

The Impact of Organizational Change on Social Work Staffing in a Hospital Setting: A National, Longitudinal Study of Social Work in Hospitals

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ABSTRACT. Market forces continue to shape the health care environment, producing radical changes within the hospital. These changes are affecting social work structure, staffing, and processes within the hospital setting, particularly in the area of social work staffing. This paper examines the changes impacting hospital settings over three fiscal years. A primary question is whether or not social work staffing is being negatively impacted by these hospital changes, and what factors predict the downsizing of social work staff. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2003 by The Haworth Press, Inc. All rights reserved.]*

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INTRODUCTION

Since the publication of Berger et al.'s (1996) study about changes that impact social work programs in hospitals, the health care delivery system has continued to change at a historically unparalleled pace. Cost-containment goals continue to drive health care reform initiatives, with market forces now steering many of the changes (Lown, 2000; Volland, 1996). Managed care penetration has continued to increase throughout the country. While markets have matured at different rates, the percentage of patients covered by some form of public or private managed care has dramatically increased. It is estimated that in the near future, managed care organizations will handle 90% of all medical benefits administration (Berkman, 1996).

In response to the fiscal pressures created by these initiatives, hospitals have continued to evolve in order to maintain fiscal viability. Mergers, service networks, and other forms of consolidation are escalating in order to increase the leverage for negotiating positive arrangements and contracts to payers (Rayburn, 1999). Hospitals are adjusting their internal management structures, with many hospitals shifting from hierarchically organized functional organizations with discipline-specific departments to flattened organizations that are integrative (e.g., disciplines are allocated to programs). This trend has created a variety of organizational structures along a continuum defined by the degree of centralized control. At one end of the continuum are traditional, bureaucratic, pyramidal organizations with distinct departments that are autonomous but interdependent. In the middle of the continuum are matrix models where professional staff is equally responsible to their department and to their program/patient care unit. At the far end of the continuum lies pure program management, which eliminates discipline-specific, functional departments such as social work and relies on programs/patient care unit administrators to hire, supervise, and evaluate professional staff (Globerman et al., 1996).

This paper presents new data from fiscal years (FY) 1996 and 1998 as follow-ups to the original Berger et al. study cited above, providing a longitudinal perspective ranging from FY 92 to FY 98. The focus is on how the changes within the hospital setting affect the social work department's organizational structure, leadership, and staffing. A primary

question addressed in this paper is to address whether or not social work staffing is declining. What are the changes occurring within the hospital setting in response to this tumultuous health care environment? How has social work staffing been differentially affected by major decreases in personnel? What factors might predict downsizing of social work staff?

METHODOLOGY

This study employed an exploratory/descriptive, longitudinal (cohort) survey design (refer to Berger et al., 1996 for a more detailed description of the methodology and sampling). The survey used a stratified random sample of 750 (of 3,700) hospitals. Data from the cohorts were collected at three different timeframes covering the period from 1992-1998. Respondents were asked questions pertaining to their present situation and any changes that may have occurred within the past two years. The time periods covered were: FY 94 (Cohort 1), FY 96 (Cohort 2), and FY 98 (Cohort 3). An institutional review board reviewed all three data collection phases to ensure human subjects' rights.

A standardized, self-administered survey instrument, specifically developed for use in this study, was mailed to the social work administrator or the person in charge of social work services. The questionnaire contained mostly fixed-response questions, with six open-ended questions at the end to gather more in-depth information about perceptions of present and future challenges and opportunities. Several hospital-based social work department administrators pre-tested the questionnaire, and also examined it, along with other leaders in the field of social work practice in health care, for content validity. Minor revisions were made to the questionnaire for the FY 96 and FY 98 follow-up studies. More detailed questions relating to hospital activity and financial information were eliminated, and questions addressing social work supervision were refined to obtain more descriptive information on the supervisory process and structure (Berger & Mizrahi, 2001).

