# Assessing Social Determinants of Health Through a Trauma-Informed Approach

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The Family Health Center and Residency program has been serving the community of the Mon Valley areas since 1974. Latterman focuses on preventative medicine, maintaining a healthy lifestyle, and chronic disease management. Latterman is an NCQA Level III certified Patient Centered Medical Home (PCMH), Patients are provided care by a team of health care providers (Doctors, Pharmacists, Medical Assistants, Nurses, and Case Managers).

## Background

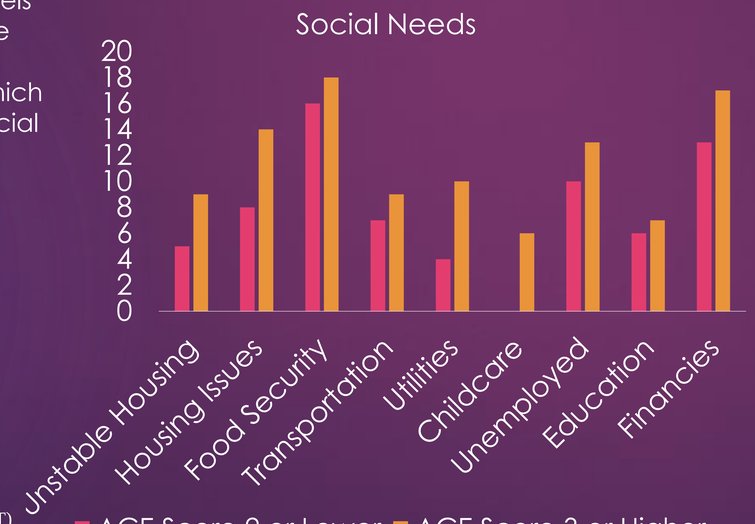
Traumatic childhood events have negative impacts on health outcomes. Individuals who experience such events are more likely to endure poor mental and physical health outcomes. Although there has been an array of studies done to survey these Adverse Childhood Experiences (ACEs), there have been only a few models in which ACE scores are used in adult populations. The American Academy of Family Physicians has recently launched an initiative called the EveryONE Project which aims to incorporate ACES and other screenings for social determinants of health in routine clinical encounters.

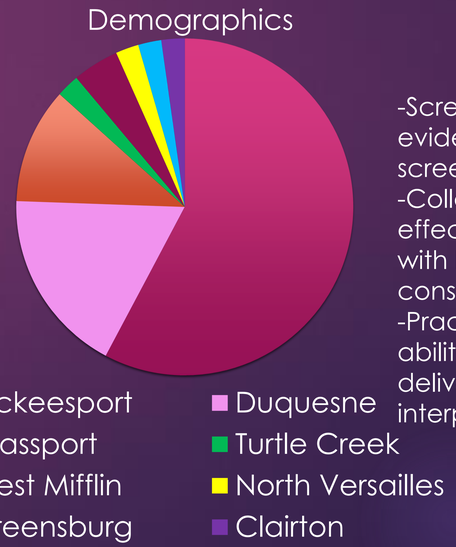
## Problem

-What types of services are needed?
-Where should these services be implemented?
-Is there a correlation between social needs and ACE scores

## Methods, Data, & Results

Patients waiting for their appointment were asked to participate in a survey that would allow us to understand the impact of childhood trauma on current social needs. The data collected provided information for understanding our patients, their needs, and strategies to improve service delivery. The surveys were designed to collect data about ACEs, social needs, and demographics. Results from this project will be used to inform and enhance future service delivery efforts. Latterman's mission is to become a trauma-informed clinic where providers understand which services are effectively utilized by patients who frequent Latterman as their primary service provider.




## Results

The results from the study showed that individuals with ACE scores of 3 or higher in most categories had more of a need for services. Understanding the types of trauma community members have experienced and its impact on their social needs can inform care planning regarding service needs and the appropriate target areas.

## Implications for Social Work Practice

Screening for ACEs provides social workers with a better understanding of the population we serve, allows us to assess client's past trauma, and facilitate treatment planning and intervention. Knowledge of services and resources based on clients/patients need is essential for holistic treatment. Data collection and background information can provide assistance to patients/clients in the future. The ability to accurately locate service needs will enhance treatment outcomes

## Core Competencies for IHC

-Screening & Assessment: The ability to conduct brief, evidence-based and developmentally appropriate screening and assessments when indicate.
-Collaboration & Teamwork: The ability to function effectively as a member of an interprofessional team with behavioral health and primary care providers, consumers and family members.
-Practice-based Learning & Quality Improvement: The ability to assess and continually improve the services delivered as an individual provider and as an interprofessional team.

## References & Acknowledgments

This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, M01HP31376, Behavioral Health Workforce Education and Training (BHWET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Bray, J. W., Del Boca, F. K., McRee, B. G., Hayashi, S. W., & Babor, T. F. (2017). Screening, Brief IntervenHon and Referral to Treatment (SBIRT): raHonale, program overview and cross-site evaluaHon. AddicHon, 112 Suppl2, 3-11. doi:10.1111/ add.13676 h2ps://www.ncbi.nlm.nih.gov/pubmed/28074566

# ACTing For the Better: A Case Study of Acceptance and Commitment Therapy in a Inpatient Geriatric Psychiatric Unit

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## INTRODUCTION

Acceptance and Commitment Therapy, or ACT, is an evidence-based "third-wave therapy" that combines mindfulness and behavioral change to increase psychological flexibility and resilience. The goal of ACT is to create a meaningful life through the pursuit of voluntary responsibility and accepting the inventible suffering that accompanies that struggle (Harris, 2006). ACT encourages acceptance of emotional distress encourages individuals to "sit with" and accept unpleasant thoughts and feelings while working towards their goals and values. Through the use of metaphor, paradox, mindfulness and many other pyschotechnologies ACT discourages "experiential avoidance" of unpleasant emotional experience and promotes "being comfortable with being uncomfortable."

For example, an ACT clinician might propose to an individual with hallucinations that the hallucinations themselves are not the problem, but it is instead the person's negative response to the hallucinations that is interfering with their ability to live an valued life. ACT works to foster acceptance along with value/goal directed behavioral modification. A 2002 study found that with only four hours of ACT, readmission rates of schizophrenic patients dropped 50% over a sixth month period ACT (Bach & Hayes, 2002). ACT has also been shown to be effective in geriatric adults with chronic pain and with older adults suffering from depression and anxiety in long-term care facilities.

The author is a MSW student at the University of Pittsburgh interning at the Behavioral Health Services Unit (BHS), sixteen-bed geriatric, milieu therapy, PT/OT services, and multiple daily group sessions inpatient psychiatric unit at Indiana Regional Medical Center in Indiana, PA. Patients typically stay 7-14 days at BHS and receive medication management provided by PT staff, nursing staff, and social work staff. Social work responsibilities include discharging the patients to an appropriate level of care and providing clinical services and support. The number of participants in group sessions varies from day-to-day depending on the number of patients in the unit. The author was interested in examining the efficacy of group ACT with geriatric psychiatric patients. For this study, the author ran a three-session "open" ACT group for patients on the unit. The sessions were held on a Monday, Tuesday, and Friday. Each session was approximately an hour in length.

## OBJECTIVES

The author hypothesizes that a 3-session group ACT treatment will be an effective transdiagnostic intervention. He hypothesized that the intervention will decrease client's depression symptoms as measured by the Geriatric Depression Score-15 (GDS-15) and will increase their psychological flexibility as measured by the Acceptance and Action Questionnaire II (AAQ-II). The author also hypothesizes that ACT's use of psychoeducation, metaphor, mindfulness, discussion and interactive activities should be especially beneficial to geriatric clients with clients with dementia and cognitive impairments.

## PRINCIPLES OF ACT

The author hopes that, although they might not express it in the following terms, the participants will have a basic understanding one or more of the following core concepts of ACT covered in the three-session ACT intervention.

Contact with the Present Moment
- This principle is about bringing the patient's attention to various aspects of their current experience such as their breath, body sensations, thoughts, etc.

Willingness/Acceptance
- This principle is about getting the patient to focus on his/her experience the present without trying to change it. It is also about educating patients that people are partially conditioned to feel that they should have experiences and emotional states. If patients do not have those experience or emotions, they often can question themselves and feel "broken."

De-fusion
- This principle focuses on getting patients to recognize their thoughts as only their thoughts. It helps them have the meta-awareness to know that every thought that bounces into their head is not true.

Self-as-Context (The Observing Self)
- PART I Conceptual Self:
  - This principle focuses helping patients understand that we use certain types of relations to build identities.
- PART II Self-as-Process:
  - This principle focuses on strengthening a meta-awareness about thoughts, feelings, and sensations.

Values
- This principle is about helping the patient identify values and goals that are important to them.

Committed Action
- This principle is about helping the patient establish a path between his/her actions and his/her values and goals. The meaning and reward patients experience when they move toward their values and goals will help motivate them to move forward despite discomfort (Westrup & Wright, 2017).

## INTEGRATED HEALTHCARE COMPETENCIES

The Baker Fellowship emphases the Integrated Behavioral Health and Primary Care competencies. The author is focusing on the following four competencies:

**Interpersonal Communication** – The author communicated with patients and staff.
**Collaboration and Teamwork** – The author worked on the unit's interdisciplinary team.
**Intervention** – The author learned and implemented an evidence-based intervention.
**Practice-Based Learning and Quality Improvement** – The author made adjustments to the intervention as necessary (SAMHSA-HRSA, 2014).

## MATERIALS AND METHODS

The intervention consisted of three sessions of group ACT therapy. The intern used *Learning ACT for Group Treatment: An Acceptance and Commitment Therapy Skills Training Manual for Therapists* as his principle guide. Every session was adapted to the participants interests and abilities, but the intern did his best to follow a rough session schedule (Table 1).

Session Curriculum & Schedule (Table I)

| | |
|---|---|
| Session #1 | Housekeeping/ACT Conceptualization/Creative Hopelessness Activity/Contact the Present /Willingness/Mindfulness |
| Session 2 | Willingness/De-fusion/Contacting the Present/Self-as-Context/Mindfulness |
| Session 3 | Self-as-Context/Mindfulness/Values/Committed Action/Wrap-up |

Post-Session Survey questions (Table II)

| |
|---|
| QUESTION I: How are you feeling today? (1 is terrible, 10 is fantastic) |
| QUESTION II: On a scale of one 1 to 10 (1 is not at all helpful and 10 is extremely helpful) how helpful was today's session? |
| QUESTION III: What did you like most about today's session? |
| QUESTION IV: During the session, did you learn something about any of the following six concepts. If so, circle the ones you learned.<br>1. Being present<br>2. Remembering or clarifying what is important to me (my values)<br>3. Doing what is important to you (living according to my values)<br>4. Noticing myself as an observer<br>5. Unhooking from difficult thoughts<br>6. Accepting things just as they are (instead of fighting my feelings) |
| QUESTION V: Is there anything you are confused about that you would like Alex to explain more |
| QUESTION VI: Is there anything Alex could do to improve his group in order to help you better? |

The intern administered two psychometric instruments, the Geriatric Depression Survey (GDS-15) and Acceptance and Action Questionnaire-II (AAQ-II), to willing participants after the first session and the conclusion of the final session. The GDS-15 is a 15-item measure that is designed to screen for depression in geriatric adults (Fig. I). On the GDS-15, higher scores more strongly suggest depression and a score of >5 suggests depression. The AAQ-II is a seven question Likert type scale that measures that measures psychological flexibility (Fig II). On the AAQ-II, higher scores indicate more psychological inflexibility and a score above 24-28 suggests clinical distress (Bond et al., 2011).

At the end of each session, six question self-report post-session surveys were administered to participants to help the author gather data on his intervention (Table II). The first two questions of the post-session survey were scale questions. Questions three, five, and six were created for continuous improvement purposes. Question four corresponds to the six skills of ACT as illustrated in Fig. III and Fig. IV. Figure III illustrates the 6 core ACT skills, and figure IV is a simplified version of figure III. Question four was constructed to help the author verify if he taught the core ACT skills. Participants were also offered a small reference and homework packet created by the author that included summaries of key concepts, worksheets, and mindfulness logs.

