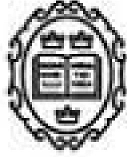

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Author(s): Barbara Berkman

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The Emerging Health Care World: Implications for Social Work Practice and Education

Barbara Berkman

Dramatic changes in patient care delivery have been stimulated by advances in technology and new approaches to the financing of health care. Traditionally, the American health care system has been based on a paradigm of unpredictable acute simple disease, a model that has become inappropriate as increasing numbers of patients are presenting with multiple, chronic health problems. Because chronic illnesses are determined by many factors, such as an individual's social, psychological, and physical environment; genetic makeup; and health care accessibility factors, the hospital, once the dominant organization in health care, must become part of a primary care network of community-oriented delivery systems focused on chronic disease management. In this model, the social worker treats the patient throughout the continuum of care. Therefore, dynamic training that addresses the changing health care environment will be needed. In addition, social workers will need to work as members of a team in addressing the needs of patients for preventive, curative, and rehabilitative services.

Key words: *chronic disease; health care; managed care; primary care*

The cost of health care in the United States is approaching $1 trillion a year, 15 percent of the gross national product (Shortell, Gillies, & Devers, 1995). Public and private entities are calling for reforms that will limit these rising costs. The acute care hospital, once the central institution of health care delivery, is particularly challenged by today's calls for controls. In response, the decentralization of expensive diagnostic services to out-of-hospital sites has accelerated, and the use of ambulatory care for procedures that were once done only on an inpatient basis has increased. These measures have resulted in cost savings by limiting the numbers of patients hospitalized and by reducing inpatient lengths of stay. Between 1984 and 1992 hospital admissions declined 11 percent and inpatient days 20 percent (Shortell et al., 1995). Currently, it is estimated that 98 percent of all medical encounters occur in nonhospital settings and that outpatient surgeries represent approximately 70 percent of all surgical procedures (Shortell et al., 1995). Empty inpatient

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beds have already contributed to the downsizing of hospital staff and the closing of facilities. Between 1980 and 1993, 949 hospitals closed (American Hospital Association [AHA], 1994). These dramatic changes in patient care delivery have been stimulated significantly by advances in technology and new approaches to the financing of health care, including managed care programs insuring specific populations.

Growth of Managed Care

"Managed care" refers to a number of organizational structures, various financing arrangements, and regulatory devices (Mechanic, Schlesinger, & McAlpine, 1995). The key idea underlying managed care is the limiting of unnecessary health service utilization by altering treatment processes in various ways: through budget restrictions and utilization controls, through financial incentives for providers to limit services, through case management review of treatment plans against pre-established criteria, and through the use of primary care physicians as gatekeepers for access to care (Mechanic et al., 1995; Society for Social Work Administrators in Health Care, 1994).

The use of managed care organizations for the administration of private medical benefits is a fast-growing trend. It is estimated that by the year 2000, 90 percent of all medical benefits administration will be handled by managed care organizations (White, Simmons, & Bixby, 1993). Physicians are challenged by the structural constraints and inherent limitations of managed care. Choices traditionally made exclusively within the patient–physician relationship are now made through the institutional arrangements of managed care (Rodwin, 1995). As a result, many providers are trying to treat patients at that point in the continuum of care at which the greatest value is added. For the most part, this point is outside of inpatient hospital services (Shortell et al., 1995).

Capitation

One particularly significant change in managed care financial arrangements is capitation. Under this form of payment, a provider system is paid a fixed amount to care for patients over a given period. In the fee-for-service payment system, greater volume is associated with more revenue. In the new world of capitation, revenue is earned up front when the care contract is negotiated on the basis of a predetermined amount of money per member per month for a defined population of enrollees (Shortell et al., 1995). Capitation is designed to provide an incentive to providers to keep patients healthy, thereby controlling the costs of patient care by staying within a budget. Although it is assumed that under capitation this flat fee will exceed the cost of some patients' care and be insufficient to cover the cost of others, it is expected that this cost differentiation will balance out and that the provider will be adequately reimbursed.

