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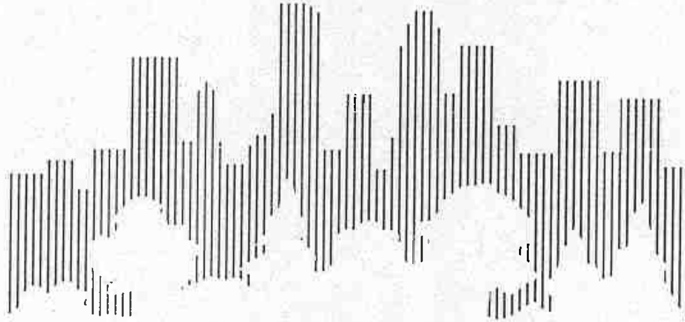

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MASTERS IN SOCIAL WORK THESIS

Shelby M. Lawrence-Hinshon

An Exploratory Study of the Attitudes among Hospital Social Workers in Relationship to Managed Care

1998

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An Exploratory Study of the Attitudes among Hospital Social Workers in Relationship to Managed Care

A Thesis Submitted to the Graduate Faculty

of Augsburg College

in Partial Fulfillment of the Requirements

for the Degree

Master of Social Work

Minneapolis, Minnesota

Shelby M. Lawrence-Hinshon

August, 1998

MASTER OF SOCIAL WORK

AUGSBURG COLLEGE

MINNEAPOLIS, MINNESOTA

CERTIFICATE OF APPROVAL

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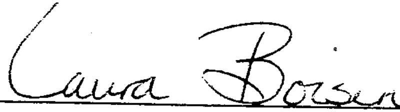
Thesis Committee: 

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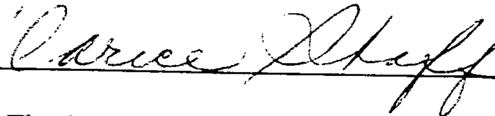

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DEDICATION

This thesis is dedicated to my wonderful daughter, Sophie Marie Hinshon.

You color my world

and

warm my heart.

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From the bottom of my heart, thank you all!

Abstract

Hospital social workers today face many challenges due to the swift and evolving scene of health care. To a large degree, managed care has been the primary force influencing health care in recent years. In fact, the inception and development of managed care has created new conditions for the hospital social worker. These conditions have meant greater responsibility as well as higher expectations for the hospital social worker. This exploratory study examined the current and future role of the hospital social worker, the functions performed and, the attitudes among hospital social workers in relationship to managed care. Results indicate that hospital social workers are spending the majority of their time performing discharge planning. Results also indicate that hospital social workers feel strongly about certain themes related to managed care.

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Chapter One: Introduction

Overview

The status of health care in the United States today has been greatly impacted by the development of managed care. Managed care has literally rearranged the delivery of health care, and for that matter, the professionals who work in it. Social workers, especially hospital social workers are among the professionals who face new endeavors in the age of managed care.

"Managed care" embodies a variety of definitions. For the purpose of this research, "managed care" will be discussed in relationship to health maintenance organizations, or "HMO's." Moreover, "managed care" will be defined as an "organized system of care that seeks to influence the selection and utilization of health services (including preventative care) of an enrolled population and ensures that care is provided in a high-quality, cost effective manner" (Fedura & Camp, 1994, p. 1).

Managed care is anticipated to have an effect on every U.S. citizen. To date, approximately 65% of those insured through their employers are now covered under some type of managed care program (Strom-Gottfried, 1996). In fact, "the membership of health maintenance organizations (HMO's) now exceeds 50 million people and may grow by an additional 50 million people by the year 2000 (Bodenheimer, 1996, p. 1601)." Moreover, managed care is estimated to take over the future of health care in the United States. According to Coile, (1990), "the new patterns of reimbursement, control and health care delivery under managed care will rapidly overwhelm to last aspects of cost-reimbursement and fee for service medicine" (p.1).

Hospital social workers are in a unique and sometimes complex position when it comes to managed care. While managed care systems strive to provide quality care to their members, systematic operations to cut costs also have been reported. One of the avenues to cutting costs by HMO's has been to decrease the number of days a patient is in the hospital. Hospital social workers have particularly been called to facilitate early and effective discharge plans as a means to trim hospital expenses. This is why discharge planning and managed care go hand in hand.

While nurses have been known to occasionally perform discharge planning in some hospitals, social workers are commonly the professionals who carry out the practices of discharge planning. In fact, discharge planning has been a customary function since medical social work's earliest days. According to some literature, "it is where the action is and we belong there" (Fields, 1978, p. 178). However, the scope of discharge planning has changed over the years in response to a variety of internal and external factors. Social workers are not only faced with the challenges of managed care, but, of utilization review teams (in accordance with DRG's) which determine the estimated stay of patients are expected to require hospitalization. "New accountability structures and constraints on hospitals, patients, and social workers have led to a reexamination of the tasks involved in the process of planning for discharge of patients from acute care hospitals and the conceptual rationale for this work" (Davidson, 1978, p. 182).

In the 1970's, government noticed that health care costs were booming. By the early 1980's, research was starting to show that managed care could decrease health care expenses without hurting patients. It was at this time when managed care began to shape

how hospital social workers spent their time as widespread attention was granted to the practices of discharge planning. A series of articles reveal that managed care has accelerated the discharge planning process.

Over the past twenty years, inpatient hospitalizations have become more costly. Managed care systems believe it is essential to coordinate a plan for discharge as soon as a patient is admitted to the hospital. Oftentimes, the expected function that discharge planning places hospital social workers in a confusing position. Many social workers believe the rules and guidelines of managed care conflicts with the profession's ethical standards. For instance, promoting self-determination and patient choice are among the values of social work that may not always be honored due to the changing scene of health care. These are among the challenges hospital social workers face in the age of managed care.

Social workers working in health care will be expected to respond swiftly to the characteristics associated with managed care. After all, managed care appears to be here to stay. "It will dominate the 1990's, affecting every hospital, physician, health professional, and service facility" (Coile, 1990, p.1). Social workers will need to focus particularly on cost containment and revisions in insurance reimbursement. Therefore, hospital social workers can anticipate that the future of their profession lies within the activity of discharge planning.

Purpose of this Research

Because hospital social work has been influenced so dramatically by managed care, the future of this profession is expected to be shaped by external influences. There is a diminutive amount of research regarding the attitudes among hospital social workers

in relationship to managed care. Because of the gaps in this particular topic and the continuing trends of health care in the United States, the researcher felt it was imperative to explore this subject more closely.

Therefore, the purpose of this research was to acquire a deeper understanding of the current and future role of hospital social work. Looking back and reviewing the steps we have taken to solidify the profession also warrants recognition in this study. Therefore, a historical piece was added to capture how the hospital social work profession has evolved over the century.

Another purpose of this study was to gather information from current hospital social workers regarding their attitudes, opinions and concerns specific to managed care. What are their thoughts regarding hospital social work functions and discharge planning? How has managed care influenced their profession's role? What do they anticipate the role of the hospital social worker being in the next 5 years? In their opinion, where are we headed?

Hospital social work directors were asked what they perceived to be the main functions of the hospital social worker five years ago and, what they anticipate the main functions will be in the next five years. Inquiries regarding the influences of managed care were also delegated to hospital social work directors.

Significance of Study

The significance of the study is intended to capture the value of the current and future role of the hospital social worker and its ties with managed care. Clearly, the need for social workers to exist in the hospital historically has been warranted as patients have other needs outside their medical situation. However, it is now apparent that the function

of discharge planning presents the greatest influence for social workers to remain the hospital setting.

It is hypothesized that the development of managed care appears to validate the need for social workers not only to be employed by hospitals, but to aggressively perform discharge planning as their main job function. Given the value hospital administration and other systems place on this function, hospital social workers may find other tasks once delegated to them to be a thing of the past.

Some critics believe that discharge planning is a low-status function and could be performed by non-social work professionals. On the other hand, some believe that social workers are the most capable and resourceful individuals to take on the challenges of discharge planning. Discharge planning is where medical care intertwines with quality of life concerns. It is where human care needs collide or blend with our technical skills and abilities (Fields, 1978).

Research is needed to explore the potential for social work in host settings, especially health care and hospital settings. Through research, hospital social workers can set a foundation and voice their concerns to prepare and plan for what lies ahead. The client or patient would also benefit from this as their plan of medical care is directly being effected by managed care.

Because managed care has had such a monumental effect on the health care industry and, because managed care and discharge planning go hand in hand, this may encourage increased job stability among hospital social work staff. In addition, hospital social work departments may recognize a need to increase their staffing as managed care is expected to overwhelm the health care industry. However, many hospitals across the

country have succeeded in downsizing departments in order to cut costs. This trend could possibly become evident in hospital social work departments as attempts are made for each social worker to have larger caseloads and consequently, less time to do their assigned tasks.

