Social Work in Hospitals: Past, Present, and Future

Michael Reisch, Ph.D., MSW
University of Michigan Hospital
Ann Arbor, Michigan
May 7, 2012
Overview

• Summary of Major Themes
• History of Hospital Social Work in the U.S.
• The Present Structure of Health Care: Implications for Hospital Social Work
• Health & Mental Health Disparities & Their Implications for Hospital Social Work
• Health Care Reform & Its Implications
• Recommendations for Hospital Social Work
Major Themes

• Professional Dominance & Competition
• Impact of Public Policies on Health Care
• Changing Political-Economy of Health Care
• Institutional vs. Community Models of Care
• Impact of Professionalization on SW Theories, Practice Models, and Education
Part 1. A Brief History of Social Work in Hospitals
FROM COMMUNITY TO INSTITUTIONAL PRACTICE & BACK
Transformation of Hospitals & American Medicine

• From “communal” to “associative” relations
• In late 19\textsuperscript{th}/early 20\textsuperscript{th} C: Hospitals redefined -
  -- Institutions of medical science, not SW
  -- Businesses rather than charities
  -- Oriented to professionals & patients instead of patrons and the poor.
• Impact of scientific discoveries, preventive medicine, and new sources of support
• Flexner Report (1910), AMA & Foundations
Origins of Hospital Social Work

• Prior to early 20th C: SW practice in health care based solely in community dispensaries.
• City Hospital in Cleveland (1891). Purpose: To set up records to identify patients.
• 1900: Relief Dept helped clear hospital wards “clogged by chronic patients & Civil War Vets”
• 1902: Johns Hopkins Social Medicine Program
• 1905: Mass General sets up volunteer unit
• 1906: Ida Cannon organizes Social Work Dept.
• 1919: Social work with inpatient wards begins
• New Roles: “Person as Patient”/“Patient as Person”
Richard Cabot & Ida Cannon
Cabot’s Original Vision (1908)

“Beyond the special disease of a special child or adult who comes to us in the dispensary, stands a family problem, ultimately a community problem, poverty, bad housing, bad food, bad habits and associations, ignorance of the ways and means of making a clean and healthy life on scanty means.”

Implication: Physician & social worker were peers in treatment of patient; not superior-subordinate, like doctor-nurse roles.
Growth of Hospital Social Work

• By 1912, medical SW taught in several schools
  -- 1905-1917: 100+ hospitals in 35 cities had SW
  -- American Association of Hospital SW’ers (1918)
  -- American Hospital Association standards
  -- By 1930: 1,000+ hospitals had SW Departments

• Expansion of Social Work Roles (I&R, CW):
  -- “Augment physician’s treatment of patients”
  -- Liaison between physician & patient
  -- Patient education to enlist cooperation

• Hospital social workers emulate physician model to separate from nurses & “old-style” charity workers
Psychiatric SW in Hospitals

- 1880s: Opposition by hospital administrators
- 1895: 1st Psychiatric Social Work
- 1902: NY State Hospital Services established
- 1905: Pathological Institute in Albany
- 1905: Dr. Adolf Meyer moves it to Manhattan State Hospital with his wife, a social worker.
- 1906: NY COS est. privately supported after care programs in each state hospital
- 1900-1920: Support from major foundations
- 1920s-1950s: Influence of psychoanalysis
Early Challenges (1920s-1930s)

- Demonstrate **scientifically** the relationship between social and medical factors
- Subordination of social worker to physician
- Establishing appropriate relations w/patients
- Functioning as part of hospital team
- Developing new ways of thinking that combine medical and social diagnosis
- 1926: Separation of medical & psychiatric SW
- By 1937: Over 1600 hospital SW departments
Group Work in Hospitals

- 1st used at Mass General with TB patients
- Growth stimulated by World War II: Work with Vets and in Children’s Wards
- 1946: Began in Cleveland VA as experiment
- 1951: Expands to include paraplegic patients
- Early ideas: (1) Need to work in integrated services setting (2) Role of psychoanalysis
- Basic Concepts: Treat whole patient, not illness; “Normalize” the situation for people
The Welfare State & Hospital SW

