

The National Society for Social Work Leadership
in Health Care

Education For Health Care Social Work Practice: Issues and Directions

Exemplars in Practice Series

**William J. Spitzer, PhD/DCSW
Editor**

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The Select Practice Series:

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The Select Practice Text Series

In Recognition of the Exemplar Series

I am honored to introduce the 10th anniversary edition of the Society for Social Work Leadership in Healthcare Exemplar educational series. This publication follows a long and rich history of both practical and academic knowledge about the many facets of social work services, and leadership, in health care. The series has covered a broad array of topics over the past nine years written by notable leaders from large health care systems, academic institutions to small rural hospitals. Theme based texts have covered the pressing issues of our profession in parallel with the challenges we faced in our individual communities and health care systems. Dedicated topics have spanned a range of critical subjects including medical ethics, Strength-Based Practice, executive leadership in large health care systems, immigration, integrated care, supervision, crisis and disaster response and cultural competence in healthcare.

The Mission of the Society has always been to provide leadership, knowledge and skills to social workers in healthcare settings. Though hospitals were historically our base, the Society became more inclusive and adapted to the changing health care environment. We embraced the many new, as well as established settings where healthcare social workers practice. Representatives from hospice and palliative care, home care, mental health, Veterans Administration, pediatrics and rehabilitation have helped expand our knowledge base, contributed to our publications and ultimately enriched our members. I believe health care reform will further provide opportunities and new avenues for professional social work leadership and envision future exemplars will explore new practice models and leadership challenges within medical homes, insurance exchanges, accountable care organizations and topics yet unknown. And I am confident Society members will be at the forefront in describing and sharing those new and emerging paradigms.

On behalf of the Society I want to personally thank the numerous authors over the years who have contributed their time, energy and expertise to make these publications happen. We are deeply indebted to each of you. And to our Editor, Dr. William Spitzer, who has owned this project from the first exemplar publication. We could not have sustained these wonderful publications over the years without your guidance, leadership, passion and commitment to the work and to the Society. Thank you.

Edward Woome, L.C.S.W.

2012 President, SSWLHC

Preface

This volume commemorates the tenth year of the Society's *Exemplars in Health Care Practice Series*. The series was instituted to bring the expertise of the Society to bear on the myriad of issues found in contemporary health care environments. The intent was and is to enhance practice, whether administrative or direct patient care. Benefiting social work professionals and their health care colleagues, the series offers nearly *eighty* recognized practitioners, administrators and educators contributing over *fifty* chapters on social work services based on extensive direct experience and research. The positive reception and use of this series during the last ten years to influence patient care services is a testimonial to its perceived value by professionals in large and small, proprietary and non-profit systems alike. Appreciation is extended to those who offered time, expertise and effort in generating this series.

It is fitting that our current edition addresses the issue of educational preparation for health care social work practice. Since its beginnings at the turn of the century, academics and practitioners have debated the theoretical and operational dimensions of social work in health care. In today's increasingly fast-paced health care environment, the demands on health care providers are significant and prompt non-stop shifts in service delivery. As our chapters convey, these impacts include an aging population, newly legislated national policies (notably through the Patient Protection and Affordable Health Care Act), remarkable advances in medical technology, shifts in physician availability, heightened consumer demands for information and decision-making control, greater pressure to restrict service costs due to tightened reimbursement and the prospect of decreased profit-margins from ever-increasing competition.

It is *because* of this challenging environment that social work has the potential to make an even greater contribution to public health and health care delivery. Efficient, effective, sensitive to socio-cultural differences and already the most prevalent provider of mental health services, social work represents a significant service resource *presuming* it recognizes the needs and directions of its changing environment. Implicit in this is the need to prepare increasing numbers of managers, supervisors, practitioners and educators well versed in contemporary practice in complex host settings where efficiency and innovation reign. This point is clearly underscored by *Silverman* in his lead chapter as he discusses the importance of not just educating for technical competence in social work techniques, but "organizational awareness". Social workers must recognize the mission, priorities, strengths and constraints of their organizations in developing services that meet patient needs while demonstrating financial responsibility with regard to overall operations.

Three variations of the signature pedagogy of social work education, the field placement, are featured beginning with a discussion by *Farrar* and *Hardesty* of the challenges and opportunities presented in a clinical research setting. *Sheets, Watson, Brandeis* and *Rivara* note a growing awareness of the unique psychosocial needs experienced by military personnel, the Veteran's Administration intent to expand social work services nationally and the evolving methodologies employed to educate for this specialized practice. Following a description of how field placements evolved in the United States, *Gilbert, Nelson-Becker* and *Spira* discuss the structure of the field placement in preparation for gerontology social work. Crucial dimensions in health, health care and education for social work practice in the United States are highlighted by *Spitzer* and *Davidson* in our final chapter. While differences in philosophy and approach remain among academics and practitioners, new approaches to education for practice hold exciting prospects for advancing health care social work.

William J. Spitzer, PhD/DCSW, Society Editor

EDITOR'S NOTE

The Editor wishes to express his gratitude to the National Society Publications Committee whose time and support contributed much to the production of this text. Committee members include Judith Trachtenberg, Kay Davidson, Adrienne Farrar, Patti O'Donnell, Carlean Gilbert, Katherine Perone, Pamela Lynch, Laura Leone, Linda Brandeis and William Spitzer. Particular appreciation is extended to those members who additionally contributed their expertise in reviewing chapters of this book, including Judith Trachtenberg, MSW, Linda Brandeis, MSW and Dr O'Donnell.

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Education for Health Care Social Work Practice: Issues and Directions

OVERALL DESCRIPTION:

This text addresses the issues related to education for social work practice in health care. It identifies factors shaping professional health care practice, reviews the history and state of education for practice and offers educational models that prepare students for contemporary practice. Attention is given to requisite skills for patient care in highly-accountable, fiscally-driven environments providing integrated care to increasingly complex, multi-need patients.

LEARNING OBJECTIVES:

Upon completion of this publication, readers will be able to:

1. Identify and describe the importance of organizational awareness in educating social work students for practice in contemporary health care environments.
2. Recognize the unique educational challenges and social work practice opportunities that exist in clinical health care research environments.
3. Understand the history and current state of social work practice in the Department of Veterans' Affairs, including issues and modalities associated with education for practice.
4. Understand the evolution of field education as the signature pedagogy of social work and the issues associated with creating a specialized gerontology social work field placement.
5. Describe the future directions of health care practice, including trends in population needs and the impacts of technological advances, national health care policy and legislation, staffing concerns and practice education ideologies.

Organizational Awareness and Health Care Social Work: Enhancing a Profession and Environmental Fit

Ed Silverman, PhD, MBA

Introduction

Debates and discussions concerning disconnects between campus-acquired knowledge and its subsequent usefulness in frontline trenches has been ongoing since the first graduates marched toward their degrees and a presidential handshake. Most scholars cringe when students and practitioners cannot identify a practice theory or model that underlines and grounds their practice. Yet, many first-day field students enter the fog of practice praying for a strong mentor who will teach them how the whole blending of social work roles, skills and values leads to something that borders on professional competency.

During my journey as a hospital social worker, healthcare administrator and faculty member I have become convinced that the above debate, though passionately explored and defended, is polarizing and ultimately futile. It is unlikely that most amongst us have sufficient data to draw any final conclusion. The learning process appears more continuous and less linear. Learning informs practice and practice informs learning. As health care-based, social work professionals, logic implores us to commit to be continuous learners and understand that knowledge comes to us in many forms and dimensions.

Social work is a practice profession leader in this regard. In fact, the Council on Social Work Education (CSWE) has declared that field experience be the pedagogical capstone of social work education. In addition, CSWE (2008) identified ten core practice competencies. Though these are clearly productive steps toward defining professional practice, they do not explicitly address the knowledge gap one experiences when transitioning from classroom to organizational setting and culture.

Although not all inclusive, CSWE efforts allow for the profession's gatekeepers, from both the practice and academic communities, to conduct a competency gap analysis on prospective social workers and create action plans to best teach and reinforce learning. It is not unusual for mediocre classroom students to excel in the practicum, while straight "A" classmates struggle in the field. The duality of class and practicum, assuming there is a strong, partnering relationship between school and field site, will allow for integrated and competency-based developed professionals. Hopefully, it also provides the opportunity to "counsel out" those least fitted for social work practice.

Finally, even in the most ideal of knowledge and competency building efforts, students and new practitioners often enter field and practice with a glaring blind spot related directly to "profession and environmental fit". There is a clear level of cultural awareness and political savvy that a social worker must acquire to enhance success in complex organizations. This is particularly true in health care given its changing nature, policy debates, political polarizations and economic crises.

Health care has become less of a host-environment for social work and more of a distant planet. In the spirit that knowledge never evolves from one experience or setting, this chapter will explore health care “macro awareness” concepts, specifically leadership and organizational issues, which a social work education may not convey. These include the current challenges and state of the health care environment, importance of differentiating competency and ideology, and the understanding of organizational culture and professional fit. The overarching goal is to close the academe-practice knowledge gap, giving the reader a broader understanding of the health care environment, thereby enhancing opportunities for productive practice and leadership within.

Historical Perspectives

Health Care

Although the Affordable Care Act (and previous presidential attempts at major health care reform) has yet to fully materialize, subsequent actions within the healthcare industry have certainly changed the role of the healthcare social worker in the past twenty years. Once perceived as financially risk-proof, health care organizations have engaged in an array of mergers, partnerships and system integration efforts that have drastically changed the industry’s landscape. To remain viable, healthcare organizations have needed to become as focused on business challenges as they historically have been on clinical ones.

Health care costs remain one of the greatest financial burdens that face families, employers and the federal government. In the 1950’s healthcare spending accounted for 4% of the Gross Domestic Product; today, the figure is at 17% with an expected rise to 30% by 2030 (*Friedman & Mandelbaum, 2011*). In addition, by most estimates, health care costs exceed 2 trillion dollars per year and account for between 16-20% of the Gross National Product (*Chaudry et al., 2008*). Perhaps most striking is that 20 % of all Medicare spending occurs in the last two months of a patient’s life (*Friedman and Mandelbaum, 2011*).

Although health care dollars continue to be over-represented in our national expenses, the providers who employ social workers are faced with shrinking reimbursement pools. Managed care plans have cut into already slim profit margins and have the volume leverage to shop their “covered lives” to integrated systems at budget rates. Medicare and Medicaid are in increasingly vulnerable financial positions and are not in a position to bail out a strained health care system. Finally, private insurers are not willing to informally subsidize health care organizations for their uncompensated care and can no longer easily pass along these costs through increased premium hikes to both individuals and business. In a sense the ongoing health care “shell-game” of shifting and moving costs around is saturated and approaching a stalemate.

Health care organizations have responded to their changing environment through several strategies. As previously alluded to, the most progressive and strong among the entities have incrementally evolved, typically through acquisitions and mergers into integrated health care continua. They each attempt to deliver a clinically effective,

financially efficient seamless model of care. Often the ownership of a string of health care entities does not equate to, or achieve, true integration. The key is to create and manage a patient-flow system that maximizes clinical effectiveness and financial efficiency by moving patients from acute care to sub-acute care through home health care, for example, in a safe, yet timely, manner. Bluntly stated, the patient needs to be at the right level of care at the exact clinically appropriate time to maximize reimbursement.

Social Work

Social workers have been employed in health care since Dr. Richard Cabot, Chief of Medicine, established the first Department of Medical Social Work at Massachusetts General Hospital in the early 1900's. He and healthcare social work pioneer Ida Cannon, believed that the function of medical social work was to supplement physician practice by alleviating, to the extent possible, patients' social problems that interfered with plans for medical care (*Cannon, 1952*).

The task of specifying a current day, universal definition of health care social work is difficult. Roles vary from facility to facility, and even among medical units within a single facility. The daily activities of a social worker practicing in a Burn Intensive Care Unit will likely have little in common with a social worker assigned to a fast paced medical or surgical unit.

There are, however, two commonalities that appear to help define current practice. While both are critically important, unfortunately neither is emphasized in social work educational curricula. First, a healthcare social worker often functions as an internal consultant or organizational counselor. They always have at least two sets of clients: one is the patient (and likely the family) and the other is the organization. This often translates to balancing potentially conflicting needs of multiple clients. Therefore, a social worker typically responds simultaneously to the needs and demands of patients, their families (or multiple factions of families that are still on speaking terms), hospital administrators, physicians, nursing, and the balance of the multidisciplinary health care team.

Second, the work of social work is essentially focused on discharge planning, a process that has grown in complexity. This complexity relates to the ongoing reduction of acute care length of stays and the financial imperative of efficient patient-flow. Health care administrators often evoke a mangled, simplistic, "Federal Express" metaphor of getting the patient/package to the appropriate level of care at the right time.

Obviously, many patients have anxiety, a desire for self-determination, family advocates, and relatives who are attorneys. Others may lack the resources or insurance coverage for the next appropriate level of care. On our easiest work days, we have a complex, stressful job inclusive of many stakeholders, with millions of weekly dollars and patient safety continually at risk. I am fairly certain our education is not an all inclusive preparation.

Differentiating Competency from Ideology

The first challenge for the student or new practitioner entering the health care environment is to recognize and reconcile the gap between professional competence and professional ideology. While all professions have a culture and brand, social work can be heavy handed in its enculturation of professional identity. Students have often asked me if it is possible for them to practice social work and be politically and socially conservative. Apparently, their voice was not readily heard or accepted in other classroom discussions. Many felt they had to hide their belief systems.

Health care, like most industries, is diverse and multi-valued. Our challenge is to recognize the fluid fit of the social work profession with the current health care environment and align our competencies with current needs. Those who lead with ideology will likely face an isolation and disenfranchisement that limits practice power and influence.

At best, health care social workers reside in an ecosystem that does not naturally support social work life. We work not only in host organizations with various missions, visions, and values, but more increasingly, in blended case management and resource management departments. Berger, Robins, Lewis, Mizrahi, & Feit (2003) report that nursing or other health care professions direct and lead an increasing number of health care social workers. It is possible that this hierarchical position has evolved due to a real or perceived organizational perception that social work ideology is in juxtaposition with health care's struggle to correct challenging or declining financial status. It is crucial that we also consider our employers as clients and continue to evolve our knowledge and talents to align with the changing face and challenges of our host—a macro-focused “start where the client is”.

Additionally, it is important to note that this does not only include acute hospitals. The current health care environment presents more as a continuum. Provider organizations are often the result of a “survival of the fittest” series of mergers and acquisitions. Through that process, they become diversified to the extent of owning various entities that may include acute hospitals, rehabilitation hospitals, home health companies, sub-acute and long-term care facilities.

Table 1 identifies the ten core competencies developed by CSWE (2008) for generalist practice. A close review of these should facilitate a series of debates regarding how well these competencies align with social work practice in health care. This is important as alignment of these competencies, or lack there-of, can translate directly to the size of the knowledge gap a social worker experiences when entering the health care environment.

TABLE 1
CSWE SOCIAL WORK PRACTICE COMPETENCIES

1) Professional Identity — demonstrates awareness and adherence to professional roles, knowledge, skills and values.
2) Ethical Principles — demonstrates aware of personal values and bias and practice is informed by NASW’s Code of Ethics
3) Human Behavior and the Social Environment — demonstrates an understanding of person-in-environment fit and can use theoretical framework in assessment, intervention and evaluation practices.
4) Engagement: Micro, Mezzo, Macro Level -- demonstrates ability to utilize the problem solving model to meet client and stakeholder needs.
5) Research informed Practice - demonstrate ability to evaluate research findings and evaluate practice
6) Diversity — ability to recognize and understand how diverse cultural variables impact client Situations
7) Human Rights/Social and Economic Justice - practice is informed by a respect for the inherent dignity and worth of all people.
8) Social and Economic Policy — understanding of the connection of economic policy on service delivery
9) Critical Thinking - demonstrates accurate and logical cognition and communication regarding the problem solving model
10) Ecological System Perspectives - demonstrates leadership, flexibility and cutting-edge knowledge on practice/education practices

In addition to alignment, one might also question what defines a competency. And, perhaps more pertinent, the question arises as to whether any of the competencies developed by CSWE (2008) actually represent an ideology. This is a critical distinction for both new practitioners and health care leaders as a competent professional is received much differently than one who is perceived as an ideologue.

A competency is traditionally defined as encompassing the behaviors, skills and talents that one must possess to make an organization (or client) successful. For example, conflict management, communication skills, people development and team facilitation are often competencies identified in leadership development models. These can clearly be operationally defined and measured as behaviors and proficiency. By comparison, an ideology is a belief or philosophy. One may believe that teamwork is a noble endeavor, but it does not necessarily translate into a team facilitation competency.

In examining the (2008) CSWE practice competencies, many align with health care practice: for example, Critical Thinking and Professional Judgment. Critical thinking requires the synthesis and communication of relevant information. Social workers demonstrate this competency by their ability to collect assessment information, formulate a precise assessment based on this data, develop a logical plan and intervention strategy based on this assessment, and finally, evaluate the success or failure of the intervention.

In measuring the developmental process of Keuka College students on this competency we utilize the following behavioral indicators:

- Demonstrates an ability to distinguish, evaluate, and integrate multiple sources of data, information, and knowledge
- Demonstrates an understanding and use of multiple sources of information (i.e. empirical literature, diversity, policy, person-in-environment) in decision-making
- Reflects on the stages of a helping relationship (assessment, intervention, outcome, diversity)
- Clearly identifies and prioritizes client needs
- Applies (or refers to) appropriate interventions
- Cognizant of the various effects an intervention(s) has on client systems

There are other CSWE competencies, however, that present as strongly ideological in nature and, perhaps, may not be useful to those transitioning from academe to a new practice environment. In fact, fair or not, the profession of social work has a “branding” or professional marketing challenge where an ideological belief in social justice (a CSWE Competency), for example, often translates into a perceived lack of business acuity. At times, we wear this as a badge of honor. It is important to recognize, however, that wearing that badge may come at a price. Ideological and competency confusion can cause perceptual and trust issues in a host agency that undermines professional efforts.

This is not meant to imply that social workers employed in health care should dismiss the ideological and philosophical pillars that ground our profession. What is recommended is that we each assume a strategic, skill-based social marketing approach that is collaborative and considers the needs of all stakeholders. In other words, *lead with social work competency versus ideology*. Those among us who fail to continuously reassess for profession and organizational fit will be practicing with an incomplete assessment and ultimately, a faulty intervention strategy. Those who prove agile at anticipating change and adapt and align their competencies with organizational goals create a marketplace for their services.

Over a decade ago, Spitzer and Nash (1996) astutely reported that the health care environment was poised for a period of continued change. The authors foresaw that the empathy and passion social workers brought to their cases needed to be infused with an additional knowledge base inclusive of service efficiency and cost containment. Furthermore, given a perceived gap between historical practice readiness and current

knowledge useful in understanding an evolving environment, the authors proposed a curricula modification for prospective health care social work professionals.

Most relevant to this chapter, is the focus Spitzer and Nash (1996) direct toward environmental factors and organizational context. Many of these insights are, perhaps, even more crucial today. The authors report that both field students and new employees require an understanding of the current individual and societal expectations on their employers. It is also crucial for practitioners and leaders to having current knowledge of their organization, mission and management philosophy (Spitzer & Nash, 1996).

Case Example

Let me conclude this section with a simple case example that demonstrates a “win-win” alignment. Policy and the law protect patients from absolute medical abandonment. If a patient arrives at an emergency room in need of care they will be treated. If their condition requires and meets criteria for admission, they will have access to a bed. Therefore, suppose a patient is admitted with a minor cerebral vascular accident (stroke). They stabilize quickly and have minor residual deficits that can be easily rehabilitated with two weeks of home physical therapy.

