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PLANNED ORGANIZATIONAL CHANGE IN A DEPARTMENT OF SOCIAL WORK

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PLANNED ORGANIZATIONAL CHANGE IN A DEPARTMENT OF SOCIAL WORK

By

Lawrence Cuzzi

A dissertation submitted to the Graduate Faculty of the School of Social Work in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York

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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.

3/27/85
date

Chairman of Examining Committee

4/9/85
date

Executive Officer

Supervisory Committee

The City University of New York

To Karen who made it all possible

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CHAPTER I

DESCRIPTION OF PROJECT

Organizations are social units (or human groupings) deliberately constructed and reconstructed to seek specific goals.[1]

They are characterized by: 1) planned divisions of labor, power and community responsibilities focused on enhancing the realization of specific goals; 2) the presence of one or more seats of authority, or power which control the concerted efforts of the organization; these concentrations of power review the organization's performance and re-pattern its structure to enable it to function more efficiently, and 3) substitution of personnel when assigned tasks are not performed efficiently.[2]

A hospital is a medical organization, which like any other organization, has multiple commitments. In addition to its commitments to patient care, research and education, it is responsible to its mandating and governing body (public or private, board or legislature); its own maintenance and survival; the needs and standards of both

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[1]Amitai Etzioni, Modern Organization (Englewood Cliffs, New Jersey, Prentice Hall Inc., 1964), p. 3.

[2]Ibid.

professional and non-professional staff and the personal needs of individuals (especially status, job satisfaction and security needs).[3]

It is imperative that each of the component parts of the hospital function in such a way so as to assist the hospital in achieving its goals or else that component, or department runs the risk of losing organizational rewards of status, money or staff.

Social work departments are important spokes in the organizational wheel, providing necessary support to the medical functions performed by other professional disciplines in the hospital. Social workers fill diverse roles within a hospital. They are counselors, resource experts, family workers, patient advocates, discharge planners, community relation specialists and educators. All of these roles require skill and a commitment to fulfilling them according to the hospital's satisfaction. The very diversity of the roles provide multiple bases upon which the department will be evaluated by the larger organization, the hospital.

Perhaps the most visible role currently is the one involving discharge planning for patients on in-patient

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[3]John Wax, "Developing Social Work Power in a Medical Organization," Social Work, Oct. 1968, p. 62.

services. The reason for this visibility has to do with the advent of what is labeled Prospective Payment for hospital care. As part of the 1983 Social Security Amendments, Congress approved a new procedure and formula for Medicare reimbursement of the cost of medical care to hospitals--prospective payments. This means that instead of the previous manner of retrospectively reimbursing hospitals for their costs incurred while providing care, all payments now would be made to the hospital prior to their actually providing health care. These payments are based on a complicated formula involving such factors as the average number of patients serviced in previous years, the intensity of care required (based on diagnosis), and certain other "fixed" hospital costs. The result of the application of the formula means that hospitals received a fixed rate per patient for providing care. If their costs exceed that which is federally stipulated, the hospitals would have to bear the extra cost. Such extra costs could result from a variety of factors such as delays in medical procedures, unnecessary in-patient days prior to an operation, etc. However, most often, the extra costs would be related to the patient remaining in the hospital beyond a length-of-stay (LOS) established on the federal level as the norm. The LOS is assigned based on the patient's diagnosis, and takes into account how

long the government believes a patient should be hospitalized ized for a specific illness or medical procedure.

As can be inferred from the above brief description, patients who remain in the hospital beyond what is "normally" required, will be a financial drain on the hospital. Thus, movement of patients through and out of the hospital will be of primary concern to hospital administration. Therefore, while the previously described roles for social work will still be required, both by the patients and the hospital, discharge planning steps to the forefront as the most vital and integral part of social work functioning throughout the country.[4,5,6]

> Discharge planning is a centralized coordinated, interdisciplinary process that ensures a plan of continuing care of each patient. It reflects both the patients and families internal and external social, emotional, medical and psychological needs and assets. It recognizes that the transition from the hospital is often more threatening than the actual hospitalization and that a plan must be developed to provide for a continuum

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[4]Ruth Ellen Lindenberg and Claudia Coulton, "Planning for Post-Hospital Care: A Follow-up Study," Health and Social Work, 1980.

[5]Regina Kulys, "Future Crises and the Very Old: Implications for Discharge Planning, Health and Social Work, 1983, Vol. 8, No. 4.

[6]Kay W. Davidson, "Evolving Social Work Roles in Health Care: The Case of Discharge Planning," Social Work in Health Care, Vol. 4, Fall 1978.

of care and address the patient's immediate needs following discharge.[7]

It is further identified as a clinical process by which social workers, patients and families collaborate to ensure that patients have access to services which help them to maintain and even improve the level of functioning achieved in the hospital.[8]

The director of a hospital based social work department must ensure that this process is as efffective and efficient as possible, while simultaenously employing staff who are able to function satisfactorily in other social work roles. Given the fluid nature of patient needs, community requirements and organizational imperatives, the director must have the ability, through his staff, to pursue fixed goals in many different ways. This ability includes effecting change both within the department and the larger organization. The objectives and implementation of such changes depend upon many factors. These may include, among others, the director's perception of the department's ability to achieve its professional and the hospital's

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[7]Edward Cochrane, et al., "Discharge Planning," Society for Hospital Social Work Directors (Chicago, Illinois, 1980), p. 1.

[8]Louise Cunningham, "Early Assessment for Discharge Planning," Quality Review Bulletin, October, 1981, p. 1.

mandated goals. When there is difficulty in reaching either of these objectives, changes have to be made in the way the department is functioning. For example, staff may have to be deployed differently; or they may require additional or specialized training. This could occur because certain aspects of the organization's environment have changed, thereby necessitating different functioning by its component parts.

The previously mentioned prospective payment approach to reimbursement is the most powerful current example of the organization (hospital) and its component structures (social work department) having to respond to new external pressures and initiate changes in its functioning.

This project will be focused upon planned organizational change, more specifically, change in a department of social work in a city, or municipal hospital. It is change which takes place within the above context of changing reimbursement practices, and more emphasis on discharge planning in hospitals. However, the precipitant for this change was not the sudden realization by the hospital of the new financial picture, nor was it a "normal" reaction by the social work department. Rather, it was the sudden death of the department's director, followed by a nine month period of temporary leadership, that set the stage for a new director assuming responsibility for the department.

This change in leadership at the highest levels of an organization is labeled "bureaucratic succession" by various theoreticians, and will be discussed at length in subsequent chapters.

Implicit in the hiring process of any new director or leader is the recognition that the executive will modify the organization in some way. The organizational change or development is defined by Beckhard as an effort (1) planned (2) organization-wide, and (3) managed from the top, to (4) increase organization effectiveness and health through (5) planned interventions in the organization's "processes," using behavioral-science knowledge.[9]

Such development requires an awareness of organization goals and the environment within which those goals must be met. Any new executive, if he is to be effective, begins accumulating knowledge about the environment from the start of his contact with the organization. Such knowledge must include the realization that the "first one hundred days" is a critical phase of bureaucratic succession which should be examined for the opportunities it offers.[10]

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[9]R. Beckhard, Organizational Development: Strategies and Models (Reading, MA., Addison Wesley, 1969), p. 9.

[10]Edward J. Pawlak, "Organizational Tinkering," Social Work, Vol. 21, 1976, p. 376.

While it is tempting to be conservative regarding implementing changes until one is more familiar with the organization, it is important for the new leader to provide the staff with an immediate direction in which the department will head. Part of the reason for this urgency is that while a new leader is being chosen, most organizations usually enter a period of inaction, which needs to be ended as soon as possible.[11]

Some description of and discussion about the search committee which selected the new director is necessary because its composition was a microcosm of the organizational environment of the hospital and its affiliation with a voluntary hospital/medical school. As such, both the nature of the affiliation and the search committee were important to the author because it offered the first clues regarding the professional environment in which he would be working and implementing planned changes. It is the kind of awareness required of anyone seeking to begin change in a complex organization.

This municipal hospital maintains an affiliation agreement with a medical school. The agreement requires that the medical school supply certain services and personnel to the municipal hospital, in exchange for the

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[11] Ibid.

availability of the hospital for training of medical students, interns, residents and fellows. In addition, all the physicians and directors of major clinical support services (including social work) are employees of the medical school/ hospital. Their responsibilities include functioning as directors of the individual hospital departments.

The search committee was atypical in one respect, in that it was composed of members of the medical school plus the executive director of the municipal hospital. This was a unique aspect of the search committee in that input was sought from hospital personnel during the recruitment phase rather than at a rubber-stamp interview at the end of the process. While the medical school had hiring/firing authority, it was deemed important that the executive director of the hospital have some influence in the selection of the social work director because of the close working relationship between the two necessary in the daily operation of the hospital.

During the course of this author's individual and group meetings with the committee, which ultimately led to being chosen director, it became apparent that two different sets of goals existed.

The municipal hospital, through its executive director, wanted an individual who would ensure that the

daily operational functions of the department be accorded top priority. This meant that social work coverage should be maximized on in-patient units and ambulatory care clinics. Also, with social work designated as the discharge planning department for the hospital, the new director was responsible for expediting the movement of patients out of the hospital. As will be seen in subsequent material, patients who no longer need acute medical care must be discharged quickly and appropriately, or else the hospital will suffer negative consequences, both fiscally and medically.

Thus, for the municipal hospital administration, the completion of designated patient related tasks, especially in discharge planning was the primary responsibility of the department and the director.

The voluntary/hospital medical school, while not ignoring the operational functioning of the social work department, was equally interested in an individual who would focus on (what will be labeled for the sake of differentiation) the "professional" aspects of social work. This is defined here as training, education and research pursuits focused on increasing specific skills as well as general social work knowledge.

Another factor which became known to the author during the search committee process was that the previous

director was already an employee of the hospital when the municipal hospital/medical school affiliation agreement first took effect. She was not hired as a result of the search committee procedure. The process described above, therefore, was the first dual attempt to choose a director and ultimately the philosophy and path of the social work department.

This social work department, as is true of any part of a large organization, will be a valued part of that organization as long as it is perceived to perform well relative to the overall goals of the larger organization. In this case, the larger organization, a municipal hospital, as its mandated mission, must provide health care to all those who need it, regardless of ability to pay. The rich and varied mixture of patients which is an outgrowth of the pursuit of this mandate, requires that quality health care is provided and is effective. Patients should not be hospitalized unnecessarily or rehospitalized for preventable reasons and the hospital should provide health care to patients efficiently, so that any financial losses are kept as low as possible.

For the social work staff to help the hospital satisfy these requirements, they must have knowledge of discharge planning regulations, housing resources, entitlement program eligibility, community agency support

services, etc., as well as being knowledgeable about human personality and behavior, and skilled in the use of intervention techniques designed to permit maximum patient use of such available aid. In addition, for social work staff to fulfill their own internal and professional directives, the care they provide to the patients should be of the highest quality, with the goal being an enhancement of the patient's ability to cope with illness and convalescence in a way that promotes healing and preserves dignity.

Many of the above elements are constantly affected by changing state reguations, fluid reimbursement laws, and the uniqueness which each patient brings to the hospital treatment situation. A social work department must have supervisory staff who are current in their knowledge and adept in their ability to transmit that knowledge to staff. The staff, for their part, must be able to use that information in their face-to-face contact with patients.

What quickly became apparent during the search committee interviews and subsequent meetings with the staff was that the previous leaders of the deparment had chosen to satisfy the above goals by employing a task-oriented, functionally directed approach. It was aimed at satisfying state and hospital administrative mandates. From reading minutes of meetings, talking to line workers and

supervisors, it appeared that staff meetings, small unit meetings, and most individual supervision was concerned with staff fulfilling specific tasks. These tasks consisted of completing the necessary paperwork to fulfill state requirements for appropriate discharge planning and emphasized completing statistics and reporting accurate social work activity. The supervisory approach resulted in lengthy notes in medical charts, detailing what was being done by each worker together with the specific reasoning behind each action.

None of the above activities are inappropriate for a social work department. However long chart notes are time-consuming to write and run the risk of not being read by other disciplines. Also the focus on statistical activity and numbers resulted in an elaborate system of checks and balances which the clerical staff maintained. Flow charts, check sheets and monthly reviews were employed to make certain that staff statistics were added correctly, that minimum numbers of interviews were conducted, and that no one started work late, nor left early. Supervisors (middle management) were mainly workers who had supervisory responsibilities in addition to their own practice. They had little or no access to policy discussion or initiation. They were expected to implement policies given to them from the top. This was guaranteed to promote a certain

amount of normative overt behavior by social workers, especially in relation to achieving hospital imposed goals.

It was the author's evaluation however, that the above approach emphasized form over substance, and did not pay enough attention to education and enhancement of one's ability via actualizing workers' potential. A department with these different goals in mind would stress the attainment of knowledge by staff and depend upon their professional striving to perform well as the spur to achieve specified ends. Supervisors would be facilitators and educators.

It was the author's opinion that for several reasons the above approach would be more effective than the one already existing in the department.

To be specific, the new director felt that some inpatients were being unnecessarily detained in the hospital because of the staff not beginning discharge planning early enough in the hospital stay. Examination of medical charts revealed that the planning that did occur was basically an automatic referral to nursing homes (Skilled Nursing Facilities-SNF, Health Related Facility-HRF), or other institutions. In addition there was little supervisory or administrative emphasis on family involvement. This was also noted by auditing charts. There were few documented attempts at engaging family members in a process which could ulitimately lead to the patient returning home

for convalescence either as a trial, or while waiting for an institutional bed to become vacant. Both of the above emphases, if effective, will tend to free up acute care beds more quickly. It is the author's evaluation that this will provide to the patient and family a more familiar atmosphere, more conducive to generating independence while not reinforcing the "sickness" image which so many patients assume while in a hospital environment.

The director's above evaluation was based on several observations:

First, for the ten months immediately preceding his assumption of the director's office, the length of stay in the hospital for patients who no longer needed acute medical care was 25.9 days. This means that patients who were not acutely ill were in the hospital only because they were awaiting appropriate aftercare placement. They remained in acute care beds for almost four weeks before they could leave. Four weeks of unnecessary time (medically speaking) in a hospital bed helps no one, patient, hospital or family. If this situation was allowed to continue, there would be several negative consequences. First, lengths of stay beyond the standardized national or state "averages" can be attributed to inefficient care by monitoring agencies, and via a complicated cost factor in Medicare/Medicaid reimbursement formulas, hospitals can suffer financial

penalties by not being paid for inpatient stays which exceed such "averages." Secondly, these patients fill up acute care beds, thereby preventing the admission of incoming patients who require intensive medical care. This slowly increases the inpatient census to levels which quickly become unmanageable for the medical staff. Too many patients tax both nursing care and the physician's ability to remain aware of everyone's medical condition.

A municipal hospital must accept anyone in need of acute medical care who seeks admission. Therefore, it is impossible to impose any restriction on the influx of patients in the way that voluntary and proprietary hospitals can. For example, most of their admissions are elective; at this municipal hospital, 80 percent of the patients were admitted through the Emergency Room. This makes it imperative that acute care beds be always available. It is the social work staff which is responsible for ensuring that availability by moving patients quickly and appro-, priately through the system.

The second factor that reinforced the new director's evaluation was the large amount of "carve-out" days attributed to social work staff. "Carve-out" is a term used to denote days of inpatient care for which the hospital will not be reimbursed because the staff has failed to adhere to state regulations in the provision of and charting

of appropriate inpatient health care. For the social work staff, this would occur when there was lack of documented effort that early planning and aggressive placements efforts were being made in the patient's behalf.

For the twelve months immediately preceding the new director's evaluation, there was a total of 119 days "carved out" of the hospital reimbursement amount attributed to lack of social work documentation. At the rate of $461. per day, this resulted in $54,859 not received by the hospital because of inadequate performance by the social work staff. Not only did this have fiscal impact, but it also was indicative of poor patient care. Patients who were no longer acutely ill should not be required to stay in a hospital. It is a drain on them and their family's emotional resources. It breeds dependence on the part of the patient, and can lead to the hopeless feeling expressed to staff by many patients that they may never get out of the hospital alive. To this extent, lack of "carve-outs" can be considered a good measure of effective (quality) as well as efficient social work care.

A third factor, closely connected with the above, was that the majority of patients discharged from the non-acute or alternate level care status (ALC) were discharged directly to other institutions. This is a relatively easy placement plan, in that all a social worker has to do is

tell the patient and family that is where he belongs, send out the application and wait. A discharge plan which consists of sending the patient home, with or without supportive medical care, involves careful, knowledgeable casework with the patient and family, often including liaison with community agencies. The sessions need to be focused on such important concepts as the patient's reaction to being sick at home and the family's ability to provide the physician and emotional support needed for convalescence to occur. This kind of planning would obviously reduce patients' hospital stays because it does not depend on the ponderous public assistance bureaucracy to work before discharge could occur. The less time a patient spends in the hospital, the better it is for all concerned, the hospital, the patient and the family.

A fourth factor which reinforced the opinion that change was needed was the lack of emphasis in the department on a Continuing Education program. In order for the necessary documentation to be done, in order for the social workers to know when and how to intervene most effectively in a patient's treatment, it is vital for the staff to have as much access as possible to educational and supervisory expertise. This expertise must include the latest advances in social work technology as well as daily supervision by the middle-managers to enable the staff to

effectively apply it to the patients. The content of such a program would be based on an evaluation of what specific abilities of staff needed to be maximized. Seminars would focus on enhancing learning in that area.

A final factor pointing to a needed change was the large and consistent movement of staff out of the department. In a department comprising 72 professional staff, for the twelve months immediately preceding the author's assumption of the directorship, 14 staff (22 percent) left. Therefore, whatever supervision and training was taking place, was being attenuated by the loss of experienced staff. There was a frustrating round-robin effect in place. Staff was hired, required intensive training, received it, and left before they could make a real impact on the delivery of service to patients. Basically, a large portion of the staff was always at a beginning level where one would expect there to be more mistakes made in documentation of work, and more tentativeness present regarding when and how to intervene with and patient and/or family. In order for any changes to be effective, consistent staff needed to be available, staff who had been trained in how to provide quality care, and who remained in the department long enough to deliver it.

The above factors are specific examples of the organizational development strategies described previously.

They might be uppermost in the mind of a social work director when any change is contemplated. In the succeeding chapters more attention will be given to the theoretical foundation of the change strategies selected and the manner in which they were implemented in a hospital social work department.

CHAPTER II

THEORETICAL BACKGROUND

We will employ the term "organization change" as it is defined by Patti:

> Organizational change is a set of interrelated activities engaged in . . . for the purpose of modifying the formal policies, programs, procedures or management practices of the agencies. The primary intended outcomes of such change efforts are to increase the effectiveness of the services provided and/or to remove organizational conditions that are deleterious to the client population served.[1]

In order to effect changes, it is necessary to utilize a framework within which we must operate. Such a framework is important because it will guide our analysis of what we want to change, and direct our problem solving activities within the organization towards specified goals.