Although capitation arrangements currently account for only 7 percent of the revenues of hospitals and medical groups, capitation growth is projected to reach 17 percent over the next two years (Shortell et al., 1995). Even today, in some hospitals, 20 percent of revenue is attributed to capitation arrangements, and there are medical groups for which capitation represents over 50 percent of revenue (Shortell et al., 1995). It is anticipated that capitation will result in the creation of networks of integrated health care delivery in which a full spectrum of services from primary to specialized care will be offered at a fixed price (Moriarity, 1993; Pear, 1993). Many hospitals have already diversified into vertical integrated networks of care by expanding or adding group practices, ambulatory care centers, home health agencies, subacute care units, and hospices. For example, between 1980 and 1992 there was a 73 percent increase in the volume of outpatient visits (AHA, 1993). Between 1972 and 1990, the percentage of hospitals offering home health services increased from 6 percent to 36 percent, and the percentage of hospitals providing subacute inpatient care increased from 9 percent to 21 percent (Robinson, 1994).

Primary Care Physicians as Gatekeepers

Within these new health care delivery systems, primary care physicians are important gatekeepers who monitor and coordinate their patients' health care. They are expected by insurers to control the access of patients to both specialized medical care and necessary community-based social and health care resources (Cassell, 1995). Unfortunately, the medical and nonmedical service systems have operated as separated and fragmented entities, raising increased concerns about accessibility, efficiency, and comprehensiveness of health care services (Itano, Williams, Deaton, & Oishi, 1991).

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Old and New Health Care Paradigms

Traditionally, the U.S. health care system has been based on a paradigm of unpredictable acute simple disease. This model has become increasingly inappropriate as increasing numbers of patients are presenting with multiple, chronic health problems. These patients, particularly those who are elderly, will be increasingly at risk of losing their ability to function independently and of living with frailty. The leading causes of morbidity and mortality are almost all related to chronic, complex processes. For example, pneumonia, once perceived primarily as an acute illness, is now frequently perceived as an episode in a chronic disease process such as obstructive lung disease or HIV infection (Pawlson, 1994).

In the new health care paradigm of chronic, complex illness, episodes of need for care tend to be relatively more predictable (Pawlson, 1994), and there is the recognition that chronic illnesses are determined by multiple factors, such as an individual's social, psychological, and physical environment; genetic makeup; and health care accessibility factors (Evans, 1994; Syme, 1994). The view that illness is a chronic process raises the question of whether an acute episode could have been prevented, placing much more importance on patients as consumers and participants in determining their health care service needs. The focus of care is logically on primary care with an emphasis on disease prevention and health promotion (Pawlson, 1994). Screening for patients at risk for physical, social, or psychological regression becomes much more essential in this new model, and the timing of intervention by health care professionals becomes paramount.

Social Work's Role in Health Care

Within the acute care model, illness is depicted as a single isolated event, with the patient hospitalized, treated, and discharged. It is therefore understandable that the role of the social worker in this framework was predominantly as a part of hospital inpatient services focusing on the discharge of patients and on outcomes related to reducing both lengths of stay and premature rehospitalization through provision of necessary posthospital care services and resources. Conversely, the chronic complex illness model assumes multiple contributing factors, with the basis of illness being biopsychosocial and the relationship among the health care systems being continuous. For this model to succeed, the hospital must become part of a primary care network of community-oriented social services delivery systems focused on broad aspects of health care and chronic disease management (Shortell et al., 1995). This requires the restructuring of the caregiving process. The biggest challenge to this restructuring (or "clinical re-engineering," as it is often called) lies in managing multiple, complex, chronic illnesses that require a continuum of care and treatments from multiple professionals in various settings. In this model, the social worker's role should be throughout the continuum of care.

