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Foreword

There have been very few comprehensive and up-to-date books on health social work published in the past decade. Dr. Dziegielewski's second edition is not only the most comprehensive book in the field to date but is also the most informative, timely, and extremely well written. In the area of health care practice, managed behavioral health care, first introduced in the 1990s, presents a new type of evidence-based health care delivery. As Dr. Dziegielewski explicates in this valuable second edition of her text, health care social workers are expected to demonstrate that the services they provide are both time-limited and evidence-based. She is keenly aware of the importance of acknowledging this fact and warns that without this recognition health care social workers will remain at risk of being replaced by other health care professionals or paraprofessionals. The book is also quick to pinpoint how incremental changes can involve compromising service agreements that are based on the needs or wishes of various political forces. This makes the role of the social workers as patient and family advocate essential in ensuring quality service delivery in an era of cost containment. Health care workers must take an active role in ethical practice while advocating for social action and social change (Strom-Gottfried & Dunlap, 1999). This translates to advocacy that seeks to help society understand the needs of the client while controlling and regulating the health care industry. The chapters in the second section of the book highlight how these efforts at advocacy are further complicated by staff reductions and changes. To remain competitive, however, Dr. Dziegielewski states that health care social workers need to be flexible, open, and ready to embrace the future. Yet she warns that, even with the implementation of an evidence-based practice approach, the health care social worker should never lose sight of the ethical and moral judgment needed to steer the profession toward the betterment of the clients being served.
Overall, this book advocates for a proactive stance, whereas, to be considered effective and efficient traditional helping must go beyond just helping the client. For the health care worker, similar to other practice areas in social work, evidence-based practice must also clearly measure the concrete and identifiable therapeutic gains achieved, in the shortest amount of time. These interventions must be socially acknowledged as necessary and therapeutically effective utilizing individualized treatment protocols (Franklin, 2002).

This second edition of the book continues to acknowledge the dramatic changes that have occurred within the field. Each chapter is clear in outlining the current state of practice as well as discussing future trends and developments. This book explicates the fact that health care practice is focusing less on formalized inpatient acute, tertiary, and specialty/subspecialty care, and moving more toward ambulatory and community-based care (Rock, 2002). This requires that health care practitioners constantly battle "quality-of-care" issues versus "cost-containment" measures, while securing a firm place as professional providers in the health care environment.

In closing, Dr. Dziegielewski clearly highlights the role of the social worker as the professional "bridge" that links the client, the multidisciplinary or interdisciplinary team, and the environment. She advocates for a proactive stance, encouraging health care social workers to increase their accountability, documentation skills, discharge planning skills, marketability and competitive edge by moving beyond the traditional definition and subsequent roles occupied in the past. In this second edition, this book once again provides a realistic portrayal of the current state of affairs for the health care social worker while actively presenting a vision for the future.

This is the fifth book to be thoroughly revised into a second edition out of the 40 volumes in the Springer Series on Social Work, which began in 1984. We have come a long way in the social work profession in the past 20 years, and I am delighted to welcome this futuristic second edition.

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During the early years of the Clinton presidency "a radical, historic shift in society's health care process took place before our astonished eyes, driven totally by market forces and entirely outside regulatory management" (Nieves, 1998, p. xiii).

Dr. Dziegielewski clearly points out that the three legs on which our health care system currently stands (or wobbles as the case may be)—cost containment, access, and quality—are in perpetual conflict; she notes that we can get any two legs working together but not all three. Something is always lost in a health care system structured this way. This book suggests how social work services can be offered in health settings under these current conditions.

Dr. Dziegielewski provides systematic overviews of the activities that make up professional social work. She gives much-needed emphasis to the interactions between people and the social systems in which they live, and offers conceptual schemes for making sense of the intricacies of these interactions. She seeks to “provide a basis for the integration of basic clinical evidence-based practice strategy with a direct link to cost containment in the health care practice area.”

Included in each chapter are examples of good social work practice, models of intervention and social work thinking based on real social workers and events that demonstrate where a social work administrator, practitioner, and client are in their work together. Dr. Dziegielewski notes that all clinical interventions in today's health care environment should (a) be time limited; (b) stress mutually agreed-on goals by patients and social workers; (c) have a focus that is concrete, realistic, and obtainable; (d) be behaviorally linked, outcome based, and measurable; (e) emphasize patients' strengths; and (f) be changeable based on patients' and families' needs.

This seminal book gives social work practitioners a basis for examining the complex issues facing us and, we hope, a rough road map for
finding solutions. Dr. Dziegielewski rightly believes social workers’ efforts will result in better care for our clients and, when combined with the hard work of our colleagues and collaborators, will be our best chance of improving social health services for all Americans.

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Preface

This book reviews the basic concepts related to the delivery of social work services in the health care setting. Health care social work involves aspects of practice that include direct work with clients and their families, whether it is in the home, community, hospital setting, clinics, or other health care institutions. With the advent of numerous health care changes, such as managed health care with its focus on behaviorally based outcomes and objectives, those working in health care service and delivery are continually presented with numerous challenges and opportunities.

This situation must be understood and embraced in order to survive and thrive in this fluctuating and complex environment. Social workers must either accept this challenge to change and reevaluate the services provided or lose the opportunity to be players in this new era of competition for the provision of outcome-based service delivery. They must be able to truly show that what they do is necessary and effective. Today, however, it is important to note that effectiveness must go beyond just helping the client. Effectiveness must also involve validation that concrete and identifiable therapeutic gain was achieved with the least amount of financial and professional support. This means that not only must the treatment that social workers provide be therapeutically effective; it must also be professionally competitive with other disciplines that claim similar treatment strategies and techniques. In health care today, the battle of completing "more service with fewer resources" continues to rage.

Simply stated, health care social workers need to embrace these changes and become PROACTIVE at all levels of practice. They need to:
P: Present and position themselves as competent professionals with positive attitudes in all health care service settings, regardless of the type of practice being provided.

R: Receive and acquire adequate training and continuing education in the current and future practice area of health care social work. Research time-limited treatment approaches that can provide alternatives for social workers struggling to provide quality of care service while cutting costs.

O: Organize individuals and communities to help themselves receive safe, accessible, and affordable health care services. Organize other social workers to prepare for the changes that are occurring, and develop strategies to continue to provide ethical cost-effective service.

A: Help address and identify the policies and issues that are relevant to providing ethical, effective, efficient, cost-effective service.

C: Collaborate with other health care professionals to provide services using an interdisciplinary team approach for addressing client concerns and needs. Complement orthodox medical practices and techniques by using holistic practices and alternative strategies that can help clients achieve increased health and wellness.

T: Teach others about the value and importance of using social work services and techniques. Take time to help themselves holistically and thereby prevent professional burnout. Remain productive and receptive professionals who can serve as good role models for clients and other professionals.

I: Investigate and apply innovative approaches to current client-care problems and issues. Involve all social workers and make them aware of the change process that needs to occur in the traditional ways that health care social work has been delivered in the past.

V: Visualize and work toward positive outcomes for all those who are affected by behavioral managed care strategies. Value the role of other health care professionals and support them as they face similar challenges and changes.

E: Explore supplemental therapies and strategies that clients can self-administer at little or no cost to treat chronic conditions and to further preserve and enhance health and wellness. Most important, empower their clients and themselves by stressing the importance of education for self-betterment as well as strategies for individual and societal change.
As health care social workers face the many changes that are in store for all health care providers, they need to remember that in this era of cost cutting and containment they can remain viable players. After all, social workers can provide unique treatments, and in some cases (to spur competition) similar treatments for less money. In the social workers' code of ethics we are sworn to provide reasonable fees and base our charges on an ability to pay. This makes the fees social work professionals charge very competitive when compared to those of psychiatrists, psychologists, family therapists, psychiatric nurses, and mental health counselors who profess they can provide similar services. Thus managed care agencies may be enticed to contract with social workers instead of other professionals to provide services that traditionally have fallen in the domain of social work practice. In this era of managed care, no aspects of taking a proactive stance can be overlooked.

This book advocates a proactive stance for health care social workers and is designed to serve as a practical guide for understanding and addressing the philosophy of practice in our current health care environment. Suggestions are made for achieving ethical time-limited, evidence-based social work practice in these settings. At the end of each chapter, a "future directions" section is provided that will help social workers understand what can be expected and how to prepare for the practice changes needed to remain viable clinical practitioners.

Sophia F. Dziegielewski, PhD, LCSW
I am very grateful for all the help I have received from the many practitioners and educators in the field of health care social work across the United States who helped in writing this book and providing me with their firsthand experiences in the area of managed behavioral health care. These visionary social workers are not only dealing with the challenges of this changing environment, but they also must bear the burden of exploring and subsequently influencing how those changes will affect our future professional practice. In addition, I would like to thank my clients and the clients of these contributing social workers for helping us see the effects of these health care strategies within an individualized “person-in-environment” framework.

I would also like to express my sincere thanks to all the individuals who helped in the production of this book. First, I would like to thank the Springer Series Editor, Dr. Albert Roberts, my mentor and colleague. I would also like to express my sincere gratitude to Sheri W. Sussman, Springer Editorial Director, whose support and encouragement were invaluable; Ursula Springer, whose drive and energy I know and admire; Melodee McAfee and Valorey Baron Young for all their help with the numerous reads and rereads of this book; and, Cindy Arnold, my colleague and new friend, who gave me the inspiration to reach for the stars in terms of my capabilities. Special thanks to Pamela Lankas for her high standards of excellence in making this second edition of the book the best it can be.