All three data collection phases used the same data collection process. Data collection occurred in a three-step process: cover letter/consent form and questionnaire, post-card reminder, and second cover letter/consent form and questionnaire. The response rates were: 340 (46%) usable questionnaires were returned from Cohort 1, 311 (42%) from Cohort 2, and 310 (42%) from Cohort 3. The small difference in re-

sponse rates across the three cohorts (less than 10 percent difference) increased confidence in the comparability between samples.

In this paper, we focus on a series of questions specifically addressing the types of changes occurring in the hospital. Information is gathered on the hospitals demographics (e.g., size, auspices, structure, location), fiscal picture, staffing, and leadership. Several questions address various strategies that the hospital may have employed to achieve cost reductions, such as implementing case management programs and care maps/pathways (e.g., standardized processes for patient care activity according to specific diagnosis). Questions specific to social work address the organizational structure of social work services, and changes in administrative and clinical staffing levels. An ordinal measure with three anchors (i.e., increase, no change, and decrease) measures staffing changes.

We entered the data into the computer for analysis, using chi-square to measure changes across the three data collection phases. We used logistic regression to examine factors predicting downsizing of social work staff by collapsing social work staffing from three (i.e., increases, no change, decreases) into two categories: Decreases or No Decreases. We set rejection levels at $p = .05$.

To understanding the tables that follow additional information is required. First, some of the questions in Cohort 1 accessed data about FY 92 while other questions only examined the present year (i.e., FY 94). Therefore, some tables contain information ranging from FY 92-FY 98, while others cover FY 94-FY 98 (i.e., the three data collection periods). Second, some of the tables depict a single question so the chi square applies to the entire table, while other tables collapse information from several separate questions for ease of discussion. For the latter tables, the chi squares are reported for each row or column.

RESULTS

Demographics

Social workers represented the overwhelming majority of respondents in the study, holding at over 85% across the three fiscal years. The number of nursing respondents grew from 25% in FY 94 to 34% by FY 98. Responses were received from 47 different states, with the majority representing urban settings. Table 1 provides additional demographic

TABLE 1. Hospital Demographics Across the Three Data Collection Periods

DEMOGRAPHICS	FY 94	FY 96	FY 98
LOCATION OF RESPONDENTS			
Urban	195 (57.5%)	165 (54.1%)	166 (54.1%)
Suburban	64 (18.9%)	48 (15.7%)	168 (17.7%)
Rural	78 (23.0%)	82 (26.9%)	77 (25.1%)
Other	2 (6.0%)	10 (3.3%)	6 (2.1%)
Total	339 (100%)	305 (100%)	307 (100%)
HOSPITAL AUSPICES			
Public, local	39 (11.5%)	38 (12.5%)	49 (16.1)
Public, state	17 (5.0%)	13 (4.3%)	18 (5.9%)
Public, federal	23 (6.8%)	14 (4.6%)	19 (6.3%)
Private, profit	23 (6.8%)	16 (5.3%)	13 (4.3%)
Private, nonprofit, sectarian	58 (17.1%)	64 (21.1%)	59 (19.4%)
Private, nonprofit, nonsectarian	154 (45.3%)	145 (47.7%)	133 (43.8%)
Public, military	17 (5.0%)	6 (2.0%)	3 (1.0%)
Other	9 (2.6%)	8 (2.6%)	10 (3.3%)
Total	340 (100%)	304 (100%)	304 (100%)
HOSPITAL STATUS **			
Free Standing	150 (45.2%)	120 (40.3%)	95 (33.2%)
Multi-Hospital System	144 (43.3%)	155 (52.0%)	162 (56.6%)
Other	38 (11.4%)	23 (7.7%)	29 (10.1%)
Total	332 (100%)	298 (100%)	287 (100%)

** $p < .01$ ($\chi^2 = 13.427$, $df = 4$, $p = .009$)

information on the respondents. Hospital auspices revealed a fairly consistent pattern, with over 64% representing private, non-profit hospitals (both non-sectarian and sectarian), with local public hospitals as the third largest group. Hospitals also showed changes in ownership status of hospitals. Free-standing hospitals continued to decline, with commensurate growth in multi-hospital systems.

