



Recruiting, Maintaining, and Sustaining Integrated Behavioral Health Sites for Field Education

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Abstract

Models of integrated behavioral health care are expanding nationwide wherein physical and behavioral health are met concurrently. Social workers, with their clinical and communication skills and strengths-based person-in-environment approach, are well-suited for these settings. In response, social work field placement settings need to keep pace with health care system demands. This paper discusses key components to successfully recruit and sustain integrated behavioral health field placement sites. Challenges encountered as well as helpful strategies to overcome barriers will be addressed to help ensure quality learning experiences for social work students, optimum support for field instructors, and sustained community partnerships.

Keywords: integrated primary care, integrated care, field education, social work field placement

Introduction

A significant body of evidence supports the important role integrated behavioral health plays in promoting healing and wellness. Since physical and behavioral health problems frequently co-occur, treating both offers the greatest potential for improved health outcomes, particularly for underserved populations (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014; Kuramoto, 2014). There are several definitions used to define integrated behavioral health. Globally, integrated behavioral health has been described as “the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system” (Waddington & Egger, 2008, p. 1). Two of the nation’s foremost federal agencies funding integrated models of care and investing in the emerging workforce, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), define integrated models as the coordination of services to address both medical and behavioral health needs concurrently (SAMHSA-HRSA, n.d.; Heath, Wise Romero, & Reynolds, 2013). Peek and the National Integration Academy Council (2013) define integrated care as:

[...] the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization. (p. 2)

The Social Work Profession and Integrated Models of Care

Integrated care requires that interprofessional providers collaborate and coordinate the assessment, treatment, and follow up of clients’ needs. As a result, integrated care is expanding nationwide and represents a transformation in health service delivery, and social work is seen as a burgeoning workforce not traditionally captured in health workforce research (Fraher, Richman, Zerden, & Lombardi, 2018). Studies focused on integrated care have proliferated in the last decade and tend to focus on patient

outcomes broadly (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015; Coventry et al., 2014; Martínez-González, Berchtold, Ullman, Busato, & Egger, 2014). Only recently has the literature focused on the social work profession and integrated models.

For example, with the Patient Protection and Affordable Care Act as an impetus for health care changes and a move towards integrated service delivery, Horevitz and Manoleas (2013) assessed the extent to which social workers are prepared for integrated behavioral health settings. These authors helped to identify key competency areas for social work practice and self-rated preparedness for effective practice in integrated settings. In an effort to further understand the role of social work as members of interprofessional teams, Fraser et al. (2018) conducted a rigorous systematic review to describe the functions and outcomes of care when social workers were part of integrated care teams in primary care settings. The findings outline three primary roles that can be performed distinctly or done in overlapping capacities: behavioral health specialists, care managers, and community specialists. This systematic review suggests that integrated models of care provided by interprofessional teams, comprised in part of social workers, appear to improve the behavioral health outcomes of patients while remaining cost-neutral (Fraser et al., 2018). Furthermore, Steketee, Ross, and Wachman (2017) conducted a systematic review on the health outcomes and costs associated with social work services. While their sample size was small and varied in study methodology, findings showed positive effects on health and service utilization and cost-savings across nearly all studies included in their analysis.

Despite the recent literature outlining the role and contributions of social work in integrated care, this is not a new phenomenon. Social work has been involved in health care since the beginning of the profession, wherein the social determinants (the social factors that impact health and well-being) were understood as fundamental to the social experience of vulnerable and marginalized groups and explored by early pioneers of social work, including Jane Addams, Richard Cabot, and Ida Cannon (Cabot, 1919; Cannon, 1917). As one example, in 1905 Ida M. Cannon, MSW graduate from the Boston University School of Social Work, was hired by Dr. Richard Cabot at Massachusetts General Hospital to serve as “Chief of Social Services.” This was the first position of its kind, leading the first organized hospital department of social work wherein patients’ social conditions were recognized as impacting physical health care (Beder, 2006; National Association of Social Workers [NASW], 2004).