Much literature suggests that organizations can be better understood if they are considered as dynamic and open social systems.[2]

In the simplest of terms, a system is a set of interrelated elements. Thus, a change in one element may

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[1]Rino Patti, "Organizational Resistance and Change: The View from Below: in Change from Within: Humanizing Social Welfare Organization, ed. Herman Resnick and Rino Patti (Philadelphia: Temple University Press, 1980), p. 56.

[2]Daniel Katz and Robert Kahn, The Social Psychology of Organizations, 2nd ed. (New York: John Wiley and Sons, 1978, p. 78.

lead to changes in other elements. An "open" system is one that in addition, interacts with its environment, so that more than the separate elements need to be considered.[3]

Systems theory suggests that when environmental factors, important to the organizations's functioning are stable, organizational programs and policies tend to persist over time. The general tendency of any organization is toward stability and maintenance of the status quo. It requires a fairly strong force to affect the organization to such an extent as to cause changes. For example, a time when there is movement in top management may be the most propitious time for change, especially if it involves a significant recomposition in distribution of power within the organization.[4]

According to Katz and Kahn,[5] organizations and systems display a number of basic systems characteristics.

1) Internal interdependence: The internal interconnections of pieces of the organization means that

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[3]David Nadler and Michael Tushman, A Congruence Model for Organizational Problem Solving (New York: Organizational Research and Consultation, Inc., 1980), p. 74.

[4]Charles Perrow, Complex Organizations (Glenview, Illinois: Scott Foresman and Co., 1979), p. 74.

[5]Katz and Kahn, The Social Psychology of Organizations, pp. 85-87.

frequently repercussions occur as a result of changes in any one of the connected parts.

2) Feedback: This is important information about the output of a system that can be used to control or modify the system.

3) Equilibrium: Organizations tend to move towards a state of balance. When an event occurs which would put an extra burden on one aspect of the system, an action (or reaction) will follow which would most likely tend to move the system back towards the previous state of balanced functioning.

4) Equifinality: In other words, there are many different ways to achieve the same goal. There is rarely a "best and only way" to organize.

5) Adaptation: If any system or organization is to survive, it must be able to maintain a healthy balance in its transactions with the environment or else it will fail. The input and output of the system (or organization) must coincide favorably with the external demands of the surrounding milieu or else the system will run down.

These characteristics are easily related to how a social work department functions within a larger system or organization (i.e., the municipal hospital) and the manner in which the hospital interrelates with an even larger system, society in general.

In order for the hospital to function smoothly and to receive recognition from society that it is providing quality service to its members, health care must be prompt, efficient and effective. This demands that all the hospital's component departments fulfill their organizational tasks. Failure to do so will lead to other departments having to work harder. (The medical staff, for example, will be forced to care for more patients if the social workers do not implement prompt discharge plans.) It will also mean that the large societal system will look negatively upon the hospital for not caring for the sick in the most optimal way. (This negative response could be in the form of less reimbursement, or skilled staff not wanting to be associated with the hospital.)

This negative feedback will be used by the hospital system as the precipitant for seeking a state of equilibrium wherein all its departments will be functioning appropriately, towards a common goal. Changes may have to be made within the system (people being replaced with more effective performers for example) such that a state of "balanced functioning" is achieved.

There could be several ways to achieve such a balance, and it is the duty of the hospital and the various component managers (such as the director of social work services) to flexibly respond to the environment

in a way that promotes the achievement of identifiable goals.

In order to move from this descriptive phase and to identify which aspects of the system need to change, it is important to utilize a model of organizational behavior, which will allow us to be specific in our understanding of the organization's functioning, our analysis of its problems, and implementation of change objectives.

Nadler,[6] Nadler and Tushman,[7] and Nadler, Lawler and Hachman,[8] have promulgated a model for understanding and describing organizational behavior since, for them, effectiveness in an organization is a function of the balance, consistency or "fit" of the various components of that organization, i.e., the congruence among these various factors.

Figure 1 represents how these congruence theorists "look at" an organization.

To briefly summarize, there are three basic inputs

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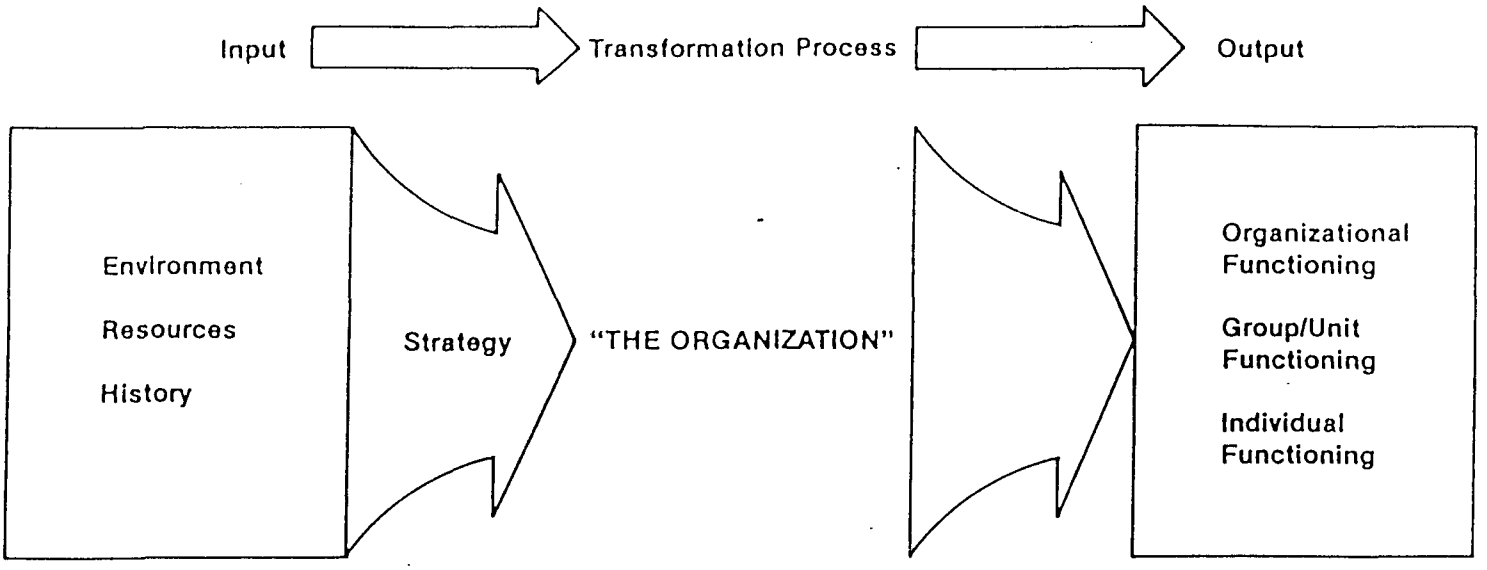
[6]David Nadler, "An Integrative Theory of Organizational Change," Journal of Applied Behavioral Science, June, 1981, p. 20.

[7]Nadler and Tushman, A Congruence Model for Organizational Problem Solving, pp. 9-11.

[8]David Nadler, E. E. Lawler and S. R. Hackman, Managing Organizational Behavior (Boston: Little Brown and Co., 1979) pp. 107-111).

Figure 1



Adapted from Nadler 1980

to an organization: environment, resources and history, with an all-important fourth input, strategy, being indicative of how the organization chooses to use or respond to the other inputs. This strategy when it describes organizational change is critical because it determines the work that the organization should be performing, and it thereby defines the nature of the desired organizational outputs.

In their model, the organization itself is the means by which strategies are implemented (the transformation process) and output is produced. Thus, we must identify the components of the organization and describe the manner in which those components interact with each other when they transform input to output.

Their congruence hypothesis is that an organization will be most effective when its strategy is consistent with the larger environment (in light of organizational resources and history), and when the organizational components are congruent with the tasks to be done to implement the strategy. Consistent with Katz and Kahn's concept of equifinality is their statement that the problem is not in finding "the best way" of managing, but "of determining effective combinations of components that

will lead to congruent fits among them."[9]

Who is to determine those "effective combinations" of "congruent fits" and how they are to be implemented are critical variables in the success of the changes.

As stated before, the precipitant for the changes may be most effectively rooted in a change in leadership. Hasenfeld and English assert that " . . . typically, major organizational change can be initiated only after executive substitution, whereby the new executive serves as a change agent, or mobilizes support to the change agents."[10]

This issue of bureaucratic succession was described most significantly by Gouldner[11] in his classic discussion of a new manager assuming administrative responsibility and operational control of a manufacturing plant.

Gouldner holds that the successor will be faced with major problems of communication and control because he has little or no access to the existing informal organizational system. His ability to utilize the formal

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[9]Nadler and Tushman, A Congruence Model for Organizational Problem Solving, p. 8.

[10]Yeheskel Hasenfeld and Richard English, Human Service Organizations (Ann Arbor, Michigan: University of Michigan Press, 1984), p. 681.

[11]Alvin Gouldner, Patterns of Industrial Bureaucracy (Glencoe, Illinois: The Free Press, 1954).

system is limited by "old lieutenants" who may owe their loyalites to the former leader under what he labeled the "Rebecca myth" of assigning idealized qualities to the departed leader, with subsequent suspicion of the new one.

He suggests two techniques to resolve the situation: first, replace management personnel with people who would be supportive of the new leader's policies. He designates this as "strategic replacement." Second, "increased bureaucratization" of stricter adherence to formal procedures would enhance communications and control because more decisions would of necessity be funneled through the main office.

In another well-documented study of succession, Guest[12] reinforces some of the major suggestions of Gouldner, i.e., strategic replacement. However, he contrasts Gouldner's image of possible negative responses to the new leader with his own statement that the "Rebecca myth" concept must be expanded to include the reverse reaction. The affectional response to the new leader can be either negative or positive based on the manner in which staff attempts to remember the former administration. Guest states that either reaction represents an effort

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[12]Robert H. Guest, Organizational Change: The Effect of Successful Leadership (Homewood, Illinois: Irwin Dorsey Press, 1962).

by organization members to deal with the loss of departing figures and the difficulties of adjustment to a new administration, and therefore both require recognition by the incoming leader.[13]

The aspect of bureaucratic succession which will most immediately affect all levels of staff is the leadership style of the new leader. How he interacts with his senior staff, middle managers (supervisors), line workers, how decisions are made, policies promulgated and implemented, will all coalesce into a leadership style which will have a strong affect on the acceptance of or resistance to any identified changes.

With this in mind, there will be a deliberate attempt on the new director's part to use what Likert[14] would describe as a Participative Democratic approach to management leadership. This is characterized by the leader who ". . . always asks subordinates for ideas and opinions and tries to make constructive use of them" (where) "subordinates are encouraged to feel completely free to discuss aspects of their jobs with their superiors," and are made an important part of the decision-making

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[13]Ibid., p. 152.

[14]Rensis Likert, The Human Organization (New York: McGraw-Hill, 1967).

process in the department.[15]

What must be emphasized here is that a participative leadership style does not imply abrogation of managerial authority. The leader must retain ultimate authority to reverse or modify decisions made by subordinates, if in his opinion client interests or organizational goals would be adversely affected. Also, participatory management does not require that all decisions be delegated, or that staff be consulted on all matters. In some cases, decisions are relatively routine. In others, there are few or no options, so that little can be gained from the participatory process. In some instances, the leader may be the only one with information sufficient enough to make an informed choice.

Patti suggests that given these contingencies, a leadership style may be most effective if it varies with (1) the kind of decision involved, (2) staff capability, and (3) external political constraints.[16]

The choice of a participative leadership style as being an effective one in human services is supported in

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[15]William Scott and James Mitchell, Organization Theory: A Structural and Behavioral Analysis, 3rd ed. (Homewood, Illinois: Richard D. Irwin, Inc., 1976), p. 331.

[16]Rino Patti, "Organizational Resistance and Change: The View from Below," p. 331.

the literature. Patti describes several studies indicating that a leader's participatory style and staff performance are positively related. That is, when lower-level staff are given more opportunity to make or participate in administrative decisions regarding such factors as program design and personnel assignments, there appeared concomitant improvements in their work with clients.

Participative management has been one result of the Human Relations theory of organizational functioning. Using this theory, it is postulated that effective leadership will lead to increased productivity on the part of employees through an employee-centered approach. This employee-participative emphasis will lead to high morale and increased effort which will result in higher production, decreased absenteeism, and decreased turnover. This will reduce disruptions caused by having to train new workers, or not having a full complement of staff.

The original research for this viewpoint was begun in 1927 by a group led by Elton Mayo.[17] That research was interpreted and expanded by Roethlisberger and Dickson.[18]

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[17]James March, Handbook of Organizations, (Chicago: Rand McNally and Co., 1965), p. 2.

[18]F. S. Roethlisberger and W. J. Dickson, Management and the Worker (Cambridge: Harvard University Press, 1939), cited in March Handbook of Organizations, p. 2.

Briefly, Mayo's research indicated that if attention was paid to individual needs, informal groups and social relationships, worker productivity and morale increased. Needless to say, this was a radical change from the viewpoint established by Weber[19] in which the organization was the focal point of rules and regulations. In this view, if individuals followed the system promulgated by the organization's leadership, they would be effective workers and lead productive work-lives because satisfying the organization's mandate, would fulfill their own personal needs.

The new viewpoint, that of emphasizing human relations in formal organizations, was the subject of much theoretical attention and research activity.[20] Attempts were made to connect morale, productivity, and "positive" environmental conditions with certain leadership qualities. Unfortunately for the proponents, "their own sophisitcated studies . . . (showed that) the relationship between . . . morale, good leadership . . . and productivity proved to be less than clear, less than substantial.[21] And what seemed to be promising early research results, turned

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[19]Ibid.

[20]Ibid., p. 3.

[21]E. Lawler and L. Porter, "The Effects of Performance on Job Satisfaction," Industrial Relations, 1967, p. 87.

out to be what came to be known as a "Hawthorne" effect (named after the Western Electric plant in which Mayo's early work took place). Essentially, what was discovered was that any attention paid to employees resulted in increases both in production and in subjective reports of morale boosts. Other critiques by Argyris, Wilensky and March,[22] have led to the human relations model not being considered a theory which is helpful as a model in predicting effective organizational behavior.

However, their ideas of organizational conduct and leadership style combined with the previous heresy that employees should have some input into their working conditions, resulted in a definite contribution to organizational thinking which could explain why certain organizational behavior occurred.

For example, there have been several attempts to identify job satisfaction as a factor which would increase productivity and then isolate what contributes to such an hypothesis. These studies concluded that organizations should pay attention to satisfying worker needs, such as "self-actualization and autonomy."[23]

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[22]March, Handbook of Organizations, p. 10.

[23]C. Hulin and M. Blood, "Job Enlargement: Individual Differences and Worker Responses," Psychological Bulletin, 69 1968, p. 48.

Hulin and Blood note that such self-actualization is different for different people. What may be positive for some is a negative for others. "Not all workers are satisfied when they are allowed to take part in decision making, and others prefer routine, repetitious and specified work methods."[24]

In an article regarding current trends towards wider worker role in industrial decision-making the New York Times quotes John Simmons, Professor of Labor Management Relations at the University of Massachusetts (Amherst) as stating "Genuine employee participation is turning the scientific management style of Taylorism upside down."[25]

He was referring to the authoritarian, rules conscious approach favored by Frederick Taylor.[26] The Times cites instances of employers finding substantial reduction in absenteeism, tardiness, grievances and strikes. It indicates that, at present, management science has moved towards workers functioning autonomously in many cases and participating in decisions that once was the role province of managers.

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[24]Ibid.

[25]"Management Turns to Sharing Decisions with Workers for Benefit of Both," New York Times, 15 January 1984, Sec. 1, p. 20.

[26]Frederick Taylor, The Principles of Scientific Management, (New York: Harper, 1911).

What we are faced with then may be described as a theory of job characteristics, worker performance, leadership style and productivity outcomes which interact with and have differing impacts on each other at different times. All of which must be considered by the leader in attempting to decide upon and implement a style of leadership which will maximize the output of his organization.

Perrow describes the situation well when he talked about "exceptional leadership" meaning not that the leader has somehow coaxed more cooperation and motivation from workers, but that decisions made by the leader with regard to the organizational structure, type of product (or service), quality control, new technologies have all been excellent choices.[27]

Thus, even if strict adherence to the human relations model of emphasis on high morale and worker satisfaction is unwarranted; even if ". . . evidence with respect to these variables . . . is typically inconclusive, the interpretations sometimes contradictory,"[28] we are left with many aspects of the organizational climate which, while they may have no provable direct

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[27]Perrow, Complex Organizations, p. 101.

[28]Conrad Arensberg, ed. Research in Industrial Human Relations (New York: Harper, 1967), p. 189.

causal link to organizational effectivness, are important for leaders to consider in administering an organization such as a department of social work in a large hospital.

Fiedler, in identifying his "contingency" theory of leadership (based on many of the factors stressed by human relation theorists) discussed some variables important to organizational effectiveness. He notes that member abilities and motivation, group heterogeneity, expertness of the leader, and his familiarity with the organizational task are likely to be important. His contention is that the above characteristics are more critical in organizations in which different groups within that organization interact, instead of compete, and where there is a high degree of stress connected with completion of the task.[29]

The preceding description provides an accurate picture of the social work staff and its mandated tasks in this municipal hospital. The job is a complicated and difficult one, with daily time pressure and financial penalties possible for ineffectiveness or non-compliance with regulations. The staff composition is both highly trained and heterogeneous. All are graduates of an accredited CSWE school of social work, with anywhere from

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[29]Fred Fiedler, A Theory of Leadership Effectiveness (New York: McGraw Hill and Co., 1967), p. 7.

six months to twenty-four years post-MSW experience. Some are holders of post-graduate certificates. There are both male and female doctoral program candidates on staff. This author's experience in teaching, field instruction, supervision and administration during the last ten years leads to the conviction that by and large social workers do not like repetitive tasks. They prefer challenges. This author has constantly been struck by their adherence to self-determination for their clients and themselves.

Thus, while Perrow can rightly criticize human relations theorists for a lack of evidence which prevents the theory from being effectively generalized to all organizations, it is possible to construct a "face validity" case for the use of some of the theorems when discussing a social work organization. By the very nature of their education, social workers are taught the value of a positive social environment; the importance of all group members working towards a mutually acceptable goal and the necessity to tap and free whatever human resources are available within their clients. Therefore, a social work department whose administration is concerned with the interaction of groups, the role of top management in setting a proper climate, and a commitment to increase the influence of all, would appear to be a department that would be effective in achieving professional goals.

We have discussed bureaucratic succession and leadership style as they impact upon the organization and any proposed changes. We have identified that the workers' need for realizing professional and personal goals are important in what changes are proposed. We have also described how the hospital and society must be considered when we establish departmental goals.

Brager and Holloway identify three variables which influence organizational change and which therefore must be considered when initiating goals in a hospital. These are 1) the complexity of the organization, 2) how centralized is the authority, and 3) how formalized are the lines of communication and responsibility.[30] We shall briefly discuss each since they all have a bearing on how change will be implemented within this department.

1) Complexity--Hage and Aiken in discussing research conducted in hospitals, indicate their evaluation that the more complex an organization, the greater the possibility of, and accessibility to, change.[31] They use as indicators of complexity the intricacy of the task as measured by the extent of the training required to perform

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[30]George Brager and Stephen Holloway, Changing Human Service Organizations: Politics and Practice (New York: The Free Press, 1978), p. 7.

