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BORN TO HELP

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To the Graduate Council:

I am submitting herewith a dissertation written by Alison Lloyd entitled "BORN TO HELP." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Social Work.

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BORN TO HELP

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Introduction

This dissertation examined the views of social workers who were employed in hospital settings with regard to their MSW preparation for their roles. The purpose of this dissertation was to ascertain the (1) level of readiness for hospital social work roles based on their perceptions of their graduate Social Work education as perceived by MSW graduates from CSWE accredited programs, (2) their sense of professional self-efficacy, and (3) the quality of life perceived by the social workers with self-efficacy as a possible mediator variable. A systematic review was conducted to review the 1) knowledge base and 2) preparation for the role of social workers in acute care hospital settings. Although roles from many professionals (e.g., physician, pharmacist, and nurse) on the interdisciplinary team are clearly defined, the social work role is not well defined, and development of the science of Social Work in hospital settings is lagging behind these other professions as a result.

Themes identified from the systematic review were: history of social work, importance of the role of hospital social worker, and the role of hospital social workers in rural and urban settings. Although some education exists within MSW curricula regarding general social work roles in health care settings, there was limited literature on the specific social work role within interdisciplinary teams in urban hospitals and even less literature on the role in rural hospital settings. Further examination is needed to evaluate the preparation for roles in acute care hospitals, especially from the perspective of social workers who are currently employed in the hospital setting, particularly in rural settings. A key gap in the literature identified was the limited and dated current scales for measuring social worker understanding of their role in acute care hospital settings within an interdisciplinary team.

The focus of Research Question One (RQ1) was an examination of the level of self-efficacy felt by social workers' in a hospital setting, and the degree to which they felt prepared

for working on an interdisciplinary team in a hospital setting by their MSW education. The level of self-efficacy was measured by responses on the Health and Social Work Self-Efficacy (HSWSE) scale. The degree to which they felt prepared by their MSW training was measured on a scale uniquely designed by the author similar to the HSWSE scale, called the Preparedness scale.

The focus of Study 3, Research Question One (RQ1), explored the comfort level of social workers within the work climate by reviewing the sum of the scores on a portion of a self-efficacy scale (HSWSE scale) and correlating with the sum of the scores on the Comfort scale, a unique scale developed by the author. Research question 2 (RQ2) tested a path model for the relationship between preparation, social work self-efficacy, and quality of life. Research Question Three (RQ3) examined themes from responses to a set of open-ended questions asked of participants with respect to working in a hospital setting.

Abstract

The purpose of this dissertation was to ascertain (1) the level of readiness for hospital social work roles as perceived by Master of Social Work (MSW) graduates from Council on Social Work Education accredited programs, (2) the extent to which MSW level social workers felt prepared for their hospital roles by their MSW education, and (3) the quality of life perceived by social workers, with self-efficacy as a possible mediator variable. A critical literature review was completed. Surveys were sent using social media. One empirical study examined the level of self-efficacy felt by social workers as they worked in hospital settings. It also investigated the degree to which they felt prepared for their hospital roles by their MSW education. A second empirical study examined a path model testing the possible moderating effect of professional self-efficacy on the relationship between perceived preparedness and quality of life. Emerging themes from open-ended comments were also compiled.

Findings from a systematic review of the literature showed an emerging pattern of themes: (1) a history of social work with a focus on the knowledge base; (2) the importance of the roles of hospital social workers; and (3) the role of social workers in hospitals as part of interprofessional teams.

Results of the first empirical study showed MSW social workers only felt moderately prepared for their hospital roles, and felt moderate levels of self-efficacy. Results of the path analysis suggested that professional self-efficacy mediated the relationship between the degree to which social workers felt prepared by their MSW training to work in hospital settings and their quality of life. Results further suggested social workers' sense of preparedness had a stronger effect on professional self-confidence than did their on-the-job experience. The results also showed professional self-efficacy had a positive effect on quality of life.

Results of the qualitative analysis revealed that social workers support and define the profession to one another. Most felt unprepared by their MSW program for hospital social work. Anecdotally, social workers reported encouraging one another, and reported excellent self-care habits, all of which can contribute to good quality of life.

Chapter 1: Critical Review of Literature

Abstract

Adequate preparation is needed for persons entering most professions and especially social workers beginning work in hospital settings since vulnerable lives are involved. This systematic review was undertaken to review the 1) knowledge base, and 2) preparation for the role of inpatient social worker in an acute care hospital setting. The knowledge base consists of the literature pertaining to social work in hospital settings, including journal articles and books specific to social work practice, specifically practice within acute care hospital settings. Preparation for the role consists of the process that social workers undertake to work in an acute care hospital setting.

The distinction between rural and urban workforce was identified through the systematic review as there was limited literature on the specific social work role in urban hospitals, with even less literature on the role in rural hospitals. The literature was analyzed for the purpose of comparison of roles within the different settings, as often rural hospitals are even less resourced than urban counterparts (Smith, Plover, McChesney, & Lake, 2019). A review of 1095 articles from 1978 to 2018 was completed. The results of this review provided direction for 1) conceptualizing the knowledge base for hospital social workers and 2) assessing the adequacy of MSW level education for the role of hospital social workers. From this systematic review, it was shown that there was a knowledge gap in social work education in MSW programs within the U.S. in terms of defining the social work role in acute care hospital settings, particularly regarding the role on the interdisciplinary medical team. Further review is needed to evaluate the preparation for the acute care hospital role, especially from the lens of the social workers who are currently employed in the hospital setting, and particularly in rural settings. Themes

identified from the systematic review of the literature were grouped into three categories: (1) the history of social work with a focus on the a) knowledge base, and b) preparation; (2) the importance of the role of hospital social workers; and (3) the role of social workers in urban and rural hospital settings. From the systematic review of the literature, essential skills identified as necessary to work in this setting were those of having a basic orientation to the medical system, managing a loosely-structured client interview process, providing rapid assessment and treatment design, dealing with grief and loss, and working with complex family systems. Further research is necessary to identify methods of preparing the future workforce of hospital social workers, especially with the expected number of health care social workers to exceed 176,500 by 2026 (U.S. Bureau of Labor Statistics, 2018).

Keywords: Social work, hospital, preparation, role, rural, urban

Introduction

Social workers have a long-standing history of addressing a range of patient needs (eg, case management, emotional support, and discharge planning) in hospital settings. With more than 680,000 social workers employed in the U.S. (U.S. Bureau of Labor Statistics, 2018), with 6210 U.S. hospitals (AHA, 2019), and 85% of social workers within health care practicing in urban hospital settings (NASW, 2009), it is vital to examine both the 1) knowledge base, and 2) preparation for these professional roles.

The role of social workers in hospital settings as defined by the American Hospital Association (AHA) is [the provision of] “organized services that are properly directed and sufficiently staffed by qualified individuals who provide assistance and counseling to patients and families in dealing with social, emotional, and environmental problems associated with illness or disability, often in the context of financial or discharge planning coordination (AHA,

2019). Despite this definition, the social work role is often ancillary to that of physicians and nurses, and is both historically and currently poorly defined across settings (Canon, 1913; Canon, 1949; Kaplan & Berkman, 2015; Praglin, 2007). Though some evidence suggests that the primary role of social workers in hospital settings today centers on discharge planning and biopsychosocial assessment (Judd & Sheffield, 2010; Shepperd, Lannin, Clemson, McCluskey, Cameron, & Barras, 2013), This systematic review of the literature resulted in more opinion based articles than empirical evidence available to guide social workers on their discrete roles on urban hospital-based medical teams, with even less literature on the role within rural hospitals.

Lack of clarity on the social work role can create confusion for not only social workers but also for non-social work providers and even patients (Bywaters, 1986; Craig & Muscat, 2013; Judd & Sheffield, 2010). The author's experience consists of working as a social worker in an acute care hospital setting with interdisciplinary teams, and this experience suggests that the training for social workers in general may not be adequate for working in this hospital setting. These views have been echoed by others in the social work literature (Brazg, 2018; Craig & Muscat, 2013; Judd & Sheffield, 2010; Kahn, 1974; Rehr & Rosenberg, 1977; Williams & Vieyra, 2018). This author's view, along with the systematic review suggests a need for further exploration of the knowledge base and preparation for social work in general, and specifically further exploration from the lens of current social workers regarding the extent to which they feel prepared to work in the specific setting of an acute care hospital as a member of an interdisciplinary team. This is especially important as there are more than 680,000 social workers employed in the U.S. (U.S. Bureau of Labor Statistics, 2018), with 6210 U.S. hospitals (AHA, 2019), and 85% of social workers within health care practicing in urban hospital settings (NASW, 2009).

Social workers possess a unique set of skills to contribute to patient care that must be better defined in order to work effectively alongside other medical providers to facilitate transitions of care and provide assessments and emotional support often at a time when patients are facing difficult decisions involved during unplanned functional decline and end of life care. In order to help address this lack of clarity of the social work role within medical teams, this systematic review explores what sources of knowledge are available for informing the roles of social workers in acute care hospital settings.

Knowledge Base.

There are currently 271 accredited master's social work programs and 26 master's programs in candidacy for accreditation through the Council on Social Work Education (CSWE) in the United States (CSWE, 2015a). One small reference pertaining to hospital social work is contained in the Specialized Practice Curricular Guide for Trauma-Informed Social Work Practice as part of the CSWE Educational Policy and Accreditation Standards (EPAS) (CSWE, 2015c). This reference consisted of an exercise of drawing a genogram and was designed for social workers themselves to recognize how their personal past trauma patterns may influence their professional development (CSWE, 2015c). The other reference within this curriculum guide pertaining to hospital social work contained a question for a small group discussion regarding interacting with a client who had been sexually assaulted and presented to the hospital (CSWE, 2015c, p. 143). Although curricula in MSW programs is designed based on CSWE EPAS guidelines, the guidelines pertain to the general knowledge base of social work, rather than specific to hospital settings (CSWE, 2015e). The Colleges of Social Work (CSW's) that are accredited by CSWE are guided by these CSWE accreditation standards and EPAS as curriculum content is developed.

MSW Level Preparation.

The Council on Social Work Education (CSWE) posits that for social work education the field education is the signature pedagogy (CSWE, 2015d,e). Further, EPAS states

> "The intent of field education is to connect the theoretical and conceptual contribution of the classroom with the practical world of the practice setting. It is a basic precept of social work education that the two interrelated components of curriculum—classroom and field—are of equal importance within the curriculum, and each contributes to the development of the requisite competencies of professional practice." (CSWE 2015e, p. 12).

Although EPAS' intent is connecting the classroom and practice, there are concerns that students are not being adequately prepared as part of the practical field experience, which is a signature of the social work education (Bogo & Sewell, 2018). Reasons for this lack of preparation have been identified as factors relating to the state of the economy, students' competing obligations and economic statuses, as well as agency environments and staff turnover (Bogo & Sewell, 2018). This distinct training that is a basic precept of social work education is not adequately preparing social workers in general, and especially not preparing for work in specific settings. The recent final report in the Field Education Survey stated that "Because students become practitioners, the functioning of social systems, the needs of clients and consumers, and the fabric of society are at stake" (CSWE 2018, p. 6). This statement emphasizes the importance of this distinct training as social work tasks affect the nature of society.

Critical Role of Social Work for Addressing Patient Needs.

From its beginnings, hospital social work was seen as helping families receive appropriate services and advocating for patients who were marginalized, especially immigrants and those with physical diseases, were homeless, and undergoing social distress (Canon, 1913; Praglin, 2007; Richmond, 1922). Today there are more than 680,000 social workers employed in the U.S. (U.S. Bureau of Labor Statistics, 2018). Currently, hospital social work has been aligned with expedient discharge planning and case management, especially regarding decreasing length of stay for patients (Auerbach, Mason, & Laporte, 2007; Auerbach, Rock, Goldstein, Kaminsky, & Heft-Laporte, 2001; Judd & Sheffield, 2010; Praglin, 2007). However, it is the hypothesis of this author that social work may be moving in a direction further from assisting patient's with basic social work needs and into an area that is more cost focused for insurance companies and hospitals by engaging in expedient discharge planning before patients feel ready to leave the inpatient setting. It is also this author's hypothesis that social workers are not adequately trained to work within these high-pressure discharge environments, with inadequate knowledge for assisting patients and families as little knowledge is taught in MSW curriculums specific to roles in acute care hospital settings and inadequate preparation during student practicums.

While undertaking these roles, social workers are addressing critical issues such as providing comprehensive psychosocial assessment, education on resources and advance directives, as well as crisis intervention and facilitating discharges, gaining insurance coverage, and locating community resources for transportation and housing (NASW, 2011). Social workers address social determinants of health, specifically, those biopsychosocial factors that affect patient health outcomes (Berger, Cayner, Jensen, Mizrahi, Scesny & Trachtenberg, 1996; Berkman, Bonander, Rutchick, Silverman, Kemler, Marcus & Isaacson-Rubinger, 1990;

Steketee, Ross & Wachan, 2017; Zerden, Lombardi, Fraser, Jones & Rico, 2017). The inpatient social worker has a critical role within hospital settings and "they" help alleviate health inequities by advocating for patients and families and assisting with health improvement measures such as safe discharge planning, home health care, and counseling.

Having access to not only health care, but community resources like food pantries, can promote health equality as those who have previously faced access and utilization barriers such as lack of insurance or transportation will be provided resources for the provision of regular medical care and healthier meals (Woolf, 2019). For example, by a social worker addressing the issue of unstable housing, a patient may then be able to more easily focus on getting to medical appointments, which in turn, affects health outcomes (Hood, Gennuso, Swain, & Catlin, 2016). Within this role, social workers must have unique and specific knowledge on how to work on interdisciplinary teams as they are often an integral part of the inpatient treatment team within acute care hospitals.

Statement of the Problem

Purpose.

The purpose of this systematic review is two-fold 1) to critically review the literature on the knowledge base for the role of social worker within acute care hospital settings and 2) to critically review the literature pertaining to the preparation for the role of social worker in acute care hospital settings, both urban and rural, in the United States. This review includes broad examination and synthesis of literature of empirical studies, theoretical pieces, and expert opinion pertaining to the 1) education and 2) preparation undertaken by social workers seeking employment within inpatient hospital settings. The purpose of understanding role expectations of

social workers in inpatient acute care hospitals is to inform future efforts of education and preparation.

Objective.

This systematic review of the literature examines the 1) knowledge base of social workers in acute care hospital settings and 2) the degree of preparation for social workers who will enter the hospital setting. This literature review was a systematic examination of current literature using the outcome variable of preparedness, as this relates to the findings regarding knowledge, educational preparation, and the unique aspects of hospital based social work on an interdisciplinary team. Preparedness was defined in a multi-dimensional manner as 1) the extent to which MSW students have been educationally prepared by knowledge obtained through curriculum content and literature such as journal articles and books specific to social work practice, and 2) the specific processes that social workers engage in to acquire the skills necessary to perform the tasks in an acute care hospital. These processes include trainings, as well as practicum experiences within the MSW programs. The systematic review provides a critique of existing literature and a framework for understanding the roles assumed by social workers in acute care hospital settings within the United States (U.S.). Further, despite the commonality of interdisciplinary work within U.S. hospitals, there is evidence of differences between these roles within the urban and rural hospital settings. Finally, the result of this review can inform future educational efforts by identifying gaps and methodological weakness in existing literature.

Methods

Search Strategy.

A comprehensive systematic review was conducted over the time span of May through June 2019 using the following databases: CINAHL, PubMed, SCOPUS, Social Work Abstracts, Web of Science, and Academic Search Complete. Publications were chosen from the dates 1978-2019, as the author's intention was to capture whether there were changes in opinion on educational content as health care has evolved with more focus on cost containment in recent years. The search strategy included combinations of the following key terms pertinent to this study: social, healthcare, preparation, education, training, urban, and rural. As part of this systematic review, one author's publications were numerous on the topic of social work in hospital setting and included two case studies, two qualitative studies, one quantitative study, and six opinion articles (Berkman, 1996; Berkman, Bonander, Kemler, Marcus, Rubinger, Rutchick, & Silverman, 1988; Berkman, Bonander, Kemler, Rubinger, Rutchick, & Silverman, 1996; Berkman & Rehr, H. 1973; Berkman, Bonander, Ritchick, Silverman, Kemler, Marcus, & Isaacson-Rubinger, 1980; Berkman, Gardner, Zodikoff, & Harootyan, 2005; Carlton, Falck, & Berkman, 1985; Rehr, Berkman, & Rosenberg, 1980; Volland, Berkman, Phillips, & Stein, 2003). One author was contacted to invite her opinion on future directions for this research endeavor as she had peer reviewed publications spanning over a time period of over twenty years.

Search Terms.

After consulting with the UTK Social Work librarian, a search of the CINAHL database was completed by entering the following search terms into the Boolean string: (social work or social workers) AND (hospital or hospitals) AND (preparedness OR readiness OR education OR

training). When searching PubMed, the following search terms were entered: (((inservice training[MeSH Terms]) OR education[MeSH Terms]) AND social workers[MeSH Terms]) OR social work department, hospital[MeSH Terms]. For the SCOPUS database, the search terms entered were: social workers AND hospitals AND (preparedness or readiness or education or training) and excluded articles greater than 10 years old, limited to medicine, nursing, social science, and health professions, United States, and English, and journals. The search string for Social Work Abstracts included the following terms: social workers AND hospitals AND (preparedness or readiness or education or training). Web of Science search terms included the following search terms: social workers AND hospitals AND (preparedness or readiness or education or training). Search terms entered in Academic Search Complete included the following: TI : (social work or social workers) AND (hospital or hospitals) AND (preparedness OR readiness OR education OR training). Reference lists in articles found were also searched and some articles dated earlier than 2009 were included as the content in the article was specific to the role of social workers in hospitals.

Inclusion and Exclusion Criteria.

Inclusion criteria focused on articles that were opinion, theoretical writings, and empirical studies. For inclusion in this review, the article must have been published in English, appeared in a peer-reviewed journal, pertained to adults in the United States, and contained content on the role of social work in urban or rural hospital settings. The dates included were 1978-2019 as the author wanted to capture whether there were changes in opinion or educational content as health care has evolved with more focus on cost containment in recent years.

Articles were excluded if they were not peer-reviewed, not published in English, did not pertain to the United States (the international focus was too broad for the purpose of this

dissertation), or did not pertain to adults (as there is an added relationship of parental unit or guardian to the patient-provider dynamic), or the hospital setting, or contain information regarding on the job training. The initial search produced 1095 articles in total. The abstracts were reviewed and articles were excluded based on criteria outlined above.

Results

Results of Search.

In total, 1095 articles met initial selection criteria for inclusion in this systematic literature review and after review of abstracts the review produced the following results: CINAHL yielded 9 results, PubMed, 128, SCOPUS, 345, Social Work Abstracts, 10, Web of Science, 361, Academic Search Complete 242. Next, articles were reviewed for content specific to 1) knowledge and 2) education for the hospital social worker role. Following, is the outline by database of publications included and excluded.

