Helping Community Partners Build Capacity within Integrated Behavioral Health: A Call to Action for Social Work Education

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Abstract: Social workers are recent additions to integrated health care teams; therefore, there is emerging literature about the work experiences and training needs of social workers in integrated settings. After receiving a Health Resources Services Administration-Behavioral Health Workforce Education and Training (HRSA-BHWET) integrated behavioral health (IBH) grant, our social work program conducted a survey among our social work field education sites to determine training needs. Results of the needs assessment revealed that a lack of clarity exists about what is meant by integrated behavioral health as well as ways to measure and interpret levels of integration within social work field education sites. Barriers to collaboration and areas of needed training revealed gaps in knowledge and workforce readiness for providing integrated care. Recommendations include using a bidirectional level of integration conceptual framework to support greater participation of social workers and social service agencies in integrated care, in addition to specific curricular and continuing education training opportunities. Social work educators are afforded a unique opportunity to support our field education partners in reviewing and enhancing their systems of care as they continue to train future social workers.

Keywords: Integrated behavioral health; training needs; social work; interprofessional team

In 2017, our social work department, within a mid-sized public university in the Northeast, received a four-year Health Resources Services Administration Behavioral Health Workforce Education and Training (HRSA-BHWET) grant to train social work students to practice in integrated behavioral health (IBH) settings. Given the importance of field education to these efforts, the grant work began with a focus on determining the current practice configurations, knowledge and skills within our social work field education training sites, as well as soliciting information about training needs. Many of our community partners were traditional social service agencies, although others were within medical settings; most were in the beginning stages of practice within integrated behavioral health. An online needs assessment was conducted to better understand self-reported levels of integration, practices used to support integrated care, and training needs of our community partners.

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Literature Review

The Rapid Evolution of Integrated Health Care for Social Work

Integrated health care is patient-centered care delivered by a team of primary care and behavioral health clinicians using a systematic and cost-effective approach (Berwick et al., 2008). While integrated services do not have to be delivered in the same location to be considered integrated care (Peek & the National Integration Academy Council [NIAC], 2013), the highest levels of integration that include fully merged practices have been identified as a best practice method to fulfill the quadruple aim of reducing cost, improving patient safety, improving the patient experience, and reducing burnout among providers (Bodenheimer & Sinsky, 2014; Brandt et al., 2014).

Social work, as a profession, has been involved in public health for over a century. The formation of the American Association of Hospital Social Workers dates back to 1918 (Ruth & Marshall, 2017), yet there has been historical difficulty in articulating the role and value of a social worker within the evolution of the complex health care systems within the Unites States. The twentieth century saw a splintering of medical and psychiatric health care, and social work became more easily defined within therapeutic settings addressing the latter. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 mandated that comparable mental health and addiction treatment to that of medical services must be covered by insurance. The paradigm shift in health care systems that began with the MHPAEA set the stage for the passage of the Patient Protection and Affordable Care Act (ACA) of 2010, and the creation of systemic integration (Beronio et al., 2013). Spearheaded by the passage of the ACA, reform efforts of the U.S. health care system include: better coordination of inpatient and outpatient health services, integration of behavioral and medical health services, and changes to payment structures to favor comprehensive, efficient care (Andrews et al., 2013). Herein, the profession of social work has been fiscally mandated to join modern day integrated health care efforts in creating models of practice, policies, special committees, and taskforces (Stanhope & Straussner, 2018).

The Council on Social Work Education (CSWE) has made a concerted effort to advance the role of the social worker within integrated health care teams. CSWE has increased education and training expectations for working with other professions, and has shifted from using the terms working in *multidisciplinary* or *interdisciplinary* teams to *interprofessional collaboration*. The social work competencies outlined in the 2015 Educational Policy and Accreditation Standards (EPAS) identify the ability to use interprofessional collaboration as a new component behavior within the core competencies. In 2016, CSWE highlighted the concept through the Annual Program Meeting theme *Advancing Collaborative Practice Through Social Work Education*. That same year, CSWE joined the Interprofessional Education Collaborative whose membership is comprised of 21 discipline associations related to health professions and was responsible for setting the interprofessional competency standards.

