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The Prevalence of Psychosocial Issues in Primary Medical Care

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The Prevalence of Psychosocial Issues in Primary Medical Care

Submitted by Malinda J. Wise

May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a master's thesis nor a dissertation.

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**ST. CATHERINE UNIVERSITY AND THE UNIVERSITY OF ST. THOMAS
MSW PROGRAM**

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By Malinda J. Wise

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Abstract

The primary medical setting is a large and important part of a vast system within the medical profession. This study looked to explore; what are the psychosocial needs of patients presenting in rural and mid-sized primary care settings, and how are providers responding to the expectations that patients have, and could there be improvements to their present systems, if so, how? A brief review of the literature looked at primary care in its historical and present forms and how economics have impacted the ways primary care is provided in the United States. Previous review of the literature also included the prevalence of psychosocial problems in the primary care setting and how collaborative interdisciplinary efforts affect responses to these issues. The biopsychosocial model was used as a framework with which to compare and analyze data in this study. A qualitative research study was conducted which looked specifically at the prevalence of psychosocial issues in two primary care clinics (one rural-one mid-sized). A sample of nine medical professionals consented to a 1:1 interview. The questionnaire consisted of eleven semi-structured open ended question asking how they as providers identify and address psychosocial issues in their clinic. Themes identified from participants were consistent

amongst the two clinics that psychosocial issues were a large part of their practice. Issues identified were often around insurance issues, social issues, transportation, treatment of anxiety, and depression. Responses to the management of psychosocial issues were defined very different. The rural clinic was self sufficient stating it lacked resources, time and skills to manage these needs. The mid-sized clinic defined itself as *resource rich* and used an interdisciplinary team approach to the management of patient's psychosocial issues. The results were consistent with previous research in this area. Implications for social work within primary care were indicated with the hope of assistance in the management patient's psychosocial issues that present each day. That medical professionals expressed that social work would be an advantageous profession that could assist them and the patients they see, not only at the micro-level of day to day care but at the higher macro-level reducing potential economic implications to the system as a whole while achieving their goal of holistic patient care.

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The primary medical care setting is a large and important part of a vast system within the medical profession. It is similarly a first point of contact for many patients entering this large system, where they are invited or required to “start.” Oftentimes primary medical care is a clinic or outpatient area of a hospital. Typically, family practice physicians, internal medicine or general pediatricians are hosts and deliver general medical services to patients in need. The specific definition of primary health care came in 1978 from the Institute of Medicine (IOM) and was defined by three basic characteristics: scope, character, and integration of services (Ashery, 2008). In 1996 the IOM adopted a new definition using terms of the 1978 definition (Donaldson, Yordy, Lohr & Vanselow, 1996). The definition is, “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (Donaldson et al., 1996).

For the purposes of this study primary care is defined within the clinic setting where family practice physicians, nurse practitioners, physician assistants and nurses along with other allied health staff come together in the delivery of medical care to patients. The primary medical settings are seen as a free-standing operation and open to anyone in need of medical care with the ability to pay on a fee-for-service basis. Often patients come seeking a wide range of services. Some of these needs are not always medical in nature but comprised of factors that are current in their life or related to their medical condition. Previous research indicates that as many as 80% of individuals are seeking physician services because of mental health and/or substance abuse problems that

accompany a physical complaint (Bauer, Batson, Hayden & Counts, 2005). Bauer et.al (2005) state that as many as 45% of individuals who receive mental health care receive this from a primary care practitioner. This is even more prevalent in rural America where mental health services are not always available (Bauer et al, 2005).

So, why is this information important? One-stop shop seems legitimate and would seem to make life easier for individuals in need of care. The American health care reimbursement system also endorses this philosophy through managed care and the respective payment system (Abramson & Mizrahi, 1986). Patients' choices are based on their medical insurer which often comes with limits and parameters in how they receive medical and/or mental health care. It is because of these limits that patients may be left with few choices. The primary physician office becomes the single point of entry to accessing services defined by the contracted insurance company or managed care provider. Sometimes it is the only resource available to individuals. In rural Minnesota primary care has become the "de facto" system for delivering mental health services (Office of Rural Health & Primary Care, 2003). This is due to limited external resources or potential "stigmas" that may be associated with seeking help from a mental health provider. The U.S. Department of Health and Human Services reports that, nationally, the supply of specialty physicians decreases as urbanization decreases (Office of Rural Health & Primary Care, 2003).

This study sought to explore: a) what are the psychosocial needs of patients presenting in rural and mid-sized primary care settings, and how are they being met in the primary medical setting? b) Are primary care providers skilled and equipped with time to assist individuals with all they are asking for assistance with? c) Are patient needs being

treated in a holistic manner, with attention to both their medical and psychosocial needs? The existing research indicates that patients are presenting with a multitude of issues, therefore, what kind of support are they receiving to accompany their complex situations?

Through previous research it is known that health care and primary care in particular are becoming much more complex with the managed care industry making the physician capacity for emotional support to patients limited (Lesser, 2000). In addition to external-system complexities, are individuals who present with chronic conditions and a multitude of psychosocial issues that complicate an already difficult situation. Psychosocial by definition is the psychological development of the individual in relation to his or her social environment (Merriam-Webster, 2005). In this context, psychosocial issues are events or disruptions in one's life such as: housing concerns, financial issues, domestic abuse, grief and loss, isolation, and other factors specifically related to mental health, depression, anxiety, adjustment issues.

Social workers are one group of professionals who possess skills in psychosocial assessment, problem-solving, and resource brokering. In addition, social workers also maintain knowledge of therapeutic interventions that can work in collaboration with an individual's physician at viewing the needs of the whole person. This exemplifies implications for social work practice through systems theory and views issues in a biopsychosocial model seeking not only a person's medical needs, but looking also at their mental health needs and psychosocial well being. The social work profession in collaboration with interdisciplinary professionals may be a helpful link to the primary care setting. This study explored their potential role in better bridging these needs or

“being a part of a treatment team” to better meet psychosocial needs, particularly in rural settings.

With the changing factors presenting in primary care, this study was interested in how the social work role may be beneficial in helping patients who present to the physician’s office with a multitude of complex issues. Is the social work component helpful to the patient but also to the primary care interdisciplinary team as a collaborative partner in patient care? This study utilized an availability sample in order to specifically ask: a) what are the prevalent psychosocial issues of patients in one rural primary care clinic and one mid-sized clinic b) how are those issues addressed? A review of literature was done looking at specific themes related to psychosocial issues in the primary care setting, both historically and present day. The study provided attention to psychosocial factors and how the social work profession responded to patient needs in the primary care setting. This study, itself, used qualitative analysis to look at the roles of the providers within the clinic, inquiring about the processes, and the interventions they use to address patient mental and psychosocial needs and how these might be built upon and improved to better serve the psychosocial needs of outpatients in rural and mid-sized primary care settings.

LITERATURE REVIEW

The literature spoke to the complex systems in the primary medical setting and the ever increasing need for support of patients beyond their complex medical issues. This brief review of relevant literature looked at primary care, its historical and present form(s), and at how economics have impacted the way care is provided through contemporary managed care systems. This review also looked at the prevalence of psychosocial problems in the primary care setting focusing on the issues and responses to these issues. Lastly, literature was reviewed that was related to the advantages of interdisciplinary collaboration in primary care and to how the social work profession was demonstrated as a beneficial discipline to improved-efficient patient care. Themes from this review were used to help formulate questions for a qualitative study in a rural primary care and mid-sized primary care setting that sought specific data to answer these questions.

Primary care past and present

Primary medical care historically creates a vision of a “country doc” who went about town and the country on horse and buggy caring for individuals who often suffered from a fever or ailment. Care was often provided at home by a generalist and one who didn’t have formal medical training. The times were indeed very different in that people didn’t live as long and often died of measles, scarlet fever, pneumonia, tuberculosis, syphilis or any of the other diseases pandemic before vaccines were developed (Shorter, 2006). Shorter (2006) outlined how things changed in medicine with the advance of pharmacological interventions and surgical procedures. Medicine became more

diagnostic with less focus on the “whole patient-as-a-person.” Shorter (2006) stated that patients became very dissatisfied with physician care; however they felt a need to adhere due to drug therapies and surgical interventions because they needed them. After 1950, the hospital and eventually the primary care clinic would become hosts to patients needing care (Shorter, 2006) a change from care given in the home environment.

Since the 1950’s medicine has taken huge strides in diagnostics, treatments, and prevention. With the wonderful advantages of modern medicine humans have had the luxury of living longer and more prosperous lives; however disease remains prevalent today in the form of diabetes, heart disease, cancer and diseases of the lung. Many of the diseases are often brought about by the way we live our lives. Many do not cause immediate death but remain “chronic” in nature requiring ongoing management and intervention by trained medical personnel. Rothman and Wagner (2003) identify an estimated 99 million Americans live with a chronic illness. They go on to stress the challenges chronic illness puts on the U. S. health care system today. It is understood that consumers place great value on having a clinician or a team of clinicians that is familiar with the “whole” patient and can communicate and coordinate across settings (Rothman & Wagner, 2003).

The primary care physician or clinician is given a lot of responsibilities to not only see the whole patient but help in the management of their chronic disease process. The U. S. economic system has not been supportive in the primary care setting. This was discussed in a British study where primary care in the U. S. was scrutinized by the British (Phillips, 2005). The medical advancements have proven profitable but it also yields uninsurance and underinsurance, poor population health compared with other developed

countries (Phillips, 2005). Primary care professionals are working longer hours, under high stress, poor reimbursement and losing their scope of practice (Phillips, 2005). Without new models of payment and models of care primary care physicians and systems will continue to suffer. They argue that the U. S. needs to move away from fee-for-service payments to a broad range of government funded primary care services (Phillips, 2005).

