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Clinical Social Work with Underserved Persons in Colorado in an Integrated Healthcare Facility

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This is to certify that the doctoral study by

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Abstract

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

There is significant documentation showing that health disparities experienced by underserved persons can be mitigated through the provision of quality integrated healthcare. This research project was grounded in social support theory and how support influences improvements in physical, psychological, and overall health. Social workers in integrated healthcare are in a unique position to be the source of social support for individuals experiencing health disparities, yet there is little research concerning how these social workers are providing services and how they affect health outcomes. This research addressed gaps in the literature concerning social worker roles in order to improve integrated healthcare for underserved populations. Data was gathered from social workers employed by Federally Qualified Health Care integrated facilities in Colorado that treated underserved populations. An action research methodology was used to investigate social worker roles through the utilization of a focus group ($N = 4$); there were 4 emergent themes. These themes were: social workers supporting patients and staff, influencing quality healthcare integration, possessing certain characteristics and competencies, and performing role responsibilities. Support through the use of personal characteristics, competencies, and role responsibilities was identified by stakeholders as the foundation of quality integrated healthcare. The potential impact of understanding social worker roles may include improved health outcomes for individuals served, improved social work practice, improved integrated healthcare provision, gaps in the literature filled, positive social change, and contribution to a wider body of knowledge.

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Acknowledgments

It is hard to believe that I have come to the end of my action research project and to the point of expressing my sincere gratitude to all who have challenged, guided, nurtured and supported me through this process.

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Section 1: Foundation of the Study and the Literature Review

Introduction

The clinical social work practice problem is the need for high-quality integrated healthcare for underserved persons in Colorado. Understanding the role of social workers as partners in an interprofessional healthcare team contributes to the field of clinical social work by adding to the current body of knowledge while promoting improved healthcare services for underserved Coloradans.

The research question addressed with action research methodology examined the role of a social worker in integrated healthcare with underserved Coloradans. The use of action research methodology aligns with the social work values of promoting social change with clients on their behalf. The very process of people investigating a specific social topic, participating in the research to understand the impact, and collaborating to influence positive policy change describes action research and the social work value of promoting social change (Shannon, 2013). The constructivist epistemology further supports the alignment with the profession of social work through understanding action as a significant and vital outcome of all research (Lincoln & Guba, 2000).

There are four sections in the overall organization of this paper. Section 1 includes the foundation of the study and literature review. In Section 1, I examine the problem statement, research question, purpose statement, nature of the project, theoretical/conceptual framework, significance of the study, and values and ethics. In addition, I present an extensive review of the professional and academic literature related to key variables and/or concepts.

Section 2 contains information regarding the particular action research study. Headings include background and context, methodology, sources of data/data collection, and ethical procedures. Section 2 ends the project proposal and leads to Sections 3 and 4, which focus on the completed project. In Section 3 I concentrate on an analysis of the findings with entries on data analysis techniques, validation and legitimation process, and findings. Section four examines recommended solutions with the headings, application for professional practice (with the sub-headings: findings vs. peer-reviewed literature and impact on clinical social work practice), solutions for the clinical social work setting, and implications for social change.

Problem Statement and Background of the Problem

In my role as a social worker in a healthcare setting, I have found the clinical social work practice problem supports Brendsel's (2015) findings that underserved persons need to receive quality integrated biopsychosocial healthcare services. Underserved Coloradans receive healthcare from Federally Qualified Health Care (FQHC) facilities regardless of ability to pay. Currently, literature reflects barriers that social workers experience when providing services within an integrated healthcare system, including significant obstacles to altering a traditionally medical-focused practice (McGinnis, Crawford, & Somers, 2014; Reardon, 2010).

In 2012, the Council on Social Work Education (CSWE) launched an initiative focused on collaboration with universities to develop an integrated healthcare curriculum for master's level social workers and to create field placements in integrated healthcare facilities (CSWE, 2017). Understanding social worker roles in healthcare adds to social

work knowledge, training, and education in integrated healthcare, with the goal of benefiting underserved persons in Colorado. Given the hindrances found in the literature and the current lack of social work education on the provision of integrated healthcare services, I wanted to understand how social workers at an FQHC in Colorado were implementing the integrated care offered to underserved persons.

Research Question

The primary research question of this study was:

RQ: What is the role of a social worker in integrated healthcare with underserved Coloradans?

The purpose of examining this research question is to improve integrated healthcare for underserved persons in Colorado. It is perplexing how little training and education social workers apparently receive focused on work in integrated healthcare. Additionally, evidence suggests a lack of research concerning how social worker roles impact the social support of integrated healthcare by increasing certainty for clients. Additional questions examine social worker roles that are consistent with social support theory, specifically, actions taken by a social worker that appear emotionally supportive, tangible, communicative, informative, and inclusive (Schaefer, Coyne, & Lazarus, 1981).

Purpose Statement

The goal of this action research study was to explore the role of social workers in an effort to improve practice and services for underserved persons in Colorado receiving their healthcare at an FQHC. This study was intended to add to the current body of knowledge and promote improved social work in integrated healthcare through education

and practice, thus ameliorating the practice problem. To ground my study, I used social support theory, defined by Cobb (1976) as a network of belonging where information and communication lead the client to feel cared for and valued. In this theory, emotional social support is strongly associated with health outcomes; therefore, improving the social support for clients through integrated care increases their certainty (Grant, 2010). This certainty ultimately improves client insight into their self-determination and becomes a contributing factor in positive health outcomes (Davis et al., 2013; Sarason, 2013).

Currently, the field of social work experiences a significant gap in practice given that CSWE began work on the development of integrated healthcare curriculum for social work education in 2012 and at this time (2017) has not formally approved a standardized program (CSWE, 2017). Identifying the social worker role assists with my professional development and clinical practice by informing what works in integrated healthcare, which helps me better understand the impact on the social support of integrated healthcare. Stakeholders benefit from collaborative learning and influence the promotion of social change as action research participants. As active research contributors, stakeholders share the research results with the focus on improving policy and practice in the provision of integrated healthcare for underserved persons.

I used action research methodology with a focus group to collect qualitative data from participants. All of the FQHCs in Colorado are part of a network that focuses on improving healthcare services for underserved populations. Given my work in an FQHC Behavioral Health Department, the network afforded me an opportunity to access and

invite up to thirty social workers employed by different FQHCs in Colorado to participate in this action research study. Questions asked of social workers focused on clearly defining their role and the skills used to overcome barriers to service provision in integrated healthcare. This study was meant to influence others learning through the use of action research where the participants gain insight and, on a larger scale, through adding to social work education curriculum.

Nature of the Project

This action research study focused on understanding the role of social workers in integrated healthcare, a relatively new direction in social work education. Briefly, action research methodology presents both action and research outcomes. The primary distinction from traditional research remains the action focus rather than the research focus. Action research is responsive and affords the researcher flexibility in creating knowledge as the data is gathered.

The development of social work curriculum and field placements in integrated healthcare was initiated in 2012 by CSWE (2017). The curriculum development team at CSWE created and posted draft versions of fifteen curriculum modules in 2016. The educational intent of this action research study was to add to the current knowledge used by CSWE to create the draft curriculum and provide qualitative research outcomes that drive growth in this field. The use of action research methodology aligns with social work values of promoting social change with clients and on their behalf (Shannon, 2013). The constructivist epistemology further supports the alignment with the profession of

social work through understanding action as a significant and vital outcome of all research (Lincoln & Guba, 2000).

Given the barriers faced by social workers in the integrated healthcare environment, understanding how current integrated social workers are defining their roles and working through these barriers improves social work practice. Collaborating with social workers employed by healthcare facilities treating underserved persons provides qualitative data. The data for this study was collected through audio recording that I transcribed leaving out identifying data. The data was analyzed using thematic analysis described in the methodology section of this paper. This collaboration also afforded the opportunity for participant growth in that they were coresearchers/colearners in this study (McNiff & Whitehead, 2010). Colearning meant that I, the researcher, and all participants learned through the use of the focus group and action research. Throughout the action research, participants became stakeholders in social change. Additionally, understanding the barriers and challenges social workers experience in their roles is a call to action encouraging continued research in this area until healthcare disparities experienced by underserved populations no longer exist (McGinnis et al., 2014; Reardon, 2010).

The epistemological paradigm used in this action research study is constructivist in nature. Truth and reality are fluid and nonbinary; therefore, reality requires interpretation. Building knowledge comes from experience rather than discovery, through active participation rather than passive observation. The use of action research methodology with a focus group provided the qualitative data to gather the various

realities experienced by the study participants. Mitigating potential biases of using a constructivist epistemological paradigm began with understanding that I could not rationally know truth and reality outside my experiences and perspective (McNiff & Whitehead, 2010, von Glasersfeld, 2001). I took steps to address the bias by journaling my experiences and perspectives as they related to the questions being asked of the stakeholders. I shared this information with my action research committee members during Sections 3 and 4 of this study.

The use of action research methodology in a constructivist epistemological paradigm builds the research process around the subjects' experiences, which is considered a limitation by those who seek to eliminate the impact of researchers. Demonstrating the quality of the constructivist epistemology to researchers utilizing a competing paradigm can be challenging because the more consistent and replicable action research methodology becomes, the more limiting the research experience. The goal of constructivism and this action research study was to inform and add to existing data collected from traditional empirical research methodology (von Glasersfeld, 2001). An additional limitation was my use of the nonprobability sampling method of convenience sampling. I sampled from seven of the ten FQHCs in Colorado because they were closest to the location chosen for the focus group. Lastly, as I transition into a discussion concerning theoretical/conceptual framework, it is important to note bias in that this action research study focuses on developing understanding through the exploration and integration of theory and practice to advance both. I took additional

measures to address this bias through transparency in my writing of Sections 3 and 4 of this study.

Theoretical/Conceptual Framework

The underlying theory of social support was initially described by Barnes (1954) as social relationship patterns. The relationship between social support and health was first described by Cassel (1976) as a protective influence on how stress affects a person's health. Gottlieb (2000) shared a broader definition of social support as the "process of interaction in relationships which improves coping, esteem, belonging, and competence through actual or perceived exchanges of physical or psychosocial resources" (p. 28).

The basic tenets of social support were described by Schaefer et al. (1981) as emotional, esteem, network, information, and tangible support. *Emotional* support is when an expression of care or concern meets the receiver's emotional needs. Communication that reinforces a person's abilities and improves their self-esteem is *esteem* support. Moving away from the focus on self, *network* support is communication that confirms and reminds a person of their belongingness and the availability of the network. *Information* support is when important, needed, and useful communication is provided to a person. The last type of support is *tangible*, which is the provision of physical aid (Schaefer et al., 1981).

