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GOAL AND OUTCOME IN SOCIAL WORK HEALTH CARE PRACTICE:
THE USE OF GOAL ATTAINMENT SCALING

City University of New York

D.S.W. 1983

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GOAL AND OUTCOME IN SOCIAL WORK
HEALTH CARE PRACTICE:
THE USE OF GOAL ATTAINMENT SCALING

by

BARRY D. ROCK

A dissertation submitted to the Graduate
Faculty in Social Work in partial fulfill-
ment of the requirements for the degree
of Doctor of Social Welfare, The City
University of New York.

1983

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This manuscript has been read and accepted for the Graduate Faculty in Social Work in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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ABSTRACT

GOAL AND OUTCOME IN SOCIAL WORK HEALTH CARE PRACTICE: THE USE OF GOAL ATTAINMENT SCALING

by

Barry Rock

Adviser: Professor Phyllis Caroff

This study examines issues of accountability and quality assurance in social work practice in health care settings. A literature review is followed by a description of a pilot project in quality assurance using outcome measures and an analysis of the data generated. The review of the literature is organized around the three major components of quality assessment in the social work and health care fields: structure, process and outcome. Among structural issues are considered systems of accountability, their organizational context and policy implications; autonomy and accountability; the Professional Standards Review Organizational Act, structural standards, management technology and systems analysis; discharge planning and utilization review. The process component is concerned with recording, audit and peer review; criteria, norms and standards. The outcome literature reviews effectiveness studies, outcome evaluation in quality assurance programs and empirically oriented

practice. Issues of individualized versus global outcome measures are explored. A major theme is that social workers and other health professionals should strive for increased accountability to various constituencies, but especially consumers; and should include in their accountability systems, structure, process and outcome components.

The outcome area is the least developed, especially in social work, yet it potentially offers a strong form of accountability --the monitoring of end results of client improvement. Because of the considerable variety and complexity inherent in medical social work practice, an individualized approach to outcome appraisal is recommended, especially as operationalized in the highly flexible method of goal attainment scaling, which relates outcome to the achievement of the initial goals of intervention. The limitations in reliability, validity and methodology of this and other methods are identified.

In an effort to add the dimension of outcome to an existing process and structural accountability system of a large social work department in an urban, teaching, medical center; the method of goal attainment scaling was introduced. On a pilot basis, a selection of social workers, under the guidance of a committee, carefully scaled individual goals for patients and families and operationalized expected outcomes in behavioral terms. A rater interviewed patients and/or families upon discharge and followed-up by telephone

one month after discharge, to determine the degree of attainment of goals. A mathematical formula was utilized to yield a single, composite score of goal attainment for each case at discharge and then again at follow-up.

A data analysis is presented which examines these scores in relation to patient and worker characteristics; as well as correlations of outcome with process, as determined by a peer review instrument which has been employed on an ongoing basis in this setting. Within the methodological limitations identified, findings suggest a correlation between older, married males and higher positive social work outcome; cases involving children as primary patients exhibited the lowest outcome scores. Among worker characteristics, greater number of years of experience was surprisingly associated with poorer outcome. The overall findings suggest that expected levels of outcome were achieved on a sample-wide basis by discharge; expected levels of outcome were exceeded at one month follow-up.

Anecdotal findings on the process of implementation revealed a pattern of worker resistance to outcome accountability. Reasons for this resistance are discussed in the broader context of the literature on practitioner resistance to evaluation and accountability measures. Although there were organizational costs to this pilot, an accountability system which adds the component of outcome evaluation can strengthen the data base available for making administrative and planning decisions for the improvement of social services.

ACKNOWLEDGEMENTS

There were a number of individuals whose assistance was instrumental in the creation of this dissertation. I would first of all like to thank my doctoral supervisory committee - Professor Phyllis Caroff, chairperson and Professor Jesse Smith, both of Hunter College School of Social Work, and Professor Bess Dana of Mount Sinai School of Medicine. There were also several faculty members at Hunter who provided valuable review and comment on preliminary drafts of the initial proposal and other papers in which key ideas were formulated; they include Professors Harold Weissman, Irwin Epstein and Harold Lewis, Dean.

At the Department of Social Work, Long Island Jewish - Hillside Medical Center, which was the setting for this project, I would like to thank Dr. Abraham Lurie, Director, for his consent to have the project conducted as well as for his many years of leadership in advancing the quality assurance of patient care. Lawrence Shulman, Associate Director for Social Work, L.I.J. Division, was very helpful in administratively "paving the way" for the execution of the project in his setting. Betsie Quitkin, Administrative Supervisor, also provided much administrative help, especially in facilitating the peer review audits.

To the following individuals I am most appreciative for their "hands-on" participation in the project itself:

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TABLE OF CONTENTS

PART ONE REVIEW OF THE LITERATURE

CHAPTER

I	INTRODUCTION	1
II	SYSTEMS OF ACCOUNTABILITY: ORGANIZATIONAL CONTEXT AND POLICY IMPLICATIONS	11
III	RECORDING, AUDITING AND PEER REVIEW . .	57
IV	GOAL AND OUTCOME: EFFECTIVENESS AND OUTCOME STUDIES, EMPIRICAL CLINICAL PRACTICE AND GOAL ATTAINMENT SCALING . .	92

PART TWO THE PROJECT

V	SETTING AND DESIGN	135
VI	IMPLEMENTATION AND FINDINGS	162
VII	IMPLICATIONS AND CONCLUSION	195
APPENDIX A.	STATISTICAL TABLES 17-22 (Not presented in text)	230
APPENDIX B.	1. EXHIBIT: CONSENT FORM 2. BRIEF CASE VIGNETTES OF PATIENTS AND/OR FAMILIES WHO REFUSED TO SIGN CONSENT FORM	234
APPENDIX C.	1. EXHIBIT: MATERIALS ON GOAL ATTAINMENT SCALING 2. OUTLINE OF STAFF ORIENTATION AND TRAINING CURRICULUM	238
APPENDIX D.	PEER REVIEW AUDIT INSTRUMENT AND INSTRUCTION MANUAL	244
BIBLIOGRAPHY		256

LIST OF TABLES

1.	Characteristics of the Sample	175
2.	Goal Categories and Frequencies	176
3.	Selected Raw Goal Scores	178
4.	Distribution of GAS I Scores	180
5.	Distribution of GAS II Scores	180
6.	Mean Scores and t-test	181
7.	Means, Standard Deviations and Average Change for Groups of Cases Measured at Discharge and Follow-Up	182
8.	Scores Above and Below Mean	183
9.	Statistical Tests by Variable	185
10.	Age in Relation to Goal Attainment Scores	186
11.	Sex Difference in Relation to Goal Attainment Scores	187
12.	Sources of Referral	189
13.	Frequency of Cases by Weeks of Case Opening (Inpatient only)	191
14.	Pick-Up Time in Relation to Goal Attainment Scores (Inpatient only)	191
15.	Services in Relation to Goal Attainment Scores	192
16.	Workers' Years of Experience in Relation to Goal Attainment Scores	193
17.	Peer Review Ratings in Relation to Goal Attainment Scores	230
18.	Raw Goal Scores by Goal Categories	231
19.	Race in Relation to Goal Attainment Scores	232
20.	Marital Status in Relation to Goal Attainment Scores (Adults Only)	232
21.	Worker/Client Agreement on Goals (Scales Negotiated) in Relation to Goal Attainment Scores	233
22.	Goal Review Committee Action in Relation to Goal Attainment Scores	233

PART ONE

REVIEW OF THE LITERATURE

CHAPTER ONE

INTRODUCTION

I. History, Definitions, Fundamental Concepts: Accountability in Health Care.

In the Platonic Dialogue, The Statesman, a participant remarks, "Every doctor, you see, can preserve the life of any he will among us, and can hurt any he will by knife or cautery or by demanding fees which are nothing but imposed taxes. . . ." This stranger goes on to state that since medicine cannot ". . . be trusted in future with absolute control in its particular sphere . . . ," then

We therefore resolve to gather together an assembly of all. . . . It shall be lawful for men of no calling or men of any other calling to advise this assembly on . . . medicine--that is to say, on the drugs and surgical instruments appropriate to the treatment of the sick. . . .¹

Young Socrates replies: "it is quite clear that the arts as we know them would be annihilated and that they could never be resurrected because of this law which puts an embargo on all research. The result would be that life, which is hard enough as it is, would be quite impossible then and not to be endured."²

Thus, the struggle of the autonomy of health professionals versus the community's need for accountability

may be found referred to in Western literature as far back as the time of Socrates! According to Chapman, the medical profession has had to surrender step by step its claims to exclusive autonomy since the late Middle Ages. He identifies the following steps: (1) malpractice law, (2) due process, (3) licensure, (4) restraint of trade, (5) quality control.³ The development of the use of language in medical practice in the Nineteenth Century allowed for the first time a descriptive science which could be subjected to quality control. Foucault has written of Nineteenth Century medical epistemology and language:

Thus, language is charged with a dual function: by its value as precision, it establishes a correlation between each sector of the visible and an expressible element that corresponds to it as accurately as possible; but this expressible element operates, within its role as description, a denominating function which, by its articulation upon a constant, fixed vocabulary, authorizes comparison, generalization and establishment within a totality.⁴

Quality assessment as it is known today began in 1865 with the work of Florence Nightingale who developed a simple reporting system in British Army Hospitals which she used to expose the unsafe conditions which prevailed. Several years later she developed sophisticated data systems which included studies of the impact of surgery in the post-surgical period, and an array of data collection around variables considered crucial today, such as mean length of stay by diagnostic category, mortality rates and discharge statistics.⁵

As medical and health science was advancing to this level at the turn of the Twentieth Century, social work was at its birth. In 1910, educator Abraham Flexner declared medicine to be a profession. Social workers expected a similar declaration for themselves when they invited him to address the National Conference of Charities and Correction in 1915 on the question, "Is social work a profession?" In some ways social workers have been reacting ever since to his conclusion that social work did not qualify as a profession. He particularly mentioned the lack of individual responsibility as one of the reasons for social work "failing" his "test."⁶ But Flexner was also addressing himself to accountability in his call for the establishment of standards and of a code of ethics.⁷ There were many early attempts in social work and social work in health care to establish such standards.

The functional school of social casework made its contribution to accountability in its insistence that the agency, not the worker, was the primary instrument of service delivery. "It is the program of service, not the independently determined activities of individual social workers, that society supports through voluntary contributions or tax money."⁸

Accountability, in its most basic sense, means responsibility.⁹ Tropp has suggested, "To be accountable is to be liable or legally bound to account for the items

of a contracted transaction. To be accountable means to keep an agreement to deliver promised services." He has also wisely warned: "The step from accountability to proved effectiveness is a tremendous jump."¹⁰ In fact, Suchman has identified five levels of evaluation relevant to accountability:

1. Effort. Evaluations in this category have as their criterion of success the quantity and quality of activity that takes place. . . .
2. Performance. Performance or effect criteria measure the results of effort rather than effort itself. . . .
3. Adequacy of Performance. This criterion of success refers to the degree to which effective performance is adequate to the total amount of need. . . .
4. Efficiency. Efficiency is concerned with the evaluation of alternative paths or methods in terms of costs--in money, time, personnel, and public convenience. . . .
5. Process. In the course of evaluating the success or failure of a program, a great deal can be learned about how and why a program works or does not work.¹¹

This very useful typology written in 1967 needs to be translated into more modern terms. By effort is meant what is now called process--the inputs into human service programs and interventions. Performance is equivalent to clinical outcome, an area of major focus of the project being reported on in this dissertation. Adequacy of performance is concerned with community indicators of health and illness--incidence, prevalence, mortality, etc.--a more

far reaching level of outcome. Efficiency is meant to be a construct of cost-benefit. By process, Suchman really means the linkage between process and outcome: how was what was achieved accomplished?

Finally, Lewis has presented yet another dimension to the understanding of accountability. A multiplicity of perspectives yields different views on accountability and standards: scene--meaning community or society; agency; act--meaning practice itself; agent--the worker; and purpose--values. Standards may be of, from, or for practice. Standards of practice are what is actually the case. Standards from practice are ". . . what is the best among the actual evidence of practice; and standards for practice . . . describe an ideal, often non-existent in practice."¹² The "scene" level offers conflicting standards of, from and for practice. "Agency" is usually concerned with the practical or standards of practice. The level of the "act" is one of great complexity. "Here the difficulties inherent in efforts to observe the performance of the practitioners objectively and to evaluate this practice systematically are sharply delineated. . . . Standards from this perspective must address results, not simply intentions. . . ."¹³ The agent usually maintains standards for practice, or the ideal. Confusion reigns at the level of purpose in which "everybody seems equally in favor of the best and the most for all. . . ."¹⁴

II. Introduction to Review of Literature

The above is a brief historical and very concise conceptual overture highlighting the many themes which will be explored in a thorough review of the literature to be presented in the next three chapters. The design of the literature review is as follows: Chapter Two concerns itself with systems of accountability, their organizational context and policy implications. Following a discussion of accountability and autonomy in social work and medical practice, and a review of Professional Standards Review Organizations and their policy implications, Chapter Two begins an examination of a variety of systems of accountability, which include structural standards, management technology and systems analysis, and discharge planning and utilization review. Chapter Three continues the examination of accountability systems by focusing on recording, audit, and peer review. Here, issues of criteria, norms and standards are also considered, as well as the organizational issues of peer review.

Finally, Chapter Four completes the discussion of systems of accountability by reviewing effectiveness studies, outcome, and empirically oriented practice. Issues of individualized versus global outcome measures are studied. The method of goal attainment scaling, which is utilized in this project, is introduced. The literature review is primarily concerned with social work in health settings,

but it liberally draws as well from the medical, health care administration, public health, and nursing literature. Health is intended to include the mental health system. The major thrust of the argument is that health care professionals including social work should strive for increased accountability to various constituencies, but especially consumers and should include in their accountability system, structure, process, and outcome components. The outcome area is the least developed in practice, especially in social work, yet it potentially yields a strong form of accountability--the monitoring of end results of client improvement. Because of the considerable variety and complexity inherent in medical social work practice, an individualized approach to outcome appraisal is recommended, especially as operationalized in the highly flexible method of goal attainment scaling. The methodological limitation of these various approaches, such as in reliability and validity, are often pointed out in the review, and the organizational context is also a theme apparent in the next three chapters.

III. Introduction to the Demonstration Project.

The above described literature review will constitute Part One of this dissertation. Part Two, consisting of three chapters, will describe a project which demonstrates many of the issues described in Part One. In an effort to add the dimension of outcome to an existing process and structural accountability system of a large

social work department in an urban teaching, medical center; the method of goal attainment scaling was introduced. On a pilot base, a selection of social workers, under the guidance of a committee, carefully scaled individual goals for patients and families and operationalized in behavioral terms, expected outcomes. A rater interviewed patients and/or families upon discharge, and followed-up by telephone one month after discharge, to determine the degree of attainment of goals. A mathematical formula was utilized to yield a single, composite score for goal attainment for each case at discharge and then again at follow-up. A data analysis is presented which examines these scores in relation to patient and worker characteristics; as well as correlations of outcome with process, as determined by a peer review instrument which has been employed on an ongoing basis in this setting.

Organizational issues in the implementation of this project are examined. Implications for practice, policy, administration, and future research are discussed.

NOTES

¹Plato, The Statesman, transl. J. B. Stemp, in Plato: The Collected Dialogues, ed. Edith Hamilton and Huntington Cairns (New York: Pantheon Books, 1963), p. 1068.

²Ibid., p. 1070.

³Carleton B. Chapman, "Doctors and Their Autonomy: Past Events and Future Prospects," in Health Care: Regulation, Economics, Ethics, Practice, ed. Philip H. Abelson (Washington, D.C.: American Association for the Advancement of Science, 1978), pp. 7-9.

⁴Michel Foucault, The Birth of the Clinic: An Archaeology of Medical Perception (New York: Vintage Books, 1975), p. 113-4.

⁵R. H. Brook, "Quality of Care Assessment: Policy Relevant Issues," Policy Sciences 5 (1974): 317-41.

⁶Encyclopedia of Social Work, 17th ed., s.v. "Flexner, Abraham (1866-1959)."

⁷Abraham Flexner, "Is Social Work a Profession?" In The Heritage of American Social Work: Readings in its Philosophical and Institutional Development, ed. Ralph E. Pumphrey and Muriel W. Pumphrey (New York: Columbia University Press, 1961), pp. 301-7.

⁸Encyclopedia, s.v. "Social Casework: The Functional Approach" by Ruth Smalley and Tybel Bloom.

⁹Encyclopedia, s.v. "Accountability in Social Welfare" by Summer J. Hoisington.

¹⁰Emanuel Tropp, "Expectation, performance and accountability," Social Work 19 (March, 1974): 141.

¹¹Edward A. Suchman, Evaluative Research: Principles and Practice in Public Service and Social Action Programs (New York: Russell Sage Foundation, 1967), pp. 61-6.

¹²Harold Lewis, "Standards in Social Work: Implication for Practice and Education" (unpublished paper, 1974), p. 3.

¹³Ibid, p. 8.

¹⁴Ibid, p. 10.

CHAPTER TWO

SYSTEMS OF ACCOUNTABILITY

ORGANIZATIONAL CONTEXT AND POLICY IMPLICATIONS

The social work profession has a long standing tradition of accountability. According to Ann Hartman, the profession's concern with accountability has approached an obsession. She has asked:

What other profession has produced mountains of records filled with detailed process recordings in an attempt to provide a data base for monitoring performance? What other profession has clung to an elaborate hierarchical, supervisory system in which the work of a professional practitioner continues to be supervised with diligence and in detail?¹

From the time of Flexner to today, social work has been struggling to prove that it has earned full professional status. But in doing so, it has attempted to carry out the mandate of community sanction through close control of workers by means of hierarchical supervision. Many students of the sociology of professionalism point to professional autonomy as the hallmark of professionalism.

A well known attempt to codify attributes of professionalism for social work was offered by Greenwood who proposed five criteria: systematic theory, authority, community sanction, code of ethics and a culture.² He unhesitatingly concluded in 1957, 42 years after Flexner

that "social work is already a profession; it has too many points of congruence with the model to be classifiable otherwise."³

Feldstein reviewed Greenwood and other authors concerned with criteria of professionalism. He states: "Autonomous expertise is the goal of professionalization. Professions succeed to the extent that society permits them to operate autonomously."⁴ He then provides a critique of professionalism, based on a value stance of consumerism (the article having been published in 1971, after a decade of the social activism of the 1960's). Among the criticism is, "Autonomous expertise is antidemocratic."⁵ Thus, the question of autonomy in professional practice, and the question of accountability to consumers, are raised by Feldstein.

Writing in a similar vein, Gartner compares four professions--social work, education, medicine and law. Placing the issue of professionalism in the context of organizational theory, he too concludes that autonomy is a central question.⁶

The conflict between professional initiative and organizational constraint has been the focus of considerable study both within and without the social work field. Etzioni highlights the problem as follows. "However, knowledge is largely an individual property; unlike other organization means, it cannot be transferred from one person to another

by decree. Creativity is basically individual and can only to a very limited degree be ordered and coordinated by the superior in rank."⁷ Since knowledge cannot, according to Etzioni, be bureaucratically controlled, those "professions" who work within the confines of organizational hierarchy are, in fact, not full fledged professions but rather, "semi-professions."⁸

Etzioni and colleagues produced a book length treatment of this theme⁹ identifying teaching (below the university level), nursing, and social work as semi-professions. Although other criteria help to determine this status--fewer years of training than the full professions (medicine, law, university teaching); lack of privileged communication; lack of life-death decision making; and the communication rather than the application or creation of knowledge¹⁰--the limitation of individual worker autonomy in day to day practice by bureaucratic control becomes a central issue in the semi-professional organization.

Nina Toren wrote the major study of social work as a semi-profession in the Etzioni work. She continually relates to the theme of autonomy and enumerates the various ways that social work practice is organizationally controlled; among them is one unique to social work: supervision, based on a personal relationship between the supervisor and the supervisee.¹¹ She also provides the following data:

. . . a total of 52 percent of all expenditures for casework services was spent on maintaining communication within the bureaucratic structure. This includes: case recording (32.15 percent); supervisory conferences (13.17 percent); and case consultations (5.77 percent). Only 42 percent was spent for direct contact with clients.¹²

Several authors have addressed themselves to the specific problems of the social worker in the bureaucracy. Wilensky and Lebeaux devoted several chapters of their classic work to agency structure and social work professionalism, warning that "between the altruist with his desire to help and the client with his need lies the machine, with its own 'needs.' These needs can result in an emphasis on technique and method, on organizational routines and records, rather than on people and service."¹³ Thus, the danger of organizational goal displacement¹⁴ is a possible consequence of an over emphasis on accountability systems. However, Wilensky and Lebeaux clearly saw the advantages, if not the necessity of organizational control, much like the functionalist. But in more recent times, following the social upheavals of the 1960's and early 1970's, articles have appeared which seem to make bureaucracy the "enemy," with such titles as "Social Workers versus bureaucracy"¹⁵ and "Casework beyond bureaucracy."¹⁶ Hanlan, in the latter article, indicates that social work's movement toward professionalism "was accompanied by increased bureaucratization of casework practice."¹⁷ This may seem paradoxical in view of Freidson's observation that

"bureaucracy" has a negative connotation, and "profession" a positive one.¹⁸ Freidson states, "By virtually all workers, expertise and professions are equated with a flexible, creative and equalitarian way of organizing work, while bureaucracy is associated with rigidity, and with mechanical and authoritarian ways."¹⁹

In a subtle analysis of the functions of professions within complex organizations, Freidson shows the ways in which professional expertise is transformed into bureaucratic power. With special focus on health organizations, he concludes that the most important professional attribute is autonomy and that the only truly autonomous profession within the health organization is medicine which becomes the dominant profession.²⁰

The term "autonomy" in the study of professions often has a double meaning: the autonomy of the profession as a whole to practice free of interference by the community, consumers or other professional and occupational groups; and the freedom of professionals as individuals to practice without controlling or interfering supervision by even their own colleagues. Freidson sees them as inter-related and as both being attributes of the dominant profession of medicine. Etzioni and Toren see social work as lacking both. The professional-wide autonomy is lacking in social work because of the absence of universal, legally sanctioned licensure; the accountability of primary social

work agencies to lay boards; and the dominance of other professions in host settings. The absence of individual autonomy within the social work profession has already been discussed above.

In more recent work, published after the passage and early implementation of the Professional Standards Review Organization Act, Freidson acknowledges the newer limitations on medical autonomy brought about by accountability systems and offers a thorough analysis of peer review as professional social control.²¹ (This work, relevant to non-medical health fields as well, will be referred to in subsequent sections of this study.)

Freidson's central valuation of professional autonomy, and Toren's declarations of social workers' lack of such autonomy and lack of full professional status caused a reaction in the social work field perhaps comparable to the post-Flexner period: a defensive need to prove it is not so or to correct the alleged inadequacies. The latter is well demonstrated by the movement for the autonomous or self-directed social worker.

Specifically, reacting to Etzioni and Toren, Laura Epstein published in 1973 her much cited, "Is autonomous practice possible?"²² Taking as a starting point Toren's stance ". . . that it is lack of autonomy in performing professional functions, not bureaucratic authority . . ."²³ which is problematic in social work," Epstein identifies

the source of the problem in the dual nature of the supervisory role: "Supervision is a process of exercising leadership to facilitate the objectives of the practitioner and the agency."²⁴ The former is the educational/growth function of supervision; the latter is the administrative/accountability function. It is Epstein's proposal that for the mature worker, the educational/growth function of supervision be abolished; and that the administrative/accountability function ". . . become less rigid . . ."²⁵

If traditional social work supervision is to be altered or eliminated, its social functions must be replaced by comparable functions which inhibit worker autonomy less than the former mode. Munson has provided a detailed functional analysis of supervision as well as recent research findings on supervision and autonomy.²⁶

Rosenberg has suggested that the teaching function of traditional supervision be replaced by continuing education and a preceptor model; and that the accountability function be replaced by peer review and outcome audits.²⁷

He has written:

By combining a seminar program with an open precepting model, and by creating feedback mechanisms through peer review and audits, the social worker has been furnished with most of the structure needed to become responsible for learning and achieving quality professional practice.²⁸

The term, "self-directed worker" is utilized in the above, instead of "autonomous worker." This has the advantage

of not denying the need for accountability implied by the concept of "autonomy." The term "autonomous worker" seems to have been utilized as a reaction to the criticisms of Etzioni, Toren and Freidson but in fact, can or should any social worker be considered "autonomous" in a profession that prides itself on being "social," accountable to clients and to communities? It is, however, quite possible to be self-directed, in the sense of freedom from the day to day control of traditional supervision, and yet also be accountable to clients, agencies and communities. Peer review, auditing, and quality assurance systems have also been seen as encroachments on workers' freedoms, as will be explored further below. But, by replacing the accountability function of supervision, they may be seen as supportive of the self-directed worker concept. They can provide a structural framework for accountability within which workers may exercise more of their own judgments. Especially if quality assurance systems are outcome oriented, social workers could be fully self-directed in the area of process, method, or means to the end. They would only be held accountable for the end product. This is a possible model for a self-directed, but accountable practice.

Wildavsky has said that "the self-evaluating organization is one that uses its own analysis of its own programs in order to alter or abolish them."²⁹ Thus, there is an obligation for an organization to do more than comply with

a series of externally imposed accountability mandates. According to Wildavsky, "evaluative activities would be inefficient, that is, they would cost more than they are worth, unless they led to change."³⁰ However, the costs may be great of continued change brought about by the continuous application of evaluative knowledge; there is an inevitable conflict between knowledge and power in organizational life. These themes will be developed further, below, as the implementation of this project is described.

A) PSRO--Its Impact and Policy Implication

The modern age of accountability in health care began in 1972 with the passage by Congress of Public Law 92-603, an Amendment to the Social Security Act, to provide for Professional Standards Review Organizations (P.S.R.O.) The intent was to "ensure that the medical services under Title XVIII (Medicare), Title XIX (Medicaid) and Title V (Maternal and Child Health Services) were medically necessary, met professionally recognized standards, and were provided in the most appropriate setting."³¹ In addition to a review of medical practice, the law required the phased-in addition of review of non-physician services, including social work.³² The method for review was essentially to be chart audits by peers, who develop norms, criteria and standards appropriate to their settings and communities.³³ Even prior to the mandated inclusion of social work by law in P.S.R.O., many departments of social work in hospitals

had begun to develop quality assurance programs.³⁴

Details and discussion of the P.S.R.O. law, its significance and problems, may be found in numerous social work³⁵ as well as medical and general health care publications.³⁶ Such information is usually provided in summary form as the introduction to almost every article in the accountability field. There is thus no deficit in the literature of basic information on P.S.R.O. law and policy.

The P.S.R.O. system of quality assurance established local organizations to oversee health care accountability, including the following components:

1. Concurrent Review - continuous monitoring of patient care at the time care is delivered.
2. Medical Care Evaluation Studies - retrospective medical care reviews, also known as "medical audits" or "patient care audits," in which assessment of the quality and nature of the utilization of health care services is made.
3. Profile and Pattern Analysis - identification of patterns of health care delivery.
4. Utilization Review - evaluation of the necessity, appropriateness and efficiency of the use of medical services.

Each type of review requires use of established norms, standards, and criteria.

The social work profession and health care industry have had high hopes for P.S.R.O., both in its cost containment and quality assurance potential. During the presidential administration of Carter, there were expectations of the creation of a National Health Insurance System. Many

envisioned an active role for P.S.R.O. which would have assumed the accountability function in such a system.³⁷

But P.S.R.O. has had its critics, not the least of which was organized medicine (which, however, by June, 1974 accepted it). Typical of critical articles is one which asks of P.S.R.O., "A high in medical accountability or a low in bureaucratic meddling?"³⁸ Among the criticisms are: "norms of care: too rigid an application of norms of care, diagnosis and treatment could result in 'cookbook medicine,' which would undermine quality and retard medical progress."³⁹ Other concerns include, threats to confidentiality, the burden of paperwork, the costs, and fees: "Services which do not meet P.S.R.O. standards will not be paid for by the government, even though they have been provided in good faith. . . ."⁴⁰ And of course, the threat to practitioner autonomy inherent in P.S.R.O. has been raised by critics.⁴¹

It is strongly believed that the Reagan Administration agrees with the critics, sees P.S.R.O. as "bureaucratic meddling," and plans its demise, as part of the overall program of "deregulation." If this does occur, P.S.R.O. and the "Age of Accountability" which it ushered in will have left the health care field and the social work profession an array of accountability measures which can be continued or ceased. Such decisions will hopefully be based on careful evaluations of each approach.