The state of primary medical care has changed from traditional bedside care to a big business, where providers are under watchful eyes with parameters and limitations of care and resources. Reasons identified for this are both substantive and economic (Hirschfield, 1998). Hirschfield states that depression is much easier to manage with the use of serotonin reuptake inhibitors or SSRI's allowing primary care physicians to manage care for depressed individuals with relative ease: this being a financial incentive as well for the primary care physician (1998). An example of this is the contemporary intervention in the management of depression in primary care. The DIAMOND (Depression Initiative Across Minnesota, Offering a New Direction) model is creating value in depression management (Williams, Jaeckels, Rumman, Somers, Nesse & Gorman, 2010). The DIAMOND is a process for implementation and a structure for ongoing support to persons diagnosed and living with depression (Williams et al., 2010). This model is set specifically within primary care and seeking to create an interface between primary care and a patient's mental health needs. Williams (2010) explains that based on PHQ-9 scores individuals are diagnosed accordingly and monitored by nurse case managers for one year following the initiation of pharmacological treatment. Follow up is cost effective in that it is done primarily by telephone. This model remains under

study but has provided some cost effective outcomes within the management of depression within the primary care setting (Williams et al., 2010).

Modern medicine has come with great advancements that will benefit the whole patient and also the family or group that identifies with the patient. Individuals are living longer better lives, however often with chronic illness (Rothman & Wagner, 2003). With longer life and the management of disease comes a multitude of issues that can be psychosocial in nature and are often interrelated to physical well-being. As a result primary care physicians and clinics have become the frontline of health care for most Americans-they are typically the first point of contact for those seeking both treatment and referrals (Bikson, McGuire, Blue-Howells, Seldin-Sommer, 2009). Patients are presenting in the primary care clinic with a medical need and a variety of psychosocial issues they need addressed. Not all patients disclose these issues specifically due to a potential stigma that may be associated with disclosure. For some, psychosocial issues are a normal part of their life that they learn to cope with well. Psychosocial issues are defined as problems in any of these domains: primary support group, death of a family member, disruption in group or family-separation-divorce, problems related to social environment loss due to death, inadequate social support, discrimination, living alone, occupational, housing, difficulty with access to health care, legal issues, financial problems, and physical/mental illness (Bikson et al., 2009).

Psychosocial issues and responses in primary care

Research indicates that patients with high levels of psychosocial stress make large demands on the primary care system (Rock&Cooper, 2000). With this awareness, it

would make good sense to implement a model of care that addresses this. One could ask: What are these psychosocial issues that present in the primary care setting? Sometimes it's as simple as loneliness and social isolation. Many studies have found that social isolation and lack of social support raise the risk of ill health and mortality especially from heart disease (Hawkey, 2004). Bikson et al. (2009) stated that coronary artery disease, gastrointestinal diseases, hypertension, infectious diseases and psychiatric illness have all be associated with psychosocial problems. Through the research done by VanHook (2003) she discovered that major psychosocial issues included family problems, depression, anxiety, substance abuse and violence. She discovered these were primarily identified with the female population. Her study further indentified that social workers provided support ranging from brief assessment to extended psychotherapy (VanHook, 2003) utilizing various therapeutic techniques.

In contrast, Rinfrette (2009) studied mental health needs in the elderly. The research stated that close to five million Americans age 65 and older have been found to be clinically depressed, with one million of those having major depression (Rinfrette, 2009). This vulnerable population very typically views the primary care provider as the one to address these issues. However, as cited previously by Rock and Cooper (2000), physicians don't always have the time or skill to assess psychosocial or mental health needs. These are often very time consuming-assessments that require follow-up and/or referral. Social workers based on holistic model possess these assessment skills and can provide direct therapeutic follow-up as indicated. The research also states that depression is often associated with underlying causes or co-morbidities in the elderly (Rinfrette, 2009). This further exclaims the need in awareness and assessment of depressive

symptoms, many of which are likely exacerbated by loneliness, isolation, grief and loss related issues. A variety of therapeutic interventions may be supportive such as supportive therapy, problem-solving therapy and interpersonal therapy at addressing psychosocial concerns when medication to treat doesn't always work and may not be wanted (Rinfrette, 2009). Bikson et al. (2009) completed a cross-sectional survey at a Veterans Administration (VA) primary care clinic. A convenience sample was taken where patients in the waiting area were approached and asked to complete a social needs checklist (SNC). Respondents were asked to rate a list of 15 social problems on a scale of 1 to 3, 1 (not at all), 3 (a great deal). Providers in the clinic were also asked what their perceptions of social problems were (Bikson et al., 2009). The results indicated that patients reported an average of almost five psychosocial problems. Finances and personal stress were by far the most frequently identified problems according to patients (over 60%) and providers (40-50%) (Bikson et al., 2009).

The biopsychosocial approach, or care of the entire person, in the primary care setting seems obvious to some who want to provide good patient care understanding that the issues of medical treatment and psychosocial-environment needs are often interrelated. The research, while fairly recent, was very clear in what psychosocial issues were identified in the primary medical setting. Patients are generally seeking the primary care provider more often for more complex needs. These needs may be medical with a lot of "extras" requiring a more interdisciplinary approach to care. Knowing the importance that the social work profession gives to psychosocial issues, this invites the question of how clinical social work and primary medical care might better work together. What does this collaboration of disciplines look like?

Social work roles in the primary care setting

As stated previously, the primary care setting appears to be a point of entry to receiving medical care and a variety of other complex needs often psychosocially related. Van Hook (2003) reinforces the point that physicians are the first contact for a majority of psychosocial problems. She discovered that there is growing need and attention going to ongoing management of chronic health conditions that go beyond medical intervention (Van Hook, 2003). Van Hook stated, “There is an opportunity for social work to carve out roles for the social work profession” (2003, p. 64). Social work has been present within the medical setting, primarily hospitals, but the primary care clinic, and is a newer phenomena which appears to make good sense (Lesser, 2000). It is also the assertion of Bikson et al. (2009), that more attention given to the social aspects of psychosocial problems that may lead to improved inefficiencies and reduce costs for patients and the economic health care system as a whole.

Research done by Rinfrette (2009) supports the finding that mental health and physical illness often go hand in hand. Rinfrette (2009) alleged the two issues are interrelated and making the need for care management of the psychological component integral to management of one’s physical illness. Patients are calling that central point of entry to access services for issues related to mental health or a psychosocial need. An example of this was in the Rinfrette study. She looked at treatment of anxiety, depression and alcohol disorders among older adults. What she found was that primary care on its own has some short-comings when it comes to the detection of alcohol abuse and anxiety/depression. She found that providers often don’t ask or assess for substance abuse issues in late stages of life. In addition, Rinfrette (2009) found that physicians

often don't have the time to do such comprehensive evaluations. They are trained to do medical evaluations and treat or refer as indicated.

Rock and Cooper (2000) found that it is unrealistic to expect physicians in primary care to manage these complex psychosocial issues; therefore, due to time constraints and lack of training, a patient's psychosocial issues may be neglected. This may be particularly true of the rural clinic setting where resources may be in limited supply. There are barriers and stigmas that appear to exacerbate patient situations whether it is lack of resources or knowing the provider on a personal basis. Bauer, Batson, Hayden and Counts (2005) state that the proportion of mental health care provided by primary care practitioners in rural America is greater than the national average, noting stigma as a contributor to this phenomena. A study done by the Office of Rural Health and Primary Care (2003) concluded that access to mental health care and concerns for suicide, stress, depression and anxiety disorders were identified as major health concerns among state offices of rural health. The study goes on to describe that the prevalence of psychosocial-mental health needs are no greater from urban to rural areas but that there is less likelihood that mental health problems in rural areas are overlooked and left untreated (Office of Rural Health and Primary Care, 2003). Rock and Cooper (2000) state that primary physicians need the skills of social work to handle the psychosocial and environmental factors of one's illness. They concluded that a comprehensive way of medical management is to encompass social work into this setting. By providing easy access to services helps alleviate any stigma associated with one seeking support of their mental health needs. They argue that patients should not have to go to another outside provider to get the help they need. Patients tend to feel more

comfortable in the environment they are familiar with. This is validated by the statement from Rock and Cooper's (2000) study which states that 50% of the patients referred would not have gone outside of the general medical setting for assistance.

The research thus far has concluded that single points of entry or all-inclusive care to be what a majority of what patients are seeking (Bikson et al., 2009). Also, the idea of right person-right profession comes to mind. Having a social worker address the psychosocial needs of the patient in collaboration with medical staff would exemplify the biopsychosocial model of patient care. This philosophy is also congruent with efficiency as well as effectiveness. However, it is important to note as seen with research done that the DIAMOND model has made successful strides as being an efficient and cost effective way to support patients living with depression. The DIAMOND model appears to be an evidenced based model that does not utilize specific social work skills yet remains effective within the primary care setting (Williams et al., 2010).

Physicians/nurses have time constraints and often limited skills and/or formal training in regard to the psychosocial needs of the patient. These are barriers to fulfilling a comprehensive assessment and plan of care. Research suggests that patients are going to seek care from their primary care provider. Rock and Cooper (2000) found that only 20% of persons with major depression are seen by a mental health provider and over half are seen by their primary care physician who will likely not be looking for such things. Bikson et al.(2009) and others have found that a social worker who is trained in assessing for psychosocial-mental health needs may be better able to identify these situations and to intervene as appropriate. Psychosocial needs are just one attribute of the social work profession but there are many situations where social workers can be of support.