Chapter Two: Literature Review

Overview

The historical context of the hospital social work profession will now be discussed. Tasks, functions and activities of the hospital social worker will be explored to present how the profession has evolved over the years. In addition, this section will highlight how managed care has changed the role of the social worker to become increasingly involved in the activity of discharge planning.

History of Hospital Social Work

The joining of social work and health care began in the late 1800's. According to Shannon (1989), Rosen, the noted historian and public health physician, stated:

> "The history of social medicine is also the history of social policy (welfare). The roots of social medicine are to be found in organized social work. It was here that medicine and social science found a common ground for action in the prevention of tuberculosis, securing better housing and work conditions. (p.34)."

The practice of social workers in the hospital began in England in 1896. "Dr. Loch, a leading physician, placed an experienced social worker at the Royal Free Hospital to act as admissions officer and to provide social service needs to patients admitted for treatment" (Beckerman, 1991, p. 20).

In the United States, social work in the hospital setting began in the early 1900's at Boston's Massachusetts General Hospital. Dr. Richard Cabot, a proponent of social work services for the poverty stricken and ill, began to include social work personnel as part of the staff providing treatment for patients while in the hospital or clinic. His desire to include social work came about as a result of his frustration in the clinics. Cabot found himself treating the same patients over and over again without resolve (Bartlett, 1975). Meanwhile, physicians were concerned that patients adhere to their prescribed course of

treatment and had a place to go once they left the hospital. They recommended two roles for social work, coordinating discharge and follow up (Blumenfield & Rosenberg, 1988). Clearly, from the very beginning, the role of the social worker was defined by the physician's needs and objectives. Dr. Cabot viewed his first social worker as:

> "One of his assistants attending to the larger social needs of the patients that physicians had neither the time nor inclination to meet. He described the earliest dynamics of the social worker-physician relationship as the social worker will only gain respect if she abides by the way of physicians and appear as an agent of the physician, as he is the only one who garners prestige" (Beckerman, 1991, p. 21).

This gap in status is one of the greatest features of early hospital social work. In other words, "this inequity of authority and prestige is a part of the heritage of the social worker-physician relationship" (Beckerman, 1991, p. 22).

Cabot brought the first social workers into the outpatient department of the hospital in October, 1905. In the beginning, Cabot took responsibility in creating, developing and leading the social service department. Bartlett (1975) revealed that "Cabot interested capable women, some with social work experience and some without, in joining the new endeavor" (p. 212). The first social worker hired at Massachusetts General was Garnet J. Pelton. Pelton described her job as "helping doctors by giving help to bewildered and confused patients who were ill-informed and advised impossible tasks such as fresh air, good food, rest and freedom from worry" (Beckerman, 1991, p. 22). Because of illness, Pelton was forced to leave her job after six months of service.

In October of 1908, Ida Cannon joined the staff at Massachusetts General. In April, 1908, Cannon was appointed lead worker, a responsibility that she held for thirty-seven years. Cannon, although a nurse by training, enrolled in sociology and psychology courses at the University of Minnesota. Prior to her appointment as a social worker,

Cannon worked as a visiting nurse for Saint Paul Associated Charities. This nursing experience was her first direct contact with clients receiving social work services (Davenport & Davenport, 1987). After only a few years at the agency, Cannon developed two important ideas: "The social elements in illness must be recognized and, medicine, nursing and social work must work together because they need each other" (Bartlett, 1975, p. 210).

Dr. Richard Cabot and Ida Cannon worked jointly on the development of the department and its policies. Because medical social work was one of the earliest fields in the emerging profession of social work, there were no clear models or examples regarding hospital social work practice. Although Cannon does not stress the difficulties, it is clear that the beginnings at MGH were full of tension and frustration. In her writings are found such comments as "A hostile administration, the antagonism of doctors, and pioneering as a disciplinary experience" (Bartlett, 1975, p. 214). While Cannon's writings reflect that stresses existed at Massachusetts General she asserted "that some skepticism was good for us…Out of acute awareness of our critics we evolved some of our soundest principles" (Bartlett, 1975, p. 214).

Cannon would eventually make numerous contributions to the profession and articulated that social work provided "an enlarge understanding of any psychic of social conditions which may cause distress of mind or body" (Davenport & Davenport, 1987, p. 742). Cannon also provided training and professional guidance to those seeking interest in the field of hospital social work.

Initially, social work in the hospital was only to be offered to patients who were poor and in situations where their medical treatment was not handled correctly. This

protocol was mainly set by hospital administration and physicians to promote efficiency within the hospital. Meanwhile, social workers continued to expand their role by beginning to see all people with a certain diagnosis who came to the facility. In addition, they worked to expand the usefulness of social work to the non-poor (Kerson, 1985). "The fields of study and activity for medical social workers were character, human relationships, and community life" (Davenport & Davenport, 1987, p. 742). Cannon believed that the most valuable asset of casework was the ability to "put oneself in another's place and still see the situation objectively" (Davenport & Davenport, 1987, p. 742).

Social workers also began to reach out to promote effective liaisons with community agencies. The aim in this design was to improve the quality of care in nursing homes and to make the best possible match between patients and facilities (Foster & Brown, 1978). Over the years, the need for discharge planning services accelerated in relationship to the pace of medical diagnosis and treatment. Hospitals and physicians soon realized that social workers were resourceful individuals and had knowledge of community services and nursing facilities. They also realized that dollars could be saved if patients could be discharged to appropriate care and, subsequently open beds for sick patients. Thus, the presence of social work had many dimensions as they not only provided help to patients following their treatment, but also to physicians.

By 1918, Ida M. Cannon and other interested social workers established the American Association of Hospital Social Workers (AAHSW), the first professional association of social workers in the United States (Carlton, 1990). This organization acted as a catalyst within the social work profession and other professions to formally

organize. Hence, over the next thirty years, six other professional social work organizations were established.

By 1919, 300 hospitals in the United States had implemented social work departments. By 1920, AAHSW appointed a committee to study social service in hospitals and dispensaries throughout the country and to make recommendations as to standards, methods or programs. Furthermore, during the 1920's and 1930's, AAHSW focused on:

> "Developing minimum standards for hospital social work departments, classifying medical social work terminology, creating curriculum requirements for medical social work education, circumscribing the functions of hospital social services, developing a knowledge and method base for the specialized practice of medical social work that resulted in an extensive body of literature, collaborating with medicine and medical schools in the education of physicians, studying the costs of medical care and clarifying the social components of medicine" (Carlton, 1990, p. 4).

The 1940's brought about many opportunities for hospital social workers. In fact, the concept of hospital social work as a profession was now established and had gained remarkable security. There was an increasing need for hospital social workers as determined by doctors and hospital administrators. In her writings, Cannon pointed to "receiving constant pressure to discharge patients and reported that referrals consisted largely of requests to arrange removal from the hospital" (Davidson, 1978, p. 183). According to Fields (1978), critical as the procedures for admission and discharge were to hospitals and patients, they were ancillary and had low ranking in relationship to the central treatment purpose of the institution.

By the early 1950's, social workers were found in various public and private settings. Social workers were called to the attention of the community, where the delivery of service to persons with mental illness was needed. Social workers also expanded their

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role into areas such as maternal and child health, public health and rehabilitation (Carlton, 1990). At the same time, group work, which began in the late 1920's, was carried out to assist psychiatric patients in hospital settings. By 1960, the availability of health care was expanded by the 1965 enactment of Title 18 (Medicare) and 19 (Medicaid) of the Social Security Act.

By the late 1970's, social work faced shrinking budgets and the reduction of other resources in several service areas (Carlton, 1990). The reason for the cuts was the shift towards "intensive Federal and State cost-containment efforts: skyrocketing costs of maintaining hospitals in the United States amounted to $25.6 billion, roughly 1/3 of the defense budget" (Beckerman, 1991, p. 25).

Despite this reality, social workers were feeling comfortable in their roles and case finding was becoming a popular function in the acute care setting. Furthermore, the need for accountability commonly was heard and became a program objective in all sectors of the profession, including hospital social work (Carlton, 1990). Department leaders recognized, as early as 1960, the need for information to identify and address service utilization and patient needs in, for example, poliomyelitis and the effectiveness of staff and programs during the epidemic of that disease of the 1950's and 1960's (Rehr et al., 1995).

<u>Changing Roles and Responsibilities</u>

Categorically, occupational roles and responsibilities have a tendency to evolve in relation to the strength or weakness of the economy. Jobs rarely remain stagnant, especially in health care. Health care professions, including hospital social workers may even be more subject to change due to ongoing scientific discovery, technological

advancement and attempts to make jobs more efficient. "These changes have necessarily had significant impact on the goals and services of social work departments" (Patti & Ezell, 1988, p. 73).