Today, social workers constitute the largest group of providers of behavioral health services in the United States (American Hospital Association, 2016). Social workers

are increasingly being hired in integrated settings because of their skill in addressing behavioral health problems and the variety of roles and functions they can fulfill (Andrews, Darnell, McBride, & Gehlert, 2013; Horevitz & Manoleas, 2013; Stanhope, Videka, Thorning, & McKay, 2015). Literature describing the skillset that social workers bring to integrated health care settings has helped outline the specific evidence-informed treatment modalities social workers utilize to promote optimal patient care and improved population health outcomes (Zerden, Lombardi, Fraser, Jones, & Garcia Rico, 2018). As members of integrated health care teams, social workers can assist in diagnosing and treating behavioral health problems that utilize their clinical training and biopsychosocial theoretical perspective (Andrews et al., 2013; Stanhope et al., 2015). Social workers, with their strengths-based person-in-environment approach, are well suited to significantly contribute to this rapidly emerging form of service delivery (Lemieux, 2015; Lundgren & Krull, 2014; Stanhope et al., 2015). Additionally, the U.S. Department of Labor projects that an almost 20% increase in the number of behavioral health social workers will be needed to fulfill these roles by 2024 in order to meet growing demand (Bureau of Labor Statistics & U.S. Department of Labor, 2016).

In an effort to expand the number of trained social workers in the behavioral health workforce, the Health Resources Service Administration (HRSA) awarded \$26 million to 62 MSW programs in 2014 to facilitate the placement of graduate students in integrated care field settings through the Behavioral Health Workforce Expansion Training (BHWET) grant (Council on Social Work Education, 2014). In 2017, a new iteration of the BHWET funding was awarded to several types of behavioral health providers. This new funding mechanism encouraged interprofessional efforts between fields such as psychology, school counseling, psychiatric mental health nurse practitioners, and social work. Around the country, changes in the health care system are requiring social work schools and programs to respond with adaptive curricula (i.e., new courses on integrated care) and by offering field placements that provide integrated models of care (DeBonis, Becker, Yoo, Capobianco, & Salerno, 2015; Rishel & Hartnett, 2017; Zerden, Jones, Brigham, Kanfer, & Zomorodi, 2016).

Yet, despite field education being considered the signature pedagogy of social work education (Wayne, Bogo, & Raskin, 2010), the literature remains limited on how to best cultivate integrated behavioral health settings, specifically in field education. Because behavioral health integration occurs on a spectrum and can fall across six levels of integration, ranging from minimal collaboration to fully integrated practice as outlined in Table 1 (Heath et al., 2013), a systematic approach to recruiting, maintaining, and sustaining integrated behavioral health field sites is vital to promote best practices and best prepare students for shifting practice realities. Integrated care can also be

conceptualized into three broad categories with the minimal or most basic level being coordinated, following by co-located services wherein some coordination exists within a physical location or space, to fully integrated with shared physical space, communication, and team-based practices (Heath et al., 2013; see also Table 1). This paper describes steps taken to recruit, maintain, and sustain integrated behavioral health sites for one such program, *UNC-PrimeCare*, funded through the HRSA behavioral health training program.

Within the University of North Carolina at Chapel Hill School of Social Work's project, a total of 93 *UNC-PrimeCare* Master of Social Work (MSW) students in the southeastern United States were trained over the course of the four-year grant. In sum, these MSW students worked with 53 different field agencies. The project team created and implemented a brief screening tool for field agencies to assess their organization's degree of integration. In conjunction with the screening tool, the field education team conducted in-person assessments of agencies before placing students in these new settings. The team discovered several strategies to maintain and sustain field education sites and foster collaborative relationships, including: the provision of on-site supervision; behavioral health-specific seminars for trainees; workshops for MSW students, their field instructors, and other team members from their site; and continuing education opportunities for MSW field instructors and task supervisors.

Influenced by experiences with *UNC-PrimeCare*, the authors offer practical ideas for newly-funded social work programs to begin implementing their training programs and expanding their integrated health care field placements.