[31]Jerald Hage and Michael Aiken, Social Change in Complex Organizations (New York: Random House, 1970).

it, and the number of diverse occupations within an organization. Complexity encourages organizational change because it increases the number of perspectives upon which decisions can be based. Thus, in a hospital, highly trained personnel who keep abreast of the current improvements in their field, will be likely to respond positively to newer, more efficient methods of functioning.

This can act as stimulation for change in allied professions. Thus, a change in medical care which results in a quicker recovery rate among patients, will require that the social workers modify their practice, i.e., faster discharge planning with prompt family involvement. Similarly, a change in social work practice which results in more efficient discharge planning, and hence a more rapid patient flow, will be met with enthusiasm by administrators who wish to keep the overall census as low as possible. It will also be appreciated by the medical staff who are interested in treating the acute medical needs of patients, and not having "well" patients occupy beds for prolonged periods.

Changes within the social work department must therefore be articulated to the other professions in the hospital, such that all can see that they will help the hospital achieve its stated goals. There is one caveat that must be added however. It concerns the medical staff,

specifically the doctors. The possibility of any change occurring within the hospital must take into account the interests of this group which is the "host" profession and hence the most powerful influence in how this large organization functions. Any change, even within another department, which is perceived as negatively affecting the doctors, will most likely be doomed to failure. Thus, in complex organizations, the easier predisposition to change may be functionally dependent upon who is viewed as benefitting from it, and to whom the change will constitute a cost.

2) Centralization--Another important organization construct affecting change is centralization, which is defined as "decision making authority" confined to the top members of a narrow hierarchial structure.[32] Hage and Aiken assert that a high degree of centralization inhibits innovation. Their reasoning is that a small group, or even one person is likely to avoid changes which may threaten to alter their achievement of organizational rewards. When decisions come to be made by relatively few people, those decision makers often consider primarily their own personal preferences. Change, especially articulated by subordinates, implies criticism of the

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[32] Ibid., p. 170.

current state of affairs. Since the centralized leaders are responsible for decisons that resulted in the present situation, change proponents and their objectives will be viewed with some suspicion by those leaders.

Blau and Scott cite research which indicates that severely centralized organizations also impede free communication.[33] This has a disastrous effect on a group's problem-solving ability. The inhibition of the free flow of ideas tends to isolate organizational units, thereby preventing the mutual stimulation that leads to change. Therefore, the social workers in the hospital should have access to one another, with senior staff having spans of supervisory control wide enough to encourage intellectual exchange among supervisees while still being managable administratively. This will provide the opportunity for cross-fertilization, while simultaneously providing specific lines of responsibility, authority and communication.

3) Formalization--The extent to which an organization is formalized, i.e., by strict rules, regulations, has a direct proportional effect on the likelihood of change. The greater the formalization, the more difficult it is to implement program change because new programs

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[33] Peter Blau and W. Richard Scott, Formal Organizations (San Francisco: Chandler, 1962).

tend to bump into established rules. Thus, the people who conduct "business as usual" are more likely to reap rewards. Proponents of change often must modify existing rules before the change can be implemented. This is why "change from the top," as in this situation, may be accomplished more easily than change initiated from within the organization, i.e., the executive can modify the existing rules to reward those who participate enthusiastically in the changes.

Let us become more specific about what theory underlies the changes to be implemented. Resnick and Patti assert that there are certain dimensions which should be characteristics of a dynamic human services organization. These are:

1. A division of labor and task assignment based on an assessment of how the knowledge, skills and experiences of staff can be flexibly utilized to accomplish the work required.
2. A relatively shallow hierarchy of authority--that is, minimal stratification--where superiors have general authority and responsibility for coordinating the work of subordinates, but tend to rely on the judgment and discretion of staff in carrying out day-to-day operations.

3. A decision-making process that allows for participation by members of all administrative levels who have knowledge and information relevant to the decision being made.
4. Rules and procedures that provide guidelines for worker performance, but allow sufficient latitude for the worker to flexibly adapt his or her behavior to the needs of the situation.
5. Communication process that allows for, and facilitates the flow of information up and down the hierarchy as well as diagonally among persons in different departments and at different levels.
6. A high value placed on subordinates' understanding and developing commitment to the organization's goals and objectives, rather than obedience for its own sake, or blind compliance with the dictates of those in authority.
7. A climate that is supportive of professional growth and development, where employees are seen as an expanding and renewal resource rather than a fixed pool of capabilities to

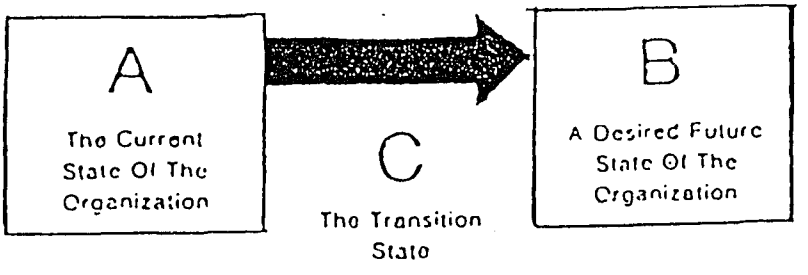
to be impersonally exploited.

8. A style of leadership that depends heavily on consultation with subordinates, individually and in groups, rather than on unilateral administrative action.[34]

As can be seen, the above characteristics are entirely consistent with the facets of this social work department which have been previously identified as the targets of change. We can now describe those aspects of the implementation process which need to be accorded particular attention.

Nadler[35] calls this implementation process "managing" organizational change and presents a model to indicate how it is to be accomplished. (Fig. 2)

Figure 2 ORGANIZATIONAL CHANGE AS A TRANSITION STATE



Adapted from Beckhard and Harris, 1977.

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[34]Herman Resnick and Rino Patti, eds. Change From Within: Humanizing Social Welfare Organization (Philadelphia: Temple University Press, 1980), pp. 6-7.

[35]Nadler, "An Integrative Theory of Organizational Change," p. 7.

Beckhard and Harris discussing the process, argue that any major change, no matter what the content, can be thought of as a transition.

A change begins with the organization existing in a current state (A). The future state (B) is how the organization will ideally exist after the change. The period between A and B can be thought of as the transition state. Beckhard and Harris assert that the transition state is critical because it greatly determines the quality of the future state, yet it contains characteristics that make it uniquely different than either the current or future state.[36]

This transition state requires a clearly identified manager of the process. This manager (it can be anyone from the leader on down the "chain of command") needs to develop a plan which communicates a clear image of the future state to the organization members. It is important to describe what the organization will look like, how the transition to that state will occur, why the change is being implemented, and how individuals will be affected by the change.

This plan should include what Nadler labels

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[36]Richard Beckhard and Reuben Harris, Organizational Transitions: Managing Complex Change (Reading, Massachusetts: Addison-Wesley Publishing Co., 1977), p. 44.

"multiple and consistent leverage points." Building on the Congruence Model previously presented, he states that if the organization is in balance, or state of fit, then major alterations in one component will tend to disrupt that balance. Forces of equilibrium, however, will then tend to move the organization back into a balance or fit, with the result that changes aimed only at single organizational components will ultimately be nullified. Significant and lasting changes in patterns of organizational behavior must involve multiple aspects of the organization. Changes targeted only at individuals or isolated parts of the organization tend to fade out quickly with few lasting effects.[37]

If a change is to be permanent, it must include the "multiple points" of structural change, task change, change in the social environment, as well as changes in how individuals respond to the transition and future states. These changes must be sequenced and structured with regard for consistency. The training of individuals for example, must dovetail with new job descriptions, reward systems, or reporting relationships. In the absence of this overall consistency of plan, changes run the risk of creating new "poor fits" among organizational components.

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[37]Nadler, Managing Organizational Behavior, p. 202.

This can result in an abortive change, or a change which results in an overall decrease in organizational performance or output.

CHAPTER III

PROGRAM DESIGN

In accord with the observations noted in Chapter I, the goals of the organizational changes will be to ensure that the social work department provides to the hospital's patients the highest quality of social health care possible. For that goal to be achieved the staff will have had to be provided with the most current technology, as well as the expert supervision necessary to make maximum use of their skills and new knowledge. And if the goal is achieved, then the social work department will have aided the municipal hospital in fulfilling its mandate from society. This will enable the department to obtain certain organizational rewards from the hospital, i.e., the prestige and status that will occur as a result of helping the patients move efficiently through the hospital system. This will save the hospital money, provide more and different patients for the training of the medical staff, and cause the hospital to be looked upon as an economical and effective provider of health care by society. This is just some of the external credit that will be accorded to the department. Internally, the social work staff will know that they have provided the

best possible human services to those patients who were involved with the social work department of the hospital.

In order for both the social workers and the hospital to achieve their goals, four factors had to be considered as objects of the change process.

1) The average length-of-stay (LOS) for patients on alternate level of care status (ALC) had to be reduced. This means that the changes must enable the staff to prevent patients from languishing unnecessarily in the hospital while awaiting either institutional care, or some form of home health services. Staff must be made aware of all the regulations, referral services and entitlement procedures which could maximize immediate placement possibilities. Family involvement needs to be stressed to improve the possibility that relatives could aid in the convalescence, or the ambulatory care of the patients. It would mean that discharge from the hospital could be toward the home rather than an institution only. This leads to the second factor:

2) More patients should be discharged to their homes, with supportive services, rather than to institutions. Not only is it better for the patient to receive care in familiar surroundings, it is more economical for the health care industry (and society) for such care to be provided in the home, by private vendors (Visiting

Nurse Service, for example) rather than in large institutions. The fixed costs of institutional upkeep, salaries, etc. is not a factor when care in the home is provided. Therefore, it is considered to be a preferred discharge plan.

3) For any improvement to occur in numbers 1 and 2, there must be a large reduction in the amount of carve-out days attributed to the social work department. It is necessary for staff to be taught and encouraged to identify certain "high risk" patients as quickly as possible and begin documented placement efforts immediately. By "high risk" is meant that certain patients by dint of having specific characteristics will definitely require social work intervention and possibly placement efforts. For example, these characteristics would include an 85 year old woman living alone in a third floor walkup, who has fractured her hip. She will most definitely need social work attention during her hospital stay, and after discharge. She will be frightened about her sudden helplessness, afraid that she will not have anyone around to care for her when she returns home. And she probably would not want to be in an institution because for many people, that means they are one step closer to death. Most importantly, she will be ready to leave the acute care hospital many weeks or months before, with the help of

physical rehabilitation, she can expect to be able to take care of herself. She is in real danger of remaining in the hospital on alternate care (non-acute) status for a prolonged period unless social work staff moves to provide quick and appropriate discharge planning. Such efforts must be documented in various places (charts, files, etc.) for the monitoring agencies to determine that the hospital has fulfilled the state mandate. The mandate is that "aggressive" discharge planning actions must begin within seven days of the patient being placed on ALC status. If that does not occur, the hospital will not be paid for any days until those efforts begin.

4) Staff turnover needs to be reduced. The nature of hospital social work demands that staff be trained in how to interface with various agencies and entitlement programs as well as having the experience to enable patients to effectively deal with the trauma of acute medical illness. Unless we were able to retain the staff whom we had taught to cope with the demands identified in numbers 1, 2, 3 above, we would constantly be spending valuable supervisory time in training new workers, and losing the creative approaches to social work that we could expect from a more veteran and stable staff.

We attempted to achieve the goals outlined above by utilizing three change strategies, 1) Leadership style,

2) A change in the mangement and supervisory structure of the department, 3) A Continuing Education Program.

1) Leadership style:

The current fiscal climate of constraint and emphasis on accountability in health care both on a Federal and State level has resulted in a hospital environment that places considerable emphasis on good management. Administrative ability has become an important part of leadership as it is viewed by the hospital's hierarchy. In a department of social work in a municipal hospital, how quickly and efficiently the patients pass through the hospital system (admission--medical treatment--discharge) is often completely dependent upon the final phase of discharge planning. In this hospital this is the province of the social work department. Thus the director of the department must be concerned with social work staff's ability to skillfully help the patient through the system; ultimately achieving the most appropriate discharge plan, i.e., home, to an institution, to a rehabilitation program. It is in this manner that organizational rewards will accrue to the department primarily because the hospital's financial viability is dependent upon treating patients and moving them out quickly. This movement of patients lends itself easily to analysis because it is data that can be quickly gathered by administration. It is commonly

cited by hospital administrators as an indicator of social work effectiveness, i.e., how many patients were discharged as a result of social work planning. This is especially important in a municipal hospital where there can be no administrative control exercised over who is admitted. We are committed to health care for all by definition and by contract with the City. Therefore, there is no way to reduce potential discharge problems by admitting only those for whom we are sure there will be little or no difficulties in their home or financial condition which would retard their passage through the hospital. This places a heavy burden on social work departments in municipal hospitals who often have to work with patients who have little or no financial or social supports in the community.

It is much easier to measure how many people are "processed" rather than how well they are treated during such processing. A problem occurs here because the social work staff, by training and tradition, place much more value on the quality of their work with clients and patients rather than on the quantity of people helped. At the same time, within certain broadly accepted limits, hospitals administrators are more concerned with numbers rather than "how well."

This confrontation between professional values and

organizational concerns at this hospital is an example of struggles currently taking place in many human service organizations.

Berg asserts that agencies currently tend to emphasize managerial skills and capacities in recruitment and evaluation of leadership personnel rather than the more traditional reliance on professional expertise.[1]

He cites Yarmolinsky's contention that the future of the professional within American organizations is contingent upon the ability to develop a role that includes both the commitment to professional skills and a recognition of the larger organizational or societal context within which professional practice takes place. If this is not done, the result may be that professionals will find their power and authority taken over by the professional managers.[2]

The challenge is clear. The departmental director must satisfy the hospital imperative of efficiency or else the department (and himself) will not be valued by the organization. He must likewise pay attention to the staff's need for rewards based on the internalized professional

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[1]William Berg, "Evaluation of Leadership Style in Social Agencies," Social Casework, 1980, p. 28.

[2]Ibid., p. 29.

values, or else staff will feel used, unfulfilled and prone to leave the job quickly.

In order to satisfy the organizational mandate and staff priorities, attention was paid to involving all levels of staff in the new emphasis on professional education. It was decided that a reliance on the participative management style previously described would help the staff become more of a partner in both departmental and hospital goals and thereby less likely to offer resistance to any behavior changes required to achieve those goals.

For example, the departmental goal involving a reduction in the LOS for patients on ALC status combined with a stronger emphasis on discharging patients to their homes required a significant change in social work practice in the hospital. This change would be more likely to be "owned" by the professional staff if they had input into the selection of the goals and the intermediate objectives of what in their practice needed to be changed in order to achieve those goals.

Another example would occur in relation to the third goal, i.e., the reduction in carve-out days ascribed to the department. Instead of the director and senior staff policing worker performance and reacting with sanctions when discharge planning was not begun early enough

to prevent carve-outs, the approach adopted was the use of small group meetings with staff. During these discussions, the problems associated with carve-outs (fiscal penalties, poor patient care, loss of organizational rewards) were identified together with a request for staff's solutions.

Any system of procedures or checks and balances ensuring staff adherence to early intervention with patients would be more likely to achieve success if it was promulgated in conjunction with all staff. Even if the plan eventually adopted differs somewhat from their recommendations, they would have had input into the process. Therefore, when staff (as the transition process in the Congruence Model) are part of the input, the output is something in which they would have a vested interest. They would be less likely to view the output as representing only the director's or the hospital's agenda rather than theirs.

2) The second change strategy is the modification of the management and supervisory structure of the department. It is here that the style of leadership becomes most apparent to staff because it is through this structure as described in the Table of Organization (T.O.) that decisions would be made, policies promulgated and implemented, and feedback received. (See Appendix)

Several of Resnick and Patti's characteristics of an organization (previously described) depict a specific structure which depends heavily on the collegial use of staff and middle-managers. They promote an emphasis on "consultation with subordinates," "a decision-making process which allows for participation by members at all administrative levels" and an "up and down free-flowing communication process."[3]

Preserving and utilizing these characteristics motivated the delineation of the new administrative structure. As can be seen from the T.O., each of the senior staff (Associate and Assistant Directors and Administrative Coordinator) is responsible for specific supervisory groups. Thus, the bureaucratic structure ("chain of command") and supervisory lines are clear to all concerned. Only when organizational structure is distinct, and responsibility unambiguous can authority be delegated in a meaningful way.

The matter of "span of control" (the number of subordinates a supervisor directly controls) is considered by many to be the primary "building block of hierarchy."[4]

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[3]Resnick and Patti, eds. Change From Within: Humanizing Social Welfare Organizations (Philadelphia: Temple University Press, 1980).

[4]March, Handbook of Organizations, p. 398.

For many years, social scientists and administration and management theorists have attempted to arrive at the optimum span of control, i.e., the magic number which would lead to maximum bureaucratic efficiency. The debate is on-going. However, there are a number of factors which have been identified as affecting supervisory span of control, and which therefore have an impact on the ability of supervisors to teach, or of line workers to learn.

In conjunction with this, Perrow[5] discusses five factors which the author believes are applicable to the administrative needs of this department and were given primacy in deciding upon the new structure and span of supervisory control.

1) The degree to which tasks are routine or non-routine.

It is generally held that routine jobs require less supervision than more complex ones.

Social workers in a municipal hospital are expected to perform a great deal of routine paperwork (i.e., forms, checklists, referral notices) at the same time that they apply knowledge of the complexities of human behavior to their patients. In addition, every rule governing a patient's eligibility for various entitlement programs

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[5]Perrow, Complex Organizations, p. 58.

has so many exceptions and unique variations, that supervisory or collegial accessibility is a must. Therefore the structure allows for immediate accessibility of middle management as well as senior staff.

2) Another factor is the difference between the expertise of the manager and that of his subordinates.

There should be some interdependence among tasks under one manager. This was applied to the department's new structure by grouping staff in similar units of service to maximize supervisory effectiveness. For example, children's services often require specific and very different chart requirements and social agency liaison than do adult services. Having one assistant director responsible for all social work with children and adolescents allowed for more sharing of information and responsibility among staff. It also simplified the task of the other hospital disciplines when they wished to communicate to social workers re: child welfare situations.

3) A third factor to be considered is the interdependence of the department as a whole, with other departments in the larger organization.

This liaison and networking factor is vital because social work interacts with every in and outpatient service offered to patients. There must be identified staff who

can interpret social work policy and procedures to these other departments, while also serving as the contact person for any communications which come into the department regarding its performance or goals.

4) The degree to which written rules and regulations can reduce the need for close personal supervision.

The fact that social workers are professionals, with adherence to national standards of performance and ethics should make it easy to expect that (generally speaking) certain rules need only to be written to ensure their observance by the vast majority of staff, i.e., rules regarding patient confidentiality and the protection of children from abuse and neglect. This factor allows more time, in supervision, to be spent on introducing new concepts in service delivery rather than on checking for staff fidelity to certain routine mandates.

5) The extent to which flexibility and rapid response is necessary to the organization.

