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The Impact of DRGs on Social Workers in a University-Affiliated, Teaching Hospital System

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The impact of DRGs on social workers in four social work departments located in one Northeast State was assessed by interviews with all social work staff and administrators. The impact of DRGs was determined to be substantial. Implications for social work education and practice are considered.

Planning effective social work services for patients in acute health care settings in a timely, collaborative, and systematic way has challenged social workers since their introduction into this setting at the beginning of this century (Lubove, 1973; Bracht, 1978). As established members of the health care team in many hospitals, social workers have broadened their roles as hospitals have expanded their available services through new technology and increased funding. But any change in funding, whether more or less, alters a complex system, creating both opportunities and problems.

Fuchs (1986) notes that the first two revolutions in health care financing in the United States, resulted in greater accessibility to health care, especially for the elderly and the poor. But the costs of health care, despite the gains of accessibility, were seen as too great. Concerned with the upward spiral in the cost of health care throughout the 1970s, the increase in federal spending on health, and the growing federal deficit, Congress set in motion the third revolution in health care financing by mandating a prospective pricing system for Medicare,

effective for most states in October of 1983 (Joseph, Sandrick & Shannon, 1983).

In the new system, hospitals are reimbursed for care on the basis of the patient's assigned Diagnosis Related Group (DRG), which is determined by principal diagnosis, secondary diagnosis and up to three procedures (Steinwold & Dammit, 1989). Several authors (Fuchs, 1986; Reamer, 1985) suggest that the emphasis of the federal government on cost, and the resulting deemphasis on access and health, have created a crisis in the entire health care system. Because social work, as a profession, is concerned with providing for basic needs of clients including health care, how has the radical change in health care financing affected social work and social workers? Studies of the impact of DRGs on social work departments, using social work directors as sources of data, indicate that they view the new financing system more positively than negatively (Patchner & Wattenberg, 1985; Dinerman, Seaton & Schlesinger, 1986; Survey Reveals, 1987), and the overall effect on staff and staffing patterns has been low (Survey Reveals, 1987).

To date, however, no research has focused on the impact of DRGs on the front line social worker. Although directors have been surveyed, their distance from direct care and their management role may give them a different perspective than that of their staff (Bailis, 1987). And recent research indicates that urban and teaching hospitals, in particular, have been disproportionately affected by DRGs due to their service to patients who are sicker and more medically complicated (Horn, Sharkey, Chambers & Horn, 1985; Sheingold, 1986). A detailed study of one urban teaching hospital system affected by DRGs might indicate some of the particular problems faced by social workers in similar settings and provide some implications for practice and education.

Description of the Study

Methodology

In 1985, two years after the implementation of DRGs, the authors planned an in-depth study of the impact of this new policy on social work departments and social workers in the

one teaching hospital system located in a Northeast state. Four hospitals, of the eight clinical facilities, were affected by DRGs and, thus, the social work departments in these four facilities were studied. The largest hospital in the system has 719 beds and 35 employed professional social work staff. The other hospitals have bed sizes of 306, 247, and 238 with social work staff positions of 10, 5, and 9 respectively.

Data collection began in August 1985 and concluded in May 1986. A total of 56 social workers and social work administrators were interviewed by the principal investigator. The interview was made up of closed ended questions and open-ended questions. Interviews lasted from 2 to 4 hours. The response rate was 100%.

Study Population Characteristics

The study population was made up of 4 directors (7.1%), one assistant director (1.8%), 4 chiefs of service (7.1%), 29 MSW level social workers (51.8%), 17 social work assistants, BA, or BSW level (30.4%), and one transfer coordinator (1.8%).

Social workers provided direct services in the following areas: Medical/Surgical (54.9%), Pediatrics (19.6%), Psychiatry (7.8%), Specialty Area (9.8%), all hospital referrals (3.9%), and nursing home placements only (3.9%). Most respondents were MSWs (66%), with a much smaller number of BSWs (16.1%), BAs (12.5%) and other degreed workers (5.4%).