Fig. I

AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| never true | very seldom true | seldom true | sometimes true | frequently true | almost always true | always true |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. My painful experiences and memories make it difficult for me to live a life that I would value. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. I'm afraid of my feelings. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I worry about not being able to control my worries and feelings. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. My painful memories prevent me from having a fulfilling life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Emotions cause problems in my life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. It seems like most people are handling their lives better than I am. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Worries get in the way of my success. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Fig. II

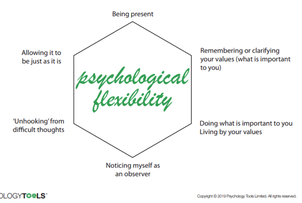
***Instructions**: Choose the best answer for how you felt over the past week.*

| No. | Question | Answer | Score |
|---|---|---|---|
| 1. | Are you basically satisfied with your life? | YES / NO | |
| 2. | Have you dropped many of your activities and interests? | YES / NO | |
| 3. | Do you feel that your life is empty? | YES / NO | |
| 4. | Do you often get bored? | YES / NO | |
| 5. | Are you in good spirits most of the time? | YES / NO | |
| 6. | Are you afraid that something bad is going to happen to you? | YES / NO | |
| 7. | Do you feel happy most of the time? | YES / NO | |
| 8. | Do you often feel helpless? | YES / NO | |
| 9. | Do you prefer to stay at home, rather than going out and doing new things? | YES / NO | |
| 10. | Do you feel you have more problems with memory than most people? | YES / NO | |
| 11. | Do you think it is wonderful to be alive? | YES / NO | |
| 12. | Do you feel pretty worthless the way you are now? | YES / NO | |
| 13. | Do you feel full of energy? | YES / NO | |
| 14. | Do you feel that your situation is hopeless? | YES / NO | |
| 15. | Do you think that most people are better off than you are? | YES / NO | |
| | | TOTAL | |

(Sheikh & Yesavage, 1986)

Fig. III

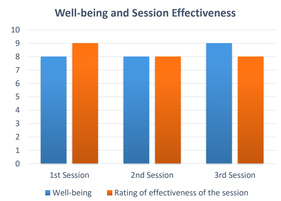

Fig. IV

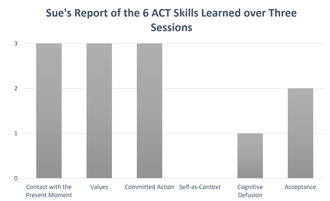



## RESULTS

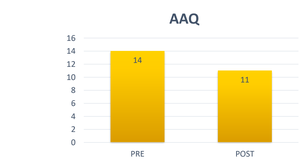
Out of all the residents, only one patient was on the unit Monday through Friday, filled out an initial and post AAQ-II and GDS-15, and three post-session surveys. The patient, "Sue", was a Caucasian 68-year-old female with a diagnosis of Major Depressive Disorder, recurrent episode, moderate and Delusional Disorder, erotomaniac type, continuous. She had an initial AAQ-II score of 14 and a GDS-15 score of 1. Her post-intervention GDS-15 score was 2 and her post AAQ-II score was 11. Her well-being self-reports over the three sessions were 8, 8, and 9. Her rating of the effectiveness of each session were 9, 8, and 8. In summary, Sue's well-being increased one point from the start, her GDS-15 increased by 1, and her AAQ-II dropped by 3. Despite the author's inexperience as a clinician, Sue rated the helpfulness of the sessions as an average of 8.3 out of 10 by Sue.

In the first session, Sue most liked "listening to other people's problems". In the second session, she most enjoyed "speaking of true thoughts." In the final session she most liked "open discussion." Regarding the the six domains of ACT, in the first session, Sue reported learning about: making contact with the present moment, values, and committed action. The second session Sue noted learning about: making contact with the present moment, values, committed action, cognitive defusion, and acceptance. In the final session she recorded learning about: making contact with the present moment, values, committed action, and acceptance. The author appeared to clearly communicate the skills of contacting the present moment, values, and committed action, although apparently did not clearly explain self-as-context to Sue as she reported not learning about it in any of the sessions.








## CONCLUSION & IMPLICATIONS FOR SOCIAL WORK PRACTICE

The patients in this study benefited from the mindfulness experiences and the metaphors of ACT, so ACT has potential to be effective in groups and with the geriatric population and author suggests all social workers gain a familiarity with ACT. ACT can be powerful in short-term treatment because it does not focus on having patients "struggle" with thoughts or emotions but encourages acceptance of their personal situation and making action towards values goals.

In addition, social workers who work with geriatric patients should be aware of the limitations older people face. When working with geriatric individuals, social workers should consider simplifying their language, speaking slowly and loudly, asking lots of questions, providing interactive exercises, and incorporating reminiscence activities. Even if social workers do not work directly with geriatric patients, all social workers would benefit in getting educated about geriatric clients since there are an increasing number of older adults in the U.S.

## LIMITATIONS

Although ACT is an evidence-based modality, the author faced many challenges in implementing group ACT therapy in a inpatient geriatric setting. First, many patients were cognitively unable to participate in the study. Secondly, since the group was "open," some patients were discharged or entered the group in the middle of the study and were therefore disqualified from the study. Due to the factors above, this intervention necessarily become a single case study - an unexpected but interesting outcome. In addition, the one patient that met the requirements for the study was not very depressed as evidenced by her low GDS-15. She did; however, have other psychiatric problems that led her to the unit.

Finally, due to the inpatient setting, there are many inherent confounding variables. Patient improvements while on the unit are (to an unknown degree) due to the psychotropic and medical medication management, medical care, and socialization with peers and staff. Despite the many challenges, the author feel this study was a very valuable learning experience that increased his competence in integrated healthcare and evidence-based social work practice.

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# University of Pittsburgh
School of Social Work

# Behavioral Healthcare Tracking


Angela Padovano & Holly Seng, Edith Baker Integrated Healthcare Fellowship

Allegheny Health Network

## Introduction/Background

The Positive Health Clinic (PHC) is located on the Northside of Pittsburgh, Pennsylvania, and is serving around 1000 patients who are diagnosed with HIV, some of these patients also seek their primary care there. The PHC is a part of Allegheny Health Network. Many patients have co-morbidities and mental health diagnoses. The PHC is an integrated and interdisciplinary care facility. Along with the medical team, the social services team aims to serve the psychosocial needs of the patients at the PHC. The PHC operates from the perspective of the harm reduction model. This approach is used in treatment, in encouraging safer drug use, and in other aspects of one's psychosocial and everyday living. The aim of the harm reduction approach is to reduce more immediate and harmful consequences of drug use through realistic programs. This approach has been adapted to be used for other behaviors that may cause harm and aims to reduce the harm. The harm reduction model aims to empower patients in their everyday lives, with the goal of reducing harm based on the individual patient's abilities and desires to change.

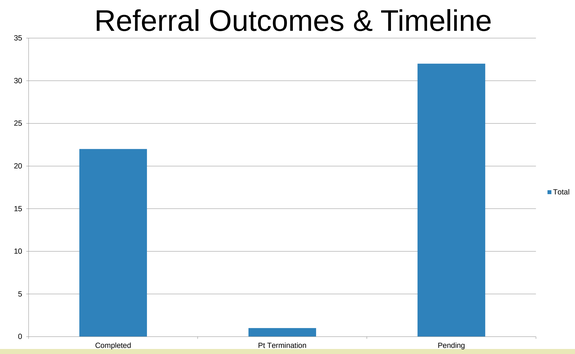
## Research Question

Will tracking behavioral health referrals and engagements ensure adequate continuity of care, intervention, and follow-ups? How does the ongoing tracking of behavioral health services increase the integration of care and present gaps in services?

## Research Method: Descriptive

We used a descriptive research method, which did not include a hypothesis prior to starting the research, but rather focused on patterns and current state of patient involvement in behavioral health services both internally at the PHC and externally in the community.

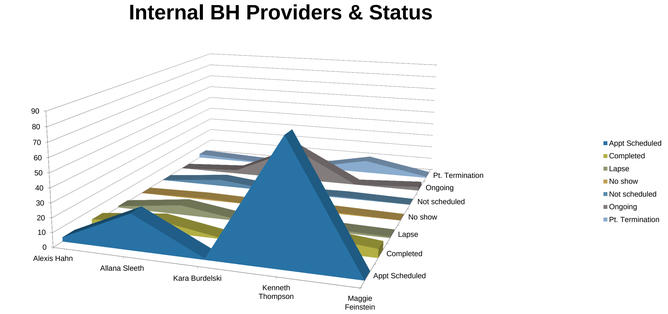
Social Work Interns created the Behavioral Health Tracking Device through Excel Spreadsheet, to track the incoming referrals and patients actively engaged in behavioral health treatment, both internally at the Positive Health Clinic, and externally, in the community. Within the spreadsheet, patients' names, behavioral health provider, their PHC provider, social worker, and RN are tracked to ensure adequate communication and follow-up with all disciplines involved. Social Work interns update the behavioral health tracking device once a week. The main point of concern is for those patients being initially referred and ensuring that they are connected with the best-fit behavioral health provider.

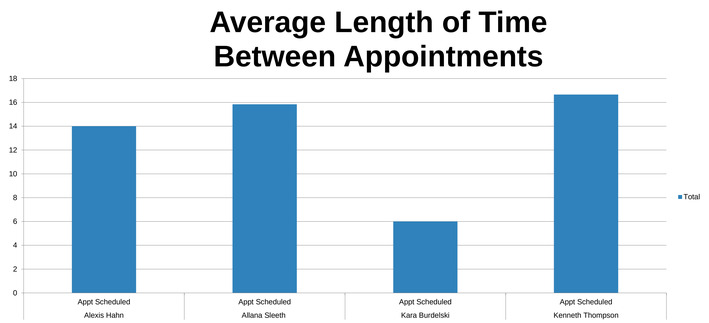


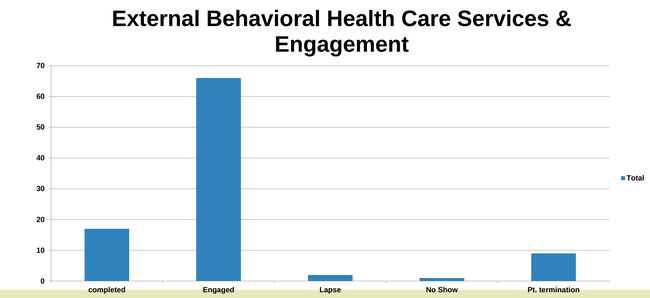

## Results/ Findings

- There is a gap in services and individual counseling offered to individuals who have particular types of insurance, such as Medicare and Medicaid.
- Lack of compliance to engage with psychiatrist is the highest among all of the other behavioral health providers, both internally and externally. Patients either no show or cancel appointments with psychiatrists more than any other type of behavioral health care.
- The tracking device illustrates the need for more therapists and psychiatrists available on site to patients so that they do not have to be referred elsewhere.
- Need to have more services available in the community for dual-diagnoses of both substance use and mental health disorders.
- Length of time between appointments is higher for psychiatry than other mental health services.

## Descriptive Results




## Integrated Health Care Competencies & Implications to Social Work Practice

1. Cultural Competence and Adaptation: The ability to provide services that are relevant to the culture of the consumer and their family.
- The PHC recognizes that its patient population is very diverse as HIV does not discriminate to a particular race, sexuality, socioeconomic status, etc. Team members educate each other on different needs as they pertain to patients, such as sexual preferences, different methods of safe sex, and use of different gender pronouns based on patients preferences.

2. Systems Oriented Practice: the ability to function effectively within the organizational and financial structures of the local system of healthcare.
- At the PHC, the entire health care meets each morning to discuss patients that have appointments that day in the clinic and any other outstanding concerns. The only other patients that are discussed in morning report related to behavioral health services are those patients that are in rehab and inpatient treatment programs

3. Care Planning and Coordination: the ability to create and implement integrated care plans, ensuring access to an array of linked services, and the exchange of information among consumers, family members, and providers.
- All members on the integrated health care team communicate regarding different services and care that patient is engaged in, including specialty care, behavioral health services, and community services.

4. Intervention: the ability to provide a range of brief, focused prevention, treatment and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses.
- The harm reduction approach is used for everything at the PHC, including substance use, use of finances, use of resources, medication compliance, and maintaining overall health and well-being.

## Conclusion

This Behavioral Health Tracking device can help to institute a tracking method via the electronic medical record. It is important to ensure that behavioral health tracking is completed in an integrated health care setting, specifically for referrals. The referral spreadsheet ensures that there is adequate follow-up and helps social worker to remain attentive to patients' needs. Overall, the use of a Behavioral Health tracker helps to ensure adequate referrals, intervention, and follow-ups with patients. As well, this project encourages an increase in integrated health care and the importance of behavioral health care in primary care and specialty care setting.

## Acknowledgments

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UPMC
Altoona Family Physicians

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# SBIRT Program Evaluation

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## INTRODUCTION AND FIELD SITE

The UPMC Altoona Family Physicians office has an 8-8-8 residency program that is the sole residency at UPMC Altoona. They offer a broad clinical experiences in an enriching academic environment with an emphasis on obstetrical, inpatient, and outpatient medicine. Residents spend time in the hospital and office while allowing for an appropriate work-life balance. They receive excellent training in obstetrics and women's health through resident-run Pregnancy Care Center and Women's Health and Wellness Center.

SBIRT
SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

## PROBLEM STATEMENT

June 2018 SBIRT was implemented in the Altoona Family Physicians and Pregnancy Care Center offices.

Goal:
-Conduct a program evaluation on the Pregnancy Care Center implementation of the SBIRT program. The purpose is to analyze the data as per the pre/post survey to recognize when patients are not receiving quality of care. The final outcome will show what can be implemented in order to enhance the efficiency of the SBIRT program in this office.

## BACKGROUND

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.
-The SBIRT Program was recently implemented at the Altoona Family Physicians and Pregnancy Care Center in June, 2018.
-SBIRT has enhanced patient care, improved treatment outcomes and increased provider and patient satisfaction. It is cost- effective care that truly belongs in the primary care setting as a key element of the patient- centered medical home program.

