentary, striving to work together rather than independent of one another or at cross-purposes. In such a scenario, it becomes important that each professional have an awareness and appreciation for their colleagues' competencies and professional orientation.

Wackerhausen (2009) discusses the formation of professional identities, noting that the public perception of a professional's identity is the consequence of various endorsements manifested in regulations, privileges, duties, public perceptions, and other professionals' views of one's status and function. Health care professionals tend to view the social work domain as one of working with patients' families, obtaining financial assistance, and locating resources, whereas the public perception is that of social workers involved with the indigent, abuse victims, mentally ill and those in need of resources. Experience has shown that when professional functions are not regulated, interprofessional strain on transdisciplinary teams may arise from territorial, professional claims of first legitimacy in responding to identified needs. This is particularly true when addressing psychosocial needs as some form of response to such is manifest in most professions' credos. Social work often finds a need to negotiate with professions such as nursing, medicine, occupational therapy, or child life to bolster its roles and functions in the workplace. Not infrequently, professions compete for work that is prestigious or offers political leverage within the organization while divesting themselves of onerous or low-status functions by transferring them to another profession. This is particularly true during times of program startup or conversely, periods of retrenchment.

Professional identity typically is associated with having secured an academic degree conferred by an accredited professional school and passing exams that certify or license practice (Clark, 1997; Wackerhausen, 2009). For social workers, official recognition is achieved through use of formal titles, obtaining state licensure, and securing professional certifications such as a Diplomate in Clinical Social Work (DCSW), membership in the Academy of Certified Social Workers (ACSW) or substance abuse counseling, case management or other program completion certificates. Acknowledged schools of social work conferring accepted academic degrees (e.g. MSW; BSW) are those accredited by the Council on Social Work Education (CSWE). Through the process of professional socialization students and practitioners typically acquire profession-specific languages, share codes of dress, ask certain types of questions to patients, understand phenomena from a specific perspective, value different ways of knowing (e.g., rational, reductionist and scientific versus humanistic, social, and ecological), generate narratives--sometimes biased--about their own and others' professions (Clark, 1997; Wackerhausen, 2009), and prioritize certain values and ethical stances. Understanding the formation of professional identities among colleagues is a prerequisite for successful, supportive, and enjoyable teamwork.

## Ethical Challenges in Interdisciplinary Practice

Health care teams were formed as providers acknowledged that medical illness required a comprehensive approach to address the clinical care needs of the patient, as well as the psychosocial and practical aspects of the patient and family care (*Lowe & Herranen, 1978*). Problems presented by patients with complex illnesses often transcend the scope of a single profession. As a consequence, team members from other disciplines may be engaged to expand the range of knowledge, skills, and perspectives available toward total patient care.

As satisfying as practice in interdisciplinary settings may be, it also gives rise to ethical issues of collective responsibility in team work and requires consideration on how conflicts are resolved (*Abramson, 1984; Joseph, 1983*). Several authors have described a number of ethical conflicts that social workers experience in team practice including establishing a professional values hierarchy, managing perceptions of the professional role, and maintaining standards for confidentiality (*Millstein, 2000; Mizrahi & Abramson, 1985; Roberts, 1989*). In respect to values-based conflicts, professional orientation influences the scope of approach to patient needs. Holland and Kilpatrick (*1991*) identify social work's interpersonal approach to ethical problems as one focused on mutuality and commonality to promote client autonomy and independence. The authors recommend a strong base in ethical reflection and judgment for social workers working on teams, especially as team members from other disciplines may have differing approaches to ethical problems. McMahon (*2003*) notes that in health social work, the social worker's holistic perspective may be in conflict with the medical model of patient care where authority resides in the team not the patient.

Perceptions of the social worker's role and scope of practice on the team and with patients can be a source of ethical tension for social workers. Manning (*1997*) outlines an activist ethics role for social workers based on the societal expectations that social workers expose ethical dilemmas in practice and take action to remedy issues at the individual and community levels. The underlying motivation for taking action is tied to the caring involved in learning clients' stories, respecting their experiences, and then utilizing both to take action and promote change for the clients. Some team members may expect the social worker to place the interests of accomplishing the team mission ahead of the interests of the patient. Other team members may have little understanding or tolerance for the social worker's advocacy in supporting patient's rights (*Dolgoff, Harrington & Loewenberg, 2012*). The NASW Code of Ethics, Section 2.03 (*1998*) offers guidelines for establishing priorities among professional obligations to clients and colleagues that appear to conflict with a focus on respectful listening, mediation, and a stepwise process approach.