CINAHL.

Of the 9 CINAHL results, 4 were included, the other 5 excluded as they pertained to children, supervisors, and hospital restructuring.

PubMed.

Of the 128 PubMed articles, 5 topic areas were identified for the included articles: discharge planning (n=4), interprofessional training (n=7), knowledge (n=11), role (n=15) and role importance (n=1). The excluded articles include 5 areas: on the job training (n=14), non-U.S. (n=16), disease specific related (n=23), child related (n=13), and non-hospital related (n=24) (Figure 1).

SCOPUS.

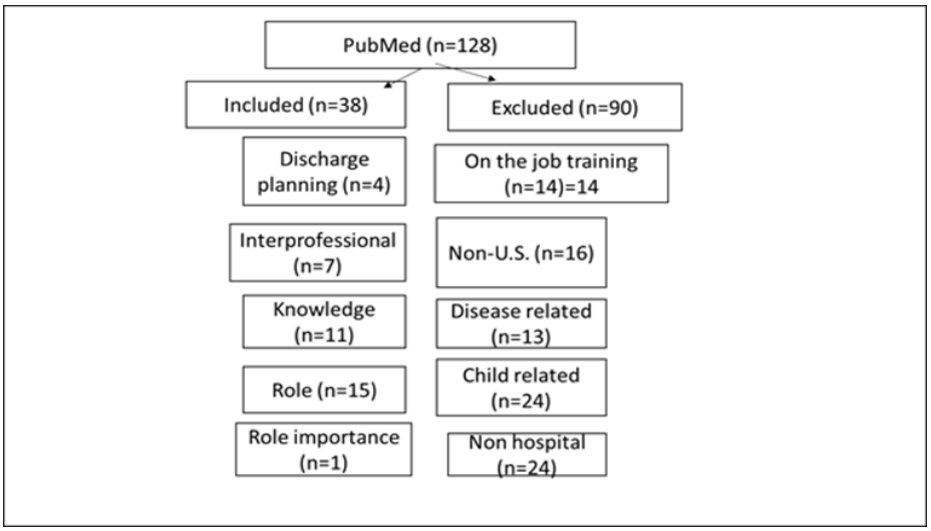

Figure 1. Flowchart of inclusion and exclusion criteria for PubMed articles.

SCOPUS articles (n=345) were reviewed for pertinent content. Of the 345 articles reviewed five topic areas were identified as pertinent to the topic of knowledge and preparation for social workers on interdisciplinary teams: discharge planning (n=56), interprofessional training (n=13), knowledge (n=25), and role (n=10). The remaining 289 articles did not meet inclusion criteria (Figure 2).

Social Work Abstracts

Social Work Abstracts produced two studies that met inclusion criteria for the systematic review, one related to discharge planning, and the other related to interdisciplinary teams. The remaining studies that were excluded were articles on the topics of specific disease related subjects and non-hospital information.

Web of Science.

Web of Science yielded 361 total results. Of the total of 361 articles reviewed, 67 met inclusion criteria. These remaining articles were grouped into the following four categories: discharge planning (n=6), interprofessional training (n=16), knowledge (n=33), and role (n=12) (Figure 3).

Academic Search Complete.

Academic Search Complete yielded 242 articles, with 49 being included and 193 excluded according to the search criteria. These articles were grouped into the following four categories: discharge planning (n= 3), interprofessional training (n=9), knowledge (n=27), and role (n=10) (Figure 4).

Results of Systematic Review of the Literature.

After reviewing the abstracts of the 1095 articles, the following articles were further excluded for the following reasons: non-U.S. (n=199), disease specific (n=326), child related

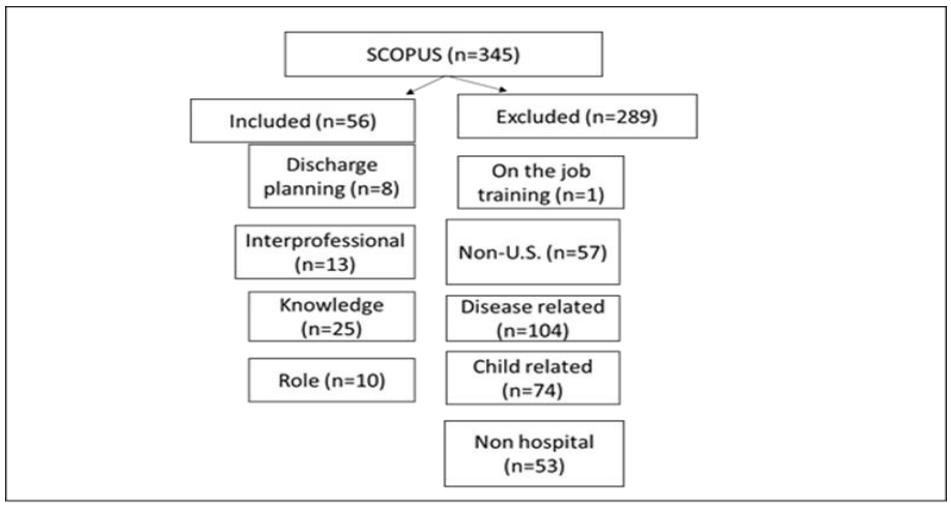

Figure 2. Flowchart of inclusion and exclusion criteria for SCOPUS articles.

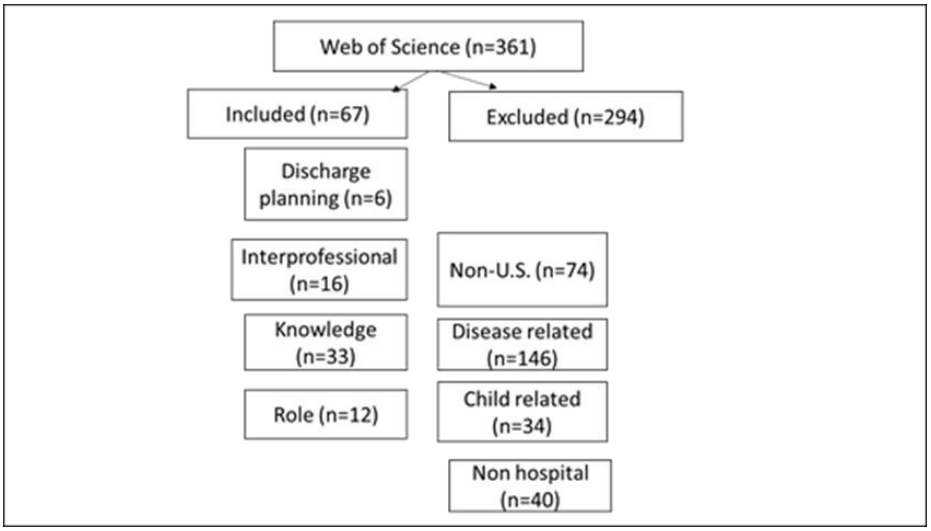

Figure 3. Flowchart of inclusion and exclusion criteria for Web of Science articles.

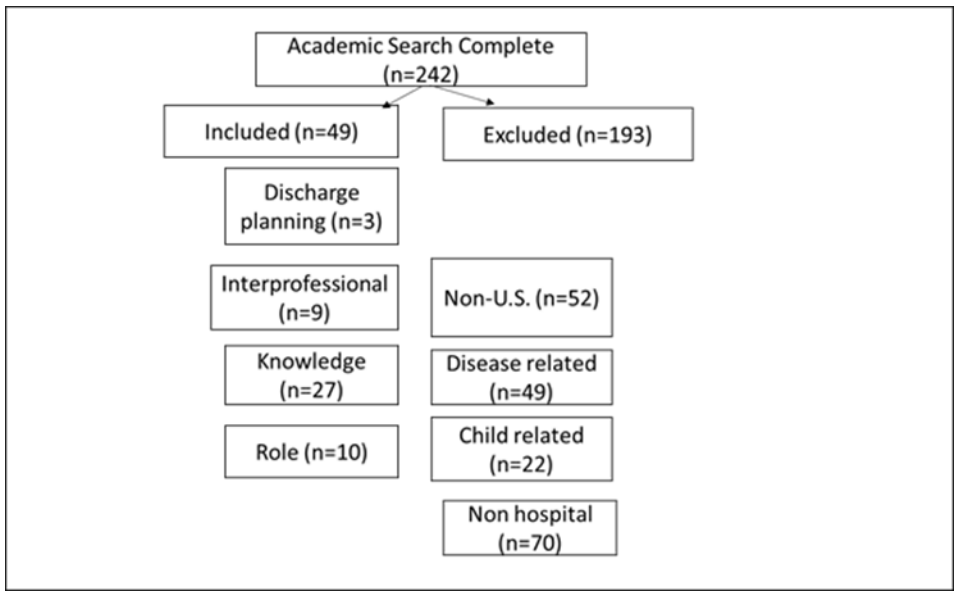

Figure 4. Flowchart of inclusion and exclusion criteria for Academic Search Complete articles.

(n=145), on the job training (n=17), and non-hospital related (n=192). The inclusion criteria for the systematic review were met by a total of 216 unique articles. These remaining 216 articles were reviewed in-depth for application to the systematic review of the literature. Of the 216 articles, 24 of the empirical articles contained results with quantitative content, 42 contained content specific to qualitative research, 4 contained mixed methods, 51 were case studies, and the remaining 95 were expert opinion publications.

Gap Identified

The knowledge gap found from this systematic review was the content missing in social work education in MSW programs within the U.S. in terms of the 1) education and 2) preparation for performing the social work role specifically in acute care hospital settings, and particularly regarding the role within an interdisciplinary medical team in rural hospital settings. Driven by the CSWE and EPAS standards, CSWE accredited programs develop curriculum content in MSW programs. These guidelines pertain to general knowledge of social work, influence course content, and currently do not contain knowledge specific to hospital settings, let alone rural hospital settings (CSWE, 2105). Although literature reflects the baseline MSW knowledge in terms of education for general social work roles, further review is needed to evaluate the preparation for the acute care hospital role, especially from the lens of the social workers who are currently employed in the hospital setting, and particularly in rural settings. Although social workers' perceptions of their psychosocial competencies with interdisciplinary medical teams have been studied recently, identification of other skills is necessary for informing education (Maramaldi, Sobran, Scheck, Cusato, Lee, White, & Cadet, 2014).

The studies in this systematic review of the literature were found to be grouped into three main themes regarding the role of social worker in acute care hospital settings: 1) importance of

social work role, 2) knowledge base and educational preparation required, 3) interprofessional interactions. After reviewing the studies, it was determined that the group labelled 'discharge planning' was similar in content to the group labelled 'role' so studies in these categories were combined into one category of 'role'. The studies within the systematic review were analyzed and categorized by the hierarchy of research provided by the Center for Evidence Based Medicine (1979). The following outlines the type of literature by research design.

One systematic literature review included a broad range of health care settings and populations (Steketee, Ross & Wachman, 2017). This systematic review included review of the online databases that contained literature on mental health, biomedicine, healthcare, nursing, allied health articles, science, medicine, and technology with over 75% of the included studies using controlled comparison study designs. Two of the studies within the systematic review showed that teams led by social work produced higher quality rankings as compared to groups led by those other than social workers but included social workers on the interdisciplinary team (Steketee, Ross & Wachman, 2017). A conclusion of this systematic review of the literature was that interventions involving social workers, regardless of whether the social worker was a team member, or a team leader, produced positive effects on health outcomes at less cost than usual care without social work involvement (Steketee, Ross & Wachman, 2017). However, this study was limited by the inclusion of maternal and child health related content, such as pregnancy prevention and high-risk pregnancies, as these elements were excluded by this author in the search terms within this systematic review of the literature. Another limitation was the inclusion of a small sample size for one study (Steketee, Ross, & Wachman, 2017). Results of this study suggest the need for further testing regarding the added benefit of social work to clinical health

services as compared to services that did not include social work, including information on the cost outcomes of having social workers on care teams (Steketee, Ross & Wachman, 2017).

Case Series and Expert Opinion

One expert opinion article linked social work's guiding framework of the biopsychosocial approach to the focus for health care reform and integrated healthcare (Stanhope, Videka, Thorning & McKay, 2015). Another recent qualitative study showed the value of social work especially when assisting the LGBT population within hospitals (Conlon & Aldredge, 2013). There is a growing body of evidence which suggests the inclusion of social workers on interdisciplinary teams leads to improved patient level health outcomes, as social workers work within systems that are patient focused, such as collaborative care models (Fraser, Lombardi, Wu, de Saxe Zerden, Richman & Fraher, 2018; Zimmerman & Dabelko, 2007). Collaborative care models have been associated with higher consumer satisfaction with patients' hospital visit, more effective team performance and better overall care coordination (Gance-Cleveland, 2005; DiMatteo et al., 2002; Ponte et al., 2004; Institute for Family-Centered Care, 2004). These collaborative care models, producing increased patient satisfaction, bring patients and families into the planning and delivery of healthcare (Zimmerman & Dabelko, 2007). The existence of collaborative care models, and the inclusion of social workers within these models, leads to the necessity for educating future practitioners to work within these environments. In order to be better prepared for working on an interdisciplinary team, understand the skills set of the various team members, and to work effectively with patients and families, social workers need education either through practicum experience, classroom, internships, or a combination of the these methods.

Further, social workers have a unique perspective and relationship with patients and families that allows for providing further assistance by addressing patients' social determinants of health, in areas such as excessive copays, difficulties applying for insurance, and transportation logistics (Powell, Doty, Casten, Rovner, & Rising, 2016). A systematic review encompassing three decades of international research showed that the role of social work increasingly helped improve social determinants of health such as housing and employment (Steketee, Ross & Wachman, 2017. Social workers have been an integral part of the U.S. health care system and possess a unique skill set to work with patients from the perspective of person-in-environment. However, the social workers practicing in hospitals are part of a greater hierarchical structure, often working alongside those who carry more authority within the medical center, such as physicians (Berkman, Bonander, Kemler, Marcus, Rubinger, Rutchick, & Silverman, 1988). The current systematic review produced three main themes regarding the role of social worker: Case Manager/Discharge Planner, End of Life Assistance, and Advocate. These themes are outlined below.

Case Manager/Discharge Planner

Studies both past and present support case management as a vital role of social workers in hospital settings (Craig & Muskat, 2013; Davidson, 1990; Fink-Samnick, 2019; Judd & Sheffield, 2010; Gregorian, 2005). The case manager role is all encompassing, as the role effects many aspects of a patient's life and this role fits easily into the fundamental value of social justice within the social work profession Code of Ethics (NASW, 2017).

The role of case manager is to assist patients and provide family support. The support can be in the form of talking through such emotional topics such as the withdrawal of life support for a loved one, providing family support for grief and loss, assisting with discharge transitions of

care, and helping families choose a hospice agency. One study identified discharge planning was initially a nurse activity, but that this aspect of patient care was eventually claimed by social work (Davison, 1990). Case management is currently being linked to the financial health of hospital systems. The fiscal identity of an organization is related to the review of readmissions as value-based care has been implemented. Bundled payments are part of value-based care. If a patient is readmitted within a certain time window after discharge, insurers often deny payment of claims on the grounds of lack of comprehensive care during the admission. Thus, the demand for interprofessional effort is shown. By understanding the professional roles of others on the health care team, it allows for seamless teamwork and breaks down the silos that were part of workforces of the past. The core goal of interprofessional practice is building interdependencies in order to best manage the needs of all patients, especially those patients with complex care needs. This interdependence has also been shown to reduce medical errors due to improved team communication (Fink-Samnick, 2019). With over 75% of readmissions costing $12 billion in the U.S., the coordination and organized care can result in more coordinated transitions and prevent these unnecessary readmissions (Fink-Samnick, 2019). Educating social workers on case management roles and expectations can assist with this much needed coordination of the hospital discharge process.

End of Life Assistance

Similar to social workers employed in outpatient hospice settings, inpatient social workers have discussions about palliative and end of life care, such as choosing to forgo curative treatment and enrollment in hospice. As stated by the National Consensus Project for Quality Palliative Care, the goal of palliative care is to “prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease

or the need for other therapies" (Puchalski, Ferrell, Virani, Otis-Green, Baird, Bull, & Pugliese, 2009, p.885). Palliative care can be involved for pain management during active treatment, while enrolling in hospice is forgoing treatment. As members of interdisciplinary team, the social work role is heavily focused on advanced planning for end of life (Daly & Matzel, 2013). Advanced planning activities were specifically found to include completing medical advanced directives for care and for resuscitation, in addition to other end-of-life planning (Daly & Matzel, 2013; Waldrop & Kirkendall, 2010). Through use of an exploratory descriptive study to determine how urban and rural approaches vary regarding end of life planning, rural social workers specifically, were found to more frequently provide services related to advanced planning for end of life, as opposed to other forms of care as compared to their urban counterparts (Waldrop and Kirkendall 2010). The main concerns identified in rural settings were logistical challenges, lower wages than urban counterparts, and therefore difficulty in maintaining staffing levels specifically with nursing staff (Waldrop and Kirkendall 2010). Another challenge identified was that of program issues, where there were not funds to have patients remain with one agency, from home health care through hospice. It was thought that this process could be more seamless for patients near end of life. There was also a lack of understanding identified regarding the continuum from curative treatment to palliative care. While this study pertained to outpatient hospice, the inpatient social workers have similar discussions with patients and families.

Advocate

From the systematic review, another role that emerged for inpatient social workers was that of patient advocate. Social workers advocate for patients by first listening to concerns in a non-judgmental way and voicing those concerns to those who may best help patients (Council on

Social Work Education [CSWE], 2015b, Curricular Guide for Economic Well-Being Practice, p.6). Advocacy is further defined by the provision of "organizational and community resources that promote client economic well-being and facilitate policy change," at the micro, mezzo and macro levels (Council on Social Work Education [CSWE], 2015b, Curricular Guide for Economic Well-Being Practice, p.37). An example of advocating at the micro level is advocating for disabled clients to receive public benefits such as Supplemental Security Income or Social Security Disability Insurance. Several studies identified advocacy as a main role for social workers for the high-risk populations served and that social workers themselves view advocacy as essential to their role (Craig & Muskat, 2013; Gregorian, 2005; Judd & Sheffield, 2009). Another study suggested that social workers help the hospital meet its organizational needs as a result of efforts by social work to increase departmental credibility (Davidson, 2009). Although several studies spoke about the importance of advocacy, there were differing levels at which to advocate, that of micro, mezzo and macro. In some studies advocacy referred to helping patients obtain resources like housing or insurance (Davidson, 1990; Judd & Sheffield, 2010), in others, advocacy was meant for the social worker themselves to define their role to other team members (Craig & Muscat, 2013). Thus, it would be important to examine this topic of advocacy from the lens of social workers.