The P.S.R.O. program was intended to have consequences,

that is, to influence health policy. In social work, there has been some attempt to understand quality assurance and accountability systems in the context of issues of social work health care delivery. Berkman and Rehr have contributed a number of articles to the accountability literature in which consequences for social work policy in the health field have been identified. Even prior to the advent of P.S.R.O., they have reported on several "applied studies" in hospital social work on case-findings and the timing of social work intervention.⁴² In the first of these important studies, they reported:

In an exploratory study of 121 aging ward patients, Mount Sinai Medical Center's Social Service Department examined its case-finding procedures, revealing the dominance of the medical profession in case referrals. Two unanticipated consequences of this system were the possible selectivity biases of referring physicians and the timing of intervention between the second and third weeks of hospitalization rather than immediately after admission, the crucial period for patient and family. By accepting this system social work has relinquished the right to set its own priorities.⁴³

In the next study they developed a framework for the "sick-role" cycle, identifying five stages: (1) the symptom experience phase, (2) the assumption of the sick-role, (3) the medical-care contact stage, (4) the dependent-patient phase, (5) the recovery phase.⁴⁴ Referrals to hospital social work services usually involve the latter two phases (though the first three have implications for prevention) in which patients encounter stress in assuming

the dependent-patient role and in which ". . . a predominance of social needs related to the post hospital phase of patient care."⁴⁵ Most of the cases in the study had been referred to social work in the "recovery phase," not allowing intervention in the earlier stages in which psychosocial adjustment of patient and family to illness and hospitalization took place, and often too late for effective discharge planning.⁴⁶

By contrast, in the third study of the series, the traditional method of referrals was contrasted with one in which social workers controlled their own early case finding. As might be anticipated, "it was found that under independent case finding social workers . . . reach significantly more patients and family members early in the course of hospitalization and . . . reach considerably more persons in need of help related to 'being ill'. . . ."⁴⁷ Having established the efficacy of social work controlled case finding and early intervention, later articles have focused on techniques for screening and identification of social high risk patients.⁴⁸

Westerman, Spano and Keyes perceive the age of accountability as stimulating new roles for social work practice. Instead of stressing the data that might evolve from high risk screening mechanisms and social problem classifications, they focus on outcome studies and specifically recommend the method of goal attainment scaling,

which is the basic method used in this project (see Chapter Four and subsequent chapters);

The implications of such a methodology for social work are enormous. Armed with an outcome-oriented procedure, the social worker is well-prepared to move beyond his traditional scope of operations into a health care system devoting increased amounts of energy to human services.⁴⁹

In addition to systematic or policy changes, proponents of accountability systems have an educational agenda; namely, as quality assurance programs identify knowledge and skill deficits in individual practitioners, strategies of corrective action are proposed, usually in the form of inservice training or continuing education. There is a beginning literature in medicine and social work on education in the context of accountability systems. They are of two kinds. One follows from the above in examining the impact of quality assurance generated data on the content and nature of continuing education.⁵⁰ The other is concerned with educating practitioners and students of the health professions in methods of accountability.⁵¹ The former is education for accountability, the latter education of accountability.

Jesse, et. al. propose a design for P.S.R.O. corrective action based on continuing education: problem analysis, corrective program design--establishment of objectives and development and implementation of the corrective program; evaluation of the corrective program.⁵² In social work, efforts to provide education of accountability are

described by Reinberg, et. al.⁵³

B. Accountability Systems

A number of accountability mechanisms which have been utilized in the last ten years in the health field will now be reviewed, with particular emphasis on the relevant social work literature. They are:

1. Structural standards.
2. Management technology and systems analysis--
 - a. functional analysis, management by objectives, and management information systems.
 - b. quantitative assurance and patient information systems.
 - c. cost effectiveness, cost-benefit analysis and cost finding.
 - d. critique of management and systems analysis.
3. Discharge planning and utilization review.
4. Recording (Chapter Three)
5. Peer review and audit (Chapter Three)
6. Outcome and effectiveness studies, and empirically oriented practice (Chapter Four)

1. Structural Standards

The three approaches to appraisal of quality in the health field are structure, process, and outcome (see Introduction--Chapter One). According to Donabedian:

Appraisal of structure involves the evaluation of the settings and instrumentalities available and used for the provision of care. While including the physical aspects of facilities and equipment,

structural appraisal goes far beyond to encompass the characteristics of the administrative organization and the qualifications of health professionals. The term structure . . . also signifies the the properties of the resources used to provide care and the manner in which they are organized.⁵⁴

Earlier efforts (prior to P.S.R.O.) to evaluate quality tended to focus on structural standards because structural data were perceived as easier and less costly to obtain. There was also an assumption ". . . that good structure automatically led to good process, which inevitably led to good outcome. . . ." ⁵⁵ There was a second assumption ". . . that we know enough to identify what is 'good' in terms of staff, physical structure and formal organization." ⁵⁶ Some studies have demonstrated correlations between structural factors and positive health outcome, but others have not. ⁵⁷ Structural factors may be said to be a necessary but not sufficient condition of quality care.

Structural standards in health care are dictated by a variety of sources: Departments of Health, Medicaid, Medicare, and private insurance agencies, professional associations, Joint Commission for Hospital Accreditation, and a host of other regulatory agencies. The Joint Commission (JCAH) offers a comprehensive audit of a structural nature to hospitals who voluntarily request it. Since this form of voluntary accreditation offered by JCAH is highly respected and valued in the health field, it has become the most universal form of structural accreditation.

JCAH had for a long time required departmentally based peer reviews audits. Currently, they have shifted their focus to a problem-oriented system in which departments select problems which impinge on the delivery of quality care, implement study designs utilizing pre-specified criteria around the priority problem areas, and document that corrective action has taken place by pre-specified dates.⁵⁸

This approach moves away from patient care audits, and itself moves toward a management-by-objectives or management information system concept. It represents an all purpose approach which can include structural standards as well as many other issues. Although it may have merit, the changing requirements of JCAH are costly to hospitals who prepare for accreditation visits. Even more costly are the redundant and often contradictory requirements of a number of organizations all demanding compliance to their particular standards.

The social work profession in the health field has generally utilized structural standards as a way of legitimizing and expanding services. Medicaid, Medicare, JCAH, and other regulatory agencies require a minimum of social services activity in facilities. Elaborating on this foundation, social work organizations such as the National Association of Social Workers and the Society of Hospital Social Work Directors of the American Hospital Association, have

proposed structural standards for hospital social work departments.⁵⁹

If education offers one strategy for corrective action, structural standards provide another: sanction. Sanctions may range from loss of funding, loss of accreditation, to loss of license of individual practitioners. Sanctions are utilized when structural factors seriously fall below acceptable standards.

2. Management Technology and Systems Analysis.

Slavin has written:

Much of the interest in administration of the social services during the Seventies developed as a result of official and public concerns for accountability and what were considered the uncontrolled excesses of the social programs of the Sixties. In substantial part this flowed from the viewpoint of the Nixon administration that these programs were failures The incorporation of managerial technology into public welfare programs was seen as one way to overcome the inefficiencies that were thought to be rampant.⁶⁰

These management technologies were often borrowed from the world of private business corporations and from the military. Initially used by government auditors who were motivated by Nixonian anti-social welfare ideology, these technologies eventually became popular among social workers and social welfare administrators--either because of the fear that if they didn't incorporate such methods themselves, outsiders would impose them on the field, or because some social workers came to accept their value. Some of these techniques in themselves, or the manner in

which they were used, proved to be clearly inappropriate for non-profit organizations who served people's needs. Other techniques have made a contribution to social welfare accountability and have a potential of even greater use.

A review of the literature reveals several categories of management technology: (a) the first group includes such management control systems as functional analysis, management by objectives, and management information systems; (b) the second, closely related to group one, involves heavy reliance on statistical data to achieve quantitative assurance and patient or client information systems; (c) the third group deals with perhaps the most basic issue-- money: cost finding, cost effectiveness, budgeting, and cost-benefit analysis.

(a) Functional Analysis and Management by Objectives.

Functional analysis studies and management information systems attempt to document what social workers actually do, to learn differentially how social workers use their time. Management by objectives is a method which allows an organization to planfully alter its activities toward the accomplishment of new goals and objectives. A functional analysis study will typically ask such questions as:

1. How much staff time is spent in each of the department's activities?
2. How is staff time spent within each activity?

3. How much time is spent in direct patient care?
4. How much time is spent in 'processing' tasks, such as case recording?⁶¹

Once a baseline is established by functional analysis, ongoing monitoring may be provided by a variety of information system strategies.⁶² Many systems combine data relevant to worker activity and to client characteristics and services. In this section, the stress is on systems which primarily provide data on worker activity for purposes of improving management decision making. The functional, as distinguished from the client-centered system, attempts to monitor caseload size, productivity, recording, continuing education, supervision, time spent in meetings, etc.

Management by Objectives was developed in industry over the past twenty-five years. "It is an approach to management in which agency staff participate in the process of specifying long-range goals and short-range objectives to be achieved within an established time period. Success in achieving these agreed upon goals and objectives is evaluated periodically."⁶³ Among the questions it can answer are: "What criteria are used by supervisory personnel in appraising the performance of social workers? How can creativity and enthusiasm in job performance be stimulated? Is it possible to establish short and long range service delivery goals in a social agency?"⁶⁴

Management by Objectives is essentially a planning

tool which can be used to create a conceptual hierarchy of mission, goals, and objectives to give new direction to the organization and to monitor the achievement of ends.

(b) Client Information Systems and Quantitative Assurance.

Client information systems attempt to monitor client attributes, demographic characteristics, problem classifications, source of referral, services rendered. If quantitative assurance is to be achieved, the data system should include some scheme of assessing outcome and provision for follow-up.⁶⁵ Among the questions which these methods attempt to answer are:

- Who was served in sociodemographic terms, and as important, who was turned away?
- How did the patient/client get into the social service system of care?
- At what location (from within or without) was the patient/client at time of entry?
- What was asked for?
- How was the patient/client perceived?
- What service/s was given? To whom? By whom? Over what period of time? How frequently?⁶⁶

Standardized problem lists are often utilized, and may be integrated with the problem-oriented style of case recording (see below, Recording). "A standardized problem list is a beginning step for building a system taxonomy as a scientific framework through which social work research can focus in the future on specific etiologies of medical problems."⁶⁷

(c) Cost-finding, Cost-effectiveness, Cost-benefit Analysis.

Cost analysis has been a concern of social welfare administrators since long before the modern "Age of Accountability."⁶⁸ However, it has become a central concern during the past ten years as limits have been placed on the growth of the welfare state and financial resources for human services have become scarce, relative to contemporarily defined need. Particularly in health care, where inflation is considerably higher than the double digit national inflation, cost factors are especially critical. Wildovsky has written of "The Law of Medical Money," which states "that medical costs rise to equal the sum of all private insurance and government subsidy."⁶⁹ The requirement of the welfare state that aggregate demand for employment and growth be maintained is challenged by spiraling inflation. The society is faced with a dilemma of enormous proportions. Janowitz is concerned with the ability of modern welfare states to maintain social control, by which he means the community's ability to regulate itself:

Therefore, the system of social control comes under fundamental strain. The essential dilemmas of the welfare state are those of ineffective social control or self-regulation. The resulting internal political conflict derives in part from the decline of an effective surplus for social welfare and the profound escalation of demand for social welfare.⁷⁰

The two goals of the P.S.R.O. program are the improvement of quality of health care and the containment of cost, which may at times conflict with each other. In a

recent report there is some evidence of effectiveness of New York State P.S.R.O.s in reduction of Medicare and Medicaid hospital costs by \$34 million (above the costs of operating the P.S.R.O.).⁷¹

Cost consideration thus became a major issue of accountability: how much does (or should) the public spend, for what quality and effectiveness of service? Just as in other areas of accountability, the cost analysis process in health care and social welfare has been greatly influenced in recent years by management technology. A number of "rational" and political models of budgetary, cost accounting and fiscal planning have been advanced in the human services,⁷² among them: Planning-Programming-Budgeting System (PPBS), zero-based budgeting, cost-finding, cost effectiveness, and cost benefit analysis. The social work literature reflects a growing interest of social workers in these and related areas.

Several social work authors have focused on cost finding.⁷³ Cost finding involves both the identification and utilization of resources to financially support social service activities, as well as the documentation of social work activity which in fact contributes to the financial well being of the institution. There is a concern with defining cost units--that is precisely identifying components of service for which costs may be assigned; and for which outcomes or benefits, may be measured, in the case of the

more elaborate cost-benefit analysis.

A debate has emerged in the literature between Rosenberg, who argues that social work should be conceptualized as a revenue center and Volland, who advocates the consideration of social work as an expense center. Drawing upon cost-benefit thinking and data, Rosenberg demonstrates how social workers in hospitals can get credit for revenue generating in both inpatient and ambulatory services. Vielhaber and Irvin, and Collins have made similar points demonstrated by data.⁷⁴ Volland has stated that Rosenberg has incorrectly applied a management concept:

The primary service in health care is health/medicine. Social work services are provided to improve the quality of those health/medical services. For that reason it is appropriate for social work services to be classified and viewed as Expense Centers.⁷⁵

From a social philosophical perspective, Volland is correct. Social work ought not have to prove its worth continually by demonstration of its revenue generating capacity. Social work services are part of a social welfare state concept of redistribution and in a sense may be seen as an in-kind, unilateral transfer. However, during the current climate of retrenchment and of attack on the social welfare provision system, Rosenberg's approaches may prove to be quite useful, although they do run the risk of social work being perceived as self-serving. All quality assurance programs, which are designed to be client serving, run the risk of becoming self-serving.

Budgeting, cost effectiveness and cost benefit analysis are the focus of a number of articles in the literature.⁷⁶ Gross identifies both the planning and monitoring functions, of budgeting.⁷⁷ Goodman identifies three functions, planning, management control and operational control. In its simplest terms, the budgeting process relates resources to services rendered.⁷⁸ During the period of 1965-75, Planning-Programming Budgeting System (PPBS), was especially popular--a systems oriented approach which encouraged the administrator to utilize budgeting as a comprehensive-rational planning tool for examination of alternatives in long range policies. Wildavsky has declared it to be a complete failure in the context of the highly political and incremental environment of government and human service bureaucracies.⁷⁹

Of more recent vintage, zero-base budgeting has advocated a periodic justification of items and programs--in essence an accountability oriented budget system. It was widely known to be a failure in the Carter Administration, for reasons similar to Wildavsky's critique of PPBS--the essential political nature of budgeting. Quality Assurance mechanisms backed up with the power of the dollar are potentially effective and thus threatening, requiring exquisite political skills for their subversion. Zero-base budgeting does still have its advocates. Buttrick and Miller have described a successful application to a school of social

work in which zero-base budgeting earned a much larger financial appropriation from the university to the school because of, in the authors' views, ". . . the credibility and the conviction that was imparted with the zero-base document."⁸⁰ Their article also provides an excellent summary of Wildavsky's ideas, as well as the history of PPBS.

The cost-effectiveness and cost benefit analysis models provide the underpinning to virtually all approaches to budget management and fiscal accountability. The cost-effectiveness approach asks if there are not less expensive alternatives to achieve the same ends. Cost-benefit analysis deals with outcomes: is the benefit (to agency, client, public?) worth the expense? Cost effectiveness has been accepted as rational and useful in most situations. Cost benefit analysis is problematic, however. The question arises: benefit for whom? Secondly, how are human service benefits to be measured, and how are values to be attached to alternative benefits? There are examples in the social work literature of cost benefit application to health care social work. Morris and Ozawa, for example, propose a five step model: (1) clear statement of objectives, (2) determination of costs, (3) determination of benefits, (4) data analysis, (5) decision.⁸¹ Benefits are determined on a ten point scale by a variety of program participants and standardized value score by the cost per unit of service.⁸²

Rivlan, generally an advocate of rational-

comprehensive, economic models of program evaluation, questions whether, in times of resource scarcity, there is any rational, methodological way of choosing between cancer cure versus reading programs: "Once we leave the fairly firm ground of income we move into a kind of never-never land where we must set values on self-reliance, freedom from fear, the joys of outdoor recreation, the pleasures of clean air, and so forth. The result may not be worth the effort."⁸³

A most promising application of some of these models of financial accountability is in the area of prevention and of high cost user analysis. Wildavsky has written:

The best estimates are that the medical system (doctors, drugs, hospitals) affect about ten percent of the usual indices for measuring health: whether you live at all (infant mortality), how well you live (days lost due to sickness), how long you live (adult mortality). The remaining ninety percent are determined by factors over which doctors have little or no control, from individual life style (smoking, exercise, worry) to social conditions (income, eating habits, physiological inheritance) to the physical environment (air and water quality).⁸⁴

In both the social work health care and public health literatures there are beginning indications--through empirical studies--of the cost benefit potential of prevention.⁸⁵ A most comprehensive review is provided by Scheffer and Paringer, who summarize the result of numerous recent studies demonstrating the costs benefits of prevention in lifestyle changes such as smoking and

alcohol consumption; in public health measures such as immunization against a variety of diseases and fluoridation of water supplies; and screening for early intervention.⁸⁶ They also provide a most useful critique of the cost-benefit method, identifying a series of limitations, which include: many factors do not lend themselves to quantification--especially difficult is placing a value on human life; most studies do not account for the pain and suffering of illness, which is a real cost to the individual; problems of discounting costs and benefits when computing future cost/benefits for time periods when the dollar may be worth less; distributions of benefits and costs are different among different members of society; the influence of third party payors--private costs/benefits differ from social costs/benefits; and in screening programs, the complexity of including false positives and false negatives.⁸⁷ Nevertheless, in spite of the limitations of the methodology which they are so careful to analyze, the authors are encouraged by the evidence that prevention programs have considerable economic potential for consumers as well as the society as a whole.⁸⁸

A new area for study has emerged: high cost users of medical care. Zook and Moore state:

A major portion of medical resources in the United States is consumed by a small fraction of patients. This fact. . . raises important issues of cost distribution, predictability, preventability, equity in treatment, and ultimate health status of the high cost users of medical care.⁸⁹

They learned through their study that six of nineteen diagnoses included two-thirds of the most costly twenty percent of patients. The diagnoses are: alcoholism and its effects, benign inflammatory bowel disease, cancer, congenital defects, renal failure and chronic degenerative vascular disease of the heart and peripheral vessels.⁹⁰ These high risk/high cost patients comprised thirteen percent of the study group, but utilized as much of the health care resources as the remaining eighty-seven percent of patients, per year. The ". . . results showed that adverse lifestyles were noted more often in the medical records of high cost than low cost adults. Alcoholism, heavy smoking, and obesity were particularly prominent."⁹¹ Repeated hospitalization, often because of the same disease, was also noted.

There are clear implications for social work in these findings. They provide a beginning series of indicators for the early identification of high risk/high cost patients, in medical as well as social areas. Amelioration through social work intervention of some of the lifestyle linked factors could have great cost effective as well as patient and community care benefits.

(d) Critique of Management Technology

Several authors in the social work literature have identified a number of limitations of the management technology and systems analysis approach.

Patti argues that the "New Scientific Management" is an ideology more than it is a technology, that it may be characterized as a particular socio-political world view, with certain, identifiable, underlying assumptions about organizational behavior.

Gruber, relating this way of thinking to Taylor's classic scientific time and motion study, warns of the reductionist, input-output concept of what he terms "Total Administration." "Total Administration" may stress the organization as a "black box" which processes inputs into outputs in the most efficient way possible, but ignores the content of the "black box"--human beings engaged in complex human interactions.⁹²

Both Patti and Gruber fear the dehumanizing and alienating potential of systems management in social welfare. Social work managers have no choice but to make use of these methods, especially in the health care field, because they are imposed by hospital administrators and government funding and regulatory agencies. As has been indicated, the literature reflects many ways in which they can be helpful and supportive of social work services. However, Gruber and Patti's warnings ought to sober social workers into a realization of the serious dangers of these approaches which came about essentially through goal displacement. That is, the technologies of efficiency may become ends in themselves, losing sight of the true ends of social work

practice. As means, and used with the necessary constraints based on their inherent limitations, they are useful tools in the never-ending struggle to achieve accountability in health care social work practice.

3. Discharge Planning and Utilization Review

Issues of Utilization Review⁹³ and discharge planning are at the center of contemporary concerns for accountability in health care, with particular relevance for social work. Utilization Review and the closely related continuous stay review are mechanisms for monitoring the appropriateness and length of patient stays in hospitals (although mandated for inpatient care, the mechanisms may be utilized in ambulatory care as well). Based on national norms for hospital stays by diagnosis, certification takes place for each hospital patient, ascertaining the appropriateness of hospitalization for the condition and stating the expected length of stay.⁹⁴ If length of stay exceeds the expected, third party payers such as Medicare, Medicaid or private insurance, may deny payment. Thus, patients are supposedly protected against unnecessarily lengthy hospitalizations, and third party payers have a cost containment protection. The pressure for shortened stays brings about an enlarged need for discharge planning capability, usually located in social work departments. Since it is assumed that quality and effectiveness of post-hospital plans have a great bearing on outcome, health status and recidivism; utilization

review and discharge planning become important in the assessment of quality health care delivery.⁹⁵

The social work role in utilization review involves the development of criteria for high risk patients who have social needs, the establishment of early intervention, and the linkage through discharge planning to community resources, long term care facilities, and support systems.⁹⁶ The emerging social work literature on discharge planning incorporates utilization review in its discussions as well as the above issues.⁹⁷

The current medical care system has not kept pace with the changing patterns of illness. The system stresses acute inpatient hospital care in the deployment of resources, neglecting prevention and primary care on the one hand, and long term care on the other. Acute care facilities are continually transferring patients to alternate levels of care that are often substandard, as evidenced by the frequent scandals in nursing homes and adult homes where conditions are often deplorable. "Hospital backlog" problems testify to the gaps in the availability of long term facilities. Social workers are often caught in the middle of this process, because of social work's emerging central role in discharge planning.

Some authors in the literature believe, as does Schreiber, that "discharge planning is the key to the future of hospital social work."⁹⁸ Others believe that discharge

planning is also consistent with social workers' oldest roles.⁹⁹

However, there are value conflicts inherent in assuming this role. The pressure to discharge brought about by utilization review and cost containment policies might force social workers into using discharge planning in the service of the institution rather than the patient.¹⁰⁰

Shulman and Tuzman have proposed a set of value principles to guard against this, among which is "consideration of the patient's and the family's right to self determination."¹⁰¹

Other issues faced in discharge planning include inter-disciplinary conflict, especially involving the nursing profession, around which profession will be central in the discharge planning process; the need for advocacy with entitlement agencies which are often obstacles to post hospital plans; the paucity of community resources, especially long term care facilities; the problem of the hard to place patient, and the difficulties of early intervention and high risk indicators. Cost containment and cost finding are ever-present as well in the discharge planning discussion and some evidence exists of social work discharge planning activity as revenue generating.¹⁰² The literature does not as yet reflect data on outcome or health status, linked to effective discharge planning. Only then will accountability truly be established.

This chapter has presented an organizational and

policy context for accountability systems in health care and social work; and has begun an examination through a review of the relevant literature, of accountability systems: structural standards, management technology and systems analysis including issues of cost, and discharge planning/utilization review.

NOTES

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²²Social Work 18 (March, 1973): 5-13.

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²⁵Ibid., p. 11.

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CHAPTER III

RECORDING, AUDITING AND PEER REVIEW

A. Recording

"If it isn't written, it didn't happen,"¹ has become the slogan of the Age of Accountability. In almost all instances, an examination by some systematic means of the written records of health care and social work activity is essential to the quality assurance process. "For a civilization, people or profession to endure, it must keep records to preserve its accumulated knowledge. From the beginning of the social work profession, social workers have obeyed this mandate and stressed the maintenance of records as essential to their professional continuity."²

A fundamental principle for social work recording is: written, systematic records must be maintained providing essential data about the client and about social work activity, in order to assure the competent and continuous delivery of necessary services. The propositional component of this principle, which is subject to empirical testing, is,--the maintenance of records in a systematic manner assures a higher quality of social work service. A series of ethical imperatives are implicit in the principle, among which are:

The client is entitled to continuous care. The maintenance of records assures that if there is a change in workers, subsequent workers will have access to the work previously done.

And, the client is entitled to competent care. The existence of systematic social work recording provides documentation which may contribute to the assessment of quality of care.

The first ethical statement concerning continuity may be traced to a value premise that the agency gives the service, not the worker. The principle of continuity may be extended beyond one agency, when referral is necessary. Here a proposition may be evolved that referrals backed up by written material are more effective than those lacking written material. The ethical component may be stated in terms of a client's entitlement to effective interagency referrals. The value is the community and professional commitment to providing a network of collaborative, comprehensive services.

The classical work on recording is Gordon Hamilton's Principles of Social Case Recording, originally published in 1936 and revised in 1946. Although considered somewhat out of date for modern use, it did establish the ethic that records are intended primarily to serve the best interests of the client. Her book contains a long chapter on values and recording, entitled "Understanding Must Include Appraising

Social Values," in which she advances the concept of evaluation, as distinct from diagnosis: the worker records judgments about "desirable and undesirable ends, goals or outcomes."³

In Hamilton's Theory and Practice of Social Casework, she summarized very well the knowledge and value justifications of recording:

In all institutional or agency practice the case record assumes great importance in the treatment of the client. This is partly because the factors in the psychosocial problem are extremely complex and it is difficult to recall them accurately and partly because of the group use of the document--more than one worker being involved concurrently or sequentially. In addition, the case record is used for the several purposes of practice, teaching, research, and on the basis of its evidence, may contribute to social planning as problems are understood, described, and classified.⁴

Kadushin cites several empirical studies relevant to recording. A time and cost study indicated that for each dollar spent on interviewing clients, an additional three dollars are spent by agencies on recording,⁵ testifying to the enormous investment in the deployment of resources to recording activity and the clerical supports necessary to sustain it. Several other studies testify to the importance of recording in maintaining competent practice. One by Kogen, as reported by Kadushin, indicates that the principal use of recording "has been in preparation and planning for direct or indirect service to the client."⁶ Another study demonstrates that, "the worker uses the record 'to organize his thinking about the case and to plan future

courses of action. Through reading the record and recording his contacts with the case in the record, the worker organizes his thinking and prepares his plans for the case.'"⁷

Wilson has written a contemporary text on social work recording.⁸ She provides the following list of purposes of recording: documentation of social work activity, continuity of service, payment from third party payers, quality control, statistical reporting, supervisory review, organizing the worker's thoughts, interdisciplinary communication, part of an eligibility requirement, teaching, research, agency defense in legal actions and a therapeutic tool.⁹

Although there is some emerging evidence for the proposition that good recording is related to good practice,¹⁰ there are several problems inherent in the use of the record as the primary means for evaluating quality of care. Donabedian has stated:

When records are available, the major issue then becomes their adequacy as a basis for assessment, and the question most often asked is whether the assessment made is to be of the care actually provided or of the care imperfectly reflected in the written record. There are here two major problems: of completeness and of veracity.¹¹

Records of medical, social work and other health practice often are missing vital data. Recording formats, check lists, and audits are methods used to assure more completeness. However, if all vital areas are covered in a given chart recording, the question still remains as to

whether it accurately reflects what transpired in the case. There are both problems of reliability and validity. Would a series of independent judges view the case in the same way and record it in the same way? Does any given chart communicate the "truth" of what has occurred? Some recordings are poorer than the practice, others are in fact superior to the practice: "It is . . . assumed that, if there are discrepancies, the care provided is probably better than the record would indicate. This may not be the case; and one should entertain the possibility that the record may present too rosy a picture of the actual events."¹²

From the quality assurance perspective, is the quality of the record or the quality of care the object of evaluation? If the former is the case, do workers record to please the auditors? This would suggest the danger of goal displacement in the quality assurance process. The direction for an answer to these questions lies in the establishment of a positive inter-relationship between good recording and good practice. Although the evidence is incomplete, this association is generally assumed by most investigation in the literature. "'Good recording is related to good practice; the relationship is not perfect but statistically significant."¹³ In a study of Freidson, he states:

However short the record may have fallen of being complete . . . it did constitute the only thing in the medical group which was designed to collect and record all medically relevant information on the treatment of every patient. . . . In its systematic

coverage of care, then, the chart recorded an amount of information that surpassed that which any individual physician could have been expected to know or remember. . . . Furthermore, the chart was also objective in the sense that the information was recorded permanently at the time of its collection. . . .

Finally, . . . the chart provided physicians in the medical group with what they themselves considered to be direct evidence of the quality of the work of their colleagues.¹⁴

There are a number of ways being utilized to help assure the adequacy of records. Structural standards, discussed in the previous chapter, play their part by almost always including standards for recording. The Joint Commission on Accreditation of Hospitals (JCAH) has, for example, extensive requirements for maintenance of patient records.¹⁵ Virtually every health and social service organization has established its own outline or check list describing record keeping policies.¹⁶

A number of professionals describe in the literature specialized recording systems. The Problem Oriented Record (P.O.R., sometimes referred to as the Problem Oriented Medical Record--POMR) has become quite popular in recent years.¹⁷ Developed by Week in 1968¹⁸ as a tool of interdisciplinary, concise recording, the problem oriented record is organized around a problem list in which the key medical, social, and/or psychological problems of the patient are identified. Initially established by the primary clinician, the problem list may be added to by other team members. In

a correctly completed problem list, problem areas are clustered and sub-problems identified. For example, "depression" and "poor self-image" ought not to be considered as separate problems. If both are present, most experienced users of POR would list "depression" as the problem, and "poor self-image" would be included as a sub-problem of "depression." All other components of the P.O.R. relate to the problem list. Thus, assessment, treatment plan, progress notes, and conclusion note take as their starting point the various identified problems. Resolved problems may be removed and newly emerging problems added, as a case proceeds.