Most recently, several social workers were included members of the National Academies of Science, Engineering, and Medicine's (NASEM) committee that produced

the consensus study report on *Integrating Social Care into the Delivery of Health Care* (2019). The report concurs with literature recommending the inclusion of social work and identifies the integral role that social workers play in achieving the goal of better health outcomes through their specialized skills for addressing social determinants of health (Fraser et al., 2018; NASEM, 2019). The NASEM report also introduces a new concept within the United States. The 2019 NASEM committee defines *social care* as "activities that address health-related social risk factors and social needs" (p. 28). This concept is widely used in in other parts of the world (Great Britain Department of Health, 1989) as an umbrella term for services provided to enable people of all ages, with a range of needs, to live their lives to the fullest and spans across traditional social work settings from services provided within the child welfare system to work with older adults to health care settings (The Kings Fund, 2017).

Specific skill-based competencies that would be included in the broader concept of social care include "collaborate in cross-professional settings, contribute to team-based decision making, administer screening instruments, engage in practice-based learning, use medical informatics, and provide behavioral health intervention" (Zerden, Lombardi et al., 2018, p. 72). Gaining these competencies prepare social workers for completing a range of functions performed in integrated settings, such as: performing standardized assessments such as the screening brief intervention referral and treatment (SBIRT) and functional assessment, providing training in relaxation, applying cognitive behavioral therapy (CBT), problem solving therapy (PST), motivational interviewing, behavioral activation, and psychoeducation. Social workers also use techniques to ensure cultural competence and inclusivity, address social determinants of health, and contribute to care plans, team-based care. Tasks fulfilled by social workers are also related to patient education and navigation, medication and care management, and in providing consultations to other team members. Finally, social workers serve as a link with resources in the community (Fraher et al., 2018; Fraser et. al., 2018). Given this context, incorporating material on integrated care across the curriculum for coursework and field experiences is needed (Mattison et al., 2017; Smith-Osborne & Daniel, 2017).

What is Integrated Behavioral Health Care?

Due to the diversity and breadth of roles and services provided by social workers, the concept of integrated behavioral health care has been complex for the profession (Rishel & Hartnett, 2018; Sankar, 2014). When introducing the IBH focus of the grant to field education sites, the vernacular surrounding the concepts of integrated care, team-based care, and collaborative care, were often viewed as synonymous with IBH, despite their different meanings (Peek & NIAC, 2013). The traditional roles of a social worker – advocate, case manager, educator, facilitator, broker - are naturally collaborative with other disciplines. Many social workers ask how is integrated behavioral health any different than social work as usual. Integrated behavioral health care is generally defined as infusing behavioral health (mental health and substance abuse services) into primary care settings although the integration can be bidirectional (Mauer & Jarvis, 2010) whereby physical health is addressed in a behavioral health setting. By integrating services, medical health and behavioral health care needs will be streamlined and provide better outcomes,

especially for those with chronic physical, mental health, and addiction related issues (Crowley & Kirschner, 2015).

Through the Substance Abuse and Mental Health Services Administration (SAMHSA) -HRSA Center for Integrated Health Solutions (CIHS), integration of health care is further conceptualized along a continuum (Levels 1-6), with lower levels characterized as having *coordinated* integration due to minimal collaboration (Level 1) or basic collaboration at a distance (Level 2). At these levels, providers communicate in order to address provider and/or patient needs. Mid-level integration is *co-located* where there is basic collaboration onsite (Level 3) or close collaboration with some system integration (Level 4) due to the closer physical proximity of providers. The higher levels, considered *integrated* indicate a change in the practice noted by "close collaboration approaching an integrated practice" (Level 5) to a full collaboration in a merged practice (Level 6). Each level of integration is further described by examining the physical proximity of providers, ways in which clinical services are delivered, what the patient experiences, levels of coordination within the practice or organization, and finally, ways in which the business model provides the infrastructure to facilitate integrated care (Heath et al., 2013).