Any hospital social work structure, by the nature of medical, emotional and environmental emergencies, must be able to quickly respond to patient needs. Therefore, the staff needs to be supervised with an eye towards maximizing their ability to react appropriately to difficult situations without having to check with

a supervisor beforehand.

All of the above factors have implicitly included an aspect of "decentralizing" which is a major characteristic of the new department. This decentralization encompasses much of the daily operational, supervisory and professional decisions made daily in providing social work services in the hospital.

Decentralization, in this context, is described by Patti as occuring when "more authority for decisions is delegated downward."[6] This is an important aspect of structure to consider because while a new Table of Organization tells how authority is formally distributed, it reveals very little about how it is actually exercised.

It would therefore help to analyze a specific "chain of command" as an example of how Perrow's theoretical constructs and the concept of decentralization were used in the formation of the departmental structure and authority configuration.

Employing the T.O., we can see Perrow's factors in action via the supervisory responsibility of the Assistant Director for Child and Adolescent Services.

Children are "covered" from Pre-natal services through birth (Obstetrics-Inpatient) through Post-Natal

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[6]Patti, "Organizational Resistance and Change," p. 134.

(Obstetrics Clinic) to possible medical or psychiatric complication (Developmental Evaluation Clinic, Pediatric Clinics, Child Psychiatry). Each of these services has a supervisor (middle manager) responsible for the daily professional performance of staff, with the assistant director designated as the backup person.

There is ample opportunity provided for collegial sharing via small "service meetings," i.e., all workers in Pediatrics meet regularly. There are also regularly scheduled large "unit meetings" at which all staff members identified as part of children and adolescent services gather for administrative or educational purposes. In addition, the supervisors meet regularly with the assistant director to discuss administrative, educational or operational matters.

At all of these meetings problems are identified, policies proposed, implementation schedules discussed and feedback from all levels of staff requested. Staff is encouraged to initiate or react to whatever problems they identify as prominent and to indicate solutions.

The small supervisory service units (Obstetrics-Pediatrics, Child Psychiatry) allow for quick, available collegial or supervisory responsiveness whenever unique or difficult situations present themselves. The fact that each of the units are working with the same age group

allows for such things as the sharing of common resources, having a similar basis for educational subjects and operational activities, and providing greater flexibility among staff during coverage in case of sickness, vacant positions or planned vacations.

The departmental goals of a reduction in the patients' length of stay (LOS), emphasis on ALC patients returning home, and a reduction in carve-out days would be addressed via small unit supervision and larger unit meetings. Problems specific to placement of children, i.e., parental resistance, lack of referral resources, non-compliance of children with post-hospital recommendations, etc., could be considered more effectively in such meetings because staff does not have to spend time worrying about factors associated with an adult patient population, i.e., lack of appropriate homemaker service, lack of skilled nursing facilities. Aspects of health care of children can be identified and problems related to long LOS and carve-out days can be considered and resolved as they apply only to children. This narrowed focus resulted in staff being able to pay attention to what needed to be done to counsel the children and their families while they are in the hospital and plans for appropriate post-hospital placement are being made.

A very similar set of positive factors are present when the job of the Assistant Director of Adult Psychiatry is considered. The same pertains to Alcoholism, Medicine or Ambulatory Care Assistant Directors. All of their workers concentrate on one kind of patient-related effective casework intervention with similar groups of patients.

As stated before, decentralization is present in much of the above description. Vacation requests, coverage during illness, conference approval, ideas for innovative programs, are all part of the immediate supervisor's responsibility. While ultimately, approval was required from the Associate Director or Director, everyday authority to make the above decisions was in the hands of workers and middle managers. For example, when workers requested vacation time, they also provided to their supervisor a list of which of their colleagues would be covering for them while they were out. The professional expectation was that anything out of the ordinary, or anything which left the supervisors or assistant director uncertain, would be cleared with the next highest person in the T.O. And, routinely, all approval decisions were routed through the Director's office for his information.

Finally, the fourth departmental goal, that of staff retention, was attended to in the above example by

staff experiencing themselves and the hospital as providing an effective, valuable service to children and their families. Simultaneously, the availability of immediate supervisory help, with emphasis on improving workers' skills, would hopefully encourage them to remain in a department where such professional attention was part of their everyday working experience.

To continue the description of the change strategies, the third factor utilized to achieve the desired goals was the establishment of a Continuing Education Program (also called Staff Development activities in the literature). Patti's description of this is that they consist of "those formal activities in agencies that are intended to enhance the role performance of employees, to increase their contributions to the achievement of organizational objectives."[7]

The most traditional approach to Continuing Education has always identified its primary mission as the acquistion of specific job relevant knowledge and skills. However, Patti cites several instances of increasing recognition that staff development programs also serve the purpose of improving the quality of the work environment by promoting improved communication and work group

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[7]Ibid., p. 218.

cohesion in regard to clinical, case management and administrative issues.

Therefore, a truly effective continuing education program must pay attention to what the social workers need in order to do their jobs. If that is done effectively the environmental impact will be a positive one.

This theory was employed by the director having all staff participate in the beginning of a comprehensive continuing education program aimed at polishing current skills and introducing new concepts of practice into the department. This emphasis flowed naturally from the philosophy of staff involvement in decisions affecting their daily functioning. It allowed staff to express preferences for different practice-related or theoretical presentations which interested them.

The thought behind this approach is to use some of the aspects of Human Relations theory of organization behavior previously described and the positive effects of change from within the organization by staff members.

However, we do not use organization "change from within" in the strict sense that Resnick and Patti employ in describing intraorganization change. They label it as "systematic policies or programs from within when they have no administrative sanction for these activities."[8]

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[8]Resnick and Patti, eds., Change from Within, p. 45.

They then state how important it is both personally and professionally for social work staff to believe that they are actively engaged in providing services to clients within an organizational environment which enhances the welfare of the agency's clients and staff.

It is this second aspect of the value of change from within which is most applicable to the thesis of this project.

There is much emphasis in MSW programs on ethical factors and the resultant obligation of practitioners to "place professional values above organizational allegiance."[9] However, without administrative sanction, following the above tenet will often place the social worker in a conflictual situation. If a worker perceives that a certain policy or procedure could compromise patient care, advocating for a change, without administrative "permission" could result in a potentially unpleasant situation. This could range from strained work relationships, restricted upward mobility, or in extreme cases, job loss. That danger was not operative here. Staff was at all times very clear that suggestions about the content of formal teaching seminars, or problems discussed in supervision concerning methods of delivering

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[9]Ibid., p. 218.

service would be received by the director as valuable information to be used in accord with what Scott and Mitchell define as "training objectives."[10]

It was presented to staff both in the large group and small unit meetings, as well as the continuing education seminars that we would look to: 1) transmit information, 2) develop certain attitudes among staff, 3) develop certain skills and 4) encourage conceptual level thinking.

To discuss each briefly:

1) Transmit Information: The essential element is the content of what is being offered. The purpose of any training program is to provide information drawn from a body of knowledge. Therefore, in social work we will look to transmit to the participants information about human behavior, personality and motivation, and the process of communication between indivduals within families and groups. In a hospital these will be connected with their specific application to health care delivered to physically ill or emotionally disturbed patients.

Thus information consistent with departmental goals of decreased LOS and carve-outs would be incorporated into formal teaching sessions. This would be done so

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[10]Scott and Mitchell, "Organizational Theory," p. 176.

that staff would be completely aware of the importance of such factors to the quality of care provided to the patients as well as its significance to the department as part of the larger organization.

2) Development of Attitudes: Staff will enter any education program with certain preconceived notions about the domain of social work practice. These ideas have been formulated throughout their lives as a result of formal schooling and their own life experiences. The attitudes thus developed will impact greatly on their ability to "hear" and use the information transmitted. Thus, education must be focused on the participants' attitude toward the clients and their relatives, and the hospital, or else their effectiveness in implementing the knowledge presented will be compromised.

For example, many people believe that when you enter a hospital, you should not leave until you are completely well, and more or less, ready to resume a "normal" existence, even if that existence includes a short period of convalescence at home. In reality, because of lack of funds, bed space and personnel, once the acute phase (intensive medical care) of an illness is over, the state mandates that people convalesce at home if possible, at a nursing care facility if necessary. This results many times in people being discharged from a

hospital in an ambulance, to be taken to another institution for long term convalescent nursing care. The families of such patients, to say nothing of the individual himself, often require hours of attention by hospital staff before they can bring themselves to accept the situation, and cooperate with the staff. Social workers are often caught between patient desires on one hand (to stay) and organizational mandates on the other (to keep beds open). If they have not come to terms with their own personal responses to such a situation, either in supervision, or in formal educational settings, they may have difficulty in moving a patient out very quickly. They could view length-of-stay penalties, or carve-outs, as "necessary evils" if a patient is to receive quality care. It is only in circumstances where particular attention is paid to their feelings that we can be assured of having some impact on the attitude of the workers.

3) Development of Skills: If the continuing education program is to be effective, the information transmitted must be used, and the attitudes of staff directed so as to help clients resolve specific problems. In most educational or training sessions, especially those of an extramural (off site) nature, there is little opportunity to evaluate whether or not effective skills were developed by participants. The approach to training

described here will not have that shortcoming.

Both line workers and supervisory staff were involved with choosing the content of the continuing education seminars, and were involved with its evaluation. The subject matter would be part of the supervisory process, as well as the large service unit meetings. Staff, at these times, would be held accountable for the learning and implementation of the seminar material. This resulted in the opportunity to determine which aspects of the LOS problem, or ALC procedure had been incorporated by staff into their practice, and which parts required further presentation either formally (to the larger groups) or via individual supervision.

4) Conceptual Level Thinking: Much of what will be presented to staff will be useful to clients, in situations not specifically identified in the seminars. Also, there may be other instances in which skills ideas or other information will be helpful in ways that were not foreseen by the seminar leaders, but would be apparent to the workers on the "front lines." The ability to "think through" problems based on specific theoretical information already presented is invaluable in any social worker, given the myriad complex situations with which he/she is faced daily. This ability to see beyond the presenting problems and paperwork demands is one factor that should

be present in a quality social work department. It allows staff to help patients and families cope with the more comprehensive problem of a supportive discharge living environment, rather than the narrower focus of how quickly can this patient leave the hospital. The former approach takes into account and uses the strengths and weakness of the patient/family in a way which offers the best chance to prevent premature or unnecessary re-hospitalization. If the emphasis was only on moving the patient out quickly, critical elements of the home/ family environment could be missed. This could lead to a discharge plan which was doomed to fail. For example, an offer of help from a family member could result in the hospital staff depending on that aid after a patient is discharged. The temptation is always present for the over-worked social worker to accept what is offered as a good plan, and then move on to the next problem. However, a family oriented approach could reveal that, for any one of a number of reasons, the family member would not be able to fulfill his promise of help. He could be too old or too young, or angry at the patient, etc. Whatever the reason, not being aware of the possibility would result in a disastrous post-discharge convalescent period. The quality social worker is always aware of how human behavior can adversely affect his work with patients. Such

a worker is therefore assessing situations and implementing approaches based on a knowledge of resources and on an ability to "see" his patient and problem on many levels.

If the continuing education seminars are effective, we can expect to have staff who know resources, human behavior theory and have the ability to combine the two. Such an ability would positively affect the department's skill in fulfilling the stated goals.

Before describing how the above-mentioned design will be implemented, one final statement is necessary.

The director's philosophy guiding the identification of the changes, and the means by which they were implemented, is simply stated. Though it is necessary for social workers to have command of the technical skills required in their work, such skills are not effectively applied if the environment contains poor communication, mistrust, and destructive competition. There is complete agreement with Patti who states that, "effective role performance by social workers is more than the sum of their individual technical competencies."[11] This factor was always accorded priority when decisions were made re:

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[11]Rino Patti, Social Welfare Administration: Managing Social Program in a Developmental Context, (Englewood Cliffs, New JerseY: Prentice Hall, 1983), p. 45.

supervisory responsibilities, organizational control and leadership behavior.

CHAPTER IV

PROGRAM IMPLEMENTATION

The crucial element in any planned organizational change is the timing of the introduction of the change strategies.

Even though the changes contemplated were initiated from the top down, cooperation of the management staff and line workers was vital. Nadler's model has the organization (staff and line) acting as the "transformation" process whereby the input, i.e., leadership style, the new organizational structure and continuing education series is converted into the output intended to satisfy departmental as well as the hospital goals.

There were three change strategies identified, leadership style, new organizational structure, and a continuing education program. All of these were focused on effecting a change in the LOS patients; the destination of discharged patients; lessening the "carve-out" days attributed to social work and reducing staff turnover.

A decision was made to implement the new organizational structure first. There were several reasons for this choice.

First, the leadership style change is the most

difficult of the three to be identified independently of the other change strategies. We are basically describing a process, a manner of relating to staff that became increasingly apparent as policies were promulgated and implemented and problems resolved by the department.

Second, the leadership style is reflective of the structural changes. The new organizational structure, which identified the department's administrative and supervisory chain of command, was the most prominent example of how policies were to be discussed, proposed and implemented. A comparison must be made here between the prior decision-making process and the one promulgated by the new director.

The previous director had ten social work staff reporting to her. These consisted of four levels of supervisors including middle managers and senior staff, comprising one supervisor I, three supervisor II's, one supervisor III, an administrative coordinator and four assistant directors. This led to confusion and blurred lines of responsibility at times because for some services the assistant directors were responsible, but for others both the supervisors and the assistant director had to both go to the director for approval before any decision i.e., vacation, compensatory time, could be made.

For example, the supervisor working in the hospital's Skilled Nursing Facility (SNF) reported to the director.

However, there was no on-going supervisory relationship between her and the assistant director in charge of medicine and surgery, even though the vast majority of SNF patients were accepted from medicine and surgery services. Therefore, any administrative or clinical decisions concerning patient flow, for example, could only be made when the director was available. What occurred was that an informal system of collegial consultation arose between the assistant director and supervisor. However, when differences of opinion arose, the director would be called upon to decide which option to take. At times, this involved a total change in practice, because the directer countermanded decisions that had been made as a result of the informal (but unauthorized) decision-making process. At other times, it resulted in an assistant director being informed that the supervisor was correct, or should be given the responsibility to perform some action with which the assistant director had disagreed.

Both of the above instances had had a negative impact on department functioning and morale. It is not efficient to have different forms of social work practice evolve via staff consensus and then have such practices prohibited because of the director being forced to resolve a disagreement among the management team.

It is also destructive to the morale of senior

staff to know that their line supervisors have regular communication with the director, and that routinely, decisions made at those meetings were conveyed to the assistant directors as a "fait accompli." Such a condition is similarly confusing to line workers who, at all times, need to know who is in charge of policy and procedure in the department.

The final reason for implementing the new organizational structure first was that the choices of the topics and leaders of the continuing education series would flow from discussions among all staff. It was imperative that senior administrative personnel take an active part in such discussions. Such participation would perform several functions. It would demonstrate to the workers the accessibility of their senior staff. And it would be the beginning opportunity for the senior staff to start sharing their own views and ideas about how services should be delivered. Thus, the content of the continuing education series would be the result of deliberations among staff, and would reflect the philosophical and operational priorities of the department.

All of the preceding three situations could occur most effectively within a very specific administrative and supervisory structure. This would provide definite lines of communication and responsibility for feedback and

implementation of whatever programs arose.

The new structure would, in reality, consist of many "old bricks." One factor which affects any new director or bureaucratic successor is that staff does not change quickly, so that any hierarchial restructuring must take into account the abilities of the senior staff. Their abilities, and as Gouldner has previously cautioned, loyalties are important elements to consider when assigning new responsibilities to old staff.[1]

Ability is vital since the new structure is the major conduit for communication, supervision and education in the department. Personnel who comprise the top positions in a hospital social work department must be able practitioners, supervisors and managers. If this were not so, then their decisions regarding the operations of the staff would be ineffective or inappropriate. This would lead to poor quality care, a decline in staff morale and an inability for decentralization to be effective.

Loyalty is co-equal to ability in importance, because if there is overt, or covert sabotage of the new director's policies, none of the objects of change will be affected. In a complex system such as a hospital, it is impossible for the director to be aware of all aspects of the delivery

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[1]Gouldner, Patterns of Industrial Bureaucracy, p. 150.

of services, hence covert resistance would be difficult to discern until the procedures were not implemented and the policies rendered useless.

Gouldner suggested that "strategic replacement" of former staff together with "increased bureaucratization" would limit potential damage done by staff if loyalties were in question.[2]

Strategic replacement meant that workers or senior staff in key positions, who demonstrated obvious strong loyalty to the departed leader should be replaced. The point was made that overcoming such a feeling would be time consuming, and in the interim the organization would be subject to much overt and covert sabotage of new policies.

By increased bureaucratization, Gouldner meant that an increased reliance on rules and formal communication would lessen the possibility that the "informal organization" would become an obstacle.

Strategic replacement was selected in this situation as a way of blunting potential divided loyalty problems. The choice was made because increased centralization of authority and very formal communication patterns ran contrary to the author's evaluation that a more participative approach would work best in the delivery of social work services in

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[2]Ibid.

a hospital.

Another factor that contributed to the choice was the fortuitous resignation of two senior staff, one of which was the Associate Director. This allowed the new director the luxury of replacing the number two person in the department, together with another senior staff without having to resort to terminating employment, a difficult and organizationally upsetting decision.

A final consideration which led to the decision to not replace other senior staff was that after interviewing the remaining members, it was discovered that two of them had been at the hospital less than a year, two others from 6-7 years. This was a short length of time and subsequent meetings revealed no difficulty with them accepting a new director with a philosophy and policy which differed from the previous director.

The new organizational structure is identified by the T.O. in the Appendix. Before it was distributed to the department and the rest of the hospital, it had been the subject of many weeks of discussions with the associate and assistant directors. The discussions themselves were new to the department, because the forum was a once weekly meeting of senior staff (the "Cabinet") wherein all policies, procedures and problems would be discussed. Implementation would flow from consensus reached in this group.

The first consensus that was necessary was agreement concerning the philosophy of administration held by the new director. This was to ensure their understanding of it and willingness to function under its imperatives. The formulation of the T.O. was the first visible example of how that philosophy was to be operationalized in the department. As can be seen, each assistant director has a clearly defined line of authority, with supervisory and line workers always having someone to whom they report in the chain of command.

Education of the cabinet, and through them the other staff, was necessary so that administrative and supervisory perogatives would be respected. Senior staff had to role model for the department in being careful not to usurp subordinates in how daily operations were conducted.

It was made clear in the cabinet meetings and in the individual unit meetings that formal communication was to flow through assigned channels, i.e., from the director and the cabinet to the supervisor I and II levels, and then to line workers, and vice versa.

For example, a decision made in the cabinet would be carried by each of the assistant directors to the next level (supervisor I and II) the goals, objectives and implementation strategy were explained, and it became the responsibility of the middle management staff to carry

out the policy.

An extension of the above procedure was that problems, suggestions, criticisms, etc., from line workers or middle managers were to be communicated to each successively higher supervisory level, eventually to the cabinet and director. At that point a decision would be made. It could involve an additional policy, a modification of one, or a problem-solving process. In such a case, the decision would be transmitted back through the communication chain to the affected parties. In certain situations it was necessary for the director or cabinet member to become involved directly in the situation. Even if that occurred, such action would be undertaken only after thoughtful consideration was given to the unique aspects of the problem, and the potential impact on departmental functioning of such deviance from established policy.