- Expansion of SW role during New Deal
  -- FERA, SSA, Fed’l Crippled Children’s Svces
- Growth in 1950s & 1960s
  -- Hill-Burton Act: Community Hospitals
  -- Kerr Mills Act
  -- Medicare & Medicaid
  -- Society of Hospital Social Work Directors
- Social Security Amendments of 1972
  -- Professional Standards Review
Organizations emphasized accountability & performance
Emergence of Private Insurance

• Until 1930s – private hospital care only for those with resources or those eligible for charitable care
• 1930’s: Blue Cross/Blue Shield Established & Kaiser Corporation starts 1st HMO
• 1943: National War Labor Board ruled that health insurance benefits not taxable
• IRS: Employers’ costs tax-deductible (1951)
• 1946-1957: Dramatic increase in workers covered. Role of unions critical.
• Current tax expenditures cost ~$200 B/year – Because health premiums are not taxable.
Trends in Hospital SW: 1920s-1980

• Assist health care team understand impact of social, economic, & emotional factors: Better patient care
• Help patients make constructive use of care & promote their well-being and morale
• Promote diagnostic approach & practice-based research (Columbia-Presbyterian Medical Center)
• 1940s: Division between psychiatric & medical
• 1960s: Social action to eliminate external causes of psychological & social dysfunction
• 1970s: Focus on productivity & outcome measures. Tension between counseling & discharge planning.
• Growing specialization of function within hospitals
1980s to the Present: The Focus on Cost Control

- 1984: Introduction of DRG’s leads to increased focus on discharge planning. It becomes widely implemented specialty.
- 1990s: Growth of Managed Care & HMOs
- Increasing complexity of health care system
- Growth of private hospitals
- Impact on staffing, leadership, and roles of hospital social workers on “Reengineering”
Impact of “Reengineering”

- Elimination of middle management positions
- Trans-disciplinary Approach: Negative impact on social work functions
- Initially, Erosion of Social Work Leadership
- Greater Inter-Professional Competition
- Lack of EBP: Decline of SW Depts’ Status
- Decentralization & Erosion of SW Supervision
- Value & Ethical Conflicts Increase
Part 2. The Present: The Structure of U.S. Health Care

The Implications of Contemporary Health Policy for Hospital Social Work
Health Care in the U.S.: A Public-Private Mix

- The U.S. “Hybrid”: -- Fee for service -- HMO’s -- PPO’s -- Government provision (e.g., VA)
- Medicare/Medicaid: Gov’t $/private provision
- Gov’t bailouts of private hospitals for ER costs
- Tax deductibility of health insurance
- Government pays 60% of health costs
- Private insurance covers 37% expenditures; Medicare & Medicaid cover 34% combined
- Rapid growth in Medicaid and Medicare rolls
The Role of Medicare & Medicaid

- ~43 M elderly Americans w/14% of budget
- ~1/2 recipients earn below 200% of poverty
- Costs will increase dramatically: Implications
- System is sustainable for ~10 more years
- Medicaid delivers health insurance to ~55 m low-income children & families and is largest source of income for elderly in nursing homes
- Implications of state control
- Recent cuts in funding & increased demand,
State Children’s Health Insurance Program (est. 1997)

- Offers families living under 200% of poverty opportunity to buy low cost insurance
- Some states cover parents thru fed’l waiver
- Block grant with predetermined, fixed level
- **Impact**: Reduced # uninsured children by 1/3
- Funding has not kept pace with rising health care costs or population growth
- Recent efforts to expand coverage
Need for Long Term Care

• ~9 m persons 65+ use some form of LTC
• **By 2020**: 12 M Americans will need LTC
• Medicare only covers time limited, medically necessary care (120 days maximum)
• Majority of elderly receive aid at home -- more economical than nursing home care
• Most spending through Medicaid or out of pocket
The High Cost of Health Care

- Per capita health expenditure in U.S. is highest
- 16%+ of GDP, 4.3 times more than nat’l defense
- US has similar life expectancy as Cuba @ 25 times the cost (WHO).
- US fares poorly on many indicators of health: infant mortality (42\textsuperscript{nd}), morbidity, longevity (48\textsuperscript{th}). WHO ranked US 15\textsuperscript{th} of 25 nations

