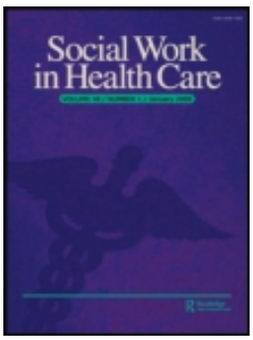

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# Hospital Social Work: Contemporary Roles and Professional Activities

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# Hospital Social Work: Contemporary Roles and Professional Activities

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*Since its inception in the 1900s, hospital social work has been impacted by the ever changing hospital environment. The institution of Diagnostic Related Groups (DRGs), the era of reengineering, and the constant struggle toward health care reform make it necessary to evaluate and substantiate the value and efficacy of social workers in hospital settings. This study identifies current roles and activities carried out by social workers in acute hospital settings from across the nation in the aftermath of reengineering. Findings suggest the primary role of respondents in this study to be discharge planning with little to no involvement in practice research or income-generating activities.*

*KEYWORDS hospital social work, discharge planning, reengineering, hospital social workers*

## INTRODUCTION

The provision of concrete resources, counseling services, and patient advocacy reflect overarching categories of activities historically carried out by hospital social workers. Since the initiation of medical social work services to patients at Massachusetts General Hospital in 1905, during the era of Medicare and Medicaid implementation in the 1960s, throughout the cost containment decade of the 1980s and beyond the reengineering period of the 1990s, hospital social workers have had to adapt to changes in both

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professional roles and accountability standards. As the American health care system continues to fall under the watchful eyes of policymakers anxious to implement reforms targeted at decreasing health care costs and improving outcomes, it is imperative that continuous efforts be made to ensure hospital social workers are proficient in sustainable areas of expertise, and to identify domains for professional growth.

## HISTORICAL BACKGROUND OF HOSPITAL SOCIAL WORK

With the introduction of social work into acute care hospital settings, the needs of patients moved beyond intervention for immediate medical issues to include addressing aspects of the larger ecological system impacting health outcomes. Operating within the theoretical framework of person-in-environment, social work practice in the hospital setting included comprehensive interventions that targeted improving outcomes for patients and initiating change in the larger community. Early roles of the medical social worker consisted of assisting patients with chronic disease management, mental health issues, drug and alcohol abuse, physical disabilities, terminal conditions, and accessing extended care services (Cannon, 1913). Hospital social workers assumed tasks that included conducting patient assessments regarding their living environment and family situation, educating patients regarding the hospital stay and potential impact of the diagnosis, assisting patient compliance with physician treatment recommendations, and providing a link to community resources to assist the patient post discharge (Beder, 2006).

Until the 1930s, private hospital care was only an option for those with the resources to pay or those in dire need who met criteria for charitable care (Starr, 1982). Pre-paid hospital plans (the precursors to private health insurance) made it possible for individuals to pay in advance for hospital care for a reasonable fee. Also, the Hill-Burton Act of the 1940s resulted in funding for the construction of community hospitals nationwide. In 1965, President Johnson signed Title XVIII & XIX into law resulting in Medicare and Medicaid. As a result of these policies, increased access to medical care within acute hospital settings was unprecedented in the decades that followed.

### Cost Containment of the 1980s

As increasing costs of providing inpatient medical services to a growing population concerned legislators, the concept of a prospective payment system termed Diagnostic Related Groups (DRGs) was introduced in 1983. The adoption of the DRG reimbursement system resulted in the need to discharge patients quickly from the acute hospital setting to ensure full reimbursement

for services elevating the activities of discharge planning to one of a professional endeavor and thereby enhancing the role of the hospital social worker (Dinerman, Seaton, & Schlesinger, 1986; Holliman, Dziegielewski, & Priyadarshi, 2001). In addition, the 1980s brought an increased emphasis on accountability within hospital systems as standards set by insurance companies and government programs required thorough documentation for reimbursement of provided services (Holliman, 1997).

