

## SOCIAL WORK IN HEALTH CARE IN 2025: THE LANDSCAPE AND PATHS TO TRANSFORMATION

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**Abstract:** *Social work in health care will, over the next 25 years, be transformed in concert with a complex and rapidly changing health care landscape and critical advances in behavioral and social science. Professional practice, research and education will be shaped by evolving patterns of health and illness, changing population demographics, developments in medicine, behavioral and social science, technological innovation and applications, and health care delivery cost and market forces. The profession's practice, research and educational communities must take actions now to guide the necessary transformation of social work in health care and, in the process, significantly influence the delivery of behavioral and psychosocial health care.*

*Keywords: health; social work practice; psychosocial care*

### INTRODUCTION

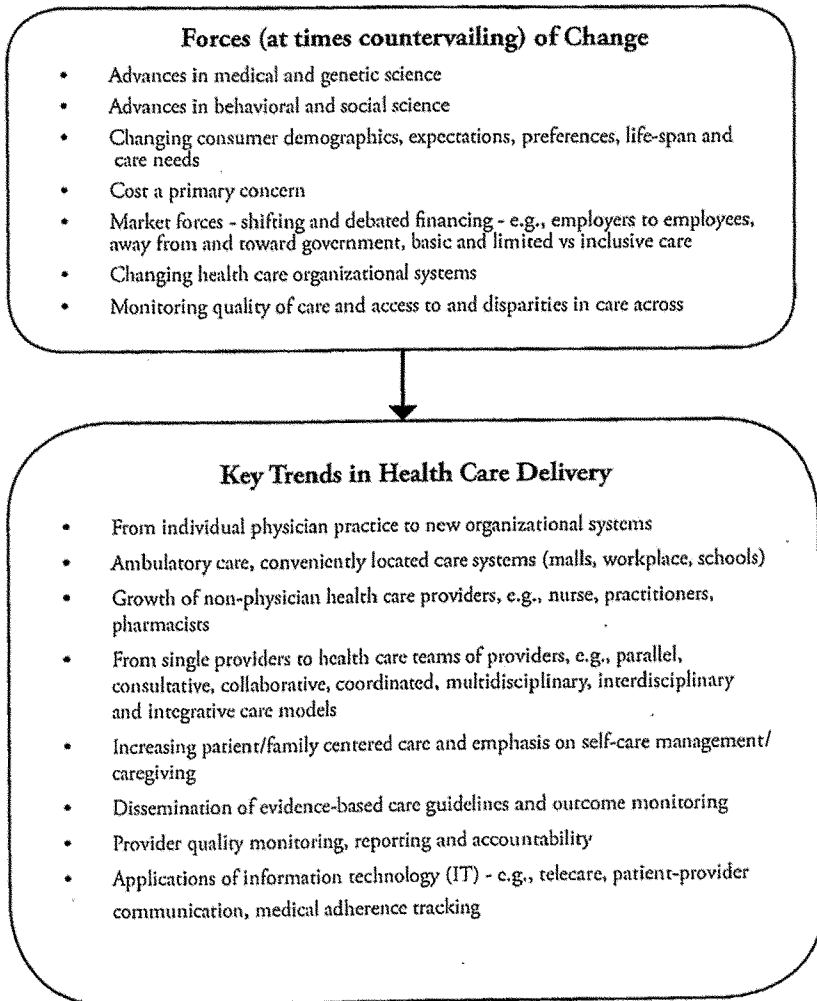
Over the past decade, health care in the United States has been in rapid transition and frequently in the limelight. Public opinion polls routinely reflect the dramatic rise in consumer health-related expectations coupled with dissatisfaction and anxiety about the state of health care delivery. The media regularly highlights seemingly intractable health policy issues, including lack of insurance for over 40 million Americans, lack of a usual source of care for many, rapidly accelerating cost, a high rate of medical errors and lack of attention to the quality of care, population disparities in access to and receipt of care, and inefficient fragmentation of care across health care systems. In-depth government and private foundation reports document a range of specific problems and explore solutions (CDC, 2005; Kaiser Commission on Medicaid and the Uninsured, 2004; Kaiser/Hewitt, 2004). The Institute of Medicine has focused national attention on serious flaws in the quality of US health care calling for major organizational improvements (IOM, 2001). Among consumers, policy makers, and private industry leaders, policy debates center on the major issues of cost, financing, quality of care, and access to care.