Prior to the 1970's, social workers primarily acted as case managers, provided psychosocial assistance and offered their knowledge to physicians about the social aspects of disease. Discharge planning, too, remained a common denominator to social work in the hospital.

Throughout history, physicians and nurses have had a powerful impact over social work practice. Over the years, continued hospital social work practice has often been defined or measured according to how effectively discharge planning is performed. Social work departments are "called upon to demonstrate their economic worth by effecting timely discharges within DRG time lines, increasing worker productivity, attending to the cost-benefit of programs provided, and generating revenues through new and innovative services" (Patti & Ezell, 1988, p. 73). In addition, some hospitals request that social workers record statistics as a tool to determine what services are being offered and, the subsequent outcomes of their social work interventions.

As some social work practices have changed, some have also remained the same. One example is how the patient referral system has not altered significantly (Davidson, 1978). Physicians continue to provide a large portion of the referrals to social services, however referrals can, too, be determined by a patient's age or diagnosis. In some cases, patients may have a specific psychosocial problem that is referred to social services.

As early as the 1920's, hospital social workers felt pressure from doctors and administration that wanted patients discharged from the hospital. However, this pressure

mainly stemmed from the need to clear rooms for patients who required urgent care, or for those patients who had no where else to go. Between the 1950's and 1960's, predictions were made that "promoted the evolution of hospital social work roles from the early model of individual direct services to a broader concept of consultation to the institution and its professions and of social work participation in social policy and program formulation" (Davidson, 1978, p. 187).

The 1970's represented a time when discharge planning emerged as the most highly regarded function of the hospital social worker. It was at this time that discharge planning metamorphorized in response to several national movements to cut health care costs. "The 1972 amendments to the Social Security Act authorized the establishment of Professional Standards Review Organizations (PRSO's) to set standards of quality and cost controls for all services paid for by the federal government" (Schreiber, 1981, p. 48). In other words, these cost cutting measures mapped out the need for hospitals to pay closer attention to how long patients were in the hospital, and provided incentives for physicians to have patients discharged as soon as possible. At the same time, Health Maintenance Organizations (HMO's) became well known in the delivery of health care. The implementation of diagnostic related groups (DRGs) in 1983 commenced a major shift in health care financing that transferred responsibility for the cost of care for Medicare clients in acute care hospitals from third party payers to the providers of services (Carlton, 1990).

In response to this growing trend, the Massachusetts Health Task Force of the National Association of Social Workers (NASW) formed a subcommittee to explore the impact of social work within HMO's. In 1981, the subcommittee conducted a national

study to articulate the current status and role of social workers in this health care model (Schreiber, 1981).

Historically, discharge planning has been the function of assisting patients from hospitalization back into the community. Some authors have critiqued that discharge planning needs to be modified to align with today's health and social trends. According to Blumenfield & Rosenberg (1988), "Discharge planning has been redefined as social health care management; a concept that includes a continuum of services from preadmission to posthospital planning" (Blumenfield & Rosenberg, 1988, p. 38).

"Social health care management" may suggest that hospital social workers should plan to expand their services beyond the realm of traditional discharge planning. In other words, Blumenfield & Rosenberg (1988) assert the following:

> "Social health care management encompasses the coordination of chronic care, the development of health promotion programs, and the negotiation of the aftermath of acute care. It includes the provision of psychosocial services along a continuum of primary, secondary care with assistance to individuals at any point in the health care system" (p. 38).

Gathering different philosophies while meeting the challenges of discharge planning will invariably be another feature to keeping up with today's changing scene of health care.

Discharge Planning

What is discharge planning? According to Barker (1995) discharge planning consists of:

> "A social service in hospitals and other institutions that is designed to help the patient or client make a timely adjustment from care within the facility to alternative sources or care to self care timely when the need for service has passed and when practiced by skilled social workers, discharge planning helps the client and relevant others understand the nature of the problem and its impact, facilitates

their adaptations to their new roles and helps arrange for post discharge care" (p. 103).

Others, like the American Hospital Association (1984), view discharge planning as a process that should include professionals on all levels, not only social work. In other words, it should be an interdisciplinary task that attempts to meet patient and family needs.

Negotiating discharge is not merely placing patients at chosen destinations. It is a "complex psychosocial activity in which participants strive to ensure quality in transition from hospital to community living" (James, 1987, p. 48). Furthermore, it is also important to note that the availability of discharge planning exists because people have needs. Therefore, social workers can provide the tools and resources needed to help clients feel secure, safe and which moves them toward mental and physical wellness.

Tasks of Discharge Planning

Discharge planning consists of an array of concrete tasks and clinical services. There are many similarities between discharge planning and problem solving. Both concepts are aimed at producing an identified result, whereby discharge planning and problem solving are both driven by obtaining a certain goal or purpose.

Discharge planning can be facilitated on "a conceptual continuum ranging from an activity involving only concrete resource provision to one involving only counseling" (Kadushin & Kulys, 1993, p. 714). According to Kadushin & Kulys (1993), the social worker's first task is to:

> "Complete a psychosocial assessment, which may include a person's living situation and available informal or formal support systems. The social worker then engages the patient and family in a decision making process to develop a discharge plan. The social worker also acts as coordinator, assisting the medical team understand the patient's psychosocial needs and helping the patient

understand the medical care plan. Finally, the social worker links the patient and family with the appropriate resources" (p. 714).

Discharge planning can be an extremely dynamic task that requires an abundance of flexibility, patience and energy. And, while discharge planning can be a methodical process with patients and families, complications or delays during the planning arrangements can occur at any point. Thus, the process of discharge planning is rarely static.

Hospital social workers are confronted with many systems. These systems include patients, families, community agencies, insurance companies and the hospital in which they work. These systems most often assist to identify and are helpful in coordinating an appropriate discharge plan. However, occasionally, these systems break down and make discharge planning a challenging endeavor. Hospital social workers may declare these as "barriers" to the discharge planning process.

Barriers may be temporary however. An example may include a patient needing nursing home care following hospitalization, but the nursing home the patient desires is full. As a result, the patient is forced to select an alternative nursing home with which he or she is unfamiliar. However, the patient could eventually transfer to the nursing home preferred.

Some managed care programs have created additional barriers to accessing care and making discharge arrangements for patients. An example would be that some insurance companies have certain requirements before they pay for specific services. For instance, a patient may need to be in the hospital for at least three days before their insurance will cover the costs of a needed extended rehabilitation stay following their

hospitalization. A three day stay is also the criteria used in order to access benefits under Medicare.

Value and Ethical Conflicts of Discharge Planning

Today, the pace of hospital social work is considerably different from where it began at Massachusetts General Hospital in 1905. Governmental regulations, managed care, and cost containment have created new dimensions to the social work profession. Ironically, hospital social workers were "first among our colleagues in health care to experience the impact" (Poole, 1996, p. 164). These bureaucratic constraints, coupled with institutional pressures, such as utilization review teams, have steered the tasks that hospital social workers perform.Social workers are becoming increasingly concerned about how managed care effects the clients they serve. In many ways, managed care has promoted institutional control over patients, discounting patient rights, reduced participation in the problem solving process, and involvement in the discharge plan. Davidson (1978) related that in order to make discharge planning an acceptable role, social workers should focus on their professional values of client self-determination and rights to quality health care. In other words, Davidson (1978) believes "social workers must redefine the administrative role of discharge planner to advocate on behalf of the client and not to serve the institution at the expense of the client's well-being" (p. 191). Cornelius (1994) adds that "The integrity of the social work profession is maintained only when clients needs and the advocacy of those needs are of first concern" (p.59).

Walsh (1987) insists that the array of diverse ethical dilemmas confronting hospital social workers today are the result of at least two factors which include:

> "The recent implementation of federal cost containment measures in health care delivery in the community and the hospital and the shift from reimbursement

programs which pay the hospital after the patient is treated, regardless of the length of hospitalization, to prospective payment programs, namely Diagnosis Related Groups, has resulted in a new set of critical ethical dilemmas for hospital social workers" (p.16).

Summary

Social workers may feel caught in this middle as their social work values remind them to act in the best interest of their clients, yet at the same time, remain loyal to their organization. It is important to note here that social workers employed in host settings, such as hospitals may be presented with greater challenges to maintain their commitment to social work standards.

Theoretical Framework

Three bodies of literature capture the theoretical framework for this research study. They are: 1) the medical model in relationship to hospital social work; 2) the biopsychosocial model in relationship to discharge planning; and, 3) the economics of managed care.

Medical Model

The medical model is largely responsible for setting a theoretical ground for hospital social work. In fact, the medical model is deeply embedded in the roots of hospital social work. Hospital social work developed from the foundation of nursing, where social workers were called upon by physicians who requested their involvement based solely on diagnosis or disease. This referral system eventually evolved into greater implications for social work involvement in the medical setting.