The collaboration between social work and primary medical care.

A study done by Lesser (2000) validated what was previously cited: that asking physicians in primary care settings to do psychosocial work through assessing, referring and counseling is unrealistic and this is particularly true in a rural setting. Lesser (2000) stated that early collaboration on treatment plans offered continuity of care and strengthened the patient-doctor relationship. Both professions address very important issues (biological-psychological). In social service and mental health settings the social worker is the professional who provides care for the psychosocial needs of individuals. Gross, Rabinowitz, Feldman and Boerma (1996) use the term “physician as gatekeeper” in the primary care setting. These authors argue that there is an inherent strain between professions due to differing values, such as saving life versus quality of life (Gross, Rabinowitz, Feldman and Boerma, 1996).

With awareness of the definition of primary care and its goal to encompass the whole person there is little choice but for the professions to collaborate in meeting the needs of the whole patient. How to collaborate seems to be challenging, particularly in rural settings. Given these challenges some models of care often seen as stated by Salvatore (1988) are: a) referral-consultation model-physician does not treat but simply refers any psychosocial issues to the social worker. However, in this model, there is often little interaction between providers. b) a collaborative model where the social worker assumes psychosocial treatment which occurs over a long period of time and is often a collaborative treatment plan. c) team approach-joint problems/decision making, which is not hierarchical but collegial in structure. These three models discussed by Salvatore (1988) seem reasonable and appear to enable the physician as the dominant

provider to recognize a psychosocial need and refer as determined. The team model appears to be the most collaborative and inclusive to meeting patient needs in the primary care setting. This study explored further what model may provide for the best collaboration between disciplines and how best to meet patients' biopsychosocial needs.

One of the barriers between social work and primary care has been limited perceptions of what social workers can do, lack of stability in funding and space, and professional isolation (Lesser, 2000). This is especially true when physical symptoms become primary or a territorialism in identification of what "a patient needs." Another concern may be the amount of time it takes to "collaborate." Physicians worry that having a social worker involved may take more of their time when discussing cases when they are already pressed for time (Keefe, Geron & Enguidanos, 2009). To combat some of these challenges Keefe, Geron & Enguidanos, (2009) found through their focus study that social workers need to be visible within the clinic, available for consultation, and to have an ability to articulate how they can assist patients at all times for there to be effective collaboration. This can enhance physicians' understanding of the social work role in providing care. This demonstrates further emphasis requiring social workers to have an office within the primary care clinic. It was discovered through Lesser's (2000) work that patients were more likely to accept in-house referrals to the social worker from their physician. That having the social work office as part of the general clinic made for an easy and natural transition for further exploration of their care needs. This was also true of Rock and Cooper (2000) study which stated that greater than 50% would not have gone to a social worker outside of the clinic setting. With the positives stated to having

social work presence in the primary care setting, there are some challenges that should be noted regarding the relationship between professions.

Team focus did not appear to be an issue for a group who believed that collaboration between primary care and social work would be beneficial. This model as cited by Lesser (2000) was enacted by a group called-the Pioneer Valley Professionals (PVP). It offered health and mental health services to individuals and families from various age groups in a family medical practice in a mid-size, ethnically diverse, northeastern town. The physician and social worker who initiated the program were committed to the holistic approach to patient care. The clinic expanded through the years to include more disciplines with skills to help with issues related to parenting concerns, adolescent adjustment issues, work stress, marital and family problems, depression, substance abuse, chronic illness and grief issues to name a few. The team meets weekly to discuss indicators of psychosocial indicators. The physician and social worker continue to work collaboratively and sometimes together with the patient. The emphasis is on the biopsychosocial needs of the patients seen. This program has been very successfully evaluated and an example of a model that may benefit primary care systems yet today.

The research in the primary care setting reviewed for this study focused on how the philosophy of primary care has changed historically: what the prevalence of psychosocial problems in primary care are and how the social work role may be of benefit in helping patients cope with psychosocial factors related to their chronic health or mental health needs. It is up to social workers to demonstrate that they are qualified to provide a wide array of services that can positively affect the lives of primary care

patients (Badger, Ackerson, Buttell & Rand, 1997). Lastly, research has examined what models of collaboration exist and what barriers remain between primary care staff and social workers. One could speculate based on the research that social work has an important potential place within the primary care setting based on statistics identifying a large percentage of psychosocial needs that present within the clinic (Gross, Rabinowitz, Feldman & Boerma, 1996). Physicians or medical providers often do not feel skilled to handle these issues nor are they allowed the time to address them. A collaborative relationship between social work and primary care would seem ideal in addressing patient needs. Safran (2003) summarized this, stating, “three elements are essential to securing the future of primary care in the face of these challenges: adapting the current functioning of primary care teams so that they become visible, meaningful, and valued from the patient’s perspective; formalizing primary care partnerships; and integrating care in the face of formidable barriers.” (p 253).

Given the literature reviewed, the focus for further analysis of this topic was on the current functions of primary medical care in small and mid-sized communities, the prevalence of psychosocial issues, how they are managed and by whom? Lastly, this study evaluated the collaboration of interdisciplinary team specifically inquiring if the social work profession may be advantageous in meeting the biopsychosocial needs of patients who present in the primary care clinic, and if so, how.

Conceptual Framework

The biopsychosocial model was utilized as a framework with which to compare and analyze data in this study. The biopsychosocial model is a conceptual framework developed by the late George Engel (1913-1999). Engel believed to understand patients and to adequately respond to their needs, clinicians must understand and attend to the biological, psychological and social dimensions of illness (Borrell-Carrio, Suchman & Epstein, 2004). Engel didn't dispute the biomedical model but believed that patients were more than objects arguing that their disease processes were representative of what else may be occurring within the realm of a patient's life (Borrell-Carrio, Suchman & Epstein, 2004). In the biopsychosocial approach, disease and illness are seen as mutually influencing one another both psychologically and physiologically; not as independent properties of mind and body (Frankel & Quill, 2005). Borrell-Carrio, Suchman & Epstein outline Engel's critique of biomedicine in a few statements: "Psychological variables are more important determinants of susceptibility, severity, and course of illness than had been previously appreciated by those who maintain a biomedical view of illness", "The success of the most biological treatments is influenced by psychosocial factors", "The patient-clinician relationship influences medical outcomes, even if only because of its influence on adherence to a chosen treatment" (2005, p. 577). The biopsychosocial model developed by Engel appears to seek and identify needs of the entire person looking beyond the illness and disease into other factors that may impact illness, disease or chronic condition and its response.

The biopsychosocial model or lens clearly has a place in the primary medical setting where it is likely practiced by many professionals already. It is the belief of this researcher that primary care physicians and allied health staff see a variety of patients with multiple complex issues, many of which are psychosocially based. Individuals make appointments to see a medical provider for a potential biomedical or physical need. What the biopsychosocial model suggests is a patient will make an appointment to meet their perceived biomedical need, but the role of the primary care practitioner or care system needs to consider what psychosocial or psychological variable may be occurring that are likely related or may even be a cause relevant to their complaints or symptoms.

The biopsychosocial model has identified the physician as the person who provides the service and the one who patients are requesting help from. Physicians have great power and expertise to provide medical diagnostics and treatments, but do they possess the skill to manage the other factors (psychological-psychosocial) that accompany and manifest symptoms within patients? A literature review of this topic suggests that psychosocial issues are prevalent within the primary care setting but that physicians don't have the time, desire, or skill to be able to effectively manage psychosocial issues (Rock & Cooper, 2000). This seems contrary to what the biopsychosocial model suggests: that physicians address all components of the person, biomedical, psychological, and social dimensions of illness (Borell-Carrio, Suchman & Epstein, 2005).

This study interviewed, through semi-structured interviews, medical professionals in two primary care clinics analyzing the prevalence of psychosocial issues in primary care, who and how are the issues addressed, and how collaboration amongst disciplines

uphold the foundations of the biopsychosocial model of care to patients. It is this researcher's belief and experience that patients go to their primary medical provider as a means of "help." Patients may seek their physician for biomedical reasons but as the biopsychosocial model outlines there are other important components to helping the whole person. The hope is that a partnership can be developed that leads to patient-centered care and more recently relationship-centered care, which emphasizes the mutual and reciprocal influences physicians, patients, family members, and the community exert upon one another (Frankel & Quill, 2005).

The social work profession offers an ideal promising representative of the biopsychosocial model in primary clinic setting. The social work profession is one that practices holistic care and can provide and respond to individual psychosocial issues. Social workers licensed at the clinical level can provide therapeutic interventions within a variety of settings, primary care being one of them. This researcher has observed the social work model as an appropriate interdisciplinary team member who can facilitate collaboration while addressing multiple needs across disciplines. The primary care clinic is prime opportunity to help those who are voluntarily seeking support related to psychological, supportive, resource brokering, and financial guidance. Primary medical professionals do their jobs well and with best intentions, but there may be limitations to what can be provided by one physician with time constraints and limited skills related to mental health or psychosocial needs. The biopsychosocial model of care has been directed to physicians to provide, but are the issues becoming more than what primary care is equipped to manage? Does there need to be more collaboration and other models that are more interdisciplinary in nature? The overarching question for the purpose of

this study was: what are the psychosocial issues that present in primary medical care, and who is addressing those issues? Nine qualitative interviews of providers in two primary care medical clinics (one rural and one mid-sized) were completed inquiring about their perceptions of psychosocial issues, and currently who if anyone provides this support to patients and what solutions through collaborative efforts may be indicated.