At present the health care system is not adequately prepared to handle the demands and complexity of the psychosocial health care needs of the increasing numbers of chronically ill ambulatory patients. Whereas primary care physicians have traditionally participated in the episodic phases of chronic illness, their physiological orientation within the acute care medical model is too restrictive in terms of the overall health concerns of their patients, making it difficult for them to play a major role in managing the patients' continuing complex needs. Concomitantly, they are often unfamiliar with the range of available nonmedical home and community-based services (Zawadski & Eng, 1988). Making in-depth psychosocial–environmental assessments; working with compliance issues; engaging the family and other support systems; and referring patients to needed services such as home health care, physical therapy, occupational therapy, financial services, day care, nursing homes, and meal and transportation services can best be addressed through the involvement and collaboration of social workers. Screening hospitalized inpatients' need for social work services has helped social workers be more effective in hospitals by making case finding more proactive (Berkman, Rehr, & Rosenberg, 1980). Similarly, in outpatient settings, screening and assessment by social workers can help increase the awareness of psychosocial and environmental issues that affect a patient's condition and lead to effective early interventions.

The biopsychosocial approach of social work in health care provides a carefully balanced perspective that takes into account the entire person in his or her environment and helps social workers assess the needs of an individual from a multidimensional point of view. Biopsychosocial assessments are going to play an increasingly important

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role in health planning and clinical practice. With the goals of maintaining patients' viability to live in independent settings and enhancing quality of life, greater attention is being given to standardized screening tools that use predictive factors to yield standardized scores, which lead to an assessment of at-risk patients' social health care needs.

Clinical Specialists

Dramatic changes in health care delivery have already affected the practice of social work, particularly in hospitals. Recently, the Society for Social Work Administrators in Health Care and NASW conducted a national research project to study the current impact of social work on these fast-moving changes (Berger et al., 1996). This research found that, indeed, social work clinical activity in ambulatory care is increasing but is not commensurate with the hospitals' movement toward service delivery in ambulatory care.

Departments of social work are moving away from traditional linear management, which includes directors, associate directors, assistant directors, and various other levels of managers and supervisors, to self-managed team approaches in which there are fewer managerial staff. The national study by Berger et al. (1996) noted that although there are anecdotal reports of decentralization of social work services, their data do not suggest this to be a major trend in the structure of social work services. Although this study sheds light on the effects of changes in health care on social work, we do not know the full impact of managed care development as it will influence restructuring and resizing activities.

Although the total number of health care professionals, including social workers, participating in hospital-based services will decrease because of reduced inpatient beds, a significant role for social workers in health care services still exists—that of clinical specialists, sophisticated and adaptable practitioners who can work flexibly under minimal supervision. Primary care physicians, as well as medical specialists, need the skills of social workers to handle the psychosocial and environmental aspects of illness. It is becoming more common to hear that mental states play an important role in recovery from physical illness (Chiacchia, 1993; Mumford, Schlesinger, & Glass, 1982; Williams, 1990). Concomitantly, psychological states and stimuli may have a direct influence on somatic function (Katon & Schulberg, 1992; Schnall et al., 1990). Neither medical specialists nor primary care physicians will have adequate knowledge of or training in the recognition or treatment of mental disorders such as mild depression or anxiety, which can have a negative effect on the patient's recovery from illness and his or her ability to follow necessary chronic care regimens (Magruder-Habib, Zung, & Feussner, 1990).

The social worker can be the member of the health care team, either inpatient or outpatient, who has the knowledge and skills to identify patients in need of the psychosocial help necessary to change negative behaviors and thus stop progression toward disability. Specifically, social workers are needed

- to help determine if the patient and family can manage the recommended treatment or discharge plan
- to counsel and support patients and significant others who are emotionally distraught (for example, as a result of a diagnosis or bereavement)
- to assist patients and families with decision making around ethical issues
- to educate patients and significant others regarding psychosocial issues in adjusting and responding to illness and to necessary role changes
- to assist in resolving behavioral problems that impede the ability of the patient and family to make decisions
- to assist in identifying and obtaining entitlement benefits
- to assist in identifying and obtaining nonmedical community resources
- to assist the health care team in resolving patient and family behavioral problems that impede the team's ability to care for the hospitalized patient
- to provide risk management by intervening with patients and families who are dissatisfied with their care
- to offer consultation to providers around behavioral and emotional issues.

