



NASW SPECIALTY PRACTICE SECTIONS  
FALL ■ 2016

# Health

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As a result of the passage of Affordable Care Act and other new policies, there is an increased emphasis toward an interdisciplinary approach in which services are geared toward the patient as the core focus; this is often referred to as “patient-centered services.”

In this issue of the Health SectionConnection, the article, *Emergency Care and Behavioral Integration: Where Do We Fit? How Do We Grow?* written by Erin L. Richmond, MSW, a graduate of the University of Missouri provides an overview of how the mental health and medical models have been merged in order to manage patients’ health care needs from a multidisciplinary prospective.

The second article, *UM Psychosocial Acuity Scale—An Update From the Field* provides an overview of a psychosocial acuity scale developed at the University of Michigan that is designed to be used across all social work systems. The acuity scale can help social workers prioritize clinical needs and align proper resources for their clients. The article was authored by Stacey Klett, MHSA; Nina Abney, LMSW; Alethia Battles, LMSW; Janice Firn, LMSW; and Aimee Vantine, LMSW; all from the University of Michigan.

As social workers we should remember what one great philosopher once said, as we work toward getting the results that we strive for: “Do, or do not. There is no try” (Yoda).

Rahikya Orr-Wilson, MSW, LCSW, LICSW  
Chair, Health Specialty Practice Section



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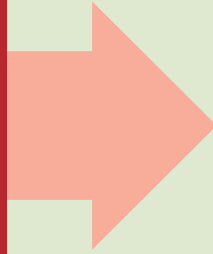
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**IT'S A FACT:**

Heart disease and diabetes are among the

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# EMERGENCY CARE AND BEHAVIORAL INTEGRATION:

## Where Do We Fit? How Do We Grow?



**ERIN L. RICHMOND, MSW**

### **INTEGRATION 101**

Historically, the health care system has been separated between medical and mental health care. This dichotomy has created a fragmented system in which we see rising costs for both medical and mental care, a lack of appropriate referrals, and the misrecognition of comorbid physical and behavioral conditions. According to Moore (2015), "It has been estimated that by 2020, nearly one-third of all Americans (almost 160 million people) will have at least one chronic

disease to manage and the cost of health care will consume over 20 percent of the Gross Domestic Product(p. 1)." To address this concern, the Obama Administration implemented the Affordable Care Act in 2010, which aimed to increase patient-centered care throughout the health care delivery system (Moore, 2015). This push has been seen mainly in the primary care setting with the development of patient-centered medical homes (PCMHs). These facilities include multidisciplinary teams of physicians, nurses, and

behavioral health consultants (BHCs) who work together to manage patients' health care needs and chronic conditions.

BHCs occupy a unique role within the primary care setting, as well as the behavioral health field in general. The principal role of the BHC is to help patients make behavioral changes to benefit their physical health, mental health, and overall well-being. They traditionally spend 15 to 30 minutes with a patient and provide action-oriented and skill-based interventions for

patients to practice and develop outside of the clinic. While a BHC has the knowledge and skills to address the more traditional conditions associated with mental health, such as mood disorders and anxiety, they are just as likely to work with patients to address weight loss, diabetes management, chronic pain, smoking cessation, hypertension, and many other physical conditions. It is BHCs' ability to develop and address the connections between physical and mental health that make them beneficial for the

# most common consequences of lifestyle choices.

integration of health care. As social workers, we are qualified for such a position because our profession recognizes the intertwining of various dimensions of individual functioning and we are adaptable to different service settings (Patient-Centered Primary Care Institute, 2013).

## HOW MIGHT IT LOOK IN THE EMERGENCY DEPARTMENT?

In the US, emergency departments (EDs) have become the main point of access for individuals experiencing symptoms of both physical conditions and mental health conditions. Okafor et al. (2015) note, "The overuse of US EDs by mental health patients who are not in crisis and poor access to appropriate inpatient psychiatric care reflect an ongoing crisis in the mental health system." They also state that an individual's number of visits to the ED will increase if he or she suffers from a physical illness in addition to a mental illness. To address the overuse of the ED, the researchers developed "Psychiatric Fast Track Service," or PFTS, with the aim of integrating behavioral services into the ED and serving as a protocol for the exchange of referrals between the ED, psychiatric services, and outpatient services. To test fast track, a licensed clinical social worker and a consulting psychiatrist were added to the ED's team at Grady Hospital in Atlanta, Georgia, and a diagram was developed to showcase the flow of integration of behavioral services into the ED.