Branding the Project: Establishing Expertise in Integrated Behavioral Health

Early in the life of the project, the team leaders named the program *UNC-PrimeCare* as a way to differentiate this specific training experience from the rest of the traditional MSW curriculum at the University of North Carolina at Chapel Hill. The word "prime" was used dually, as the intention was to place students in *primary* care settings, something emphasized in the 2014 BHWET funding announcement, and also to emphasize the importance, or *primacy*, of integrated behavioral health care. In addition to distinguishing and highlighting this project within the School, the team leaders also wanted to give it name recognition throughout the University and greater community. Therefore, in addition to coming up with a simple project name, a project logo was devised that has been used on all project materials (Figure 1). Naming the program and devising a logo have helped to create a brand by giving the project a distinct identity both within and outside of the School of Social Work.



Figure 1

The project team also created a *UNC-PrimeCare* website that was housed on the School of Social Work's website. The original grant budget included a small percentage of resources for a web developer to work with the team to create this page. The website included information on the training program for prospective MSW students (e.g., calendar of events, related class syllabi) as well as a resource tab for field instructors and community agencies who wanted additional resources on integrated behavioral health. As time went by, application and orientation materials were added for students to download. Written information was supplemented with photos taken at seminars, workshops, and group photos at the end of each academic year.

When funding was first awarded, the School sent inquiry letters to all field instructors in the School's field database announcing the program. This letter outlined the benefits of being a *UNC-PrimeCare* agency and field instructor, including:

- Invitations to expert-led behavioral health interprofessional workshops and other continuing education trainings at no cost (at least twice per year). These workshops were open to as many of their agency colleagues they wanted to bring (regardless of discipline).
- An opportunity to network with the School and other agencies conducting similar work to share challenges, solutions, research, promising practices, and updated resources from SAMHSA-HRSA.
- Assurances that *UNC-PrimeCare* MSW students would receive integrated behavioral health care-specific curricula and training, which included a course and 8 seminars based on the core competencies of integrated behavioral health as set by SAMHSA-HRSA and detailed in Hoge et al. (2014). [Appendix A provides a full outline of seminar topics.]

The inquiry letter also included a brief 4-question survey to assess the level of behavioral health integration within the site, accompanied by an explanation of the levels of integration (see Table 1). This brief survey was based on the levels of integration as defined in the literature and was something the authors created because, to their knowledge, no brief assessment like this was available. While the School was aware of the typical health-field placements (i.e., medical social work at a hospital),

the authors hoped to find out which placements had plans to move towards integrated models of care.

Identifying Field Placement Sites for Inclusion

After the initial surveys were returned, the project and field teams met to go over responses and determine which placements were viable field options. This was an important step because it helped determine how many more field placement sites had to be newly recruited as the program expanded. Once existing field placements were identified as being integrated (or working towards higher levels of integration) based on their response to the brief survey, a field faculty member met with the field instructor in person or by phone to ensure inclusion criteria were met (see Table 2). Because integration occurs on a spectrum, it was not always clear which sites would be most appropriate to meet the specific aims of this BHWET grant. Inclusion criteria were based on previously described definitions of integrated care and interprofessional collaboration. Over the four-year grant period in total, *UNC-PrimeCare* trained 93 MSW students in the southeastern United States and worked with 53 different field agencies. Of these, 25 were newly developed field placement partnerships and 28 existed prior to the grant. As a result of conversations about health care integration and the *UNC-PrimeCare* program, the department's long-standing relationships with existing agencies were renewed and invigorated. In addition, several agencies increased their number of social work student interns within one academic year in order to meet changing needs, as their organizations moved towards more integrated models of care within their clinical sites.

There were several key requirements for field sites participating in *UNC-PrimeCare*, which included: 1) Have a mission of helping patients achieve positive health outcomes by integrating physical and behavioral health care services; 2) Engage in the practice of providing health care through interprofessional teams, at least to some degree; and 3) Be a provider of some form of primary care for at least some subpopulation of its patient base. The program prioritized primary care outpatient settings over inpatient clinical sites (i.e., hospital settings). It is also worth noting that the funding mechanism emphasized integrated care for children and transitional age youth to help mitigate the long-term consequences of physical and behavioral health conditions across the life course. Because of this, specialty clinics focused on pediatric populations that would concurrently address a range of client needs were included. Table 2 offers a brief overview of the types of placements included and a rationale of the decision to accept them as integrated behavioral health field sites.