Case Managers

In the role of case manager or care coordinator, social workers provide interventions that are short term and intensive with the goal of creating the support systems necessary to enhance and maintain social functioning (Williams, Warrick,

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Christianson, & Netting, 1993). Social workers have historically focused on transactions between individuals and the environment from a biopsychosocial perspective in an attempt to improve the quality of life for the individual in terms of psychosocial functioning (Hartman, 1991; Zayas & Dyche, 1992). The social work case manager addresses both the individual client's biopsychosocial status and the state of the social system in which he or she operates. It is in this position, which focuses on screening and assessing the needs of the client and the client's family, that the case manager also arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs (NASW, 1992). To this end, early intervention, such as screening of patients by social workers, may determine the existence of depression, delay the physical deterioration of the patient, and help prevent hospitalization (Berkman et al., 1996; Lockery, Dunkle, Kart, & Coulton, 1994).

Furthermore, social workers can help physicians identify patients' needs more appropriately and define their problems more specifically (Azzarto, 1993; Dobrof, Umpierre, Rocha, & Silverton, 1990; Eggert, Zimmer, Hall, & Friedman, 1991; Fielden, 1992; Mayer et al., 1990; Morrow-Howell, 1992; NASW, 1992; Oktay, Steinwachs, Mamon, Bone, & Fahey, 1992; Seltzer, Litchfield, Kapust, & Mayer, 1992). For example, studies have found that somatization can be reduced with case management involvement. By addressing the social and emotional needs of patients, social work case managers are able to alleviate the demand for time and attention that such patients place on their physicians (Azzarto, 1993; Colone, 1993). In addition, the social work case manager, under managed care, must be able to manage the benefits available to the patient by understanding what services are available, what their costs are, what the benefit limitations are, and which benefits are cost-effective.

Efficiency in interdisciplinary collaboration for effective patient care both within the institution and in the community at large is a necessary practice skill for all health care professionals. Collaboration with community agencies and with programs for patients with particular diseases, including nursing and home care services, local community programs, hospices, and support groups, is even more essential for optimum social work case management practice. Neither the doctor nor the nurse has the knowledge necessary to assess social services needs or to secure and coordinate community-based services. Central to collaborative practice is the establishment of effective means of communication among all disciplines. Communication skills, particularly in conveying information electronically, are necessary.

Another important role of the case manager is to provide information about public or private resources available to clients and about ways to gain access to these resources. Social workers are trained to be aware of and use community resources to make the environment on all levels more supportive and enabling for the individual. The social worker, as case manager, is able to identify gaps in services that the client is receiving (Loomis, 1988) and has been shown to be successful in linking patients, particularly elderly ones, to the services they need (Colone, 1993; Howell, 1992; Oktay et al., 1992; White et al., 1993). Clinical case management is particularly important in gerontological social work because of the multiple problems that elderly people face and their need for supports and resources (Morrow-Howell, 1992).

Is the social worker, as a case manager or care coordinator, cost-effective? Although more research is needed to ascertain exact savings, social workers can reduce costs by means of preventive measures (Azzarto, 1993; Gropper, 1988; Loomis, 1988). Early intervention, decreased rates of hospital readmissions, and decreased emergency department visits are enormously cost-effective (Colone, 1993; Dobrof et al., 1990; Eggert et al., 1991; Migchelbrink, Anderson, Schultz, & St. Charles, 1993; Oktay et al., 1992; Wofford, Schwartz, & Byrum, 1993). Adding a social worker to a primary care practice can result in significant financial benefits for the physician. Medicare considers each patient visit as potentially billable, so a physician can free up valuable billable hours when the social worker has relieved the doctor of the need to spend time providing attention and arranging home care services, family meetings, and the like (Azzarto, 1993; Colone, 1993; personal communication with S. Shearer, program manager, Senior Care Network, Huntington Memorial Hospital, Pasadena, CA, May 10, 1996). The use of social workers to attend to the psychosocial needs of patients also benefits insurance providers because costs are decreased

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significantly when mental health problems are detected early. For example, early detection of mental health problems can result in the decreased likelihood that patients will misuse medical appointments for psychosocial problems (Azzarto, 1993; Clarke, Neuwirth, & Bernstein, 1986; Colone, 1993; Dobrof et al., 1990; Gropper, 1988; Loomis, 1988). Studies are needed that specifically operationalize social work interventions and tie their services to specific outcomes, including indicators of cost-effectiveness.