The P.O.R. has the advantage of a system which encourages interdisciplinary recording.¹⁹ Advocates of the P.O.R., among which are social workers,²⁰ argue that accountability is strengthened and quality of care enhanced by its use. While its systematic nature encourages improved organization of the record, the departure from the traditional narrative runs the risk of losing the sense of the "whole person" and of reducing person to problem. Further,

While the P.O.R. has become a fairly established method of record-keeping there is no body of data examining the usefulness of the P.O.R. in terms of resource allocation, better definitions of the relationships between specific problems, treatments and outcomes, and improved communication between clinicians.²¹

The P.O.R. does not stress a specific identification of goals. Although not widely utilized, there exist goal

oriented recording systems which replace problems with statements of goals of care as the central focus. Advocates of this approach argue that problems stress pathology whereas goals stress client strengths.²² In a particular approach, Goal-Oriented Social Services (G.O.S.S.), client participation in goal setting is encouraged. These approaches are closely allied to goal attainment scaling which is utilized in the project and about which much will be said in subsequent chapters.

A series of empirically oriented recording systems have also been proposed which attempt to structure case recording in such a way that retrieval for research purposes is easily achieved.²³ Closely allied with the movement of empirically oriented practice (see Chapter Four), this approach to recording is designed to encourage " . . . the scientific focus in social work practice. . . ." ²⁴ Urbanowski has commented: "It is difficult to imagine that the profession will ever be able to ascertain, demonstrate, or explain its accomplishments until its system of record-keeping and its recorded content are standardized."²⁵

Since there is an increasing trend toward using recording for other than direct patient care (accountability and research), the issue of confidentiality arises. The new Code of Ethics of the National Association of Social Workers makes explicit in a five item section, the central importance of confidentiality to an ethical practice. The

Code states: "The social worker should inform clients fully about the limits of confidentiality in a given situation, the purposes for which information is obtained, and how it may be used."²⁶ Wilson has published a comprehensive treatment of this complex subject, including an exhaustive bibliography.²⁷

The new directions in recording require an educational strategy for preparing social work students for roles in the health care systems. The literature contains only one item concerned with a systematic curriculum for teaching social work students the new demands of recording in the health system.²⁸ Marshack writes, "Recent rapid changes in the nature and requirements of the health care system have mandated corresponding changes in documentation of social work practice." She goes on " . . . to describe . . . an effort to develop a new format for student recording in health field work agencies."²⁹

B. Auditing and Peer Review

In the assessment of quality of care, some form of surveillance or audit is necessary. Peer review has proven to be the most widespread method of quality assurance in the health care field. However, prior to a discussion of the components and issues of peer review, the primary question, "What is quality," must be examined. This is not an easy task, as Donabedian has stated:

The quality of medical care is extraordinarily difficult to define because one must first indicate what dimensions or aspects of care are subject to consideration and then specify what constitutes 'goodness' or 'badness' with respect to these aspects or dimensions.

The specification of relevant dimensions is a matter of considerable difficulty because medical care comprises a complex set of interactions. These include provider behavior, client behaviors and client-provider interactions. . . . Even more difficult is specifying what 'goodness' is.³⁰

Quality has been viewed as a process which optimizes a patient's welfare, an individualized definition of quality of care, emerging from the perspective of the practitioner and/or patient. However, there are contextual factors, such as costs and availability of resources, and social factors--quality for the poor may be defined differently than for the wealthy. The disparity between individual definitions and social definitions of quality creates moral dilemmas, and raises the issue of equity, the social distribution of quality. Is the practitioner accountable to the patient, the institution or society? Each level may yield a different understanding of what is quality.³¹ Further, " . . . the achievement of quality in one component of care may be associated with a tendency to deterioration in another."³²

According to Donabedian, there are essentially two domains in assessing quality care:

One is that of technical performance. Here, the heart of the matter is the application of medical knowledge and technology in a manner that maximizes

its benefits and minimizes its risks, taking account of the preferences of each patient. The other domain is the management of the personal relationship with the patient in a manner that conforms to ethical requirements, social conventions, and the legitimate expectations and needs of the patient.³³

These two domains may in fact come into conflict with each other. "Is it possible, for example, that technical excellence may tend to be associated with fragmentation and impersonality of care?"³⁴

In spite of the difficulties, complexities, ambiguities, conflicts, and moral dilemmas inherent in attempting to define quality of health care, a variety of definitions may be found in the literature, among them, Lee and Jones: "'Good medical care is the kind of medicine practiced and taught by the recognized leaders of the medical profession at a given time or period of social, cultural, and professional development in a community or population group.'"³⁵

Payne states that quality is " . . . that level of excellence produced and documented in the process of diagnosis and therapy, based on the best knowledge derived from science and the humanities, and which eventuates in the least morbidity and mortality in the population."³⁶

A less general definition which provides direction for the actual process of assessment is,

The term 'quality' implies attributing a standard or level of attainment to a particular characteristic of an individual or organization, whether determined implicitly or explicitly--thus to measure that 'quality of health care' is to develop criteria against which the operation of components of the

health care delivery system may be assessed.³⁷

The above definition leads to a discussion of three central concepts which appear in all of the medical and social work quality assurance literature: criteria, norms and standards. Specific criteria and standards serve to make operative and precise the definition of quality in a given context.

The "official" definition of these terms as provided in the P.S.R.O. Program Manual are:

Criteria--Medical care criteria are predetermined elements against which aspects of the quality of medical service may be compared. They are developed by professionals relying on professional expertise and on the professional literature.

Norms--Medical care appraisal norms are numerical or statistical measures of usual observed performance.

Standards--Standards are professionally developed expressions of the range of acceptable variation from a norm or criterion.³⁸

These terms as defined above appear throughout the literature and have also been adopted by social workers. Donabedian, a leading contributor to quality appraisal literature, is not satisfied with these widely used definitions, and has recently offered a critique and a set of more refined concepts as an alternative. He identified three components of the quality appraisal process. First, phenomena (elements, attributes, characteristics) " . . . must be so clearly defined that we can say with confidence whether they are present or absent."³⁹ Then a general rule must be stated which guides the judgment "as to what

constitutes goodness with respect to each. . . ."40 Finally, there is needed a " . . . numerical statement of what constitutes acceptable or optimal goodness with regard to each of the phenomena under study."41

The phenomena would constitute "criteria." The general rules of what constitutes goodness are "norms." The numerical statements of acceptable goodness are "standards." For example, a phenomenon or element of the process of medical care is the taking of blood pressure (the actual blood pressure reading is an element of outcome). A general rule of what constitutes goodness is that the lowering of abnormally high blood pressure is defined as desirable. A process measurement standard might be that 90% of all adults who see a physician out to have their blood pressure taken; an outcome standard might be " . . . that of a group of younger adult patients with hypertension, 70% should have a diastolic pressure of 90 mms or below within one year of the initiation of therapy."42 This very precise understanding of the nature of criteria, norms and standards is rarely used in medical care assessment, let alone social work quality assurance, but is an important ideal to strive for. Donabedian's concern with the traditional approach to these terms is that they falsely attempt to be neutral: "But the 'norms' as used in this official formulation, do not necessarily have normative force, since they signify neither goodness nor badness, but simply an observed phenomenon."43

Thus, he is clear about the underlying value-based nature of judgment in the quality assessment process. Combining precise definitions and measurements with an openness about the essentially normative and thus value-choice nature of these processes, Donabedian has made a contribution to the field of quality appraisal.

Another issue involves the choice between implicit or explicit criteria when conducting an audit. It is possible and not uncommon for a reviewing health care professional or group to examine records and then to make judgments on quality based on their experience or expertise. The criteria being employed would be implicit. There are obvious reliability problems inherent in this approach.⁴⁴ "Implicit judgments rely on the subjective opinion of the individual judge; no predetermined criteria are used."⁴⁵ A study by Brook and Appel clearly shows the limitations of the use of implicit criteria.⁴⁶ However, the same study demonstrated that explicit criteria yield the harshest judgments--something not necessarily desirable in certain contexts in which quality assurance is already threatening to practitioners.

The social work profession has a long history of attempting to establish criteria and standards of quality practice. As early as the Milford Conference in 1929, it was inevitable that the issues of standards and criteria would arise, as the key question of the conference was

posed: "Are there sufficient commonalities among the various specialties to preserve the idea that all social workers are part of one profession?"⁴⁷ A chapter of the Report of the Conference is devoted to "Standards of Social Case Work Practice." For each field of practice (Family Welfare, Child Welfare, etc.) a set of standards were agreed upon. For example, medical social work:

1. Medical-social diagnosis, based on analysis of inter-relationships, especially causal inter-relationships, between social and health factors in case situations.
2. Interpretation of No. 1 to other agencies and to the patients and the patient groups.
3. Teamwork with physician in medical-social case study and treatment.⁴⁸

The list continues to nine items. They are quite general, and they actually are not standards in Donabedian's sense--they are more statements of phenomena--elements and components which should be identifiable in good practice. In another section of the report entitled "Particularization of the Individual," is contained an explicit and detailed guide to the assessment of individual clients, which could well serve as a guide to the writing of a psycho-social summary, or serve as explicit criteria for the auditing of a chart.⁴⁹ Thus, the accountability-minded profession of social work not only developed models of supervision early in its history, but developed as well a framework for the beginning appraisal of quality of care.

In modern times and especially since the passage of the P.S.R.O. law, there have been many attempts in the social work profession to develop norms, standards and criteria.⁵⁰ In 1979, Claudia J. Coulton reported on a major national study which she had conducted on behalf of the National Association of Social Workers in the quality assurance area. The study addressed among other issues, criteria, defined as " . . . predetermined indicators against which aspects of actual care can be compared to judge their quality."⁵¹ Twenty-seven social work quality assurance programs were surveyed (including Long Island Jewish-Hillside Medical Center). The study established that there was agreement across all programs in the sample on general peer review criteria for the process of social work, as follows:

1. Initial contact
2. Assessment/diagnosis
3. Treatment plan/goal formulation
4. Intervention
5. Termination/outcome⁵²

Each criterion is subdivided into sub-criteria, for example:

2. Assessment/diagnosis
 - a. A psychosocial assessment should be reported for every patient.
 - b. Several areas of functioning should be included in the assessment.
 1. The patients' psychological (cognitive,

affective and attitudinal) characteristics.

2. The patient's environmental (social, cultural, legal, economical, familial and physical) situation.
- c. This assessment should lead to the identification of the problems that are within the capacity and authority of the department.
- d. The patient's perception of the problems to be worked on should be noted.⁵³

It is quite significant that a well designed study such as Coulton's has shown that there is a consensus in social work in health care settings on criteria for peer review. Peer review has been defined as " . . . a continuing monitoring process in which professionals look at the work of their peers, those who are members of the self-same profession."⁵⁴ Four assumptions of peer review have been identified. The first is that good social work practice can be distinguished from bad practice by social workers. The second assumption is that quality of practice can be determined by assessing the recorded chart notation. A third is that social workers can evaluate the practice of their peers. A final assumption is " . . . that professional review is sufficiently valuable to warrant the investment of departmental resources that implementation requires."⁵⁵ These assumptions will be examined further as the discussion proceeds.

A beginning literature has emerged which attempts to inform social workers of the "how to do" of peer review.

A good overview is provided by Chernesky and Young who have identified characteristics and stages of social work peer review systems. Characteristics include

1. determination of the professionally recognized standards of care for acceptable and non-acceptable behavior ,
2. an ongoing and systematic process by which practicing professionals monitor the quality of care given by their colleagues as demonstrated in their chart notation ,
3. compilation of review results to identify patterns of trends in the quality of service provided , and
4. establishment of corrective mechanisms to deal with deficiencies identified. . . . ⁵⁶

Stages or components are: chart retrieval, screening, review, monitoring and feedback,⁵⁷ according to Chernesky and Young. These schemes are quite useful to those social work health care administrators who wish to initiate peer review in their settings. A series of articles focuses on technical aspects of auditing, design of peer review systems and audit instruments.⁵⁸

Several important issues have arisen in the practice of peer review which have been identified in the literature. They may perhaps best be presented in the form of options which an administrator must decide upon when designing a peer review system. Among the options are:

1. implicit vs. explicit criteria,
2. process vs. outcome orientation,
3. generic vs. disease specific vs. social problem criteria,

4. departmental vs. interdisciplinary review

Implicit and explicit criteria have been discussed above, and the outcome question will be the focus of the next chapter. On the issue of generic vs. more specialized protocols, several authors have advocated a specificity of diagnosis approach:

By defining standards according to medical diagnosis, recognition is given to the unique requirement of individuals affected by illness or injury. This then legitimizes the specialization of social work in medical settings and emphasizes the special knowledge required in dealing with patients and families around the stress precipitated by medical problems, injury, or disease.⁵⁹

They present several sample protocols which are quite interesting in their degree of specificity of social work activities. The approach is consistent with P.S.R.O. and interdisciplinary audits, which are disease specific. It can be argued that the themes of social work practice in health care, e.g., loss and grief, adjustment to altered body image " . . . can vary significantly across diagnostic and age groups. . . ."⁶⁰ Helen Rehr has commented: "Although the social work in health concentration in working with patients and families is generally interrelated with the impact of the specific illness, it is not exclusive or discrete to the one disease."⁶¹ She has proposed instead a social problem orientation, which focuses on what social problems worker and client contracted to work on. The approach is also concerned with the question, "Do social worker 'outcomes' vary according to types of psychosocial

problems?"⁶²--an issue which will be explored in the next chapter. The "Social Health Care Evaluation" proposed by Rehr (and utilized at Mount Sinai Hospital Department of Social Work) is a protocol based on a social problem typology. It contains the following general headings (which are then further subdivided): patient functioning, family functioning with relation to patient illness, environmental needs, home care service needs, temporary care needs, long term care needs, and community support needs.⁶³ The social problems approach has great potential for establishing criteria based on what most social workers do most of the time--help clients solve social problems. It also helps social work conceptualize and specify these activities and establish to other disciplines the unique role of social work.

Since there is no clear empirical evidence identifying as more effective generic, diagnostic, or social problem orientation for peer review criteria, social work administrators will continue to choose the approach most suited to their settings and hopefully comparative analysis will eventually determine the most satisfactory approach.

Likewise, the choice must be made between departmental and interdisciplinary review. Advocates of the interdisciplinary approach argue that health care professionals not only need to work together, but they have to evaluate together. Among the benefits are a hoped for greater objectivity

(departmental peer review has been accused of being self serving): an improvement in the interaction of the multi-disciplinary approach; an aid toward the development of interdependent criteria; greater opportunity for criteria to be related to total patient care, and greater opportunity for social work learning through participation in a multi-disciplinary process.⁶⁴ On the other hand, social work might be lost in the midst of interdisciplinary conflicts, the full role and value of social work intervention perhaps not being expressed in the interdepartmental protocol. Some large settings have had the luxury of simultaneously participating in departmental and inter-disciplinary review processes. Further experience, experimentation and analysis are necessary.⁶⁵

Another topic of concern in a discussion of peer review is that of validity and reliability. "Determination of the degree of reliability, validity and bias is an essential element in the development of any instrument for measurement or evaluation."⁶⁶ What has been stated earlier in this regard with respect to recording stands as a fundamental limit in the quality appraisal process. As long as the medical social work record remains the major source of data in assessing the quality of care, validity and reliability cannot be guaranteed.

The most thorough method for the establishment of validity of quality assurance mechanisms is to test them

against the end results of care: "The ultimate validation of any criteria of quality is that care complying with these criteria is more beneficial to patients than care that does not comply with them."⁶⁷ Donabedian has suggested, " . . . that the validity of any given method of assessing quality can be tested against a method believed to be of superior validity."⁶⁸ However, he and others have pointed out that such validation studies are unusual in the field. There is a particular paucity of outcome studies in social work in health care, so that validation against end results is not appropriate at this stage of development in the evaluation field.

An alternative method involves the use of consensus among experts. Coulton's study does establish consensus among leading hospital social work departments on process criteria for peer review (see above). The Society of Hospital Social Work Directors and National Association of Social Workers have achieved agreement on structural criteria. It is clear though, that validity has not been established by empirical method of most audit instruments.

Reliability is likewise compromised. Although many studies of reliability in medical care quality appraisal have been reported, only a minimum of adequacy in inter-rater reliability has been established, while " . . . very little has been reported about the reliability of repeated judgments of quality made by the same person."⁶⁹ Inter-rater

reliability is quite problematic in social work peer review (see Chapter 5) and no studies have yet been reported demonstrating efforts to deal with this issue. It is generally felt in quality assurance as well as in research, that the more explicit and clearly stated the criteria, the greater the reliability of raters. It is clear that much work must be done in this area.

A set of organizational issues also confronts the student of peer review. Peer review attempts to capitalize on the informal, self-regulatory processes of professionals, by formalizing those processes. What then occurs is the bureaucratization of social control,⁷⁰ which has organizational consequences. In Freidson's study of peer review in a medical group, he notes:

Chart review is considered by academics and medical policy-makers to be an essential method of assessing and controlling the quality of medical care, and its presence in a medical institution is considered to mark a high quality of care. Nonetheless, the physicians of the medical group, taken collectively, were quite ambivalent about the evaluation of performance by review of the record, whether performed informally or formally, by peers or seniors, by insiders or outsiders. Indeed, the idea of chart review threatened their most basic conceptions of themselves as physicians.⁷¹

Consequently, there was much resistance and denial of the legitimacy of formal methods of evaluation, even by peers.⁷² "How likely is it that social workers, striving for a professional identity and recognition, would also resent the imposition of mandated review?"⁷³ Roslyn Chernesky

has studied social workers' attitudes toward peer review.⁷⁴ Although social workers are continually exposed to evaluation in supervision, team meetings, and case conferences, the act of evaluating one's colleagues in a peer review system is a conflicted one. Chernesky found in her study a generally positive attitude on the part of social workers toward the idea of peer review, toward the importance of accountability in the health field, and a general belief in the validity of the audit instrument being utilized in the setting in which she conducted her study, as expressing criteria for high quality practice. However, in the auditing process itself, where a judgment of someone else's work is required, anxiety, hesitation and ambivalence became evident. There was " . . . a disparity between staff's support of professional review in principle and their support of it in reality. . . . It is important to appreciate that staff may harbor negative feelings even when their outlook appears favorable."⁷⁵

Chernesky's comparative study of the use of a one session orientation program, a ten session training program, or neither, concluded that social workers can take on the responsibility of reviewing the work of their peers; that attitudes can be positively influenced; and that some form of orientation or training is essential because social workers who do not participate in any preparatory program " . . . grow increasingly negative about professional review

in time."⁷⁶ The most important aspect of training is socialization, to develop identification with auditing as a function of social work, rather than as a separate administrative activity which "they"--the administrators--do to "us"--the workers.

In addition to the organizational costs, there are of course fiscal costs, which must be weighed against benefits. The only social work author to discuss costs of quality assurance is Coulton, who identifies two areas of costs, those of program development and operations. Program development in quality assurance can be quite time consuming and thus costly--some settings take up to two years for the process of organizing planning committees; establishing criteria and instruments; pre-testing; developing a total system including feedback mechanisms; training peer reviewers, and orienting staff. "Cost estimates ranged from \$500 for a small list of peer review criteria to \$100,000 for a complex, extensively tested program. . . ."⁷⁷ Estimates for operational costs are harder to ascertain. "Peer review included costs for personnel to conduct record reviews, examine exceptions, produce reports, and plan and undertake corrective action."⁷⁸ In a sense a whole staff participates in one way or another and at various times in the operation of a peer review system.

What are the benefits of such a potentially large outlay of resources which may take away from direct service

time? In the medical field, Donabedian documents a number of studies which mostly justify costs by demonstrating effectiveness in the improvement of patient care. For example, he writes:

Lembacke has reported on the remarkable immediate effects of an external audit conducted in one hospital. . . . There is a clear, immediate effect. During the first post audit period of thirteen weeks, the number of criticized operations was more than halved. Furthermore, the effect was progressive and sustained. The number of criticized operations during the last two periods combined was almost twelve times less than that during the two pre-audit periods.⁷⁹

In addition to the direct improvement of practitioner performance and patient care, there are indirect benefits in the form of staff education,⁸⁰ planning, organization and administration.⁸¹ Record keeping almost always improves at the very least: " . . . as a result of quality assurance activities, the role of the social worker in the hospital became clearer to both social workers and other professionals. This occurred . . . from improved communication through better recording."⁸²

Thus, although no studies have yet demonstrated the linkage between peer review and outcome, or between structure, process and outcome, there is evidence, both empirical and anecdotal, that the total impact of contemporary accountability systems on the organization and delivery of patient care is positive; and that health care organizations are commonly making the cost investment in such systems because

of the apparent benefits. Peer review remains central to almost all quality assurance programs.

NOTES

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CHAPTER IV

GOAL AND OUTCOME: EFFECTIVENESS AND OUTCOME STUDIES, EMPIRICAL CLINICAL PRACTICE AND GOAL ATTAINMENT SCALING

The recent social work literature on quality assurance in health care settings has been quite critical of the absence of outcome measures in accountability systems. Three approaches to quality assurance have been identified: (1) performance or process evaluation; (2) structure evaluation; and (3) outcome studies, of which two methods may be further distinguished--(a) prospective outcome analysis and (b) retrospective outcome analysis.¹ The three may best be seen as components of one system, because outcome in isolation from process leads to a reductionist input/output formulation. Process accountability in the absence of outcome measures only requires that social work intervention activities meet certain standards and does not examine whether contractual arrangements with clients have been fulfilled in the attainment of ends. Finally, both process and outcome in isolation from structural accountability ignores the critical roles, functions and responsibilities of both the agency and of community resources

in meeting human needs.

Helen Rehr has been a consistent advocate of the development of linkages between process and outcome in social work assessment.² She distinguishes between "performance accountability" which is concerned with process-- "a sequence of acts, or interventions, in the delivery of care;" and "outcome accountability": "Outcome is the result of a case. It is what happened to the patient."³ Other social workers and health care professionals have also recommended the inclusion of outcome measurement in accountability systems.⁴ Newman and Turem have written:

If credible professional accountability is to occur, casework and group work must be viewed as inputs that may or may not reduce the incidence of definable social problems, and the profession must develop a new orientation based on outputs that can be measured objectively.⁵

And Brook and Appel have stated: "Few evaluative studies have used information about the end results of care, even though the purpose of medical care is to maintain or improve health, and it therefore seems logical to evaluate care in terms of how well this objective is achieved."⁶

Among the uses of end-result appraisal are the monitoring of program quality, demonstrating program effectiveness and aiding administrative and clinical decision-making.⁷ The advantages of outcome measures as indicators of quality of care, are, according to Donabedian: (1) their seldom questioned degree of face validity; (2) their

integrative function, that is their ability to summarize the net effect of many complex processes and operations; (3) their innovative function--they often raise questions which can lead to change; and (4) their tendency to be concrete and thus easy to measure.⁸

Not all authors are enthusiastic about an outcome approach to accountability.⁹ Charles Levy expresses concerns that in stressing certain global, societally desirable outcomes, such as reducing public assistance roles or eliminating juvenile delinquency, social work will be set up for failure, because of the lack of necessary resources, skills and mandates. He warns us:

Before outcomes can even be estimated let alone appraised, a determination must be made regarding who wants them . . .; how valid they were in relation to clients' needs and social work's function; and what the propriety and prospects for movement in any given direction were when the social work service was requested or initiated.¹⁰

In addition, Hartman thinks that, " . . . the attempt to limit and control social work and other inputs in order to test their effects tends to narrow the definition of practice and rule out both extended action and extended client system models."¹¹

These objections should be taken seriously in the attempt to develop refined outcome measures, rather than rejecting outcome-oriented social work evaluation altogether. The systems model ground for rejecting outcome

measures begs the question. Throughout all systems, social as well as biological, task accomplishment continually takes place. The argument that social work clients are subject to complex environmental processes in no way eliminates the need to specify and measure task accomplishment within the many sub-systems of the human service ecology. It is time that methods be developed to insure the professional's fulfillment of his/her terms of the contract: the resolution of clients' problems, the achievement of mutually agreed upon goals.

However, in order to achieve this, the methodological limitations inherent in outcome study designs must be examined, and taken into consideration. Donabedian, a firm advocate of the outcome approach, has identified the following limitations: (1) outcome cannot easily be attributed to the process of care because of the multiplicity of factors involved in medical care as well as patient characteristics and environmental influences (confounding variables); (2) outcome standards are not easy to specify; (3) the longitudinal nature of some outcomes--positive results may not appear until years after intervention; (4) end results are not always concrete and easy to measure; (5) cultural differences may cause variable interpretation of the validity of outcome; and (6) the need for selecting and limiting the expectations of an outcome indicator to one relevant to reality.¹²

The most thorough-going analysis of the limitations of outcome-study methodology is provided by McAuliffe.¹³ In summary, he states that, (1) advocacy of the outcome approach was based primarily on theoretical rather than empirical grounds; (2) quality of care may be more directly measured by process--outcome is a less direct measure; (3) outcome measures do not have the face validity which their adherents claim for them; (4) "Factors unrelated to the medical care system accounted for substantial proportions of outcome variance . . .;"¹⁴ (5) little empirical validation exists for outcome measurement; (6) "Outcome assessment is not an adequate regulatory solution when medical knowledge is inadequate."¹⁵

It must be pointed out that the outcome indicators for which Donabedian has defined the limits and of which McAuliffe has challenged the foundations, are broad health status end-results such as mortality and morbidity. There is a more incremental approach to be discussed below and to be utilized in this project, based on an assessment of more narrowly defined goals and more short term client changes. This approach, which attempts to measure client specific goal attainment, may escape some of the harsher methodological criticism, simply because its claims are much smaller. Also, as McAuliffe himself points out, there are major differences between "correlation in an experiment (indicating causality) and a correlation in a

descriptive audit."¹⁶ Nevertheless, these criticisms must be integrated into an overall discussion of the value of outcome assessment.

The general approach to dealing with these criticisms, beyond maximizing the quality of particular outcome study designs, involves placing outcome measures in a broader context. Outcome should be one component of a comprehensive accountability system which takes into account structure, process, community norms, community resources, and individual client characteristics. Several authors have argued for such a multifaceted data source approach.¹⁷ Coulton, for example, recommends the following components for comprehensive and systematic assessment of social work care in health settings: a patient/provider information system, a peer review system, patient's characteristics, patient's problems, services received, patient outcome.¹⁸

There are a variety of approaches to outcome assessment, which shall now be reviewed. Coulton and Solomon have provided a useful classification scheme based on the following variables: individualized versus generalized measures, anchored versus unanchored measures, and the degree-of-specificity.¹⁹ Regarding the first issue they write: "Individualized scales are designed so they can be customized to fit each client. They are based on the assumption that the desired outcome of intervention is unique for each client."²⁰ Generalized scales assume that desired

results are the same for all clients and employ the same criteria to assess all. Although these authors do not employ the vocabulary, they are really talking about a central issue in psychological measurement often referred to in the literature as the idiographic versus nomothetic point of view. The idiographic approach holds "that the individual's personality is to be understood and measured only in terms of himself--the unique constellation of his history, his behaviors, his values. . . ." By contrast, the nomothetic approach stresses "the development of general laws of personality--that individual characteristics can be applied to populations of individuals."²¹ Although both idiographic and nomothetic generated knowledge are essential in research and evaluation, "the scientist usually focuses on establishing nomothetical propositions . . . whereas the practitioner most often attempts to establish idiographical propositions."²²

The anchored versus unanchored dimension essentially deals with whether a scale contains specific behavioral referents, descriptions, or case vignettes characterizing each point on the scale. Unanchored scales only use such descriptions as more, less, a little, etc. Degree of specificity refers to whether a scale is capable of expressing separate scores for several components of a complex concept or whether all factors are reduced to a single, unidimensional score. By using these dimensions,

a typology of eight outcome scales is developed by Coulton and Solomon.²³

The oldest kinds of outcome research predate the modern age of accountability. In medicine, clinical trials were (and still are) concerned with the effects of various treatments. Epidemiology studies the influence of environment and lifestyles on health status. In psychotherapy and casework, classical experimental designs have been used for many years to determine effectiveness.

"Since the early 1930's many studies have attempted to evaluate the outcome of psychotherapy. . . ." ²⁴ The most well known of the earlier psychotherapy effectiveness studies was conducted by Eysenck who concluded in 1952:

In general, certain conclusions are possible from these data. They fail to prove that psychotherapy, Freudian or otherwise, facilitates the recovery of neurotic patients. They show that roughly two-thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, whether they are treated by means of psychotherapy or not. This figure appears to be remarkably stable from one investigation to another. . . . The figures fail to support the hypothesis that psychotherapy facilitates recovery from neurotic disorders.²⁵

Ever since, a literature has grown reaffirming, revising or challenging Eysenck's initial conclusions. After many studies of studies and numerous new research findings, data are still inclusive as to the effectiveness of psychotherapy, although there is a trend toward a

relatively more positive view of effectiveness, particularly when the behavioral therapies are involved, because of their goal-specific, concrete nature allowing for easier and more reliable measurement.²⁶

There is an almost parallel development in the history of social casework effectiveness studies, with earlier pronouncements of failure, later considerable controversy, and recent claims of effectiveness, especially in the behavioral, short-term, and task-centered modalities.²⁷ A central figure in the ongoing debates in the literature is Joel Fischer, who wrote in 1971:

This issue of outcome--or success in validating effectiveness with clients--is second to none in the evaluation of a clinical theory of individual change. Presumably, a search for the most effective means of providing help to clients is the raison d'etre for the development of a theory of therapy. . . .²⁸

In 1973 he published his well known and highly controversial "Is Casework Effective?" in which he concluded, after a review of the research literature, "that at present lack of evidence of the effectiveness of professional casework is the rule rather than the exception."²⁹ By the late 1970's, his articles and books have indicated that certain kinds of casework, especially behaviorally oriented practice, are effective. This has not settled the question, because behavior therapy was created by research oriented practitioners and is often designed from the beginning to be measurable in traditional research terms. The challenge

still remains of developing outcome instruments which are not dependent on particular schools of practice.