Lastly, the time and effort necessary to complete a book impose burdens on those with whom we share our lives inside and outside the work environment. I would especially like to thank my husband, Linden Siri, for over 22 years of love, understanding, and support. In addition, I would like to thank my other family members, colleagues,
and friends who understood and supported me when I said, “I can't because I have to work on this book.” I have been blessed with many caring and supportive family members, colleagues, students, and friends and with that encouragement and support, all things really are possible.
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PART I

Understanding the Practice of Health Care Social Work
HEALTH CARE PRACTICE IN TURBULENT TIMES

This book reviews the basic concepts related to the delivery of social work services in health care settings. Health care social work has generally involved aspects of clinical practice with clients and their families in hospital settings, clinics, and institutions. However, with the advent of the current form of managed health care that began in the 1990s, there have been changes never before experienced. These changes have altered the role of health care professional and have required social workers and the services they provide to continually prove that evidence-based services are truly necessary, effective, and cost-efficient (Mitchell, 1999). In this arena, however, it is important to note that effectiveness goes beyond just helping the client. Effectiveness must also involve validation concrete and identifiable therapeutic gain was achieved with the least amount of financial and professional support (DePoy & Gilson, 2003). This means that not only must the interventions that social workers provide be socially acknowledged as necessary, but they must also be therapeutically effective (Franklin, 2002). In addition, these services must be professionally competitive with those of other disciplines that claim similar treatment strategies and techniques. Client betterment must now be evidence-based in order to be acknowledged as effective (Donald, 2002).
WHAT IS EVIDENCE-BASED HEALTH CARE?

Evidenced-based health care is best understood as a “decision-making framework that facilitates complex decisions across disciplines and sometimes conflicting groups” (Donald, 2002, p. 1). In this type of practice the social worker must use methods that have been shown to be effective and that are based in research. Evidence-based practice involves recognition of treatment or intervention options as well as risk management considerations for individuals, families, and groups.

Over the last 10 years, the battle in the health care arena of “more with less” has continued to rage. Social workers have one strong weapon in this struggle, and it should not be underestimated. It is the traditionally held notion that “social workers can provide similar treatments for less money.” In the social worker’s code of ethics, we are sworn to provide reasonable fees and base our charges on an ability to pay (National Association of Social Workers, 1996). This makes the fees social work professionals charge very competitive when compared with those of psychiatrists, psychologists, family therapists, psychiatric nurses, and mental health counselors who profess they can provide similar services. For this reason, managed behavioral care agencies may contract with social workers instead of other professionals to provide services that traditionally have been in the domain of social work practice (Dziegielewski, 2002). With the right marketing, this strength can help social workers gain additional ground, adding to their employment desirability.

Armas (2002) reported that according to the latest U.S. Census Bureau an additional 1.4 million people were without health insurance in 2001, over the previous year, as a result of increased unemployment and employers cutting benefits to save costs. This resulted in over 41 million people, or 14.6% of the U.S. population who lacked health coverage for all of 2001. In turbulent times, this is just one of the problems that health care social workers must help clients face.

This book is designed as a practical guide to help social workers understand the philosophy of the current health care environment and to illustrate how evidence-based social work practice can be delivered in various settings. The concept of “future directions” is always high-
lighted because providing social workers with a possible view into the future can help them understand what can be expected and can provide insight into how to prepare for practice changes needed to remain viable in the health care setting.

CASE STUDY

The following scenario is becoming a common practice situation that health care social workers must address.

Ms. Martha Edda had been living with her family for approximately a year. Before that, she had lived independently in her own apartment. Ms. Edda had to leave her apartment after she was found unconscious by a neighbor. The apartment was unsafe and filled with rotted food, urine, and feces throughout. On discovery, Ms. Edda was immediately admitted to the hospital. Originally, she was believed to have had a stroke. Later, she was formally diagnosed with a neurological condition called vascular dementia. Doctors believed that she was in the moderate to advanced stages, since Ms. Edda, at age 62, had pronounced movement and memory difficulties.

After discussion with the hospital social worker, it became obvious that Ms. Edda needed a supervised living arrangement. Joan, Ms. Edda's daughter, admitted openly how guilty she felt about what had happened to her mother, but did not think she could handle her at home. The social worker reminded Joan that the family would be able to benefit from Ms. Edda's receiving services from a home health care agency, and that a community day care program could be explored. After convincing her family to give it a try, Joan took her mother home.

Once in the home, Ms. Edda did receive home health care services. However, much to her daughter's surprise, all services stopped after just 2 months. Ms. Edda's daughter had relied heavily on these services, particularly the nurses' aides who helped with Ms. Edda's baths. Ms. Edda weighed 170 pounds and could not get into or out of the tub by herself. To help address this problem, Joan recruited the help of her husband, who reluctantly agreed. Unfortunately, Ms. Edda could not get into the adult day care center in the area because there were no spots available. She was placed on a waiting list. Ms. Edda required help with all of her activities of daily living, and her daughter feared leaving her at home alone during the day. So Joan quit her job to help care for her.
On the morning of January 12, Joan found her mother lying face down in her bed. She had become incontinent of bowel and bladder, was unable to speak, and her features appeared distorted on the left side of her face. When Joan could not arouse her, she began to panic and called an ambulance. Ms. Edda was immediately transported to the emergency room.

In the emergency room, they began to run numerous tests to see if Ms. Edda had had another stroke. Plans were made to admit her to the hospital, but there were no beds available. Based on the concern for supervised monitoring and possible bed availability in the morning, an agreement was made to keep her in the emergency room overnight. In the morning, she was admitted to the inpatient hospital. While in the hospital, Ms. Edda remained incontinent and refused to eat. She was so confused that the nurses feared she would get out of bed and hurt herself. She was therefore placed in restraints for periods throughout the day.

After 2 days, most of the medical tests had been run and were determined to be negative. Ms. Edda's vital signs remained stable. The physician thought that her admission in the hospital could no longer be justified, and the social worker was notified of the pending discharge. When the call was placed to prepare Ms. Edda's family for her return home, the social work case manager was told that the family would not accept her, and that they wanted her placed in a nursing home. The social worker was concerned about this decision because she knew that Ms. Edda did not have private insurance to cover her nursing home stay, and she was too young for Medicare eligibility. This meant that an application for Medicaid would have to be made. This state-funded program had a lower reimbursement rate, and most of the privately run nursing homes drastically limited the number of clients they would accept to fill these beds. After calling around, the social worker was told no beds were available.

When the social worker related her discharge problem to the physician, he simply stated, "I am under pressure to get her out, and there is no medical reason for her to be here—discharge her home today." Because it was after 4:00 p.m. and the administrative offices had closed for the day, the social work case manager planned to try to secure an out-of-area placement the following day.

When the physician returned at 6:00 p.m., he wanted to know why the client had not been discharged. The nurse on duty explained that a nursing home bed could not be found. The physician became angry and wrote an order for immediate discharge. The nurse case manager called Ms. Edda's family at 6:30 p.m. and told them about the discharge. Ms.
Edda’s family was angry and asked why she was not being placed in a nursing home. The nurse case manager explained to the family that discharge orders had been written, and she was only trying to do her job. Ms. Edda’s daughter insisted on speaking to the discharge physician before picking up her mother. A message was left for him, and at 8:00 p.m. her call was returned. The physician sounded frustrated when he told the family that all medical emergencies had been addressed, and she had to leave the hospital now. Ms. Edda’s daughter became furious and yelled, “If she is still incontinent and in restraints, how do you expect me to handle her?” Seeing how upset she was, the physician softened his voice and said, “I will put the nurse on the phone to update you on her condition. In addition, the social work case manager will call you in the morning to arrange home health care services.”

When Ms. Edda’s daughter arrived at the hospital, her mother was hooked to an intravenous line, wearing a diaper, and still in restraints. Pleased to see the client’s family member, the nurse sent for a wheelchair, unhooked the intravenous tubing, removed the restraints, and helped place her in the wheelchair for transport to the family’s car.

Although this situation may sound unbelievable, unfortunately, situations similar to this one continue to occur. This case study is an accurate depiction of the events that occurred. With Joan’s perseverance, she was eventually able (several months later) to get her mother placed in a nursing home. The strain, however, was so great on Joan that she ended up requesting that she be placed on medication to combat depression. Joan also began to fight with her husband and children over numerous issues related to the time required for her mother’s care and the loss of the second source of family income. Like most American families, her paycheck was used not only to supplement basic needs (rent and food), but also for any sources of family luxury (movies and dining out). It is clear that in situations such as this, the price of this seemingly “cost-effective” strategy far exceeded the dollar emphasis placed on it. Sadly, in this situation, the client and her family become the silent victims.

For all professionals working in the health care area, reports of such cases are becoming increasingly more common. There was a calm (possibly cold) desperation reflected in the tones of many professionals involved in this case. Feelings of desperation and frustration are not uncommon when many professionals, not only social workers, feel trapped within a system where clients trust the professionals to have
power to intercede on their behalf (i.e., to heal and to help). For health care social workers, the belief continues that they are regulated and snared within a system that does not allow them to exercise what they believe is the best ethical course of action. It appears apparent that ethical conflicts will continue to become more acute (Galambos, 1999) as social workers will need to balance quality of care with service limitations. Originally, it was postulated that a health care delivery team (physicians, nurses, social workers, physical therapists, etc.) with specialized roles could best meet the needs of each client while in the health care setting. However, when professionals are feeling frustrated, this degree of specialization can also provide a barrier, creating client–health care worker separation.

