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Integrating Social Workers into Primary Care: Physician and Nurse Perceptions of Roles, Benefits, and Challenges

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Integrating Social Workers into Primary Care: Physician and Nurse Perceptions of Roles, Benefits, and Challenges

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The primary aim of this article is to identify, from the perspective of primary care physicians and nurses, the challenges encountered in provision of health care to older adults and to identify potential roles, challenges, and benefits of integrating social workers into primary care teams. As more older adults live longer with multiple chronic conditions, primary care has been confronted with complex psychosocial problems that interact with medical problems pointing to a potential role for a social worker. From a policy perspective, the lack of strong evidence documenting the benefits that will accrue to patients and providers is a key barrier preventing the wider use of social workers in primary care. This article presents findings from three focus groups with primary care physicians and nurses to examine the perspectives of these key providers about the benefits and challenges of integrating social workers into the primary care team.

KEYWORDS *social work, primary care, older adults, interdisciplinary teams*

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INTRODUCTION

The primary aim of this article is to identify, from the perspective of primary care physicians and nurses, the challenges encountered in provision of health care to older adults and to identify potential roles, challenges, and benefits of integrating social workers into primary care teams. As more older adults live longer with multiple chronic conditions, primary care has been confronted with complex psychosocial problems that interact with medical problems (Berkman, Gardner, Zodikoff, & Harootyan, 2005), pointing to a potential role for a social worker. From a policy perspective, the lack of strong evidence documenting the benefits that will accrue to patients and providers is a key barrier preventing the wider use of social workers in primary care. This article presents findings from three focus groups with primary care physicians and nurses to examine the perspectives of these key providers about the benefits and challenges of integrating social workers into the primary care team.

BACKGROUND AND SIGNIFICANCE

The vast majority of older people who receive health care obtain it in the context of a visit to their primary care provider (American Hospital Association, 2006). This is due, in part, to advances in medical technology that provide better treatment options and allow many illnesses to be treated in outpatient settings that had previously required hospitalization, and also because of financial incentives to healthcare providers to reduce inpatient hospital stays (Bodenheimer, Wagner, & Grumbach, 2002). The challenges we face in health care in the coming decades will be maximizing the effectiveness of our health care workforce, which is already facing extreme shortages in key provider groups (Noelker, 2001), and creating interdisciplinary team-based models of care appropriate for meeting the health and psychosocial needs of older adults in the changing settings in which care is provided.

Treating older adults in primary care poses a myriad of complex practice issues. As modern technology expands and people continue to live longer, many older adults are living with multiple chronic illnesses such as congestive heart failure, chronic obstructive pulmonary disease, Alzheimer's disease, and dementia (Sloane, 1991). About 80% of older adults have at least one chronic illness and almost 50% have at least two chronic conditions (He, Sengupta, Velkoff, & DeBarros, 2005). The number of older adults with limitations in at least one activity of daily living is expected to increase from 5 million (presently) to over 11 million by 2050 (Alecxi, 2001). The aging of the baby boom generation, coupled with greater life expectancies and increases in chronic diseases and greater frailty, will drive

an exponential demand for health and long-term care services over the next half-century (Stone, Dawson, & Harahan, 2003).

Additionally, older patients often have psychosocial problems that require attention, such as social isolation, depression, or dementia, and generally need more reassurance, time, and consideration than younger patients (Netting & Williams, 2000). Studies indicate that as many as 50–70% of all primary care medical visits among older adults are related to psychological factors (McGuire, Bikson, & Blue-Howells, 2005). Increasing numbers of older adults are turning to their primary care physicians for help beyond management of acute medical needs, expressing concerns around issues such as forgetfulness, loneliness, transportation, or difficulty with everyday tasks such as bathing, dressing, and housework (Sloane, 1991). Mizrahi and Abramson (2000) found in their analysis on matched shared cases between social workers and physicians that social workers were significantly more likely to identify psychosocial problems than physicians.

The primacy of primary care as a location of health care for frail older adults makes it an ideal setting to integrate a social worker in order to identify and treat mental health and psychosocial problems among this population. Depressive symptoms have been linked with increased disability, impaired functioning, increased morbidity and mortality, and decreased quality of life (Schoevers et al., 2000). Untreated mental illness has also been associated with increased healthcare costs, increased use of primary care visits and consultations, and longer hospital stays, even after adjusting for preexisting medical comorbidities (Unutzer, Katon, Sullivan, & Miranda, 1999).

