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How Hospital Social Service Directors Perceive the Current and Future Role of the Medical Social Worker

Molly Schwegman Martin
Augsburg College

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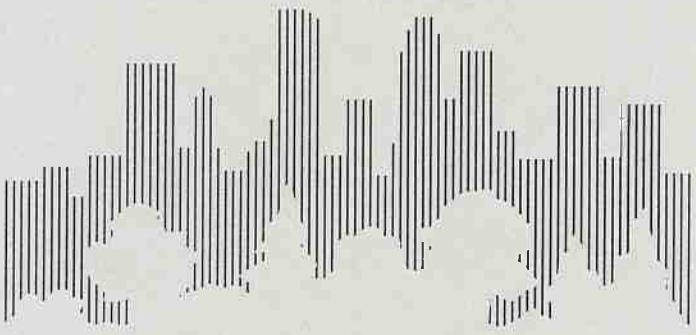

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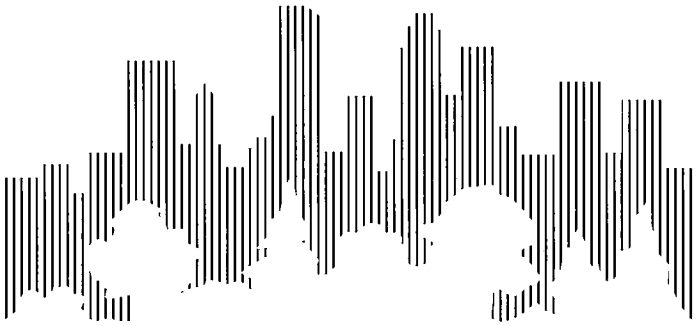

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How Hospital Social Service Directors Perceive the Current and Future Role of the Medical Social Worker

by

Molly Schwegman Martin

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CERTIFICATION OF APPROVAL

This is to certify that the Master's thesis of:

Molly Schwegman Martin

has been approved by the Examining Committee for the thesis requirements for the Master of Social Work Degree.

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Thesis Committee:

Thesis Advisor-Carol Kuechler, PhD.

Thesis Reader-Beverly Nilsson, PhD.

Thesis Reader-Joe Clubb, MSW

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ABSTRACT OF THESIS

HOW HOSPITAL SOCIAL SERVICE DIRECTORS
PERCEIVE THE CURRENT AND FUTURE
ROLE OF THE MEDICAL SOCIAL WORKER

METHODOLOGY: RESEARCH

MOLLY SCHWEGMAN MARTIN
MAY, 1996

This research explored the current roles and attempts to understand the future roles of medical social workers in hospital settings. The subjects of this study were members of the Minnesota Chapter of the Society of Social Work Administrators in Health Care who completed a 16 question mailed survey. The findings illustrated the necessity to expand social work services beyond the hospital walls into such areas as emergency rooms, community settings, and physician clinics. The information gathered and compiled for this study will be used by directors of hospital social work service departments, along with medical social workers, to examine and be proactive about their roles and future service delivery in hospital settings.

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Introduction

Overview

This section will discuss the historical development of the medical social work profession. Changes in the delivery of health care services, including shifts in the location of practice and tasks performed by the medical social worker will be addressed in terms of their impact on the social worker in the hospital setting. Meanwhile, medical social workers who practice in hospitals have also impacted the delivery of health care. They have helped to shape service delivery to guarantee clients' access to high-quality care and to take into account the person and situation (Kerson, 1985). Medical social workers have worked to define high-quality health care that requires the physical, social and psychological preparation of patients who leave the hospital, insuring that their post-hospital plans are appropriate (Boone et al., 1981).

Historical Development

This section addresses the construct of the identity of medical social work as a profession and gives a historical overview of roles and tasks over the last eighty years. Nacman (1977), Germain (1983), and Rehr (1984) are key resources in the documentation of the evolution of medical social work.

Medical social work began around the turn of the century in the United States; however, medical social work existed as early as 1791 in one London hospital (Shamansky et al., 1984). Ida Cannon and Dr. Richard Cabot were instrumental in the development and growth of medical social work in the United States (Shamansky et al., 1984; Rosenberg 1983; Kerson, 1985; & Nason, 1990). The first American hospital social service department was established by Ida Cannon on October 3, 1905 at Boston's Massachusetts

General Hospital in collaboration with Dr. Richard Cabot (Shamansky et al., 1984). In 1905, Garnet Pelton was appointed the first medical social worker by Dr. Cabot and was on staff at Massachusetts General Hospital (Trattner, 1994).

Social work began in hospital settings in the preprofessional era. Initially, nurses were employed in social work positions because they were familiar with hospital organization and community resources. The role of the medical social worker was modeled after the "friendly visitor". Nacman (1977) describes the "friendly visitor" as "sympathetic to the plight of the patients, but paternalistic and moralistic" (Nacman, 1977, p.11). As health care workers evaluated this role, they concluded that there were such social and cultural gaps between the giver and receiver that often both parties were frustrated. The giver was frustrated because of the lack of appreciation and the absence of results, while the receiver did not feel listened to and felt judged (Nacman, 1977).

It was clear that the "friendly visitor" model was not working and that workers required more training in the understanding of social problems. The School of Philanthropy was founded in 1898 to provide formal training for the emerging profession (Nacman, 1977). In 1912, the Boston School of Social Work offered a one-year course in medical social work (Davenport & Davenport, 1995). However, it was not until 1932 that the American Association of Schools of Social Work adopted a specific medical social work curriculum policy (Nacman, 1977).

Nacman's (1977) historical review exemplifies the progress made by social workers in the last eighty years. Hospital social workers have been affected by the development and advances of the profession. According to

Nacman, medical social workers have helped to break down barriers that separate aspects of patient care from psychosocial factors.

In the thirties and forties, medical social workers defined their unique tasks and responsibilities as professionals. Social workers counseled patients and focused on issues such as patients with syphilis, women who were pregnant and unmarried, and children impaired by polio (Nacman, 1977). During this time period, the government made a commitment to care for children, the elderly, the poor and disabled (Rehr, 1984; Abraham, 1976). The Federal Emergency Relief Act of 1933 and the Federal Security Act of 1935 also created a demand for medical social workers (Kerson, 1985). These added responsibilities increased the need for social workers in the hospital setting during the profession's formative years.

In the nineteen fifties, with the establishment of the community health movement, social workers expanded their role to serve patients with mental illness (Abraham, 1976). Social workers focused on the importance of social and cultural factors in the diagnosis and treatment of psychiatric patients. In the same era, group work developed to assist psychiatric patients, but resulted in expanded services for medical patients as well (Nacman, 1977).

In the sixties, access to health care for large segments of the population was assured. More attention was given to people who did not have health insurance, including children and the elderly. Medicaid, Medicare and other government programs created an even greater demand for social work coverage in hospitals (Rehr, 1984). Medical social workers played a vital role in working with these populations (Germain, 1983).

In the nineteen seventies and eighties, widespread attention was given to the task of discharge planning by health professionals. Sicker patients were being discharged from the hospital sooner, thus patients required more

services in the community setting (Shamansky et al., 1984; Bendor, 1987). According to Blumenfield & Rosenberg (1988), historically, the task of discharge planning involved two type of services. The first type focused on counseling services to help patients deal with their reactions to illness, hospitalization and preparation for discharge. The second type of service involved the actual coordination of resources for continued care outside the hospital setting. Discharge planning as a task of the medical social worker has become increasingly important. Today, medical social workers continue to provide the two types of services mentioned above but, with changes in reimbursement patterns and governmental regulations, early discharge planning has become an economic necessity for patients and hospitals (Blumenfield and Rosenberg, 1988). The profession still struggles to respond to cost containment and changes in insurance reimbursement policies. Because changes in reimbursement led to decreased hospital stays, it became crucial to identify patients in need of post-hospital care early, so effective discharge plans could be implemented (Simmons, 1994).

As illustrated above, the expansion of the roles and tasks that have occurred over the past eighty years have impacted the way medical social work is practiced today.

Location of Practice

The locations in which social workers actually practice have also changed over time. During much of the century, medical social workers have been based primarily in hospital settings, such as on medical floors and orthopedic units (Simmons, 1994). However, a shift has occurred as patient care moves from inpatient settings into outpatient settings (Simmons, 1994; Blumenfield & Rosenberg, 1988; & Rosenberg, 1994). Between 1980 and 1989, hospital inpatient admissions dropped from 36.1 million to 31.1 million,

a decrease of 14%. If this trend continues, projections suggest that there will be an additional 17% loss in inpatient admissions between 1989 and the year 2000 (Rosenberg, 1994). Cost containment, prospective payment procedures and insurance reimbursement have impacted the nature of service delivery (Rosenberg, 1994).

In today's health care environment, with patient care moving from the inpatient setting to the outpatient setting, new structural arrangements in the health care system are essential (Blumenfield & Rosenberg, 1988). Outpatient visits are up 40% in the last five years and are expected to increase another 106% by the year 2000 (Rosenberg, 1994). These changes are driven by technological advancements, government cost containment, insurance companies, and consumer demand. Essential acute care, modeled by the inpatient nature of traditional health care service delivery in the hospital setting, has changed (Rosenberg, 1994).

Tasks of the medical social worker

This shift from inpatient services to outpatient services will not only affect the location of social work practice, but it also will impact the tasks performed by the medical social worker. The National Association of Social Workers (NASW) has developed a list of major functions and tasks provided by the medical social worker. Some of these tasks include counseling, information and referral, community planning and coordination of activities, post-hospital planning and preadmission planning (NASW, 1990). These tasks are currently performed by the medical social worker and will continue to be important in the future (Blumenfield & Rosenberg, 1988).

Role of the Medical Social Worker

According to the NASW, social work services are provided to patients and their families to meet their medically related social and emotional needs

as they impinge on their medical condition, treatment, recovery, and safe transition from one care environment to another (NASW 1990). The role of the social worker can be very complex and multi-faceted. Donnelly (1992) articulated the unique role of the medical social worker: "hospital social workers play to a number of audiences simultaneously: patients and families, hospital administrators, nonprofessional staff, and other professionals in the treatment team" (p.107). On a given day, social workers deal with many different situations involving a variety of audiences. "Audiences can vary in level of sophistication, degree of interest, hostile or benign intent or degree of emotionality and stress" (Donnelly, 1992, p.109). Medical social workers assist patients and families in a variety of settings, including medical, psychiatric, home and hospice, to mention only a few. Social workers are capable of working in complex settings and understand obstacles to care in the health care environment (Rehr, 1984).

Purpose of this Research

The purpose of this study was to answer the research question," How do directors of hospital social work departments perceive the current and future role of the medical social worker in the hospital setting?" The participants for the study, members of the Minnesota Chapter of The Society of Social Work Administration in Health Care, were chosen because of their knowledge about the roles of medical social workers who practice in the hospital setting. The goal of this research is to assist directors of hospital social work service departments and medical social workers in examining their roles and the future of service delivery in the hospital setting.

Literature Review

Overview

This literature review will discuss the historical development of the medical social work profession. The theoretical framework used to describe the practice of medical social work is the ecological model. The changes in location of practice and the nature of tasks performed by the medical social worker are also discussed. The impact of these changes as they relate to the medical social work profession will be examined.

According to the literature, the primary discussion about the shift in the location of practice and tasks performed by medical social workers occurred in the 1980's. The most current literature focuses on issues related to managed care, ethical issues, and the importance of the interdisciplinary team approach in the health care setting.

