Social work: Integral to interprofessional education and integrated practice

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A B S T R A C T

Although the debate on US health care reform is ongoing, existing policy has expanded access to preventative and treatment services through new models of integrated care. This has resulted in the creation of interprofessional healthcare teams comprised in part of social workers who undertake brief behavioral health intervention, care management, and service referral. To promote patient care and population health, integrating social workers onto interprofessional teams requires educating all members of the healthcare team on the roles and functions of social workers. A case vignette is included to demonstrate how interprofessional teams can use the skills of social workers to offer brief, evidence-supported interventions and inform team-based care. Suggestions are offered for moving forward to increase the participation of social work in IPE and practice settings.

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Improving clinical and population health outcomes often focuses on system-wide changes viewed as part of an evolving, if not radically changing, landscape in health care.[1,2] Much of the discussion related to improving outcomes has centered on the need for implementing new models of care. Specifically, the disease/diagnosis model would be replaced with an integrated model of care that includes early intervention (ie, prevention) as well as the coordinated treatment of physical and behavioral health problems. This transition is conceptualized as moving from *sick care* to *health care*[3] and replacing the physician-centric model with a patient-centric, team-based model of care. The move toward a team-based approach in health care is supported by research evidence suggesting that providing primary care through interprofessional teams not only improves the quality, safety, and efficiency of services, but also increases use of available services.[4–6] Nevertheless, health systems have been slow to adopt team-based practice, and this innovative practice approach continues to face implementation challenges.[4,7,8]

Increasing the uptake of interprofessional teams in health care systems is a complex challenge because doing so requires changes at the practice and administrative levels, as well as changes in education and training for practice. Educational approaches need to align preparation for professional practice with health care reform.[9]

Across health care professions, interprofessional education (IPE) is becoming an integral element of preparation for practice.[10,11] Defined by the World Health Organization,[12,p.196] IPE occurs 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 IPE is to prepare future health providers with the knowledge, skills, and attitudes necessary to embrace team based care. That is, IPE is intended to prepare practitioners to work collaboratively as partners on interprofessional teams. Across disciplines and professions, IPE prepares students to problem-solve interprofessionally, think as a team member, and ultimately, understand and appreciate the contributions of each profession to clinical outcomes and population health.[10]

Models of IPE were developed and pioneered in nursing and medicine.[13,14] In contrast, the social work profession has been late in embracing IPE and interprofessional practice despite the profession's historical involvement in health care.[15,16] The Council on Social Work Education[17] (CSWE; the accrediting body of social work education in North America) only recently became a member of the Interprofessional Education Collaborative (IPEC), a national association for schools in the health professions. IPEC was formed "to promote and encourage constituent efforts that would advance substantive interprofessional learning experiences to help prepare future health professionals for enhanced team-based care of

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patients and improved population health outcomes."[18,p.1] Although the debate on US health care reform is ongoing, recent policies have expanded insurance coverage and increased access to preventative and treatment services through new models of integrated care.[19] This expansion has significant implications for the way in which social work is practiced as well as the potential contribution of social work on interprofessional health care teams.

The purpose of this article is to further articulate the roles and functions of social workers in integrated health care systems and to briefly review evidence for the inclusion of social workers on interprofessional integrated treatment teams. Moreover, for health professionals outside of social work, this article describes the skills that social workers bring to integrated health care settings. We outline the functions fulfilled by social workers in promoting patient care and population health. We have included a case vignette to demonstrate how a social worker, as a member of an interprofessional team, might use brief, evidence-supported interventions in an integrated health care setting. In addition, we identify the roles of social workers in contributing to a patient's plan of care that address both physical and behavioral health, including the social determinants of health. Further, suggestions are offered for moving forward to increase the participation of social work in IPE and practice settings.