The emphasis placed on team member specialization (i.e., these are my specific job duties and responsibilities) can influence individual members to avoid taking overall responsibility for client welfare. This avoidance can create a type of shock absorber, affectionately known in the business as the client "buff and turf." During "buff and turf," only surface concerns related to the client are addressed. The real issue is left untouched, and the case is referred to the next professional on the health care delivery team. For example, in this case, the nurse avoided responsibility by stating that she was only doing her job. Later, the physician commented superficially and handed the telephone to the nurse for the problematic details. The social worker also had a role in addressing this situation. Other professionals on the health care team may view her primarily as “in charge of securing placement services.” For example, some nursing professionals believe that nurses involved in discharge planning should take more of an administrative role; others see the nurses as people who teach patients and families complex postdischarge treatments, such as breathing treatments, decubitus and skin care, feeding tubes, and home injections (Penrod, Kane, & Kane, 2000). This puts the responsibility of placement on the shoulders of the social work provider, ignoring the inadequacy of the placement limitations and available options. In cases like this, it is important to note that the reality of the situation is that none of these professionals had the power to take control over what was happening; however, the client, the family, and possibly the community still believed they did or should have.

Cases like this force professionals to question the services they give, how they are being given, and why they are giving them. Many also
question the system and what is happening to “patient care” as they knew it. The question remains: Is what is really happening now different from what would have occurred ten years ago? The answer for many social workers is “yes.” For example, ten years ago Ms. Edda (see the case study earlier) would have been kept in the hospital until a bed could be found. Although this alternative might be best to help the overall family situation, is it really an efficient and effective use of an expensive hospital stay? One point remains evident—there are problems in the current system, and there does not appear to be an easy solution to this dilemma. Little emphasis is placed on community support (Meenaghan, 2001). Health care social workers can be assured that in these turbulent times more changes in the delivery of health care services will result because of cost containment, which is considered the primary method of controlling excessive health care costs (Alperin, 1994).

**TODAY'S HEALTH CARE SOCIAL WORKER**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Mary O. Norris, MPH, LCSW</th>
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<tr>
<td>List State of Practice:</td>
<td>Florida</td>
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<tr>
<td>Professional Job Title:</td>
<td>Clinical Social Worker</td>
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**Duties in a typical day:**

I am director of a department comprising 40 clinicians who provide services at five hospitals. Our department's goal is to provide clinical interventions to both inpatients and outpatients. The corporation's case management department does discharge planning at all sites except at our children and women's hospital.

Arriving early in the mornings to work allows me to gather my thoughts and set priorities for the day. The schedule usually includes attending committee meetings, meeting with supervisors to decide how to handle issues and working on various projects. There is also the usual complement of voice mails and e-mails that need responses.

**What do you like most about your position?**

Developing our department for the last five years has always been considered a calculated risk. Thus, it is most rewarding now to witness the growth of line staff and watch them flourish in the
practice of their clinical skills. Equally satisfying is seeing social workers being recognized for the clinical expertise they bring to the health care team.

What do you like least about your position?
Although I enjoy the coordination and sense of satisfaction I get in team building, I miss providing direct patient and family care.

What words of wisdom do you have for the new health care social worker who is considering working in a similar position?
It is essential to have sufficient “hands-on” experience. Complementing this background should be additional education in administration so as to have the requisite theoretical and analytic skills. For me, having the dual degree of Master in Public Health and Master in Social Work has been invaluable. Further professional commitment is demonstrated by membership in a professional organization such as the Society for Social Work Leadership in Healthcare. Membership provides a wealth of networking opportunities and mentors to assist in the leadership of a department.

What is your favorite social work story?
While working as a clinical social worker on a pediatric pulmonary team, I counseled a young man with cystic fibrosis. When we first met he was extremely shy and nonverbal. During these 3 years of clinical interventions, we worked on body image, self-esteem, and sexuality issues. By the time I left this position, he had become verbal and self-disclosing regarding the many issues surrounding the impact of his chronic illness.

Several months after relocating to another city, the chief of pulmonaryology called me to notify me that the patient was hospitalized and was asking to see me. It seemed he was in the end stages of his disease and the team was uncertain if he truly comprehended the gravity of his situation. After having spent time at his bedside and with his family, I was preparing to leave. During the entire visit, he had never alluded to what issues were behind his request for my visit. Finally, he yelled out in a labored breathing “everyone out but Mary.” He said he needed to ask me something but could not. After I explored with him his impending death, he verbalized his comfort level with dying; however, he was still unable to explain why he
wanted to speak with me. I proceeded to ask him several questions, trying to understand his obviously intense issues. After verbalizing several possible concerns, I hoped to “hit” upon the right topic. Finally, I suggested he write down his thoughts. He then handed me a written note on a piece of brown paper towel. The note simply said, to my surprise, “please ma’am take off your shirt. Thank you.” He said, “Mary, you know I have never been with a woman. I know I am dying, and I just want to be with one before I do.”

“I am so flattered to have you ask me this.” I responded. “I am your social worker, not your girlfriend.” We talked a little more, and I told him good bye. He died during the night. When I went back to the pulmonary team, they were all anxious to know if he knew he was dying. My response was, “Believe me, he knows!”

**EFFECT OF THE ENVIRONMENT ON HEALTH CARE DELIVERY**

To understand the current practice of health care social work, we must first examine the environmental context of general health care delivery. This high-pressure health care environment requires that the following factors, different and contradictory as they may be, are expected to coexist. Table 1.1 lists and briefly describes the five factors.

The first factor to be considered is the public demand for quality service and “state-of-the-art care” (Shortell & Kaluzny, 1994). Politicians, consumers, and consumer advocates all agree that the American health care system is desperately in need of repair and reform (McKinney, 1995; Mizrahi, 1995). Americans are watching this transition and the resulting provision of health care with hesitancy and trepidation in fear of ending up with “less for more.” American people are demanding quality service, but they are not willing to support increased costs in a system they believe is plagued by waste.

In addition to quality service, clients also expect to be able to gain access to state-of-the-art technology. Clients expect links between medical knowledge and technology in the provision of quality service. Therefore, health care delivery systems are expected to hire and retain the most qualified personnel, as well as purchase the most sophisticated equipment. The pressure to secure these services is great because
without these ingredients health care agencies cannot effectively compete for "covered" or "reimbursable" client resources.

The second factor related to the problems found in health care delivery is associated with (and among) the professionals who actually deliver health care services (Shortell & Kaluzny, 1994). An important aspect that must be considered when trying to understand this conflict is in the increased numbers of health care professionals in practice. The number of these professionals has increased dramatically over the years (Freudenheim, 1990). The health care industry alone is the nation's third largest employer, preceded by government (nonhealth) and retailing (Hernandez, Fottler, & Joiner, 1994).

In addition, not only have the numbers and types of health care professionals increased, but so also has their education level. In 1990, 4.9 million individuals in health delivery required some type of professional training or a college degree. This seems unbelievable when compared with the previous 200,000 health care professionals in 1900 (Ginzberg, 1990). According to the U.S. Bureau of the Census (1991), two thirds of all individuals employed in the health care industry are considered nontraditional allied health or support personnel. Here we find that the number of social workers has grown along with physician assistants, nurse practitioners, multiskilled health workers, laboratory

<table>
<thead>
<tr>
<th>Factors</th>
<th>Results</th>
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<tr>
<td>Quality of service and technological advances</td>
<td>Constant updating of training and equipment required to provide state-of-the-art care</td>
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<tr>
<td></td>
<td>Constant updating for providers in terms of utilization of technology (e.g., computers, Internet)</td>
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<td>Number and variety of professionals in competition</td>
<td>&quot;Buff and turf&quot; service delivery</td>
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<td>Organizations that deliver services</td>
<td>Organizational competition</td>
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<tr>
<td>Preserving quality of care</td>
<td>Strive to survive and progress</td>
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<tr>
<td>Cost-containment</td>
<td>Pressure to provide &quot;more for less&quot;</td>
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<td>Cost-based service delivery is given primary consideration rather than quality client care</td>
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TABLE 1.1 Factors That Influence Health Care Delivery
technicians, occupational therapists, and physical therapists. This causes the position of the social worker to be viewed as just one of many "adjunct" professionals involved in health care delivery.

To compare salaries of social workers in health care with those in other professions such as:

- clinical nurse specialist
- staff nurse RN
- recreational therapist
- case manager
- counselor
- physician family medicine

Try this Web address: http://aolsvc.salary.aol.com/

After addressing the increased number of professionals providing health care service delivery, to avoid confusion, an examination of similar or duplicating functions that many of these professionals perform must be made (Buppert, 2002). This is particularly relevant for those directly providing services in the allied health fields of which social work is part (Lister, 1980). Often the roles that social workers perform overlap with these other disciplines (Davidson, 1990; Dziegielewski & Leon, 2001). For example, today nurses are often asked to run therapeutic support groups in the health care setting. This invitation remains contradictory to the traditionally held belief that most group leadership is the realm of the social work professional (Toseland & Rivas, 1984). Based on the increased number of allied health care professionals and the overlapping of skills, tasks, and roles, one point remains certain: all trained professionals will be forced to continue to compete and strive to find a solid niche in this new and emerging managed health care market.