Utilizing Social Media

Despite the project's best attempts to survey existing field placement sites and find new ones through word-of-mouth or reviewing webpages of resources within North Carolina, one of the best mechanisms for recruitment of integrated behavioral health field placement sites was through the power of social media. For instance, the project team used as many opportunities as possible to have sponsored events or conference presentations covered in the School's online newsletter. As social media announcements about the BHWET HRSA funding and subsequent events circulated to the School's network of field agencies, field instructors, alumnus, and others, the Field Education office was contacted by a number of agencies that the School had not worked with before. Several of these contacts were from physicians or administrators in health care settings who had never employed a social worker before but were moving toward an integrated model of care and were interested in adding a social worker to their interprofessional team of providers.

Consultation and Incentives for Field Instructors

As the School was getting more familiarized with recent literature on integrated care models, it became clear that agencies were (and still are) grappling with how to become more integrated and respond to the mandates of an ever-evolving health care system (i.e., the Affordable Care Act [ACA], efforts to repeal the ACA, and Medicaid expansion). Field placement sites were in a variety of stages of integrated development. This made the field placement process varied as integrated field placement sites ranged from level 5 or 6 to a lower level on the spectrum on integration as outlined in Table 1 (Heath et al., 2013). While most organizations were eager to integrate and place greater emphasis on preventive services, such as early screening and collaborative care, they also faced a host of challenges in doing so. These obstacles ranged from the concrete, such as lack of space for private or team meetings, to procedural issues, such as how to bill for social work (behavioral health) services; changes in work flow; and the need for training especially among social work and other supervisors (Zerden et al., in press). A number of agencies reached out to the *UNC-PrimeCare* team for ideas and support on ways they could move towards integration. For example, sites would call project team members and ask for consultation about billing for behavioral health services, or for job descriptions on how to hire a licensed clinical social worker to increase their behavioral health assessments at the clinical site. While some issues were beyond the purview of the project leaders' expertise (for example, when the team was asked to comment on building design and clinical layout of the workspace for flow), in many cases the project field coordinator was able to provide guidance and consultation

as a seasoned social work practitioner who had worked in an integrated setting within an academic medical center before joining the project team. Additionally, half-day or all-day workshops provided by *UNC-PrimeCare* also helped to provide at least some needed training for field supervisors and their teams to adapt to the demands of the rapidly changing health care environment (see Appendix B).

The Field Education Office and *UNC-PrimeCare* teams were cognizant of the added responsibility of supervising field students, especially during a time when many health-oriented field agencies were in flux. Therefore, a concentrated effort was made to offer as many benefits as possible to the *UNC-PrimeCare* field instructors. In addition to the consultation mentioned above, field instructors were invited to utilize their expertise by helping to guide the development of the project. Several field instructors were asked and agreed to serve on the newly formed *UNC-PrimeCare* Advisory Board. The Advisory Board enhanced the project by providing a cadre of professionals working in the field whom project leaders could check-in with and ask questions, and request their consultation or participation as panelists or in workshops hosted by the program. Additionally, the social work practitioners who served on the Advisory Board were excited to have a leadership role in how this emerging area of practice was being conceptualized by the School. Increasingly, over the course of the life of the project, *UNC-PrimeCare* has been seen a “go to” for agencies in and around the state of North Carolina to find social workers with integrated health care knowledge and expertise. The project has been able to directly link students and graduates with potential employers. The websites and the alumni listserv also served as a no-cost venue for agencies to advertise job openings specific to integrated behavioral health. Although not specific to *UNC-PrimeCare*, other ways the field program incentivized field instructors’ participation and showed appreciation for their partnership included the following strategies:

- **Clinical Lecture Series** (offered in two locations) to clinicians needing continuing education. In fact, many of these seminars related to the clinical skills necessary in integrated settings and students were encouraged to attend. In academic year 2017/18, some of these lectures qualified as one of the required seminars for the program due to related content.
- **Field Instructor Appreciation Day** hosted annually. This full-day includes breakfast, lunch, a thank you gift, and continuing education credits. During this full-day, workshops have focused on integrated care and health disparities due to the emphasis of *UNC-PrimeCare*.