Historical Development

Ida Cannon and Dr. Richard Cabot were instrumental in the development and growth of medical social work in the United States (Shamansky et at., 1984, Rosenberg 1983, & Kerson, 1985). They both became convinced of the importance of social factors related to a person's health. According to Cannon (1923) social work provided "an enlarged understanding of any psychic or social condition which may cause the patient distress of mind and body" (p.98) and medical social workers studied "character, human relationships and community life" (p.98) which allowed them to see the situation objectively (Cannon, 1923). Dr. Cabot believed that a patient's personal difficulties might prove to be the cause and not the result of the person's illness (Nacman, 1977). The first hospital social service department was established on October 3, 1905 at Boston's Massachusetts

General Hospital by Ida Cannon in collaboration with Dr. Cabot (Shamansky et al., 1984).

The idea of medical social work spread very rapidly to other areas of the country and throughout the world. Cannon and Cabot both supported the idea of a professional social worker who would meet defined educational criteria and have the skills to perform certain functions (Bartlett, 1975). Ms. Cannon provided on-site training and direction to individuals who wanted to educate themselves about the role of the medical social worker. After training and working side by side with Ms. Cannon at Massachusetts General Hospital, most of her staff left to take executive positions in new social service departments across the county and throughout the world.

By 1920 professional organizations for medical social workers were developed. In 1918, in Kansas City the American Association of Medical Social Workers was formed, signifying the nationwide expansion of social work into health care settings. In 1920, the American Hospital Association sponsored the first formal survey of hospital social services, making recommendations that led to the formation of a committee on training for hospital social workers (Nacman, 1977). These organizations made statements in support of a permanent commitment to the function of medical social work which led to major developments for the profession of medical social work.

Theoretical Framework

According to Germain (1984), the theoretical framework that is applicable in the field of medical social work is the ecological perspective (Germain, 1984). When applying the ecological perspective to health care organizations, one must first look at the environmental context. This framework is useful for understanding the relationships and sensitive balance

that occurs between people and their environment. "The ecological perspective suggests that our social purpose is to improve the quality of transactions between people and environment so there is a better match between people's adaptive potential and environmental qualities " (Germain, 1977, p. 52).

In the hospital setting, medical social workers are aware of and active in three main environments: with patients and families, in hospitals, and in the community. With the shifts in health care today, patients and families will be affected by and may need assistance in adjusting to a permanent or temporary change in health. Family members provide a large proportion of health care and often find themselves negotiating between the large health care systems and the ill person (Hartman and Laird, 1983). The ecological model takes into consideration that patients and family members are constantly changing and adapting to what is occurring around them. Social workers need to understand the complex components of the ecological system of the patient and aid patients and families in coordination of health care service (Germain, 1983).

Medical social workers in the hospital setting assist with formulating post-hospital plans to meet the needs of the patients and families, who often need guidance as they readjust their roles and expectations when faced with an illness. This ecological approach allows the social worker to gather and assess large amounts of data and make the process more user-friendly for the patient and family. For example, if an elderly woman falls on the ice and comes into the emergency department for treatment but does not require hospitalization, the social worker, patient and family members need to establish an appropriate and safe discharge plan. This may involve temporarily placing the patient in a nursing home, discharging the patient

home with a family member or discharging the patient home with community services such as meals on wheels or home health care services. Rehr (1984) reports that social work is the only profession in the medical setting that concentrates on individuals, families and groups in the psychosocial environment and services network.

The ecological approach takes into account the person and the situation that is occurring. Using this approach has led to further clarification of duties and responsibilities of the professional social worker (Germain, 1983).

The ecological perspective also supports the strengths perspective that helps individuals, families, groups, and communities discover their own capabilities (Germain, 1983). The strengths perspective builds on the skills people already possess. The goal is to have patients maintain as much autonomy and decision-making power as possible. Patients and family members have a wealth of resources to draw from and can usually solve their own problems with some guidance from the medical social worker (Germain, 1983). The role of the social worker is to nourish, encourage and support the strengths available in their own environment. To do this medical social workers help patients and families "articulate the nature of their situation, identify what they want, explore alternatives for achieving those wants, and [then] achieving them" (Cowger, 1994, p. 264).

Emphasizing deficits can cause a patient to have feelings of self-doubts and inadequacies. The medical model of thinking has focused on the diagnosis of a patients medical problem. "Diagnosing is incongruent with the strengths perspective" (Cowger, 1994, p.267). For example, by using the word assessment rather than diagnosis, social workers focus on the strengths perspective.

Location of Practice

For most of its history, medical social work has been centered primarily in the inpatient setting (Simmons, 1994). However, patients are no longer being admitted to the inpatient hospital settings as they were in the past. Schwart and Stanton (1993) report "the United States has the lowest admission rate for acute hospitals, United States, 12.4%, Canada 13.3%, Germany 19.7%, coupled with the shortest length of stay of any major industrial country" (p. 16). According to Simmons (1994), the inpatient hospital will not continue to be the primary location for social workers to practice. This is also likely to have an effect on the way medical social workers practice within the inpatient hospital setting.

Ambulatory care is defined as health care service that does not require hospitalization of a patient including such areas as the same day surgery, radiology, laboratories, and physical therapy (Rosenberg, 1994). Since 1985, hospital-based, ambulatory care facilities have increased revenue by 123%, with the result that ambulatory care now accounts for nearly 25% of total hospital revenue. Ambulatory surgery accounts for approximately 47% of all hospital surgeries. Social work support services are needed in the ambulatory care setting to help address the anxiety and depression often experienced by patients and their families who face medical procedures (Rosenberg, 1994).

According to Simmons (1994), the internist/family practice office is another ideal setting for a social worker. Over 85% of individuals over the age of 65 see a physician each year in an office setting. Social work services located in these settings allow early intervention for those in need, and at a time when help can have the most significant impact (Simmons, 1994).

The following statistics were gathered from the Minnesota Hospital and Healthcare Partnership (1996). These statistics illustrates some of the changes in healthcare in the state of Minnesota.

* In the last ten years, approximately 3,000 Twin Cities hospital beds have closed. Another 1,000 beds are predicted to close in the next five years.

* Between 1980 and 1990, average daily Twin Cities hospital inpatient occupancy dropped from 63.3% to 43.3%.

* One-day maternity stays for uncomplicated vaginal deliveries in the Twin Cities increased nearly seven fold between 1985 and 1995- 42.5% of women with uncomplicated deliveries in the first quarter were discharged after one day, compared to 6.2% in 1985.
(Minnesota Hospital and Healthcare Partnership, 1996)

A new report from the American Medical Association (1995) announced that the national average length of stay for Medicare patients took a big drop last year, from 8.1 days to 7.3 days. In Minnesota, the average length of stay for a Medicare patient was less than 7 days.

1991- average length of stay 6.71 days
1992- average length of stay 6.48 days
1993- average length of stay 5.95 days

Throughout the 90's Minnesota Medicare average length of stay was consistently 2 full days below the national average (Minnesota Hospital Association, 1995).

Adjusting locations and expanding service areas will allow the medical social worker to better serve patients and families. This literature review illustrates that health care services are now being delivered more often outside the walls of the acute inpatient setting.

Tasks of the medical social worker

Not only is the location of practice for the medical social worker shifting, but the tasks performed by the medical social worker in the hospital setting are changing as well. Medical social workers perform numerous tasks. Examples include: counseling and support, information and referral, community planning and coordination activities, post-hospital planning and preadmission planning. (NASW, 1990).

Counseling. Health care professionals expect counseling to be part of the social worker's task, even though counseling is far from the only task performed (Cowles & Lefcowwitz, 1992). Counseling services are important in the hospital setting to help people adapt to the needed support services and also to ensure the appropriateness of care (Simmons, 1994; Rosenberg, 1994; & Nason, 1990). Families, friends, and neighbors provide supportive care to the patient and often need direction from the medical social worker. Family counseling skills are used when working with patients and families who are experiencing a health care crisis (Simmons, 1994). Medical social workers are in a unique position and have the specialized knowledge base to assist in building informal and formal partnerships between families and hospitals and between families and community agencies. Their skills have proven to be enormously helpful in easing the burden of care to the chronically ill and elderly (Rosenberg, 1994). Social workers are versed in the area of counseling and are available to help people adapt to the changes in their medical condition.

Information and Referral. Information and referral is another important task of the medical social worker (NASW, 1990). With the rising costs of health care, patients and families will be concerned about the parameters of

insurance coverage. Social workers' knowledge about payment regulations will be useful in coordination of services for people needing medical care. "Social workers will find themselves becoming spokespersons for the limitations of what the hospital can provide, even as they advocate for patients within the hospital system" (Blumenfield and Rosenberg, 1988, p.36). Medical social workers will look to community agencies to provide additional services to assist patients at home; such services include, meals on wheels, transportation services and chore programs. Social workers will also be more involved in educating and informing patients and families about the changes in the health care system. Consumers will require more information and guidance as they assess different health care systems (Nason, 1990).

Community Planning. Coordination of community planning is a relatively new task for the medical social worker (Rosenberg, 1994). As reported above, health care services are more frequently being provided in hospital outpatient areas and in community settings such as physician's offices. Therefore, the structural boundaries of hospital services need to mirror this change and join with other systems in the community (Rosenberg, 1994). Social work administration can be a leader in delineating inter-organizational linkages which will facilitate integration. Collaboration with community agencies may lead to developing partnerships with community agencies which can lead to programming for specific populations. For example, the Southeast Michigan AIDS Consortium reflects a collaboration of hospitals, home health providers, and insurance companies to develop methods of payments for uninsured patients with AIDS (Rosenberg, 1994). This kind of community partnership maximizes existing programs and creates opportunities for innovative approaches to the needs of patients and families

(Rosenberg, 1994). Expanding social services into community settings may increase the responsibilities of the medical social worker.

Post-Hospital Planning. Discharge planning, also called post-hospital planning, with patients and families is an important tasks of the medical social worker (Kerson, 1985). It is a complicated professional task that affects the quality of post-hospital care and the financial well-being of hospitals and patients (Proctor and Morrow-Howell, 1990). Patients and families often need to access support services beyond those offered at the hospital, and social workers fill the crucial role of resource persons. Needed support services may include meals, transportation, personal care, bathing, shopping and light housekeeping chores. These services often allow patients to stay in their home settings longer and help delay or avoid nursing home placements (Simmons, 1994).

Historically, the task of discharge planning involved two types of services: helping patients deal with their illness and preparing them for discharge while coordinating resources for continued care outside of the hospital (Rehr, 1984). According to Blumenfield and Rosenberg (1988), the task of discharge planning has expanded and now has three major parts.

> "The first provides social health services to complement medical treatment beginning at admission where possible and in at least the emergency room. The second encompasses the social health services normally provided during hospitalization. In the third part, post-hospital social health care and treatment services are included for those chronically ill patients and their families who are connected to hospital physicians or to hospital services" (p.39).

Ferren (1991) completed a study of the effects of early discharge planning on length of hospital stays. The study utilized an experimental design comparing length of stay for patients receiving early discharge planning to similar patients with no specific discharge planning protocol. Participants in the study included 432 medical patients from a southwestern medical center. This experiment tested the following hypothesis: discharge planning begun within 24 hours of a patient's hospital admission will facilitate a decrease in hospital length of stay by two or more days. The study found that when discharge planning began within 24 hours of admission, patient's length of stay in the hospital decreased by two days. Patients reported that the earlier the discharge planning process was implemented, the better their attitude was towards recovery. The difference in length of stay represented potential cost savings to all involved. Anticipating the two day difference in length of stay, hospitals could save a significant amount of money. For patients who do not have health care coverage or have inadequate insurance coverage, this decrease in stay provides a clear advantage to both the hospital and the patient (Ferren, 1991).