How and when information is shared with and among members of the health care team as well as with the patient is a constant source of ethical concern for social work team members. Team paternalism or "knowing what is right" for the patient can narrow the information shared with the patient. This effectually limits true informed consent and places the social worker in a position of balancing the best interests of the patient versus team solidarity (*Beauchamp & Childress, 2009*). Teams may expect access to all information that the patient shares with the social worker as part of team membership. This can be especially complex when professionals have developed personal relationships in addition to

professional relationships. The act of withholding of information can be interpreted as lack of trust or betrayal by other team members. Establishing clear boundary relationship expectations and standards for information sharing are proactive steps to avoid conflict and risk in practice situations (*Reamer, 2001*).

If established patterns for conflict resolution fail to resolve ethical issues, there are other resources available to teams. The first step is to apply a model of ethical problem solving that includes key contextual details, a review of relevant literature, consideration of ethical principles and perspectives, guidance offered by codes of ethics, and reflection on the range of values involved in the dilemma in a considered manner. Mattison (*2000*) notes the use of a principled model in ethical decision-making not only facilitates resolution but enhances the social worker's sense of professional self. It also promotes the knowledge that supports ethically sound professional practice. If the dispute continues, consultation with an ethics committee as an outside resource may clarify issues and bring forward suggestions toward resolution that were not immediately apparent to team members. Social work support and leadership in debriefing post-ethical dilemmas and in provision of ongoing ethical training and sensitivity are keys to maintaining team equilibrium.

## **The Role of Supervision**

Changing societal conditions and health care practices influence the nature of clinical supervision as past concerns give way to new challenges. Advances in biomedical technology, the shift from acute to chronic care, shortened length of stays, co-morbid disorders, poverty, cultural practices, pandemics (such as H1N1) and migration are just some of the factors affecting both patient care delivery and supervision of health care practitioners.

Social work supervision has been a cherished, agency-based tradition that served to promote practitioners' professional development while ensuring adherence to agency policies and mission (*Kadushin & Harkness, 2002*). The challenges and complexities of providing supervision in health care social work are many and well-documented (*Munson, 2006; Rosenberg and Weissman, 1995; Spitzer, 2004*). One important emerging theme is that the form, frequency and content of supervision is often driven by organizational needs and supervisor availability rather than the needs of the staff (*Bogo & McKnight, 2005; Kadushin, Berger, Gilbert & de St Aubin, 2009*). Organizational sanction and allocation of resources for supervisory functions can range from complete dissolution of supervision programs to weekly provision of supervision, primarily to post-graduate staff seeking to fulfill licensure requirements. In an analysis by Bogo, Paterson, King, & Tufford (*2011*), social workers and occupational therapists were found to express a desire for regular, reflective supervision sessions supplemented with ad hoc supervision in times of crisis. Workload demands and a crisis orientation were perceived as barriers to scheduled supervision. The system-driven content of supervision frequently focused on administrative issues such as non-clinical aspects of discharge planning, length of stay, and cost control at the expense of clinical ones (*Bogo, Paterson, King and Tufford, 2011; Kadushin, Berger, Gilbert, & de St Aubin, 2009*).

Kadushin, Berger, Gilbert, and de St Aubin (2009) also determined that supervisees were experiencing upheaval that affected supervision as institutions reorganized. For some, the change had more to do with role assignments while for others restructuring strategies led to the elimination of social work directors, transfer of reporting relationships to non-social work personnel, and/or implementation of matrix models for organizational structure. These matrix structures retained a social worker as one of the managers, but the supervisor could be a nurse, social work department director, or social worker at the corporate level. Even when the supervisees retained social workers as managers or supervisors, some reported their ability to obtain supervision was eroded by the altered administrative responsibilities of their supervisor. Approximately 25% of hospital-based participants in the Kadushin et al study purchased clinical supervision from private practitioners, and one group of social workers succeeded in having their facility pay for clinical supervision from a licensed supervisor.