The increased availability of clinical guidelines for identifying and responding to mental health problems for health care providers has not adequately addressed these issues (Edell, 1991). For example, guidelines for the treatment of depression in primary care have been developed and disseminated by the Agency for Healthcare Research and Quality (AHRQ, 1993); however, few depressed older adults receive treatment adhering to these guidelines for depression either in primary care or in specialty mental health care settings (Callahan, 2001).

While the lack of adherence to proven mental health treatment guidelines is one obstacle to effective mental health treatment of older adults in primary care, the main barrier appears to be the providers' lack of adequate time to spend with their older patients in a pressured environment. As typically structured, primary care providers—usually physicians and nurses—are limited in the scope of services they are able to provide due to constraints on time and cost; in part due to the restrictions of practicing in a managed care environment (Linzer et al., 2000). Often restricted to 10–15 minutes per patient, physicians rarely have the time to address psychosocial issues, especially when combined with

multiple medical comorbidities (Netting & Williams, 2000). Studies have shown that interdisciplinary collaboration can have a range of benefits including an improved quality of care and patient safety (Oandasan et al., 2006).

Integrating social workers into primary care settings offers an innovative approach to address shortfalls in patient care. Social workers possess specialized training and can provide needed services in any of the following: (1) administering psychosocial assessments; (2) working effectively with family systems; (3) implementing effective problem-solving skills; and (4) providing in-depth knowledge of community resources (Geron, Andrews, & Kuhn, 2005; Scharlach, Simon, & Dal Santo, 2002). Social workers have long served as care managers or care coordinators in programs and services for older adults (Geron, 2000a, 2000b). A growing number of empirical studies employing social workers in key roles in health care have found reductions in emergency visits and hospital admissions (Claiborne, 2003); reduced length of hospital stay and nursing home placement (Nikolaus, Specht-Leible, Bach, Oster, & Schlierf, 1999); and lower overall costs per patient (Williams, Williams, Zimmer, Hall, & Podgorski, 1987). A number of trials have also noted increases in self-reported indicators of quality of life among elder patients receiving social work interventions (Rizzo & Rowe, 2003).

Social work services, specifically care coordination, in primary care settings has been shown to improve patient health and mental health outcomes among community dwelling older adults who may or may not require home-based care services (Firth, Dyer, Marsden, & Savage, 2003; Lorig et al. 2001), as well as reduce acute care service use and primary care visits (Sommers, Marton, Barbaccia, & Randolph, 2000). While there is growing evidence that primary care physicians and nurses recognize that having social workers available to address psychosocial and environmental aspects of illnesses would enhance their practice (Golden & Iris, 2005; Rock & Cooper, 2000; Sommers et al., 2000), addressing providers' hesitations to integrating social workers is likely to be one of the greatest obstacles to developing more collaborative care models in primary care. Additionally, a number of studies have found that physicians and nurses do not fully understand roles of social workers, suggesting the importance of provider education if these collaborations are to be successful (Netting & Williams, 1996, 2000; Badger, Ackerson, Buttell, & Rand, 1997).

With the growing surge of older adults representing the majority of primary care appointments, this study aims to investigate the challenges faced by primary care nurses and physicians in meeting the needs of these older adults. Additionally, given that social workers are not regular members of the primary care team, attitudes and beliefs toward integrating social workers into the primary care setting were sought.

METHODS

Focus groups were employed to explore four primary areas with primary care physicians and nurses: (1) perceived unmet needs of frail elders living in the community; (2) roles social workers can play in addressing the needs of frail older adults; (3) perceived challenges in integrating social workers in primary care; and (4) ways social workers can improve service delivery and effectiveness of care to older primary care patients.

Setting

The focus groups were conducted at two primary care clinics of a managed care organization in a large metropolitan area. Collectively, the medical offices have approximately 24 primary care physicians who serve an estimated 45,000 patients, approximately 15%, or 6,750, of whom are 65 or older. The medical offices offer family medicine, gynecology, internal medicine, laboratory, mammography, member health education, pediatrics, and a pharmacy.