Hospital Financial Picture and Cost-Containment Strategies

The fiscal picture for the hospitals showed a significant decline over the study period, even though 80% of the hospitals had a positive or breakeven situation for each fiscal year (see Table 2). While the number of staffed beds for operations stayed relatively stable (277 in FY 94, 270 in FY 96, and 260 in FY 98), the percentage of the hospital's budget derived from managed care showed a significant increase from 16% in FY 94 to 34% by FY 98 (anova, $f = 41.298$, $df = 2$, $p = .000$).

Faced with the changing national fiscal climate, hospitals have employed different strategies to improving efficiency. These strategies could be characterized as both structural and process innovations. Table 3 captured the number of hospitals reporting the presence of: care maps (i.e., structured processes for standardized patterns of care), decentralization with matrix management (i.e., dual reported arrangements), decentralization with elimination of departments, benefits management (i.e., working with insurance companies to flex insurance benefits to achieve cost-efficiency for patient care), and care management (i.e., case managers assigned to facilitate the process of care to achieve cost-efficiency). The majority of hospitals report the use of care maps and care management strategies, and their use significantly increased from FY 94-FY 98. Both models of decentralization strategies significantly increased, though matrix approaches appeared to be slightly more common. Finally, benefits management experienced the greatest growth, more than doubling during the study period.

Changes in Hospital Staffing and Programs

A series of questions focused on structural and programmatic revisions, and staffing modifications. The answers provided a picture of the

TABLE 2. Changes in Hospitals' Financial Status

Fiscal Year	Positive \$	Breakeven \$	Negative \$	Total
FY 94	196 (63.0%)	64 (20.6%)	51 (16.4%)	311 (100%)
FY 96	206 (72.3%)	46 (16.1%)	33 (11.6%)	285 (100%)
FY 98	129 (43.6%)	83 (28.0%)	84 (28.4%)	296 (100%)
Total	531 (59.5%)	193 (21.6%)	168 (18.8%)	892 (100%)

$$\chi^2 = 54.080, df = 4, p = .000$$

TABLE 3. Hospital Strategies to Reduce Costs Across the Three Data Collection Periods

Fiscal Year	Care Maps	Decent.– Matrix	Decent.– No Departments	Benefits Management	Case Management
FY 94	229 (70%)	77 (23.8%)	67 (20.6%)	86 (26.5%)	172 (52.9%)
FY 96	232 (82.3%)	122 (47.7%)	98 (36.7%)	126 (51.9%)	200 (72.2%)
FY 98	218 (75.4%)	110 (44.7%)	112 (40.0%)	152 (63.1%)	230 (81.3%)
Chi Square	$\chi^2 = 45.558$ df = 2 p = .000	$\chi^2 = 71.847$ df = 2 p = .000	$\chi^2 = 77.498$ df = 2 p = .000	$\chi^2 = 61.316$ df = 2 p = .000	$\chi^2 = 53.986$ df = 2 p = .000

degree to which the organizational environment was undergoing major alterations, so that the changes impacting social work could be placed within a larger contextual framework.

Significant changes were identified in areas pertaining to hospital leadership (e.g., new CEO), structure, and activities (see Table 4). Changing leadership showed a steady growth and represented the most consistent change reported by hospitals. The introduction of new product lines grew by 1996, but dropped to FY 94 levels by FY 98. Elimination of product lines had a steady increase. Finally, hospital's use of external consultants to achieve changes grew between FY 94-FY 96, but appeared to level off by FY 98.

What is the impact of these changes on hospital staffing? Respondents are asked to indicate whether hospital staffing "increased, no change, or decreased." Table 5 shows the number of respondents reporting decreases in staffing, noting that the majority are reporting decreases across all three data collection periods. However, the number of respondents reporting decreases did not significantly change over time, suggesting a large and relatively stable amount of downsizing.