1. Social work in health care

Social workers fulfill a crucial role in addressing the modifiable determinants of health[20,21] —or the social determinants of health wherein social and environmental factors that affect physical and behavioral health outcomes are considered.[22] Social workers with graduate training are well equipped to apply a person-in-environment perspective and to recognize the full array of biopsychosocial factors that influence the health status of patients.[20,21,23] Health care reforms require a holistic approach because both physical and behavioral health are influenced by risk and protective factors that include biological and social influences.

The involvement of social work in addressing the social determinants of health is not new. A century ago, health scholars understood that physical health was fundamentally linked to the social environment and wrote about the potential of social work to contribute to better health.[15,16] These scholars argued that the social environment frequently delimited the capacity of patients to access care and subsequently respond to treatment. Although, as compared with the social work case descriptions that dominated the literature in the early 20th century, current perspectives on social work in health care are based on more systematic research; however, the conclusions are much the same. This new literature is compelling: "A population's health is shaped 10% by the physical environment, 20% by clinical health care (access and quality), 30% by health care behaviors (themselves largely determined by social and physical environments), and 40% by social and economic factors."[24,p.4,25] Link and Phelan's seminal work "*Social Conditions as Fundamental Causes of Disease*" largely attributed suboptimal health outcomes to social factors, including education, income, employment, and neighborhood or housing conditions.[26]

Social workers constitute the largest group of providers of behavioral health services in the United States.[27] Historically, behavioral health services have not been integrated with health care systems; therefore, it is not surprising that IPE and the social work role in integrated care settings have not been incorporated into social work curricula. However, recent funding by US federal agencies has created new opportunities for schools of social work to engage in interprofessional training. For example, in 2014, the Health Resources Service Administration (HRSA) awarded more than $26 million to 62 social work programs around the country to fund pilot programs designed to train and expand the behavioral health workforce.[28] These awards were targeted to masters of social work (MSW) programs and MSW students doing direct practice work in integrated health care settings. Additionally, $54.6 million was awarded to community health centers to hire mental health professionals, with the aim of increasing access to community-based mental health services.[29] Because this funding was based on the recognition that social and environmental factors contribute to both population health outcomes and national costs for health care, this level of funding reflects an important re-alignment in the provision of health care services across the United States. Moreover, these funding streams were established with the intent of reducing fragmentation and "siloed" approaches to the delivery of physical and behavioral health care. These initiatives emphasize the collaborative delivery of physical and behavioral health care in one setting and through the creation of an individualized plan of care developed for each patient by an interprofessional team.[30]

2. Models of integrated care and emerging roles for social work

The term *integrated health care,* often referred to as *interprofessional health care*, refers to the coordination of care that involves both physical and behavioral health services to address the whole person.[31] However, other definitions of integrated care consider integration more broadly. For example, Kodner and Spreeuwenberg[32,p3] defined integration as "a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment, and collaboration within and between the cure and care sectors." These multi-tiered approaches synchronize treatment across multiple providers for the assessment, treatment, and follow-up of multiple health conditions affecting patients. The resulting comprehensive set of services is organized through a single, unified plan of care to which each member of an interprofessional team contributes.[33,34] As members of interprofessional care teams, social workers are increasingly hired to work in primary care settings where they provide screenings, assessments, brief interventions, care management, crisis intervention, and prevention interventions to address behavioral health problems and the social determinants of health.[21,35–37]

The precise structure of integrated care and the inter-organizational processes associated with this practice approach tend to be setting dependent. That is, models of integration might look different from setting to setting, as health care entities contingently develop mechanisms to meet the unique needs of diverse patient populations, health systems, and communities. Although the research on the provision of integrated care is mixed, several models of care have empirical support.[35,38–42] Perhaps, the 2 most commonly studied models of integrated care are the chronic care model (CCM) and the collaborative care model. The CCM was developed to treat individuals with complex, co-morbid, and unstable physical health conditions.[42] The CCM uses a care manager to regularly track patient health and relay that information to a team of providers who ensure a rapid, coordinated response. CCM care managers also work to meet the psychosocial needs of patients to stabilize non-medical factors that disrupt treatment compliance and compromise patient health. Like the CCM, the collaborative care model includes a multidisciplinary provider team—typically a primary care provider, a care manager, and a consulting psychiatrist—working together on a patient treatment plan.[43–45] Whereas the CCM focuses on unstable medical conditions, the collaborative care model focuses on the assessment and treatment of behavioral health conditions, most commonly within primary care settings.[43–45]