Nineteen social workers (34%) had been employed by their respective hospital social service department for less than 2 years. The remaining 37 social workers (66%) had been employed from 2 to 16 years. Thus the majority of respondents had worked in a hospital prior to and during the implementation of DRGs.

Forty-six (82.1%) of the interviewed social workers were female, 10 were male (17.9%). Sixty six percent of the administrators were males. The average 1985 salary of the responding MSW nonadministrator social workers was $21,600; the average salary of the responding BA/BSW social workers was $18,800.

Findings

The Social Workers Responses

When asked "What has been the impact of DRGs on the work that you do?" 47.8% responded that DRGs had created more pressure and increased their caseloads. Several respondents (14.6%) reported that there was more of a focus on discharge planning, 6.3% discussed their perception that social work values were in conflict with the hospital bureaucracy, and 31.3% said they experienced no change in their work (N=48). Although more than two-thirds of the respondents reported a change, close to one-third did not.

Many respondents discussed particular changes that they had experienced in medical settings since DRGs. One worker said:

> I feel I can manage and handle the intensity — it's manageable — theoretically it's copable. I think it is fast moving; it's a fast moving environment. It almost becomes impersonal. That's what really bothers me — the human element is diminishing. It's quick. For example, someone needs to leave today, and needs oxygen. The task will be completed, but without the human contact. Five years ago, we'd go and talk to the patient about the oxygen. It may not be that way today, depending on the day of the social worker.

Many social workers commented on bureaucratic control that affected their autonomy as professionals. An MSW commented: "In 1983, I decided who I was going to pick up; I was more in control. Now I feel as though someone else is defining my work for me." Another MSW reflected: "There is conflict here — I realize that the hospital is under financial pressure and the hospital pays you. Or is your responsibility to the patient who should be advocated for? It's a perpetual bind we all feel."

When asked, "What aspects of patient care, with which you have worked directly, have changed as a result of DRGs?", 62.5% responded with a combination of the following: less time to work, more tasks to do, patients are leaving sicker, the work is less thorough. Another 4.2% felt that there was less autonomy to evaluate situations and 33.3% saw no change (N=48).

The open ended comments of the workers revealed additional details. A worker commented: "It seems like right now we're just pushing bodies around and we're not treating people as people."

Another worker reflected on time and tasks:

> I feel really good about what I do, but my dissatisfaction about what I don't get to do outweighs it. I do a good job but I don't have enough time to really utilize my skills and develop them — if you don't use them you lose them. Occasionally I have a good day. Overall I'm being underutilized, I'm not underachieving. Personally, I think that's unhealthy for me professionally.

Social Workers' Views of DRG Impact on other Professionals

Because DRGs have had a system wide impact on many professionals, the social workers were asked, "What differences have you seen on the part of physicians with whom you interact as a result of DRGs?" Thirty four percent reported that physicians were more aware of the need for discharge planning, 30% said there was no change, 26% said they perceived that physicians felt out of control, were frightened, angry or frustrated. Six percent felt that doctors were documenting more in the charts while only four percent said that doctors were discharging patients early (N=50).

Nurses appeared to be less directly affected by DRGs. Most of the responding social workers (56.6%) saw no change in nurses, 22.6% reported that nurses were affected by shorter stays of sicker patients, 18.9% said that nurses were more interested in discharge planning, and 1.9% saw interprofessional conflict between nurses and social workers (N=53).

A new or restructured division had emerged in most of the hospitals to deal with the implementation of DRGs. Staffed by nurses, and referred to by such titles as quality assurance or utilization review coordination, this unit was charged with assisting in assignment of the appropriate diagnosis and, consequently, determining the length of stay a patient would have in the hospital (In one hospital in the study, the size of this division had increased 300% since 1983).

When asked about changes social workers had seen in the quality assurance/utilization review staff, the modal response was that there was "more monitoring of social workers" by the utilization review staff (38.7%), followed by "no change" (31.8%). A smaller percentage (11.4%) perceived that quality assurance/utilization personnel were referring more patients to social workers, the same percentage (11.4%) felt that there was more collaboration between the two departments. The remainder (6.8%) reported that more quality assurance staff now covered smaller areas of the hospital (N=44).