Because hospital social workers function in a host setting, they are more likely to be exposed to the medical model. The medical model tends to place emphasis on the patient's diagnosis or treatment, rather than the entire scope of the patient's situation.

Kane (1982) believes that the medical model is very useful for social work practitioners. She insists that "integration, not polarization of health and social services is sorely needed" (p. 315).

Integration of these two fields has unified over the years as the demand for social work services and discharge planning has increased. Despite the increased need, social work in the hospital continues to respond to the needs and requests of medical personnel, such as physicians and nurses. In other words, social work involvement most often is reactive in nature to a patient's diagnosis. Moreover, the social worker makes arrangements to correspond with the patient's medical status as outlined by the patient's doctor. While social workers are expected to have a fairly good understanding of medical terms and disease processes, they are not typically expected to communicate the details of this to patients and their families.

Biopsychosocial Model

On the other hand, the biopsychosocial model is a unique combination of philosophies. In 1913, Dr. E. E. Southard, then director of the Boston Psychopathic Hospital, and Mary Jarret, appointed to take charge of the hospital's social service program, joined efforts and determined that the medical and social aspects of outpatient treatment for nervous and mental disorders are so closely interwoven that it would be difficult to discuss separately. In most cases, medical treatment is supplemented and reinforced by medical care (Shannon, 1989). Literature has shown that due to the evolving scene of health care, the components of psychosocial care must not be overlooked.

According to James and Studs (1985), more recent social work literature reveals increasing agreement about certain aspects of discharge planning. The biopsychosocial approach is highlighted in particular as it includes the collaborated efforts of a variety of health care professionals; and, the coordinated use of institutional, patient, family, and community resources. Pooling systems together has always been a characteristic of social work. However, interdisciplinary collaboration has become increasingly important due to the multiple complexities of health care.

The biopsychosocial model incorporates the environmental, physical, behavioral, psychological and social factors of a person's life. In review of the literature, social workers tended to utilize the biopsychosocial model to describe their assessments, interventions and techniques when working with patients and families. Social workers tended to feel more comfortable with this model because it offered a holistic approach in evaluating a patient's needs. The biopsychosocial model was identified in the literature as the primary approach utilized by hospital social workers, but also as the approach used by other ancillary staff in the hospital, such as physical and occupational therapy. In fact, when those disciplines completed their assessments, it was imperative to determine what the patient's support systems were and what kind of living situation they would be going to upon their release from the hospital. Once this information was obtained, the therapist could make his or her recommendation for disposition.

The activity of discharge planning most often involves the utilization of the biopyschosocial model. However, because of the effects of managed care, fully utilizing the model has become another challenge for hospital social workers. Blumenfield &

Rosenberg (1988) believe that the biopyschosocial model is threatened by the prospective payment system because:

> "1) There is decreased time available to work with patients and families; and, 2) all care within the hospital is speeded up, necessitating quicker assessments, interventions and community resources; and, 3) patients have less recuperation time in the hospital; and, 4) the various pressures from patients, staff, institution, and government may be contradictory and conflictual; and, 5) documentation to protect reimbursement and provide legal substantiation of services is now emphasized; and, 6) there is less leeway in providing services to patients in the hospital and emphasis on completing work-ups prior to hospitalization; and, 7) home care services are increasing in demand and if these (home care services) are cut back, the experience of the deinstitutionalized, disenfranchised patient may occur again as it did the '60's when, with the Community Mental Health Act, there was an emptying of institutions, but no concomitant increase in community services" (p. 36).

Utilizing the biopsychosocial model as a guide to identify needs is not only important to social workers, but to the entire team of professional staff. The biopsychosocial model is truly a collaborative model. As physicians and nurses have become more concerned about discharge plans, their need to know information about a patient, including their living situation and other dynamics has greatly increased. Therefore, the biospychosocial model is not exclusively applied for social work purposes.

Managed Care and the Economy

Managed care has forever revolutionized the delivery of health care, and for that matter, discharge planning. Social workers, along with physicians and nurses, are under pressure to perform timely treatment and assistance to assure that patient hospital stays do not exceed the amount needed.

Caputi & Heiss (1984) theorized that two majors trends have prompted social workers to make discharge planning a priority. These trends include: the development of health insurance systems that emphasize hospital care and reimburse hospitals for the

diagnosis and treatment of disease, and the technological advancement hospitals are now utilizing. Shreiber (1981) postulated that overstays in hospitals, broadly defined, refers to days spent in hospitals by patients who did not need acute care. "According to statistics, a reduction of one day in the current average hospital stay of seven days would save two billlion dollars a year" (Schreiber, 1981, p. 48).

The managed care movement was initiated after the enactment of the Health Maintenance Organization Act in 1973. The Act was "directed toward establishing alternative models of health care delivery, emphasizing comprehensive health care, and utilizing a financial structure fixed on capitation and involving enrollment and prepayment of fees" (Caputi, 1978, p. 17). Meanwhile, PSRO's (Professional Standard Review Organizations) as noted earlier, were created to look at quality and appropriateness of care. Furthermore, this was the "beginning of the concept that physicians alone could no longer determine the scope and extent of health care services: as the federal government paid for an increasing share of the health care dollar, it had its own stake in how health care was delivered in its efficiency and effectiveness" (Blumenfield & Rosenberg, 1988, p. 34).

Three years after the Health Maintenance Organization Act was passed, President Gerald R. Ford signed amendments that increased financial assistance to HMO's allowing them to be more competitive with hospitals (Mayer & Rubin, 1983). And, "in November of 1978, President Jimmy Carter further extended the funding potential and authority of programs" (Mayer & Rubin, 1983, p. 284). Ironically, the final outcome of this federal initiative has been the overwhelming expansion of federally certified health maintenance organizations, better known as "HMO's."

Independent from the increase in HMO's, the U.S Department of Health and Human Services expected to spend $24.3 billion for Medicare patients' hospital bills in 1980 (Schreiber, 1981). Concerns regarding Medicaid developed as the nation's governors had claimed a sixfold increase in expenditures, and, furthermore, they believed it would force the states into bankruptcy if it were to continue at that rate.

A large amount of energy surfaced around managed care during the Reagan administration. The Deficit Reduction Act of 1984 implemented the prospective payment system, which entailed a new system for managing costs in Medicare. "For the first time, financial risks in Medicare shifted through aggressive payments from a third party payer (the federal government) to health care providers" (Poole, 1996, p. 163). Meanwhile, the commencement of diagnostic related groups (DRG's) in 1983 brought about a major change in health care financing that transferred accountability for the cost of care for Medicare clients in hospitals from third party payers to the providers of services (Carlton, 1990).

According to Poole (1996), the defeat of President Clinton's Health Security Act in 1993 expedited the nation's march toward managed care. This defeat closed the door on national health care reform but opened corridors of reform in state governments for managed care (Poole, 1996). With the rising state costs of Medicaid, states move quickly to implement their own reforms to get costs under control. "The federal government helped, not with new dollars, but with waivers giving states great latitude in the design and delivery of their Medicaid programs" (Poole, 1996, p. 164). Influenced by national trends, states opted for managed care in the hopes that this system would save them from spiraling Medicaid expenses (Poole, 1996).

Currently, every state (with the exception of only a few states) have some type of a managed care plan in operation for Medicaid expenses. According to Foster & Brown (1978), "both federal and local governments find themselves actively in the health care business" (p. 55). Foster & Brown also assert that "the government's involvement in the practice and control of medicine in itself makes for an uneasy partnership" (p.55).

Three specific forms of managed care exist in Minnesota. According to the Star Tribune (December, 1997), the first includes the "Gatekeeper Plan". Members of this plan elect a primary care clinic or doctor and must obtain an authorization form from their doctor, or gatekeeper to see a specialist. A "gatekeeper" is usually a system of casemanagers who reviews and authorize services for members.

The second form of managed care in Minnesota is the "Point of Services Plan" in which members receive all the benefits detailed in their contract when their care is coordinated by a primary care gatekeeper. Members in this plan have some flexibility, and if they pay a higher out of pocket cost, they can (on their own) go to any particpating provider in the plan without authorization (Star Tribune, December, 1987).

According to the Star Tribune (December 1987), the third form of managed care is the "Open Access Plan." In this plan, members can see any provider in the network without a referral, and without a higher cost. In other words, this plan allows the consumer much more flexibility and choice.

In review of the literature, managed care will continue to impact the delivery of health care. In fact, managed care will be the future of every health care transaction. At its worst, managed care is perceived as a system in which no real dollars are saved, and money is redirected to administrative operations and profits at the expense of needed

patient services. On the other hand, it is viewed as a system in which appropriate structure, control and accountability enable the most efficient utilization of health care resources to promote the highest degree of health and wellness (Poole, 1996)

Chapter Three: Methodology

Overview

This section will highlight the research design, the selection of the sample, the instrument design, data collection and data analysis.