In reaction to Fischer's work and to the tradition of effectiveness research, Wood has written, in her study of studies: "The basic assumption of this paper is that . . . attempting to find global answers to global questions such as whether casework is effective makes little sense as a research endeavor in itself."³⁰ Instead she argues for a much sharper and more concrete focus which would be useful to practitioners. In the effectiveness research, the designs have been experimental, often attempting to emulate laboratory-like conditions, and have often dealt with theoretical issues.

Among the simpler forms of outcome studies in the health and social work field, but one which has promise of providing immediate and useful clinical and programmatic feedback, is the client satisfaction survey.³¹ Based on the premise that the client or patient is a consumer of social services whose views about the service should be taken seriously by clinicians and administrators, the satisfaction survey often explores the following areas:

(1) the client's perception of his own social needs during . . . illness, (2) the client's initial expectations of the social worker, (3) the services the client believed he actually received, and (4) whether the client was satisfied with the help.³²

Funch and Marshall reported that 94 percent of

patients surveyed in an outcome/satisfaction study "were glad to have participated and 58 percent felt they had received some personal benefit."³³ Clients often feel positively about follow-up interviews because they perceive the hospital as caring about what happens to them once they leave. Ogren, however, warns of methodological problems in such studies, especially sample bias from self-selection of patients with strong opinions (either negative or positive) who may receive a gain from investing their time.³⁴ In spite of these difficulties, health professionals are becoming increasingly sensitive to the need to ask consumers about their perceptions of services rendered. Clients are continually making judgments anyway, in the form of the decision of whether to return or whether to recommend others to the agency.³⁵ It is important to the accountability process to document their reasons for such decisions.

Client satisfaction measurement provides only one perspective or one component of outcome. The component is attitude toward the service. Satisfaction surveys in themselves rarely also address objective measurement of changes in behavior, symptoms, functioning, and health status. The perspective is the crucial one of the client, however, the options of vantage point in outcome measurement include as well the therapist, an independent judge and significant others in the client's life. Another more

global level of outcome may be measured in the social or community sphere--epidemiological studies of incidence or prevalence of disease in the population. Outcome is a complex construct which includes "the initial personal characteristics of the clients, the type of . . . intervention employed, and . . . environmental factors."³⁶ The choice of instruments is yet another variable, which focuses on the question of what is to be measured to assess outcome.

The generalized, global, or nomothetic approach to outcome measurement will now be reviewed. At the most global level--usually national in scope, is the health indicator approach to outcome.³⁷ "Measures that are frequently used as indicators of health status include the prevalence or incidence of conditions, the percent of the population with various degrees of limited activity or mobility, . . . the number of restricted activity days (bed days, school-loss and work-loss days) per person per year,"³⁸ and mortality rates. These measures are of questionable validity of true health status and sometimes are inversely related to each other, for example, a lower mortality rate is often associated with an increase in disability or activity restriction rates.³⁹ (Those who survive because of advanced bio-medical technology lower the mortality rate but increase the other indices.) Further, there is an unresolved conflict in the literature:

Wilson states that, "there is a need for indicators of health that are sensitive to medical intervention;"⁴⁰ whereas Starfield's view is that "a scheme for evaluating outcome should not be restricted to specific medical diagnoses. For the same reason, it should be independent of specific medical therapies. . . ."⁴¹ Brook in medical care and Ferguson, et al. in social work are advocates of a linkage between diagnostic category and outcome assessment.⁴² For purposes of health care accountability at the level of the delivery system, it seems reasonable to at least design outcome measurement to be sensitive to intervention; the more global, intervention-free approach seems more appropriate to social policy and political decision-making. At the level of the local community, a variant of the indicator model, profile analysis, may be utilized to compare estimates of need with actual utilization of service. Over time, as need declines and utilization increases, inferences may be made about impact. Such data must be useful to local community health planners and administrators.⁴³

The most well known and best validated nomothetic outcome instruments may be found in the mental health field, where there is a long tradition of psychometric study. Among these tests are instruments for,

- (1) pre-post, single, global ratings of the client's 'overall level of functioning;' (2) pre-post, more comprehensive, multiple

ratings of the client's 'symptoms;' (3)
pre-post, multiple ratings of the client's
'personal, social and community adjust-
ment.' . . .⁴⁴

Some of the instruments include: The Brief Psychiatric Rating Scale, the Inpatient Multidimensional Psychiatric Scale, the Symptom Check List (SCL-90), the Levels of Functioning Scale, the Global Assessment Scale, the Katz Adjustment Scale, the Personal Adjustment and Rate Skill Scale, the Target Complaint Measure, the Interpersonal Discrimination Test and the Minnesota Multiphasic Personality Inventory.⁴⁵ The field of mental health after-care⁴⁶ and deinstitutionalization⁴⁷ present special problems in outcome evaluation. Traditionally, recidivism or re-hospitalization has been used as an outcome measure for inpatient psychiatric care, however, several authors have pointed out the fallacy of this and the complexity of community adjustment of ex-psychiatric inpatients.⁴⁸ There are those in the mental health field who challenge the whole idea of standardized tests on the grounds that standard knowledge of the nature of mental health and illness do not yet exist, and that definitions of these concepts are closely related to local and differing community norms and values. Those who share this view, yet are not willing to completely give up the nomothetic stance, have developed several instruments which have a general structure but can be adjusted to local norms⁴⁹ . . . the outcome of treatment should be determined by and

measured against empirically derived norms which are representative of the actual functioning levels of people in the communities where the services are rendered."⁵⁰

Social workers involved in mental health settings may find any of a number of these psychometric tests useful in measuring outcome of practice, however, in medical and other health settings, these instruments are not useful and were not designed to measure the kinds of concrete service delivery and psychosocial adjustment to physical illness which medical social workers deal with. There are very few nomothetic-style instruments described in the literature appropriate to social health practice. Spano and Lund have proposed a standardized psychosocial problem list but have not yet linked it systematically to outcome.⁵¹ Berkman and Rehr have developed and subjected to a large scale validation study the "Berkman-Rehr Classification of Psychosocial Problems and Outcomes."⁵² The instrument has been used by over 500 social workers in fifty hospitals. In the validation study,

Three hundred and forty-three randomly selected clients of 152 social workers served as external sources to determine the validity of the instrument. In 77 percent of the problems, social workers and clients agreed on the nature of the problem dealt with during intervention. However, workers tended to give more negative values to their assessments of outcome of intervention than did their clients.⁵³

The instrument lists thirty-one psychosocial

problems commonly found in inpatient medical social work services, for example,

- 3. Coping with grief reaction and bereavement. . . .
- 7. Family members need help in coping with patient's needs.
- 8. Financial needs. . . .
- 17. Long term institutional care needed.⁵⁴

To the right of each problem area are a series of ratings for outcome, divided into, I Problem Status and II Outside Resource Referral Status. The choices for Problem Status are: "A. Resolved, B. Improved, C. Situation Unchanged, D. Situation Worsened." The Resource Referral section contains six choices such as "Resource Not Needed," "No Resource Available," "Patient and/or Family Refuses Resources."⁵⁵ Berkman and Rehr have provided the first real effort to standardize psychosocial health problem/outcome. Their validation between worker and client of 77% agreement on problem is a promising start. However, the total average of 57 percent agreement on outcome is disappointing, but understandable. Utilizing the Coulton and Solomon classification of outcome instruments, the Berkman and Rehr instrument may be classified as "un-anchored," because specific behavioral referents are not used in the rating scale. This compromises both validity and reliability. The difference between problem "resolved" and "improved" has much vagueness and ambiguity, for example.

Further, there was 23% disagreement between worker and client on problem definition, because 31 problem areas cannot possibly capture the unique constellation of all possible psychosocial problems encountered in acute hospital settings. Today's hospitals also tend to be multi-service centers offering an array of services such as home care, hospice, substance abuse, psychiatric, on an inpatient as well as ambulatory basis. The Berkman/Rehr instrument is limited to inpatient care and is thus not appropriate for use in a single accountability system encompassing many different medical/social services.

This leads to a discussion of individualized or idiographic approaches to outcome assessment. Such methods were developed early in the history of the study of human behavior. For example Freud, who certainly was seeking nomothetic knowledge, nevertheless employed individual case studies as his primary method of research. And Maslow said,

Just as all trees need sun, water, and foods from the environment, so do all people need safety, love and status from their environment. However, in both cases this is just where real development of individuality can begin, for once satiated with these elementary, species-wide necessities, each tree and each person proceeds to develop in his own style, uniquely, using these necessities for his own private purposes.⁵⁶

The contemporary popularity of the individualized approach may be traced to the frustrations of researchers

in arriving at conclusive evidence of effectiveness of treatment, through experimental, nomothetic designs. Bergin, who was previously cited with respect to the inconclusiveness of psychotherapy effectiveness research has stated:

I seriously doubt that there is any point in doing more of the kind of outcome research that has typically been done or that has been described in the articles cited above. . . . I believe that the present review has made it quite clear that gross tests of the effects of therapy are obsolete. . . . The possibility of tailoring change criteria to each individual in therapy is being mentioned with increasing frequency, and the idea offers intriguing alternatives for resolving several recalcitrant dilemmas in measuring change. This notion strongly supports the development of a general trend toward specific rather than global improvement indices.⁵⁷

Others in social work have made similar points.⁵⁸ In fact, several recent articles in the social work literature have challenged traditional research on philosophical, or epistemological grounds.⁵⁹ For example, Rein and White have asked, "What if . . . the role of the social sciences is to make contextual knowledge--knowledge about events that is not timeless and spaceless and personless but that, instead, unfolds the present and future possibilities of specific settings of human action?"⁶⁰ These articles attempt to establish the theoretical foundation for two important and related trends in contemporary social work research--single subject designs and what has come to be called "empirically oriented practice."

Believing, with Ford and Urban, that "only with a representation of the laws specific to the behavior of the particular subject himself could understanding and prediction of individual behavior become possible,"⁶¹ the advocates of single subject designs have proposed methods which allow practitioners to monitor and measure the effectiveness of their interventions with clients on a case by case basis.⁶²

This approach focuses on changes in a patient's behavior over a fixed period of time. Reliable methods of measuring these behavioral changes must be selected and first applied to gather baseline (i.e., pre-treatment) data over a short period of time. As social work intervention is carried out, progress is monitored; after treatment, outcome behaviors are assessed.⁶³

The quasi-experimental, interrupted time series designs, as described by Campbell and Stanley,⁶⁴ provide the foundation for single-subject research (also known as "N of 1 studies"). Single-subject research,

. . . can be used by every practitioner with each case, is designed by the practitioner to be used for the practitioner's and client's benefit, provides crucial information to help in assessing the case or situation, allows monitoring of progress with all cases, can provide feedback about whether or not the intervention program is working, allows the practitioner to make changes in the intervention program if it does not appear to be working, focuses on the individual or individual system so that variations in effects of intervention can be seen from individual to individual and provides a format for establishing accountability to clients, agencies, and community.⁶⁵

Growing out of and encompassing the "N of 1" movement, but in some ways going beyond it, is the movement for empirically oriented practice.⁶⁶ Since some modifications in practice are necessary to successfully carry out single-subject studies, advocates of empirical clinical practice have suggested that practice be re-structured in such a way that it is more easily researchable. Stressing the similarities between the phases of good practice and the steps of research, they feel that not only does empirical practice enhance research, but practice as well. Jayaratne and Levy have written a most articulate and comprehensible book on this approach. They present an integrated treatment/research model as follows:

- Step 1: Formulating the problem
 General activity:
 Identifying the presenting
 problem and specifying the
 goals of intervention. . . .
- Step 2: Designing the study
 General activity:
 Determining the intervention
 strategy and ways to measure the
 effect of intervention. . . .
- Step 3: Putting the plan into operation
 General activity:
 Implementing the intervention
 strategy according to plan and
 facilitating its effect. . . .
- Steps 4 Collecting and analyzing
 and 5: the data
 General activity:
 Collecting and tabulating or
 graphing the incidents of
 target problem or goal. . . .

Step 6: Drawing conclusions

General activity:

On the basis of the obtained data, determining if the intervention had any effect. . . .

Step 7: Presenting the results

General activity:

Displaying the results in a manner that communicates the impact of intervention. . . .⁶⁷

The authors indicate that these steps are analogous to those of most intervention programs--presentation of results, for example, would be equivalent to case recording in practice situations. The key to this approach "is a requirement that intervention objectives and practice methods be defined and measured empirically."⁶⁸

Hudson has gone so far as to maintain that the following two statements are "first axioms of treatment":

The first states: 'If you cannot measure the client's problem, it does not exist.'
The second, a corollary of the first, states: 'If you cannot measure the client's problem, you cannot treat it.' Since these axioms are stated as universal propositions, they may be refuted by citing only one concrete exception. Everyone is invited to find and cite such exceptions.⁶⁹

There are critics of empirically-oriented practice who feel that such models are narrow and, in contrast to Hudson's view exclude the unmeasurable which may in fact be valuable. Haselkorn points out that clients bring nebulous problems to treatment; goals may emerge as the process of helping advances. Goals related to personal discomfort tend to resist specification. Some goals are

potentials not directly aimed at--by-products.⁷¹ In spite of such reservations, the development of single-subject research and empirical clinical practice are significant advances in the quest to measure outcome. They have the advantage of placing in every practitioner's hand a tool, if an imperfect one, to evaluate effectiveness.

An earlier form of this, identified with a particular school of intervention, is task-centered casework.⁷² In an effort to develop methods of short-term casework treatment which necessarily involves high specification of goals, tasks, and intervention, Reid and Epstein also realized the measurability of such techniques; "the close tie between practice and research. . . ." In their framework, "a task not properly formulated not only constituted poor data but also questionable practice."⁷³ In conjunction with their method, the Task Achievement Scale was constructed, an idiographic outcome instrument.⁷⁴ However, the instrument is specific to the method of intervention. If practitioners reject the treatment technique, the instrument is useless. Task-centered casework has been criticized for stressing structure, specificity, and practitioner-client congruence, at the expense of communication, relationship and empathy skills.⁷⁵ It is just such narrowness and rigidity that have caused critics to reject empirical practice. Nevertheless, Reid and Epstein must be given credit for pioneering a research oriented practice.

As empirical practice is more widely used, researched, and refined, it has considerable potential.

Central to all forms of idiographic research and empirically oriented practice is the careful attention to identifying, specifying and operationalizing in measurable terms, the goals of intervention. The discussion of goals that follows will serve as a preface to a presentation of goal attainment scaling, the idiographic outcome measurement instrument employed in this project.

Philosophers through the ages as well as the twentieth century behavioral scientists and psychotherapists have understood goal-directed behavior to be central to the human experience. Maslow wrote: "Goal-directed, motivated, coping, striving, purposeful action is an aspect or by-product of the necessary transaction between a psyche and a non-psychic world."⁷⁶ Ford and Urban, in their comprehensive comparative study of all the major systems of psychotherapy, ask, among the first questions for each system, "Who determines these goals?" and what are the "characteristics of the goals?" Thus, the goals of therapy are a major criterion in their analysis.⁷⁷

In social casework, the goals of treatment have also been of central concern. Helen Harris Perlman has identified goal formulation as a major step in the problem solving process. From the writings of philosopher John Dewey, she formulated the following orderly procedures in

problem solving:

1. The facts constituting the problem must be known.
2. The facts must be understood, that is, they must be seen into in several ways: in their single significance; in relation to one another and their composite meaning; and in relation to the solution that is being sought. These constitute ideas about the facts.
3. Some conscious choice of action must be selected as conclusion and then tested for its validity by experimentation or reconsideration.⁷⁸

The third element above, "choice of action . . . as conclusion," is the goal/outcome component. In another work, she anticipated by eleven years goal attainment scaling:

. . . the goal with each single client must evolve out of the realistic diagnosis of his problem and his internal and external solution means. . . . Such estimation of goal must be considered by a kind of slide measure, susceptible to extension or contraction, scaled on the one edge for what is desirable and on the other for what is possible.⁷⁹

Another leading social work theoretician, Florence Hollis, writing from a psychoanalytic perspective, also stressed the importance of goal identification and specification in casework.⁸⁰

Several authors in the contemporary literature have been critical of the state of the art of goal formulation in practice.⁸¹ Reid identified three inter-related problems in goal formulation, overgenerality, overambitiousness, and drift. "It appeared . . . that the root

source of the difficulty was the overgenerality of the goals, which in turn, led to unrealistic aspirations and to repeated shifts in direction."⁸² Some empirical studies have linked good goal formulation with more effective treatment.⁸³

The issue of goals raises the question of who sets them. Mutuality of goal selection is often seen as desirable. The contract between worker and client around problem focus, goal selection and treatment plans has had a central place in social work tradition: the maximization of client participation in the helping process. Contracting has again become the focus of the human service professions. An emerging literature links the presence of mutual agreement and contracting with improved effectiveness.⁸⁴ A recent study in outpatient medical care concluded "that practitioner-patient agreement about problems is associated with greater expectations for improvement and with better outcome. . . ."⁸⁵ Although most authors agree that "mutual agreement between worker and client concerning the nature and course of interaction is an essential component of practice,"⁸⁶ some have correctly warned that the contract is an ideal which often is not fully realized.⁸⁷

Goals (hopefully mutually agreed upon) have been recommended not only because their careful specification appears to enhance effectiveness, but also because they may

be used as standards against which to measure outcome.⁸⁸ Goals are closely linked to outcome measures because goals seek to achieve some degree of predictive accuracy in the attainment of ends. Goals are the anticipated, desired ends in the social work process. Fischer has written:

In actual practice, general goals must be translated into specific behavioral objectives for each client. . . . This kind of specification permits the development of distinct outcome measures for evaluative purposes.⁸⁹

A measurement instrument has been developed which precisely utilizes goals as outcomes: goal attainment scaling. Several social work authors concerned with outcome measurement have recommended the adaptation of this method to social work in health care⁹⁰--the method was initially designed for use in community mental health centers. In spite of the enthusiasm for goal attainment scaling by social workers, there are no reports in the literature of its actual use or of findings of empirical studies based on its use in social work practice.

Although the idea of measuring individual goal attainment was reported in the literature prior to 1968,⁹¹ the technique of goal attainment scaling was first introduced by Thomas J. Kiresuk and Robert E. Sherman in their article, "Goal Attainment Scaling: A General Method for Evaluating Community Health Programs," based on work which the authors had conducted at the Hennepin County Mental

Health Center in Minneapolis, Minnesota.⁹² As of 1978, a published bibliography on goal attainment scaling listed over two hundred citations.⁹³

Several factors led to the development of the technique. The great expansion of community mental health centers brought about innovation and diversification of the treatment modalities and underlying theories of mental health and mental illness. Psychotherapy itself became a multi-professional affair, and therapeutic roles for para-professionals evolved as well. The philosophical mandate of community mental health brought about an inclusion into the definitions of target population, the full demographic range of the American community. At the same time, government agencies responsible for funding made greater demands for accountability through program evaluation.

Kiresuk wrote:

In our outpatient therapy unit, for instance, there are patients of both sexes, of varying marital status, ages ranging from 10 to 30, education level ranging from less than eighth grade to Ph.D. candidate. The use of the same psychometric or rating device for all patients inevitably led to evaluating some patients on variables that were irrelevant to their particular dilemma or circumstances. . . . To rate all patients with regard to their anxiety level, sexual problems, and thought disorders, whether or not these variables had anything to do with the patient's reasons for coming to the clinic appears to be unreasonable and wasteful.⁹⁴

The underlying philosophical/psychological premise of goal attainment scaling is that a human being "is trying to get at something. Knowing what that something is and studying the means by which it is gotten or striven for, constitute central issues for measurement."⁹⁵ Goal attainment scaling attempts to preserve "the idiosyncratic goals that are established for each client, . . . but at the same time provide data that would be used in comparing programs."⁹⁶

Goals are selected by a rater, goal selection committee, therapist, or patient, or a combination of these. Each goal is scaled on a scale of five, from plus two to minus two. For each point on the scale, expected outcomes are operationalized, indicating behavioral referents of degree of attainment of the goal. The zero point is the expected level of treatment outcome. Minus two represents the most unfavorable treatment outcome thought likely; minus one, less than expected outcome. Plus two represents the best anticipated treatment outcome; plus one more than expected outcome. A determination is made at intake of which point on the scale a patient's behavior should be rated for each goal, and then measurements may be taken at points during treatment, at termination and during a post treatment follow-up period. The choices of subsequent follow-up measurement beyond intake depend on the particular purpose and design of evaluation utilizing goal attainment

scaling.

Since more than one goal is usually expected for each client, weights may be assigned to each goal. A formula was developed for derivation of the standardized composite goal attainment score, which is essentially a technical refinement of a simple weighted average.

The result is a pre-specified judgmental transformation of the set of possible outcomes of therapy (or any activity it is applied to) into an approximate standard score (that is one with an expected value of 50 and standard deviation of 10), intended to measure the success of the activity.⁹⁷

Goal attainment scaling has the advantage over most other forms of empirical clinical practice of great versatility. Since almost all approaches to social work and almost all schools of psychotherapy agree that goal specification is an important if not crucial step, goal attainment scaling contributes to most methods but does not alter them. It can offer idiographic outcome scores which may be used in the aggregate for program-wide evaluation. All methodological considerations and issues of reliability and validity with respect to goal attainment scaling will be discussed in the following chapter on design.

This chapter has reviewed the outcome dimension in accountability and quality assurance. In summary and conclusion, Rehr has written:

Applied studies are the sine qua non of professional accountability for achieving both quantity and quality assurance. This means that a professional social worker is committed first to constant self-assessment of his practice so that it can change and grow, and then to peer review and to program assessment within standards professionally determined. Measures of outcome are essential to achieve these purposes.⁹⁸

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PART TWO

THE PROJECT

CHAPTER V

SETTING AND DESIGN

I. SETTING

The setting for this project was the Long Island Jewish-Hillside Medical Center (LIJ-HMC). The Long Island Jewish-Hillside Medical Center/Queens Hospital Center Clinical Campus is one campus composed of two Medical Centers covering the north shore of Long Island in Queens and Nassau Counties. LIJ-HMC is a non-profit 693-bed teaching hospital on a 48-acre site in New Hyde Park, located on the boundary of Queens and Nassau Counties. This portion of the campus consists of a 490-bed general hospital--the L.I.J. Division--in which this project was executed; and a 203-bed psychiatric hospital--the Hillside Division. The L.I.J. Division (general care) has 23,000 inpatient, 46,800 emergency, and 38,000 outpatient visits annually. The Hillside Division (psychiatric) has 1,400 admissions and 91,000 outpatient visits per year.

Under a contractual affiliation initiated in 1964 at the request of the City of New York, and presently continuing with the New York City Health and Hospitals Corporation, LIJ-HMC has assumed additional responsibility for planning, organization and delivery of all professional

health services, except nursing, at the Queens Hospital Center (Q.H.C.). The Q.H.C. is a 750-bed municipal facility centrally situated within New York City's Borough of Queens. Located on a 20-acre site in Jamaica, the Center is the Borough's largest medical care facility with nearly 3,300 health professionals employed to deal with 15,000 inpatient admissions; 105,000 emergency room visits, and 189,000 outpatient visits annually.

In addition to patient care, research and education are priorities in the mission of LIJ-HMC. There are many medical research programs in progress in various departments of the LIJ-HMC. Since its inception, LIJ-HMC has had significant involvement in the education of new generations of health professionals. An extensive series of continuing education programs is also conducted. In a single academic year nearly 1,600 physicians, dentists, nurses, social workers, and other health professionals from over twenty states and several foreign countries attend courses offered by the clinical campus.

The Department of Social Work Services has a staff of about 300 social workers, 85% of whom have MSW degrees: approximately 140 in the Hillside Division, 100 in Q.H.C., 40 in the L.I.J. Division, and 25 in Substance Abuse Programs. The Department is very active in all aspects of the various programs in all Divisions. The orientation manual for new staff contains the following statement of

philosophy and goals:

The Social Work Services Department, functioning as an integral part of the health care program, provides services to help patients and families who come for health and mental health services to LIJ-HMC.

1. To treat their complex psychosocial problems through social work methodology.
2. To improve their capacity to cope with crises, and their life functioning.
3. To work with other disciplines through the team approach in order to ensure comprehensive and integrated treatment plans for patients and their families.
4. To assist the hospital in giving better patient care through its various services by involving patients and families in participating in their medical care.
5. To enlist, coordinate and collaborate with whatever appropriate community resources exist in their behalf.
6. To encourage and advocate for the development of new programs and resources for patients and their families.
7. To develop new research and evaluative instruments which will lead to better service delivery.
8. To develop quality educational programs for social work students as our commitment to the profession and patient care.
9. To develop inservice training programs for staff in order to ensure ongoing improvement in patient care.
10. To organize, develop and supervise groups of volunteers that meet the needs of patients within the services of the Medical Center.
11. To develop continuing education seminars and workshops for the professional community in order to expand our knowledge base for helping patients and their families.

It is interesting to note that quality assurance is part of the Department's mission as expressed in Goal 7, "To develop new research and evaluative instruments which will lead towards better service delivery."

The social workers in the L.I.J. Division provide social services on a wide variety of inpatient, ambulatory and satellite medical services. A description will now be provided of the social work role only on those services which were involved in the implementation of this project.

(1) Medical/Surgical -- Approximately 280 beds are used for patients in need of acute care or treatment of serious and complicated medical/surgical conditions. Social workers offer individual, group and family counseling; referral, discharge and post hospital services. These services are generally brief and crisis-oriented, particularly in light of the pressure for shortened bed days to ensure efficient bed utilization. Longer term counseling may occasionally be provided. Team rounds are held on all services at least weekly with physician, nurse, home care and social worker.

(2) Pediatric and Adolescent Services -- There are fifty-five beds on the Pediatric Service and eighteen on the Adolescent Service. Social work staff are expected to maintain close and responsible relationships with the entire family, as the child is medically treated as part of the family unit. In addition, family situations are

evaluated in terms of what further services may be needed, such as referrals to psychiatric clinics, Bureau of Child Welfare, protective services or other community resources. Weekly social work rounds occur in which treatment plans are discussed with other disciplines for more effective coordinated patient care services.

(3) Neonatal -- Social work staff provide support services to the families of 35-40 premature and acutely ill infants as needed. The crucial task is the evaluation and assessment of the home situation, so that appropriate referral and discharge planning can be effected.

(4) Home Care -- The Home Care Department provides medical, nursing and social services for persons sixty and over who need home health supports. Referrals are received from staff attending patients in-house as well as requests directly from the community. Persons are served who live within an eight mile radius of LIJ-HMC.

(5) Hospice Program -- The Hospice Program is a special home care program for the terminally ill. Social workers, on an interdisciplinary team, play a crucial role in helping patients and their families face death and dying, in their own homes.

The source of referrals to social workers in these programs includes physicians, nurses, families and patients themselves. The primary casefinding method utilized on all inpatient services is interdisciplinary team rounds

during which all patients on the unit are reviewed, their needs assessed, psychosocial areas identified, and integrated treatment and discharge plans formulated. Participating in such conferences are physicians, nurses, social workers, home care workers and discharge planning coordinators.

A brief description of the organizational structure of the Department of Social Work Services will now be presented because of its relevance to further discussion of accountability issues. The chief administrator is the Director of Social Work Services who presides over social work programs on all campuses and in all functions. There are three associate directors who function as divisional directors of social work in each of the three division -- L.I.J., Hillside, Q.H.C. There is also a coordinator for the Substance Abuse Programs. Within each division, there are assistant directors, administrative supervisors, senior social workers, social workers (MSW level) and several paraprofessional titles. It is a large, complex program utilizing a bureaucratic hierarchy.

Traditional social work supervision has been a major vehicle of accountability in the department. Recently, following a management retreat from which the idea was generated, a policy has been implemented around the concept of the "self-directed worker." (See Chapter II for reference in the literature.) Criteria have been established to select those workers who have sufficient knowledge,

experience and an orientation toward taking responsibility for their own growth, learning and direction. These workers will not participate in individual or group supervision; they will periodically meet with administrative or supervisory staff for administrative purposes such as case assignments. Their learning needs will be met by a system of individual preceptors, with whom they will contract around specific learning issues.

The department has an extensive system of structural accountability meeting J.C.A.H., Society of Hospital Social Work Directors, and N.A.S.W. standards. It also utilizes quantitative assurance accountability through a computerized statistical reporting system. There are many divisional and interdivisional committees around many issues, but of most relevance to this report is the Quality Assurance Committee which is responsible for all quality assurance activity in the social work department throughout the Medical Center.