The third factor that compounds the problems found within current health care delivery involves not only the individual providers, but also the organizations of delivery. Managed health care has created a competition for survival never before experienced. Previously, most health care organizations focused their attention on expanding and increasing marketability through services provided. Today, the ideal organization for health care delivery must base service delivery on insurance reimbursement while providing all levels of competitive evidence-based care to their defined population (Shortell & Kaluzny, 1994; Donald, 2002).
Each health care delivery organization must ensure that, at a minimum, at least two things are done to make it viable. The first is to take the necessary steps to ensure its own survival; the second is to be able to record progress toward the agency's and society's mission (Shortell & Kaluzny, 1994). Striving to survive and progress creates an air of competition that was originally designed to provide quality and competitive services for all. To compete, a variety of major strategies have been incorporated (Hernandez, Fottler, & Joiner, 1994). These include (a) provision of low-cost traditional health services; (b) provision of superior service through technology or client service; (c) specialization into certain areas of practice (i.e., centers of excellence); (d) diversification outside of the traditional bounds of health care delivery (i.e., wellness centers); and (e) creation of new and ingenious ways to relabel the traditional service to be more reflective of the greater society. For example, recently under the influence of managed care policies, many organizations have begun to look toward presenting their service in a new and different light. A societal and political paradigm shift has occurred, transforming health care from what we knew (e.g., focused on fixing problems or curing illness) toward wellness, resulting in a greater emphasis on the spirit and a continuum of health care services—not illness care services (Shortell & Kaluzny, 1994).

As with all societal change, people and the culture are slow to respond; therefore, this paradigm shift will require changes be implemented at the most basic levels. For example, there is little debate that in the traditional medical mode, the individual who receives the services has traditionally been referred to as the "patient." In health care social work, this caused many social workers to stop using words like client when referring to the individuals served and to adopt the dominant label used in the medical environment. This use and acceptance of the term patient is obvious when reading articles in the social work health care literature (Alperin, 1994; Brown, 1994; Coursey, Farrell, & Zahniser, 1991; Cowles & Lefcowitz, 1992).

To reflect consistently this societal paradigm shift away from the medical model in which the receiver of services is viewed as "sick," a wellness outcomes-based cost-effective approach is being emphasized today. For all health care professionals, referring to an individual service recipient as the "patient" is now in need of revising. The term patient is in conflict with the wholeness and prevention strategy that is advocated by most organizations to increase marketability in this com-
petitive environment. Terms now being utilized include client (a term familiar to social work professionals), service consumers or patrons (to represent those buying or purchasing a service), product recipients or individual recipients (those receiving a direct service), and covered persons (reflecting those who have some type of medical insurance coverage). Those in favor of the euphemism covered persons argue that it is not used just to indicate medical coverage but to indicate the universal care perspective and the assurance that comes with an individual having the security of medical coverage. Therefore, “covered entities” are referred to as the health care providers that serve “covered persons.”

No matter what the final determination is, the influence it will have in enhancing the survival and progress of the organization, and its marketability, so to speak, most assuredly will be considered. As for social workers practicing in the health care arena, they will probably soon follow suit and use the same terms to identify the recipient defined by managed health care plans. After all, as one of the allied health care professionals providing service, it is important to conform for uniformity and provider eligibility.

The fourth and fifth factors are a combination often hailed as the two most powerful forces driving managed health care delivery today (Shortell & Kaluzny, 1994). These factors involve the balance between preserving the quality of care delivered while maintaining cost control. Usually these factors are considered equal in the political discussion of health care delivery, however, under most of the capitation or fixed fee models being proposed, revenue schemes that increase quality of care while increasing the cost of health care fail to garner support (Flood, Shortell, & Scott, 1994, Hernandez, Fottler, & Joiner, 1994, Ross, 1993).

Along with other professionals, many health care social workers feel the pressure to use for cost containment. It is my expectation that, in the future, continued emphasis will be placed on cost containment at the expense of quality of care (Dziegielewski, 1996, 1997, Schneider, Hyer, & Luptak, 2000). Therefore, the role of the social work professional in actively advocating for the provision of quality services cannot be overstated (Dziegielewski, 2002, Franklin, 2002, Gibling, 2002, Rock, 2002). Colby and Dziegielewski (2001) warn, however, that social workers need to do more than simply ensure the provision of “micro” (individually based) or “mezzo” (environmentally based) quality services. They urge social work professionals to be active in the “macro” aspect of practice by monitoring policies and programs that will affect not
only the clients they serve directly but also all Americans. Advocacy of this type means actively identifying and supporting state and federal legislation that provides basic standards of quality care. Services that allow universal accessibility, affordability, and service comprehensiveness need to be endorsed (National Association of Social Workers, 1994), while culturally sensitive practice is maintained (National Association of Social Workers, 2001).

THE ROLE OF MANAGED HEALTH CARE

In the early 1990s, the debate that secured its place in the forefront of the social and political agenda was that of health care delivery. The cost of health care delivery had been defined as a national crisis. Many thought that several of the key causes of this inflation were beyond control. Several reasons postulated for pushing health care costs beyond direct control included the increasing number of Americans reaching "old" age that would require services, the technological advances within the society, and the unregulated and varied cost of the services provided (Edinburg & Cottler, 1995). Other societal and professional factors included the fact that (a) many health care consumers were considered medically uneducated and unknowledgeable about medical services; (b) Americans were sensitive and resistant to paying more for the delivery of medical services; (c) the insurance industry was highly fragmented, with managerial administrators and leaders who were trained in a different environmental context that did not include "standardized cost containment techniques"; (d) there were simply too many hospital inpatient beds with the pressure to have them filled; (e) there was a focus on acute illness rather than a more holistic, wellness, or preventive perspective; (f) there was insufficient medical outcomes-based data that focused the benefit as the end result of service; (g) there were difficulties separating quality-of-life issues from technological advances, causing heroic attempts to implement expensive procedures without regard to quality of continued life; and (h) the medical community had been rocked by numerous malpractice suits that resulted in fear and pressure to ensure fewer complaints (Edinburg & Cottler, 1995; Shortell & Kaluzny, 1994).

Even though many of these societal and technological factors were considered difficult to address and change, concern about future
predictions of the cost of health care delivery continued to send shivers down the spines of the entire American population. Health care costs were estimated at more than $640 billion in 1990 (Shortell & Kaluzny, 1994), and at that current rate, accrual was expected to reach $1 trillion (Hernandez, Fottler, & Joiner, 1994) to $1.5 trillion by the year 2000 (Skelton & Janosi, 1992). In 2002, the National Institutes of Health could receive a funding increase of $3.7 billion for the fiscal year that began October 1, with an additional expectation to double the agency's funding over five years under a bill approved by a U.S. Senate subcommittee (Reuters Health Information, 2002). To fuel the concern further, it was believed that as the years progressed, the baby boomers who would reach their 70s and 80s in the year 2030 would bring health spending to an astonishing peak at $16 trillion, or 30% of the gross domestic product (Burner, Waldo, & McKusick, 1992).

To add to this concern for cost containment, in the late 1970s and into the middle 1980s, it was estimated that the number of individuals without health insurance in the United States increased from 28.7 million to 35.1 million (United States Bureau of the Census, 1984). This left an estimated 37 million Americans who experienced health risks with an inability to afford needed health care (Roland, Lyons, Salganicoft, & Long, 1994). This fact particularly disturbed insurance companies, which complained of bitter upsets, and in 1988 the nation's top twelve health insurers reported financial losses of $830 million (Edenburg & Cottler, 1995).

In review, the 1980s represented a time when the nation was in the midst of economic stagnation and recession (Mizrahi, 1995); the alternate health care reform strategies suggested to alleviate this unprecedented burden were all of a "solution-based" or "evidence-based" nature (Donald, 2002). To address this situation, a course of action was considered successful if it ultimately resulted in a decision-making framework that supported efforts toward cost control, cost containment, or cost reduction.

In the early 1990s, the message of concern was clear, and the social climate was rich with politicians' verbal responsiveness to the American peoples' concern for reform. This acknowledgment was reflected in the election strategy of many of the candidates seeking office. It was not uncommon for many of the campaign platforms to present possible solutions designed to address health care reform. In fact, President Bill Clinton in his 1992 election, made health care reform his highest
domestic priority (Mizrahi, 1995). Numerous proposals were considered, from single-payer-system approaches to limited policies for universal health care coverage.

After the 1992 presidential election, the victor, democratic President Bill Clinton, proceeded to address his campaign goal by establishing a task force to complete a plan for health care reform. The model emphasized was different from the single-payer approach that he had originally supported early in his campaign. This later approach involved a type of managed competition in which purchasing alliances were formed that would have the power to certify health plans and negotiate premiums for certain benefit packages (The President's Health Security Plan, 1993). Since employer–employee premiums would finance payment for these plans, the actual consumer out-of-pocket cost could vary based on the benefit package chosen. Title XVIII, Medicare, a federal entitlement program to pay for physician and hospital services for disabled individuals or others age 65 or older, remained a separate program. Title XIX, Medicaid, a means-tested program based on provision of medical services for low-income Americans, was included in the plan (Mizrahi, 1995). One possible economic reason for the attraction to include Medicaid in this reform process was that between 1990 and 1991 one third of the increase in the total U.S. expenditures was based on states' use of this program (Letsch, 1993).