Research Design

The purpose of the research study was to explore the attitudes among hospital social workers on the subject of managed care. The research design was a combination of quantitative and qualitative tools to provide insight on the research questions. This type of design was chosen as it best captured the desired subjective and objective information pertaining to my research questions.

Quantitative methods emphasize the making of precise and generalizable statistical findings (Rubin & Babbie, 1993). On the other hand, "research questions that emphasize depth of understanding, that attempt to tap the deeper meaning of human experience, and that intend to generate theoretically richer observations which are not easily reduced to numbers are generally termed qualitative methods" (Rubin & Babbie, 1993, p. 30). Furthermore, "qualitative methods are particularly oriented toward exploration, discovery, and inductive logic " (Patton, 1987, p.15).

Sample Selection

The criteria for obtaining the sample consisted of a two-part process. First, a roster of Twin Cities hospitals with 200 beds or more was established. The researcher elected hospitals with 200 beds or more as it was theorized that these hospitals would have larger social work departments and, perhaps more interactions with systems like managed care. The researcher then randomly selected four hospitals. The researcher

expected that these hospitals had existing social work departments. After this was completed, the researcher mailed a letter to each of the four hospitals. The letter was mailed to the director of social work (see Appendix A). The letter detailed the purpose of the study and the participation level needed. Attached to each letter to the director was a statement of permission (see Appendix B) that required their signature. This signed statement would allow the researcher to proceed in presenting the study to their employees.

After the statement of permission was signed and returned to the researcher, arrangements for a time to present the study and distribute the questionnaires was made. Next, the researcher traveled to each of the four hospitals to present the study at their staff meeting. At the meeting, the researcher asked those who had been a hospital social worker more than five years to voluntarily participate in the study. Questionnaires were then distributed. The questionnaires were left with the participants. The researcher requested that completed questionnaires be mailed directly to a confidential P.O. Box at Augsburg College.

My units of analysis were individual social workers employed in a hospital setting. This study used non-probability sampling. The sample was selected by utilizing a purposive approach, which is "a sample of observations that the researcher believes will yield the most comprehensive understanding of the subject of study, based on the researcher's intuitive feel for the subject that comes from extended observation and reflection" (Rubin & Babbie, 1993, p. 25). Because the researcher had general knowledge of the population being sampled, a purposive sampling approach emerged.

Instrument Design

The researcher developed two separate questionnaires to serve as the survey instruments. The contents of the questionnaire mainly came about from the researcher's eagerness to learn more information and gather more insight from hospital social workers. The questionnaires for the directors of social work and for hospital social workers had similar characteristics in terms of design and subject matter. The survey instrument constructed for the directors of social work consisted of a combination of twelve open-ended and closed-ended questions (see Appendix D). The questionnaire asked the directors about what they felt the main job functions of the hospital social worker was currently in comparison to five years ago, the number of hospital social workers who were currently employed in their department, and the number of hospital social workers employed five years ago. Directors were also asked, "Do you believe managed care has changed or influenced hospital social work?' And, Do you anticipate managed care effecting the role of the hospital social worker in the next five years?"

The questionnaire developed for the hospital social workers consisted of seventeen open-ended and closed-ended questions (see Appendix E). Question areas presented inquiries on their perceptions of main job functions. For instance, one question asked, "List the three main job functions you currently spend the majority of your day doing" and another, "Think back five years, list what your three main job functions were as a hospital social worker." Open ended questions asked participants about certain aspects of discharge planning and managed care. These included, "Do you believe managed care has changed or influenced hospital social work? And, "How would your job be different without managed care?"

Both questionnaires posed questions regarding whether or not participants believe managed care has or will have an effect on the role of the hospital social worker. In fact, quantitative measures included a Likert scale to gain understanding regarding the level of agreement or disagreement among hospital social workers in relationship to their attitudes towards managed care. Both questionnaires inquired about years of experience, level of education, gender and age of participant.

Protection of Human Subjects

Throughout this study, measures have been taken to ensure the protection of human subjects. Those participating in the study received a cover letter (see Appendix C) which described who the researcher was, intent of the research, how they were chosen and, how their confidentiality would be protected.

Participants of this study were notified that there were no direct benefits to being in the study. They also were informed that they could cancel their participation in the study at any time. Responses from the questionnaire were completely anonymous and all data collected would be secured in a private area. The only person having access to the data was the researcher. Participants were also informed that all data would be destroyed upon completion of the project. Before any portion of research with human subjects was initiated, an application to conduct this research was submitted and approved by Augsburg College Institutional Review Board.

Data Collection

A cover letter and questionnaire was distributed to each participant. The self-administered questionnaire was a one-time commitment that was anticipated to take 15-

20 minutes to complete. The researcher handed out the questionnaire at the meeting pre-arranged with the director of social work at the corresponding hospital. The researcher then left the meeting after all of the questionnaires were completed. The participants were asked to return the questionnaires in a provided self-addressed envelope. The data collection period began in April, 1997 and ended in June, 1997.

Data Analysis

Once all of the questionnaires were returned, the data was analyzed to organize central themes and information. Analysis is the process of bringing order to the data, organizing what is there into patterns, categories, and basic descriptive units (Patton, 1987).

First, the manner in which the data was analyzed entailed separating the two different questionnaires, one for the directors, the others for the hospital social workers. These were easy to organize because each questionnaire was originally assigned a number for identification purposes. Second, the researcher began reading through the questionnaires and making written comments as key data emerged. The researcher relied heavily on content analysis, which involves identifying coherent and important examples, themes, and patterns in the data (Patton, 1987). This information was reported through narrative forms, and illustrated tables.

Quantitative data was presented in percentages. These percentages were used to explain attitudes and what percentage of the participants agreed or disagreed about a specific statement in the questionnaire.

Chapter Four: Findings

Overview

This section will provide answers and insight to the research questions introduced earlier in this paper. This section will describe the outcomes from the hospital social workers questionnaires. Information and comments from the directors of hospital social workers will randomly be noted throughout this section, as the researcher's aim was to capture more information from the individuals who work more intimately with managed care.

Findings will be presented in three separate categories. First, background information will be presented to provide a detailed description of the sample, including gender of respondent, level of education and years worked in the hospital setting.

Secondly, three of the primary tasks identified by the hospital social work participants will be reported. These will be presented from each of the hospital social workers and hospital social work directors' questionnaires to gain comparative information from two distinct groups. Qualitative explanations will also be presented to describe if and how discharge planning and managed care has changed over the past five years. Participant attitudes regarding managed care will be reported from 5 point Likert scale. This will explain the range of disagreement or agreement to the statements found in their respective questionnaires.

Findings will be articulated in three separate categories. First, background information will be presented to provide a detailed description of the sample, including gender of participant, years worked in the hospital setting, and level of education.

Secondly, three of the primary tasks identified by the hospital social workers will be reported. These will be presented from each of the hospital social workers and

hospital social work directors' questionnaires to gain comparative information from two distinct groups. Qualitative explanations will also be presented to describe if and how discharge planning and managed care has changed over the past five years.

Introduction of Findings

Forty-three questionnaires were distributed to hospital social workers among four Twin Cities metropolitan hospitals. Seventeen questionnaires were returned resulting in a 39.5% return rate. Four questionnaires were administered to each of the hospital social work directors at each of the sample hospitals. Three questionnaires were returned, resulting in a 75% return rate.

Characteristics of the Sample

Gender, Level of Education and Years of Experience

The gender of the sample population among the hospital social workers included a total of 15 (88%) females and 2 (12%) males as noted in Table 1. Eight (47%) of the hospital social workers hold a BSW and nine (53%) hold a MSW (see Table 1). The majority of the respondents have worked between 11 to over 20 years as a hospital social worker. Thus, those remaining have worked in the hospital setting less than ten years (see Table 1).

Table 1

Demographics of Hospital Social Work Participants

	N	%
Gender		
Female	15	88.2
Male	2	11.8
Level of Education		
MSW	9	52.9
BSW	8	47.1
Years of Experience		
0-5 Years	3	17.6
6-10 Years	2	11.8
11-15 Years	4	23.5
16-20 Years	4	23.5
Over 20 Years	4	23.5

Hospital social work directors who participated consisted of two females and one male. The level of education indicated that two held a MSW, and the other, a BSW. Unlike the hospital social workers, directors were asked to identify the number of years they have specifically held their position as a "director." All directors varied in their years of experience; one worked less than five years, the other, between 11-15 years and one who has worked as a director more than 20 years.

Table 2 identifies the distribution of hospital social work participants from each sample hospital. Hospitals B and D represent the majority of the sample. In fact, 70% of the sample came from these two hospitals.