3. Key features of team-based care

Team-based care is considered crucial for addressing patient health needs. However, the design and management of team-based care is complex. Wohler and Liaw[46],p2 observed, "the study and implementation of team-based primary care has been complicated by the flexible nature of teams in primary care." Studies of interprofessional care rarely "dismantle" the unique contributions of professions to patient outcomes in integrated care research. Instead, outcomes are attributed to the interventions provided collectively by members of interprofessional teams. Hence, it is difficult to parse out the individual contributions of physicians, nurses, social workers, and other allied health professionals. However, recent systematic reviews suggest interprofessional teams comprised in part of social workers produced positive patient-level health outcomes.[37]

4. Evidence for social work integration on interprofessional teams

Social workers have a diverse set of skills that can contribute substantially to the efficacy and efficiency of interprofessional care teams. Depending on a social worker's training and licensure, as well as the needs of the patient and team, these skills can range from providing evidence-informed interventions for behavioral health problems (eg, depression, anxiety), to coordinating services provided by the care team members, to linking patients with community services (eg, transportation for appointments). A systematic review conducted by Fraser et al.,[37] identified 26 randomized trials that used a social worker as part of the interprofessional treatment team in integrated primary care settings. Compared with routine services, care delivered by an interprofessional care team comprised in part of social workers produced positive significant patient-level outcomes in 19 of the 26 studies, with the largest effect sizes seen for the treatment of depression and anxiety.[37] Similarly, Steketee[47] et al. (2018) conducted a systematic review of social worker-involved health services interventions in 15 identified studies that reported on both health and cost outcomes.

5. How do social workers contribute to interprofessional teams?

Social workers fulfill many roles in healthcare systems (eg, care coordination, discharge planning, behavioral health treatment, prevention intervention). However, social workers typically contribute to interprofessional teams through 3 primary roles. The Fraser et al.[37] systematic review suggests the functions of social workers in health care settings fall into 3 domains or roles: (1) provision of behavioral health interventions; (2) management of care, especially for older adults and patients with chronic conditions; and (3) engagement with social service agencies on behalf of patients. Each of these roles aligns with different sets of skills and the combination of the 3 roles defines the potential contribution of the social worker on the interprofessional team. Indeed, some social workers might fulfill all 3 roles within their teams, whereas social workers in specialized settings might fulfill only 1 or 2 roles. This variation, or flexibility, in the roles fulfilled by social workers is precisely the reason for much of the confusion regarding the potential contributions of social work on interprofessional teams. The scope of social work education and the functions of social work on interprofessional teams require better calibration. To further describe the skills that social workers bring to integrated teams across these 3 roles, the following section outlines the specific contributions social workers make to integrated care teams.

5.1. Screening and assessment

As health systems move toward metrics-based health care, new emphasis is being given to understanding measurement and using standardized assessment tools as a basis for practice.[48,49] Social workers are actively involved in screening and assessment in integrated care settings. *Screening* is the process of identifying a problem (ie, the presence or absence of a health condition), whereas *assessment* is the process of determining the nature of a problem, including whether the problem meets diagnostic criteria, developing treatment recommendations, and specifying social and environmental factors that have the potential to disrupt treatment recommendations.[50] Across integrated settings, social workers use a variety of screening and assessment tools to identify problems, including behavioral health issues such as substance use disorders (SUD), depression, and anxiety. Examples of the screening and assessment tools typically used by social workers in integrated health settings include the Alcohol Use Disorders Identification Test,[51] Drug Abuse Screening Test,[52] the Generalized Anxiety Disorder-7,[53] and the Patient Health Questionnaire-9.[54]