## Reengineering of the 1990s

Faced with continued escalating costs, hospital systems embraced a conceptual model of reorganizing in the decade of the 1990s—referred to as reengineering. Dramatic changes were undertaken with a focus on targeted cost containment by means of eliminating middle management positions, altering traditional roles and responsibilities of current staff positions to become transdisciplinary, flexible, and empowered (Neuman, 2000). This shift in organizational structure once again placed the activities carried out by hospital social workers under the spotlight. Decentralization, devolution, cross-training and standardization of care, and the forces within reengineering negatively impacting social work's function within the hospital systems both in the United States and Canada (Globerman, Davies, Mackenzie, & Walsh, 1996; Globerman, White, & McDonald, 2002: Michalski, Creighton, & Jackson, 1999; Mizrahi & Berger, 2001; Neuman, 2000; Ross, 1993).

The process of decentralization resulted in trends that shifted supervisory responsibilities for social work staff to those with other areas of professional expertise and resulted in the initial erosion in social work leadership (Berger, Robbins, Lewis, Mizrahi, & Fleitt, 2003; Neuman, 2000; Ross, 1993). As social work leadership began to evaporate and free standing departments were absorbed into case management units, hospital social workers were placed into a position of competing for roles they had historically filled.

In theory, the movement toward devolution and cross training made sense. Assigning routine tasks to individuals with less skill and education supported the streamlining of services and cost-saving initiatives. However, these systematic changes posed inherent risks to the position of the hospital social worker by relying solely on established practices that demonstrated cost-effective measures. To complicate matters, hospital social workers had not routinely produced evidence-based outcomes that substantiated social work roles and interventions within hospital settings (Auerbach, Rock, Goldstein, Kaminsky, & Heft-Laporte, 2000; Kossman, Lamb, O'Brien, Predmore, & Prescher, 2005; Preyde, Macaulay, & Dingwall, 2009). Social service departments collapsed and the recognition of the importance of specialized skills evaporated, resulting in an escalation of

competition between nurses and social workers for roles in addressing the psychosocial outcomes and discharge planning needs of patients (Sulman, Savage, & Way, 2001). At the same time, the onset of managed care resulted in the proliferation of case management departments focused on the need to contain costs. Consequently, current research indicates hospitals are one of the top five work place settings for nurse case managers (Park & Huber, 2009).

In response to real and potential threats resulting from the reengineering movement, it has been proposed that hospital social workers need to cultivate evidenced based practices in relation to activities of discharge planning, and cost-containment (Globerman, 1996; Mizrahi & Berger, 2005; Neuman, 2000; Preyde et al., 2009). In addition social workers need to position themselves as change agents within the hospital setting, seeking opportunities to participate and/or develop income producing projects while working to create key roles on multidisciplinary teams, taking part in ethical activism and developing community partnerships (Jansson & Dodd, 2002; Sulman et al., 2001).

While there is substantial literature examining potential impacts and early trends emerging as a result of reengineering activities, there is limited information within the published literature as to current expectations and responsibilities of hospital social workers. The aim of this research study is to capture a picture of contemporary roles and activities being carried out by hospital social workers following the era of reengineering.

## METHODS

### Survey Instrument

A self-administered questionnaire was designed specifically for this study with data collection occurring between July 2006 and January 2007. The questionnaire was piloted with five hospital social workers at Texoma Medical Center in Denison Texas resulting in only grammatical changes to the document.

Consisting of four sections, the survey instrument was designed to capture respondents' educational background, employment, professional goals, and demographic information. Descriptive information regarding employment status, professional goals, and demographic information is utilized in this analysis. Employment status included questions designed to capture the following job attributes: (1) if this is the first paid position in health care, (2) length of employment in health care, and (3) presence or absence of supervisory duties. In addition, 17 specific service lines were presented with respondents being asked to indicate the top area consuming the majority of their work efforts. Services lines represent "an organizational arrangement for planning, marketing and/or coordinating multiple disciplines in

the delivery of services defined by disease, population group or clinical intervention" (Byrne, Charns, Parker, Meterko & Wray, 2004, p. 28).