It was recognized that there is a danger in the above procedure of the top executive being cut off from contact with everyday departmental functioning. This may occur via top administrative staff's screening of material presented to the director individually or in cabinet. It could be a misguided attempt to protect or shield the director from specific details, so as to allow him time for more overall, conceptual administration. Or it could be that an inadequate or incompetent management staff is

interested in protecting themselves from discovery.

To reduce the possibility of such an occurrence, three formal procedures were instituted.

First, anyone on staff was to have guaranteed direct access to the director if there was an emergency problem perceived, or a chronic one reoccurring, in which the staff member had received (in his/her eyes) little or no positive response. If a staff member determined that such a meeting wascritical, then it was scheduled. The only qualification placed on such a meeting was that all lower level supervisors were aware of the situation, and had been informed by the staff member that he/she was seeing the director, as a final attempt to resolve the specific issue.

Second, once per month, the director met with middle-management staff only, i.e., the supervisors I and II identified on the T.O. This provided formal access of the director to the supervisors, and vice versa. The object was to allow a forum in which philosophy and policy could be discussed with the middle managers who had the greatest responsibility for implementing of procedures. The dialogue resulting from such a regularly scheduled meeting would clarify doubts about the professional and operational policies of the department. In line with the director's management philosophy, it would allow for staff "owning" many of the decisions and thereby implementing them fully

and enthusiastically.

Finally, the director, on a rotating once per month basis met with individual assistant directors and their workers. This was not a meeting in which the director presented administrative issues, that process took place at monthly staff meetings (to be discussed in a later section). Rather, the unit meetings were to take place as scheduled, with whatever agenda items were appropriate. The director was there as a participant-observer, who would ask, and be asked questions based on the content of the discussion generated by the agenda items. As with the meeting with the supervisors, this provided an opportunity for the director to interact with workers who did not have regular access to him. Communication and a recognition of mutuality of goals was the objective of this type of meeting.

An observation could be made from examining the T.O. and thinking about the reliance on formal lines of communication and specific job responsibilities that the organizational structure is centralized in the hands of a few assistant directors, rather than decentralized as is the director's philosophy. However, Perrow in discussing research conducted by Blau and Meyer, makes an interesting point that intuitively one might expect that the more narrow the span of control, or hierarchical structure, the more centralized an organization would be. Instead, what

they discovered was that decentralized organizations used a tall hierarchy, in combination with written rules, an emphasis on expertise, and a clear ordering of positions, in their attempt to maximize efficiency. Such emphasis is the opposite of what Perrow labeled the "traditional" model of organizational functioning featuring personal rule, personal evaluations and a low dependence on general worker expertise.[3] Thus decentralization is not contradicted by a tall hierarchical structure, with formal lines of communication.

The administrative and supervisory emphasis on the first goal, i.e., reducing the LOS of patients on ALC status was clearly communicated to the workers through the various individual unit and staff meetings. This was done in several ways.

First, the existence and extent of the problem was made known to the staff in the same terms employed in Chapter I. Reference was made to patients remaining in acute care beds unnecessarily, the impact of elongated stays on the patient and family, and the potential negative impact on the hospital's financial condition. Quality of care issues were stressed rather than financial reasons in an attempt to highlight for staff that these were

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[3]Perrow, Complex Organizations, p. 39.

people that were being discussed not days or money. This was in recognition of a professional social worker's allegiance to patient rights and the integrity of the family system. It was decided that an appeal to change practice based mainly on financial considerations would be less effective.

Second, the connection of LOS problems to where the patients are discharged was described. Patients who were medically no longer in need of intensive nursing care often must remain in the hospital for weeks, sometimes months, because of a lack of other institutional beds in a nursing home or other health related facility. The patient's ultimate destination may be his home, but there is the necessity of an intervening stop where his convalescence would be helped by regular (though not critical or intensive) nursing attention. Facilities which provide such care will only do so if they are certain of being paid immediately, and regularly. For most patients, this requirement means that Medicare or Medicaid must pay. The enormous daily cost in such facilities (approximately $300. per day) precludes the vast majority from being able to afford it from their own financial resources. Having to await Medicare/Medicaid eligibility is a long, often frustrating period of time for the patient and family. It is likewise problematic for the hospital which has an

acute care bed occupied by someone no longer in need of such care.

As stated previously, it is seductively simple for a social worker to follow the initial plan indicating the need for additional post-hospital care by making the appropriate applications to Medicaid and the nursing facility and then wait. It allows the worker to feel that his "job has been done," and then to concentrate on the newer cases brought to his attention. However, in many of the cases, it is possible for the patient to leave the hospital and return home, either to await a bed opening in another facility, or to stay home for good. Both of these two circumstances require that the social worker spend a large amount of time in assessing the family's emotional strengths and weaknesses in caring for a convalescent member. Such an assessment also demands a thorough knowledge of the medical condition, including what equipment is needed to ensure the optimum post-hospital environment for the patient. This kind of discharge planning necessitates sensitive, knowledgeable, intensive intervention with the identified patient, family members, medical staff as well as the vendors of home medical supplies. It is obvious that it likewise requires more time from the social worker than merely sending in an application to a nursing home.

It was the director's evaluation that for staff to

agree to, and actually implement this new approach, they would have to be made aware of and "own" the problem, and then be provided with the tools to effectively address it. The awareness would be attended to by introducing and explaining the topic at the staff and unit meetings. The ability to effectively combat the problem was addressed in the continuing education series (to be discussed in a later section) in which both supervisors and line staff were exposed to seminars and workshops designed with these matters in mind.

Finally, the large amount of carve-out days attributable to tardy social work action in identifying patients on ALC status was approached in a similar matter.

The carve-outs led to a quality care situation similar to the one described above. Patients who were not identified quickly enough as needing discharge planning sometimes remained in the hospital unnecessarily until such planning began. However, in the vast majority of cases, such a delay was only a couple of days and did not have nearly the obvious impact of the previous problem in which patients languished for long periods of time. But while the carve-out days were a quality care issue, they were equally a financial consideration to the hospital, which was not reimbursed $461.00 for every day designated as a carve-out. While this factor was important to the hospital,

it was less so to staff who did not have their salaries affected by the money loss, and also who knew that the city administration historically covered any financial shortfall the hospitals experienced.

Therefore, in this case, the presentation to staff required a more subtle approach which combined quality care issues, fiscal realities and some education concerning organizational rewards and penalties.

The quality care issues were important, and obvious, and have been described elsewhere: the quicker someone leaves the hospital, the better it is for all concerned. Quickly identifying a patient who requires sophisticated discharge planning is vital for the patient's well being, and it reflects positively on the professionalism of the department.

The fiscal reality was that although it was true that the city couldn't and wouldn't allow a municipal hospital to go bankrupt, neither would it reward a hospital for inadequate financial management. Thus, if new grant monies were being allocated by various federal or state agencies, there would be an understandable tendency to provide new monies (new staff, new services to patients) to those hospitals which had demonstrated skill in this ability to manage money. If this hospital developed a reputation as a sloppy or irresponsible manager of funds,

both patient care and staff would be adversely affected. Patients would not benefit from new programs or new services. Staff would not be augmented by additional social workers, which would have allowed them to provide more social work attention to patients. Thus, it was clearly in staff's best interest to identify and begin social work discharge planning as soon as possible.

The organizational rewards that would accrue to the department were many. As the department assigned the responsibility for discharge planning, doing it effectively leads to a "no money lost" situation for the hospital. Social work here is in the enviable position of being able to put a price tag on effective social work, and have non-social work administration equate that with efficient performance. Far from being a support service that only spent money and who constantly had to defend its right to exist via human-values and quality-of-life arguments, we were now able to identify that with prompt, relevant intervention social work had saved the hospital a certain amount of money. The department would be an acknowledged contributor to the hospital, both professionally and financially. This situation can help when decisions are made in the hospital concerning not only tangible problems, i.e., do we need additional staff, but in less tangible ways, i.e., whose offices get painted, air-conditioned or

decorated. These intangibles are exceptionally important in how staff would feel they are valued by the hospital for their performance.

All of these factors were identified at cabinet meetings, and transmitted to staff in small unit meetings and supervisory sessions. Their importance was stressed and painstakingly described until it was felt that there was a consensus on the identification of the problem.

At that point, as a natural consequence of a participative management style, staff was asked to propose ideas, policies and procedures that would address the problem areas of long LOS, specific discharge locations and carve-outs.

There was no attempt at this point to address staff turnover, or its correlate, job satisfaction. It was the director's opinion that if staff did an adequate job in a satisfying professional atmosphere, and their performance was verbally and materially recognized by the larger organization, then they would be encouraged to remain in the department.

Individual unit meetings, entire staff meetings supervisory meetings and the cabinet discussions all resulted in new procedures aimed at solving the identified problems.

A system was instituted whereby on a daily basis

the central social work discharge office indicated to specific workers which of their patients were on ALC status and therefore required immediate attention and discharge planning. There was an alternate system of checkbacks, conducted by the clerical staff through the supervisors and cabinet members, which allowed them to independently be aware of which patients staff should be working with more intensely.

Additionally, regular meetings were begun for the first time with the financial staff in the hospital to identify both specific and generic problems related to the establishment of patient eligibility for Medicaid/Medicare entitlement programs. This eligibility is vital if patients are to be moved out of the hospital to other institutions, or home with supporting medical services and supplies. Social workers and the financial clerks were given permission to talk directly to one another without supervisors being called first. It was thought that working together on a common problem would lead to more cooperation and less of the feeling that the financial people didn't care about people and social workers didn't concern themselves with money. As before, there was a backup written report generated to supervisors and cabinet members to which they were expected to give attention in individual and group supervision with line workers.

In recognition of the vital role other disciplines maintain in the hospital, regularly scheduled meetings were begun with nursing staff. In an attempt to collaborate in the interest of quality health care for the patients all levels of the social work department met with their counterparts in the nursing department to enlist their support in focusing on ALC, or difficult to place, patients with the aim of moving them out more quickly. For example, nurses were urged to write notes in the charts providing information about weekend or evening visits by other family members which could aid the social workers in understanding the dynamics of the patient's functioning within the family.

A heavy teaching emphasis was begun in the supervisory, unit and cabinet meetings on chart notations. Social work staff was directed to use the chart as a communication tool with an emphasis on brief, conceptual writing, not on detailed process notes. The focus was on information needed by other disciplines about the status of the social work plan for the patient and family, both in the hospital and upon discharge. Thus hard-to-reach family members, who were unavailable to social work staff, were able to be contacted by nursing staff during visiting hours. This collaborative approach resulted in more family members becoming available to help plan for discharge

with the patient and social worker.

Shift changes were also used as a way of maximizing social worker contact with other disciplines and with family members. Depending on the identified needs of the patients and services, social workers did not only work 9-5. On some units such as Psychiatry, for example, attending physicians only worked in the morning. To maintain their daily availability to staff as well as ensure evening social work hours for family contact, flexible hours were initiated. Some staff members worked 9:00 A.M. to 9:00 P.M. on certain days, 9:00 A.M. to 1:00 P.M. on others. On other services, such as Pediatrics, where family was always present during the day, evening hours were scheduled only on an as-needed basis. The emphasis in scheduling was on maximizing staff contact with supportive family members. The aim being to make the hospital stay as positive as possible and the post-hospital plans effective in ensuring rapid convalescence.

Throughout all the departmental discussions and proposed changes, the participative style of leadership and the congruence model of organizational behavior was visible to staff.

To once again look at Fig. 1 on page 26 we can see how the <u>environment</u> of the hospital, the <u>resources</u> of the hospital and social work department, and recognition

of the historical relationships among hospital departments all were utilized by staff to arrive at a strategy. This strategy, under the guidance of the director, was transformed into the individual, group and organizational processes described above. This was accomplished by staff consensus. On only a couple of occasions was it necessary for the director to decide among several different, strongly held beliefs regarding problem resolution and procedures.

This style of decision making and model behavior had been theoretically explained to the cabinet, supervisors and staff. It had been graphically represented in the organizational restructuring exemplified in the T.O. And it was operationalized via the department-wide problem-solving process undertaken concerning the director's goals.

We have described some of the concrete changes made, i.e., shift modifications, meetings, etc. Just as important as affording staff the opportunity to interact with other professionals or family members, was providing them with the knowledge and skills necessary to make those meetings optimally effective. To that end, it was a logical step to plan for a continuing education approach to supervision and teaching in the department. There we would attempt to go beyond the case-by-case problem specific approach endemic to most supervision. We would provide

theoretical and conceptual level material which would add to staff's understanding of what was occuring while simultaneously challenging their creative abilities to supply innovative responses to difficult situations.

To begin the continuing education emphasis a member of the cabinet chaired a committee comprised of interested staff members. These staff had volunteered to take part in a process which would ultimately lead to a proposal for an in-service, continuing education program.

An attempt was made to ensure that the committee was as representative as possible of the general composition of the department's staff, i.e., years post-masters degree, years on staff, different services in the hospital, etc.

The committee's charge was to canvas staff for topics in which they would be interested and to research different continuing education programs at different hospitals to determine which appeared to be most effective in the opinion of line workers and management. Particular attention was paid to topics suggested, format of the seminars and identity and training of the teaching staff.

During the meetings of this Staff Development Committee it was important that the parameters within which they were to function be carefully delineated. For example, it was the director's goal to increase staff skill, morale and theoretical knowledge, but not as the expense of patient

care and their appropriate movement out of the hospital. There is always the danger that asking social workers what they want may result in a request for a seminar on treating sexual dysfunctioning. This topic may be interesting, but it would have little immediate applicability to satisfying the goals previously outlined. Therefore, the chairperson of this committee carefully and consistently stated the group's mandate that the continuing education seminars should simultaneously satisfy staff's desires, departmental imperatives and hospital goals. The final choices of seminar topics would be made by the director and cabinet with the above factors in mind.

An additional element that also was considered while choosing the continuing education topics was who would do the teaching.

It was the director's intention to strengthen as much as possible the visibility, authority and responsibility of his associate and assistant directors in the eyes of the hospital administration and the staff of the department. The reasons have been stated in previous sections. Briefly however, it was felt that the difficult, crisis-oriented world of hospital social work requires that decisions be made as quickly as possible. The new organizational structure clearly identified the cabint members as the daily operational authority on all matters within

their span of supervisory control. Only very unique situations, or problems which involved departmental policy or interactions with other directors of service in the hospital (i.e., Medicine, Psychiatry, etc.) were brought to the departmental director. The vast majority of problems were to be resolved at the supervisory or assistant director level. They were then to be discussed in the weekly cabinet meetings, or in scheduled individual sessions with the director. At those times a more intensive examination of the issue involved might lead to reinforcing the decision made, or result in a modification of the policy or procedure so as to provide better guidance for the next time someone was faced with a similar problem. It was through this constant evaluation and education that the cabinet became familiar with the overall organizational and professional philosophy of the director. They were then able to administer policy and manage staff in accordance with that philosophy.

In addition to the daily operational and supervisory responsibility, it was the director's goal to strengthen the cabinet members authority and prestige by identifying them as teachers who had professional skills and expertise that they were able to transmit to the rest of the department.

Therefore, the seminar leaders had to be members of

the cabinet, not professionals imported from other hospitals or schools, because that would have given a message to the department that the expertise was not available within. However, in order for this tactic to be successful, it was necessary for the topics of the seminars to be those which the cabinet members were competent to teach.

One initial problem that had to be overcome was that most of the cabinet members had not taught in a formal teaching environment. They had been trained in, and were accustomed to teach via supervision and the informal collegial consultation which occurs daily in hospital social work.

This difficulty was addressed via a brief intensive (2 day) workshop conducted by the director. The focus of this workshop was how to teach adult learners in a continuing education format. The material presented was a summary of the teaching principles espoused by Knowles[4] and Towle[5] among others. These precepts emphasize that for adults, learning is behavior and is what the learner does, not what the teacher does. From their viewpoint, adult education is a process of mutual self-directed inquiry between the

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[4]Malcolm Knowles, The Adult Learner: A Neglected Species (Houston: Gulf Publishing Co., 1973).

[5]Charlotte Towle, The Learner in Education for the Professions (Chicago: University of Chicago Press, 1954).

students and the teacher. Therefore, it was important for the seminar leaders to nurture an environment in which their expertise and the workers' experience would come together, and aided by selected literature, result in a satisfying atmosphere which fostered learning, together with the ability to apply it in their daily functioning.

In addition, their participation in the workshop was used as an "in vivo" example of what staff would experience by participating in the continuing education seminars. How the cabinet members felt, how they reacted, how they learned or didn't learn, etc., all were topics of discussion during this seminar.

With all the above factors in mind, four subjects were chosen as seminar topics: a new workers seminar; a seminar on the impact of chronic illness on the patient family and staff; working with families in a hospital setting, and the use of contracting in social work practice in a hospital setting. Each of these topics were focused on achieving the departmental goals articulated in previous sections of this paper.

The first issue to be considered after the topics were chosen was how to decide which staff should attend which seminar. There was a recognition that if given an absolutely free choice, some staff could choose the most "interesting" topic, rather than one which addressed some

practice weakness. Therefore, it was decided that staff participation would be a dual process. Workers, in conjunction with their immediate supervisor, would select a specific seminar. The choice was based on previous personnel evaluations, current needs of the service, and which aspects of the worker's functioning needed particular attention. Thus it was made clear from the start that this was a functionally directed series, not offered just to quench thirsty minds.

This approach was used for all seminars except the new workers meeting. For that one it was decided that all workers on staff less than one year would attend.

We shall describe each of the seminars in brief: (A specific description of the content of the seminars is contained in the Appendix.)

NEW WORKERS SEMINAR: The "raison d'etre" for this topic was a realization that social work in a hospital setting is very different than working in schools, social agencies or for the government. Social workers need to be aware that the hospital is a complex organization in which medicine, not social work is the host profession. New staff needs to be sensitive to this fact. The history and mission of a municipal hospital (health care to all, regardless of ability to pay) needs to be understood in conjunction with the often contradictory demand to move patients out as

quickly as possible. Thus, concerns and decisions about patients, collaboration with other disciplines, chart noting, all take on a specific character, and need to be addressed in a generic formal manner away from specific patients. It is in this manner that departmental goals would be explained to new staff as an attempt to have the workers incorporate them as their own as quickly as possible. What had taken place on a department-wide basis would take place in this seminar of six sessions in which all new staff members would participate immediately upon beginning work. LOS problems, carve-outs and discharge destinations would be highlighted together with the processes through which these problems were to be addressed.