THE QUALITY ASSURANCE PROGRAM

The Quality Assurance Committee has been in existence since 1974. After eighteen months of planning, the operational phase of the program began in October, 1976. The first year of planning has been fully described in a published article.¹ The goals of the Quality Assurance Program are:

1. Make staff members aware of the high standards of practice they will be expected to achieve.
2. Enable staff members to compare their level of performance with others in the department.
3. Locate practice and service that are below standard, identify the factors contributing to poor quality, and implement corrective action to raise performance levels.
4. Identify practice and service that are more than adequate and the factors contributing to high quality and take action to raise performance elsewhere.
5. Contribute to an overall improvement of the services rendered and to a decline in the differences in the quality of practice by all staff members.
6. Provide a composite picture or score of the quality of service provided on a regular basis.²

During the first year a decision was made to utilize the medical audit model. "The system lends itself to a medical setting where records and charts already exist that note and describe the care given to patients."³ Criteria were established and an audit instrument was developed. The instrument initially consisted of eighty-three questions, but later, after some experience with it, it was reduced to fifty-five questions. The instrument covers the following areas of social work practice: (1) referral (request for service); (2) psychosocial history; (3) assessment; (4) problem selection; (5) goal formulation; (6) treatment plan; (7) social work activity (intervention); (8) recording; (9) outcome (results). These areas are consistent with findings reported in the literature suggesting that

they encompass the important elements of social work practice.⁴

There are questions linking each section to other sections, for example: "Does the assessment lead systematically and directly to problem formulation, goals and treatment?" There are also, throughout the instrument, questions directed at client participation in the treatment process, for example: "Were the goals mutually agreed upon by workers and patient/or family?" Questions are answered "yes" or "no," and each section ends with an overall evaluation with the choices, "Better than Average, Average, Below Average, Unacceptable." A face sheet provides space for basic data, as well as a summary of the scores of each section and room for additional comments. A comprehensive manual has been written which guides an auditor through each question, providing detailed definitions of each criterion and attempting to anticipate problems. (See appendix for copy of instrument and manual.)

The second year of planning accomplished the following tasks: establishment of a peer review system, a feedback and appeal system, a training program for auditors, and orientation of the total social work staff. Committee members took responsibility for organizing peer review teams in their respective divisions, under the overall leadership of the associate directors of social work. The principle of "professional review" was advanced, that members

of a profession regardless of status or rank can review their colleagues. Thus, each division set up a review team consisting of at least one representative from each staff level. The size of a team is approximately 10% of the number of staff in the division. The interdivisional planning committee has continued to meet to monitor the system, share experiences and results, and plan for future changes or modification.

Each social worker is audited at least twice every eighteen months--in most cases twice every twelve months. Charts are randomly selected from among recently closed cases (closed within the last three months). The feedback system begins with the worker who has been audited, who receives a copy of the completed audit. The worker then shares the results with his or her supervisor. Thus, the worker is the first to receive results, and the supervisory process is supported by immediate integration of this data, rather than bypassed through a diversion of the data to higher levels of administration. A summary of each month's audits is sent to the Associate Director of each division and to the Director of Social Work. These summaries provide aggregate data of performance in each of the areas covered by the instrument.

Although the feedback system works slowly and is clearly consistent with a hierarchical bureaucratic structure, it respects the integrity of the supervisory

relationship, and it organizes the data in clusters consistent with the service delivery system, for purposes of administrative accountability and planning. Quality Assurance thus becomes a function of the total department of social work services.

Training and ongoing monitoring of these procedures is crucial. In the second year of planning orientation for the training of auditors was conducted. In addition, a doctoral project was conducted⁵ (see Chapter III) involving two control groups in a pilot of a training program. By the time the program began a number of auditors had already been trained. Negative feelings toward aspects of peer review persisted in some workers after extensive experience as auditors. Some began positively and developed negative attitudes later. In training sessions and auditor/team meetings, full opportunity to express and ventilate these feelings must take place in order to free auditors to continue effectively in the auditing process. A significant fear of auditors was generated by the uncertainty of how results will be utilized. A commitment was made by administration at the start of the program that results would not be used in a punitive manner. Audits are, however, of individuals, and there is no escape from the reality that poor quality of work can be revealed through the process. When summary data are reviewed by administration, it is done in conjunction with other departmental statistical data

such as size of caseloads and nature of the service and its population. Ultimately the delivery system becomes the object of audit so that patient care may improve. An example of this occurred when audits revealed the inconsistent pattern of coverage of families of patients on an inpatient psychiatric unit. The cause of the problem was found to be organizational, not the deficiency of any worker. Corrective action steps were taken.

In October, 1976, two of the three hospital divisions began the actual review of medical charts. The third division was forced to delay until March, 1977. This was the municipal hospital, which was experiencing serious budgetary cutbacks and laying off of staff. It was quickly discovered that an atmosphere in which workers did not know on any given day if they would be working the next was not conducive to beginning a new accountability system. Similar conditions proved to be seriously disruptive in the execution of this project (see Chapter VI).

A major problem encountered was reliability. A brief study indicated that there was considerable scatter in inter-rater reliability. This stimulated the refinement of the instruction manual and the holding of more training sessions to work on questions in the instrument that had proved to be problematical. Reliability has steadily improved through the years because of depth of experience with the procedure.

Another problem is related to the size and diversity of the Medical Center. A single, generic audit instrument was utilized to review social work practice in both medical and psychiatric hospitals; inpatient; outpatient; satellite community based programs; and other innovative services. Styles of work, requirements, recording methods and protocols differ widely from division to division, and from service to service. It was found to be necessary to remove the Hillside Division (psychiatric) from the general social work audit. Instead, social workers at Hillside actively participate in interdisciplinary auditing. Not only does this allow for criteria to be utilized which are more specific to mental health services, but it provides an opportunity for the department to compare experiences of departmental and interdepartmental quality assurance.

A review of monthly summary reports from June, 1977 to April, 1980 indicates that most ratings on most items are "Average" or "Better than Average." Lower ratings do appear. A consistently lower rated item is "Outcome." Outcome is poorly operationalized in the instrument and there is no systematic method for the recording of outcome in charts. This deficit in the outcome area has been a motivation for the development of this project.

II. DESIGN

The project design as originally proposed will now be presented.

The practice principles to be demonstrated were as follows:

(a) Social Work practice is enhanced by the early identification by worker and client of specific goals which will constitute the desired ends in the social work process.

(b) Such specification of ends will not only improve the quality of service, but also lead to the identification of individualized, client-specific outcome measures, enhancing accountability to client, agency, and community.

The goals of the project were:

(1) The improvement of social work service to patients by the systematic attentiveness to goal formulation.

(2) The improvement of service delivery by the addition of outcome measurement to the existing accountability system.

The objectives were:

(1) To improve workers' clarity and focus in social work practice by systematic attentiveness to goal formulation through the use of goal attainment scaling.

(2) To improve the attainment of client-specific social work goals by the use of goal attainment scaling.

(3) To expand the peer review, chart audit quality assurance system by the addition of individualized client outcome measures.

The sub-objectives were:

(1) To establish a balance between minimizing punitive or threatening consequences to individual workers, yet allowing the evaluation generated by the accountability system to have consequences for improved patient care.

(2) To achieve workers' sense of ownership of the technique of goal attainment scaling, as opposed to a sense of outside imposition.

(3) To test the viability of the process of a committee reviewing and revising goals formulated by workers.

These objectives were to be achieved by means of introducing into the Department of Social Work Services of the Long Island Jewish-Hillside Medical Center, the method of goal attainment scaling (the fundamentals of which were described in Chapter IV).

A formula was utilized for derivation of the standardized composite goal attainment score, which is essentially a technical refinement of a simple weighted average. "The result is a pre-specified judgmental transformation of the set of possible outcomes of therapy (or any activity it is applied to) into an approximate standard score (that is, one with an expected value of 50, and standard deviation of 10), intended to measure the success of the activity."⁶

It was proposed that goal attainment scaling be introduced as a regular procedure in patient care by the social work department. It was to be piloted at the Long Island Jewish Division which provides primarily medical,

not psychiatric care. A crucial element in the program design was a training program in the use of the technique, intended to provide an educational and therapeutic advantage in sharpening the identification and formulation of goals in medical social work practice (see appendix for outline of training program).

Worker selection, service selection and patient selection were key variables to be considered in this pilot project. Randomization of all three would have increased external validity or ability to generalize the findings. However, since this was a "first run" on a pilot basis, considerations of internal validity--"the basic minimum without which any experiment is uninterpretable,"⁷ had priority. Thus, worker and service were the variables to be controlled. Workers might have been selected on the basis of experience, however this was limited by service selection. In order to have a cross section of services for valid comparison of findings by type of service, five services were initially selected. Consultation with the divisional social work director had yielded the following choice of services: (1) inpatient--medical/surgical; (2) inpatient--pediatric; (3) outpatient; (4) special projects and grants; (5) emergency room/drug and alcohol. Ten workers were to be utilized.

Patient selection was to be randomized, as the patient universe was much larger than worker or service.

From a given date on which the project was to begin, workers were to utilize goal attainment scaling with their next five consecutive admissions. This was to have provided a sample of fifty cases, on a random basis stratified by service. A minimum of two patient or family contacts was required for inclusion. Those cases not utilized for any reason were to be examined for an understanding of the biasing effect of attrition.

It was expected that further modifications in the selection process, based on the unique nature of the service, may have become necessary.

Goals were scaled by the worker at initial contact, and if more than one goal was selected for a client, weights were assigned to each goal. A committee was established to review the appropriateness and accuracy of goal scaling, a procedure commonly used in goal attainment scaling. The committee was to consist of this writer (the project initiator and chairperson, quality assurance committee), the Divisional Director of Social Work of the Long Island Jewish Division, and an administrative supervisor (one who did not have supervisory responsibility for any of the workers who were participants). It was understood that the composition of the committee might have been modified at a later date based on possible organizational/administrative factors. If modification was suggested by the committee, the worker was expected to handle this in the

same manner as workers handle situations in which the supervisory process influences a worker to re-negotiate a contract, expectation, or understanding with a client. For data analytic purposes, note was to be made of those situations in which external modifications were imposed by the committee.

It was expected that upon discharge, a measurement of goal attainment would be determined by the worker. The independent rater who conducted the post discharge follow up also made a determination at discharge. This was designed to allow for worker-rater reliability analysis. The rater was to be trained initially with the workers, as well as alone, and be provided with explicit guidelines for observation. Post discharge ratings were to be conducted by home visit (understood to include other institutions, nursing homes, etc.), not less than one month nor more than two months after discharge. The rater(s) was to be either, a graduate social work student with special interest in administration, accountability, evaluation or research, or a volunteer recruited for this purpose, or if feasible, social workers in the department not connected in other ways to the study.

Since LIJ-HMC is a research institution, federal law required a human subject review procedure for all applied research activity. This proposal was subject to modification by this committee whose commendable goal is the protection of patients' rights in the research situation.

A possible condition to anticipate was that consent forms might be required of all participating patients. If this occurred, possible sources of bias inherent in attrition caused by unwillingness to sign consent needed to be monitored.

In terms of goal attainment scaling as an outcome measurement instrument, the literature raises some questions concerning validity and reliability. Since these questions are vital to this project and its evaluation, a brief overview of these areas will now be given.

The advocates of goal attainment scaling generally present a construct validity argument. The essential construct is "the attainment of expectations." "If a clinician developed the expectations as appearing on a particular follow-up guide, the result could be taken theoretically as a one person sample of the expectations for treatment which would be imposed by the hypothetical average clinician."⁸ Critics have raised questions as to the validity of the content of goal scoring follow-up guides, and to validity as it interacts with who sets the goals: intake workers, committees, researchers, therapists, clients, families of clients. Further, there have been fairly poor findings of studies of concurrent validity with standardized tests such as the Minnesota Multiphasic Personality Inventory (M.M.P.I.). For example, one study reports a Pearson correlation of .285 between goal attainment scores and the

M.M.P.I. mean-change index, and .306 between goal attainment scores and the M.M.P.I. mean-change score.⁹ On the latter point, it is argued that the method was not intended by virtue of its individualized nature, to correlate well with standardized tests.¹⁰ This is again the conflict of the idiographic versus the nomothetic point of view.

For purposes of this project the following should be noted regarding the validity of goal attainment scaling as an evaluation tool for outcome measurement: There is a certain "face" validity to the notion that goals in the helping process, already established to be of vital importance to that process, will be focused upon, clarified, and moderately well measured by following the procedures of goal attainment scaling. It must be recognized, however, that validity of this instrument is variable and has some limitation as an outcome measure.

Reliability, although receiving some "mixed" reviews, has generally fared better than validity. It is felt that many of the variables affecting validity also affect reliability. To strengthen reliability is thus to strengthen validity for this instrument. The following variables have been identified as relevant to a consideration of reliability in goal attainment scaling:

- a. Who constructs the follow up guide?
(client, therapist, or intake interviewer, etc.)
- b. How many scales appear on the follow up guide?

- c. When is the follow-up guide scored? (How long after follow-up guide construction?)
- d. Who scores the follow-up guide? (Are they experienced in such scoring? What background do they have?)
- e. How many raters are there?
- f. In what circumstances are the follow-up guides scored? (In person, by mail, by telephone.)¹¹

A number of reliability studies have been conducted. Reliability coefficients range from .57 to .85. One study of inter-rater reliability yielded .81.¹² Follow up guide construction by different guidemakers at different times (alternate form reliability) has been reported to be .85.¹³ Among the suggestions in the literature for improved reliability are:

1. "There is a tendency to achieve greater reliability when the anchoring points for the problems, goals, or tasks include concrete behaviors rather than attitudes or cognitions...."¹⁴

2. For improved therapeutic effectiveness as well as reliability, several authors have recommended that the content of goal attainment follow-up guides be negotiated between worker and therapist, the resultant guide being a product of mutuality.¹⁵

3. Multiple follow-ups¹⁶--the method had originally consisted of initial follow-up guide construction only, without initial indications of client's status on goal

scales at point of intake, and one follow-up rating, usually six months after discharge (in cases of psychotherapy for mental illness). The design employed here utilized multiple measurements.

4. Therapists conducting their own follow-ups has been suggested, with the warning that this "modification suffers the possibility of therapist bias."¹⁷ In this project, workers were to conduct a follow-up at discharge.

The method has also been criticized for assuming that a goal attainment scale has equal distance between referents, and has utilized computations appropriate to an interval scale. "If one is persuaded that Goal Attainment Scales are not interval-level data, then the formula for calculating Goal Attainment scores apply improper mathematical operations to ordinal data."¹⁸ Kiresuk and Sherman have replied: "Practically all psychological measures rely on judgment at some point for interval-level justification. G.A.S. does not differ substantially in this regard."¹⁹ Further, Kerlinger has written:

Yet, though most psychological scales are basically ordinal, we can with considerable assurance often assume equality of interval. The argument is evidential. If we have, say, two or three measures of of the same variable and these measures are all substantially and linearly related, then equal intervals can be assumed.²⁰

Such an assumption was made in this project, but with the understanding that some have challenged this.

The design employed was essentially a quasi-

experimental interrupted time series.²¹ The initial goal scaling and construction of follow up guides constituted baseline measurements. Since only one baseline measurement of this kind can be conducted, true pre-intervention data stability was not established representing a design weakness and a modification of the interrupted time series design. The social worker was responsible for the initial measurement, in consultation with the committee described above. Upon discharge, both the social worker and an independent rater were to each separately determine a goal attainment score. (See appendix for formula and instruction, for this procedure. To simplify computations, an available book of tables was to be utilized.)²² An inter-rater reliability study was planned at this point. One to two months post discharge, a follow-up score was computed, based on a home visit by the rater. The short follow-up time was justified because of the expected acute nature of medical social work contact, many of whose outcome expectations concern discharge plans in the period immediately following hospital care.

This design did not control well for "history"--especially considering the seasonal fluctuations in hospital admissions as well as in patterns of health and illness. Other potentially confounding variables such as "maturation" and "testing" were moderately well controlled.²³ The "test" is relatively unobtrusive: the client might have been

aware of an emphasis on the goals of the social work interaction, but was not to be actively involved in the technical aspects of goal scaling and scoring.

Although the interrupted time series design does not control for all factors affecting internal validity, does not produce knowledge that is clearly and undisputably causal, and does not produce findings that are generalizable to other programs, it does generate knowledge that is highly informative about a specific program.²⁴

Demographic data, normally available in the chart, was to be highlighted on a face sheet to be filed for data collection purposes, with each client's follow-up guide. It covered age, sex, income, race and ethnicity, and pay class (self-pay, insurance, Medicaid, etc.). Demographic data have been recommended as an important adjunct to goal attainment scaling.²⁵ Linkages between demographic characteristics and social health outcomes may constitute important findings for planning of social services.

It was hoped that the quality assurance peer review system would be auditing all charts in which goal attainment scaling had been utilized, for a review of social work process. The summary areas of the audit instrument were to be compared with goal attainment results, to begin to determine linkages between components of social work interventive processes and outcome. At post discharge a final scoring of goal attainment was to be made.

NOTES

¹Roslyn H. Chernesky and Abraham Lurie, "Developing A Quality Assurance Program," Health and Social Work 1 (February, 1976): 118-30.

²Ibid., p. 119.

³Ibid., p. 121.

⁴Claudia J. Coulton, Social Work Quality Assurance Programs: A Comparative Analysis. (Washington, D.C.: National Association of Social Workers); Katherine M. Wood, "Casework effectiveness: A new look at the research evidence," Social Work 23 (November, 1978): 437-58.

⁵Roslyn H. Chernesky, A Training Program to Prepare Social Workers for Professional Review, unpublished DSW dissertation, C.U.N.Y., 1976.

⁶Robert Sherman, "Will Goal Attainment Scaling Solve the Problems of Program Evaluation in Mental Health Field?" in Robert D. Boursey, editor, Program Evaluation for Mental Health: Methods, Strategies, Participants (New York: Grune and Stratton, 1977), p. 108.

⁷Donald T. Campbell and Julian F. Stanley, Experimental and Quasi-Experimental Designs for Research (Chicago: Rand McNally College Publishing Co., 1963), p. 5.

⁸Geoffrey Garwick, A Construct Validity Overview of Goal Attainment Scaling. (Minneapolis: Program Evaluation Project, 1974), p. 4.

⁹James R. Seaberg and David F. Gillespie, "Goal Attainment Scaling: A Critique" Social Work Research and Abstracts, 13 (1977): 5; Robert J. Calsyn and William S. Davidson, "Do We Really Want A Program Evaluation Strategy Based Solely On Individualized Goals? A Critique of Goal Attainment Scaling" Community Mental Health Journal 14 (Winter, 1978): 302.

¹⁰Thomas J. Kiresuk and Robert E. Sherman, "A Reply to the Critique of Goal Attainment Scaling," Social Work Research and Abstracts, 13 (1977): 9.

¹¹Geoffrey Garwick, An Introduction to Reliability and the Goal Attainment Scaling Methodology. (Minneapolis: Program Evaluation Project, 1974), p. 12.

¹²Ibid.; Robert E. Sherman, Ph.D., et. al. An Examination of the Reliability of the Kiresuk-Sherman Goal Attainment Score by Means of Components of Variance. (Minneapolis: Program Evaluation Project, 1974); Thomas J. Kiresuk and Sander H. Lund, "Goal Attainment Scaling: Research Evaluation, and Utilization" in Herbert C. Schulberg, Ph.D. and Frank Baker, Ph.D., ed. Program Evaluation in the Health Fields, Vol. II (New York: Human Sciences Press, 1979) pp. 221-232.

¹³Kiresuk and Sherman, p. 10.

¹⁴Claudia J. Coulton and Phyllis L. Solomon, "Measuring Outcomes of Intervention," Social Work Research and Abstracts, 13 (Winter, 1977): 7.

¹⁵Thomas J. Kiresuk and Sander H. Lund, "Goal Attainment Scaling: Research, Evaluation, Utilization" in Program Evaluation in the Health Fields Vol. II, ed. Herbert C. Shulberg, Ph.D. and Frank Baker, Ph.D. (New York: Human Science Press, 1979). p. 225.

¹⁶Sherman, p. 8.

¹⁷Ibid.

¹⁸Seaberg and Gillespie, P. 7.

¹⁹Kiresuk and Sherman, pp. 11-21.

²⁰Fred N. Kerlinger, Foundations of Behavioral Research, Second edition, (New York: Holt, Rinehart and Winston, Inc. 1973), p. 440.

²¹Donald T. Campbell and Julian C. Stanley, Experimental and Quasi-Experimental Designs For Research, (Chicago: Rand McNally, 1963), pp. 37-43.

²²Geoffrey Garwick and Joan Brintnall, Tables for Calculating the Goal Attainment Score, (Minneapolis: Program Evaluation Resource Center, 1973).

²³Campbell and Stanley, pp. 39-41.

²⁴Irwin Epstein and Tony Tripodi, Research Techniques for Program Planning, Monitoring and Evaluation, (New York: Columbia University Press, 1977), p. 117.

²⁵Calsyn and Davidson, pp. 303-305.

CHAPTER VI

IMPLEMENTATION AND FINDINGS

This chapter will present findings based on the experience of implementing this project as well as statistical data produced by the project. The final chapter will discuss implications and conclusions.

IMPLEMENTATION

There were a series of issues, events and problems encountered in the implementation of the project. The project was initiated in November, 1980 by submitting copies of the proposal to the Human Subjects Review Committee of the Long Island Jewish-Hillside Medical Center, and to the Director and Associate Director (L.I.J. Division) of Social Work Services.

The Human Subjects Review Committee approved the project, but stipulated that a consent form be devised to ensure informed consent of patient and/or family participants. The consent form was relatively benign (see Appendix) since the only experimental procedure described was: "Prior to discharge, a volunteer will visit the patient to conduct a brief interview in order to determine, in the patient's view, the degree of achievement of the goals of contact

with the social worker. A month after discharge, the volunteer will telephone the patient to again determine social work goal achievement."

The Director and Associate Director of Social Work Services had previously indicated their approval of the project. A series of meetings took place between the Project Director (the author of this report) and the Associate Director, to begin planning a strategy for implementation. It was decided to seek the advice of the administrative supervisors group. This group was very supportive of the project. The following decisions were made:

(1) services to include -- medical, surgical, ear/nose/throat (ENT), pediatrics, neonatal, orthopedic, hospice and home care, allowing a focus on the acute inpatient/aftercare continuum (and excluding outpatient and satellite programs);

(2) workers -- all on those services on an assigned, not a voluntary basis (a total of ten workers, but one went on medical leave prior to the beginning of the study period, leaving nine who participated);

(3) committee -- two experienced outpatient social workers were recommended and their recruitment was to be on a voluntary basis because of the time commitment involved; and the one administrative supervisor who did not supervise the nine workers.

(4) informing of participants -- to be done by the

Associate Director by memo followed by the administrative supervisors meeting with their supervisees regarding their participation (after this was accomplished the project director was to take over communication with the workers by arranging orientation and training sessions).

Workers were informed by memo of the Associate Director and also by their administrative supervisor. At this point, no serious objection on the part of the workers was raised and no resistance emerged. The project director then arranged a series of meetings for orientation and training for workers and committee members. Four training sessions took place in late February and March, 1981. A graduate social work student majoring in administration with a particular interest in evaluation attended, as an observer, all training sessions and goal review committee meetings.

The first problem to arise in conjunction with training was attendance. The nine workers were never all together in any single session. Several people missed several training sessions. It was necessary to arrange make-up sessions. Although there were a variety of circumstances involved in the absences, it was likely that some pattern of resistance was emerging.

A negative attitude expressed early in the training period by a number of participants was based on the following: the project director should have approached workers, in their view, on an individual, personal basis

and should have asked for their voluntary participation-- they would have "gladly participated to help the project director with his doctoral project." Instead, they resented the mandate by the Associate Director imposing participation on them. They rejected the legitimacy of the Divisional Department of Social Work Services' expansion of its accountability program. They chose to recognize the project as research, the end of which was only the personal gain of the project director. They also complained about additional paperwork and thought that the time projected for their participation was conservatively low. These were the initial attitudes encountered.

In the first two sessions, a basic overview of goal attainment scaling was provided (see appendix for curriculum outline and copies of materials given to participants). In the next two sessions, a workshop was conducted in which participants brought case material for practice in goal formulation and follow-up guide construction, which also served as an opportunity to informally pre-test the instrument. In spite of the negative attitudes shared by a number (not all) of the workers, once ventilation of feelings took place, the level of involvement was of a professional caliber. Everyone presented cases for practice and there was active group participation in criticizing each others' work.

The supervisors of participating workers had been

asked to assess their worker's ability to formulate client goals, prior to the beginning of the study period. Each supervisor responded with a brief memo stating that each of the workers was strong in the goal formulation area. The experience in the training workshop and goal review committee did not confirm this. Each worker struggled in the training period with the exact specification and scaling of client goals. By the time the study period had commenced some had fully mastered the skill while others still struggled.

At the end of the training period, case selection procedures were established for each service. Based on the volume of new cases which are usually expected, an attempt was made to project how long it would take to open five consecutive cases. This unevenness from service to service in randomly entering cases into the study served to stagger cases coming before the goal review committee, which was fortunate in that it prevented overload. However, the patterns as projected turned out to be quite unrealistic. It was originally hoped that 50 cases would be opened in six to eight weeks by the nine workers. As it happened, a sample of only 30 was achieved after four months (April-July, 1981). There were a number of circumstances which impinged on the process.

The consent form was one problem. Some attrition resulted from the reluctance and refusal of certain patients/

families to sign, or the worker's judgment in advance that the request for signature would surely be rejected. Such situations involved cases in which the Bureau of Child Welfare was going to place a child based on a petition of neglect or abuse; cases in which patients were going to sue the hospital; cases in which death was imminent and the request of the relative to sign a consent form was seen as clinically inappropriate. This pattern suggests some sample bias in that some of the more difficult social work cases were excluded. It was impossible to monitor this process on a case by case basis, but some workers were able to provide vignettes of such situations. (See Appendix.)

In addition to the nature of the cases, other reasons for delayed and/or less than expected number of cases included: serious illness requiring hospitalization of two workers; jury duty of a third; financial crisis of the Medical Center necessitating reorganization and layoffs; and the pervasive negative attitude toward the project on the part of several workers. The financial crisis of the Medical Center was a major complicating factor in the implementation of this project. In the previous chapter, it was stated that implementation of the quality assurance/peer review program had been delayed, several years before, at Queens Hospital Center because of its financial crisis. Unfortunately, the current L.I.J. crisis surfaced after implementation of this project had begun. As could be

anticipated, in spite of all assurances to the contrary, some workers feared that outcome data might be used in assessments of who should be laid off. This obviously exacerbated existing negative feelings. Further, although no one was in fact laid off, participating workers were directly affected. Several people had their work hours lessened and others had assignments changed. This was most disruptive of the study.

If workers felt threatened by having to participate in an outcome study, the goal review committee provided yet another source of discontent. The members of the committee were quite supportive of the project and approached their participation on the committee with enthusiasm. They had volunteered; their motivation was high; their belief in evaluation as a professional activity was strong. They were the evaluators and would be judging the work of others. Also, unlike the workers who for the most part did their work for the project in isolation from each other, the committee was a supportive group. The two ambulatory care social workers and one administrative supervisor comprised the "voting" members (actually, decision-making occurred by consensus); the project director and his student were present, participated in discussions and provided a facilitating role, but did not intervene in dispositions. The committee reviewed each follow-up guide, in conjunction with an initial chart note and face sheet information. The

objective of the committee was to determine the appropriateness of goals, their measurability and scaling. The use of a committee or of some review process is a usual procedure in goal attainment scaling in order to improve reliability and validity of the instrument and to educate staff on goal specification and formulation. Committee members had attended some of the training sessions, and had much opportunity to interact with the project director during preliminary committee meetings--they developed expertise in evaluating the quality of goal follow-up guides.

When there were questions that the committee had regarding the written submissions, and/or when it was clear that modifications were necessary, the workers were invited to meet with the committee. The response varied greatly. One worker described the experience as "humiliating." Others approached it as yet another of many inconveniences and infringements on their autonomy, inherent in their job. A few enjoyed the interchange and seemed to actively appreciate the learning opportunity. All but one worker cooperated with the committee and made the necessary changes in goal definitions, scaling, etc. The worker had submitted only one case after a long period had elapsed. She was the most resistant of the workers. Repeated administrative intervention was not successful in getting her to submit the other cases.

The committee became in some ways a target for

workers' anger at the project. This was not overtly expressed. The committee member who acted as chairperson, a line social worker, was often the object of underlying hostility from workers in the project. The committee was a form of peer review and a possible consequence of peer review is division among staff: reviewers versus reviewees. It was necessary for the project director to hold a special meeting after the first several weeks of the study period, in order to allow workers to express their feelings and take the "heat" off of committee members. The meeting provided an opportunity to clarify some conceptual issues related to goal attainment scaling.