Significant changes did appear for hospital activity (see Table 6). When combining "increases" and "no change," the number of staffed beds is about evenly split between "decreases" and "no decreases" (i.e., beds increased or had no change); and the amount of time a patient stayed in the hospital (i.e., average length of stay) showed large decreases. The combination of these two factors could account for the slight majority of hospitals reporting decreases in average daily census. While neither the number of ambulatory visits nor the use of contracted services showed significant change, the amount of ambulatory activity

TABLE 4. Changes in Hospital Leadership and Structure

Fiscal Year	Change in Key Leadership	Hospital Mergers	Consulting Firms	New Product Lines	Deleted Product Lines
FY 94	171 (0.6%)	73 (21.6%)	126 (37.3%)	111 (32.9%)	32 (9.5%)
FY 96	175 (64.1%)	93 (34.1%)	136 (49.8%)	140 (51.3%)	33 (12.1%)
FY 98	196 (66.4%)	102 (34.5%)	126 (42.7%)	103 (35.0%)	54 (19.7%)
Chi Square	$\chi^2 = 19.439$ df = 2 p = .000	$\chi^2 = 16.370$ df = 2 p = .000	$\chi^2 = 9.699$ df = 2 p = .008	$\chi^2 = 24.415$ df = 2 p = .000	$\chi^2 = 13.299$ df = 2 p = .010

TABLE 5. Reported Decreases in Hospital Staffing

Fiscal Year	All Personnel	Administrative Personnel Only
FY 94	198 (62.3%)	160 (50.2%)
FY 96	172 (61.2%)	152 (53.9%)
FY 98	165 (58.9%)	145 (51.4%)
Total	521 (60.7%)	446 (51.7%)

TABLE 6. Reported Changes in Hospital Activity

Fiscal Year	# Staffed Acute Beds			Average Length of Stay			Average Daily Census		
	I	NC	D	I	NC	D	I	NC	D
FY 94	23 7.3%	142 45.1%	150 47.6%	6 1.9%	39 12.2%	274 85.9%	50 16.1%	60 19.3%	201 64.6%
FY 96	18 6.5%	110 40.0%	147 53.5%	14 5.1%	19 6.9%	244 88.1%	49 18.7%	54 20.6%	159 60.7%
FY 98	35 12.0%	132 45.4%	124 42.6%	20 6.9%	47 16.3%	221 76.7%	84 29.9%	56 19.9%	141 50.2%
Chi Square	$\chi^2 = 10.588$, df = 4, p = .032			$\chi^2 = 22.006$, df = 4, p = .000			$\chi^2 = 20.104$, df = 4, p = .000		

Note. I = increased, NC = no change, D = decreased

was noteworthy. Ambulatory services remained stable and very strong throughout the study period, with over 84% of the hospitals reporting activity in this area for each fiscal year.

Social Work Structure and Leadership

Respondents were asked to describe the organizational structure that predominantly characterized the delivery of social work services. While asked to select only one structure, respondents often indicated more than one response. When respondents checked multiple categories, we coded the responses based on a hierarchical approach. For example, if the respondent checked centralized and matrix, we coded it as centralized; if they checked matrix and decentralized, we coded it as matrix. This decision evolved from two key issues. First, anecdotal reports and professional discussions were concerned about the elimination of social work departments and the decentralization of social work staff. We were particularly interested in examining the erosion of a centralized, social work administrative entity. Second, as most respondents did follow the directions, we could not convert this into a multiple response question, and we did not want to lose the data from those who gave multiple responses. Table 7 provides a breakdown of this data. The structure of social work services showed significant changes across the four fiscal years. Centralized models continued to be the predominant structure for social work services, but showed a consistent decline, while matrix and decentralized structures grew.