Unique Aspect of Hospital based Social Work-Interprofessional Teams- Urban

One hundred forty six of the studies found pertaining to the role of social worker in an urban acute care hospital setting were expert opinion or case studies examining various populations and tools for performing the job (Berkman, 1988; Berkman & Rehr, 1978; Clare, Fink-Samnick, 2019; Clarke, Neuwirth & Bernstein, 1986; Davidson, 1990; Gregorian, 2008; Naleppa & Reid, 2000; Netting, 1992; Treiger & Fink-Samnick, 2013). One study utilized

random selection for an experiment on case finding while controlling for social work as independent case finders (Berkman & Rehr, 1973). Results indicated that independent case finding reached significantly more patients, including those who needed social work as a result of becoming ill and hospitalized (Berkman & Rehr, 1973). One limitation of this study was the participant selection was limited to those aged 65 and older and this may impact generalizability to other populations. Another study distributed a needs assessment that was completed by members of the interdisciplinary palliative care team (Daly & Matzel, 2013).

Another article consisted of role definition through a self-administered questionnaire from an initial sampling frame of a list of 5,000 hospitals within the United States (Judd & Sheffield, 2010). The final article consisted of a qualitative study using focus groups to collect data about the social work profession's role in primary health care settings (Craig & Muskat, 2013). Further, as members of interprofessional teams, research showed that social workers have fulfilled an important role in assisting patients with modifiable determinants of health, specifically assisting in the areas of social and environmental factors that affect physical health (Braveman, Egerter, & Williams, 2011; Maramaldi, Sobran, Scheck, Cusato, Lee, White & Cadet, 2014; Salas, Altamirano & Williams, 2012; Stanhope, Videka, Thorning & McKay, 2015).

Findings Regarding Knowledge and Educational Preparation

Four of the studies meeting the inclusion criteria for review were cross-sectional case series studies and included social workers' perceived confidence and understanding of the social worker roles (Acker & Lawrence 2009; DeMartini & Whitbeck, 1987; Sagah Zadeh, Shepley, Sadatsafavi, Owora & Krieger, 2018; Sidani, Reeves, Hurlock-Chorostecki, van Soeren & Collins, 2018). One publication included measurement of social workers perceived confidence

(Acker & Lawrence, 2009) and another was comprised of a literature review of peer reviewed social work journals and peer reviewed health and mental health journals which contained articles on psychosocial interventions (Volland, Berkman & Phillips, 2008). Several other studies included primarily qualitative data and expert opinion (Berkman, Kemler, Marcus & Silverman, 1985; Browne, 2006; Browne, Keefe, Ruth, Cox, Maramaldi, Rishel, Rountree, Zlotnik & Marshall, 2017; Goldstein, 1990; Held, Black, Chaffin, Mallory, Diehl & Cummings, 2019). Another article contained a secondary data analysis examining what is known from education and what is learned from practice (Carlton, Falck & Berkman, 2008)

As early as 2003, the Institute of Medicine listed work in interdisciplinary teams as one of the five core competencies needed for health care professionals (Institute of Medicine, 2003; Knebel & Greiner, 2003). Other professions have followed suit in providing guidance for incorporating interprofessional learning into the curriculum, such as public health, which has requirements for interprofessional learning outcomes for students (Association of Schools of Public Health, 2006). As recent as 2016, the CSWE was added to the Interprofessional Education Collaborative which provides guidelines for Core Competencies for interprofessional practice (Interprofessional Education Collaborative, 2016). The Interprofessional Education Collaborative gathered decision makers on higher education from various medical fields and created core competency guidelines for a providing a well-rounded education for preparation on working on interdisciplinary teams (Interprofessional Education Collaborative, 2016).

Below are four subsections in which identified interdisciplinary team membership is discussed. These descriptions include competencies defined through the professional organizations for working on interdisciplinary teams.

Physicians.

Medical schools and residency programs began teaching interdisciplinary education as a focus in 2008 (Association of American Medical Colleges, 2012). The concept of education for the interprofessional team has even extended to the American Dental Education Association, as interprofessional work with other health disciplines has been added as a competency (The American Dental Education Association, 2008).

Nurses.

Interprofessional training focus is found in most nursing curriculums. Nursing programs incorporated interprofessional collaboration into their curriculums first in doctoral programs in 2006, next in baccalaureate programs in 2008, and finally into the master's program in 2011 American Association of Colleges of Nursing, 2011; Held, Mallory & Cummings, 2017). Nursing educators determined DNP graduates needed preparation in the interprofessional aspect of healthcare as functioning on an interprofessional team was important for collaboration (American Association of Colleges of Nursing, 2006, 2008).

Psychologists.

As early as 2002, training guidelines have been updated for psychologists for working in primary care settings, and these guidelines were then updated in 2011, with competencies being distributed in 2013 for psychologists working in primary care settings (American Psychological Association, 2015). These competencies contain essential components and behavior anchors such as recognizing team dynamics and having mutual respect with other professionals by developing collaborative relationships which include mutual respect and shared values. Other behavioral anchors contained in the APA competencies is the promotion of collegial and mutually respectful relationships with colleagues from different disciplines (APA, 2015).

Pharmacy.

Pharmacy programs first began including interprofessional education in their vision statement and even into their accreditation criteria in 2005 (Accreditation Council for Pharmacy Education, 2015; Maine, 2005). The Accreditation Council for Pharmacy Education (2015) incorporated interprofessional simulation experience and non-pharmacy preceptors into its most recent accreditation standards and schools are given permission to approach interprofessional education based on insight provided by evolving research within this area (Accreditation Council for Pharmacy Education, 2015).

Social work-Lack of preparation for interdisciplinary team

Although Social Work programs have offered courses related to integrated health care, there are not defined core competencies in Social Work for how to prepare to work on integrated health care teams (CSWE, 2017). This is concerning as the profession of social work is lagging behind other disciplines in this area (Held, Mallory, & Cummings, 2017). Research identified that although the social worker in the medical setting is a member of a self-directed interdisciplinary team, working with minimal supervision when providing services to patients and families, social workers were not prepared by their MSW curriculum for the job tasks (Berkman, Bonander, Kemler, Rubinger, Rutchick, & Silverman, 1996). As early as 1990, role blurring of hospital social workers was thought to be problematic and this continues to be a concern presently especially with the focus on more collaborative efforts from interdisciplinary teams (Davidson, 1990; Fink-Samnick, 2019). Fink-Samnick (2019) take an approach that calls for educating students of all disciplines on the importance of integrated teamwork prior to working in the hospital setting. This is a new approach and different from previous approaches where social workers were responsible for setting boundaries and defining their role on the team (Craig & Muscat, 2013; Davidson, 1990; Judd & Sheffield, 2009. If the role of social workers is

not understood by others within the hospital, this lack of understanding limits the roles and activities of social work, creating less positive outcomes for patients and impacting the bottom line for the hospital (Judd & Sheffield, 2009). The latest approach of interprofessional education involves students from different professions learning about, from and with each other, thus establishing a collaborative effort for the health care workforce (Fink-Samnick, 2019). This collaboration is consistent with the World Health Organization (WHO) emphasis on comprehensive and intentional education for the upcoming healthcare workforce ([WHO], 2010). Although there are benefits for practicing on an interprofessional health care team, there are barriers to providing this type of care. One barrier is that of limited educational preparation for working within the team, especially for the role of social worker (Held, Black, Chaffin, Mallory, Diehl & Cummings, 2019).

Craig and Muskat (2013) conducted a qualitative study of hospital social workers, in which participants reported that they enacted roles of advocate, counselor and resource provider, despite inadequate training for the work required within the hospital setting. The identified needs of the participants in this study called for further coursework in their educational preparation for the role of inpatient social worker (Craig & Muskat, 2013). Other recommendations from this study were to focus on the structure of the work provided by hospital social workers and identify common elements of the practice, especially since the work involves interaction with vulnerable populations within an ever-changing health care delivery system (Craig & Muskat, 2013). Similarly, even the most current NASW standards speak only to general health social work (NASW, 2016).

Along with the social work students feeling unprepared by their curriculum, there is also recent research that showed the Deans' of Colleges of Social Work throughout the U.S. felt

unprepared for implementing integrated healthcare into the Social Work curriculum (Held, Mallory, Cummings, 2017). This topic is timely and significant because of the large number of social workers going into health fields will outpace all other social worker fields by the year 2026 (Bureau of Labor Statistics, 2016). If the role is not defined, the lack of definition leaves it open to interpretation by those who are external to the profession. Being externally defined would not provide for unity and organization for determining basic skills needed in MSW programs.

Other studies have shown that social workers' own health is vulnerable due to dealing with emotionally taxing areas of life and death in health care settings (Beemsterboer & Baum, 1984; Borland, 1981; Taylor-Brown, Johnson, Hunter & Rockowitz, 1982; Mor & Laliberte, 1984; Taylor-Brown, Johnson). A recent systematic review of rural social workers showed that there were challenges to social work practice, especially in rural settings and some of these challenges were identified as knowing community members who came in for treatment, lack of agencies to refer clients, and less job satisfaction which has been linked to burnout (Brown, Walters, Jones & Akinsola, 2017). Further, there are challenges identified for social workers in urban settings. These challenges relate specifically to lack of educational preparation, collaboration as part of an interdisciplinary team, and identifying as a professional social worker (Ambrose-Miller & Ashcroft, 2016; Carlton, Falck & Berkman, 1985; Farmer, 2017).

Education Available for Social Work Students

Along with defining the profession to other professions, some researchers have suggested that practice wisdom and scientific technologies be merged within the profession of social work (Rehr, Rosenberg, Showers & Blumenfield, 1998). The divide between academics who assume a scientific rationality and the practitioners who align with experience, practical and intuitive

reasoning tends to impede progress in the profession of social work. For the purpose of developing the profession, social work educators may need to merge the two sides of the profession, that of academia and practitioners. Once the two sides are in a cooperative stance, the profession will benefit from having more clearly defined structure, thus creating accountability and ease of definition for other professionals and drawing minimally from professional energies as compared to conflictual splits (Rehr, Rosenberg, Showers & Blumenfield, 1998). Earlier researchers have suggested that research oriented social workers and practice oriented social workers find common ground for the purpose of integration of practice and research that will benefits patients (Austin, 1991; Fraser, Taylor, Jackson & O'Jack, 1991; Jenkins, 1990).

Further studies support the integration of scientific knowledge with practice experience. Integrating the theories of social work education, the empirical knowledge, and practice experience is defined as practice wisdom (Klein & Bloom, 1995). It is this practice wisdom that translates the theory and previous practice experience into professional behavior. This type of wisdom draws from both direct practice experience and theory and culminates into professional action for the benefit of the patients (Klein & Bloom, 1995; Payne, 2014). Another similar publication posits that knowledge base of social workers combines practice wisdom, humanities, and the contributions of interpretive human sciences (Goldstein, 1990). Practice wisdom draws in part on the prior experience of the professional and on the established knowledge that is yet incomplete (Klein & Bloom, 1995). Without mutual interaction between knowledge and practice, each entity is described as less than it could be (Klein & Bloom, 1995).

Kadushin and Egan (1997) reviewed graduate-level health care practice courses across CSWE accredited schools for the purpose of ascertaining their health specific content in the course curriculum. Although most respondents were from large state universities and there was

some consensus on basic foundational content, course units were found to include content related to the changing health care environment less consistently (Kadushin & Egan, 1997). This core knowledge provided was thought to adequately prepare social worker for practice in health care but suggested that the content needed to prepare social workers for their role in the changing health care environment was not adequately preparing them (Kadushin & Egan, 1997). The course content needed would be related to managed care issue, deinstitutionalization, HIV/AIDS population, and aging and gerontology (Kadushin & Egan, 1997). Other literature supporting aging focus had been identified recently (B. Berkman, personal communication, June 7, 2019). Similarly, a U.S. national analysis reviewing U.S. social work programs' websites, found that there was broad health or health related content across baccalaureate and master's curricula (Ruth, Wachman, Marshall, Backman, Harrington, Schultz & Ouimet, 2017).

Importance of More Knowledge

Current educational efforts in the broader health care industry are trending towards interprofessional team-based care (IPTBC) in order to provide case management services in a fiscally responsible way (Fink-Samnick, 2019). The IPTBC approach to patient care aligns each professional and avoids the silo approach within a team, while preventing overlap of services provided to patients (Fink-Samnick, 2019). Health systems that did not utilize an IPTBC were found to have higher costs and penalties associated with health care delivery (Fink-Samnick, 2019). In the midst of keen focus on readmissions and costs of health care, the IPTBC has been referred to as "poetry in motion" due to the smooth interchange and handoff for care coordination (Fink-Samnick, 2019).

Some schools of allied health have transitioned from siloed departments to cooperative health services, combining training for nursing, social work, and rehabilitation sciences so

students can learn alongside other allied professionals during their academic preparation, thus receiving training on interdisciplinary teams (Fink-Samnick, 2019). Further research into the specific role of social workers includes education for the provision of such services as distance counseling and home monitoring via technological devices like smartphone apps, thus requiring social workers to understand their professional scope of practice as they work as part of the interprofessional team (Powell & Fink-Samnick, 2013). Efforts toward interprofessional care teams are encouraged by the Centers for Medicare & Medicaid Services (CMS) since working within these teams is a method to improve patient outcomes, which are ultimately tied to hospital reimbursement (Nester, 2016). Further training for interprofessional teams is necessary as no single discipline is equipped to independently navigate the complexities of the unique health care environment of today (Nester, 2016). The area of interprofessional practice was recommended by the World Health Organization (WHO) Framework for Action as a collaborative practice model which brings multiple talents and professional backgrounds together to work towards delivering the highest quality of care (WHO, 2010). Inherent in this collaborative practice model of care is the concept of relational coordination, which is present in organizational structures that have professionals connecting across workgroups, as opposed to fostering a silo approach to patient care (Gittel, Siedner & Wimbush, 2010).

Focusing specifically on the healthcare workers, another systematic review that was recently updated by adding thirty-nine studies, concluded that there was a need for more organizational level interventions aimed at reducing healthcare worker's stress levels (Ruotsalainen, Verbeek, Marin`A, & Serra, 2015). In this study, fifty-four of the included studies were randomized controlled studies and concluded that healthcare workers did not have enough time, skill or social support in the workplace which led to distress, burnout and bodily illness

(Ruotsalainen, Verbeek, Marin` A, & Serra, 2015). The majority of the studies in this review had been conducted in North America (twenty-four), with nineteen in Europe. This study encompassed the broad terms of "healthcare workers" which consisted of nurses, pastoral care, respiratory therapy, physicians, surgeons, and social work (Ruotsalainen, Verbeek, Marin` A, & Serra, 2015). While this review was specifically focused on interventions for stress prevention, it highlighted an important area requiring further examination, that of the training of social workers within healthcare settings. Without adequate training for practicing within the realm of the managed care world, the stress level for social workers was found to increase (Hall & Keefe, 2000). With this increased stress, if social workers are unable to perform their job duties, they are at increased risk for burnout (Bandura, 1989; Cherniss, 1993). Social workers in hospitals can have difficult, demanding roles, with high caseloads, which can lead to increased stress and burnout. Role clarification can assist with helping social workers navigate these inherently challenging responsibilities as part of an interdisciplinary team.

According to the Bureau of Labor Statistics, almost all of the growth in social workers between 2004 and 2014 occurred in health care social work and projected growth in health care social workers was found to be higher than any other category of workers (19.3%) (Salsberg, Quigley, Mehfoud, Acquaviva, Wyche, & Silwa, 2017). In conjunction with this workforce growth, the social work profession has undergone steady growth in all educational programs, for BSW, MSW, and Ph.D. programs, with current number of accredited MSW programs standing at 255 (Council on Social Work Education [CSWE], 2017). With this growth comes the responsibility of adhering to the highest standards to serve patients in accordance with the guidelines afforded by the National Association of Social Workers (NASW) and in a professionally competent manner. However, the strides made by social work in growth in

number must be followed by the careful delineation of the boundaries of the profession to those who are both in the profession as well as to those outside of the profession (Williams & Vieyra, 2018). Educators posit that the continued success of social work depends on the ability to best define the profession to external audiences, including clarification about boundaries and practice areas (Williams & Vieyra (2018).

Importance of More Social Work Education

Ideal practice areas for hospital social workers have been identified by researchers. These areas include screening for high risk social problems (Rehr, Berkman & Rosenberg, 1980), suicide risk assessment (Wharff, Ross & Lambert, 2014), alcohol and drug screening (Duong, O'Sullivan, Satre, Soskin & Satterfield, 2016), problem identifiers in interdisciplinary team rounds (Murphy & Reddy, 2017), and mindfulness trainers (Garland, Baker, Larsen, Riquino, Priddy, Thomas, Hanley, Galbraith, Wanner & Nakamura, 2017). Recent literature showed social workers' role as that of providing support to family members of patients who were being resuscitated **(**Mureau-Haines, Boes-Rossi, Casperson, Çoruh, Furth, Haverland, & Shushan, 2017).

Other literature utilized retrospective case review methodology to document the reflections of social workers who participated on interdisciplinary teams (Maramaldi, Sobran, Scheck, Cusato, Lee, White & Cadet, 2014). This literature showed the function of social workers on interdisciplinary teams from 43 cases identified as the following: rapid 360-degree screening (from all available sources), psychosocial intervention, and placing referrals (Maramaldi, Sobran, Scheck, Cusato, Lee, White & Cadet, 2014). This finding was limited by the view from only the perspective of the social worker on the interdisciplinary team and specific to only one institution and authors acknowledged a future area of research could include the

views of other team participants such as nursing or physicians (Maramaldi, Sobran, Scheck, Cusato, Lee, White & Cadet, 2014). Another limitation acknowledged by the authors was the lack of feedback loop with others who were outside of the research panel, beyond the single institution where the study occurred (Maramaldi, Sobran, Scheck, Cusato, Lee, White & Cadet, 2014).

The authors of one paper recommended greater integration of practicum and classroom for social workers in health care (Volland, Berkman, Phillips, & Stein, 2003). These authors argue for advanced training with health specific content into the MSW curriculum. This is because the social worker in the academic medical system is involved in a complex system with ever changing authority and communication**.**

Recent research showed the need for further inquiry with a more robust research methodology to address the early learning and perceived professional development needs of social workers in health care (Nicholas, Jones, McPherson, Hilsen, Moran & Mielke, 2019). This study included 24 groups of social workers within health care settings as they identified core competencies such as core knowledge base, understanding practice implications in health care, confidence working under conditions of sparse supervision, skills necessary for working as part of a multidisciplinary team, understanding power dynamics, accountability and commitment to personal professional development, reflectiveness on practice, and understanding of the broader organization's drive towards building capacity (Nicholas, Jones, McPherson, Hilsen, Moran & Mielke, 2019).