Preadmission Planning. Social workers today are faced with complex problems and play an expanded role in the planning process and coordination of services. Early case finding and preadmission planning for those at high-social risk will continue to be key functions (Rehr, 1984). This continues to be a task of the medical social worker (Blumenfield & Rosenberg, 1988). Early case finding and preadmission planning aim to identify, prior to admission or at admission, those patients who will be in need of services at time of discharge. For instance, a patient awaiting a scheduled admission to the hospital may have questions and needs ranging from what the hospital will be like to anticipated needs following hospitalization. According to

Blumenfield & Rosenberg (1988), a broad range of concerns related to impending hospital stay and post hospital planning can be addressed prior to hospitalization. Becoming involved before hospital admission does not necessarily increase the work load for the social worker, instead it requires a shift in the timing of their work from during hospitalization to before hospitalization (Blumenfield & Rosenberg, 1988).

Role of the Medical Social Worker

New knowledge and technology, new social designs and new services affect the social work role (Germain, 1977). These changes need to be acknowledged as they will impact each patient's medical care. Germain (1977), discusses four prescriptions for humanizing health care: action and decision making, self image, lifestyle, and information. These prescriptions also fit the professional purposes of medical social work, influence its roles and functions, and shape its practice domain.

Prescription number one refers to opportunities for action and decision making power for patients. When patients are admitted to the hospital, they may lose some of their sense of identity by leaving their home and the environment that is the most familiar and comfortable. At admission time, patients also have to separate from friends, family and treasured possessions. Patients give up their previous roles and assume new roles, which are usually dictated by authority figures and strangers. It is part of the role of the medical social worker to assist patients in regaining some control. Germain (1977) states that something as simple as making a menu selection or choosing the time to eat can help the patient feel more in control.

The second prescription for humanizing health care requires health care professionals to respect the patient's sense of dignity. Patients need to be viewed as whole persons, not as objects. The ecological perspective supports

the importance of patient identity, dignity and self-image. The third prescription refers to respect for a patient's life-style and cultural values (Germain 1977). For instance, a patient who does not speak English may try to follow medical orders even though he/she may not understand them. It is the social worker's role to advocate for that patient's rights to understand what medical care is being provided. This may involve hiring an interpreter who can help the patient understand what is happening.

Germain's final prescription for humanizing health care is to provide an environment in which patients can access information about their medical condition. Research evidence indicates that patients cope with stress more effectively when they have information (Germain 1977). Patients require and deserve information related to their illness. The social worker can assist in providing needed information to patients and family members. According to Germain (1977), the above four prescriptions allow patients to maintain more control over the medical care that is provided to them.

Summary

This chapter reviewed the historical development of medical social work, the ecological framework, the location of practice, the tasks performed and lastly, the role of the medical social worker in the hospital setting. The next chapter will discuss the methodology of this study.

Methodology

Research Design

The research design of this study is exploratory in nature. It utilizes a combination of quantitative and qualitative information to answer the research question. The purpose of this research study is to explore the current roles and attempt to understand the future roles of the medical social worker in the hospital setting. This researcher used purposive sampling, a type of non-probability sampling (Rubin & Babbie, 1993). The research participants all belong to a professional organization and have knowledge about the research topic. The unit of analysis consists of individuals who are directors of hospital social work service departments and current members of the professional organization.

Research Question

The research question for this study was: How do directors of hospital social work service departments perceive the current and future roles of the medical social worker in the hospital environment?

Operational Definitions

Key terms for this research are: medical social worker, role, current, and future.

medical social worker- professional social workers employed in health care settings, primarily to provide for the psycho-social needs of patients and to alert other health care providers to the social needs of the patients (Baker, 1995).

role- a culturally determined pattern of behavior that is prescribed for an individual who occupies a specific status. A social norm that is attached to a given social position that dictates reciprocal action (Baker, 1995).

current- The time frame for questions asked about current practice is the year 1995.

future- The time frame for questions asked about future practice is the year 2000.

It should be noted that throughout this research project post-hospital planning is used interchangeably with the term discharge planning. Ambulatory care and outpatient services are also used interchangeably.

Sample Selection

The identified participants for this research project included directors of hospital social work service departments who practice in the state of Minnesota and belong to a professional organization, The Society of Social Work Administrators in Health Care. The public list of participants was obtained from the president of the Minnesota chapter (Appendix A). The sample subject population included 43 participants, ten males and thirty-three females. While, there was no intent to exclude anyone on the basis of gender or race from participating in this research project, this information was not collected to protect the anonymity of respondents.

Instrument Design

The questionnaire consisted of a combination of sixteen open-ended and closed-ended questions along with an opportunity for comments (Appendix B). The survey questions focused on medical social work in the hospital setting. The survey asked about respondents background such as educational level, years of medical social work experience, number of hospitals served, primary work performed, location of patient population served and staffing ratios. Respondents were also asked to identify current service delivery and expected service delivery for the year 2000, ranking of current and projected tasks, and to report on planning activities for the future.

Piloting of the survey for clarity was completed with three medical social workers, not eligible to participate, who have been directors of hospital social work departments in the past or have practiced in the medical social work for over fifteen years.

Protection of Human Subjects

This study has taken a number of steps to ensure protection of the subjects studied. The cover letter (Appendix B) mailed to the participants explained who the researcher was, the purpose of the research, and how the participants were selected. By completing the survey and returning it, the participants indicated consent to participate in the study. In the event a participant began to feel threatened, he/she could have withdrawn from the study or skipped any question at any time. Participants were informed that participation in this study would in no way influence their current or future relationship with Augsburg College or The Society of Social Work Administration in Health Care.

The participants were aware that there were no direct benefits or rewards from participating in this study. Lastly, participants were assured that their responses to the survey were completely anonymous and that all data would be kept private. Only the researcher had access to the completed surveys. All data were destroyed at the end of the research project. Prior to the initiation of the research, approval was granted by Augsburg College's Institutional Review Board-Project Number 95-14-2 (Appendix C).

Data Collection

A cover letter and survey were mailed to each of the participants. The cover letter explained the purpose of the research and instructed subjects in the completion of the survey (Appendix B). The data collection procedures were as follows: Surveys were mailed on November 27, 1995 and were

returned between November 30th and December 22nd, 1995. A reminder postcard was mailed on December 8, 1995. Surveys returned by December 22nd were included in the data analysis. A total of 36 questionnaires were returned for an 84% return rate. According to Rubin and Babbie, "A response rate of 70% is very good" (p. 340). Of the 36 returned surveys 35 met the criteria for the study and were included in the data analysis.

Data Analysis

Upon receipt of a returned survey, a number was assigned, which was used to identify a particular respondent throughout the analysis process. The questionnaire gathered both quantitative and qualitative data; the findings are presented in narrative form and illustrated with tables and graphs in the following section. Because of the small number of participants, the nature of the data analysis is limited to the use of descriptive statistics. Findings are reported in aggregate form so no individual respondent will be identifiable.

Comparative analysis was completed using on several key variables with cross tables developed. According to Weinbach and Grinnel (1995) cross-tabulation refers to the process of putting the values of two nominal level variables into a table. Using percentage "equalizes" the size of the two variables or groups thus allowing easier comprehension and comparison of findings (Weinbach & Grinnell, 1995). In order to interpret the relationships between variable in this study, the researcher utilized the Excel 5.0 program to compute cross-tables.

To conduct the content analysis, the responses for the open-ended question were indexed and then subdivided according to major themes, patterns and categories that emerged from the data. These were reported in tables and narrative form.

Study limitations

While this research study has many potential uses, it is necessary to examine the limitations as well. The survey developed for this research project was limited to sixteen questions which examine some of the issues facing medical social work. Surveys seldom develop the feel for the entire scope of a research project and may even feel superficial in the coverage of a complex topic (Rubin and Babbie, 1993). This particular survey asked directors about the role of the medical social worker in the hospital setting. If one were to survey direct practitioners one may find different opinions and findings.

The final limitation has to do with the lay out and development of the research instrument. The majority of the questions were quantitative, which resulted in more structured and less flexible responses than would have been the case with open-ended or qualitative questions. This hindered the respondent's ability to answer each question creatively and ultimately limited the amount of information provided to the researcher (Rubin and Babbie, 1993). Surveys generally are weak in the area of validity but they are reliable (Rubin and Babbie 1993, p353). Surveys, however, have two particular strengths as they relate to this research project. First, surveys are useful in describing the characteristics of a large population. Second, surveys can be self-administered and are beneficial for both descriptive and exploratory analyses (Rubin and Babbie 1993, p 351).

The specific method used to answer the research question has been outlined in this section. The participants of this research project were directors of hospital social work service departments who belonged to a particular professional organization. The subject population included 43

participants, ten males and thirty-three females. The following section will present the findings of this research.

Findings

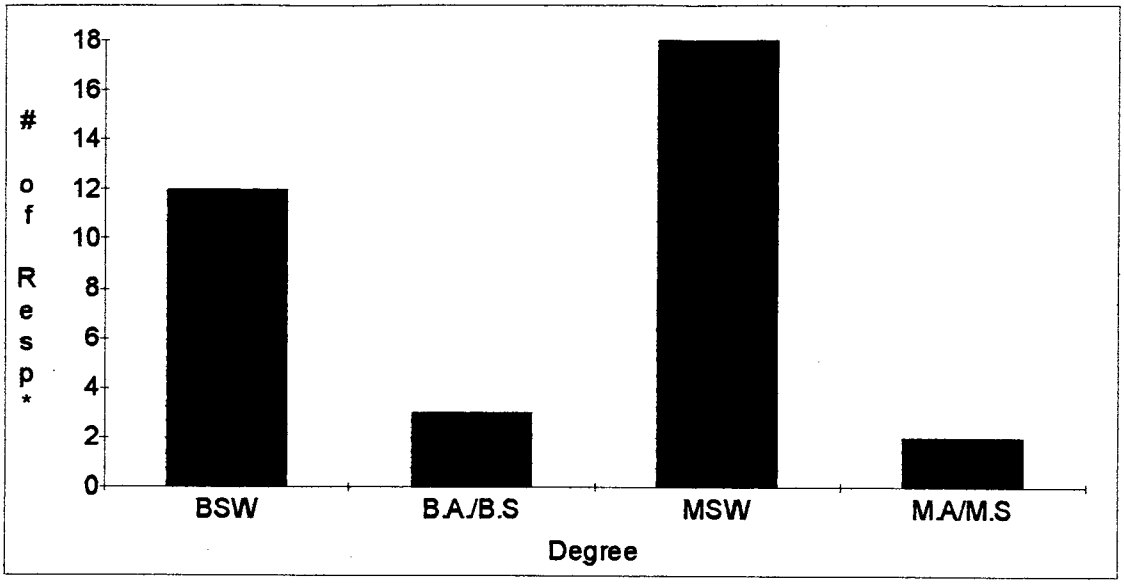
Of the 43 survey questionnaires mailed out, 36 were returned, and 35 were eligible for the research project. This resulted in an overall return rate of 84%, and a return rate of 82% for those who met the criteria for the research project. It must be noted that not all 35 participants answered all survey questions so the number of responses to each question of the survey varies. Questions on the survey related to staffing levels, years as a social work practitioner, and number of hospital beds did not yield useful data and will not be included in this section. Findings will be presented in the following order and categories: background information, population served, location of practice and tasks performed by the medical social worker. Qualitative findings including perceptions about hospital administrators' understanding and support of the medical social worker and directors preparations for the future. See Appendix B for a copy of the survey.