The fast track consisted of three categories: ED, psychiatric emergency services, and outpatient services. The idea behind these three categories was that patients could

potentially be funneled into the most appropriate services based on their presentation. The three patient presentations were "medically stable, psychiatrically unstable;" "medically unstable, psychiatrically stable;" and "medically stable, psychiatrically stable." A fourth presentation was then included in the ED category: "medically unstable and psychiatrically unstable." This presentation is where the behavioral integration truly began. When a patient experiencing both medical and psychiatric problems arrived in the ED, the emergency physicians had the ability to then stabilize the patient medically while the behavioral specialist had the ability to stabilize the patient psychiatrically or behaviorally.

The results of this integration showed improvement in various quality metrics between January 2011 and May 2012. These quality metrics included length of stay, time to triage, disposition to discharge, admission disposition to departure, psychiatric length of stay, and use of restraints. While this model improved the quality of these measures, the researchers state: "As a result of this pilot, several areas were identified as target areas for initiatives to improve quality that directly relate to our integration efforts. This included the care for patients with an underlying psychiatric issue who present to the ED through the detention system, and the medical care for patients with comorbid acute medical and psychiatric issues" (Okafor et al., 2015).

Integrative fast tracks such as the one discussed do provide a foundation for the integration of behavioral health services into EDs across the United States,

but the focus of integration must then switch to the questioning of what brief behavioral services can be utilized to benefit patients presenting with chronic medical conditions, acute mental conditions, and a combination of the two. Ideally, the integration of BHCs as members of the ED team would allow for brief behavioral interventions to decrease symptoms of mental illness and increase patients' self-management of chronic physical conditions.

## POTENTIAL TECHNIQUES: WHAT A BHC CAN DO

Many treatment modalities commonly utilized by BHCs allow them to complete brief and focused assessments and intervention plans. These include motivational interviewing, behavioral activation, solution-focused therapy, relaxation training, and various cognitive-behavioral approaches. Brief intervention techniques from these different modalities can be utilized with patients within a 15- to 30-minute time frame, which would translate well to the ED environment.

Brief intervention techniques, which are utilized in the primary care setting and may be plausible in emergency care, include the following (Patient-Centered Primary Care Institute, 2013):

- Behavior modification
- Values clarification
- Goal setting and action step planning
- Mindfulness
- Motivational interviewing
- Problem-solving
- Relapse prevention planning
- Relaxation skills
- Scheduling social and physical activities

## MODALITY ILLUSTRATION

While there are many kinds of modalities that may be used, it is sometimes easier to understand how they may be utilized in the primary care or emergency settings by viewing one specific modality in detail. Acceptance-Commitment Therapy (ACT) can demonstrate how a specific treatment modality may be utilized in the primary care setting and is a form of therapy that has branched out of the category of cognitive-behavioral therapies and is recognized as a therapeutic approach that can be modified to work with a large range of individuals and presenting problems. Its main purpose is to help individuals react to situations in a constructive manner, as well as to negotiate and accept challenging thoughts and feelings rather than to avoid or replace them.