This was accomplished by presenting a brief overview of this particular municipal hospital, its mission and the demographics of the people it served. The role of the social worker to the hospital and community was described, with emphasis on how professional performance in their jobs contributed to better patient care. Particular attention was paid to identifying important factors such as quick assessment, clear and concise charting, interdisciplinary collaboration, and the use of formal and informal supervisory channels. New workers were asked to provide samples of their chart notes, and these were used as examples for mutual discussion. Emphasis was placed on how quick

assessment and sure interdisciplinary collaboration led to better patient care and allowed both the social work department and the hospital to achieve its goals. Vignettes were used to highlight different situations in which communication and cooperation was necessary on the wards. The new workers were encouraged to present difficult situations which they had encountered on the wards. Time was spent on learning how to conduct themselves when faced with unique problems or unresponsive colleagues. As with all of the seminars, the emphasis was on "how-to deal with this situation now" rather than on understanding theory. This was in accord with Knowles' theory that adult learning was most effective when it could be applied immediately. Also, this approach would be more likely to "pay-off" in the staff quickly being able to respond appropriately to the achievement of the departmental goals.

IMPACT OF CHRONIC ILLNESS: Another six session seminar in which the often devastating emotional effect that a chronic illness has upon the patient, his family and staff, was presented. Often a patient or family is so frightened of a medical or psychiatric illness that they refuse to discuss appropriate ways of confronting it. This can lead to prolonged stays in the hospital, or inappropriate expectations of what the patient can do, or family should do upon discharge

from the hospital. Families and patients frequently swing between unrealistic extremes concerning their functioning during the convalescent period. Either too much or too little is expected of each other, with the common result being an emotionally unhealthy environment and a potential rapid, often preventable readmission to the hospital. In order for the social worker to enable the family to deal with this issue, his/her own feelings about illness need to be conscious. This awareness must be combined with medical knowledge and the clinical skill necessary to provide the patient and family with a realistic foundation for coping with chronic illness.

This was addressed by a two session didactic presentation followed by four sessions in which each seminar member was required to present a patient, or situation which was difficult, or unique to them. Collegial discussions occurred on various ways of dealing with such a problem: The aim was to provide staff with concrete "how to" information which they could use immediately upon leaving the seminar.

WORKING WITH FAMILIES: In many cases the identified patient is too ill, or too old, or too young to actively participate in much of the in-hospital counseling and post-hospital discharge planning. This requires a quick, sure entry into the family by the social worker. Knowledge of family dynamics and different methods of intervention need

to be part of the repertoire of each social worker. This six-session seminar began with a two-session didactic overview of family theory and therapeutic models. Staff was required to produce current material relative to their work with problematic family situations. This was used as a springboard for discussions concerning alternate ways of helping the family use their strengths to deal with the reality of the illness. Special attention was given to helping staff identify family resources in the interest of maximizing use of the home as a discharge location either permanently or while awaiting admission to a nursing facility.

CONTRACTING: Its use in social work practice in a hospital setting was discussed. This particular theoretical approach for engaging a client, or family in treatment is a relevant, immediately applicable tool for use by a social worker. Contracting is short-term, time limited work with someone concerning a mutually agreed upon problem. It is very useful in overcoming initial resistance and the suspicion that if the patient or family becomes involved with the worker, then there will be "meddling" in all aspects of their life. The technique used in contracting allow the trained worker to identify which part of the situation is most problematic for the patient's in-hospital or post-hospital functioning, and to concentrate only on that. People are

generally less threatened by the mutual decisions that are arrived at regarding social work intervention. Being treated as partners in a problem solving arrangement leads to cooperation around treatment plans that is not as possible if the worker jumps in and attempts to resolve all difficulties.

The demands of discharge planning and the lack of extensive community-based resources make contracting skills an integral part of a social worker's repertoire. The patient, family and worker all must agree on the definition of the discharge problem upon which they will be concentrating. It is destructive to patient care, wasteful of staff time and insensitive to the families' feelings if there is a hidden agenda on anyone's part while the discharge planning process is unfolding. It was the goal of this seminar to enable social workers to begin acquiring new skills, or enhance old ones, enabling them to engage clients quickly and with a definite focus.

As before, staff was encouraged to present problems encountered in attempting to contract with patients, especially regarding the psychosocial problems inherent in discharge planning. Various ways of approaching a solution were offered. In accord with department goals, priority was given to helping the worker move into the case as soon as possible and enable the family to help in the convalescent process.

At the end of the seminars, each of the participants was asked to fill out a questionnaire (see Appendix) in which they rated the seminar and its leader. Questions were asked concerning the seminar's relevance and applicability to their practice in the hospital. Information was thus gathered about the contents and manner of presentation, such that evaluations could be made regarding whether or not these seminars aided staff in satisfying departmental goals.

During the implementation of the continuing education seminars, one additional action was taken by the director. It was decided that the new organizational structure and leadership style would result in little change visible to the rest of the hospital. The changes were mainly internal and would have little immediately observable effect on how social work interacted with other disciplines. Of course, it was felt that over a longer period of time there would be some positive changes, but that was in the future and would be dealt with accordingly.

The continuing education series, however, involved the entire staff and required that they be absent from their various medical and psychiatric ward assignments for regularly scheduled periods of time. This, of necessity, lessened their accessibility to medical staff and created the potential for medical staff and administration to obstruct or curtail the effectiveness of the series by requesting

that it be shortened, or moved to later in the year or eliminated completely. As stated before, what had to be kept in mind was how change affected the powerful members of the organization.

This potential conflict was addressed by the director meeting with appropriate administrative personnel together with the medical directors of the various services. The intention to conduct the in-house continuing education series was presented. This was combined with a statement regarding the goals of the department and how they were to be realized as a result of the seminars. There was a danger to this approach in that once having surfaced the problems which the continuing education series was designed to combat, it became imperative that the goals be achieved. If they were not attained, then far from having rewards accrue, the department would be in the unenviable postion of having identified problems about which they could do nothing. However, it was decided that it was a risk worth taking, in that the potential for better patient care and increased organizational rewards were greater than the possible undesirable effect of having medical staff react negatively to the whole education process.

The administrative and medical staff accepted the reasoning for and therefore the existence of the continuing education series. These potential obstacles being erased, there was no other inter-organizational resistance encountered.

The identification of the problems and goals required that statistics be gathered showing the LOS statistics, carve-out figures, specific discharge planning destinations and the amount of staff turnover. Once that was done, daily, weekly and monthly numbers were gathered on a regular basis. This was begun before the changes occurred, while they were taking place and for several months thereafter. This was done so that there could be a comparison of the increase or decrease in the numbers in conjunction with the months in which the changes were implemented. It is recognized that it is impossible to ascribe a specific causal relationship, but the figures provide us with trends which indicate if the changes resulted in positive outcome tendencies toward the identified goals.

CHAPTER V

RESULTS

In the presentation of the results, much use will be made of the "interrupted time series design" discussed by Epstein and Tripodi.[1]

It is described as an evaluative design which controls factors for measurement instability before and after program intervention. While it is not possible to ascribe specific cause-effect relationships, "using an interrupted time series design does generate knowledge which is highly informative about a specific program."[2]

Thus, we gathered statistics describing the various aspects of social work practice, patient and staff movement, and discharge planning prior to the introduction of our change strategies. We then obtained LOS statistics, discharge destination of patients, numbers of patients serviced and numbers of staff, subsequent to the structural reorganization, new decision-making process, and the continuing education seminars. The first set of numbers were used as a baseline against which the post-intervention numbers were

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[1]Irwin Epstein and Tony Tripodi, Research Techniques for Program Planning, Monitoring and Evaluation (New York: Columbia University Press, 1977), p. 118.

[2]Ibid., p. 119.

compared.

We will first show a chart indicating the pre- and post-intervention measurements for each change object.

Then a graph will be presented for each of the first three change objects, patient LOS, discharge destination and carve-out days. The number of patients serviced will also be measured. There will be no graph presented for the numbers denoting staff movement because positions were vacant for periods of time over several months and other staff moved internally to fill certain positions. These movements made it impossible to graph numbers of staff in any accurate manner relative to months, or positions filled, i.e., some staff filled more than one position for varying lengths of time.

The graphs are then visually compared to determine trends. Are there changes in LOS statistics, numbers of patients served, number of carve-out days, etc.? If there were changes identified, we then sought confirmation that such changes did not occur as a result of chance variations, and were statistically significant.

We employed a technique described in Epstein and Tripodi using a graphic representation of means and standard deviations. If the post-intervention observations are found beyond the graphed boundaries of 2 Standard Deviations (SD) above (or below) the mean, it strongly suggests that the

post intervention changes are statistically significant at the .05 level of probability.[3] The specific technique will become clearer as we consider individual measurements in the following pages:

Chart A shows the mean lengths of stay for patients awaiting discharge for the first twenty months following the director assuming leadership of the department. The total number of patients discharged is also indicated. The asterisks indicate the time during which the new organizational structure was introduced and the period of time during which the continuing education series was conducted.

It shows that for three of the four months prior to the organizational changes, patients waited between three and four weeks, on an average, before being discharged from the hospital. This means that once a patient was declared no longer in need of acute intensive medical care, they spent long periods of time in the hospital before returning home, or leaving for a health related facility or nursing home.

For the four months after the structural change, there was a slight decrease in time waited. It was down from an average of 21.8 days waited for the four months to an average of 19.8 for the second four months.

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[3] Ibid.

For the ten months following the continuing education series there was a marked trend towards a reduction of time, the lowest being 11.0 days waited, with an overall average of 15.9 waited.

An additional statistic that is important is the increase in the numbers of patients on ALC status who were identified by the social workers as requiring help in formulating and implementing discharge plans.

For the months preceding the organization changes, an average of approximately 83 patients per month who had received social work intervention were discharged from ALC status. The four months immediately following the introdurction of the changes saw an average of approximately 103 patients per month discharged after being seen by a social worker, an increase of almost 25 percent.

For the ten months following the continuing education series, an average of 157 patients per month on ALC were seen for discharge planning. This was more than 100 percent increase over the monthly average prior to the introduction of the new administrative structure and more than a 52 percent increase in patients seen when compared with the four months immediately following the structural changes.

Graph A is a representation of the material contained in Chart A. It is presented in accordance with the interrupted time series design previously described.

CHART A

LOS (Mean Days Waited on ALC Prior to Discharge)

N = Number of Patients

Month			Month		
1	22.7	N = 71	11	17.7	N = 129
2	23.6	78	12	19.9	129
3	16.0	92	13	17.9	181
4	25.3	92	14	18.8	146
5*	22.1	123	15	15.1	155
6	16.9	88	16	13.6	156
7	17.7	68	17	13.5	164
8**	22.7	134	18	17.9	160
9**	14.6	121	19	11.0	161
10**	18.1	97	20	13.5	190

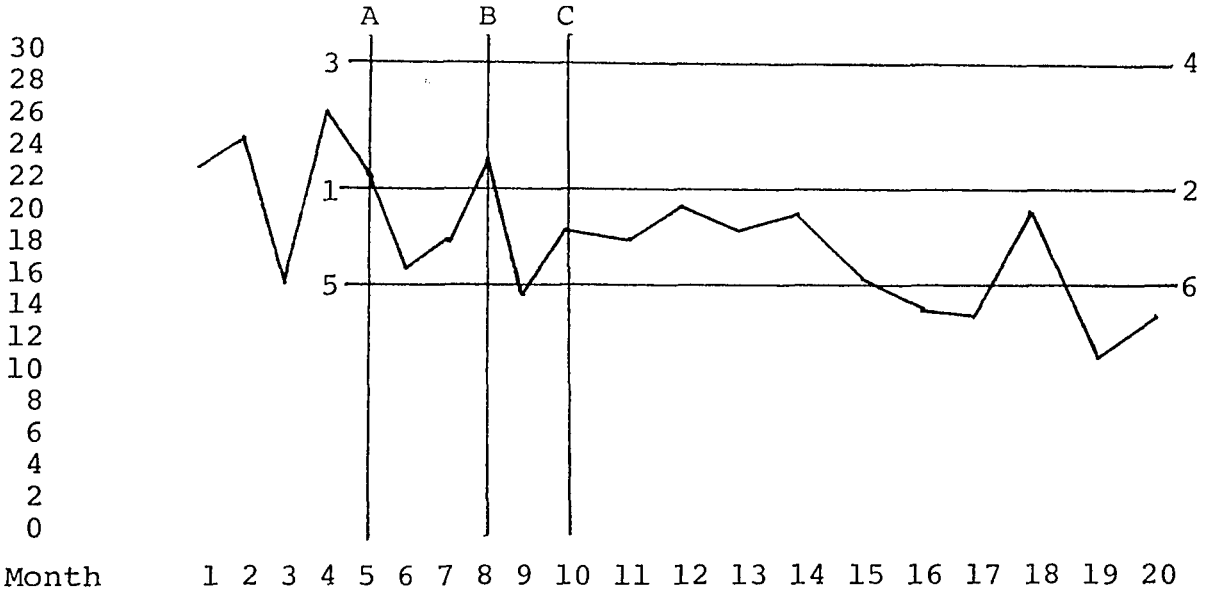
* = month in which the new organizational structure was introduced.

** = months during which the continuing education series was conducted.

GRAPH A

Length of Stay

(Mean Days Waited on ALC Prior to Discharge)



Point A = month in which new organizational structure was introduced.

Point B and C = months during which the continuing education series was conducted.

Line 1-2 - mean days waited = 21.9 days.

Line 3-4 - two standard deviations above the mean = 28.2 days

Line 5-6 - two standard deviations below the mean = 15.6 days

Point A indicates the introduction of the change strategies. It is the month during which the new organizational structure was introduced and the time in which staff was exposed to the new leadership style, supervisory process and decision-making procedure previously described.

Points B and C indicate the months during which the continuing education series was conducted.

A visual examination reveals that following the first organizational intervention (point A), there was a beginning overall, steady decrease in the number of days waited on ALC status prior to discharge.

Utilization of the simple technique described by Epstein and Tripodi is indicated by lines 1-2, 3 and 4 and 5-6.

Line 1-2 is the mean for days waited. Lines 3-4 denotes a point two standard deviations (SD) above the mean. Since we were interested in lowering the number of days waited, the points below line 5-6 are important. They represent post-intervention numbers that strongly suggest statistical significance at the .05 level of probability.

Visual inspection shows that 14 of 15 post-intervention statistics are below the mean number of days waited, (line 1-2) with six of the fifteen occurring outside line 5-6. This denotes a definite trend towards lesser days waited on ALC post-intervention. Thus, we can state that there is a

strong indication that the interventions had an impact in the desired direction, on the number of days patients waited prior to discharge.

The information reflected in Chart A and Graph A was derived from monthly statistics generated by the hospital's central discharge planning office and the utilization review department. The utilization review department is mandated by state regulations to identify, on a daily basis, the number of patients in a hospital who continue to need acute care, and those who are medically ready for discharge, i.e., are on ALC status.

An additional point must be raised regarding the characteristics of the patients on ALC status. Patients are either on or off ALC status, based on a decision made by a physician member of the hospital's utilization review committee. Patients are not identified by social work staff. Therefore, the results indicated in Graph A and Chart A were not subject to any pre-selection by social work staff, which could have influenced the findings.

The goal of reducing LOS for patients on ALC status appears to have been accomplished. There has been a steady trend of a decrease in days waited beginning the month after the introduction of the administrative and supervisory changes. This tendency was still in evidence, if anything in a more definite fashion, following the continuing

education series. Patients were waiting less time before leaving the hospital.

An unexpected result was that the total number of patients on ALC status identified by social workers increased sharply. So that not only were patients leaving quicker, there were more of them who received attention from the social work department.

Graph B is a representation of the increase in the total number of patients on ALC status who received service from the social work department.

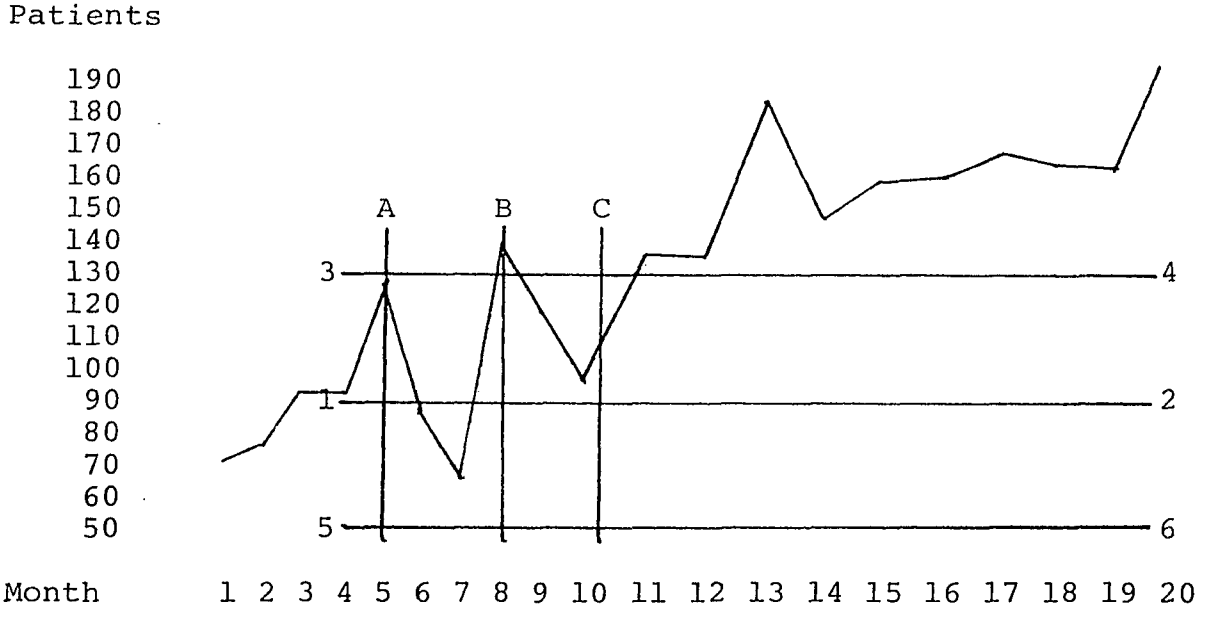
Visually, we can see that after point A, the beginning of the change strategies, only two of the next fifteen observations are below the mean (line 1-2) while eleven of the fifteen are beyond two SD above the mean (line 3-4).

Using the statistical shortcut previously described, we can state that the number of patients increased, and that the increase is most likely statistically significant at the .05 level of probability. This would indicate that the increase in numbers of patients seen, post-intervention, was strongly connected to the intervention strategies.

Chart B denotes the numbers of patients on ALC status who returned home with supportive services and the mean number of days waited before such a discharge. As before, the asterisks indicate the months in which the new structure was introduced and the time during which the continuing

GRAPH B

Number of Patients Discharged from ALC Status



Point A = month in which new organizational structure was introduced.

Point B and C = months during which the continuing education series was conducted

Line 1-2 - mean number of patients discharged = 91.2

Line 3-4 - two standard deviations above the mean = 127

Line 5-6 - two standard deviations below the mean = 55.4

CHART B

Days Waited for Patients Discharged Home with Supportive Services

Month	Patients	Mean Number of Days Waited on ALC	Month	Patients	Mean Number of Days Waited on ALC
1	6	10.3	11	64	11.4
2	24	22.8	12	46	11.1
3	23	14.5	13	63	17.1
4	25	24.5	14	61	12.3
5*	36	19.4	15	74	15.9
6	33	14.5	16	79	15.5
7	24	13.9	17	71	9.4
8**	51	16.1	18	82	14.4
9**	58	13.5	19	62	10.8
10**	44	11.9	20	83	15.7

*Month in which the new organizational structure was introduced.