Overall Changes Due to DRGs

When asked what differences they saw in their respective departments due to DRGs, the most frequent response included more pressure/stress/decreased job satisfaction (69.2%). Other differences were: the department was more concerned with discharge planning (10.9%), that more staff had been added (3.6%) and that there was conflict with quality assurance (3.6%). Only 12.7% of the respondents said that there had been no change in their department (N=55). Thus, almost 90% of the respondents perceived that change had occurred in their respective departments due to DRGs.

An MSW worker reflected on job satisfaction and impersonality.

> People's satisfaction with their jobs has decreased; they tell you that they feel like they can't sit down in a room. They need to make an exit instead of a comprehensive assessment. They don't feel that they've had an interaction with a person. Two months later, when the patient is readmitted, they don't remember the patient.

Increasingly, social workers discussed the change in the patient population and the more complicated needs of patients.

> Although the census is down here, due to the private physicians who see their patients privately (and outside the hospital), the smaller number of people who come here are more complex in their needs. The psychosocial needs are more

complex. So there is a greater need for social work services although the numbers are fewer.

Finally, many workers reflected on their overall satisfaction with their work. An MSW commented:

> Generally, I enjoy hospital social work. I enjoy the stimulation of dealing not only with the patient population but a diverse group of other professionals. There are times I enjoy the stimulation of the pace, but there is a very thin line between optimism and stimulation and enjoyment, and being overwhelmed, overstimulated and harassed. It's like being on a pinnacle and falling down one side or the other. It's hard to maintain a balance.

The Departments

Since the implementation of DRGs in 1983, two of the four departments reported a 25% increase in caseloads, coupled with a drop in the average length of stay for Medicare patients. The other two departments reported no substantial change in caseload size or length of stay.

A very important finding was the increase in the average number of staff sick days: 4.8 in 1983, 5.7 in 1984 and 7.1 in 1985. In computing the average number of sick days, outliers were excluded. Although there were no significant differences between 1983 and 1985, the increase in the number of sick days was identified by several social workers as a source of concern in their respective departments.

One administrator, commenting on the overall impact of DRGs stated, "The stress and tension have caused demoralization and powerlessness. The demand and expectations from the DRGs are sometimes different than what we were trained to do." Every administrator noted that his/her staff was experiencing additional stress.

Conclusions

The findings of this study contrast sharply with the research to date on DRGs and social work departments. Available research, which has relied on the responses of hospital social

work directors, indicates that the impact of DRGs on social work departments has been low (Survey Reveals, 1987; Patchner & Wattenberg, 1985; Dinerman, Seaton, and Schlesinger, 1986). There are several reasons for these research results to be so different from those of prior researchers. It is possible that this teaching hospital system may be unrepresentative of such institutions and/or that the responses of the staff are atypical. Alternatively, it may be that hospital social service directors have a very different perspective than that of the front line social worker. Further research is necessary to determine if this is an isolated or more general finding.

In the present study, however, the impact of DRGs seems substantial, both on a person level for the social workers directly affected by DRGs and, particularly, on a department level. Workers reported that they experienced additional stress in their own workload and in their departments in general with the implementation of DRGs. Another possible indicator of stress, the average number of staff sick days, showed a clear increase from 1983 to 1985. Interestingly, several respondents had independently discussed their own perceptions of increased sickness in their departments, which affected the caseloads of other workers.

Another important finding, more often discussed in the open ended interviews, was the issue of the bureaucratic/professional conflict and the influence of that conflict on work satisfaction. This conflict is not new; social workers have always had to deal with this, particularly in health care settings. But the intensity of this conflict appears to be heightened by DRGs which tend to focus so much on cases, that quality and humaneness may be comprised, a concern of other social work authors (Reamer, 1985; Dinerman et al., 1986). Concurrent with the heightened awareness of the bureaucratic/professional conflict is the issue of autonomy. There appears to be an erosion of the autonomy that workers perceive that they enjoyed in the pre-DRG era. In addition, there is a problem of balance; balance between dealing with emotional and tangible needs,

balance between doing a comprehensive job and an adequate job. Workers care about those differences and they worry about them. Ultimately, these factors may influence work satisfaction, professional challenge and, finally, job turnover.