Table 2

Distribution of Hospitals Represented among Hospital Social Work Participants

Hospital	N	%
Hospital A	2	11.8
Hospital B	6	35.3
Hospital C	3	17.6
Hospital D	6	35.3

Hospital Social Work Participant's Job Functions

The majority of the hospital social work participant's felt that "discharge planning" was the main job function currently performed by the hospital social worker (see Table 3). It was also determined that when participants documented "discharge planning" as their primary task performed, hours spent ranged from six hours to one hour per day. It was determined that the average amount of time spent on discharge planning was 4.6 hours of an eight hour day. Only five of the 17 participants felt that other functions outside discharge planning took more of their time. In other words, discharge planning was documented as the primary job function by 12 of the 17 hospital social work participants.

Category one reveals that "Counseling," "Resources," "Education," "Assessment," and "Documentation" proved to be the most frequent functions performed. The second category indicates that "Crisis Intervention," "Advocacy," "Program Development," and "Outpatient Services" also were thought to be among possible job functions.

Table 3

Hospital Social Worker's Primary Job Functions Performed in the Hospital Currently Compared to Five Years Ago

Function	Currently	Five Years Ago
Discharge Planning	12	13
Counseling	10	10
Resources	9	9
Education	5	5
Assessment	3	3
Documentation	2	2
Crisis Intervention	1	1
Advocacy	1	1
Program Development	1	1
Outpatient Services	1	1

The majority of social work respondents had similar thoughts regarding their job functions performed five years ago. "Discharge planning" again emerged as the most frequent job function performed as it was documented twelve difference times. (see Table 3). "Counseling" and "Resources" were also common practices performed by hospital social workers five years ago. Other functions include; "Education," "Assessment," "Documentation," "Crisis Intervention," "Advocacy," "Program Development" and, "Outpatient Services."

In addition to Table 3, findings generally indicate that most hospital social work participants believe the function of discharge planning has changed over the past five years. Examples of comments addressing what hospital social workers specifically said about how discharge planning has changed over the past five years include:

> "Inpatient hospital stays are more intense...Patients are being discharged with more care needs (IV's, dressing changes, rehab)...Patient stays are often shorter and require faster intervention...More insurance involvement needing prior authorization for specific agencies...Not as much time to plan...Need to be more creative...MD voice smaller...More insurance checking...More team work."

Thus, hospital social work participants believe the actual function of discharge planning has changed in response to both internal and external factors. The above comments suggest that hospitals, along with insurance companies have influenced the practice of discharge planning.

The Future Role of the Hospital Social Worker

All of the social work participants agree that the role of the hospital social worker will be to continue the tasks of discharge planning. Only a few comments were made suggesting that social work may be "phased out" and replaced by nurses or other case management staff. Some comments included:

> "I think the role of hospital social work will still be in discharge planning because of the financial benefit to the hospital...much more emphasis on outpatient services...working with clients when surgeries are scheduled or planned...I believe it will be insurance broker/discharge planner...serving the indigent populations....Hospitals will decentralize social workers."

Again, many themes came up regarding the issue of based planning coordinating care even before a patient is admitted. Some participants suggest that social workers will be located outside the hospital setting. This theme may suggest either decentralization of

social work departments at specific cites, or placing social workers in clinics in order to identify discharge needs early and coordinate services.

Hospital Social Work Directors Perceptions of Current Functions of the Hospital Social Worker

All of the hospital social work directors agreed that "Discharge Planning" is the most frequent job function performed currently by social workers see (Table 4). "Crisis Intervention," "Counseling," "Advocacy" and, "Resources" were also construed as being primary functions according to hospital social work directors. It was interesting to find that one director noted that "Insurance Policy Interpretation" among the job functions performed currently.

Table 4

Hospital Social Work Director's Perceptions of Job Functions Performed by Hospital Social Workers Currently Compared to Five Years Ago

Function	Current	Five Years Ago
Discharge Planning	3	3
Crisis Intervention	2	1
Counseling	2	1
Advocacy	1	0
Resources	1	2
Insurance Policy Interpretation	1	0
Peer Consultation	0	1

All hospital social work directors concurred that "Discharge Planning" was the main function of the hospital social worker five years ago (see Table 4). "Resources," "Crisis Intervention," "Assessment," "Peer Consultation," and, "Counseling" were also listed as another common functions performed by hospital social workers in accordance with how directors viewed their role.

Managed Care

One of the goals in seeking information about attitudes among participants was to determine the impact managed care has had on hospital social work. Four keys areas were chosen : 1) the day to day influences of managed care; 2) primary job functions (discharge planning); 3) time constraints related to managed care and, 3) ethical dilemmas related to managed care.

Responses to these questions, answered on a 5 point Likert scale from strongly agree to strongly disagree, are organized by topic. The researcher combined strongly agree and agree into one category, and strongly disagree and disagree into one category. A neutral category was replaced with the category neither agree or disagree. Table 5 describes hospital social work participant's attitudes of how managed care has influenced hospital social work in four specific areas.

Table 5

Hospital Social Work Participant's Attitudes of Managed Care

	Agree		Neutral		Disagree	
	%	N	%	N	%	N
Managed Care affects my job daily.	100	17	0	0	0	0
I face ethical dilemmas with patients due to managed care.	88.2	15	11.8	2	0	0
I have more time constraints due to managed care.	82.3	14	11.8	2	5.9	1
Discharge planning is one of my main job functions due to managed care.	58.8	10	23.5	4	17.7	3

All social work participants agreed that managed care affects their job on a day to day basis (see Table 5). None of the social work participants disagreed with the statement. This finding suggests that managed care has had significant influences on the day to day operations of the hospital social worker. It also suggests that hospital social workers are impacted each day by some general aspect of managed care. This finding could include a number of things including prior authorization or pressures to facilitate an early discharge.

Over half of the sample (58.8%) agree that managed care has a significant influence over the functions they perform (see Table 5). 17.7% disagreed that discharge planning was a direct result of managed care, and only 23.5% were neutral. This finding suggests that a large portion of the sample believe discharge planning and managed care co-exist, or are interrelated functions. It is possible to consider that social workers responsible for populations such as maternal health may be unlikely to perform discharge planning. Their role, perhaps, may be more consistent with education and gathering resources.

It appears evident that the majority of participants believe that time constraints are also a result of the features of managed care (see Table 5). Over eighty percent of those sampled agree that time constraints are a direct result of managed care. Only 5.9% disagreed and only 11.8% were neutral. Due to the multiple complexities that hospital social workers face today due to insurance, the issue of time may be among these factors.

Finally, Table 5 indicates that 88.2% of participants agreed that they experience ethical dilemmas due to managed care. None of the participants disagreed with the statement and only 11.8% remained neutral. This finding suggests that managed care

does not always consistently correspond with the ethical standards outlined by social workers. In fact, this finding mirrors what the literature now reveals about the multitude of dilemmas facing hospital social workers today.

Hospital Social Work Director's Perceptions of Managed Care

Like the hospital social work participants, hospital social work directors were also asked if they felt managed care has influenced or changed hospital social work. All three directors indicated that it had and added the following comments:

> "It has added many layers of work with case managers, benefit people, etc, managed care has influenced significant decreases in patient length of stay accelerating the discharge plan process and leaving little time for psychosocial intervention...Managed care has increased more frequent social work interventions from hospital emergency departments to avoid hospital admission."

Furthermore, all directors believe that managed care will continue to influence the role of the hospital social worker. Although three cases are insufficient for meaningful statistical analysis, it provides some hints to what the future holds for hospital social workers.

Hospital Social Work Director's Perceptions of Staffing Trends

According to the three directors of hospital social work, the number of staff currently employed in their departments compared to five years ago differed across hospitals. One director made note that 26 full-time social workers were employed five years ago, compared to a current staff of 32. This director reported that more staff was added because of the "need to facilitate a discharge." Another director reported that there were 28 full-time social workers five years ago, compared to a current full time staff of 26. This director reported that the decrease in staff occurred due to the "closing of behavioral health units." The third director reported no change in the number of staff,

noting a full-time staff of five. Because the staffing of these directors remained unchanged, comments were not made about the reason.

Two of the three directors sampled noted they anticipate their departments will be adding social work staff in the future. One suspected that there would be downsizing of the department. Questions to determine the specific reasons for staffing changes were not posed to the hospital social work directors sampled.

Summary

General findings suggest that all hospital social work participants feel that discharge planning has changed over the past five years, due to cost containment and changes in reimbursement. They also feel that managed care has changed or influenced hospital social work. Participants indicated that managed care has shortened the time social work intervention is provided to patients. Participants indicate that more time is now being spent on obtaining authorization for needed services. Meanwhile, the influences of managed care have created new and additional factors to consider when implementing discharge plans. In fact, over the past five years, participants noted that changes have especially occurred in the areas of patient choice and coverage for services. Participants also indicated that managed care systems minimize decision-making power among their members.