- **Free Online Digital Library** access to new or updated evidence-informed research. As the field of integrated care is emerging and new research is being published, this is an invaluable resource.
- **New Field Instructor Training** (in-person or online) to help field instructors feel prepared for their role. Given the project has recruited dozens of new agencies, these trainings have become very important to ensure quality of placement and requisite supervision are met.
- **Ongoing advanced supervision workshops** professional renewal around supervision.
- **Opportunity to provide statewide trainings** for interested field instructors coordinated by a continuing education liaison at the School of Social Work
- **Auditing School of Social Work courses** for skill development. While this is available to all field instructors, the new course offering in integrated care was not something that was available when most of these field instructors were students.

Challenges Encountered

Although the School and the *UNC-PrimeCare* program were purposeful in how field instructors were recruited and engaged, barriers were experienced.

The “Newness” of Integrated Models of Care

Over the past several decades, a number of integrated behavioral health care models have been developed. However, until recently the social work literature has remained scant on the role of the profession in collaborative models of team-based care (Fraser et al., 2018). Given the fact that integrated health care is still relatively new and social work’s participation in it even newer, we encountered multiple field sites in the midst of adopting integrated models of care and also becoming a field placement site for the first time. This meant that some field instructors had the triple responsibility of: 1) developing organizational structures to deliver behavioral health care services in their agency/clinical setting; 2) providing direct patient care; and 3) simultaneously teaching field students while familiarizing themselves with new models of care delivery. In some of these situations, students expressed concern about their integrated care clinical skill development. For example, students sometimes wanted more clinical

opportunities and were framing this request thinking about a traditional 50-minute psychotherapy assessment. In fast-paced health settings, brief interventions are much more common. Another common challenge was that students felt their field instructor was learning integrated care simultaneously as they were and were not necessarily the practice “experts” they hoped for as role models. In both of these examples, students had to be assured that everyone is learning and practice modalities, evidence, and models change. It was highlighted to students that social work practice realities do not always reflect the models or examples in textbooks that lack the complexity of real setting and contexts. These challenges were surmounted by providing consultative support to these developing sites. A key to being able to overcome these barriers included the hiring of a .50 FTE *UNC-PrimeCare* Coordinator who was a seasoned clinician familiar with interprofessional social work practice (for more on this role, please see Zerden et al., 2017).

The *UNC-PrimeCare* Coordinator position was filled by a licensed clinical social worker with an extensive clinical background in a large academic hospital and previous experiences as a field instructor for the School. This position allowed the project to be responsive to the variety of issues that arose at each site and ameliorate some common challenges with the following strategies:

- Meeting with physicians and medical students to educate them about the array of services social workers are trained to provide
- Working individually with field instructors to provide support to them, and not just responding to the students’ perspective
- Meeting with students to address gaps and provide additional support
- Identifying students best suited to these developing sites, specifically those who are highly flexible, motivated, mature, and assertive

This *UNC-PrimeCare* Coordinator position allowed the project to expand into clinical field sites that had not yet hired a social worker, or where the social worker was unable to fully take on the supervision required for MSW students set forth by the Council on Social Work Education. For example, when there was not an available social worker to provide the required hours of supervision, the Coordinator met with the student at their field site and sometimes on campus to provide supervision. The Coordinator helped students understand that integrated care occurred across a spectrum and that models from textbooks may differ from practice realities. The Coordinator helped

reframe this challenge as a teachable moment for students to recognize what they could bring to their clinical sites. Students were empowered to serve as ambassadors for the profession by helping to articulate what social workers could do on integrated behavioral health teams if one did not currently exist.

Advocacy and Specific State Challenges

Given the School of Social Work's position within North Carolina's flagship university, advocacy became an unanticipated but important function of the project. In order to contribute to workforce expansion, as the HRSA BHWET funding intended, state-level advocacy issues quickly arose as a challenge since there remains a lag in how integrated care is understood clinically as well as whether and how these hours can count towards licensure after graduation. Because social work licensure varies from state to state (Vasquez, Buche, Beck, Ruffolo, & Perron, 2016), project staff, graduates, and field instructors expressed concerns regarding how to accrue hours towards licensure, and how to hire if a MSW cannot yet bill for services. In response, the School's Dean, Associate Dean, project personnel, and representatives from the state chapter of NASW met with the state's clinical licensure board to advocate for change. As a result, within North Carolina, it is now possible for provisionally licensed social workers (those working towards full clinical licensure) to bill Medicaid for certain brief assessments that previously could only be billed by a full licensed social worker. Further, although not yet passed through new legislation, significant in-roads have been made in creating an expanded definition of clinical social work in licensing regulations and in how the profession is understood through Medicaid transformation plans being drafted currently at the North Carolina Department of Health and Human Services.