## IHC COMPETENCIES

- **II. Collaboration and Teamwork**- This competency will be addressed based on collaborating with the residents and the PCC nurses to create improvements for the SBIRT research program.
- **III. Screening and Assessment**- There will be pre/post surveys given to assess questions and concerns regarding the SBIRT research program implemented in the UPMC Altoona Family Physicians office and the Pregnancy Care Center in June, 2018.
- **IV. Care Planning and Coordination**-Evaluation coupled with the SBIRT protocol leads to increased effectiveness of care planning and coordination as it continually addresses individual needs of patients.
- **V. Intervention**- The intervention for this project is the pre/post survey given to all residents and the Pregnancy Care Center nurses.

## METHODS

1. Develop pre/post surveys to elicit resident, physician assistants and PCC nurse input.
2. Work with faculty, students, and staff to create a better implementation flow.
3. Provide different discussions and training opportunities for residents, physician assistants and nurses to better understand how an interdisciplinary team functions.

Questions surveyed to the residents, nurses, and PA's were:
- Would you use a more efficiently developed screening method for patients already in treatment?
- Do you document SBIRT in the electronic health record (EHR)?
- Do you complete a brief intervention for all SBIRT positive patients every time?
- What are the barriers or limitations with the new SBIRT program?
- Would you be more inclined to address SBIRT if you had more time with your patients?

## PRELIMINARY RESULTS

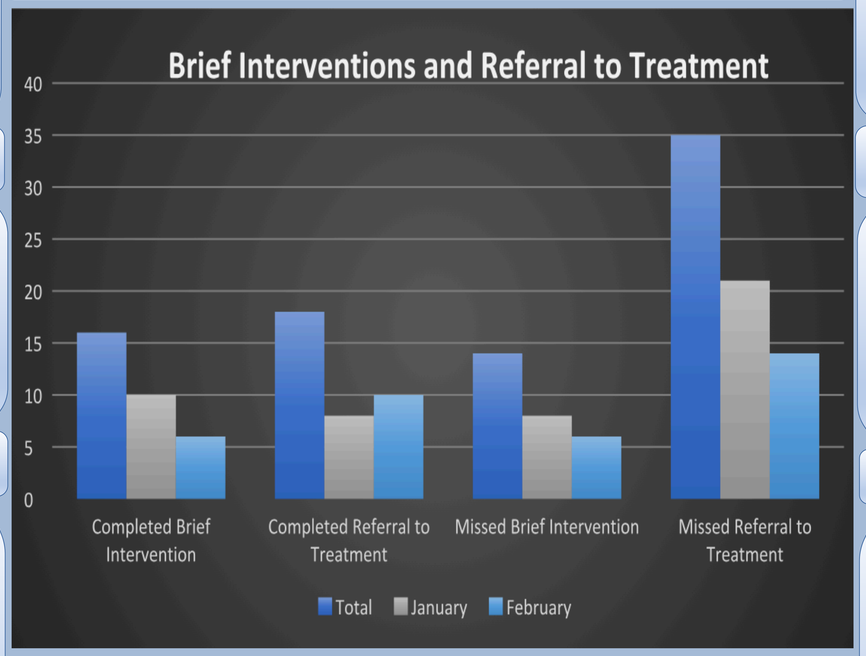


*Figure 1 illustrates results from UPMC Altoona Family Physicians residents and Pregnancy Care Center nurses survey questions regarding brief interventions and referrals to treatment. See the methods sections for survey questions.*

Total number of patients seen in January: 318
Total number of patients seen in February: 277
Total number of patients seen: 595

## PRELIMINARY RESULTS, cont.

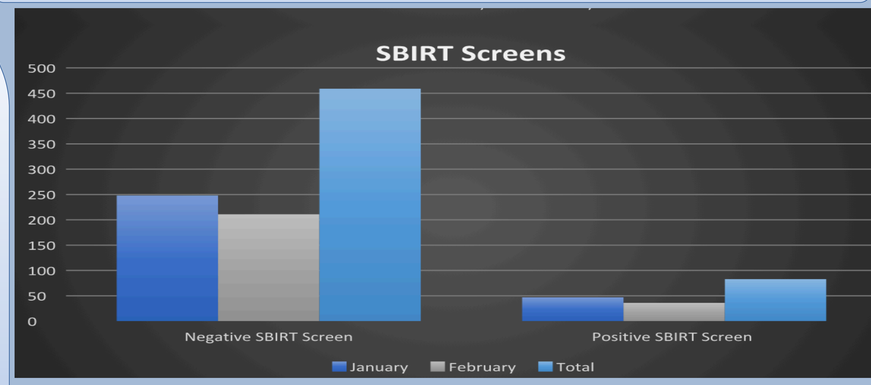


*Figure 2 illustrates the number of positive and negative SBIRT screens for the months of January and February.*

Total number of SBIRT positive patients: 83
Total number of SBIRT negative patients: 459
Total number of patients seen in January: 318
Total number of patients seen in February: 277
Total number of patients seen: 595

## FUTURE DIRECTION

1. Implement a second care coordinator to review and score waiting room screenings.
2. SBIRT Booster Training.
3. Develop an electronic screening process.
4. Add an additional 5 minutes with the patients for the residents.
5. Motivational Interviewing Training.
6. Adjust screening questions that refer to partner or peer substance and/or alcohol abuse..
7. Provide educational brochures on SBIRT, domestic violence, substance abuse, etc.

## IMPLICATIONS FOR SOCIAL WORK

This study has highlighted the need for continued program evaluation so that changes to the work flow can be made to provide more individualized care. As social workers, we should be advocating for the implementation of an interdisciplinary care team to address the needs of patients with high utilization.

Limitations are that this study's results are generalizable only to the implementation of SBIRT in the UPMC Altoona Pregnancy Care Center.

## REFERENCES AND ACKNOWLEDGEMENTS

This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, M01HP31376, Behavioral Health Workforce Education and Training (BHWET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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University of Pittsburgh
School of Social Work

# Addressing Identified Financial Barriers to Pediatric Healthcare

**Carolin Fan, Anna Frantz, Miranda Gray, Haley Lipton, Carolyn Prutting**
**Edith Baker Integrated Healthcare Fellowship**

UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

## UPMC Children's Hospital of Pittsburgh

UPMC Children's Hospital of Pittsburgh is located in an urban setting and has 415 beds, with a 62-bed emergency department, a 36-bed intensive care unit, and a 12-bed cardiac intensive care unit.

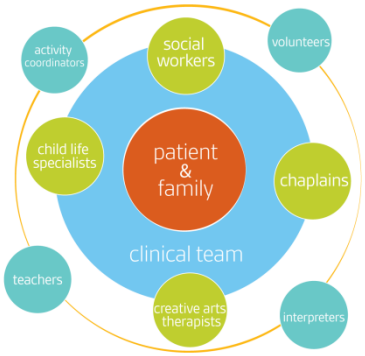
*UPMC Children's Hospital of Pittsburgh*
*4401 Penn Ave, Pittsburgh, PA 15224*

## Introduction

Financial expenses continue to present various obstacles for patients and families accessing both inpatient and outpatient services at the Children's Hospital of Pittsburgh of UPMC. Identifying financial barriers and community resources for patients and their families is an imperative component of integrated healthcare social work practice in an acute healthcare setting. Financial expenses often present as some of the main biopsychosocial stressors related to medically complex patients and their families. Parking, transportation, childcare, housing, and food costs are some of the identified financial needs for diverse patients at this particular facility. It is important to acknowledge that the presenting needs of each family differ greatly and require individualized interventions. To effectively address these needs, it is important for social work staff to identify the systemic issues that impact families and their ability to be at bedside during their child's hospital admission.

## Project Goals

This student project is designed in response to identified gaps in funding available to families and patients who greatly rely on the financial assistance provided by the CHP Social Work Department. It is the goal of this project to explore the biopsychosocial impacts of financial stress on patients and families at the Children's Hospital of Pittsburgh of UPMC and to identify culturally competent solutions to current funding difficulties.




## Research Question

How can integrated hospital social workers more effectively identify and assess the various financial barriers evident in pediatric hospital settings for patients and families?

## Financial Barriers to Care

- Transportation
- Hospital parking
- Housing
- Food insecurities
- Childcare for siblings who remain at home
- Lack of hospital funding sources

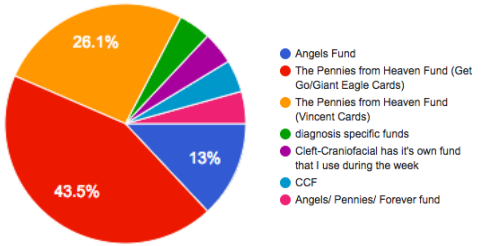
*"Socioeconomic conditions underlie many health inequalities and compel attention to social policies that affect health, strengthening existing programs that can reduce disparities, and shifting health financing to reward improvements in individual and community health." (Adley, Glymour, & Fielding, 2016)*

## Integrated Healthcare Competencies

IV. Care Planning & Care Coordination
VI. Cultural Competence & Adaptation
VII. Systems Oriented Practice
VIII. Practice-Based Learning & Quality Improvement

## Current Funding Sources for the Social Work Department

Multiple service-specific funds are available for social workers at UPMC CHP to utilize in helping address financial barriers to care for patients and families who seek inpatient and outpatient hospital services. From a survey implemented to the social work department at CHP, the following funds were identified.




- *Enduring Hearts*
- *Pennies From Heaven*
- *Mother's Hope*
- *Muriel's Breath of Life*
- *Forever Fund*
- *Angels Fund*
- *Diabetes Family Financial Assistance Fund*
- *Jereme Dudzinski Foundation Fund*
- *Children's Cancer Fund (CCF)*
- *Sickle Cell Family Fund*
- *Cystic Fibrosis Pediatrics*
- *Cystic Fibrosis Adults*
- *Jameson's Army*
- *Zachary's Mission*
- *General Transplant Fund*
- *Grady's Decision*
- *NCCS (National Children's Cancer Society)*

## References & Acknowledgements

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*Adley, N. E., Glymour, M. M., & Fielding, J. (2016). Addressing Social Determinants of Health and Health Inequalities.Vital Directions for Health and Health Care Initiatives, 1641-1642.*

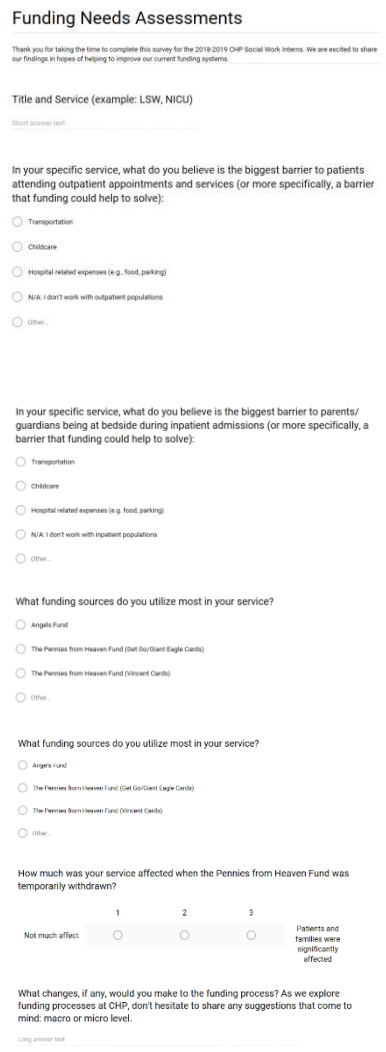
University of Pittsburgh
School of Social Work

# Addressing Identified Financial Barriers to Pediatric Healthcare

**Carolin Fan, Anna Frantz, Miranda Gray, Haley Lipton, Carolyn Prutting**
**Edith Baker Integrated Healthcare Fellowship**

UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

## Method: Survey of Social Work Department at CHP



Funding Needs Assessments

Thank you for taking the time to complete this survey for the 2018-2019 CHP Social Work interns. We are excited to share our findings in hopes of helping to improve our current funding systems.

Title and Service (example: LSW, NICU)

Short answer text

In your specific service, what do you believe is the biggest barrier to patients attending outpatient appointments and services (or more specifically, a barrier that funding could help to solve):

- Transportation
- Childcare
- Hospital related expenses (e.g., food, parking)
- N/A: I don't work with outpatient populations
- Other...

In your specific service, what do you believe is the biggest barrier to parents/ guardians being at bedside during inpatient admissions (or more specifically, a barrier that funding could help to solve):

- Transportation
- Childcare
- Hospital related expenses (e.g. food, parking)
- N/A: I don't work with inpatient populations
- Other...

What funding sources do you utilize most in your service?

- Angels Fund
- The Pennies from Heaven Fund (Get Go/Giant Eagle Cards)
- The Pennies from Heaven Fund (Vincent Cards)
- Other...

What funding sources do you utilize most in your service?

- Angels Fund
- The Pennies from Heaven Fund (Get Go/Giant Eagle Cards)
- The Pennies from Heaven Fund (Vincent Cards)
- Other...

How much was your service affected when the Pennies from Heaven Fund was temporarily withdrawn?

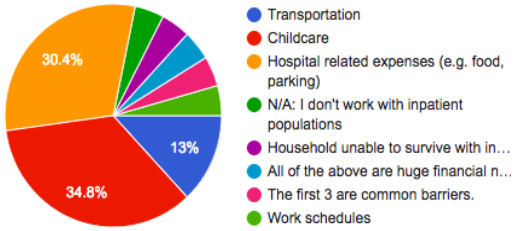
| | 1 | 2 | 3 | |
|---|---|---|---|---|
| Not much affect | ○ | ○ | ○ | Patients and families were significantly affected |

What changes, if any, would you make to the funding process? As we explore funding processes at CHP, don't hesitate to share any suggestions that come to mind: macro or micro level.