In order to further analyze the findings, cross-tabulations were performed to examine the relationship between educational level and years of experience. The researcher also examined location of patient population served related to differences in key variables such as directors education level, type of work performed and administrators understanding of the role of the medical social worker.

Background Information on Study Participants

Respondents were asked questions related to educational level, years of experience and type of work performed in order to describe and understand the survey respondents.

Respondents were asked to identify their highest level of education. Five main categories were provided, as well as an "Other" category. Respondents were instructed to check only one. As noted in Figure 1, 12 (34%) have a BSW; 3 (9%) hold a college degree in something other than social work, including family environment, psychology and sociology. Eighteen (51%) have an MSW; and 2 (6%) reported having a master's degree in human services and health care administration and counseling.



* Number of Respondents

Figure 1

Educational Level of Directors
N=35

Respondents were asked to identify their years of experience as directors. Five main categories were provided. As indicated below, 11 (34%) report that they have been directors between 0-5 years; 10 (30%) report they have been directors between 6-10 years; 5 (15%) report they have

been directors between 11-15 years; 5 (15%) report they have been directors between 16-20 years; and 2 (6%) report they have been directors for 21 years plus. Two of the respondents chose not to answer this question.

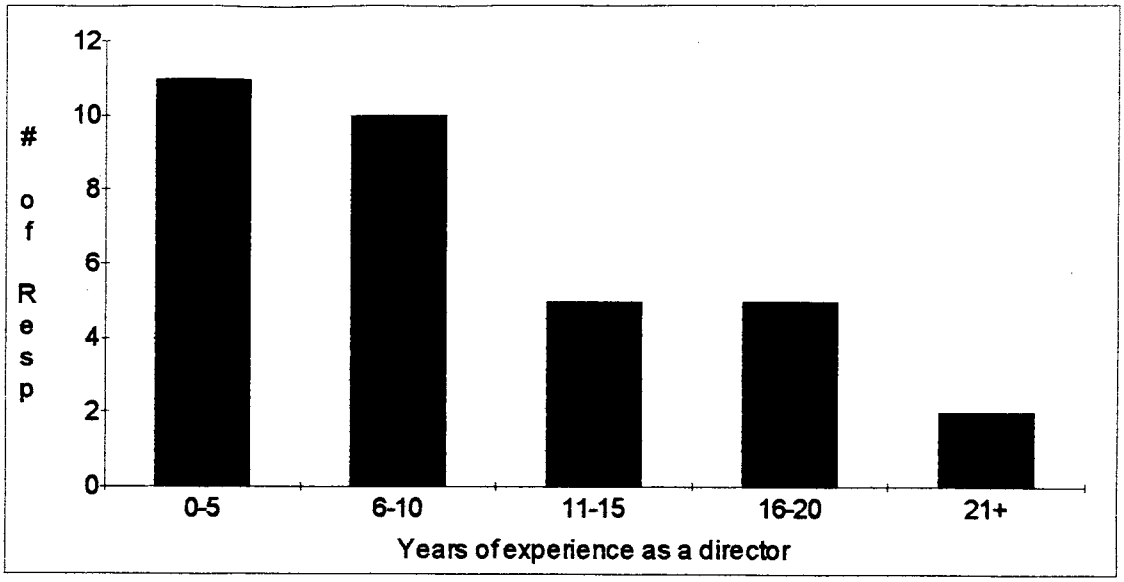


Figure 2

Number of Years as a Director

n=33

Table 1 illustrates a cross tabulation that examines the relationship between the educational level of the directors and years of experience as a director. As illustrated, the majority of the directors who have less than 10 years of experience have an MSW, compared to only 2 MSW directors who have been directing over 16 years.

Table 1

Education Level of Directors by Years of Experience as a Director
N=35

Yrs of Exp.	BSW	BA/BA	MSW	MA/MS	Total
0-5 yrs	3	2	6	-	11
6-10 yrs	3	-	6	1	10
11-15 yrs	1	-	4	-	5
16-20 yrs	4	-	1	-	5
21 + yrs	-	-	1	1	2
Total	12	2	18	2	33

Table 2 identifies the number of hospitals served by respondents. Thirty-two (91%) of the respondents serve one hospital; 2 (6%) serve two hospitals; and 1 (3%) serves three hospitals.

Table 2

Number of Hospitals Served
N=35

Number of hospitals served	n
1	32
2	2
3	1

When asked to describe the primary type of work they provide as directors, three categories were provided: administrative, direct service and combination of both administrative and a direct service. Respondents were instructed to check only one. Results are illustrated in Figure 3.

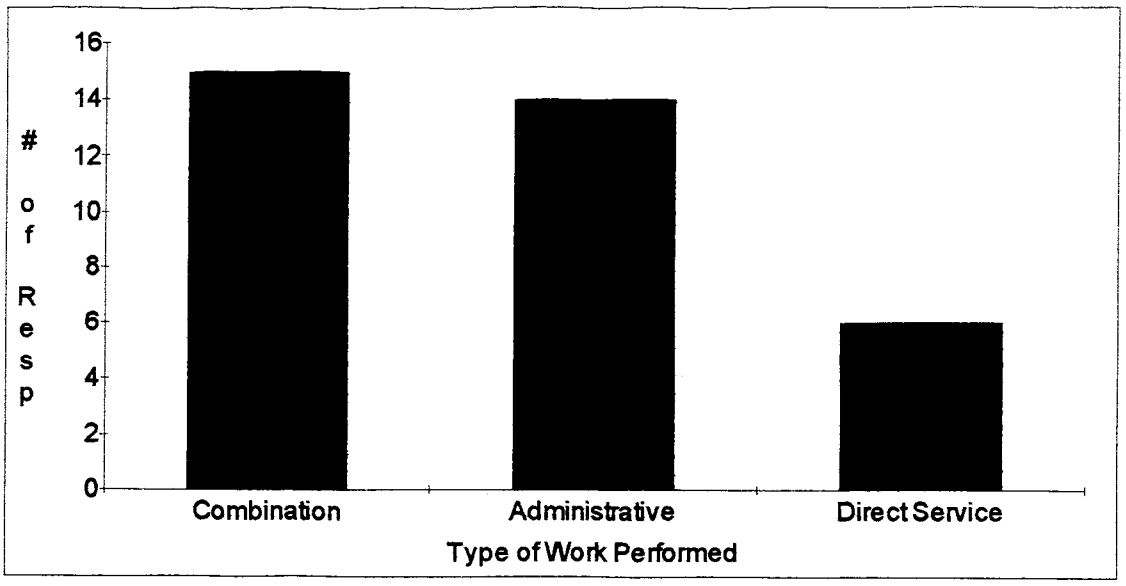


Figure 3

Primary Type of Work Performed
N=35

Population Served

Figure 4 illustrates the primary location of patient population served. Directors were asked to identify the location of patient population served by indicating rural, urban, and suburban. Seventeen (49%) serve mainly rural patients; 11 (31%) serve mainly urban patients; and 7 (20%) serve mainly suburban patients.

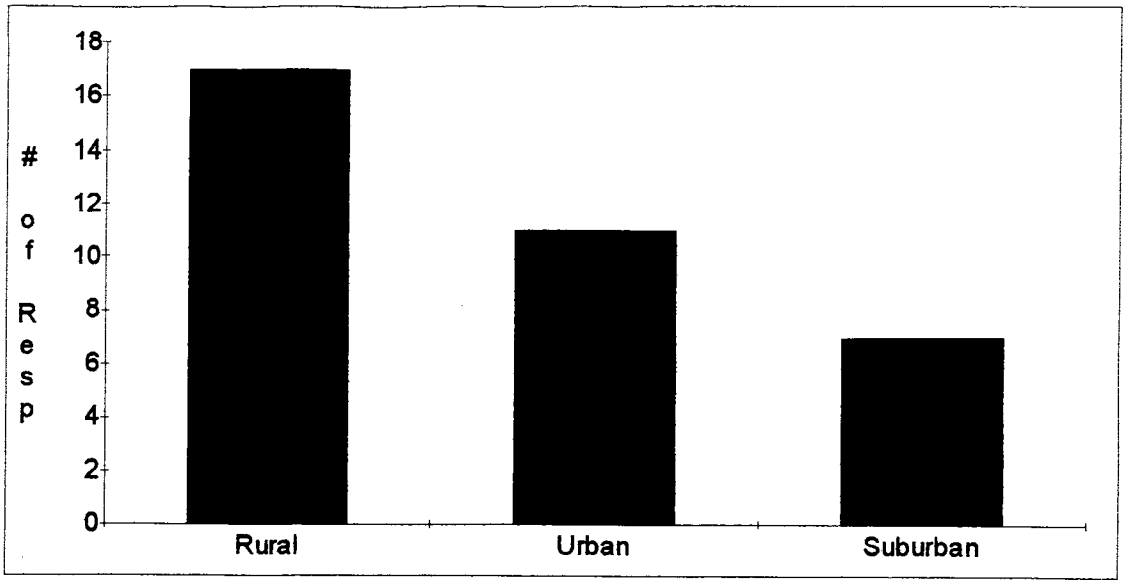


Figure 4

Primary Location of Patient Population
N=35

Table 3 shows the relationship between patient population served and level of education of the respondents. Of those respondents with social work degrees who serve mainly rural patients, seven (58%) have BSW's and five (42%) have MSW's. All directors who practice in the urban and suburban setting either have an MSW or a BSW.

Table 3

Location of Patient Population Served by Respondents Level of Education
N=35

Ed level	Rural	Urban	Suburban	Total
BSW	7	3	2	12
BA/BS	3	-	-	3
MSW	5	8	5	18
MA/MS	2	-	-	2
Totals	17	11	7	35

As indicated in Table 4, a majority of the respondents who serve mainly a rural population provide a combination of both administrative duties and direct service. Those who serve urban and suburban populations primarily perform administrative functions.

Table 4

Location of Patient Population Served by Respondents Primary Type of Work
N=35

Primary Work	Rural	Urban	Suburban	Totals
Combination	10	3	2	15
Administrative	2	8	4	14
Direct Service	5	-	1	6
Total	17	11	7	35

Staffing Ratios

Table 5 identifies the number of MSW's who practice in the hospital settings reported by directors who serve only one hospital. One-third of the directors reported no MSW's on their staff and another 9 (29%) have 1 MSW on their staff and 4 (13%) have 2 MSW's on staff at their hospital.

Table 5

Number of Social workers with their MSW
n=31

Number of MSW's	n	percent
0	10	32
1	9	29
2	4	13
3-10	3	10
11-15	1	3
16-20	1	3
21-28	3	10

Table 6 identifies the number of BSW's who currently practice as medical social workers in the hospital setting. The number of BSW's are included only for those who serve one hospital. One (3%) director reported have no BSWs on staff. Twelve (37%) of the directors reported having 1 BSW on staff and 5 (16%) have 2 BSW's on staff at their hospital.

Table 6

Number of social workers with their BSW
n=32

number of BSW's	n	percent
0	1	3
1	12	37
2	5	16
3-5	6	19
6-10	5	16
11-17	3	9

Respondents were asked to identify the minimal educational level needed to practice medical social work in the year 2000. Three main categories were provided: MSW, BSW and "Other". As indicated in Figure 5, 6 (19%) of the respondents reported that by the year 2000 medical social workers will need at least an MSW to practice in the hospital setting. Twenty-six (81%) reported that a BSW would be adequate to practice in the hospital setting. Three of the respondents chose not to answer this question.