The social worker is faced with a dilemma. Though a hospital is required to admit a patient suffering a stroke, a home health care company has no such requirement. In many ways social workers are challenged by the fact that parts of the emergent health care system are “socialized” in terms of open access, while others are restricted by ability to pay. In such a scenario hospital administration will expect the patient to be discharged as soon as possible. The patient has no insurance and no longer meets acute criteria. This is a rational expectation. The nurses will want an available bed for the next patient still waiting in the emergency department. The admitting physician will likely be ambivalent, but willing to discharge so long as the patient receives the therapy someplace. Not one among these stakeholders is wrong. However, this only escalates the pressure on the social worker.

If the social worker takes a social action-like advocacy approach for the patient to remain hospitalized to receive physical therapy he/she may be correct from a social justice perspective, but totally misaligned from an organizational one. However, to advocate that the hospital subsidize the home therapy from a cost-effective perspective (versus charitable) might work. In fact, many social work leaders have successfully received cost-centers to execute similar discharge plans--the rationale being one of cost-effectiveness, patient safety, and decreased chance of readmission.

Organizational Awareness: The Missing Competency

Though one may argue semantically what to call it, there is clearly a missing competency in formal social work education. While the academic arm of the profession speaks to micro, mezzo and macro targets of intervention, new graduates are typically client system, or perhaps community organization, focused. Few enter their first professional jobs

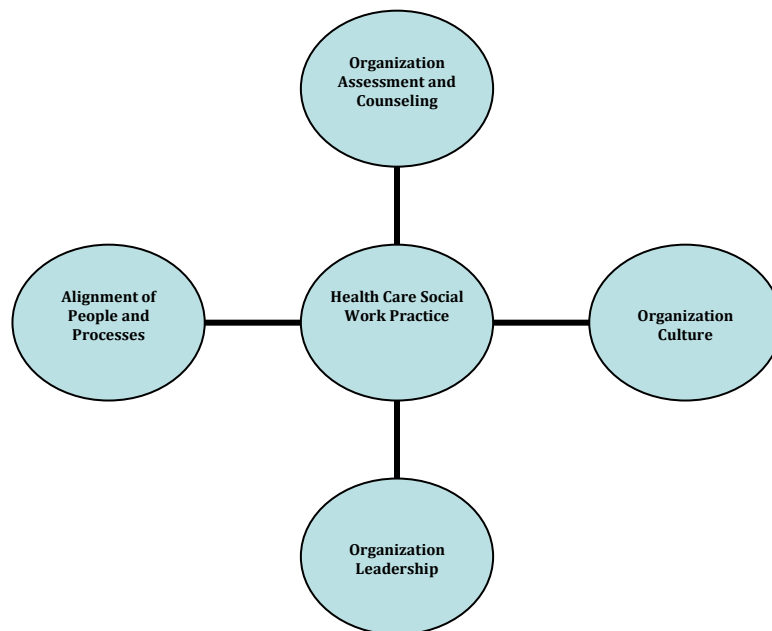
with an “organizational awareness” competency. Furthermore, social work, like other practice-based professions tend to promote their best clinicians into supervision and management positions, creating an additional misalignment of needed leadership competencies.

Bennis and O’Toole (2005) note that even business schools are susceptible to the same phenomenon. They report that business schools focused on research agendas tend to hire professors with limited real world experience and are thus “graduating students who are ill equipped to wrangle with complex, unquantifiable issues—the real stuff of management” (p.96). The parallel challenge for the health care social worker is to develop the skills and knowledge to assess the health care organization as one might a client. Interacting and integrating with an organization is truly a practice competency that is inclusive of enhancing profession and organization fit.

The competency of organizational awareness requires the health care social worker to engage with and practice within the context of an organization with full understanding of the professional and environmental fit. In doing so, practice has the potential to be more informed, allowing for more strategic judgments and decisions.

Figure 1 depicts the practice of health care social work in the context of environment. The environment is complex enough to grasp, but one must additionally be cognizant of any current societal, economic and political forces acutely affecting health care service delivery. Four major components comprise the total competency of organization awareness. Although there are some overlap and synergies among these, each requires specific proficiency.

Figure 1
Components of Organization Awareness



Paralleling the template developed by CSWE, it is perhaps most consistent and clear to speak to all organizational knowledge, skills and values under the broad competency of organizational awareness. Awareness can then be inclusive of, and encompass, the following:

- Understanding how the skills and values that underlie counseling and facilitation can be utilized in the organizational context
- Understanding organizational development
- Understanding organizational systems and culture
- Understanding organizational leadership

The overarching tenet of the above is the ability and willingness to assess the entirety of the organizational environment and then align our practice and interventions with its current needs.

Counseling the Organization

Johns Hopkins and several other universities have tinkered with an organizational counseling specialty. The goal was to secure a niche that combined the skills of a professional counselor with that of a traditional human resource educated organizational development specialist. The resulting hybrid professional would better serve an organization by employing both organizational knowledge and counseling skills. The incumbent would have the ability to assist organizations in managing the human aspects of its functioning.

The above is an intellectually complex and courageous undertaking, but one that links the social worker to an organization's "marrow". In assessing, constructing and evaluating interventions one quickly realizes they are serving multiple stakeholders. The individual members of the organization and the organization as a whole must be considered as well as the economic, social and political environment the organization inhabits. Although the social work role in health care does not typically have a formal organizational counseling function, the development and execution of these skills can help facilitate organizational and profession fit, and thereby guide and maximize formal practice. It is a piece, perhaps, of the bridge-competency that allows for effective and timely "classroom to practice" transition.

Organizational counseling is a natural extension of systems thinking which is prominent in the social work knowledge base. Competency in this arena provides the social worker with a "30,000 foot view" and macro understanding of their health care entity. We begin to see the interrelatedness and interdependencies of various departments, division and processes. In addition, the social worker is part of a continuous process of developing the skills and awareness to best align their professional role with both the organizational mission and the needs of their client systems.

Mizrahi and Berger (2001) write of the importance for health care social workers to seek out non-traditional roles and tasks that align with organizational need. The task of assessing and counseling the organization is not typically listed in a social work position

description, but the ability to do so gives one an x-ray vision-type super power. Assessing and counseling the organization is typically inclusive of the following:

- Knowledge of the organizational structure and culture
- Understanding of to activities and organizational process fit together
- Understanding of organization leadership, decision-making, conflict resolution and communication style

It is important to understand that health care organizations, much like organisms, strive to exist in environments that are rarely stable and in constant flux. A profit margin is their oxygen. Funds are needed to breathe life into existing programs and create new ones that meet the needs of their stakeholders. Organizations need to recruit top-level clinicians, pay salaries every two weeks, invest in cutting edge technology and equipment and, in general, keep the lights on. Employees, including social workers, are hired because they contribute to institutional life.

This level of organizational understanding helps to supplement the more abstract and perhaps naive level of knowledge one leaves the classroom with. No matter the subject matter, I ask all my students to convey their knowledge of a non-profit. Unfortunately, few grasp the need for non-profit organizations to have a positive profit margin. They understand the term in a literal sense. It is critical to understand that while a for-profit organization strives solely to maximize shareholders' wealth, a non-profit fiduciary responsibility is to maximize mission. And, as the old cliché goes: "No profit, no mission".

Leadership

The ability to understand and provide counsel to a health care entity relies on traditional assessment and intervention competencies taught in school, but the process is more leadership based than clinical. Clinical work typically requires a contract between the client and practitioner, while leadership can occur informally and at any level of the organization. Social work's practice skills applied strategically and courageously give us the potential for leadership and influence.

Slavin (2010) writes that a precise definition of leadership in health care can be elusive. He does list the following leadership characteristics which seem highly consistent with social work values and talents: making a difference, creating change, sustaining what works, making difficult choices with infinite resources, and mobilizes and motivating others.

Colone (1993) was one of the first social work leaders to recognize the need for a dual practice prospective inclusive of both effectiveness and efficiency. Health care clearly requires interdisciplinary perspectives and efforts from those who can, at least temporarily, move beyond their professional ideology, identity, and instincts and think "organization too". This is not meant to suggest we acquiesce to the authority, but rather seek to understand, and

than join processes and activities infusing organizational power and influence. In doing so, we begin to provide counsel to the organization.

Even physicians are acknowledging the need to evolve professionally to best create profession-environment fit. Historically, they have not had to fight for power and influence because of their clinical status in health care. With changes in reimbursement, increases in malpractice insurance and settlements, physicians have had to assume more of an engaged participant and leadership role. Even with the formal and informal power that shadows them, they are faced with the same missing competency challenge faced by the health care social worker. Despite its relevance, Chaudry, Jain, McKenzie & Schwartz (2008) report that no formal curriculum exists in medical education that provides future physicians with the leadership and organizational behavior skill set required in the evolving health care environment.

Similar to their social work colleagues, it is critical that physicians have the competency to function productively and contribute beyond the needs of the current caseload. To effectively serve as chairs, committee members and educators, physicians are becoming aware of the need to step down from their historical pedestal and join the process. To do so, they are developing a new competency and skill set inclusive of communication, self-awareness, team building, critical thinking, conflict management, financial expertise, and culture development (Chaudry *et al.*, 2008). Social work has a head start on their physician colleagues in many of these skills, but must commit to developing and utilizing the entire of the “organization awareness” competency.

Organizational Culture

Often, when a new coach is hired by an underachieving sports team, it is noted that they will attempt to change a losing culture. It sounds easier to just secure better players. However, talent in a dysfunctional culture is often unrealized. Organizational culture is a difficult concept to define.

Case Example

While working at a major non-profit I noticed an artifact of its culture. Pictures of old board presidents hung on the walls. Some dating back to the early 20th century seemed austere and creepy in nature. The photographs were not hung in a board room (there was none), but in the clinical areas. I tried unsuccessfully to have the photographs removed only to discover that respect (or fear) of board members took precedence to creating a therapy environment for clients. It was part of that organizational culture.

Organizational culture is directly related to stakeholders. They create, maintain and, at times, transform a culture. All organizations have certain values and norms that tend to drive, or at least influence, how people behave. As a graphic but sad illustration of this dynamic, a spate of aircraft crashes by Korean Air was blamed on the hierarchical culture of the company. In more than one instance a co-pilot was aware of approaching danger but felt

culturally obligated to defer to the pilot's opinion and failed to effectively communicate his concerns (*Gladwell, 2011*).

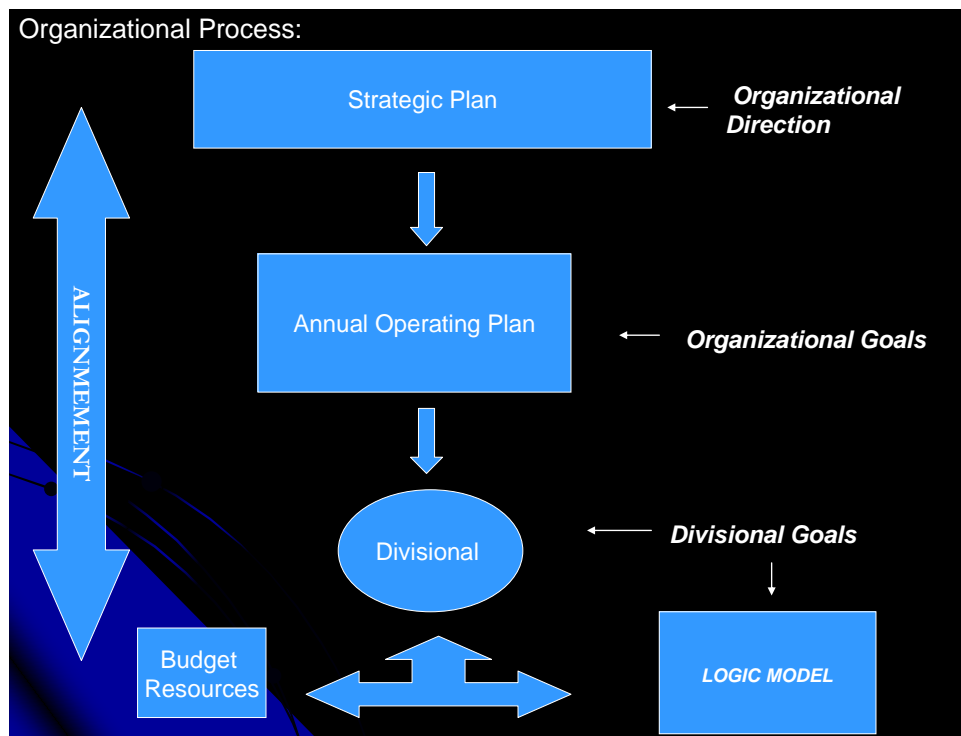
As one might wish with a client, it is important that the social worker become more aware of the cultural nuisances of their organization. These include, but are not limited to: power sources, decision-making style, and employee treatment. Does the organization, for example, function in an autocratic manner with power and influence hoarded at the top? Perhaps, it is bureaucratic in nature, with layers of policy and management slowing change and stifling creativity. Perhaps by comparison, the organization is more of a "learning organization" inclusively using the talents of all. Work is done in non-hierarchical teams and effort is made to implement team decisions. How is social work perceived in this environment? How might we envision the future?

Finally, it is helpful for field students and newly hired health care social workers to consider the congruence perspective. Vandenberghe (*1999*) demonstrated that the level of congruence between a health care organization's culture and its new employee values preference is a predictor of turnover. This has implications for social work in particular. By understanding the culture of one's employer, superimposed on the current social, economic and political forces effecting health care in general, one can first assess for profession and environment fit, and then determine the fit on a personal-profession level. Social workers who experienced "burn-out free" careers in health care possibly developed an awareness of their employer's culture and were comfortable co-existing with a health-care versus social welfare driven mission. It can be hypothesized that these professionals succeeded in aligning the skills and talents of social work with the challenges faced by the organization.

Organizational Alignment

Assessing and understanding organizational alignment is a two-fold challenge for the health care social worker. It is crucial because this level of organizational awareness leads to the development of a competency-based (versus ideological) marketing strategy that will allow for full engagement with one's health care organization. As represented in *Figure 2*, the following are vital to any assessment: the organization's mission and vision statements; the current strategic plan and annual operating plan; the leadership styles of senior management, and; the acute and long-term fiscal challenges to the organization.

Figure 2
Alignment of Key Variables



Regardless of a social worker's values and training, it is very unlikely that any professional subgroup can maximize effectiveness detached from organizational oxygen. By developing a line-of-sight from the organizational mission through the annual operating plan, one begins to understand organizational direction and both short-term and long term goals. Ultimately, this will allow social work an informed effort to best create a profession and environment fit; aligning our knowledge, competencies and talents with the current focus and challenges of our employer.

It should be noted that patients and clients are very much a part of this alignment. However, we should never assume that this is a given. Our social work values will hopefully ensure these thoughts to stream through our brains on a continuous loop. But our value system need not be worn as a badge of honor while fighting for scarce resources. Knowledge obtained from the above-discussed organizational assessment will allow for more strategic attempts at securing staffing and operational resources that benefit patient care. An enhanced degree of organizational awareness allows one to seek out win-win situations with, and for, one's organization. This alignment and macro level linkage can greatly enhance a natural marketplace for social work services. In addition, it may create more opportunities for non-traditional influence and committee work within the organization.

Conclusion

It is doubtful that any amount of academic rigor will totally prepare the social work graduate for life in the field of healthcare. A career in health care is one of continuous learning. Technologies, politics and challenges change weekly. Because the environments are perpetually in flux, it is rare for a health care organization to set more than a three-year strategic plan. This said, there still appears to be a glaring chasm in social work education—one of organizational awareness.

Patient advocacy and self-determination are always critical and should remain so. We should, however, also have the capability to demonstrate organizational empathy; to understand the pressures faced by one's interdisciplinary colleagues and administrators. Perlmutter, Bailey and Netting (2001) speak to the importance of social workers recognizing both professional and organizational cultures. To strategically demonstrate this empathy and awareness we need to continuously assess and gain knowledge related to the demands placed on our organization by the current political, social and economic environment. As social workers, we are expected to demonstrate this competency while assessing and assisting our clients. Further expanding our organizational awareness will not only maximize our overall impact with clients, but potentially enhance the profession's power and influence with our macro systems.

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Social Work Field Instruction in a Clinical Research Environment: Challenges and Opportunities

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Introduction

This chapter reviews the social work field instruction program in the Social Work Department (SWD) at the National Institutes of Health (NIH), Clinical Center (CC) for advanced or second year students interested in clinical practice in a hospital setting. It describes the process of recruiting students, matching students with field instructors, as well as the unique clinical practice and social work field education issues faced by students in a Federal free care research setting. In addition, this article discusses best practices that schools of social work should consider in preparing students to work in health care settings.

Overview: The National Institutes of Health and Clinical Center

The National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services, is the largest source for funding medical research in the world. It is comprised of 27 Institutes and Centers, each with an individual research agenda typically focusing on particular diseases or body systems. Although 80% of NIH's budget goes to more than 300,000 researchers located in 3,000 research institutions and universities around the country and the world, approximately 6,000 intramural researchers are located on its main campus in Bethesda, Maryland. Included on this campus is the NIH Mark O. Hatfield Clinical Research Center (commonly referred to as *the CC*) which is the nation's and the world's largest hospital entirely devoted to clinical research (*National Institutes of Health, 2012a*).

Initially established in 1954, the CC is a Joint Commission accredited facility with 240 inpatient beds and 82 day hospital stations whose mission as "America's research hospital" is "to lead the global effort in training today's investigators and discovering tomorrow's cures." (*National Institutes of Health, 2012b*). In addition to the inpatient facilities that admit approximately 4,000 patients annually, there are also outpatient clinics that average about 62,500 visits a year. The CC is unique in that all of the patients are volunteers who come from all over the country and world to participate in clinical research. This research is conducted by Institutes funded by the NIH such as the National Cancer Institute, the National Heart Lung Blood Institute, the National Institute of Allergy and Infectious Diseases, the National Institute of Mental Health, etc.

The various Institutes study blood diseases, kidney diseases, aging, alcohol abuse, eye disorders, cancer (e.g. lymphomas, melanoma, prostate, lung cancers), sickle cell anemia, bipolar disease, and schizophrenia to name a few. The CC is also noted for its study of rare

diseases such as Proteus Syndrome, Xeroderma Pigmentosa, and Progeria, and is distinguished by more than 1,600 laboratories in the hospital conducting basic and clinical research (*National Institutes of Health Clinical Center, 2012c*). Unlike typical Academic Medical Centers (AMCs) which bear the closest resemblance to clinical and research programs and services offered at the NIH, the CC does *not* provide all of the medical programs and specialties found in tertiary care or community hospitals. On one hand, there is no labor and delivery program, no orthopedics program, and no research done on children younger than two years of age. There is no Emergency Department, although there are very robust Medical and Surgical Intensive Care Units. On the other hand, there are expanded programs and departments that are not typically found in Academic Medical Centers (AMCs). The Recreational Therapy section of the Rehabilitation Medicine Department, for example, provides patients with a library and computer access as well as art and massage therapy programs. Recreation Therapy also sponsors trips to community malls, theaters, and museums as part of its program to support patients and families who are sometimes away from home for many months at a time.