Several questions explored the issue of social work leadership within the program. Table 8 shows data on the presence of a social work director/manager within the department. The number of departments reporting no social work director remained small, but the data showed a steady and significant increase. Respondents were also asked to indicate the education level of the director. The number of directors holding MSW degrees dropped significantly from 79.1% in FY 92 to 61.9% by FY 98 ($\chi^2 = 27.059$, $df = 3$, $p = .000$), while those holding a non-social work degree increased from 13.3% to 23.8% ($\chi^2 = 24.348$, $df = 3$, $p = .000$). The numbers of BSW directors also showed an increase (7.6% in FY 92 to 12.2% in FY 98) but was not found to be a significant change. These changes in leadership were accompanied by a significant increase in the span of control of the social work leader. In FY 92, 23.4% reported increased responsibility for multiple departments, rising to 44.6% by FY 98 ($\chi^2 = 35.117$, $df = 3$, $p = .000$).

TABLE 7. Structure of Social Work Services

	Centralized	Matrix	Decentralized	Contract	Total
FY 92	288 (87.3%)	29 (8.8%)	7 (2.1%)	6 (1.8%)	335 (100%)
FY 94	264 (80.5%)	47 (14.3%)	12 (3.7%)	5 (1.5%)	328 (100%)
FY 96	221 (77.0%)	42 (14.6%)	18 (6.3%)	6 (2.1%)	287 (100%)
FY 98	204 (73.9%)	47 (17.1%)	23 (8.3%)	2 (0.7%)	257 (100%)
Total	977 (80.0%)	165 (13.5%)	60 (4.9%)	19 (1.6%)	1221 (100%)

$$\chi^2 = 28.031, df = 9, p = .001$$

TABLE 8. Presence of a Social Work Director

	SW Director Exists	No SW Director Exists	Total
FY 94	320 (94.4%)	19 (5.6%)	339 (100%)
FY 96	276 (90.5%)	29 (9.5%)	305 (100%)
FY 98	267 (88.7%)	34 (11.3%)	301 (100%)
Total	863 (91.3%)	82 (8.7%)	945 (100%)

$$\chi^2 = 6.909, df = 2, p = .032$$

We next explored the changes to social work staffing. Social work personnel in all areas decreased from FY 94 to FY 98 (see Table 9), though the changes in overall personnel were not found to be significant. Reductions in administrative personnel as well as levels of administrative staffing (e.g., layers of management such as Associate Directors, Assistant Directors, and/or Supervisors) showed a steady decline.

To gain a better understanding of how administrative staffing was affected, we asked respondents to report on the changes to specific levels of management, including senior management (e.g., Director, Associate Directors, Assistant Directors) and supervisors. It was interesting to note that the decreases in supervisory staff slowed down by FY 98 (36.7% in FY 94 to 32.8% by FY 98). Decreases in senior management however, revealed a significant pattern of decline, from 16.1% in FY 94 to 27.9% by FY 98 ($\chi^2 = 11.841, df = 2, p = .003$). Declines in clinical and non-professional staff (e.g., social work technicians or aides)

TABLE 9. Reported Decreases in Social Work Personnel

Fiscal Year	SW Personnel Overall	SW Administrative Personnel	SW Administrative Levels
FY 94	112 (33.3%)	83 (25.5%)	60 (19.2%)
FY 96	118 (40.3%)	93 (33.7%)	69 (26.3%)
FY 98	111 (37.4%)	95 (37.0%)	75 (31.3%)
Chi Square	NS	$\chi^2 = 9.510$ df = 2 p = .009	$\chi^2 = 10.769$ df = 2 p = .005

were not found to be significant, but reported decreases in secretarial support grew from 10.5% in FY 92 to 36.2% by FY 98 ($\chi^2 = 12.975$, df = 2, p = .002).