An important artifact of shifts in organizational structure and implementation of transdisciplinary practice is that it can lead to inter-professional supervision. Of equal note, social workers, nurses and occupational therapists who participated in the Bogo, Paterson, King and Tuffort (2011) study reported mixed feelings about receiving supervision from another discipline. While participants valued supervision they received from other professionals, they also reported that much of their profession-specific work did *not* get discussed in inter-professional supervision as the language, philosophies and ethical concerns were different and required lengthy dialogue to explain. In particular, one recurring theme that arose among nurse participants was fear of “correctional” supervision. The request by a supervisor to meet with a nurse was often perceived as negative, e.g., what mistake was made. Nurses also reported harboring fears that colleagues would report them to regulatory bodies. These findings may very well be associated with the litigious nature of health care practice, which unfortunately emphasizes risk management rather than professional support. Bogo’s examples underscore the need for those providing *and* receiving inter-professional supervision to understand and acknowledge the importance of professional identities. Some nurse case managers without training in supervision or knowledge of the social work profession reported feeling uncomfortable because they were thrust by their administrators into supervisory positions over graduate-trained social workers (*M. C. Gilbert, personal communication, April 10, 2011*). One solution to the lack of profession-specific content in inter-professional supervision is to supplement it with peer supervision, peer consultation or contracted clinical supervision.

In the most recent meta-analysis of supervision, Mor Barak, Travis, Pyun, and Xie (2009) reviewed twenty-seven published studies of combined practitioner samples in child welfare, social work (including gerontology and management), and mental health. Task assistance, social and emotional support, and supervisory interpersonal interactions were determined to have a statistically significant beneficial impact on workers. These factors increased job satisfaction, worker effectiveness, a sense of psychological well being, job retention and commitment to the organization. At the same time, supervisees reported decreased anxiety, reduced depression, diminished stress, less burnout, a lowered rate of job turnovers, reduced role conflict, diminished role ambiguity and decreased role overload. Such findings clearly underscore the benefit to patients, practitioners and health care provider organizations of affording knowledgeable, supportive and timely professional supervision.

## Summary

The contemporary health care environment is characterized by unprecedented advances in medical knowledge, technology, procedures and equipment; increased consumer expectations for access to all available interventions, and; ever-building expectations for both revenue maximization and cost-minimization in the face of decreased reimbursement. Predictably, more attention is being directed toward practice accountability. The focus is on the creative, efficient use of health care resources and documentation of their success in effectively delivering positive patient outcomes.

The unmistakable evolution of transdisciplinary teams and integrated care reflects the priorities of both existing and forecasted health care environments. By rapidly and constructively engaging diverse expert practitioners in the most efficient, ethical manner possible, provider organizations seek to achieve both positive patient care outcomes and the optimal value for health care dollar expenditures. Executing the delivery of services in this format, however, is daunting as it obligates an elevated level of professional understanding, technical competence and collaborative teamwork.

This chapter has identified the specific challenges and opportunities for social work education within transdisciplinary/integrated care delivery models. While collaboration and teamwork are widely taught in social work health care courses, preparation for transdisciplinary teams remains a concern. Classroom and fieldwork experiences must address the ten CSWE core competencies, but do so recognizing the changing demands of a very fluid health care environment. To accommodate contemporary service delivery models, social work students must be cognizant and appreciative of other disciplines' values and practice contributions, possess politically astute *and* ethical interpersonal communication skills, demonstrate a commitment to advocacy, possess the capacity to promote patient care services at the program level, contend with potential structural obstacles to coordinated service delivery (including inter-disciplinary "competition"), and be able to ascertain the balance of client confidentiality with transmission of patient information to an ever-increasing array of team colleagues. Students must also be prepared for the prospect that their professional supervision in transdisciplinary/integrated care settings may well be delivered by *non*-social workers and as such, be able to both convincingly educate about the social work profession's patient care contributions and lobby that sufficient resources be consistently available so as to enhance their ongoing professional skill development.

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# Glossary

## ***The Evolving Practice of Social Work Within Integrated Care***

### ***Care Coordination*** (as developed by the National Coalition on Care Coordination, N3C)

A person-centered, assessment-based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual's (and families) needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator. The coordinator may change among team members, depending on the focus of care and skill set required during a given period.

### ***Concurrent documentation***

The process of documenting therapy sessions collaboratively with the patient present. Regarded as a patient-centered treatment approach given that the patient is directly involved with their health care chart documentation. Also noted for contribution to overall service efficiency as it reduces or eliminates post-session therapist time necessary for documentation. (See Leone, p. 17).

### ***Core Social Work Competencies***

As established by the accrediting body for social work practice, the Council on Social Work Education, ten competencies are deemed necessary in social work students' educational development. This approach measures the integration of knowledge, values, and skills as demonstrated in students' practice with individuals, families, groups, organizations, and communities (Council on Social Work Education, 2010). Classroom based courses and field instruction alike must include content to meet core competencies which expect students to:

- identify as a professional and conduct oneself accordingly
- apply social work ethical principles to guide professional practice
- apply critical thinking to inform and communicate professional judgments
- engage diversity and difference in practice
- advance human rights and social and economic justice
- engage in research-informed practice and practice-informed research
- apply knowledge of human behavior and the social environment
- engage in policy practice to advance social and economic well-being and deliver effective social work services
- respond to contexts that shape practice
- engage, assess, intervene, and evaluate with individuals, families, groups, organizations and communities.