Care at the CC is free. Unlike other hospitals, insurance information is not obtained upon admission. A recent study, however, conducted by Pricewaterhouse Coopers (2011) found that about 85% of patients have some kind of insurance. This is very important for the patient's primary and non-research related health care needs in the community. In addition, it is crucial information obtained and needed by social workers for activities related to continuity of care, resource referral, and discharge planning.

To ensure ongoing creativity and exploration, the NIH has numerous training programs for future researchers and professionals in the health care arena. The CC, in support of the overall NIH mission regarding training and like many other AMCs, also has a number of departments and divisions focused on training of health care professionals.

The Social Work Department

The Social Work Department (SWD) in the CC is similar to, but also different from, social work departments in typical AMCs. All twenty-five of the full- and part-time social workers are licensed and credentialed BSW, MSW, and Ph.D. trained professionals who provide a full range of clinical psychosocial interventions, resource identification, referral and discharge planning, and administrative services to research participants and their families. The department adheres to Joint Commission accreditation standards, but as a free-care facility, there is no Medicare, Medicaid or other insurance oversight. Utilization review and insurance case management are therefore not issues for the departments and services at the CC. In addition, length-of-stay (LOS) is driven by the research protocol and patient need. Thus in 2012, LOS was about 9.7 days (*National Institutes of Health Clinical Center, 2012d*) - a stay longer than the typical LOS of approximately 4.9 days reported for all non-Federal hospitals (*U.S. Department of Health and Human Services, 2011*).

Like many hospital-based social work programs, the SWD at NIH interfaces with a variety of internal customer groups (i.e. Institutes that admit and see patients). However, its services are distinguished by the different nature in which each of these Institutes operate and

provide support to patients and families. Each Institute has its own screening programs and means of providing financial and material support to patients and families while they are participating in Bethesda, Maryland for a study. Some Institutes provide full or partial stipends and reimbursement for travel, some do not. In addition, as many as 60% of patients and families come from outside of the Bethesda area from all over this country and the world to participate in clinical trials at the NIH.

Given these circumstances, social workers are often faced with the challenge of identifying resources and services for patients who are away from their normal means of financial, community, and social supports. Discharge planning is often complicated as social workers must interact with many and often unfamiliar insurance companies, health care and social service agencies located nationwide along with the varying rules and procedures of each entity. In addition, social workers may need to provide discharge planning for patients from communities throughout the world that lack the social safety nets found in the United States. Discharge planning is conducted while managing the diversity of backgrounds, cultures, and languages of patients and families and contending with a range of financial and social resources.

Psychosocial interventions comprise approximately 60% of the day to day social work services. These interventions include: screening, assessment, patient and family counseling and education, group facilitation, or attendance at rounds. Another 30% of SWD services are concrete including discharge planning, locating housing, applying for insurance or disability benefits, or identifying additional sources of financial support. The remainder of the time is devoted to administrative functions such as clinical documentation, participation in departmental or CC wide committees and initiatives, or supervising field students. This division of responsibilities differs from those in acute care settings where it has been reported that 60% or more of time is characteristically allocated to discharge planning activities while other clinical activities are performed 30% or less of the time (*Judd & Sheffield, 2010*).

In addition to the clinical social work program, the SWD manages and is administratively responsible for the Language Interpreters Program and the Volunteer Services Program. Both of these programs support the research and training missions of the hospital. As such, they each train and work with students in their respective disciplines and work collaboratively to provide education and support to social work staff and students.

The Social Work Field Instruction Program

Since the 1980s, the NIH CC SWD has trained social work students interested in health and mental health service delivery. Congruent with the NIH's and the CC's training vision and mission, the SWD includes education of students and staff as vital to its program. The field instruction program in the SWD averages between three and ten students annually, including one or two block placement students. The SWD maintains affiliate relationships with accredited graduate schools of social work in the Metropolitan Washington D.C. and Bethesda areas including: The Catholic University of America; Howard University; The University of Maryland; and George Mason University. Additional students are trained from

out of state schools such as The University of Alabama, The University of Texas at Austin, Virginia Commonwealth University, Washington University at St. Louis, and the University of Pennsylvania. Field instruction is provided in accordance with the standards and guidelines of the university and the Counsel of Social Work Education (CSWE, 2010). Since 1999, the SWD has trained 65 Master's level social work students. The program is coordinated and managed by a supervisory senior management level Deputy to the Chief for Education and Training, who is responsible for all student and staff training and the credentialing of all social workers at NIH.

Recruitment and Selection of Students and Field Instructors

Students interested in a field placement at the CC/SWD either self identify or are referred by the schools that are familiar with our training program. The primary goal and methodology in accepting and placing students is to identify advanced level (BSW graduates) and second year Masters degree students who are interested in health care and who understand that many aspects of their training will occur in a non-traditional health care environment.

The department seeks to ensure that field instructors are, first and foremost, committed to and passionate about the education of future professionals and have demonstrated expert clinical, discharge planning and interdisciplinary collaboration skills in their practice. Field instructors must be outstanding role models who are able to articulate to students, as well as interdisciplinary professionals in the organization, the role of social work in a research setting. All potential field instructors must obtain the prior approval of their supervisors.

While the majority of field instructors are licensed at the Independent Clinical level and are rated as exceptional or outstanding performers, there are some exceptions. Second career licensed graduate (LGSW) social workers with previous experience in education or in managing professionals may be utilized in certain instances. These individuals have worked in the department at least one year, demonstrated exceptional clinical and education skills, and want to be part of the student training program. They are partnered with fully licensed field instructors to provide additional proctoring or mentoring to field students. These licensed graduate social workers often play a role throughout the year in the department's student seminar program described elsewhere in this chapter. Many of these graduate social workers are hired after gaining experience as students in the SWD.

Prospective students submit resumes and university field placement applications to the program coordinator who makes them available for review by field instructors in an "on-line folder". Field instructors then identify students they would like to interview and, with the program coordinator, arrange to begin the interview process. Both the program coordinator and field instructor individually interview the potential student concentrating on mastery of foundation level clinical skills, appreciation of diversity, curiosity, flexibility, openness to learning, verbal ability, willingness to ask questions, and commitment to social work values and ethics. Students are additionally given a paper and pencil case scenario

about a typical research patient to determine current level of clinical and critical thinking /analytical abilities (CSWE, 2010). Writing samples are obtained from all student applicants.

While other programs may require a similar level of scrutiny and testing prior to admission to their student program, it is considered particularly important at the NIH for a number of reasons. One of the most important reasons for extensive pre-screening of students is that they will be exposed to a constant array of clinical research physicians and scientists whose foremost concerns are the clinical care of their patients and their ability to conduct research *with as little interruption as possible*. These physicians understand that research must be done in light of, as well as in spite of, the psychosocial factors each patient and family brings to research participation. As leaders of interdisciplinary teams and principal investigators, research physicians rely on team members who are able to succinctly and knowledgeably communicate verbally and in writing the psychosocial risk factors, emerging psychosocial issues, needs, and intervention strategies that will be required for their patients and families to complete the research process. Therefore, it is very important for the field instructor and student program coordinator to identify students who have or possess the potential to learn these very important skills.

Silverman (2012) identifies “organizational awareness” as a missing competency in health care field education. In line with this belief and the view of the organization as both a stakeholder and a client system that must be addressed and managed by the social worker, it is incumbent on student programs to assess what the organization both needs and respects. Without basic skills, students would be unable to minimally function in this environment. Therefore, the student program expends a fair amount of energy in determining students’ current abilities and needs in the areas of communication and critical thinking.

Student Facilities and Resources

While the facilities at the CC are new and state of the art, the accommodations for students in the SWD are by no means glamorous. They are only mentioned here as they relate to the attempt to create an environment for students conducive to learning and integrated with the overall department environment. It is therefore important that all students in the department are housed together whether they are social work students, the Language Interpreters Program students, or health care administration and management students working with the Volunteer Services Program. This is a crucial admixture of future professionals who are able to benefit from exposure to and knowledge of each of their contributions to the health care endeavor. The presence of the Hispanic Association of Colleges and Universities (HACU) students for the Language Interpreters Program has the added advantage of exposing students to the center of the cultural diversity programs and services in the hospital. The student office contains basic supplies, computers, phones, and seating for each student. Students are encouraged to take advantage of the total NIH environment which includes a world class library (The National Library of Medicine) and weekly grand rounds, lectures, and seminars offered by the NIH on a variety of topics in research, health, and mental health.

Students are required to participate in the new hospital employee orientation which includes training in organizational competencies including, but not limited, to Universal

Precautions, Patient Confidentiality, Information Security Awareness, Diversity Awareness and Fire Safety. To ensure integration in the department, there are additional required competencies such as clinical documentation, high-risk screening for mental health issues, suicide risk assessment, substance abuse screening, domestic violence screening, the purpose and use of Advance Directives, familiarity with SWD and CC resources, and the use of the Social Work Activity and Tracking (SWAT), the department's data management system that records the activities and time spent by all members of the SWD. Social work students must also be trained, organizationally and by the department, on the use of the Clinical Research Information System where clinical documentation is electronically recorded by patient care providers.

Field Instruction Program Features

Foundational concepts of health care social work related to basic principles of social work ethics, cultural competence, evidence based practice, a strengths-based perspective, critical thinking skills, ecological systems theory, and a biopsychosocial model of practice (*Borst, J., 2010*) are all part of the fabric of social work practiced and taught in the CC SWD. Along with the learning goals and supervisory requirements of each of the schools of social work, these concepts form the theoretical underpinnings of the field instruction program in the SWD.

Each student has an assigned field instructor and within the first week after completing the required competencies, begins on the units and clinics shadowing the instructor, attending rounds and ultimately being assigned patients to screen, assess, or provide needed social work interventions. New field instructors are commonly required to attend training at the individual schools of social work where their students attend. This is often supplemented by training events offered by schools of social work for new and experienced field instructors. These trainings are considered mandatory by the SWD. Learning contracts, process recordings, and weekly supervision are basics attended to by the student, the field instructor, and the SWD student program coordinator. Each of the faculty liaisons is an essential partner in the program's endeavors, and they are heavily relied upon for ensuring continuity between the academic and field settings and for troubleshooting and addressing problems and issues that arise during the school year.

Between the requirements of the schools and the opportunities offered at the NIH, the field instruction program contains many of the features suggested years ago by Marshack, Davidson, and Mizrahi (*1988*) including: assigning students to more than one area of practice and over the year to more than one field supervisor; group seminars with guest speakers; experienced-based peer learning; active demonstrations by students; and opportunities to learn and practice interdisciplinary interaction and collaboration. In the second semester, our students are able to expand their experiences by working with other field instructors and on different programs within the CC.

Of particular importance to the training program is the seminar series which runs throughout the academic year. Mandatory ninety minute weekly seminars are conducted in addition to the weekly supervision provided by individual field instructors. Depending on the topic under discussion, other students (language interpreter or management interns) may also attend the lecture portion of these sessions. There are usually two seminar facilitators

each semester who are MSW social workers in the department. They may be either senior clinical social workers or one or two years post graduate social workers who bring their own experience as recent graduates or as experts from other professions. Seminar facilitators generally do not have their own students, but have the time and desire to contribute to the student program and are particularly skilled in the areas of group facilitation, education, program management, clinical practice, and/or discharge planning. Social workers from around the NIH (not all NIH social workers are members of the CC SWD), other professionals in the SWD, and guest lecturers from throughout the NIH CC and the Institutes are brought in to discuss their current research as well as their knowledge and practice around specific topic areas. These may include lectures and discussions about discharge planning, clinical assessment, advanced directives, professional boundaries, pain and palliative care, suicidality and suicide assessment and psychopharmacology. The goal of the seminar is to impart information as well as provide opportunities for discussion. Topics are chosen because of their particular relevance or to illustrate variations in practice in the clinical research environment.

In the seminars, students are able to discuss common issues and concerns and their own responses and reactions to difficult patient and interdisciplinary team situations. The newest feature of the seminars is sessions between social work students and physician fellows from the Pain and Palliative Care Program. These provide opportunities to practice trans- and inter-disciplinary collaboration skills and to engage in positive learning around difficult issues such as delivering bad news or addressing medical and psychosocial issues with culturally diverse populations. These sessions are conducted using discussions as well as role play to give students and fellows the opportunity to practice different techniques for working with typical, but complex patient and team concerns.

What Do We Teach?

As the “signature pedagogy” of the social work profession (*CSWE, 2010*), field instruction in the SWD integrates theory and concepts learned in school with real world situations and practices. Therefore, social work field education in the CC is predicated on traditional principles and tenets of social work and practice in health care.

Students learn to utilize the person-in-environment schema to understand the circumstances of a diverse patient population. Working within the biopsychosocial framework, (*Dziegielewski & Green, 2004*), students receive hands-on experience in screening (brief, focused encounter) and assessment (detailed evaluation) of patients, as well as a variety of interventions with patients, caregivers, professional colleagues, and community organizations. With their field instructor as teacher and other staff members as mentors, students develop and strengthen diagnostic and assessment skills and develop treatment plans based on those assessments. They learn to negotiate the details of treatment planning with patients, their caregivers, and the multi-disciplinary team. They research and utilize resources available in the patient’s home community or locally if the patient will remain in our area for follow-up after discharge. Building upon their own developing professional experiences, supervisory conferences, classroom readings and descriptions, students begin to consider approaches and then apply theoretically grounded interventions to address identified problems.

As the year progresses, students are exposed to the opportunities and challenges of working with the multi-disciplinary team: varied perspectives on patient and caregivers, enhanced learning, and also role overlap, competition for resources, and power dynamics. They learn to identify and manage their own responses to the challenges and strengthen skills in effective communication, mediation, and when necessary, conflict management. Importantly, collaboration is emphasized to facilitate treatment planning at every step of the patient's experience. We teach 'case management,' not as a separate skill set but as part of the social work 'tool kit' of skills, strategies, and techniques. The person in environment schema provides a framework from which individual and caregiver dynamics and community resources inform discharge planning.

Students are encouraged to develop confidence as teachers. They offer education about specific and general psychosocial issues to staff members and trainees from other disciplines that are providing patient care. With the support of the field instructor, the social work student learns to provide consultation and education about illness, treatment, the research consent process, and aftercare to patients, caregivers, and interested community members.

The *NASW Code of Ethics (2006)* provides guidelines for the everyday professional conduct of social workers and offers a framework for the field education of social work students. In the CC, we address not only the values related to direct patient care - Service, Dignity and Worth of the Person, Importance of Human Relationships - but also the values of Social Justice, Integrity, and Competence. We work with students to identify professional ethical dilemmas (boundary issues, mandatory reporting requirements, access to care issues, for example), clinical ethical dilemmas (transitions of care when a research protocol is no longer appropriate, end of life issues), and organizational ethical issues (utilization of scarce resources is a frequent topic for discussion). Students learn from their field instructors and other mentors the importance of management of personal responses, participation in discussions aimed at problem-solving, effective communication with all interested parties, and collaborative work toward consensus. We emphasize the importance of work in the community related to patient care needs, including advocacy, education, prevention, and when appropriate, policy development.

Students are exposed to research in a number of ways during their placement year. They see the end product of the protocol development process and are involved in consent discussions when the treatment team describes the clinical trial, risks and benefits, and obtains informed consent. They observe and discuss the patient's and caregivers' responses to clinical trials at many points of treatment. Students can participate in the design of performance improvement projects in the SWD which may lead to research studies. As described below, students may also investigate their own patient work using a single subject research design. In addition, students learn to investigate available clinical trials and help patients access information and enrollment guidelines.

The Clinical Center and the NIH campus offer a wide variety of learning opportunities. We stress the importance of life-long learning to build and maintain competence and to inspire growth and innovation. We also recognize the challenge for

students as well as practitioners to balance the demands of patient care with the necessity for on-going learning.

Field Instruction in Research Settings: Opportunities and Challenges

The research environment provides multiple opportunities to begin and complete interventions with patients whose lengths of stay or availability is guaranteed. In many cases, the LOS is longer than it is in traditional hospital settings. In this setting, the social worker has the opportunity to focus on adjustment to illness, patient and family education, understanding the meaning of illness and treatment to the patient and family and therefore, the ability to anticipate and address potential compliance issues. In addition to a focus on such psychosocial barriers, social workers investigate physical and logistical barriers (housing, transportation, finances, and caregiver support, for example) that could interfere with adherence to treatment or completion of the research protocol. Solution-based, problem-solving, and cognitive-behavioral interventions are extensively employed in this environment, but social workers and students must also additionally be comfortable using crisis intervention strategies and working with grief, loss, and end of life issues.

Social workers on the medical units are more conversant with end of life care, care planning, discussions about advance directives, and indications and use of hospice and palliative care services. With their long-term patients, who have lengthy hospitalizations or who return for episodic care, they apply various psychotherapeutic interventions in discussions about transitions or life review. Those workers on the behavioral health units or units focused on substance abuse may be more familiar with DSM-IV-R diagnoses, working with dual diagnoses, effective strategies for work with individuals with schizophrenia, severe depression, or long-term substance abuse, and discharge planning in an era of few comprehensive resources. Successful work in a complex multi-disciplinary environment also requires strong communication and collaborative skills. Students learn from their field instructors, departmental leadership, and other effective social work practitioners, to assess power dynamics and to intervene with increasing ability, using conflict management, negotiation, and mediation skills.

Management of these multiple priorities and rolling from patient to team to resource identification to administrative tasks often requires the skill of a talented juggler. Social workers and students are at increased risk of burn-out, compassion fatigue, or stress-related illness. Self care, setting priorities and limits, and negotiation of boundary issues are important topics addressed in individual supervision, in the student seminar, and in other presentations available in the SWD and CC.

Negotiating Competing Priorities

High risk screening, assessment, development and implementation of intervention strategies, resource identification and discharge planning are at the heart of the clinical field instruction program in the CC as in other health care settings (*Dziegielewski & Jacinto, 2004*). Each, however, presents unique challenges due to the organizational structure,

operations, and the research mission of the placement setting. For example, as part of the Joint Commission provision of care requirement (*PC.01.02.01(1)* see <https://edition.jcrinc.com/Standard>, June, 4, 2012) for early high risk screening of inpatients, *social workers in the CC are required to see all new inpatients within 24 hours of admission*. Every attempt is made to screen patients in person; on-call social workers come in on week-end days and holidays to complete necessary screenings, and during the work-day, social work staff members make several attempts to meet with patients. Chart screens, with input from the bedside nurse and treatment team, are done only as a last resort.

Since protocols are conducted by individual Institutes, some patients are not routinely screened by social workers. Instead, screenings are conducted by the nurses or research study coordinators, and social workers may be called in to conduct a complete assessment based on patient need. Some patients may be assessed by social workers and determined to require or to be capable of benefiting from a particular kind of clinical intervention, but the intervention may be the research protocol itself. For example, the protocol may demand medication only for depression while the social worker believes that evidence-based cognitive behavioral therapy and/or psychotherapy with medication may be the appropriate intervention (*Engstrom, 2006*). In this situation, the role of the social worker is developed considering the needs of the patient in coordination with the requirements of the research.

Using a medical service as an example, a patient may be referred to evaluate their eligibility for a protocol investigating treatment options for lymphoma. While completing a routine screening, the social worker learns that the patient has no insurance and is living in the US without legal immigration documents. As an adult, this patient is not eligible for public benefit programs, including Medicaid. The physician who referred him for the research protocol did so with the hope that the research protocol would offer the patient a chance at life-saving treatment. The social worker must investigate the patient's understanding of the overlap and differences between treatment and research protocols and identify the patient's level of understanding and ability to comply with the requirements of the research protocol. The social worker is also called upon to guide the treatment team's understanding of the psychosocial challenges that could impact the patient's adherence to the research protocol. Finally, the social worker works with the patient and his community support network to identify and utilize available services to address patient needs while he is enrolled on the research protocol and particularly when he is no longer eligible for treatment at the Clinical Center because of disease progression, adverse physical reaction to the treatment regimen, or completion of the protocol.