Recruitment and Incentives

A convenience sample of physicians and nurses were recruited to participate in the focus groups. Flyers were developed that explained the purpose and location of the focus groups and were distributed to all physicians and nurses serving older adults at each participating site inviting them to attend. Physicians excluded included pediatricians and obstetricians due to the population they serve. In one site, focus groups were held separately with physicians and nurses. In the second site, the focus group was held with both provider groups together. Focus groups were held at each of the primary care clinics. All participants were offered a catered lunch and participants from one site also received a gift certificate to a local book store.

Interview Protocol

A semi-structured focus group protocol was developed by the research team to elicit responses to specific probes; this allowed facilitators enough flexibility to query and follow up with questions in response to comments received. This protocol was developed by the Principal Investigator and reviewed for face validity by the co-investigators. The final protocol received expert review by a primary care physician to further assess its appropriateness for the audience.

The focus group facilitator obtained initial unfiltered responses from providers and then asked probes based on recurrent themes and issues that

emerged during the course of discussion. The following questions were used in both groups: (1) What are the biggest challenges you face in working with frail older adults? (2) What role can a social worker play in helping to address these problems? (3) How do you think a social worker can help you to improve the care you provide to patients? and (4) Do you see foresee any challenges in integrating a social worker into primary care? All three focus groups were facilitated by the study investigators and lasted approximately 60 minutes.

Focus groups were audiotaped with the exception of one, where equipment malfunction prevented taping. For this group, two project staff members took verbatim quotes from participants. Notes from each of the two recorders were compared and analyzed for accuracy and reliability. Discrepancies in notes were discussed; if no agreement was reached on the accuracy of a statement, it was dropped from the analysis. The two audio tapes of the focus groups from the first primary care office were transcribed and the tapes were reviewed by project staff for accuracy and completeness. Focus group facilitators reviewed the transcripts for reliability.

Data Analysis

Transcripts were analyzed using a grounded theory method (Charmaz, 1999; Glaser & Strauss, 1967). In this approach, transcriptions of the sessions were sorted into content categories and synthesized for analysis. Three researchers independently identified major themes and sub-themes using a constant comparative method of data analysis. Atlas-ti (Muhr, 1997), a qualitative analysis software program that allows interactive and automatic coding of rich text, was used to facilitate data storage and coding of themes and subthemes, as well as identify key passages related to the themes and sub-themes. An iterative review process was used to examine and revise the initial coding until 100% agreement was obtained by all coders and no new themes emerged. The analysis of the focus group interviews from the second site were compared to the findings from the first site and incorporated into the overall findings. Because the subthemes from the second site were consistent with those of the first two groups, no additional subthemes were added.

RESULTS

Subjects

Between October and November 2004, three focus groups were held: one with physicians only ($n = 5$), one with nurses only ($n = 8$), and the third as a combination of both nurses and physicians ($n = 12$). Focus group participants included 13 physicians, 11 nurses, and 1 nurse practitioner with 100%

TABLE 1 Subject Demographics

	Physicians <i>n</i> = 13	Nurses <i>n</i> = 11	Nurse practitioner <i>n</i> = 1	Total <i>n</i> = 25
Gender				
Female	3 (23%)	11 (100%)	1 (100%)	15 (60%)
Male	10 (77%)	0 (0%)	0 (0%)	10 (40%)
Ethnicity				
African American	1 (8%)	6 (55%)	0 (0%)	7 (28%)
Caucasian	3 (24%)	1 (9%)	1 (100%)	5 (20%)
Latino	2 (16%)	2 (18%)	0 (0%)	4 (16%)
Asian	7 (54%)	1 (9%)	0 (0%)	8 (32%)
Other	1 (8%)	0 (0%)	0 (0%)	1 (4%)

of nurses and 23% of physicians female. Focus group participants were reflective of the multicultural community they serve with 28% of participants being African American, 20% Caucasian, 16% Latino, and 32% Asian (see Table 1). Only one participant, a physician, had previously worked with a social worker in the primary care setting.