The Influence of IBH on Social Work Field Education

Considered by CSWE as the *signature pedagogy*, field education is of equal importance within the curriculum as classroom learning and serves to integrate the theoretical and conceptual contribution of the classroom with the practical world of the practice setting (CSWE, 2015). The top five MSW field education placements reported by CSWE are: 1) community mental health, 2) health and mental health, 3) school social work, 4) child welfare, and 5) family services (CSWE, 2017). Within these placements social work students routinely work with other professionals providing social care. Additionally, field education training sites increasingly exist within varying levels of integration. Given these changes, field education has experienced a shift in how training sites are perceived. Traditionally, a social work setting that exclusively provided social services was identified as a primary social work setting, and a distinction of a secondary social work setting was where social workers' main role was to support the central goal of the institution/organization (Suppes & Wells, 2018). Now, many training sites are viewed within the lens of integrated care/ interprofessional teaming. Within the interprofessional team, a hallmark of higher-level integration is the notion that each representative from the different disciplines on the team is an integral member to meeting the overall goals of the quadruple aim (Nester, 2016). While the concept evolved from health settings, an interprofessional organizational approach changes how we understand ways that field education settings function, what type of social work training is expected, and requires consistency across social work curriculums, field supervisor trainings, and continuing education offerings for social workers in the field.

Furthermore, because the discipline of social work entered the integrated care conversation later than other disciplines, several current challenges arise in field education for integrated behavioral health training programs (Zerden, Kanfer et al., 2018). One challenge is the limited number of placements at training sites considered integrated through the SAMHSA-HRSA CIHS definition that are available to social workers. When

entering the field of integrated care from the end of the continuum that is predominantly behavioral health services, the majority of social work settings do not fit seamlessly within the levels of integration framework (Heath et al., 2013). Limited access results in the need to diffuse training opportunities across settings that are attempting to integrate care in new ways (e.g., outpatient mental health and schools; Smith-Osborne & Daniel, 2018; Zerden et al., 2017).

Although using a range of training sites can bring diversity and richness, it also means that field instructors and students have greatly varied lived experiences of integration in the field. Lack of a clearly defined role, overlap with other interprofessional team members, and difficulty in identifying functions served within the social work activity is also an area of need in curricula, with field supervisors, and as continuing education opportunities (Foster & Clark, 2015). As field education sites are comprised of various levels of systemic integration, social work programs must work closely with community stakeholders to determine the range of opportunities for their students to gain the knowledge and skills necessary to work within integrated health and social care settings. An additional challenge related to gaining applied knowledge is the lack of clarity among and across field instructors, faculty field liaisons, and students about integrated care language and interprofessional training expectations and experiences (Putney et al., 2017). Moreover, generational differences have been shown to exist between students receiving the current social work curricula and for seasoned supervisors in the field who may have continuing education needs related to more recent expectations for social workers in gaining competence in evidence-based practices such as SBIRT (Fraher et al., 2018).

In order to better understand the self-reported levels of integration and training needs of our community partners, we conducted a needs assessment with the agencies at which our first group of HRSA-BHWET IBH MSW students were placed. This needs assessment was the first step in developing systematic efforts to support agencies' efforts at integration, and thereby provide high quality field education training experiences for our MSW students.

Methods

Needs assessments are commonly used in the field of social work to gather information about gaps and priorities for program development and service delivery (Royse & Badger, 2015). For efficiency and ease of participant response, we developed an online survey for our needs assessment. Following IRB approval, the needs assessment was disseminated via Survey Monkey to the 15 field education training sites that were hosting our HRSA-BHWET IBH MSW students. In our university, advanced MSW students spend 20 hours per week for an academic year receiving field education training within local community organizations under the supervision of an experienced social work clinician. A setting was considered to have a degree of integration if at least two health care disciplines were present. There was a range of settings, from traditional outpatient behavioral health clinics, to full service medical centers, to settings whose primary purpose was to provide integrated health services. The survey was sent to the organization's executives with a request that it be forwarded to whomever they felt was best able to complete an integrated behavioral health needs assessment for the social work field education training site. All executives

identified the field supervisor as the respondent. During the data collection process, three reminder emails were sent directly to the field supervisors to maximize the response rate.