Students are exposed to these dilemmas and participate in discussions - about the ethical issues, the patient's need for care, the external medical and resource realities, the team's wish to enroll an appropriate candidate on a treatment protocol appropriate for him - with their supervisors, other experienced social workers, treatment team members, and in Bioethics department consultation if appropriate. Such experiences often propel students to relevant reading materials and seminars and bring alive the Ethical Principles of the NASW Code of Ethics. Specifically, they challenge students, and staff members, to balance their ethical responsibilities to patients and to the organization.

Even on medical units, there may be differences in how or why screening is conducted. One Institute and program may require and support traditional high risk psychosocial screening for patients inclusive of insurance status for ongoing care and discharge planning needs. Another Institute or program may require very limited screening of patients around adjustment to illness or coping with rigors of the research protocol because the researcher is only interested in the needs of patients while they participate in brief or a single intervention protocol. Each student and field instructor adapts to these variations and adjusts screening, assessment techniques, and intervention practices accordingly. These differences in in-patient unit, out-patient clinic, or Institute program become a teaching and learning opportunity around the CSWE competency of Engagement at the individual, family, group and organizational levels (*CSWE, 2010*) to develop problem-solving skills to meet client and stakeholder needs. The variations in need and perception of the social work role allow the field instructor to teach not only about the different ways of conducting screens and assessments, but also about responding to the organizational environment and its needs.

Professional Ethics and Research

Informed consent is a significant patient right in health care in the United States. (*Borst, 2010*). Though Institutional Review Boards, Principal Investigators, and research teams are responsible for obtaining and ensuring informed consent throughout the research process, social workers are often involved in extended discussions that allow them to judge and determine if patients and families are participating in research freely with both informed consent and willing assent.

In health care, social work ethics of self-determination and informed consent are frequently the focus of clinical care and procedures, discharge planning, and post hospitalization follow-up. The challenge in research is to ensure that self-determination and informed consent are present when: 1) research is the only alternative; 2) the purpose of the research is to determine toxicity levels of a drug, or; 3) the chance of a research protocol succeeding is only 5%. Many research subjects understand this and still want to contribute to research. Others operate on the hope that they will be the miracle subject and really do not understand the risks and limitations of the research experience. In addition, there are often vulnerable populations (e.g.: uneducated, impoverished, cognitively impaired, limited English speaking, and patients from different cultural traditions with different perceptions of the role of patient in health care decision- making) who also have the right to participate in research and who, despite limitations, may still be able to fully consent. However, these patients challenge the concept of informed consent and self-determination and create unique learning experiences for social work students in health care, who grapple with complex issues in informed decision-making (*Wendler & Grady, 2008*).

Free Care and Insurance Concerns

Although the health care provided within the walls of the NIH CC is without cost to the patient or his insurance provider, social work students in this setting are not removed from the realities of health care finance. Patients still need to access health care services in their home communities for medical problems not related to their research participation.

They may also need routine lab work related to research but not want to make a long journey back to NIH for that purpose only. When routine medical care is required or when patients are no longer eligible for treatment at NIH because they have completed a protocol or because of disease progression and ineligibility for any other available protocol, they will return home for follow-up medical care. Insurance is a must in this situation. In addition, some patients are referred to NIH for treatment because they have either no health care insurance or limited coverage, and there is an available research protocol that offers treatment targeted to their disease. If any of these patients becomes ineligible for treatment on protocol, they are propelled back into an environment with limited or non-existent options. Students, as well as social work staff members, are challenged to research solutions to the problem of access and to educate their colleagues, patients, and families about the realities of health care outside of NIH environments and help them investigate strategies to manage those stresses.

The Successful Interface with Schools of Social Work

Schools of Social Work have continued to make strides in responding to the needs of students who complete field placements in host agencies, including hospitals, schools, and prisons, where the focus of intervention is not typically psychotherapy or primary social services. The National Catholic School of Social Services (NCSSS, part of Catholic University of America in Washington, DC), beginning in 2002 under the leadership of a Dean and faculty members who are health care veterans, has been among those schools developing best practices in healthcare social work field work.

For students, these practices include a specific healthcare concentration in the second year of the MSW program, separating the frequently combined health/mental health track. Second year students are offered many electives plus required courses – clinical skills with adults, children, and older adults, and a two-semester healthcare course “Advanced Field Education & Integrative Seminar.” The practice and seminar classes teach assessment and intervention techniques most useful in healthcare and also consider clinical, organizational, and professional ethics and research from a healthcare perspective. The seminar provides an opportunity for students to share experiences with those peers also placed in health care settings, identify and address thorny problems in patient care, multi-disciplinary collaboration, ethics, and self-care. Students receive support and problem-solving assistance from their peers as well as from the seminar instructor, who is often a veteran health care social worker.

For field sites, these NCSSS practices include field liaisons – usually the instructor for the integrative seminar – who are familiar with the issues encountered in current health care practice. The liaison/instructors recognize the unique qualities of this practice and develop a curriculum that discusses the role of social work in a health care setting, work with patients throughout the continuum of care, and how assessment, treatment planning, interventions, transference and counter-transference are managed in the context of health care social work practice. Assignments are relevant to the students’ practice and allow for submissions based on one-time interventions, short-term, episodic interventions, as well as

the longer-term interventions more commonly experienced by students in mental health placements. Students are encouraged to discuss the clinical as well as professional ethical issues encountered in health care settings. In terms of research, students receive instruction in traditional research methods and are encouraged to develop a research project. They are also able to focus on single subject research design so that they can develop and test a hypothesis related to work with one patient. Such an intervention makes research a more approachable topic for most social work students.

Field liaison visiting the field site as veteran healthcare social workers are able to understand the goals of social work in the setting, identify the standards of effective practice in healthcare, and if necessary, help the student and field instructor develop an action plan, including meaningful, measurable, and achievable steps to meet those standards. When there are issues that the field instructor and student cannot resolve themselves, the liaison can intervene as facilitator to bring the school, student, and health care setting to consensus.

Other Schools of Social Work have adopted similar specific areas of concentration and adapted core requirements to assist students in health care and other specialized placements. The Clinical Center social work students are enrolled in many different schools and report that most classroom discussions, readings, and assignments are flexible enough, while remaining academically rigorous, to recognize the learning opportunities and challenges of a health care placement. In general, our students describe a much more integrated experience between classroom and placement than students did 10 years ago.

Conclusion

Social work field instructors have an obligation to help students compare, contrast, and generalize from their particular settings to other sites where social workers are employed. In every health care placement, field instructors can describe how screening and assessment skills learned there translate to other settings. In this Federal research hospital, field instructors prepare students for future health care practice in more traditional, non-research, for-profit or not-for-profit facilities. We focus on the similarities – risk screening, patient education, adjustment to illness and treatment, team collaboration, planning for transitions, end of life care issues, resource identification, and discharge planning. We also discuss apparent differences, but seek to identify how their experience at NIH can enhance their practice in other settings. Knowledge of clinical trials and the consent process are assets for any social worker involved with medically vulnerable patients. Such knowledge can help in education of patients about potential risks and benefits and support appropriate referrals for clinical trials. Understanding the informed consent process and helping patients through a consent meeting is invaluable as all patients face informed consent documents for admission, procedures, blood transfusions, and surgery. Social workers well-versed in these processes can help patients and families understand and help the team feel assured their consent is truly informed and willingly given. Students' experiences helping patients understand the benefits and limitations of their insurance coverage translate directly to any setting. Complex discharge planning, with insurance coverage problems and multiple needs, is as challenging

in this setting as in any other the student may encounter, and the skills they learn from their field instructor will generalize to future employment.

The foundation elements of social work practice are relationship-building, effective communication, and problem-solving (*NASW Standards for Clinical Social Work Practice, 2005*). The social work training program in the CC at NIH helps students strengthen these skills, apply them in a complex medical system, and build upon them to develop the techniques, strategies, and additional skills described in this article. Although this is a specialized hospital setting, the training that students receive here translates into other healthcare and social work settings. Students successful in this placement have the necessary tools and skills to begin effective practice as professional social workers.

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NOTE: This chapter is dedicated to the memory of Deborah Dozier-Hall, MSW, LICSW, Assistant to the Chief for Education and Training, Social Work Department, Clinical Center, National Institutes of Health, (1997-2012). Her legacy as a leader in social work field education will live through her students for many years to come.

“The opinions expressed are the authors’ and do not represent any position or policy of the U.S. National Institutes of Health, Public Health Service, or Department of Health and Human Services.”

Education for Health Care Social Work Practice In the Department of Veterans Affairs (VA)

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Introduction

Under its statutory mission, the Department of Veterans Affairs (VA) is to develop and carry out a program of education and training of health care personnel for the Nation...

“..in order to carry out more effectively the primary function of the Veterans Health Administration and in order to assist in providing an adequate supply of health personnel to the Nation, the Secretary . . . shall develop and carry out a program of education and training of health personnel” (38 USC §7302)

Overview: Veterans Affairs Health Care Social Work Practice

Professional Evolution

Social workers are an integral and vital part of the Department of Veterans Affairs (VA) health care system. Social workers support and advance the mission of the Veterans Health Administration by providing high quality psychosocial services to Veterans, their families and caregivers. The VA is the single largest employer of professional social workers in the United States, with over 9,500 master's prepared social workers assigned to VA health care facilities across the country.

Social work became a profession over one hundred years ago. Social workers have been taking care of Veterans since 1926 when thirty-six social workers were hired in Veterans Bureau psychiatric hospitals and regional offices. The Veterans Bureau General Order, dated June 16, 1926, introduced the profession of social work into the VA. Early social work involvement was centered exclusively on treatment of psychiatric and tuberculosis patients. Following World War II, the emphasis was on readjustment to community living following medical care. During the 1950s, VA Social Work developed the highly successful and cost effective Community Residential Care (CRC) Program. The program provides health care supervision to eligible Veterans not in need of acute hospital care, but who, because of medical and/or psychosocial health conditions, are unable to live independently and have no suitable family or significant others to provide needed supervision and supportive care. The program constitutes an important component in VA's continuum of care. Since the 1960s, VA social workers have expanded supportive services provided to Veterans, their families and caregivers across the continuum of care and in all specialty

programs with a continuing emphasis on outreach and community care (*United States Department of Veteran Affairs, 2012*).

During the 1990s, social work fully participated in the many evolving administrative and programmatic changes in VA health care. When VA health care facilities reorganized into care lines, many social workers were afforded leadership roles, allowing them to develop innovative programs and foster changes in service delivery within and outside social work. Dr. Kenneth Kizer, VA Under-Secretary for Health changed VA from a system of hospitals to a health care system (*Kizer, 1996*). His visionary changes resulted in a much leaner and more efficient reorganization of VA medical centers.

Today, VA provides patient-centered care that is a fully engaged partnership with the Veteran, family and health care team. This is a new VA approach that transforms health care from a problem-based disease care system to a patient-centered health care system. When the Veteran is at the center, we build our health care around their life and what matters to them. Health care is provided by a Patient Aligned Care Team (PACT) that is patient-centered, integrative care established through continuous healing relationships in an optimal healing environment.

When major clinical programs were introduced in the VA, social workers played key roles. When the Care Coordination Program was expanded across the VA, social workers were selected as care coordinators and as managers of Care Coordination Programs at the facility and network level to implement Home Tele-health (HT). HT uses health informatics, disease management, and tele-health technologies to target care and provide case management thereby facilitating access to care and improving the health of Veterans. Home Telehealth changes the location where health care services are routinely provided and supports Veterans' preferences to live in the least restrictive settings possible. In HT programs, social workers assist with supportive counseling and monitor health informatics responses, following up on depression and caregiver stress. In this capacity, social workers monitor Veterans' health status in their homes using tele-health technologies.

In response to the needs of active duty service members injured in Operations Iraqi Freedom and Enduring Freedom (OIF/OEF), a 2003 national VA task force developed the VA Seamless Transition Program, now known as the VA Liaisons for Healthcare. The first component of that program assigned VA social workers to the major Military Treatment Facilities (MTF) to assist Department of Defense (DoD) staff in transferring the care of injured OIF/OEF active duty service members to VA health care facilities. When VA facilities were mandated to appoint seamless transition points of contact and seamless transition case managers, they often looked to social workers to fill these critical roles.

The VA now utilizes thirty-three VA Liaisons for Healthcare stationed at eighteen MTFs to transition ill and/or injured service members from the DoD to the VA system of care. The VA Liaisons facilitate the transfer of service members from the MTF to a VA health care facility closest to their home or to the otherwise most appropriate location providing the specialized services their medical condition requires.

As the VA transformed Traumatic Brain Injury Centers to Polytrauma Rehabilitation Centers, social workers again played a key role providing specialized intensive and comprehensive case management services to Veterans and active duty service members with polytraumatic injuries, including traumatic brain injury, spinal cord injury, visual and hearing impairments, amputations and blast injuries in VA Polytrauma Rehabilitation Centers and across the system of care.

The VA has a robust system in place to provide transition assistance and care management for wounded, ill and injured Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans. Each VA Medical Center has an OEF/OIF/OND Care Management team in place to coordinate patient care activities and ensure that service members and Veterans are receiving patient-centered, integrated care and benefits. OEF/OIF/OND clinical case managers screen all returning combat Veterans for the need for case management services to identify Veterans who may be at risk in order for VA to intervene early and provide assistance before the Veteran is in crisis. This screening includes the risk factors for psychosocial issues such as homelessness, unemployment, legal and family issues, and substance abuse in addition to identifying prevalent medical and mental health issues related to deployment. Severely ill or injured service members/Veterans are provided with a case manager, and other OEF/OIF/OND service members/Veterans are assigned a case manager as indicated by a positive screening assessment or upon request. OEF/OIF/OND case managers are experts at identifying and accessing resources within their health care system as well as in the local community to help Veterans recover from their injuries and readjust to civilian life.

Social work principles guide efforts in meeting the needs of service members and Veterans returning from Iraq and Afghanistan. Priority attention is paid to obtaining the best recovery, rehabilitation and reintegration to civilian life utilizing VA and community resources. A collaborative approach between the Department of Defense and Veterans Affairs underscores the fact that involvement of VA and DoD case managers in providing support to a Veteran and their family may be a long term endeavor. Building the community's capacity to meet the needs of returning Veterans is a shared responsibility and includes formal and informal support systems and interagency networks anchored in community values. Focus is maintained on the individual needs of the Veteran including financial, employment, vocational rehabilitation, education, housing, and family support.

Clinical social workers in VA provide one third of all outpatient mental health treatment services. Appropriately trained and clinically licensed social workers provide counseling and psychotherapy services, including assigning independent DSM-IV diagnoses. In 2012, 2,902 clinical social workers were trained in Evidence Based (EB) Practice through VA training programs, constituting 40% of VA's trained mental health providers. The focal areas for EB trainings included:

- **Depression:**
 - Acceptance and Commitment Therapy for Depression (ACT-D)
 - Cognitive Behavioral Therapy for Depression (CBT-D)

- **PTSD**
 - Cognitive Processing Therapy (CPT)
 - Prolonged Exposure (PE)
- **Serious Mental Illness**
 - Social Skills Training (SST)
 - Behavioral Family Therapy (BFT)
 - Multi-Family Group Therapy (MFGT)
- **Motivation**
 - Motivational Interviewing (MI)
- **Relationship Distress**
 - Integrated Behavioral Couples Therapy (IBCT)
- **Behavioral Health**
 - Cognitive Behavioral Therapy for Insomnia (CBT-I)
 - Problem Solving Training (PST)

Service Description

To best support the VA mission with Veterans, social workers provide a wide range of services designed to best meet the identified needs of Veteran patients and their families.

Clinical Services

- *Psychosocial Assessment:* Social workers provide comprehensive psychosocial assessments that involve interviewing Veterans and their family members/significant others to gather pertinent demographic data; conducting a thorough history, including military and vocational information; identifying strengths, problems and risk factors; assessing the Veteran's level of functioning; determining the Veteran's family and community support systems; assessing the home and community environment; identifying cultural and spiritual factors; and identifying psychosocial treatment needs. The psychosocial assessment is part of the overall health care assessment conducted by the interdisciplinary treatment team. Reassessments are conducted at least annually as well as when Veterans' conditions or needs change.
- *Psychosocial Treatment and Intervention:* Upon completion of the psychosocial assessment, a psychosocial treatment plan is established that identifies needed psychosocial interventions. The plan, developed in collaboration with interdisciplinary team members, the Veteran and the Veteran's family/significant others, incorporates measurable goals that are reviewed regularly and revised as needed. Social workers regularly evaluate the effectiveness of the services provided by thoroughly reviewing outcome measures.
- *Psychosocial Rehabilitation:* This intervention serves to assist emotionally and physically disabled Veterans in becoming productive members of society. The intent is to maximize the Veteran's potential and assisting them in their transition to community living.

- *Psychosocial Case Management:* These services are offered to Veterans manifesting one or more high psychosocial risk factors, such as homelessness, frail elderly, inability to provide self-care, frequent hospitalizations or emergency department visits, suspected victims of abuse/neglect, terminal illness, catastrophic illness or injury, non-compliance with treatment plans, or need for a guardian or conservator. Case management services are provided across episodes of care.
- *Discharge Planning Coordination:* Social workers often serve as the primary coordinators of the discharge planning process. Such coordination includes assuring that Veterans have appropriate care and needed services once they are discharged from an inpatient or outpatient treatment program. Coordination is done in collaboration with interdisciplinary team members, the Veteran and family members/significant others.
- *Community Care/Community Linkage:* Social workers serve a critical function by identifying Veterans who are not currently receiving VA health care services and serving as community liaisons between VA health care facilities and community agencies. They develop networks with representatives of both public and private community agencies for purposes of outreach and referral. Social workers assist in the development of new resources and frequently represent the VA in community meetings.
- *Interdisciplinary Collaboration, Coordination and Consultation:* To assure the best possible care, social workers collaborate regularly with other disciplines involved in providing care. As key members of interdisciplinary treatment teams, they regularly confer and consult with other team members regarding treatment and provision of health care services. The exchange of information and recognition of the unique contributions provided by each team member are vital to maximizing patient outcomes. Social workers often facilitate team meetings and patient/family conferences using their systems orientation and group process skills.

Non-Clinical Functions

In addition to clinical functions, social workers are involved with:

- education and training;
- research and practice evaluation;
- support for the Department of Defense, emergency/disaster response and preparedness, and;
- program development, coordination and evaluation.

VA Social Work Educational Training

Available Practice Settings

Social work training experiences provide opportunities to work in a variety of VA health care programs and to work with special populations of Veterans. Nearly 50% of VA social workers have completed a VA field placement. As the nation's largest employer of master's prepared social workers, it is vital to VA's succession planning efforts to provide access to these training opportunities as graduate students enter the workforce.

