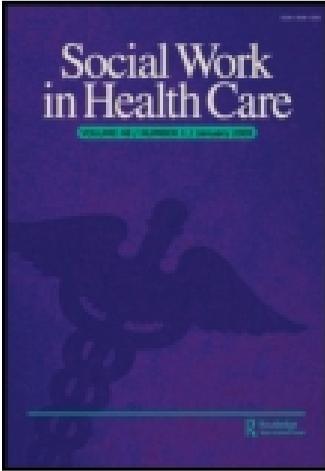


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The Challenges of Health Care Reform for Hospital Social Work in the United States

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This article examines the potential impact of the Patient Protection and Affordable Care Act (ACA) of 2010 on the practice of hospital social work in the United States and its implications for social work education and training. It briefly traces the history of hospital social work, outlines some contemporary issues in the health care field, particularly those that create persistent health disparities, summarizes the major provisions of the Act that have implications for social work practice, and discusses how social workers in hospital settings might respond effectively to the changes produced by the legislation.

KEYWORDS *hospital social work, health care disparities, Affordable Care Act*

INTRODUCTION

The recent Supreme Court ruling that most of the provisions of the 2010 Patient Protection and Affordable Care Act (ACA) are constitutional marks not the end, but as Churchill once said, merely the “end of the beginning” of the process of health care reform in the United States. While the Act still faces substantial political challenges, its implementation will have significant consequences not only for the structure and delivery of health care in the nation, but also for the practice of social work, particularly in

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hospitals. This article explores these potential implications by placing the future of social work practice in its broader historical context. The major themes it will explore include the effects of public policies and the changing political-economy of health on the structure of health care and the role of social services within the U.S. health care system; differences between institutional and community models of care; the role of professionalization and inter-professional competition; and the impact of professionalization on social work theories, practice models, and education.

A BRIEF HISTORY OF HOSPITAL SOCIAL WORK IN THE UNITED STATES

The emergence of hospital social work in the United States resulted from four inter-related phenomena: the transformation of American medicine that occurred at the turn of the twentieth century; the development of social work as an organized occupation whose practitioners sought professional status; the dramatic demographic and social changes occurring in U.S. society, particularly in urban areas; and the shift from communal to associative relationships in U.S. institutions that these changes produced (Leiby, 1978; Lubove, 1965; Rosenberg, 1987; Starr, 1982). During the so-called Progressive Era (~1890–1917), with the support of foundations established by powerful industrialists like Andrew Carnegie and John D. Rockefeller, the field of medicine became the dominant profession in the United States. The establishment of the American Medical Association (AMA), the introduction of increasingly restrictive admissions practices in medical schools, the promotion of what is now called “evidence-based practice” based on new scientific discoveries, the emergence of the field of preventive medicine, and the discovery of new sources of financial support altered the character of hospitals and hospital-based care. They were now businesses, rather than charities, as they had been since the Middle Ages. They were institutions of medical science, not social welfare organizations. Consequently, they were now oriented to professionals and patients, instead of their patrons and the poor (Rosenberg, 1987; Rothman, 1980; Starr, 1982). The 1910 Flexner Report on medical education affirmed the triumph of this new type of medicine. The emergence of hospital social work during this period reflected similar trends in the social work field (Wenocur & Reisch, 1989).

Prior to the early twentieth century, the antecedents of what became social work practice in health care settings were based solely in community dispensaries, which appeared in major American cities around the time of the American Revolution (Mandler, 1990). The first social service program in a hospital was established in City Hospital in Cleveland in 1891. Its purpose was to create a recordkeeping system that would help staff identify patients, who were often poor immigrants who did not speak English, so that family

members of the ill and dying could be located. By 1900, the city's Relief Department worked with the hospital to help relieve overcrowding when its wards became "clogged by chronic patients and Civil War vets" (Wagner, 1957, p. 3, cited in Ross, 1995). From the outset, therefore, hospital social workers served the fiscal needs of its host institutions as much as they did the human needs of their patients (Margolin, 1997).

Two years later, Johns Hopkins Hospital in Baltimore established a social medicine program and, in 1905, Dr. Richard Cabot of Massachusetts General Hospital in Boston set up an all-volunteer unit to provide social services to impoverished patients (Cabot, 1915). Within a year, Ida Cannon, often considered the grandmother of hospital social work in the United States, was asked by Cabot to organize a formal social work department that dealt primarily with outpatients. It was not until 1919, in the aftermath of World War I, that social work practice with inpatient wards was introduced (Ross, 1995; Caputi, 1978). This development coincided with the emergence of new roles and new models of practice in both hospital social work and social work practice in general. Social workers were now expected to regard the "person as patient" and the "patient as person" (Cannon, 1913).