According to Larmar, Wiatrowski, and Lewis-Driver (2014), "Unlike cognitive-behavioral approaches that reinforce the dynamic interplay between cognition, behavior, and affect and the focus on replacing maladaptive thought processes with healthier cognitions, ACT teaches individuals to 'just notice,' accept and embrace private experiences and focus on behavioral responses that produce more desirable outcomes." ACT functions on the acronym FEAR (F: Fusion of thoughts, E: Evaluation of experience, A: Avoidance of experience, R: Reason-giving). In response to the concepts in this acronym, ACT utilizes various mindfulness techniques, including acceptance of thoughts and emotions, cognitive defusion, awareness of the moment, and observation of



self. In addition, there are seven core processes that could be implemented with patients in the ED (Larmar et al., 2014):

- Confronting the system
- Recognizing control as the problem
- Identifying cognitive defusion and mindfulness
- Developing a transcendent sense of self
- Promoting acceptance and willingness
- Clarifying values
- Establishing commitment

The types of interventions that relate directly to the core processes of ACT and can be taught to patients in 15 to 30 minutes include mindfulness skills such as diaphragmatic breathing, body scanning, and grounding. Values clarification exercises may also be utilized to help patients identify and solve conflict between their core values and emotional or behavioral responses to negative events. Because ACT is rooted in cognitive-behavioral therapy, various handouts can be provided for the patient to complete after leaving the ED. This helps patients to better accept their negative thoughts and feelings while developing their self-management skills.

### CASE STUDY

A 27-year-old man presents to the ED for the fourth time in three months with shortness of breath, sweating, and an elevated heart rate. Each time, his EKG comes back within normal range. The ED physician contacts the BHC to speak with this patient about anxiety and panic. The patient reports to the BHC that he has been under a high volume of stress lately because of financial concerns. He has also quit exercising but feels he has great family support and wants to be present for his family. The BHC first

## Research

- Currently, the amount of research published on the concept of integrating behavioral health care into the emergency department is sparse. Without research to support the systematic changes necessary to accomplish such a feat, it is most likely patients in the emergency department may never receive the mental health care appropriate to their varying levels of severity and crisis.

## Funding

- As mentioned many times, it may be necessary to add new positions to the existing emergency department. The department may have to hire additional social workers or psychologists to effectively reach a substantial amount of patients while increasing the efficiency of the emergency department's functioning. Funding will be required to complete pilot studies for research due to these systematic changes and additional employee positions.

## Advocacy

- As social workers, it is ethically our responsibility to advocate for the needs of others. Individuals entering the emergency room are often experiencing some form of crisis, whether it is a physical emergency or behavioral emergency. By integrating ourselves into the emergency department services, we have the ability to advocate for their needs while still maintaining the function of the ED.

provides education to the patient on primary care clinics within the area and what kind of hotlines he can call rather than going to the ED. The BHC then provides psychoeducation on anxiety and panic before teaching the patient mindfulness and relaxation techniques, including diaphragmatic breathing, sensory stimulation, and body scanning. The BHC also discusses the patient's values with him, including the value of family, and provides a values clarification exercise for him to complete at home. The timeline of this visit fits well within the BHC role and reads as follows:

- BHC introduction: 3 minutes
- Biopsychosocial assessment of patient: 10 minutes
- BHC interventions: 7 minutes
- Total time spent: 20 minutes

### FIRST STEPS

As social workers, our values and ethics tell us to help patients, increase their self-determination, and influence systematic change to benefit the individuals we

with whom we have working relationships. The idea of integrating true behavioral intervention into the ED setting is novel. For this reason, there are crucial first steps we must take to nourish this concept and create sustainable change in research, funding and advocacy.

As the integration of behavioral health into medical settings continues to grow, it is part of our responsibility to grow with it and innovate new ways to reach populations in need.

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# UNIVERSITY OF MICHIGAN PSYCHOSOCIAL ACUITY SCALE —An Update From the Field

STACEY KLETT, MHSA • NINA ABNEY, LMSW  
ALETHIA BATTLES, JD, LMSW • JANICE FIRN, PHD, LMSW  
AIMEE VANTINE, LMSW

## ABSTRACT

The UM Psychosocial Acuity Scale (“the scale”), developed by the University of Michigan (UM) Health System Department of Social Work, measures the psychosocial acuity of patient and family situations across a comprehensive health system, including inpatient and outpatient, primary care and subspecialties, mental and physical health, and disciplines ranging from pediatrics to geriatrics. Following challenges with implementation of the scale and gathering reports of measures, we are currently utilizing the scale to do what we set out to do: couple acuity measures with productivity information to tell a more complete story of social work contributions and aid in aligning social work resources.