The future of most health care delivery (70% of all coverage) is to be provided by managed health care plans (Edinburg & Cottler, 1995). In this system, managed care plans will cover preauthorization for service by qualified consumers; precertification for a given amount of care with concurrent review of the treatment and services rendered; continued determination of the need for hospitalization through a process of use review; and predischarge planning to ensure that proper after-care services are identified and made available (Hiratsuka, 1990).

Five major types of managed care programs for health care delivery follow, all of which may employ social work professionals (Wagner, 1993). The first is managed indemnity plans. In these plans, traditional coverage is offered; however, the cost of the plan is directly related to the usage needs and requirements of the subscriber. A second type of managed care plan is the preferred provider organization (PPO). Here employers or insurance carriers contract with a select group of health care delivery providers to provide certain services at preestablished reimbursement rates. The consumer has the choice of whom to
contact to provide the service; however, if the option of using a provider not on the provider list is chosen, higher out-of-pocket expenses will result.

A third type of managed care plan is the exclusive provider organization. This plan type is generally considered more restricted than the PPO because the consumer does not have the choice to go elsewhere, and services must be provided and received by the contracted organization or partnership. Employers often choose this type of health care delivery as a cost-saving measure. If a consumer does go outside of the system, reimbursement is generally not obtained (Wagner, 1993). The use of these facilities is the only way to gain reimbursable access to specialty care services (surgery, etc.).

A fourth type of managed care program is the point-of-service plan. Usually at the initiation of coverage, a choice is made whether to request a PPO format or an indemnity/HMO format for delivery of services. Thus the consumer can go outside of the provider system with minimal additional cost (Wagner, 1993).

The fifth type of managed care program is probably both the oldest and the most commonly related to the idea of managed care, the health maintenance organization plan (HMO). These plans provide service for a prepaid fixed fee. The organizations provide both health insurance and health delivery in one package. If a consumer must go beyond the traditional services offered by the HMO, the HMO determines where these covered services will be obtained. Five common types of HMO models for service delivery are staff models, where the physicians are employed directly by the HMO (i.e., a type of closed model); group models, where contracts are held with multispecialty groups of physicians (i.e., a type of closed model); network models, which result in a greater choice of physicians because any specialty physician who has the proper credentials can join (i.e., an open panel plan because enrollment is not limited to contracted staff or a group); individual practice association models, where the physician becomes a member but can still retain his or her own professional office; and direct contract models, where physicians are contracted to provide services on an individual basis (Edinburg & Cottler, 1995). It is important to note that the concept of using managed care plans through the use of health care organizational providers is not a new one. This type of delivery was originally formulated to provide efficient, comprehensive, and high-quality health care services (Shortell & Kaluzny, 1983).
CHAPTER SUMMARY AND FUTURE DIRECTIONS

In summary, the complexity and diversity required to define simply the current concept of managed health care in the area of health service delivery cannot be underestimated. In today's health care market, a specific definition of the term managed health care simply does not exist (Edinburg & Cottler, 1995). Unfortunately, attempts at a standard definition continue to change, and the term has expanded and broadened in complexity. Generally speaking, one characteristic remains consistent across all evidence-based managed care provision strategies: these strategies are designed to provide an array of features that will ultimately balance quality of care with cost containment, allowing this type of health care to survive and progress (Donald, 2002). In addition, directives and principles relevant to managed care that extend beyond it remain strong. These factors include evidence-based practice principles, brief goal-directed treatment, outcome measures, primary and preventive care, and case management (Rock, 2002). This will require that social workers continue their practice emphasis in this area, becoming proficient in formulating care plans and addressing the person as a whole, integrating health and mental health as well as mixing mind and body influences toward the achievement of comprehensive client care (Dziegielewski, 2002).

For health care social workers in the managed care environment, practice expertise will be measured through the use and development of technology-based interventions. This requires that intervention skills incorporate the use of computer-based data systems, telephone counseling, multimedia educational tools, and the Internet (Franklin, 2002).

In health care practice, computers are now often used for assessments, progress notes, routine correspondence, and reports (Gingerich, 2002). Social workers, like other health care professionals, will need to utilize this technology and employ these techniques to help clients to secure the services they need.

In closing, the intention of this first chapter is to set the stage for enlightenment regarding some of the concepts, ethical dilemmas, and resulting problems that a health care social worker can confront while ensuring service delivery. Health care social workers need to be aware of the many societal, philosophical, and technological trends that have occurred over the last ten years, and how the history of runaway health care expenses has influenced current expectations for future
service delivery. These influences, combined with requirements for evidence-based practice, have truly transformed health care delivery (Donald, 2002). Changes relevant to controlling costs through managed behavioral health care have required that social workers be flexible, and there are new and varied expectations of what they will be required to perform. For today’s health care social work professional, issues and problems similar to those experienced by Ms. Edda (see the case study earlier) are not unusual; unfortunately, unless health care social workers strive to understand and anticipate current and future trends in service delivery, cases like the one presented will become more common.

REFERENCES


**GLOSSARY**

*Exclusive provider organization:* This form of a managed care plan is generally considered more restricted than the PPO. Consumers do not have the choice to go elsewhere. Services must be provided and received by the contracted organization or partnership. Many times this plan is referred to as the "gatekeeper" because use of the services provided is the only way to gain reimbursable access to specialty care services.

*Health care delivery organizations:* In today's health care environment, these organizations are considered responsible for providing low-cost traditional and specialized health services; incorporation of technology into the service provided; diversification outside the traditional bounds of health care delivery (i.e., wellness centers); and new ways to label traditional service to be more reflective of environmental demands.

*Health maintenance organization plans:* These plans provide service for a prepaid fixed fee. These organizations provide both health insurance and health delivery in one package. If a consumer must go beyond the traditional services offered by the HMO, the HMO determines where these covered services will be obtained. Five common types of HMO models for service delivery are staff models (physicians are employed directly by the HMO), group models (contracts are held with multispecialty groups of physicians), network models (where enrollment is not limited to contracted staff or group providers), individual practice association models (physicians become members, but can still retain their own office and consumers), and direct contract models (physicians are contracted to provide services on an individual basis).

*Length of stay:* This is the actual time used or allotted (usually specified in number of days) for a consumer to receive a needed health care service.

*Managed care:* An organized system of care that attempts to balance access, quality, and cost-effectiveness.
Managed care programs: Programs designed to provide an array of features that balance quality of care with cost-containment strategies.

Managed indemnity plans: A type of managed care program where generally traditional coverage is offered; however, the cost of the plan is directly related to the usage needs of the subscriber.

Preferred provider organizations: Here employers or insurance carriers contract with a select group of health care delivery providers or service organizations to provide certain services at pre-established reimbursement rates. The consumer has the choice of whom to contact to provide the service; however, if a provider not on the provider list is chosen, higher out-of-pocket expenses will result.

Primary and preventive care: Client care that is focused on ambulatory and community-based care approaches as well as physicians' offices and health maintenance organizations.

Prospective payment system: This is a system of reimbursement for what is determined the average length of stay or duration of care for an individual with a certain medical or psychiatric diagnosis.

QUESTIONS FOR FURTHER STUDY

1. What changes do you predict for the field of health care social work because of the pressure to balance cost containment with quality of care?
2. Based on what you know of the social work profession, what new areas of practice “marketability” would you suggest for social work professionals to consider?
3. What do you believe is critical information to allow social workers to balance social work ethics with the reality of the practice environment?

WEBSITES

www.hmopage.com
www.NoManagedCare.org
www.tiac.net/biz/drmike/managed2.html
Evolution of the "New" Health Care Social Work

THE PROFESSION OF HEALTH CARE SOCIAL WORK

No text on health care social work practice would be complete without a review of the profession's struggle to define the historical and current role of the health care social worker. What is most disturbing in today's practice environment is the fact that many individuals outside the social work discipline continue to remain unsure of what it is the health care social worker does. In addition, social workers themselves often battle over what constitutes "health care" social work. Establishing and agreeing upon a unified definition of health care social work remains critical for survival in today's behavioral managed health care environment. The current practice of health care social work is reflective of the environment where change and constant restructure are the usual state of affairs. Today, health care practice can present challenging times for all health care professionals (Donald, 2002; Imperato, 1996), not just social workers. Changes in the scope of practice, the roles social workers assume, and the expectations of both clients and practitioners have occurred quickly; and many times professionals feel trapped and lost in this whirlwind of activity.

In this turbulent, ever-changing environment, professional social workers must constantly balance "quality-of-care" issues versus "cost-containment" measures for the clients they serve (Dziegielewski, 1996, 2002). This delicate balance must also be reached in a time when the social worker's role and current position in the health care setting are tenuous at best. As social workers, we continue to remain skeptical as to whether quality of care will actually be able to win in a system that
was originally characterized by social welfare institutions that represented the nonprofit motive (Poole, 1996).

The most important aspect of the profession of social work that makes it unusual when compared with other disciplines is that it involves helping individuals, families, and groups. This unique perspective, stated in its most simplistic form, is that of recognizing the importance of the "individual in the situation" or the "person in the environment" (Hepworth, Rooney & Larsen, 2002; Skidmore, Thackeray, & Farley, 1997). Today, however, for the health care social worker, recognizing the cultural uniqueness of an individual or person within an environmental context or situation can be much more complicated than what was traditionally perceived (Lum, 2003).

This perspective requires that the health care social worker go beyond the traditional confines of the health care institution and consider the needs of the individual, family, group, or community regarding their unique situations or environments. In the turbulent health care environment, the practice of the health care social worker must not only concentrate on providing important concrete services that clients need to function effectively within their environments, but also try to anticipate future changes in those environments to ensure that services remain effective and helpful. In addition, the health care social worker, also affected by the environment, must ensure that he or she continues to be able to maintain his or her own position as a service provider.