Cabot's original vision of hospital social work differed substantially from how the field evolved. Reflecting the powerful influence of the public health orientation embraced by many Progressive Era reformers, including social workers, he recognized the environmental causes of illness and the potential role of social services in addressing them. He also acknowledged the important role that social workers could play in improving the quality of health care in hospital settings:

There is a vast deal of work in a hospital that the doctor can't do and doesn't want to do. For example, —he has neither the time nor the talent to teach hygiene. . . . Yet, without hygiene most of medicine is useless. Therefore to make the doctor's work worthwhile to himself and to the patient, it must be done (in hospitals) in co-operation with someone who has time and ability to teach hygiene and to see that it is carried out. . . . This "someone" is the social worker. . . . (pp. 177–179)

One implication of Cabot's perspective was that in the treatment of patients physicians and social workers were peers and not in a superior–subordinate role, as were doctors and nurses.

This new approach to social services spread rapidly. Between 1905 and 1917 over 100 hospitals in 35 cities created social work departments. By 1912, several schools of social work included courses on medical social work in their curriculum and the American Association of Hospital Social Workers was established in 1918. Abraham Flexner's keynote address at the 1915 National Conference of Social Work spurred the development of the specialization of hospital social work and the adoption by social work departments of

American Hospital Association standards. By 1930, more than 1,000 hospitals in the United States had social work departments (Hagerty, 1931). By the late 1930s, there were over 1,600 such departments (Carlton, 1990).

The growth of hospital social work between World War I and the Great Depression was reflected not merely in the number of practitioners or departments. There was also a significant expansion of social work roles. They now included information and referral, casework—to “augment the physician’s treatment of patients” (Cabot, cited in Caputi, 1978, p. 12) and serve as a liaison between physicians and patients; and health education, primarily to encourage patients’ to comply with physicians’ directions (Caputi, 1978). Inspired by the writings of social work leaders such as Mary Richmond, hospital social workers emulated the model of the physician to distinguish themselves and their practice from nurses and “old-style” charity workers (Wenocur & Reisch, 1989).

During this period, psychiatric social work also played an increasingly important role in the field of hospital social work. For many years, the inclusion of psychiatric care had been opposed by hospital administrators. It was not until 1895 that the first psychiatric social work program was established. In 1902, the New York State Department of Hospital Services established a Pathological Institute in Albany. Three years later, Dr. Adolf Meyer and his wife, a social worker, moved the Institute to Manhattan State Hospital in New York City. In 1906, the New York Charities Organization Society established privately supported psychiatric after care programs in each state hospital. By 1920, the popularity of psychiatric social work had grown considerably through the support of major foundations and the impact of the mental hygiene movement, particularly during World War I. During the 1920s, the significance of psychiatric social work further increased due to the influence of psychoanalytic theories, an influence that lasted through at least through the 1950s (Bartlett, 1934; Hamilton, 1951; Lubove, 1965; Sedgwick, 2012; Specht & Courtney, 1994).

Between World War I and the onset of the Great Depression the field of hospital social work had to respond to several challenges that threatened to undermine both its growth and its influence. First, hospital social workers were challenged to demonstrate scientifically the relationship between social and medical factors in the origin and treatment of illness. This proved particularly difficult given the limitations of social work research at the time (Zimbalist, 1977).

At the same time, the growing power of the medical profession led to demands that social workers in hospitals subordinate their roles to physicians, undermining the model of inter-professional collaboration that Richard Cabot had attempted to establish at the beginning of the twentieth century. These demands had several important implications for the practice of hospital social work. First, social workers had to establish appropriate relations with patients in the context of their new role within the occupational

hierarchy of hospitals. Second, they had to learn how to function as part of a hospital team, with all of its differences in professional sub-cultures and inter-professional competition (Webb, 1931). Finally, they had to develop new ways of thinking that combined medical and social diagnosis (Bruno, 1948; Rehr & Rosenberg, 2006; Sedgwick, 2012; Warner, Queen, & Harper, 1930). By 1926, these tensions led to the separation of medical and psychiatric social work, reflective of broader tensions between “generic” and specialized practice as discussed in the report of the 1929 Milford Conference (American Association of Social Workers, 1929).

This report affirmed and endorsed the split between medical and psychiatric social work. In making this distinction, it listed the major functions of hospital social work as:

1. Medical–social diagnosis
2. Interpretations of this diagnosis to other agencies, the patient, and the patient group
3. Teamwork with physical in case study and treatment
4. Casework within hospital organization
5. Discharge planning (called convalescent care)
6. Casework with physically handicapped individuals primarily regarding adjustment to their condition
7. Provision for chronically ill and disabled patients (e.g., admission to special institutions)
8. Health education regarding communicable disease
9. Public health promotion (p. 37)

Another significant development in the evolution of hospital social work was the introduction of group work practice. Social work with groups was first used at Massachusetts General Hospital prior to World War I in work with patients who had tuberculosis (Northen, 1990). During the 1930s, the field of group work acquired increased legitimacy within the social work profession as a whole and a stronger theoretical base (Reisch, 2008; Wenocur & Reisch, 1989). Further growth of hospital group work occurred during World War II, particularly with wounded veterans and in children’s wards. In 1946, the broader use of group work in hospitals began as an experimental program in the Veterans’ Administration Hospital in Cleveland. Five years later this successful program was expanded to include paraplegic patients.