A total of only seven cases were actually modified by the committee (N=30), although the committee met more often with workers to seek further information and clarification. By mandate of the Associate Director, in case of an unresolvable dispute between the committee and worker, the worker's view would have prevailed. However, the workers who were asked to modify their work did so compliantly, in spite of the negative feelings which prevailed. Workers had learned in training to avoid vague, global, or unachievable goals. Goals that were modified generally required word changes for greater precision, rather than a re-working of the goal concepts of the case.

Another issue in the implementation process was that of the rater. Two volunteers had been interviewed.

Both were "high level" volunteers who would have been appropriate raters, but both, after initially committing themselves, found paying jobs and withdrew their applications as volunteers. By this time, workers had been trained. It would have been destructive to further delay the beginning of the study period, yet the process could not begin without a rater who might have been needed quickly if a case was opened and closed in a short time.

The solution was to find a member of the social work staff whose job allowed enough flexibility to free time for work as a rater, yet who also had no direct connection to the workers and services in the study. Such a person was found--she had six years of clinical social work experience in another division. Her current position was administrative assistant to the Director of Social Work Services. Her position created some concern on the part of some workers that the rater would share results immediately with the Director of Social Work. That concern was balanced by positive feelings that she was an experienced practitioner, a member of staff, who could be clinically "trusted" with follow-up of the workers' clients. There had been previously expressed feelings of lack of confidence in a volunteer interviewing patients and families who were in acute crisis. The rater was also able to see patients for exit interviews on a very short notice which would not have been easily accomplished by part-time volunteers.

She was trained extensively by the project director. All patients and/or their families received a follow-up interview one month after discharge, as planned.

The various problems and issues in implementation forced a series of modifications of the design which will now be summarized. Nine workers were included in the study, not ten as originally planned, because of a medical leave of one worker. Cases were unevenly distributed among the nine workers: one worker produced only one case, four workers had three cases each, three workers had four cases each, and one had five cases. Thirty cases, not fifty, comprised the sample. Reasons for the uneven distribution and the more limited sample size were given above. In addition, a rule built into the initial design stipulated that two contacts had to occur prior to termination, for a case to qualify. This further limited entry of cases into the study. Attrition due to refusals of patients to sign consent forms probably introduced some sample bias, excluding some of the more difficult case situations. Randomization may have been compromised because of some of the negative attitudes toward the study and the possibility of workers entering cases that would make them look better. This is an unconfirmed speculation. The major sample bias involves those cases in which consent forms were not signed.

Another modification which spontaneously occurred

was that without exception workers did not perform their own goal ratings at discharge. This expectation was designed to study workers' ability to engage in self-evaluation and to test inter-rater reliability with the rater who also made judgments at the time of discharge. This universal avoidance of worker conducted ratings, in spite of several reminders, is a most interesting occurrence. The act of self-evaluation of outcome, in the specific organizational context previously described, apparently became intolerable. This also deprived the study of rater reliability data.

Follow-up interviews which were originally intended to take place face to face on a home visit basis, were instead conducted by telephone. Since L.I.J. Division serves a very wide geographical area, the time and expense of home visits could not be supported.

STATISTICAL FINDINGS

The presentation of the statistical findings of this study will begin with the general characteristics of the sample. Thirty cases comprised the sample. There were thirty-one individual identified-patients because one pediatric case involved identical twins who had the same medical diagnosis and were treated with their family as a single social work case. Since the basic unit of this study was the case, including in all instances identified patient and family, the twins have been considered as a unit on all

patient attributes except sex, since one was male and the other female. This accounts for the N=31 on sex identification but N=30 on other demographic areas. For marital status, all pediatric cases were removed yielding N=20. Table 1 summaries N's and percent for age, sex, race, marital status, diagnosis, and pay class; all identified-patient related attributes. Half of the sample were above the age of 65 and one third below the age of 12. Sex is distributed almost equally between males and females. The sample was three quarters white, and 70% of the adult group was married. Pay class is dominated by Medicare (57%), consistent with the high percent of elderly patients. Thirteen diagnostic categories were present (for primary diagnosis; there were secondary diagnoses in ten cases). A white, elderly, married group supported by Medicare, with a wide variety of diagnoses headed by cancer (24%) and cardiovascular disorders (14%) characterizes the predominate demographic patterns of the sample.

For each of the 30 cases, goals were established by the worker or by mutual agreement between the social worker and patient/family (mutuality is one of a number of variables which will be examined below). A total of 65 goals were present in the 30 cases--a mean of 2.16 per case. Thus, the typical case involved 2 goals. The range was from 1 to 4. (See the Appendix for a complete listing of goals by case, plus all other relevant data.) The content of the 65

TABLE 1
CHARACTERISTICS OF THE SAMPLE

	N	%		N	%
Age			Diagnosis		
0-5	8	27%	Cancer	7	24%
6-12	2	6%	Heart Disease	4	14%
13-20	0	0%	CVA	3	10%
21-64	5	17%	Orthopedic	3	10%
65+	15	50%	Prematurity	3	10%
Sex *			Vascular	2	7%
Male	16	52%	Diabetes	2	7%
Female	15	48%	Hernia	1	3%
Marital Status**			Neurological	1	3%
Married	14	70%	Kidney Disease	1	3%
Unmarried	6	30%	Toxicity	1	3%
Pay Class			R/O apnea	1	3%
Medicare	17	57%	Tracheostomy	1	3%
Private Insurance	7	23%			
Medicaid	4	13%			
Unknown	2	7%			

*Sex, N=31, because one case contained twins, 1 male, 1 female.

**Marital status, N=20, because children were excluded.

goals was carefully examined and 12 goal areas were identified which summarize in a more concise form the types of goals found in the sample. They are described with the frequency of each goal category in Table 2.

TABLE 2
GOAL CATEGORIES AND FREQUENCIES

A. Concrete services (25)	
1. Discharge Planning	4
2. Placement in Nursing Home/ rehab. fac. (alternate level of care)	3
3. Referral-community supports/resources	11
4. Entitlement facilitation/advocacy	7
B. Psychosocial (40)	
5. Improve interpersonal relationships	4
6. Family/patient participation in discharge planning	8
7. Strengthen family role as care- taker	2
8. Strengthen patient role of self- care	1
9. Family/patient adjustment to illness	18
10. Family/patient adjustment to death and dying	2
11. Compliance with medical regime	1
12. Strengthen family decision- making	4
Total N=65	

Although many of the goals involved discharge planning activities, it is to be noted that the goal category 1, "Discharge Planning" was utilized when a discharge plan, such as placement in a nursing home, was not apparent at case opening. Thus, in the face of uncertainty regarding disposition, the goal of establishing a discharge plan became appropriate. This occurred, however, in only 4 or 13% of cases, and represented only 6% of the total number of goals. Concrete services accounted for 25 or 38% of the goals; psychosocial goals accounted for 40 or 62% of the total.

The 12 goal categories were also examined in relation to the frequency of actual scores. The goal attainment scaling method yields an outcome score which represents an overall measure of goal achievement in a case taken as a whole; the score is a weighted mean of all the individual scores of each goal of the case. The G.A.S. outcome scores will be presented below. However, the G.A.S. scores themselves do not permit analysis of individual goals, only of progress in a case on a composite basis. In order to gain an understanding of goal category scores, the raw scores were totaled for each goal area, so that frequencies for -2, -1, 0, +1, +2 were computed and may be examined by goal category. A display of this data for all 12 areas may be found in the Appendix. However, it will be instructive at this point to examine these findings on a selective basis.

The concrete goal with the highest frequency was "Referral-community supports/resources," which had a frequency of 11 or 17% of all goals. The psychological goal with the highest frequency was "Family/patient adjustment to illness," which had a frequency of 18, or 28% of all goals.

The raw scores for both G.A.S. I (discharge) and G.A.S. II (one month post-hospital follow-up) may be found in Table 3.

TABLE 3
SELECTED RAW GOAL SCORES

	Time of Measurement	G.A.S.					
		N	-2	-1	0	+1	+2
Referral-community supports/resources	I	11	2		6	1	2
	II	11	1	2	4	2	2
Family/patient adjustment to illness	I	18	3	1	11	3	
	II	17*		6	5	6	

*The difference is accounted for by the death of 1 patient in the sample between G.A.S. measurement I and II.

Several trends are evident in Table Three. Movement of scores from G.A.S. I to G.A.S. II is more limited in the concrete service area. The psychosocial goal scores demonstrate less stability; greater change takes place. Secondly, there are no +2 scores in the psychosocial area, but there

are 2 in the concrete area. Both of these trends are confirmed by an examination of the complete display of these data (see Appendix). Only 2 scores of +2 (G.A.S. II) were recorded out of 40 in the psychosocial area (5%), whereas in the concrete area there were 5 G.A.S. I and 7 G.A.S. II scores of +2, out of 25 and 24 respectively (20% and 25%).

More revealing and more significant in accountability terms, however, are the G.A.S. scores themselves which provide a composite outcome measure on a case by case basis. These scores will first be discussed on a sample-wide basis, followed by an analysis of the relationship between outcome and a variety of variables. The characteristics of the scores may be viewed from several perspectives.

The mean of all G.A.S. I scores (N=30) is 49.356; the mean of all G.A.S. II scores (N=29) is 52.712. The frequency distribution of scores by units of 10 may be seen in Tables 4, 5 and 6. The G.A.S. methodology produces expected scores at 50; below 50 indicates less than expected and above 50 greater than expected. The higher the score, the greater the goal attainment, the more successful the outcome.

The mean scores that are reported suggest that by discharge social work cases almost met expected levels of outcome attainment; by one month post-discharge, outcomes exceeded levels of attainment. A t-test of the difference between the G.A.S. I and G.A.S. II mean scores indicates

that the positive change is significant at less than .02.

TABLE 4
DISTRIBUTION OF G.A.S. I SCORES
N=30

SCORES	FREQUENCY	SCORES	FREQUENCY
Above 70	0	Above (+) 50	12
61 - 70	4		
51 - 60	8		
50	5	50	5
40 - 49	6	Below (-) 50	13
30 - 39	6		
Below 30	1		

TABLE 5
DISTRIBUTION OF G.A.S. II SCORES
N=29

SCORES	FREQUENCY	SCORES	FREQUENCY
Above 70	0	Above (+) 50	12
61 - 70	6		
51 - 60	6		
50	8	50	8
40 - 49	7	Below (-) 50	9
30 - 39	2		
Below 30	0		

TABLE 6
MEAN SCORES AND T-TEST

G.A.S. I	N=30
Mean = 49.356	Standard deviation = 11.92
	Standard error of the mean = 2.18

G.A.S. II	N=29
Mean = 52.712	Standard deviation = 9.19
	Standard error of the mean = 1.71

Change from G.A.S. I to G.A.S. II = +3.356
t = +2.65 p < .02 (2-tailed)

This may be further verified by Tables 4 and 5 which show that in G.A.S. I a combined total of 17 or 57% of cases met or exceeded expectations (50 and over 50); and in G.A.S. II a combined total of 20 or 69% of cases met or exceeded expectations.

Another perspective of the characteristics of the scores may be gained by comparing those scores with positive change, no change, and negative change. Table 7 summarizes these findings.

TABLE 7
MEANS, STANDARD DEVIATIONS AND
AVERAGE CHANGE FOR GROUPS OF CASES
MEASURED AT DISCHARGE AND FOLLOW-UP

	N	<u>G.A.S. I</u>		<u>G.A.S. II</u>		<u>CHANGE</u>
		$\bar{X}$	SD	$\bar{X}$	SD	
Positive change	17	42.77	9.18	50.85	7.81	+8.08
No change	7	53.54	7.81	53.54	7.81	
Negative change	5	58.75	5.20	50.88	6.79	-7.87

Thus, a majority of cases (N=17) showed improvement between measures, from somewhat below expectation (42.77) to just over expectation (50.85). Those cases which showed no improvement (N=7) scored fairly highly above expectation (53.54). The cases exhibiting decline (N=5) started somewhat above (58.75) but leveled out at about anticipated expectations (50.88). It is interesting to note that cases showing improvement received such low scores initially, that no change cases maintained relatively high attainment, and that deteriorating cases started out initially high.

Yet another perspective of change may be viewed in Table 8 which displays frequencies of scores above and below the actual sample means (rather than the standard score of 50). A general stability of effect is revealed by this table: 12 cases began and remained below the

TABLE 8
SCORES ABOVE AND BELOW MEAN
G.A.S. II $\bar{X} = 52.712$

		BELOW	ABOVE
G.A.S. I	Above	6	10
$\bar{X}=49.356$	Below	12	1

respective means and 10 cases began and remained above the means (22 or 73% of the cases exhibit this stability). The means within the groups are as follows: below/below - G.A.S. I, $\bar{X}=37.92$, G.A.S. II, $\bar{X}=45.38$, difference = 7.46; above/above - G.A.S. I, $\bar{X}=60.84$, G.A.S. II, $\bar{X}=63.22$, difference = 2.38. Only 6 cases began above and deteriorated to below the means: G.A.S. I, $\bar{X}=54.38$, G.A.S. II, $\bar{X}=48.79$, difference = 5.59. A single case experienced a gain from below to above the means: G.A.S. I = 40.88, G.A.S. II = 59.12, difference = 18.24. Within these various groups some limited patterns may be observed. With the below/below group, 3 cases belonged to a worker on the ENT service and 4 cases belonged to another worker on the Neonatal service. In the above/above group 2 medical/surgical cases and 2 hospice cases are present. In the above/above group 2 pediatric cases are present. These patterns may have some meaning for the workers, supervisors or director, but the number of cases in each cell are too small to appropriately

submit them to tests of statistical significance in this sample.

The above represents an examination of the properties of the overall scores. Cross breaks were performed on a number of the variables in relation to scores. These data are also limited by the small size of frequencies within cells, precluding the use of multiple regression analysis, which would have yielded for each variable a sense of its influence on outcome scores. An approximation of this was achieved by utilizing t-tests on each crossback square, and in one area in which contraction of data into a 2X2 square was not possible, an F-test was performed. Where appropriate, estimated omega squared was used to approximate the influence of an independent variable on the dependent variable (outcome score). In all cases tests were two tailed, because clearly outcome scores can increase or decrease, and such knowledge is most relevant to the study. The tests are of comparisons within time periods (G.A.S. I, G.A.S. II) Table 9 contains a summary of the t-tests and F-test by variable (each crossbreak chart may be found in the Appendix or selectively in the presentation below).

Among the demographic data (age, sex, marital status, and race), only age proved to be statistically significant, within G.A.S. II. Table 10 contains the crossback on age, in which outcome scores for each time period are compared for those patients from birth to 21 years of age

with those over 21 years of age. Initially for this and other variables, data was examined through more detailed categories. For example, regarding age, Table 1 presented 0-5, 6-12, 13-20, 21-64, 65+. However, the individual cells have too few frequencies to appropriately submit to statistical testing. Some degree of specificity is sacrificed in contracting data, but more meaningful conclusions can then sometimes be made.

TABLE 9
STATISTICAL TESTS BY VARIABLE

VARIABLE	G.A.S. I	G.A.S. II
Age	t=1.59 p < .10 not significant	t=2.13 p < .05 significant
Sex	t=.06 not significant	t=1.31 p < .10 not significant
Marital Status	t=.16 p < .50 not significant	t=-.21 not significant
Race	t=.72 p < .50 not significant	t=1.19 p < .50 not significant
Scales negotiated	t=.22 p < .50 not significant	t=.69 p = .50 not significant
Social Work pick-up time	t=.47 not significant	t=.95 p < .50 not significant
Committee Actions	t=.35 p < .50 not significant	t=.55 p < .50 not significant
Years of worker experience	t=1.53 p < .10 not significant	t=2.47 p = .02 significant
Services	F=1.29 not significant	F=2.13 p < .25 not significant

The comparison, then, is between children and adults. As can be observed from the Table, at follow-up adults achieved a mean goal attainment score which is 7.17 higher than children and this difference is statistically significant at the minimum "alpha" level of .05. Of those under 21, 1 child was on the ENT service, 5 on neonatal and 4 on pediatrics.

TABLE 10
AGE IN RELATION TO GOAL ATTAINMENT SCORES

AGE	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
0-21	10	44.96	12.04	10	48.01	8.93
21 Plus	20	51.54	9.96	19	55.18	8.5

G.A.S. I $t=1.59$ $p < .10$

G.A.S. II $t=2.13$ $p < .05$

Estimated omega squared = .11 (G.A.S. II)

Although the other demographic variables did not correlate with systematic variance in outcome scores within measurement time periods (G.A.S. I, G.A.S. II), interesting data suggested itself in another way. In computing a crossbreak and t-tests for sex difference, it was noted that females exhibited no progress in their mean score from G.A.S. I (50.16) to G.A.S. II (51.03)--a very

slight increase (.87) is evident. Across all other variables studied, some increase is noted between measurement I and II, consistent with the overall statistically significant increase in the sample mean score. Males, on the other hand, exhibited an increase of 5.65. (See Table 11.)

TABLE 11
SEX DIFFERENCE IN RELATION TO GOAL ATTAINMENT SCORES

SEX	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
Male	16	48.89	13.66	15	55.54	9.95
Female	15	50.16	11.12	15	51.03	8.93

(within) G.A.S. I $t=.06$ not significant

(within) G.A.S. II $t=1.31$ $p<.10$ not significant

from G.A.S. I to G.A.S. II Male, $t=3.69$, $p<.005$
significant

from G.A.S. I to G.A.S. II Female, $t=.48$, $p<.50$
not significant

This change was statistically significant at $p<.005$, suggesting that the positive change in scores of males is essentially responsible for the positive change in the sample.

Upon further investigation it was discovered that most adult men in the study were married (11 out of 13, or

85%). All but one were over 65 years of age ($\bar{X}=73.4$, S.D.=9.6). There were 7 adult females, only 3 of whom were married (43%). Even though t-tests within measurement times of the crossbreak on marital status and on sex difference were not in themselves significant, it appears that married, adult men over 65 emerge as having the highest social work outcome follow-up scores, and the strongest positive change between measurements. Age has been identified above as a significant variable, and since a majority of the children were female (8 of 10 or 80%), female children appear to be the high risk group in the sample, achieving among the lowest scores.

It would have been desirable to study a number of intersecting variables such as married adult males and single adult women, etc., but again the frequencies in each cell would have been too small for statistical tests.

Another set of variables concerns issues of intervention (see Table 9) such as scales negotiated, social work pick-up time, committee action, years of worker experiences and hospital services. The meaning and use of these terms, and an examination of the data will now be presented. Scales negotiated refers to whether or not goals were mutually agreed upon between worker and patient and/or family. Any case in which one or more goals were mutually arrived at (as reported by the worker) was counted as a "yes." The distribution was 15-yes, 15-no and there

was no significance when mean G.A.S. scores for each group within each measurement time was subjected to t-tests. Committee action refers to whether the goal review committee recommended modifications in the goals or scales as initially formulated by the worker. As indicated in the previous chapter, only 7 cases required such committee action; there were not significant differences between "yes" and "no" cases.

An area of considerable interest in hospital social work is screening, case-finding and early pick-up time (see previous chapters on review of the literature). Sources of referral--their frequencies and percents, may be found in Table 12. Interdisciplinary team rounds in

TABLE 12
SOURCES OF REFERRAL

Source	Frequency	Percent
Team Rounds	13	42%
Physician	5	17%
Other Hospital Service	5	17%
Community Agency	3	10%
Nursing	2	7%
Family	2	7%
T O T A L	30	100%

which social work is an active participant, has replaced the sole physician as the largest source of referral. Families are a surprisingly limited source. Pick-up time refers to how soon in the duration of a case social work has begun. This data was initially analyzed by mean G.A.S. scores grouped by weeks, that is, cases opened in the first week of hospitalization, second, third, and more than three weeks. Many of the cells were quite small leading to a contraction into a 2X2 crossbreak of up to 2 weeks (14 days) or greater than 2 weeks, for G.A.S. I and G.A.S. II. The frequencies by weeks and the 2X2 crossbreak are reported in Tables 13 and 14, (for inpatient services only; pick-up time in hospice and home care is automatically immediate). 40% of the cases were opened in the first week and a total of 70% by the end of 2 weeks. Although the mean outcome score for G.A.S. II of those cases opened within 2 weeks is 4.38 higher than those opened beyond 2 weeks, there is about a 50% probability that the variation is caused by chance, causing the finding to be insignificant.

Hospital service on which the patient was placed was initially examined in terms of all services but again because of small cells was contracted--this time to a 3X2 crossbreak, since any further contraction was not appropriate (See Table 15). The 3 service categories are inpatient/adult, inpatient/children, and aftercare. Analysis

TABLE 13
FREQUENCY OF CASES BY WEEKS OF CASE OPENING
(INPATIENT ONLY)

WEEKS	FREQUENCY	PERCENT
1 (1-7 days)	9	40%
2 (8-14 days)	7	30%
3 (15-21 days)	4	17%
More than 3 (21+ days)	3	13%
T O T A L	23	100%

TABLE 14
PICK-UP TIME IN RELATION
TO GOAL ATTAINMENT SCORES
(INPATIENT ONLY)

WEEKS	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
2 (1-14 days)	16	49.44	12.66	16	54.16	9.26
More than 2 (15+ days)	7	46.81	11.51	6	49.78	10.64

G.A.S. I $t=.47$ not significant

G.A.S. II $t=.95$ $p < .50$ not significant

TABLE 15
SERVICES IN RELATION TO GOAL ATTAINMENT SCORES

SERVICE	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
Inpatient/Adult Medical/Surgical/ Ortho/ENT	14	50.84	10.27	13	56.17	8.6
Inpatient/Children Pediatrics and Neonatal	9	45.21	14.53	9	48.33	9.42
Aftercare Hospice and Home Care	7	51.72	11.82	7.	51.91	8.42

G.A.S. I $F=1.29$ not significant

G.A.S. II $F=2.13$ $p < .25$ not significant

of variance was conducted and F-tests showed no significance. There is a striking difference between inpatient/adult and inpatient/children scores, however, this is probably attributable to age differences rather than service, since age did prove to be statistically significant variable (see above).

The only worker-related attribute which is readily quantifiable is years of experience, post masters. A 2X2 crossbreak divided up to 6 and greater than 6 years experience (see Table 16).

There is an inverse relationship of significance

TABLE 16
WORKERS' YEARS OF EXPERIENCE
IN RELATION TO GOAL ATTAINMENT SCORES

YEARS OF EXPERIENCE	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
1-5 (N=6 workers)	18	54.1	11.73	18	55.74	9.42
6 or more (N=3 workers)	12	42.24	8.37	11	47.77	6.42

G.A.S. I $t=1.53$ $p<.10$ not significant

G.A.S. II $t=2.47$ $p=.02$ significant

Est. omega squared (G.A.S. II) = .14

between G.A.S. II scores and years of experience: the greater the years of experience, the lower the scores; the lesser the years of experience, the higher the scores. The omega squared of .14 indicates that approximately 14% of the outcome may be determined by worker experience. This inverse finding is significant at $p=.02$. It also should be noted that change from G.A.S. I to G.A.S. II was +1.64 for less experienced workers but +5.53 for experienced workers. There were 6 workers with less than 5 years experience and 3 with more than 5. All workers were female.

A final area to be examined is the relationship of peer review scores to goal attainment scores. The peer

review instrument was discussed in Chapter Five and may be found in the Appendix. The instrument was not designed to be quantifiable. For purposes of this study, quantities were assigned to each rating category: Better than Average --3, Average --2, Below Average --1, Unacceptable --0. The ratings for each of the sections of the instrument (psycho-social history, assessment, etc.) were added for a composite score. One section was eliminated because in 4 of the 12 peer review instruments available for the sample, "outcome" was not filled in by the raters. The maximum score was 24. The G.A.S. scores and peer review ratings for the 12 cases may be found in the Appendix. It is apparent that there is no systematic variance of any kind.

The implications of this and the other findings will be discussed in the following chapter.

CHAPTER VII

IMPLICATIONS AND CONCLUSION

IMPLEMENTATION

A review of the process of implementation reveals several findings of an anecdotal, but nevertheless significant nature. A most striking finding of this kind was the degree of resistance of the workers to participation in a project in accountability. A set of circumstances can be identified which interacted with, increased, and reinforced the negative attitudes of staff: the consent form; unavoidable absences of staff due to serious illnesses, jury duty; the financial crisis of the medical center and its impact upon the social work department; the presence of a graduate social work student as assistant to the project director; the use of a rater who was administrative assistant to the director of social work.

The literature confirms that workers are often ambivalent, if not negative, toward accountability measures.¹ Choate, et al., in an article on training in goal attainment scaling, report results which parallel what occurred in the project:

Perhaps the greatest source of resistance to Goal Attainment Scaling comes from its intimate relationship to accountability. For therapists to

state explicitly in Goal Attainment format what they believe will be the outcome of successful mental health treatment for a given patient may arouse within them concerns that their skills and therapeutic prowess will be judged on the basis of those goals. Although this issue is not often directly brought up by the therapists, discussion with many convinced us that it is a rare therapist indeed who does not have at least initial trepidation over therapeutic 'attainments' becoming a matter of written record.²

In fact, as had been found in this project, Choate, et al. also found that "resistance to Goal Attainment Scaling can become dramatic."³ The generation of 30 instead of 50 cases, one worker having contributed only a single case, and all workers' refusal to do ratings at discharge constitute "dramatic" resistance. Another perspective is that in spite of strong, persistent negative attitudes, workers did participate in a process that yielded 30 cases whose goals had been successfully operationalized, scaled and measured. This dichotomy of negative attitude and positive professional performance (with some "acting-out") was present throughout the duration of the project. Chernesky had found some evidence of this in her study also conducted in this setting, but she found the opposite as well: some workers had verbalized approval of quality assurance but their later behavior contradicted this.⁴ In this project some subversive "acting-out" took place, as described above, but many workers were able to separate their feelings from practice. As one worker expressed it: "I resent this whole process greatly, but I will do what

is expected of me, and do it well!" This worker produced four cases in a relatively timely manner, none of which required committee modification. The committee process was especially distasteful to workers, and once the process was well underway, it was distasteful to committee members as well. The committee review and the goal attainment scaling methodology itself represented a new, formidable encroachment on professional autonomy. The range of responses to this encroachment varied from overt resistance, to moderate cooperation with some passive resistance, to full compliance with verbalized negative feelings, to full compliance with positive feelings about the project. These patterns suggest the emergence of a typology of worker response to accountability systems. However, regardless of the response, the underlying attitude in most instances was negative.

A number of authors in the literature have discussed the issue of worker resistance to evaluation.⁵ The essential dynamic, described in most articles, is well stated by Gurel: "Every organization has two superordinate sets of goals. One has to do with stability and survival; the other has to do with growth and change. And the two always operate to a significant degree to pull the organization in different directions."⁶

More specifically, Weiss has identified a series of factors influencing resistance to evaluation: personality differences, differences in role, conflicting goals

and values, and institutional characteristics. The issues that typically provoke resistance, according to Weiss, include data collection, changes in record-keeping procedures, selection of program participants and status rivalry.⁷ Many of these factors and issues were evident in this study, as well as others: the threatening nature of outcome accountability in possibly exposing poor practice results; the additional paper work imposed upon already high workloads with considerable amounts of existing paper work; the identification of the project with administration and the fear that data would be used against workers; the particular circumstances of worker illness, and of a fiscal crisis in the medical center resulting in threatened layoffs and actual re-organization. Beyond these reasons looms the larger issue of social worker autonomy and accountability. In the literature review presented in earlier chapters (see especially Chapters 1 to 3) the issues of accountability in relation to professionalism and autonomy were identified. "Autonomy" in professionalism was defined by Freidson as, "control over the content if not the terms of the work."⁸ In social work, the self-directed worker is "responsible for his own practice, and accountable for learning and performance through quantitative and qualitative measures."⁹ The essential dilemma is that professions must demonstrate that they can exercise some control over the behavior of their members in order to maintain accountability to society,

yet a characteristic of professionalism is autonomous practice. The usual attempt at resolution of this dilemma is education, credentials and socialization. In the process of educating professionals, socialization fosters an internalization of values, education imparts knowledge and skills, and credentials assure that minimum standards have been met. Other forms of surveillance exist, such as supervision, various kinds of peer review and ethics boards. However, within this framework, professionals are often assumed to be self-directing, autonomous practitioners who have internalized controls and who are capable of a degree of self-evaluation. It may be that, in the contemporary practice arena, professional autonomy is an illusion, especially in health care in which collaborative practice and interdependence are prevalent.

Social work has been demonstrated to be an accountability-minded profession from its earliest days. This is particularly appropriate because of the institutional nature of social work practice and the community sanction and social sponsorship of social work activity. Social work serves a clear social control function in society at large (as in some fashion, all professions do). Traditionally, social work accountability has been carried out through an emphasis on case recording and supervision. The movement for the autonomous worker emerged as an alternative to hierarchical supervision, objecting especially to the infantilizing,

dependency-inducing, and over controlling tendencies which were felt to be inherent in the supervisory process. At the same time, social work practice more and more was subjected to the many new methods of accountability which came about since the passage of the P.S.R.O. Act. The concept of self-directed practice is preferable to autonomous practice, because autonomy is probably not achievable in any profession today nor necessarily desirable - especially in social work. It is possible to envision, as mentioned in a previous chapter, that peer review of process, and outcome evaluation of end results could replace the administrative/evaluative component of supervision; and that a perceptor model could replace the educational component -- providing a framework within which some self directed practice becomes possible. Freedom from the controlling nature of supervision for the advanced worker can provide the opportunity for self-direction while at the same time the existence of quality assurance mechanisms as described throughout this report can assure the maintenance of accountability.¹⁰ But such an approach does not yet have wide support in the profession.