Reasons:
-- Cost of drugs, tests, hospital stays, & MD’s
-- High number of uninsured persons
-- High administrative costs in private co’s (31%)
-- Absence of preventive & primary care
Controlling Health Care Costs

• Inflationary aspects of unlimited access to care not recognized until after Medicare & Medicaid were implemented in 1960s

• 1980s: Containing costs replaced emphasis on access & concerns about quality of care

• Efforts to control costs included higher deductibles, using HMO’s to limit services, and introduction of DRG’s in 1980’s

• US spends 6 times more per capita on health care system than Western European nations
Long-Term Financing Problems

- People are living longer (good news/bad news)
- The worker-beneficiary ratio has dramatically declined. In 1935, it was 7:1. By 2050, it will be 2:1.
- Health care costs have soared, especially care for the “old old” (85+) are bankrupting Medicare.
- Ratio of elderly to children (nation’s neediest populations) has shifted dramatically since 1980.
- Demographic changes create the potential for inter-generational conflict: In 2050, elderly population will be 65% white & workforce will be more than 50% persons of color. **Key: Inter-generational equity.**
Number of Workers Per Social Security Beneficiary, 1970-2040

Source: Table IV.B2 in Social Security Administration (2008b).
Number of Older Americans, 1960-2040 (in millions)

Ages
- 85+
- 65-84

Year
- 1960: 17
- 1980: 23
- 2000: 31
- 2020: 47
- 2040: 65

Age Distribution of the Population, 1980-2040

Years of Life Expectancy at Birth by Sex, 1900-2000

Source: Social Security Administration (2008c).
Remaining Years of Life Expectancy at Age 62, 1960-2040

Year Turns Age 62

Source: Social Security Administration (2008c).
Major Functions of Hospital SW

• Screening & Case Finding
• Crisis Intervention & Bereavement Services
• Psychosocial Assessment & Intervention
• Brief Counseling & Group Work
• Documentation & Record-Keeping
• Discharge Planning & Case Management
• Post-Discharge Follow-Up & Outreach
• Emergency Services
• Inter-Professional Collaboration & Advocacy
Focus of Hospital Social Work

Values + Practice = Family Centered Care

Social Work Core Values:
- Service
- Social Justice
- Dignity & Worth of the Person
- Importance of Human Relationships
- Integrity
- Competence

Social Work Practices:
- Involve the Family in Treatment
- Identify Strengths
- Respect Self-Determination
- Reduce Barriers
- Advocacy
- Support

CHILD and FAMILY
Issues for Hospital SW

• Medical vs. Bio-psychosocial Models
• Cost containment vs. Service Quality
• Cost containment v. Self-determination
• Needs of Interdisciplinary Practice vs. Maintenance of Professional Hierarchy
• Institutional Efficiency v. Patient Information
• Ethical Conflicts Among Practitioners with Different Value Systems
• Implications of Growing Health Disparities
Part 3. Disparities in Health & Mental Health Care & Their Impact on Hospital Social Work
Inequalities in Health and Mental Health in the U.S.

- Different groups are differentially affected by certain health and mental health problems based on:
  - Race/ethnicity, age, gender, socioeconomic status, geographic location, occupation, & sexual orientation

- Health & mental health disparities have a reciprocal relationship with inequalities in other domains, e.g.
  - Social, political, and economic conditions
  - Education
  - Housing
  - Environmental pollution
Inequalities in Health & Mental Health

SES

Access to health care
Psychosocial factors
Working conditions
Environmental exposure

Physical Health

Mental Health

Social Isolation/Support
Social Stress
Labelling
Inequalities in Health & Mental Health

Race/Ethnicity

Access to health care
Psychosocial factors
Working conditions
Environmental factors
Residential Segregation

SES

Physical Health

Mental Health
Elderly Women of Color: A Particularly Vulnerable Population
Causes of Racial & Ethnic Inequalities in Health and Mental Health Care