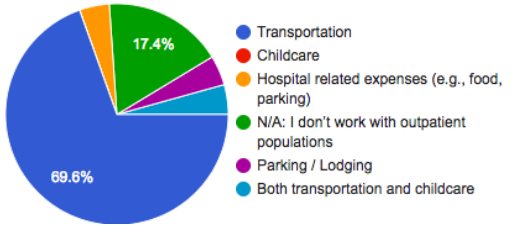
Long answer text

## Results

### Inpatient Barriers to Care




### Outpatient Barriers to Care




### Themes

- Travel expenses
- Greater weekly financial assistance to allow for more presence at bedside
- Financial assistance distribution based on specific needs only
- Equity of service; more funds for general inpatient stays
- Communication between foundations and the SW Department
- Improved guidelines for fund disbursement

## Proposed Solutions

**Designate Funds for Specific Needs:** Distribute funds for specific patient and familial needs in the form of gift cards for parking, transportation, and/or meals

**Transportation:** Encourage patient enrollment in Medical Assistance Transportation Program (MATP) in order to conserve financial assistance funds

**Financial Counseling Services:** Representative Payee available to families to assist with medical and personal bills

**Screen for Social Determinants of Health:** Assess need for ancillary emergency funding to appropriately allocate funds and/or resources

**Connect to Outside Resources and Community Supports:** Maintain updated list of community resources to connect families with community supports

**Reform Guidelines and Communication in Regard to Funds and Foundations:** To streamline allocation of funding and maintain open communication with funders and foundations

## Impact in the Community

It is our hope that the proposed solutions will benefit the lives of patients and families in our community on all levels.

**Micro**: patients and families will be able to access integrated healthcare facilities and receive high quality, collaborative care in both inpatient and outpatient settings. It is our hope that families will experience less fear of socioeconomic barriers hindering successful treatment.

**Mezzo**: interventions will help to address the financial needs of the family system across multiple facets of their lives while holistically addressing social determinants of health.

**Macro**: these efforts will help to properly ameliorate social determinants of health and subsequent barriers to effective care. As a result, the health of our community will slowly improve as financial burden decreases.

## References & Acknowledgements

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University of Pittsburgh
School of Social Work

UPMC Magee-Women's Hospital

# Pilot Project for Decreased 7-Day Readmissions

UPMC LIFE CHANGING MEDICINE

**Mackenzie Danzer and Courtney Powell, Edith Baker Integrated Healthcare Fellowship**

## Background

High rates of readmissions are commonly seen within 30 days after discharge. Decreasing these rates is a focus in healthcare reform due to readmissions being costly, common, and avoidable. These rates are can indicate poor patient care. Factors for increased risk vary drastically among populations (Vest et. al, 2010). Identifying preventable readmissions, improving quality of patient care, and others can be used to decrease readmission rates (Goldfield, 2010).


## Issue

Increased 7-day readmission rates in hospitals indicates an area of improvement in patient care.

Focus areas to improve patient care are:

- Consulting specialties
- Creating plans of care for medically complex patients
- Involvement for follow-up care
- Increase compliance through patient education
- Identify high risk patients for readmission

## Method

### Location

Pilot program implanted on General Medicine Unit at UPMC Magee-Women's Hospital.

### When

Project began on November 1, 2018.

### Implementations

•Educating staff on readmission prevention

•Readmission dashboard

•Morning care coordination rounds and afternoon "lightning rounds"

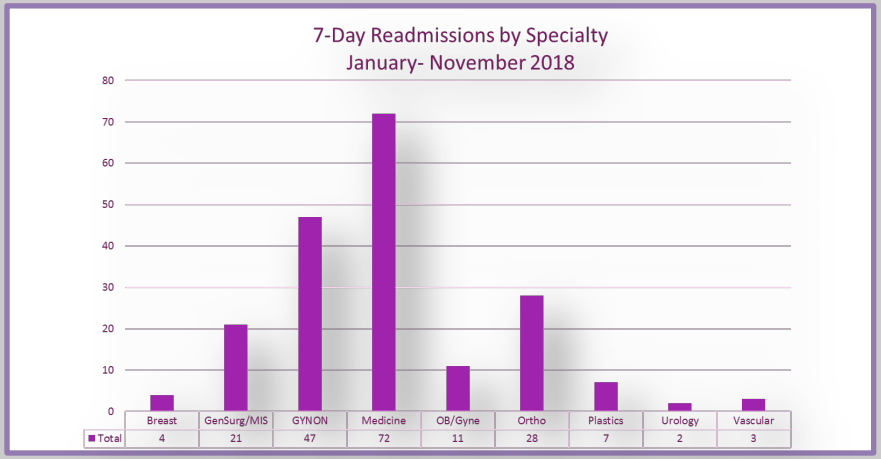
•Medication reconciliation

•Increased collaboration with specialties

•Follow up phone calls

•ED Uturn

•Identifying high-risk patients




## Future Plans

### Next Steps:

- Schedule follow up appointments prior to discharge
- Implement on other units within the hospital
- Engage outpatient clinical staff in follow up process
- Physician champions
- Incorporate valuable professionals into readmission task group

## Impact on the Community

The reduction of readmission rates in hospitals will increase the quality of patient care. Patients and hospital will experience less financial strain from a reduction of readmission rates. Placing a focus on patient care will improve overall population health.

## Competencies

- Collaboration and Teamwork
- Care Planning and Care Coordination
- Practice Based Learning and Quality Improvement

## References & Acknowledgements

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# 412 Food Rescue Improving Healthcare

University of Pittsburgh
School of Social Work

Meghan GaNung
Edith Baker Integrated Healthcare Fellowship

UPMC LIFE CHANGING MEDICINE

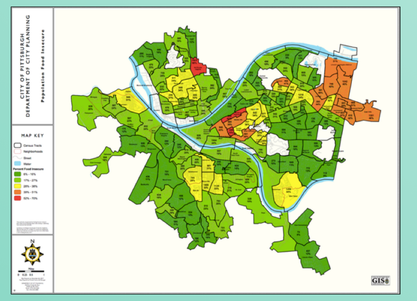
## Background

412 Food Rescue is an organization that created a way to combat food insecurity in the Greater Pittsburgh area. UPMC Matilda Theiss Health Center is a recipient of this program. Patients receive a food donation from 412 every four weeks. The intended goal of this intervention is to improve the quality and access of food our patients receive, ultimately increasing their overall health. The purpose of this research is to provide similar clinics with evidence behind this intervention.

## Research Question

**Is the patient's access to nutritional food improving their overall health?**

- According to The Journal of Nutrition (2004), "Adults in food-insecure households were significantly more likely to rate their health as poor/fair and scored significantly lower on the physical and mental health" (Stuff, Casey, Szeto, & Gossett 2004).
- According to the Journal of Health Care for the Poor and Underserved, "food insecurity was associated with fair/poor health status in the community health center population" (Alvarez, Lantz, Sharac & Shin 2015).
- According to the Journal of Health Psychology, "Young adults with a history of food insecurity had higher average levels of body mass index, waist-to-height ratio, depressive symptoms, stress, and disordered eating scores than individuals with no history of food insecurity" (Darling, Fahrenkamp, &Wilson, 2015).




The graph above documents food insecure communities within the Pittsburgh area. The Hill District, which is where Matilda Theiss is located is pictured in the middle of this map. The community is distinguished by red and orange colors, representing 39-70% individuals being food insecure.

## IHC Competencies

- **Interpersonal Communication:** While patient's attend food deliveries, staff will create positive conversation, building rapport with patients.
- **Cultural Competence:** Theiss staff recognized the disparities in healthcare for our patient's due to lack of nutrition. Address this problem through 412 Food Rescue.
- **Intervention**: While patient's are picking out their food, Theiss staff will provide health promotion.
- **Collaboration & Teamwork**: Fellow will work with Theiss staff as well as 412 Food Rescue to better understand the benefits this intervention has had with patient's health at the clinic.

## Study Design

- Mixed Methods
- IRB Approved Quantitative Surveys- Anonymous

*For purposes of this study, the research focuses on the first 12 questions of this survey. The questions used were 1) I am satisfied with the food provided by 412 Food Rescue 2) I am satisfied with the variety of food 3) I use nearly all of the food I take 4) I will try new foods provided by 412 Food Rescue 5) Because of 412 Food Rescue I eat healthier 6) Food provided by 412 Food Rescue helps make ends meet 7) Because of 412 Food Rescue I get to make more choices about the kinds of food I eat 8) Because of 412 Food Rescue I can put money elsewhere 9) I am less stressed because of 412 Food Rescue 10) I am more connected with my community because of 412 Food Rescue 11) The food is distributed fairly 12) It is east to find out how to use the food provided by 412 Food Rescue. Answers were ranked by Strongly Disagree, Disagree, Agree, Strongly Agree. The graph titled 412 Food Rescue Survey is grouped together by having more then 3 of a cluster answer.*

- Qualitative interviews with Staff

*Five staff members were asked 1) If they thought having access to nutritional food improves a patients health 2) If they have seen a difference in patients since they have been receiving food donation 3) Do you refer patients to the food donation. Answers were yes, no.*

## Location

- Matilda Theiss Health Center
- March 5th, 2018
- 17 participants

## Results

A majority of the survey answers were in favor of the positive impact that 412 Food Rescue has had on their food access. The highest scored answer for this survey was that the individual could pay for other financial expenses. The lowest disagreed answer was that I nearly use all the food that I take. Staff interviews provided evidence that the food distribution has been effectively changing patients health outcome. Professional staff all agreed that having access to nutritional food benefits an individuals health. Providing food donation has built rapport with patients and the clinic, allowing them to depend on this food distribution to feed themselves and their families. All professional staff refer patients to this food donation if they believe the patient needs food aid.

## Results

This intervention is intended to provide evidence of increased positive health.

Outcome Goal: Access to nutritional food
Outcome Goal: Increased health of patient

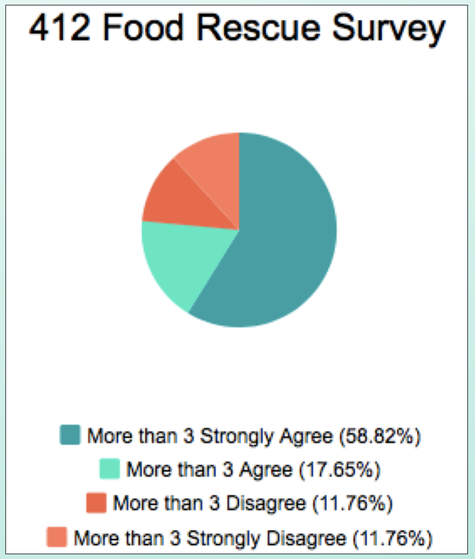



*Figure 1 illustrates results from 412 Food Rescue Survey. See section Study Design to reference survey questions.*

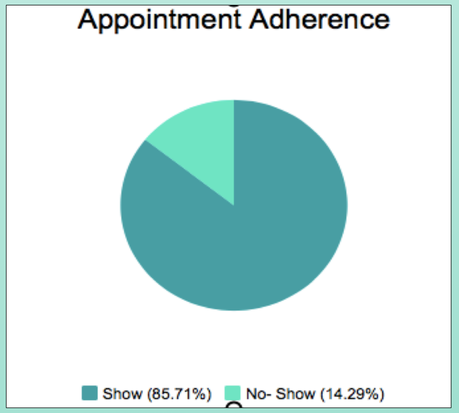



*Figure 2 illustrates the appointment adherence on March 5th for doctor, nurse, nutrition, and social work.*

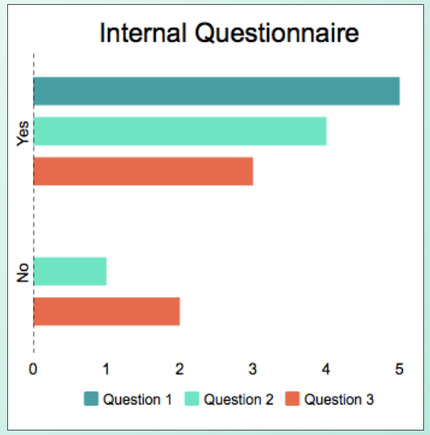



*Figure 3 illustrates results from Matilda Theiss staff interview questions. See section Study Design to reference interview questions.*

## Implications for Social Work Practice in Healthcare

This research indicated that there is a direct correlation between patient's having their basic nutritional needs met and their health. According to Maslow's theory of Hierarchy of Needs, an individual needs to have their basic needs met in order to conquer the next level of needs. The hierarchy proceeds as physiological, safety, love/belonging, esteem, and self-actualization. The 412 Food Rescue has been an intervention to meet patient's physiological needs. Results from this research showed that although there has been a positive impact from this intervention, there is still more work to be done. Social Work can always be an advocate to support and provide resources to patient's to get additional help when it comes to their basic needs.