The future of social work in health care will grow and change against this troubling landscape, shaped by evolving patterns of health and illness, changing population demographics, developments in medicine, behavioral and social science, technological innovation and applications, and health care delivery market forces (See Figure 1). The profession's practice, research and educational communities, however, must take actions now to guide the necessary transformation of social work in health care and, in the process, significantly influence the delivery of behavioral and psychosocial health care. Failure to take specific action will leave the transformation of social work and the delivery of behavioral and psychosocial health care to other health professions.

## FORCES OF CHANGE

Powerful forces of change characterize the health care landscape. In some cases these forces exert countervailing expectations and response, while in other cases the forces are synergistic. The imperative of cost reduction filters all forces of change in health care. Examples of counter-valence are particularly likely to revolve around the cost of health care, which for a time was increasing at a rate above the rate of inflation. In the ongoing debate on restructuring Medicare, countervailing forces are evident – greater consumer choice (with an as yet untested assumption of resulting improved access to care), but with increasing consumer out-of-pocket costs. Examples of more synergistic action are evident in the reciprocal effects of medical advances on lengthening life-span and the shift from acute episodic care to long-term management of chronic disease, which together increase consumer expectations of care.

**Fig 1: A Changing Health Care Landscape and Trends In Psychosocial Care.**



A critical element in the forces for change is the dramatic change in the demographics of the U.S. population. Over the next 25 years, the nation will experience increases in the number of people who are older (with likely unbalanced gender distribution), who belong to an ethnic minority group, have disabilities and chronic disease, who live in poverty or endure significant periods of marginal economic stability (with the risk of unstable access to health care), and who self-identify as lesbian, gay, bisexual, or transgendered (Yali & Revenson, 2004).

According to the 2000 census, 25-30% of the U.S. population self-identified as a member of an ethnic or racial minority group (U.S. Bureau of the Census). Given that this figure is widely expected to continue to grow and to affect social and racial disparities in health, there will be ongoing need for health care providers to become culturally competent and for health care researchers to study complex contexts (i.e., multi-level systems) of health, illness and health care delivery to identify problems and solutions (Yali & Revenson, 2004).

Medical breakthroughs are improving preventive care, early detection of health risk and disease, and survival from life-threatening illness and trauma. As a result, the average life-span and the numbers of people living longer with chronic illnesses and disabilities is rising as is the cost of health care. However, the latest research takes years to reach medical practices. The uncovering of uneven quality of care across health systems, geographic regions, individual providers and patient demographic groups has spurred the development of quality improvement approaches. Advances in information technology (IT) with the potential to improve the quality of care by empowering patients and health care providers in making choices and managing care is yet to be widely used or tested. Recent cost savings analyses indicate that fully implemented electronic health care information exchange and interoperability would yield a net value of \$77.8 billion per year (Walker, Pan, Johnston, Adler-Milstein, Bates & Middleton, 2005).

In recent years, evidence based medicine (EBM) has been widely elevated to something approximating a new paradigm (Timmermans & Mauck, 2005). Accompanying the EBM movement are new government and private institutions concerned with EBM, an increase in randomized controlled trials in medicine and health care research, an increase in care plans, critical care paths and outcomes research, the development of EBM medical education curricula, and a striking array of clinical practice guidelines (leading to questions about their quality) (Timmermans & Mauck, 2005).

### **KEY TRENDS IN HEALTH CARE DELIVERY**

Response to cost, medical advances and consumer challenges are reflected in current trends and evolving changes in health care delivery. This era of rapid and dramatic change might be described as a very large, somewhat incoherent, national experiment with a laundry list of specific and sometimes competing aims, research questions and hypotheses, using an array of structured, pseudo structured and unstructured research designs.

Individual physician practices are evolving into new organizational systems such as independent physician associations, ambulatory care is replacing hospital based care and conveniently located care systems are emerging in local neighborhoods, shopping malls, workplaces and schools. The number of licensed non-physician health care providers is

growing (e.g., physician assistants, advanced nurse practitioners, pharmacists, nutritionists, naturopaths, physical therapists, chiropractors (Carlson, 1999). Collaborative, integrated and interdisciplinary health care teams are being tested to address specific patient population needs and to reduce fragmented care (Cashman, Reidy, Cody & Lemay, 2003; Gross, Temkin-Greener, Kunitz & Mukamel, 2004). The proliferation of EBM guidelines include those focused on individual physician decision-making, but increasingly apply to all members of clinical teams (Eddy, 2005).