The premise of social support theory focuses on how support influences improvements in physical, psychological and overall health. Therefore, I examined the quality-integrated biopsychosocial healthcare services to understand the impact on support for underserved persons in Colorado. Social workers are in a unique position to

be the source of social support for individuals experiencing health disparities, yet there is little research concerning how social workers in integrated healthcare are providing services. Understanding the role of social workers integrated into healthcare serves to provide information for improving social support for underserved persons in Colorado (Evans, Baker, Berta, & Barnsley, 2013). The emotional, esteem, network, information, and tangible support types are embedded in the roles of social workers and strengthen the discussion questions. Research participants were asked to discuss social worker roles within the context of support while having a list of the five types in front of them as a reminder.

Significance of the Study

Understanding what works for current social workers in integrated healthcare adds to the current body of knowledge helping to shape the future of integrated healthcare in working to end health disparities currently experienced by underserved persons in Colorado. The use of action research with social workers in integrated healthcare facilities addresses social work education, understanding what works for current social workers, the impact social workers make in integrated healthcare by asking about the social worker role, and identifying parallels with the basic tenets of social support theory. This knowledge is meant to influence future social work education and research to end healthcare disparities for all individuals.

Participants in this study were licensed social workers currently employed by one of the seven chosen FQHCs in Colorado. As colearners, the stakeholders had the opportunity to contribute to the field of social work knowledge and improve their practice

through the collaborative work of defining social work roles. This work empowered social workers to learn from and with each other while developing competence. The National Association of Social Workers (NASW) Code of Ethics (2008) stresses competence as a social work value through improvement of the social worker's professional knowledge and adding to the general body of social work knowledge. Cameron, Lart, Bostock, and Coomber (2014) discussed gaps in research evidence related to integrated healthcare. They found a lack of higher-quality studies that provided detailed working practices/roles of healthcare providers in integrated care (Cameron et al., 2014). This action research study was meant to fill these gaps in the literature and social work practice. The contribution is information specific to the role of social workers through the use of a focus group. Additionally, potential implications for positive social change begin with an informed and improved practice that affects underserved populations and ultimately advances healthcare services.

Values and Ethics

The NASW Code of Ethics (2008) calls for competent social workers who work collaboratively with interdisciplinary teams while promoting social welfare and professional integrity through research and evaluation. One core value related to social worker roles in integrated healthcare for underserved persons is the significance of relationships. The ethical principle calls for social workers to recognize and understand how relationships affect change by seeking "to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities" (NASW, 2008, p.

4). This study supports the values and principles of the NASW Code of Ethics (2008) through the exploration of social worker competence, roles, and relationships in integrated healthcare.

> The mission of my employer FQHC, Metro Community Provider Network (MCPN), is to partner with the community to provide excellent, culturally sensitive health services to meet the needs of each individual . . .every touch, every time. MCPN is committed to expanding and creating an infrastructure that provides excellent healthcare and wraparound services to our communities (MCPN, 2014).

The values of my employer FQHC are "Integrity, Compassion, Accountability, Respect, and Excellence" (MCPN, 2014). The mission and values of MCPN are not only consistent with the focus on relationships; they are also the core ingredients needed to strengthen them.

Review of the Professional and Academic Literature

The clinical social work practice problem is the need for underserved persons in Colorado to receive quality integrated biopsychosocial healthcare services (Brendsel, 2015). The purpose addressed in this study starts with the needs of underserved individuals and the use of action research to improve the understanding of social worker roles in integrated healthcare settings.

Relevant databases such as EBSCOhost, Social Work Abstracts, PubMed, and PsycINFO through Google Scholar linked to Walden University and the University of Colorado Boulder were the research tools used to review and retrieve academic literature

on relevant topics from 2011-2017. Every keyword search contained the following words: *social work/worker* and *healthcare*. Specific keyword searches carried out for this study included *social work roles biopsychosocial healthcare, social work roles collaborative healthcare, social work roles integrated healthcare, social work roles healthcare, social work behavioral healthcare integration,* and variations of these word themes. Additional terms used in keyword searches included *job description, job responsibility, duty, task, support,* and *behavior* combined with the words *social work* and *healthcare.* Search results ranged from 14,000 to 16,000 articles that addressed various topics specifically related to integrated healthcare such as effectiveness in treating patients, and comprehensively defining integrated healthcare. The searches resulted in fewer than 20 resources that specifically addressed social worker roles in integrated healthcare.

This literature search revealed extensive pertinent information concerning theory and empirical data. Theories in the literature vary with the focus on similar populations such as persons experiencing health disparities and social workers providing services through integrated healthcare. For example, self-determination theory is relevant to social work in integrated healthcare due to the core component of autonomous self-regulation being in line with social work ethics and values. Underserved populations experience health disparities due to the lack of understanding of behavioral health components and their effects in integrated healthcare (Deci & Ryan, 2012). Specific areas of focus begin with theoretical literature aimed at identifying social worker roles through leading, educating, relationship building, collaborating, advocating, preparing,

communicating, evaluating, and improving services. The foundation of these roles is evaluated through the lens of emotional, esteem, network, information, and tangible support from social support theory (Schaefer et al., 1981).

Literature Review Related to Key Variables and/or Concepts

Social Support Theory

Social support theory found in the theoretical literature focuses mainly on the use of technology or social media in health communication. For example, Moorhead et al. (2013) conducted a systemic examination of peer-reviewed studies over a 10-year span from 2002 through 2012. The authors reviewed 98 research studies focused on the social support of health communication through the use of social media. Social media, according to Schaefer et al. (1981) is best described in social support theory as network and informational support. Benefits of improved communication and support in integrated healthcare were identified as a greater number of interactions, enhanced person-specific shared information, and increased access to support and health information (Moorhead et al., 2013). The literature focus remains on the social support of specific communication devices rather than on the social support of a social worker's role in integrated healthcare.

Contrary to Moorhead et al. (2013), Stanhope, Tennille, Bohrman, and Hamovitch (2016) categorize social worker role types through the lens of social support theory as emotional and esteem. The authors describe the role of a social worker as focused on person-in-environment and relationships to change the behavior of teammates and persons receiving integrated healthcare. Specifically, Stanhope et al. (2016) propose

putting the social worker in the role of disseminating and sustaining motivational interviewing among interdisciplinary teammates asserting that "social workers are uniquely positioned to lead" (p. 474). A strength of this proposal for social workers to use motivational interviewing is in the emotional and esteem support it provides. The authors assert that this strategy will communicate evidence demonstrating social work effectiveness in integrated care (Stanhope et al., 2016). The weakness inherent in this approach is placing the social workers in the precarious position of performing therapeutic interventions with coworkers instead of patients.

Tangible support is the fifth and last mode of social support mentioned by Schaefer et al. (1981). Kroenke et al. (2013) studied 3,139 women diagnosed with breast cancer within a 5-year period from 2006 to 2011 to examine how social support types affect their quality of life (QOL). Tangible support improved a participant's social and physical well-being, particularly when it was perceived to help the patient's family. Additionally, tangible support was found significantly important for QOL outcomes with women experiencing late-stage cancer. The effect tangible support has on QOL outcomes suggests that help with household chores, transportation to an appointment, and so forth, may be of greatest help to those women dealing with more severe symptoms.

Conversely, Tang et al. (2015) found tangible support negatively affects the QOL of terminally ill cancer patients. Tang et al. (2015) followed a convenience sample of 325 Taiwanese patients longitudinally until the death of the patient. The authors found that a high prevalence of patient family members provided customarily concrete, tangible assistance to the patient without being asked. The more tangible help received correlated

with higher experienced depressive symptoms for the patient at the end of life. Tang et al. (2015) reason that a substantial amount of tangible support may prompt the Taiwanese terminally ill patient to focus on their loss of autonomy and independence, in turn, exacerbating psychological stress.

Overall, social work and social support strategies are found effective in promoting positive behavior and health changes in the people we serve. For example, Marquez et al. (2016) and Alvarez, Ginsburg, Grabowski, Post, and Rosenberg (2016) studied the effectiveness of social support on client health behavior changes. Marquez et al. (2016) collected data from 278 Latino/a men and women with type 2 diabetes in a program that focused on the provision of social support types. The authors found that greater weight loss and adherence to physical activities was directly correlated to emotional, esteem, network, and tangible supports from family and friends who engaged in the activity with the research participant. Alvarez et al. (2016) found emotional, esteem, network, information, and tangible supports in the form of "care coordination, case management, and patient engagement" to decrease the number of hospital readmissions post intervention (p. 2). Participants in the Alvarez et al. (2016) study were 5,753 persons identified as having chronic medical conditions from 2012-2014 who had been admitted to a hospital more than once in a 30-day period. After the social support interventions, 30-day readmissions decreased by close to 31%, 60-day readmissions decreased by over 9% and 90-day readmissions decreased by almost 14% (Alvarez et al., 2016). Both the Marquez et al. (2016) and Alvarez et al. (2016) studies resulted in positive overall health and behavioral outcomes when social supports were used as interventions. A limitation

shared by both is that the supports were built into structured programs and not broken down by specific team member roles or responsibilities that could be used to inform the field of social work and improve service provision.

Understanding how social worker roles in integrated healthcare influence support for underserved persons, is meant to help the social work profession and education system focus on the health care professional role beyond traditional behavioral health to improve integrated health services (Stanhope, Videka, Thorning, & McKay, 2015). Gottlieb (2000) shared that social support can influence relational factors and Pietromonaco, Uchino, and Dunkel Schetter (2013) found that relationships influence health results and are relevant to effective social work roles in integrated care. These influential relationships establish a means for social workers to provide emotional, esteem, network, information, and tangible supports to affect health outcomes positively. The difficulty lies in what Lemieux-Charles and McGuire (2006) found in the literature concerning social support and healthcare effectiveness. The literature is riddled with a lack of specificity about what healthcare providers are expected to be doing, and this highlights the barriers social workers experience filling their roles in integrated healthcare (Lemieux-Charles & McGuire, 2006).