Themes and Subthemes

Analysis of the focus group transcripts revealed four primary themes that were closely associated with the probes used in the focus groups. These primary themes were (1) patient problems; (2) provider challenges in serving older adults; (3) perceived role of the social worker; and (4) challenges of having a social worker in primary care. Within each primary theme, the analysis revealed distinct subthemes; these are identified under each major theme and are delineated in Table 2. One primary, overarching subtheme throughout all three focus groups was time pressures facing providers in primary care practices. While there were also important differences between physician and nurse perceptions of the roles, some common views of benefits and challenges of integrating a social worker into primary care are described in what follows.

PATIENT PROBLEMS

Both primary care physicians and nurses reported that they observe numerous unmet problems among their older patients, with nurses observing a wider range of these problems than the physicians. Some of the most prominently identified psychosocial issues by the nurses were the need for a consistent caregiver, high rates of social isolation, and depression. Several nurses observed that many older adults lacked caregiver support. One nurse reported asking a patient: "Do you have family or somebody who calls you?"

TABLE 2 Themes and Subthemes

Major themes	Subthemes
Patient problems	<ul style="list-style-type: none"> ● Need for a consistent caregiver ● Loneliness and social isolation ● Depression ● Transportation ● In-home supportive services ● Financial assistance
Provider challenges in serving older adults	<ul style="list-style-type: none"> ● Time constraints and pressures ● Lack of knowledge and training in nonmedical issues ● Limited patient disclosure ● Physician burden and stress
Perceived role of the social worker	<ul style="list-style-type: none"> ● Assisting with placement in long-term care facilities ● Accessing community-based services and resources ● Patient education and training ● Care coordination ● Caregiver support ● Home visits ● General patient assistance
Challenges of having a social worker in primary care	<ul style="list-style-type: none"> ● Added time burden required for case discussion ● Office space

[to which he replied] No, I live with my dogs, and I just came in because some neighbors saw this thing on my nose and thought I should see a doctor." According to another nurse: ". . . we see that a lot. That nobody's taking care of them."

Loneliness and social isolation are prevalent among older adult primary care patients. Nurses stated that it is very common to discover that older patients have no one caring for them, that they have no family nearby, or that they are living on their own. Many of the nurses observed that it is not uncommon for older adults to use visits to the primary care office as an opportunity to increase social interactions: "And I noticed that sometimes you'll see the elderly patients will make appointments, not because they're sick, but also because they're lonely and need someone to talk to."

Depression was identified by both nurses and physicians as a common problem among their older patients. Nurses associated depression with situational events (such as death of spouse), whereas physicians tended to see it as a medical issue. The physicians cited patient appointment time constraints as a barrier to treating depression in their older patients, but also expressed a proactive approach to identifying and addressing depression: "I think we certainly keep depression on a very high alert level . . ." Psychosomatic illnesses due to depression were also associated with increased and unnecessary visits: "A lot of them have depression that shows up as psychosomatic problems. We will take care of one thing and then they show up with something else."

Access to community resources was also identified as a serious unmet need of older adults. This included transportation, in-home supportive services, and financial assistance. The nurses identified lack of timely transportation as a principal barrier impeding patients' ability to access primary care. They noted that transportation services are oftentimes unreliable, causing the patient to miss appointments and have lengthy waits in the primary care clinic for return rides home. Nurses and physicians identified a wide range of other needs, such as long-term care placement options, home health aides, and home maker services.

Nurses also identified lack of financial resources as a barrier to obtaining medication and medical care. Nurses discussed the conundrum faced by older patients who have difficulty in paying the co-payment for their prescriptions and having to choose the most critical medications to fill because they can not afford to get them all. In addition, older patients' concern about co-payments sometimes influences the frequency of office visits. Nurses mentioned that some older adults "save up" their symptoms for one visit to avoid having to make multiple co-payments: ". . . well you know there's something wrong with his eye, and he's got a sore throat, and 'I'm having shortness of breath', and 'well, yeah, the knee hurts, but I'm more concerned about the ankle than I am the knee.'"