Increasingly grounded in biopsychosocial evidence and clinical effectiveness trials, quality of care improvements include prevention and health promotion and interdisciplinary disease or case management intervention models (Nasmith, Coté, Cox, Inkell, Rubenstein, Jimenez, 2004; Schaefer & Davis, 2004; Shojania & Grimshaw, 2005; Smith, Orleans & Jenkins, 2005; Suls & Rothman, 2005). Telecare, computer and internet technologies are aimed at improving information transfer, patient/provider and provider/provider communication and tracking care management and patient medical adherence (Garrison, Bernard, Rasmussen, 2002). While cost reduction goals influence health insurance coverage, these decisions are beginning to confront scientific evidence (Gelijns, Brown, Magnell, Ronchi & Moskowitz, 2005). Notably, a recent analysis of Medicare's national coverage decisions for new medical technologies found that coverage determinations were generally consistent with the strength of the evidence (Neumann, Divi, Beinfeld, Levine, Keenan, Halpern, et al., 2005). Patients and family members are increasingly expected to assume more active and extensive self-management and caregiving roles, however, family caregiving incurs human and financial cost that is yet to be factored into overall health care cost estimates.

### **TRENDS IN THE DELIVERY OF BEHAVIORAL AND PSYCHOSOCIAL CARE**

Behavioral and psychosocial care interventions and services have assumed increasingly important roles in the delivery of health care (Borrell-Carrió, Suchman & Epstein, 2004; Nicassio, Meyerowitz & Kerns, 2004). Preventive screening and follow-up and chronic disease management intervention models are multifaceted and routinely incorporate health education, behavioral interventions, interactive case/care management components and patient empowering self-management interventions.

A dramatic shift is occurring wherein primary care physicians and nurses are beginning to provide mental health screening, counseling and pharmacotherapy. Of particular interest are collaborative and integrated care models for depression (in which specialized clinical specialist social workers or nurses provide psychotherapy, medication management, and adherence follow-up) (Dietrich, Oxman, Williams, Kroenke, Schulberg, Bruce, et al., 2004; Gallo, Zubritsky, Maxwell, Nazar, Bogner, Quijano, et al., 2004)), but also for other psychiatric disorders (Bartels, Coakley, Zubritsky, Ware, Miles, Arian, et al., 2004; Felker, Barnes, Greenberg, Chaney, Shores, Gillespie-Gately, et al., 2004).

Professional organizations and government have developed an array of specific practice guidelines that are available on the web and testing of methods to improve implementation of these guidelines in real world practice is growing. A variety of organized monitoring of quality of care programs has been developed in recent years and there is a strong movement to make these reports and data readily available to consumers.

## **TRANSFORMING SOCIAL WORK PRACTICE AND PRACTITIONERS: SERVICE SYSTEM, RESEARCH AND EDUCATION ROLES**

How will the changing health care landscape shape the future of social work practice, research and education? What is easiest to predict is that transformations of social work and all other health professions will involve the need to effectively address seemingly countervailing forces. For example, cost-conscious/cost-driven administration and policies in proliferating health care settings will interact with the burgeoning need for psychosocial services of an aging and racially/ethnically diverse population with a significant poverty rate. The increased recognition of social/behavioral/environmental components of illnesses and adherence to their treatment will lead to further integration of health and mental health care, interacting both with cost concerns and other psychosocial specialties' (e.g., nursing and psychology) turf claims. All of these forces will interact with increased consumer demand for quality care and organizational demand for evidence-based practice, accountability, and consumer driven cost utility (comparing the monetary value of resources used with health effects such as health-related quality-of-life measures for a defined population) interventions and services (Tovian, 2004).

Further challenging the profession, the historical tensions inherent to social work practice as a part of health care will remain. These include work within host settings where adequate understanding of the social work role and function cannot be assumed; the need to deploy with maximum efficiency a costly professional service and routinely demonstrate its value added; and potential for competition and conflict with nursing and other professionals that can cloud consideration of the real needs of patients and systems. On the other hand, the increased emphasis within medicine on the mind-body synthesis in the health/illness paradigm and policy attention at the national level to health disparities will provide an increasingly strong platform of legitimacy for the psychosocial professional as a member of the health care team. The usefulness of social work's multi-system perspective on problems in health and illness will only continue to grow, with ample opportunities available.

It is unlikely, however, that these opportunities will carry the restricted and specific label "social work." As has long been the case, needs and opportunities within health care will outstrip the social work profession's ability to educate and deploy sufficient person power to create "ownership" of most valued roles and functions. Thus cooperative/collaborative service, educational and research models with nursing and other non-physician and physician providers will be needed (Claiborne & Vandenburg, 2001; Simpson, 1999).