The VA Office of Academic Affiliations conducts annual Learner Perception Surveys for VA-wide trainees with social work students consistently rating the highest satisfaction with 92% rating their training as excellent or very good. Being a field instructor and a student is a rewarding experience and excellent opportunity for newly graduated social work students to come work in VA health care. Two levels of traineeships are available:

- *Social Worker (doctoral)* - Graduates of a masters level program accredited by CSWE (Council on Social Work Education), and enrolled in doctoral programs for advanced education in social work. Social work students may be appointed on a With-Out Compensation (WOC) basis only. Traineeships are offered in Palliative Care, Psychosocial Rehab/SM, Centers of Excellence in Substance Abuse Treatment and Substance Abuse.
- *Social Worker (baccalaureate or masters)* - Enrolled in CSWE schools, baccalaureate students are appointed on a WOC basis while masters candidates may be appointed on either a stipend or a WOC basis. Master level traineeships are offered in regular, Geriatric Research Education Clinical Center (GRECC), Post Traumatic Stress Disorder (PTSD), Center of Excellence for Substance Abuse Treatment Education (CESATE) and Palliative Care settings.

The VA trains more MSW students than any other single agency in the United States and has affiliation agreements with more than 180 colleges and universities. Based on the academic requirements of the affiliated school, field placements may be either concurrent or block and either clinical or administrative. Each VA health care facility is encouraged to enter into affiliation agreements with accredited Schools of Social Work. Efforts are made to establish affiliations with Historically Black Colleges and Universities (HBCU) and Hispanic-Serving Institutions (HIS) to promote cultural diversity directly in training programs and within the workforce. In order to become affiliated with VA, each School of Social Work must be accredited by the Council on Social Work Education (CSWE). Affiliation agreements are typically initiated by the Chief of Social Work or the Social Work Executive and are often reviewed by the facility's Education Office or Designated Education Coordinator. The Medical Center Director, along with representatives of the School of Social Work, must approve all terms of the affiliation agreement.

VA facilities with affiliation agreements with Schools of Social Work must have a pool of experienced, journeyman-level social workers to serve as field instructors. Each VA facility receives a designated number of stipends for Social Work Associated Health Trainee positions, which are disbursed annually by the VA Office of Academic Affiliations. Trainee positions require a minimum of 500 hours of VA field work. If the affiliated School of Social Work requires more than 500 hours, the student must complete the number of hours required by the School. The intent of the stipend is to attract quality students who may later choose the VA for post-graduate employment.

Current Innovative Learning Initiatives

The VA has entered into a promising collaboration with the John A. Hartford Foundation, the Social Work Leadership Institute at New York Academy of Medicine, the Hartford Foundation Program for Aging Education (HPPAE) for social workers with field placements at designated Geriatric Research Education Clinical Care (GRECC) VA medical centers. Aging Veterans from World War II, Korea and Vietnam Era comprise 55% of all Veterans and make up the largest segment of Veterans VA cares for. We know older Veterans and their families wish to continue living at home and in their communities. Many aging Veterans who live with chronic medical and cognitive impairments that impact daily functioning continue to live successfully at home. Social workers intervene early to arrange for an array of home and community based services as well as respite care for the family Caregiver. The HPPAE model is specifically designed to prepare an aging-competent workforce to meet the demands of an expanding geriatric population. The model differs from traditional social work education because it trains students through use of rotational field experiences that provide them a unique breadth and depth of knowledge for working with older adult clients. Over the course of their education, students rotate through multiple field settings, gaining exposure to different care systems and a broad spectrum of life phases.

VA Social Work's call to action is to strengthen the capacity of social workers to address the health and psychosocial needs of aging Veterans and their caregivers. Promoting social work field placements in GRECCs and other geriatric programs that impart these competencies will support meeting the needs of a growing geriatric population.

Future Educational Challenges and Opportunities

The VA system, similar to its civilian counterparts, faces a myriad of issues related to the future delivery of health care and the preparation of appropriately skilled social work practitioners:

- *Clinical Challenges*
 - What will the health care system(s) be like in the future?
 - What number and type of health care professionals and support staff will be needed?

- *Educational Challenges*
 - Education for an unknown future
 - Demonstration of value to VA
 - Quality of training programs
 - Alignment with work force issues
 - Creation of new programs
 - Partnerships with Affiliates and other organizations.

Field Placement Example: VA Puget Sound Health Care System

The placements at the VA Puget Sound Health Care System both in Seattle and at American Lake are among the most sought-after placements in the Seattle/Tacoma area. The placements utilize an established model proven to be successful in developing new practitioners. In *The Field Educator (Spring 2012)*, the Children's Hospital of Michigan is featured as a best practice practicum site (*Gail & Meyring, 2012*). Of note, their program and process is very similar to one developed by Taylene Watson in Washington state more than a decade earlier.

The process of matching and placing students starts with the commitment of dedicated educators and staff interested in the future of the profession and the training of new professionals. The VA Puget Sound trains students at many different levels including undergraduate BASW students from the University of WA School of Social Work (UWSSW) and Seattle University and MSW students from the Seattle and Tacoma campuses of the UWSSW as well as graduate students from other schools of social work as far away as Massachusetts.

In a letter written to William H Campbell, Chief of Staff at the VA Puget Sound Health Care System when he arrived in 2009, Dr. Edwyna Uehara, Dean of the UW stated:

“The UW School of Social Work (UWSSW) has had a long-standing training affiliation with the Social Work staff at the VA in Seattle and American Lake for over 20 years. Ms. Taylene Watson, Director of Social of the VA Puget Sound Health Care System and her SW staff, have made contributions of national significance toward education in the health professions and have established what has often been considered the premier Social Work Department in the VA in the US. She has spearheaded an impressive SW training unit, our largest health care unit at the school with on average 18-25 students each year from the UWSSW. During the past twenty years approximately 300 masters' level students (MSW level) have completed their formal advanced internships. More than half of the 100 +VA social work staff are graduates of the UW Master's Degree Program in Social Work, and many now serve as our Practicum Instructors for our students. When he was appointed as President of the UW in 2004, President Mark Emmert selected the UWSSW as one of the Schools he wanted to learn more about. As one of the programs that the School of Social work chose to showcase, the VA Social

Work Department training program was selected for a visit and Dr. Emmert spent an afternoon dialoguing with VA Social Work Staff on site.”

The Practicum Placement Process

Initial Placement Determination

The planning for Practicum starts with health system staff identifying their desire to participate in the student program. The VA Puget Sound Health Center Service Line Director meets with staff to review staff interest and desire to work with students. Staffs next submit summaries of their practice areas to the UWSSW. These summaries are included in the online STAR Practicum Placement Description for the Office of Field Education and their students. Clarification of the placements and ongoing dialogue occurs between the Service Line Director and the designated Practicum Liaison from the Tacoma and Seattle Campuses. In coordination with the UWSSW Liaison, the Service Line Director facilitates an informational meeting with students about the VA and potential social work department placements available through the VA. The meeting provides a forum in which the director and staff members answer student questions and discuss the mission of the VA and its Social Work Services.

In March, second year/advanced standing students are able to indicate an interest or choice of potential placements. At the VA Puget Sound system, a number of social workers work with the Director and Associate Director to identify and initially screen interested students, numbering between 25 and 30 from the two University of WA campuses. Student screening interviews are conducted much like a screening job interview, utilizing both standardized questions and a student writing sample. At this initial meeting student preferences for placement are noted and the interview team discusses potential practicum instructors for each specific student. Before the student leaves the initial interview, they are provided the names of two or three potential instructors to contact for the next phase of the matching process.

Following completion of the initial interviews, the identified VA staffs are given the students' contact information, resumes and writing samples and are advised the students will contact them by telephone or e-mail to set appointments. The designated Practicum Instructors (PI) interview each referred student candidate and provide them with a summary of practice opportunities available in their respective areas of expertise. Some instructors meet multiple students before confirming a match. Matches are critical to the success of the placement and must be made with consideration to the students' learning style.

Both the students and PI's are expected to contact the Director to advise her as whether they feel there is a match and to indicate the prioritized ranking of their interviews. Most students find a match through this initial process. Increasingly however, as the VA has become sought after, more students will apply for training at the VA than there are available field placements. When this occurs, the Director and Field Practice Liaison from the university will work to identify additional instructors that might constitute a good fit with the identified interests of the previously unmatched student. All interviews and matching are

done individually and confidentially. Students are informed of their acceptance and match in early April. Determination of stipends occurs several weeks later.

The reputation of the social work training program at the VA in Seattle and American Lake has been built over the past 20 years, prompting students to seek training opportunities based on the known quality of the program. Students enthusiastically commit to accepting an offer without any assurance of being awarded a VA stipend. That enthusiasm independent of stipend is based on students' appreciation for the diverse, quality opportunities to learn about medical and mental health social work from almost any service area. If a student is interested in a stipend, they submit a written statement of their interest and goals in working with Veterans. Stipends are not awarded to every student placed at the VA. Although some "generic" stipends can be designated for any service area, typically stipends are tied to specific programs including Geriatric Research Education Clinical Care (GRECC), and Mental Health and Addictions. Stipends are conferred based on match to designated areas and the interest statements submitted after the initial interview. The placement process is completed by the middle of May when stipends are announced and again when acceptance letters are mailed by the director.

Field Experience Orientation

At the beginning of the internship, students attend the entire VA New Employee Orientation plus a Social Work Department Intern Orientation. They also receive training on the computerized medical records and get security clearance for their training within the VA. A select number of Talent Management System (TMS) modules must be passed before students become involved with Veterans and their families. These modules are also annually required of staff working with Veterans and provide information on: HIPPA; Confidentiality; Privacy; electrical safety; Prevention of Violence in the Work Place; Patient Safety, and; Cultural Competency.

Each area of the VA has specific orientation material that must be reviewed by practicum instructor and intern. Although regarded by some as lengthy, the orientation detail gives students an insight and understanding of what it is like to be part of the larger National system and then on an individual level, being part of the other smaller systems that exist within VA Medical Centers.

The School of Social Work incorporates the Council on Social Work Education (CSWE) required Competencies and Practice Behaviors (*CSWE, 2008*) into the UWSSW learning contracts and quarterly evaluations. Covering all of the educational competencies and experiences associated with the placement, this contract guides interns and practicum instructors by giving direction and requiring examples of activities leading to "best" practice. The contract is a plan for learning experiences; students are able to create an overview of what they want to derive from the Practicum Experience and, for instructors, it serves as a guide to what must be addressed.

Over the years, administrative students working with the Director and Associate Director have organized the student seminars with input from Administration and the

Department Education Committee. The student interns are included in all staff education and training as well. Students have their own seminars weekly with speakers from the department or from other departments that social work interacts with on a regular basis. There are also brown bag lunches that are student lead so they have a forum to discuss practicum issues that arise at the VA, or share cases and do peer case consultation.

Interns are not restricted to seeing only one person's practice, but at the end of the second quarter and the third quarter "shadow" other social workers in areas different from their practicum placement to see how things are done in different programs and by different workers. They are able to see different multidisciplinary teams in action and to observe a treatment group in Addiction or Mental Health or Woman's Clinic. Interns are encouraged consider different sites as well and since we have two campuses, they can visit the Community Living Center at Seattle and see the Community Living Center at American Lake in the Tacoma area.

Training of Practicum/Field Instructors

First time Practicum Instructors are offered training seminars to help them understand and learn about adult learners. They are offered a formal Field Instructor Training series of 10 modules by the UWSSW to help prepare in advance for assuming responsibilities for a student. The sessions are as follows:

SESSION I is 4 hours and includes:

Module 1: Mission and Requirements of Field Education,
Module 2: Conducting an Effective Agency Orientation,
Module 3: Incorporating Adult Learning Styles and Theory
Module 4: Developing the Learning Contract

SESSION II is 4 hours includes:

Module 5: Providing Effective Supervision
Module 6: Integrating Theory and Practice
Module 7: Feedback and Evaluation

SESSION III is 3 hours and includes:

Module 8: Building Cultural Competency in Practicum

SESSION IV is 3 hours and includes:

Module 9: Ethics in Practicum, and
Module 10: Working with Challenging Students

Practicum: the "Signature Pedagogy" of Social Work Education at the VA

The CSWE 2008 Educational Policy and Accreditation Standards reference "Signature pedagogies in the professions" (*Shulman, 2005*). Shulman states:

“if you wish to understand why professions develop as they do, study their nurseries, in this case their forms of professional preparation. When you do, you will generally detect the characteristic forms of teaching and learning that I have come to call signature pedagogies. These are types of teaching that organize the fundamental ways in which future practitioners are educated for their new professions.” (p.52)

Shulman indicates that there are three dimensions or levels to the signature pedagogy: The first level is the *surfrastructure*, which is operational learning that involves showing and demonstrating, questioning and answering, and interacting and withholding. The next level is the *deep structure* where there is a set of assumptions about best methods to impart a body of knowledge. The final level is the *implicit structure*, which is moral dimension that is a set of beliefs about professional attitudes, values, and dispositions. (Shulman, p.55-56)

The VA Puget Sound program illustrates all three dimensions of training. Interns are immersed in their areas and shadow their practicum instructors initially while having trainings and seminars that go over the information needed to do assessments and understand what is required to function in the social work role within this setting. Each practicum instructor is involved with demonstrating the role in their area, answering questions and explaining procedures and processes. Seminars and trainings are also part of imparting knowledge of the role, the type of patients served and the differing techniques employed in various areas. Interns practice new learning while consistently under the guidance of experienced social work practicum instructors who demonstrate “best practices” and convey the values of social work practice and mission of Veterans’ Affairs.

Practicum Instructors utilize *Best Practice in Professional Development for Sustained Educational Change* (Speck, 1996) as a guide to adult learning theory. The principal elements of that theory are:

- Adults will commit to learning when the goals and objectives are considered realistic and important to them.
- Adults want to be the origin of their own learning and will resist learning activities they believe are an attack on their competence. Thus, professional development needs to give participants some control over the what, who, how, why, when and where of their learning.
- Adult learners need to see the professional development learning and their day-to-day activities are related and relevant.
- Adult learners need direct, concrete experiences in which they apply the learning in real work.
- Adult learning has ego involved. Professional development must be structured to provide support from peers and to reduce the fear of judgment during learning.
- Adults need to receive feedback on how they are doing and the results of their efforts.
- Adults need to participate in small-group activities during the learning to move them beyond understanding to application, analysis, synthesis, and evaluation. Small-group activities provide an opportunity to share, reflect, and generalize their learning experiences.

- Adult learners come to learning with a wide range of previous experiences, knowledge, self-direction, interests, and competencies. This diversity must be accommodated in the professional development planning.
- Transfer of learning for adults is not automatic and must be facilitated. Coaching and other kinds of follow-up support are needed to help adult learners transfer learning into daily practice so that it is sustained.” (pp. 36-7)

We realize that adult learners must be able to see how new skills will benefit their practice and that they are equal partners in developing the learning contracts and deciding what they want to learn. Practicum instructors guide the learning and assist with accessing different experiences with other mentors within the system. The intern who worked in the Geriatric Clinic indicated in her memories that are shared at the VA Student Graduation,” I knew that my PI had confidence in me when she asked me if I was comfortable to do clinic appointments without her. I knew I could call her to ask questions, but she had faith in my ability to function and it helped me grow.” (*Angeli Bhatt statement made at VA Graduation Celebration, June 2012*) The students see the value of their skills develop through doing tasks and making assessments in different places within the system. They are able to demonstrate their learning and mistakes are worked on and used to improve practice. The interns also help evaluate their experiences and review their developing competencies.

Student Impressions / Professional Acknowledgements

Interns at VA Puget Sound provide positive, constructive feedback as to the nature of their training experience and its impact on their preparation for professional practice. The interns are included and regarded as colleagues in committees, program planning and evaluation of practice. They are afforded opportunities and experiences typically extended only to permanent staff. That interns sense they are legitimately integrated into the day-to-day life of the VA social work department is reflected in the following comments of one recent intern:

“Interning at the VA heavily revolves around working on interdisciplinary teams. Healthcare in general has been pushing toward a more comprehensive approach to working with patients. This shift has allowed social workers to be recognized for their inherent clinical strengths, ability to see the big picture with a patient’s care, and network with others to uphold patient centered practices. In my practicum placement this year, I have observed my own practicum instructor teach medical residents how look at managing pain in hospice patients from a patient and family perspective. This experience, along with others, has been instrumental in identifying my potential for leadership as a social worker in the future.”—Angeli Bhatt, Social Work Intern, 2012 (*personal correspondence to PI*)

Interns learn through practice and hands-on experience with Veterans and families, utilizing what they have seen demonstrated, modeled, or otherwise taught through close contact with their instructors. Ample support is provided to assist their development,

residing in the overall VA administration, practicum instructors, department director, intern peer group, and the School of Social Work. As a result, they are able to initiate a learning experience in which they feel accepted, comfortable able to get involved, participating in team meeting, family conferences and disposition planning. While not every intern who trains at a VA will be employed by the VA, all will have an understanding of and respect for Veterans. Of importance, they will be prepared to assist Veterans in any setting where they may work in the future: hospitals; community agencies; community clinics; mental health setting; nursing homes or private industry.

In the University of Washington School of Social Work *Forum (Summer 2005)*, MSW student Fran Collette reflected that, as interns: "We're able to do the work of a social worker - we have clients and responsibilities instead of just observing." In that same publication, the UW Practicum Liaison summarized that: "...the benefits of the partnership are enormous. Students can specialize in multiple medical and mental health areas and are given the highest quality of instruction with a weekly seminar program and opportunities to both specialize in certain areas and to observe many other areas of social work practice."

With regard to social work and veterans, NASW (*NASW, nd*) noted: "The needs of the nation's veterans are changing, and as such, the profession of social work and the National Association of Social Workers are adapting to this population's changing needs and increased demand for social work services." VA social work is acknowledged for its commitment to offer a variety of services to veterans and their families, an effort particularly valued in light of their increasing need for more services. The educational programs of social work services represent another value of the overall training found within the VA system and demonstrates an ongoing commitment to quality care for all Veterans regardless of location.

Reflecting the quality and innovation of the VA social work educational program, the VA was awarded the *Arlie Johnson Agency Excellence Social Work Award* in 1997 and the *University of Washington School of Social Work Dean's Award for Excellence in Practicum* in 2004. In the context of recognizing one of the VA practicum instructors, University of Washington Dean Dr. Edwyna Uehara (*personal correspondence*) wrote to Dr. William Campbell, Chief of Staff at the VA Puget Sound Health Care System, about the excellence of the program in 2009, commenting that:

"Through her mentoring and modeling Ms. Watson (Director of Social of the VA Puget Sound Health Care System) has supported, encouraged and inspired her staff to develop leadership and teaching skills required to become UWSSW *Practicum Instructors* (PI's).many VA Social Workers have been nominated by their students and have received recognition by the School for their outstanding practicum instruction. Those who have continued to supervise for the required three years have formally applied and received promotions in their faculty status from *Practicum Instructors* to *Clinical Instructor...Clinical Assistant Professors* and later to *Clinical Associate Professor* because of their ongoing and extensive teaching and service contributions to the UWSSW required for such promotions.

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Putting Health Care Social Work Theory to Practice: An Example of Educating for Gerontology Social Work

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Introduction

Many social work students and alumni view field education as an important if not *the* most valued educational experience of their undergraduate or graduate programs. Anecdotal reports of the importance of the internship experience were validated by Tolson and Kopp (2004), who reported that students found the most important influence on their development of practice abilities was the practicum. Field education is where “the rubber hits the road”. In field education health care students have opportunities to submit the tidy theories and models learned in the classroom to the complicated realities of practice, to respond to cultural, political, economic, and social injustices, to evaluate the effectiveness of their interventions, and to develop a professional identity. Health care students are also confronted with significant ethical dilemmas as they work with multifaceted cases in complex organizational settings, navigate among the different values, ethics, and priorities of transdisciplinary colleagues, and cope with the implications of advances biotechnology.