Early group work practice in hospitals was influenced both by the hospital context and by theories that were popular during this period. Group workers needed to work in an integrated services setting and group work appeared to be an ideal modality to do so. This complemented the influential concept of treating the patient as a whole person, not merely as his/her illness, in order to “normalize” people’s situations. This was an updated version of the concepts proposed by Cabot and Cannon four decades earlier.

Finally, the enduring influence of psychoanalysis continued to be reflected in group work practice in hospitals (Fisher, 1949; Gifford, Landis, & Spafford Ackerly, 1953; Hollis & Taylor, 1951; Wilson & Ryland, 1949).

From the 1930s through the 1970s, the development of the U.S. welfare state played an important role in the evolution of hospital social work. During the New Deal, social work's overall role in U.S. society grew substantially as a result of the policy initiatives of the Roosevelt administration (Bartlett, 1934; Day, 2009; Lewis, 1937). In the 1950s and 1960s the Hill-Burton and Kerr-Mills Acts spurred the development of community hospitals and the passage of Medicare and Medicaid in 1965 vastly increased the use of hospitals, particularly among the elderly and indigent (Judd & Sheffield, 2010). The Social Security Amendments of 1972 further strengthened the role of hospital social work.

At the same time, the field of hospital social work became increasingly professionalized (Meyer, 1959). In 1961, a joint committee of the American Hospital Association (AHA) and the newly formed National Association of Social Workers formalized the functions of hospital social workers as set down by the Milford Conference over three decades before (AHA, 1961). The Society of Hospital Social Work Directors, founded in 1966, promoted the increased use of professional standards to demonstrate the field's commitment to accountability and improved performance. Increased government spending on health and mental health research, primarily through the National Institutes of Health, also promoted the development of hospital social work.

Another important political-economic influence during this period was the emergence of private health insurance. Until the 1930s private hospital care was available only for individuals who possessed the resources to afford it or those who were eligible for charitable care (Judd & Sheffield, 2010). This began to change during the 1930s and 1940s with the establishment of Blue Cross/Blue Shield and the creation of the nation's first health maintenance organization (HMO) by the Kaiser Corporation (Starr, 1982).

During and after World War II, the growth of private insurance was spurred by three major developments. In 1943, the National War Labor Board ruled that workers' health insurance benefits were not taxable, a policy that while much debated continues to exist today. In 1951, the Internal Revenue Service declared that employers' costs for health insurance were tax deductible. At the same time, unions such as the United Automobile Workers and the United Steel Workers signed contracts that provided members with extensive health insurance benefits. As a result, between 1946 and 1957 there was a dramatic increase in workers covered. Today, the cost of these tax expenditures is estimated at over \$200 billion/year (Moniz & Gorin, 2010).

By the early 1980s, therefore, the features of hospital social work had been clearly and formally established. The primary role of hospital social workers was to assist the health care team understand the impact of the social, economic, and emotional factors affecting patients in order to promote

better care. Another function was to help patients make constructive use of the care provided them and to work with patients to promote their overall well-being and boost their morale, particularly when dealing with serious or life-threatening illnesses. The division between psychiatric and medical social work, which emerged in the mid-1920s and became firmly established in the 1940s, continued in most health care settings. Some hospitals, such as Columbia-Presbyterian Medical Center in New York, promoted a diagnostic approach and practice-based research (Sedgwick, 2012). Others, inspired by the activism of the 1960s, incorporated elements of social action into their practice, including advocacy to eliminate the external causes of psychological and social dysfunction (Day, 2009; Simon, 1994; Specht & Courtney, 1994).

By the mid-1970s, the latter influence subsided, and hospital social work departments focused increasingly on the development of productivity and outcome measures. As a result, tensions emerged between their counseling and discharge planning functions (Davidson, 1978). In addition, the practice of hospital social work became increasingly specialized, reflecting the growing specialization of function occurring within hospitals in general (Ross, 1995; Rosenberg, 1987).

Since the 1980s these trends have continued to shape hospital social work practice. In 1984, the introduction of Diagnostic Related Groups (DRGs) in the Deficit Reduction Act led to an increased focus on discharge planning and case management, which soon become widely implemented specialties (Holliman, 1997). Social workers also played a major role in implementing cost-cutting measures through highly professionalized discharge planning. In recent years, however, this role has been usurped by nurses through utilization review and by hospitals subsuming discharge planning under the role of case management (Ross, 1995; Schneiderman, Waugaman, & Flynn, 2008).

In the 1990s three important developments dramatically changed the nature of hospital social work: the growth of so-called “managed care” and HMOs, largely for reasons of cost-efficiency; the expansion of the number of private hospitals; and the increasing complexity of the U.S. health care system. The dramatic impact of these developments on the staffing and leadership of hospital social work departments and the roles of hospital social workers is often referred to as “reengineering” (Berger et al., 2003; Caronna, 2004; Globerman, White, & McDonald, 2002; Judd & Sheffield, 2010).