## BACKGROUND

Psychosocial acuity can be defined as the severity of illness or client condition that indicates the need for the subsequent intervention (Huber & Craig, 2007). After researching existing acuity models, we determined that the available scales did not provide the scope needed to

capture the psychosocial acuity of patient and family situations across our comprehensive health system. We began developing the scale in 2011, published it in *Social Work in Healthcare* in June 2014, and fully implemented the scale across the University of Michigan Health System (UMHS) in June 2014. Acuity measures are recorded, along with patient services data, when clinical documentation is completed within our electronic medical record. Following the publication of the scale, several health systems—U.S.-based and international—have partnered with us to receive training on the scale and advice on its successful implementation.

## CURRENT STATE

### Scoring situational acuity:

Currently, MSW and BSW staff utilize the scale on a daily basis to record acuity on all direct interactions with patients and families and/or on behalf of patients and families. Clinicians have expressed that once they become familiar with the scale, scoring patient and family encounters takes very little time. In addition, clinicians have



shared that their documentation has improved since the implementation of the scale, given that their psychosocial assessments and progress notes are more comprehensive, and more completely highlight the areas of highest acuity.

Our first lesson learned was related to initial scores in inpatient areas. The original scale included the word “normative” in Level 2 of the coping/mental health domain. It was noted that in the areas of highest medical acuity (i.e., intensive care units), psychosocial acuity scores were consistently low. Although medical acuity does not always dictate psychosocial acuity, it was concerning that in areas where it could be safe to assume family members are experiencing the most difficult moments of their lives, their psychosocial acuity scores were low. Given this discovery, committee

members met with a group of intensive care unit (ICU) social workers to understand how the scores were being determined. It was revealed that MSWs’ were utilizing the scale from the frame of reference on how most families cope normatively in the ICU setting. For example, a parent whose daughter is dying in the ICU may be coping normally, as most parents in a similar situation would be considering the fact that their daughter is dying, but to a non-ICU clinician, normative adjustment would look very different. The fact that one’s child is dying in the ICU is not a normative experience for a parent. Therefore, the word “normative” was removed from the scale. The term was misleading, as what is normative in one area of clinical care may be very different from what is considered normative in everyday life.

The second lesson learned was the need for greater utilization of the gray boxes at the top of the scale to determine acuity. The gray boxes highlight what interventions will be needed (though we are scoring prior to the intervention). Using the above scenario, it is common for a parent whose child is dying to require support, so in most cases, a situation as described would be a Level 3 for the coping/mental health domain. This holds true for other domains as well. If a family has transportation available through their insurance, but do not know how to access that service, such that they require support or coaching, the transportation and local lodging domain would have an acuity score of 3, regardless of the fact that they have this as a benefit through the insurance. In the updated training, more time was spent emphasizing the use of the gray boxes to help clinicians determine the appropriate acuity level.

#### Reporting on measures:

The acuity report is quite voluminous as every patient encounter can have as many as seven acuity scores. It took about a year to develop a report that provided all the information needed providing larger, rather than very small, increments. Acuity measures can be reported based on time frame, clinician, clinical location, score, or domain.

In reviewing the acuity of patient and family situations, we can determine if particular clinical areas have patients with higher or lower psychosocial acuity and which domains seem to reflect the highest needs. Recently, we have utilized acuity measures to align resources and determine the most appropriate level of social work services required (i.e., BSW or MSW). Instances with higher acuity scores in tangible domains such as transportation/local lodging or insurance/finances might suggest the need for greater BSW services, rather than additional MSW resources. Of course, these scores are utilized in partnership with productivity information to share a more complete story.

As mentioned, we have met with staff from several institutions nationally and internationally to provide training on the scale. Nearly all were interested in not only learning more about the scale, but also trying to implement the scale within their institution. The primary limiting factor in their ability to move forward was whether they had an electronic resource to record and export acuity scores. Institutions with electronic medical records that could be modified to record and report scores have had the most success in implementing the scale.