Field Education: The Signature Pedagogy

Signature pedagogy is the term used to describe the central form of instruction and learning in which professions such as medicine, nursing, and social work prepare students to perform their roles as practitioners by connecting the theoretical and conceptual contributions of the classroom with the “hands-on” world of the practice setting. In social work, the signature pedagogy is field education.

The intent of field education is to connect the theoretical and conceptual contribution of the classroom with the practical world of the practice setting. It is a basic precept of social work education that the two interrelated components of curriculum—classroom and field—are of equal importance within the curriculum and each contributes to the development of the requisite competencies of the professional practice. Field education is systematically designed, supervised, coordinated, and evaluated based on criteria by which students demonstrate the achievement of program competencies (*Council on Social Work Education [CSWE], Educational Policy 2.3. 2008*).

Field education has its roots in the Charity Organization Societies (COS) that began to emerge in the late 1800s and which used volunteers called *friendly visitors*, predecessors of professional social workers, to help persons in need. These visitors were secured, trained and

directed by “paid agents” employed by the societies (Kadushin & Harkness, 2002). Like contemporary supervisors, the paid agents performed educational and managerial functions by assigning friendly visitors to families, reviewing their case records, advising volunteers regarding their work, and serving as liaisons between the visitors and COS district committees and administrators. Through the advocacy of Edward T. Devine, director of the New York COS, twenty-seven students attended a six-week training program in 1898. This first professional social work education program became the New York School of Philanthropy and eventually evolved into the Columbia University School of Social Work (Richmond, 1917). The first course for training supervisors was offered in 1911 by the Charity Organization Department of the Russell Sage Foundation, whose director was the social work pioneer, Mary Richmond. In 1917 Richmond published the classic social work textbook *Social Diagnosis*, a title that reflected her adaptation of the medical model to the conceptualization social ills. Supporting the establishment of training schools for social workers, Richmond emphasized from the beginning of social work education the equal importance of the practicum.

On the other hand, practical instruction in social diagnosis and treatment was made possible for the school students by the case work opportunities (analogous to “bedside opportunities” in medical instruction) offered to them from the beginning by the charity organization societies and later by other agencies. Case work cannot be mastered from books from classroom instruction alone, though both have their place in its mastery (p. 32).

Interestingly, the final chapter of *Social Diagnosis* is comprised thirty-eight questions from former students of the 1916 Charity Organization Institute relating to the practice setting.

Beginning in the early 1980s with the introduction of the Medicare “capitated payment” system for hospital care, health care delivery and funding underwent radical changes in the United States. This prospective payment system reduced hospital revenue by shifting costs from the payers to the providers of health care services. Confronted with an unstable and fluid environment, hospital administrators responded by developing alliances with multi-hospital systems, merging with competitive institutions, and separating functions into independent, decentralized programs or teams (Bazzoli, Dynan, Burns, & Yapp, 2004; Weil, 2003). Since that time the health care industry has continued to respond and reorganize in response to policies, regulations, and demographics.

In 2010 the Patient Protection and Affordable Health Care Act (PPAHCA) was enacted in an attempt to control health care expenses and provide health care services to defined populations including those with low or modest incomes and/or pre-existing health conditions. The Act also promoted the improvement of patient care and reduction of costs through Accountable Care Organizations, which are integrated, systems-level of care with providers from diverse professions. This restructured form of clinical practice emphasizes integrated health care teams and challenged educators to increase content in both courses and practicum experiences. Health care educators who participated in the 2010 health track meeting at the Annual Program Meeting of the Council on Social Work Education (CSWE) confirmed the need for increased curricular content on working in integrated teams and developing leadership skills (M. C.

Gilbert, personal communication, October 15, 2010 in this new environment). The programs described later in this chapter illustrate how a select number of these skills can be developed.

Meeting the CSWE Core Competencies in Field Education

In Chapter One Silverman lists the ten core practice competencies identified in 2008 by the Council for Social Work Education (CSWE), the accreditation body for social work education (*Council on Social Work Education, 2010*) in the United States. Reviewed briefly, both university-based courses and field instruction must include content designed to meet these competencies and which expect students to:

- identify as a professional social worker and conduct oneself accordingly
- apply social work ethical principles to guide professional practice
- apply critical thinking to inform and communicate professional judgments
- engage diversity and difference in practice
- advance human rights and social and economic justice
- engage in research-informed practice and practice-informed research
- apply knowledge of human behavior and the social environment
- engage in policy practice to advance social and economic well-being and to deliver effective social work services
- respond to contexts that shape practice
- engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities (*CSWE, Educational Policy 2.1.1 to 2.1.10, 2008*).

Academicians deem these capabilities as necessary for proficient generalist practice. This outcome-based educational approach measures the integration of knowledge, values, and skills as demonstrated in students' practice with individuals, families, groups, organizations, and communities.

Field education is contingent upon partnerships between undergraduate and graduate programs in social work and external institutions that voluntarily provide space, sanctioned use of employees' time, and access to clients to provide experiential learning opportunities for students. Analysis of the strength of this "*town and gown*" relationship may be enhanced by utilizing Bogo and Globerman's (1995, 1999) conceptual framework, which identifies four inter-related organizational components: (a) commitment to education; (b) organizational support and resources; (c) interpersonal relationships, and; (d) collaboration and reciprocity. Bogo and Globerman (1999) tested their framework by interviewing 62 field instructors, 34% of whom were in the fields of health or mental health. They categorized the organizational settings as "teaching centers," "key contacts," and "lone rangers." Teaching centers, over half of which were in health and mental health programs, were defined as having formal university agreements that guaranteed yearly internship availability, an educational coordinator with multiple field instructors, and an institutional mission that included professional education. Key contact programs had several field instructors, one of whom was designated as the contact person, limited educational programming for students, and an informal, unpredictable agreement with the educational institution. Lone-ranger agencies had a social worker who volunteered to be a

field instructor, unpredictable annual availability, and an informal inter-organizational agreement.

Bogo and Globerman (1999) measured the *commitment to social work education* by collecting data on the recognition of students and support for field instruction by the organization. The researchers found that 85% of students had their own offices, 95% were formally welcomed by the director, 98% were invited to staff meetings, and 97% experienced a farewell event. In all settings being a field instructor was included in performance evaluations; however, a statistically non-significant trend revealed this role to be more valued for hiring and promotion in teaching centers than in semi-formal or informal settings with fewer field educators.

All three types of settings provided *organizational supports and resources* through which students participated in staff development trainings, cases, and group projects with social workers and other professionals. Opportunities for research and interdisciplinary education, however, were most likely at the teaching centers. The teaching centers, however, offered the most formalized programs for field instructors; at 81% of them the field instructors met as a group, and 48% of them also met individually with the educational coordinators. Although the majority of respondents indicated that their organizations were supportive of field instruction, 33% of the educational coordinators indicated they received no authorized work time to perform associated functions or to attend university-sponsored events. New field instructors were encouraged to attend seminars offered by the universities at 62% of the teaching centers.

Bogo and Globerman also examined the *effectiveness of the interpersonal relationships between field instructors and faculty liaisons*. All of the educational coordinators reported knowing their faculty liaisons, but 26% and 23% of field instructors in key contacts and lone ranger settings respectively could not name their faculty contact. Including those field instructors who could not name their faculty liaison, however, 95% stated that they would contact their liaison if there were a problem with a student and also that they received speedy responses from practicum staff.

The researchers used shared research, policy making, and education as measures of *collaboration and reciprocity*. Although 18% of respondents served on university committees, these committee members were significantly more likely to be affiliated with teaching centers than with key actor and lone ranger organizations. No statistically significant difference occurred among the settings among the 26% of field instructors who gave guest lectures on campus although the teaching centers were more likely to invite faculty to come and speak at their settings. In addition to examples referenced by Bogo and Globerman, university-institutional collaborations occur in the acquisition of student awards such as American Cancer Society Training Grants in Clinical Oncology Social Work (see: <http://www.cancer.org/acs/groups/content/@researchadministration/documents/document/acspc-023676.pdf>), Hartford Foundation scholarships (see: <http://www.jhartfound.org/grants-strategy/social-work-education/>), and The Albert Schweitzer Fellowship program (see: <http://www.schweitzerfellowship.org/features/us/>)

Developing Leadership between the Classroom and Field

The ability to teach students skills in leadership is critical in collaborating with health care agencies that already have diminished resources. Working in environments with reduced assets means that students must be prepared to quickly assess the agency context and determine areas where they can both assist the agency while simultaneously developing and extending their individual capacity. Leadership in the last century was largely defined by skill in navigating complex hierarchical organizational structures and guiding others effectively (*Davidson, 2010; Weinbach, 2008*). As organizations have become increasingly responsive to client needs, leadership has moved out of the organization and into the community. This is particularly true in the social work profession, where case managers must often deal with emergent situations. Not only do leaders need to be able to meet organizational needs and engender positive outcomes in organizational initiatives and policy, they must also have the skills to move fluidly among a broad array of constituents ranging from consumers to potential funding sources, community leaders, and agencies with whom their work intersects and to families (*Poertner & Rapp, 2007*).

The contemporary context for leadership is manifested by sudden shifts, highly interdependent roles, and a need for creative solutions. It is about participants having a voice. In successful community-academic partnerships, both groups take responsibility for decision-making and managing outcomes. Rather than a role, leadership is a process involving risk and stepping into the unknown with confidence. It can be defined as doing things in the best way possible with regard for human values and meaning (*Denhardt, Denhardt, & Aristiquesta, 2002*).

Response to community needs requires macro- and micro-level attention as well as preparedness through prior training and exposure. This is the environment for which field and classroom educators prepare social workers—not only for current needs, but for yet unknown needs that will surface decades into the future. Gerontological social work is one example of a field of practice that has sought to build this leadership capability in students. Aging as a social work practice area was targeted due to the perceived gap in the number of students trained to meet the special needs of older people (*Scharlach, Damron-Rodriguez, Robinson, & Feldman, 2000; Volland & Berkman, 2004*). The Hartford Foundation in particular noted the disparity between the increasing numbers of older adults and the seemingly *decreasing* interest in service to this population by health professionals. To address this gap, the Foundation began funding training for physicians to study geriatrics, then added nursing, and finally followed with several social work programs administered by one of three different entities: the Council on Social Work Education, the Gerontological Society of America, and the New York Academy of Medicine. These programs target integration of aging content into undergraduate and graduate curriculum, training for social work scholars in aging, and development of university-community partnerships.

General Characteristics of the University-Community Aging Model

To nurture direct learning while engaged with older adult communities and the nonprofit agencies who serve them, the Hartford Foundation funded the Partnership Program for Aging Education (HPPAE) national program with the assistance of the New York Academy of

Medicine. While five principles initially guided development of individual program proposals, a sixth principle, leadership, was added shortly afterwards. This program enhanced field education by: 1) promoting university and community partnerships; 2) increasing experiences with aging populations through internship rotations, and; 3) emphasizing student recruitment into aging (most students chose other concentrations in social work even though there was a growing need due to demographic changes). An expanded role for field instructors (4) was also envisioned as one of the first five key elements of the collaboration, with the field taking on a stronger formative part of student preparation, and 5) development of a competency-based approach helped students to assess the areas where they most needed to strengthen learning and evaluate their growth subsequent to their internship experience (*Damron-Rodriquez, Lawrance, Barnett & Simmons, 2006*). The New York Academy of Medicine and the Partnership Program for Aging Education goals specifically targeted the need to develop leaders in social work and aging as one of its six goals listed above. The leadership initiatives implemented varied by grantee and were both innovative and imaginative.

Gerontological Competencies

Development of the gerocompetencies began in 1999 using a Delphi method to develop a list of over 200 possible competencies that was then sent to clinical, academic, community and other aging experts (*Burnette, Morrow-Howell, & Chen, 2003; Galambos & Greene, 2006*). The resulting list of items became the foundation for the current CSWE Gero-Ed Center Social Work Competencies. These include: 1) values, ethics and theoretical perspectives; 2) assessment; 3) intervention; and 4) aging services, programs, and policies.

A fifth set of competencies was added in 2008 by a team of eight including one of the current authors (*Damron-Rodriquez et al., 2008; Nelson-Becker, 2011*). This set of competencies was developed to enhance life-long learning. Several characteristics were considered including that competencies needed to be *specific*, identifying at least one skill. These competencies had to meet criteria for *distinctiveness* not already addressed in other skills. Was the skill important or essential enough to be included? Did the skill or competency include *aging specific* content? The list of competencies identified here were not the same as generic skills of the social work profession. These competencies were considered essential for effective practice with, or on behalf of, older adults. The relevance to geriatric practice should be clear. The set of competencies had to meet criteria for *parsimony* and finally be *domain appropriate*.

The fifth and last competency, leadership in the practice environment of aging, was conceptualized as an aspiration - a competency for life-long learning that specifically included strategies of building collaborations across the service spectrum in aging and building age-friendly community capacity among other items. Consideration of policy at community, local, and national levels and its consistency with global human rights were also emphasized.

Academic/Practitioner Collaboration in Gerontological Education: The Kansas Experience

The University of Kansas was awarded an HPPAE grant for three years, which in turn was developed into a two-year program to foster greater opportunity for student development. The last and fourth year of the program was thus unfunded as the third cohort of students completed their tasks. Students were sent recruitment materials when they first accepted enrollment to the school and invited to apply. Applications were reviewed, and students were selected based on an essay about their desire to enter this program and other standard admissions criteria. Students without prior aging practice experience were especially recruited because the goal of the program was to introduce students to gerontology and provide them with skills. Recruitment was accomplished through flyers, online through the Office of Aging and Long Term Care at KUSSW and later on, through the active involvement of current HPPAE students at career and other student fairs.

An advisory committee established at the beginning of the program was comprised of the project director, PI, and staff of the program, field partners, and older adults who were active as local advocates for the aging community. The committee facilitated and nurtured university-community partnerships from inception through sharing ideas in program planning and implementation.

The Kansas program developed two rotation models for the first year HPPAE cohort of students so that they could experience two or more aging populations. Both models were suggested by community partners. Depending on the need and desire of the community agencies in which students were placed, the two models were: 1) a host agency with two satellites, and; 2) a two- agency model with one agency as the overarching host agency. In later years, all field sites affiliated with this program adopted the two-agency model. Field supervisors and students both thought students were more engaged and involved in the latter model which also proved easier for them to administer. The host and two-satellite model was more difficult to supervise and left less opportunity for students to become part of the organization.

Leadership seminars were conducted in the fall and spring. Because students entered the program for two years, speakers were re-invited for each new cohort. For two years, the Acting Kansas Secretary of Aging, Kathy Greenlee, now Assistant Secretary of Aging for the US Department of Health and Human Resources served as keynote speaker and provided outstanding presentations on the aging network, federal and state aging policies, reimbursement issues, the importance of collaboration, and grassroots advocacy. Other seminars focused on consumer advocacy for aging individuals and their families while emphasizing the importance of collaboration in community-based work.

Community Leadership Projects

As a requirement of participation in the PPAAE, which was re-named HPPAE, the leadership project was a major aspect of an aging-rich experience for second-year students in the program. Students were expected to work closely with their field instructors during the

conceptualization and development of their individual leadership projects. The following format was an alternative assignment in students' required aging course:

- a. Goal of project (e.g. research, education development, etc.) in specific terms
- b. Background (why did you choose this project, how did the idea develop, what literature supports it);
- c. Collaborators (who you will be working with on this project),
- d. Major Project Steps (especially if you are working with someone else);
- e. Specific steps you will be responsible for
- f. Desired outcomes
- g. Resources needed (from agency, from the HPPAE)
- h. Anticipated restraining and supporting forces (Gantt chart)
- i. How this project will contribute to your learning and leadership development

Projects included Bridging Older adults Learning Technology (B.O.L.T) that brought older adults together with teens who taught the elderly about modern technology, including programming cell phones, sending and receiving e-mails with attachments and understanding digital television converter boxes. Another project was the development of a community resource database for human service and other providers in the Kansas City metropolitan area. Ideas for these leadership projects were provided by students in their first year in the HPPAE and culminated in formal presentations of these projects in the second year. Three students selected in different years to work with the national Committee on Leadership in Aging contributed to a newsletter and worked on other projects with New York Academy of Medicine and the HPPAE.

University Relations selected HPPAE student stories which were highlighted in on the KU website and in graduation news. These stories included a campaign to heighten awareness of stereotypes of aging for staff at Sweet Life [an assisted living facility] and teens at Shawnee Mission North High School and proposed changes in the inpatient psychiatric unit's geriatric team at the Veterans Hospital that involved engaging older patients and their families. In addition, new research was proposed on elder abuse and an area resource guide developed for staff and caregivers of geriatric patients. A Spanish-speaking student prepared and delivered Spanish aging-related presentations to older adult clients in the community. All of the projects were creative, need-based, and facilitated through direct intervention and support of field supervisors.

Evaluation

Evaluation of the program utilized focus group data from each of the cohorts and separately from focus groups with field supervisors. Students' comments included that:

"I think the biggest thing for me is giving me the confidence to realize 'I can do this.' It's not rocket science, its education, and its drive and its listening. Being a good leader is not way up here [motioning with hand], it's perfectly attainable and all of us really have the strengths to do this."

“My new boss commented about all the things I had done on my resume; they were all basically because of the HPPAE and Medicare advising. Those were the facets that he said were exactly what he needed. I wouldn’t have had that focus and checklist of all the things I had done had we not had the HPPAE to really funnel our talents and ideas in those areas.”

Many students who had been in the program remained connected to faculty and field supervisors, coming back to share in later leadership seminars and provide updates about their own experiences. While program implementation proved challenging at times, work with new cohorts progressively enhanced the program. Particularly important was the opportunity to witness the professional growth in all the stakeholders, including field leaders and practitioners, as students were taught to be advocates and leaders in the field of aging.

Academic/Practitioner Collaboration in Gerontological Education: The Chicago Experience

The University of Chicago School of Social Service Administration and the Loyola University Chicago School of Social Work formed a consortium and received one of the three-year awards from HPPAE, which was formerly known as the Practicum Partnership Program (Teigiser & Spira, 2009). This university-community partnerships formed the foundation for the HPPAE program and the first point of integration. Collaboration between the agency and the university was enhanced through regular communication regarding the student experiences, including awareness by the field instructor and faculty of the learning components of each part of the student’s program. The coordinators of the HPPAE program from the university met with the agency field instructors to provide a reality check on the inclusion of content relevant to the context of field in classes and to ensure field experience that provided opportunities for application and reflection of academic content.

The set of competencies noted above was delineated by the Council of Social Work Education (Damron-Rodriguez, Lawrance, Barnett, & Simmons, 2006) to insure that students would acquire a reasonable proficiency in the knowledge and skills necessary to provide a high standard of care to older adults. The fifty-item, self-rated competency assessment scale containing macro and micro content, continues to be used in gero programs in schools of social work. Each student was asked to assess their level of aptitude in values, ethics and theoretical perspectives, assessment, intervention, aging services, programs and policies and leadership associated with aging practice. The degree of mastery of these competencies served as measure of change in students enrolled in the educational program, and they also helped to facilitate the integration of classroom knowledge with practice skill.