- Absence of Care
- Accessibility to Care
- Accountability for Care
- Affordability of Care
- Allocation of Health Care Resources
- Appropriateness of Care
- Quality of Care
- Overall Growth in Socio-Economic Inequality
INTERESTING. THE GAP BETWEEN RICH AND POOR IS NOT AS GREAT AS WE THOUGHT.
Absence of Care

- Post-Hospitalization/Rehabilitation Care
- Preventive Programs
- Long-Term Care for Chronic Illness
- Oral Health/Dental Care
- Mental Health Care: Stigma & Limitations
- Prescription Drugs & Medical Equipment
- Discrimination in Coverage for LBGTQ Pop.
- Lack of Portability of Insurance Coverage
- Lifetime Caps in Benefits
Who is Uninsured?

- ~50 M persons uninsured: 40% increase since 1987.
- Vast majority are citizens; African Americans (20.5%) and Latinos (34.1%) have highest percentage.
- Over 20% of working adults
- Drop over past 20 yrs in employer-provided insurance
- Health care premiums increased 143% since 2000
- High cost is primary reason for lack of insurance
- More than 11% of children lack health insurance
- 12.9% covered by Medicaid; 13.6% by Medicare
- Impact: Less preventive care, higher mortality, higher costs
Access to Care

- Maldistribution of Providers Esp. in Rural Areas
- **Lack of**: Preventive, Primary Care & Public Health; Programs for Women, Gays, & Racial/Ethnic Minorities; and Programs with Cultural & Language Sensitivity
- **Denial of Care** due to: Pre-Existing Conditions; Immigration Status; Differences in States’ Medicaid Coverage and Eligibility Rules
- Loss of Insurance Due to Unemployment and Fiscal Cutbacks (State Gov’ts, Corporations)
Affordability of Care

• Lack of Health Insurance (~50 million)
• Inadequate Insurance for Millions More
• Reliance on Employer-Sponsored Insurance
• High Deductibles and Co-Payments
• High Cost of Prescriptions, In-Home After Care & Transportation
• Recent State Cutbacks of Medicaid & S-CHIP
Appropriateness of Care

- Coverage affected by employment status, income, geographic location, age, gender, race
- Lack of research on different health issues and needs of women & persons of color.
- Relationship between health/mental health disparities and other manifestations of inequality including socio-economic status, social isolation/support, stress
- Variations in quality of health/mental health care across populations, age cohorts, regions.
Part 4. The Future of Health Care Reform

Prospects for Practice in the Wake of the Affordable Care Act (or its Repeal)
Ways to Enhance Access

- Create government-funded health care facilities, especially in inner cities and rural areas.
- Provide incentives to develop private facilities and to practice in under-served areas.
- Link provision of health care to established institutions (schools, churches, workplace).
- Utilize advanced technology to increase access to diagnostic centers & facilitate coordinated care.
- Implication for SW: More community-based care.
Suggested Ways to Expand Care

• Extend coverage to include MH & Dental Care
• Eliminate ban on pre-existing conditions & lifetime caps on expenditures (ACA)
• Add LTC and post-hospitalization coverage
• Provide domestic partner coverage
• Make employer-sponsored insurance portable
• Create more satellite and primary care clinics
• Use greater variety of health care professionals
• Promote more self-care through public education and expanded use of technology

**Implication:** New Roles for Hospital Social Work
Ways to Increase Affordability

- Provide subsidies or tax credits for purchase of private health insurance (ACA)
- Create Medicare for all (Single payer system)
- Create nat’l health care system (like VA, military)
- Link provision of health care to existing services
- Cap costs of payments/insurer profits/drugs, etc.
- Purchase drugs in bulk from other providers

**Implication**: Changes in funding would shift locus of social work practice in health care field
Allocate Resources More Equitably

- Prioritize needs of vulnerable populations: e.g., elderly, poor, children, disabled, unemployed
- Focus on primary & emergency care provision
- Restrict access to tertiary care facilities
- Use means test for Medicare & other benefits
- Spend more on public health education
- Increase administrative efficiencies
- **Implications**: Changes in clients & SW Role
Address Persistent Disparities