Benefits

The presence of a social worker in a primary care outpatient setting provides several therapeutic benefits to patients and physicians. When a social worker is able to share information about a patient's social problem, the physician is able to provide more comprehensive care. Having someone with sufficient mental health practice competency in a medical practice allows the physician to see more patients with emotional problems (Williams & Clare, 1979), thus widening the range of patients in the practice. The physician has the support of the social worker's skills when patients' presenting physical symptoms are secondary to social and emotional issues. Hence, the physician can deal with the medical aspects of care without neglecting the social and psychological needs of his or her patients (Robertson, 1992). In addition to outpatient primary care offices, there are many excellent avenues for offering outpatient case management, such as geriatric assessment clinics, mental health services, health satellite clinics, alcohol and substance abuse programs, home health care services, outreach programs, and wellness programs. There are also specialty centers for people with neurologic disorders, organ transplant patients, and oncology patients, to name a few (Rango & Kunes, 1995).

Another important aspect of social work health care services involves family members. The importance of balancing the client's capacities with informal help and formal structures so as to maximize client functioning cannot be overstated (Morrow-Howell, 1992). The social worker who is conversant in medical terminology can relate to providers and is able to explain medical jargon to patients and their families (American Hospital Association Council, 1987; Applebaum & Christianson, 1988). Assessing the relationship between the patient and caregiver is important because of the potential for caregiver burnout. A knowledgeable social worker can assess for this possibility and offer respite services. Knowing about the existence of respite services may also enable the patient to use informal support systems more fully and enable family members to be more willing and more effective in assisting their sick family member and improving his or her quality of life (Seltzer et al., 1992; Sizemore, Bennett, & Anderson, 1989).

Legal and Ethical Issues

The practice of social workers either as clinical specialists or case managers involves decisions that have legal and ethical considerations, primarily around the prolongation of life and dilemmas relative to providing information about specific types of illnesses or social concerns. In addition, the allocation of limited resources can be a source of ethical conflicts. There are no clear answers to many questions raised by new medical technologies, new illnesses, or new resource restrictions. These clinical decisions must be addressed by all health care practitioners. In addition, social workers as case managers are beginning to discuss advance directives with patients while they are in the primary care setting, before an emergency life-or-death medical crisis (Berkman et al., in press).

Role of Social Work Education

Social work practitioners must be independent players who assume a significant role on the health care team. Their training should be dynamic, addressing the changing health care environment with an anticipation of tomorrow's advances (Berkman et al., in press). Social workers will be needed who are trained to work together as members of a team in which they are able to address the needs of patients for preventive, curative, and rehabilitative services. Interdisciplinary education for advanced students should be a core component of all health professional education programs, both practicum based and school based.

The knowledge and skills required for practice as a clinical specialist in health care are well documented (Berkman et al., 1990). School-based and hospital-based models for developing a program to teach this knowledge and skills are also available (Berkman & Carlton, 1985; Caroff & Mailick, 1980). In light of the rapidly evolving changes in health care practices, it is all the more critical to

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review the knowledge base needed for specialist social workers and to make it a priority to learn the knowledge that is essential for both today's and tomorrow's health care world.

Theoretical Framework

The theoretical framework necessary for practice in health care should not emphasize psychopathology but instead should focus on the adaptive capacities of patients and significant others with the goals of preventing maladaptive behavior and enhancing recovery. The emphasis of practice in health care is on enhancement of coping. Preexisting emotional problems are a focus of intervention only to the extent that they compromise coping, not as primary illnesses to be treated in and of themselves. The framework for practice in health care must include an understanding of the interaction among psychological, social, cognitive, and biological factors.