Predicting Declines in Social Work Staffing

Logistic regression was used to examine the influence of organizational variables on social work staffing. The variables for the model were selected based on a political-economic framework (Wamsley & Zald, 1973) for understanding organizational behavior within a hospital setting, particularly in relation to downsizing (Berger, 1993). According to this model, organizational priorities and decision-making can best be understood by examining the political (e.g., leadership and influence) and economic (e.g., financial) structures of an organization. The hospital's decisions regarding organizational restructuring and resizing are likely to be influenced by these variables. Therefore, they may increase one's ability to predict downsizing activities. The variables included in our model are measures of political and economic factors. For example, an economic variable would be the hospital's financial situation (e.g., "Positive financial bottom line"). Political variables would include the Chief Executive Officer (CEO) and the Social Work Director. Changes in these key leadership positions could reflect changing priorities and/or influence, as would social work's *involvement in decision-making within the hospital*. Both the use of an external consultant for the hospital and review of social work functions, whether by an internal hospital process or an external consultant, can represent both political and economic factors. As discussed earlier, the use of ex-

ternal consultants usually occurs in response to fiscal concerns and/or a change in leadership direction. Similarly, the review of social work functions could be in response to fiscal or political influences.

The dependent variable in the model was the natural logarithm of the odds that a hospital experienced a decrease in social work personnel ($\ln(P(D)/1-P(D))$). The independent variables in the model were: (1) whether a hospital had a positive difference between its total revenue and total expenditures; (2) whether there was a change in a key administrative position, outside the social work department, over a two-year period; (3) whether the hospital used external consultants (e.g., contracted with a company external to the hospital to provide consultation around resizing, restructuring, or financial improvements); (4) whether the director of the social work department changed over a two-year period; (5) whether a hospital's social work department's functions were reviewed (e.g., this may have been done by an external consultant or could have been a process internal to the organization); (6) whether the social department's management was involved in hospital decision-making; (7) whether a hospital responded in 1996 (those that responded in 1994 was the reference category); and (8) whether a hospital responded in 1998 (those that responded in 1994 was the reference category).

Table 10 displays the results from the logistic regression model.¹ The last column shows the difference in the probability that a hospital's social work department experienced a decrease in personnel with respect to the independent variable in question.² For example, controlling for the effects of the other variables in the model, the probability of a decrease in social work personnel in hospitals that had a positive difference between total revenue and total expenditures was 52% less than those that did not have a positive difference between these sums. In other words, hospitals with more revenue than expenditures (i. e., a positive bottom line) had a statistically significantly lower chance of having experienced a decrease in social work personnel than those without a positive bottom line. Six of the eight variables included in our model had a statistically significant impact on the probability that a hospital experienced a decrease in social work personnel. Because the figure in column eight (52%) is the largest in the model, it suggests that the hospital's financial status (i.e., a positive difference between its total revenue and total expenditures) had the biggest impact on the probability that a hospital's social work department experienced a decrease in personnel. Only two variables were not found to be significant for the hospitals participating in the study in FY 96 and FY 98, suggesting that a

TABLE 10. Results from Logistic Regression Model

VARIABLE	β	S.E.	Wald	d.f.	Sig	Exp β	Dprob/ dvariable
Positive financial bottom line	-.644	.147	19.114	1	.000	.525	52%
Change in key hospital admin position (CEO)	.582	.150	15.117	1	.000	1.789	48%
The hospital used an external consultant	.602	.150	15.978	1	.000	1.825	48%
Director of social work position changed	.540	.152	12.590	1	.000	1.716	43%
External review of social work functions	.436	.159	7.465	1	.006	1.546	33%
Social work administration involved in hospital decision making	.346	.148	5.505	1	.019	1.414	29%
Year 96	.243	.174	1.946	1	.163	1.275	19%
Year 98	-.096	.180	.285	1	.594	.908	10%
Constant	1.366	.192	50.731	1	.000	.255	-

Cox & Snell R Square = .103 or about 10%

social work department's likelihood of a decrease was not predicted by past decreases, (i.e., it was not affected by time).