Barriers to Performing Social Work Roles

Social workers have a long history in the health system yet face significant challenges practicing in integrated healthcare settings today (NASW, 2016). Ashcroft and Van Katwyk (2016) discuss the biomedical paradigm to understand barriers experienced between social workers and physicians in healthcare. This biomedical

paradigm holds the binary view of health as the absence or presence of disease and defines disease as something discoverable, treatable, and curable (Ashcroft & Van Katwyk, 2016). The focus of the biomedical paradigm is on physiology and provides a clear scientific context for understanding a disease that has a single cause. What the authors found was the biomedical paradigm negatively influences the social worker's ability to preserve their role as agents of change and support in the interest of healthcare equity and social justice by promoting a narrow focus on the physiology of disease (Ashcroft & Van Katwyk, 2016; Longino & Murphy, 1995). Social work practice in healthcare must retain awareness of the systemic context in working with health. The biomedical paradigm ignores individualism; therefore, this paradigm supports inequity in addition to negating the impact of economic, social and environmental factors on an individual's health. Social work in healthcare has the potential to be depoliticized through immersion in the biomedical paradigm, so it is imperative that social workers improve healthcare environments through continued work with social change and justice for all persons receiving healthcare (Ashcroft & Van Katwyk, 2016; Lock & Nguyen, 2010).

Glaser and Suter (2016) share examples of how the biomedical paradigm negatively influences social worker roles and creates barriers. They performed a secondary analysis of data, from interviews with social workers in integrated healthcare settings, collected in three qualitative research projects previously completed by Suter (Glaser & Suter, 2016). The first barrier identified is the medical providers lack respect for social work ideology and practice; hence, a social worker is not fully appreciated

because they are a non-medical provider. Another barrier experienced by these social workers is their inability to work to their full scope of practice. Specifically, the interviewed social workers identified lack of role clarity as a factor that limited how often they were able to work to their full scope of practice (Glaser & Suter, 2016). The lack of understanding social work roles from medical disciplines tends to lead to inappropriate requests such as consulting a social worker about something a care coordinator would do like helping the patient set up an appointment with an external medical provider. The last barrier shared by Glaser and Suter (2016) is that social workers are often constrained by the short patient length of stays making quality time with a patient minimal. Thus, a social worker may spend time with the patient completing tasks such as paperwork instead of being able to provide social support for the patient and families (Glaser & Suter, 2016).

Aside from the biomedical paradigm, NASW (2016) and Buche et al. (2017) list barriers as financial and healthcare delivery, lack of social worker effectiveness data, and lack of role understanding. NASW (2016) released standards for social worker practice in healthcare that was completed by an expert panel of 5 social workers while Buche et al. (2017) conducted seven 2-hour interviews to collect qualitative data. While both NASW (2016) and Buche et al. (2017) listed the three overarching barriers, the examples given for the first barrier show divergent interpretations. NASW (2016) identifies financial and healthcare delivery barriers as agency cost saving, meaning social work tasks are being performed by other personnel, and social workers are not hired. Or, a social worker may be employed and supervised by someone without a social work degree

to reduce costs. Buche et al. (2017) take the focus from the individual to organizational by identifying the barrier as federal and state policy hindering reimbursement for social work services.

Given the organizational barriers to supporting social worker roles in integrated healthcare, Evans, Grudniewicz, Baker, and Wodchis (2016) introduce the context and capabilities for integrated care (CCIC) framework to address the inconsistency of organizational implementation of integrated healthcare and the lack of organizational ability to measure readiness for healthcare integration. The CCIC is a research and practice-informed model that is meant to improve the realization of effective integrated healthcare and will require additional examination to validate this framework. The end goal of the CCIC framework it to ensure the provision of quality integrated healthcare for underserved populations which is examined in the next section (Evans et al., 2016).

Quality Integrated Healthcare

The provision of high-quality, effective care for uninsured families experiencing prominent levels of psychosocial issues requires social workers and medical providers to work together in integrated healthcare (Abramson & Mizrahi, 1996; Lynch & Franke, 2013). Lynch and Franke (2013) identify health communication theory as relevant to improved care for underserved persons in that communication and collaboration improve when social workers are co-located in medical practices being closer in proximity. Communication and collaboration between providers positively impact the support experienced by persons served. Thus, co-location needs to move toward true integration

of healthcare to provide better-quality communication and building professional relationships (Abramson & Mizrahi, 1996; Campo et al., 2005; Lynch & Franke, 2013).

Both Unützer, Harbin, Schoenbaum, and Druss (2013) and Goodrich, Kilbourne, Nord, and Bauer (2013) examined existing literature, 70 and 74, articles respectively about a collaborative care model for integrating medical and mental health services. While both studies concluded with identifying collaborative/integrated healthcare as effective service provision models, Goodrich et al. (2013) point out the need for agencies to adapt amongst unique practice settings to provide high-quality integrated healthcare. Valentijn, Schepman, Opheij, and Bruijnzeels (2013) contribute to the discussion of collaborative/integrated healthcare from the perspective of primary care. Valentijn et al. (2013) suggest agencies adapt a systemic implementation of integration to provide high-quality integrated health services. They add dimensions of integration that were not addressed by Unützer et al. (2013) or Goodrich et al. (2013). Those dimensions are clinical on the micro-level, organizational and professional on the meso-level, and systemic on the macro-level (Valentijn et al., 2013).

Researchers have empirically approached the role of social work in integrated healthcare focusing on the health improvements made by patients as a result of having all care located in one facility. The more integrated healthcare services are, the better the health outcomes experienced by patients. The evidence points to a significant amount of patient health improvements through integrated healthcare and to minimal research focused on social worker roles and how they affect those outcomes. For example, Thota et al. (2012) performed a systematic review of 37 randomized controlled trials and 32

additional studies of collaborative care models treating depression. The meta-analysis compared groups of people who did and did not receive integrated healthcare interventions for depression. The authors found that organizations needed to support the implementation of integrated healthcare for improved treatment, and the diverse team members providing simultaneous care made it difficult to distinguish how individual actions and roles affected the overall outcomes in collaborative care (Thota et al., 2012). This systematic review of the literature showed that integrated healthcare is effective "in achieving clinically meaningful improvements in depression outcomes and public health benefits in a wide range of populations, settings, and organizations" (Thota et al., 2012, p. 525).

Integrated healthcare overall has been found to effectively improve patient health and decrease health disparities (Zonderman, Ejiogu, Norbeck, & Evans, 2014). Peek, Ferguson, Bergeron, Maltby, and Chin (2014) analyzed all papers on the PubMed database published between 2010 and 2013 that included 20 keywords and were related to integrated healthcare addressing diabetes disparities among adults. Peek et al. (2014) presented the examined articles in a conceptual model of health system components. What they found was that health disparities decrease as one experiences the provision of integrated care. The decline in health disparities continues to decrease, and care improves, with professionals actively collaborating. Lastly, reducing health disparities begins with co-location of providers/resources, yet the most effective type of intervention for decreasing health disparities is fully integrated healthcare which requires clear role delineation (Peek et al., 2014).

The results from Thota et al. (2012) and Peek et al. (2014) are reinforced by Coventry et al. (2015) who asked if integrated healthcare affects depression and a patient's ability to manage diabetes and heart disease. Out of 387 patients diagnosed with depression and diabetes, 191 received integrated care while 196 received standard medical care. Coventry et al. (2015) found that integrated care reduces depressive symptoms while improving self-care of a chronic disease in people with mental and physical multi-morbidity. Another example comes from Schnall (2005) who discusses social support as a primary role for social work in the prevention of hypertension. Schnall published a medical literature review of over 25 articles written between 1976 and 2004 and the effects of social support on the prevention of hypertension. The author further suggests that social workers use interventions that improve social integration for patients (Schnall, 2005).

Quality integrated healthcare addresses the needs of all underserved populations including children. Kolko et al. (2014) studied the results of behavioral interventions in integrated healthcare for 321 children experiencing behavior difficulties, anxiety or attention deficit hyperactivity disorder (ADHD). Half of the children received doctor-office collaborative care (DOCC), which is integrated healthcare, while the other half received enhanced usual care (EUC), which consists of psychoeducation and referral for external behavioral health (Kolko et al., 2014). What Kolko et al. (2014) found was that "implementing a collaborative care intervention for behavior problems in community pediatric practices is feasible and broadly effective, supporting the utility of integrated behavioral health care services" (p. e991).

The common theme found in all of these studies is the quantifiable gains shown by patients experiencing quality integrated healthcare. One study explored how long these gains remain from a social work perspective. Ray-Sannerud et al. (2012) found that 70 primary care patients experienced clinical gains from social work in integrated healthcare for close to 2 years after their last appointment. None of these studies can identify what social workers and other behavioral health providers are doing to produce or contribute to these outcomes; therefore, it is difficult to understand how to reproduce these positive results.

A gap analysis based on 26 studies in addition to four economic evaluations was completed by Wilson and Lavis (2014) to understand the need for research in integrated healthcare. Six of the studies were considered *high-quality* by the authors, seventeen were found to be *medium-quality*, and the last three were found to be *low-quality*. Two of the priorities identified as needing more research were "improving patient experience of care and improving the health of populations" as it relates to integrated healthcare (Wilson & Lavis, 2014, p. 16). Also, Raghallaigh, Allen, Cunniffe, and Quin (2013) discuss the lack of research concerning the roles of social workers in primary care. This action research study is meant to assist with filling these gaps through understanding social worker roles. Once social worker roles are more clearly defined, future research will be able to focus on social worker impact concerning improvements in patient experience and health in integrated care.

Social Worker Roles

Understanding social worker roles in providing quality integrated biopsychosocial healthcare services requires awareness of the current healthcare climate. There is a shift in healthcare delivery throughout the United States from siloed small medical practices to collaborative larger healthcare facilities that join providers to address biology, psychology, and social needs of patients (Silow-Carroll et al., 2013). This change in healthcare is driven by public policy and market influences. Medicaid programs are leaning toward payment of bundled services of coordinated healthcare which pays for the value of services rather than fee-for-service based on volume (Centers for Medicare & Medicaid Services, 2016). Colorado is one of the states to pursue accountable care which stresses collaboration of healthcare professionals to provide quality interventions that remove any barriers to care (Silow-Carroll et al., 2013).

Ashcroft and Van Katwyk (2016) discuss the tripartite typology of social work to understand social work roles in integrated healthcare. The social work tripartite typology lists three views fundamental to social work as therapeutic, social order, and transformational. The therapeutic view focuses on the work between a social worker and client for individual well-being. In social support theory, Schaefer et al. (1981) identify this view as the opportunity for a social worker to provide emotional, esteem, and informational support. A critique of this view is that it does not acknowledge concerns that are structural, for example, social determinants of health, inequities, and opportunities that are not accessible to all (Ashcroft & Van Katwyk, 2016; Beddoe, 2011).

The social order view is the work a social worker does with clients to access maintenance programs such as welfare to obtain temporary assistance that is situation specific. This social order view is comparable to tangible support in social support theory (Schaefer et al., 1981). Criticism of this view is that it encourages people to thrive in the presence of structural inequities by using a temporary system that helps with immediate needs yet does not nurture or promote change or development (Ashcroft & Van Katwyk, 2016; Payne, 2014).