PROVIDER CHALLENGES IN SERVING OLDER ADULTS

The most frequently identified challenge by both physicians and nurses in providing primary medical care to older adults was time constraints. Both nurses and physicians repeatedly discussed the challenges in providing comprehensive care to older adults within predetermined primary care appointment slots: "We have 15 minutes to listen to the patient, diagnose, and treat." Providers were clear in stating that these limited appointment periods influenced their ability to provide comprehensive care. As one physician noted, "I definitely think that if I had an hour per patient, I would definitely [be] a better physician." The multitude of chronic conditions and psychological problems exacerbate time pressures. As these physicians noted, ". . . we're just given 15 minutes with each patient, and sometime it takes 15 minutes just to walk them from the hallway."

The insufficient time period also limited physicians' and nurses' ability to effectively educate the patients on their medical conditions, medications, and follow-up care plans: "We don't always have time to sit there and do post-education." Another area that often goes unaddressed due to time constraints is psychosocial issues. Physicians stated that they infrequently have time to ask questions about their patients' emotional and psychosocial needs: "Like we're all saying, because we don't have the time, there are these gaps in the care of the patient—the psychosocial part."

Physicians often lack adequate training to address the patient's non-medical problems. Medical staff are provided a depression check-list and trained by the clinic, although several physicians cited a lack of knowledge in correctly identifying psychosocial issues, depression, and cognitive impairment: "Sometimes they can just fool you. The family may warn you in advance, or tell you after the fact, 'Did they mention how depressed they are?' They may not. They may be bright and cheerful when you see them. I even had one patient, he actually had dementia, and he totally fooled me. And I was never asking questions that would solicit that. The family never complained of it. But he had mild dementia."

Some physicians expressed difficulty in getting proper medical histories from the older patients, let alone an accurate account of their psychological state during this brief visit. Physicians were concerned with what they described as a lack of disclosure from their older patients surrounding their overall well-being, which includes an accurate assessment of their home environment and support system. Mostly they attributed this lack of disclosure to time constraints, but physicians also believed that their older patients withheld information in fear that the physician would deem them incompetent or recommend that they no longer live independently. A physician stated the following regarding patient disclosure: "And if the patient doesn't say, 'Doctor, I'm depressed, I'm down, whatever', it may not come up. Because you're too busy focusing on the medical issues, medications, and all the other things."

In addition to time constraints, caring for older patients posed a number of burdens on providers, including stress and fatigue, as the following quotes indicate:

We are taking care of patients who are really needy, and it really gets to you after awhile.

There is a lot of stress because they want to give their problems to you. . . . It is hard because they have unfixable problems. Their expectations and their family's expectations are sometimes unrealistic.

When the wife or husband of the patient is there, sometimes it is like there are two patients, and it is hard to separate them.

PERCEIVED ROLE OF THE SOCIAL WORKER

Physicians and nurses differed in their perceptions on the role of the social worker. Some of the physicians had never worked with social workers: "I don't know what to expect because I've never had one." In general, most providers had positive perceptions of social workers and the roles they could play. One physician eagerly anticipated having a social worker

based on prior experience working with a social worker in another setting: “The social worker made my life so much easier. We had a patient who was suicidal. The social worker was able to get the patient over to the emergency room. . . . Having a social worker made a huge difference in my practice.”

Physicians were more likely to see the social work role as helping with placement in long-term care facilities and accessing community-based services and resources, whereas nurses perceived the social work role to encompass a broader array of tasks ranging from walking patients down the hall to the exam room to providing necessary psychosocial care. The following response was typical of physician perceptions: “Resources, resources—that’s what we really need, you know, letting you know what’s available. Because we’re busy keeping up with medicine, not keeping up with what’s available out there.” Nurses, alternatively, felt that social workers would be ideal in providing follow-up and patient education, particularly related to medical conditions and medications:

Well, when the doctor changes their medications, a lot of times they [patients] don’t understand.

A lot of the patients, they really appreciate that follow-up call. They really do feel that ‘somebody cares enough for me to call me back.’ And it does reinforce whatever it was that the nurse or doctor said.

Physicians and nurses concurred in believing that social workers could provide care coordination and support to patients and their caregivers: “[So] the patients don’t feel like they’re just out there by themselves. They know that they have some kind of support. So that the social worker can . . . [give] the patients and caregivers support, so they’re not out there, dangling.”

Further, both disciplines felt that social workers could “check out the home situation” and effectively assess whether living at home is still the best option or intervene when necessary, as in elder abuse cases: “. . . call the social worker and have someone check on these people, because this is ridiculous, something’s wrong in that house.”