The process of reengineering hospital care resulted in a number of major changes in the nature of hospital social work. Through decentralization, it eliminated many middle management social work positions, which diminished the quality of supervision, long a hallmark of hospital social work departments. At least initially, it eroded the role of social work leadership, making social work departments less influential in hospitals’ administrative hierarchies. The promotion of a transdisciplinary approach undermined social workers’ long-established functions in patient care and

led to greater inter-professional competition and increased value and ethical conflicts among staff. Finally, the lack of evidence-based practice diminished the status of social work departments in the health care system as a whole (Davis, 2004; Ell, 1996; Galambos, 2005).

THE STRUCTURE OF U.S. HEALTH CARE AND ITS IMPLICATIONS FOR HOSPITAL SOCIAL WORK

The passage of the ACA did not fundamentally change the nature of the U.S. health care system, although it helped correct some of its more undesirable aspects. Unlike most other industrialized nations, the U.S. system continues to be a hybrid of public and private provision, whose major features, such as a fee-for-service model of reimbursement, the use of HMOs and other structural mechanisms to attempt to restrain cost increases; and selective use of government intervention, were virtually unchanged by health care reform. The government currently pays approximately 60% of all health care costs, 34% through Medicare and Medicaid alone; private insurance covers near all of the rest. Government continues to “bail out” private hospitals for the emergency room costs they are compelled to bear. Given the Supreme Court’s recent ruling about the ACA’s attempt to expand Medicaid coverage, it is not clear what the size of these bailouts will be in the future.

At present, Medicare provides coverage to 43 million elderly Americans. About half of its recipients earn less than 200% of the federal poverty line. Medicaid covers about 55 million low income children and families and is the largest source of health-related income for elderly persons in nursing homes. The cost of both programs has increased substantially during the past decade and is projected to grow dramatically in the future (Gifford, Smith, Snipes, & Paradise, 2011). In addition, both programs are under enormous fiscal pressure. Without increases in its revenue base or cuts in health care spending, it is estimated that the current Medicare system is sustainable for only ten more years. The aging of the baby boomer generation, who have just begun to reach the age of Medicare eligibility, will further strain an already fragile system.

Medicaid faces similar problems despite the passage of the ACA which was designed to expand the program’s coverage significantly. In June 2012, the Supreme Court decided that the federal government could not compel states to accept the Act’s expanded coverage (even though the federal government will pay 100% of its costs for the first three years and 90% thereafter). Several governors, citing fiscal constraints on their states, have already announced they will reject these federal funds. As of this writing, the implications for health care coverage of low-income individuals and families and for the hospitals that serve them are unclear.

The pressures facing Medicare and Medicaid and, to a lesser extent, the State Children's Health Insurance Program (S-CHIP), are the consequences of the extraordinarily high costs of health care delivery in the United States; the per capita cost of health care in the United States is the highest among industrialized nations, six times more on average than Western European nations. The United States spends over 1/6 of its Gross Domestic Product (GDP) on health care—over four times what it does on national defense—yet, the United States fares poorly on many indicators of health such as infant mortality and longevity. The World Health Organization (WHO) ranks the United States 15th among 25 industrialized nations (WHO, 2012). The primary reasons include the high costs of prescription medications, medical tests, and hospital stays; the large fees doctors receive; the growing number of uninsured persons (nearly 50 million before the ACA); the high administrative costs of private insurance companies (~31%); and the relative absence of preventive and primary care (Moniz & Gorin, 2010). Attempts to reduce costs have often resulted in cuts in funding for “ancillary” hospital services, such as social work, which places increased burdens on social work staff. Other cost-control mechanisms implemented since the 1980s, such as the introduction of higher deductibles and co-pays, the use of HMOs to limit services, and the introduction of DRGs, have reduced access to care and the quality of care for the most vulnerable populations (Holliman, 1997).

The long-term outlook is particularly stark for several reasons. Americans are living longer and, as they age, people place increasing demands on an already strained health care and social service system, particularly its most costly aspects, such as specialized medical care and long-term care. Demographically, the fastest growing segment of the population is the “old old,” persons over 85. The worker-beneficiary ratio, which affects the balance sheet of Medicare, has dramatically declined (from 7:1 in 1935 to 2:1 in 2050) and the ratio of the nation's elderly to its children (the nation's two neediest population cohorts) has shifted significantly since 1980 (Figures 1–4). Finally, demographic changes create the potential for heightened inter-generational conflict. By the middle of the twenty-first century, the elderly population of the U.S. will be 65% white while more than 50% of the workforce whose taxes pay for their care will be comprised of persons of color (U.S. Bureau of the Census, 2012). The fiscal and social tensions these changes will produce will be reflected in the practice of hospital social work departments in all regions of the nation.