- Invest in programs for underserved pops.
- Create mental health parity
- Address structural causes of disparities: housing, employment, education, pollution

Issues:
-- Which programs should we prioritize?
-- How should such initiatives be funded?
-- What roles can social workers play?
Key Features of 2010 ACA

- **Overall Goals:** Expand **Access** & **cut costs**
- **Projected impact** (2019): Add coverage for 32 m
  **Projected cost:** $938 b. Reduce deficit by $124 b.
- **Mandates for Individuals & Employers -- Subsidies**
- **Expansion of Public Programs:** Medicaid & S-CHIP
- **Creation of Health Insurance Exchanges**
- **Changes to Private Insurance, State Role & Taxes**
- **Improving Quality/Health System Performance**
- **Focus on Prevention/Wellness**
- **Long-Term Care Provision** (since removed)
Individual Mandates

• Obtain coverage or pay tax penalty
• Penalty will be phased in between 2014-2016 & increased thereafter by COLA
• Exemptions:
  -- Financial Hardship
  -- Religious Objections
  -- American Indians, undocumented immigrants, and incarcerated individuals
  -- Those w/o coverage for less than 3 months
Employer Mandates

• Variable tax penalties for employers with 50+ employees who do not provide coverage

• Must offer employees free choice voucher

• Requirement for employers with 200+ employees to automatically enroll employees in health coverage. Employees may opt out.
Changes to Medicare

- Create exchanges w/oversight & regulatory roles
- Freeze Medicare Part B premiums
- Control spending growth by reducing some payments to hospitals & physicians
- Create Innovations Center to improve quality & reduce rate of cost growth
- Authorize FDA approval of generic drugs
- Pay for preventive services
Expansion of Medicaid

• Covers all eligible individuals under 65 with incomes up to 133% of Federal poverty line
• Excludes undocumented immigrants
• Guaranteed benchmark benefit package
• Federal gov’t will fund 100% from 2014-2016
• Decreasing subsidy 2016-2020, down to 90%
• 100% federal subsidy for primary care
• Permit states to create a Basic Health Plan for uninsured in lieu of providing premium subsidies
Expansion of S-CHIP

- Require states to maintain current income eligibility levels until 2019 & extent funding through 2015.
- Through 2015: States to receive increase in S-CHIP match up to 100%
- Children who are unable to enroll due to caps eligible for tax credits
Subsidies & Cost-Sharing

- Limited to citizens/legal immigrants in income limits
- Employees who are offered work-based coverage are not eligible with some exceptions
- Legal immigrants barred from Medicaid for first 5 years will be eligible for premium credits
- Refundable & advanceable credits to individuals and families with incomes between 133-400% of FPL
- Sliding scale subsidies between 100-400% of FPL
- Cannot be used to purchase coverage for abortion
- Phased in credits for small businesses
- Temporary reinsurance program for retirees 55+
State Health Insurance Exchanges

- Administered by a government agency or non-profit
- Access only to citizens & legal immigrants who are not incarcerated & businesses with <100 employees
- Wide variations among states: e.g., public plan option, restrictions on abortion coverage, approval of plans, creation of basic health plan for those 133-200% of FPL
- Foster creation of non-profit, member-run co’s
- 4 Benefit Tiers & Catastrophic Plan
- Reporting, Accountability, and Access Requirements
Changes to Private Insurance

• Establish temporary high-risk pool to cover individuals with pre-existing conditions, funded at $5 B.
• Provide dependent coverage for children up to age 26
• Prohibit plans from placing lifetime cap on coverage & from rescinding coverage except in cases of fraud
• Create uniform market regulations for all plans
• Establish process for reviewing premium increases
• Require most policies to comply with benefit standards
• Build in consumer protections
• Allow insurers to sell policies in states thru compacts
Improving Quality

- Support comparative effectiveness research
- Develop national quality improvement strategy
- Develop alternatives to current tort litigation
- Independence at Home demonstration program
- Pay hospitals based on quality performance measures
- Increase payments for primary care
- Establish Community-based Collaborative Care Network Program to coordinate & integrate services for low-income and underinsured populations.
- Require collection & reporting of data on disparities
Focus on Prevention/Wellness