### **A Look at Social Work Practice**

Key changes are likely to characterize social work practice in the future. Primary among them is the reliance on "sole position" social workers, capable of "self-directed practice" (Volland, Berkman, Phillips & Stein, 2003) as cost constraints continue to eliminate social work administrative and support structures in settings where once they existed, and limit their development in new settings. The independent entrepreneurial "private practice" model of social work, insofar as it requires skills in accountability, autonomous definition and negotiation of role and function, administrative expertise, and a keen eye for

shifting financial realities and incentives will be a useful model for social work health care practitioners, often working as the sole social work provider in a larger system or a disease management team. Cost and efficiency considerations will also dictate that these practitioners, whether in nursing homes, primary care clinics, or down-sized hospitals, will need well-honed consultative and supervisory skills so that they can oversee (rather than directly provide) many types of psychosocial services that can be provided effectively by lesser trained (and cheaper) personnel. Highly trained social workers will likely limit their direct practice to a small number of special needs patients and/or highest skill functions.

The increasing integration of mental health within primary care medical settings across the age continuum will be a major trend leading to the transformation of social work practice, as the distinctions between health and mental health social work practice and education blur. Basic clinical mental health assessment, engagement, crisis management, resource negotiation, referral and brief treatment skills will be required for all health direct practitioners. Expertise in mental health, including serious and persistent mental illness, will not be confined to a specialty mental health system. For example, nursing homes today serve as the primary provider of mental health services for the elderly population (Shea, Russo & Smyer, 2000). The staff social worker must be able to provide accurate initial assessment for mental illness, with referral and follow-up.

The demands of EBP will challenge social work education, practice and research in a number of mutually influencing ways, constantly interacting with cost concerns. A comprehensive understanding of the needs of EBP will lead to development and implementation of evidence-based practical program/practice management tools and approaches on the one hand, and on the other social work intervention research that demonstrates the effectiveness and value added of practice interventions to achieve desired health and quality of life outcomes.

Social work practitioners will need to have and use systematic quality management tools and processes to monitor and improve their social work services at the individual case, aggregate case, and facility-wide levels. The essential similarity of key management skills, including planning, organizing, coordinating, and monitoring outcomes for successful direct practice helping as well as system accountability will be explicated in professional education and training (Veeder and Dalgin, 2004).

As sole providers in many settings, direct practitioners will require basic expertise and familiarity with fundamentals of a comprehensive evidence-based practice. Key aspects of evidence-based practice will include the data/information on which to base decisions concerning WHO gets HOW MUCH of WHAT for WHICH problems to effectively achieve certain OUTCOMES, including an efficient allocation of scarce resources. Social workers will need to have expertise in information technologies for documenting, monitoring and evaluating their practice, and will use this expertise in a variety of clinical and services applications.

As a costly service, social work in health care settings will need to carefully target, based on evidence, those health care consumers potentially at highest psychosocial risk and level of need, regardless of setting. Social work's priority clients in health care will be those individuals and their families who are living in poverty, members of minority groups, and

medically under-served, regardless of age. Other priority target groups are people with co-existing mental illness and/or substance abuse, those with dysfunctional, extremely limited, or non-existent social support systems, and individuals at points of transition, including discharge, admission to a nursing home, and at the end of life.

Actual assessment of individual patient psychosocial risk and needs will make more use of standardized tools or elements of standardized tools to improve accuracy and to assist in prioritizing goals. Reliable standardized instruments, normed for different populations and conditions, will be available for mental and emotional health, social support, self-efficacy to handle the health problem, patient's knowledge, attitude and beliefs concerning the health problem and treatment, and perceived and actual system and resource barriers.

Social work interventions will be based on evidence-based guidelines or flexible "packages" of such guidelines that are tailored to individual circumstances. Increasingly, evidence-based guidelines are likely to be implemented using a multifaceted approach that seeks input from multiple stakeholders – e.g., multiple members of health care teams, patients and families, and health care administrators (Timmermans & Mauck, 2005). Over-arching psychosocial service functions, such as case/care management, will be increasingly needed as chronic disease management assumes growing importance in health care delivery. These functions, when necessary, will be integrated interventions that bundle proven effective strategies to influence multiple system levels; for example, simultaneous use of a patient-empowerment strategy, mediation with another health care provider, and new resource acquisition to achieve results (Vourlekis & Ell, 2004).

Cost constraints and quality practice management will call for demonstrated correctness and efficiency in the provision of social work services. Explicit social work intervention protocols for different psychosocial care levels will guide the intensity (amount or "dosage") of care as well as the nature and required provider skill level of different care routines, once psychosocial assessment has detailed patient and family circumstances.