HOSPITAL SOCIAL WORK IN THE TWENTY-FIRST CENTURY

After more than a century of development and response to systems change, the major functions of hospital social work in the United States today have evolved to include screening and case finding; crisis intervention and

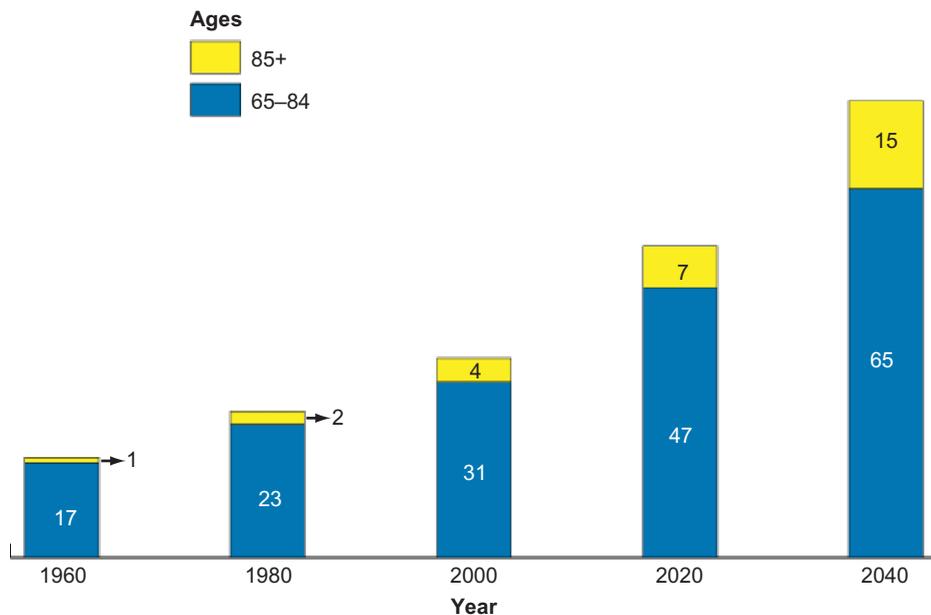


FIGURE 1 Number of older Americans, 1960–2040 (in millions). Source: U.S. Census Bureau (2004a, b, c) (color figure available online).

bereavement; psychosocial assessment and intervention; brief counseling and group work; documentation and record-keeping; discharge planning and case management; post-discharge follow-up and outreach; emergency services; and inter-professional collaboration and advocacy (Judd & Sheffield, 2010). These functions are likely to increase in number and become even more complex in response to both social changes and policy reform (Figure 5).

As a consequence of the increasingly complex, confusing, and conflict-ridden environment of U.S. health care, hospital social work currently faces a set of practical and ethical issues, some of which are new and some of which have been present for decades. Conceptually, hospital social workers are still divided on the question of the efficacy of medical and bio-psychosocial models. Organizationally, they are challenged by the pressure to engage in inter-disciplinary practice while maintaining their position within the professional hierarchy of hospitals, and by the conflict between institutional efficiency and expanding patient access to health care information. In the policy arena, they must resolve the dilemma created by the often contradictory goals of cost containment and enhancing service quality. They frequently must choose between cost containment and patient self-determination and are increasingly compelled to resolve ethical conflicts among practitioners with different value systems. Finally, they must address the implications of growing health disparities in both health and mental health care (Koh, Graham, & Glied, 2011; Budrys, 2010).