*Limitations include sample size, knowledge of program, severe weather conditions, anonymous participants, access to transportation to the clinic, and lack of comprehension of surveys.*

## Acknowledgements

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*References:*

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University of Pittsburgh
School of Social Work

# Formation of a Weekly Team Huddle in an Integrated Work Environment

Jason A. Zingaro, Edith Baker Integrated Healthcare Fellowship

## UPMC Rehabilitation Institute Presbyterian

The integration of healthcare services is most prominent in a physical rehabilitation setting. The combination of physical, occupational, and speech therapies, along with the services of physicians, social workers, and nurses, is essential to providing the best care possible for patients. Because of this need for integration, it is imperative that each profession have up-to-date information on patients and be on the same page in the treatment process.

## In the past

Historically, team members have met once a week to discuss patients and their progress in treatment. This interdisciplinary team conference involved the combined efforts of each profession to give updates on patient's goals, progress, and discharge planning. It became evident, however, that a weekly meeting was not sufficient for effective communication and best patient care.

"A weekly meeting was not sufficient for effective communication and best patient care."

## The formation of team huddles

As time progressed, the rehab team began implementing additional "team huddles" to try and compensate for the lack of communication. These huddles, however, were time consuming and not conducive to the hectic schedules of each member of the team. As a result, the team strove to find a time efficient and effective form of formal communication.

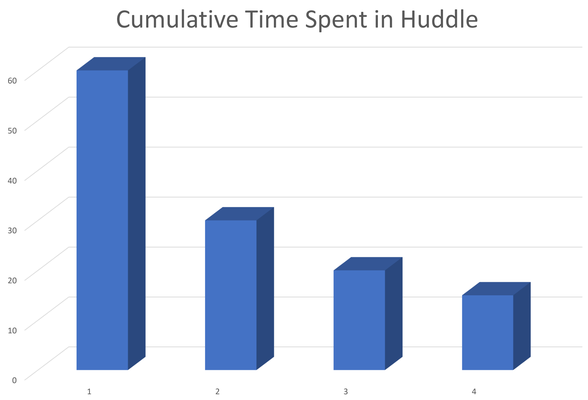
## Competency: Collaboration and Team Work

Effective communication is essential to collaboration and team work in a professional environment

## Progression of team huddles

The evolution of team huddles occurred over many weeks of trial and error.

1. The first attempt at team huddles consisted of meeting bi-weekly (Mondays and Thursdays) for 30 minutes. All team members cycled through and each patient was briefly discussed.




2. The second attempt at team huddles was a weekly meeting (Monday) in which all team members cycled through and each patient was discussed.

3. The third attempt was a weekly meeting (Monday) in which all team members cycled through and select patients were discussed.

4. The final attempt was a weekly meeting (Monday) in which team leaders from each profession talked about select patients.

## Competency: Interpersonal Communication

Team huddles foster interpersonal communication not only among the healthcare professionals, but also patients and their family members.

## Results

The resulting study effectively created a team huddle focused on time efficiency and proper communication. Leaders from each team came together to collectively discuss patients in whom current issues or limitations had arisen. By holding the huddles on Mondays, the team was able to receive weekend updates on the client's progress and rely pertinent information to other members of the team. Effective communication enables team members to create the best plan of care possible and ensure a safe patient discharge.

"The team was able to receive weekend updates on the client's progress and rely pertinent information to other members of the team."

## Importance of team huddles

Team huddles are effectively used for the collective gathering of information on patients and structuring a proper discharge plan. During these huddles, team members discuss the patient's progress and barriers they have encountered. The physical, occupational, and speech therapists inform the team of the patient's physical and cognitive needs and their progress in therapy. The physicians and nurses inform the team of any medical problems that may currently be presenting themselves. The social workers inform the team on progress of discharge planning and the psychosocial strengths and limitations of the patients.

## Competency: Care Planning and Care Coordination

Team huddles are essential to the proper care and planning needed to make a safe discharge while effectively helping patients in their recovery process.

*This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, M01HP31376, Behavioral Health Workforce Education and Training (BHWET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.*

University of Pittsburgh

School of Social Work

UPMC St. Margaret

# Long-term Solutions Provided in an Acute-Care Setting

Jordan Wittekind, Edith Baker Integrated Healthcare Fellowship

## Field Site

The research data in this study was collected at University of Pittsburgh Medical Center (UPMC) Saint Margaret Hospital, located in Pittsburgh, PA. I am completing my concentration fieldwork for the final year of my MSW education at this location.

## Introduction and Purpose

A social worker's primary focus at an acute-care hospital is to assess each patient's needs and ensure a safe discharge from the hospital. Patients' needs vary and can be complex, social needs. Most needs presented can only be addressed outside of the hospital, and they ultimately influence health outcomes. In these cases, social workers provide patients with resources tailored to each patients' needs. Needs identified during this study include medical assistance applications, psychiatrists, methadone clinics, alcohol use resources, smoking resources, & more. Patients often require reinforcement, or encouragement, to follow through with the resource provided, therefore, a follow-up call was made to patients regarding the resource provided. The purpose of this research is to determine if patients have followed through with the resource provided and aims to determine the barriers preventing follow-through. This research will help clarify if calling patients to determine if they have followed through should be part of hospital social workers' duties, and determine if there are inadequate resources provided based on patient feedback.

## Background

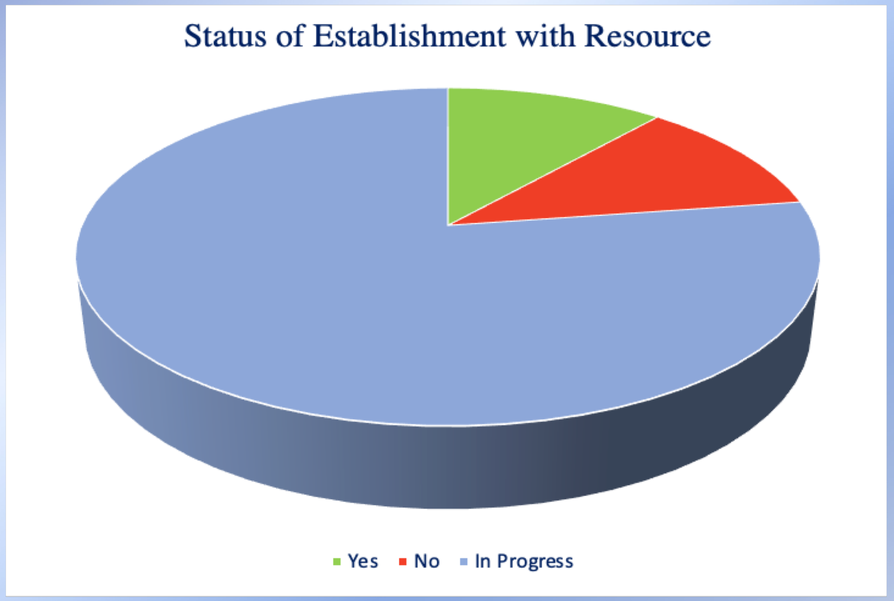
When patients are discharged from the hospital with needs unmet, it can increase the likelihood for hospital readmission. Unplanned readmissions cost between 15 and 20 billion dollars annually (Alper, O'Malley, & Greenwald, 2017). A common cause of readmission is a patient's patient inability to follow through with a portion of a discharge plan. To the doctor, the discharge plan can include instructions for medications and/or when they plan to follow-up as an outpatient. To the social worker, this could be the patient's location for discharge (i.e. home or another facility), or what resources the patient intends on pursuing once returning to the community. There is virtually no research on a patient's likelihood to follow-through with resources provided by a social worker at an acute-care hospital. Perhaps this research will sit at the forefront of a new wave of social work research.

## Method

**Design** This study's design is qualitative research through interview by phone.

**Sampling** The sampling used is nonprobability, purposive/judgmental sampling. Subjects are only included in this study if they were provided a resource by this social worker during an inpatient hospital admission.

**Method** 10 patients were identified, provided a resource, and tracked using each patient's FIN (Facility Identification Number), unique to each patient's particular admission. The patients' demographics, respective resource provided, discharge date, call date, and responses to the phone interview were logged. All information was recorded in an Excel spreadsheet. First, it was recorded if (Yes or No) the patient was able to be reached via phone. For those that answered the phone, this social worker identified herself and refreshed the patient of the resource provided. Next, this SW inquired if the patient was able to follow through with the resource provided, and the patients indicated either "Yes", "No" or "In progress". If the patients were unable to establish themselves with the resource, this SW provided the patient with an opportunity to explain the barriers to becoming established with the resource.




## Results

Of the 10 patients included in this study, 7 were male and 3 were female. The average age of the patients was 54.8, with the youngest being 28 and the oldest being 77. Most patients were Caucasian (9) and there was 1 patient that was African American. Most patients answered this social worker's phone call (6), while 4 did not answer. Of those that answered the phone call, 1 reported they are not established with the resource provided, 1 reported they are established with the resource provided, and 3 reported getting established with the resource provided is in progress. The patient that reported "not established" was provided with alcohol use resources, which included AA meeting locations and outpatient rehab. He noted that he is not established with those resources because he has quit drinking without them, adding that his family is his strongest support. The patients that reported they are "in progress" of getting established with the resource, were provided with resources that take a significant amount of time (sometimes months) to become established, like Medical Assistance and Off The Floor Pittsburgh.

## Implications for Social Work Practice in Healthcare

Social workers aim to fill the gaps in each client's life. In this case, the client is an individual seeking medical treatment. While the individual's physical needs requiring attention can be addressed through medical treatment, there can be additional, sometimes complex, social needs that impact health outcomes. The results of this study show that providing patients with initial education and information on resources while they are still in the hospital, pave the way for patients to establish themselves with vital resources that attribute to their positive health outcomes. By promoting positive health outcomes through providing resources, hospital social workers reduce likelihood for unnecessary hospital readmission, fulfill their duty as a hospital employee, all while fulfilling the National Association of Social Workers' standards for social work practice in healthcare.

## References & Acknowledgements

Alper, E., O'Malley, T. A., & Greenwald, J. (2017). Hospital discharge and readmission. UpToDate. [Epub ahead of print].

*This fellowship is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number, M01HP31376, Behavioral Health Workforce Education and Training (BHWET) Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.*

University of Pittsburgh
School of Social Work

# Assessing Staff Cohesiveness Across Disciplines

Justin Thiry & Jack McClaskey, Edith Baker Healthcare Fellowship

UPMC LIFE CHANGING MEDICINE

## UPMC Addiction Medicine McKeesport Hospital

The Addiction Medicine Unit opened on 2/14/2018 at UPMC McKeesport Hospital. The program includes medical detoxification and short-term drug and alcohol rehabilitation. In addition to substance use disorder, patients generally have a co-occurring medical need that requires hospital-based observation and treatment.

## Issue

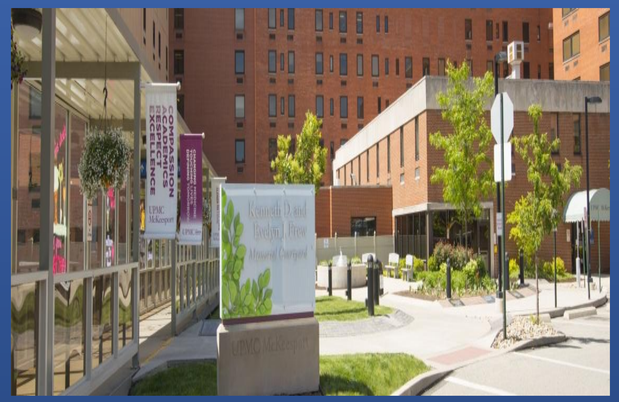
To what degree does staff relationships, perceptions, and cohesiveness impact outcomes on unit?

## Core Competencies for Integrated Healthcare Addressed:

Screening and Assessment, Collaboration & Teamwork, Practiced-Based Learning, Quality Improvement.

## Background

A disconnect exists between staff on the unit that appears to impact effective communication and outcomes for the Addiction Medicine program. Specifically, role perceptions, role responsibilities, and peer/management support seemed to be noticeably insufficient at times.




## Methods

A survey was administered to the entire staff via email. There were seven questions that were intended to measure the *perceptions and roles of co-workers in an integrated healthcare setting.*

The questions were as follows:
1. How supported do you feel by your management/supervisors on the unit?
2. How supported do you feel by your coworkers?
3. Generally, how well do you feel like the responsibilities of roles on the unit are defined?
4. How well do you feel like you understand the roles of your coworkers outside of your discipline?
5. Does knowing your co-workers on a more personal level impact the cohesiveness of the unit as a whole?
6. How much do you think your personal life experience impacted your decision to work on this unit?
7. How much do you think the unit staff cohesiveness impacts the patient's experience on the unit

The responses were measured on a Likert scale. Possible responses were as follows with numerical values assigned to each.

Very much (5), Somewhat (4), Neutral (3), Just a little (2), or Not at all (1).

Responses were anonymous, and 26 staff members participated across all unit disciplines.