Activities and/or roles carried out by hospital social workers as reflected in previous literature included five domains—discharge planning, direct practice activities such as counseling and/or crisis intervention, conducting evidenced-based practice activities, identifying and participating in bioethical issues, and income-producing projects. Discharge planning activities were further divided into categories of (a) assisting patient/family in understanding the diagnosis, anticipated level of functioning, prescribed treatment, and planning for follow up; (b) providing specialized instruction so the patient/family can carry out post-hospital care; (c) coordination of essential community support systems; and (d) relocation of the patient or transfer to another health care facility. Described as a self-directed model of practice, encompassed within a multidisciplinary setting (Berger et al., 2003; Kadushin & Kulys, 1993; Volland, Berkman, Phillips, & Stein, 2003; Vourlekis, Ell & Padgett, 2001) interdisciplinary collaboration was not a separate component examined here as there is an inherent understanding that hospital social workers' activities are encompassed within this overarching role.

Evidenced-based practice was defined as participation in research activities to evaluate the efficacy and effectiveness of specific strategies and/or to test underlying theoretical assumptions (Dhooper, 1997). Bioethics referenced actions taken to address patients' quality of life and reconciliation of this concept with medical professionals for the purposes of understanding and impacting the appropriate use of high-cost care and the equitable distribution of scarce resources in the health care arena (Dhooper, 1997; Kadushin & Egan, 2997; Reamer, 1985). Participation in income producing projects included grant writing, fundraising, political advocacy, and other activities to assist the organization's efforts to increase financial resources.

## Sampling Method

The initial sampling frame consisted of a list of 5,000 hospitals in the United States obtained from a member list of Healthcare Hiring (http://sss.healthcarehiring.com/hospitals), which is loosely based on the American Hospital Association Member list. To obtain a sample of 1,000 hospitals (with a goal of 20 from each state) a non-random sampling method was utilized. Initially the list was divided by state and any hospital identified specifically as a psychiatric facility was eliminated as the goal was to incorporate hospitals primarily treating physical health issues. All hospitals in states with 20 or fewer meeting criteria were included in the sample. A sampling of every 10th hospital was utilized in states having more than 20 hospitals meeting inclusion criteria until 20 hospitals were identified. As several states had fewer than 20 eligible hospitals, additional hospitals were chosen using the same sampling method of every 10th hospital listed from the five states

with the largest number of hospitals (California, Texas, Florida, Illinois, and Pennsylvania) until a sample size of 1,000 was achieved.

Once approval was received from the Institutional Review Board survey instruments were mailed out in two waves. The first 500 were mailed in July 2006, with an additional 500 being mailed in August 2006. Questionnaires were addressed to the Department of Social Work/Case Management at the main address listed for each hospital. All mailed envelopes included one copy of the survey instrument, along with a cover letter explaining the purpose for the study, and a self-addressed stamped envelop for return. Additionally, a note was attached to each questionnaire indicating copies could be made if the department employed more than one social worker and if others desired to complete the questionnaire. Questionnaires completed by respondents who indicated they held a Bachelor's of Social Work (BSW) or Master's of Social Work (MSW) degree and were received via return mail during the time frame of July 2006 through January 2007 were eligible for inclusion in the study.

## Data Analysis

Analysis of data was completed using the Statistical Package for Social Sciences (SPSS 16.0). Data was initially screened and prepared for analysis in the following manner. Univariate descriptive statistics were computed for all variables and analyzed for accuracy of input, evaluating amount and distribution of missing data, along with the variance and skewness of scale-level variables. Evaluation of the amount and distribution of missing data revealed widely dispersed, minimal missing cases across all variables (<5%). As the focus of this study was to describe the current roles and activities of hospital social workers findings are based on descriptive and chi-square statistical analysis.