Guiding the formulation of the needs assessment questions was the Sustaining Integrated Behavioral Health Services: A Step-by-Step Guide Part II (SAMSHA, 2018). This resulted in five sections: 1) demographics, 2) assessing the settings level of integration, 3) organizational communication, 4) barriers to collaboration, and 5) workforce training needs. In total, there were 46 questions with a combination of multiple choices, open-ended, and preference ratings for training needs. Questions aimed at assessing the level of integration within the setting included those that identified the various disciplines at the setting, the physical locations, and proximity of the various disciplines. Organizational communication questions were multiple choice that focused on the infrastructure that supported or impeded communication such as the presence of shared electronic medical records (EMR) or daily huddles. Multiple choice questions where respondents chose all that applied were aimed at gathering the barriers to collaboration that were described in the literature including: not part of the agency culture, EMRs not accessible by all team members, not enough time, lack of knowledge about other professions, lack of interest from other disciplines, collaboration not billable/counted towards productivity, release of information issues, and an open response to gather information not listed. Questions about workforce training need questions were adapted from the needs assessment described in Horevitz and Manoleas (2013) and specifically focused on knowledge of interprofessional competencies, training in evidence-based clinical practices, techniques used in integrated care such as warm handoff, and service delivery models used in treatment planning and evaluation. Each field education training site also completed the Integrated Practice Assessment Tool (IPAT), a standardized tool based on the SAMHSA-HRSA CIHS Levels of Integrated Healthcare, that determines the organization's perception of their baseline level of integration (Heath et al., 2013). Lastly, throughout each section of the needs assessment, questions addressed access to and barriers impeding further integration, readiness to make changes, and type of workforce development that would help the agency achieve their integrated behavioral healthcare goals.

Results

Demographics

Of the 15 field education training sites surveyed, 13 responded providing us with a robust 80% response rate (where questions were not answered missing data is noted). The majority of respondents identified as female (92%), white (100%), all had their MSW Degree (100%), and the majority held an independent social work license (83%). Experience in the profession ranged from 7-30 years with a median range of 11-15 years. All respondents also served multiple roles within the agency (e.g., supervisor [75%], clinician [58%], field education supervisor [58%], administrator [50%]).

The respondent agencies represented a range of settings, falling into 3 broad categories, 38% (n=5) were community behavioral health clinics, 38% were (n=5) integrated

healthcare agencies, and 23% (n=3) were medical centers. The majority of respondents reported providing integrative health services (75%), addressed substance use disorders (67%), mental health needs (67%), issues related to aging (58%), and homelessness (58%). All of the agencies provided services to adults and elders, and 75% of agencies also served children and adolescents. By way of federal designation, 100% of the sites served medically underserved areas/ populations. A variety of healthcare professions worked within each agency setting, with 5 disciplines minimally represented (see Table 1 for the specific healthcare disciplines represented at the field education training site and the disciplines collaborated with outside of the setting).

Table 1. *Healthcare Professions Represented During Field Education Training (n=12)*

Healthcare Discipline	Setting n (%)*	
	Field Education	Outside
Social Worker	12 (100%)	9 (75%)
Advanced Nurse Practitioner	11 (91.7%)	5 (41.7%)
Mental Health Counselor	10 (83.3%)	7 (58.3%)
Registered Nurse	10 (83.3%)	4 (33.3%)
Direct Care Staff	9 (75%)	7 (58.3%)
Medical Doctor (Psychiatry)	9 (75%)	4 (33.3%)
Addiction Counselor	8 (66.7%)	4 (33.3%)
Medical Doctor (Physical Health)	7 (58.3%)	10 (83.3%)
Physician Assistant	7 (58.3%)	5 (41.7%)
Nutritionist	6 (50%)	3 (25%)
Occupational Therapist	6 (50%)	2 (16.7%)
Psychologist	5 (41.7%)	3 (25%)
Physical Therapist	5 (41.7%)	2 (16.7%)
Chaplain	4 (33.3%)	1 (8.3%)
Community Health Worker	2 (16.7%)	1 (8.3%)
School Personnel	0 (0%)	1 (8.3%)