**DEFINING HEALTH CARE SOCIAL WORK PRACTICE**

Recently, I consulted with a colleague who has been a health care social worker for fifteen years. She had been asked to justify her position and the health services she rendered in the home health care environment—a job she had been doing for the last eight years. She knew the services she provided, but thought that these tasks needed to be presented in a perspective that made her duties different and marketable when compared with the nurses and other professionals working with clients. She feared that if she could not do this, budget cuts would force her duties to be turned over to the nurses and physical therapists, and she would lose her job. She also believed that as of late she was receiving fewer referrals, and thus was unable to provide
adequate care to clients in need. Although the nurses often visited clients, they were generating fewer social work consults. When my social worker friend asked the nurses why this was happening, she was told that no clear need for a social work assessment could be established, based on the nurses' increased role in determining service use criteria. Her concern escalated when one of the agency's clients attempted suicide in response to the recent death of his wife. Although the client was being seen regularly by the service for medication injections, no referral was made to the social worker—even after the wife's death.

This social worker's concern is real. The competition for professional legitimacy has increased, and social workers are forced to compete for a place in the health care arena. Questions that seek to establish what social workers do, different from the services of other professionals, are becoming more common. Developing an answer to satisfy these questions is now necessary. This social worker, like many others, is being forced to justify her current and continued role as a vital member of the health care delivery team. The traditionally held belief that what social workers do is different, necessary, and unique from other counseling professionals continues to be questioned; the environmental climate of maintaining quality of care and cost containment is demanding that it be answered.

To help address this issue and the unique contributions social work brings to the practice of health care, a clear linkage between social work and the other related disciplines needs to be established. Traditionally, the role of social work has been to advocate for the poor, the disadvantaged, the disenfranchised, and the oppressed (Hepworth, Rooney, & Larsen, 2002; National Association of Social Workers, 1996, 2001). Historically, this has been accomplished by promoting and enhancing client well-being in a societal or environmental context. In this book, as in most of the social work literature, the term client is considered inclusive and may involve individuals, groups, families, organizations, or communities.

According to the National Association of Social Workers (1996) as stated in the revised Code of Ethics:

The primary mission of the social work profession is to enhance human well-being and help meet the basic needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social
work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is the attention to the environmental forces that create, contribute to, and address problems in living . . .

These activities may be in the form of direct practice, community organizing, supervision, consultation, administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. (p. 1)

Considering this definition, it becomes obvious that the general role of the social work professional in dealing primarily with the poor and the disadvantaged has expanded over time. For the health care social worker, in particular, it now involves working with diverse populations that can include those who are homeless, suicidal, homicidal, divorced, unemployed, mentally ill, medically ill, or drug abusing and delinquent, just to mention a few. In addition, the health care social worker must always strive to achieve restoration, enhanced wellness, the provision of concrete services, and prevention. Strategies to assist clients must address all of these areas, since many times these factors are considered intertwined and interdependent (Skidmore, Thackeray, & Farley, 1997).

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<th>TODAY'S HEALTH CARE SOCIAL WORKER</th>
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<tr>
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**Duties in a typical day:**
I deal with people who have suffered a major tragedy surrounding a disease. I provide educational training to the client and his or her family members on the medical aspects of the disease and how to learn to live and cope with the disease process. I often act as advocate, to help the client get the necessary supports to improve the quality of his/her life.

**What do you like most about your position?**
I really enjoy working with the wide diversity of client problems and issues. I enjoy helping clients learn how to best cope with the disease process, encouraging empowerment each step of the way.
What do you like least about your position?
I often work long hours. At the end of the day, although I feel satisfied with what I have accomplished, I sometimes wish I could have done more.

What “words of wisdom” do you have for the new health care social worker considering work in a similar position?
In the area of medical social work, it is important to completely understand the process of the disease, from both a medical and psychosocial point of view. It is critical for the social worker to help the client to adjust and work through his or her feelings. Social workers need to help clients anticipate and prepare for the future. In terms of a progressive disease, acceptance and preparation are critical factors leading toward client empowerment and change.

THE UNIQUENESS OF HEALTH CARE SOCIAL WORK SERVICE PROVISION

CONTINUING EDUCATION

Given their understanding of the human condition, most social work health care professionals agree that, in general, the profession of social work is different from most of the other helping professions. Today, however, this assumption has come under direct attack. There are two important reasons for this attack: (a) in our current system of health care delivery, the number of practicing health care professionals has risen dramatically (Freudenheim, 1990; Shortell & Kaluzny, 1994); and (b) these professionals often perform the same or similar tasks (Lister, 1980). Often the roles and tasks that health care social workers perform overlap with those of practitioners from other disciplines (Davidson, 1990).

This will continue to make survival in the health care arena difficult for health care social workers, especially if we do not openly acknowledge and embrace the competition created by the circumstances noted earlier. For example, in a discussion at a National Association of Social Workers branch meeting, the issue of providing health care social work professionals with an ongoing series for continuing education was addressed. Many of the social workers at this meeting thought that if the
state was going to require continuing education, then social workers should be able to obtain these hours through "related" workshops or seminars. In principle, this would make it easier for social work professionals to expand their choices of workshops and allow them to learn from other professionals.

As the task of establishing speakers and exploring topics for presentation began, a statement was made by one of the members and rapidly escalated into a heated discussion. Simply stated, the member asked, "How can we truly say that what we do as health care social workers is different from these other disciplines when we choose to receive most of our continued educational training from them?" This comment caused a lengthy debate. Some social work members stated that they appreciated this "additional" information, whereas others said it was not "additional" at all—it was "required" for effective practice. Regardless of what side was taken, most agreed that as social workers battle for a place in the health care delivery system, this "lack of uniqueness" concerning the skills and techniques often employed could be used against them. This makes the argument that social workers provide services not provided by other professionals a complicated one.

The disagreement and mixed emotions shared in this small meeting are not uncommon. Many states continue to struggle with continuing education requirements for social workers. How much is needed? Who should be eligible to provide programs? In this meeting a resolution was reached; however, it was not unanimous. These social workers recommended that continuing education should be required of all social work professionals, and this education could be provided by social workers or "other professionals." Thirty hours were recommended, with a minimum of fifteen being provided by social work professionals only. Although this policy recommendation was made for all areas of social work practice, most workshop presenters and topics under consideration were from the health care area.

For health care social workers in particular, the issue of the "uniqueness of social work services" remains a problem that we are forced to address. The competition for service delivery is fierce, and health care social workers must clearly establish that (a) what they do works; (b) they can do it quickly and in the most cost-effective way possible; and (c) what they do is different, contributing uniquely to the health and well-being of the clients served (Dziegielewski, 1997b).
As stated in chapter 1, many other disciplines in the health care arena are doing the tasks that have traditionally been considered the role of social worker. In turn, social workers are also doing some of the tasks that have traditionally belonged to other disciplines. This complicates the ability to clearly establish a definition of what the health care social worker does as different and unique from the other related disciplines.

For example, most individuals know the difference between nursing and social work; however, in today's health care environment this distinction is no longer clear. Not only is there a blurring of roles between these two professions regarding the delivery of health care services, but there is overlap. Many nurses are now delivering services that were traditionally the role of the social work professional.

The role of the nursing professional is rapidly changing. In the past, nurses generally focused on the direct provision of medical and health-related services from the medical model perspective. Traditionally defined, a nurse was a person who was specially trained to care for sick or disabled persons (Webster's Dictionary and Thesaurus, 1993). It is this traditional role that secured them a place in health care along with physicians as essential personnel. Most of the psychosocial issues regarding patient care were either consulted with the social worker or left directly for the social worker to address. Today, however, this simplistic definition of the role of the nurse and of the social worker has clearly changed. No longer can the roles and tasks performed by social workers and nurses be so clearly differentiated. Nurses are now doing much more varied tasks than what would have been previously considered as "unusual nursing methods" of practice.

For example, for over a century "discharge planning" has been a part of the practice of health care social work as well as nursing. Historically, both disciplines recognize the need for formalized services that reflect discharge planning and have often worked together to provide subsequent aftercare activities. To date, studies (Egan & Kadushin, 1995; Holliman, Dziegielewski, & Teare, in press; Holliman, Dziegielewski, & Datta, 2001; Kulys & Davis, 1987; Sheppard, 1992) have looked at the differences between social work and nursing and the overlap of activities that often occurs. This role sharing has recently been noted...
as prospective payment systems have assigned discharge planning activities increased status, and overlapping and convergence of social work and nursing tasks has led to turf battles. The overlap and sharing between the two disciplines has led to the question of the exact role of the social worker and the nurse. To answer this question, Egan and Kadushin (1995) surveyed social workers and nurses to ascertain what generic hospital social service tasks should be done by social workers, nurses, or both. Both social workers and nurses agreed that social workers were better qualified to provide concrete services such as setting up home equipment, arranging nursing home placement, and helping patients understand insurance and finances. However, both social workers and nurses saw themselves as qualified to perform the tasks of supportive counseling (Holliman, Dziegielewski, & Teare, in press).

In addition some studies have focused on systematic differences between the two groups. For example, Sheppard (1992) studied the communication styles of social workers and nurses during their interactions with physicians. Sheppard found that nurses contacted physicians more frequently than social workers, and the reason for contact often differed. Nurses generally contacted physicians about the patient's condition and treatment. Social workers contacted physicians less frequently; and when they did, they addressed the case's outcome, the final treatment plan, or family issues.