The rotational field experience was a fundamental component of the program. Long discussed in educational literature (Abbott [1931], 1942; Bogo & Taylor, 1990; Marshack, Davidson & Mizrahi, 1988; Spitzer & Nash, 1995), field experiences using two to three rotations expose health care students to a broad range of experiences and practice styles (Spitzer, Holden, Cuzzi, Rutter, Chernack & Rosenberg, 2001; Cuzzi, Holden, Chernack, Rutter & Rosenberg, 1997; Cuzzi, Holden, Rutter, Rosenberg, & Chernack, 1996). In the model described by Teigiser

and Spira (2009), each student rotated through two sites in addition to their primary field placement. Integration occurred as students recognized the relationships between each of the unique settings and the range of skills required of them as social workers in each environment. Students evaluated themselves with regard to the designated competencies and skills targeted and developed for each rotation. They developed specific skills in each setting; for example, therapeutic skills in one placement and case management skills in an accompanying rotation. Linkages were established between sites through the articulation of these competencies. The application of the same skills sets were also examined within different placements. Competency in conducting an assessment could be articulated through a primary outpatient mental health placement, but could also be developed in an inpatient hospital setting. Students were asked to articulate the similarities and differences in the assessment competencies required in each setting as well as distinguish the common values of social work among the diverse values represented in different settings. By using rotations, Spira and Teigiser (2010) noted the students were exposed to the diversity of older adult clients across practice settings and the different roles social workers filled across geriatric services.

The rotations were dependent on the expanded role of the field instructors. The field instructor and the student designed specific rotations together, setting the mastery of particular competencies identified for development in the evaluation given at the beginning of the program as the goal of the rotation. Importantly, field instructors also were invited to speak in the classroom with the intention of promoting further integration of the field and classroom content. The field supervisors further collaborated with students to create the integrative seminars that proved to be the most fundamental aspect of the program.

The Integrative Seminar was a feature of the Practicum Partnership Program designed to achieve several purposes. It was established so that students, faculty and field personnel could incorporate the component parts of education and practice into their professional development. With the usefulness of regularly scheduled core seminars with field site department directors, invited presenters, field liaisons and academic faculty well documented (*Showers & Cuzzi, 1991; Marshack, Davidson, & Mizrahi, 1988; Robinovitch & Nash, 1983*), Volland and Berkman (2004) continue to underscore the need for integration between field and classroom teaching. Reishch and Jarman-Rohde (2000) also recognized the need to link knowledge derived from classroom, conceptual thinking and skill development as a basis for building competencies in work with older adults.

The problem of teaching knowledge in social work has been examined for decades in countries around the globe. Lam and Wong (2004) suggested that focusing on outcomes for learning may actually *preclude* students from gaining an appreciation of the (integrative) process as they become more concerned with the form (the method or the content of the class) than the substance (of clients' needs). Reflecting on that study, Teigiser and Spira (2009) noted that if students were continually worried about achieving a particular outcome, they became distracted from the opportunity to use self-reflection and meaning from the events beyond a circumscribed framework. In order to shift the emphasis to a more integrated process, the Integrative Seminar of the Practicum Partnership Program focused on blending both education and practice into professional development by students, faculty and field personnel.

Spira and Teigiser (2010) articulated specific goals for an integrative seminar. They emphasized that: 1) students have a broad array of agency placement options in which classroom knowledge could be applied, and; 2) macro and micro levels of practice be integrated in agency field work. Professional skills, competencies and critical thinking needed to be linked between primary sites and rotation sites. As one step in developing leadership skills, the authors promoted students and professional collaboration in developing seminars in which the focus would be integration of theoretical perspectives and practice experiences. Seminars highlighted that professional impacts on patient care were maximized by integrating the macro issues of the agency and the micro concerns of clients. To promote interdisciplinary teamwork, faculty emphasized the students' commitment to becoming familiar with other health care disciplines and the contexts.

Seminars were initiated in each agency having one or more of the Hartford students. Each student participated in the presentation of macro and micro issues. The macro issues were incorporated into a presentation of the agency history and mission. Students learned how the agency fit within the context of the community as well as how agency policies informed practice. The students were made aware of agency budgets and how agency resources were allocated. Students learned that practice decisions were not made solely in response to client needs but also to reflect the parameters of agency practice.

Throughout this process, students were encouraged to reflect on the development of professional skills and identity. This was accomplished in the seminar through the use of case presentation. The presentation was the vehicle through which the students articulated issues of micro practice, allowing students to describe a theory of human behavior, their personal responses to the client and client system as well as their responses to the context of their practice. The specifics of presented cases reflected the development of student knowledge, values and skills in work with older adults.

An overarching goal of the seminar was to facilitate development of social work leadership skills on interdisciplinary teams. Students assumed leadership roles through collaboration among peers and professionals in developing the seminar. Each student in the host agency was asked to arrange for a presentation by the director or professionals from other disciplines to describe the history of the agency, the programs it supports, and the context of the agency in the community. Through these presentations the students recognized the contributions of other disciplines in the agency or setting while contributing their social work perspective. In addition, students learned how to present particular clients or client systems. Students were expected to gather pertinent information for distribution to the audience and contribute specific content regarding social work skills relevant to the case presentation and agency.

Evaluation

Evaluations focused on student perceptions of learning during their field work. At the end of the final year in the HPPAE program, students participated in a focus group and were invited to identify the elements of their educational experience that integrated class content and field experience, including theories on aging and the realities of practice in diverse settings. Integrative functions were expected to include effective use of professional skills on

interdisciplinary teams, application of professional knowledge, values, skills and perspectives to a client or client system, and ability to negotiate the contribution of social work in a multi-professional context.

The following student responses reflect their field work experiences:

- *“We were exposed to so many different settings, each with a different angle of care”*
- *“What I was reading finally seemed to make sense with what I was doing”*
- *“My field supervisor encouraged me to write about the relationships between the different agencies, what they had in common and how they were different....that really helped my understanding of how different older people can be from one another”*
- *“The integrative seminars led to understanding different service delivery systems...it seems to make sense that agencies often have different programs that fit together”*
- *“I finally understand how to apply what I was learning in the classroom to practice and now can bring issues from the field back to school and discuss in the seminar!”*
- *“I can now see the relationship between kinds of practice - like policy to direct practice”*
- *“Attending a class at the field site made the experience more real. I realized how much the policies of the agency influenced my understanding of the clients I was serving.”*
- *“The best part of the program was the integrative seminar”*
- *“I have come to rely on my peers to help put the pieces together”*

The seminar proved to be a particularly effective means to enhance the education of social work students for work with older adults. Students developed professional competence in intervention skills as well as the ability to practice in multidisciplinary settings. The process required collaboration between HPPAE coordinators from the universities, students and field instructors and this partnership became a new focus for learning. It also mitigated the historic disconnect that has occurred between classroom preparation and internships. The program employed a competency-driven rotational model to teach integration, providing students with the opportunity to consciously and intentionally link their knowledge and skills across the full continuum of care settings for older adults.

Students were unanimous in perceiving the integrative seminars as crucial to understanding the services available to older adults and the types of clients served by the various agencies. At the same time, field instructors reported valuing their participation in the seminars. Field instructors reported a stronger sense of participation or “buy in” to the program through direct participation in the seminars.

Academic/Practitioner Collaboration: The University Experience

The integration of theory and practice is a continual two-way process involving not only field education, but classroom education. Bringing the practice experience of field instructors to students can be accomplished by inviting them to be guest speakers for classes, as part-time faculty members, presenters at university-sponsored workshops and conferences, and as collaborators in developing training programs for both new and experienced field instructors. Field instructors may contribute to curriculum development by participating on field education, alumni, and university boards and committees as well as CSWE Commissions. Linking theory and practice, field instructors consult and collaborate with university faculty on research projects, co-author publications, and co-present for professional organizations such as the Society for Social Work Leadership in Health Care and CSWE. Faculty members also have played active, integrative roles in professional organizations such as the National Society for Social Work Leadership in Health Care, Association for the Advancement of Social Work with Groups, National Association of Oncology Social Workers, National Association of Social Workers and American Case Management Association at local, state national levels, and international levels. Classroom and field faculty may also participate through consultations, journal clubs, and other activities that promote life-long learning.

Conclusion

Many of the challenges that face field education in health care and classroom education mirror each other. Beginning in the early 1980s, the health care industry has continued to react to shifting policies, regulations, and demographics. Health care administrators have remained concerned about controlling costs while increasing efficacy and efficiency. Some have responded by increasing standards of productivity of social work staff who are assisting increasingly medically complex patients, emphasizing evidence-based practice, embracing the use of technology, reducing the length of hospital stays, transferring health care to community agencies, creating integrated teams, preventing readmissions, and reducing support for non-revenue generating activities such as clinical supervision and field education.

Universities have likewise become “corporatized” in recent years. Many full-time faculty seeking promotion and tenure have increased pressures to publish in high impact, peer-reviewed journals, to obtain external funding for research in a context of dwindling private and public monies, to master laborious on-line teaching technologies and pedagogies, to acclimate to increasing class sizes and simultaneously fewer supportive resources such as administrative staffs and student assistants, to support the education of seemingly increased numbers of students with health and mental health challenges, and to relinquish their non-revenue generating roles as faculty liaisons and consultants to internship sites.

In spite of these significant challenges, there are reasons to be hopeful. The two examples provided in gerontological social work demonstrate new models are evolving that provide non-traditional forms of instruction and guidance. Integrative seminars and student-led, agency-based leadership projects provide new ways for students to learn from the field in what constitutes a “360 degree” format, with learning and teaching flowing reciprocally in every

direction. Health care social workers and others who typically did not have teaching roles now have opportunities to share their skill and knowledge with students whenever their positions interface. Rather than representing a burden, this offers opportunity for a fresh consideration or re-consideration of both field and classroom practices. Ultimately in the unfolding environment of reduced tangible resources, imagination can continue to flourish where intent to create new avenues of learning is strong and collaboration can lessen the workload stresses of both field and classroom faculty.

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Crucial Dimensions in Health, Health Care and Education for Social Work Practice in the United States

William J. Spitzer, PhD/DCSW
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Introduction

This book has presented a host of perspectives on contemporary health care social work practice in a health care environment that is in flux. The question is raised of how much change in social work practice will respond to the present and how much will be self-initiated *in anticipation* of the future? This chapter summarizes the financial impact of health and health care, demographic and health changes, evolving health care consumer trends, innovations and directions of health care delivery, changing nature of social work health care practice and implications for professional social work education. The future emphasis of health care is on preventative care, wellness, intervention with chronic illnesses (including mental health) and attention to both the elderly and those affected by social problems such as poverty and violence. Service delivery focuses on cost-reduction (and thereby revenue maximization) through use of benchmark practices, increased interdisciplinary collaboration and care coordination, utilization of enhanced technologies, integrated services across the continuum of settings and evolution of new physician practice models.

Demographic Shifts / Health Status Changes

Significant demographic shifts are occurring that impact health care delivery and professional social work practice. Most dramatically, since 1900 the percentage of Americans aged 65 years or older has *more than tripled* to over 13% in 2010 while their number has increased *almost thirteen times* (from 3.1 million to 40.4 million). That number will increase by 36% in the decade to 55 million in 2020. By 2030 nearly one in five US residents will be aged 65 years or older and by the year 2050 there will be about 88.5 million older persons, *over twice their number in 2010* (Vincent & Velkoff, May 2010). Those aged 65 years and older will constitute 20% of the US population, attributable to a decline in fertility and mortality rates combined with increased life expectancy (CDC, 2007; Shrestha, 2006). Even more dramatic the Administration on Aging (2012) forecasts the cumulative growth of the population 85 years and over from 1995 to 2050 to be *over 400 percent*.

With aging comes a predictable deterioration of health, including increases in chronic illnesses and disabilities. These trends challenge future health care delivery. The numbers of elderly with poor health are projected to increase sharply from 1990 to 2030, paralleling the population increase. One in four Americans – and two out of three Americans over 65 – has *multiple* chronic conditions. Along with chronic illnesses, a massive increase in the projected number of moderately or severely disabled persons is projected by 2040. The number would grow from about 5.1 million in 1986 to 22.6 million in 2040, with a nearly 350 percent increase in the overall population and a 175% increase among the elderly population

(*Administration on Aging, 2011a*). Chronic health conditions are a costly concern for all ages, but particularly for the aging. The CDC (2007) notes that “more than two-thirds of health care expenditures are for treating chronic illnesses; among older Americans, almost 95% of health care expenditures are for chronic diseases” (p.5). In 2005, 133 million Americans – *almost 1 out of every 2 adults* – had at least one chronic illness (*Centers for Disease Control and Prevention, 2010*); the most frequently reported chronic conditions of the elderly include arthritis, hypertension, hearing and orthopedic impairments, heart disease and cataracts (*Spitzer & Neuman, 2003*). Chronic diseases are the leading cause of death among those aged 65 years or older (*CDC, 2007, p.4*).

Chronic illnesses and disabilities among the aging increase the prospect of poverty, dependency and need for further health and social services. During 2011, the U.S. Census Bureau released a new Supplemental Poverty Measure (SPM) which shows a significantly higher number of older persons below poverty than is shown by the official poverty measure. For persons 65 and older this measure reveals a poverty level of 15.9% (an increase of over 75% above the official rate of 9.0%) (*Administration on Aging, 2012*). AOA notes with further concern, “...the rapid growth of the elderly (will) require a disproportionately large share of special services and public support. There will be large increases by 2030 in the numbers requiring special services in housing, transportation, recreation, and education, as well as in health and nutrition. There will also be large increases in some very vulnerable groups, such as the oldest old living alone, older women, elderly racial minorities living alone and with no living children, and elderly unmarried persons with no living children and no siblings” (*Administration on Aging, 2011b*). There is growing concern about the availability of sufficient caregivers and needed services.

Mental illness is rising as a national health concern, particularly given the current and projected insufficiency of intervention resources. The Substance Abuse and Mental Health Services Administration (SAMHSA) within HHS released a plan identifying eight strategic initiatives to reduce the impact of substance abuse and mental illness in communities. The plan “*Leading Change: A Plan for SAMHSA’s Roles and Actions 2011-2014*” reports that *by 2020 behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide* (*Bloch, 2011*). An immediate concern is that more than half of all U.S. counties have **no** practicing psychiatrists, psychologists *or social workers* (*Butcher, 2012*), a circumstance that will contribute to expanded use of telemental health as an intervention modality.

Impacts on Health Care Delivery

The health care delivery system is being reconfigured on a daily basis as providers anticipate and respond to a myriad of influences ranging from legislated policy, availability of crucial practitioners, shifts in consumer preference, demands from payers, and revolutionary scientific technologies that impact both medical equipment and procedures.

Legislated Health Care Policy Shifts and Practice Models

On June 29, 2012, the US Supreme Court upheld the basic elements of the ***Patient Protection and Affordable Health Care Act (PPAHACA)***. Enacted in March 2010, the ACA was a comprehensive effort to check rapidly rising health care costs and provide significant financial assistance to help people with low and moderate incomes afford coverage and associated cost sharing. The need for a focus was obvious, with health care spending representing 17.9% of the nation's total economic activity (GNP). The intended impact of this legislation on health and health care delivery cannot be overstated.

In addition to increasing access to health care through expansion of Medicaid eligibility, elimination of “pre-existing conditions” and extension of parental coverage to young adult children, the ACA has a fundamental focus on care coordination and quality improvement. For Medicare patients, this is achieved principally through development of ***Accountable Care Organizations (ACOs)*** that create incentives for health care providers to collaborate in treating an individual patient across care settings – including physicians’ offices, hospitals, and long-term care facilities (*US Department of Health and Human Services, 2012*). ACOs improve the partnership between patients and physicians in making health care decisions, giving patients more control over their health care and providing physicians information about their patients’ medical history. Providers demonstrating cost-effectiveness through the use of “benchmark” care practices stand to gain in “shared savings” through Medicare program reimbursement. The amount of ACO cost sharing is specifically predicated on its performance in patient/caregiver experience of care, care coordination, patient safety, preventive health, and at-risk population/frail elderly health (*US Department of Health and Human Services, 2012*).

Emphasis on cost-efficient integration of systems with a broad span of proprietary and community providers coupled with a focus on primary care and supportive services to medically underserved populations is evident not only in the ACOs, but also in the newly introduced ***Federally Qualified Health Centers (FQHCs)***. The intent is for FQHCs to connect with other primary care providers in an effort to help Medicaid beneficiaries with services that allow them to manage their own health and reduce costly hospital visits. Along with ACOs, the FQHCs are designed to influence the fundamental redesign of health care delivery in the US.

Decreasing Physician Availability

During the last decade, the growth in physician supply has been outstripped by demand for physician services. The Association of American Medical Colleges’ Center for Workforce Studies notes that there will be 45,000 too few primary care physicians and a shortage of 46,000 surgeons and medical specialists in the next decade. Physicians are also aging, with nearly *one-third* expected to retire *in the next decade* (AAMC, 2010). Women who constitute an increasing proportion of physicians typically work fewer hours per year than their younger male colleagues, and consequently the total hours of physician services provided is increasing *less rapidly* than the number of licensed physicians (13 percent versus 16 percent between 2005 and 2020) (*Martz & Smith, 2012; US Department of Health and*

Human Services, 2008). Concern over decreasing physician availability is occurring just as demand is increasing, particularly among Americans aged 65 and over, the fastest growing population and one with the greatest health care needs.

Shifting Consumer Focus and Behavior

The most pronounced change in consumer behavior is the concentrated attention now afforded to ***wellness, prevention*** and ***personalized care*** from health providers. In addition to engaging in healthier diets and exercise, conscientious consumers monitor their own health and are aware of technologies that allow for the collection, interpretation and transmission of vital health information. With consumers already comfortable using I-Phones, Skype, Twitter, Facebook and other social networking mediums, availability of new mobile telephone applications has enhanced interest in personal health and the connections between behaviors, health status and medical compliance. Providers are more likely to use these media to communicate with consumers as “physicians are realizing that patients want more than a fifteen minute office visit and callback at the end of the day” (*Tanner, 2012, p. A2*). This developing trend in social media use allows for greater patient education and increases communication.

For consumers who can afford it, personalized medicine with ***retainer-based practices*** offer 24 hour/7 day per week availability of a primary care physician via cell phone, e-mail and home or nursing home visits with guaranteed appointments within 24 hours (*Schimpff, 2011*). These practices are predicated on a payment of a flat fee, ranging up to \$2500 per year with additional charges should specialists, testing or hospitalization be warranted.

Enhanced New Technologies

Dramatic development of new health technologies has occurred ranging from tele-robotics, tele-medicine and bioinformatics to revolutionary surgical procedures based on ***nanotechnology*** and ***genetic engineering***. New advances include wearable robots, mechanical exoskeletons, electronic “physicians assistants” that offer technical advice to physicians, “digital pill boxes” for in-home distribution of medications and remote sensing devices for people with disabilities and aging adults, enhancing the confidence of patients to remain in their own homes while aging and/or infirm (*Schwartz, 2012*). Nanotechnology and genetic engineering are propelling the growth of ***personalized medicine*** in which medical interventions are customized to the individual patient and focus on enhancing good health and/or minimizing the impacts of chronic conditions. Exemplifying this direction, surgical simulation systems (known as patient-specific simulated rehearsals or PsRs) have now been developed that construct virtual models of a patient's exact anatomy from CT scans, allowing surgeons to then plan and practice a specific procedure *in advance* as well as determine the appropriate access strategy, select the necessary tools and equipment and choose the most effective fluoroscopic views (*Ellis, Shanley, Pontes, Weaver & Auner, 2012*). In the realm of ***bioinformatics***, nearly 15,000 mobile telephone applications are currently available for savvy consumers to self-monitor vital signs as well as capture various images and data which may be relayed to health professionals for rapid analysis.