5.2. Brief substance-use interventions

The variety of psychosocial treatments that social workers can deliver to treat substance-use conditions include cognitive-behavioral therapy (CBT), contingency management, the community reinforcement approach, motivational interviewing (MI), and motivational enhancement therapies.[50] Social workers regularly use brief evidence-supported interventions as a part of plan of care activities related to SUD. In primary care settings, brief interventions might last from a few minutes to an hour or more. Aimed at interrupting the cascade of negative individual and societal effects associated with SUD,[55] these interventions can be provided by MSW-prepared social workers in integrated health care given their expertise and clinical training.[56] One of the emerging challenges remains how to best integrate SUD prevention and treatment interventions into integrated primary care settings.

Use of tobacco products, for example, is a well-known predictor of health outcomes, and, brief interventions for smoking cessation provided by social workers in primary care settings have been shown effective.[38,57,58] Although primary care physicians screen for tobacco use, physicians' time with patients is usually too limited to provide an actual intervention.[59] A randomized controlled trial (RCT) of 943 smokers with military-related PTSD recruited from an outpatient clinic at 10 Veterans Affairs medical centers and followed up for 18–48 months integrated a tobacco cessation program into typical behavioral health care using social workers and psychologists.[57] Compared with a non-integrated smoking cessation program, the integrated program was effective in producing a prolonged abstinence of tobacco as measured by both self-report and bio-verified measures. Similarly, social workers have demonstrated success in using brief MI-related interventions (15–20 min) in primary care settings with teenagers at risk for substance use; these brief interventions take place within the context of a scheduled appointment for other primary care services.[38,58] Although randomized, these pilot studies involved small sample sizes and warrant further work based on larger and more diverse samples.

5.3. Brief mental health interventions

Clinical social workers—those who have a MSW degree and are licensed to provide direct mental health services—possess the training and skills necessary to perform brief mental health interventions in integrated care settings.[56] Licensed social workers are trained, for example, to provide brief CBT, which typically lasts

between 4 and 8 sessions and can be implemented in integrated care settings such as primary care clinics.[60,61] Sometimes called brief CBT (B-CBT), this approach uses a condensed version of CBT adapted for use in settings where clinicians have limited time for patient contact.[62] B-CBT focuses in part on cognitions that elevate risk (eg, thoughts of hopelessness or helplessness). B-CBT has been shown effective in reducing symptoms of depression and anxiety in patients with chronic health conditions,[63] older adults,[64] adolescents,[65] and veterans.[66] Additionally, B-CBT can be used in a group format providing flexibility in the primary care setting.[67]

Problem-solving therapy (PST) is also supported with growing empirical evidence and is a therapeutic modality commonly taught in MSW programs.[60,61,68] PST has been shown effective in primary care settings, where it is often called problem-solving therapy—primary care (PST-PC).[69] PST-PC interventions are educational in nature and use an intervention approach in which patients learn to breakdown problems into smaller, more manageable units. Working with a social worker, patients identify and evaluate potential solutions for each unit or issue. PST-PC relies on the clinical skills routinely taught in MSW education. These skills emphasize starting "where the client is," and are founded on a core value of client/patient self-determination.[70] For example, a study compared usual care to PST-PC for older adults (N = 433) with depression or dysthymia in primary care settings delivered through collaborative care via a depression care specialist comprised of a social worker or nurse and a medical provider.[71] Findings demonstrated that older adults who received PST-PC through collaborative means had more depression-free days in 1 and 2 years post intervention and fewer depressive symptoms 12 months post intervention.

