Between the years 1987 and 2030, the number of Americans over age 85 is expected to increase nearly threefold. Unless steps are taken soon, the United States will slam into a financial wall that will make current funding problems in Medicare and Medicaid look like small fiscal hurdles. This prospect alone will keep issues related to chronic illness high on the national policy agenda for some time and influence the future of social work practice in health care.

HEALTH CARE ISSUES

Some issues stem from recent disruptions and changes in the American health care industry. Pressures from diagnostic related groups (DRGs), health maintenance organizations, preferred provider organizations, and freestanding surgical centers have forced hospitals, the hub of the American health care system, to become more outward looking. Empty beds and shortfalls in revenues have forced hospital administrators to move away from their usual push to horizontal growth, such as more burn units and more specialty services, to greater vertical growth. As one executive in an acute care hospital recently stated, “The term ‘hospital’ is passé.” No longer are acute care hospitals institutions where sick and injured persons come for medical and surgical treatment only. To attract and retain consumers under one institutional umbrella, many hospitals now are offering an impressive selection of other services: community education, health promotion, case management, rehabilitation, skilled long-term care, adult day care, home health, respite care, hospice, supervised living apartments, and even retirement homes.

Although vertical integration in the health care industry undoubtedly will create new opportunities for social workers, the trend may be only a mixed blessing for health consumers. Some experts argue that the changes are good. Converting empty wings of beds into skilled long-term beds, for example, helps shift patients to an alternate level of care that is under the control of one health care facility. For the patient, there is the advantage of staying with one multi-level care facility, which is less disruptive than moving to another facility for long-term care. Other experts, however, argue that, in some instances, vertical integration of service in health care is not good for consumers. One federally funded project that allowed hospitals in four states to swing an acute care bed to a long-term bed when a patient no longer required acute care found that hospitalized patients receiving this level of care were more depressed, lonely, and isolated than patients classified at the same level in area nursing homes that were judged to be of relatively high quality.

Still, the financial incentives for hospital administrators to expand their operations vertically are great at the moment. Under the prospective reimbursement system, hospitals must absorb any treatment costs that exceed the DRG amount. Thus, it becomes of utmost importance...
to discharge Medicare patients to an alternate level of care as soon as possible.

One response from hospital administrators has been to generate revenues from non-DRG-regulated services. Converting empty beds into skilled long-term beds will allow the institution to generate revenues that often are lost when patients are backed up in the hospital. Usually these include Medicare and Medicaid patients who are ready for discharge but who, for a variety of reasons, are unable to be placed in an appropriate long-term setting. Similarly, adding rehabilitation units allows hospitals in certain cases to move patients out of DRG-regulated care to non-DRG care, which reduces the number of backup patients in the facility. Such an addition also produces an attractive financial bonus for the institution, because the average charge to Medicare for rehabilitation care is up to three times higher than for comparable acute care cases. Though much less lucrative, home health also has become an alluring service area for hospitals. Medicare expenditures for home health care are expected to increase at an annual rate of 20 percent over the next four years, and services provided through home health are not DRG-regulated.

The fiscal problem is that DRGs are fairly effective at controlling “front door” but not “back door” Medicare costs. By reducing patient length of stay and by curbing the use of certain medical procedures performed in hospitals, DRGs have restrained the growth of Medicare dollars spend on acute care. However, they do not prevent cost shifting to alternate levels of care after the patient leaves the hospital. If adopted by Congress, plans by the Health Care Financing Administration should help to control escalating costs by introducing some form of prospective payment into Medicare reimbursable services in home health care, rehabilitation, and nursing home care.

Another cost-saving strategy adopted by the Reagan Administration has been to reject proposals that would increase substantially the financial commitments of the federal government in the provision of long-term care. Other sectors—state and local governments, charitable organizations, kith and kin, and for-profit enterprises—have been called upon to fill the gap. Regarding the proprietary sector, many policy analysts believe that the private insurance industry will play an increasingly important role in the financing of long-term care. It has been estimated, for example, that long-term care insurance can reduce state Medicaid costs by about 8 to 23 percent annually—a substantial amount given that long-term care accounts for about 50 percent of all Medicaid spending.

Yet cost alone often obscures many of the more fundamental social welfare issues that the chronically ill and their families face today. One issue stems from the way chronically ill persons are treated in nursing homes. Studies have shown that DRGs and other measures to tighten public health care expenditures have encouraged some nursing homes to avoid accepting Medicare patients who might become eligible for Medicaid after exhausting Medicare funds. Even when these patients are accepted for placement, some nursing homes shift them to second-class care after their Medicare funds have been exhausted. Second-class care can mean moving them to another area of the facility where accommodations are dingy, food preparation is substandard, and treatment is inferior.

Another issue stems from the burdens placed on receiving families when patients are discharged from the hospital too soon and require high levels of continuing skilled care beyond the usual abilities of respective caregivers. Although home health agencies could help to reduce some of the burdens experienced by these families, they, too, are not always able to provide the kinds of skilled care many patients require to remain in the home. Consequently, some home health agencies are reluctant to accept sick patients for placement.