DISCUSSION

The data from the second two data collection periods support a continuing picture of the constant change in the health care environment. These changes create a challenging and tumultuous work environment; hospitals are experiencing alterations in leadership, hospital structures, financial arrangements, and clinical activity (Nauert, 2000). These changes affect social work in the areas of leadership, structure, processes and staffing. Yet, the findings of this research do not support anecdotal reports and impressions of the disproportionate attack on social work programs. While dramatic, the downsizing of social work staff is not commensurate with the overall decreases in hospital staffing. Over 70% of the respondents report that social work staff is not experiencing decreases. Still, a closer examination of hospital variables reveals some

interesting patterns about their impact on social work programs in hospitals.

While the majority of respondents report positive or break-even financial situations, the number of hospitals with a positive financial picture is significantly declining, while those with breakeven or negative bottom lines are growing. This trend may be related to the reported increasing dependence on managed care as a revenue source for the hospital. With financial data suggesting an unstable organizational environment, the implications for social work staffing are of great concern. As discussed earlier, over 50% of the variance in staffing decreases can be explained by a hospital's financial picture.

Hospital activity provides further evidence of the precarious situation of hospitals. Decreases in the number of staffed acute beds appear to have leveled off by FY 98, but the majority of hospitals report that length of stay and average daily census continue to decrease. The growing influence of managed care, both in terms of more rapid patient throughput, and increasing patient volume through effective contracting arrangements, might be one explanation. However, it is important to note that one-third of the hospitals reported increases in average daily census by FY 98.

These hospitals have responded to their declining fiscal situation by implementing a variety of structural and procedural changes both within their external and internal environments. Structurally, there are increasing reports of hospital mergers, and growth of multi-hospital systems, as the freestanding hospital continues to shrink. Internally, hospitals are restructuring by increasing use of matrix and decentralized models.

The combination of these factors may account for changing leadership in both the hospital and social work program. New leaders may bring different priorities, and perspectives that can contribute to a chaotic work environment. New ideas can create new structures, just as new structures necessitate changes in ideas. These changes may have a positive or negative impact on individual departmental operations. Changing leadership can also be an indicator of the need for change, particularly when leadership is brought in from the outside. The logistic regression reveals that changes in hospital administration are one of the strongest predictors of social work downsizing. While this study cannot specifically address how leadership influences downsizing decisions, it is an area that warrants further exploration.

Staffing represents another type of structural change. The majority of hospitals report decreases in staffing, though this remains relatively stable across the three fiscal years. Social work staffing also is declining, but not at the same rate that these hospitals report. While overall hospi-

tal staffing decreases hover around 60%, social work staffing decreases range from 33% to 40%. Administrative staffing within the social work department are experiencing the largest decreases in FY 94, paralleling those of hospital administration. However, social work administrative decreases fall into the 33% to 37% range in subsequent years, while hospitals report steady numbers in the lower 50% range. This data suggests that while social work is being decreased, it is not over-represented when compared with decreases within the hospitals.

The data also reveal increased use of strategies to achieve process improvements. The majority of respondents report the use of care maps, and case management, representing the most common activity reported in FY 98. The use of benefits management is experiencing the greatest growth, increasing by more than 40% by FY 98. Social work's involvement in these activities is not addressed within this research project, but represents an opportunity for potential benefit to social work's role within the hospital setting.

Mizrahi and Berger (2001) report that social work leaders identify case management as an area for opportunity to expand social work functions and roles. While nursing is the most common discipline involved with case management in the hospital setting, the use of interdisciplinary case management teams involving nurses and social workers are a viable model that may offer increased benefits to patients and health care organizations (Berger, 1996). Social work's involvement in patient care can lead to increased awareness of opportunities for benefits management. While social work may not generate clinical revenue, potential savings achieved through benefits management can be linked to social work intervention. Further understanding of how social work roles and responsibilities are evolving in response to these and other organizational changes would add depth to our understanding. For example, Mizrahi and Berger (2001) found that social work leaders were successful at developing new revenue sources, and promoting innovative roles and functions for social workers. Further research in this area is clearly needed.