Similar to PST-PC, social workers in integrated settings often use psychoeducation in combination with other brief mental health interventions. Psychoeducation—sometimes called patient or consumer education—is used to increase knowledge, information, and support for patients and their families. It has a strong foundation of research evidence from decades of testing.[72,73] As the name implies, psychoeducation provides patients with information on their health diagnoses. Personalized and more prescriptive than the brochures and written materials that are ubiquitous in clinics and pharmacies, psychoeducation often "normalizes" concern for health problems—both physical and behavioral—and begins the process of learning ways to manage symptoms. Psychoeducation interventions can be applied across settings and adapted to serve patients with a range of medical and behavioral health needs.[73]

MI is commonly used to engage patients in treatment and is often used in conjunction with other forms of behavioral health interventions.[74–76] One example of using MI to engage patients in behavioral health treatment was a trial of Brief Interpersonal Psychotherapy for perinatal depression provided in an OBGYN setting.[77] By delivering an initial engagement interview that used MI, Grote et al.[78] found a significant increase in participation in treatment compared to participants who received no engagement interview. MI can be applied to a variety of populations including adolescents, adults, and families and has been used by social workers in primary care settings to facilitate treatment engagement and promote referral to needed resources.[76,79] MI is sometimes used as a primary intervention. For example, in a randomized trial at an infectious disease clinic, Golin et al.[80] used MI as an element of safe-sex counseling for people living with HIV/AIDS. Provided by MSWs, the intervention involved 3 consecutive monthly sessions intended to help motivate patients towards safer-sexual practices. Compared with a counseling program that includes adapted nutrition and physical activity, the results indicated that the MI-based intervention program significantly increased patients' motivation to change behaviors.[80]

Finally, mindfulness interventions, which blend Eastern meditation approaches with Western medicine and cognitive psychology, have shown promise in primary care settings.[81,82] A comprehensive meta-analysis of 209 studies enrolling 12,145 participants assessed the evidence of mindfulness-based therapies for patients with comorbid physical and behavioral health problems.[81] For example, in an RCT of adults with chronic pain and prescription opioid misuse (N = 115), clinical social workers delivered an 8-week mindfulness oriented intervention.[83] Preliminary findings from this RCT indicate that as compared with participants in a support group, participants who received the mindfulness-oriented intervention reported significantly greater reductions in pain severity, stress arousal, and self-reported desire for opioids at 3-months post intervention.[83]

6. Social work care management

In addition to the provision of behavioral health interventions, social workers also often participate in care management activities on integrated care treatment teams.[21,37] The deployment of care managers has expanded in integrated care settings toward ensuring the quality of care and promoting cost efficiency. Care managers are often responsible for continued assessment of symptoms, facilitation of treatment goals, and coordination of services.[21] In addition, care managers provide individual and family education about health and behavioral health diagnoses as well as assist in linking patients to community services. The extensive training of MSW-level social workers to identify psychosocial factors that affect the uptake of health services make social workers effective care managers, especially for patients suffering from chronic conditions that are associated with difficult social situations.[84–86] Curricula to train social workers to fulfill care management roles is rapidly growing in the United States, and CSWE has developed course standards for core competencies in care management.

7. Behavioral health plus care manager role: an emerging practice model for social work

The skills of MSW social workers allow them to fulfill several roles on integrated care teams. The configuration of their roles and functions is dependent on patient needs and, often related to setting conditions and constraints, the aggregate skillset of the interprofessional team. A series of recent RCTs has deployed social workers as behavioral health specialist-care managers.[85,87] For example, in Ell et al.'s[87] work in a safety-net community, clinical social workers participated in a multifaceted diabetes and depression program as diabetes-depression clinical specialists. Social workers provided problem-solving therapy and relapse prevention through monthly patient check-ins that included monitoring symptoms and the social determinants of health for 387 low-income patients, of whom 96% were Latino. Study participants reported significant reductions in depression and improved functioning at 18 months.[87] In another test of this model, social workers fulfilled a hybrid role serving on a collaborative care team at an OBGYN clinic working with disadvantaged women in a multisite RCT trial with masked outcome assessment conducted in the Seattle-King County Public Health System.[39] In this RCT (N = 168), social workers served as depression care specialists and provided engagement services, interpersonal psychotherapy, and treatment care management on a multidisciplinary team. The collaborative care treatment model produced significant reductions in depression scores and increases in behavioral health service utilization.[39]