A unique critical skill necessary for social workers in health care practice is the ability to integrate physiological data. This skill is as important to social work assessment and practice as the ability to integrate psychodynamic data. The issue for education is to create an understanding of how the psychological and biological interact physiologically and behaviorally. Social work specialists must have the tools to advance their understanding and use of biomedical knowledge. For social workers to offer optimal help to patients and families, they must have knowledge of the specificity of the illness or disease and its effect. They should be able to use the numerous sources of current medical data and have an understanding of the questions that must be asked about each patient. This is particularly relevant given that advances in health care technology significantly affect patients physiologically, psychologically, and socially. At the same time it is equally important to understand the patient and family perceptions of the disease (its causes and its cures), to be able to identify common and uncommon psychosocial needs of patients and families, and to understand how they will cope with the illness. Students must enter the health care setting with an understanding of how to get the information they need. There will be little time for mentoring, and supervision will be minimal. MSW programs must provide students with a framework to enable them to understand what information is needed and how to get it.

Practice Skills

In health care practice, the social worker must be competent in using the most helpful modes of individual, family, and group therapies at the various stages of illness. During the past several decades, practice courses in master's-level education programs typically have been structured to encompass general principles that are applicable to a variety of settings. Although these generic principles are certainly basic to the learning needs of the health care trainee, preparation for actual field experience is often less than adequate. Therefore, a number of practice issues must be addressed.

The health care specialist must be able to design treatment interventions based on an assessment of the problems facing an individual or family within the specific context of the disease or disability, giving consideration to internal and external resources. In the health care setting, the emphasis is on enhancing the patient's and family's ability to cope with health problems. This may involve strengthening social support, mobilizing external resources (for example, by means of advocacy, provision of concrete services, or involvement of family and community resources), or strengthening internal resources (for example, through clarification, education of the individual and family about the illness and its implications, priority setting, and regulation of the tempo of the coping activity). Although MSW educational programs generally teach these interventions, the specific context of health care delivery systems and the context of disease and disability must also be integrated.

An important aspect of clinical work in health care is the element of uncertainty confronting increasing numbers of families as technological developments in medicine transform life-threatening diseases into chronic illnesses. An area that deserves more attention by MSW programs is the use of systemic work to better understand and intervene more effectively with families stricken by chronic illness (Leahey & Wright, 1985). Courses in chronic illness interventions should be a major focus of health care curricula. Working within a family systems perspective can be especially useful in opening lines of communication, helping family members support each other in the tension of the uncertainty, and dealing with lack of synchrony when it occurs.

There is growing acknowledgment of and use of groups in helping patients and families. Group

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work is significant for intervention in health care settings. Most groups in health care are used to provide information and support to their members in an effort to increase coping skills and thereby foster some behavioral change (Berkman et al., in press).

Context of Health Care

There is a significant role for social workers in primary care in the coordination of nonmedical services, particularly in the community. These efforts at providing linkages with needed services save time for doctors, nurses, and patients by enabling faster access to needed care and thus can improve consumer relations (White et al., 1993). This clinical specialist role, or "case management" as it is called, has been given little attention in current social work curricula.

An emerging structure of health care is that of patient-focused care: a patient-centered and clinically driven approach to care from preadmission through posthospitalization (Clancy, 1994; Parsons & Murdaugh, 1994). There are key elements present in patient-focused care models, including decentralization of services with self-contained patient units, clinical pathway (practice protocol) development, multiskilled workers and cross training, and organizational restructuring. Social workers, as part of interdisciplinary work teams, will have minimal supervision once licensure requirements are met. Interdisciplinary teamwork requires communication skills, both electronic and written, and an understanding of the roles and functions of core and consultative team members.