#### FUTURE PLANS

We plan to focus on connecting psychosocial acuity measures to specific diagnosis groups, like diabetes, to determine if psychosocial acuity and MSW interventions have any impact on population health and other clinical outcomes. We are also reviewing scores to determine if there is a relationship between the time spent on a patient and family situation compared with their psychosocial acuity. Our preliminary review is showing that there may be a correlation to high acuity scores and lengthy patient and family interactions. Also, we intend to further explore trends with acuity scores over time. Currently, it appears that acuity scores start at one point, increase, and then begin to consistently decrease. We will continue to use scale measures from an administrative standpoint as well, to help social work departments across the nation communicate the value of social work and social work contributions to best serve patients and families.

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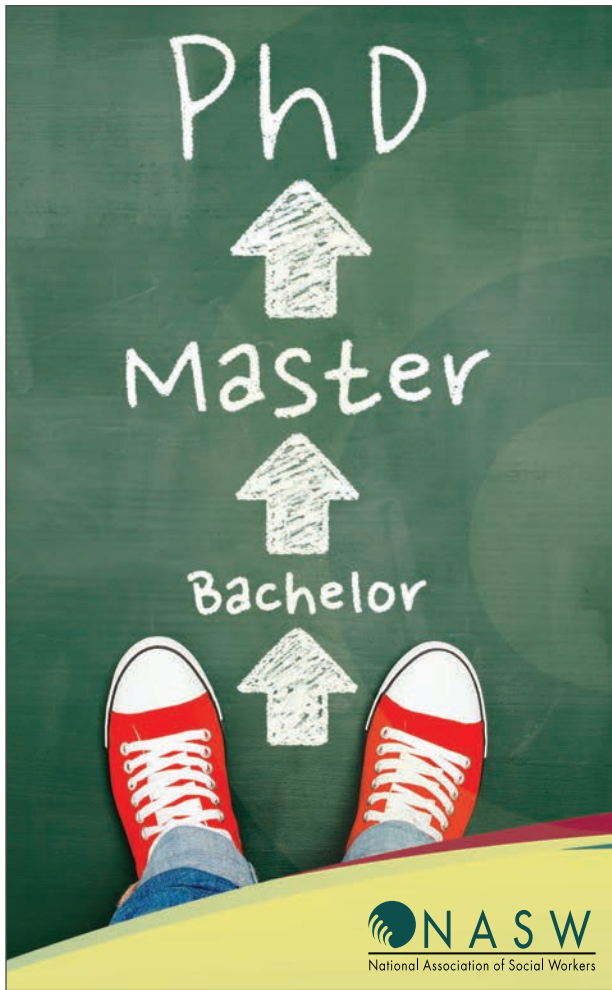
Huber, D., & Craig, K. (2007). Acuity and case management: A healthy dose of outcomes, part I. *Professional Case Management, 12*(3), 132-144.

#### RESOURCE

Klett, S., Firn, J., Abney, N., Battles, A., Harrington, J., & Vantine, A. (2014). Developing a reliable and valid tool to measure psychosocial acuity. *Social Work in Health Care, 53*(5), 503-517.

For the complete UM Psychosocial Acuity Scale go to [www.michigan.gov/documents/mdch/FORM\\_-\\_Client\\_Acuity\\_Scale\\_Worksheet\\_1\\_225816\\_7.pdf](http://www.michigan.gov/documents/mdch/FORM_-_Client_Acuity_Scale_Worksheet_1_225816_7.pdf)





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### Beyond Treatment As Usual: The Case for Cognitive Remediation

Tuesday, December 6, 2016 • 1:00 PM - 2:00 PM ET • 1 Clinical CE Contact Hour

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Tuesday, January 31, 2017 • 1:00 PM - 2:00 PM ET • 1 Social Work CE Contact Hour

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Tuesday, February 7, 2017 • 1:00 PM - 2:30 PM ET • 1.5 Social Work CE Contact Hours

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