### ***Critical Access Hospital***

Facility with a maximum of seven beds, 24-hour emergency care and at least 35 highway miles or 15 secondary road miles from another full service hospital (*see Perone & Aguiniga, p.41*)

***Enhanced Discharge Planning Program (EDPP)***. A social work-driven, telephone-based model at Rush University Medical Center for providing transitional care to patients returning home after an inpatient hospital stay (*see Shier et al, p.57*).

### ***Evidence-Based Practice (EBP)***

Introduced into medicine during the 1980s, EBP is defined as the “integration of best researched evidence and clinical expertise with patient values” (*Institute of Medicine, 2001, p. 147*). This definition recognizes the importance of professional experience and knowledge in consideration of patient values and preferences when selecting treatment options. EBP is a decision-making process that uses established evidence to design, select, implement and evaluate practice interventions. Empirical evidence is established through testing in formal research studies.

### ***Field Education***

Social work’s signature pedagogy, field education is *the* critical form of professional education in which students are socialized regarding the norms, roles, and functions of practice. The intent of field education is to unite the theoretical and conceptual content of classroom instruction with the realities of the practice setting. It is systematically designed, supervised, coordinated, and evaluated based on criteria by which students demonstrate the achievement of program competencies (*see Gilbert et al, p.74*).

### ***FLEX (Medicare Rural Hospital Flexibility Program)***

Designed to assist states in maintaining rural health care service by improving collaborative health care services with an emphasis on emergency care. One impact was to increase the designed number of critical access hospitals in rural areas (*State Office of Rural Health, 2010*)(*see Perone and Aguiniga, p.41*).

### ***FQHCs (Federally Qualified Health Centers)***

Federally mandated providers that can offer a full complement of physical and mental health services. Reflecting more mature integrated care models, FQHCs receive higher reimbursement rates and often achieve medical/clinical home status (*see Little, p.5*).

### ***Interprofessional (Transdisciplinary) Collaborative Practice***

Occurs“...when multiple health workers from different professional backgrounds work together with patients, families, care givers, and communities to deliver highest quality of

care.” (WHO 2010) Interprofessional teams are intentionally created, recognized by others and themselves as having a collective identity and shared responsibility for the patient or group of patients. Ideally they have been educated together to grasp each others’ skills and competencies and know when and how boundaries can be blurred for the betterment of care.

### ***Interprofessional (“Transdisciplinary”) Education (WHO, 2010)***

“When students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.” The goal of this learning is to prepare the health care professionals, paraprofessionals, and non- professionals to work deliberately together with the “common goal of building safer and better patient-centered and community/population oriented...health care system(s).” (*Core Competencies for Interprofessional Collaborative Practice, Report of an Expert Panel, May 2011*) (see: [ip@aamc.org](http://ip@aamc.org).)

### ***Matrix Organizational Structure***

A structural form in which two dimensions of management may exist to control management of an organization or its subunits. On one axis, operational control is exercised by a manager overseeing a service or product line (e.g. oncology, transplant, rehabilitation services, pediatrics), while the second axis of this model engages managers in the same patient care area to address individual discipline or professions. This approach can be fraught with role identity, task ownership and supervisory issues evolving from having two or more leaders with different practice orientations, needs and knowledge base concurrently directing the same work group (see Gilbert et al, p. 80).

### ***Medical Home***

Group health care practices that can be localized in multiple sites- hospitals, community based health settings, nursing homes, schools, anywhere feasible to access and care for identified populations. These are ideally co-located sites in which a number of health care professionals practice side by side, including physical and mental health practitioners. The goal is to provide “warm handoffs”, integrated care that gives needed services on site, in a timely fashion (same day referrals), focuses on patients and their caregivers, and is cost effective.

### ***Medical Record System***

Within this text, alternately referenced as Computerized Patient Record System (CPRS) (Amdur, Sheets & Lynch, p.32) and Electronic Health Record (EHR) (Leone, p.14), these password protected, computer-based systems are designed to provide centralized medical records to health care staff so as to simplify and expedite access of uniform, continuously updated patient information. See Gilbert et al (p.76) for impacts of these systems on educational preparation of social work students.