The majority of participants generally had strong attitudes about managed care in relationship to their profession and what the future holds for them. The directors also suggested that the existence of managed care has not only changed the role of the individuals they supervise, but the also in the manner in which the department operates. Clearly, the findings indicate that the majority of hospital social worker's time is now

spent performing the tasks of discharge planning, and may be more likely to perform tasks that are affiliated with discharge planning.

Study Limitations

It would be unlikely to conduct a study without the presence of limitations. Limitations in the study are worth noting. In fact, describing the limitations of a study aids in recognizing areas of strength, potential and may guide further research.

In reference to this study, the questionnaires distributed may have posed certain limitations. The questionnaire, in itself, is limited to the scope of questions that could potentially be asked about the topic. Granted, there were several questions that allowed the participant to answer in an open-ended fashion, and state their attitudes and opinions regarding discharge planning and managed care. Qualitative methods; such as open ended Questions capture individual creativity and insight, but lack the clean and concise statistical results that many studies aim to achieve.

The 17 questionnaires that were returned form the hospital social work participants and the three questionnaires returned from the directors of hospital social work represented a small sample size. Therefore, the findings are not generalizable to the entire population of hospital social workers and their directors. Social workers also working in the hospital setting less than five years were not allowed to participate. These social workers may have indeed had some insight on the topic, but lacked the five year hospital employment history that was required for this study. In addition, the sample was recruited from four, Minnesota metropolitan hospitals, leaving greater Minnesota and other metropolitan hospitals absent from the results.

Participants may have also had their own interpretation of terms. Although specific terms were defined and explained on the cover letter of the questionnaires, participants may have developed their own biases of the terms; “managed care” and “discharge planning.”

Chapter Five: Discussion

Overview

This section will review the information provided by the participants and give further explanation to the findings. In this study, seventeen hospital social workers and three hospital social work directors responded about their professional opinions, attitudes and reflections on their profession's current and future role. Their responses not only articulated what the present nature of hospital social work is, but what is yet to be.

Discharge Planning

The findings indicate that discharge planning is the task that social workers are spending the majority of their time doing. This finding was also true of the tasks performed five years ago. Table 3 revealed that "Counseling," "Resources," "Education," "Assessment," and, "Documentation" have been among the common functions hospital social workers perform. It was interesting to learn that little variation occurred over the five-year time frame. While discharge planning was the primary function documented in each time block, it is important to mention that the functions that followed could be associated or co-exist with discharge planning, or be performed as separate functions. The second category disclosed that "Crisis Intervention," "Advocacy," "Program Development," and, "Outpatient Services" are also job functions performed, but not nearly as much as the functions outlined in category one. Table 4 addressed the director's perceptions of hospital social work functions. The findings indicate that directors believe social workers perform "Discharge Planning" as their main job function currently and five years ago, followed by "Crisis Intervention," "Counseling," and

"Advocacy." It appears that there was more emphasis placed on assisting with "Resources" and "Peer Consultation" five years ago.

Many social workers indicated that "Discharge Planning" was a process that included "patients and their families to coordinate a plan of care following hospitalization." Those who indicated that they spend the majority of their time performing discharge planning had a tendency to declare that they spend between 4-6 hours per day executing the task of discharge planning.

In reviewing the findings and literature, there is a general sense that discharge planning has always been among the primary tasks of professional hospital social work. The AHA believes that discharge planning as an interdisciplinary hospital wide activity which should be available to assist patients and families in developing a feasible post hospital plan of care (AHA, 1984). However, the findings and literature reveal that hospital social workers perform the majority of the work surrounding discharge planning. And, in recent years, hospitals have appreciated the task of discharge planning more because of the institutional incentives (reimbursement) they receive from Medicare and other insurance companies.

Social workers indicated that the task of "Assessment" was a large part of the discharge planning process. Some indicated that the assessment was important to ensure that a safe plan was in place before patients left the hospital setting. A fair amount of accountability exists for hospital social workers when working with patients and families. Careful planning and good communication will need to be practiced and reviewed among social workers as the pace of health care continues to be swift.

Many participants documented that the pace of discharge planning has become "faster" due to the volume of patients that need social work services. As indicated in the findings, all participants believe discharge planning has changed over the past five years. Many participants indicated that they have "less and less time" to do their assigned tasks because patients are no longer in the hospital for a long period of time, unless their medical situation is complex. This particular finding correlates with what the literature revealed about the reality of shorter hospital stays. Peterson (1987) asserts that the inpatients found in the hospital today may be the people who were admitted at the last possible moment and will be discharged as soon as they are medically stable. Ironically, these patients are sicker than the inpatients of the past, yet they have a shorter length of stays. The reality of shorter stays has highly influenced, and in some cases, compromised the profession of social work. In cases where patients may be discharged too early, social workers may need to reevaluate their role and utilize their advocacy skills. Some hospital social work departments have implemented new strategies to identify their patient's needs prior to hospitalization. In situations where patients know that they are going to be admitted to the hospital, particularly those scheduled for surgery, social workers are meeting with these patients and families to educate them about services that may be available to them post-hospitalization. This process also gives the social worker time to learn about the patient's living situation, coping mechanisms, support systems, and their level of functioning. In addition, this activity may reduce the level of anxiety among patients and their families. Themes regarding insurance also emerged when asked about discharge planning. Many commented about how they are spending time obtaining insurance authorization, and reviewing insurance benefits with patients and families.

Comments were also made regarding the limitations placed on those insured under HMO's, and some patients need to choose certain nursing homes or providers under their HMO contract.

Managed Care

From this research, we now know that both hospital social workers and hospital social work directors believe that managed care has changed the profession of hospital social work. In fact, we also learned that the majority of respondents believe discharge planning is one of the main job functions because of managed care. In addition, the findings in this study suggest that our current and future steps will be taken with managed care in mind.

The findings indicate that managed care has greatly impacted the delivery of hospital social services. It seems apparent that it has shaped the manner in which hospital social workers spend their time, problem-solve and make decisions. According to these findings, hospital social workers have developed their own attitudes about managed care. It was surprising to learn that the majority of participants felt that managed care not only influences their job on a daily basis, but it also creates time constraints and ethical dilemmas.

Although this study did not inquire about why participants held particular attitudes regarding managed care, the research revealed some general similarities, and patterns. As indicated in Table 5, the first three statements indicate a clear pattern and reveal that participants generally had consistent perceptions specific to managed care. Some variation existed regarding the idea that discharge planning was a main job

function because of managed care. Perhaps, some social workers believe discharge planning would still be a main function without the presence of managed care.

According to the literature, many hospital social workers are faced with large caseloads, and are expected to perform the same amount of work that they did when assigned fewer patients. The literature also revealed that the patients who need social work services are often admitted with complex medical issues and pyschosocial problems. Social workers may find themselves in the midst of an ethical dilemma knowing that they need to sort through their cases to determine which client is in the greatest need for social work services even though they have several cases that need intervention.

McKinney & Young (1985) insist that ethical issues are unavoidable in social work practice. Poole (1996) adds that managed care raises many concerns for social workers. "For the people we serve, managed care raises a host of issues pertaining to confidentiality, duty to aid, self-determination, freedom of choice, access, quality of care, research protocols, informed consent, participation in treatment decisions and client rights" (p. 163). Saleebey (1992) asserts that in order to overcome obstacles like these, the strengths perspective can enhance and change the outcome of our social work interventions. One of the corner stones of the strengths perspective is that "change can only happen when you collaborate with clients' aspirations, perceptions, and strengths and when you firmly believe in them" (p. 42).

Implications for Social Work Practice

Social workers may need to try new techniques and programs to identify populations that require social services before patients present to the hospital setting. Meanwhile, this may require more linkages with local county and social service agencies.

Social workers also may need to consider learning more about corporate health care, like managed care systems as it will continue to permeate the profession and the clients they serve. Schools of social work could be instrumental in educating students about the various components of the health care system. Offering classes which educate students about health care policy and managed care systems would be of great benefit.

Although this study provided a small sample size, there is indication that many hospital social workers have specific concerns and attitudes when discharge planning and managed care interface. Directors of hospital social workers should consider holding discussions among social workers, and other disciplines to specifically discuss the issues surrounding discharge planning and managed care. Collectively, a great deal could be learned through the exchange of information.

Implications for Social Work Policy

Due to the dynamic and complex nature of managed care, social workers may be the perfect candidates to communicate and advocate on behalf of the clients they serve. Hospital social workers could describe their direct experiences with patients, including the ramifications of discharging patients too early. By voicing our concerns, it will not only bring more awareness, but will also provide educational tools for health care providers and managed care systems, and may guide changes in social policy.