Bennett and Beckerman (1986) believed that the 1970s brought a change of status regarding the professionals who performed discharge planning. These authors pointed out that the "drudges of yesteryear" (i.e., those social workers who did not avoid assignments to medical and surgical services) had been transformed into major players. Carlton (1989) and Ross (1993) commended social workers for their ability to work with elaborate systems, and claimed that social workers were the best-qualified professionals to do discharge planning. Cox (1996), in a study of discharge planning with patients suffering from dementia, found that social workers were the team members most involved and influential with discharge decisions and nursing home placements. Atkatz (1995) found that social workers were commonly involved in discharges with the homeless because of the problematic placement issues with this group. Social workers were also frequently involved in cases of discharge planning with HIV/AIDS patients (Fahs & Wade,
1996; Marder & Linsk, 1995), the mentally ill (Gantt, Cohen, & Sainz, 1999; Tuzman, 1993), and infants with special care needs (Gentry, 1993). These studies support the importance of including social workers in discharge planning, especially when multiproblem cases occur and there is a lack of available community resources.

From the nursing perspective, several sources have claimed that nurses are the most qualified discharge planners because their medical training allows them to complete physical assessments, provide medical information with referrals, and assess the quality of health care resources and facilities (Lusis, 1996; McWilliams & Wong, 1993; Nurse specialists make discharge planning pay” 1994; Steun & Monk, 1990; Thoms & Mott, 1978; Worth, 1987).

McHugh (1994) and Spataro (1995) agree that although discharge planning remains a priority in nursing, the perceptions of what this requires vary. Some nursing professionals believe that nurses involved in discharge planning should take more of an administrative role; and others see the nurse’s role as teaching patients and families complex postdischarge treatments such as breathing treatments, decubitus and skin care, feeding tubes, and home injections (Lusis, 1996; Penrod, Kane, & Kane, 2000).

The primary debate in the area of discharge planning focuses on who should be doing it, and what should be done. Turf battles between social work and nursing have increased over the last decade, as health care resources have become more limited. In summary, despite the continuous debates about who should do discharge planning, there is no empirical evidence that one group is more qualified than the other. Holliman, Dziegielewski & Teare (in press) conclude that despite role conflict and overlap, both social workers and nurses are able to make unique and substantial contributions in health care.

In addition to health care, many nursing professionals have advocated strongly for all nurses to be aware of the mental health aspects of practice, advocating for a new holistic approach to practice (Carson & Arnold, 1996). These professionals believe that nursing needs to expand and actively reach for a more comprehensive stance from which to base practice intervention strategy. According to these professionals, the idea that individuals are more than the sum of their parts must be incorporated into every aspect of professional nursing service. “In Mental Health Nursing, we therefore look at the total person, not just feelings and thoughts, but interaction of those feelings and thoughts with bio-
logical, social, cultural, and spiritual aspects of the person" (Carson &
Arnold, 1996, p. xiii). These authors may be considered somewhat
radical in their approach; however, they clearly reflect what is happen-
ing in the field. Whether it be the sheer numbers of nurses available to
practice or the significant shifts in ideological thought among nurses
practicing in the field, the profession of nursing is changing. Many of
these changes have and will continue to affect the field of social work
and the health care social work provider.

In this era of behavioral managed health care, nurses and physicians
who are referred to as critical providers of medical services have a
great deal of power in establishing a firm place in the delivery of
health care services. Social workers, like many other allied profession-
als, are not considered essential. Therefore, nurses, in particular, can
and often do compete for jobs or direct services that were usually done
by social work professionals.

This means that nurse professionals are now, in addition to their
traditional medical duties, initiating individual therapy, group therapy,
crisis therapy, family therapy, mind-spirit therapies, health counseling
and therapy, social work supervision, administrative services, and nu-
merous other services that were usually considered the domain of the
health care social worker.

After reviewing the services provided by helping professionals in
the health care area, one sees that there is a great deal of overlap of
roles and functions. With all the overlap, it is easy to see where con-
fusion can originate as to the actual differences between the services
these professionals provide. However, on careful examination, one in-
crement remains conspicuously weak in the professions described, but
prominent within social work. It is assistance to better the human
condition, with the primary emphasis being placed on the environ-
ment that influences, surrounds, and reinforces it.

In summary, the greatest single factor that makes the professional
health care social worker unique is the long-uncontested professional
interest in the of "person in the situation" or the "person in the envi-
ronment." This stance has long been our heritage or, more practically
stated, our "guiding light for practice." Many of our basic texts describe
it, and it is clearly reinforced in the classroom setting as well as in
direct practice.

It is important to note that in today's practice environment, social
workers are not the only ones aware of the importance of addressing
clients within the environmental context. The importance of including a "person–environment stance" has not gone unrecognized within the other disciplines. Therefore, many of the traditional premises central to the field of social work (e.g., the total equals more than the sum of the parts) have been adopted by other health-related helping professionals for inclusion in their practice. These professionals now use many of the same principles and ideas of social work, further complicating or blurring the differences between the disciplines and the uniqueness of the roles that each professional provides.

TOWARD A DEFINITION OF CLINICAL HEALTH CARE SOCIAL WORK

Clinical social work in the health care setting is an area of practice that has sometimes been referred to as medical social work; it is not uncommon to see these terms used interchangeably. The Social Work Dictionary defines medical social work as a form of practice that occurs in hospitals and other health care settings and that facilitates good health and prevention of illness, as well as helps physically ill clients and their families to resolve the social and psychological problems related to disease and illness (Barker, 1995). To highlight the concept of facilitating good health further, wellness with its emphasis on promoting and maintaining a sense of client well-being has recently gained in popularity. In this definition, it is also important to acknowledge the role of the medical social worker in sensitizing other health care professionals to the social-psychological aspects of illness (Barker, 1995). In practice, the health care social worker addresses the psychosocial aspects of the client, alerts other team members to these needs, and facilitates service provision. Additionally, the social worker not only represents the interests of the client, but also is expected to be reflective of the "moral conscience" for the health care delivery team.

As defined in this book, clinical health care social work practice includes a full range of social work services. These services include social work assessment or diagnosis, goal establishment, interventive foci, methods, and referral. It is important to note, however, that whenever possible, brief or time-limited intervention methods are strongly recommended for future practice survival (Dziegielewski, 1997a). When using time-limited interventions, no single theory or standard for
practice application should govern a social worker's attempts to help an individual, group, family, or community resolve the problem being addressed. Further, many of the services that today's health care social workers are forced to provide can no longer be considered traditional. Many times the health care social worker is forced to see a client only briefly, or she or he may be unable to do more than concrete service referral and provision. Today's health care social worker must remain flexible and open to change, but there will always be exceptions.

In summary, the clinical health care social worker should always remember that clinical social work in the health field is a mutual process of face-to-face interventions in which the professional social worker provides social work services to clients, including services on behalf of those clients, who use them to resolve mutually identified and defined problems in client social functioning precipitated by actual or potential physical illness, disability or injury. (Carlton, 1984, p. 6)

Keeping this traditional definition in mind, the struggles that social workers must face in the health care area today should not be underestimated. Often the health care social work professional is viewed as "just" one of many providers. This makes purpose justification regarding service provision a daily struggle. Yet, it has become obvious that a clear statement of purpose and role performance is expected if one is to compete for and maintain a seat at the health care delivery table.

Establishing a clear definition of health care social work practice, either today or in our past, has not been an easy task. Health care social workers must remain flexible in the delivery of services. As a profession, this flexibility needs to be maintained not only to help our clients, but also to adjust to the environment in which our clients exist and need to be served.

**ROLE OF THE HEALTH CARE SOCIAL WORKER IN MANAGED CARE**

The current state of social work practice in the health care setting mirrors the turbulence found in the general health care environment. Medical social workers, like other health care professionals, are being forced to deal with numerous issues that include declining hospital admissions, reduced lengths of stay, and numerous other restrictions
and methods of cost containment. Struggling to solve these issues has become necessary because of the inception prospective payment systems, managed care plans, and other changes in the provision and funding of health care (Davis & Meir, 2001; Johnson & Berger, 1990; Ross, 1993; Simon, Showers, Blumenfield, Holden, & Wu, 1995). Previous research has linked not receiving services to higher rates of high-risk patient relapse (Coulton, 1985). Social workers are being forced to discharge clients from services more quickly, and clients are being returned to the community in a weaker state of rehabilitation than ever before (Bywaters, 1991).

With so many changes in the social environment, there is little consistency in the delivery of health care social work and a great emphasis on cost containment (Davis & Meier, 2001). When health care administrators are forced to justify each dollar billed for services, there is little emphasis placed on the provision of what some term as “expendable services,” such as mental health and well-being services, thorough discharge planning, and so on.

Unfortunately, the services that social workers perform are often placed in this category, and, as a result, they often feel the brunt of initial dollar-line savings attempts (Dziegielewski, 1996, 2002). As discussed earlier, just the sheer numbers of allied health care professionals who are moderately paid provide an excellent hunting ground for administrators pressured to cut costs. These administrators may see the role of the social worker as adjunct to the delivery of care, and may decide to cut back or replace them with concretely trained nonprofessionals simply to cut costs. These substitute professionals do not have either the depth or breadth of training that the social work professional has, which can result in substandard professional care. For example, a trained paraprofessional in hospital discharge planning may simply facilitate a placement order. Issues, such as the individual’s sense of personal well-being, ability for self-care, or family and environmental support, may not be considered. Therefore, the employment of this type of paraprofessional can be cost-effective but not quality care driven. If personal/social and environmental issues are not effectively addressed, clients may be put at risk.