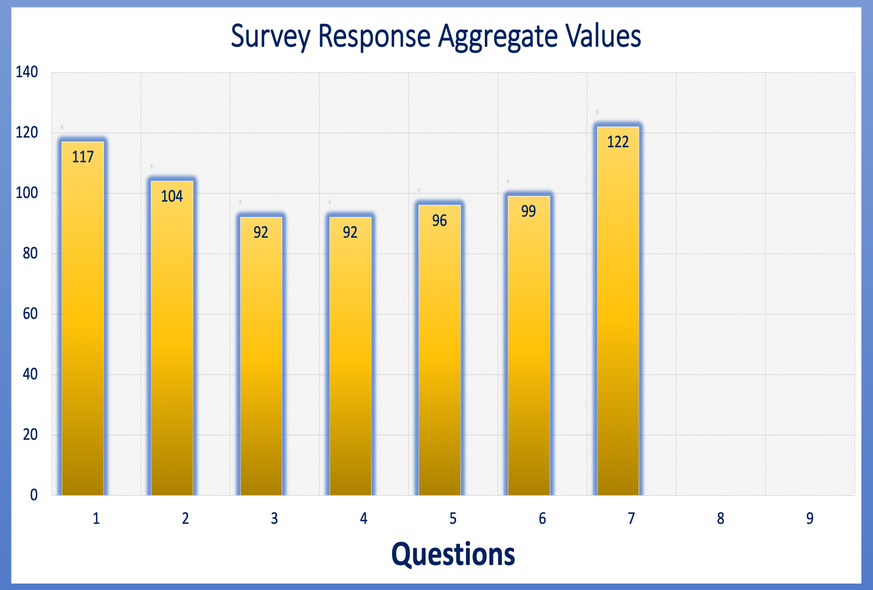
## Proposed Intervention

After the surveys had been administered, a separate document was sent regarding what constitutes assertiveness, non-assertiveness, and assertiveness techniques. Individuals display different levels of assertive behavior depending on situations, environment, personal experience, etc.

An assertive individual exhibits traits such as standing up for self, speaking honestly, and is confident when addressing other people.

The document was sent with the intent to promote assertive communication between the staff on the unit. The belief is that assertive communication can remedy the perceived lack of cohesiveness.

## Survey Results




## Conclusions and Discussion

The responses to questions 3 and 4 may indicate a need for more assertive communication among staff regarding their own role definitions within the program. The responses may also indicate that staff would benefit from clear information regarding the roles of their coworkers. Responses to question 7 seem to indicate the unit staff are aware that cohesiveness, open communication, and interactions with each other do in fact impact the patient experience and overall outcomes of treatment.
A post intervention survey, had time permitted, would have illustrated more clearly the potential impact of staff implementation of assertiveness techniques. Future students on the Addiction Medicine unit may follow-up on this work to pinpoint more effective ways to promote assertiveness, open communication, and clear role definitions for the staff.

## References and Acknowledgements

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University of Buffalo School of Social Work (1999). *Assertiveness, Non Assertiveness, and Assertiveness Techniques*

# Measuring Attitude and Behavior Changes in Adolescent Health

University of Pittsburgh
School of Social Work

Trevor Wideman, Kat Rehberg, Lauren Klingman

Edith M. Baker Integrated Healthcare Fellowship

University of Pittsburgh
School of Social Work

## Introduction and Field Site

One day a week each fellow placed at the Adolescent and Young Adult Medicine Clinic goes to the 412 Youth Zone, a one-stop center for young people ages 16-23 that are transitioning out of the foster care system. Youth there are able to utilize the UPMC health clinic within the Youth Zone to address their medical needs in hopes of reducing rates of emergency department visits. Our program, titled "Healthy You" intended to empower youth to adopt healthier attitudes and behaviors in regards to nutrition and exercise.

## Issues and Research Questions

Data depicts a variety of poor health outcomes among youth from marginalized/disadvantaged backgrounds; thus, Baker Fellows analyzed the impact of CBT and psychoeducational interventions on improving positive health attitudes and behaviors of youth at the 412 Youth Zone.

- According to the *Journal of Adolescent Health* (2016):"Potentially effective interventions for adolescent health and well-being include interventions for adolescent sexual and reproductive health, micronutrient supplementation, nutrition interventions for pregnant adolescents, interventions to improve vaccine uptake among adolescents, and interventions for substance abuse" (Salam, Das, Lassi, & Bhutta, 2016).
- According to the *Children and Youth Services Review* (2018), "In multivariate analysis adjusting for sex, residence, age, race, educational attainment, and income, adverse childhood events were associated with worse general health in adulthood" (Crouch, Stompolis, Radcliff, & Srivastav, 2018).

**Table 3**
General physical health of respondents to 2014-2015 SC BRFSS survey, unadjusted and adjusted for sex, age, race/ethnicity, education, household income, and types of childhood experiences.

| Types of childhood experiences | Good Health | Poor Health | Adjusted Odds Ratio[1] (95%CI) | | |
|---|---|---|---|---|---|
| | Weighted Percentage (Unadjusted)[a] | Weighted Percentage (Unadjusted)[a] | Point Estimate | 95% Wald Confidence Limits | |
| Household dysfunction only | 21.3 | 18.9 | 1.37 | 1.36 | 1.38 |
| Emotional and physical abuse only | 9.0 | 9.3 | 1.48 | 1.46 | 1.49 |
| Sexual abuse only | 1.5 | 1.7 | 1.66 | 1.62 | 1.68 |
| Household dysfunction + Sexual abuse | 1.9 | 2.4 | 1.92 | 1.89 | 1.96 |
| Household dysfunction + Emotional and physical abuse | 20.1 | 24.6 | 1.91 | 1.89 | 1.92 |
| Sexual abuse + Emotional and physical abuse | 1.1 | 1.6 | 2.01 | 1.97 | 2.06 |
| All three categories | 5.9 | 12.4 | 3.63 | 3.60 | 3.66 |
| None | 39.2 | 29.1 | Referent | | |

[a] Differences by health status in characteristics of the respondents, all values $p < 0.0001$.
[1] Predicting poor physical health; adjusted for sex, residence, age, race/ethnicity, education, and income.

The above table pulled from Crouch et al., (2018), shows the percentage of survey respondents who reported "Good" and "Poor" health that suffered adverse childhood experiences (ACE). ACE reported by the respondents are also depicted in the table.



## Methodologies

Our program is a non-experimental design with a pre and post survey to measure health attitudes and behaviors.

**Resources**: 3 healthcare providers, 1 social worker, 3 social work interns, healthcare clinic with medical resources

**Constraints**: no funding for participation incentives, participation rates, no show rates, social determinants of health

**Activities**: 2 counseling sessions with a social work intern, utilizing motivational interviewing ,CBT skills, case management, and care coordination. Weekly check-ins at the clinic to assess goals, track health variables. Healthy social activities provided at the Youth Zone.

**Outputs**: x number of youth enrolled in program, x demographic information of youth (age, race, gender), x number of counseling sessions with social work intern, x number of check-ins at clinic, x number of healthy social activities

## IHC Competencies

**Interpersonal Communication & Care:**

- Baker Fellows met with youth and collaboratively identified barriers, health concerns, goals, and developed exercise/nutrition plans to help youth attain their self-determined health goals.

**Intervention:**

- Fellows used Motivational Interviewing (MI) and CBT techniques during brief counseling sessions with the participants, including: coping cards, homework assignments, journaling, problem-solving and thought records.

**Cultural Competence & Adaptation:**

- Fellows tailored the structure of the "Healthy You" program to meet the specific needs of youth representative of those at the Youth Zone.

**Collaboration & Teamwork:**

- Fellows worked directly with CHP nursing staff and medical providers at the Youth Zone to fulfill any/all medical needs of the participants.

**Care Planning & Coordination**

- Fellows developed/monitored personalized treatment plans educational materials, and psychotherapeutic interventions to facilitate each participant's success within the program.

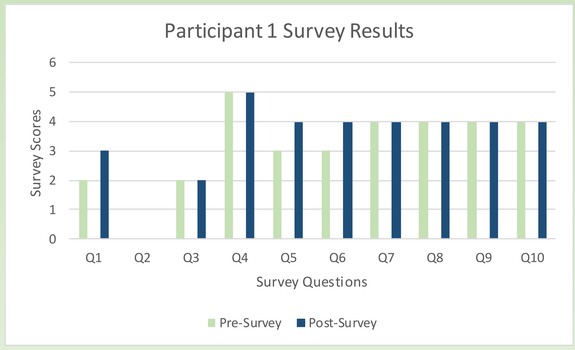
Social Work Fellow Lauren Klingman working with a Youth Zone provider to coordinate care.

## Results

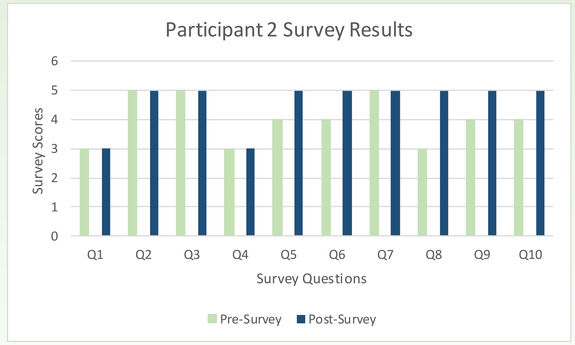
Our program intended to improve health attitudes and increase healthy behaviors.

Outcome Goal: Increase in positive attitudes about health
Indicator: 75% of youth will self-report an increased positive attitude about healthy eating by the end of the program as indicated by an increase of 2 points on the post-survey as compared to the pre-survey

Outcome Goal: Increase in Healthy Behaviors
Indicator: 75% of youth will self-report an increase in healthy behaviors by the end of the program as indicated by an increase in 2 points on the post-survey as compared to the pre-survey




Data for Participant 1 shows an increase in healthy attitudes and behaviors at pre vs post screen. Total score for Participant 1 improved from an initial score of 31 to 34. Participant 1 had an increase of 3 points in questions screening for health attitudes.




Data for Participant 2 shows an increase in healthy attitudes and behaviors at pre vs post screen. Total score for Participant 2 improved from an initial score of 40 to 46. Participant 2 had an increase of 4 points in questions screening for health attitudes and an increase of 2 points for health behaviors.

## Discussion

All questions were coded for screening attitudes or behaviors. The outcome goal for an increase in positive attitudes about health was met with 100% of participants self-reporting an improvement of at least 3 points in pre and post survey comparison.
Only 50% of participants self-reported an increase in healthy behaviors, meaning the outcome goal for behaviors was not met. The program was only able to run for six weeks, limiting time for behavioral changes to manifest.

## Limitations

Our main limitation was our small sample size which was the result of several factors. The adolescents at the youth zone had many psychosocial stressors that could have inhibited them from having the time or transportation to sign up for the program. There was no incentive for enrolling in the program, so youth needed high motivation to make a change.
Most importantly, working with our particular population at the Youth Zone required attention to be paid to social determinants of health. Meeting basic needs was a cornerstone of our project. With our time constraints, it was difficult to address many of the barriers the youth faced such as access to fresh food and means of exercise. Continuing the program would allow youth more time to receive psychosocial interventions from the Youth Zone clinic team, thus increasing their potential for more positive outcomes.

## Implications for Social Work Practice

Our project indicated a need to ensure social workers are non judgmental and meet clients where they are, paying close attention to cultural competence and adaptation. We found that reaching goals can boost self esteem and clients may see a positive impact in other areas of their life, demonstrating the interconnection between physical and mental health. In particular, effective care coordination for clients with unmet medical needs impeding their health goals is necessary for improved health outcomes. Despite our limitations, training clinic staff to provide counseling on reaching health goals has the potential to improve health attitudes and behaviors. Other useful skills include effective interpersonal communication to build rapport and help clients reach their goals. Developing lifelong healthy habits will serve as protective factors for this vulnerable population.

## References and Acknowledgement

Crouch, E., Strompolis, M., Radcliff, E., & Srivastav, A. (2018). Examining exposure to adverse childhood experiences and later outcomes of poor physical and mental health among South Carolina adults. *Children and Youth Services Review,84*, 193-197. doi:10.1016/j.childyouth.2017.11.031

Salam, R. A., Das, J. K., Lassi, Z. S., & Bhutta, Z. A. (2016). Adolescent Health Interventions: Conclusions, Evidence Gaps, and Research Priorities. *Journal of Adolescent Health,59*(4). doi:10.1016/j.jadohealth.2016.05.006

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## Division of Adolescent and Young Adult Medicine

To promote and ensure positive health outcomes for youth through:

Accessible health care services for adolescents and young adults within the context of the individual, family, culture, and community

Interdisciplinary Health Care Models allowing open communication and collaboration between health professionals and providers across various healthcare fields and specialties

Research devoted to understanding, advocating, and addressing disparities and inequities in adolescent health, as well as improving health outcomes

Community Engagement

Children's Hospital of Pittsburgh of UPMC

University of Pittsburgh
School of Social Work

UPMC LIFE CHANGING MEDICINE

# Transportation Accessibility in Emergent Settings

*Bethanie Lee, Edith M. Baker Integrated Healthcare Fellowship*

## Introduction

- UPMC is one of the largest healthcare systems in the nation, headquartered in Pittsburgh, PA.
- Presbyterian Hospital is the flagship facility of the company
  - located in Pittsburgh's Oakland neighborhood
  - attached to other facilities including lecture halls, biomedical science towers, and a dormitory.
- UPMC Presbyterian is a Level I Trauma Center
  - highest level of care available
  - Presbyterian is a referral resources for nearby regions
    - the Emergency Department (ED) receives a large volume of patient transfers from other hospitals
    - More than 53,000 patients are seen in Presbyterian's ED every year[1]

*UPMC Presbyterian Hospital, Oakland, Pittsburgh.*

- MATP (Medical Assistance Transportation Program) is a state-wide program providing transportation to medical appointments for MA recipients.
- Run by individual counties across PA.
- Provides non-emergent transportation
  - Part of the provisions by Allegheny County include transportation home from the ED for qualified recipients.