Methodology

Research Design

A qualitative research study was conducted which looked specifically at the prevalence of psychosocial issues in two primary care clinics asking how psychosocial issues are identified and addressed in their respective clinic. Secondly, this study examined how the profession of social work may impact care delivery in a primary care clinic by working in collaboration with medical providers as an integral member: an interdisciplinary team member who can work to fulfill the holistic components of the biopsychosocial model of care. The purpose was to know what the prominent psychosocial issues are in the clinic, who provides this support and if it would be beneficial to utilize the skill of the social work profession to fill this gap in care, and how this might be done in smaller, rural settings. This study gathered information by means of survey design through personal 1:1 interviews. Providers were invited to participate therefore results are based on availability and willingness of providers who work in the primary care setting at two primary care clinics located in the Midwest region of the United States. One clinic is rural the other is a mid-sized in comparison.

Sample

The characteristics representative of this sample were that they are medical professionals who are employed in one of two primary care clinics (one rural and one mid-sized). The professionals interviewed were physicians, a psychiatrist, and nurse practitioners. Physicians, psychiatrist, and nurse practitioners were the primary focus because this is who patients appear to be coming to seek assistance from. The study

succeeded with a desired sample of nine one-to-one interviews from medical professionals in their respective clinic. Interviews were completed individually and at a location determined by the professional provider with thoughtful intention regarding privacy and confidentiality. All but one interview occurred within the primary clinic where the interviewee is employed. The one interview as determined by the medical provider was done within the privacy of the researcher's office.

A non-probability availability sample of medical providers was solicited to participate in a one-to-one interview from a list of employed physicians, nurse practitioners, physician assistants, nurses or other allied health staff from two primary care clinics (one rural-one mid-sized). The list of providers was available from a roster of staff employed within each of these two clinics. Participants were selected based on their individual professional credentials and work within their clinic. Individuals were employed at least on a part-time basis and seeing patients regularly in the outpatient clinic area. The sample size remained between eight to ten interviews based on participant's acceptance to be a part of this study, with a completed sample of nine one-to-one interviews.

Data Collection

Data were collected from primary sources exclusively consisting of individual interviews with consenting providers employed within two primary care clinics. A short letter was drafted outlining the purpose of the study and invited providers to participate. The letter was sent via email for convenience on behalf of subjects (see Appendix A) to

their email address. Based on acceptance responses from the letter this investigator coordinated a meeting time and place to conduct each interview.

Each interview consisted of eleven semi-structured, open-ended interview questions (see Appendix C) which were asked of each participant. The semi-structured open-ended questions were reviewed prior to data collection through peer and research committee review to establish face validity. At the designated time and place of each interview, I briefly introduced myself as the interviewer and reiterated the importance of gathering information based on each provider's experiences within the primary care clinic setting. The interviews conducted with medical providers were audio-tape recorded and transcribed by a hired transcriptionist. Names were not used in order to comply with confidentiality in protection of participant responses during transcription. Interviewed participants were named as interviewee 1, interviewee 2, with appropriate information transcribed accordingly for the purposes of the study. The investigator quoted individual statements in support of qualitative analysis. Quotes were identified by profession not by name.

Protection of Human Subjects

Protection of the sample interviews was maintained during data collection and after. Efforts were made to ensure protection of each interviewee's rights and privacy. This was established through the University of St. Thomas' consent form that was reviewed at the time of meeting with each participant and prior to gathering any data through the interview process. Risks and benefits were discussed prior to conducting the interview. A copy of the consent form and research proposal summary were reviewed by

the University of St. Thomas Internal Review Board and also the Mayo Clinic Internal Institutional Review Board prior to any data collection. It was determined that this study poses low risk to human participants, calling for an expedited level of review. Benefits of participation were determined by consenting interviewees. A consent form (see Appendix B) for each participant was signed verifying their willingness participate in the study. The consent will be destroyed once the research is complete and has been presented in May of 2012. A blank consent form will be maintained with the study as validation of process (see Appendix B).

Data received through interviewee responses was kept private. Field notes, emails, signed consent forms, audio-tape recordings were secure under safeguard of the researcher by locking information in a lock box within the investigator's home when data was not utilized. All identifiable information received during this process will be destroyed after the study's dissemination in May of 2012. Paper copies of transcription and any related field notes will be recycled in a locked disposal bin for confidential materials. The audio-taped interviews will be deleted from the tape recorder. Each interviewee also had the right to decline or stop the interview at any point during this study and was reminded of this during the review of the consent form prior to conducting the interview.

Data Analysis

Manifest and latent content analysis were completed upon finishing the personal one-to-one interviews. This process consisted of the researcher taking audio-taped interviews to the transcriptionist to complete transcription when all interviews were

completed. A transcriber confidentiality agreement was completed between the researcher and the hired transcriptionist. All participant responses were named by number (i.e. interviewee #1, interviewee #2) with the interviewee responses italicized. Completed transcriptions came in a Word document form via email from a hired transcriptionist and sent to the researcher. Each document was printed in preparation for coding procedure and organization of questions based on responses of participants. The researcher broke down statements or phrases into identified themes or trends from transcribed records to analyze content of each interview. The system consisted of manually cutting statements and taping onto themed boards or coding frames to break the data into themes that develop from the interview questionnaire (Berg, 2009). This investigator listened for sensitive-common themes across the interviewed professionals' statements.

Themes, words, cultural concepts, practices, and expectations were identified based on the qualitative responses given by participants. This information varied dependent upon what words were used to express perceptions. Careful review of data was used to develop the results section of this study which was organized accordingly: identifying the prevalence of psychosocial issues in primary care, how are they addressed and who is, or would be a collaborative professional to help in the management of these issues.

Strengths and Limitations

A potential strength of this study is that primary care providers of this study come from well established organizations that currently uphold the a biopsychosocial model of

care. The biopsychosocial components may be a part of their system already. This study will potentially provide validation to their system and procedures they already practice strengthening the belief that there are psychosocial factors and methods of management in place. Another strength is that the study can have the potential to provide rich data through qualitative interviews/responses that may benefit primary care professionals and the patients they service in any demographic region throughout the United States.

The same strength may prove to also be a limitation in that it was a small study. The sample size included nine 1:1 interviews of providers representing only two relatively smaller clinics operating in the upper Midwest. The region where the study took place is predominantly white middle class professionals and patients. The study may also lack cultural diversity making the responses not generalizable across inner city regions or cultural groups throughout the United States. Even with these limitations, the results will hopefully be able to speak to both the psychosocial needs of those to seek their primary care provider for support in rural settings where little attention has been given, ways they are currently addressed, and ways that they might be better addressed, potentially pointing to even better or more refined/novel models of delivering care in smaller (i.e. rural) settings.

Results

A qualitative study was conducted with the intention of gaining understanding of what specific psychosocial issues present when patients seek their primary medical provider, how the primary medical provider responds to psychosocial issues and what can be done to improve meeting patient psychosocial needs in the primary care setting. Participants were invited from a list of medical providers currently working in two primary care sites, one rural clinic and one mid-sized clinic. Each provider was sent an email invitation explaining the intent of the study. Interviewees were allowed to determine the time and a private place for the individual interview. Each consenting interviewee was asked 11 questions. The interviews were audiotaped and later transcribed. Each transcript was carefully reviewed by this researcher, who sought consistent themes from provider comments. The results provided a natural divide or point of comparison between providers from a rural primary care clinic and one from a mid-sized primary care clinic where a current integrative behavioral model is currently part of a separate pilot study.

Sample

This study consisted of one-to-one interviews with a total of nine participants. Each interview consisted of 11 questions that were asked of primary care providers. Five primary care providers were from a rural clinic, which included three physicians and two nurse practitioners. Each interviewee reported that they see a wide range of patients from birth to old age. The qualitative data collected at the mid-sized clinic also included one-to-one interviews with two primary care physicians, one psychiatrist, and one nurse

practitioner. Five providers were from a rural clinic. All providers clearly outlined their daily appointment time slots set out by their system of on average 15, 30 or 45 minute increments they are given to assess and recommend treatment for patients. This was a consistent theme among all providers with the one exception of a psychiatrist who has more time allowed for assessment and treatment 30-60 minute appointment times. Also consistent was the medical providers' perception that patients generally were coming in to see them for a medical reason or physical complaint.

Rural primary care clinic

The rural primary care clinic is a small clinic located in a Midwestern town of approximately 2,500 people. They work in conjunction with a larger entity but are a free standing organization that sees patients from all age groups and help manage multiple medical needs ranging from sore throats to annual physicals to chronic disease management. Three physicians and two nurse practitioners from this clinic were interviewed.

Mid-sized primary care clinic

The participating providers from the mid-sized clinic were two physicians, one psychiatrist and one nurse practitioner. This clinic is located in an average size Midwestern town of approximately 100,000 people. It is one of many clinics located in this same town. The mid-sized clinic interviewees made it known that they had been participating in a pilot study referred to as the Integrative Behavioral Health or (IBH) project. The goal of integrative behavioral health (IBH) is to address patient mental health needs in a collaborate team approach with the supports of a psychiatrist, a PhD psychologist, a certified nurse specialist, two social workers, and two registered nurses all

within the primary care clinic. They identified their weekly meeting as *the huddle*. The IBH team collaborates weekly for approximately 30 minutes to address more difficult patient needs. Patients are referred to the team from providers within the primary care clinic to address mental health/psychosocial needs. The IBH team is a natural part of the primary care clinic where patients are referred from within. This mid-sized clinic also participates in the DIAMOND program (Depression Initiative Across Minnesota, Offering a New Direction). The DIAMOND program is a process and structure for providing ongoing support to persons diagnosed with depression. It works within the primary care setting as an interface between nurses specializing in management of depression and a patient's primary medical provider.