The final view is transformational which focuses on the core values of social justice and equality, believing that individuals are not able to achieve empowerment until systemic, large-scale transformation takes place. The transformational view shares similarities with social support theory concepts of network and information support (Schaefer et al., 1981). This view is criticized for potentially taking the focus and resources away from people and temporary supports that are needed until the changes take place (Ashcroft & Van Katwyk, 2016; Payne, 2014).

Horevitz and Manoleas (2013) discuss different forms of integrated behavioral services that are dependent on the type of location, service integration, and collaboration among professionals. Colorado FQHCs focus on a provision of care that is co-located, collaborative, coordinated, team-based, and acts as one system. Social workers are found to address health issues from a biopsychosocial perspective which aligns with services provided in an FQHC. Through the use of snowball sampling online surveys, Horevitz and Manoleas (2013) identified competencies needed for social workers in this line of

work and the type of training they received to learn these skills. The competencies are identified as:

> Functional assessment, warm handoff, behavioral activation, Motivational Interviewing, Problem-solving treatment, Cognitive Behavioral Therapy in Primary Care, relaxation training, team-based care, chronic illness, psychotropic medication, alcohol and drug brief assessment and intervention, psychoeducation, curbside consultation, stepped care, family systems, case management, cultural competence, standardized outcome measures, and patient-centered medical home (Horevitz & Manoleas, 2013, p. 763).

The authors received 141 completed surveys yet only used the data from social workers with a Master's degree or higher to compile these competencies (N=84). A weakness of the Horevitz and Manoleas (2013) study is their use of non-probability sampling which affects the ability to generalize the information. Most importantly, competencies can be seen as part of a social worker's role and are limiting at the same time. Limiting meaning there is a difference between practice roles and the language used to describe competencies (Horevitz & Manoleas, 2013).

Lynch, Greeno, Teich, and Delany (2016) support Horevitz and Manoleas (2013) findings determining this same need for social work practice competencies to be identified. Competencies and supportive social worker roles are related and distinctly different. For example, a social worker may be skilled with providing relaxation training (competency) for an anxious patient. The social worker may define their function as a supportive role-model (role) for the medical provider and patient when the intervention is

provided in an exam room with both present. Role-model is not a competency; it is a function that a social worker may perform. This research was focused on roles identified by social workers that are perceived to provide support for underserved persons using the qualitative method of a focus group. Focus groups are found to be effective means to address an individual unit of analysis such as social worker roles in integrated healthcare.

Current research concerning social work roles in integrated healthcare is minimal. Davis, Darby, Likes, and Bell (2009) conducted qualitative research using focus groups to understand and make recommendations about the roles of social workers in improving treatment for 36 African-American, medically underserved breast cancer survivors. The recommendations are:

> (1) The Social Worker needs to address access to quality care issues; (2) The Social Worker needs to address the emotional and practical concerns of the cancer survivor; (3) The Social Worker needs to address family concerns; (4) The Social Worker needs to be involved across the continuum of care from time of diagnosis into long-term survivorship (Davis et al., 2009, p. 576).

Additionally, Zonderman et al. (2014) published a supplemental article stressing the importance of addressing cancer health disparities through integrated care rather than medical silos to address health literacy, education, and to negotiate barriers such as culture, language, and poverty.

Social Worker roles in integrated healthcare are identified by Wodarski (2014) as more traditional assessment, support, guidance with the system, advocacy, education, addressing behaviors, emotions, and mental health while identifying and facilitating

community resources. Wodarski (2014) presents a profile of a behavioral health social worker and names three characteristics as foundations of the roles social workers fill in integrated healthcare. The attributes are: (a) the depth of an acceptable knowledge base, (b) the behavioral skills necessary for an intellectual and conceptual understanding of theories of human development and learning, and (c) the utilization of techniques necessary to bring about behavioral changes in clinical practice (Wodarski, 2014, p. 314). Perhaps Ferguson (2014), who used ethnography and qualitative observations/interviews of 24 social workers totaling 87 encounters, sums up Wodarski's (2014) findings the best with, "social worker's individual characteristics, relational styles, and capacities to act creatively—or not—are significant" (p. 11).

Given the consistent evidence that integrated healthcare is effective with improving behavioral, mental, and physical symptoms, in addition to decreasing health disparities, there is a need to understand the roles social workers play in this type of service delivery. Additionally, the recommendations in the literature concerning social worker roles are used to inform this study and drive the continued quest for clarification from those working in FQHCs. Mitchell et al. (2012) looked to nearly 500 professionals working in integrated healthcare to understand the importance of clear roles in providing effective integrated healthcare. Their research found that "roles and responsibilities of integrated healthcare team members must be clearly defined and explicitly assigned" (Mitchell et al., 2012, p. 9). The gaps in the literature and clinical social work practice related to social work in integrated healthcare with underserved populations indicate the need for a research study focused on participant reflective processing to address the

issues (Talmi et al., 2016). In this case, the action research focus was on social worker roles, in integrated healthcare, through the lens of social support theory. Section 2 contains information concerning my action research project and includes the following headings: background and context, methodology (with the sub-heading: participants), sources of data/data collection (with the sub-headings: prospective data, instruments, and data analysis), and ethical procedures.

Section 2: The Project

Introduction

The purpose of this action research study was to add to the current body of knowledge concerning social work in integrated healthcare and to promote better-quality healthcare for underserved Coloradans through education and practice. Improvement of services begins with understanding the following RQ: What is the role of a social worker in integrated healthcare with underserved Coloradans? With this research question in mind, I discuss the background and context of this research study as well as methodology, sources of data, and ethical procedures.

Background and Context

This action research study focused on understanding the roles of social workers in integrated healthcare. The intention of this research was to learn how current integrated social workers are defining their roles and working through barriers, thus improving the social support available through integrated healthcare (Evans et al., 2013). This information will inform future social work education and may improve social work practice in integrated healthcare, thus supporting health equity for underserved persons in Colorado. DeBonis, Becker, Yoo, Capobianco, and Salerno (2015) evaluated an advanced clinical social work course in integrated healthcare and recommended continued evaluation to improve and expand this course content in social work education. An FQHC is a healthcare center that provides comprehensive services to underserved individuals. These healthcare centers receive higher reimbursements from Medicaid and Medicare for the integrated services they provide (Centers for Medicare & Medicaid

Services, 2016). FQHCs are mandated to show the effectiveness of services through ongoing quality assurance. FQHC agency leaders invest in improving their services for the underserved and support research focused on improving health equity (Centers for Medicare & Medicaid Services, 2016).

The U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (2010) states:

> The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators (p.1).

I used action research methodology with a focus group to collect qualitative data from social workers described by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality. I work for an FQHC in Colorado as an associate director of behavioral health. My role is direct care provision and quality data analytics for my employer. I am not in a supervisory position, and my role at an FQHC does not influence or impact any power differential with the social workers participating in this research study. All 10 FQHCs in Colorado belong to the Colorado Community Health Network (CCHN). This network brings all Colorado FQHCs together to improve services for underserved persons. Social workers employed by FQHCs connect through CCHN quarterly meetings, training, and additional e-mail communications. Given this

work connection, I had the opportunity to invite up to 30 social workers who are currently employed with an FQHC in Colorado to participate in this action research project. This collaboration with social workers provided an opportunity to collect qualitative data and afforded the opportunity for participant growth in that they are coresearchers in this study (McNiff & Whitehead, 2010). Additionally, understanding the barriers and challenges social workers experience in their roles is a call to action encouraging continued research in this area until healthcare disparities experienced by underserved populations no longer exist (McGinnis et al., 2014; Reardon, 2010).

There are 10 FQHCs in Colorado, and the majority of these facilities are in the Denver Metro Area serving the greater part of the Colorado population. Three of the 10 FQHCs serve rural mountain communities on the western slope and southern Colorado. Given the extreme distance, this research was conducted with social workers from the remaining seven FQHCs. The agencies are Clinica Family Health Services in Northern Colorado, People's Clinic in Boulder, Pecos Medical Center in Denver, Thornton Medical Center in Thornton, Denver Health in Denver, Inner City Health in Denver, and Metro Community Provider Network, which covers the neighborhoods surrounding Denver. These seven FQHCs are members of CCHN whose mission is "to increase access to high-quality health care for people in need in Colorado" (CCHN, 2013, p. 1).

Stakeholders in this study were licensed social workers/behavioral health providers currently employed by one of the seven chosen FQHCs in Colorado. As colearners, the stakeholders had the opportunity to contribute to the field of social work knowledge and to improve their practice through the collaborative work of defining

social work roles. This work empowered social workers to learn from and with each other while developing competence. The NASW Code of Ethics (2008) stresses competence as a social work value through improvement of the individual's professional knowledge and adding to the general body of social work knowledge.

Methodology

Participants

Participants were asked to join a focus group with a maximum of 10 social workers representing a little over one-third of the total population working in FQHCs. I used the nonprobability sampling method of convenience sampling. The social worker participants were recruited from the seven FQHCs in and around Denver, Colorado. A letter of support was obtained from the CCHN that represented the seven FQHCs in this study (see Appendix A). Flyers were e-mailed to behavioral health departments of the FQHCs to recruit social workers for this study (see Appendix B). Interested social workers were given information about the action research study and asked to voluntarily complete a participant informed consent form in an individual meeting with me prior to the focus group. Eligibility for the study required the participants to (a) be a licensed social worker/behavioral health provider in Colorado, (b) be English speaking, (c) be in a job position that provides integrated care in an FQHC, (d) be willing and able to participate in one focus group for one and a half to two hours, and (e) complete the written informed consent agreeing to confidentiality and to being audiotaped. Light refreshments were offered to participants of the focus group.

As of the week of November 7-11, 2016, there were 28 licensed social workers employed by the seven FQHCs. The goal was to have 4-10 persons participate in a focus group. The group met once for 1 hour and 45 minutes at Community First Foundation, 5855 Wadsworth Bypass, Unit A, Arvada, CO 80003. This centralized location was chosen to alleviate undue transportation hardships for the research participants. Additionally, the rooms were new, private, and free for members of the community to use.

Sources of Data/Data Collection

Prospective Data

A focus group was conducted to collect data for this study. Interested social workers were asked to call Trisha Goetz, LCSW, CACIII, a doctoral student at Walden University, to learn more about the research and to complete appropriate consents with the researcher before the focus group. Trisha Goetz, LCSW, CACIII, conducted the focus group after receiving Institutional Review Board (IRB) permission (IRB approval no. 06-21-17-0582758). This action research supported self-reflection of social worker roles, commitment to improving integrated healthcare for underserved populations, and a shift in social work practice education through feedback, reflection, and revision. An objective of this action research study was to support collaborative learning and further develop social work practice with underserved persons in Colorado.