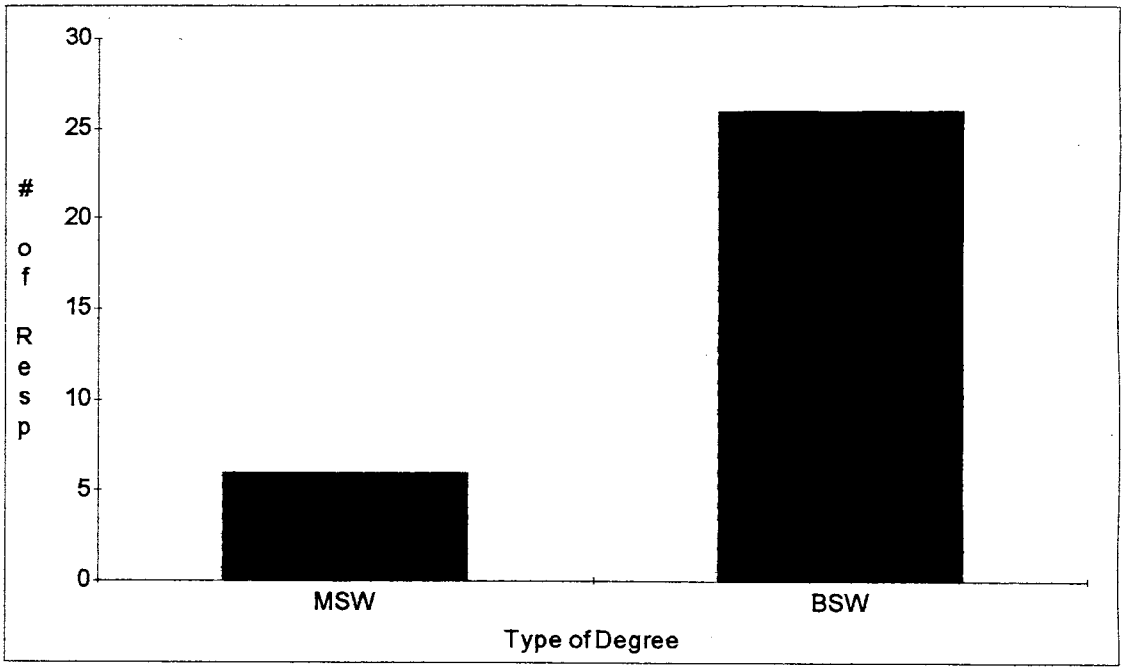


Figure 5

Minimal Educational Level of Medical Social Workers in the Year 2000
n=32

Location of Practice

Practice locations were organized into inpatient and outpatient services. The following section examines the current and expected provision of medical social work services. Inpatient areas include: obstetrics and nursery (OB/Nur), medical, surgical, oncology, pediatrics (peds), chemical dependence (C.D.), orthopedics, Intensive Care Unit (I.C.U.), mental health and neurology. Out patient areas include: Emergency room (E.R.), after-hours coverage in the hospital, on-call, community setting, same day surgery (S.D. Surg), outpatient rehab and physicians clinics.

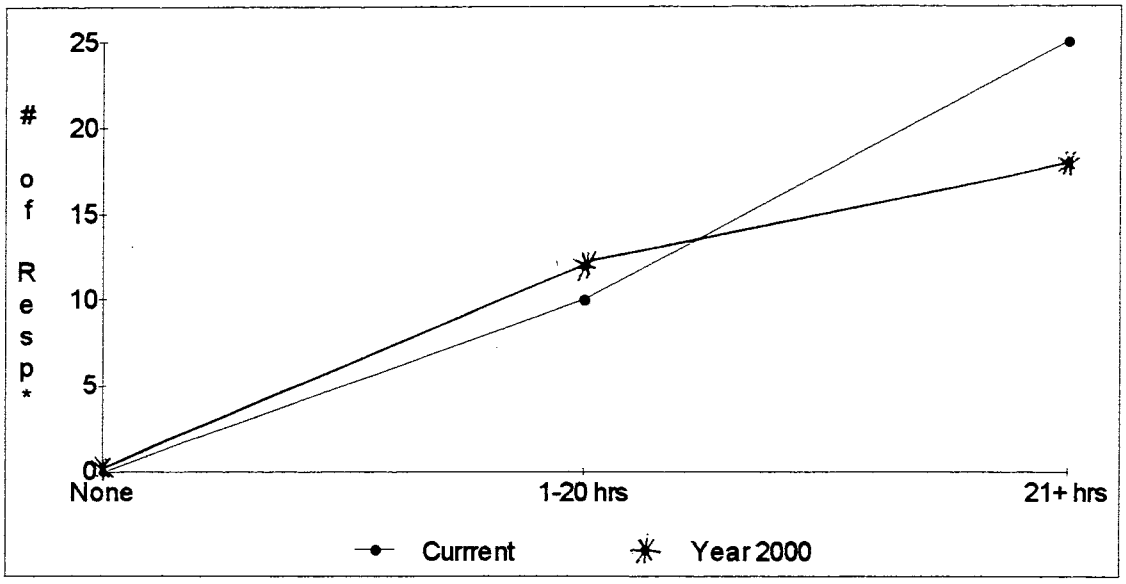
Data are presented for responses related to current inpatient service delivery and expected inpatient service delivery for the year 2000. Findings are presented by the number of hours per week reported by social service directors. Categories include: none, 1-20 hours, and 21+ hours. Findings compare total responses for each category and are not person-specific. Tables 7 reports the findings related to inpatient settings.

Table 7

Use of Medical Social Work Services in inpatient settings: Current and Year 2000

	Current Use			Use -Year 2000		
	None	1-20 hrs	21+ hrs	None	1-20 hrs	21+ hrs
OB/Nur	5	21	7	4	16	7
Med	0	10	25	0	12	18
Surg	3	12	19	2	13	15
Oncology	11	8	15	8	12	8
Peds	7	17	6	8	13	5
C.D.	22	8	5	17	15	1
Ortho	5	15	12	3	11	13
I.C.U	2	20	9	2	16	9
MentalHlt	15	5	11	11	7	10
Neuro	16	7	8	14	7	6

In Figure 6 and 7, the researcher has highlighted two inpatient areas and illustrated the findings in graph form, the areas include: medical and surgical. The researcher choose these areas because they appeared to represent an overall trend for the inpatient settings.



* Number of Respondents

Figure 5
Use of Medical Social Work Services Currently and for Year 2000 on Medical Units

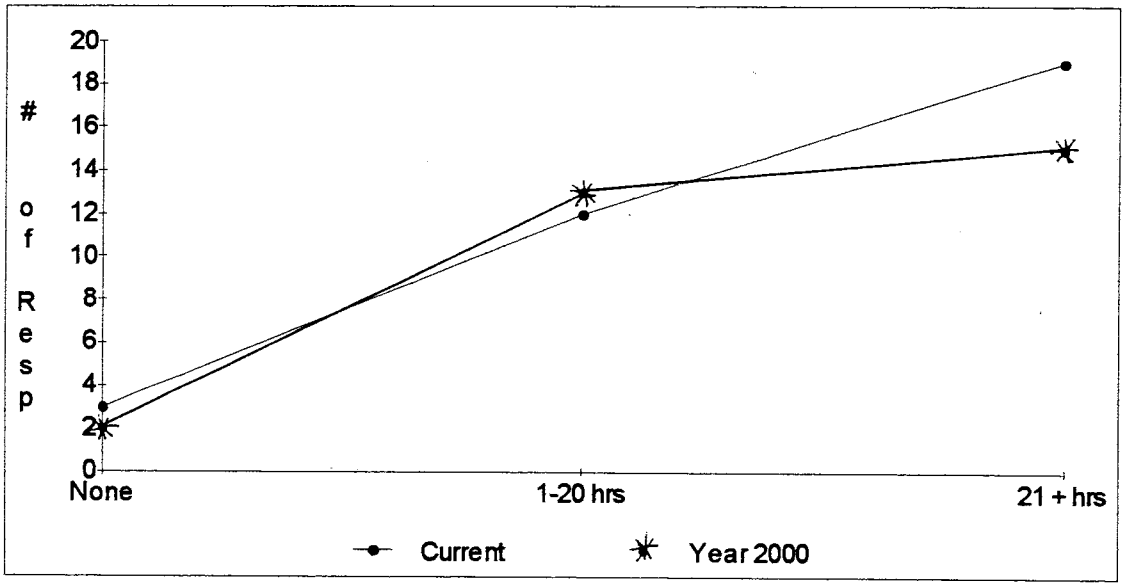


Figure 7
Use of Medical Social Work Services Currently and for Year 2000 on Surgical Units

Data are presented for responses related to current outpatient service delivery and expected outpatient service delivery for the year 2000, findings are presented in Table 8. Findings are presented by the number of hours per week reported by social service directors. Categories include: none, 1-20 hours, and 21+ hours. Findings compare total responses for each category and are not person-specific.

Table 8

Use of Medical Social Work Services in Out patient Settings: Current and Year 2000

	Current Use			Use-Year 2000		
	None	1-20 hrs	21+ hrs	None	1-20 hrs	21+ hrs
E.R.	3	25	4	2	19	7
After-hrs	12	15	5	7	18	3
On-Call	15	14	3	5	18	6
Com.Set.	25	6	1	9	15	7
S.D. Surg	3	28	1	1	24	5
OPRehab	14	16	2	6	19	4
Clinics	8	20	4	3	17	10

The researcher has highlighted two outpatient areas and illustrated the findings in graph form, the areas include: on-call and community setting. The researcher choose these areas because they illustrate increase in hours needed for outpatient areas.

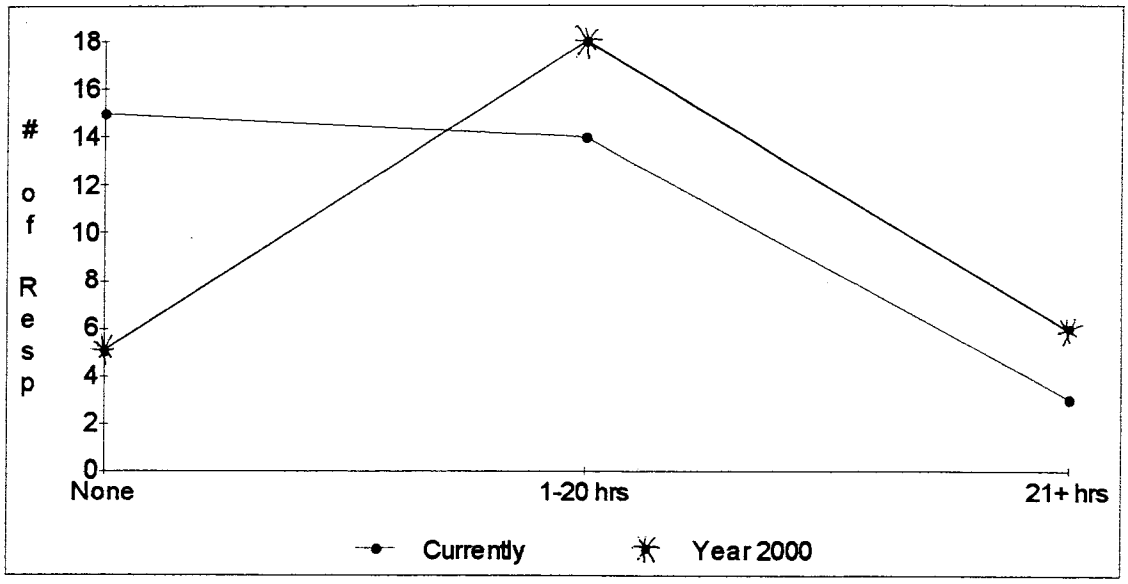


Figure 8
Use of Medical Social Work Services Currently and for Year 2000 for On-Call Coverage