One narrative review on the theoretical underpinnings of social work skills showed lack of holistic biopsychosocial assessment underlying skills and this type of assessment is a basic foundation in social work skill sets (Karpetis, 2017). This study identified the lack of clearly

stated theoretical perspectives in social work learning and highlighted that there was also lack of elaboration on the operationalization of skills to practice (Karpetis, 2017). The conclusion of this narrative review was that there is a need for more qualitative case studies exploring how social work techniques, with underlying theories, inform social work assessments and interventions due to the gap in knowledge (Karpetis, 2017). This knowledge gap presented an area of focus for researching the views of practitioners as they practice in urban and rural hospitals.

Other recent research from a nationwide survey of social work graduates indicated that of those MSW's with the main focus of their job in the health care setting, over 50% plan to work in a hospital setting (Salsberg, Quigley, Mehfoud, Acquaviva, Wyche, & Silwa, 2018). This research does not specify whether the hospital is urban or rural. More detailed analysis is needed to ascertain the numbers of social workers specifically entering the rural hospital setting. This proposal is well-positioned to identify the numbers of social workers who are placed in rural vs. urban hospital settings, and their feeling of preparedness for those roles in each setting.

Social workers in academic medical centers were found to need advanced training specific to disease lines, treatment and prognosis, course of illness and survival rates (Berkman, Bonander, Kemler, Rubinger, Rutchick & Silverman, 1996). There is a gap between advanced practice needs and MSW education that needs focus. This education could be integrated into the curriculum, on the job training, or workshops. More questions than answers were found in a related study that was designed to examine the clinical base utilized by social workers in health settings (Carlton, Falck & Berkman, 1985). This same study raised questions about the preparation for social workers in health care as their practice was determined to be more of an individualistic approach, which is less consistent with social work philosophy of defining the person as a social being (Carlton, Falck & Berkman, 1985). Further questions arising from this

research were those of whether the social workers had been taught the essential elements of social work for the integration of social work in medical settings.

Having more social work knowledge of the role within the interdisciplinary team is vital to the future of social work in acute care hospitals. If roles are not clearly defined, they will be left to interpretation, both by individualistic approach and by other professionals who have previously had their team roles defined. With managed care changes and more focused efforts on cost reduction with the healthcare world today, if roles lack definition, this is an additional stressor, which can increase risk of burnout (Bandura, 1989; Cherniss, 1993; Hall & Keefe, 2000). Despite commonality within social work roles, there is reason to believe roles of social work differ between urban and rural settings.

Urban and Rural Settings

For the purpose of this study, rural has been defined as the opposite of what is considered urban. The definition of urban according to the U.S. Census Bureau is an urbanized area (UAs) of 50,000 or more people; urban clusters (UCs) of at least 2,500 and less than 50,000 people (U.S. Census Bureau, 2019). According to the 2010 Census, 59.5 million people, comprising 19.3% of the population, were considered as living in rural areas (U.S. Census Bureau, 2019).

The role of social workers has been explored in rural settings from the viewpoint of the physician and the social worker Egan and Kadushin (2008). In this study, the sample design consisted of surveys being sent to individual physicians and social workers from a registry of Iowa Hospital Director's Society. The results showed that both physicians and social workers thought social workers performed discharge planning better than RN's. Conclusions were that social workers need to work with perfecting this aspect of the profession as it is recognized and

valued by physicians. Other results from this publication showed that an emerging area of focus is that of coordination of community-based services.

Specific to rural patients, research has shown that older female patients from rural areas tend to be more impoverished and have less education than their urban counterparts (Sherr and Blumhardt, 2002). However, these women surprisingly did not perceive themselves as being poor, when compared to their parents. As many of these older women in rural areas did not work, upon losing their spouse, the need for accommodation was found to be greater than that of their urban counterparts. These older women were in poorer health with more chronic diseases as compared to their urban counterparts, thus having more risk for poor health outcomes. It was recommended these rural women stay functionally integrated into their social networks for informal support and rely less on urban agencies for support since the urban health care infra-structure was considered costly and ineffective for assisting rural older women (Barnes & Bern-King, 1999). It is thought that informal support systems provide women in rural areas with a sense of empowerment as the women may be able to remain in their homes longer with the increased support available. Social workers consider these support needs when placing patient's with home health agencies, skilled nursing facilities, and hospice agencies.

Further study of rural states gathered information from NASW members from eight rural states in a national random cross-sectional sample design (Mackie, 2007) The sample size was n=1665. There were individual and group interviews of social workers in rural settings. The outcomes suggested that there are implications for social worker's being placed in urban settings. First social workers need to be strategically placed in urban settings based on their background and matching with community needs. Secondly, it had been suggested to identify the term

"urban social work" and then develop curriculum specific to these social workers. Thirdly, evaluation was found necessary for effective recruitment of social workers to rural areas.

Other research consisting of a systematic literature review on the recruitment, job satisfaction, burnout and turnover of rural social workers showed that most rural social workers utilized a generalist approach when providing services to patients due to limited community resources (Brown, Walters, Jones, & Akinsola (2017). This study along with a subsequent study also found that rural living tended to produce social workers who stayed local after graduation and rural social workers also had the highest degree of intention to leave their employment, especially if they were employed as child welfare workers (Brown, Walters, Jones, & Akinsola, 2017; Walters, Jones, & Brown, 2019). Conclusions from this study were to develop technology to assist with paperwork as this is a cumbersome task in social worker roles, and also to advocate for salary increases for all social workers as social workers were found to be underpaid compared to other fields that require master's degrees (Brown, Walters, Jones, &Akinsola (2017).

An exploratory study was conducted to address effectiveness of lay health workers (LHW) (Caradelli, Horsley, Ray, Maggard, Schilling, Weatherford, Feltner & Gilliam, 2017). LHW were dedicated to care transition efforts for a rural population in Kentucky. Results showed a decrease in odds of readmission if patients were seen by the LHW, and therefore the importance of addressing social factors of a patient's life when providing patient centered care.

Differences in Hospitals

According to the annual survey conducted by the American Hospital Association (AHA)(2019), there are 6210 registered hospitals in the United States. Of these hospitals, there are 5262 community hospitals (defined as non-federal short term general and other special

hospitals (obstetrics and gynecology, rehabilitation, orthopedic, and other individually described services) and academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals), with 1875 being classified as rural community hospitals (AHA, 2019). Results from a stratified random sample of approximately 10,000 licensed social workers in the U.S. conducted in 2004, showed that 85% of social workers within health care practiced in urban settings (NASW, 2009).

Differences in Rural and Urban Health

According to population health researchers, rural residents were found to have more prevalence of smoking, less exercise, less nutritional diets, and were more likely to be obese than their suburban counterparts (Hartley, 2004). A cross-sectional, comparative, and descriptive design sample of 566 urban, 49 large, 18 small, and 9 isolated hospitals from California, Florida, and Pennsylvania underscored the need for more rural health policies to allocate nursing resources to these areas that are under-resourced, with more chronic diseases and poorer health outcomes compared to their urban counterparts

Differences in Social Work Practice Between Urban and Rural Settings

Rural communities face specific challenges compared to urban counterparts: poverty (United States Department of Agriculture [USDA], 2018), limited healthcare access (Health Resources and Services Administration, 2017; Rural Health Information Hub, 2017); physical and mental health disparities **(**Befort, Nazir, & Perri, 2012**;** Dawson, 2017), along with reduced educational resources (Showalter, Johnson, Klein, & Hartman, 2017); less transportation options (Young Pistella, Bonati., & Mihalic, 2000), and those social workers who live within the same small community in which they practice, may attend church, interact in multiple roles with the local school (as parent and social worker), shop at the same stores, or even have multiple

relatives in common with patients (Humble, Lewis, Scott, & Herzog, 2013). Rural social work practice brings ethical challenges, especially regarding confidentiality and dual relationships within the confines of rural towns as the roles of professional and resident overlap in rural areas. (Humble, Lewis, Scott, & Herzog, 2013; Young Pistella., Bonati., & Mihalic, 2000). Rural social workers also often perform their jobs in isolation, using a generalist perspective, and there are limited coworkers for support and face-to-face supervision (Humble, Lewis, Scott, & Herzog, 2013). Thus, rural social workers take on multiple roles such as group workers, community organizers, researchers and administrators as they are likely the only social worker within a 100-mile radius (Humble, Lewis, Scott, & Herzog, 2013; Young Pistella., Bonati., & Mihalic, 2000).

Review results indicated sparse literature in this category. One quasi experimental study focused on a lay health worker model for addressing social needs and reducing readmissions for high risk patients (Cardarelli, Horsley, Ray, Maggard, Schilling, Weatherford, Feltner & Gilliam, 2018). One national random sample cross-sectional survey measured demographic and educational differences between rural and urban social workers (Mackie, 2007). Another article contained a literature review about rural social work recruitment, job satisfaction and burnout (Brown, Walters, Jones & Akinsola, 2017). Two articles contained exploratory descriptive studies of various professional's views of differences between urban and rural social workers (Egan & Kadushin, 1997; Waldrop & Kirkendall, 2010). One finding included the application of human behavior theory to the trends in social work education for the population of rural elderly women (Sherr & Blumhardt, 2002). The final article included a survey of patients who attended rural health clinics, with no outcome measures surveyed (Nanjunda, 2009).

Due to these differences between urban and rural hospital settings and the social worker role within these hospitals it is important to examine the factors that comprise this phenomenon

more thoroughly. Closer examination of the contributing factors comprising the role of social workers within both rural and urban hospital settings will offer insight from the viewpoint of those who work closely with patients and have an in-depth view of this area. Viewing this area from the lens of those who deliver care will provide a basis for guiding future educational efforts of social workers especially if rural settings remain challenged by limited access, resources, and transportation.

Discussion

Further study is needed from the unique perspective of the social workers who are employed in hospital settings. This view from the lens of the social workers within the acute care hospital settings would provide a unique perspective from the "inside" that has been only briefly viewed by a qualitative study (Craig & Muskat, 2013) and a doctoral dissertation (Brazg, 2018). In the qualitative study, the participants articulated that although they were still doing the jobs of advocate, counselor and resource provider, they were not trained for the work required within the hospital setting and asked for further coursework in their educational preparation for the role of inpatient social worker. Recommendations from this study were to focus on the structure of the work provided by hospital social workers and identify common elements of the practice especially since the work involves interaction with vulnerable populations within an ever-changing health care delivery system (Craig & Muskat, 2013). Even the most current NASW standards speak only to general health social work (NASW, 2016). Another similar study of the interprofessional identity of social workers examined a small sample (n=20) of social workers within the Pacific Northwest region of the U.S. (Brazg, 2018). This study was a small sample size, thus reducing the power of the study in correctly rejecting the false null hypothesis (Keith, 2015). One of the themes identified was role ambiguity and this topic is one that needs further

exploration from the viewpoint of social workers, including health indicator as the work can be emotionally taxing (Beemsterboer & Baum, 1984; Borland, 1981; Mor & Laliberte, 1984; Taylor-Brown, Johnson, Hunter & Rockowitz, 1982).

The views from those in the field will provide a unique approach to determining whether social workers feel prepared for the job tasks and explores whether there are differences between rural and urban hospital social worker roles, providing implications for future social work education in the U.S. There is also recent research that showed the Deans' of Colleges of Social Work throughout the U.S. felt unprepared for implementing integrated healthcare into the Social Work curriculum (Held, Mallory, Cummings, 2017). This topic is timely and significant because of the large number of social workers going into health fields will outpace all other social worker fields by the year 2026 (Bureau of Labor Statistics, 2016).

Early studies had shown no in-depth examination of social worker's own vulnerability when dealing with emotionally taxing areas of life and death in health care settings (Beemsterboer & Baum, 1984; Borland, 1981; Mor & Laliberte, 1984; Taylor-Brown, Johnson, Hunter & Rockowitz, 1982). A recent systematic review of rural social workers showed that there were challenges to social work practice, especially in rural settings and some of these challenges were identified as those of knowing community members who came in for treatment, lack of agencies to which to refer clients, and less job satisfaction which has been linked to burnout (Brown, Walters, Jones & Akinsola, 2017). Further, there are challenges for social workers that have been identified in urban settings. These challenges relate to lack of educational preparation, collaboration as part of an interdisciplinary team, and identifying as a professional social worker (Ambrose-Miller & Ashcroft, 2016; Carlton, Falck & Berkman, 1985; Farmer, 2017).

Limitations

Limitations were found during the design and data collection of this systematic review. First, the inclusion criteria in the study design were U.S. studies exclusively, so this precluded examination of studies completed in other countries that may have captured role perceptions of those in the field. However, evidence indicated that the health systems of other countries were quite varied from the U.S. health system, and therefore the social work role could be influenced by the various political and health care arenas. Secondly, recruitment efforts were specifically aimed at acute care hospitals in an effort to narrow the study focus and even the field across all social work roles within this setting. The hospitals in the systematic review vary in size and location and the role of social workers may be influenced by size and location of the entity for which they work, thus the results may not be generalizable across all hospital social work roles.

Future Implications

One of the implications from this systematic review is that although a general knowledge base exists for social workers within health care settings, literature is limited on the preparation for the specific role of the social worker within acute care hospital settings. Researchers must further identify both the specific knowledge base for acute care hospital social work and the preparation needed for this acute care hospital role. Further study is needed to examine factors that contribute to social worker competency for work in acute care hospital settings, as well as health and well-being of the social workers in these roles. Along with this future study, an exploration of the level of preparedness experienced by acute care hospital social workers, via a uniquely designed qualitative survey, a health scale, general mental health scale, and burnout measure, could be used to inform future social work education and preparation. Other future

areas of study could be the exploration of social work roles with specific populations, especially interdisciplinary teams who work with older adults.

More opportunities are needed for practice on interdisciplinary teams prior to entering the hospital work setting. These opportunities could be provided as part of the general MSW curriculum, as part of their chosen practicum, or in a separate track within the MSW program. Other avenues for training could be considered for medical based interdisciplinary teams such as offering certificate programs within the university setting. For example, a Certificate such as Interdisciplinary Specialization in Aging at The Ohio State University provides a practice environment within the medical center setting. Programs such as this specialization allow students who are interested in medical social work an opportunity to gain experience as part of an interdisciplinary team prior to employment within the medical setting.

Social work is often emotionally demanding, because the patient's with which engagement occurs are often those who have experienced trauma and are in crisis (Newell & MacNeil, 2010). Since part of the job of social work is to delve into personal histories of patients and families in order to truly understand their experiences, social workers might endure feelings of unrest and secondary trauma, burnout and employee turnover (Conrad & Kellar-Guenther, 2006; Dagan, Ben-Porat, & Itzhaky, 2016; Middleton & Potter, 2015; Wagaman, Geiger, Shockley, & Segal, 2015). As human beings with feelings social workers might struggle to observe and process the feelings associated with the trauma, loss and grief experienced by patients. However, to be helpful to patients, social workers must manage emotions and maintain a position of neutrality while being emotionally healthy in order to be provide optimum social work services. Studies have shown that stress affects providers as well as reduces efficacy of service delivery (Collings & Murray, 1996; Grise-Owens et al., 2016; National Association of

Social Workers [NASW], 2008; Smullens, 2015). Examining the skills needed for the inpatient social worker to remain emotionally healthy and offset burnout could help inform future education (Cohen & Gagin, 2005).

Conclusion

This systematic review of the literature was completed to provide insight and synthesize the exiting literature on the role of social workers within acute care hospital settings in the U.S. The most pertinent finding is that even today there is still a lack of role definition, particularly regarding interdisciplinary team participation and rural hospital social work, although social workers have been performing their roles in acute care hospitals since the early 1900's. Furthermore, this systematic review identified quantitatively more articles on the urban setting role of social work as compared to those in the rural setting. This systematic review identified a gap in the research area pertaining to the role definition of social workers in urban settings and an even larger gap in research for the role in rural settings. This lack of evidence provides opportunity for study from the lens of social workers in the urban and rural acute care hospital settings. The risk of not identifying these roles is that the roles could potentially be determined by those outside of the social work field, having values different than those in the Code of Ethics for Social Workers. The systematic review is consistent with the hypothesis of the author that social workers are not being adequately trained to work within these high-pressure discharge environments, with inadequate knowledge for assisting patients and families as little knowledge is taught in MSW curriculums specific to roles in acute care hospital settings, along with challenges found in practicum settings. Though limited, the majority of the knowledge base within U.S. MSW programs was pertinent to the role of urban social workers. A future study could include a review of course content for analysis of hospital-specific content related to social

worker preparation for health settings, specifically hospitals in urban versus rural settings. Future empirical research is needed for the knowledge base and preparation for acute care hospital social workers.

The systematic review of the literature showed an emerging pattern of three themes in the data. Themes identified were grouped into three categories: (1) the history of social work with a focus on the knowledge base; (2) the importance of the role of hospital social workers; and (3) the role of social workers in urban and rural hospital settings as part of an interprofessional team. From the systematic review, essential skills identified as necessary to work in this setting were having a basic orientation to the medical system, managing a loosely-structured client interview process, providing rapid assessment and treatment, supporting patients and families who are processing grief and loss, and working with complex family systems. Further research is necessary to identify methods of preparing the future workforce of hospital social workers, particularly in rural settings and with the expected increase in health care social workers by 2026. The following research questions were generated from the results of the critical review of literature.

Study 2: Research Question 1 (RQ1). What level of self-efficacy do social workers' feel to work in a hospital setting, and how prepared do they feel to work as part of an interdisciplinary team in a hospital setting as a result of their MSW education?

Study 3: Research Question 1 (RQ1). Regarding comfort within the work climate, will the sum of the scores on a portion of a self-efficacy scale (HSWSE scale) positively correlate with the sum of the scores on the Comfort scale?

Research Question 2 (RQ2). Does a path model, shown in Figure 7, differ between urban and rural settings?

Research Question 3 (RQ3). What themes emerge from open-ended comments made by participants with respect to working in a hospital setting?

Chapter 2: Self-efficacy and Preparation

Introduction

Social workers have a long-standing history of addressing a range of patient needs (e.g., case management, emotional support, and discharge planning) in hospital settings. With more than 680,000 social workers employed in the U.S. (U.S. Bureau of Labor Statistics, 2018), with 6,210 U.S. hospitals (AHA, 2019), and 85% of social workers within health care practicing in urban hospital settings (NASW, 2009), it is important to examine the degree to which social workers feel prepared by their masters social work education to work in hospitals as part of an interdisciplinary team and their sense of self-efficacy working on the job.