Qualitative data was collected from a focus group, which is a method of data collection where participants share information in a semistructured group process. These groups are frequently moderated by a researcher and are typically used to identify new

information for further research or reinforce existing evidence (Cyr, 2016). This method aligns with the study focus on understanding the roles of social workers in integrated healthcare; the interaction between social workers from separate yet similar agencies can lead to additional in-depth insights. The purpose of using a focus group was to gain access to participant attitudes, beliefs, experiences, feelings, and reactions while exploring social worker roles in the healthcare environment (Cyr, 2016).

Typically, focus groups are comprised of 6-10 participants; however, the number can vary from 3-15 (Cyr, 2016; Kitzinger, 1995). Given the limited total population of approximately 28 social workers for this study, I held one focus group with 4 participants for data collection.

The group was audiotaped, which allowed me to be present with the group and be more specific with the interpretation of the data (e.g., addressing relevant nonverbal observations). I transcribed the focus group recording ensuring that all identifying information was deleted. I compared the typed data with the recording three times to check for accuracy after it was transcribed. This qualitative data was then organized and sorted using categories based on keywords. The goal of the analysis was to interpret the data and present it in a way that clearly represented the information shared in the focus group.

I needed to remain mindful of the limitations of this study. First, the participants were from different agencies that provide similar services to underserved persons yet have their distinct definitions of integrated healthcare. Second, the individual perspectives and multiple realities of the participants may have influenced the focus

group results. For example, participants may have disagreed with each other or attempted to focus on irrelevant topics because they had different perceptions and experiences than other group members (Cyr, 2016). Additionally, the focus group members were self-selected and represented a small sample size; therefore, they may not have been representative of the larger population. Krumpal (2013) adds that results could have been skewed by the moderator's skills or lack thereof and poorly designed research questions. Lastly, group members may have felt pressure to follow the dominant view or experience the influence of social desirability (Krumpal, 2013). The outcome of understanding social worker roles in integrated health illuminates features of organizational frameworks and delivery of healthcare, which is meant to influence performance and the quality of patient care.

The focus group participants were asked several open-ended questions intended to elicit pertinent and detailed information. The discussion guide focused on questions concerning defining social worker roles, understanding these roles and skills needed to do them well, and how these roles are perceived by the social workers to improve health equity. An example question was, "What makes you as a social worker successful with supporting patients in this environment (see Appendix C)?"

Instruments

The instrument used in this research was a semi-structured discussion guide with open-ended questions (See Appendix C). The discussion guide was reviewed by my committee chair Dr. Cynthia Davis who is a content expert and one of the authors cited in this proposal (See Appendix C). The discussion guide questions were written based on

criteria from a Krueger and Casey (2015) book about focus groups and is specific to this research.

To begin the focus group, each participant was welcomed and given a handout of the research review section for reference throughout the focus group (See Appendix D). I then reviewed the expectation of confidentiality and afford participants an opportunity to ask any questions. Following the guide, I continued with stakeholder introductions, asking participants to describe their work setting and roles throughout a typical workday to capture initial thoughts about their job responsibilities. Subsequent transitional questions were related to social worker roles in integrated healthcare, barriers, and supports and were meant to promote responses that trigger additional thoughts and memories of participants to explore perceptions. Krueger and Casey (2015) support this use of questioning because it evokes conversation. The authors provide a further list of criteria for researchers to consider when creating focus group questions that includes the use of open-ended, one-dimensional, introductory, transition, and ending questions (Krueger & Casey, 2015).

The next to last question on the discussion guide asked for stakeholders to list items they believe important for social work students to learn (See Appendix C). This question asked the participants to consider the topic from a different perspective since previous questions were focused on first-person experiences. Additionally, asking group members to list things was an alternative way to engage them (Krueger & Casey, 2015). I personally wrote the group responses to this question on the whiteboard in the meeting room. The use of a whiteboard was meant to help participants remember topics that have

already been shared. This list was used to prompt further conversation since there was additional time for the focus group. I was sure to erase the board when the focus group ended. Lastly, the ending question asked stakeholders to identify something from this focus group that had been most impactful for their practice in integrated healthcare. This is considered the final question by Krueger and Casey (2015) which seemed helpful with identifying critical areas covered.

Data Analysis

The data collected consisted of entries from the transcribed recording of informed participants in a focus group discussion. The transcript was then examined using thematic analysis described by Boyatzis (1998) to highlight, code, and sort key data points. The thematic code addressed the following five elements, (1) naming the theme, (2) defining the theme, (3) knowing how to recognize the theme in the data, (4) naming the data to be excluded, and (5) identifying an example. The codes were initially validated via a review by my committee chair to ensure the integrity of the data. Themes and subthemes were based on patterns from the coded data. To achieve rigor in data analysis, I cross-checked themes by running the transcript through a software called QDA Miner 5 (n.d.). QDA Miner 5 (n.d.) sorted and analyzed textual data, distinguishing and identifying themes in addition to providing independent validation of the thematic code findings. The final check of the analyzed data came from a review by my action research committee. In conclusion, this information has been consolidated and finalized in a clear manner.

Ethical Procedures

The research participant social workers completed the informed consent before the focus group in a one-to-one meeting with this researcher. Stakeholder participation can involve some risk that can be encountered in daily life, such as fatigue, stress or becoming upset. Being in this study did not pose a risk to participant safety or well-being. Protective factors considered for this focus group research revolved around respect, privacy, and maximizing confidentiality for participants. Respect was shown when speaking with and about participants. Respect included being timely, transparent, listening, and providing a safe environment for group members to share their views. Stakeholder privacy in the community appeared to be difficult in that the total population consists of approximately 28 people and the likelihood of participants knowing each other is high. I avoided the collection of sensitive information and reminded participants at the time of the focus group that they are free to refuse to answer questions. Using guidelines shared by Fritz (2008), confidentiality was ensured through the following established procedures:

- I have completed ethics training.
- My journal notes do not contain personal identifiers.
- The raw and processed data compiled in this study was only obtained for the purpose of research and is kept locked in a file and on an encrypted laptop at my home for a minimum of five years per Walden University standards. The locked file and laptop are only able to be accessed by this researcher.
- I only shared raw data with my action research committee members.

- I added, “Discuss the expectation of confidentiality and the importance of open communication with each other” to the focus group discussion guide (See Appendix C).
- If I became concerned about risks or protective factors, I would have immediately stopped data collection and reached out to my action research committee members for guidance.

Summary

The data collected in the focus group was analyzed and organized into themes. This research is a step toward understanding how the critical roles social workers in integrated health are affecting the care of underserved people in Colorado. It is my belief that social workers are uniquely qualified to provide high-quality treatment in the integrated care environment. The following information begins with an analysis of the research findings in section three; specifically, data analysis techniques, validation and legitimation process (with the sub-headings: reflexivity, validation procedures, and limitation to trustworthiness and rigor), and findings (with the sub-headings: research question, supporting patients and staff, influencing quality healthcare integration, possessing characteristics and competencies, and performing role responsibilities). The fourth and final section focuses on recommended solutions including the application for professional practice (with the sub-headings: findings vs. peer-reviewed literature and impact on clinical social work practice), solutions for the clinical social work setting, and implications for social change.

Section 3: Analysis of the Findings

Introduction

The intent of this action research study was to provide additional data to the current body of knowledge concerning social work practice in integrated healthcare while promoting better-quality healthcare for underserved Coloradans through education and practice. The investigation of social work roles in practice took place with a focus group of four licensed behavioral health providers who worked in an FQHC in Colorado. The focus group participants answered questions and held discussions that concentrated on the following RQ: What is the role of a social worker in integrated healthcare with underserved Coloradans? Keeping this research question in mind, I discuss in Section 3 data analysis techniques, validation and legitimation process, and research findings.

Data Analysis Techniques

The results of this qualitative research project add to the current body of knowledge concerning social worker roles in integrated healthcare. The focus group members provided qualitative data concerning the role of social workers specifically in FQHCs in Colorado. The focus group was audio recorded for the 1 hour and 45 minutes of the meeting. I transcribed the recording in a little under 40 hours and compared the audio recording and final transcript three times on separate days to ensure accuracy. I then analyzed the transcript using thematic analysis outlined by Boyatzis (1998) by naming and defining themes and identifying data to be excluded. Examples are presented in Section 3 of this project report. This analysis resulted in four prominent themes related to the focus group participants' understanding of integrated social worker roles in FQHCs

regardless of the employment agency. The themes are: (a) the role of supporting patients and staff, (b) the role of influencing quality healthcare integration, (c) possessing characteristics and competencies, and (d) performing role responsibilities.

I used the software QDA Miner 5 and Wordstat 7 by Provalis Research to identify word frequency, topics by paragraph, proximity plots, and clustering keywords using Jaccard coefficient comparing keyword similarities and diversity, based on occurrence in paragraphs. This software provided independent validation of my thematic code findings with the removal of all single word clusters in this data analysis. The following section examines the validation and legitimation process with the headings reflexivity, validation procedures, and limitations to trustworthiness and rigor.

Validation and Legitimation Process

Reflexivity

I used journaling to examine and acknowledge assumptions and preconceived ideas that I held concerning this research. The purpose of using a journal was to mitigate any influence I may have on the outcome of this study. Journaling has improved this data collection process from writing the proposal through the analysis of the findings. During the proposal phase of this research, I was working on constructing focus group questions. I had journaled that I was hoping the questions would foster a form of esteem and information social support for the focus group participants. After reviewing this entry, I realized that my "hope" had the potential to have influenced the questions in the discussion guide. For example, I had thought about asking each participant to share a success story of their work with a patient. This questioning would have been more

focused on the participants' esteem and information sharing rather than on social worker roles. To address these concerns, I read the questions out loud to four of my friends who are social workers. None of these friends were eligible to participate in this research. I asked for their feedback concerning the questions and my presentation and used their insight to improve my discussion guide.

The second example of my use of reflexivity was when I was transcribing the focus group audio recording. I realized that before holding the focus group, I was harboring an internalized belief that the focus group participants would only discuss information I had covered in my extensive literature review. Understanding this view prompted me to take a two-day break from this project after triple checking the transcript for accuracy. I needed those two days to clear my head and come back with a fresh look to identify all themes. The result of my reflection and action was the discovery of an additional area I had not initially identified.