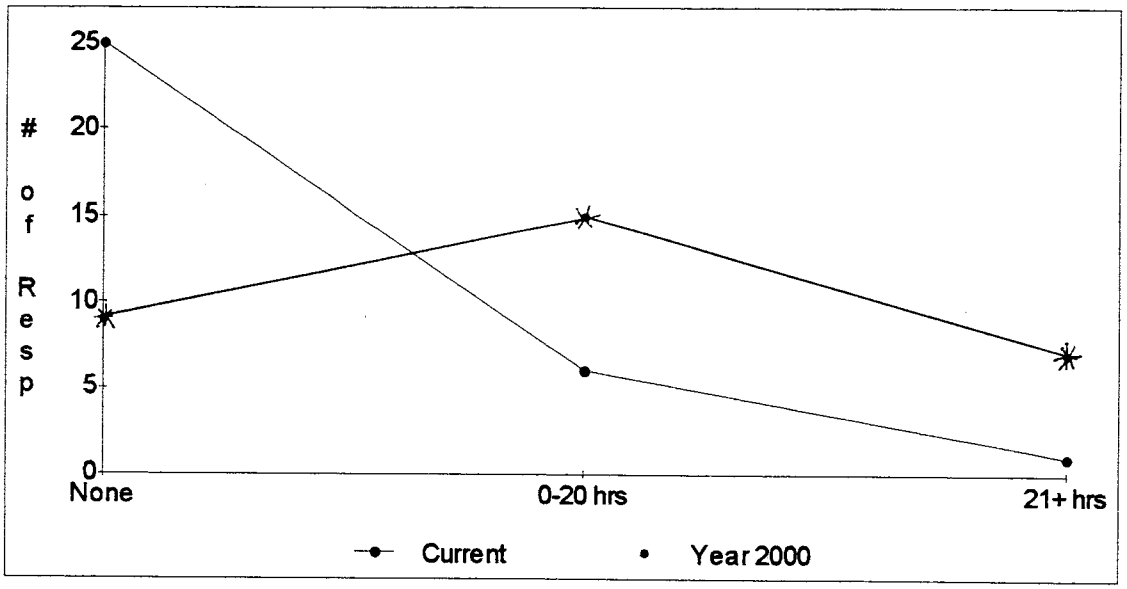


Figure 9
Use of Medical Social Work Services Currently and for Year 2000 for the Community Setting

Tasks of the Medical Social Worker

Tables 9 & 10 present priority ranking of medical social worker tasks. Six common medical social work tasks were identified and respondents were asked to rank them in order of importance---1 being most important and 6 being least important. The question was repeated for both current and year 2000. As illustrated in Table 9, currently 25 (86%) of the directors ranked post-hospital planning as the most important task; information and referral was selected as the second most important task by 13 (45%) respondents; 12 (41%) of the directors ranked counseling and support as the third task and 8 (28%) ranked preadmission planning as the fourth task.

Table 9

Current Ranking of Tasks Performed by Medical Social Workers

n=29

Tasks	Current-Ranking of Tasks Ranked 1	Ranked 2	Ranked 3	Ranked 4
Post-Hosp plan	**25**	4	0	0
Inf & Ref	1	**13**	10	2
Counseling	1	7	**12**	6
Preadm plan	0	2	2	**8**

Table 10 addresses ranking of medical social work tasks for the year 2000. As shown in the table, 15 (58%) of the respondents ranked post-hospital planning as the number one task; 10 (39%) ranked preadmission planning as the second most important task, a shift from fourth place in Table 9; 9 (35%) ranked information and referrals third and 10 (38%) ranked counseling and support fourth. Community planning and "other" were listed as the last two tasks by hospital directors in Tables 9 & 10. There was no pattern in what was reported as "other" examples include: hospital team planning, assessments, finances, treatment planning and patient education, reporting of vulnerable adults and child abuse, community planning and coordination.

Table 10

Ranking of Tasks Performed by Medical Social Workers for the Year 2000 n=26

Tasks	Year 2000-Ranking of Tasks Ranked 1	Ranked 2	Ranked 3	Ranked 4
Post-Hosp plan	**15**	4	5	0
Preadm plan	7	**10**	3	1
Inf & Ref	1	7	**9**	6
Counseling	1	2	5	**10**

Role of the Medical Social Worker

Respondents were asked if administrators in their hospital understand the role of the medical social worker. Twenty-five (72%) reported Yes; 5 (14%) reported No; and 5 (14%) reported Unsure. A comparative analysis of patient population served by administrators' understanding of the role of the medical social worker is illustrated in Table 11. Seven (41%) of the rural directors reported "no" or "unsure" about their administrator's understanding of the role of the medical social worker. Fifteen of the urban and suburban directors reported that their administrators understood the role of the medical social worker.

Table 11

Location of Patient Population by Administrators Understanding of the Role of Medical Social Worker
N=35

Understand Role	Rural	Urban	Suburban	Total
Yes	10	10	5	25
No	4	1	-	5
Unsure	3	-	2	5
Total	17	11	7	35

Administrations Stance on Changes in Health Care as Related to the Future of Medical Social Work

When asked if administration was taking a proactive stance on changes in health care as it relates to the future of medical social work in the hospital setting, 21 (68%) reported "Yes" and three main themes emerged from their explanations. Eleven (53%) of the respondents cited the expansion of service area and location of practice; 4 (19%) noted that the social service department was part of the health care team and 3 (14%) reported that administrators were seeking out opportunities for producing revenue for the social work services provided.

Table 12

Proactive Stance by Administration
n=18

Major Themes	n	percent
Expansion of services	11	53
Health care team	4	19
Producing revenue	3	14

Examples of answers addressing the importance of **expanding the service area and the location** of practice include:

> "They have agreed to expand to home care and increase hours in hospice....We are researching the need for social services in clinic settings....We are expanding our services to include more out-patient programs as well as on-call coverage and more services to the emergency department....We are doing more phone assessment to clinics....We are reaching out in the community setting to improve the health status of the community....Actively shifting staff to change

sites of care and have begun reengineering of services....Social workers are now doing family health assessments in homes."

Those who reported that administration viewed the social service department as an important **member of the health care team** commented that:

"Administration backs the positioning of social work staff as an integral member of the treatment team in the hospital....Social workers are critical to quality of care....Administration believes it is important for social services to be involved in both short-term and long-term planning committees."

Illustrations of how hospital administration identified **revenue-producing opportunities** for the social work department included:

"Billing for social work services, especially in out-patient areas....We are working with third party payers....Administration is open to considering revenue-producing opportunities for the department."

Non-Proactive Stance by Administration

Ten (32%) of the directors reported that their administrators were not taking a proactive stance regarding the future of medical social work. In the explanation of their responses, three main themes emerged from the data: five of the directors indicated that administration was proactive in health care but did not focus much attention on the social service department; three reported that social service departments were being decentralized into other departments within the hospital; and two identified that administration was decreasing the hours for social work services.

Table 13

Non-Proactive Stance by Administration
n=10

Major Themes	n	percent
Other areas of focus	5	50
Decentralizing s.s dept.	3	30
Decrease of hours	2	20

Those who reported that administration **does not focus much attention on the social service department** said:

> "I believe no attention will be given to the future of social services until I make it an issue....We are a small hospital and we are progressive with health care reform overall in the hospital setting, but not specifically to the social service department....Administration would consider this my job and would work with me."

Illustrations of how hospital administrators are **decentralizing** social service department include:

> "Decentralizing all social workers to the care centers at which they work and answer to nurse management....I feel nursing will be doing social services in the future....We no longer have a department. We have no decision making power or no power to take action as a group. We meet as a group one time a month for one hour to review one case and discuss resources, that is all that is allowed. If we have any concerns, we each have to take them individually to our care center directors (nursing) for resolutions."

Comments regarding **budgetary cuts** in social services include:

"Administration is cutting social work service hours and eliminating the social work department....Hours threatened and human resource director is empowered to cut as he does not understand our role. He does not support graduate school and undermines our preparation for the future."

Preparation for the Future

Respondents were asked to describe what they had done to prepare for the future. Six main themes emerged from the data. Nine (27%) of the 33 respondents indicated that they have prepared for the future by adjusting location of social work practice; 6 (18%) identified changes in staffing patterns; 5 (15%) reported that they had investigated reimbursement for services; 5 (15%) indicated the importance of increasing their education and knowledge base; 5 (15%) reported the increase of technology as it related to their jobs; and 3 (10%) identified the importance of an interdisciplinary team approach.

Table 14

Preparation for the Future by Social Work Directors
n=33

Major Themes	n	percent
Adjusted Location of practice	9	27
Changes in staffing patterns	6	18
Reimbursement issues	5	15
Education	5	15
Technology Improvement	5	15
Interdisciplinary team app.	3	10

Those who reported a **shift in the location of practice** commented that:

> "We have increased our services to seven days a week in order to provide better coverage and begin discharge planning earlier....A future goal is how to be more involved in clinics and ambulatory care settings....Proactive in planning to meet patient needs inside and outside of the walls of the hospital. We currently are staffing the emergency department and provide on site coverage over the weekend....Beginning to move to a community focus."

The **staffing of social workers** was discussed by directors as a way to prepare for the future. Examples include:

> "We will be hiring two additional MSW's to expand our focus....Use a staff mix of different levels of MSW's, BSW's, and paraprofessionals support staff....Our department is cross training social workers to work in a variety of acute settings....We are looking to add staff."

When preparing for the future, directors also identified **reimbursement of services:**

> "Understanding reimbursement practices....Establish productivity expectations and cost per hour....Identifying social work contributions to the hospital fiscal health....Developed strong relationships with HMO's and managed care groups....Moved staff to ambulatory care settings as much as possible and billing for services."

Education and increasing the knowledge base of social workers were identified by 5 respondents:

> "Improve competency and increase sensitivity to diversity....Our existing expertise in family and community had prepared us well for the significant move from primary care to more of a case management focus....Review of current literature....Attend conferences....Continue to broaden knowledge base....One of us has an MSW and the other was accepted into graduate school."

Illustration of how **modern technology** has affected social work practice include:

> "We monitor social work outcomes by using a computer....Use of computers and network accessing are becoming more important and available to social workers....We are also working on computerized care plans....Use computers to support clinical practice."

The importance of becoming a **team player** with other health care professionals was identified:

> "We are part of an interdisciplinary team that is looking at managed care....We have tried to make our "interdisciplinary team" role apparent to administration....We have taken a leadership role in developing a team approach to patient care."

Comments/Thoughts

The final section of the survey asked respondents for any additional comments or thoughts not covered in the survey. Two main themes appeared: funding issues and status of current and future practice issues.

Examples of answers addressing **funding issues** include:

Being a non-revenue producing department (except in home care) is definitely a problem--although administration values social services they are reluctant to increase hours of coverage.

If health care is delivered by payer controlled integrated networks, social workers will need to be represented at all service points along the continuum of care to be effective. We will also have to demonstrate cost effectiveness to survive.

Funding for graduate school is a major concern I am hopeful we might move to Ph.D.'s in social work.