Moving Forward

As a project, *UNC-PrimeCare* continues to recruit new field sites, particularly those at a Level 3 or higher on the continuum of integration (see Table 1). Given the steep learning curve from 2014 when the project started to where the field is today, *UNC-PrimeCare* is on much more solid footing. First, it has allowed the project team to become more connected to practitioners and health care administrators in North Carolina working in integrated settings. Members of the project team have joined a Health Workforce Research Center on campus to capitalize on their work promoting social work as an important and burgeoning health workforce. Collaboration has also increased with other social work faculty members who are working in this space and these efforts to increase scholarship and dissemination of lessons learned will

continue. Additionally, in the fall of 2017, the School received 2017 BHWET funding which included more emphasis on interprofessional training. The MSW program has partnered with the School of Nursing's Psychiatric Mental Health Nurse Practitioner program. The pilot year for this project (*UNC-PrimeCare 2.0*) is in progress. The goal of this new iteration of funding is to develop field placement sites that will take nursing and social work students together. Another *UNC-PrimeCare 2.0* goal is to develop more online learning opportunities so that field instructors and teams may more easily take advantage of the clinical training opportunities (i.e., workshops and seminars) offered by the program. Given demanding clinical schedules, off-site training is not always convenient, even if it is offered for free.

Conclusion

This paper highlights strategies to help recruit, maintain, and sustain field placements focused on integrated behavioral health from one HRSA-funded BHWET program called *UNC-PrimeCare*. Identified field placements encapsulated a spectrum of integration, ranging from minimal collaboration to full collaboration in a transformed integrated care practice that transcends siloed care. Over the course of the 4-year project, over two dozen new field placement sites have been developed. Since securing the HRSA BHWET funding, the School of Social Work has become a sought-after leader within its larger University to help the academic hospital units and clinics move towards integrated behavioral health care delivery. Evidence of this has come from requests from the Medical School and the Dental School to have MSW student interns (what are new field placements for the School's field education program) work in their clinics to improve patient care. The Medical School has also created a position, and hired a *UNC-PrimeCare* graduate, to provide behavioral health and wellness supports for the Medical and PhD students. Interestingly, the Dental School heard about this position and wants to hire a social worker to work in this capacity as well. In terms of interprofessional education, members of the project team have worked very closely with the University's newly appointed Assistant Dean for Interprofessional Education to further expand how graduate students in the professional schools are being educated in classroom and clinical learning environments. Prior to receiving the BHWET funding, social work was not typically associated with the allied health and health affairs units on campus, whereas now the social work department is seen as a key partner in convening some of these conversations.

Even in the midst of further changes to health care policy, systems, and services, successful recruitment of integrated behavioral health field sites is crucial to the development of quality learning experiences for students and therefore the growth

of a well-trained workforce of social workers. By sharing the School's approach and exploring some of the challenges that were encountered as well as how those challenges were addressed, it is hoped that these strategies can be replicated by other social work programs to help strengthen the field education experience for students, field instructors, and agency partners. While changes to health care reform remain ambiguous, undoubtedly behavioral and physical health needs will persist. Therefore, social work programs need to be responsive and strive to become early adopters in cultivating the most conducive field education learning environments. The changing health care landscape is an opportunity to prepare social workers for real life practice realities as well as utilize their contributions to strengthen field placements and, ultimately, the role of the profession.

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Table 1

UNC-PrimeCare Brief Agency Assessment Example (Fall 2014)

Please type or print your responses to the following questions below. We recognize these questions may not be answered simply and that identifying your agency’s level of integration may be complicated. There are no right or wrong answers; we are aware integrated care occurs on a continuum so there is no need to over-state where your agency currently lies on this scale.