There are currently 271 accredited master's social work programs and 26 master's programs in candidacy for accreditation through the Council on Social Work Education (CSWE) in the United States (CSWE, 2015a). Results from a critical literature review showed minimal content pertaining to hospital social work, in particular content concerning working on interdisciplinary teams. Only one small reference pertaining to hospital social work was found in the Specialized Practice Curricular Guide for Trauma-Informed Social Work Practice as part of the CSWE Educational Policy and Accreditation Standards (EPAS) (CSWE, 2015c). This reference consisted of an exercise on drawing a genogram and was designed for social workers themselves to recognize how their personal past trauma patterns influenced their professional development (CSWE, 2015c). The only other reference within this curriculum guide pertinent to hospital social work contained a question for small group discussion regarding interacting with a client who had been sexually assaulted and had presented to a hospital (CSWE, 2015c, p. 143). Although curricula in MSW programs were designed based on CSWE EPAS guidelines, these guidelines pertain only to the general knowledge base of social work, rather than to specifically

working in a hospital setting (CSWE, 2015c). There appears to be no formal content requirement through CSWE for training hospital social workers.

While MSW field placements may provide some training relevant for hospital social work, field placements often depend on availability of placement spots, so often students are not able to be placed in their first or second choice for required fieldwork hours. It is speculated that those students who desired hospital field placements and were placed in settings other than hospitals would not feel that they had been adequately prepared to work in a hospital setting. Further, social workers who secured employment in hospitals without this adequate training would lack the training needed, especially for working on interdisciplinary teams, thus creating a large learning curve on the job. They would feel unprepared for the roles they have to fill in a hospital setting, especially working as part of an interdisciplinary team.

My hypothesis is that MSW graduates feel largely unprepared to work in hospital settings as part of interdisciplinary teams. My experience has consisted of working as a social worker in an acute care hospital setting with interdisciplinary teams, and this experience suggested that the training for social workers in general may not be adequate for working in this hospital setting. These views have been echoed by others in the social work literature (Brazg, 2018; Craig & Muscat, 2013; Judd & Sheffield, 2010; Kahn, 1974; Rehr & Rosenberg, 1977; Williams & Vieyra, 2018). Therefore this study investigated the extent to which masters level social workers who are working in hospitals 1) felt adequately prepared by their social work education for their role as part of an interdisciplinary team, and 2) the degree of self-efficacy they have felt on the job. Specifically, this research examined the level of self-efficacy felt by social workers in a hospital setting as demonstrated by their responses on the Health and Social Work Self-Efficacy (HSWSE) scale, and the degree to which social workers felt prepared to work as part of an

interdisciplinary team in a hospital setting as indicated by their scores on a scale uniquely designed by the author, similar to the HSWSE scale, to measure the extent to which they felt prepared to work in a hospital setting as part of an interdisciplinary team by their MSW education. This is a scale the author refers to as the Preparedness Scale.

Methods

Sampling.

The sample size goal was approximately 200 responses. The target population was all social workers within the United States with MSW degrees from CSWE accredited programs who were working in acute care hospital settings. The survey (see Appendix A) included a question about years of experience post MSW in acute care hospital settings. Per the Annual Statement by CSWE, 63,569 MSW students were enrolled as of 2017 in MSW CSWE accredited programs in the United States (CSWE, 2018).

Scores on these scales were obtained using social media avenues. Using data from the National Association of Social Workers (NASW) and state licensing boards in order to create a sampling frame was cost prohibitive as there were fees associated with obtaining names of social workers. Recruitment efforts were centered around social media, including Facebook, Reddit, and Twitter as recruitment from rural areas has historically been challenging (Brown, Walters, Jones, & Akinsola,2017; Dusek, Yurova, & Ruppel, 2015). Recruitment efforts were completed over a 30-day time frame as there exists a precedent for this time frame (Walters, Jones, Brown, 2019). Two reminder emails were sent along with the survey link during the recruitment phase of the study. The author's personal social media accounts were utilized to share links with potential participants. Previous studies have utilized social media platforms for participant recruitment with sample sizes close to 200 (Walters, Jones, & Brown, 2019). Extending the recruitment time

was expected to garner more participants. The Qualtrics survey estimated time to complete the survey was approximately 15-20 minutes.

Participants were given the opportunity to consent to an online survey and then proceeded with answering questions regarding their preparation for the social work role. No incentive or compensation was provided for participation in the survey. The informed consent was attached to the survey. The survey was provided to participants via Qualtrics. Once the participants read and checked the box consenting to the survey, participants were provided a link to the survey. Qualtrics was set to collect responses anonymously so participants identifying information could not be identified through the survey process.

Measures.

Hospital Social Work Self-Efficacy Scale (HSWSE).

This scale consisted of 39 items with item scores ranging from 1 (Not at all confident) to 9 (Totally confident) (Appendix). The range of total scores on this scale could range from 39 to 351, with higher scores indicative of higher levels of confidence and self-efficacy. Questions pertained to participants' confidence level in their ability to perform specific hospital social work tasks (Holden, 2017). For example, item 1 on this scale asks, "How confident are you that you can work successfully with the following groups in a hospital setting?: Children with medical illness."

This scale was developed by Dr. Gary Holden in 1996. Initial questions (1-19) were related to how confident the participants felt when working with various groups in a hospital setting. The next set of questions (20-21) related to how confident the participants felt regarding successfully writing chart notes and psychosocial histories. The next set of questions (22-28) queried the participants' level of confidence as they worked with other hospital social workers,

supervisors, administrators, non-social work administrators, clerical staff, nurses, and physicians. The next set of questions (29-39) related to participants' level of confidence with keeping abreast of the following: current hospital policy, aftercare resources for patients, and insurance benefit information.

The final set of questions pertain to the confidence level of the participant regarding successfully managing the following: stress of a fast-paced work environment, feelings regarding working in a bureaucracy, working with patients who are in extreme pain, working with patients who die, and managing feelings when they may be blamed by patients or families for things going wrong.

For evidence of convergent validity, the scores on the HSWSE were compared to scores on the Social Worker Empowerment Scale (SWE), a 34-item self-report measure with five subscales that collectively measure the topic of empowerment (Franks, 1993). Researchers have posited Cronbach's alpha was an average of .80 or greater for HSWSE subscales showing evidence of convergent validity (Holden, Cuzzi, Spitzer, Rutter, Chernack, & Rosenberg, 2009). The HSWSE is the second version of a scale that was initially provided to social work students to measure general self-efficacy (Cuzzi, 1997; Holden, Cuzzi, Rutter, Chernack, & Rosenberg, 1997; Sherer & Adams, 1983; Sherer, Maddux, Mercandante, Prentice-Dunn, Jacobs, & Rogers, 1982). The HSWSE scale is considered public domain.

Preparedness Scale.

A second measure used in this study was one designed by the author. This uniquely designed scale was an altered version of the HSWSE scale in which the word "preparation" was substituted for the word "confidence" in each item. For example, rather than "How confident are you that you can work successfully with the following groups" the word "prepared" was

substituted for "confidence." Thus, for example, item 1 read as, "Specifically considering your knowledge from your MSW curriculum classroom learning, bookwork, how adequately prepared do you feel to successfully work with the following groups in a hospital setting?: - Children with medical illness." This scale was developed after obtaining permission from Dr. Gary Holden, the developer of the HSWSE scale. The word prepared was substituted as a means to ascertain how prepared participants felt by their formal education and practicum experience to work in hospital social work roles. The goal was to query the participants' specifically about their education and practicum as it prepared them for hospital social work on an interdisciplinary team.

As with the HSWSE scale, item scores on this scale could range from 1 to 9, with the same word anchors for numerical item scores as on the HSWSE scale. As with the HSWSE Scale, higher scores on the Preparedness Scale indicated higher levels of felt preparedness, and lower scores lesser levels of felt preparedness.

Data Analysis

Data were analyzed using the SPSS descriptive statistics routine. A missing data analysis was completed and missing values imputed using the EM method in SPSS. Little's MCAR test was used to determine if data were missing completely at random. A non-parametric One-Sample Kolmogrov-Smirnov Test was completed to assess normality of the distributions of HSWSE and Preparedness Scale scores. Correlations were run between HSWSE scores and Preparedness Scale scores.

Results

Demographics

Participants ages ranged between 24 and 67, with a mean age of 24 (SD = 10.8) and 89% of the sample was female. The number of years participants reported in their social work roles ranged from 1 year to 20 years, with a mean of 8.75 years (SD = 7.0). The responses showed that 19% had 20 or more years in their current social work role, 17% had 1 year, 10% had 2 years, and the remaining 54% had 3 to 19 service years. The majority of respondents had attended only in-person programs (80%), with 7% attending fully online programs, and 13% attending a combination of in-person and online programming. Respondents identified their practice focus as clinical (60%), community organization (9%), older adults (6%), school social work (3%), administrative (3%), and other (19%).

Respondents identified their practice foci in multiple areas such as hospital inpatient (56%), outpatient healthcare (30%), inpatient mental health (5%), outpatient mental health (16%), children (14%), adolescents (6%), older adults (17%), substance abuse (7%), skilled nursing facility (10%), research organization (4%), and higher education institution (5%). Participants reported that they had a prior history of mental health concerns all of the time (6%), most of the time (13%), some of the time (15%), a little of the time (36%), and none of the time (30%).

Reliabilities of Scores.

The reliability (Cronbach's Alpha) of the scores on the HSWSE scale was .91. The reliability of the scores on the Preparedness scale was .97.

Missing Data.

Table 1 below shows the missing data values for scores on the two scales.

Missing values were imputed using the Expectation Maximization (EM) algorithm in SPSS. Results of Little's MCAR test were, χ^2 (22) = 22.02, p > .05. This result was consistent with data missing completely at random.

Results for Research Questions.

***Study 2 Research Question One (RQ1*).** What level of self-efficacy did social workers' feel to work in a hospital setting as demonstrated in responses on the Hospital Social Work Self-Efficacy (HSWSE) scale and a uniquely designed scale (Preparedness) similar to the HSWSE scale?

The general level of confidence was indicated by the mean score on the HSWSE scale. The mean total score was 262.8 (SD = 30.8), 95% CI (256.0, 269.6). The distribution of HSWSE scores is shown in Figure 5.

The mean item score was 7.3, 95% CI (7.1, 7.5), indicating that respondents felt slightly more than moderately confident in dealing with various workplace scenarios. Quartile scores on HSWSE Scale were the following: 25th: 239; 50th: 265; and 75th: 287.

The mean preparedness total score was 203.5 (SD = 57.3), 95% CI (190.8, 216.2). The mean Preparedness item score was 5.5, 95% CI (5.2, 5.8). The distribution of Preparedness scores is shown in Figure 6.

Quartile scores on the Preparedness Scale were the following: 25th: 165.5; 50th: 203.5; and 75th: 239. These findings suggested respondents felt moderately prepared by their MSW training for the hospital roles in which they worked.

One hypothesis was that there would be a positive correlation between HSWSE and

Table 1. Table of Missing Data Values

Scale	Number Valid Responses (N)	Mean	Missing Count	Percent Missing Data	Standard Deviation
HSWSE	74	262.74	14	15.9	31.97
Preparedness	72	106.53	16	18.2	35.04
Years Exp	80	8.75	1	1.2	7.04

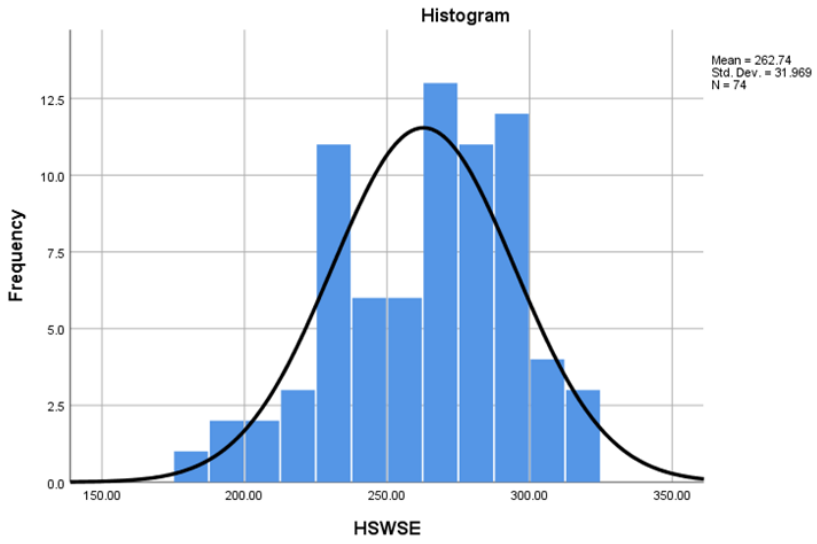

Figure 5. HSWSE score frequency distribution.

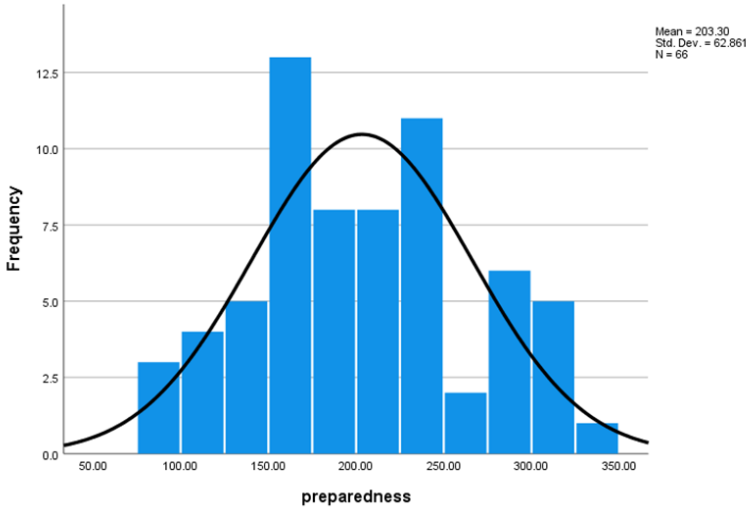

Figure 6. Preparedness score frequency distribution.

Preparedness scales. Thus, the correlation between the HSWSE scale scores and the Preparedness scale scores was estimated. The correlation between these scores was +.50, $p < .001$. The correction for attenuation formula was used to correct this estimated correlation for unreliability. The estimated reliability for HSWSE scores was .91, and the estimated reliability for Preparedness scores was .97. The estimated dis-attenuated correlation was .53 (Lord & Novick, 1968). This was the estimated correlation with no random measurement error. The mean item score of 5.5 on the Preparedness Scale demonstrated that participants felt only moderately prepared for their hospital role, a result which was consistent with findings in the literature Brazg, 2018; Craig & Muscat, 2013; Judd & Sheffield, 2010; Kahn, 1974; Rehr & Rosenberg, 1977; Williams & Vieyra, 2018).

The results of one-sample Kolmogorov-Smirnov tests suggested the observed distribution of HSWSE scores and the observed distribution of Preparedness Scale scores were consistent with normality.

Conclusion Study 2

With regard to the self-efficacy scores on the HSWSE scale, social workers were slightly more than moderately confident working with various populations in a hospital setting. Through tasks such as case management for discharge planning and end of life support, social workers can experience challenging scenarios and at the same time influence the fiscal well-being of the hospital (Daly & Matzel, 2013, Fink-Samnick, 2019). With pressures to discharge expediently, it is imperative that social workers have the confidence and skills necessary to perform their job duties prior to entering the workplace, and scoring slightly more than moderately confident does not seem adequate to meet the demands of a busy interdisciplinary team. For example, one question on the HSWSE scale asked about comfort in managing feelings when patients have

died. Social workers need good coping strategies, along with confidence in managing a variety of populations. Scores of slightly more than moderately confident do not seem adequate enough for the challenges inherent in a hospital setting. More specific training might lead to scores on the HSWSE scale to be more in the range of "totally confident."

As hypothesized, the Preparedness scale demonstrated hospital social workers felt only moderately well prepared for their hospital roles. This finding, consistent with that of other researchers, suggests changes in MSW program content may need to be made to help better prepare social workers for hospital work.

Limitations

There was a large number of incomplete survey responses. There were 203 participants who opened the survey link but did not complete the survey. The response rate was only 29%, with 81 participants who chose to complete the survey. The sample is not a random sample, rather a unique sampling of those participants who chose to complete the survey. The small sample size and low response rate suggest this sample may be unique and not be representative of the target population. The strategy of sending survey links through social media networks may also have led to a unique sample.

Implications for Future Research

Further study is needed to examine factors that contribute to social workers' sense of competency for work in acute care hospital settings, as well as the health and well-being of the social workers in these roles. A study with a larger sample size should be a focus of future study, along with a more representative sample. Another important study would be an exploration of the level of preparedness experienced by acute care hospital social workers, via a uniquely designed qualitative survey, a health scale, general mental health scale, and burnout measure.

The results could be used to inform future social work education and preparation. Other future areas of study could be the exploration of social work roles with specific populations, especially interdisciplinary teams who work with older adults.

More opportunities are needed for training for and practice on working as part of an interdisciplinary team prior to entering the hospital work setting. These opportunities could be provided as part of the general MSW curriculum, as part of their chosen field experience, or in a separate track within the MSW program. Other avenues for training could be considered for medical based interdisciplinary teams such as offering certificate programs within the university setting. For example, a Certificate such as Interdisciplinary Specialization in Aging at The Ohio State University provides a practice environment within the medical center setting. Programs such as this specialization would allow students who are interested in medical social work an opportunity to gain experience as part of an interdisciplinary team prior to employment within the medical setting.

Chapter 3: Path Model and Qualitative Synthesis

Introduction

Social workers have a long-standing history of addressing a range of patient needs (eg, case management, emotional support, and discharge planning) in hospital settings. With more than 680,000 social workers employed in the U.S. (U.S. Bureau of Labor Statistics, 2018), with 6210 U.S. hospitals (AHA, 2019), and 85% of social workers within health care practicing in urban hospital settings (NASW, 2009), it is vital to examine the degree to which social workers feel prepared by their masters social work education to work in hospitals as part of an interdisciplinary team and their sense of self-efficacy working on the job. This study expanded on the previous study, study 2, to test a path model of the relationships between social worker preparation, professional self-efficacy, years of experience, and quality of life. This path model is shown in Figure 7.

I hypothesized that both preparation and experience on the job influence professional self-efficacy, and that professional self-efficacy affects quality of life. Examining quality of life is important, as higher quality of life and happier employees would be expected to remain in their jobs longer than those who were unhappy. It was expected that employees with lower quality of life scores may have higher job turnover rates.