Beyond the widespread adoption of *electronic medical records* by health providers, *telemedicine* has evolved into a principal tool for cost-savings and meeting service needs in remote areas, where practitioners are scarce, when decision-making is urgent or when other professional opinions are needed. The potential utility of telemedicine is particularly evident when considering mental health care. With nearly 80 million Americans living in areas lacking mental health professionals according to the U.S. Health and Human Services Health Resources and Services Administration (Novotney, 2011), it is expected that behavioral health disorders will surpass all physical diseases as a major cause of disability (Bloch, 2011). To promote coordinated, multidisciplinary care, use of *telemental health* technologies is likely to expand significantly. Telemental health systems use interactive telecommunication technologies to integrate comprehensive services within a specified region (Smith & Allison, 1998) and evidence exists that the differences between Internet-based therapy and face-to-face interventions are **not** statistically significant (Barak, Hen, Boniel-Nissim & Shapira, 2008).

Evolving Trends in Service Delivery

Patient-centered primary care and use of *integrated services* will be central to *coordinated health care delivery*, attending to individual patients and unique needs while constraining health care costs. *Primary care* is "... the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Institute of Medicine [IOM], 1996, p.31). *Patient-centered care* is healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care (IOM, 2001, p.3).

The fastest growing model of primary care redesign is the *patient-centered medical home* - a team based health care delivery model led by a physician that provides comprehensive and continuous medical care to patients, including provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues. A team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety. (American College of Physicians, nd)

Directions in Health Care Social Work Practice

All the above will undoubtedly affect our professional future and influence our practice. We can expect the increase in those seeking health care, reductions in physician numbers, more health-conscious consumers, an aging and medically needy population, innovative medical technologies, a heightened focus on integrated care, and provider efforts to maximize revenue while minimizing operational costs, will combine and contribute to reconfiguring health care social work practice responsive to greater numbers of the neediest patients and families.

An incomplete list of potential practice changes would emphasize:

- Greater gerontology focus
- Expansion of practice environments employing social work services
- Increased thrust to outpatient and home settings with a focus on prevention
- Complex discharge planning arising from greater need/limited resources
- Development of care coordination and collaboration among disciplines
- Attention to service cost reduction and outcomes accountability
- Increased reliance on bioinformatics, particularly telemental health modalities
- Greater focus on standardization of “benchmark practice” as revised using Continuous Quality Improvement (CQI)

Demographic changes with a burgeoning population aged 65 years or more will present an increased need for support services as their physical conditions change and dependency needs increase. While advancing medical technologies are striving to address physical health issues, the gamut of psychosocial needs associated with aging are far from adequately addressed. Additional resources will be needed for those who require financial, social and psychological supports to sustain them in later years. The need for such assistance may underscore the value of social work services to health care practice and the importance of social workers being involved in planning and executing evolving patient care programs.

The increasing numbers of aging patients will need alternative care placements or augmented in-home services. We face an unprecedented need, however, for care scenarios including independent living, assisted living (assisted living facilities and continuing care retirement communities) and long-term care (skilled nursing facilities). Although social work activity in these contexts has been limited, clear support for gerontology practice including employment in long-term care settings repeatedly appears in the literature (*Dziegielewski, 1998; Michelsen, 1989; Butler, 2002; Feinberg, 2002; Franks, 2002; Harrington, 1999; Williams, 2002; Spitzer, Neuman & Holden, 2004; Spitzer & Newman, 2004; Stahlman & Kisor, 2000; Dhooper, 1997*). Social work must address the anticipated care needs of a burgeoning senior population by making an impact on policies that provide for an expanded professional presence. We must influence long-term care providers to recognize that the contributions of social workers positively affect quality of life for residents and can make their services more attractive to potential consumers.

The need for expansion of social work services goes beyond gerontology practice. With an emphasis on wellness and preventative care (including intervention with chronic illnesses), it seems clear that more attention will be focused on service delivery within outpatient, physician office and home settings. Activities in these contexts will include identification of factors impacting on patient wellness, provision of patient education and supportive counseling. The timeless relevance of these functions is evident in that they are essentially the functions served by the “first” health care social worker, Ida M. Cannon, at Massachusetts General Hospital at the turn of the 20th century.

The changes occurring in health care delivery are also evolving as new practice opportunities within the military. Greater deployment of US troops into combat zones has created needs for increased services by mental health professionals, addressing injury adjustment, post-traumatic stress and related disorders among troops. Dao (2012) notes that this “tide of new veterans needing psychological care (has led the VA to increase) its mental health care budget by 39 percent since 2009 and hire more than 3,500 mental health professionals”. Within this volume, Sheets et al (2012) make a compelling case for the principal and multi-faceted role of social work in delivering needed psychological care to our military.

Policy and practice shifts, driven by reimbursement, together with declining physician availability focus attention on interdisciplinary collaboration and reliance on other professionals to deliver crucial health care services (Schimpff, 2011). *Specifically recognizing social workers*, Schimpff suggests that specialized practitioners will have important patient care decision-making roles in collaborative, integrated care delivery as physicians’ roles change. Research findings suggest, however, that existing professional and organizational cultures will require negotiation before care coordination can be integrated into existing contexts. The challenge then is in acknowledging and overcoming professional practice boundaries that define existing care through reflective practice and shared resourcing (Ehrlich, Kendall & Muenchberger, 2012).

Within the context of hospital-based practice, opportunities for social work may abound, arising from new policy thrusts encouraging “robust discharge planning programs that ensure patients requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings” (HR3590-205, Section 2704, (a)(5); see <http://www.govtrack.us/congress/bills/111/hr3590/text>). Given the historically central role of social work in post-hospitalization care planning, such Congressional emphasis can well lay the groundwork for inclusion of social work in development of new patient care models, leading to systematic integration into care systems. Another such opportunity exists in the 2010 announcement by the Department of Health and Human Services that it was funding nearly \$4 million to support grants for Patient Navigator Outreach and Chronic Disease Prevention Programs. These programs develop and operate “patient navigator” services to improve health care outcomes for individuals with cancer or other chronic diseases, with specific emphasis on health disparity populations. These services facilitate care by helping patients coordinate health services and assisting community organizations in conducting outreach, helping individuals receive better access to care and information on clinical trials (US Department of Health and Human Services, 2010). Such activities are consistent with the practice of health care social work in “boundary-spanning”, “brokering resources” and serving as both care coordinator and patient advocate.

Implications for Future Social Work Education

The perpetual challenge for social work education is to evaluate and continuously update the professional knowledge base and curriculum, and develop methods to teach practice skills addressing contemporary needs. It is projected that the number of positions in health care social work will increase 22% by 2018...*the highest rate in the social work field*

(see: <http://msw.usc.edu/mswusc-blog/the-five-most-popular-social-work-careers/>). Health care constitutes a challenging field of practice, with intellectual and emotional demands of the workers. It features:

- A complex, technologically-driven practice environment
- Often brief intervention timeframes requiring sharp, accurate focus
- Highly skilled, well-educated colleagues possessing different professional perspectives
- Often “life-death” aspects to patient/family care interventions
- Particularly strong attention to pragmatic (cost-driven) service delivery
- A social work focus in a context where social issues are not customarily the central theme

Acknowledging these dynamics and characteristics, the goals and activities relevant for social work education become:

- Awareness and appreciation for the factors shaping health care delivery
- Active collaboration with health care professionals designed to promote social work’s role in enhancing patient/family service and facility outcomes.
- Reassessment of the required competencies for contemporary practice
- Integration of new learning technologies in classroom and practicum sites
- Expansion of the array of field sites to reflect (*or impact*) evolving practice
- Adjustment of practicum formats to facilitate greater exposure to diverse practices

Efforts at collaboration by social work practitioners and educators have historically been fraught with differences of perspectives, values and priorities (*Carlton, 1989a, 1989b; Cohen, J., 1977; Dana, 1969; Meyer, 1969; Robinovitch & Nash, 1983; Silverman, 2012; Spitzer & Nash, 1996; Tropman, 1977*). Much of the friction arising between academia and the field has been associated with a sense that students have not been prepared for contemporary practice. Meyer once even went so far as to say “...it is an accident...when a graduate of a school of social work is prepared to practice in accordance with the demands of a particular agency” (1969, p.34).

There have been many efforts to deal with this perception and to avoid the experience of students arriving at health care field sites only to find they have insufficient understanding of: 1) contemporary health care environments and 2) the skills necessary for efficient and effective professional practice within health care service settings. Sixteen years ago, Volland (1996) observed “social work in health care has increasingly been *defined* by events and boundaries set by the health care delivery system in which practice occurs” (p. 37). In some ways, this continues to be the case and makes it frustrating when Meyer’s (1969) observation still applies:

“Social work knowledge evolves unevenly – sometimes through research, sometimes through theory development, and sometimes through

practice experience in various stages of articulation. Thus, while agency staffs may be experimenting with advanced forms of family treatment, faculty members may be finding it difficult to identify the significant concepts of family treatment that can be taught in the classroom.” (p.34)

This disconnected circumstance must be addressed if social work is to better prepare its practitioners at a time of increasingly urgent need and help *shape rather than react* to the health care environment. Volland’s observation is relevant that...”a key ingredient to planning future social work practice is to understand what is fundamental to future individual/family needs and systems of care” (1996, p.40). For students to become effective practitioners, they must have an awareness and appreciation for the factors shaping health care delivery. Rosenberg (1983), referencing an earlier observation by Bracht (1974), noted that our profession short-changed itself in having a role in managing, coordinating and planning the functions of the emerging health care system by maintaining a focus only on what we perceived to be the manner of conducting one-on-one clinical work (p.148). We may well have paid a price for that going into the tumultuous 1980s and beyond by not having as pronounced a role as we were capable of fulfilling in designing patient care. Going forward, it is not unreasonable to think we might find ways to have a greater role planning in health systems, especially in medical homes and in long-term care. Practitioners competent in evolving contemporary models may need to interpret changes to faculty members less directly involved in rapidly changing health care environments (Gilbert et al., 2011).

Thus for students to acquire a contemporary, fully encompassing perspective requires not just use of continuously updated literature and classroom discussions with health care social workers, but also challenging field placements and frequent classroom interaction with seasoned health care professionals. There has also been concern that field instructors, even in new settings, may be tempted to use teaching models from their own earlier experiences and may need to change their teaching methods, encouraging adult learning (Davidson, 2004). Students need ongoing exposure to health care administrators, physicians and allied personnel addressing contemporary practice directions, as well as with those designing health care policy. Constructive dialogue must occur at every level, ranging from that between institutions (such as particular universities and local health care systems) to collaboration with The Council on Social Work Education (CSWE), The Society for Social Work Leadership in Health Care and The National Association of Social Workers (NASW) with emphasis on maximizing social work participation in care *planning* and delivery.

The purpose of such dialogue is to clearly establish a base for contemporary health care social work practice, acknowledging Silverman’s (2012) comment that “most scholars cringe when students and practitioners cannot identify a practice theory or model that underlines and grounds their practice” (p.1). While CSWE (2008) has identified ten core practice competencies, it is necessary to make sure that: 1) students are versed in the competencies; 2) those competencies *have continuing relevance* to the needs of contemporary patients and families as well and reflect the contextual reality of practice setting expectations, priorities and constraints, and; 3) field work experiences afford opportunities to practice those competencies.

In Silverman's (2012) spirit of pursuing competency including "organizational awareness" versus ideology, the focus of education for practice must be on factors such as using collaborative skills to promote our integration in the unfolding ACOs and FQHCs, preparing practitioners to utilize telecommunications rather than in-person contact for patient care, and advancing evidence-based practice through the use of evaluative techniques such as "kaizens" ("Lean" process related rapid-cycle improvement activities)(Garfinkel, 2012).

Gerontology practice is a paramount concern, given that it has long been evident from demographic statistics that those aged 65 years or greater are rapidly becoming the largest population segment and experience unique, complex (*and increasingly unmet*) health concerns with major social implications. Yet, a study by Damon-Rodriguez et al. (1996) revealed that *seventy-five percent* of social work schools had **NO** gerontology field faculty and Klein (1998) determined that only *five percent* of graduating MSW students had taken a course in gerontology social work. CSWE notes in a 2005 survey of social work programs (both MSW and BSW) in seven major states (California, Florida, Illinois, New York, Ohio, Pennsylvania and Texas) that an average of only 5.9% of students (predominantly master's level) were in an aging concentration and that approximately *only one in ten* students received an aging field placement, including *both* BSW and MSW programs (*Center for Social Work Education, 2005*). The CSWE statistics do not inspire confidence about social work being sufficiently "geared up" for future senior services in policy, program planning or practice arenas.

Field work experiences are widely appreciated for their role as the capstone of education for social work practice and acknowledged as the signature pedagogy of the profession (*CSWE, 2008, p.8; Fortune, McCarthy & Abramson, 2001; Schneck, Grossman & Glassman, 1991; Spitzer, Holden, Cuzzi, Rutter, Chernack & Rosenberg, 2001*). Bogo and Vayda (1987) point out that "educators in social work have always characterized the practicum as the place where theory is integrated with practice" (p. 2). A field placement can prove to be invigorating and set a student enthusiastically forward or may be superficial, unchallenging and leave a student lacking in skills and self-confidence and unprepared for the rigors of future employment. Field instructors themselves must acquire knowledge of non-traditional practices and integrated health care models in order to prepare students for contemporary practice (*Gilbert et al., 2011*).

The range of health-related field work sites should be broadened. In keeping with population trends and both demonstrated and anticipated areas of practice need, areas ripe for field work expansion include: 1) gerontology with sites including assisted living communities, skilled nursing homes and home care (*Feinberg, 2002; Franks, 2002; Harrington, 1999; Spitzer, Neuman & Holden, 2004; Williams, 2002*); 2) military settings (*Sheets & Brandeis, 2012; also see: <http://msw.usc.edu/military>*) and; 3) the continuum of placements that intervene with chronic health conditions. Intensive fieldwork experiences such as those portrayed in this book by Sheets et al (2012) and Farrar and Hardesty (2012) represent models for preparing future practitioners. The emphasis placed by these authors and others (*Laurie & Pinsky, 1973; Rehr & Caroff, 1986; Spitzer, Holden, Cuzzi, Rutter, Chernack & Rosenberg, 2001; Spitzer & Nash, 1996*) on deliberate student selection and a rotation format with multiple field instructors is to maximize students' exposure to variations

in technique, practice sites and patient populations. Such exposure benefits students in formulating their own “synthesized” practice and contributes to a broader perspective on how elements of health systems interact in providing patient services.

The future of classroom education will increasingly feature virtual learning, with asynchronous and synchronous simulations, experiential environments and virtual laboratories. Beyond facilitating distance learning from student home to university, examples abound of its value in pursuing the learning expectations (*Beaulaurier & Haffey, 2005; Vernon, Lewis & Lynch, 2009*). Virtual learning techniques in the classroom have particular appeal when preparing students for technologically sophisticated health care environments already characterized by bioinformatics and telemedicine practice. Virtual worlds with three-dimensional computer simulations, including use of “avatars”, for example, can provide well-developed visual settings that lend themselves to role playing and scenario building, thereby affording students occasion to assume responsibilities without real-world consequences (*Vernon, Lewis & Lynch, 2009*). On-line integrative seminars can be utilized to allow students to reflect on their field work experiences, comment on other students’ experiences and vicariously benefit from expanded exposure to diversified placement dynamics (*Birkenmaier et al, 2005*). In preparation for direct patient care, students can explore what it is like to experience the visual and auditory hallucinations of a patient with schizophrenia. Management students can “sit in” staff meetings where decision-makers evaluate strategies and resources. By learning to provide patient assessments and supportive counseling through electronic mediums rather than necessarily in person, social work students gain valuable preparation for practicing telemental health.

Conclusion

The evolving field of health care social work practice is filled with opportunity, but also includes looming challenges. Using avant-garde technologies, new service delivery configurations and legislatively prompted incentives for enhancing patient care, social workers can have a major impact on future professional practice and positive patient outcomes. To reach that point, however, requires the collaboration of social work practitioners and educators with health system management, other disciplines, “policy-makers”, community leaders and service consumers. While potentially rigorous, such collaboration has been a hallmark of the profession since our beginnings with Ida Cannon and our diligence in reframing our practice for the future would make her proud.

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Glossary

Education for Health Care Social Work Practice: Issues and Directions

Accountable Care Organizations (ACOs) – developed in the PPAHCA, ACOs create incentives for health care providers to collaborate in treating an individual patient across care settings that include physicians’ offices, hospitals, and long-term care facilities. The goal is to improve the partnership between patients and physicians in making health care decisions, giving patients more control over their health care and providing physicians information about their patients’ medical history.

Council on Social Work Education (CSWE) - nonprofit national association representing more than 2,500 individual members, as well as graduate and undergraduate programs of professional social work education. Founded in 1952, this partnership of educational and professional institutions, social welfare agencies, and private citizens is recognized by the [Council for Higher Education Accreditation](#) as the sole accrediting agency for social work education in this country. CSWE established *ten “core” competencies for social work practice*; encompassing the behaviors, skills and talents that one must possess to make an organization (or client) successful.

Dr. Richard Cabot – as Chief of Medicine, Dr. Cabot established the first Department of Medical Social Work at Massachusetts General Hospital in the early 1900’s. He and healthcare social work pioneer **Ida Cannon**, believed that the function of medical social work was to supplement physician practice by alleviating, to the extent possible, patients’ social problems that interfered with plans for medical care.

Federally Qualified Health Centers (FQHCs). The intent is for FQHCs to connect with other primary care providers in an effort to help Medicaid beneficiaries with services that allow them to manage their own health and reduce costly hospital visits. Along with ACOs, the FQHCs are designed to influence the fundamental redesign of health care delivery in the US.

Field Work (Internship) - the capstone of education for social work practice and acknowledged as the signature pedagogy of the profession (CSWE, 2008, p.8). Internships are typically either block or concurrent in format and may involve a single or multiple field work instructors.

NASW Practice Standards – fifteen sets of defined expectations for professional social work practice. In addition to defining social work ethics, the standards address services rendered in clinical, long-term, palliative and health care settings.

National Institutes of Health (NIH) - a component of the U.S. Department of Health and Human Services, is the largest source for funding medical research in the world. It is comprised of 27 Institutes and Centers, each with an individual research agenda typically focusing on particular diseases or body systems. Although 80% of NIH's budget goes to more than 300,000 researchers located in 3,000 research institutions and universities around the country and the world, approximately 6,000 intramural researchers are located on its main campus in Bethesda, Maryland.

Patient-Centered Care - healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care (*IOM, 2001, p.3*).

Patient-Centered Medical Home - a team based health care delivery model led by a physician that provides comprehensive and continuous medical care to patients, including provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues. A team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety. (*American College of Physicians, nd*)

Patient Protection and Affordable Health Care Act (PPAHCA) – signed into law on March 23, 2010 by President Barack Obama, the act establishes a mandate that every American have health insurance, mandates coverage for preventative health care, supports medical research/education and promotes use of primary care physicians rather than specialists. The law tracks adverse complications and focuses on quality and patient safety. The law is paid for by increasing Medicare taxes on the wealthy and by estimating that cost savings will result from improved quality of care and reducing duplication. The Congressional Budget Office (March 20, 2010) estimates that from 2010-2019, PPAHCA will reduce the federal deficit by 25 billion dollars.

Personalized Medicine - medical interventions are customized to the individual patient and focus on enhancing good health and/or minimizing the impacts of chronic conditions.

Primary Care - “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (*Institute of Medicine [IOM], 1996, p.31*).