1. Based on the chart below, would you classify the services you provide at your agency as Coordinated, Co-located or Integrated? Please specify a level 1-6.

2. What percentage of your caseload is serving individuals age 25 or younger and their families?

3. Does your agency have a plan to move towards integration in the future? Please briefly explain.

4. Based on a scale of 1-10 (1= the least interested and 10= the most interested), how would you rate your interest in being a UNC-PrimeCare site for MSW students?

COORDINATED		CO-LOCATED		INTEGRATED	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal collaboration	Basic collaboration at a distance	Basic collaboration on site	Close collaboration on site with some system integration	Close collaboration approaching integrated care	Full collaboration and integrated practice
In separate facilities where:	In separate facilities where:	In same facility, not same office where:	In same facility, similar space/near one another where:	In same space within the same facility where:	In same space within the same facility where:

<ul style="list-style-type: none"> • There are separate systems • Communication is rare and for compelling cases • Communication is driven by provider needs • There is limited understanding of other's roles and resources • Providers may never meet as part of a team 	<ul style="list-style-type: none"> • There are separate systems • Communication occurs sporadically about patients • Communication is driven by patient issues • There is appreciation for each other's resources • Providers may meet as part of a larger community 	<ul style="list-style-type: none"> • There are separate systems • Communication occurs regularly about shared patients (i.e., phone, email) • Collaboration is driven by need for other's services and more reliable referral • Providers feel part of a larger yet poorly defined team • Providers meet occasionally to discuss cases 	<ul style="list-style-type: none"> • There are some shared systems (i.e., scheduling or records) • Communication is in person as needed • Collaboration is driven by need for consultation and coordination for difficult patients • There is a basic understanding of culture and roles • Providers have regular face-to-face interactions about some clients 	<ul style="list-style-type: none"> • Providers actively seek system solutions together to develop plans • Communication is frequently in person • Collaboration is driven by the desire to be a member of the team • There is an in-depth understanding of roles and culture • Providers have regular meetings to discuss overall and specific patient care 	<ul style="list-style-type: none"> • Providers have resolved most or all of the system issues and function as one system • Communication is consistent at all of the system, team, and individual levels • Collaboration is driven by the concept of team care • Roles and cultures have blended • Providers have formal and informal meetings
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Table 2

Selected *UNC-PrimeCare* Field Placement Overview & Rationale for Inclusion

Type of Settings			
<p>Ambulatory Care/ Primary Care</p> <ul style="list-style-type: none"> • Adult, family, and pediatric primary care offices • Student health services on campus 	<p>Ambulatory Specialty Care</p> <ul style="list-style-type: none"> • Infectious disease • Nicotine dependence services within the hospital • Pediatric oncology unit • Pediatric obesity clinic • OBGYN clinics 	<p>Community Health Clinics & Federally Qualified Health Centers (FQHCs)</p> <ul style="list-style-type: none"> • Health care clinic for the homeless at a FQHC site • County health departments 	<p>Substance Use Programs</p> <ul style="list-style-type: none"> • Substance use treatment sites (outpatient and/or residential) • Medication assisted treatment programs within primary care
Rationale for Inclusion			
<p>This was a priority field placement setting when possible.</p>	<p>After consulting with field instructors and field faculty, it became clear this was likely the patient’s medical home. For example, pediatric oncology: Initially we did not feel this met criteria but in consultation with the field instructor, his clinic became the source of general pediatric care and was the patient’s medical home.</p>	<p>Given community health clinics and FQHCs primarily provide care to those who may not have access to health services in other ways, providing comprehensive behavioral health services to this group of consumers was a priority foci area of the project, when placements were available.</p>	<p>Initially we planned to work with physical health sites offering behavioral health services. However, given the quick expansion of this area, we realized we could provide reverse-co-located field placement sites – meaning these were primarily mental health or substance use focused who were bringing in more physical health care.</p>