[1]University of Pittsburgh, Department of Emergency Medicine (*n.d.*)

## Problem

- Part of the social workers' role in the ED is coordinating transportation at discharge, particularly during overnight shifts
- As a Level I Trauma Center, Presbyterian receives patient transfers from out of county as well as out of state
- Policy constraints prevent us from providing transportation for anyone who lives outside of Allegheny County

***Patients are routinely transferred from other hospitals to Presbyterian for higher levels of care, and are subsequently stranded when they are ready for discharge.***

## Implications for SW Practice

This poster explores the logistical issues surrounding patient transportation and offers possible alternative solutions to begin facilitating improved patient care.

The role of a hospital social worker is to act as an advocate for patients and families' needs, both during their stay and at discharge. While this issue is beyond the scope of a single department or hospital, social workers can play a crucial role in the development and implementation of company, county, state, and federal policy.

This issue is at the crux of social worker's positions as direct practice advocates and policy influencers, and draws on the strengths of the diversity of the field.

## IHC Social Work Competencies

IV – Care planning & care coordination
VII – Systems oriented practice
VIII – Quality improvement

## Suggestions for Improved Patient Care

While there are no readily available short-term solutions, there are some areas worth exploring.

- **Mid-term Option** – non-emergent inter-facility transportation among UPMC facilities.

Many patients are transferred within the UPMC system. If patients can be returned to facilities in and around their communities, it is often easier to coordinate transportation home. UPMC may consider investing in a wheelchair van-type of service to shuttle patients between facilities.

- **Long-term Option 1** – coordinating transfers between counties' MATP programs.

MATP is run by each county in PA, and it may be worth exploring the possibility of integrating these counties' programs for cases of emergency visits, particularly as many patients qualify for or are already enrolled in MATP in their home counties.

- **Long-term Option 2** – coordinating between relevant out-of-state facilities

There are a finite number of in-network, out-of-state hospitals that refer patients to Presbyterian, and by establishing a system similar to that suggested for UPMC inter-facility transportation, out-of-state facilities can put patients in contact with those services that they qualify for and are available to them.

## Acknowledgements

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# Social Work and Nursing Collaboration in the Neonatal, Perinatal and Postnatal Units of West Penn Hospital

By: Mallory Marta & Rhonda Strozier

University of Pittsburgh School of Social Work

West Penn Hospital

## West Penn Hospital

Western Pennsylvania Hospital, known as West Penn, was founded in 1848 as the first chartered public hospital in Pittsburgh. West Penn currently has 317 beds across many specialized units including a certified burn unit, oncology unit and a level three neonatal intensive care unit. West Penn opened its first obstetrical unit in 1950.


## Our Problem:

For our internship, we spent four months in the prenatal and neonatal units of the hospital. We observed an opportunity for growth within the relationship between hospital social workers and floor nurses. We hypothesized that the disconnect between nurses and social workers could stem from a lack of agreement about the role of a social worker.

AHN policy states that a social worker is responsible for the following aspects of patient's care:

- Assessing psychosocial factors which impact care
- Providing information and referral in areas of: domestic violence, drug/alcohol dependency, suspected child maltreatment, psychiatric services and guardianships
- Crisis intervention

## Background of Problem:

Additional strain on the collaboration between nursing and social work, *may* stem from:

- Engaging with families with more complex social situations
- Caring for critical patients
- Patients in the NICU have a longer length of stay
- Engaging with families with multi-system involvement
- Knowledge surrounding unique circumstances (surrogacy/adoption)

There are currently 4 full-time social workers between labor and delivery and NICU.

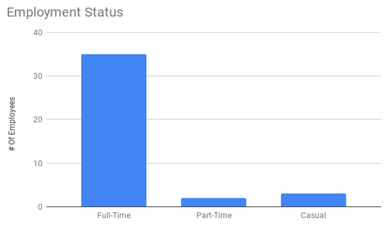
## Our Methods:

We surveyed nursing staff on the following units: social work, labor and delivery triage, labor and delivery perinatal, NICU, and pediatric unit. We provided the survey to management to disperse via email. We received 22 survey responses online. We also provided paper surveys. We received 18 survey responses via paper. In total, we received 40 surveys.

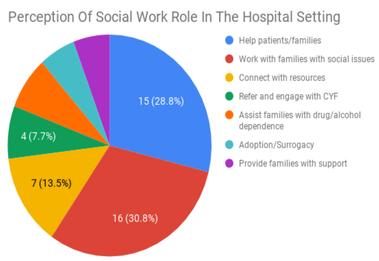
We utilized three demographic questions, two qualitative questions and one quantitative question in the survey.

The results of the qualitative question were averaged to find a mean score of 3.57.

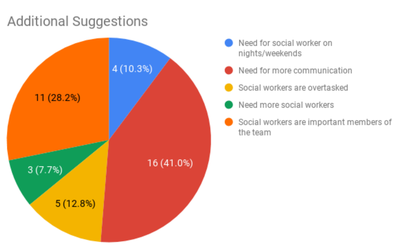
The results of the quantitative questions were evaluated for recurrent themes found within the written responses.

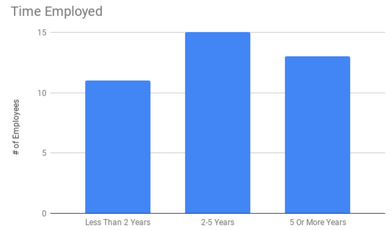



Additional themes noticed but not represented on the chart included: bereavement services, transportation, safety in the home, support parents, assess patients and teen pregnancy.



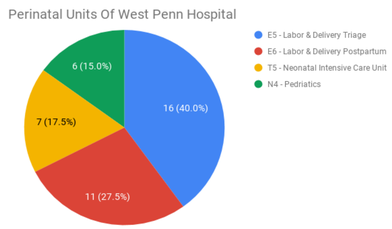

Additional themes noticed but not represented on the chart included: social workers being pulled from the unit to cover other floors, social workers not being paid/appreciated enough, and a suggestion for one social worker per perinatal floor.



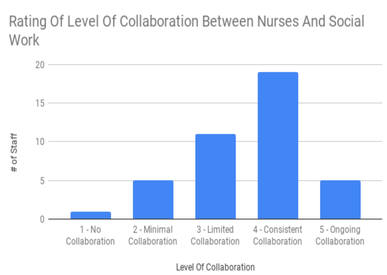




## Our Results:

Of the 40 surveys received, the largest portion came from E5: Labor And Delivery Triage. Due to the set up of this unit, it was easier to provide surveys to more nurses at one place and collect the results.




Most respondents rated the collaboration between nursing and social workers as consistent collaboration. Many respondents that provided lower ratings mentioned that there are often extenuating circumstances to more collaboration with social workers.




## Our Recommendations:

Based on suggestions given, it is our recommendation that the following changes could improve the collaboration between nursing and social workers:

- Nurses can receive ongoing training regarding the role of social workers.
- Social workers can increase face-to-face communication with nurses.
- Management can create more effective policies regarding social work's workload and assignment to particular units.

## Implications On Social Work:

From an interdisciplinary standpoint, the social work and nursing professions each have distinct roles. Within their distinct roles, there is a joint goal of comprehensive patient assessment and care. Effective team-based care has been tied to a reduction in health service utilization and improvements in patient satisfaction and in communication avenues. This is a crucial outcome for our premature and full-term babies. Our findings suggest that social workers must continue to educate other professions about their roles are and highlight their importance to the team and patients.

## Competencies:

- **Collaboration and Teamwork**
  Focus on the collaboration and teamwork between nurses and social workers
- **Screening and Assessment**
  Focus on screening and assessing the needs of patients and families
- **Cultural Competence and Adaptation**
  Focus on understanding complex social identities and situations of families

## Acknowledgements

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*We extend thanks to the University of Pittsburgh School of Social Work, the Edith. Baker Integrated Health Care Fellowship, faculty members, Allegheny Health Work & West Penn Hospital Director of Case Management and Manger of Social Services, and the West Penn Nursing Staff.*

University of Pittsburgh
School of Social Work

# Patient Adherence to Chronic Diagnosis Treatment Plan

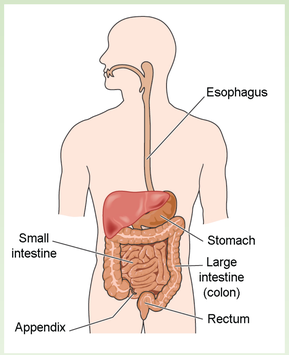
UPMC LIFE CHANGING MEDICINE


Heather Messa

Edith M. Baker Social Work and Integrated Healthcare Fellowship
University of Pittsburgh


## INTRODUCTION

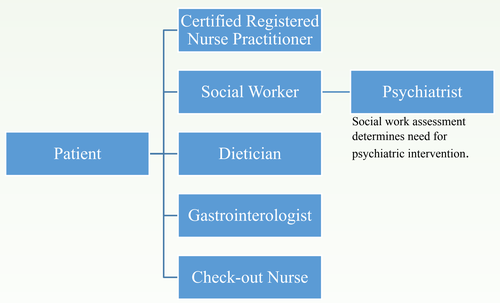
Total Care IBD Medical Home is a clinic setting located in UPMC Presbyterian Hospital. Our client population consists of adults with Inflammatory Bowel Disease (IBD). IBD is a chronic disease involving the functioning of one's gastrointestinal tract. Our clinic follows an integrated healthcare model, offering medical, mental & behavioral health, and dietary health services to address "whole patient health."




## OBJECTIVES

- Advance patient adherence to their individualized treatment plan
- Promote accessible communication between patients and medical providers
- Lower instances of emergency room presentations

Typical Structure of a Total Care Appointment




Patients of Total Care IBD Medical Home may see a variety of providers during their visit, followed by a slew of instructions to follow. Although IBD is a chronic disease, patients are more likely to achieve remission, the absence of symptoms, via adhering to their individualized treatment plan created and agreed upon by the patient and the medical team. The purpose of this study was to assess patient adherence, as well as the logic behind lack of adherence.

## METHODS

This graduate level social work intern conducted follow-up phone calls with patients approximately one month after their in-person appointment. Prior to calling patients, this intern would review office visit notes, and compiled patient instructions in a Microsoft Excel spreadsheet to record and track data.

If a patient voiced non-adherence to their individualized treatment plan instructions, this intern would assess the patient's logic for doing so. If concerns were medical, patients would be directed to the IBD nurse line. If concerns were behavioral or dietary, the patient would be directed to their respective providers.

This intern created two voicemail scripts in the event that a patient did not answer the phone. The first was a generic UPMC provider voicemail for those with an unidentified voicemailbox. The second was for patients with identified voicemails, and referenced UPMC Total Care as their provider, but did not include any confidential information.

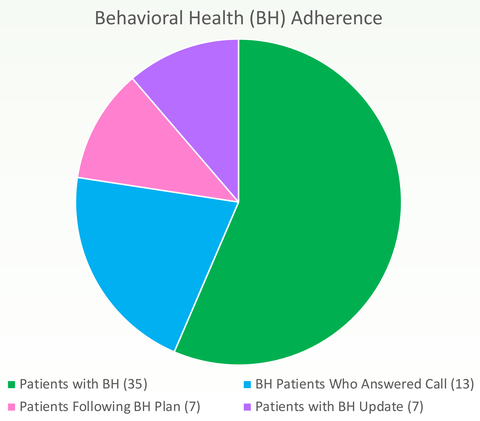
## RESULTS

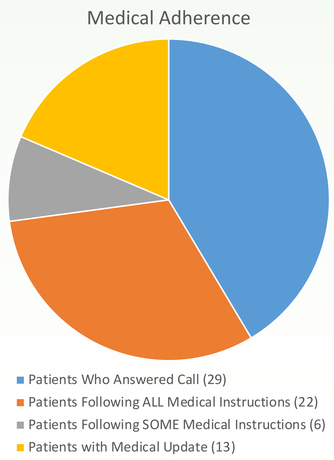
Of the 70 phone calls conducted, 29 were answered.










## CONCLUSIONS

Adherence to medical instructions (76%) was prioritized over adherence to behavioral health instructions (62%). Adherence to individualized treatment plan varied for numerous reasons. Common medical adherence troubles were following through with referrals, insurance issues, and trials of a new intervention. Adherence to behavioral health lacked in the realms of scheduling regular follow-ups, or behavioral health issues failing to be resolved.

The follow-up call was effective in that some individuals required the intervention of our medical and/or behavioral health staff. For example, one patient was experiencing new symptoms following the start of a new medication, and had not informed any person on the team of these symptoms. This follow-up call allowed me to connect this patient to the necessary team member to address her issue and avoid a potential emergency department presentation.