# RESULTS

## Respondents

A total of 394 surveys were returned; however, only 377 met inclusion criteria resulting in a response rate of 37.7% based on the 1,000 questionnaires mailed. The majority of respondents were female, White, aged 45 or older and worked full time. Demographic characteristics of respondents can be found in Table 1. Most respondents report they have a MSW degree ($n$ = 301, 79.8%) with 102 respondents (27.0%) indicating they hold both a BSW and MSW degree. Those with a MSW degree are significantly older ($x^2$ (2, $n$ = 377) = 9.489, $p$ = .009) and report significantly more income ($x^2$ (2, $n$ = 371) = 61.508, $p$ = .000) when compared to those without. No other differences were identified between respondent categories. Years of graduation for those earning a BSW ranged from 1965 to 2006 with most

**TABLE 1** Demographic Characteristics of Respondents ($n = 377$)*

| | MSW | |
|---|---|---|
| Degree status | YES *n* (%) | NO *n* (%) |
| Gender | | |
| Male | 37 (90.2) | 4 (9.8) |
| Female | 264 (78.6) | 72 (21.4) |
| Age** | | |
| 29 or younger | 22 (61.1) | 14 (38.9) |
| 30 to 44 | 108 (79.4) | 28 (20.6) |
| 45 or older | 171 (83.4) | 34 (16.6) |
| Ethnic background | | |
| White | 264 (79.8) | 67 (20.2) |
| African American | 14 (77.8) | 4 (22.2) |
| Hispanic or Latino | 9 (75.0) | 3 (25.0) |
| Asian | 5 (83.3) | 1 (16.7) |
| Other | 7 (87.5) | 1 (12.5) |
| Income*** | | |
| 35,000 or less | 23 (45.1) | 28 (54.9) |
| 35,001 to 55,000 | 148 (78.3) | 41 (21.7) |
| More than 55,000 | 124 (94.7) | 7 (5.3) |

*Changes in sample size reflect missing data on certain variables; **$p \leq .05$; ***$p \leq .001$.

(86.5%) earning the BSW degree prior to 2001. Respondents having a MSW degree reported years of graduation ranging from 1960 to 2006 with the majority (78%) earning the degree prior to 2001. Most respondents (73.8%, $n = 274$) anticipate continued employment within the health care field over the next five years.

The majority of respondents had extensive work history in health care overall with 56.4% ($n = 211$) indicating in excess of 10 years experience. For most their current position was not the first paid position in health care (65.5%, $n = 247$) and the majority were employed in a non-federal, short-term hospital (83.8%, $n = 316$). The largest percentage of respondents (45.6%, $n = 172$) report there is less than 5 degreed social workers in their hospital settings, with only 11.9% ($n = 45$) indicating more than twenty. Respondents with 10 or more years of health care work experience were significantly more likely to report having administrative supervisory duties (53.8%, $n = 113$) than those with less than 10 years of work experience (27.7%, $n = 44$). ($p = .000$ Fisher's exact test). Additional employment characteristics of respondents are found in Table 2.

## Patient Caseload and Service Lines

A substantial number of respondents (43.8%) indicated they provided services in a one-month period to 60 or more patients, while fewer than

**TABLE 2** Employment characteristics of respondents ($n = 377$)*

| | *n* | % of total |
|---|---|---|
| Employment setting ($n = 373$) | | |
| Non-Federal, short-term hospital | 316 | 83.8 |
| Non-Federal, long-term hospital | 18 | 04.8 |
| Federal hospital | 18 | 04.8 |
| Other | 19 | 05.0 |
| Length of time employed in health care ($n = 374$) | | |
| Less than 1 year | 17 | 04.5 |
| 1–5 years | 73 | 19.9 |
| 6–10 years | 70 | 18.6 |
| Greater than 10 years | 211 | 56.4 |
| First paid position in health care ($n = 373$) | | |
| Yes | 126 | 33.4 |
| No | 247 | 65.5 |
| Has supervisory duties ($n = 370$) | | |
| Yes | 158 | 41.9 |
| No | 214 | 56.8 |
| Has a degreed social worker as direct supervisor ($n = 370$) | | |
| Yes | 88 | 23.3 |
| No | 282 | 74.8 |

*Changing sample size reflects missing data on certain variables.