**Months during which the continuing education series was conducted.

education seminars were conducted.

The chart indicates that over the 20 month period increasing numbers of patients were discharged home with supportive services after waiting for decreasing lengths of time.

For the four months immediately preceding the start of the new organizational structure, an average of almost 20 patients per month waited an average of 18.0 days before being discharged home with supportive services. For the four months immediately following the organizational change, an average of 36 patients waited only 15.9 days before being discharged. Almost double the amount of patients went home with services after waiting 12 percent less time in the hospital.

This trend continued in the ten months following the continuing education seminars. During that time the average number of patients discharged home with supportive services increased dramatically, by almost 350 percent to an average of 70 patients per month. At the same time this was occurring, the average days waited in the hospital decreased to 13.3 days, a drop of 26 percent compared to the first four months, and almost 17 percent less than for the four months preceding the continuing education series.

The numbers indicate that patients did not have to wait as long to be discharged home at the end of this twenty

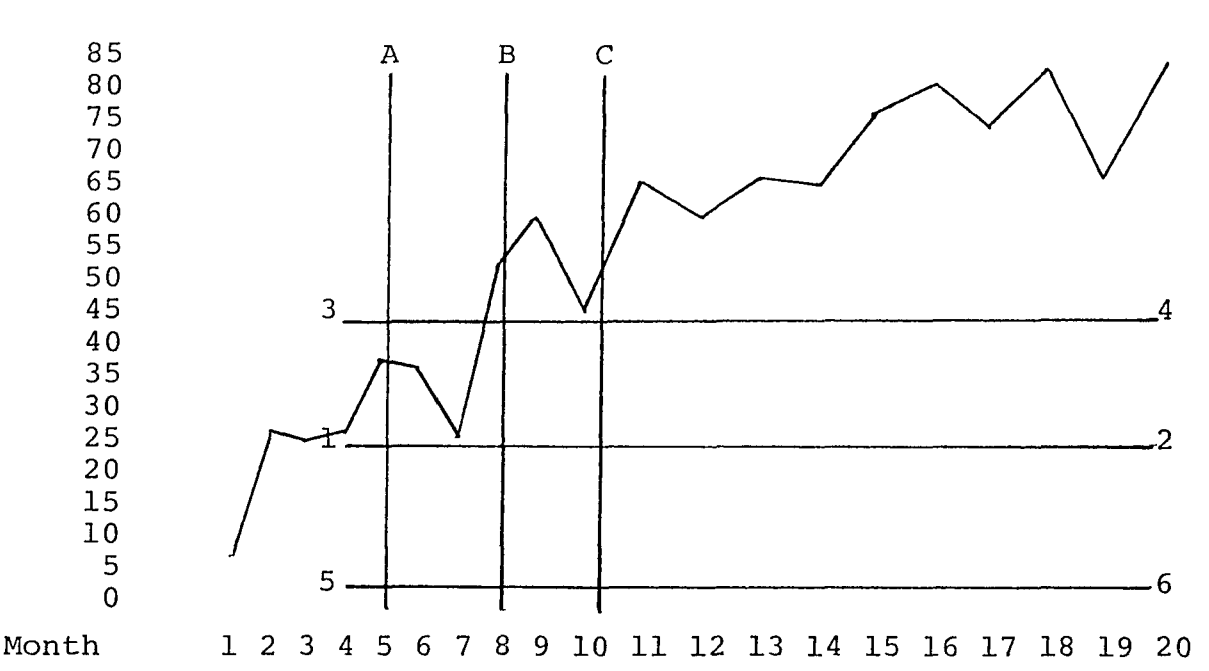
month period as they did at the beginning. Again, as in the LOS stay statistics, an unexpected result occurred, in that the total number of patients serviced increased very sharply. Social workers began working with an ever-growing number of patients, with the goal of returning them home, with appropriate supportive services such as Visiting Nurse Services, Meals on Wheels, physical therapy visits, etc.

There was no simultaneous occurrence in the hospital at large which would account for this increase. Admissions and total census in the hospital were stable throughout this report period. Census was between 90-92 percent of bed capacity. No area hospitals closed or opened. There were no hospital or nursing home strikes which could have altered conditions under which patients sought hospitalization. Also, there was no drastic change in either of the two government entitlement programs, Medicare/Medicaid, which could have affected the patient's hospital stay.

In summary, what happened vis-a-vis both length-of-stay and discharge destination statistics was that social work staff identified dramatically larger number of patients who required social work intervention. This attention was supplied in a skillful enough manner, so that these patients were able to leave the hospital very quickly and begin their post-hospital convalescence sooner.

GRAPH C

Number of Patients Returning Home with Supportive Services



Point A = month in which new organizational structure was introduced.

Point B and C = months during which the continuing education series was conducted.

Line 1-2 - mean number of patients = 22.8

Line 3-4 - two standard deviations above the mean = 42.04

Line 5-6 - two standard deviations below the mean = 3.56

CHART C

Hospital Carve-Out Days Attributed to Social Work Staff

Month	Days	Month	Days
1	13	11	0
2	14	12	7
3	6	13	3
4	5	14	0
5*	13	15	0
6	0	16	0
7	0	17	0
8**	0	18	0
9**	0	19	0
10**	0	20	0

*Month in which the new organizational structure was introduced.

**Months during which the continuing education series was conducted.

Graph C presents the increase in the number of patients returning home with supportive services.

As before, line 1-2 represents the mean and line 3-4 represents a number 2SD above the mean. We can see that thirteen of the fifteen observations post-intervention are located beyond this point. This indicates that the increase is likely to be statistically significant or at beyond the .05 level of probability.

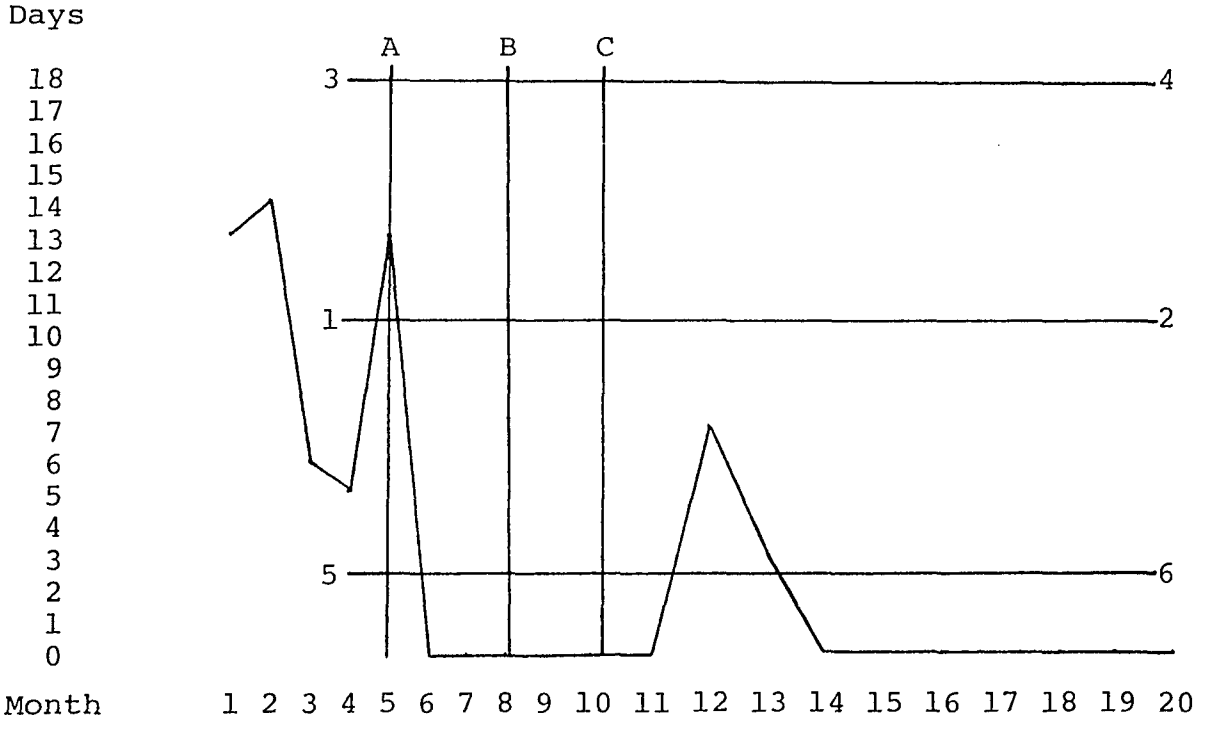
Chart C shows the number of carve-out days attributed to the social work department during the period of this project.

There was a total of 38 days denied reimbursement to the hospital during the four months immediately preceding the inception of the new organization structure. Thirteen days were lost the next month and then none at all for the next six months. For the fifteen months following the new structure, only 10 days were carved out for reimbusement denial.

During this time period there were no modifications in reimbursement practices in the state, or the local designated monitoring agencies. The same rules were being enforced throughout this period relative to official requirements for reimbursement certification by the state. Thus the reduction in number of days lost for reimbusement truly reflected a change in social work practice in the

GRAPH D

Hospital Carve-Out Days Attributed to Social Work Staff



Point A = month in which new organizational structure was introduced.

Point B and C = months during which the continuing education series was conducted.

Line 1-2 = mean number of carve-out days - 10.2

Line 3-4 - two standard deviations above the mean = 18.0

Line 5-6 - two standard deviations below the mean = 2.4

hospital. This change not only resulted in more patients being attended to more quickly by social workers, but the hospital retained valuable income during a time of shrinking fiscal resources.

Graph D indicates the decrease in the number of carve-out days attributed to social work staff post-intervention. Line 5-6 represents a figure 2SD below the mean indicated by line 1-2. The appearance of thirteen of fifteen post-intervention measurements below this line strongly suggests that these numbers are statistically significant at or beyond the .05 level of probability and are influenced by the intervention strategies.

The fourth factor identified as a change goal was a reduction in staff turnover. In the 12 months prior to the new director arriving, 14 social workers, almost 22 percent of the professional staff, left the department. During the 12 months following the assumption of his position by the new director, 6 staff members left, approximately a 9 percent turnover rate.

During the twenty month period immediately preceding the project, the staff turnover was over 64 percent or 41 positions.

The data for this section was gathered from the personnel department of the hospital, not from social work department records. As was true of the prior results, there

appears to be no external factors which could account for the increase in staff retention. Salaries and fringe benefits were constant, a result of a city-wide contract under which this department functioned. There were no merit increases, or promotional opportunities offered to staff which were not already inherent in the established union contract.

Thus, it would appear that staff were remaining based on qualities they felt were present in the department.

CHAPTER VI

EVALUATION AND SUMMARY

Three change strategies, leadership style, new organizational structure and a continuing education program were used to effect change in 1) the average length of stay of patients, 2) destinations of discharged patients, 3) the number of carve-out days attributed to social work staff, 4) the turnover rate of professional staff.

The results presented in Chapter V indicate that there were changes in the desired directions for all four goals.

Reduction in the Average Length of Stay--Not only did the number of days waited decrease, but the numbers of patients to whom services were provided, increased in a marked way.

Examining Graphs A and B shows that from the introduction of the change strategies there was an immediate tendency for the days waited to decrease and the numbers of patients to increase. There is some evidence that the numbers of patients discharged were, in general, significantly higher post-intervention (at the .05 level). Also, four of the last five observations regarding

days waited on ALC before discharge indicated a trend toward significance at the .05 level.

Thus, the reduction in LOS on ALC status, and the concomitant increase in patients worked with, appears to have a strong relationship to the change strategies utilized.

This would indicate that the philosophical, ethical and quality-care issues highlighted as the basis for decreasing patient LOS days, positively impacted on staff. They were able to use these issues, and combine them with the supervision and education available in the department to effect a definite change in patient waiting time. They then seem to have taken the goals one step further and performed some aggressive case finding, such that many more patients were the recipients of social work intervention focused on discharge planning. This affected an entirely new group of patients, one which had not previously been identified as requiring social work attention. This means that patients who previously had gone through their hospital stay, and were discharged home without social work intervention, were now being aided by the social work department. The assumption is made here that professional involvement leads to a more effective and supportive convalescent environment, thereby lessening the possibility of a quick readmission

because some important aspect of the discharge plan might have been ignored.

Support for this assumption comes from the evaluations completed by staff after the continuing education series, as well as statements made by both new and veteran staff members.

The evaluation questionnaires were designed to elicit information regarding the applicability of the seminar content to the staff's functioning in the hospital. Data was gathered concerning the continuing education seminars. Opinions were requested about whether new useable ideas were presented, whether the meetings were stimulating, were the leaders knowledgeable, and was the group process helpful to the participants. Finally, they were asked about suggested future topics.

All of these questions were presented in accord with the leadership philosophy previously described described. Thus, the evaluations not only gathered information, but staff was also made part of the current and future process of choosing continuing education topics. Also, by focusing on the relevance of the material presented and the effectiveness of the seminar leaders, attention was focused on the assistant directors as experts, and on the immediate relevance of the content to staff's daily responsibilities.

Forty-two staff attended the seminars. Thirty rated the content of the seminars as "good" or outstanding" relative to its applicability to current practice in the hospital. Twenty-nine described the enhancement of skills and introduction of new ideas as either "good" or "outstanding."

Additionally, some of the narrative statements revealed that staff was enthusiastic about the process and experience. Examples of such comments are: "Showed great sensitivity to workers' problems/difficulties," "Very organized, clear," ". . . been able to immediately apply the ideas to my charting, assessments, and family work," "Sharing with others in different services is important and learning that chronic care patients and families are the same whether in medical or psychiatric units," "The leader was exceptionally knowledgeable about the literature and practical application of theory."

All of the feedback indicates that the continuing seminars as previously described, were successful in presenting supervisors as experienced teachers with relevant knowledge which staff could utilize to do their job. In addition, the continuing education questionnaires were referred to when designing the following year's series. Special attention was paid to those sections which critiqued this year's presentation and resulted in

suggestions about next year's topics. Such information would be used to maximize the positive impact of future continuing education seminars on staff functioning relative to specified departmental goals.

Destination of Discharged Patients: This was the second goal for which the change strategies were developed. An evaluation has been made that simply waiting for nursing home beds to become vacant was a passive and non-productive approach to discharge planning for patients. It allowed the patients to languish in a hospital to their detriment as well as to the hospital's. What was introduced to staff via the actions of the director and assistant directors and the continuing education seminars was that aggressive, skillful social work with the patient and family was necessary if this problem was to be resolved. This was done via a focused, intense, aggressive supervision by assistant directors combined with emphasis on staff use of all appropriate community support services. It was a combination of societal supports together with family work which would enable patients to convalesce more appropriately at home rather than in an acute care hospital bed.

This approach was stressed in the staff meetings, smaller unit meetings and face-face supervision. As was indicated and described before, the subjects of the

continuing education seminars were chosen with this goal in mind.

An examination of Chart B indicates that the identified goals were met. There was a steady reduction in the number of days waited by patients before they went home with supportive services. This meant that more patients went home first, rather than waiting for convalescent institutional beds to open. Families were providing interim care to the patient with the help of community agencies thus enabling patients to leave the hospital more quickly.

A surprising result, similar to what was noted in the reduction in LOS statistics, was that many more patients received social work attention after the goals were articulated. Before the new structure, only about 20 patients per month on ALC status were discharged home with services. After the new organizational structure, and after the seminars, that number jumped to an average of 70 per month, hitting a one month high of 83 patients in the last month of the survey. About three and one half times more patients were identified as needing social work help in planning for supportive care arrangements at home than had been previously noted.

A further examination of the LOS statistics via a comparison of month #1 versus month #20 reveals that at

the end point (20 months), social workers were seeing more patients, and those patients were remaining in the hospital less time before being discharged.

As was indicated before, the philosophy associated with social work assuming discharge planning responsibilities mandates that social health services be provided to patients as quickly and completely as possible. The numbers presented indicate that this occurred in this social work department.

It was accomplished through the organizational structure and supervisory process previously described. The specific lines of responsibility, or chain of command, made it clear which workers were accountable to which senior staff. It was likewise clear that middle managers and senior staff were to help staff identify patients and aid such staff in providing quality discharge planning. This was done in the small unit meetings and larger staff meetings, as well as in individual supervision. The collegial approach to problem identification and resolution was utilized in the above instances in order to maximize staff "owning the problem" and becoming part of the solution.

Graph C is a visual representation of how dramatically the numbers increased. The jump in the last thirteen observations indicated patient numbers that were

significantly higher thant pre-intervention measurements. There was no change in the general hospital admission rate or policy. Nor was there any notable difference in the kinds of patients admitted or discharged which would help account for such a large increase. Bed capacity remained at approximately 90 - 92% throughout the survey period. There appears to be no external source which could help account for the rise other than the administrative, supervisory and educational input given to the social work staff. The workers were able to use such organizational emphasis in a most positive manner. More patients received necessary help, and in a shorter period of time. This indicates quality social work care.

It would be interesting to discover if the increase in the number of patients coupled with a decrease in time waited in any way compromised the long-term effects of such planning. For example, was there any change in the readmission rate for those patients when compared with those for whom discharge planning took a longer time? This is a fact which would enable us to ensure that we were not initiating a medical "revolving door" with patients leaving and then being readmitted because discharge plans fell through. Such readmission statistics are not easily gathered, and were beyond the scope of this survey. In addition there could have been a control group used to

determine any differences between that group and those included in this project. However, that was not done since it would have involved withholding from patients an approach which, in the author's opinion, would have positively affected their quality of life. In such a case, utilizing a control versus experimental group was deemed to be inappropriate.

Reduction of Carve-out Days: The third goal was the reduction of carve-out days attributed to social work staff. The time within which a social worker must make contact with a patient on ALC status is precisely defined by state monitoring agencies. The planning instrument, a form known as the DMS-1, must be completed within 24 hours of the patient's placement on ALC status. Contact with appropriate placement facilities must be made and documented with seven days from that date. The quicker the planning contact, the better chance there is for the patient to leave the hospital for an appropriate convalescent locale, be it home with supportive services or a chronic care facility.

This goal involves facts and figures that are used frequently by hospital administrators to determine the efficiency of individual departments who have direct patient contact. This occurs because the state monitoring agency is concerned with all the aspects of patient care,

which impact upon a patient's stay in the hospital (and for which they must reimburse the institution). Thus, social workers, nurses, physicians, physical therapists, etc., all must interact with patients in certain prescribed ways, within certain time limits or else their departments will have carve-out days attributed to them.

For the social work department this meant that when the weekly carve-out days were collected and sent to administration, there were large amounts of money not recoverable by the hospital because of social work staff. Money lost is an easily understood concept which is then able to be used whenever the social work department was discussed. It placed the department in the unenviable position of being identified to administrators only as a financial cost center, which lost money, not one which generated income, or at least "protected" it. Also important was that during this time the municipal hospital system was not allowed to bill third party insurors for social work services. Thus, there was no revenue generated by social work which could be used to offset the financial losses of carve-out days. In a medical setting where nurses and physicians are the host professions, it is very easy to guess where administrators look when deciding where expenses must be cut to offset losses. Social work all too often came to mind, based unfortunately

in large part on the carve-out figures.