8. Case example: social work in the behavioral health-care manager role

The following case study demonstrates the behavioral health-care manager role in integrated primary care settings. This case study illustrates how the use of brief interventions, combined with care coordination, community referrals, and team-based communication, results in care that addresses physical and behavioral health, including the social determinants of health. The case study also demonstrates the early identification of behavioral problems such as alcohol use, and, consistent with research findings, it shows the potential of prevention interventions in interrupting the development of behavioral health problems into long-term debilitating and costly conditions.

Exemplar case: role of social workers in an integrated health care setting

Maria is a 17-year-old, mildly obese Latina high-school student in Burlington, North Carolina. Following complaints of increased fatigue, Maria was seen at a university primary care clinic for a re-check of her type 2 diabetes. While the team's physician was reviewing the symptoms with the patient, Maria acknowledged some alcohol use, non-compliance with medication, and feelings of anxiety. After ordering additional lab work, the physician gave Maria a "soft hand-off" to the team social worker for further assessment. Maria recounted what she had told her physician. She said she was feeling "stressed out" and that she was using alcohol primarily to feel more relaxed. She also reported inconsistent use of her diabetes medication because she read on the Internet that a potential side effect was weight gain.

Maria's score of 7 on the 10-point AUDIT (ie, Alcohol Use Disorders Identification Test) was in the low-risk group, just 1 point below the clinical cut-off, indicating a moderate level of alcohol use and the need for "simple advice focused on the reduction of hazardous drinking.[41] Her score on the GAD-7 (ie, Generalized Anxiety Disorder Test) placed Maria in the severe anxiety category. She disclosed that she was struggling in school and that her anxiety had widened to a range of things, including issues with friends, taking tests, her appearance, and worrying about her future after graduation. The social worker explained the implications of her scores and explored Maria's willingness to return for brief counseling around her alcohol use and anxiety. Maria, who had been crying throughout the last part of the interaction, appeared relieved and agreed to return. With consent from Maria, the social worker arranged for a joint meeting with Maria and her mother to talk about her anxiety. After this discussion, Maria's mother consented to allowing Maria to make return visits to address the anxiety and medication compliance.

Over the course of the next 2 months, Maria returned to the clinic for 4 sessions with the team social worker. During these sessions, the social worker provided the following services: (a) she provided behavioral health interventions; (b) she managed and coordinated care, reporting routinely to other members of the interprofessional team; and (c) she linked Maria to community resources. Using psychoeducation, the social worker initially focused on helping Maria understand that alcohol use can cause dangerously

low blood sugar levels in people taking oral medication for diabetes. Maria was unaware of the physical repercussions of alcohol use, and her general understanding of type 2 diabetes was limited. The social worker then arranged for Maria and her mother (who also had diabetes) to meet with one of the team nurses for a "refresher" of diabetes education, including the etiology of diabetes, nutrition, and daily management. The social worker provided Maria with psychoeducation on the cycle of anxiety, including internal (eg, anxious self-talk) and external factors that contribute to anxiety. In addition, the social worker used B-CBT to assist Maria in monitoring and modifying her self-talk. The social worker taught Maria some mindfulness and relaxation techniques as a way of coping with stress when she started to feel overwhelmed.

Additional time was spent working with Maria on medication compliance. Using motivational interviewing, the social worker explored Maria's positive and negative views related to taking her medication. Although Maria easily identified several benefits of her medication, she was adamant that the medication caused her to gain 15 pounds; , and the weight gain was a non-negotiable barrier to consistent daily use. Before the next session with Maria, the social worker explained Maria's objections to the physician, nurse, and nutritionist at their bi-monthly team meeting. Although not convinced that the medication was causing the weight increase, her physician agreed to switch Maria to a different medication that did not have weight gain as a side effect. Maria was satisfied and agreed to begin taking the new medication daily.