Some physicians perceived social workers as having more flexibility with time and less demanding jobs, perhaps reflecting an unawareness of social worker roles. An effect of this perception is that physician participants perceived that one of the benefits of having social workers in the primary care setting is that social workers would be able to spend as much time as needed with each client: “[The social worker] seemed like she had all the time in the world, which I don’t.”

Overall, in all focus groups, no concern about role overlap or role confusion was identified. Both provider groups foresaw clear role delineation in their respective professional responsibilities from social

workers and also indicated that social workers would complement their own responsibilities in providing patient care: “We’re giving it to you. You’re the social worker. Do your social thing and we will do our medical thing.”

CHALLENGES OF HAVING A SOCIAL WORKER IN PRIMARY CARE

Nurses and physicians clearly identified a need for social workers in primary care practices. Both provider groups felt that having a social worker in the office would result in improved patient care and patient outcomes, both in response to patient problems and as a preventive measure to avoid crisis situations for older patients. “And if the social worker steps in and fills that gap, then we’re providing better care. And then members are more satisfied. In the end, everyone benefits.”

Although both physicians and nurses recognized the many benefits to having a social worker on site, there was divergence in their perspectives of the challenges in integrating a social worker into the primary care setting. Nurses felt that a social worker would only enhance their ability to provide comprehensive care and were anxious to include social workers in the primary care team. They felt that having a social worker would expand their ability to provide medical care and reduce the time needed to spend with patients on non-medical issues.

Alternatively, some physicians voiced concerns about the time the social workers would take to communicate and discuss cases with them. These physicians were apprehensive that having a social worker on site would further encroach on their already pressed schedules. Needing to interact frequently with the social worker on cases would interrupt their work and distract them from their task at hand. Physicians preferred to simply make a referral to the social worker and move on to their next case, or to receive electronic communication from social workers. These physicians requested any communication to be succinct: “diagnosis, outcome—short and sweet.” Another physician noted: “I think what we have in mind when we send the patient to a social worker is there will not be a lot of interchange. . . . I would prefer the e-mail route rather than very long, winding conversations.”

Another challenge identified by physicians and nurses were finding a physical location in the clinic for the social worker. The preference identified by both providers groups was to have a social worker on site and readily available on call during clinic hours. Both nurses and physicians discussed the challenges for them, as well as the patients, in receiving social service support from a part-time social worker located outside the clinic. Many felt this integration model would only work if the social worker was on site at all times and anything less might lead to additional problems.

DISCUSSION

This qualitative study supports previous literature on both the need and potential benefits of having a social worker in the primary care setting, as well as the increasing time pressures experienced by primary care clinicians that circumvent their ability to provide comprehensive care to older adults. Having insufficient time to spend with older patients was the primary, underlying theme throughout the focus groups. Other studies have found that physicians are dissatisfied with the amount of time they have with each client (Murray et al., 2001; Linzer et al., 2000). Further, the time allocated for patient visits within HMOs has been found to be significantly less than in private practice settings, with physicians reporting that they need up to 40% more time than allocated for patient visits (Linzer et al., 2000).

From a practice perspective, the findings from these focus groups support the need to redesign service models to allow greater integration of social workers in primary care. Overall, primary care clinicians in this study clearly stated that social workers could enhance their ability to provide comprehensive care to their older adult patients. This is similar to findings in other studies that state social workers could serve as physician “extenders,” providing the psychosocial follow-up and community referrals that physicians have insufficient time to do (Netting & Williams, 1996). Interestingly, both physicians and nurses in these focus groups felt that social work services must be provided on site by a full-time social worker. This finding is also consistent with the experiences described by Netting and Williams (1995) in their study integrating geriatric case management into primary care physician services.