Findings

The providers interviewed were asked 11 questions in a one-to-one format. The questions focused on what this study sought to explore, specifically: a) what are the psychosocial needs of patients that present in rural and mid-sized primary care settings? b) How are providers responding to meeting patients' psychosocial needs? c) Are patients' needs being treated in a holistic manner where both medical and psychosocial needs are being addressed, and what improvements if any, can be made to enhance meeting these needs? Participants were asked specific questions regarding their perceptions based on their professional work experiences with patients they see each day in the clinic.

What are the psychosocial needs that present in primary care?

The themes identified from participants in rural primary care included insurance issues, social issues, transportation needs, general direction and the expectation that the

physician will solve a certain problem for them. Some patients made appointments simply to just talk or receive reassurance regarding an issue. One interviewee questioned had a difficult time articulating what psychosocial issues are, however she felt comfortable managing routine depression and anxiety diagnosis. The participants referenced depression and anxiety to be the two primary mental health diagnoses they see and manage on a regular basis. All interviewees felt that at least 50% of patients receive mental health care from their primary care provider.

Oh yeah, we're the first people that they'll see or talk to about their problem. Sometimes they don't even really recognize that a lot of the physical problems that they are having are actually depression manifesting itself.

The themes identified from participants in mid-sized primary care clinic were more specific. The psychiatrist whose primary role was mental health management could easily articulate patients' psychosocial needs and viewed their psychosocial needs as a barrier to their getting better.

So often it's hard to think of a single patient where psychosocial issues aren't a factor. Some have issues that seem to be unsolvable, there's the full gamut, but I really feel strongly that we need to address those and take them into consideration each and every time we're coming up with a treatment plan, whether it's for a behavioral health problem or a medical problem or a surgical problem.

The other providers identified specific psychosocial issues as chronic mental health issues, again depression, anxiety, social situations, insurance issues, resources, or *just other things that created a stigma around them.* Even in the mid-sized area transportation remained a barrier as did unemployment. Being uninsured or underinsured provided a particular challenge, in that providers may have good ideas or

treatment options but the logistics of follow through are not realistic due to limited access which is often financially based.

What are the Psychosocial Issues that Present in Primary Care

Rural Clinics: *I will occasionally have patients come in and unload a number of social issues, on me, and they have the expectation that I will solve them.*

I've had some patients come in and give me other social-related concerns. For example, they were dropped off at the clinic, and it's their expectation that maybe I'll provide them a ride home. You know, I've even had patients ask me for money to pay for a cab to get home.

I do have a fair amount of, of, I would say psych-soc needs in the female as she goes from different stages of her life. And so that, um, there's days where there's a lot more psychosocial kind of counseling that goes on than actual physical type of counseling.

I have one lady who has several issues that are very active, that just needs to come in and talk and know that someone's there that can hold her hand a little bit and tell her that everything is alright and for her peace of mind, which can go a long way.

The main issue is how expensive medical care is.

I'd say, it's probably close to half the people that have some sort of depression or anxiety.

My patient's story that comes to mind is a diabetic patient in his late 20's who I think works for a fast food restaurant, so obviously he doesn't make a lot of money, but can't afford insurance, and is at a place where he really needs to be on insulin, and obviously that's really expensive, and he can't afford that, he'd need teaching because he's not, you know, I mean, he's marginal intelligence and when I call the county, and this was in another state to see about health care coverage they were like, oh, he doesn't qualify because of his age, and I said, so in ten years when he's on dialysis? They responded oh yeah, he would then qualify. Something is wrong here and I don't know what to do about it.

Mid-Sized Clinics: *The ones that have a lot of psychosocial problems are the ones that are frequently here, and just anecdotally the ones who have illnesses that seem to be more treatment refractory.*

The medication I suggest doesn't work, but maybe it's not because the medication is ineffective, but because when can't pay your bills and you have all these other things going on at home or in a relationship or at work, or in life that just makes it more difficult.

I was doing DIAMOND supervision, and I think out of the eight new patients that I heard about, I thought that one of them is probably going to get better because of this being an episode of depression that will be responsive to medication, and the other seven I would say, four of them had such dire psychosocial problems that I sat there as the provider with two other nurses, and we just looked at each other like, "what are we going to do for this person?" This is an issue of having no money, of having unstable housing, and of living with abuse, of being unemployed, of looking for disability, we were talking about resources that were needed.

We try to delve into more at their physical exam, but sometimes those issues come up if they're coming in for, you know, depression, anxiety symptoms or fatigue. You know, they don't recognize that it's depression, anxiety. Our appointments are 30 minutes, so we don't get a whole lot, you know.

The frequent flyers are the ones that, and we know almost every physician will tell you they know who their frequent flyers are. They are seeing them often. Sometimes it's a personality disorder where they just feel a need to have consistent, recurrent follow-up with that; sometimes its drug seeking behavior or pain behaviors.

I have a number of patients who really just need reassurance and for many of them that works. For others, it doesn't. They'll find a new worry that requires an office visit. I would say I have a lot of this.

What I tell the students I teach is; what I didn't expect when I went into family medicine was how much of, your care would be mental health issues.

How do providers within primary care respond to meeting the needs of patients?

The interviewed providers despite their similar professional affiliation and medical focus responded to meeting patients' psychosocial/mental health needs very differently. This rural clinic voiced some issues specific their system and how the American system has created more troubles for itself. Actually viewing the approach that the American political system, *that we've caused more problems by our attempt to solve the problems*. This statement was viewed as an outlier and an opinion related more to structure and a personal political statement. This person's statement was interpreted by this researcher as suggesting that the American health care system has been too generous in allowing access medical services and that some individuals may be abusing the privilege, resulting in a large financial burden on the system as a whole. The rural clinic interviewees made it very clear that they are responding by managing the psychosocial factors as best they can. They have limited time, limited resources within their system and community. They have access to one psychiatrist who they perceive as heavily over-worked. It was stated that there is one mental health organization locally and patients referred may wait months to be seen. Rural medical providers are making referrals to this agency and providing counseling themselves until the patient can be seen. One provider indicated that: *I am dealing with this 100% on my own*.

It was identified that the rural clinic has a social worker available within the hospital and nursing home who they will ask assistance from on occasion but not as a rule since the social worker's job is at the hospital/nursing home which is part of a different medical corporation. The providers will collaborate with one another as the situation deems appropriate and the system allows. Lack of time, resources and knowledge of how to help seemed to be the predominant themes amongst this rural group of providers.

The mid-sized clinic medical providers all spoke to the new model currently being piloted at their clinic, integrated behavioral health (IBH) model. Each provider identified that when they encounter mental health or psychosocial issues they feel are a concern they are able to logistically refer within to whatever professional provider is appropriate or needed. A physician spoke to the fact that they have extra resources and can do what they refer to internally as the *warm hand-off*. It is still determined by the medical provider if the patient needs additional support. The primary care provider proceeds with the *warm hand-off*. This is a practice of inviting the patient and other disciplines/providers, often a part of the IBH team, to collaboratively work together in an attempt to manage patients' psychosocial issue. One nurse practitioner felt comfortable handling the basic "depression symptoms" but if she didn't she would refer to the DIAMOND program within the clinic. Other providers are utilizing social work services who are onsite to assist with counseling, specifically for management of anxiety. One provider spoke to being *resource rich* at this clinic. Other supportive professionals aside from the IBH and DIAMOND providers were physical therapy, diabetes educator, and nicotine dependence center.

How do providers within primary care respond to the psychosocial needs of patients?

Rural Clinic: *I think that how we can manage these problems in a clinic setting obviously is to have a social worker be able to deal with these requests, and that takes the burden off, the physician. I could say, Hey, I am going to send you down the hall to speak with so-and so because, I'd like him or her to address this issue. I'll take care of the medical issues they can take care of the non-medical issues.*

Our resources are limited, and there's not an official referral process. There's not a magic button that I push.

Access is limited based on insurance and that seems to be our biggest road block, if their insurance doesn't cover one or other providers, then they can't be seen, it might be weeks before there is an opening.

We do have access to some social work, some psychiatry, but that is about the extent of it.

I can put someone on medication and have them come back in a month, but it would be really nice to be able to get them into talk to a counselor within instead of waiting weeks or months.

It's the time. To really deal with all those issues when it gets into that, you know more complex, therapy, you know, I really don't know that I have the skill set for that next level of therapy. This is a problem; we don't have access to resources for this service.

Mid-sized Clinic:

I am very fortunate now to have the support of two social workers on site, so I call on them to help me with resources. That is the real benefit, though, of working in this team setting we have full-time, two social workers every day of the week to utilize so I get resources for them, they get resources from me.

Certainly if it's something related to, let's say, insurance coverage; not my area of expertise.

I have the opportunity to call on social workers and nurses, and I do all the time. We, really work as a team and we have, once a week the behavioral health providers, that is two social workers, two RN's, a clinical nurse specialist, our PhD psychologist and we meet to discuss issues.

We have the capacity to interface with our social workers for all those needs, so we're able to provide short term psychotherapy to do other resource, information and assistance for patients, whether its insurance, or medications or assisted living information, or other community resources. It's a one-stop-shop.

I think it's good use of the primary care providers time then to say, we'll focus on my area of expertise, but then I'm going to pass you on to my colleague whose area of expertise is this other issue that

you've brought up during your appointment, which is equally, sometimes more, important than the medical need.