*Presented by highest % of field education followed by outside setting

Levels of Integration

The Integrated Practice Assessment Tool (IPAT) was used to assess level of integration. Of the field education training sites, 23% (n=3) identified being at a Coordinated level of integration, 16% (n=2) were Co-Located, and 61% (n=8) were Integrated. As seen in Table 2, the needs assessment data from questions that addressed the domains associated with integrated care (proximity of healthcare providers, organizational readiness, and business model) are compared to results from the IPAT showing the discrepancies. For example, when asked specific questions about proximity to other healthcare providers, organizational structures that promote collaboration, and aspects of their business model that support collaborative work, only 8% (n=1) reported that their setting was integrated at the *Coordinated* level; yet, according to the IPAT, 23% (n=3) of respondents were identified at the *Coordinated* level. As Table 2 illustrates, there are inconsistencies throughout.

Table 2. *Center for Integrative Health Solutions Levels of Integration (n=13)*

Integration	Level	Collaboration	IPAT Results n (%)	Behavioral & other healthcare prov. proximity	Practice/ Organizational Structures	Business Model
				Domain n (%)		
Coordinated	1	Minimal	3 (23.1%)			
	2	Basic		1 (7.7%)	1 (7.7%)	1 (7.7%)
Co-Located	3	Basic at a distance	2 (15.4%)	3 (23.1%)	2 (15.4%)	2 (15.4%)
	4	Close, onsite w/some system integration		3 (23.1%)	4 (30.8%)	4 (30.8%)
Integrated	5	Close, approaching integrated practice	8 (61.5%)	3 (23.1%)	3 (23.1%)	3 (23.1%)
	6	Full, in transformed/ merged integrated practice		3 (23.1%)	3 (23.1%)	3 (23.1%)

Organizational Communication

Readiness for integrated care relates the day-to-day practices within the team-based communication system within the organization (SAMHSA, n.d.). These internal processes inform the culture of the setting, as well as opportunities and/or barriers as it relates to readiness for integrated care. All of the respondents reported a business plan that included language about integrated/patient centered care teams, and 67% (n=8) knew that their mission statement was in alignment. Communication systems varied, with 75% (n=9) of the settings using electronic medical records to communicate across all disciplines, but 15% (n=2) had discipline restrictions to access, and 8% (n=1) had limited communication through a mix of electronic and paper medical records. Additionally, agencies used a variety of methods to communicate between team members, from weekly interdisciplinary meetings to daily huddles and warm handoffs (see Table 3). Of the settings, 92% (n=11) reported already engaging in agency-wide reviews of communication strategies on patient centered care teams, and 83% (n=10) wanted consultation to review their communication systems.

Table 3. *IBH Communication Strategies Endorsed (n = 12)*

Communication Strategies	n (%)
Email	12 (100%)
Warm Hand Offs	10 (83.3%)
Weekly Interdisciplinary Team Meetings	8 (66.7%)
Daily Team Meetings or Huddles	7 (58.3%)
Text	7 (58.3%)
Bi-Weekly Interdisciplinary Team	1 (8.3%)

Barriers to Collaboration

Regarding barriers to collaboration with other professions within their respective settings, 64% (n=7) of respondents identified lack of time, 45% (n=5) noted a misunderstanding of other disciplines' expertise, 36% (n=4) cited lack of interest from other disciplines. Billing or productivity issues accounted for 23% (n=3), inaccessible

electronic medical records 18% (n=2), and 8% (n=1) identified lack of proximity as a barrier to collaboration. No respondents identified agency culture as a barrier to collaboration. When trying to collaborate with healthcare professionals outside of the field education training site, lack of time 73% (n=8), misunderstanding other disciplines' expertise 45% (n=5), and release of information issues 36% (n=4) were the top three barriers, see Table 4 for the complete list.