Although promising, the findings from the focus groups also suggest that if the widespread integration of social workers in primary care settings is to occur, providers, particularly physicians, will need more information about the skills and training of social workers. We found that the perceived scope of social worker roles was narrower for physicians than nurses. Studies based on physicians’ opinions of social workers have found that social workers defined their roles more broadly than physicians (Leipzig et al., 2002). Salvatore (1988) identified five types of social work provided in primary care: (1) psychosocial assessment; (2) provision of community services; (3) provision of counseling; (4) consultation with health care providers on psychosocial issues; and (5) education and training of health care providers in psychosocial issues. In our focus groups, physician participants were largely focused on the first three areas: psychosocial assessment, community services and referrals, and counseling. Nurses saw the social worker not only as a nurse “extenders” who could provide instruction on care plans, follow-up, and support, but also as someone who could fill other needed roles with the patient, such as with transportation and navigating the health care system.

Previous studies on physician perceptions of challenges in integrating the social worker within the primary care setting have revealed mixed findings. In a study to assess physicians' attitudes toward the potential roles for social workers in a primary care setting, Badger, Ackerson, Buttell, and Rand (1997) found that fewer than half of the providers interviewed reported that social workers could conduct screening or provide therapy for mental health disorders, or that social workers could have a role in preparing patients for hospitalizations and the accompanying life changes with this type of admission. Alternately, Netting and Williams (1996) found that physicians voiced concerns that collaborating and coordinating care with social workers located in their office will take up too much of their time. Our study revealed similar findings to the study conducted by Netting and colleagues in that physician apprehension about integrating the social worker in primary care focused largely on the impact it would have on their already tight time constraints. Physicians did not question the ability of social workers to function within the roles discussed.

Physicians, more than nurses, appear to be an obstacle to the development of collaborative care models in primary care. Netting and Williams (2000) have stressed the importance of educating health care providers on how social workers can enhance patients' quality of life and overall care. Their research found that once medical residents were aware of the range of services social workers were able to provide, they were more likely to utilize them. Somewhat paradoxically, perhaps the best way for physicians to gain familiarity with social workers is to work with them. Netting and Williams (1996) found that a primary challenge to the acceptance of social workers by the primary care physicians was the location of the case managers' offices, which were not within the same building as the physicians. This distance resulted in a lack of integration, limited knowledge of the role of the case manager by the medical team, and interfered with the development of a relationship between the disciplines. For social workers, the need to be visible within the practice, available for consultation, and ability to articulate their potential contribution to the patients' well being at all times, may be necessary in order for physician and nurse providers to truly understand their roles, and ultimately forming a cohesive collaboration. Interestingly, despite the voiced concern about potential time consumption of having a social worker in primary care, physicians and nurses in the current study unanimously felt that the social workers must reside within the primary care setting on a full-time basis in order to provide sufficient support. Thus, location of the social worker was not perceived as a challenge in this study.

Although studies using convenience samples typically have limited generalizability, the findings from this study are consistent with the literature. Other limitations in generalizing these findings are the small sample size of each focus group and that all the physicians and nurses were employed by the same health care organization. Additionally, in one of the

three focus groups the participants were a combination of nurses and physicians, which may have led to less sharing among certain providers for fear of being judged. Participants were also selected from an extremely diverse community and employed within an HMO, further limiting generalizability.

CONCLUSION

In summary, with a future of increasing public costs for health care, fragmentation in the system of care, and pressures on health care providers to treat patients on an outpatient basis and in ambulatory settings, the development of cost-effective interventions to address multiple chronic illnesses and psychosocial needs of frail older adults in primary care is urgently needed. Integration of social workers into primary care settings to address psychosocial issues in primary care and provide ancillary services, such as care coordination and care management, was viewed as a potential method for meeting this multitude of issues with older adults. As the pressure on providers continues to increase, interdisciplinary collaboration may be vital to improving the health outcomes of older patients in primary care settings.

For participants of this study, clear articulation of the social work role would be a necessary precondition for effective collaboration by social workers with other team members. While social work educators have made a strong beginning in defining social work roles (Compton & Galaway, 1989; Cournoyer, 1991; Germain & Gitterman, 1996), not enough has been done to define how these roles are delineated or described in collaboration with others (Specht, 1985). Clear articulation of the social work role is critical to maximize social workers' impact as members of effective interdisciplinary teams (Abramson, 1993). Social workers, with training in psychosocial intervention, assessment, and care management, can serve an important role in creating well-coordinated, interdisciplinary teams in primary care to address the needs of frail older adults. However, more research is needed to determine the cost-effectiveness of adding a social worker to the primary care setting.

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