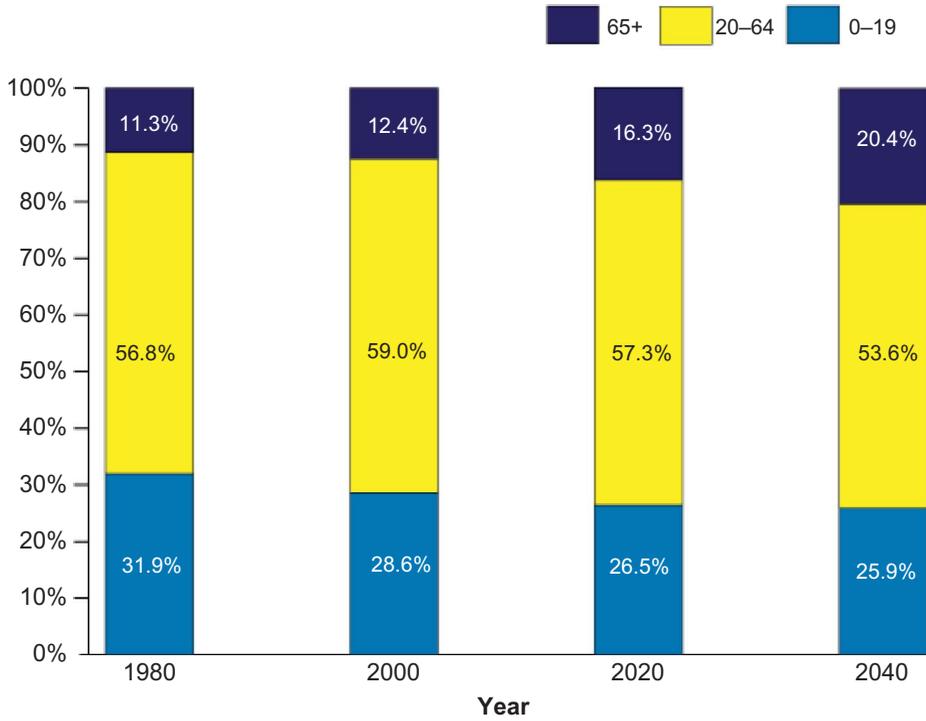


FIGURE 2 Age distribution of the population, 1980–2040. Source: U.S. Census Bureau (2004a, b, c) (color figure available online).

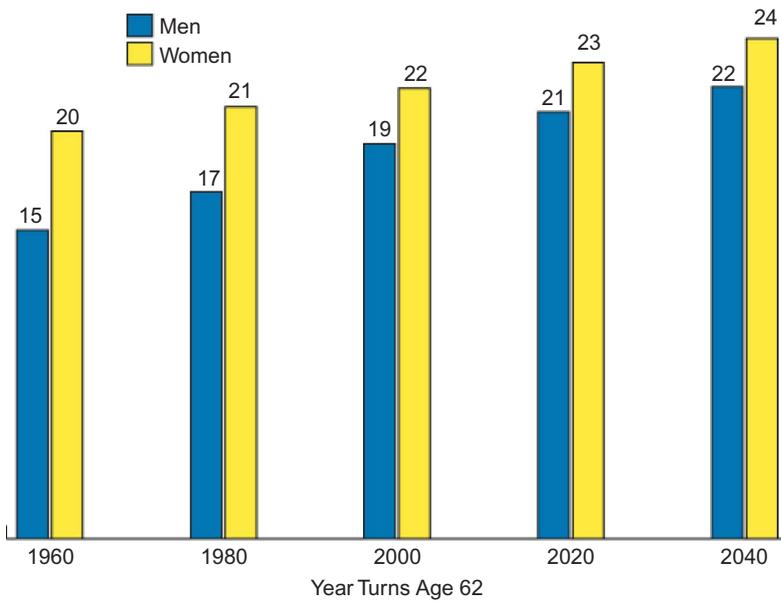


FIGURE 3 Remaining years of life expectancy at age 62, 1960–2040. Source: Social Security Administration (2008c) (color figure available online).

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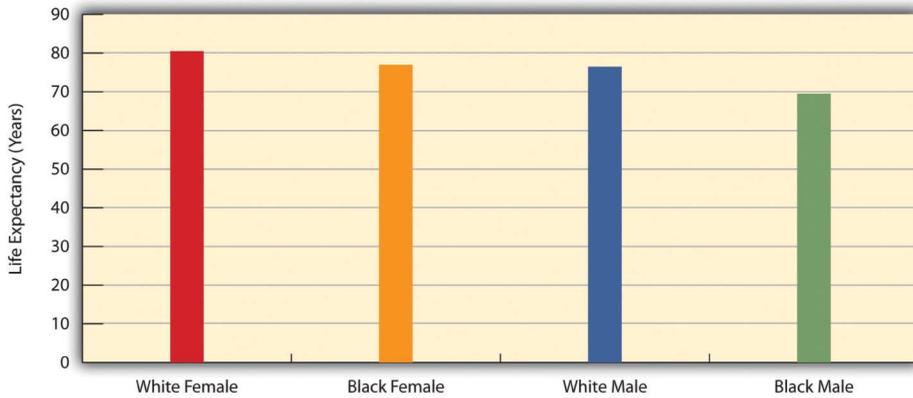


FIGURE 4 U.S. life expectancy by race and gender. Source: U.S. Census Bureau (2010) (color figure available online).



FIGURE 5 The focus of hospital social work (color figure available online).

Recent evidence indicates clearly that different groups in the United States, particularly racial and ethnic minorities, are disproportionately affected by different health and mental health problems (Almgren & Lindhorst, 2011; Families USA, 2009). Differences based on age, gender, and socioeconomic status (SES) compound these effects. Although all of these factors are important contributors one cannot ignore the interactive effects of these variables. Childhood poverty, for example, is an enormous risk factor for poor health and mental health outcomes even if the child grows up and becomes very wealthy (Wizemann & Anderson, 2009; Case, Fertig, & Paxson, 2005).