Table 4. *Barriers to Collaboration Between Healthcare Professionals* (*n*=11)

Barriers to Collaboration	Setting	
	Within	Outside
Lack of time	7 (63.6%)	8 (72.7%)
Misunderstanding of other disciplines' expertise	5 (45.5%)	5 (45.5%)
Lack of interest from other disciplines	4 (36.4%)	4 (36.4%)
Billing or productivity issues	3 (27.3%)	2 (18.2%)
Inaccessible electronic medical records	2 (18.2%)	3 (27.3%)
Release of information issues	1 (9.1%)	4 (36.4%)
Lack of proximity not allowing in person collaborations	1 (9.1%)	0 (0%)
Not part of agency culture	0 (0%)	1 (9.1%)

Knowledge and Clinical Workforce Training Needs

Due to the relative infancy of integrated healthcare within traditional social work settings, it was necessary to gather baseline data on training that respondents from field education sites had received. Agency respondents also identified the integrated care practice methods employed within their setting, and finally, methods they would like training in. To begin, 27% (n=3) were trained in the Interprofessional Educational Practice (IPEC) competencies and 64% (n=7) were trained in integrated healthcare service delivery models. Regarding future training in these areas, 55% (n=6) of respondents wanted more training on both topics for themselves and their staff, and 45% (n=5) felt higher level administrators would benefit from training. In terms of specific practice-oriented training needs, the top five were psychosocial implications and management of chronic physical conditions with 75% (n=9), EBP tools for alcohol and other drugs at 67% (n=8), trauma-informed care at 58% (n=7), EBP tools for depression, motivational interviewing, EBP tools for physical health assessment, and psychotropic medications all were endorsed at 50% (n=6). See table 5 for the full list.

Table 5. *Integrated Behavioral Health Training Needs (n=12)*

Training Needs	n (%)
Psychosocial implications & management of chronic physical conditions	9 (75.0%)
Alcohol and other drugs EBP prevention, screening, & assessment tools	8 (66.7%)
Trauma-informed care	7 (58.3%)
Depression and risk prevention EBP screening & assessment tools	6 (50.0%)
Motivational interviewing	6 (50.0%)
Physical health EBP prevention and screening tools	6 (50.0%)
Psychotropic medications	6 (50.0%)
Functional assessment tools	5 (41.7%)
Curbside consultation	4 (33.3%)
Self-Care & burnout prevention	4 (33.3%)
Stress management & relaxation techniques	4 (33.3%)
Understanding role of poverty & culture in health disparities	4 (33.3%)
Warm hand off	3 (25.0%)
Psychoeducation	2 (16.7%)
Team-based care	2 (16.7%)
Interprofessional education models	1 (8.3%)
Case management	-

Discussion

The needs assessment was completed by social work field supervisors within a diverse group of community agencies that provided training for masters level social work students. Results provide a better understanding of levels of integration, practices that support integrated care, and identified training needs of our community partners.

Levels of Integration

Discrepancies between levels of integration identified on the IPAT and responses on CIHS framework suggest that identifying levels of integration is subjective and there might be a lack of clarity about how to appropriately identify levels of integration. For example, according to the IPAT, over half the settings (n=8) were functioning at the level of integrated (Levels 5-6) whereas answers on specific domain questions (e.g., provider proximity, business model, and organization structures) suggested that only six were at this level. Similarly, the IPAT scored two organizations at Co-located (Levels 3-4) but answers on specific domain questions suggested that six organizations were at this level. We believe that domain related questions about collaboration were a better indicator of the levels of integration because they operationalized *integration* in a more specific way for respondents. Therefore, we view the levels of integration within our sample as: one Coordinated (one behavioral health clinic), six Co-Located (four behavioral health clinics, two medical centers), and six integrated (one medical center, five integrated health agencies).

When applying systemic integration concepts to field education training sites in social work, it is important to recognize the historical context - and consequences - of having vast separation between medical and mental health care in the United States. This separation has resulted in two unequal systems that have provided suboptimal care (Compton-Phillips

& Mohta, 2018). Within these two systems, both mental health and physical health providers routinely work with other health care professionals. Social workers are currently the largest group of mental health care providers in the U.S. (Heisler, 2018) and have been practicing collaboratively for over a century in the mental health system (Vourlekis et al., 1998).