My hypothesis in study 2 was that MSW graduates feel largely unprepared to work in hospital settings as part of interdisciplinary teams. My experience has consisted of working as a social worker in an acute care hospital setting with interdisciplinary teams, and this experience suggested that the training for social workers in general may not be adequate for working in this hospital setting. These views have been echoed by others in the social work literature (Brazg, 2018; Craig & Muscat, 2013; Judd & Sheffield, 2010; Kahn, 1974; Rehr & Rosenberg, 1977;

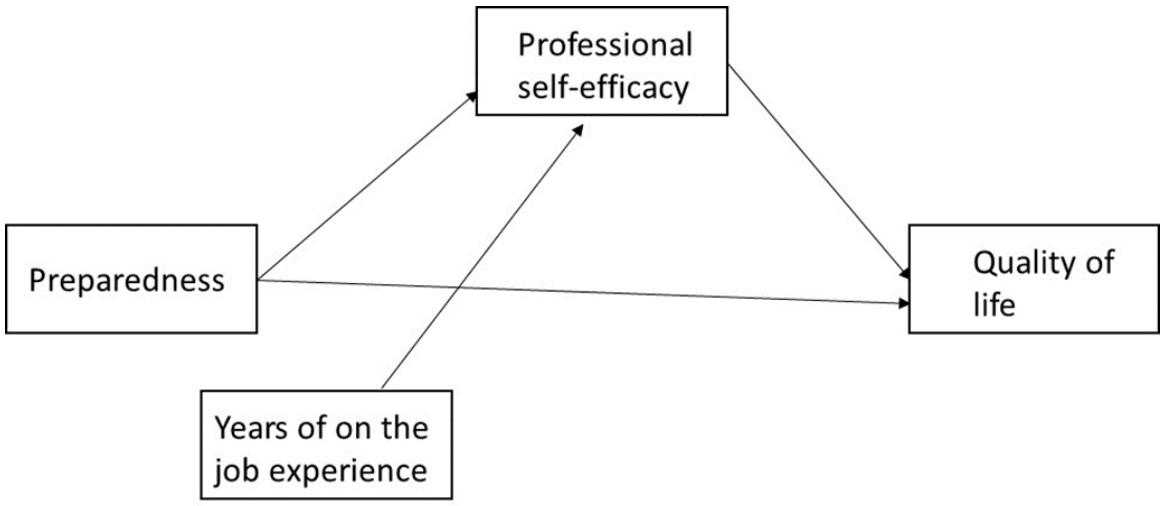

Figure 7. Path model tested.

Williams & Vieyra, 2018). I anticipate that as social workers actually work in a hospital setting and learn on the job, their professional sense of self-efficacy will increase. Then, as professional self-efficacy increases, quality of life will also increase.

Testing the path model above allowed for the comparison of the extent to which social workers sense of the degree to which they were prepared for their roles in a hospital setting and their on-the-job experience differentially affect their professional sense of self-efficacy. It was also conjectured that self-efficacy may fully or partially mediate the relationship between preparedness and quality of life. The goal was also to test the extent to which this path model may differ for social workers in urban and rural settings.

A final goal was to explore comments made by participants with respect to working in a hospital setting. The research objective of asking questions that were open-ended and qualitative in nature was to gain meaning from interpreting the underlying context. Further, these qualitative questions were utilized to seek a deeper understanding of the data as symbolic phenomena using an unobtrusive approach (Krippendorf, 1980, p. 7).

Methods

Sampling.

The sample size goal was approximately 200 responses. The target population was social workers within the United States with MSW degrees from CSWE accredited programs who were working in acute care hospital settings. The survey (see Appendix A) included a question about years of experience post MSW in acute care hospital settings. Per the Annual Statement by CSWE, 63,569 MSW students were enrolled as of 2017 in MSW CSWE accredited programs in the United States (CSWE, 2018).

Scores on these scales were obtained using social media avenues. Using data from the National Association of Social Workers (NASW) and state licensing boards was cost prohibitive as there were fees associated with obtaining names of graduating social workers. Recruitment efforts were centered around social media, including Facebook, Reddit, and Twitter as recruitment from rural areas has historically been challenging (Brown, Walters, Jones, & Akinsola,2017; Dusek, Yurova, & Ruppel, 2015). Recruitment efforts were completed over a 30-day time frame as there exists a precedent for this time frame (Walters, Jones, Brown, 2019). Two reminder emails were sent along with the survey link during the recruitment phase of the study. The author's personal social media accounts were utilized to share links with potential participants. Previous studies have utilized social media platforms for participant recruitment with sample sizes close to 200 (Walters, Jones, & Brown, 2019). Extending the recruitment time was expected to garner more participants. The Qualtrics survey estimated time to complete was approximately 15-20 minutes.

Participants were given the opportunity to consent to an online survey and then proceeded with answering questions regarding their preparation for the social work role. No incentive or compensation was provided for participation in the survey. The informed consent was attached to the survey. The survey was provided to participants via Qualtrics, an online survey platform. Once the participants read and checked the box consenting to the survey, participants were provided a link to the survey. Qualtrics was set to collect responses anonymously so participants identifying information could not be identified through the survey process.

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Measures.

Hospital Social Work Self-Efficacy Scale (HSWSE).

This scale consisted of 39 items with item scores ranging from 1 (Not at all confident) to 9 (Totally confident). The range of total scores on this scale can range from 39 to 351, with higher scores indicative of higher levels of confidence and self-efficacy. Questions pertained to

participants' confidence level in their ability to perform specific hospital social work tasks (Holden, 2017). For example, item 1 on this scale asks, "How confident are you that you can work successfully with the following groups in a hospital setting?: Children with medical illness."

This scale was developed by Dr. Gary Holden in 1996. Initial questions (1-19) were related to how confident the participants were when working with various groups in a hospital setting. The next set of questions (20-21) related to how confident the participants felt regarding successfully writing chart notes and psychosocial histories. The next set of questions (22-28) queried the participants' level of confidence as they worked with other hospital social workers, supervisors, administrators, non-social work administrators, clerical staff, nurses, and physicians. The next set of questions (29-39) related to participants' level of confidence with keeping abreast of the following: current hospital policy, aftercare resources for patients, insurance benefit information.

The final set of questions pertain to the confidence level of the participant regarding successfully managing the following: stress of a fast-paced work environment, feelings regarding working in a bureaucracy, working with patients who are in extreme pain, working with patients who die, managing feelings when they may be blamed by patients or families for things going wrong.

For evidence for convergent validity, the scores were compared to Social Worker Empowerment Scale (SWE), a 34-item self-report measure with five subscales that collectively measured the topic of empowerment (Franks, 1993). Researchers have posited Cronbach's alpha was an average of .80 or greater for HSWSE subscales showing evidence of convergent validity (Holden, Cuzzi, Spitzer, Rutter, Chernack, & Rosenberg, 2009). This scale is the second version

of a scale that was initially provided to social work students to measure general self-efficacy (Cuzzi, 1997; Holden, Cuzzi, Rutter, Chernack, & Rosenberg, 1997; Sherer & Adams, 1983; Sherer, Maddux, Mercandante, Prentice-Dunn, Jacobs, & Rogers, 1982). The HSWSE scale is considered public domain.

Comfort Scale.

A second measure used in this study was one designed by the author. This uniquely designed scale was an altered version of a section of the HSWSE scale in which the wording "comfortable" or "supported" was substituted for the word "confidence" in each subsection item. For example, rather than "How confident are you that you can work successfully with the following groups" the word "comfortable" was substituted for "confidence." Thus, item 19.2 read as, "I feel comfortable interacting with social work colleagues." This scale was developed after obtaining permission from Dr. Gary Holden, the developer of the HSWSE scale. The word comfortable or supported was substituted as a means to ascertain the degree to which participants felt comfortable or supported by their team members. The goal was to query the participants' specifically about their experience as part of their interdisciplinary team.

Items scores on the Comfort Scale were in Likert format and ranged from 0 to 4, with lower scores on this scale indicating higher levels of felt comfort or support, and lower scores higher levels of felt comfort or support. In the interests of ease of interpretation of the path analysis results below the item scores on this scale were reverse scored, so higher scores were indicative of higher levels of comfort and support and vice versa.

Preparedness Scale.

Another measure used in this study was one designed by the author. This uniquely designed scale was an altered version of the HSWSE scale in which the word "preparation" was

substituted for the word “confidence” in each item. For example, rather than “How confident are you that you can work successfully with the following groups” the word “prepared” was substituted for “confidence.” Thus, item 1 read as, “Specifically considering your knowledge from your MSW curriculum classroom learning, bookwork, how adequately prepared do you feel to successfully work with the following groups in a hospital setting?: - Children with medical illness.” This scale was developed after obtaining permission from Dr. Gary Holden, the developer of the HSWSE scale. The word prepared was substituted as a means to ascertain how prepared participants felt by their formal education and practicum experience to work in hospital social work roles. The goal was to query the participants’ thoughts specifically about their education and practicum as it prepared them for hospital social work on an interdisciplinary team.

As with the HSWSE scale, item scores on this scale could range from 1 to 9, with the same word anchors for numerical item scores as on the HSWSE scale. As with the HSWSE Scale, higher scores on this scale indicated higher levels of felt preparedness and lower scores levels of felt preparedness.

Quality of Life Scale.

The Quality of Life scale (QOL) was used to obtain the current level of satisfaction felt by participants regarding material, health, relationship, and work satisfaction, along with independence (Burckhardt & Anderson, 2003). This scale consisted of 16 items with item scores ranging from 1 (Delighted) to 7 (Terrible). The range of total scores on this scale could range from 112 to 16, with lower scores indicative of higher life satisfaction, and vice versa. Questions pertained to participants’ satisfaction with material, health, relationships, and independence (Holden, 2017). For example, item 1 on this scale asked, “Please read each item and circle the

number that best describes how satisfied you are at this time.: Material comforts, home, food, conveniences, financial security." In the interests of ease of interpretation of path coefficients, item scores on this scale were reverse scored so higher scores indicated higher levels of life satisfaction and vice versa.

The QOL scale was developed in 1975 by John Flanagan. This scale measured the extent that participants were satisfied with their close social relationships, material comforts, expressions of creativity, participation in organization, creative outlets, socializing, and participation in active recreation. (Burckhardt & Anderson, 2003). The scale contained 16 questions regarding physical and material well-being, relations with others, social and community activities, personal development, and recreation. This instrument was tested on a nationally representative sample of 3000 adults (Burckhardt, 1988).

The items are scored as the following: 7= Delighted, 6=Pleased, 5=Mostly Satisfied, 4=Mixed, 3=Mostly Dissatisfied, 2=Unhappy, 1=Terrible. The QOL scores were summed so that higher scores indicate higher quality of life. This scale demonstrated internal consistency with alpha =.82 to .92 and had high test-retest reliability over a time span of three weeks in chronic illness groups (r=.8=78 to r=.84) (Burckhardt, Woods, Schultz, Ziebarth, 1989). In the current study the reliability of QOL scores was .91. The QOL scale is considered public domain.

Open-Ended Response Questions

The final questions consisted of a uniquely designed set of open-ended questions developed by this author containing content specific to inpatient social workers. Questions in this scale pertained to supervisory experience, feeling respected by interdisciplinary team members, workload, practicum placement, clarity of directions from management, knowledge sharing, and peer support.

Data Analysis

Data was analyzed using SPSS descriptives. A missing data analysis was completed and missing values imputed using the EM method in SPSS. Little's MCAR test was conducted to determine if data were missing completely at random. A non-parametric One-Sample Kolmogrov-Smirnov Test was completed to assess normality of the distributions of HSWSE and Preparedness Scale scores. Correlations were run between a portion of HSWSE scores (Q10.1-Q10.6) and the Comfort Scale scores.

The path analysis was run using AMOS. Given the small number of rural cases (n = 8), the path model was fitted to the combined rural and urban data and no rural versus urban comparison was made.

For the qualitative data, content analysis was used as the qualitative research technique (Krippendorf, 1980). Data was read thoroughly and slowly. Categories of codes were defined as themes emerged from reading the data. As codes were derived from the data, conventional content analysis was employed (Hsieh & Shannon, 2005). Once responses were received, they were compiled into single pages for each qualitative question with the corresponding answers that were provided. Next, the transcripts were read thoroughly and slowly from beginning to end. Next the researcher highlighted text within the transcript that described an emotion. Keywords were written in the margin using the participants own words as much as possible. Codes were written next to the data and new codes were added when responses did not fit into previously written codes categories. After reading through the coded data, some of the codes were combined into one coded category and others were divided to make a new category. For example, a new category of 'Activism' was added to the existing categories as this category more accurately represented the participants' words.

Results

Demographics.

Participants ages ranged between 24 and 67, with the mean age of 24 (SD = 10.83) and 89% female. The number of years in participants social work role ranged from 1 year to 20 years, with a mean of 8.75 years (SD = 7.04). The responses showed that 19% had 20 or more years in their current social work role, 17% had 1 year, 10% had 2 years, and the remaining 54% had from 3 to 19 service years. The majority of respondents had attended only in-person programs (80%), with 7% attending fully online programs, and 13% attending a combination of in-person and online programming. Respondents identified their practice focus as clinical (60%), community organization (9%), older adults (6%), school social work (3%), administrative (3%), and other (19%). Respondents identified their practice focus in multiple areas such as hospital inpatient (56%), outpatient healthcare (30%), inpatient mental health (5%), outpatient mental health (16%), children (14%), adolescents (6%), older adults (17%), substance abuse (7%), skilled nursing facility (10%), research organization (4%), and higher education institution (5%). Participants shared that they had prior history of mental health concerns all of the time (6%), most of the time (13%), some of the time (15%), a little of the time (36%), and none of the time (30%).

Reliabilities of Scores.

The reliability (Cronbach's Alpha) of the scores on the HSWSE scale was .91. The reliability of the scores on the Preparedness scale was .97. The reliability of the scores on the QOL scale was .91. The reliability of scores on the Comfort scale was .64. The reliability of the scores on the portion of the HSWSE scale was .77.

Missing Data.

The table below shows the missing data values for the different scales (Table 2). Missing values were imputed using the Expectation Maximization (EM) algorithm in SPSS. Results of Little's MCAR test were χ^2 (22) = 22.02, p > .05. This result was consistent with data missing completely at random.

Study 3 Research Question One.

For this study research question one was: Will the sum of the scores from the uniquely designed scale (Comfort scale) (Q19.1-Q19.6) and a portion of the HSWSE scale (Q10.1-Q10.6) (Confidence) positively correlate? The Comfort scale presumably shows the comfort level experienced by hospital social workers when working and interacting with members of the interdisciplinary team. This is presumably a more tailored scale aimed at delving into the totality of the social workers experience on the interdisciplinary team. Further, the Comfort scale could be used for future research and to support answers from participants on the qualitative survey questions. Correlating the Comfort scale with a similarly worded portion of the HSWSE scale would be one method of demonstrating validity of the Comfort scale. The frequency distribution was calculated for Comfort scale scores (Figure 8). The Kolmogrov-Smirnov test suggested the observed distribution of Comfort scale scores were not consistent with normality.

The frequency distribution for a portion of the HSWSE scale was run (Figure 9). The Kolmogrov-Smirnov tests suggested the observed distribution of portion of HSWSE scale scores were not consistent with normality.

The correlation between the scores on the uniquely designed Work Comfort Scale, that is, the sum of scores Q19.1-Q19.6 in the survey, and the sum of scores on six items, Q10.1-Q10.6 from the HSWSE scale on the survey, was estimated (Appendix). The sum of scores from this

Table 2. Table of Missing Data Values for Study 3.

Scale	**Number Valid Responses (N)**	**Mean**	**Missing Count**	**Percent Missing Data**	**Standard Deviation**
HSWSE	74	262.74	14	15.9	31.97
QOL	73	42.36	15	17.0	12.65
Portion HSWSE	79	48.76	9	10.2	5.53
Comfort	73	12.33	15	17.0	3.45
Preparedness	72	106.53	16	18.2	35.04

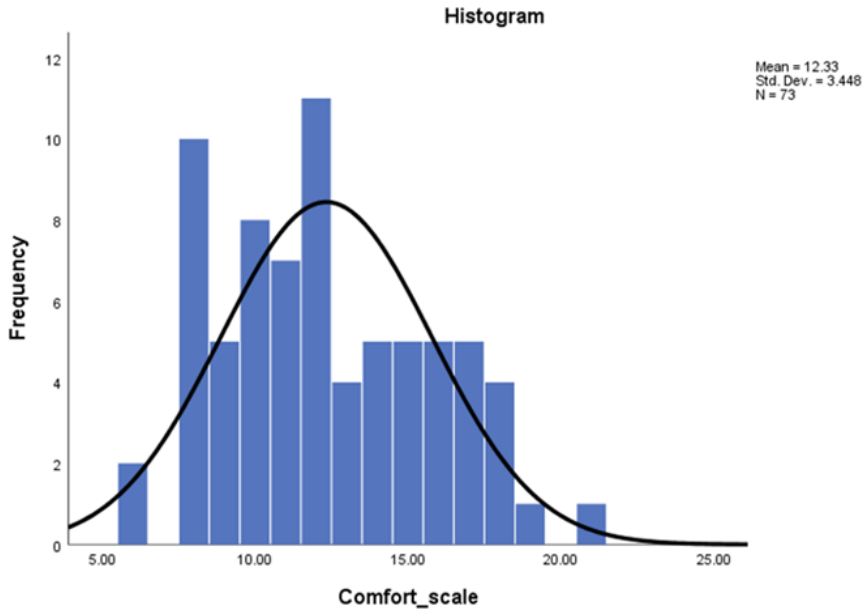

Figure 8. Comfort scale score frequency distribution

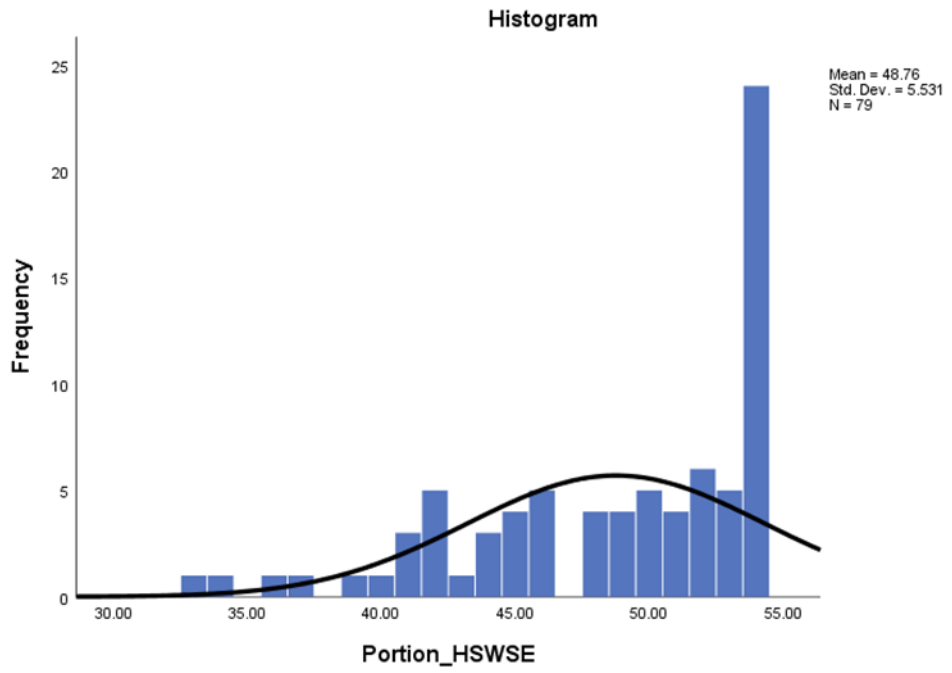

Figure 9. Portion HSWSE score frequency distribution

set of HSWSE item scores presumably indicated the participants' confidence level when working with other hospital social workers, supervisors, nurses, and physicians. This sum was compared to scores on the Comfort scale, which was designed to ascertain the support and comfort experienced by participants when interacting with managers, colleagues, and those on the interdisciplinary team. The estimated Pearson correlation was .26, $p < .05$. The estimated reliability for the section of the HSWSE scale was .77, and the estimated reliability for the unique work comfort scale was .64. The estimated dis-attenuated correlation was .37 (Lord & Novick, 1968).