Validation Procedures

After transcribing the focus group audiotape, I listened and read along to validate the transcript three separate times on different days, and I used statistical software to confirm my original themes. Additionally, I examined previous findings in research and found consistencies with the results of this study throughout. While these are not extensive validation procedures, I am presenting the findings transparently as one way to understand this research issue instead of sharing the results as "truth."

Limitations to Trustworthiness and Rigor

Qualitative research is frequently questioned in regards to its trustworthiness, reliability, and validity. Reliability and validity are described differently in quantitative research. I am addressing this issue and the integrity of this research by using a framework. This framework was shared by Shenton (2004) to address trustworthiness in qualitative studies and promote rigor. Shenton (2004) outlined four constructs, originated by Guba (1981), as credibility, transferability, dependability, and confirmability.

Credibility. Limitations related to the credibility of this study were in the lack of random sampling and the use of one method for data collection. Additional methods of data collection such as individual interviews would have strengthened the results of this research. I addressed credibility by familiarizing myself with the integrated healthcare culture before the study, using a focus group, which is a well-established research method, and using procedures in data collection/analysis that have been used successfully in previous research concerning this topic. Lastly, I addressed credibility by requesting and responding to the scrutiny of my action research committee.

Transferability. I cannot demonstrate wholly that my findings and conclusions can apply to additional populations. The sample population of four is much too small to generalize the results. Initially I had six social workers respond with interest in participating in this research study. Two of the respondents could not attend either of the proposed focus group dates. At the time of this study, the total population was approximately 28 social workers employed by FQHCs, so I chose to hold the focus group with four group members. Having four participants provided more time for greater in-

depth discussions and was said by one of the stakeholders to have been "very informative and helpful for my practice." I attempted to increase transferability of the data by providing a significant amount of contextual information that allows readers the opportunity to make transfer inferences on their own. Therefore, transferability will not come from claims I make about this research; it will originate from those who read this research.

Dependability. Using more than one method of data collection would have strengthened the dependability of these research results. For example, using the focus group and individual interviews would have improved the reliability of the data. I address dependability by fully describing the design and implementation of this research and by providing a detailed description of the data gathering. Lastly, I have reflected on and evaluated the process and its effectiveness as I have been carrying out this research.

Confirmability. A limitation of this research is my humanness, bias, and influence throughout, which has impacted the outcome no matter how hard I have tried to prevent it. For example, the semistructured discussion guide was reviewed by Dr. Cindy Davis, a content expert in the field, and written based on criteria from Krueger and Casey (2015) about focus groups distinct to this research, yet it is not wholly objective. I addressed these concerns by taking steps to be reflective and fully transparent. Also, I presented detailed data used to conceptualize, summarize, and make recommendations concerning the findings in this study.

Findings

Research Question

The primary research question examined the role of a social worker in integrated healthcare with underserved Coloradans. Information from this project resulted in four themes from the focus group under the following headings: (a) supporting patients and staff, (b) influencing quality healthcare integration, (c) possessing characteristics and competencies, and (d) performing role responsibilities.

Supporting Patients and Staff

The research results related to the roles of social workers focused primarily on supporting patients and team members in integrated healthcare. The social worker provides support through coordination and communication with all team members to help the patients. The focus group members are all "integrated" in an FQHC. A participant defined their role as "an inclusive and included member of the healthcare team that actively participates in patient treatment."

This research was grounded in social support theory, and the focus group members received a handout (Appendix D) to use as an aid in the process to remember five support types while examining the research question concerning social worker roles. Words sorted by frequency places emotional support at the highest use (90%), esteem support and information support tied for second position (42%), network support was third (28%), and tangible was last (21%). This data corroborates the descriptions given by focus group members about the types of support used in their roles working with persons receiving and providing healthcare in an FQHC.

The focus group participants overwhelmingly agreed that they provided emotional support most frequently in their roles with patients and staff. This assertion was corroborated by the software review results placing emotional support as the highest frequency of use in the transcript. The definition of emotional support utilized by the group was when a social worker shares care/concern that meets the patient's emotional needs. The participants described their actions of "listening, empathizing, and providing a safe place for patients to express themselves" as examples of providing emotional support. They quantified the amount of emotional support provided to patients as "the vast majority of time" and "nine times out of ten."

The provision of emotional support for staff, mainly medical providers, was reported as "daily" by two members and "frequently" by the other two. Emotional support with staff members was described as "providing a safe place to talk and emote while ensuring clarity about my professional boundaries." A participant continued saying,

> There are times when staff come into my office, close the door and cry. It is a safe space to be able to emote that stuff where, in that moment, I am holding the emotion for them, and I'm going to give them a safe place to express themselves and validate if there is something to validate.

Esteem support was reported by the participants to "figure in frequently" when working with patients and was found to be the second most often discussed support type from the software review of the transcript. One of the group members described esteem support as "identifying the patient's strengths." Others discussed how they "practice

giving patients a voice" and "support patients in feeling confident advocating for their health." Another participant discussed how they provide esteem support to medical providers, particularly those who are new to work in an FQHC, by asking questions such as, "What can we do to support this provider? How can we offer them advice or esteem support?"

Additionally, esteem support was identified as a type of support needed by social workers in this environment to improve patient care. The following quotes from group participants are meant to clarify that assertion:

> We need esteem support as social workers in FQHCs, and all the skills that we use with patients are the exact same skills that we would use with a medical provider. But because of those old, hierarchical systems that exist, I think a lot of what gets in the way is a sense of I can't go tell a doctor or I can't go share my skills with a doctor because I'm just a social worker.

Information support tied with esteem support for the frequency of use by the focus group participants. Information support is when the social worker communicates useful resources or data. One of the participants reported providing a significant amount of psychoeducation and identified "information support as vital in this work with pain management and substance use." Another group member used "information support with medical providers to educate them on how integrated healthcare and working together is better for their patients." Lastly, as mentioned earlier, information support given to medical providers was perceived to assist social workers with maintaining professional boundaries and still supporting better healthcare for patients. A participant added,

> The unique skills that integrated social workers have, unique situations that someone in our setting would find themselves in, and I think that's one of the biggest ones, is being able to support staff, being able to have these conversations, being able to educate. So, when we're doing things in our huddles, and when we're leading talks on burnout prevention, those are unique skills and opportunities that social workers have in an FQHC that a traditional social worker might not ever get to do.

Additional examples of information support focused on "reminding medical providers" how integrated social workers can help them. One participant gave an example of "oh, this person is coming in, let me go find out what happened with the referral process and make sure that the medical provider gets that information before the appointment which helps them feel more stable." Another group member added,

> Medical providers are terrified of emotional and behavioral situations . . . so, you're not just taking care of the patient in that situation, but in my mind, you're taking care of the medical provider because they are probably like, "Oh God, this person's coming today, I wonder what this is going to look like," and information support is teaching the medical providers that when they utilize a BHP with these patients that [sic] they can't stand because they are so exhausting that we could make their job better.

Network support was described by participants as less frequently utilized in their roles and was used less frequently according to the software. A social worker confirming belongingness and availability of internal services was the definition used by focus group

members to define network support. Family and community support were perceived by the participants as a bit more prevalent in the populations served; however, the theme of quality integrated healthcare seemed to have a direct impact on the lower frequency of providing network support for patients in an FQHC. A participant stated "I think integration is a word that we throw around a lot, but it's not necessarily a word that all practices truly practice. You have to be visible, because practicing behind an office door is colocation, not integration."

Tangible support is a social worker providing physical aid to patients. All of the focus group members named persons in "care coordination" or "patient navigation" positions as those who provide tangible support for the patients. The positions are considered "lower level" and are not frequently filled by licensed social workers because "anyone can assist a patient with resources and discharge planning." This type of assistance was not identified as playing a significant part of a social worker's role in integrated healthcare.

Perhaps the most unexpected findings came from the group focus on the need of social support for social workers working in an FQHC. All of the group participants addressed how essential it is for the social worker to have emotional, esteem, information, network, and tangible support to be effective in their roles in integrated healthcare in an FQHC and to "see value in what they bring to the table." The thought of the participants was that the patients treated in an FQHC are often high acuity, and there are "often barriers such as a hierarchical medical profession that could present an obstacle to a social worker in their role." The group members hypothesized that the more

support a social worker has in their role, the more effective they will be in overcoming these barriers, improving treatment for patients, and influencing quality healthcare integration.

Influencing Quality Healthcare Integration

To influence and provide quality integrated healthcare, the group members say they use emotional, esteem, information, and network support with patients, medical providers, and additional team members. One stakeholder shared,

> Our role, that is not in our job descriptions, is to be the experts in really helping people who are struggling, whether it's a patient, or it's a staff member, and focus on things that happen in medical settings across the board.

The focus group members unanimously agreed that a key component of their roles is building relationships with patients and team members "to be visible and work better together to improve healthcare for the patients." "We can sit with people and have that sometimes-challenging conversation because we have built relationships which are the foundation of quality integrated healthcare." This group of social workers appeared to take a significant amount of responsibility for the quality of integrated healthcare in their FQHCs and identified role tasks such as "participating in daily huddles, scrubbing schedules, and providing expertise and training to team members" as a few examples of what they do to improve integrated healthcare. A participant stated:

> This is super-highlighting the difference between co-location where a co-located therapist is waiting for a referral versus integrated where it's like, oh, I happen to

> be free, and taking the initiative and being proactive, when I see BHPs who are hiding out, I know it's not going to be a good fit.

Quality integrated healthcare improves as barriers are addressed. One such barrier identified by the participants is "hierarchy in the medical field." Also, they describe the patient population in FQHCs as a high acuity/high risk and believe that staff turnover is "hemorrhaging" due to compassion fatigue and burnout. Staff turnover then makes building working relationships challenging and partnerships for treating patients seem to be constantly fluctuating. Additional barriers identified by the group participants are "medical providers not utilizing behavioral health services, and patients having negative perceptions about behavioral health." The focus group members confront these barriers by "shifting stigma with patients and staff, thus influencing and promoting quality integrated healthcare."

Lastly, agency priorities need to be on integrated healthcare to provide quality services in an FQHC. One of the participants commented that their organization makes integration a priority and "it makes a difference." This member went on to explain that they informed their team about this focus group and the consistent feedback from the team was that medical providers wanted a full-time behavioral health provider in each of their clinics. This type of response from medical providers seems to reflect quality integrated healthcare. The focus group members began to discuss what it is about the social worker that may influence positive integrated care. The following section is a summary of the third theme identified by the focus group members. They examine traits and competencies a social worker needs to be successful in integrated healthcare.