25% ($n = 31$) assisted 30 or fewer patients during the same time period. Respondents were asked to choose the top service lines in which the majority of their professional activities were concentrated (see Table 3).

## Identified Roles and Activities of Hospital Social Workers

Direct patient care activities consumed the majority of time for respondents. Table 4 presents respondents reports of estimated time associated with each service activity.

Discharge planning activities represented the area in which most respondents spent the greatest percentage of their time. Of those indicting they conducted discharge-planning activities, 40.8% ($n = 147$) spent greater than 60% of their time carrying out associated tasks. The majority of time allocated by respondents to tasks associated with discharge planning fell into the categories of coordinating essential community supports systems and relocation of patients. Activities involving the coordination of essential community support systems constituted 25% or more of discharge planning practice time for almost half of the respondents (43.5%, $n = 164$). One-third of respondents (33.4%, $n = 126$) spent 25% or more of their time related to discharge planning in the relocation of patients—transferring to other medical facilities and/or long-term care settings. Providing specialized instruction so the patient and family can perform post hospital care constituted less

**TABLE 3** Service Lines Consuming the Majority of Respondents Time

| Service line | *n* (%) |
|---|---|
| Acute medical ($n = 156$) | |
| Surgery services | 89 (23.40) |
| ICU/CCU | 28 (7.70) |
| Orthopedics | 7 (1.80) |
| Transplant | 3 (0.80) |
| Inpatient physical rehabilitation | 14 (3.70) |
| Oncology | 15 (3.90) |
| Aging services ($n = 97$) | |
| Geriatric floor | 91 (23.00) |
| Skilled nursing | 6 (1.70) |
| Other ($n = 68$) | 68 (18.80) |
| Children's services ($n = 22$) | |
| Pediatric floor | 12 (3.30) |
| Neo-Natal Care Unit | 10 (2.60) |
| Ancillary services ($n = 19$) | |
| Home health | 1 (0.30) |
| Outpatient | 6 (1.70) |
| Dialysis | 6 (1.70) |
| Emergency Room | 6 (1.70) |

**TABLE 4** Estimated Percentage of Time Spent in Service Activities

| Estimated time | Discharge planning ($n = 327$)% | Direct practice ($n = 343$)% | Bioethics ($n = 318$)% | EBP ($n = 283$)% | Income generating ($n = 292$)% |
|---|---|---|---|---|---|
| 20% or less | 22.0 | 41.7 | 93.4 | 97.2 | 98.3 |
| 21–40% | 14.4 | 22.4 | 05.0 | 02.5 | 01.0 |
| 41–60% | 22.3 | 18.4 | 00.9 | 00.4 | 00.3 |
| 61–80% | 26.9 | 11.1 | — | — | — |
| Greater than 80% | 14.4 | 06.4 | 00.6 | — | 00.3 |

than 25% of time for 81% ($n = 305$) of respondents with one-third (33.6%, $n = 113$) reportedly spending no time in this endeavor. Similarly, activities to assist the patient and family in understanding the diagnosis, anticipated level of functioning, prescribed treatment and planning for follow up was carried out by less than one-third of respondents (30.1%, $n = 128$) more than 25% of the time.

Direct practice which includes counseling services or crisis intervention activities for patients within hospital settings was conducted only 20% of the time or less by 43.8% ($n = 165$) of respondents, with almost one-third (29.4%) indicating they spent 10% or less of their time in these activities. The majority of respondents reported spending no time participating in issues related to bioethics (93.4%, $n = 297$); evidenced based practice (97.2%, $n = 275$); or income producing projects (87.7%, $n = 306$).

## DISCUSSION

The era of reengineering within hospital systems was projected to impact medical social workers and their respective departments primarily in a negative manner unless proactive steps were taken to prevent an impending demise (Berger et al. 2003; Globerman, 1996; Globerman et al., 2002; Michalski et al., 1999; Mizrahi & Berger, 2001, 2005; Neuman, 2000, 2003; Sulman et al. 2001). To capture an image of contemporary roles and activities carried out by hospital social workers in a post-reengineering era, a sample of hospital social workers from across the nation were surveyed. First, it is important to outline the strengths and limitations of the current study.