The change of medications opened the door to discussing behavioral strategies that Maria could use to take off the weight she had gained, and perhaps, eventually lower her glucose level and achieve her goal of no longer needing to take medication. The social worker also put in a consultation for the team nutritionist to meet with Maria and her mother regarding dietary choices. At her next meeting with the social worker, Maria reported that she and her mother were preparing healthier meals for dinner and that she now packed a school lunch rather than buying snacks from the vending machines. Maria was excited that she had lost 2 pounds while consistently taking her medication. With updates from the social worker at team meetings and the electronic medical record, team members made extra efforts to reinforce Maria's, as well as her mother's, changes.

Maria and the social worker also discussed the importance of exercise as a strategy for managing stress and weight loss. However, Maria was not on any sport teams at school and was not interested in joining one. The one activity that she could think of that she might like to do was Zumba classes at a nearby YMCA. Several months earlier, she had gone to a Zumba class and had enjoyed it; however, her family could not afford a YMCA membership. After the session, the social worker did some checking, downloaded a scholarship form that she forwarded to Maria, and within a couple weeks, Maria's family joined the YMCA at a highly-reduced rate.

However, Maria still needed motivation to attend the Zumba classes. The social worker worked with Maria on developing a behavioral activation plan, including a peer support strategy; the plan consisted of a schedule of classes she would take and then, a list of what she would need to do

to prepare herself to get to class (eg, put Zumba on her calendar, set her phone alarm, ask her friend to go with her, and arrive early and introduce herself to the instructor). Maria did not make it to the first class on her schedule, but she did follow through and go to the second class, and thereafter, attended regularly. When seen by the social worker at a follow-up visit 4 months later, Maria reported that she had not only lost the 15 pounds but had also gotten a part-time child care position at the YMCA.

9. The promise of prevention

In part, the intent of integrating physical with behavioral healthcare is to promote early identification, brief treatment, and preventive interventions—which if done widely—are expected to improve population health and reduce healthcare costs.[88] Integrated care is argued to increase access to prevention because services provided in primary care will have less stigma than services provided in specialized mental health clinics or other settings.[89,90] At the same time, early identification allows for treating behavioral health problems when they are less complicated and more responsive to brief interventions.

Based on the case exemplar, in Maria's case, the social worker created a plan of care that included diet and exercise prevention interventions; however, a broader challenge in integrated care is how to provide systematic prevention interventions that are more prescriptive (ie, manualized, multi-session, group-based). One example of a prevention intervention is the *Incredible Years*, an evidence-supported program shown to reduce conduct problems in childhood.[35] In a RCT in a pediatric primary care clinic, 273 parents of children between the 2—4 years old participated the *Incredible Years*, a 10-week intervention provided by a psychologist and a social worker. At the post-test assessments and 12-month follow-up, parents who received the intervention demonstrated significantly less negative parenting behavior than parents in the control condition, and the children of parents in the intervention condition showed less disruptive behavior as compared with children of parents in the control condition.[35] Such findings demonstrate both the feasibility and the potential of prevention interventions to influence health outcomes in primary care. Social workers, nurses, psychologists, and others are able to provide these interventions; however, the fit of prevention to primary care and funding mechanisms remains challenging.

10. Moving forward: IPE, social work, and other health professions

Although interest in interprofessional collaboration abounds, education efforts have not kept pace with the rapidly evolving healthcare system. Although organizations like the US Institute of Medicine, the World Health Organization, and IPEC have expanded over the last decade to promote IPE, many students in health care professions continue to be trained in professionally siloed settings.[91] Depending on the institution, for example, schools of social work in the United States are often affiliated with graduate schools within social sciences rather than the health sciences.