Study 3 Research Question Two.

Research question two was: Does the path model differ between social workers in rural and urban settings in regard to preparation and education of social workers with respect to self-efficacy?

Due to the small number of respondents (n = 8) from rural hospital settings, the path model comparison between those in urban and rural settings could not be done. Therefore, the path analysis was conducted for the entire sample, with no comparison between those respondents in urban and rural settings. Results indicated the path from Preparedness to Quality of life was statistically non-significant, $b = .02$, $z = .99$, $p > .05$, and so this path was dropped from the model. This modified model tested whether HSWSE scores fully mediated the relationship between preparedness and quality of life. The Kolmogrov-Smirnov tests suggested the observed distribution of QOL scores were consistent with normality (Figure 10).

The fit indices for the modified full mediation model were $\chi^2(3) = 2.78$, $p > .05$; CFI = TLI =1.00; RMSEA < .001 (< .001, .18), $p = .51$; SRMR = .06 (Figure 11). These fit indices

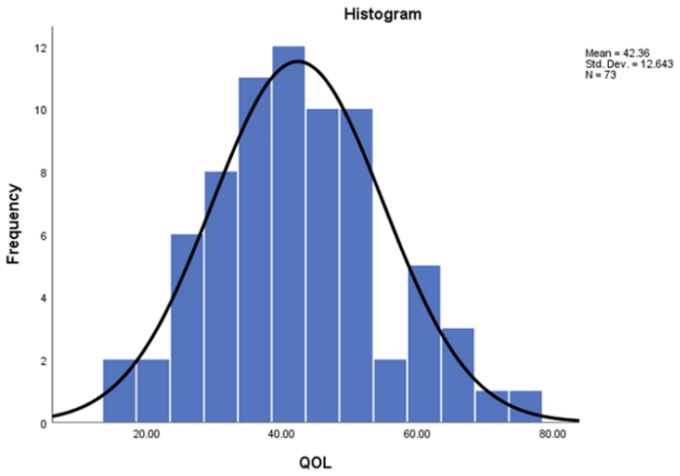

Figure 10. QOL score frequency distribution

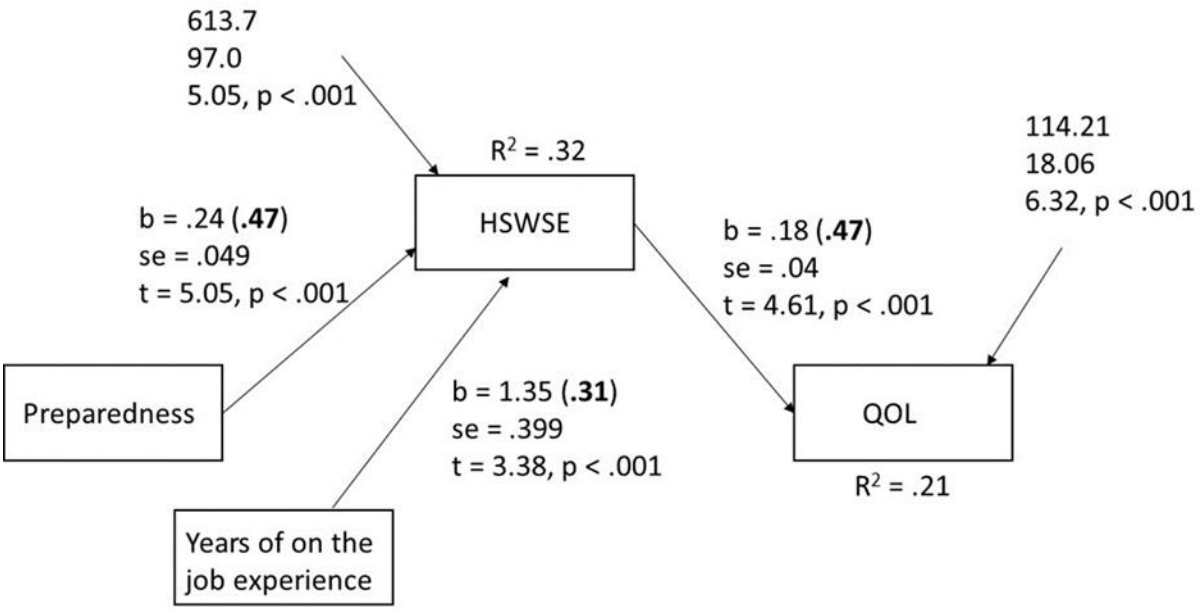

Figure 11. Modified Path Model. The numbers in bold font are standardized path coefficients.

converged to suggest a close-fitting model. The path coefficient for the relationship between preparedness and HSWSE was .24 (SE=.05, CR= 5.05, p < 001). The results show that the paths from preparedness to HSWSE, and from years of experience to HSWSE, were both positive and statistically significant. The standardized effect of preparedness on HSWSE was .47, while that for years of experience on HSWSE was .31, suggesting that social workers' sense of preparedness had a stronger effect on professional self-confidence than did their on-the-job experience. The results also showed professional self-efficacy had a positive effect on quality of life, as anticipated. This model showed professional self-efficacy fully mediated the relationship between preparedness and quality of life.

Limitations

There was a total of 284 respondents. Of this total, only 81 respondents completed all survey questions. Due to the number of people who failed to complete the survey, the survey responses may represent a special population and may be biased with respect to the target population. Results suggested self-selection bias for those who responded versus those who chose not to complete survey. The use of social media platforms for recruiting participants may also have introduced biases into the sample. Finally, the small sample size and small number of degrees of freedom for the path model indicate the results of the path model need to be interpreted with caution.

Study 3 Research Question Three.

Research question three was: What themes emerge from the open-ended comments made by participants with respect to working in a hospital setting?

Reasons for entering profession.

As there are currently 680,000 social workers employed in the U.S., with the anticipated growth of health care social workers expected to exceed 176,000 by 2026, it is important to ensure these social workers are well educated and are a good fit for their role as they will be working with vulnerable populations (U.S. Bureau of Labor Statistics, 2018). It is important that their "heart is in the right place" as patients and families place trust in hospital social workers as they discuss personal topics such as home discharge needs, family support or lack of, hospice and other life altering diagnosis and medical recommendations.

When asked about what prompted them to enter the social work profession (n=68), most participants (34%) reported they chose social work due to the desire to help others, as responses included "I like working with people," "I wanted to help others and found social work to be meaningful and seemed to [be] something that would fulfill me," "to care for others social needs," and "having a great sense of empathy and understanding real life situations and circumstances of others from all walks of life." Others expressed a desire to work as part of the social work field, but with specific populations of interest, such as "I liked working with older adults after volunteering in nursing home," "I wanted to help older adults," and "working with homeless."

Several participants (25%) voiced that personal interactions or experiences with other social workers brought them to enter the field. Among these personal reasons were "born to help," "personal relations to professional social workers," "diversity of the profession," "experience as a pregnant teen," "personal experience as a disabled person," and

> it was the best profession that would allow me to get to know people and their experiences and understand how people are influenced by their environments.
>
> I've come to learn that my own personal attributes are a great fit for the skills

required to build strong, therapeutic relationships with clients.

Those participants who were activism oriented (16%) were drawn to social work, stating it was important to them to be an "advocate for others," they were "passionate about helping others," and expressed a desire to "make a difference in the lives of others." Others (13%) were led to social work by their significant family experiences, such as having a "brother who was disabled," "a child who died of cancer," "death of a daughter, daughter with special needs," and "experienced trauma in childhood and a social worker 'saved' me." Some participants (6%) thought that the profession provided job security and voiced the following sentiments about being drawn to social work: "money," "numerous opportunities in different fields," and "professional growth." The remaining participants (6%) shared other reasons for choosing social work such as "other options didn't work out," "it was 20 years ago, I forget exactly why," and one who "didn't see how this question was relevant."

These various reasons provided for entering the social work field collectively appear to provide some sense of internal fulfillment and possible healing for the social workers' themselves, as they work with these vulnerable populations. Although there appears to be good internal motivation for choosing the profession, participants encountered/elucidated many barriers to owning their professional role in the hospital setting.

Barriers to owning the social work role.

Social workers in hospitals work alongside other professionals when caring for patients (Shoham, Harris, Mundt, & McGaghie, 2016), Clark (2014). An identified key gap in literature was the limited and dated current scales for measuring social worker understanding of their role in acute care hospital settings within this interdisciplinary team. Study results using the data from the HSWSE scale, showed the social workers' general level of confidence to be a mean item

score of 7.3, indicating that respondents felt slightly more than moderately confident in dealing with various workplace scenarios (item scale scores ranged 1-9). Due to this moderate degree of comfort when working with patients, families, and other professionals, it would appear that there were little, if any barriers to owning this role on the interdisciplinary team.

Looking further into the barriers encountered by social workers (n=72) in owning their role, there were several identified obstacles. Not only did they have to define the role with other disciplines (17%), a surprisingly large number of participants (31%) spoke of incivility in the workplace as one barrier. For example, one participant called the work environment "toxic" and others mentioned issues of “intimidation, rudeness, not being heard, disrespect, and being belittled.” Still others said that “working on an interdisciplinary team can be difficult, also being an ‘n’ of 1 versus 20 nurses or 10 doctors can seem difficult to navigate.” Others echoed this sentiment as they said that “nurses feel that social workers are unnecessary” and there were “interdisciplinary team members who overstep my SW expertise.”

The social work role is often ancillary to that of physicians and nurses and has been poorly defined across settings (Cannon, 1913; Cannon, 1949; Kaplan & Berkman, 2015; Praglin, 2007). This lack of clarity on the social work role as seen in the literature can create confusion for not only social workers but also for non-social work providers and even patients (Bywaters, 1986; Craig & Muscat, 2013; Judd & Sheffield, 2009). Consistent with the literature, some participants identified the barrier of having to define the role for other team members, including families. Sentiments expressed were that participants were “dealing with physician[s] that have a pre conceived notion of what social workers are good for,” “other disciplines not honoring patients right to make poor choices,” “nurses and others not understanding the differences in our roles, young nurses who are entitled.” Participants even spoke of hospital administration as

“pressuring” and lacking “understanding of the barriers and complexities of some patients’ situations.”

Despite the steady growth in all educational programs, for BSW, MSW, and Ph.D. programs, and with current number of accredited MSW programs standing at 255, (Council on Social Work Education [CSWE], 2017), the social work profession is said to still be in need of careful delineation of the boundaries of the profession to those who are external to the profession (Williams & Vieyra, 2018). The continued success of social work depends on the ability to best define the profession to external audiences, including defining boundaries and practice areas Williams & Vieyra, 2018).

Social worker participants also identified the barrier of lack of confidence (13%) in owning their role. They stated “my status as a recent graduate left me with some confidence issues when I entered my role. I am still learning to move past this and build confidence in my position and skills,” “learning to project confidence in my work, working with colleagues who had different work ethics than myself,” and “my own personal anxiety as a I struggled to develop my own professional identity. The lack of familiarity with the hospital setting made the adjustment to working in one much longer and stressful.” One participant identified this lack of confidence as “imposter syndrome” and another as “overcoming the phrase "you’re just a social worker."” Participants identified other barriers to owning their role as lack of knowledge of medical terminology and lack of training (7%) by voicing “medical terminology was foreign,” “learning basic skills such as medical knowledge,” and “there was no relationship between internship and coursework,” as well as stating that there was “minimal training due to low staffing.” Still others shared they felt a lack of supervisory support (6%) due to “inept leadership” and having a “horrible supervisor,” and “high workloads.” Others (10%) thought

"having to deal with supervisees" was challenging. A small group identified further barriers in owning the social work role to be "gaps in resources available to help patients" (4%) and "earning trust" and "building trust with coworkers." (3%). Only a few participants (7%) found no barriers to owning their social work role.

Need to define social work.

One might think role definition would be unnecessary to those who work side by side with a given profession. However, when participants were asked with whom (what other professions) they felt the need to define the profession, 71 participants responded. These respondents revealed the need to define the profession to nurses (38%) and physicians (29%) more than any other professions. Comments mentioned were "expecting social workers to be miracle workers," "even my own boss is a nurse by trade and doesn't seem to understand the importance of social work and constantly feeling like I have to defend my profession," and "leadership too----no one on leadership is a social worker." Social workers even defined their role (18%) to other coworkers, including chaplains and "everyone." Comments included that they defined their role with "everyone other than social workers" and "thought it's more about level of education than individual discipline at work."

"A few respondents (6%) shared that they even defined the profession to families of patients as well as to their best friends. Smaller groups of participants defined the profession to management (3%). Surprisingly, some social workers (3%) even defined the role to other social workers, stating

> Mostly with other SW especially in the medical field. I am caseworker so I don't "counsel " clients, I discharge them. I am not a "bleeding heart." I am an educator. I offer choice.

Only a small group (3%) said they did not need to define the role to anyone. Of the participants who answered this question, an exceedingly high combined total of 97% of them had felt the need to define the social work profession to others who worked alongside them, including managers, chaplains, families, and even other social workers. This surprisingly large number of social workers who had felt the need to define the profession would likely have contributed to the mean item score of 6.7 out of a total of 9 on the HSWSE scale. This score indicated that participants felt only slightly more than moderately confident in dealing with various workplace scenarios. Perhaps if others knew what role social workers' had, the social workers could focus on performing their job duties rather than explaining their role to others, and they would therefore be totally confident (indicated by a score of 9) in various workplace scenarios.

Value of opinion on team.

Though in a role that was perceived as misunderstood, 69 participants overwhelmingly reported that they felt their opinion was very valued (52%) or mostly valued (32%) on a team. Comments included "I feel like the team sees the value that the social work profession brings to the multidisciplinary team approach," and "I find the team approach is alive and well with the doctors and nurses." Although feeling valued on a team, several participants felt it took much time and effort to get to that place of being valued, as they stated, "it took years of proving myself as a team player. Also, it depends on who is in the leadership roles," "took me several years to get there," and "this took blood, sweat, and tears literally." This question on perceived value corresponds with the uniquely designed "comfort" scale as the mean value regarding comfort on the interdisciplinary team was 12.31 (range 6-21) (SD=3.14). This indicates that the participants comfort within their team is moderately high. Questions on this scale pertained to

feelings of comfort working with social work manager, colleagues, interdisciplinary team, as well as support felt by hospital administration, and workload.

A smaller percentage (14%) of participants voiced that they felt their opinion was hardly or almost not valued whatsoever, stating "not at all. I feel like other disciplines see Social worker as a necessary evil- particularly in hospice work. They wouldn't have you if Medicare didn't require it," "It depends on which profession on the team, many use SWs to "do the dirty work," "Often feel like the "dumping ground" and are told to deal with something when no one knows what to do," and "I don't feel my opinion is very valued because other disciplines feel psychosocial and emotional needs are always secondary to physical needs." The smallest percentage (1%) answered this question as "N/A."

Sources of encouragement.

When asked about sources of encouragement, 66 participants responded. They overwhelmingly (52%) identified social work peers and managers as primary encouragement sources as they assumed their hospital role, along with non-social work colleagues (26%). Participants shared that "my team and former mentor have been a great source of strength as I learn and grow in my position," "my social work colleagues 100%. They listened to how I was feeling and gave me the guidance and reassurance I needed," and "ESPECIALLY when dealing with wage negotiation which is NOT taught in any educational program." Sadly, other participants (18%) shared that they felt no source of encouragement. Comments consisted of predominately "N/A," "none," "no," and shockingly, "none—no one at the leadership level is versed in social work and many *demean* the profession." 8% of participants identified patients as a source of encouragement. Illustrative comments regarding patients were "patients and other colleagues telling me I made a difference in their or patients' lives."

It is concerning that 18% of participants felt *no* sense of encouragement. As social work can be demanding emotionally, it is imperative that avenues of support and encouragement are in place before social workers need these supports. Tang & Li (2021) identified support in the work environment as a buffer of role stress on burnout for social workers who were in their first year of employment. Although Tang & Li's study did not measure support by family and friends, workplace support could sometimes provide similar emotional support as family. This lack of support by colleagues which can lead to burnout and leaving social work is an important topic for future research if we want to at least try to prevent turnover. The topic of burnout in the specific discipline of health social work is important to study as in the past twenty years there were only fourteen international studies published (Frieiro Padín, Verde-Diego, Arias, & González-Rodríguez, 2021).

Self-care.

Hospital social workers discuss "heavy" topics on a daily basis. They may be part of such conversations such as determining next steps because treatment options were exhausted or there was a decline in patient's medical status and are even called to support family as patient's pass. Sometimes there are cultural and language barriers, financial concerns and even discussions about getting extended family members into the country in an expedient fashion so patients can see them before passing. Social workers are called to assist with all of these requests as the profession centers around patients and patients' self-efficacy. These conversations can be emotionally taxing and therefore the topic of self-care is important to examine as social workers need to balance their stress with good relaxation techniques. When queried about self-care, 68 social workers chose to respond to this question. As each self-care area was counted each time it

was mentioned, and there were participants who identified more than one item, the total percentages were greater than 100% so the totals were reported in whole numbers.

The totals participants who identified exercise as their source of self-care was 45. For exercise, participants mentioned “running,” “swimming,” “kickboxing,” “dance,” “hiking,” and “walks.” One participant mentioned that they exercise during their workday by taking “short breaks to walk outside.” Exercises such as Tai Chi and yoga, which involve mindfulness were coded under *mindfulness*. Examples of mindfulness included “Meditation and tai chi,” “tai chi and yoga…need more though,” “it’s been an enormous struggle lately. But I do have a therapist, I exercise, meditate, try to keep a routine to get enough sleep,” “remind myself I cannot change the outcome but can help family members through the experience,” “taking care of basic needs, boundaries and limit setting---not taking work home,” and “breathe..learn what is mine and what is not.”

Of the 16 participants who identified mindfulness as their self-care, one participant identified they used a combination of self-care activities.

> Self-care for me means doing something that allows me to focus solely on one task. Hospital social work requires me to multitask for hours on end, so being able to just do one thing at a time is very therapeutic. At this moment, cooking Italian recipes is my self-care practice. Over the summer, swimming was my self-care practice.