The growing use of external consultants has been identified anecdotally as a major cause of downsizing. While a causal relationship cannot be tested within this research study, its predictive relationship to social work downsizing does add credence to anecdotal reports. A priority area for social work in health care is to develop strategies to deter the deleterious effect of consultants. A key to effective advocacy will be the availability of rigorous outcome studies demonstrating the cost-effectiveness of social work services to the health care delivery system.

Two possible explanations for the slowdown in social work downsizing emerge from the data. The apparent decrease in the use of consultants by FY 98 may be one explanation, while another may relate to social work's having achieved "lean" structures and operations through previous restructuring/resizing efforts. For example, the drop in reports of social work administrative cuts may be reflective of an already lean administrative structure developed in previous years, or social work administrators are positioning social work more strategically during organizational restructuring.

Another concern is the impact of staffing reductions on practice. Significant social work decreases are reported for social work management and clerical staff. In the face of downsizing, protecting clinical positions may be the correct priority, but at what cost to the remaining management and clinical staff? With fewer managers to distribute the administrative responsibilities, the pressure on the remaining social work leaders can affect their practice and may lead to greater burnout. Clinicians may be faced with a similar dilemma. Although their numbers may not be shrinking as rapidly, the decreased administrative and clerical support may create additional barriers to their effective practice. Further understanding of these dynamics, as well as information about the changing roles and functions of hospital-based social workers, is needed to enhance both academic and practice priorities.

CONCLUSION

Given the turbulent health care environment, it is important for social work managers to be aware of threats to social work integrity and to be proactive leaders. Mizrahi and Berger's (2001) analysis of the original study (FY 92-FY 94) highlighted the many ways in which social work directors/managers displayed strategic, proactive leadership in the face of significant change within the hospital environment. To be proactive, social work managers require a better sense of what factors in the hospital environment are most likely to affect their programs. For example, economic realities are likely to influence downsizing of staff across the entire hospital, but it is important to remember that economics alone does not explain staffing declines. A turbulent environment driven by economic rather than humanistic ideology does not have to necessarily put social work leaders on the defensive, nor create an intimidating environment for leadership. Mizrahi and Berger (2001) found that social work leaders in hospitals demonstrate both a willingness and ability to

shape organizational changes within their environments. This ability allows the social work manager to increase strategies to position social work when political and environmental factors suggest increased risk to social work staffing. The logistic regression attempts to build a model to increase a manager's ability to predict environmental risk to social work.

To be sure, the findings of this study need to be understood within the context of the limitations of this research approach. As with any self-administered survey, there is no way to ensure the accuracy of responses. Respondents can intentionally falsify information or their perceptions may not be accurate. For example, respondents were asked their perception of staffing changes (e.g., increased, decreased, or did not change). There is no way to determine if they used actual data on staffing changes or relied on their perception in answering the questions. In addition, when indicating staffing changes in the social work department, one could have falsified information in order to appear more effective as a manager. A second limitation relates to the regression model. The total model only explained 10% of the variation, suggesting that there are a number of other factors accounting for decreases that the model did not capture.

Further research is needed into many areas previously cited in this paper. For example, more understanding is needed of how or why changes in leadership produce increased risk of social work downsizing. How have social work roles and functions evolved in response to the organizational changes within the hospital? Finally, a better understanding of what predicts social work growth is also needed. Just as this paper attempts to identify political and economic factors associated with downsizing, further research is recommended to understand the factors and leadership strategies associated with social work's ability to thrive within these chaotic health care environments.

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NOTES

1. The equation we estimated was: $\ln(P(D)/1-P(D)) = \alpha + \beta_1\text{review} + \beta_2\text{swdir} + \beta_3\text{swman} + \beta_4\text{year96} + \beta_5\text{year98} + \beta_6\text{positive} + \beta_7\text{keyad} + \beta_8\text{consult}$.

2. These figures were calculated using the appropriate figures from the column labeled "Exp β ." For a discussion of how to use the Exp β column figures to calculate those in column eight, see Menard, Scott (1995). *Applied Logistic Regression*. California: Sage Publications.

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