### Strengths and Limitations of the Study

Strengths of the current study include not only the substantial number of respondents but also the fact that most have been employed within the health care arena for an extended time period and many would have been in the health field during the era of reengineering. Given that non-random sampling was employed generalizing the results beyond the study population is limited. While it has been estimated that three-fourths of hospital systems in the United States underwent reengineering (Neuman, 2003), there was no mechanism incorporated within this survey process to delineate respondents who were employed by hospital systems that did undergo reengineering activities or to determine the extent to which organizational change may have occurred. Additionally, the population surveyed reflects hospital social workers currently employed and does not capture those who may have left the hospital setting as a result of downsizing or dissatisfaction with changes resulting from reengineering processes.

### Social Work Leadership

As decentralization of hospital departments took place, an erosion of social work supervision was noted (Berger et al. 2003; Neuman, 2000; Ross, 1993). With the majority of respondents indicating they did not have supervisory duties and a larger percentage indicating they did not have a supervisor who held a social work degree, a continued trend in the dismantling of departmental social work supervision could be substantiated. However, a contradiction is found as a large number of respondents did indicate responsibility for providing administrative supervision. This may be indicative of social workers providing administrative supervision to direct line social workers, while they report to individuals with a non–social work degree. In addition as almost one-half of respondents in this study report their work setting has less than 5 degreed social workers employed, concerns regarding

struggles to maintain professional connections arise, a problem identified in a post-reengineering era (Michlaski et al, 1999).

## Patient Care Activities

Patient care activities included providing counseling and crisis intervention and discharge planning services. Respondents reported spending less time in counseling or crisis intervention (direct practice) activities when compared to discharge planning, which is reflective of findings that counseling activities decreased following a period of reengineering (Michalski et al., 1999).

Trends in reengineering tended to move social work from a separate, autonomous service for hospital patients to one in which social work activities were integrated into service lines such as orthopedic, geriatric, or oncology (Alvelo, Garcia, & Rosario, 2008). To streamline costs, tasks identified as being "low skilled" were often reassigned to individuals with lower levels of education and thus lower pay scales. While the cost reduction measure was anticipated to eliminate the coordination of concrete resources for patients provided by hospital social workers, this was not manifested within this study population. Discharge planning continues to be a primary role for hospital social workers consuming the preponderance of their time. The process of discharge planning has encompassed two areas of activities for hospital social workers (a) counseling to help patients deal with reactions to illness and hospitalization while preparing to leave the hospital setting and (b) provision of concrete resources (Blumefield & Rosenberg, 1988: Kadushin & Kulys, 1993).

The primary discharge planning activities reported by respondents in this study include the securing of concrete resources such as coordinating post hospital services and/or assisting in the relocation of patients to other care institutions. Similar to findings in other studies following the era of change (Holliman, Dziegielewski, & Teare, 2003) respondents in this study indicated they did not participate in activities to assist patients and families in understanding of their diagnosis or specialized instruction related to treatment planning for the purpose of ensuring continuity of post-discharge care. However, these components are often encapsulated within the discharge process itself, not necessarily a separate interaction and may not have been viewed as a distinct activity by respondents.

## Non-Patient Care Activities

Non-patient care activities included participation in activities for evidenced-based practice, income-generating projects, and addressing bioethical issues. Virtually all respondents indicated they did not participate in research activities targeted at evaluating the efficacy and effectiveness of specific strategies and/or to test underlying theoretical assumptions. Given the lack

of understanding as to what constitutes evidence-based practice in the social work literature (Gambrill, 2007; Webb, 2001) and evidence-based medicine in the medical literature (Buetow, Upshur, Miles & Loughlin et al., 2006; Gupta, 2010) it is not surprising the majority of respondents indicated they had not participated in such activities.