Possessing Characteristics and Competencies

The focus group members discussed individualities and competencies they believe contribute to a social worker being "a good fit" in integrated healthcare. The participants considered the characteristics that benefit a social worker in an integrated healthcare setting as "having an acceptable knowledge base, age, autonomy, boundaries, calmness, confidence (being comfortable feeling uncomfortable), experience, flexibility, individual characteristics, relational styles, and visibility in the clinic." One of the group members described a characteristic as "experience…knowing that you have the clinical chops basically to deal with whatever comes in the door." A second member asked, "Where does that come from?" The answer given by a participant was "with age."

When identifying confidence as a characteristic, a stakeholder reported, "I'm not intimidated by patients or staff, and that's helpful and makes me move with more confidence probably." A response was, "yes, confidence and calmness, because it helps providers know I've got this." When delving deeper, the participants added that the social worker needs to have a solid knowledge base, strong relational styles, and "be comfortable" being visible in the clinic.

The competencies discussed by the focus group were considered very important to have before beginning practice in integrated healthcare. The patients seen in FQHCs in Colorado are diverse and high acuity much of the time; therefore, a social worker must be competent in many content areas. Participants considered competencies as "having the skills and knowledge to work with people in certain practice areas" and identified

those they felt were important in meeting the diverse patients they encounter in their work in integrated healthcare. These competencies included:

> behavioral activation, chronic illness, chronic pain, Cognitive Behavioral Therapy in Primary Care, compassion fatigue/burnout, cultural competence, consultation, evidence-based short-term treatment interventions, family systems, functional assessment, grief and loss, Motivational Interviewing, psychoeducation, relaxation training, substance use assessment and intervention, team-based care, Trauma Informed Care, and warm handoffs.

One of the group participants suggested that a social worker would benefit from competency in the treatment of patients with chronic pain "to assist the provider and patient with how to manage the chronic pain." Another conversation concerning competencies was, "I think substance abuse is so prevalent that a social worker needs that competency." A group member responded with, "that ties into Motivational Interviewing…which is being seen by medical providers as an effective intervention." I now move to the last theme of the focus group which examines social workers carrying out their role responsibilities.

Performing Role Responsibilities

While discussing roles, the participants considered tasks or actions they tend to complete in their daily functions. This list includes the following eighteen responsibilities:

> addressing barriers, addressing behaviors, addressing emotions, addressing family issues, addressing health literacy, addressing mental health, advocacy, assessing

> and planning for safety, building relationships, coordinating and communicating with the treatment team, education/psychoeducation, facilitating integration, guidance with the system/navigation, identifying and facilitating community resources/networking, initial assessment, meet and greet, scrubbing schedules in advance, and supporting patients and staff.

The responsibilities topic then lead the group members to a discussion about the importance of the social work skills "we all learned in college." A participant shared their thoughts concerning role responsibilities as:

> What makes us successful . . . is our basic foundational skills. Like if you can come into a room, do an assessment, triage and intervene in the moment. Make sure the person is safe. Build rapport and come up with a treatment plan. That is going to baseline make you successful. All the other stuff is like the cherry on top. But we forget sometimes the very basics, it's like we have to keep what's close to us our very foundational, the basics what separates us as social workers from everyone else in the room. Like assessing for suicidal or homicidal ideation, that's like the one thing that we do that no one else does. . . getting consent, making sure that we've assessed thoroughly for safety and just relying on those foundational skills.

Summary

The four themes of supporting patients and staff, influencing quality healthcare integration, possessing characteristics and competencies, and performing role responsibilities are distinct and interconnected. Keeping the differences and similarities

of these findings in mind, I move to the fourth and final section of this study to focus on recommended solutions. This portion examines the suggested solutions with the headings: application for professional practice, solutions for the clinical social work setting, and implications for social change.

Section 4: Recommended Solutions

Introduction

The purpose of this action research study was to promote better quality healthcare for underserved Coloradans through education and practice and to add to the current body of knowledge concerning social work in integrated healthcare. Improvement of services begins with understanding the following RQ: What is the role of a social worker in integrated healthcare with underserved Coloradans? The focus of this action research study was on the roles of social workers in integrated healthcare at FQHCs. The intention of this study was to explore how current integrated social workers define their roles and work through barriers, thus improving the social support available through integrated healthcare (Evans et al., 2013). This data will inform future social work education and may improve social work practice in integrated healthcare, thus supporting health equity for underserved persons in Colorado.

The key findings are four themes that include lists of characteristics, competencies, and role responsibilities of social workers in FQHCs. The focus group participants ascertained that their "overarching responsibility is to support patients and staff members, thus improving and providing quality integrated healthcare for unserved persons in Colorado." With these research results in mind, the following sections will focus on applicability, solutions, and implications.

Application for Professional Practice

As colearners, the stakeholders contributed to the field of social work knowledge and improved their practice through the collaborative work of defining social work roles.

This work empowered social workers to learn from and with each other while developing competence. The collaborative learning of these action research participants also promotes social change through shared results meant to positively influence policy and practice in the provision of integrated healthcare for underserved persons. An objective of this action research study was to support collaborative learning and further develop social work practice with underserved individuals in Colorado.

The participants identified information from the focus group that made the most impact on them and their practice. The group agreed that "a lot of the behaviors that we do professionally are regular life things, we do them without realizing or thinking about it," so having time to learn from each other supported them in feeling more competent in their practice. One of the group participants took notes and reported learning "to take my pulse first and not be reactive to situations." Others added, "Strategize before reacting when others come to you with a crisis," and "Get your balance, get your footing, then move forward."

Lastly, application for professional practice is dependent on the trustworthiness of this research. I discussed transferability earlier in Section 3, and within this section I share contextual information concerning social worker roles. This contextual information is centered around focus group findings and outcomes from peer-reviewed literature and is presented to allow the reader to make transfer inferences freely.

Findings and Peer-Reviewed Literature

The focus group participants identified characteristics, competencies, and role responsibilities of social workers in their roles in FQHCs. The social worker

characteristics named by the focus group were 50% similar to those identified by Wodarski (2014) and Ferguson (2014; see Table 1). Horevitz and Manoleas (2013) listed 19 competencies of social workers in integrated healthcare settings, and the focus group produced 68% of the same results (see Table 2). The focus group replicated 88% of the research results specific to social worker role responsibilities by Davis et al. (2009), Zonderman et al. (2014), and Wodarski (2014; see Table 3).

Table 1 addresses characteristics that are thought to contribute to a social worker being “a good fit” in integrated healthcare. Although this was not a focus of the questions for the group, the participants discussed characteristics a social worker would benefit from having to succeed in providing integrated healthcare. The focus group identified three out of six similar characteristics from Wodarski (2014) and Ferguson (2014). The majority of information from the participants fit into the "individual characteristics" category and included “age, autonomy, boundaries, calmness, confidence (being comfortable feeling uncomfortable), experience, and flexibility.”

Table 1

Integrated Healthcare Social Worker Characteristics

Characteristics	Wodarski (2014) & Ferguson (2014)	Focus Group
Acceptable Knowledge Base	X	X
Behavioral Skills to Intellectually and Conceptually Understand Theories of Learning and Human Development	X	
Capacity to Act Creatively	X	
Individual Characteristics	X	X
Relational Styles	X	X
Utilization of Techniques Needed to Bring About Behavioral Changes	X	
Visibility in the Clinic		X

Note. An X represents the characteristics identified in the research.

Horevitz and Manoleas (2013) identified competencies needed for social workers in integrated healthcare, and the focus group participants in this study listed thirteen of the nineteen as elements of their roles in integrated healthcare (see Table 2). The group added to the competencies in five areas: "chronic pain, compassion fatigue/burnout, evidence-based short-term interventions, grief and loss, and Trauma Informed Care," which were not identified by Horevitz and Manoleas (2013). There were two areas where the focus group did not use the exact verbiage. Instead of using "alcohol and drug brief assessment and intervention" the focus group members used "substance use assessment and intervention," most likely due to the updated *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5™; 2013) diagnosis change to Substance Use

Disorder. The participants also left off the word “curbside” when discussing consultation.

Table 2

Role Competencies

Role Competencies	Horevitz and Manoleas (2013)	Focus Group
Alcohol and Drug Brief Assessment and Intervention	X	*X
Behavioral Activation	X	X
Case Management	X	
Chronic Illness	X	X
Chronic Pain		X
Cognitive Behavioral Therapy in Primary	X	X
Compassion Fatigue/Burnout		X
Cultural Competence	X	X
Curbside Consultation	X	**X
Evidence-Based Short-Term Interventions		X
Family Systems	X	X
Functional Assessment	X	X
Grief and Loss		X
Motivational Interviewing	X	X
Patient Centered Medical Home	X	
Problem-Solving Treatment	X	
Psychoeducation	X	X
Psychotropic Medication	X	
Relaxation Training	X	X
Standardized Outcome Measures	X	
Stepped Care	X	
Team-based Care	X	X
Trauma Informed Care		X
Warm Handoffs	X	X

Note. An X represents the role competencies identified in the research. *The focus group called this "Substance Use Assessment & Intervention." **The focus group called this "Consultation."

Table 3 compares the definitions of social worker role responsibilities in current literature to the focus group definitions. The focus group members identified 14 out of the 16 definitions found in three published articles. Additionally, the focus group added six responsibilities that were not found in the comparison existing literature. They are: "assess and plan for safety, building rapport/relationships, coordinating and communicating with the treatment team, facilitating integration, meet and great, and scrubbing schedules." The focus group members discussed how they often see patients in acute situations and may only see them once for 15 minutes, so they offer services including emotional, esteem, information, network, and tangible support and hope the intervention becomes internalized and helpful.

Table 3

Role Responsibilities

Role Responsibilities	Davis et al. (2009)	Focus Group
Address Access to Quality Care	X	
Address Emotional and Practical Concerns	X	X
Address Family Concerns	X	X
Involvement Across Continuum of Care	X	
	Zonderman et al. (2014)	
Address Health Literacy	X	X
Assist with Negotiating Barriers (e.g. Cultural, Language, and Poverty)	X	X
Education	X	X
	Wodarski (2014)	
Addressing Behaviors	X	X
Addressing Emotions	X	X
Addressing Mental Health	X	X
Advocacy	X	X
Assess and Plan for Safety		X
Building Rapport/Relationships		X
Coordinating and Communicating with Treatment Team		X
Education	X	X
Facilitate Integration		X
Guidance with the System	X	X
Identify and Facilitate Community Resources	X	X
Meet and Greet		X
Scrubbing Schedules in Advance		X
Support	X	X
Traditional Assessment	X	X

Note. An X represents the role responsibilities identified in the research.