Those who reported a **change in the status of current and future practice issues** commented that:

Hospital based medical social work is a fast-paced career with poor compensation. I feel overwhelmed with the expectation of direct services and administrative responsibilities. Health care reform is making a huge impact on hospital settings, and all departments are feeling it. I'm looking for better days in Year 2000.

To add to my comments about smaller hospitals and more community based practices, I do not necessarily see the current hospital social workers doing that. In our system, for example, there are also social workers in clinics, home care, and the health plan. I would expect those practices to grow. They are now separate from us, but our jobs are linked with theirs.

Most of the services will be provided in community, home, outpatient clinics NOT INPATIENT.

Care is shifting to ambulatory care centers and prevention.

Our health care environment is changing so fast year to year we do not even do five year strategic planning anymore. I do think hospitals will

be much smaller. Much of what is now done in the hospital will be done in community settings.

The following chapter will discuss key findings in relationship to the research question and the literature.

Discussions and Implications

Overview

This chapter will cover the limitations of the study. Key findings will be highlighted and discussed as they relate to educational level, administrative support and type of work performed by the medical social worker. The researcher will also discuss the impact of current and projected location of practice and tasks performed by the medical social worker. Implications for practice, policy, and research will conclude the chapter.

Study Limitations

The primary limitation involved the selection of participants. The researcher chose purposive sampling, which determines a group of people to sample based on their knowledge and expertise in an area (Rubin and Babbie, 1993). This sample is not representative of hospital social work directors in Minnesota or the nation as a whole. Due to time and financial considerations, the invited sample only included those directors who are members of The Society of Social Work Administrators in Health Care. Because of the affiliation with the organization, many of the members surveyed may be of like minds and therefore limit the variety of responses. The sample selection process and the low number of participants (N=35) do pose a threat to the external validity of the study.

Another limitation is that the researcher just surveyed directors of hospital social service departments. The researcher could have surveyed social workers who provide direct practice or other health care professionals, about the role of the medical social worker. Any additional data obtained would be helpful and should be considered for further research.

A final limitation of this study is that the researcher did not triangulate measures. The survey was the only tool used to collect information. Using additional tools, such as in-depth interviewing and field observation could have increased the internal validity of this study. According to Rubin and Babbie (1993), triangulation of measures would have resulted in more credible data.

Key Findings and Comparison of Findings with Literature

Education

It was not surprising that the majority of the directors held either an MSW or a BSW as their highest degree. As illustrated in Table 3, all of the urban and suburban directors have a social work degree. This finding suggests that to be a director of a hospital social service department most hospitals require a social work degree.

The researcher expected that the majority of directors who have an MSW practice in urban or suburban areas. The comparative analysis in Table 3 illustrates that less than one-third of the directors who serve the rural population have MSW's compared to almost 75% of directors who serve urban and suburban populations. Administrators may prefer to hire MSW prepared directors in the urban and suburban settings due to the number of social workers each director needs to supervise. For example, one director reported that he/she supervises a total of 40 social workers. Supervising such a large department requires management and supervisory skills which may require a higher level of education (Levin & Herbert, 1995).

Another reason for the difference in the education level may be due to the lack of graduate programs in social work in rural communities. In the Twin Cities Metropolitan Area, there are three MSW programs which allow more opportunities for social workers to pursue graduate education.

Another interesting finding is illustrated in Figure 5. Most of the hospital directors indicated medical social workers will need at least a BSW to practice in the hospital setting in the year 2000 compared to only 19% who reported the need to have a MSW. According to Levin & Herbert (1995), considering the current fiscal constraints throughout the health care system, hospitals may be pressured to hire social workers who cost the least amount of money. BSW's may meet this criteria based on salary compared to MSW's. Although this was a closed-ended question, some respondents commented on the questions; examples included: "An MSW will be needed and is on the horizon, but not by the Year 2000... Difficult to say, hospitals may not want to pay for a masters level people. However, third party payors may require it...Primarily MSW's, however, some services could be provided by experienced BSW's...MSW will be the minimum in some jobs."

Primary Type of Work

As reported in Figure 3, another key finding is that the majority of hospital directors provide either "administrative duties" or "combination of administrative and direct services" as the primary type of work performed in their hospital settings. A comparative analysis was completed on the type of work performed as it relates to the location of patient population served. This researcher speculated that social workers who practice in rural settings essentially provide a combination of administrative and direct practice services. Table 4 reports that most directors who serve patients in rural communities find themselves providing both administrative duties and direct service. This is most likely due to the small number of social workers who are needed in rural, community based hospitals. Therefore, directors need to perform both duties.

In contrast to directors in rural areas, those who practice in suburban or urban settings focus primarily on administrative tasks. Directors who manage and supervise large social service departments need to concentrate more on the administrative aspect of their job. In addition, directors in urban and suburban settings may be more involved and active in committees and community initiatives as part of their administrative duties.

Location of Practice

Respondents were asked to report current and projected location of practice and hours of services per week for their hospitals. Most respondents reported that the location of practice and hours of services per week will change by the year 2000, particularly in outpatient settings. For example, in Table 8 and Figures 8 & 9, respondents reported that in the Year 2000 there will be an increased need for social work coverage in community settings and for on-call coverage in the hospital.

There did not appear to be a major change in the expected hours of service to be provided in the inpatient setting. Table 7 and Figures 6 & 7 show that hours of service per week on medical and surgical units remained relatively stable for both current and future time frames. The majority of the directors reported that hours of service in the inpatient setting might decrease slightly for the year 2000.

These findings are consistent with the existing literature. A shift is occurring and patient care is moving from inpatient settings into outpatient settings. In the future, the outpatient hospital setting is likely to be one of the locations for social work practice (Simmons, 1994; Blumenfield & Rosenberg, 1988; & Rosenberg, 1994). As indicated by Simmons (1994), there are rapid changes in the delivery and location of health care services that will affect the practice of social work in the hospital setting.

Tasks of the medical social worker

Hospital social service directors were asked to rank, in order of importance, tasks performed by medical social workers currently and for year 2000. It was not surprising that the directors chose post-hospital planning, also called discharge planning, as the most important task for the medical social worker currently and in the year 2000. Proctor and Morrow-Howell (1990) agree that discharge planning is an important task of medical social work. The existing literature also indicates that post-hospital planning is a complicated task which affects the quality of patient care and the financial well-being of hospitals (Kerson, 1985; Proctor and Morrow-Howell, 1990). The findings of this research project suggest that discharge planning will be as critical to social workers in the Year 2000 as it is currently.

As illustrated in Table 10, hospital directors ranked preadmission planning as the second most important projected task for the year 2000; this is compared to its fourth place ranking currently. Blumenfield & Rosenberg (1988) discuss the importance of preadmission social work consultation to patients. They suggest that hospital social service departments develop a preadmission screening program. "In specialty areas, the social worker can develop high risk criteria which can be used by physicians and their office staff to identify patients in need of service. The relationship and work can begin prior to patient's hospital stay"(Blumenfield & Rosenberg, 1988, p.42). Concerns about hospitalization and discharge planning, discussed early in the process, may lessen the anxiety level for patients and their families.

Role of the Medical Social Worker

Another key finding relates to how hospital administrators understand the role of the medical social worker. The majority of the respondents reported that their administrator understood the role of the medical social

worker. It is important that administrators understand the practice of medical social work because they often make budgetary decisions which impact the department.

A comparative analysis (Table 11) illustrates how administrators' understanding of the role of the medical social worker related to the location of patient population served in the hospital setting. Findings indicated that the majority of urban and suburban hospital social service directors reported their administrators understood the role of the medical social worker. However, 41% of hospital directors who serve patients from rural communities reported that their administrators either did not understand the role of the medical social worker or were unsure if their administrator understood the role of the medical social worker. The amount of support received from administration may depend on who the director reports to. For example, in some hospitals the director may report to the vice president of patient care and in others the vice president of operation. It is important that the director reports to an administrator who understands the role of the medical social worker.

Rural administrators may not understand the role of the medical social worker because rural hospitals have small social service departments and social workers fill both direct service and administrative functions. This finding is illustrated in the Table 4 titled, Location of Patient Population Served by Respondents Primary Type of Work. This double role may leave less time to promote services and educate administrators about the role of the medical social worker. Social workers in the rural setting may perform a number of different duties, and therefore, their roles may not be as clearly defined or as easily articulated as those who practice where the social service director is primarily an administrator. Rural social workers may also be more

isolated and have less support than those who practice in the urban or suburban settings (Davenport & Davenport, 1995). Networking and collaborating with other professionals through organizations like the Society of Social Work Administrators in Health Care may be beneficial.

Administration Support and Preparation for the Future

Directors were asked if their administrators were taking a proactive stance on health care as it related to the medical social workers. The majority of the directors responded "yes" to the question. Expanding the service area and location of practice were explanations given most often. Directors were also asked what they had done to prepare for the future, the findings are reported in Table 14. Adjusting the location of practice was reported by the majority of directors. Simmon's (1994) findings indicate that the inpatient hospital setting will not continue to be the primary location for social workers to practice. The findings reported in this thesis are consistent with Rosenberg (1994) and Simmons (1994) who support the idea of developing support services, such as social services in ambulatory care settings and physicians clinics. Interdisciplinary team approach was also mentioned as a theme by the directors. It is crucial that health care professionals understand each others' roles and duties, for example, being aware of what duties are shared and what duties are unique to each profession.

Recommendations for Future Policy, Practice and Research

Policy

It is important for medical social workers in the hospital setting to be involved in the political arena on the local, state, and national levels (Germain, 1983). Medical social workers should become involved early in the design of legislation so they can assist in developing state and federal policies (Kerson, 1985). Political activity is organized through professional

organizations such as the Society of Social Work Administrators in Health Care. Being part of an organization gives medical social workers an opportunity to voice collective concerns related to changes in the delivery of health care services. In these ways, medical social workers can take initiative and be directly involved in the latest trends in health care by lobbying for new policies. It may also be beneficial to collaborate with other health care professionals, such as nursing and physicians when advocating for changes in the political arena. Recently, in the state of Minnesota, concern about the short stays for maternity patients was addressed with a legislative mandate. Insurance companies are required to pay for 48 hour stay for normal vaginal deliveries and 96 hour stay for cesarean sections, Minnesota Statute, Section 1 62A.0411-Maternity. This was achieved by collaborative efforts of healthcare workers and patients advocating for new mothers.

Medical social workers can advocate for changes in areas such as location of social service practice, insurance reimbursement of social services, and the importance of furthering education. This can be done through identifying and documenting unmet needs and sharing information, such as the findings of this study with hospital administrations, government officials and other health care professionals. Social work directors or social workers in direct practice have first hand knowledge about the impact of changes on patients and families. Collecting and organizing this knowledge for presentation allows them the opportunity to advocate for and shape service delivery.

Research

Modifications could be made to the current study that would be useful for further research. It would be interesting to replicate the current study using a larger sample of hospital directors. As mentioned in chapter three,

not all hospital social service directors were included in this study, only the directors who belong to the Minnesota Chapter of The Society of Social Work Administrators in Health Care. It would be beneficial to survey all directors in the state of Minnesota and examine and compare their views about the role of the medical social worker. The study could also be expanded to focus on a region of the United States or the entire country by surveying the national organization of The Society of Social Work Administrators in Health Care. A random sample of a larger population would allow the researcher to gather more data and make a stronger case for the view points expressed. The researcher could develop a better understanding of what is occurring in the field of medical social work and explore similarities and differences in the roles and tasks of the medical social worker based on a larger geographic area.