Appendix A

Seminar Topics and Connection to Integrated Care Core Competencies

Seminar Topic	Specific Content & Integrated Care Core (ICC) Competencies Addressed
<i>Interdisciplinary Teams; Communication & Collaboration</i>	<ul style="list-style-type: none"> • Key characteristics of interprofessional teams and social workers' roles • Using common terminology on health care teams • Establishing rapid rapport with consumers and family members to facilitate BH screening as part of a medical visit <p>(ICC Competencies I, II, and IV)</p>
<i>Screening and Risk Assessment with Youth & their Families</i>	<ul style="list-style-type: none"> • Tailoring engagement and assessment for youth and young adults in health care settings • Recognizing signs and symptoms of abuse, neglect, substance use, self-harm, and violence; and using evidence-based tools to screen/assess conditions • Practice and reflection <p>(ICC Competency III)</p>
<i>Care Planning & Coordinating Services</i>	<ul style="list-style-type: none"> • Preparing, evaluating, and updating integrated care plans; Engaging families and community supports; Including patients and families in developing a plan of recovery • Practice & reflection <p>(ICC Competencies II and IV)</p>
<i>Brief Interventions with Children, Adolescents, & Families</i>	<ul style="list-style-type: none"> • Using evidence-based brief interventions (e.g., MI, CBT, crisis intervention) in time-limited settings to motivate consumers and family members for change and to resolve presenting problems • Health education techniques, psychoeducation • Practice and reflection <p>(ICC Competencies IV & VI)</p>

<p><i>Engaging Families as Members of the Treatment Team</i></p>	<ul style="list-style-type: none"> • Adapt engagement strategy & intervention to a family’s cultural norms & values; Family as part of the care team • Link to community & social support; Using health education materials to reflect reading levels and cultural competence • Practice and reflection <p>(ICC Competencies I, II, V, and VI)</p>
<p><i>Psychiatric Medications & Physical Health</i></p>	<ul style="list-style-type: none"> • Medications commonly prescribed for child and adolescent populations; Side effects and potential misuse of medications; Common over-the-counter drugs, side-effects, and potential for misuse; Conditions that may need a medication evaluation <p>(ICC Competencies IV & V)</p>
<p><i>Cross-Cultural Issues in Integrated Care</i></p>	<ul style="list-style-type: none"> • Understanding barriers to engagement and follow through caused by a history of negative experiences, discrimination, marginalization, and oppression • Promoting self-awareness and personal biases <p>(ICC Competencies V and VI)</p>
<p><i>The Use of Informatics</i></p>	<ul style="list-style-type: none"> • Computer-based and Web-based tools commonly used in health care settings • Computer applications to increase motivation and compliance with treatment regimens • Safeguarding patient confidentiality and privacy <p>(ICC Competencies VII and IX)</p>
<p><i>Evaluations & Wrap Up</i></p>	<ul style="list-style-type: none"> • Verbal and written feedback; Submit portfolio; Importance of completing career evaluation survey; Discussion of Alumna Network listserv and Website as resources
<p>Integrated Care Core Competencies: <i>I. Interpersonal communication; II. Collaboration & teamwork; III. Screening & assessments; IV. Care planning & coordination; V. Intervention; VI. Cultural competence & adaptation; VII. Systems-oriented practice; VIII. Practice-based learning; IX. Informatics.</i></p>	

Appendix B

Selected Examples of *UNC-PrimeCare* Behavioral Health Workshops for Field Instructors and Agency Staff

The Role of Social Work in New Models of Care: Gear Up for Interprofessional Learning

Motivational Interviewing

Living in the Nexus of Interprofessional Practice and Education: The Need to Think and Act Differently

LGBTQI 101 – Sexual Orientation, Gender Identity, and Expression

Culturally Competent Counseling with LGBTQI-Identified People

Using Solution-Focused Brief Therapy in Primary Care

Health Care for North Carolina’s Most Vulnerable Citizens: The Intersection of Macro & Micro Practice

Integrated Care: Behind the Scenes Using an Interprofessional Team to Treat Co-Occurring Developmental Disabilities & Behavioral Health in a Primary Care Setting

Implicit Bias: How What We See Impacts What We Do

Note: Some of these workshops were conducted by colleagues from within the School and across campus, free of charge. Others included invited national guests wherein a small honorarium was given and paid for by the grant. All workshops were offered with free continuing education credits for social workers.