Another concern was the issue of severity of illness and the need for more services. The medical literature is beginning to address the issue of severity of illness and how that factor is not adequately reflected in the present DRG system (Horn, Sharkey, Chambers, and Horn, 1985; Sheingold, 1986). Severity of illness also affects the work social workers do and the plans which are formulated with a patient. It seems critical that recording systems should reflect social work *interventions* which are different from the number of *patients/clients* in a caseload (Coulton, 1984) (A word of caution is necessary here. The most significant area of job dislike was paperwork/documentation/statistics, thus recording systems need to be streamlined, nonduplicative and useful, while meeting the need for accountability).

Although mentioned only occasionally by the direct service providers, all of the administrators discussed the increase in interdisciplinary rivalry which they had observed since the implementation of DRGs. As resources contracted, they reported the need to be well-positioned politically to defend their budgets and staffing. All the directors of social work discussed the necessity of defending their own departments against the perceptions of their respective utilization review staffs, the hospital unit with power directly related to the determination of diagnoses and, ultimately, hospital reimbursement. When the direct service providers were aware of interdisciplinary rivalry, it was with nurses, typically utilization review/quality assurance nurses.

The findings of this study, though different from prior research, are not surprising. If, as Victor Fuchs (1986) suggests, the health care system of the United States is undergoing a "revolution" and DRGs have created "...the most fare reaching" (Vladeck, 1984) change since the creation of Medicare in 1965, the effect on direct providers of health care services, including social workers, should be substantial.

Implications for Practice & Education

Given the findings of this research, that substantial change has taken place in these hospital social service departments since 1983, what can be learned from this study that has more general utility for other social workers in health care systems?

First, the comprehensive needs of patients and their families must guide practice. With shorter in-patient stays and shorter recovery time, patients are leaving "quicker and sicker" (Grady, 1986; Wallis, 1986). As a result, high risk screening is essential along with extensive use of outside resources, ranging from skilled nursing facilities to in-home support programs. Recent research (Semke, VanDerWeele, and Weatherly, 1989) indicates that a critical variable in discharge delay is the lack of post-hospital beds, a systems problem that an individual social worker is unable to address.

Therefore, it is incumbent upon social workers and social work departments, in collaboration with hospital administrators, to deal with the impact of DRGs on state and national levels, particularly at the level of policy formation. The particular knowledge of the front line social worker is essential to addressing and providing humane solutions in the creation of health care policy which equalizes the weighting of access, health and cost. As care for patients moves outside the acute care hospital, social workers must also be involved in leadership positions in planning services for the complex needs of patients and families.

A particularly disturbing finding of the research was the increase in interdisciplinary rivalry, noted by all the directors of the departments surveyed. With the pressures to cut costs, all hospital departments find themselves involved in a zero-sum game (Thurow, 1980); if one department receives a benefit, it is likely to be at some cost to another. Social work departments must seek out allies in this difficult climate while continuing to demonstrate the importance of their own role in service provision for patients and families.

A second issue relates to the education of social workers for practice in such a changing environment. Knowledge of high risk screening is essential, as well as rapid assessment skills. Utilization of community resources and close working relation-

ships with home care services are other areas in which social workers must maintain their expertise. Patients/clients must also be informed of their rights, an important educational role that the social worker needs to assume during the shorter hospital length of stay (Mizrahi, 1988).

A closer look should be given to the skills and tasks required in the specific area of discharge planning. Careful consideration should also be given to the use of entry level professionals who might make up a team, or share cases with experienced, advanced level practitioners.

While the post-hospital needs of patients discharged expeditiously are likely to be tied to community resources, the social worker's critical contribution is " . . . enhancing the participation of patient and family" (Kerson & Zelinka, 1989, p. 199) in the entire planning process. Social work has a central role to play in the planning and delivery of health care services. It is our responsibility, as a profession, to advocate for accessible, as well as affordable, health care.

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