- National Council to coordinate Federal efforts.
- Prevention research, screenings, educ., outreach.
- Grants to support evidence-based & community-based prevention & wellness services
- No cost-sharing for prevention in Medicare Medicaid. Require private plans to cover prevention
- Provide Medicare beneficiaries access to health risk assessment and personalized prevention plan
- Incentives for employer-based wellness programs
- Require chain restaurants & vending machines to disclose nutritional content of each item sold.
ACA Timetable: What’s Already in Place

• Insurance reforms
• Changes in Medicare & Medicaid
• Cost Controls
• Approval of Generic Drugs
• Increased Focus on Prevention/Wellness
• Funding of School & Community-Based Care
• Encouragement of Home Care for Elderly
• Emphasis on Quality Improvements
ACA Timetable:
What May Lie Ahead

• Additional Insurance Reforms: Co-Ops
• Insurance Exchanges Established
• *Individual & Employer Mandates
• *Premium Subsidies
• *Expansion of Medicaid Coverage
• *Prevention & Primary Care Coverage Under Medicaid and Medicare
• *Reduced Medicare Payments to Hospitals
• Ease Requirements for Catastrophic Coverage
Specific Features Re Hospital SW

• **Readmissions & Community-Based Care Transitions:** Address environmental and socio-economic factors

• **Independence at Home:** Coordinating care as part of home-based primary care teams

• **Patient-Centered Medical Homes & Interdisciplinary Community Health Teams:** Focus on non-medical barriers and unique patient needs

• **Accountable Care Organizations:** Use SW skills to meet patient-centered criteria (e.g., assessment)

• **Centers for Medicaid/Medicare Services Innovation:** SW role in coordination, team-based approaches

• **Workforce Development Grants:** Geriatric SW’ers
Challenges to Reform

• Lawsuits filed by states – Sup Ct decision in June
• Efforts by House Republicans to cut funding for implementation of the law (FY 2013 Budget)
• Efforts by House Republicans to repeal the law (FY 2013 Budget Proposal – passed by House)
• Overhaul of Medicare in Republican Budget Blueprint: Replace with voucher system
• Overhaul of Medicaid in Republican Budget Blueprint: Replace with block grant system
• Mixed Public Opinion & the 2012 Elections
# Comparing Massachusetts Law & the Affordable Care Act

<table>
<thead>
<tr>
<th>Massachusetts Law</th>
<th>Affordable Care Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has individual mandate</td>
<td>Has individual mandate</td>
</tr>
<tr>
<td>Subsidies up to 300% of FPL</td>
<td>Subsidies up to 400% of FPL</td>
</tr>
<tr>
<td>Employer mandate (11+ wkrs)</td>
<td>Employer mandate (50+ wkrs)</td>
</tr>
<tr>
<td>Employer subsidy (up to 15%)</td>
<td>Employer tax credit (up to 50%)</td>
</tr>
<tr>
<td>Health insurance exchanges</td>
<td>Health insurance exchanges</td>
</tr>
<tr>
<td>Coverage up to age 26</td>
<td>Coverage up to age 26</td>
</tr>
<tr>
<td>No long-term care</td>
<td>Had long-term care; scrapped</td>
</tr>
<tr>
<td>Coverage can’t be rescinded</td>
<td>Coverage can’t be rescinded</td>
</tr>
<tr>
<td>Coverage for pre-existing cond.</td>
<td>Coverage for pre-existing cond.</td>
</tr>
<tr>
<td>Lifetime limits (but few have)</td>
<td>No</td>
</tr>
<tr>
<td>Annual limits on coverage</td>
<td>No annual limits on coverage</td>
</tr>
<tr>
<td>No free preventive care</td>
<td>Free preventive care</td>
</tr>
<tr>
<td>No current cost control measures</td>
<td>Has cost control measures</td>
</tr>
</tbody>
</table>
If the ACA is Repealed: Key Issues for the Future