Bioethical issues tend to be entwined with direct care patient activities as hospital social workers address needs related to services access and transition out of a hospital setting. Hospital social workers are often involved with individuals from high-risk groups, with empowerment and advocacy being instituted on a case-by-case basis (Gibbons, & Plath, 2006; Holliman, 1997). Thus, while the majority of respondents indicated they did not participate in bioethical activities, this may reflect limited activity undertaken on a systemic level.

It appears respondents, as identified in other research studies, may not be undertaking necessary tasks to promote best practices for patient outcomes nor taking action to provide evidence of the necessary social work skills and knowledge required to carry out such complex activities (Preyde, MaCaulay, & Dingwall, 2009) despite the need to demonstrate effective and efficient outcomes (McDonald, 2009; Upton, 1999). One study has demonstrated actual participation in education and research activities by hospital social workers declined following the era of reengineering (Michalski et al., 1999).

Another area not often associated with hospital social work but recommended for social work participation is that of developing and participating in income producing projects. Suggestions for aligning the social work profession with income producing endeavors emerged well over 20 years ago and remain relevant today (Blumenfield & Rosenberg, 1988). As reimbursement for hospital services continues to be cut and reallocated, social workers are in pivotal positions for developing services that promote fiscal viability. One such example complements trends toward the self-management of chronic illnesses and promotion of preventive activities by developing cooperatives with local employers to provide educational services regarding stress reduction techniques.

## CONCLUSIONS AND RECOMMENDATIONS

As the era of reengineering brought about concerns and opportunities for social workers in hospital settings, the health care arena continues to be one in which change is required. Continued investigation of the roles and activities of hospital social workers as well as the impact social workers can make for patients, communities, and organizations along the health care continuum is vital.

As managers in the hospital setting are increasingly more likely to hold degrees in disciplines other than social work it will be important to explore

how their understanding of the professional knowledge, skills, and abilities, as well as how professional values and ethics impacts opportunities for hospital social workers. If in fact a limited understanding results in restraining the roles and activities of hospital social workers, patients may not receive optimum outcomes, which will in turn impact the hospitals ability to maintain a positive bottom line. In addition, concerns regarding morale and job satisfaction among hospital social workers have also been tied to decentralization (Alvelo et al., 2008; Neuman, 2003). While this survey process did not directly inquire as to respondents' job satisfaction, or the current level of burnout and/or morale, the majority of respondents indicated they anticipated being in their current position or one similar over the next five years. Remaining in hospital social work has been linked to a "tolerance" for the environment and not necessarily tied with a positive experience, which may have a potential for undermining patient outcomes (Pockett, 2003).

Furthermore, it is vital that hospital social workers, along with those in other health care settings, take a proactive stance and conduct outcome evaluations for the services they provide which will contribute to the foundation of evidenced based practice. Within the Veterans' Administration system, where social workers are a primary and dominant force, the utilization of data and published research aided in regaining a distinct social work department following its initial decentralization (Alvelo et al., 2005). As reimbursement of health care services become increasingly tied to patient outcomes and best practices, it will be vital for hospital social workers to demonstrate the efficacy of their interventions.

Hospital social workers can be creative in developing programs that produce income and positively impact patient outcomes and while helping to assure hospitals remain viable institutions to serve those in need. Utilizing a bio-psychosocial perspective, the hospital social worker can design programs focusing on wellness and health education, and then work with various employers to provide financial coverage for such services to be provided to their employees. Implementation of new programs positioning social workers for policy and practice roles such as rape crisis services, support groups, student initiatives, and consultation services have been documented (Mizrahi & Berger, 2001).

Throughout history social workers have been a vital force within the hospital system and continue to maintain pivotal roles associated with discharge planning. Despite efforts to minimize and compartmentalize discharge planning activities, it is once again being recognized as a complex feat requiring a professional level of knowledge and skills (Auerbach, Mason & Laporte, 2007; Holliman et al.; 2001; Preyde et al., 2009). Hospital social workers must focus on expanding this role beyond providing concrete resources and assisting with patient's transition to other institutions to include proactive actions that promote positive patient outcomes post-hospitalization.

As Ida Cannon stated almost a century 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. (p. 34)

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