With the passage of the Mental Health Parity and Addiction Equity Act of 2008, mental health was legislated to be as equally important as physical health. However, this legislation alone did not create the systemic change necessary to reduce the barriers for accessing mental health services (Gertner et al., 2018). As we see the growing efforts to increase access to mental health care through creating a more integrated system of care, vis-à-vis the ACA mandates, we would suggest that an unintended consequence is that social work has only recently joined the integrated care discussion. Consequentially, the conceptualization of integration was crafted from the vantage point of a single system, the physical health system. This conceptualization does not fit as seamlessly in the systemic practice of mental health care, more recently referred to as behavioral health care.

Behavioral health providers routinely collaborate with other disciplines to provide more comprehensive behavioral health services (e.g., social workers collaborating with nurse practitioners or psychiatrists who are the medication providers for their patients). In this way they are indeed engaging in integrated care through an interprofessional team. While they may not be in a traditional medical setting, the care may be coordinated or co-located. Our medical counterparts are doing the same, providers within the physical health care system also routinely collaborate along the continuum of integration with other disciplines (e.g., doctors of family medicine, or pediatrics collaborating with nurses, phlebotomists or radiologists) to provide comprehensive care.

One critique of the movement to fix these broken systems through integrated primary care is that it is layering services on top in a "cookie-cutter manner" (Compton-Phillips & Mohta, 2018, p. 2). Integrated systems guided by community health needs assessments allow for care redesign that is responsive to the specific health needs of the community that is served. Social work has long operated from the perspective of starting where the client is at; applied here, it is joining the integrated movement starting where the system is at. Social work education is in a unique position to contribute to the integrated movement by advocating for a more inclusive understanding of the concepts surrounding levels of integration. An alternative is the bidirectional levels of integration conceptual framework. The term has been formerly used to describe the business design along the continuum of integration (Mauer & Jarvis, 2010). Figure 1 illustrates this framework applied to the ways in which behavioral health and medical health services are delivered. If not fully integrated, both systems are simultaneously engaged in their own version of coordinated and co-located integration efforts. A bidirectional framework allows for the inclusion of social work that recognizes the long history of interdisciplinary collaboration, responsiveness to community health needs, and validates the full spectrum of health care delivery.

Figure 1. *Bidirectional Levels of Integration Conceptual Framework*
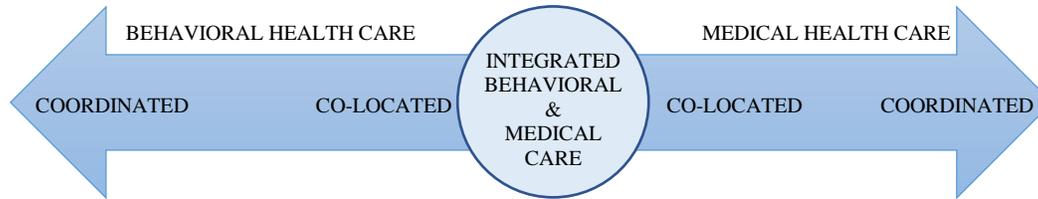
Interprofessional Collaboration and Communication

Data on collaboration and communication were more consistent, and support the aforementioned bidirectional framework. Each of these settings identified the same top 5 disciplines (social work, mental health counseling, prescribers that included psychiatrists, physician assistants, advanced practice registered nurses, and registered nurses) that they worked with which were predominantly behavioral health focused. This persisted regardless of level of integration and whether their collaboration was within or outside their setting (with the exception of more primary care doctors outside of their setting). In terms of ways in which social workers collaborated with other disciplines, 67% engaged in weekly IBH meetings while 58% met daily for meetings or huddles, and 83% endorsed using warm handoffs.

When reporting barriers to collaboration, the three highest to be endorsed were the same regardless of the location (within or outside the setting): lack of time, a misunderstanding of each other's discipline, and a perceived lack of interest from other disciplines. Two-thirds of the sample reported having weekly interdisciplinary meetings, while just over half have daily "huddles." Encouragingly, very few respondents identified "billing" as a barrier to collaboration, suggesting that fee for service models of care may be shifting in behavioral health. When asked where they would like to be in one year in relation to overcoming barriers, 82% of the agencies identified wanting organizational structures in place to promote deeper collaboration, yet only 18% endorsed wanting strategies for achieving operational and administrative readiness. Similarly, 73% wanted greater physical proximity to collaborate with other healthcare providers, but only 9% wanted consultation to realize this goal. With the elements of integrated care still in its infancy within social work, it is difficult to ascertain the meaning related to these results, overall organizational culture and the capacity for self-assessment about training needs in these areas.