We did start a new program where they would do just a triage. If we had somebody we had a mental health issue with, we would just say, let's get the social worker, they can come in and evaluate the patient, see what is needed from the patient, whether it's therapy issue, social work issue, or if there was some other issue that needed to have referral, they would know where to make the referral from. It's like having a point person.

There aren't enough psychiatrists and psychologists to take care of all the mental health needs of this country.

In primary care, we need to handle mental health. It's a huge piece of people.

Cuz sometimes, as primary care, we're not real sure what we need and what the patient needs? And it just is needs someone who can sit down that knows resources, and has those brains that we don't have....

Having a social worker in primary care, in one building allows us to cement the whole process.

There is a new referral process in place, that they've come to our family practice meetings, and you know, make sure that we were clear on what areas were available for referral, and, ah, so I think it's actually very, very good.

The interviewees responded differently to ways of improving meeting patient needs in the primary care setting. The rural clinic presently does not have access to support services to help with the management of psychosocial issues. They can refer out; however that can come with long waits and lack of follow through, a choice that may not be realistic in meeting patient needs. In some situations the nurse was assisting but the majority indicated that they are providing the counseling and management psychosocial issues on their own, an area viewed as outside of their expertise. One interviewee was

not sure who else could assist. Her response was: *more time, more providers*. She was unsure of social work roles and how that profession may be supportive. Others wanted help and voiced a willingness to learn ways to collaborate to increase ease for patients and ultimately for themselves. The system was identified as becoming more difficult, taking them away from what they do as medical professionals who currently have to respond to all patient needs at this time.

The mid-sized clinic responses were more favorable in how they are responding with the support of the new IBH model which was perceived to be helpful according to their responses. Improvements identified were that this current model be able to be implemented in other primary care settings but that as holistic providers they are able to see patients in their own home settings (case management model), especially if the patient cannot come into the clinic due to transportation issues. The mid-sized clinic viewed the IBH pilot as cost-effective, patient-centered which currently may even be decreasing ER visits. One provider verbalized the need for all patients to have psychosocial evaluations, suggesting that the model move from visit based to population based. That there may be issues that are getting missed since only a small percentage, those who are at the highest risk, are being referred to helping professions in their resource rich clinic. One other area for improvement discussed was supports specifically for evaluation and treatment of chemical dependency. Lastly was the thought to have more groups within the clinic setting such as outpatient support groups for mental health needs, weight loss, obesity, and addiction, the thought being that patients may be more likely to attend group meetings, because the stigma of going to “the clinic” is viewed as

more favorable than going to a mental health facility or substance abuse center to access a group.

What can be done to improve meeting patient needs in the primary care setting?

Rural Clinic: *We do not have a social worker physically in the clinic to call on for resources. I feel that a social worker could very easily be integrated in the primary medical setting because there is a need for that.*

You know, we need more doctors, and we need more nurses, and we need more social workers.

It takes more people to take care of more people. We as a nation have implemented an electronic medical record, that has further limited access because a physician such as myself, who could have ten years ago seen 40 people and five years ago seen 25 people, is not seeing 15 people because the system does slow you down.

I think if we had a psy-soc department, I could see that being a really important part. Because often her, the nurse right now is doing that, and that's not really the nurse's role either to be doing those kinds of things.

You know, depression that is not responding to medication treatment, it would be nice to have more available, more resources

It would be nice to have more mental health providers in the area, because I am a strong believer in medication and counseling.

If we had more mental health services here in town, even attached to the hospital, or even better communication with the Department of Social Services in town, you know, that may be helpful?

It would be nice if we could have more services that we could refer people to.

Mid-sized Clinic: *In a perfect world it would be great to have providers who could go out and do home visits and meet with their patients in their environment rather than expecting that everyone is going to be mobile and able to get here to the clinic. Many don't have access to transportation or other sources that are TV or internet based.*

Another thought would be to have some form of groups available to patients in the clinic. These may be psychotherapy groups, less specific groups, informational, problem solving, activities.

How to engage social services and social work into the entire practice as a whole rather than just the patients that fall in through, the , front door; way to figure out how to meet the needs of the population rather than just the individual patients.

I talk to my social work colleagues every single day. They are an indispensable part of my practice.

That the IBH model be able to be practiced in all primary care settings especially rural areas.

What would be helpful would be for at least someone to come to them and, with a list, rapid phone numbers, addresses, what is available for the social services community. If you don't have that in place to make the referral or to have a warm hand-off, then those environments really need to have definite approach to handling those sorts of situations.

In conclusion, the qualitative data revealed that psychosocial issues are prevalent within the primary medical settings sampled. The issues range from mental health issues: depression, anxiety, adjustment to new living conditions/circumstances, to financial concerns, transportation, lack of insurance, and sometimes the need for simple reassurance from someone the patient trusts. These similar characteristics were representative within both rural and mid-sized clinics. The differences became evident in how the rural and mid-sized clinic providers responded to patients' psychosocial needs. The rural clinic appeared to be self-reliant in the way they responded to meeting patients' psychosocial issues. The providers in the rural clinic are performing the supportive counseling needs and making referrals to outside mental health agencies which lack timeliness in meeting individual needs. Clearly the providers feel the stress of

managing patients' holistically but voiced limited time, skill and resources as barriers. The providers of the mid-sized clinic are responding to meeting patients' psychosocial needs through the use of a behavioral health team model, which has been helpful to meeting patient biopsychosocial needs. The IBH team consists of a psychiatrist, two nurses, one clinical nurse specialist, one psychologist and two social workers.

All providers believed that they could improve in meeting patient psychosocial needs. Specifically, for the rural clinic it was to have access to someone or a system that would assist with support of patients in need mental health services or resources. They also wanted to learn more about the role of social work as a profession that could provide such service in working collaboration. The mid-sized primary care clinic was focused on the goal of moving forward by implementing their pilot program permanently; with the hope of IBH implementation at other primary care sites. The mid-sized clinic also had the additional goal of expanding group work within their system, but to also to be able to identify psychosocial needs among populations thus, being able to help more than the small percentage of those referred to the IBH team for support.

All providers interviewed also verbalized the difficulty in the current health care system as a whole. The current system for accessing health care is making it more difficult for patients and for providers to be able to provide best care practices. When asked what providers' ultimate goal each day was; all responded with patient-centered statements and a sincere sense of pride in helping individuals on many levels.

Discussion

This research set out to explore what psychosocial issues present in the context of the primary medical setting, how medical professionals respond to patients who are seeking support in regard to their psychosocial issues, and what collaboration between professions looks like in these settings in relation to helping to meet these needs. A fair amount of research has been done looking at different variables within the primary medical setting. Bikson, McGuire, Blue-Howells, Seldin-Sommer (2009) articulate that primary care physicians and clinics have become the frontline of health care for most Americans; they are typically the first point of contact for patients seeking treatment and referrals. Another reality is that patients are living longer, however often with chronic illness (Rothman & Wagner, 2003). It is with these known facts that this study hoped to provide some clarity as to what systems might be helpful in responding to patients' complex psychosocial needs, particularly in rural settings and in smaller cities. A dominant finding in this study was that patients are using their primary care provider as a one-stop shop to address a multitude of needs. All providers interviewed for this study agreed with Bauer, Batson, Hayden & Counts (2005) who identified that as many as 45% of individuals who receive mental health care receive it from their primary care practitioner. This was particularly clear especially in the rural clinic setting. The mid-sized clinic practitioners' reports were also consistent with this statistic but demonstrated a very different response to addressing patient psychosocial issues, which will be described below. The intent of this study was not to compare and contrast responses between the rural and mid-sized clinics, but as data were gathered and received it became a natural

and significant divide between these two settings in how they worked at the macro-level perspective

Rural clinic issues and response

The responses of medical providers within the rural care setting could be summarized as *psychosocial issues are prevalent each day as providers encounter patient care*. The issues varied from loneliness, lack of medical insurance, depression, environment changes in their home life, anxiety, issues related to women's health, and just lack of resources and the need for counseling. In this rural Midwestern clinic it has become the "de facto" system for delivering mental health services; as referred to through research and statistics from the Office of Rural Health & Primary Care (2003). The providers in this clinic described presently managing patient psychosocial and mental health needs, often independently. The issues stated appeared consistent with what other researchers have identified such as VanHook (2003) who discovered that major psychosocial issues included family problems, depression, anxiety, substance abuse and violence.

While the issues identified appear consistent, the response from VanHook (2003) was that social workers could provide support ranging from brief assessment to extended psychotherapy utilizing various therapeutic interventions. This small rural clinic represented in this study did not have access to social workers within their clinic. There were social work services available at the county level and within the hospital setting but not within their access. Some providers interviewed expressed difficulty in identification of what psychosocial issues were or how social worker services may be beneficial. It

may be was because these providers didn't see the delineation and took the responsibility on as their job in assessing patients holistically, a responsibility that George Engel believed should occur in addressing the dimensions of illness through his biopsychosocial framework (Borrell-Carrio, Suchman & Epstein, 2004). This researcher perceived that the providers consistently had their patients' needs as primary but it came down to the fact that in the rural setting there simply was a lack of resources, lack of access to the resources that may be available, and lack of awareness as to how to help patients with complex psychosocial needs. These providers were indeed managing their patients holistically but not necessary because they wanted to. They were doing the best they could given their area of expertise and in the interest of time.