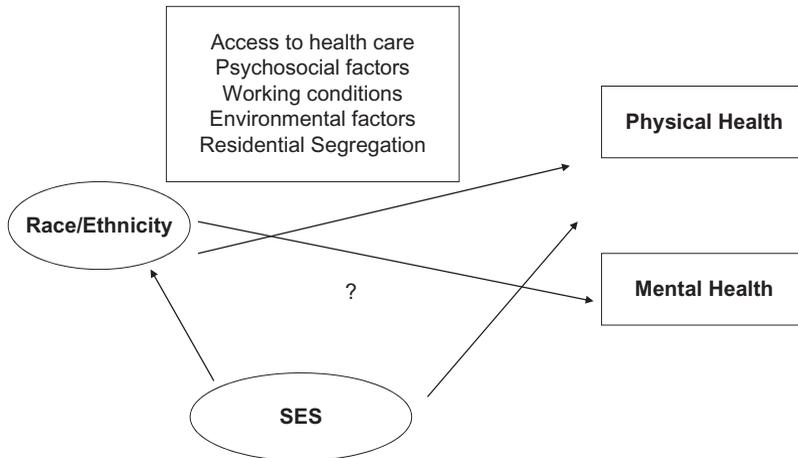


FIGURE 6 Inequalities in health & mental health.

There are other factors, however, that produce inequalities in health and mental health outcomes such as income distribution, housing, environmental quality, and neighborhood effects (Braveman et al., 2011; Diez-Roux & Mair, 2010). In addition, political participation has been associated with female mortality rates. Adult literacy has been found to be one of the strongest predictors of life expectancy in developing nations. Children and elderly women of color are particularly vulnerable populations. In sum, each of these inequalities is inextricably connected in a mutually interacting reciprocal relationship (Annie E. Casey Foundation, 2012; Abel & Chaudry, 2010; Holzer, Schanzenbach, Duncan, & Ludwig, 2007). The persistence of these disparities shapes the populations with whom hospital social workers interact, the nature of their needs, and the impact of social services on patients' well-being (Lechman & Duder, 2009) (Figure 6).

In addition to the overall increase in socioeconomic inequality in the United States, the causes of these persistent and growing disparities can be succinctly summarized as:

- **Absence of Care:** This is particularly significant in the areas of post-hospitalization and rehabilitative care, the lack of preventive and primary care and long-term care for chronic illnesses; the paucity of oral health care, particularly for children; and the stigma still attached to mental health care.
- **Accessibility to Care:** This is due to the maldistribution of health care providers, especially in rural areas and low-income urban neighborhoods; the lack of health care programs that are culturally attuned to the health care needs and help-seeking behaviors of racial/ethnic minorities, women, and lesbian, gay, bisexual, and transgender (LGBT) persons; the denial of care due to preexisting conditions, immigration status, and differences in

states' Medicaid coverage and eligibility rules; and the loss of insurance coverage due to unemployment and fiscal cutbacks since 2007.

- **Affordability of Care:** Prior to the passage and implementation of the ACA, not only did 50 million Americans lack any form of health insurance, millions more have inadequate plans which include high deductibles and co-payments. Disparities are also due to the high cost of prescription medications, in-home after care, and transportation to health care facilities. Recent state cutbacks in Medicaid and S-CHIP have exacerbated this situation considerably (Johnson, Oliff, & Williams, 2011).
- **Appropriateness and Quality of Care:** The nature and quality of health care are affected not only by race, but also by employment status, income, geographic location, age, and gender. In addition, there is a lack of research on the different health needs of persons of color and women. Finally, there is need for additional research on the relationship between health and mental health disparities and other manifestations of inequality, including SES, social isolation, and stress (Davis, 2004).

THE ACA AND HOSPITAL SOCIAL WORK

The ACA contains a number of features that will have direct and indirect consequences for the scope and nature of hospital social work in the United States. Individual and employer mandates, premium subsidies, and the expansion of Medicaid will increase access to outpatient and inpatient care, producing larger caseloads in hospital settings. This increase might be offset by the legislation's increased focus on prevention, primary care, and wellness programs, and the funding of school- and community-based care. A great deal depends on the extent to which individuals who will be newly covered will be informed about and take advantage of these provisions. The cost controls included in the Act, particularly reduced Medicare payments to hospitals, will intensify existing fiscal pressures on hospital budgets (Gorin, 2011).

The legislation has several broad potential consequences for hospital social work staff. First, the health education and information and referral components of their role are likely to increase. Second, potential constraints on hospital budgets may lead to staffing cuts or to increases in caseloads or overall workload requirements. Third, variations in states' responses to the legislation (e.g., refusal to establish insurance exchanges or expand Medicaid coverage) will make individual and class advocacy more critical than ever. Finally, the increased complexity of health care delivery will require hospital social workers to possess enhanced skill in inter-organizational collaboration (Zabora, 2011).

The emphasis of the ACA on cost control and community care will lead to an enhancement of social workers' brokerage role. It will produce the need for more consultation and collaboration with other professionals,

faster assessments, and more time spent on discharge planning. In the future, longer hospital stays will not necessarily mean more social work duties with individual patients. Once a discharge plan is complete, social workers will move on to a new case while the patient awaits transfer out of the hospital. The changes in health care delivery the legislation creates also provide social workers with the opportunity to become a specialized knowledge resource for community-based practitioners and serve as bridges with newly emerging and established community systems of care (Golden, 2011).