Establishing the efficacy of a variety of psychosocial interventions will be the task of the social work research establishment, as discussed below. However, demonstrating actual links at a given facility between psychosocial care processes and a variety of outcomes will be an important component of practice and program management, requiring use of practitioner-friendly evaluation tools. These tools will need to be linked conceptually and operationally to facility level, regulatory, and accreditation quality improvement/monitoring processes of overall care provision. Examples of such links could be that case management processes lead to improved facility treatment adherence rates; or that conflict resolution interventions with family members of nursing home residents lead to fewer complaints to corporate headquarters.

The demographics discussed earlier carry the obvious imperative of culturally competent social work practice in health care, as in every other field. While the knowledge, skills and attitudes of this practice will not differ by field, the manifestations of culturally relevant influences will. Patient and family culturally mediated beliefs, attitudes and behaviors in relation to health and illness are potentially potent influences on every aspect of the process of health care. Difference in culture between patients and providers (for example, the prevalence of ethnic minority care staff in nursing homes where the majority of

residents are white women; and the growing diversity of the health professional workforce itself) will grow even more pronounced. These realities will call for practitioners' ability to modify and tailor evidence-based interventions, such as cognitively based treatment, for an ethnically diverse clientele, but also the ability to recognize and mediate exchanges and communications troubled by cultural differences for the health care team or facility as a whole.

### **A Snapshot of Social Work Research**

In responding to the challenges in health care, social work research must dramatically accelerate its focus on intervention studies, including comparing interventions with different intensity and diverse team membership and interventions targeted for specific patient populations (Reid, Davis Kenaley, & Colvin, 2004). The development of a strong evidence base for practice in health care will take decades and will require using more advanced research designs, larger sample sizes, and clearly specified interventions (Helfand, 2005; Proctor, 2004). Given the multidisciplinary nature of health care, contributions of social work to intervention research will inevitably require that social workers lead and participate on interdisciplinary research teams. Social work researchers must also become expert in designing intervention studies with attention to real world practice needs (as in adapting psychotherapy models for health care systems and populations) and participate in dissemination and implementation studies. Social work researchers must become expert in conducting both efficacy and effectiveness intervention studies and in evaluating the cost-utility of specified interventions. The latter particularly represents an area of research that is relatively new to social work and will require collaborating with health economist researchers (Kaplan & Groesel, 2005).

Given the likely ongoing disparities in care across populations, social workers will need to design and evaluate interventions to eliminate disparities (Cooper, Hill & Powe, 2002). Research will also need to uncover the critical and minimal elements in cultural competency in diverse contexts (Yali & Revenson, 2004).

### **The Role of Social Work Education**

The practitioner for 2025 will require an education that provides a roadmap to specialized practice that may look very different than what is commonly offered in many programs today. For example, mental health and gerontological competencies will be fundamental to any practitioner working in health care. Familiarity with emerging brain-behavior connections and the operations of both legal and illegal drugs will be essential content, while the specifics of individual diseases, their symptoms, treatments and side effects, and long-term course and management will need to be learned in field practicum or on-the-job. Social workers, who will be practicing independently on health care teams, will require confidence in their knowledge of specifics of medical care. Realistically, social work education can provide the parameters and resources for such expertise, but not the content except in the form of an exemplar.

In addition to teaching evidence-based practice (Howard, McMillen & Pollio, 2003), it will be necessary to prepare students for self-directed and population specific practice



(Volland, Berkman, Phillips, & Stein, 2003; Volland & Berkman, 2004). It is critically important to increase gerontological competence for health care practice (Rosen, Zlotnik, & Singer, 2002). Clinical skill in structured mental health therapies such as Cognitive Behavioral Treatment and Problem Solving Therapy adapted for primary and specialty health care, for diverse patient populations, and for collaborative care program models will be required elements of master's education.

Curriculum on health care delivery models and on the knowledge and skill base of a range of health care professions will also be needed to prepare practitioners for integrative team practice. It is also likely that social work education will test new hybrid education models such as two innovative programs at the University of Southern California School of Social Work—the social work-nurse practitioner specialization under development and a randomized pilot test of a program in which social work graduate students will provide counseling, while students from the dental school provide oral health education designed to meet the needs of those with developmental disabilities and their families. New dual degree programs are likely to emerge and field placements will expand into the array of new health care settings.

## CONCLUSION

Behavioral and psychosocial health care over the next 25 years will undoubtedly be characterized by continued advances in behavioral and social science, in evidence of the cost-utility of interventions and services, and in increasing consumer and policymaker demand for these services. The likely advances will present both challenges and opportunities and will be inevitably and inextricably linked to the ongoing external forces described above as well as new forces – e.g., the area of biomedical ethics. However, equally important in determining whether and in what ways social work in health care is transformed will be the direct actions begun now by the social work practice, research and education communities.

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