The focus group research findings seem to reiterate a significant amount of knowledge found in peer-reviewed literature. The additional social worker characteristics, competencies, and role responsibilities from the focus group extended current social work knowledge, filling gaps in the literature on this topic. The confirmation of knowledge concerning clinical social work practice is applicable in all integrated healthcare practices from influencing hiring practices to improving training and support for social workers in this field. These findings can also be utilized to inform future social work education and internships. The more knowledge concerning this topic, the more qualified social workers can be when entering the field of integrated healthcare, thus positively impacting services for underserved populations.

Impact on Clinical Social Work Practice

Social workers in integrated healthcare settings are delivering services in a dramatically different way than traditional 50-minute outpatient office visits. The potential impact of this research on clinical social work practice begins with understanding the delivery of patient care in the integrated healthcare setting. This study corresponds with findings in the previous literature (Wodarski, 2014) that social workers in integrated facilities provide brief interventions that are empirically validated and effective assessments and screenings of patients.

As found in previous research (Horevitz and Manoleas, 2013), this study finds social workers in integrated healthcare need specific training and competencies that are not currently present in social work education programs or internships. For example, consultation was described by a focus group participants as “talking with a medical

provider and basically telling them how to work with a patient," which is not a particular skill currently taught in social work curriculum (CSWE, 2017).

Integrated healthcare is influenced by two goals; to decrease costs and health disparities (Wodarski, 2014). This research impacts clinical social work practice by reducing costs and health disparities through the provision of social support which mirrors results found by Wodarski (2014) who writes,

> The main influence pushing integration is the need to control medical costs that directly arise from psychosocial, mental health, or substance abuse factors by providing quality treatment. The clinician needs to be focused on enhancing . . . outcomes and providing appropriate ongoing social support. (p. 302)

Understanding the roles of social workers in Colorado FQHCs has impacted the stakeholders and this researcher through learning how to overcome barriers in practice and provide quality integrated biopsychosocial healthcare services to underserved Coloradans. When the focus group participants discussed unique characteristics needed to be successful in their roles in integrated healthcare, age and experience were mentioned. The intent of this research was to impact the field of social work through knowledge so social workers do not need to wait for "age or experience" until they can provide quality integrated healthcare for underserved populations.

Solutions for the Clinical Social Work Setting

Solutions for the clinical social work setting are connected to the education of all staff members, supporting social workers, considering the work environment, and reflecting upon potential hiring practices. Social workers provide unique skills that

provide health benefits for patients as healthcare moves away from segregated delivery of services to a more comprehensive system. Based on the findings in this research study, a solution related to the problem statement is for agencies to focus on educating staff members about the importance of integrated healthcare. Specifically, teach others about the work social workers/behavioral health providers do to promote integration because this improves patient outcomes (Goodrich et al., 2013). The focus group members unanimously suggested having the medical providers "who understand integrated healthcare" train all newly hired medical providers. One of the participants summed up the subject of training with this statement: "here's a specific example of why integrated healthcare works well and why you want this." "And, here's why even if you don't want this you need to understand that this is a valuable resource, not only for you but the patients we serve." The training of medical providers by medical providers is meant to address the hierarchical and insular experiences the participants identified in the group. The belief of focus group members was that "medical providers will respond to medical providers more seriously than they will a social worker."

Another practical solution is for agencies to provide social support for social workers in integrated healthcare. Emotional and esteem support "reminding us to see value in what we bring" and "to help us when we spend so much time climbing hurdles and helping others." It was interesting that all of the group participants reported that they are the only behavioral health professionals in their facilities, so they have no peer support. Additionally, they all report "loving their jobs" because of the "constant change, flexibility, and autonomy" experienced. Even with the independence, the participants

discussed how this focus group provided them with the ability to support and be supported by each other. They learned from and with each other and described taking away something helpful from this group.

An additional solution to consider for the clinical social work setting is to look at how the work space is set up to support the social worker being an active member of the integrated healthcare team. For example, as we learned from the focus group, a social worker provides care as a part of the team so having a workspace in the middle of the team would promote visibility and integration. If the social worker's office is a floor above the medical office, there is less accessibility, and there are barriers to the social worker providing quality integrated healthcare.

Lastly, the results of this study can be used by the clinical social work agency to inform hiring practices. For example, an organization might recruit social workers by identifying individual competencies they are looking for in the employee. Additionally, this research information could be used to determine a social worker's training needs or to build a job description. The characteristics of a social worker identified by the focus group as personal traits most likely to help a social worker be effective in integrated healthcare could be used to build interview questions to recognize a possible "good fit."

Implications for Social Change

The potential impact of the research results for a positive social change affects the individual, group, and organization levels and has the potential to influence overarching policy decisions. The single person impact is the effect on patients and social workers in integrated healthcare settings. This research was grounded in social support theory and

contributes to understanding the social worker's professional role and competencies that influence to the whole health of a patient. The focus group members cited several uses of social support with patients, and as existing literature (Buche et al., 2017) suggests, this type of intervention is linked to improved health outcomes. Thus, a patient receives age, cultural, gender, and racially affirming individualized supportive treatment which is accessible through integrated healthcare. Therefore, the better a social worker's role is defined and understood, the better outcomes for individuals.

The groups affected are underserved people in Colorado who receive healthcare services at FQHCs and the healthcare teams who treat them. Understanding social worker roles is meant to improve service delivery and increase public awareness to decrease health disparities experienced by underserved persons. The more data about social worker roles added to the current body of knowledge is also meant to ease the way for future researchers to distinguish how social workers affect outcomes in integrated healthcare.

The organizational impact is acquired knowledge that can improve integrated healthcare which is proven to improve health outcomes (Goodrich et al., 2013). As the focus group participants pointed out, social workers "are providing services that are more available and affordable in integrated healthcare facilities." Integrated social workers focus with patients on the improvement of health and their quality of life which in turn supports agency missions and improves funding. Another organizational impact is the information that social work education programs can glean from the results, thus providing information specific to integrated healthcare to social work students. As

mentioned earlier, there is a lack of Master's level social work education in integrated healthcare, so this research is meant to inform future education with data from the focus group members.

On a policy level, these findings contribute to the provision of improved integrated healthcare in Colorado and potentially nationwide. The focus is on an accountable care reimbursement for services which stresses collaboration of health professionals to provide quality interventions that remove any barriers to care (Silow-Carroll et al., 2013). Understanding the role of social workers in these settings, and filling gaps in the literature, impacts positive social change and contributes to this wider body of knowledge.

Summary

Social workers in integrated healthcare settings, particularly FQHCs in Colorado, participate in supporting patients and staff members using a significant number of characteristics, competencies, and responsibilities as part of their roles. This support is identified, by the focus group members, as the foundation of quality integrated healthcare which in turn improves healthcare for underserved populations. The use of action research has afforded the stakeholders and this student the opportunity to add to the current body of social work knowledge and improve our practice through collaborative learning and defining social work roles in Colorado FQHCs.

Recommendations regarding dissemination of this information begin with the stakeholders. They are to receive a one to two-page summary of research results and will be asked to share the research results and focus on improving policy and practice in the

provision of integrated healthcare for underserved persons. All Colorado FQHCs will also receive a summary of the research results through Colorado Community Health Network (CCHN), the network of FQHCs in Colorado that focuses on increasing access to excellent healthcare for underserved persons in Colorado. CCHN supported this research and will assist with disseminating the results statewide. Lastly, when I graduate, I plan to work with others to repeat this research and to pursue new research that focuses on decreasing health disparities.

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Appendix A: Letter of Support

Colorado Community Health Network
600 Grant Street, Suite 800
Denver, CO 80203

01/03/2017

Dear Trisha S. Goetz,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Clinical Social Work with Underserved Persons in Colorado in an Integrated Healthcare Facility within the Colorado Community Health Network. As part of this study, I authorize you to recruit licensed social workers/behavioral health providers through e-mailing a flyer to voluntarily participate in an action research study. Individuals' participation will be voluntary and at their own discretion. All additional research activities will occur offsite.

We understand that our organization's responsibilities include: Our support to e-mail social workers/behavioral health providers in Colorado Federally Qualified Healthcare Centers asking for volunteers for your action research study. All additional research activities will occur offsite. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Appendix B: Flyer

Social Work Research: Call for Participants

If you are a Colorado Licensed Social Worker at a Federally Qualified Healthcare Center,

Trisha Goetz, LCSW, CACIII, a Walden University Doctoral Social Work student, is looking for you to participate in a 2-hour focus group.

This group meeting will take place at the Community First Foundation, 5855 Wadsworth Bypass, Unit A, Arvada, CO 80003

Topics of discussion include a typical work day, understanding of your roles, and ways for you to inform future social work in integrated healthcare settings.

This research is meant to add to the current body of knowledge and promote improved social work in integrated healthcare through education and practice.

If you are interested in participating, please contact Trisha Goetz, LCSW, CACIII at (303)704-3050 or e-mail trisha.goetz@waldenu.edu.

Appendix C: Discussion Guide

- ✓ Welcome and review of the topic.
- ✓ HANDOUT: Research Review Section (This information can be used throughout this process as an aid to remembering support types.
- ✓ Discuss the expectation of confidentiality and the importance of open communication with each other.
- ✓ Facilitate introductions with name and a description of participant work setting.
- ✓ Describe your role in a typical work day as it relates to supporting healthcare for people served.
- ✓ What is it about the role of integrated social workers/behavioral health providers that provides support for underserved Coloradans?
- ✓ What makes you as a social worker successful with supporting patients in this environment?
- ✓ What are things you would like to do in your role as a social worker/behavioral health providers that you believe would improve healthcare for underserved persons in the community?
- ✓ What would help improve social workers' roles in integrated healthcare thus ultimately improving support for the people served?
- ✓ What do you believe is important for social work students to know about roles working in integrated healthcare?
- ✓ Of all of the information, we covered today, what has been the most impactful for your practice in integrated healthcare?

Appendix D: Handout

Research Review Section (This information can be used throughout this process as an aid to remembering support types)

The primary research question asks about the role of a social worker in integrated healthcare with underserved Coloradans. The purpose of examining this research question is to improve integrated healthcare for underserved persons in Colorado. Additional questions examine social worker roles that are consistent with social support theory; specifically,

1. Emotional Support (Sharing care/concern to meet the receiver's emotional needs)
2. Esteem Support (Identifying and communicating the receiver's strengths)
3. Network Support (Confirming belongingness and the network's availability)
4. Information Support (Communicating useful resources/data)
5. Tangible Support (Providing physical aid)