Providers in the rural clinic not only verbalized a lack of resources, but lack of time and skill in assessing psychosocial needs: a statement consistent with previous research done by Rock and Cooper (2000). This was reinforced also by Rinfrette (2009) who found that physicians often don't have the time to do such comprehensive evaluations. They are trained to do medical evaluations, treat, and refer as indicated. All providers spoke to their allotted-limited time frames of seeing patients in 15, 30 and for an annual exam 45 minute intervals. The providers identified that their primary goal was medical management of their patient's needs. The providers stated that having a social worker available would be a benefit for them and the patients they see. All were open to having social work as an integral part of the team. They knew they would need to educate themselves on what social workers could do to assist them in meeting patients' psychosocial needs. They as medical professionals were not trained to do such comprehensive assessments nor had the time to do them. This was supported through

previous research by Rock and Cooper (2000) who stated that primary care physicians need the skills of social work to handle the psychosocial and environmental factors of one's illness. Lesser (2000) validated that asking physicians in primary care setting to do psychosocial work through assessing, referring and counseling is unrealistic which is particularly true in rural settings.

Mid-sized clinic issues and response

The research participants from the mid-sized clinic were able to clearly articulate the psychosocial needs they see in their patients each day. This was particularly easy for the psychiatrist interviewed who knew how to assess, treat and manage psychosocial-mental health issues readily. The psychosocial issues identified were similar to those identified in the rural clinic: chronic mental health, depression, anxiety, social situations, financial, insurance, housing or other issues associated with stigma in the American culture. What was interesting was how the mid-sized clinic has responded to addressing these issues. This clinic has been piloting an integrative behavioral health team (IBH). IBH is a model of care similar what other systems have implemented in response to the management of patient psychosocial-mental health needs. The Pioneer Valley Professionals (PVP) was a group cited by Lesser (2000) that offered health and mental health services to individuals and families from various age groups. This mid-sized group, PVP, was committed to the holistic interdisciplinary team approach to patient care. They assisted patients who were coping with depression, marital and family problems, substance abuse, chronic illness, and grief issues. The IBH team representative in this mid-sized clinic works similarly where providers are able to refer patients or do what they call the *warm hand-off*. The *warm hand-off* is a process whereby the provider

draws the line with an awareness of limitations often related to time or expertise and proceeds with a referral to a professional from the IBH team or the DIAMOND (Depression initiative across Minnesota, Offering a New Direction) program. The IBH team may be a nurse, psychiatrist, psychologist, social worker or clinical nurse specialist depending on the identified variables. Providers reported that they are able to access assistance immediately and actually introduce the patient to the provider; often a social worker to help them to assist with the issue as opposed to giving a phone number with the expectation that the patient will follow through. This study revealed social work to be a big part of a provider's response to patient needs. The mid-sized clinic is staffed with two full-time social workers who are highly valued and utilized in addressing patient needs. Referrals may be for resource brokering, insurance issues or psychotherapy for management of depression and anxiety.

The DIAMOND program is solely focused on the management of depression through nurse case managers who provide phone follow-up consultation after the initiation of pharmacological treatment (Williams, Jaeckels, Rumman, Somers, Nesse & Gorman, 2010). The DIAMOND program appears to work in conjunction with the IBH team within this mid-sized clinic. Its goals are specific as is the IBH team. Once referrals are made, they are triaged to the appropriate professionals for follow up. Previous research done by Salvatore (1988) identified that various models of care are effective within primary care. The mid-sized clinic appears to have adopted Salvatore's model of team approach-joint problem/decision making, which is not hierarchical but collegial in structure. It is collaborative and effective model in this mid-sized primary care clinic that was studied. The DIAMOND program can be assisting patients with

medication management while professional providers of the IBH team are working to assist with how the patient will pay for the medications. The IBH providers will have other access to support groups, community resources to further support the depressed individual.

Outside of the IBH team the social workers are utilized for their professional skills in assessment, resource brokering, and psychotherapy. They share space within the medical clinic with the other medical and interdisciplinary professionals. Keefe, Geron & Enguidanos (2009) found that social workers need to be visible within the clinic, available for consultation, and to have the ability to articulate how they can assist patients at all times for there to be effective collaboration. This can also serve to educate others as to what social workers can do in their role within primary care. To emphasize social work presence directly within a clinic even further Lesser (2000) found that there was a natural transition reducing any stigmas to meeting with a social worker. This was also true of Rock and Cooper (2000) which stated that greater than 50% would not have gone to see the social worker outside of the setting, making a case for why social workers as team members need to be logistically in the clinic available for consultation and collaboration.

Implications for Social Work

The implications for the social work profession may seem obvious as the two clinics had distinct responses in meeting patients' psychosocial needs. The mid-sized clinic had social workers and other disciplines available on-site vs. the smaller rural clinic which had very limited social work services available. As a response all providers

interviewed at the rural site expressed a belief that social work would be an advantageous profession that could assist them and the patients they see, not only on the micro-level of day to day direct patient care but at the higher level by helping to actually reduce the economic burden of “frequent flyer” visits or emergency room visits. The mid-size clinic participants voiced a future interest in providing groups to support countering obesity and/or substance abuse intervention and prevention programming. The negative stigma of needing help or potential labeling appears to also be reduced for patients going to the primary medical clinic as opposed to an outpatient mental health center or county welfare office. This may also increase adherence to appointments and reduce crisis/emergent situations. Previous research by Rock and Cooper (2000) found that greater than 50% of patients would not have gone to a social worker outside of the clinic. This further suggests the importance of having social work service available is great but on-site is really the key to cementing the process. This may be especially true in the rural setting given the limited access to resources outside of the primary care setting. However, authors Gross, Rabinowitz, Feldman and Boerma (1996) found that the physician does become “the gatekeeper” in the primary care setting. These authors argue that there is an inherent strain between professions due to differing values, such as life versus quality of life. This statement is contrary to this study but does point out the important power structure that could occur. This may be especially true with the establishment of social work services as providers come to learn how to utilize the supportive service. Or, provider’s preference may be in favor exclusively of the DIAMOND program as it develops or expands to managing patient’s depression. Its future may or may not support the implications for social work.

The social work profession within primary care may also provide added benefit at the macro-level knowing how the medical system as a whole has changed by being able to recognize and provide adjunct into these changes with awareness, flexibility and collaboration in meeting patients where they are at. The system as discussed early within the literature has gone from the country “doc” to a very complex system further exacerbated by the challenges of patients’ chronic medical and social needs. Rothman and Wagner (2003) remind us that an estimated 99 million Americans live with a chronic illness. These researchers also go on to say that patients are expecting more of their providers. Consumers are placing great value on having a clinician or a team of clinicians that is familiar with the “whole patient,” and can communicate and coordinate across settings (Rothman & Wagner, 2003). Whether the system as a whole has enabled the process as interviewees from this study identified, “frequent flyers,” or those patients who frequent the clinic for a multitude of issues with little regard for appropriateness or how the service will be paid. Or, is it the medical profession’s advancement with the help of pharmacology that has facilitated the need for “a pill or quick fix.” These are all issues that appear to be prevalent where the social work profession can have an impact through addressing the uninsured or by providing support through therapeutic interventions to address mental health issues, issues that the medical provider doesn’t have the time to do, or the patient has limited resources and cannot afford pharmacological recommendations from the provider. The psychotherapy skill at the LICSW level can be a practical intervention within primary care. This would potentially allow patients’ medical providers, who may have prescribed medication and counseling, to better collaborate in meeting patient’s biopsychosocial needs. Rinfrette (2009) in her

study found that depression is often associated with underlying causes or co-morbidities in the elderly and that a variety of therapeutic interventions such as problem-solving therapy and interpersonal therapy, may be effective at addressing psychosocial concerns when medication to treat does not work sufficiently and/or may not be wanted.

There are truly a multitude of factors that the primary medical setting appears to be facing on many levels. This was reported by providers of this study and validated in current research. Phillips (2005) states primary care professionals are working longer hours, under high stress, have poor reimbursement and losing their scope of practice. Phillips stressed that without new models of care primary care providers and systems will continue to suffer (2005). This was evident from the responses of the rural primary care clinic interviewees. The mid-sized clinic providers appear to be getting on-board with changes in how they as providers need to address the issues and meet patients where they are at. The mid-sized clinic appears to have adopted a model of care, IBH, that encompasses social work services in an attempt to address patients who are experiencing more complex often chronic conditions. Their hope was to be able to move this model to other clinic sites in the future. Their integrative behavioral model is one way of addressing patient's biopsychosocial needs but doing it interdisciplinary through joint collaboration of not only social work but other disciplines as well. It is uncertain if the IBH model would work as well in the rural setting. It would seem that consideration with potential modification of a similar plan might be worth a trial to support the current medical practices who clearly have stated their limitations and desire for more education, support and collaboration of resources. The goal being improved management of patients biopsychosocially with the added benefit of support to provider and macro-level system.

Strengths and limitations to the study

There are several strengths to this study. First, this is a topic where a lot of discussion and controversy are currently active. There has been recent research done in the last ten years with which to compare. People are concerned about the health of primary medical care and are asking if today's patients' needs being met. People are beginning to look for better ways to meet psychosocial needs in this setting. This researcher found that providers are recognizing these concerns and feeling a need to have more supportive services available. The days of a one man operation have changed. They are not sure how to remedy the complexities of the patients they see but are hopeful. It was very clear especially in the rural setting that providers want help. They humbly admitted to not knowing how social workers could help them but wanted to learn. A second strength of the study was the natural comparison that occurred between the two clinics. The opportunity to compare and contrast systems occurred which demonstrated what is not currently working compared to what may be working well. This was not the intention at origination of the study, but provided good insight into how the perception of social work and a team model can be of benefit.

This study also had the fortunate ability to tap into some very experienced, intelligent providers who were willing to take the time to share. The informal semi-structured nature of the interviews allowed providers to openly share their feelings and opinions in a non-judgmental way. This was an opportunity with guided questions to gain qualitative responses to what providers are experiencing in their practice with patients each day in the clinic.