### ***Open Access Scheduling Model***

Provides for unscheduled or same-day appointments on request. By facilitating patient visits on same day of referral, aids patients with imminent risks to find proper treatment at time of need (*see Leone, p.17-18*).

### ***Patient Acuity***

Methodology for prioritizing patient situations for possible social work intervention based on severity of identified patient stressors and need. The Department of Veteran's Affairs assesses patients in six domains (access to care, economics, housing, psychological status, social support, and functional status) and assigns patients to one of four possible levels of acuity (Level 4 having greatest need) (*see: Amdur, Sheets & Lynch, pp.27-30*).

### ***Patient Aligned Care Team (PACT)***

Veterans' Administration patient-centered, team-based healthcare services model that is comprehensive, collaborative, coordinated and continuous. The PACT typically includes a primary care practitioner (Physician, Nurse Practitioner or Physician Assistant), an RN Care Manager, a Clinical Associate, and a Clerical Associate. Every patient requiring case management is assigned to either a registered nurse or social work case manager. The team establishes patients' health care plans, provides primary care services and care management that facilitate comprehensive, effective care delivery (*see Amdur, Sheet & Lynch, p.26*).

### ***Project IMPACT***

One of the first models of integrated care, it was introduced into a primary care setting to identify and treat a mental health disorder. The study proved instrumental in promoting collaborative care, especially in primary care settings. (*see Little, p.2*).

### ***Rapid Assessment Tools (RAT)***

These tools are employed for initial screenings of patients to determine a potential need for more comprehensive assessment. Questions may broadly range from identifying patients' perceived burdens and benefits of health care treatment and quality of life to narrower foci on depression or substance use (*see Gilbert et al, p.73*).

### ***Rural***

Areas or settlements with 2,500 or less population or census tracts with a population density of less than 1,000 people per square mile and the adjacent census tracts with a population density of less than 500 residents per square mile (*United States Census Bureau [UCSB], 2007*). Estimates of the United States population who are rural can range from 17 to 49 percent (*Cromartie & Bucholtz, 2008*).

### ***Targets***

Individuals at substantial risk of hospitalization usually within the coming year who are most likely to benefit from comprehensive transdisciplinary care team intervention. Risk categorizations may be based on diagnoses and their stages or on socio-economic and emotional factors such as age, access to health care, understanding of illness, language capacity, etc.

### ***Telehealth***

“The use of electronic information and communication technologies to provide and support health care when distance separates the participants. A telemedicine network “connects distant ‘spoke’ sites, often located in rural communities with one and another and also with a ‘hub’ site, which is usually a larger urban center” (*Capalbo & Heggem, 1999, p. 8*). Telehealth alternatives reduce the need for costly trips by both patients and professionals. Telehealth allows the patient to stay in the community for health services such as medical tests and can be used for (but not limited to) services such as radiology, mental health, home health, hospice, cardiology, oncology and pediatrics (*Whitacre, Harman, Boggs & Schott, 2008*)(see *Perone and Aguiniga, p.45; also Amdur, Sheets & Lynch, p.32*).

### ***Telecare***

A service that utilizes technological assistive devices such as alarms and medication monitoring systems to support activities of daily living (*Rowney, 2007; Smith, 2008*). Telecare is primarily used for homebound older adults, veterans or rural residents (*Hersh et al., 2001*). Telecare education and usage has primarily focused on nursing but is applicable to social work practice (see *Perone and Aguiniga, p.46*).

### ***Time-Effective Treatment***

Earlier inaccurately referred to as “brief treatment”, these modalities have been appreciated as a good fit in managed care environments as they feature clear goals, explicit interventions and measurable outcomes. They assume there will be less time for patient contact due to shortened hospitalizations and therefore tend to be direct and specific. They may include problem-solving therapy in primary care (PST-PC), solution-focused treatment and motivational interviewing (see *Gilbert et al, p.72*).

### ***Transitional Care***

An interprofessional/transdisciplinary care team effort that starts early in a “targeted” patient’s hospital or other location stay and continues during the transition period, often up to 90 days or more post that location. The follow up can be via email, telephone, or a face to face visit by a purposely designated team member. This term may seem similar to discharge planning but emphasizes the on -going transitional care and the need to “stay connected” with the patient/family over time to assure a workable transition.

***Urban***

Settled areas with high population density. Urban areas (settlements of at least 50,000 people) and urban clusters (settlements of at least 2,500) consist of census tracts with a population density of at least 1,000 people per square mile and the adjacent census tracts with a population density of at least 500 residents per square mile (*United States Census Bureau [UCSB], 2007*).

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