The client who is discharged home to a family that does not want him or her is more at risk of abuse and neglect (Kemp, 1998). A client who has a negative view of self and a hopeless and hapless view of his
or her condition is more likely to try to commit suicide. Many paraprofessionals or members of other professional disciplines can differ from social work professionals because they do not recognize the importance of culture and environmental factors. The deemphasis or denial of this consideration can result in the delivery of "cheap" but substandard care.

As administrators strive to cut costs by eliminating professional social work services, the overall philosophy of wellness has been sacrificed for a concentration on cost cutting. It is important to note, however, that many times these types of staff reductions are not personal attacks on social work professionals. Changes and cutbacks in the delivery of services and those who provide them are often done to address an immediate need—cost reduction. The fluctuating and downsizing of social work professionals, as with other allied health professionals, may simply reflect the fluctuating demands of the current market (Falck, 1990, 1997).

Ross (1993) points out that health care employees who are at the greatest risk of losing their place in the delivery of health care services are those who (a) do not create direct hospital revenues; (b) are not self-supporting parts of the health care delivery team; (c) hold jobs where productivity is not easily measured or questionable; (d) provide service where the long-term benefit for cost of service is not measured; and (e) engage in a service where the professional's role is often misunderstood, challenged, and underrated in the system. Unfortunately, social workers, along with other allied professionals who participate in the health care delivery system, often meet these criteria (Dziegielewski, 1996). Therefore, it is important for social work professionals to be viewed as an essential part of the health care delivery team, providing both needed direct clinical services as well as fiscal support for the agency setting (Dziegielewski, 2002).

In closing, it is important not to confuse the social worker who works in managed care with the concept of providing case management in the health care setting (Davis & Meier, 2001). In the traditional provision of case management services, the goal is to get the client the best and most cost-effective treatment based on client need (Edinburg & Cottler, 1990), whereas, in behavioral managed health care the role of the social worker as a case manager is to help cut costs by discouraging any unnecessary services or procedures (Shorter, 1990).
CHAPTER SUMMARY AND FUTURE DIRECTIONS

The problem of developing a definition of health care social work as described in the beginning of this chapter is not an uncommon one. Originally, the roots of the health care social worker, similar to those of the social work profession, were generally linked to serving the poor and the disfranchised. However, over the years the role of the health care social worker has expanded tremendously. This makes defining exactly what social workers do a difficult task. Clarity of definition has been further complicated by changes in scope of practice, the diverse roles of social work, and the expectations within the client-practitioner relationship. This turbulent environment requires that social work professionals constantly balance “quality-of-care” issues with “cost-containment” measures for clients, while securing a firm place as professional providers in the health care environment.

In this chapter, a general definition of the role of the health care social worker was presented along with a discussion of role ambiguity and confusion. Some of the differences between health care social workers and the other related disciplines were outlined. In summary, the major distinguishing factor found was the practice-based environmental stance that has historically reflected the roots of social work practice. Therefore, health care social work needs to be viewed as the professional “bridge” that links the client, the multidisciplinary or interdisciplinary team, and the environment. Now, more than at any time in the past, it is important to define clearly the similarities and differences between the professions. The numbers of health care professionals in practice have risen dramatically; and these professionals who often perform similar or duplicating functions are competing for limited health care jobs.

For future marketability and competition, it is believed that social workers need to move beyond the traditional definition and subsequent role of the health care social worker. In the area of clinical practice, new or refined methods of service delivery need to be established and used. Social workers are encouraged to become managers, owners of companies, employees, administrators, supervisors, clinical directors, and case managers so they can help influence specific agency policy and procedure. They also need to make themselves aware of basic programs beyond their own individual practice that can affect health care service delivery. The specific recommendations, techniques,
and guidelines discussed in the following chapters will be useful in helping health care social workers equip themselves with the tools in practice, administration, and supervision that they will need to secure a seat at today's table for health care delivery.

In closing, several steps are suggested to help social work profession-als survive the numerous changes presented with managed care.

First, social workers need to market the services they provide and link them to cost-effectiveness. Social work is an old profession in the competition scheme when compared with many of the newer health care delivery professions. Traditionally, social workers helped the poor and disenfranchised (Hepworth, Rooney & Larsen, 2002), both of which are not considered desirable client populations in the managed care context. This is not to suggest that social workers abandon their roots simply to appear more marketable in the scheme of managed care. Rather, we should consider professional self-marketing and emphasize the myriad services that we actually do provide.

It is essential to link the provision of each service the health care social worker provides with the cost saving it creates (Dziegielewski, 1996, 1997b). For example, traditional services, such as hospital discharge planning, should emphasize dollars saved in the overall prospective payment reimbursement system. Dollar amounts should be calculated to justify of overall savings because of service provision. A second example of saving costs through prevention can involve the home health care social worker. Home visits can assist families and clients in the home to acquire needed counseling to defuse stressed situations, can provide needed social support, and can provide access to services to maintain community placement. The cost-cutting feature of living in the community is phenomenal when compared with institutionalized care of patients. Options like these are facilitated by the provision of effective social work services.

A new mind-set needs to be established with service provision. Each service needs to be competitive, and emphasis must be placed on income generated or cost savings incurred (Dziegielewski, 1996). Many times, even without direct income being generated, services can be valued based on the costs they can save the organization.

A second thing that health care social workers can do to compete successfully in the managed care market is to present their professional roles as essential ingredients to the success of the health care interdisciplinary team. For this to happen, the process must start with the
individual social work professional. Each social worker, with each service provided, whether it be discharge planning, referrals, or direct clinical work, needs to make the client aware that the service being provided or coordinated is being done by a social work professional. Laypeople may mistake social workers for nurses or teachers, or even call them counselors. Many times we become so task-oriented that we forget this simple but essential point. Tell them you are a health care social worker.

As you work with the health care team, you also must make them aware of your importance in the overall success of the team. Thinking of the services you provide in a cost-saving prevention perspective will also help with gaining professional recognition. You help the other team members to be able to complete their jobs, and in addition, you help save them time and money.

A third aspect in the survival of social work in the health care delivery scene rests in the larger environment. Here, social workers need to support and lobby for political and social recognition of the value of social work services from both a quality-of-care and cost-effectiveness basis. In this constantly changing environment, it is important for social workers to be visible and ready to secure their current position as well as additional positions that may come open. For example, social workers may choose to fight for limited prescription privileges as a cost-cutting quality-of-care standard for practice (Dziegielewski, 1997a). Lobbyists, well aware of social work’s goals and missions, need to be strategically placed as these managed care decisions are being made. Managed care planners need to be made aware of and enticed to include the services that social workers can provide.

Lastly, the role of the social worker in behavioral managed health care needs to continue to grow beyond what is considered traditional. Social workers need to continue to assume varied positions, such as managers, owners of companies, employees, administrators, supervisors, clinical directors, and case managers (Edinburg & Cottler, 1995). Once in these positions, social workers will have power to help influence specific agency policies and procedures. They also need to make themselves aware of basic programs and services that are available beyond their own individual practice that can affect overall wellness and service delivery. The profession of social work is strong enough to compete, but there is no time for hesitancy. The plans for tomorrow
are being outlined today. These plans outline the delivery of services in which health care social workers can and need to remain an integral part.

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**GLOSSARY**

*Allied health care workers:* Professionals involved in health care delivery. The individual, group, family, or community is the focus of intervention.

*Clinical social work practice:* Often referred to as medical social work (see *medical social work*).

*Family counseling:* A practice methodology that centers on the "family" as the client or unit of attention.

*Health care practice:* Activities that are designed to enhance physical and psychological well-being.

*Health care social work:* The practice of social work that deals with the aspects of general health, specifically in the areas of wellness, illness, or disability. The social work professional can address these issues through working directly with individuals, groups, families, or communities, or to effect broader social change.

*Health care social worker:* Is seen as the professional "bridge" that links the client, the multidisciplinary or interdisciplinary team, and the environment.

*Hospital social work:* Historically defined as the provision of social services in the medical setting. Currently, refers to the delivery of social work services in hospitals and related health care facilities.

*Medical social work:* A form of social work practice that occurs in health care settings with the goal of assisting those who are physically ill, facilitating good health, and preventing illness.
Nursing: A field of practice versed in medical matters and entrusted with caring for the sick.

Practice of social work: The application of social work knowledge, theories, methods, and skills to provide professional, sound, ethically bound, culturally sensitive social services to individuals, groups, families, organizations, and communities.

Psychology: The profession and science concerned with the behavior of humans and related mental and physiological processes.

Public health: Tasked with prevention of disease and maintenance of health in the population.

QUESTIONS FOR FURTHER STUDY

1. In your own words, state several concrete differences between what nurses do and social workers do in the health care setting.
2. What do you believe can make health care social work practice an integral part of health care delivery?
3. What characteristic of social work practice makes it the most marketable in today's health care practice arena?
4. How do you believe health care social work will be defined in the future?

WEBSITES

www.ahcpr.gov
Health care research and policy information.

www.policy.com/vcongress/pbor/index.html
Information on Patient Bill of Rights.

www.patientadvocacy.org
Information on patient advocacy.