Furthermore, directors of hospital social work departments could be key contributors and leaders in the future of health care delivery.

Implications for Further Research

There is an abundance of research that could be drawn from this study. This topic is rich and contains many dimensions. The findings from this study suggest that hospital social workers commonly are faced with a variety of challenges in the era of managed care, and the changes in health care have undoubtedly redefined the role of the hospital social worker. The results presented on Table 5 supports this reality. Hospital social workers today experience day to day challenges, struggles and ethical dilemmas that are particularly oriented to aspects of managed care. Although specific problems were not revealed in this sample, this research could be expanded to develop a better sense of the apparent frustrations among hospital social workers. While identifying that these problems exist may be disappointing, the information gathered may lead to creative solutions and alternatives. Pre-hospital planning may be among the strategies to consider to allow more time with patients during their hospitalization. If social workers were to spend more time with patients prior to their hospital admission, (reviewing benefits, discussing services) social workers may find it less likely to experience ethical dilemmas. Therefore, research that strives to determine how hospital social workers can perform their job duties more effectively, due to the complexities of insurance is warranted. And, because discharge planning will continue to be a function mainly performed by hospital social workers, continued research is needed to determine ways in which the profession can formulate linkages with other health systems to better serve our patients.

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Appendix A

Hospital Social Work Director
XXXX Hospital
XXXX, Minnesota XXXXX

April, 1997

Dear Director

I am writing this letter as a follow-up to our phone conversation on April, xx 1997. As you may recall, I am an MSW student at Augsburg College where I am required to do a thesis project.

As we discussed, the purpose of my thesis project is to explore and gain an increased level of understanding about social worker's attitudes in relationship to managed care. A portion of the study will require that I gather information from a specific population to support my thesis project. For my study, I hope to circulate questionnaires to hospital social work directors and hospital social workers that have worked in the hospital five or more years.

If you are agreeable, I would like to present my questionnaire to you and the members of your staff at one of your department meetings. I will need between 15-20 minutes to explain the purpose and goal of my study. I plan to leave the questionnaires with those who are willing to participate in the study. I will provide a stamped envelope that can be returned to me upon completion of the questionnaire. The names of those participating in the study will remain anonymous. For your review, I have enclosed a copy of the cover letter and questionnaires I plan to distribute.

Augsburg College Institutional Review Board requires that written permission be obtained prior to gathering information from those participating in a study. Please return the attached form if you are willing to participate. If possible, please respond by April, xx 1997. When I receive this form, I will be contacting you to make arrangements to present and distribute my questionnaires to you and the members of your staff. If you have any questions, please contact me at XXX-XXXX. Thank you for your time.

Sincerely,

Shelby Lawrence-Hinshon

Appendix B

I am in agreement and give permission to Shelby Lawrence-Hinshon, Augsburg College MSW student to gather information from me and the members of my staff on the subject of "Social Worker's Attitudes regarding Managed Care."

I have read the consent letter and understand the purpose and objectives of the study.

_______________________________ ________________

Signature of Permission Date

_______________________________ ________________

Signature of Principal Investigator Date

Appendix C

Cover Letter

Dear Participant,

You have been invited to participate in a research study about hospital social worker's attitudes towards managed care. You were selected as a possible participant because you are currently employed as a hospital social worker and have been employed in the setting five or more years. Please read this form before agreeing to be in the study.

I am conducting this study as part of my MSW graduate requirements at Augsburg College. I have received approval from the Institutional Review Board at the college. For research purposes, my approval number is 96-58-2.

The purpose of this study is to seek information concerning attitudes among hospital social workers in relationship to managed care. The information gathered from this study will provide me an increased level of understanding on the current and future role of hospital social work. I also hope to attain more insight regarding how hospital social workers believe their profession has been influenced by the managed care movement.

You will be asked to complete a brief questionnaire. The questionnaire is divided into four sections. It will take approximately 15-20 minutes of your time. Questions include demographic information, as well as questions asking for your opinion and attitudes regarding managed care.

Participation in this study is voluntary. All answers are acceptable, completely anonymous and you may cancel your participation in the study at any time. There are no direct benefits to being in this study. Information from the questionnaire will be gathered, analyzed and coded for statistical purposes. No participant can be identified in any report of the responses. The responses will be destroyed upon completion of collecting the data. If you have any questions regarding this study, you may contact me at . or my thesis advisor, Laura Boisen at If possible, please return the surveys no later than June 18, 1997.

Sincerely,

Shelby Lawrence-Hinshon

Appendix D

Social Work Directors and Managed Care Survey

The purpose of this study is to gather information on the current and future functions of the hospital social worker in relationship to managed care. For the purpose of this survey, "managed care" can be considered Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's), and privately managed idemnity insurance plans. In addition, insurance plans under Medicaid can be considered "managed care."

This questionnaire is divided into three sections. It will take approxiamately 15-20 minutes of your time. Please answer all the questions as completely and thoroughly as possible. Thank-you for participating in this study.

Instructions: Either a pen or pencil may be used to complete this questionnaire. Some of the questions may require written responses, others requiring a yes or no answer or checking the appropriate box.

I.Job Functions

Q1. As a director, what do you think the three main functions were of the hospital social worker 5 years ago?

A.

B.

C.

Q2. What do you think are the three current main functions of the hospital social worker?

A.

B.

C.

I. Managed Care

Q3. In your opinion, do you believe managed care has changed or influenced hospital social work?

( ) yes
( ) no
( ) don't know

Q3A. If yes, please explain

Q4. Do you anticipate managed care effecting the role of the hospital social worker in the next five years?

( ) yes
( ) no
( ) don't know

Q4A. If yes, please explain

Department Structure

Q5. How many full-time (FTE's) social workers did you have on your staff five years ago?______

Q6. How many full-time social workers do you have on your staff currently?______

Q7. If there was an increase or decrease in the number of FTE's, could you explain why?

Q8. Do you anticipate downsizing or adding more social workers in the next five years?

___yes
___no
___don't know

Participant Information

Q9. What is your gender?

___Male
___Female

Q10. What year were you born? 19___

Q11. What is your level of education?

___Bachelors Degree in Social Work
___Masters Degree in Social Work
___Other, please specify_________

A12. How many years have you been a hospital social work director?

___0-5 years
___6-10 years
___11-15 years
___16-20 years
___over 20 years

Thank-you for participating in this study!!

Appendix E

Social Work and Managed Care Survey

The purpose of this study is to gather information on the current and future functions of the hospital social worker in relationship to managed care. For the purpose of this survey, "managed care" can be considered Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's), and privately managed indemnity health insurance plans. In addition, insurance plans under Medicaid can be considered "managed care."

This questionnaire is divided into four sections. It will take about 15-20 minutes of your time. Please answer all the questions as completely and thoroughly as possible. Thank-you for participating in this study.

Instructions: Either a pen or pencil may be used to complete this questionnaire. Some of the questions may require written responses, others requiring a yes or no answer, or checking the appropriate box.

I. Job Functions

Q1. Think back five years, list what your three main job functions were as a hospital social worker.

A.

B.

C.

Q2. List the three job functions you currently spend the majority of your day doing.

A.

B.

C.

Q3. Indicate the approximate amount of time you spend each day on the functions specified in question #2.

A._____hours

B.____hours

C.____hours

Q4. In your opinion, has discharge planning changed over the last 5 years?

____yes
____no
____don't know

Q4A. If yes, please explain

Q5. How would you define discharge planning?

II. Managed Care

Q6. In your opinion, do you believe managed care has changed or influenced hospital social work?

___ yes
___ no
___don't know

Q6A.If yes, Please explain

Q7. If you answered yes to question #6, how would your job be different without managed care?

Q8. Do you anticipate managed care being a positive or negative aspect of your job in the next five years? Please explain

III. Future Roles of Hospital Social Work

Q9. What do you believe the role of the hospital social worker will be in the next 5 years?

IV. Social Work Attitudes Regarding Managed Care

Q10. Managed care currently effects my job on a day to day basis.

1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

Q11. Discharge planning is one of the main functions of my job due to managed care.

1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

Q12. I experience more time constraints due to managed care.

1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

Q13. I experience some ethical dilemmas when working with patients due to managed care.

1 Strongly Disagree	2 Disagree	3 Neither Agree or Disagree	4 Agree	5 Strongly Agree

Participant Information

Q14. What is your gender?

___Male
___Female

Q15. What year were you born? 19___

Q16. What is your level of education?

___Bachelors Degree in Social Work
___Masters Degree in Social Work
___Other, please specify__________

Q17. How many years have you worked in a hospital setting?

___0-5 years
___6-10 years
___11-15 years
___16-20 years
___over 20 years

Thank-you for participating in this study!!