Lastly, a researcher could survey other health care professionals about the role of the medical social worker and tasks performed in the hospital setting. Physicians, nursing staff and hospital administrators may perceive the role of the social worker very differently than do directors of social service departments. A study conducted by Cowles and Lefcowitz (1995), focused on the role of the medical social worker in addressing health-related patient problems.

Practice

Medical social workers who practice in a hospital setting are faced with a number of challenges in the changing health care climate. As additional information is compiled and analyzed, directors of hospital social service departments, along with medical social workers, can utilize the findings to examine their roles and future service delivery in the hospital setting. This creates an opportunity to examine what is happening in the field

of medical social work and plan how to best prepare for the upcoming changes. The changes that are occurring currently in the health care field will impact the way medical social workers practice today and tomorrow. Social work leadership in the design and delivery of social work services is critical to the current and future roles of the social worker in the hospital setting (Simmons, 1994).

The findings presented in this thesis may be helpful for medical social workers as they continue to refine their role and the importance of social work in the hospital setting. For example, social services need to be effectively located in key areas, such as the outpatient setting, to best serve patients and families. The existing literature suggests that this will be important in the future (Simmons, 1994; Rosenberg, 1994; Blumenfield & Rosenberg, 1988). This research project may also be beneficial when orienting new medical social work staff, in particular the history of medical social work and information regarding the changes in location of practice.

Particularly in rural areas, social work directors will need to continue to promote and educate hospital administrators and personnel about the role of the medical social workers. Encouraging involvement from the Society of Social Work Administrators in Health Care may be one way to provide support and information to rural hospital social workers around the state.

In the findings, some respondents indicated the possibility that nurses would take over duties now performed by medical social workers and that some hospitals would or have already decentralized their social service departments as a step in this direction. Under this arrangement, medical social workers would be supervised by a nurse manager, rather than a social service director. This is a concern for this researcher because nursing and social work are two different professions with different codes of ethics and

frames of reference. Such a change might result in the loss of cohesiveness and professionalism for medical social workers. Medical social workers need to be accountable and responsible as professionals. Having a social work director allows for a chain of command and support for medical social workers who provide direct practice. Rehr (1984) states that social workers are the only professionals in the medical setting that concentrate on individuals, families and groups in the psychosocial environment. Social workers also connect patients and families to needed community resources, which can include financial assistance, housing, and transportation options.

It is critical for social worker directors to be knowledgeable about these changes, so they can become involved in the redesign of social work practice. They should constantly evaluate their practice and prepare for the future.

Summary

From this thesis comes a clear and detailed literature review and information about the current and future role of the medical social worker in the hospital setting. This research has produced a number of thought-provoking findings in relation to location of practice, tasks performed and preparation for the future of medical social work. These findings will assist social work directors and direct practitioners in planning for the future. Medical social workers need to consciously define their roles, so they can participate in and influence the changes that are occurring around them. In order to survive as a profession and best serve patients and families, medical social workers need to be aware of and respond to the changes in health care as the twenty-first century approaches.

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Appendix A

HealthEast St. Joseph's Hospital

69 West Exchange Street
St Paul MN 55102
612-232-3000

October 12, 1995

To Whom It May Concern:

This is to advise you that Molly Martin has my permission to use the list of social work directors from the Society of Social Workers in Health Care Administration, Minnesota Chapter, so that she may contact them for her master's level research project.

If there are any questions, I can be reached at (612)232-3337.

Sincerely,

Joseph R. Clubb MSW

Joseph R. Clubb, MSW
Minnesota Chapter President
Society ofSocial Workers in Health Care Administration

Appendix B

November, 27, 1995

Dear_____,

I am working on my graduate degree in social work at Augsburg College in Minneapolis and am currently employed as a medical social worker. As part of my master's thesis, I am conducting a research project on the current and future role of the medical social worker in the hospital setting.

The purpose of this study is to examine current and future roles of the social worker in the hospital setting. This research will explore location of practice, tasks and what has been done to prepare for the future of medical social work in the hospital setting.

You are invited to participate in this research study based on the knowledge you have as a director of a social work service department. Your participation in this survey will allow me to gather information on medical social workers who practice in the State of Minnesota. This questionnaire has been mailed to all directors of hospital social work service departments who are members of the Minnesota Chapter of The Society of Social Work Administrators in Health Care. If you agree to participate in the study, complete the enclosed survey and return it in the stamped, addressed envelope provided by **December 18, 1995.** The survey will take approximately thirty minutes to complete.

Please be assured that your responses will be kept private. In any presentation of the data collected in this study, it will not be possible to identify individual participants. Only the researcher will have access to the completed surveys. Do not place your name or other identifying information on the survey.

Your decision about whether or not to participate in the study will not affect your current or future relationship with Augsburg College, or the Society for Social Work Administrators in Health Care. By completing the survey, you have given consent to participate in the study. A summary of the research findings will be made available to The Society of Social Work Administrators in Health Care in July, 1996.

If you have questions regarding this research project contact me or my thesis advisor Dr. Carol Kuechler at (612) 330-1439.

Thank you for your participation,

Sincerely,

Molly S. Martin, LSW
MSW Student-Augsburg College
Augsburg College IRB approval # 95-14-2
(612) 686-5070 (home)
(612) 924-5925 (work)

In today's environment, medical social workers play an important role in the delivery of health care services. The goal of this survey is to further understand the current and future role of the medical social worker in the hospital setting. This survey has been approved by the Augbsurg College IRB-95-14-2.

General Instructions

Either a pen or pencil may be used to complete this questionnaire. If you choose not to answer a particular question, please move on to the next question. Do not place your name or other identifying information on the survey.

Survey questions

1. In which areas of your hospital(s) are you or your staff CURRENTLY providing social work services? For each location of practice please check hours of service a week.

	AS NEEDED	10-20 HRS	21-40 HRS	N/A
Obstetrics/Nursery	_____	_____	_____	_____
Medical Unit(s)	_____	_____	_____	_____
Surgical Unit(s)	_____	_____	_____	_____
Oncology Unit(s)	_____	_____	_____	_____
Pediatric Unit(s)	_____	_____	_____	_____
Emergency Department	_____	_____	_____	_____
Chemical Dependency Unit(s)	_____	_____	_____	_____
After Hours Coverage in Hospital Setting	_____	_____	_____	_____
On Call Coverage	_____	_____	_____	_____
Community Settings i.e community centers	_____	_____	_____	_____
Same Day Surgery	_____	_____	_____	_____
Orthopedics	_____	_____	_____	_____
Outpatient Rehab	_____	_____	_____	_____
Physician Clinics	_____	_____	_____	_____
Intensive Care Unit(s)	_____	_____	_____	_____
Mental Health Unit(s)	_____	_____	_____	_____
Neurology	_____	_____	_____	_____

2. Which of the following are CURRENTLY the most important tasks of the medical social worker in the hospital setting?
   * Rank in order of importance (1 most important task, 6 least important task).

_____ Counseling and Support	_____ Post-Hospital Planning
_____ Information and Referral	_____ Preadmissiom Planning
_____ Community Planning and Coordination Activities	_____ Other Please Specify _____

3. Now take yourself to the year **2000** (in five years). In which areas of your hospital(s) do you think you or your staff will be providing social work services? For each location of practice please check projected hours of service a week.

	AS NEEDED	10-20 HRS	21-40 HRS	N/A
Obstetrics/Nursery	_____	_____	_____	_____
Medical Unit(s)	_____	_____	_____	_____
Surgical Unit(s)	_____	_____	_____	_____
Oncology Unit(s)	_____	_____	_____	_____
Pediatric Unit(s)	_____	_____	_____	_____
Emergency Department	_____	_____	_____	_____
Chemical Dependency Unit(s)	_____	_____	_____	_____
After Hours Coverage in Hospital Setting	_____	_____	_____	_____
On Call Coverage	_____	_____	_____	_____
Community Settings i.e community centers	_____	_____	_____	_____
Same Day Surgery	_____	_____	_____	_____
Orthopedics	_____	_____	_____	_____
Outpatient Rehab	_____	_____	_____	_____
Physician Clinics	_____	_____	_____	_____
Intensive Care Unit(s)	_____	_____	_____	_____
Mental Health Unit(s)	_____	_____	_____	_____
Neurology	_____	_____	_____	_____

4. In the **year 2000**, which of the following will be the most important tasks of the medical social worker in the hospital setting?
   * Rank in order of importance (1 most important task, 6 least important task).

_____ Counseling and Support	_____ Post-Hospital Planning
_____ Information and Referral	_____ Preadmissiom Planning
_____ Community Planning and Coordination Activities	_____ Other Please Specify _____

5. Which of the following best describes your currrent patient population? Please check one.
   [ ] Mainly Urban
   [ ] Mainly Rural
   [ ] Mainly Suburban

6. The administration in my hospital(s) understand(s) the role of the medical social worker? Check one.
   Yes_____ No_____ Unsure_____

7. The administration in my hospital is taking a proactive stance on changes in health care as it relates to the future of medical social work in the hospital setting. Place a check in the most appropriate box and explain.
   [ ] Yes please explain_____
   _____
   _____
   [ ] No please explain_____
   _____

8. What has the social service department in your hospital done to prepare for the future?
   Please explain_____
   _____
   _____
   _____
   _____
   _____

Background Information

The NEXT FOUR QUESTIONS will ask you about each hospital that you serve. If you serve more than one hospital, please keep the hospital numbers consistent.

9. As a director, how many hospitals do you serve? _____

10. How many operating beds does your hospital(s) have? If you serve more that ONE hospital please indicate by placing a check by the appropriate column.

	Hospital 1	Hospital 2	Hospital 3	Hospital 4
0-50 beds	_____	_____	_____	_____
51-100 beds	_____	_____	_____	_____
101-300 beds	_____	_____	_____	_____
301-500 beds	_____	_____	_____	_____
500 or more beds	_____	_____	_____	_____

11. Please indicate how many FULL-TIME and PART-TIME social workers are employed in your hospital(s). If you serve more than ONE hospital, please indicate staffing at each hospital.

	Hospital 1	Hospital 2	Hospital 3	Hospital 4
Full-time.....	_____	_____	_____	_____
Part-time..... (less than 20 hours)	_____	_____	_____	_____

12. Please indicate the educational level of the social workers at your hospital(s). Please fill in blank with a number.

	Hospital 1	Hospital 2	Hospital 3	Hospital 4
Number with MSW	_____	_____	_____	_____
Number with BSW	_____	_____	_____	_____

Other_____ Please specify_____

13. In the **Year 2000**, what will the minimal educational level of medical social workers be in order to practice in the hospital setting? Please check one.

MSW_____

BSW_____

Other_____ Please specify_____

14. How many years of medical social work experience do you have?

As a director?_____

As a practitioner in direct practice?_____

15. Which of the following best describes the primary type of work you do? Please check one.

[ ] Administrative

[ ] Direct service

[ ] Combination of both administrative and direct service

16. Which of the following best describes your education? Please check one.

[ ] College graduate with major in social work

[ ] College graduate with major in something other than social work

Please specify_____

[ ] Masters degree in social work

[ ] Masters degree in something other than social work Please specify_____

[ ] Ph.D. in social work

[ ] Ph.D. in something other than social work. please specify_____

[ ] Other Please specify_____

Please add any other comments or thoughts you'd like to share that have not been covered in this survey.

UPON COMPLETION OF THIS SURVEY, PLEASE PLACE IT IN THE ENVELOPE PROVIDED AND MAIL BACK NO LATER THAN DECEMBER 18, 1995.

THANK YOU FOR PARTICIPATING IN THIS SURVEY.

Appendix C