Still another issue to be addressed, especially in home health care, is the “medicalization of services” for the chronically ill. Services provided through home health care tend to be medical only, as if the patient were just a cluster of cells with no psychosocial components. This process of “making things medical” accords legitimacy to acute care needs, denies legitimacy to psychosocial needs, and weakens a comprehensive approach to the delivery of health care services. Because of the restrictive nature of its home health care provisions, Medicare reinforces this medical conceptualization of the problem.
The policy issues faced by social workers and other professionals today in the health care field are not new in other sectors. Chronically mentally ill and developmentally disabled persons have been moved out of institutions and into community residential facilities and family homes in many states for at least a decade. Similarly, juvenile and adult offenders and alcohol and substance abusers have been moved systematically out of institutionally based treatment programs into community-based service systems for about the same number of years. However, this movement has led to new problems. Perhaps most striking is that gains made in costly treatment facilities often are lost after discharge, or they never realize their expected potential.

Professionals contribute to this problem. Most professionals in health care, for example, are trained in the medical model—that is, in how to diagnose, treat, and cure client problems; they are not trained to habilitate, rehabilitate, or functionally restore persons with chronic illness. Simply stated, chronic disability is not professionally exciting to them—it only can be managed on an outpatient basis, and not cured. Thus, family members and the patient often leave the hospital with much hope and optimism, only to discover that no professional from the hospital or the community is monitoring their care closely with follow-up, nor is any professional helping them to identify needed supportive services, and then providing them. Instead, family caregivers and their chronically ill members find themselves alone and facing a local human service delivery system that usually is specialized and fragmented, complex and uncoordinated, incomplete and inadequate. Overwhelmed and frustrated by the task of managing this system, they feel powerless to change the system to deliver the kinds of services they need.

Social workers can help deal with these problems by first recognizing that their professional responsibilities extend far beyond the provision of “hard” services. In many instances, what family caregivers and disabled persons need from social workers is help in securing concrete services, not “professional” ones. For example, parents of handicapped infants sometimes complain that when they telephone hospital social workers for advice about the kinds of services their children might need, they are abruptly told “we don’t provide that service.” Moreover, nothing is done by the social workers in the department to facilitate the movement of these parents to other professionals who might be able to give them the needed advice or service.

To be truly helpful, professional responsibility must entail an understanding of, and a willingness to perform, service functions that often extend beyond the social worker’s particular job description. In medical social work, for example, the question may be asked, “Whose responsibility is it to follow up high-risk patients after discharge from the hospital: the social worker’s, the nurse’s, or the home health worker’s responsibility?” Recently, this question, which was asked at a national conference for rehabilitation social workers, elicited hardly a comment or a reply, because few of the social workers in attendance performed this function on a routine basis. Interestingly, after the presentation, the director of one social work department confided, “I don’t think we do much follow-up because, frankly, I think we are afraid of finding out that our discharge plans really don’t work.” Later, on the issue of discharge planning and follow-up, another departmental chief said rather tersely, “That’s not our responsibility.” When asked what she and her staff did to ensure that their discharge plans were implemented successfully after the patient left the rehabilitation facility, she replied with candor, “We do nothing.”

Criticizing her for this response would be easy except that most of us in medical social work also do little or nothing to follow up our clients after discharge. Our hospitals are neither reimbursed for, nor mandated to provide, the service; and our social work departments, already understaffed, have a tough enough time as it is meeting other service responsibilities.

Hence, social workers argue, “Follow-up is not our responsibility—it’s not in our job description.” The argument has merit. However, we should remember that social workers in other settings have been making the same argument for many years, much to the detriment of the chronically ill clients they profess to
serve. In state mental hospitals, for example, social workers have helped to develop comprehensive discharge plans, even though the services that exist in most of the communities that receive their discharged clients are grossly inadequate. In addition, they have not done much to follow up on the implementation of the plan. A similar criticism can be made of school social workers who help to develop individual education plans for handicapped children who are mainstreamed into local school systems that cannot, or will not, provide adequate levels of support to implement the plan fully. Where does professional responsibility in social work begin and where does it end?

Fortunately, in medical social work, the guidelines established by the Society for Hospital Social Work Directors (SHSWD) are useful in helping us to clarify our responsibilities, even those that might lie outside our particular job description. SHSWD identified 19 functions that social workers can, and perhaps should, perform in health settings. Collectively, the guidelines call for a broad conception of social work practice, one that extends professional responsibility beyond the walls of the institution and into the home and the community. Also, they call upon social workers to inform hospital administrators about the nature of professional social work practice, the documented benefits it produces for the hospital and community it serves, and the bottom-line resources needed to deliver social work services of professional quality. Professional responsibility also must entail informing administrators about the kinds of services that social workers can deliver in hospital settings and, within reason, refusing to deliver anything less than professional services. In that regard, it is useful to keep in mind what one hospital executive recently told a group of medical social workers: “I don’t know one administrator who comes around and asks you what you need. It’s the squeaky wheel that gets the attention of the hospital administrator.”

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HELPING PATIENTS COMPOSE

A Life of Their Own

In 1973, Raphael Izoo, a talented music major in his junior year of college, sustained a head injury, and his promising future suddenly changed to one of uncertainty and frustration. For the next eleven years, Raphael struggled alone, trying to put order and meaning to his life. He did not succeed.

Then in 1984, Raphael entered the Outpatient Program at Baylor Institute for Rehabilitation. There he found a team of rehabilitation specialists who understood the complex issues faced by head-injury survivors. An individualized program was developed for Raphael, to help him gain insight into his deficits and build on his strengths.

Today Raphael is a businessman, musician and active member of the community. With the help of Baylor Institute for Rehabilitation, Raphael is busy composing a life of his own.

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