Training Needs

The training needs most frequently identified included: psychosocial implications of chronic health conditions, evidence-based screening and assessment tools for alcohol and drug use, depression, and physical health issues. Trauma informed care, motivational interviewing, and psychotropic medications were also at the top of the list. These training topics seem to be in line with the literature about the newness of integrated care and related practices expected of social workers, particularly as evidenced by the knowledge gap

experienced by our respondent group of seasoned field supervisors (Fraher et al., 2018; Putney et al., 2017).

Recommendations for Social Work Educators

Our findings suggest that there is lack of clarity in the field about what integrated care is and how agencies that have traditionally focused on behavioral health exclusively can better align with new models of care that are responsive to their community health needs. Helping to educate stakeholders (students, faculty, field supervisors, practicing social workers, other behavioral health disciplines) about integrated care, potentially through a framework such as the bidirectional level of integration, can help by providing clarifying information in this new field. Educators are being called on not only to educate the new generation of social workers to practice in integrated care models, but also to orient our profession to this new reality and work closely with field sites to identify and further develop integrated care internship opportunities. Educators can do this by providing continuing education opportunities for practitioners in the field. For example, our grant team currently provides and tracks usage by organization of our online training modules (with free continuing education credit) on topics related to integrated behavioral health care in order to support workforce development in this area.

Field education is the signature pedagogy of social work and it is of fundamental importance that agencies that host social work students for training receive the resources necessary to align with CSWE competencies and best practices/models of care. This could be accomplished through site-specific consultation on integration as well as targeted educational information to leadership, administrators, and supervisors. Finally, as social work educators, we are being called upon to implement CSWE guidelines for preparing social workers to practice on interprofessional teams. This entails changing traditional curricula to focus on such topics as interprofessional communication and evidence-based practice in integrated care settings. Given that CSWE is also a member of IPEC and committed to the value of interprofessional education, social work programs could also consider developing and/or joining interprofessional education efforts at their institutions as well as within their communities. These efforts could be as small as a one-hour educational seminar, or as large as shared field experiences or interprofessional courses (Zerden et al., 2017; Zerden, Lombardi et al., 2018).

Limitations

Our study sample was small and homogenous. We also only surveyed one geographical region although issues raised by this needs assessment are in line with national literature. We sent a link to the online needs assessment to executive-level administrators, asking that they determine the person in their agency who was best situated to complete the needs assessment. Based on respondent information, the executive-level administrators did not complete the survey themselves but rather asked front-line field supervisors to do so. These supervisors likely understand agency culture and training needs but are less likely to have knowledge about administrative tasks and their organization's vision for the future. Future needs assessment might target both administrators and supervisors in an effort to gain more robust organizational information. In addition, we did not seek information from the other

disciplines present within the settings, nor did we seek the perspective of the patients receiving services. Information from these constituents would have provided an understanding inclusive of the members within integrated teams, and is a suggestion for future research.

Conclusion

This needs assessment was the first step in supporting community partners' efforts at integration and thereby provide high quality field education training experiences. As the field is new to the integrated care movement, social work educators have an opportunity to help shape views on integrated systems of care that is inclusive of social work and the systems in which we work. This study demonstrated that despite momentum in embracing integrated care, a lack of clarity remains; information from community partners about their understanding of IBH, levels of integration, practices used to support integrated care, and their training needs, is an essential component to create community responsive curricula and continuing education offerings. Social work educators have an opportunity to lead the integrated behavioral healthcare efforts. Bridging the field of academia and practice can facilitate capacity building among IBH social workers and support organizations in identifying structural models and strategies that promote IBH practice. Specific opportunities include in-person and online trainings, site-specific consultation on integration, and new programs for interprofessional education.

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