Instead, upon the structure of traditional recording, statistical reporting of case activity, and supervision has been added the super-structure of modern management technology, peer review, and utilization review. Rather than replacing a layer in the accountability hierarchy,

several new layers have been added. At Long Island Jewish, although a pilot of self-directed practice was being planned, the workers who were participants in the project were all subject to regular individual and group supervision with social work supervisors, and additional supervision from psychiatrists. They were subject to considerable demands for statistical accountability, discharge planning monitoring, utilization review, and peer review. Although the intellectual content of goal attainment scaling might have been attractive to some as a tool of practice (and its potential was acknowledged), this advantage was obscured because the method was clearly presented in the context of accountability. It was an addition to an already overburdening system of accountability. Just as the expectations for greater autonomy were raised, its prospect in reality seemed more remote to workers.

If a project design similar to this one were to be replicated in this or other settings, certain changes would be necessary, based on the experiences described above. Although there was some effort to prepare workers, much more extensive preparation would be appropriate. A full orientation to the quality assurance field, its key issues, and the importance of it for social work; as well as a conceptual introduction to outcome evaluation, would be important content to share with participants. The general approach to dealing with resistance and negative attitudes

involves frequent group meetings to clarify issues, to allow for ventilation, and to bring about a process of socialization. The establishment of the usefulness of the technique for practitioners can also help offset initially negative feelings, but such a process takes time. An honest sharing with workers in advance, of the expectation that they may have negative feelings about participation, is another approach. If possible, allowing workers some role in planning and decision-making, however limited, can contribute to a sense of their ownership of a new technique, offsetting the feeling that it is totally imposed by administration.

The group of participating workers knew that the social work department was fully supportive of the project, but except for a brief initial memo, administrative presence was not evident. It may have been helpful to have the Director and Associate Director of Social Work meet with workers, along with the Project Director, so that administration's goals in supporting the project would be made explicit from the start. Once administration's intentions were clearly known, it would have been prudent to select a rater who was not directly connected to administration; and having had a student even peripherally involved may not have been wise. These latter measures would eliminate any factors which would additionally contribute to the workers' sense of being threatened by the

project. "Very little empirical research has been done on arrangements and methods that lessen tension in applied research projects."¹¹ Among the suggestions in the literature for improving evaluator/practitioner relations are: support from administrators, involvement of practitioners in the evaluation, minimizing disruptions, the feedback of useful information, clear role definitions and authority structures,¹² sharing of credit and acknowledgements in reports and publications.¹³

In the light of the realization that one accountability mechanism was being added to an array of others, another possible modification would have been the freeing of workers from some existing demand, especially an accountability related one. This is complex and requires a restructuring of a total system and this may not be possible. But, in principle, some effort should be made of not weighing down workers by an ever-proliferating series of demands. Although the goal attainment scaling method is in itself not time consuming, it was perceived in context as another major demand. Some relief or reward structure needs to be built-in to such projects.

Another consideration for future replication involves possible stages of introduction of the method. It might have been possible to separate the objective of improving goal formulation in practice from the objective of adding an outcome component to the accountability system

(see below for an assessment of the project in light of its initial goals and objectives). A sequence of modest objectives, building on each other over time, may have avoided a feeling of being overwhelmed. If the workers became comfortable with the professional/practice advantages of G.A.S., they may have accepted more easily its use in outcome accountability. Although conceptually goal and outcome are inseparable, and the goals of social work practice are in fact a major issue in accountability, from a practical, strategic perspective, such a staging may have been effective in lessening resistance and negative feelings. A further issue is the general timing of the project. It was not possible to really have anticipated the external events and circumstances which so much contributed to the exacerbation of negative attitudes, however the project might have been delayed once it was clear that its context was not conducive to its immediate continuance. If it can be avoided, a new accountability or evaluation system should not be introduced in an atmosphere of fiscal austerity and budget cuts.

Both this project and Chernesky's were limited in that the introduction of new accountability mechanisms were examined only in their earliest phases of development, when anxiety and resistance would be anticipated to be high. The peer review program at L.I.J.-Hillside Medical Center has become institutionalized in the Department of Social

Work Services. There is little resistance or negative attitudes after six years of experience. At hiring, workers are oriented to the expectation that peer review, along with many other accountability systems, are part of the job. What is needed in future research are studies which examine the various stages of adaptation, over time, of staff to new accountability systems. An understanding of which processes help staff cope with the threats of accountability will help administrators plan better ways to maximize the timely integration of accountability into the day to day life of a social work department or agency.

Another consideration is informed consent. While Human Subject Review Committees uphold a strong social value of protecting patients rights -- a value social workers embrace -- it is questionable that the benign and unobstrusive design utilized in this study should have required a consent form. Although the literature on the ethics of informed consent in the social and behavioral sciences generally supports the use of mechanisms for protection of subjects,¹⁴ some authors have questioned the wholesale replication of the biomedical research model of consent, in which issues of physical harm are often present.¹⁵ The emphasis in the literature is on the ethics of and necessity for establishing standards of subject participation in research, not on the consequences of consent for the research itself. The literature is very sparse on the latter.¹⁶ Assuming that Human Subject Review

Committees will usually require such consent in the future in similar studies, it is recommended that serious attention be given to creating ways of including the most hard to reach clients in social work outcome evaluation studies. The requirement for a patient or family member's signature on a consent form was a major obstacle present in this study, causing sample bias because of refusal to sign. Singer, in an empirical study of this issue found that "of ... three experimental variables, only the request for a signature had a statistically significant effect on the probability of responding."¹⁷ She concludes: "Since the request for a signature appears to function largely as another sensitive question, the requirements that researchers obtain a signature to document consent seems unnecessarily burdensome."¹⁸ Of those who refused to participate in the Goal Attainment study, most would have participated except for the requirement of a signature. There are ways to document that a subject is informed about the nature of a study and its consequences other than a signature.

Separate studies which identify the highest at risk population and develop specific ways to reach and measure this population will be a contribution to the field of health care social work. The field of epidemiology is becoming sensitive to the consequence of subject refusal to participate in studies.¹⁹ Pearlin and Schooler describe a technique in door to door epidemiological research in which substitutes

from the same block took the place of people who refused to be interviewed.²⁰ An equivalent to this may be possible in social work health care outcome studies.

It was disappointing, although understandable, that workers did not rate their own outcomes. In order for the mission of empirically oriented practice to be realized, the norm of self-evaluation needs to be more firmly integrated into social work education and agency practice systems. Studies should be conducted which focus on the processes, dynamics and constraints of worker self-evaluation of practice.²¹

STATISTICAL DATA: INTERPRETATION AND IMPLICATIONS

The modifications of the design brought about by the various implementation problems are:

1. Services studied - The initial proposal called for a broad inclusion of a variety of medical services in which social work services were offered. However, from both a practical and conceptual point of view, it was decided to limit the study to adult and children inpatient services and two aftercare programs: medical, surgical, ear/nose/throat (ENT), pediatrics, neonatal, orthopedic, hospice and home care. Thus, a clear focus emerged on the acute inpatient/aftercare continuum, providing an opportunity for examining outcome in a critical area in contemporary health care policy: discharge planning.

2. Selection of social workers - In order to control service selection, it followed that workers could not be

recruited on a voluntary basis. Thus, all social workers on the above mentioned services were assigned to the study. The consequences of this decision have been described above.

3. Sample size - For reasons given above, 30 instead of 50 cases comprised the sample. In addition to not being as representative as 50, 30 cases did not allow for certain kinds of statistical tests, because the numbers in the individual cells of cross breaks were often too small to be the appropriate subject of tests.

4. Sample bias - Attrition of cases because of the consent form was one source of sample bias. The randomization design itself may have been altered by workers for reasons previously described. The speculation is that the most difficult cases may have been passed over. This is unconfirmed.

5. Worker self-evaluation/rater reliability - The absence of worker conducted ratings at the time of patient discharges not only deprived the study of the opportunity to examine worker self-evaluation, but also deprived the study of the opportunity to test rater reliability.

6. Follow-up interviews/rater - As has been discussed, the rater was a member of staff associated with the Director, not a volunteer recruited from the outside. Although the proposal allowed for the possibility of a staff member as rater, the particular rater's other functions added to worker anxiety. Discharge interviews were conducted

face to face, but follow-up interviews were conducted by phone. The initial proposal had called for in-person follow-up interviews, which were not feasible. There is a diminished ability to make assessment by phone.

Although fully discussed in other chapters, other sources of limitation will be briefly summarized. Outcome measurement in general has inherent limitations among which are: the difficulty of attributing outcome to the process of care because of numerous confounding variables which are hard to control; the difficulty of specifying outcome standards; positive results may not appear before a long time elapses following intervention; outcome may be a less direct indicator of quality than process; validity is difficult to establish for outcome measurement; psychosocial and medical knowledge may not be advanced enough to establish a clear understanding of outcome. Beyond these theoretical considerations, it has been identified that the idiographic approach, and in particular goal attainment scaling, have a series of limitations based on issues of validity and reliability (see Chapter 5 for a full description of the methodological limitation of G.A.S.). The design employed here, the interrupted time series, also limits the assertion of firm conclusions which have external validity (see Chapter 5). Nevertheless, this project represents an exercise in applied evaluation conducted in the real work world of ongoing social work practice. The methods used have enough strengths

as identified in the literature (for example, the attractiveness and flexibility of using case specific goals as outcome criteria) and enough care was taken in their execution, in spite of limitations, to at least identify important patterns of interest which should be useful to practitioners, administrators and evaluators.

This project was intended, among other objectives, to demonstrate the feasibility and desirability of adding an outcome component to a quality assurance program. It was not intended to test hypotheses of a causal nature. Nevertheless, although not scientific experiments themselves, quality assurance programs must be grounded in scientific principles. As has been discussed elsewhere in this report, issues of validity, reliability and design are relevant to quality assurance programs. Thus the various limitations discussed above must be kept in mind as further conclusions are tentatively drawn from data in what follows. The general demographic patterns of the sample had been characterized as predominantly white, over 65 years of age, married, receiving Medicare benefits, suffering from a variety of illnesses with cancer and cardiovascular disorders the more frequent. A minority of the sample were children, mostly 5 years or younger, many suffering from severe, debilitating and sometimes life-threatening disorders. (See Table 1. Note: all tables referred to may be found in Chapter 6). These patterns presented no

surprises; they are typical of what one would expect in an urban/suburban, middle-class acute care general hospital. The 65 goals identified by the participating social workers for their patients were confirmed by the supervisors and members of the goal review committee to also be typical of the setting and population. Thus, the sample may in general be assumed to be fairly representative (see Table 2).

The percent of concrete goals (38%) in contrast to psychosocial goals (62%) was striking. Psychosocial concerns are certainly an integral component of the discharge planning process; but in today's climate of hospital care, with stress on utilization, alternative levels of care, and discharge planning, one might have expected a greater emphasis on concrete services. Clearly in this sample psychosocial goals were stressed. One of the objectives of this study was the enhancement of workers' abilities to formulate case-specific goals. By examining goals in clusters and on a service-wide or departmental level, accountability may be enhanced and planning decisions may be made concerning the future deployment of resources toward specific ends. Administrators might decide that a greater or lesser emphasis should be placed on concrete or psychosocial goals. A display of goals, their frequencies and outcome scores, can aid along with other data, in making policy choices. There are of course risks inherent in such an approach. Patient needs and overall context must be considered. This aspect of

the project suggests the possible usefulness of a goal information system as part of a social work accountability program.

"Referral-community supports/resources" was the concrete goal with the highest frequency; "family/patient adjustment to illness" was the most frequent psychosocial goal. These two goal areas represent the essence of medical social work; the orchestration of community resources to meet post-hospital needs; and professional intervention to facilitate emotional adjustment to illness, to help patient and family cope with the separation, loss, anger, anxiety and/or depression that accompany physical illness. It is thus a reasonable expectation that they would be the most frequently cited goals. An examination of the raw goal scores for these two areas (see Table 3) as well as for all goals (see Appendix) revealed that from time 1 (G.A.S. 1) to time 2 (G.A.S. 2), psychosocial goals exhibited less stability, that is greater change took place. Also, no psychosocial goal score was rated at the +2, or highest level of expectation. Since concrete goals can be specified in exact terms, such as "placement in nursing home within two weeks," the +2 or "much better than expected" level of outcome may be achievable. However, the psychosocial areas, which deal with the ambiguities and conflicts of human emotion, are much less likely to reach ideal states of outcome achievement. The general instability of scores in this

area is also reasonable. Concrete services are more predictable. With experience, workers can more easily predict the psychosocial dynamics of a family experiencing a major crisis around serious medical illness one month after discharge. Thus a study of goals and raw scores can provide some understanding of social work practice in health settings. The issue of the balance between the psychosocial and the concrete remains a major area of controversy in the field.

Another perspective is that the structure of the study methodology may have reinforced a false dicotomy in the medical social work field between concrete and psychosocial goals. The expectations which health care institutions have for social work often stress the achievement of concrete social work goals, such as placement in a nursing home. Social work practice principles encourage the understanding of the whole person in situation. Thus the data discussed above on the balance between concrete and psychosocial goals may be a distortion based on the particular artifact of reporting in this study. A challenge for future studies is the capturing in measurable terms of an integrated concrete/psychosocial practice.

In contrast to the raw goal scores, the goal attainment score is a composite outcome measure of all goal scores and weights in a case. The G.A.S. I mean score was 49.356 and the G.A.S. II mean score was 52.712. The logic of the method leads one to expect mean scores of approximately 50,

or the expected outcome. From these findings one might conclude that the method was employed correctly. If mean scores had significantly deviated from 50, this might have indicated flaws in the application of the method. It also could have indicated lower or higher overall levels of outcome achievement on a sample wide basis. The range of scores and standard deviation (see Tables 4, 5 and 6) demonstrate considerable variation within the sample. It is likely that the mean scores represent a valid use of the instrument.

Since 57% of the cases met or exceeded expectations by discharge and 69% met or exceeded expectations by one month post-discharge; and since the t-test of change from mean G.A.S. I to mean G.A.S. II was significant at the .02 level, one may tentatively conclude, taking into consideration the limitations of the study, that the overall outcome of the sample is positive. There is irony here. Workers were so threatened by the project, yet it seems that the good quality of their work was confirmed. It is reasonable to expect that if improvement is to occur following short-term social work intervention on acute medical services, the improvement would be more evident after discharge, since there might be a delay in realizing gains of a concrete and/or psychosocial nature. There are implications in this finding for worker morale. If gains are in fact more evident after discharge and follow-up is not routine (it is not routine in most settings), then social workers in acute, short-term settings

are deprived of the satisfaction of knowing the impact of their interventions. This finding suggests a future study of the timing of patient improvement, follow-up, worker satisfaction and morale.

Of course, other variables can account for the gains as well. Patients may improve medically after discharge contributing to a general feeling of improvement; relief of symptoms combined with discharge from the institutional setting may dissipate the sense of crisis. For some patients and their families, however, return to the community can be accompanied by more stress and crisis, as difficult medical regimes must be followed, and new disabilities must be adjusted to in the home environment. An examination of the diagnoses and of the discharge plans, as contained in the content of the goals, indicates that in most of the cases in the sample difficult adjustments after discharge were necessary. The findings lead to the possibility that social work intervention did make a positive contribution in providing necessary emotional and concrete support during and immediately following hospitalization. An experimental design which controls for potentially confounding variables would be necessary to test such an hypothesis.

The analysis of outcome scores in relation to demographic variables revealed some interesting patterns (see Tables 7 - 11). Adults achieved significantly higher scores than children. If this is not a particular artifact of the

study, it may be understood by the degree of medical pathology on pediatric and especially neonatal services. The consequent psychosocial impact on patients and families is severe. Serious illness and hospitalization is less congruent with normal life cycle expectations in children than adults. If subsequent studies continue to confirm such outcome patterns, social work hospital administrators may wish to augment services and resources in the pediatric social service area.

Another demographic - outcome pattern emerged in relation to age, sex and marital status: married, adult men over 65 had the highest social work outcome follow-up scores and the strongest positive change between measurements. Again, the possibility of an artifact aside, some speculation is in order. Women have a longer life span than men, and consequently outnumber men, especially in the higher age groups. Men who survive into old age are considerably more likely to be married or re-married than women. Marriage has often been associated in all age groups with better health status. Although an epidemiological analysis of this data is beyond the scope of this report (and the sample is not large enough to draw firm conclusions which have external validity), the patterns of age, sex and marital status with respect to social work outcome which emerged from this study are not inconsistent with generally known epidemiological patterns.²² Enough patterns of

interest are present to suggest that studies of social work outcome in relation to demographic characteristics would be a worthwhile activity for social work departments to pursue.

Of the intervention oriented variables, only years of worker experience had a statistically significant association with outcome. This was an inverse association that new workers produced higher scores than experienced workers (see Table 16). A possible explanation is that workers who have practiced for longer are subject to the phenomenon of burn-out; they may be less open to an approach as was required in this project of defining goals in behavioral and measurable terms. Other possibilities are the unique attributes of workers in this study or the particular difficulties of cases that may have confronted the more experienced workers. Experienced workers did however bring about more change in their clients - but as was pointed out in the previous chapter, lower scores tended to rise (regression to the mean).

The psychotherapy research literature which reports empirical data correlating therapist experience with therapeutic outcome, identifies the opposite pattern: "Even though data are limited in this area, more positive outcomes do seem to accrue to experienced than to inexperienced therapists."²³ Although there are methodological problems inherent in such studies, and little conclusive evidence

exists to support higher experience level as a powerful predictor of positive outcome,²⁴ the inverse association evident in this study is not replicated elsewhere. The available literature focuses on psychotherapy, however; this issue does not appear to have been studied in medical social work, in which other factors may be present to explain such data. Further study beyond this sample is obviously necessary.

Service, committee action, scales negotiated and social work pick-up time did not associate in a statistically significant fashion with outcome scores. It was not surprising that service did not - it is a vague concept. A large scale study with a large sample in whose design is built a valid and reliable recording of medical diagnoses would potentially provide a better way of understanding the relationship between medical illness and social work outcome. Only 7 cases were the subject of committee action and they showed little systematic variance. Scales negotiated deals with the central issue of mutuality between worker and client. However, no attempt was made to conceptualize, operationalize and control this intervention variable. A separate study would be necessary, probably of an experimental nature, to ascertain the impact of mutuality on outcome. This is a fruitful area for future research.

The descriptive table on sources of referral (Table 12) indicates that the older patterns of physician dominance in

determining who will use hospital social service as reported by Berkman and Rehr,²⁵ have changed. If this is characteristic of practices at L.I.J., it is an important development in social work's struggle for its own identity in medical settings, less subject to the direct authority of the medical profession. The crucial area of pick-up time (early intervention) did not correlate with outcome; however, since the assumption in the profession is that earlier pick-up time is positive, it is commendable that 70% of all cases become known to social work by the end of the second week of hospitalization. Since source of referral, case finding, screening, and pick-up time are central issues in today's practice of hospital based social work -- with both professional values and fiscal implications -- future studies of the impact of these variables on social work outcome would be important. Length of stay and utilization data were not readily retrievable in this study but they are crucial variables to be added to future studies.

In the case of all of the variables discussed so far, some systematic variance appeared, at least superficially, to be present: in only a few instances (as described) did the variance turn out to be statistically significant. In the case of peer review, however, chaos reigned. An examination of G.A.S. scores and peer review "ratings" (see Appendix) reveals no variance of any kind. This was disappointing, because the establishment of linkages

between process and outcome is a central issue in quality assurance (see chapters 3 and 4). A null hypothesis emerges regarding these assumed linkages, based on this study. Unfortunately, these findings (or lack of findings) are not in isolation. Brook, a leading medical researcher in the quality of care, had a similar experience in attempting to link general process indicators to outcome. He warned:

. . . however, considering medical-care recording practices and the disagreements on efficacy in the literature, the use of criteria lists, such as those generated in this study, as standards may be likely to decrease efficiency of medical care by dramatically increasing the number of medical-care processes performed without substantially affecting the health of patients.²⁶

This would be equivalent in social work to those who warn that stressing recording (process accountability) in the absence of evidence that it improves patient care (outcome) will bring about a form of goal displacement in which time is taken away from work with patients in order to do paper work of dubious value. Before such conclusions are drawn, more careful study must be conducted. In this project, the peer review instrument was quantified for purposes of data analysis; the instrument was never initially designed to be quantified. Further, this peer review system has never been subjected to any systematic or controlled studies. Chernesky had studied training and socialization for peer review, not the actual process of peer review. A brief and exploratory attempt several years ago at examining

inter-rater reliability yielded very poor results. Thus, the validity and reliability of peer review in this setting is questionable and no attempt to control it took place in this project. In addition, it is unknown whether the reviews obtained for part of the G.A.S. sample were conducted with reviewer knowledge that results would be compared with outcome measurements in this project. If reviewers were aware of that context, bias may be assumed. Also, only 12 cases of the 30 had peer reviews conducted. Thus, there were distinct methodological weaknesses inherent in this tentative exploration of process/outcome correlations. The recommendation for future research is as follows: both process and outcome measurement methods must be carefully refined; process criteria should be explicitly operationalized, quantified and tested for reliability; outcome methods must be validated. Both must be accepted over time as part of the ongoing operation of a department of social work. Then, controlled studies comparing both may be conducted with some confidence about the value of the results. All other considerations aside, in this project the fact of a new, threatening and controversial method for measuring outcome being compared with an established, ongoing monitoring system of peer review virtually invalidates results on process/outcome linkage, whatever they might have been. An incremental strategy for phasing in accountability mechanisms is a strong recommendation which emerges from this project.

The findings which emerged from the process of implementation as well as from the statistical data, have been reviewed. An assessment of the project as a whole will now be made by re-examining its initial principles, goals, objectives, and sub-objectives. (refer to Chapter 5, pp. 148-9). Practice principle "a" and goal "1" are similar, as is principle "b" and goal "2". The first principle/goal refers to the enhancement of social work practice by the systematic attentiveness to goal formulation. To firmly establish such a principle, an experimental design study would be needed in which one group of patients would be provided social work services using goal attainment scaling as its method of goal specification and in a control group G.A.S. would not be utilized. A method independent of G.A.S. would have to be used to determine if social work practice had been enhanced. However, within the limits of this project most social workers who had something to do with its execution (workers, committee members, supervisors, etc.) felt that G.A.S. forced social workers to clearly think about goals and is an aid in goal formulation. Evidence in the literature supports the contribution of goals to practice (See Chapter 4).

The second principle/goal refers to the use of goals as client-specific outcome measures, enhancing accountability to client, agency and community. Whether accountability is achieved cannot yet be appraised based on such a pilot project, but the usefulness of goal attainment scaling as a

social work outcome instrument has been tentatively established. The goals as specified by workers did seem to readily lend themselves to outcome criteria and the G.A.S. method provides a 5 point numerical standard adjustable to each client. That the project could produce significant displays of aggregate outcome data and selected variables which shed some light on key practice and professional issues, as discussed above, is in itself a measure of its potential for social work accountability systems. As has been suggested, the initial separation of principle/goal 1 and principle/goal 2 in future studies, would allow first the establishment of the method for professional practice, and then the use of it for outcome accountability purposes. Given the behavior of workers and the consequent cost to the organization and to the project, one can conclude that the project goals were too ambitious; that it attempted to accomplish too much too soon.

Objective "1", the improvement of workers' clarity and focus through careful goal formulation, was probably achieved (see above). Objective "2", the improvement of client goal attainment, can only be tested experimentally, but the study did tentatively demonstrate a relatively high attainment of patient specific goals. Objective "3", the expansion of the ongoing accountability system by the addition of an outcome component was demonstrated to be achievable on a pilot basis, but at some organizational cost

(negative worker behavior toward the project).

Sub-objective "1", establishing a balance between workers' negative reactions and the generation of valuable data for accountability, was partially achieved. In spite of resistance, data was produced. Sub-objective "2", achieving a sense of worker ownership of the method rather than a sense of outside imposition, obviously was not achieved for the many reasons discussed. Finally, sub-objective "3" refers to testing the viability of the goal reviewing committee. A committee structure was necessary for such a pilot study. However, because it only found it necessary to modify 7 goal attainment follow-up guides and at the same time generated considerable hostility -- in some ways it was the most threatening aspect of the project -- a recommendation for the future would be to find alternative ways for consensually validating the appropriateness of goal formulation. Those alternatives might take the form of existing peer reviewers or supervisors fulfilling this function, and probably on a sampling basis. If continued experience reveals that it is not a necessary function, it should be completely eliminated. It clearly represented an additional assault on a sense of autonomy or self-direction of social workers.

In conclusion, this project was too ambitious in scope. A more modest, incremental approach would have been more appropriate. It did generate significant information

on social work behavior in response to new accountability measures. It also established the potential value of outcome quality assurance in social work.

The findings reported above should be understood in the context of the methodological limitations described. There are some statistically significant findings, especially in the relationship between certain demographic characteristics and outcome. The overall assessment is in the direction of the L.I.J. social workers having achieved or surpassed initial client expectations, which is to the credit of the Department. Although there was clearly an organizational cost to this pilot, it is equally clear from an examination of these findings that an accountability system which adds the component of outcome evaluation strengthens the data base available for making administrative and planning judgments for the advancement of improved social services. Since the many goals identified in the study were readily categorized into 12, with further refinement a semi-standardized list of goals, valid at least for this setting, could be utilized in future experiments in outcome measurement. It is hoped that future research in individualized and standardized outcome measurement will be conducted, and along with other accountability mechanisms, will improve the quality of social work services to patients in health and other settings.

NOTES

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APPENDIX A

STATISTICAL TABLES 17-22
(Not presented in text)

TABLE 17

PEER REVIEW RATINGS IN RELATION TO GOAL
ATTAINMENT SCORES (12 CASES / 8 WORKERS)

GOAL ATTAINMENT SCORE		TOTAL PEER REVIEW SCORE
G.A.S. I	G.A.S. II	(MAXIMUM = 24)
60	60	24
57.35	62.25	24
50	50	24
43.20	51.70	24
42.65	45.10	24
41.20	45.60	24
32.40	43.40	24
25.20	37.60	24
43.79	50	23
40.88	59.12	20
70	70	19
39.80	39.80	14

TABLE 18
RAW GOAL SCORES BY GOAL CATEGORIES

			G.A.S.				
	Time of Measurement	N	-2	-1	0	+1	+2
A. Concrete Services:							
1. Discharge Planning	I	4			1	1	2
	II	4			1	1	2
2. Placement Nursing Home/Alternate Level of Care	I	3			3		
	II	3			1	2	
3. Referral-Community Supports/Resources	I	11	2		6	1	2
	II	11	1	2	4	2	2
4. Entitlement Facilitation/Advocacy	I	7	3	1	1	1	1
	II	6*	1	2	1		2
B. Psycho-Social:							
5. Improve Interpersonal Relationship	I	4		2	2		
	II	4		3		1	
6. Fam. /Pt. Participation In Discharge Planning.	I	8			7	1	
	II	8			4	4	
7. Strengthen Family Role as Caretaker	I	2			2		
	II	2					2
8. Strengthen Patient Role in Self-Care	I	1	1				
	II	1	1				
9. Fam. /Pt. Adj. to Illness Separation, loss, anger, etc.	I	18	3	1	11	3	
	II	17*		6	5	6	
10. Fam. /Pt. Adj. to Death and Dying	I	2	1			1	
	II	2		1		1	
11. Compliance with Medical Regime	I	1			1		
	II	1	1				
12. Strengthen Family Decision-Making	I	4	1		2	1	
	II	4	1	1	1	1	
Totals	I	65	11	4	36	9	5
	II	63*	5	15	17	18	8

* The difference is accounted for by the death of 1 patient in the sample between G.A.S. measurement I and II.