Educational reform is needed to fully and effectively integrate social workers into collaborative behavioral and physical health models of care. In schools of social work, training for service as behavioral health specialists and care managers is particularly important because these roles and the hybrid application of those roles require high clinical skill. In the United States, the core competencies for integrated behavioral health specified by HRSA are foundational for the preparation of an integrated care workforce.[34,36] These competencies emphasize skills such as the ability to

- collaborate in cross-professional settings,
- contribute to team-based decision making,
- administer screening instruments,
- engage in practice-based learning,
- use medical informatics, and
- provide brief behavioral health interventions.

To achieve this competency goal, MSW education should promote fluency in common medical terminology, medications, and the complexities of health systems. MSW education must emphasize the roles of health care professionals and models for treating patients with chronic conditions, including the role of social workers as care managers across the life course. Enriched content across professions, including social work, focused on the social determinants of health is likely to improve patient outcomes in the sense that interventions will be more purposively developed to address the biopsychosocial complexity of health.

In social work, medicine, nursing, and the allied health professions, reforms are needed also in preparation for interprofessional education and practice. A seemingly simple approach to IPE is to create courses that encourage co-study among graduate students in the health professions, thus promoting professional cross-pollination within classroom settings. However, as discussed by others, this seemingly simple approach is hampered by administrative barriers related to tuition, registration processes, and workloads across units/schools.[92] These barriers are complex and need to be overcome through concerted institutional and administrative efforts, and ultimately, at the university level.

So how can students in the various health professions work together to "learn about, from, and with each other to enable effective collaboration and improve health outcomes" — the core definition of IPE practice?[12,p.196] A natural setting for this type of co-learning and cross-pollination among students is found in integrated care field placements/internships. Because field education is the signature pedagogy of social work education,[93] and most, if not all, graduate programs in the health professions require clinical rotations or internships, a logical approach to IPE would be to create joint internships and field practicums for teams of students across multiple health disciplines to share clinical learning environments. Administratively, interprofessional clinical learning environments can benefit health systems that work separately with various disciplines to create individual placements with specific schools. This often includes developing a memorandum of agreement with each individual school/discipline, and this can be time consuming and repetitive. Instead, the IPE approach allows health system administrators to think collectively about creating teams of students from multiple professions to work in integrated care settings. By creating these joint internships, the experience in clinical learning environment provides early educational socialization that enables students across health professions to identify the strengths and contributions of all team members. Logistically, creating joint internships is a complicated process that must account for accreditation standards and supervision requirements that meet criteria for professional licensure. Nevertheless, if the goal is to train students in interprofessional models of care, practicum sites at the training level need to reflect the conditions of practice in vivo.

11. Conclusion

In the evolving health care systems of the United States and other countries, social work is integral to integrated practice.

Growing evidence suggest interprofessional teams involving social workers hold promise for improved patient level health outcomes. For example, findings in Fraser et al.[37,p.] suggest that when compared with routine care, "Integrated primary care provided by interprofessional teams comprised in part of social workers appears to improve the behavioral health and care of patients, while reducing the use of higher cost health services."

Often responsible for engaging community resources on behalf of patients, social workers are deeply involved also in providing care management and evidence-supported behavioral health interventions. In MSW education, emphasis on the social determinants of health, screening, brief treatment, and care management are congruent with the core features of interprofessional social work practice. That is, course work is strongly linked to the multiplex of roles fulfilled by social workers in integrated care.

To provide quality IPE, social work and other health professions face emerging challenges in order to better understand each other's potential contributions on interdisciplinary healthcare teams. Interprofessional course work and clinical learning experiences in practicums/internships must be developed to better prepare students to understand these potential contributions and the skill sets associated with various professions on health care teams. Additionally, clinical training and professional licensure must be better aligned with the rapid changes occurring in health care practice. Social work licensure, which tends to be focused on psychotherapy, is particularly misaligned with the needs of the integrated health workforce in many parts of the United States. However, along with other professions, social work education is making substantial contributions to the development and implementation of integrated care. In order to further accelerate IPE, fostering an in-depth understanding of social work remains both a challenge and opportunity to advance integrated models of care and, ultimately, to improve population health outcomes.

Appendix A. Supplementary data

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