• Who will pay for health care in the 21\textsuperscript{st} C?
• How should finite resources be allocated?
• What criteria should be used to make these decisions? Who should decide?
• What types of benefits, populations, and issues should take priority?
• What types of cost efficiencies can be implemented? What would be their benefits and consequences? For whom?
• What are the implications for social work?
Hospital Social Work & Cost Control/Length of Stay

- More emphasis on community care will lead to social workers playing a Brokerage Role
- More consultation & collaboration, faster assessments, & more time with discharge.
- Longer stays no longer mean more SW duties
- Opportunity to become a specialized knowledge resource for community practitioners as bridge w/community systems
Implications for Hospital SW

• Shift in locus of care: Acute to ambulatory.
• Emphasis on primary/preventive care: Major role for SW if we can show effectiveness.
• Need for clearer job descriptions & inventory of required skills, knowledge, tasks
• Need for high-risk screening instruments for assessment, treatment, & outcome measures
• Need for new treatment protocols & outcome measures linking psychosocial & medical approaches to care.
Recommendations: Back to the Future

• Become more actively involved in primary & secondary prevention efforts

• Adopt evidence-based interventions for disease management in multiple settings: Minimize effects of range of chronic illnesses

• Add an economic outcome (cost reduction) to other measures such as distress, reduction of other symptoms, and quality of life.

• Help bridge medical & social health models
Personal Qualities & Skills Needed

• Strong Personal and Professional Boundaries: Self-protect to handle loss & prevent STS
• Thick Skin: Don’t personalize issues
• High Self-Esteem & Tolerance for Ambiguity
• Openness to New Experiences
• Increased Self-Awareness & Self-Monitoring
• **Skills**: Communication, social media, teamwork, system negotiation, work with elderly
• Importance of paying staff decent salaries
Provide Adequate Compensation

MEDIAN SALARIES BY SPECIALTY

Elementary and Secondary Schools: 54k
Individual and Family Services: 34k
Medical and Surgical Hospitals: 51k
Mental Health & Substance Abuse Facilities: 34k
Nursing Facilities: 41k
Community and Relief Services: 32k
Implications for Social Work Depts

- Increase amount of clinical supervision in lieu of administrative supervision
- Encourage self-care & self-monitoring by staff
- Use forums & other group settings to process
- Communicate to hospital administrators and policymakers the impact of stress on staff & its implications for well-being & care quality
- Importance of developing strong leadership
Stress Importance of Leadership
Implications for Research

• Focus on evidence-based outcome assessment of bio-psychosocial interventions

• Demonstrate economic benefits of social work to patients, institutions, & society

• Emphasize community & environmental factors & their relationship to individual health outcomes

• Increase collaborations w/SSW faculty

• Increase participation in clinical trials

• More training in outcome-based research
The Challenge of Creating A Socially Just Society
100 Years Ago

“It is because of the complexity of the social problems involved in the various groups of patients, and the interdependence of the medical and social treatment, in any attempt at adequate solution, that the social worker is needed in our hospitals.” – Ida Cannon

“Doctor & social worker must each look to the other for the causes of the trouble he seeks to cure. At bottom, medical ills are largely social & social ills largely medical.”- R. Cabot
And Today ....

“Housing policy is health policy. Educational policy is health policy. Anti-violence policy is health policy. Neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in our society has an impact on their health and is a health policy.”

- Dr. David Williams

Harvard School of Public Health

http://unnaturalcauses.org/assets/uploads/file/UC_Toolkit_2_Background.pdf
Focus of Hospital Social Work

Values + Practice = Family Centered Care

Social Work Core Values:
- Service
- Social Justice
- Dignity & Worth of the Person
- Importance of Human Relationships
- Integrity
- Competence

Social Work Practices:
- Involve the Family in Treatment
- Identify Strengths
- Respect Self-Determination
- Reduce Barriers
- Advocacy
- Support

CHILD and FAMILY
The Alternatives: Despair
Or Greater Well-Being
THANK YOU FOR YOUR ATTENTION

MICHAEL REISCH
MREISCH@SSW.UMARYLAND.EDU
Sources


Sources


Sources