Some limits to the study were that it was a relatively small sample of providers interviewed, with a sample of only nine providers. The providers were somewhat diverse but a larger sample of more providers in different regions of the United States would be interesting comparison and a potential for future studies. Another potential limitation was that all providers interviewed were aware that the researcher was a social worker. This may have biased their responses and suggestions to questions asked of them. A potential positive effect, in relation to that, though, is the provider or interviewee may have gained some knowledge of social work potential within the primary care setting and how it could work well in the management of patients' biopsychosocial needs.

While this study gained great information and validated current research relative to social work in primary care, it may be beneficial to inquire in future studies about what patients perceive they need when they go to see their primary care provider. Such a study could ask, Are they (outpatients in such settings) seeking support of their psychosocial issues or are those issues a side effect to their current life situation? A random sample of interviews of patients would be very interesting to know for the knowledge of it but also as a comparison to what providers perceive patients are seeking. This researcher believes this would provide a true statement to the added benefit of the social work profession, but there may be contraindications and limitations that would require further exploration.

In conclusion, this study set out to ask: what are the psychosocial issues within primary care, how do providers respond, and collaboratively meet patients' needs. Clearly, providers agreed that there are a very often a multitude of psychosocial factors in primary care. The two clinics interviewed (one rural-one mid-sized) are electing to meet these needs in different ways; one more contemporary through the use of team and the

integration of social work services, and the other addressing as best they can with limited access to resources and time but open to learning how supportive services in this setting may be advantageous. The constant here is that medicine and primary care are forever changing. Patient needs are more complex due to chronic disease and extended life expectancy. Primary care in the United States has been scrutinized by the British. This was identified in a study by Phillips (2005), who found that medical advancements have proven profitable but also yields uninsurance and undersinsurance, poor population health compared with other developed countries, a truth is that as a country the United States needs to address. Regardless of how the primary medical setting responds psychosocial-mental health issues will always be present. Multidisciplinary collaboration to address patient psychosocial needs may be one way to manage these issues as this study examined. This was evident in a quote from one interviewed physician who tells his residents, *what I didn't expect when I went into family medicine was how much of your care would be mental health issues.*

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APPENDIX A

Invitation to Participate

Dear Medical Professional,

I am conducting a study looking at what the prevalence of psychosocial issues in the primary medical setting. Psychosocial issues in this context are defined as problems in any of these domains: primary support group, death of a family member, disruption in group or family-separation-divorce, problems related to social environment, loss to death, inadequate social support, discrimination, living alone, occupational, housing, difficulty with accessing health care, legal issues, financial problems and physical/mental illness.

This study is being conducted by myself, Mindy Wise, a graduate student at the University of St. Thomas School of Social Work under the supervision of Dr. David Roseborough.

As a medical professional working in this setting I invite you to participate in this research. You are invited to participate because you are currently working in the primary care setting and seeing patients on a regular basis.

If you agree to participate in this study, I will ask you to meet with me to complete an eleven question interview about your perceptions of the psychosocial needs of individuals who present in the primary medical setting. This interview will be arranged at your convenience and should not take more than 30-45 minutes of your time. The interview will be audiotaped and transcribed for the purposes of this study. Neither you nor your responses will be personally identified.

Your participation is completely voluntary. If you would like to be a part of this study I would ask you to please email me to schedule a time and date to complete this interview. I am hoping to complete a total of eight to ten personal interviews. Your consideration is very much appreciated. I look forward to hearing from you.

Mindy Wise, MSW student

University of St. Thomas

CONSENT FORM**APPENDIX B**

Please read this form and ask any questions you may have before agreeing to participate in the study. Please keep a copy of this form for your records.

The prevalence of Psychosocial Issues in Primary Care

IRB Tracking Number 286478-1

Project Name

General Information Statement about the study:

This qualitative study is being conducted which is asking what are psychosocial issues that present within the primary medical setting. What are the specific concerns with which present, who addresses these issues and what might the collaboration between interdisciplinary team look like to best address biopsychosocial needs of individuals seeking support from their primary care clinic.

You are invited to participate in this research.

You were selected as a possible participant for this study because:

You are a provider currently working in a primary medical clinic. You are seeing patients on a regular basis and can provide valuable information that may answer the pertinent questions of study.

Study is being conducted by:

Mindy Wise, LSW, current MSW graduate student

Research Advisor (if applicable):

David Roseborough, Ph.D

Department Affiliation:

School of Social Work-MSW Clinical program

Background Information

The purpose of the study is:

To analyze how primary care clinics are currently working to address the needs of patients coming to them and to assess how providers in a primary care setting address these needs. The study will give particular attention to "biopsychosocial" concerns as complexities that are influencing or exacerbating a patient's medical condition, to how their providers respond, and to what this suggests about how we might more optimally respond, particularly in rural and medium size clinic settings.

Procedures

If you agree to be in the study, you will be asked to do the following:

State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.

You will be asked to participate in a 30-45 minute interview by the primary investigator who will ask eleven questions related to the primary question of study. This interview can be scheduled at your convenience. The interview will be audio recorded and with the discussion being transcribed by a professional transcriptionist. Your identity will remain private and confidential as you will only be identified to this investigator. Your identity from that point forward will be as interviewee-1, interviewee-2, etc. You may choose to stop the interview at any time which will not affect your job at your designated clinic or your relationship with the University of St. Thomas or with St. Catherine University.

Risks and Benefits of being in the study

The risks involved for participating in the study are:

There will be little risk to you. Your responses will not be individually identified. Your response may be quoted, but you would only be quoted by profession. Again you will not be identified by name under any circumstance.

The direct benefits you will receive from participating in the study are:

There will be no direct benefits to you other than a private lunch or snack that will be provided by the investigator in an effort to support your busy schedule. Data received may or may not provide information that may potentially enhance patient care for your patients and others.

Compensation

Details of compensation (if and when disbursement will occur and conditions of compensation) include:

Note: In the event that this research activity results in an injury, treatment will be available, including first aid, emergency treatment and follow-up care as needed. Payment for any such treatment must be provided by you or your third party payer if any (such as health insurance, Medicare, etc.).

No direct compensation will be provided.

Confidentiality

The records of this study will be kept confidential. In any sort of report published, information will not be provided that will make it possible to identify you in any way. The types of records, who will have access to records and when they will be destroyed as a result of this study include:

By choosing to participate in this study you will be invited to participate in a 1 to 1 interview with the principal investigator. Upon consent for the interview your name will be kept confidential and private. Any correspondence by email or telephone will only be done by this investigator. The audiotaped interview once completed will be kept in a locked box within the investigator's home. Only this investigator will have access to the safety lock box. Any email correspondence can only be accessed by this investigator's password secure account. At the end of this study, May of 2012, all records, emails, and audiotapes will be erased or destroyed by shredding. A large shredder is available, all notes, emails, transcripts will be taken to a secure locked recycling bin at this investigator's place of employment.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with any cooperating agencies or institutions or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until the date/time specified in the study.

You are also free to skip any questions that may be asked unless there is an exception(s) to this rule listed below with its rationale for the exception(s).

Should you decide to withdraw, data collected _____ will NOT be used in the study about you

Contacts and Questions

You may contact any of the resources listed below with questions or concerns about the study.

Researcher name	Mindy Wise
Researcher email	
Researcher phone	
Research Advisor name	David Roseborough
Research Advisor email	
Research Advisor phone	651-962-5804
UST IRB Office	651.962.5341

Statement of Consent

I have read the above information. My questions have been answered to my satisfaction and I am at least 18 years old. I consent to participate in the study. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent to participate in the study.

Signature of Study Participant	Date
--------------------------------	------

Electronic signature

Print Name of Study Participant

Signature of Parent or Guardian (if applicable)	Date
--	------

Electronic Signature

Print Name of Parent or Guardian
(if applicable)

Print Name of Parent or Guardian
(if applicable)

*Electronic signature**

Signature of Researcher	Date
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*Electronic signature**

Print Name of Researcher	Mindy Wise
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APPENDIX C**Interview questions:**

- 1.) Briefly explain to me your professional role here and tell me about your typical day in the primary care clinic?
- 2.) Who comprises the majority of the patients you see in the clinic each day? And on average how much time is spent assessing and managing these individuals?
- 3.) What do you perceive patients are seeking when they schedule an appointment with you? And do any of these patients have unique characteristics requiring more frequent visits?
- 4.) Are there other factors not medically related that patients present or share during their scheduled time with you? What are those factors and how could we better respond to meeting those needs?
- 5.) Research shows that as many as 80% of individuals are seeking physician services because of mental health and/or substance abuse problems; these issues accompany physical complaints and that as many as 45% of individuals receive mental health care from their primary care practitioner. Does this match with your experience or not?
- 6.) Does your setting allow you the time to assist patients who present with complex mental and psychosocial needs? And if-it doesn't, is there a process of referral to person who can follow through with these issues? How are these broader concerns

handled formally and informally? What would help to have to meet these needs even better?

- 7.) Are there collaborative methods within your medical clinic with other disciplines to assist with management of patient biopsychosocial needs?
- 8.) How might the profession of social work be able to help you better manage your patients? Do you currently make use of social work services and if so, how?
- 9.) Do you feel social workers could be integrated in the primary medical setting as collaborative team members (if they are not already)? Are there other ways we might help meet these needs we might not have considered, particularly in a rural (or mid-sized) setting like this?
- 10.) What is your ultimate goal each day with seeing a patient in the clinic?
- 11.) Anything I haven't thought to ask that you'd like to add?