Therefore, carve-out days become important both to hospital administrators and to the department, though for very different reasons. For one, it is a measure of how efficient the department is functioning; for the other, it is an indicator of quality social work intervention.

Chart C indicates a rapid decrease in the carve-out days almost immediately upon the introduction of the change strategies. In Chapter I there was a statement that 119 days were carved out of potential hospital reimbursement in the twelve months preceding this project. Chart C has the last four months of that period indicated as months 1 through 4.

As can be seen, the immediate response was a complete reduction to zero in carve-out days. With the exception of one unique case spread out over two months, there was no carve-out attributed to social work staff for a thirteen month period. This is a remarkable statistic given the fact that on the average, there are almost 300 patients per month placed on ALC status, with whom social work must interact.

Graph D visually presents these figures. Line 5-6 is the line beyond which we may begin to infer statistical significance beyond the .05 level of probability. Thirteen

of the last fifteen measurements are below line 5-6 and are, in fact, zero. This is evidence of another strong relationship between the introduction of the change strategies and an indicator of quality social work practice.

The fourth goal was a reduction in the number of staff who terminated employment. Without trained staff remaining on the job, the supervisory and educational efforts would forever be stalled at the introductory level. We would be unable to go beyond the rudiments of social work practice in hospitals because of the constant influx of new staff members. Such a condition limits the creative response to patients' needs more likely to be generated by a veteran staff who know the basics well enough so that conceptual level thought and practice would result. This potential for an increase in creativity is important because in this time of fiscal constraints, we are unlikely to receive large additions to staff. Hospital social work departments are much more likely to be asked to do more with the same staff. Trained, veteran staff is vital if the department is to discharge such additional responsibilities in the most skilled manner possible.

The figures indicate that this hospital social work department was able to retain staff for longer periods of time than had been possible previously.

Two periods of time were used to give us as full a picture as possible.

The first time frame, twelve months before and after the new director's arrival, show a reduction from a 22% rate to a 9% rate for staff turnover.

The second time frame which contrasts the twenty month period used in this project with the twenty months preceding it, showed an even larger decrease in staff terminations. This reduction was from 64% to 31%.

The results indicate that staff remained at the hospital, learning additional skills and contributing positively to the achievement of departmental goals. There is no doubt in the author's mind that the positive results achieved in reaching the other goals were made possible by the greater number of social workers who remained on staff throughout the project period. Retention of skilled staff should be a vital part of any comprehensive administrative strategy in a social work department.

The motivating factor for the identification of the goals and implementation of a program designed to achieve those goals was the desire to have the social work department function on the highest possible level. If that occurred, then the patients who were entrusted to the care of the hospital would maximally benefit from the counseling, collaboration and discharge planning efforts

of the social workers. This would improve their quality of life and go a long way towards fulfilling the role of social work in a hospital setting. However, an additional goal was attended to throughout this project explicitly. It concerns the fact that the department functions within a medical setting as a semi-independent unit. As such, it competes with other units (or departments) for a share of the financial pie and other organizational rewards contingent upon its status in that organization. In a time of decreasing services, strict financial accountability and increasing emphasis on management ability, it is crucial for social work directors to demonstrate the ability to lead departments which are respected and valued by the hospital administration (or any host organization).

The risk of identifying but not achieving stated goals is obvious, and has been discussed elsewhere in this paper. What occurred, however, was in fact an achievement of the goals. The next step was the use of the achievement in such a way so as to increase status and power within the organization. Power is used here as "the acquisition of resources and service roles within a host organization."[1]

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[1]Jansson, B. and Simmons, J., "Building Departmental or Unit Power Within Human Service Organizations: Empirical Findings and Theory Building," Administration in Social Work, Vol. 8, 1984, p. 107.

Using this perspective, Jansson and Simmons assert that obtaining power within human service organizations is vital because without it significant resources and major roles will be denied social workers. Without such resources, departments will be understaffed, or given only limited service mandates and will therefore be unable to serve large numbers of patients, or would be able to help them in a very limited way.

John Wax states that the keystone of power in a professional organization is competence and that it can either be "ascribed" or "achieved."[2]

Social workers must rely heavily on "achieved" power in a hospital since "ascribed" power is largely in the hands of physicians. The attempt to achieve power, and the resulting dynamic tension it creates is a major factor in the complexity and turbulence that characterize the hospital as a social system.[3]

As part of an attempt to maximize "achieved" power and gain access to resources, the results of this project were prepared and presented to administrators and key medical personnel (i.e., President of the Medical Board; Director of Medicine). Emphasis was placed on

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[2]Wax, John, "Developing Social Work Power in a Medical Organization," Social Work, October 1968, p. 65.

[3]Ibid.

the aspects of the goal achievement that would be the most persuasive to the individuals.

For example, the presentation to administration focused on the reduction in LOS, in ALC days and in carve-outs, as evidence of the social work department functioning efficiently, maximizing patient flow, and minimizing financial losses to the hospital.

To the medical staff, stress was placed on how the counseling referral services and discharge planning aided the medical treatment and subsequent convalescence of their patients. Since this is a teaching hospital, which requires large numbers of patients through which the residents learn, the increased flow was used to demonstrate social work's value to educational efforts as well as professional health care.

At the time of this writing, publicizing the goal achievement in such a manner appears to have had the intended effects. The department was officially designated as the central discharge planning arm of the hospital. Previously, there had been discussion regarding using the Nursing Department in that manner. Also, three new programs were approved for the hospital, all of which had extensive social work staffing. The inclusion of social workers was almost "automatic." The discussions focused on "how many" not "if." Again, given the current fiscal

climate, and with the knowledge that the hospital still is not reimbursed by Medicaid or private payors for social work services, this increased staffing points to a recognition of social work as a valuable service.

Of course, the interpretation of the goal achievement to the staff of the department was in many ways the most critical. Without their continued efforts, the results would have been short-lived and subject to a regression. Such an occurrence would be disastrous to the attempt to gain increased organizational status.

The project has demonstrated that planned organizational change in a department of social work in a hospital can be effective if clearcut goals are identified, specific change strategies used and a leadership philosophy employed which emphasizes staff participation in program implementation.

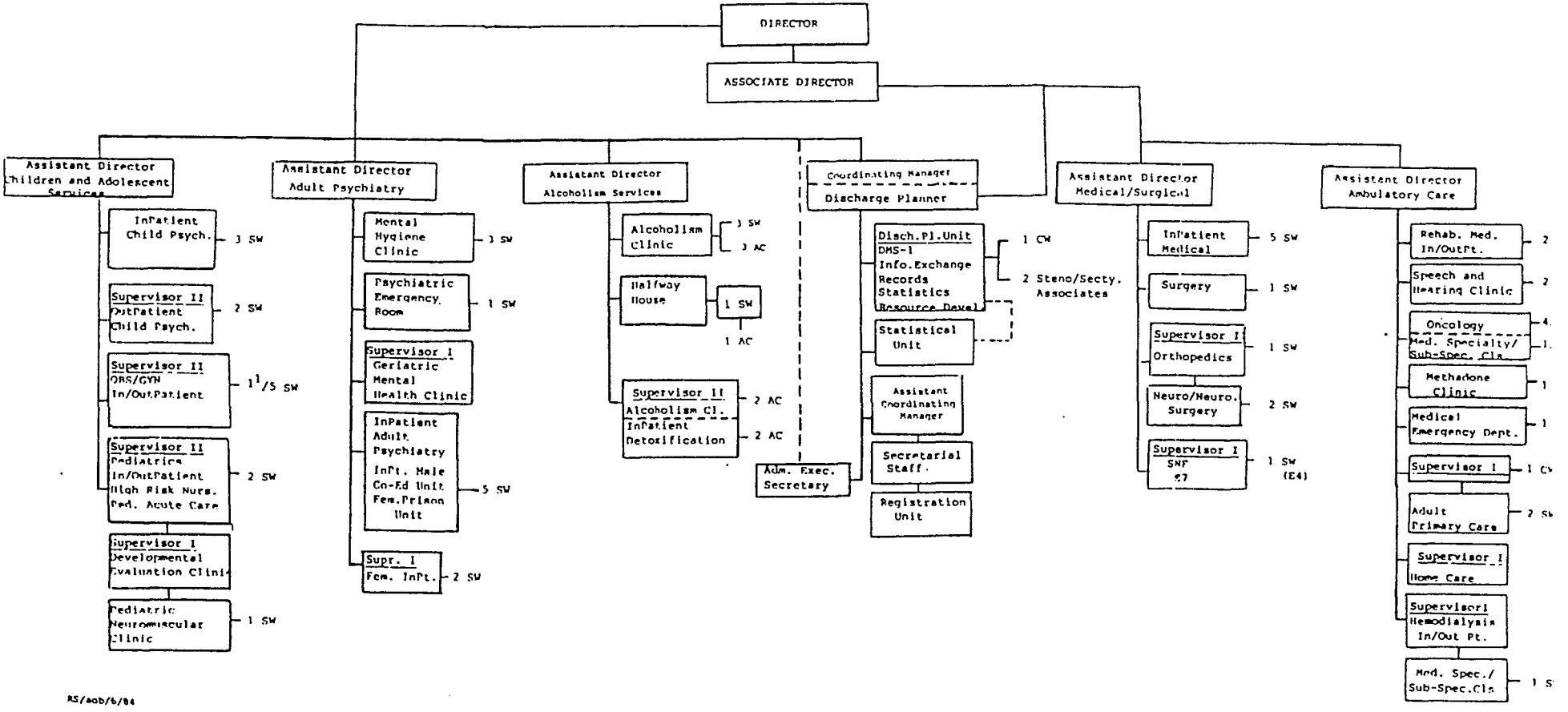
APPENDIX

TABLE OF ORGANIZATION

COURSE OUTLINES FOR CONTINUING EDUCATION SEMINARS

EVALUATION FORM FOR CONTINUING EDUCATION SEMINARS

Table of Organization



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CONTINUING EDUCATION SEMINAR--NEW WORKERS

The Continuing Education Seminar for new workers will begin in February. There will be a total of eight sessions, held consecutively on a weekly basis for a two hour period.

The Seminar will focus on the role of the social worker in a complex, multidisciplinary health care setting. Participants are expected to prepare and share written clinical material. The leader will distribute articles which are relevant to specific topics and will lead theoretical discussions related to clinical input.

The outline which follows encompasses course content.

Session 1: The impact of working in an acute care hospital--problems and rewards. Workers will share their perceptions, identify areas of stress and highlight sources of gratification.

Session 2: The group will share their experiences at the point of case entry. Workers will learn to identify high risk criteria and solidify skills in prioritizing cases which need to be screened. An outline will be developed out of the group process which highlights the major psychosocial and biological components of a sound assessment.

Session 3: Participants will share written assessments with a view toward writing succinctly and conceptually.

Session 4: Contract theory will be addressed. Members will learn how to formulate contracts, set small sequential, realistic and achievable goals which can be measured in relation to outcome.

Session 5: Creative styles of intervention will be shared. The group will present material which focuses on problems in their therapeutic work.

Session 6: Continuation of intervention with patient/family. Interdisciplinary skills will be addressed as

well as identifying ways to integrate the expertise of others into ongoing treatment and planning.

Session 7: The group will address issues related to termination and outcome. Workers will share closing notes.

Session 8: Evaluation.

IMPACT OF CHRONIC ILLNESS ON PATIENT, FAMILY AND STAFF

Session 1: A general overview of proposed course content and goals will be presented. The three types of chronic illness identified for course discussion will be delineated. Stress will be placed on intent to contrast the perspective of chronic medical and chronic psychiatric illness throughout the course.

Participants will be asked to identify areas of proposed course content of particular interest and relevance to their work. Practice issues of greatest concern will be identified by participants, followed by establishment of initial participant goals.

The plan for utilization of case material in sessions 3, 4, and 5 will be discussed. Participants will be selected for preparation of case material for those sessions.

Session 2: A variety of psychological and emotional problems related to chronic illness disability and loss will be identified. Workers will be helped to broaden their conceptual understanding and develop skills in helping patients adapt to chronic illness, live with disability and cope with the accompanying stress.

Following material presentation, response from the perspective of chronic psychiatric illness will be offered. Participants will be encouraged to discuss the material presented.

At the end of this session, case material illustrating practice issues in working with patients with chronic medical illness will be distributed.

Session 3: The first half of this session will be a discussion of case material distributed the previous week.

During the second half of this session, material will be presented regarding the impact of

chronic psychiatric illness on the family. Psychological, emotional, and economic components will be identfied, with attention to behavioral manifestations and social work interventions which can help the family cope. Discussion of approaches, including dealing with adversary relationships will be geared towards enhancing workers' skills in helping families adapt and deal with ongoing tensions.

Response from the perspective of chronic medical illness as it impacts on the family will be offered. Participators will be encouraged to discuss the material presented.

At the end of the session, case material illustrating practice issues in working with families of patients with chronic psychiatric illness will be distributed.

Session 4: The first half of this session will be a discussion of case material distributed the previous week.

During the second half of this session, material will be presented regarding the impact of terminal medical illness on patient, family, and significant others. We will look at some of the social work tasks related to work with the dying patient and work with grief and bereavement. Response will be offered from the perspective of terminal psychiatric illness.

At the end of this session, case material illustrating practice issues in dealing with terminal illness will be distributed.

Session 5: The first half of this session will be a discussion of case material distributed the previous week.

During the second half of the session, material regarding the impact of chronic illness and terminality on staff will be presented, with discussion by seminar participants. Strategies will be identified which can help staff cope with the impact.

Session 6: This last session will focus on evaluation of the course. Initial participant goals will be

reviewed, with feedback regarding the extent to which original goals have been met. Participants also will be asked to offer feedback regarding format and suggestions for redesigning the course for future offering. Participants will be asked to complete a written evaluation at the end of the session.

WORKING WITH FAMILIES

I. --"Its not what you look at, but the way you look at it."

Louis Malle,
Film Director

The goal of this session is to sensitize worker to a way of observing the family, using the experience of this meeting, and one's own family recollections and feelings. Subjects addressed are: positioning, communication (verbal and non-verbal), interactions (meaning and effect on others)

Discuss the workers' expectations of course with proposed content.

II-III. The goal of these sessions is to provide workers with a conceptual framework of family to enable them to organize perceptions for assessment and treatment.

Subjects addressed are:

Family as a system
Classification by structure
Intergenerational issues
Classification by developmental stages
Boundaries
Roles and Function
Power
Homeostasisis (Effect of Illness)
Identified Patient--Scapegoating
Identified patient reflects family dysfunction

IV. The goal of this session is to enable workers to integrate understanding of adaptations to illness with assessment of family functioning to develop appropriate treatment goals.

Subjects addressed are:

Dependence/Independence
Compliance/Resistance
Hopelessness, Helplessness
Mourning, Loss
Shame/Guilt

V. Family interviewing and interventions to enhance family functioning.

Subjects addressed are:

Impact of whole family in a room on family/ on worker
Interviewing bedside
Stimulating interaction
Facilitating communication (how communications are received)
Making family members aware of one's effect upon each other
Encouraging new ways in the system
Challenging the system
Using potentials of strengths within the system

VI. Continued Case Discussion and Evaluation

Case material will be used throughout the seminar. Notwithstanding overlap in discussions, in Meetings II and III case material will primarily be used to examine the family systems and dynamics. In Meeting V and VI, material will be used to examine treatment goals and interventions.

Evaluation.

THE USE OF CONTRACTING IN SOCIAL WORK PRACTICE IN A HOSPITAL SETTING

This seminar will discuss contracting as a dynamic, flexible tool to be used during the ongoing process of social work intervention. Workers will be helped with the task of engaging patient and/or family in identifying problems and setting goals.

Articles will be distributed, phases of contracting examined and case examples used to illustrate application of contracting to direct practice.

Following is course outline:

Session 1. Workers share their experience with and understanding of contracting. Expectations of and/or what they would like from the course.

Define contracting, emphasizing contracting as a dynamic, fluid tool, and need for explicitness throughout social work process.

Beginning states of contracting will be discussed:

1) exploration, negotiation and clarity, assessment, identifying and setting goals

2) preliminary contract phase

Course will be experiential wherever possible to demonstrate contracting.

There will be sharing by leaders and course members of knowledge, skills, techniques and clinical experience.

Workers assigned for presentations at meetings number 3-5 (2-3 presentations for each meeting).

Distribute article (Haley).

Session 2: Phases of contracting continued.

Contract becomes more specific, better understood and accepted as social work process unfolds. Contracting involves family members, use of contracting in crisis intervention, with involuntary patients fluid use of contracts and accountability with reference to Quality Assurance Peer Review Instrument will be discussed.

Leaders' case material will illustrate some of the foregoing concepts as practiced in this setting.

Distribute article (Seabury).

Session 3: Workers' Case Material on Initial Contracting.

Session 4: Workers' Case Material--Examining Contracting With Patient and/or Family Receiving Ongoing Service--with emphasis on re-negotiation and contracts.

Session 5: Workers' Case Material on Contracting--general.

Session 6: Evaluation.

CONTINUING EDUCATION PROGRAM EVALUATION FORM

IN ORDER TO IMPROVE THE QUALITY OF OUR CONTINUING EDUCATION PROGRAM, ONGOING ASSESSMENT IS ESSENTIAL. WE ARE THEREFORE ASKING YOU TO FILL OUT THIS EVALUATION FORM. THANK YOU FOR YOUR COOPERATION.

TITLE OF SEMINAR: _____

SEMINAR LEADERS: _____

I. Why did you choose to participate in this Seminar?

_____

_____

_____

II. How did the Seminar fulfill your expectations?

_____

_____

_____

III. Relevance of Seminar (check one for each category)

	Inadequate	Adequate	Good	Outstanding
A. Applicability to your practice in hospital	____	____	____	____
B. Enhancement of skills	____	____	____	____
C. Introduction of new ideas	____	____	____	____

IV. Evaluation of Seminar Leader (check one in each category)

	Inadequate	Adequate	Good	Outstanding
A. Knowledge	____	____	____	____
B. Presentation	____	____	____	____
C. Stimulation	____	____	____	____
D. Quality of material (readings, cases, etc.)	____	____	____	____
E. Overall rating of Leader	____	____	____	____

Comments: _____

_____

_____

Seminar Leader _____

	Inadequate	Adequate	Good	Outstanding
A. Knowledge	____	____	____	____
B. Presentation	____	____	____	____
C. Stimulation	____	____	____	____
D. Quality of material (readings, cases, etc.)	____	____	____	____
E. Overall rating of Leader	____	____	____	____

Comments: _____

_____

_____

V. Evaluation of Seminar's Group Process
(check one for each category)

	Inadequate	Adequate	Good	Outstanding
A. Quality of member's preparation for group	____	____	____	____
B. Quality of presentations	____	____	____	____
C. Group's support for encouraging participation and risk taking	____	____	____	____
D. Group response to your presentation	____	____	____	____

Comments: _____

_____

_____

VI. What was most helpful in the Seminar:

_____

_____

_____

VII. What suggestions would you make to improve the Seminar?

_____

_____

_____

VIII. Should this Seminar be offered to other staff? Yes___ No___

IX. Suggested topics for future Seminars:

_____

_____

_____

_____

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