## IMPACT IN THE COMMUNITY

Studies have found that conducting follow-up phone calls can reduce numbers in avoidable hospital admissions (Johnson, Laderman & Coleman, 2013). Patients with a chronic diagnosis often require the intervention of multiple healthcare providers, and the amount of instructions to follow that comes along with these providers can be difficult to juggle. Conducting a follow-up call to review what was discussed can lead to better patient health outcomes.

In regards to social work in an integrated health setting, we understand that mental health can surface secondary to health conditions. Keeping this in mind, by assisting an individual in managing their physical health conditions, positive mental health outcomes may follow.

## LIMITATIONS

Limitations of this study were the small sample size and time limited nature of the study. This study was limited to a two-month time period. However, the practice of conducting follow-up phone calls with patients has proven to be effective by the means of the medical team, and these efforts are ongoing.

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## ACKNOWLEDGEMENTS


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# Improving Behavioral Health Access

## Screening Tools and Social Work Contact In Health Clinics

University of Pittsburgh
School of Social Work

Nikki Cohen, Mylee Moyher, & Ashley Ridgway, Edith Baker Integrated Healthcare Fellowship

UPMC St. Margaret



### UPMC St. Margaret Family Health Centers

The UPMC St. Margaret Family Health Centers (FHCs) work to provide holistic quality care to patients in an outpatient setting. The 3 community centers—Lawrenceville, Bloomfield-Garfield, and New Kensington—"provide more than 35,000 visits a year to patients and families, in a comprehensive, collaborative team-based model of family practice care" (UPMC St. Margaret, 2019). Due to their patient-centered, coordinated care model, all 3 FHCs have been recognized by the National Committee for Quality Assurance (NCQA) as the highest tier, Level 3, Patient-Centered Medical Homes (UPMC St. Margaret, 2019).

The FHCs provide 20+ services to the Pittsburgh medical community for patients and families: primary medical care, behavioral health services, nurse visits, well-child checkups, sick visits, adult care, geriatrics, gynecology, prenatal care, physicals, hearing and vision testing, referral for dental care, x-rays, EKGs, lab services, diabetes education, nutritionists, health screening, sports medicine, minor skin surgery, clinical pharmacists, psychiatry, and provider home visits.

### Research Focus

"Mental health problems, such as depression [and] anxiety…are among the most common and disabling health conditions worldwide. They often co-occur with acute and chronic medical problems and can substantially worsen associated health outcomes. When mental health problems are not effectively treated, they can impair self-care and adherence to medical and mental health treatments, and are associated with increased morbidity and mortality, increased health care costs, and decreased productivity." (Patel, et al., 2013)

Since UPMC St. Margaret Family Health Centers (FHCs) work to provide holistic quality care, the mental health of our patients is a key concern. To address this issue, the FHCs screen every patient for depression and anxiety.

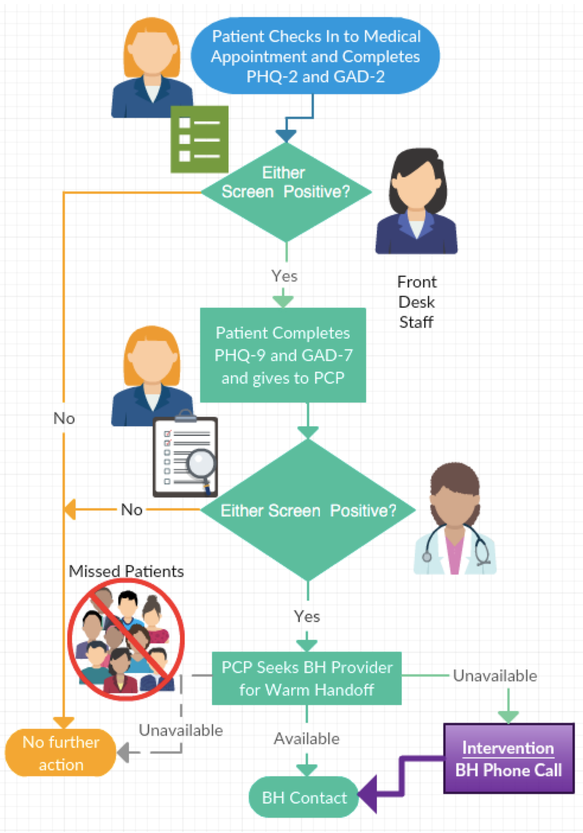
"The nine-item Patient Health Questionnaire (PHQ-9) [and] seven-item Generalized Anxiety Disorder scale (GAD-7)…are valid and reliable measures of depression [and] anxiety… However, the time required in their administration may limit their use in routine care." The use of two-item short form questionnaires, the PHQ-2 and GAD-2, is empirically supported to identify symptoms of anxiety and depression. (Staples, et al., 2019)

In an effort to identify patients in need of behavioral healthcare (BH), the FHCs screen every patient with the PHQ-2 and GAD-2, and every patient with a positive screen completes the more sensitive full-form PHQ-9 and GAD-7.

The FHCs attempt to connect any patients that have a positive PHQ-9 or GAD-7 with BH via a warm handoff, in which a BH provider is introduced to the patient on the spot to discuss potential engagement with services. However, many patients needing and willing to engage with BH do not get connected, often due to unavailability of a BH provider during a patient's medical appointment as well as a lack of referral or patient follow-through. As social work students, we sought to reach those patients needing BH that do not get connected when they come to a St. Margaret FHC for a medical appointment.

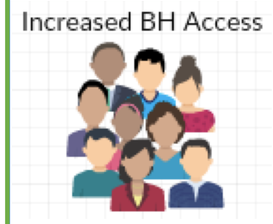
### Methods

We decided to reach out to individuals that had a positive PHQ-9 or GAD-7 and were not receiving behavioral healthcare (BH) treatment at UPMC St. Margaret Family Health Centers (FHCs). With that goal in mind, we started collecting all the completed PHQ-9 and GAD-7 forms from October 1 to March 15, 2019. For a positive screen, we accessed the patient's chart to see if they had an encounter with a BH provider in the last 30 days. We called patients not currently engaged in our BH to discuss over the phone the results of their mental health screens and how they might benefit from the BH services offered by St. Margaret FHCs.




### Findings

More than 50 patients per month screened positive on either the PHQ-9 or GAD-7. Due to the high volume of positive screens and our limited field hours, we were able to contact only a fraction of the patients identified for intervention. Some patients did not answer phone calls or return voicemails, and some of the patients we contacted were receiving behavioral healthcare (BH) services elsewhere or unwilling to engage in BH treatment. Our intervention ultimately engaged 12 patients in BH treatment, *all of whom expressed they would have not accessed BH services had they not been called.*




- 12 patients*
- Ages 16 to 67
- Significant symptoms of depression, anxiety, panic, and/or PTSD

*Plus 1 patient scheduled outside BH services at a higher level of care

A 34-year-old patient contacted by and engaging in therapy with a social work student discussed how the BH treatment is providing them needed support during a time of increased challenges with depression and fear of future suicidal ideation.

By engaging patients in a discussion about their BH needs and the BH services available to help meet those needs, we empowered them with increased knowledge about their health and increased access to BH treatment. Even for those patients who chose to not access treatment, our intervention made them aware of the BH services offered and further aware of their symptoms of depression and/or anxiety, both of which may have a positive impact on their future utilization of BH treatment.

### IHC Competencies

II. Collaboration & Teamwork

Fostered shared healthcare decision-making between patients and behavioral healthcare providers

III. Screening & Assessment

Screened patients for symptoms of depression (PHQ-2 and PHQ-9) and anxiety (GAD-2 and GAD-7) to help identify and engage individuals needing behavioral healthcare treatment

V. Intervention

Provided behavioral health interventions by contacting patients via phone and offering direct individual short-term therapy with a social work student (which may begin as or extend to longer-term therapy with a St. Margaret Family Health Center-employed behavioral healthcare provider)

### Implications for Social Work Practice

The large number of patients coming to community clinics for a medical appointment that are experiencing overall significant and under- or untreated symptoms of depression and/or anxiety implies the great need for and underutilization of behavioral healthcare (BH) services. Medical facilities can improve BH access by implementing a standardized process for mental health screening with social work follow-up.

### Recommendations for Health Clinics

1) Screen every patient with the PHQ-2 and GAD-2
2) Administer PHQ-9 and GAD-7 if a positive initial screen
3) If a positive secondary screen, connect patient with behavioral healthcare (BH) services, in decreasing favor:
   a) Warm handoff to embedded BH provider
   b) Patient follow-through with referral to BH provider
   c) Social worker-initiated telephone contact

In these scenarios, social workers/BH providers engage patients in a discussion about their BH needs and the BH services available to help meet those needs.

We recommend that medical settings increase their number of social workers/BH providers to help identify and treat those patients experiencing mental health problems. We recommend that all health clinics be familiar with local BH services to make good outside referrals to patients in need of services the clinics are unable to provide internally.

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University of Pittsburgh
School of Social Work

# Clarifying Roles and Responsibilities in High Risk Care Coordination Teams

**Ruby A. V. Walker, Edith Baker Integrated Healthcare Fellowship**

UPMC Health Plan
COMMUNITY CARE Behavioral Health Organization

## Introduction

### SNP/SMI Community Team

UPMC Health Plan's Special Needs Program - Serious Mental Illness (SNP/SMI) Mobile Care Management Team provides long-term care coordination services for dually-eligible UPMC Health Plan / CCBHO members. Each SNP/SMI member is diagnosed with at least one chronic physical illness and at least one mental illness. This leads to high healthcare utilization and a high risk of 30-day hospital readmission. Our members are also at a high risk of various other issues including housing instability, drug and alcohol use, and elder abuse or domestic violence.

### IHC Core Competencies

1. Interpersonal Communication
2. Collaboration and Teamwork
3. Care Planning and Coordination

## Issue

### Rapid Changes in Healthcare

Over the past decade, the healthcare industry has begun to recognize care management and coordination as a vital piece in high-quality integrated care teams that reduce unnecessary healthcare usage and emergency room visits. However, these relatively fast changes have led to confusion about the responsibilities of each professional in today's interdisciplinary teams.

### Clarifying Roles

As more and more roles are introduced to healthcare teams, it is important for everybody to understand the unique goals, strengths, and connections that each team member brings to the table.

## Design

### Data Collection

- We collected information about eight unique roles within the University of Pittsburgh Medical Center (UPMC), Community Care Behavioral Health Organization (CCBHO), and Community HealthChoices (CHC).
- We included roles related to healthcare social work, health coaching/counseling, care management, and service coordination.
- Data sources included job and program descriptions, employee manuals and workflow reports, and interviews with team members.

*High risk patients can have especially complex interdisciplinary care teams. With so many people at the table, it can difficult to understand who's who.*

### Data Analysis

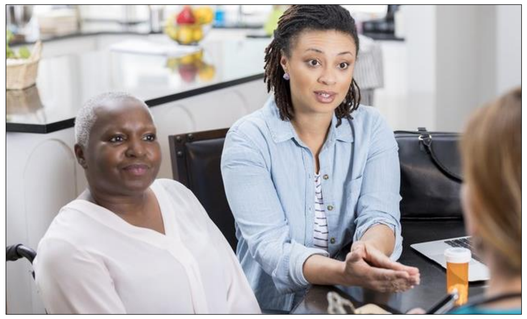
- Data was analyzed for distinct keywords and themes with the help of NVivo qualitative data analysis software.
- After computer-aided-analysis, the intern and supervisor narrowed results down to 1-3 key phrases that highlight the most important unique aspects of each role.

## Results

### Meet the Team!

1. **Hospital Social Worker (MSW):**
   *Assess new patients. Visit at least every 3 days. Find coverage for un/underinsured.*
2. **Transition Coordinator (MSW/RN):**
   *Create the discharge plan. Connect hospital team with PCP/community orgs.*
3. **Home Health Social Worker (MSW):**
   *Visit patients receiving hospice/home health services. Assist family members with caregiving and grief.*
4. **Health Coach (Bachelor's):**
   *Provide short-term telephonic sessions for weight-loss, smoking cessation, etc.*
5. **Mobile Care Manager (RN/MSW):**
   *Provide long-term, in-home coordination services for high risk patients. Connect to new providers and community resources.*
6. **Telephonic Care Manager (RN/MSW):**
   *Provide short-term telephonic services after hospital discharge.*
7. **CHC Service Coordinator (Bachelor's):**
   *Help patients with Long Term Services and Supports (LTSS) access caregiving, housing, and medical services.*
8. **Physician's Office Based Clinical Care Manager (RN/MSW):**
   *Develop care plans for each patient in the PCP office. Coordinate with hospitals.*

(Please note that other organizations may use alternate job titles to describe these roles.)



*SNP/SMI Mobile Care Managers have the unique opportunity to visit members in their home over long periods of time.*

## Community Implications


*UPMC and CCBHO team members gather for a charity walk benefiting mental health.*

### Coordinated Care Leads to Better Healthcare Results

When professionals and patients alike understand who is on their team and why, we dramatically increase communication, efficiency, and competency. This is a critical piece in putting the Integrated Health theories we learn in class into practice, and will ultimately lead to better health for everybody involved.

## References & Acknowledgements

### References

Medicare.gov, Healthcare.gov, UPMC.com, Insurance.PA.gov, CCBH.com, HealthChoices.PA.gov

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