TABLE 19

RACE IN RELATION TO GOAL ATTAINMENT SCORES

RACE	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
White	22	48.40	11.21	21	51.47	8.78
Other	8	51.97	14.18	8	55.05	10.05

G.A.S. I $t = .72$ $p < .50$ not significant

G.A.S. II $t = 1.19$ $p < .50$ not significant

TABLE 20

MARITAL STATUS IN RELATION TO GOAL ATTAINMENT SCORES
(ADULTS ONLY)

MARITAL STATUS	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
Married	13	51.84	11.08	13	54.95	7.94
Other (Div., Widow, Single)	7	51.03	10.56	6	54.03	10.48

G.A.S. I $t = .16$ $p > .50$ not significant

G.A.S. II $t = .21$ $p > .50$ not significant

TABLE 21

WORKER-CLIENT AGREEMENT ON GOALS (SCALES NEGOTIATED)
IN RELATION TO GOAL ATTAINMENT SCORES

SCALES NEGOTIATED	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
Yes	15	49.85	12.20	15	53.88	8.47
No	15	48.86	12.05	14	51.46	10.08

G.A.S. I $t = .22$ $p < .50$ not significant

G.A.S. II $t = .69$ $p = .50$ not significant

TABLE 22

GOAL REVIEW COMMITTEE ACTION IN RELATION
TO GOAL ATTAINMENT SCORES

COMMITTEE ACTION	G.A.S. I			G.A.S. II		
	N	$\bar{X}$	S.D.	N	$\bar{X}$	S.D.
Yes	7	47.92	10.47	7	54.4	8.44
No	23	49.79	12.46	22	52.17	9.54

G.A.S. I $t = .35$ $p > .50$ not significant

G.A.S. II $t = .55$ $p > .50$ not significant

APPENDIX B

1. Exhibit: Consent Form Used
2. Brief Case Vignettes of Patients and/or Families Who Refused to Sign Consent Form

LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER

SUBJECT CONSENT FORM (NEW PROCEDURE, STUDY OR DRUG UNDER CLINICAL INVESTIGATION)

Investigator(s) or Project Director Barry Rock, CSW, ACSWAdministrative Social Work SupervisorTitle of Protocol Process and Outcome in Social Work Health Care Practice: The
Use of Goal Attainment Scaling

I hereby agree to (have my ward) participate as a subject in the following project: _____

Social Workers will carefully identify with patient the goals of the social work
service. The social worker will scale the goals so that they may be measuredat a later time to determine the degree of progress in achieving the goals.

I understand that the project will include the following experimental procedures:

Prior to discharge, a volunteer will visit the patient to conduct a brief interview
in order to determine, in the patient's view, the degree of achievement of the goals
of contact with the social worker. A month after discharge, the volunteer will tele-
phone the patient to again determine social work goal achievement.

I understand that the possible discomforts or risks are as follows:

None

Detailed Description _____

I also understand that the possible and desired benefits of this project are:

Improved social work services to patients and families.

I am aware that the following alternative procedures could be of benefit to me (my ward)

Not applicable.

The Institution will make available hospital facilities and professional attention at Long Island Jewish-Hillside Medical Center (or at an affiliated hospital should the research study have been conducted at the affiliated hospital) to a patient who may suffer physical injury resulting from the research study. The Institution will make available hospital facilities and professional attention at Long Island Jewish-Hillside Medical Center borne by the patient. Financial compensation from Long Island Jewish-Hillside Medical Center will not be provided.

I have been given the opportunity to ask further questions and know that I can do so during the course of the project. I understand that in comparison to the costs of medical care which I would normally bear, my participation in this study may: a) greatly increase; b) increase; c) have no effect; d) decrease; e) greatly decrease my cost. (The researcher must circle one of the preceding.)

I am aware that I am under no obligation to participate in this project. I am also aware that I may withdraw my (ward's) participation at any time without prejudice to my medical treatment at Long Island Jewish-Hillside Medical Center.

I further understand that should I have any questions about my (ward's) treatment or any other matter relative to my (ward's) participation in this project, I may call the Office of Grants and Contracts at (212) 470-2386, and I will be given an opportunity to discuss, in confidence, any questions with a member of the Human Subjects Review Committee. This is a Committee which, as required by Federal regulations and New York State law, is an independent Committee composed of Medical Center physicians and staff as well as lay members of the community not affiliated with this institution. This Committee has evaluated the potential risks and possible benefits of this study.

To the extent permitted by law, my participation in this study will be confidential.

Patient's Name _____ Date _____
(Please Print)

Patient's Signature _____ Chart No. _____

Parent/Guardian's Name _____ /Signature _____
(Please Print)

Witness _____ /Signature _____

Relationship of Witness to Patient _____

BRIEF CASE VIGNETTES OF PATIENTS AND/OR
FAMILIES WHO REFUSED TO SIGN CONSENT FORM

I. NEONATAL SERVICE:

1. J. Case - Client was a nineteen year old unmarried mother of a premature baby who had surgery and has a colostomy. The mother was intact and concerned. She was reluctant to give name or address of the father, however he was apparently very involved in this relationship. She read the consent form carefully and said "uh - uh!" She said that she didn't want to sign anything.

2. L. Case - Clients were the intact parents of a very sick baby with a cardiac condition. The worker spoke with them at length around the baby's grave condition. The baby died the night that the case was opened. Worker did not ask the parents to sign the consent form and enter the study, because she felt it was clinically inappropriate.

3. B. Case - Client was a twenty eight year old unmarried mother of a second child, admitted for a possible heart problem. The mother refused to sign the consent form, saying she does not want to talk to any more people. Her first child had been at L.I.J. as "failure to thrive." She had not told the worker about her previous experience which may have been related to her current reluctance. The second child was fine and quickly discharged.

II. PEDIATRIC SERVICE: Three cases were not entered in

the study. Two involved child placement by the Department of Social Services Bureau of Special Services to Children (previously known as Bureau of Child Welfare). In the third case the mother of a hospitalized child herself required psychiatric hospitalization and it was considered clinically inappropriate to pursue her consent.

III. ADULT SERVICES: Two cases were not entered in the study because of the patients intent to sue the hospital.

IV. HOSPICE: Three cases were not entered in the study because the patients were very near expiring and they and their families were too distraught, in the worker's view, to be approached concerning participation.

APPENDIX C

- 1. Exhibit: Materials on Goal Attainment
Scaling**
- 2. Outline of Staff Orientation and Training
Curriculum for Goal Attainment Scaling**

A key factor in GOAL ATTAINMENT SCALING is the preparation of the Goal Attainment Follow-up Guide. This Goal Attainment Follow-up Guide will frequently be scored by someone other than the person who constructed it, consequently, precise descriptions and clearly discriminated levels are essential to accurate follow-up and evaluation. The Goal Attainment Follow-up Guide should be constructed so that it applies to a particular date in the future. The example below illustrates the general process. Further information on Goal Attainment Scaling may be gained from "Programmed Instruction in Goal Attainment Scaling."

1. Major concerns or GOALS of the client are isolated and each concern to be used is placed at the head of a scale, described in a brief phrase called a "scale heading." The scale heading may be general or theoretical.

	X	Y	Z	-	-
MOST UNFAVORABLE					
LESS THAN EXPECTED					
EXPECTED					
MORE THAN EXPECTED					
MOST FAVORABLE					

In this case, an educational situation, the client has three main concerns. Each concern is used as the basis for one "scale": Scale X, grades; Scale Y, reading speed; and Scale Z, number of times sent to the principal's office by the teacher. Since no other major concerns were selected, three scales were constructed and the fourth and fifth columns were left blank. For best results with Goal Attainment Scaling, at least three scales should be constructed.

2. The professional (a counselor in this case) had interviewed the client, a problem student. The counselor discovered

	X	Y	Z	-	-
MOST UNFAVORABLE					
LESS THAN EXPECTED					
EXPECTED	C-	200	3		
MORE THAN EXPECTED					
MOST FAVORABLE					

that the client has an average grade (Scale X) of D, a reading speed of 50 words per minute (Scale Y), and has been sent to the principal at least six times a month (Scale Z). Together, the counselor and the client estimated that the client could reasonably expect, by the end of the school year seven months later, to raise his average grade to C-, raise his reading speed to 200 words per minute, and lower his visits to the principal to three per month if the client cooperated in counseling and remedial reading programs. These predictions became the "expected" levels for the time of follow-up (seven months later).

3. Predictions for some of the other levels on each scale of the Goal Attainment Follow-up Guide are then filled in. Not all levels need to be filled, but the Goal Attainment Follow-up Guide should be adequately detailed for the follow-up eight months later and must have at least three levels per scale.

HOW IS THE GOAL ATTAINMENT SCORE CALCULATED?

This commentary explains the mechanics of calculating the Goal Attainment Score which is one possible method of expressing the results of the Goal Attainment Scaling system. For the purposes of demonstration, the following sample Goal Attainment Follow-up Guide will be used:

	Scale 1: Happiness ($w_1 = 10$)	Scale 2: Creativity ($w_2 = 5$)	Scale 3: Accuracy ($w_3 = 20$)
MOST UNFAVORABLE			
LESS THAN EXPECTED		..*	
EXPECTED	..*		
MORE THAN EXPECTED			
MOST FAVORABLE			..*

On this sample "w" stands for weight. Thus, this Goal Attainment Follow-up Guide shows that the intake interviewer thought that "happiness" should be weighted 10, twice as much as the "Creativity" scale which was only weighted 5.

Each of the five outcome levels, "most favorable" through "most unfavorable," should be assigned a value (+2 through -2) as indicated on the sample.

The "*" shows the "outcome level" of the client as scored by the follow-up rater. In other words, the client was scored at the expected level (0) on Scale 1, at less than expected (-1) on Scale 2 and at (+2) on Scale 3. On a real Goal Attainment Follow-up Guide, of course, each scale would contain items pertaining to one of the major concerns for the client. THE WEIGHTS AND RAW SCORES ON THE GOAL ATTAINMENT SCALING GUIDE ARE THE ONLY NUMBERS NEEDED TO CALCULATE THE GOAL ATTAINMENT SCORE. In the formula below, "x" refers to the "raw score" or "outcome level."

The formula for calculation is: Goal Attainment Score = $50 + \frac{10\sum w_i x_i}{\sqrt{.7\sum w_i^2 + .3(\sum w_i)^2}}$

or $50 + 10 \frac{(w_1 \text{ times } x_1 + w_2 \text{ times } x_2 + \dots \text{out to as many items as you have scales for})}{\sqrt{.7(w_1^2 + w_2^2 + \dots \text{out to as many items as you have scales for}) + .3(\text{all the weights added together})^2}}$

The formula for this sample would read:

$$\text{Goal Attainment Score} = 50 + \frac{10(w_1 x_1 + w_2 x_2 + w_3 x_3)}{\sqrt{.7\{(w_1)^2 + (w_2)^2 + (w_3)^2\} + .3(w_1 + w_2 + w_3)^2}}$$

* * * * *

Using the Weights and Raw Scores from the demonstration guide above:

$$\text{Goal Attainment Score} = 50 + \frac{10(0 \text{ times } 10) + (-1 \text{ times } 5) + (2 \text{ times } 20)}{\sqrt{.7\{(10)^2 + (5)^2 + (20)^2\} + .3(10 + 5 + 20)^2}} =$$

$$50 + \frac{10(0 - 5 + 40)}{\sqrt{.7(100 + 25 + 400) + .3(35)^2}} = 50 + \frac{10(35)}{\sqrt{.7(525) + .3(1225)}} = 50 + \frac{350}{\sqrt{367.5 + 367.5}}$$

$$50 + \frac{350}{\sqrt{735}} = 50 + \frac{350}{27.11} = 50 + 12.91 = 62.91$$

12/73

Staff orientation and training curriculum for Goal Attainment Scale.

I. FIRST SESSION:

1. Overview of accountability and quality assurance in social work practice in health settings and the need for outcome evaluations.

2. Review of the importance of goal identification in social work practice.

3. Introduction to Goal Attainment Scaling and its application to social work, the latter based on

"The Application of Goal Attainment Scaling to Social Work" (Excerpted from "The Application of Goal Attainment to Adoption Practice" by Samuel Finestone, mimeo, Columbia University School of Social Work, 1977.)

4. Overview of this project.

II. SECOND SESSION:

Explicit training in the method of Goal Attainment Scaling.

1. Detailed presentation of the method step by step, utilizing "Guide to Goals, Format One," published by the Program Evaluation Resource Center.

2. Review of all forms and materials plus other learning aids.

3. Special topics:

- a.) goal selection
- b.) overlapping of goals
- c.) combining short and long term goals
- d.) scaling problems

III. THIRD SESSION:

Workshop in Follow-up Guide Construction. Case material will be utilized by the trainees in operationalizing the use of the method.

IV. FOURTH SESSION

Workshop in Committee-Worker interaction around modification of goals. This will provide committee members and participating workers an opportunity to test out the committee process of review and possible modification of goals initially determined by workers.

Sessions will be 1½ hours.

Participants will include: all workers selected for the project; committee members; raters. It will be conducted by the author of this proposal.

APPENDIX D

**Exhibit: Peer Review Audit Instrument
and Instruction Manual**

DEPARTMENT OF SOCIAL WORK SERVICES
LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER
PROFESSIONAL REVIEW AUDIT

244.

SUMMARY REPORT

Case (patient) Identification: _____

Status of case at time of audit: _____ Service _____

Closed _____
Open _____
Unknown _____

Length of time case has been a Social Work Service case: _____

Social Worker/s on case: _____

Date of Audit: _____ Length of Audit
Review Time: _____

Auditor/s: _____

Audit Comments: _____

Attributes	Better than Average	Average	Below Average	Unaccept- able	C O M M E N T S
PSYCHO-SOCIAL HISTORY					
ASSESSMENT					
PROBLEM					
SELECTION					
GOAL					
FORMULATION					
TREATMENT PLAN					
SOCIAL WORK					
RECORDING					
SOCIAL WORK					
ACTIVITY					
CONCLUSION					
NOTE					
OUTCOME					

DEPARTMENT OF SOCIAL WORK SERVICES
LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER
PROFESSIONAL REVIEW AUDIT

REFERRAL (Request for Service)

To determine whether the case should have been taken on and/or continued as a Social Work case beyond the initial interview or screening. To determine whether a need for Social Work Service is indicated, especially with self referrals or where mandatory Social Work coverage exists.

	<u>YES</u>	<u>NO</u>	
1. Is the date of referral to Social Work Services stated	_____	_____	1.
2. Is the date of initial contact stated?	_____	_____	2.
3. Is the source of referral or how the client got to Social Work Services clearly stated?	_____	_____	3.
4. Is the reason for referral (request for service) clearly stated or implied?	_____	_____	4.

PSYCHO-SOCIAL HISTORY (INFORMATION GATHERING)

To determine if necessary information, relevant to request for service is presented; to determine whether the information is sufficient and complete so that the worker has the kind of knowledge about the patient's need and situation which would aide in the evaluation, care and planning in relation to the patient; to determine if unnecessary or extraneous information has been gathered.

	<u>YES</u>	<u>NO</u>	
5. Is there a social history?	_____	_____	5.
6. Has the psycho-social information essential to this case been presented? (e.g., demographic characteristics, family composition, economic status, living arrangements, patient's relationships, patient's perception of presenting problem, past history of the problem, previous hospitalizations or treatment, etc.)	_____	_____	6.
6a. If NO - what was deleted? _____			6a.
7. Has all information presented been verified or documented, if necessary?	_____	_____	7.
8. How would you judge the overall quality of the Psycho-Social History?			
_____ Better than Average		_____ Below Average	
_____ Average		_____ Unacceptable	8.

ASSESSMENT (Evaluation)

To determine whether the data on patient and his problem/s are identified, analyzed and evaluated with understanding and insight, and with the application of behavior and practice theories in order for the worker to arrive at a sound professional judgment for goal/s and treatment plan to be formulated.

	<u>YES</u>	<u>NO</u>	
9. Is there some assessment? (If NONE, <u>skip to Problem</u>)	___	___	9.
10. Does the assessment indicate an integration and an understanding of data?	___	___	10.
11. Does the assessment lead systematically and directly to problem formulation, goals and treatment?	___	___	11.
12. Have all significant points been covered in this assessment?	___	___	12.
12a. If NO, what else should have been included?			
			12a.
13. How would you judge the overall quality of the Assessment?			
___ Better than average	___ Below average		
___ Average	___ Unacceptable		13.

PROBLEM

To evaluate the delineation of the problem/s and selection for Social Work intervention. Problem is defined here as the unmet need, the state of affairs which brought about concern to the patient or others, the condition about which something should be done.

	<u>YES</u>	<u>NO</u>	
14. Are the patient's problems clearly stated?	___	___	14.
15. Are the problems related to the request for service or referral?	___	___	15.
15a. If NO, was an adequate explanation for the difference given?	___	___	15a.
16. Have all potential problems been noted or explained?	___	___	16.
16a. If NO, what others are evident?			
			16a.
17. Is it understood which problems will be the focus of Social Work intervention?	___	___	17.

PROBLEM (continued)

247

18. How would you judge the overall quality of the problem selection?

☐ Better than average☐ Below Average☐ Average☐ Unacceptable

18.

GOALS

To evaluate the Goals that are formulated. Goals are defined as the desired results, the hoped for outcome of the treatment plan, the state of affairs the worker hopes to achieve.

19. Are the goals (or goal) stated? YES NO 19.

19a. If NO, are they implied:

(If NONE, skip to Treatment Plan) 19a

20. If there is an assessment, do the goals follow logically from the assessment? 20.

20a. If NO, what goals would have followed logically? _____

20a.

21. Has it been stated or implied that the goals were mutually agreed upon by worker and patient (or family). 21.

21a. If NO, was an adequate explanation given? 21a.

22. Are the goals realistic? 22.

22a If NO, why not? _____

22a.

23. If there is more than one goal, are priorities amongst goals clear? 23.

23a. If YES, are the priorities appropriate? 23a.

24. How would you judge the overall quality of the goal formulation?

☐ Better than average☐ Below average☐ Average☐ Unacceptable

24.

TREATMENT PLAN

To determine if an appropriate Treatment Plan was selected, one that addresses the problem and the goals, and takes into account the realities of the patient's situation, the Social Worker's role and responsibility, the agency's function, and external (environmental) constraints.

	<u>YES</u>	<u>NO</u>	
25. Is there a treatment plan?	___	___	25.
26. If there was a reassessment, does the treatment plan take it into account?	___	___	26.
27. Does the treatment plan take into account the following: Social Work's parameters, function of service and external constraints.	___	___	27.
27a. If NO, specify _____			27a.
28. Was the treatment plan mutually agreed upon by worker and patient or family?	___	___	28.
29. If changes have been made in the treatment plan, are adequate reasons given?	___	___	29.
30. Is the treatment plan sufficiently clear so that anyone picking up the case would be able to implement it?	___	___	30.
31. Have the aspects of the treatment plan that should be followed by other disciplines been identified?	___	___	31.
32. How would you judge the overall quality of the Treatment Plan?			
___ Better than average			
___ Average		___ Below average	
		___ Unacceptable	32.

SOCIAL WORK RECORDING

	<u>YES</u>	<u>NO</u>	
33. Are there progress notes describing Social Work activity on the case? (If NONE, <u>skip to conclusion note</u>)	___	___	33.
34. Do the progress notes present an easily understood flow of sequential recording?	___	___	34.
35. Where appropriate, are the notes signed for each entry?	___	___	35.
36. Is the frequency of progress notes timely in order to be useful?	___	___	36.

Social Work Recording - continuedYESNO

37. Are the progress notes sufficiently clear so that anyone picking up the case would be able to understand the Social Work activities? _____ 37.
38. Are the progress notes potentially helpful to other providers? _____ 38.
39. Are the progress notes legible? _____ 39.
40. How would you judge the overall quality of the recording?
- | | | |
|---------------------------|---------------------|-----|
| _____ Better than average | _____ Below average | |
| _____ Average | _____ Unacceptable | 40. |

SOCIAL WORK ACTIVITY

41. If there is a treatment plan, does the Social Work activity follow from the treatment plan? _____ 41.
42. If involvement with the health care team was called for, does the Social Work activity indicate involvement with the team? _____ 42.
43. If involvement with the patient's family was called for, does the Social Work activity indicate involvement with the family? _____ 43.
44. Does the Social Work activity give the impression of thoughtful, appropriate service? _____ 44.
- 44a. If NO, specify _____ 44a.

45. How would you judge the overall quality of Social Work Activity?
- | | | |
|---------------------------|---------------------|-----|
| _____ Better than average | _____ Below average | |
| _____ Average | _____ Unacceptable | 45. |

CONCLUSION NOTE

46. Is there a conclusion note summarizing the work between client and worker, indicating the following: progress, reasons for concluding, why & whether the case was closed, transferred, or referred? _____ 46.
47. Is the note dated and, where applicable, signed? _____ 47.
48. Does the conclusion note indicate whether there was a need or lack of need for follow-up? _____ 48.

	YES	NO	250
49a. Has this case been appropriately terminated?	_____	_____	49a.
49b. referred?	_____	_____	49b.
49c. transferred?	_____	_____	49c.
49d. continued for follow-up?	_____	_____	49d.

49e. If NO, please explain: _____

50. How would you judge the overall quality of conclusion note?

_____ Better than average

_____ Below average

_____ Average

_____ Unacceptable

49e.

50.

OUTCOME (Results, Achievement of goals)

To gauge effectiveness of Social Work intervention where possible and to determine factors that contributed to results.

	YES	NO	
51. If the treatment plan was NOT implemented are reasons clearly stated?	_____	_____	51.
52. If the treatment plan was implemented were the goals achieved?	_____	_____	52.
53. For the GOALS THAT WERE ACHIEVED, which of the following might account for their achievement?			
a. quality of intervention	_____	_____	53a.
b. external circumstances	_____	_____	53b.
c. patient/family cooperation	_____	_____	53c.
d. the nature of patient's illness	_____	_____	53d.
54. For the GOALS THAT WERE <u>NOT</u> ACHIEVED, which of the following might account for their not being achieved?			
a. quality of intervention	_____	_____	54a.
b. external circumstances	_____	_____	54b.
c. patient/family cooperation	_____	_____	54c.
d. the nature of patient's illness	_____	_____	54d.
55. How would you judge the overall quality of outcome?			
_____ Better than average			
_____ Below average			
_____ Average			
_____ Unacceptable			55.

DEPARTMENT OF SOCIAL WORK SERVICES
LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER
PROFESSIONAL REVIEW AUDIT

INSTRUCTION MANUAL

REFERRAL (REQUEST FOR SERVICE)

- 1) The date of referral to Social Work Services should be stated in all cases. This date may be different from, and should not be confused with, the initial date of recording. It cannot be assumed that the initial date of recording is the same date of referral. Therefore, the referral date must be cited.
- 2) The date of initial contact should be stated in all cases. This date may be different from, and should not be confused with, the date of referral to Social Work Services. It cannot be assumed that the date of referral is the same date as the initial contact. Therefore, the initial date of contact must be cited.
- 3) The source of referral - how the client got to Social Work Services - should be stated in all cases. If the case is self-referred or one of mandatory coverage, this should be noted. Reviewers will not always be familiar with the policies and procedures of every service.
- 4) There should be an understanding of why the case was referred. A clearly stated reason for referral is preferred but an implied reason will be acceptable. However, the reviewer should not have to search out or guess the reason; implication or inference is acceptable only in instances in which there is no doubt in the mind of the reviewer.

PSYCHO-SOCIAL HISTORY (INFORMATION GATHERING)

- 5) It is assumed here that a social history of some kind should and will always be present. The quality of the social history, however, may differ considerably. Therefore, it would be only in the most unusual circumstances that the response would be NO.
- 6) The reviewer must determine what information is essential to the case and then must judge whether that information has been presented. The question should be answered in light of what information is deemed necessary for the worker to evaluate and plan for this case. If the reviewer believes that essential material is missing, the response would be NO.
- 7) Under some circumstances, information collected should be verified or documented (e.g. prior hospitalization, receiving SSI, being evicted from apartment). The reviewer must decide whether there was a need for any documentation and whether it was obtained. When documentation was considered necessary and there is no indication that it was sought, the reviewer must be satisfied with the worker's reason for not having done so.
- 8) Rating the overall quality of the psycho-social history should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgement.

ASSESSMENT (EVALUATION)

- 9) Although every case should have some assessment, it is possible that the assessment will not be evident or clear. A YES answer should be given if the worker has interpreted the information that is presented, attached meaning to the items of information (rather than merely reporting them), or has related the information in a narrative form that conveys an understanding of the data and their implications. Length of the assessment, whether it is placed in a separate section with or without a heading, are not criteria used for judging the presence or lack of an assessment.
- 10) An assessment should reflect the worker's having organized and integrated data and will convey an understanding of what the discrete pieces of information mean. Integration and understanding are not to be thought of as the same thing although the two tend to coincide.
- 11) Integration and understanding of the information are not sufficient for an adequate assessment. The assessment should also logically connect the information to the problem formulation and treatment plan.
- 12) The reviewer is obligated to comment on any significant gaps in the assessment, e.g. information the worker has not fully understood or information that the worker omitted from the analysis.
- 13) Rating the overall quality of the assessment should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgement.

PROBLEM

- 14) Where the Problem-Oriented Record is used, it is likely that the problems will be clearly stated. It is expected that even when the POR is not used, the problems will also be clearly stated. This may not be the case. The reviewer should not have to search out the problems; they should be easily discernible. The question does not ask whether the problems are apparent but rather if they are clearly stated.
- 15) It is likely that the problems presented will be the same as or closely related to the request for service or the reason for referral. This does not necessarily have to be the situation.
- 15A) Should there be a difference between the problems identified and the initial reason for service, this fact and the reason for it should be adequately explained by the worker. The reviewer should not have to try and figure out what caused the discrepancy.
- 16) At times the reviewer may feel that certain problems have been overlooked by the worker; the worker may have failed to pick up or follow through on certain problem indicators.
- 16A) In these situations, the reviewer is obligated to specify what the problems are.
- 17) More than one problem may have been identified by the worker. The record should clearly indicate which of the problems is the focus of social work intervention.
- 18) Rating the overall quality of the problems formulation should relate to the previous answer. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgement.

GOALS

- 19) Goals are defined here as the desired results, the hoped for outcome of the treatment plan, or the state of affairs the worker hopes to achieve.
- 19A) In some cases the goals may not be stated as such but will be implied or inferred. While this will be considered acceptable, the reviewer must be able to determine the goals without difficulty.
- 20) Assuming there is an assessment, it is expected that the goals should follow from it.
- 20A) If they do not, the reviewer must indicate what goals would have logically followed.
- 21) It is expected that the goals formulated would have been mutually stated or implied by the worker and the patient. This must be explicitly understood by the reviewer. There may be indications, however, that the worker's goals and the patient's are at variance.
- 21A) In these instances, the worker is expected to acknowledge the difference as well as the goal(s) toward which treatment is directed. Although the worker may have provided an explanation, the reviewer must judge if it is satisfactory.
- 22) It is expected that the goals will not be formulated in a vacuum, without regard to the realities of the situation. The reviewer must judge whether the goals seem realistic.
- 22A) If the reviewer believes they are not, he should indicate why.
- 23) Frequently more than one goal may be formulated and it is likely that not all can be pursued simultaneously.
- 23A) The worker is expected to state the priorities among goals and the reviewer must judge if they are appropriate.
- 24) Rating the overall quality of the goal formulation should relate to the previous answers. However, it should not be a summing of the YES and No answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgement.

TREATMENT PLAN

- 25) It is expected that there will be a treatment plan in every case.
- 26) In cases of reassessment, the treatment plan should also reflect a reassessment.
- 27) If the treatment plan does not seem to take into account the parameters, functions of the agency, or the external constraints the reviewer should explain how it failed.
- 27A) The reviewer should specify the constraints not accounted for in the treatment plan.
- 28) It is expected that the treatment plan will have been mutually agreed upon by worker and patient. This can be stated or implied.
- 29) It is possible that somewhere along the way the treatment plan may change. If this occurs, the worker must give an adequate reason for the change.
- 30) The treatment plan is expected to be sufficiently clear so that anyone picking up the case would be able to implement it.
- 31) At times the treatment plan will require participation and cooperation of other disciplines or agencies. The worker should specify which aspects of the treatment plan are to be followed by others.
- 32) Rating the overall quality of the treatment plan should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather the rating should be the reviewer's overall impression based on his best professional judgement.

SOCIAL WORK RECORDING

- 33) All cases must have progress notes.
- 34) Notes should be easily understood and in sequential order.
- 35) All entries must be signed.
- 36) Although frequency of entry will vary according to requirements, they should be frequent enough to reflect progress of the case.
- 37) Notes must be understandable.
- 38) Progress notes should reflect the development of the case in order to assist other disciplines/providers who may also be providing treatment.
- 39) All notes should be legible.
- 40) Rating the overall quality of recording should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgement.

SOCIAL WORK ACTIVITY

- 41) What the social worker does should follow from the treatment plan (which flows from problem identification, assessment, and goal formulation).
- 42) Communication between and among members of the health care team (especially with inpatient cases) is essential. The reviewer should be able to ascertain from the record what the worker has communicated and/or obtained necessary information from relevant others (whether in person or in writing).
- 43) In some cases, there may be the need for the social worker's involvement with the patient's family. The reviewer should be able to ascertain whether the worker has been so involved.
- 44) What the worker does should give the impression of thoughtful and appropriate service. This is where the worker's relationship with the patient, for example, can come across.
- 44A) If the reviewer does not get the impression of thoughtful and appropriate service, he must specify why.
- 45) Rating the overall quality of social work activity should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's impression based on his best professional judgement.

CONCLUSION NOTE

- 46) A conclusion note, in which the worker summarizes his work, progress made and how the case was ended, must appear in all cases. The summary should also explain why the case was ended in the way it was.
- 47) If a case is audited after it has been closed, there should be a closing note, dated, and where applicable signed.
- 48) The conclusion note should indicate whether follow-up was considered necessary and arranged for.
- 49 A-E) The reviewer should indicate how he thinks the case should have been ended, regardless of what the worker decided or did.
- 50) Rating the overall quality of the conclusion note should relate to the previous answers. However, it should not be a summing of the YES and NO answers. Rather, the rating should be the reviewer's overall impression based on his best professional judgement.

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