Managed care uses new tools such as clinical pathways to ensure that patient care complies with predetermined standards. Clinical pathways delineate profession-specific responsibilities in assessment and care and describe the nature of team interactions, time frames for intervention, and processes and resources by case type. Beginning with the patient's entry into the health care system, the clinical pathway also establishes review procedures that measure patient outcomes. Social workers will be expected, and will want, to participate in the development of these clinical pathways so as to define more clearly their role in patient care delivery (Colone, 1993). Although clinical pathways generally have been developed for inpatient services, there is some initial movement into primary care. The ability to conceptualize social work interventions and expected outcomes is a critical practice skill.

The Future

What does this transition in the American health care system mean for social work practice and education? What are the fundamental issues that social workers should be considering? Instead of thinking primarily in terms of acute inpatient care delivery and discharge planning, which has been the main focus of social work delivery since the advent of Medicare, social workers must now think of redistributing their services within the continuum of care. Instead of treating acute care illness episodes, social workers must offer services that are oriented toward the goals of disease prevention and health promotion. Instead of caring for individual patients, social workers should be accountable for the health status of vulnerable at-risk populations such as elderly people, people infected with HIV, abused children and adults, victims of domestic violence, and pediatric oncology patients. Instead of thinking primarily of inpatient specialty services, social workers must now think of ambulatory care services, emphasizing primary care and ongoing health care management of chronic illnesses. Finally, for those who will still be needed to work with inpatient issues, social workers must shift their focus from discharge planning to thinking in terms of what patient care issues require their services. Social workers must determine when they are the primary health care professional with the skills to deal with specific issues, such as resolving behavioral problems, that impede the ability of the patient and family members to manage recommended treatment or discharge plans. Thus, instead of thinking in terms of inpatient beds and covering beds, social workers must think about covering care at the appropriate level, and instead of managing a department, they must manage a market (for example, dysfunctional families who hinder patient care and recovery) and promote their services throughout the hospital and within the community (Shortell et al., 1995).

Although social work education has placed greater emphasis in past years on the psychological and interpersonal elements of social functioning, there is a growing substantive argument for the inclusion of both biomedical- and psychological-based knowledge as the necessary thrust of social work education. The recent trend in health

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care toward increased diagnostic and treatment specialization has led to the formation of social work specialty groups such as oncology social workers, renal disease social workers, HIV/AIDS workers, heart and lung transplant workers, and neonatal workers. This trend reflects the awareness that specialized, diagnostically specific knowledge and skills of both a psychodynamic and physiological nature are required for truly valued social work practice in health care.

It is evident to those who practice in health care that the content areas conceptualized as necessary in advanced health curricula must encompass a blend of cultural, social, psychological, environmental, spiritual, and biological dimensions of social functioning. The bottom line is that a strong social work specialist in health care is one who is not easily overwhelmed by organizational complexities; who is knowledgeable about and comfortable around sophisticated state-of-the-art medical care; who is able to be flexible, creative, and a leader in service delivery both in the hospital and in the community; and who can work collaboratively as a key member of the health care team. As the face of health care changes dramatically toward outpatient care for complex medical situations, social work must also expand its focus of concern and articulate a new vision for itself. ■

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***Barbara Berkman, DSW,** is director, Social Work Research, Department of Social Services, Massachusetts General Hospital, Fruit Street, Boston, MA 02114; e-mail: berkmanb@a1.mgh.harvard.edu. She is also Helen Rehr/Ruth Fizdale Professor, School of Social Work, Columbia University, New York.*

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John S. Wodarski, Ph.D.
Janet B. Wattles Research Professor
Director, Doctoral Program and Research Center
University at Buffalo
State University of New York
School of Social Work
359 Baldy Hall, Box 601051
Buffalo, NY 14260-1050

Faculty

Namkee Choi, Ph.D.	*Senior Policy, Aging*
Arthur Cryns, Ph.D.	*Psychogeriatrics*
Howard J. Doueck, Ph.D.	*Child Abuse and Neglect, Child Welfare*
Jacquelyn Gyamerah, Ph.D.	*Substance Abuse, Mental Health*
Wilburn Hayden, Ph.D.	*Community Action, Management*
Kathleen Kost, Ph.D.	*Poverty, Employment*
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