The shift in the locus of care, from acute to ambulatory care and the increased emphasis on primary and preventive care could lead to a major role for hospital social workers if they can demonstrate that their interventions are effective. One implication is that hospital social work departments will have to develop clearer job descriptions that reflect an inventory of the new tasks staff will be expected to perform and the new knowledge and skills they will require. Departments will also have to devise high-risk screening instruments which include improved assessment, treatment, and outcome measures. Finally, they will have to create new treatment protocols and outcome measures that link psychosocial and medical approaches to care (Rock, 2002).

The ACA also contains provisions that have more specific and immediate concerns for hospital social workers. Its emphasis on community-based care transitions will require greater attention to the environmental and socioeconomic factors that affect patients' illnesses and lead to readmission into hospital care. The promotion of independence at home will make the coordination of services, as part of home-based primary care teams, a more critical role. The development of patient-centered medical homes and the increased use of inter-disciplinary community health teams will lead to a heightened focus on non-medical barriers to health care and the unique needs of patients. In addition, the application of social work skills will be critical to respond to the ACA's demands for greater institutional accountability, particularly the need to establish and maintain patient-centered criteria in such areas as assessment. Hospital social workers will also play a greater role in coordinating team-based approaches through newly established centers for Medicaid/Medicare services innovation. In combination, these extensive changes will have major implications for the education, training, and staff development of both current and future hospital social workers.

RECOMMENDATIONS: BACK TO THE FUTURE

In some significant ways, the ACA reflects a revival of the public health focus that dominated health care and social work a century ago. The implications of this shift for hospital social workers are potentially profound. First, they need to become more actively involved in both primary and secondary

prevention efforts. Second, they need to adopt evidence-based interventions for disease management in multiple settings to help minimize the effects and the costs of a range of chronic illnesses. Third, in assessment and the development of intervention strategies, they need to add an economic outcome (such as cost reduction for both individuals and institutions) to other measures such as personal distress, the reduction of other symptoms, and the quality of an individual's life. In doing so, hospital social workers can play a significant role in bridging medical and social health models.

Health care reform also has significant implications for how hospital social work departments are administered. The greater complexity of staff functions that will emerge requires departments to increase the amount of time spent on clinical supervision rather than administrative supervision. At the same time, budget limitations will necessitate more attention to self-care and self-monitoring by staff. Balancing these imperatives will create ongoing challenges for supervisors. One possible solution is the use of forums and other group settings to process difficult cases and new intra-organizational problems. Another is to communicate to hospital administrators and policymakers the impact of stress on staff and its implications for institutional well-being and the quality of care to patients. Finally, hospital social work departments need to place as much emphasis on internal leadership development as they do on staff development (Berger et al., 2003; Ezell, Menefee, & Patti, 1997).

In addition, policy changes will affect the qualities and skills that hospital social workers will require in the future. They will need to possess greater skills in internal and external communication, the use of social media, interdisciplinary teamwork and inter-organizational collaboration, the negotiation of complex systems, and, perhaps above all, the ability to work with the elderly and patients from different racial, cultural, and class backgrounds (Kosoko-Lasaki, Cook, & O'Brien, 2009). The hospital social workers of the future will also need to maintain strong personal and professional boundaries to self-protect. In systems that emphasize greater accountability, they will be required to possess a high level of self-esteem and self-awareness, a tolerance for ambiguity, openness to change, and the ability to self-monitor (Badger, Royse, & Craig, 2008; Gregorian, 2005; Holden et al., 1997). To attract and retain staff with these professional and personal characteristics, hospital social work administrators will need to advocate for increased salaries and improved working conditions.

Finally, the changes in the U.S. health care system produced by the ACA have implications for the focus of future social work research. Hospital social workers will need to engage in evidence-based outcome assessment of their bio-psychosocial interventions and demonstrate the economic benefits of their practice to patients, institutions, and society. Research will also need to examine the relationship of community and environmental factors to individual health outcomes. These pressures underscore the importance

of increased collaboration between hospital social work staff and faculty in schools of social work, more extensive participation of social workers in clinical trials, and more training in outcome-based research (Davis, 2004).

CONCLUSION

A century ago, the founders of hospital social work stated its purposes clearly:

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. (Cannon, 1913, p. 34, quoted in Judd & Sheffield, 2010)

Doctor and 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. (Cabot, 1915, p. 105)

Today, Dr. David Williams of the Harvard School of Public Health has framed this issue for a twenty-first-century context in similar ways:

Housing policy is health policy. Educational policy is health policy. Antiviolence 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. (Williams, 2008)

Now that the constitutionality of most of the provisions of the Affordable Care Act has been upheld, it is the responsibility of social workers in the health care field, particularly in hospitals, to adapt their practice skills, their education for practice, and their research focus to increase the likelihood that health care reform will produce its intended results. In the years ahead, hospital social workers can help determine whether the legislation leads to greater well-being and a reduction in health disparities or to increased disillusionment with the nation's health care system and the political and economic forces that create it.

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