Participants identified reading and resting a total of 39 times in regard to self-care. Comments included “read,” “read books,” “read novels,” watch “movies,” “Netflicks,” “mindless television,” “reality tv,” as well as “downtime” and “take time off and disconnect.” Some

participants mentioned doing “puzzles,” “using hot tub,” and also “therapy” and “psychological first aid.”

As expected, 32 participants mentioned time with family and friends as a self-care activity. Responses mentioned were “close relationships,” “spend time with family,” “hang out with friends via Zoom,” and even time with “colleagues” and “community volunteering.” Another commented that they believed “community care is better than just self-care.” 17 others mentioned cooking and crafting, such as “floral arranging,” “interior decorating,” “ jigsaw puzzles,” “knitting” and “eat comfort food moderately.” Techniques such as “massage” and beauty routines like “hair,” “nails,” and “mani/pedi” wre mentioned by 17 participants. 8 participants mentioned music as a form of self-care, including “listening to music” and “playing guitar.”

Surprisingly, only 9 participants mentioned pets for self-care. Comments were “spend time with my dogs,” “be with my pets,” and “play with dog.” The 5 participants who listed travel as a form of self-care commented simply, “travel,” with one specifying “go to festivals.” Given the taxing nature of hospital social work, I would have expected more responses that were more robust in nature such as “psychological first aid,” which was only mentioned once. Sadly, 5 participants said they did nothing for self-care, commenting that “it’s been an enormous struggle lately,” “working mom of three-no self-care,” and “I am not good in that department.”

Preparation through didactic social work courses.

It would be hoped that didactic lecture-based coursework would prepare social workers for the job by providing foundational content for human behavior. Although Social Work programs have offered courses related to integrated health care, there are not defined core competencies in Social Work for how to work on integrated health care teams (CSWE, 2017).

With 70 participants opting to answer this survey question, 72% of them said they felt they were only “some” or “not at all prepared” from their didactic courses. Participants reported more learning from internships than classroom didactic learning and stated, “honestly feel like my internship in the hospital prepared me more than my course work,” “barely I had less than a handful of professors working in the medical fields,” “not very much, learned most things hands on,” and “none of my MSW courses even touched on the medical acute hospital setting environment, practices, nor dynamic cases in which present in the medical acute care setting.” One participant voiced much frustration with supervisors’ ego getting in the way of learning,

> “There’s a significant difference between being an intern and an employee. Interns are managed by field instructors and preceptors. An employee will have supervisors who often are not interested in educational growth of another but their own growth and ego. It’s much more challenging to have a supervisor as a social worker who may not have clinical skills or people skills. This is the reality and I’m personally trying to figure out how to prevent this.”

This group of participant comments were consistent with the mean item score of 6.7 in the quantitative analysis on the HSWSE scale, which measured confidence levels when working with various groups in hospitals.

Survey participants who identified that didactic courses in their MSW prepared well or very well (28%) commented as expected about baseline content, “it gave me a baseline on how to work with others by meeting them where they are” “it gave me a decent foundation,” and “provided a framework for subsequent practice.” Others commented “It was fine. It helped to create a lens that was appropriate for practicum. I learned about useful assessment tools and policies,” “it was helpful to practice empathy with pretend clients since me for the real job. Some

face to face discussions in the classroom helped me as we went through case examples," "well, I had multiple mental health focused classes," and "very well but some of the life lessons were in the job."

As 72% of participants shared that didactic coursework only prepared them "some" or "not at all," this learning method may need reconsideration in MSW programs. Concerns voiced centered around instructors' lack of experience in hospitals to lessons being mostly learned in fieldwork. Some participants felt they had been provided a framework in theory, but given the HSWSE scale scores, it appears that confidence levels being only slightly more than moderately confident may have been driven by this feeling of lack of training. Further, participants expressed the need for more hands-on training and less theoretical learning. Perhaps increased practicum hours with decreased hours required for classroom learning would be helpful in providing the skills desired by participants. The next question examined the thoughts of participants regarding fieldwork.

Fieldwork experience.

Based on comments previously provided regarding lack of preparation felt by didactic courses work, it would be expected that the hands-on fieldwork experience for social workers would be thought of as excellent preparation for hospital social work. As expected, when queried about their fieldwork portion of their MSW education with respect to preparing them for their current hospital role, participants (71 answered) shared that they felt *very* well prepared (31%) or well prepared (24%), while 24% chose slightly or somewhat prepared. For those participants who commented that they were well or very prepared, the following statements were made: "I was essentially able to transition straight from my fieldwork into a job. My fieldwork prepared me to do the job effectively" and "my fieldwork experience well trained me for my current role

in the hospital setting, and I credit that experience with my success in the field so far," "very well that is where I feel like I gained all of my knowledge and experience." and "I had a fantastic fieldwork experience which excellently prepared me for working in health care." One participant spoke of the hands-on learning, stating, "I carried out responsibilities during those experiences that helped. I'm a hands-on learner."

The remaining 20% stated they were "none" or "poorly prepared." Those who said they felt unprepared spoke about having placements in other settings than a hospital. Sadly, this group who felt unprepared, commenting. "not at all. I worked in a disability office and had no hospital experience during fieldwork," "poorly but I am educated on what patients experience outpatient," "not much. my placement was not in a hospital," and "my fieldwork was not in a hospital and was mostly crisis mental health so not much at all." This group likely scored lower on the HSWSE scale regarding confidence in working successfully with the various patient groups. The remaining 1% referred to their fieldwork as "my field is my university."

Although 55% of participants felt very well or well prepared by fieldwork, this leaves almost half who needed more preparation. For those participants who had been placed in hospitals for fieldwork, their experience provided more preparation than those who had been placed in non-hospital settings. Some who were placed in hospitals were "able to transition straight from my fieldwork into a job," further stating "my fieldwork prepared me to do the job effectively." It appears that the field placement process may need revamping to consider accounting for students who have a preference for hospital social work as this place of learning provided such positive experiences for those who had been placed in that setting.

Skills learned on the job.

Given the previous responses regarding fieldwork experience preparing social workers, it would be expected that participants would want to learn more about hospital settings. Of the 71 participants who chose to answer, the majority of participants identified medical terminology and ethics (22%) and interdisciplinary teamwork and politics (25%) as a skill learned on the job that they wished had been learned in their MSW program. These participants had hoped to learn about getting along with other team members, stating "how to deal with unreasonable nurses," and "how to communicate with those who do not have emotional intelligence yet are promoted to leadership positions (ie. Many nurses get promoted but have NO leadership or communication skills)." Others in this group wanted learning around topics of "navigating organizational politics" and "interdisciplinary teamwork and charting in medical records." Others expressed a desire to learn about more intense topics such as "medical comorbidities in detail and how it impacts the work of social work" and "how to deal with death and dying."

Smaller groups of participants expressed that they wished they had learned assessment skills (16%) such as bio-psychosocial assessments, suicide assessments, and documentation skills. Another smaller percentage of participants (15%) had expressed that they had wanted to learn about insurances, specifically Medicare and Veterans, billing, and community resources and systems, stating "More in benefits and insurances, more on Veterans benefits," " More about the legal systems involvement with mental health," and "Medicaid and Medicare rules and processes."

Other participants (10%) identified the topics of stress, trauma and self-reflection as skills they wished had been learned in their MSW program. Examples included: "how to manage stress and do better with time management," "time management and prioritizing," and "the high

expectations the community has for social workers, heavy caseload, dealing with non-social worker supervisors." One participant summarized by stating the following:

> Trauma (as a medical acute social worker "float," one day I encounter three patients elected for Hospice and/or WOLST's; the next, I'm working with Children's Services representatives and local law enforcement to assist with emergency infant removal. A course depicting trauma-related stresses regarding SW dynamic cases in which I encounter within a two-day timeframe would have been very helpful. I have coping mechanisms, I have escapes and avenues, although a deep course reflecting how to deal with the aftermath of these events would be so helpful.

Another group (4%) wanted to learn the real world of social work as they stated "Just about everything. I got ethics and concepts but that's about it." They had hoped to learn "Everything about social work. The real world of social work." Still another 4% was unsure of what they could have learned in their MSW program, stating "don't think you can really learn the actual skills in a classroom" and "not sure." The remaining 3% of participants answered relating to salary concerns, stating "how to set boundaries with workload. Negotiating pay" and "hospital politics, colleagues' politics, how the real-world deals, not by theories...but by programs and money. HOW TO NEGOTIATE A FAIR WAGE. How to know your worth as a SW."

Participants gave an inside view of skills they had learned on the job that could have been gained during their MSW program. These are important voices from which to learn as the participants were on the ground doing the "real" social work jobs in the hospital. These participants are on the cutting edge of learning the skills needed to perform as a hospital social

worker. Joining this reported experiential learning with required coursework would provide educators a view from the inside so coursework could be tailored to the real time hospital setting. Participants have asked for this content so translating these requests into current classrooms could help future hospital social workers' ease into their hospital roles.

Specialization track in medical social work.

As some schools offer specialization tracks in medical social work, participants were queried about their option to participate in such aa track, and if they did elect this track, what was the most important skill learned. The responses were reported in numerical form as the question was two parts. Of the 83 participants who elected to answer this question, only 14 of the participants stated that they had taken a course or had a specialization in medical social work, while 44 had not. Of the low number who had a course or specialization, only 6 had identified the important skills learned as documentation or medical terminology, 4 learned health or public health, and 4 learned critical thinking and about interdisciplinary teams. Of the others who had taken a course or had a specialization in medical social work 3 had learned about death and hospice and 3 learned about geriatrics, while 2 learned self-care, 1 learned research design, 1 learned about children, and 1 learned listening skills. Those who mentioned documentation and medical terminology stated, "the art of thorough and ethical documentation," "personal documentation is necessary," and "independent study course…gained a lot more medical terminology knowledge."

One participant who had taken a social work healthcare track shared that they "were not able to learn effectively due to not being able to apply skills hands on." Surprisingly, although there was a medical track as an educational option, those who chose this option did not feel the

didactic learning was adequate and voiced preference for hands-on learning. Another participant said

> I was in the "health & mental health" track which included one mandatory course on health theories, one optional course on health policy, and one optional course on hospital social work (as an introduction). I chose all three courses which provided a solid grounding for my practice, but did not fully prepare me to enter the hospital setting

Another participant took courses in another university department, gaining skills for healthcare, stating

> I did not take a course or have a specialization as it was not offered at my university. However, I was able to take all my electives within the masters in public health department. Those classes were the most helpful in learning about the healthcare system, it's complexity, and how to navigate it

Another participant had taken an integrated healthcare track, stating

> I participated in an Integrated Health specialized track. The most important skill I learned was understanding and assessing the experience of chronically ill patients. I enjoyed listening to panels of families with real lived experiences

Open-ended response question.

Participants were asked an open-ended question of "Please share any other pertinent information that you feel is important related to the preparation for hospital social work." Of the 44 participants who answered this question, 36% overwhelmingly identified the need for more experience in medical terminology as well as more experience in hospital settings. Comments were: "a hospital setting is 24/7 which can create a sense of never ending your job," "after 35

years in medical/hospital social work the increased pressure to do more with less is challenging. Constantly working to help hospital administration understand the value of social work and compensate accordingly," "knowing your stuff before you set foot in the role. It should not be a job for a new grad," and "the acute medical social work is difficult as all get out. The amount of medical vocabulary, fast-pace, and dynamics you encounter is a world within itself. Prepare yourself to be challenged every single day, yet so rewarding."

Other participants (16%) spoke of complicated systems and difficult people. For example, participants shared the importance of "how to manage difficult people," "being able to work with stakeholders and the impact they have," and "being ready to navigate a forever complicated and changing system, to never feel like you know the answers…" further comments included were "be ready to navigate a forever complicated and changing system, to never feel like you know the answers, but to pair with patients and families to support them and sit with them in the discomfort," "being able to understand the role of the MDT, how to work with stakeholders and the impact they have, fundraising, medical jargon," "how to manage difficult people," and

> I feel many programs send social workers out with unrealistic expectations of the changes we can make. We do a lot of damage control, and people will not embrace interventions until they're ready. It's a disservice to tell students otherwise

Another participant echoed these sentiments and provided concrete suggestions stating "MSW programs need to have classes on Medicare, Medicaid, Insurance, Disability etc. They need to focus on psychopathology and how to diagnosis mental illnesses - A class on adjustment to life-limiting illnesses."

Other participants (11%) spoke about having patience and a calm demeanor, as well as knowing the role and ethics. Comments included “patience and tolerance,” “prioritizing tasks is a must; remaining calm during high stress times,” “being able to articulate the social work role confidently and efficiently. Also being able to articulate a clinical impression both confidently and efficiently; need to prepare MSW's for the rudeness of other professions,” and “all social workers should get to know the code of ethics! It wasn’t until I studied for my LCSW that I got into it with my supervisor. Too many social workers don’t understand the ethics of the day-to-day duties of hospital social work.”

A smaller group voiced concerns of lack of preparation for hospital social work, including how to interview. Comments were “MSW programs have a long way to go to prepare social workers period, healthcare included,” “it is a high stress field,” and

> One thing I regret not advocating for as a student was preparation for the job hunt in the medical social work field. I was never coached on how to network properly within hospital systems, prepare for interviews, or set me apart from other qualified applicants. I struggled to gain access to the field, even with an MSW from a well-respected university and a full year internship at a well-known trauma hospital, and as a result I struggled feeling confident in my role once I did land a position

Another participant spoke of frustrations with hospital culture, stating

> Social workers are not prepared for hospital settings and the few that are is because of their internships. Most hospital settings want LCSWs. MH settings are in need of ASWs but the culture in those settings lack empathetic supervisors and administration. I was given the education on being a change agent but it’s

> nearly impossible to change a culture and people. The income is poor compared to your responsibility and workload there

Others (7%) felt they were made for the job, stating “I switched from a nursing career to a LMSW,” “it is a tough job, but for me it was where I excelled,” and “be open to always grow and learn!” Other participants (5%) spoke of boundaries and self-determination, stating “ensure you have the ability to set boundaries and make them known to other associates” and “don’t let others define who you are as a social worker.” Still others mentioned pay. Comments were “any SW should learn how to speak their knowledge and for me understand their value, yes even financial value, of the team” and “take your time. Ask for the pay you deserve. Work your schedule & not extra. Call yourself a social worker & not a case manager. Believe in yourself. Go to CEU & stay updated on SW practices. Dream Big!!” other (11%) wrote “none,” “n/a” and “have to ensure lots of psychiatrists in clinical hospital settings.”

Again, social workers identified medical vocabulary, and the fast-pace dynamics of hospital social work as important skills to have during *preparation* for the work. These are voices of current social workers. Learning the complicated systems and workplace dynamics takes immersion in this setting and could be learned during fieldwork if students were provided the opportunity. Other participants spoke of personal attributes of having a calm demeanor and able management of difficult people. Many times, these are attributes that are inherent in those who are drawn to social work. When answering this question, social workers cheered on their soon to be colleagues and encouraged them to dream.

Conclusions

While social workers support and encourage one another, they also define the profession to one another. Most felt unprepared by MSW programs for hospital social work roles. Those

who were working in hospitals provided valuable real time information for the skills that were necessary for them to function effectively within their various hospital systems. Surprisingly, 58% of participants had to define the social work role to physicians and nurses. Also surprising is the large number of participants who had experiences of being belittled and intimidated by other members of interdisciplinary teams, especially calling out nurses for this behavior. Role definition is one item that clearly needs a place in MSW curriculum. Although feeling as if they were being belittled on the job, social workers (84%) identified that they felt very valued or mostly valued by their interdisciplinary teams. Further, they were slightly more than moderately confident regarding professional self-efficacy as demonstrated by the HSWSE scale mean item score of 7.3, 95% CI (7.1, 7.5). Although slightly more than moderately confident, social workers indicated that they felt only moderately prepared by their MSW training for the hospital roles in which they worked, as indicated by the mean Preparedness item score of 5.5, 95% CI (5.2, 5.8).

As preparedness increased, professional self-efficacy increased. As self-efficacy increased, quality of life increased. There was no direct effect between preparedness and quality of life. As hospital social workers increased self-efficacy, their quality of life scores increased. Providing more opportunities for social workers to participate in more activities that increase self-efficacy may help their overall happiness with relationships as well as health. In the path model in this study, preparedness had a stronger effect on self-efficacy than years of experience. Providing curricula changes that more adequately prepare hospital social workers would be a starting place for learning and practicing the necessary skills, especially how to manage work flow and communicate as a member of an interdisciplinary team. Including more curricula content relevant to hospital settings would likely help increase social workers' self-efficacy more

than only years of experience. Social workers are usually tasked with resolving difficult scenarios with patients and families. Providing adequate training, managerial support, and updated hospital policies could affect their quality of life in a positive direction,

Anecdotally, even though there was no significant direct effect from Preparation to QOL, social workers encouraged one another and had excellent self-care habits, all which contribute to good QOL. While on the job, although they were moderately prepared, social workers were belittled and treated with disrespect by non-social work team members, while working under pressure to discharge expediently and mitigating stressors for patients and families. Being moderately prepared and having to define ones' role makes for a stressful work environment compounding what was already a stressful work environment dealing with topics such as end of life care.

Social workers identified many personal reasons for entering the profession. Among those reason were events such as experience as a pregnant teen, having a child die from cancer, and having experienced trauma in childhood and a social worker 'saved' them. Social workers appear to have internal motivation and almost seem "called" to be social workers by their prior life events. These are people with big hearts who have turned their personal tragedies into help for others who are at difficult points in their lives. It is hoped that those who have endured personal hardship and have dedicated their careers to helping others would feel more prepared for their role and would feel at the very least encouraged by team members, but certainly not belittled.

Throughout these survey questions these social workers have provided a candid inside view of their personal meanings and reasons for being called to the profession. They have also provided suggestions for teaching the skills that they had to learn on the job. MSW programs

could use these ideas to inform future curriculum, especially regarding placing students in hospital settings for fieldwork. Social workers spoke candidly about needing different educational content than didactic learning and voiced the need for field placements within interdisciplinary team so these skills can be practiced and developed during the MSW program. Learning about medical terminology, interdisciplinary teams, death and grief, and role definition could make the transition to hospital social work more seamless with less learning curve as they progress from student to hospital employee. This mentored learning could help new social workers have their role defined and could then be explained and defended to others when and if needed.

Providing positive social work role models and strong managerial backing were some areas identified for helping current social workers to manage their inherently stressful roles. With increased pressures on health care systems to reduce length of stay, it is imperative to have social workers ready to tackle the challenges of hospital social work as they emerge from their MSW programs. Without this training, role confusion can result, thus lowering feelings of self-efficacy and therefore likely lowering quality of life.

It would take minimal effort to include topics such as medical terminology and teamwork practice in the MSW didactic courses and readings. Other ideas for increasing educational content for hospital social workers in their MSW program would be inviting physicians or nurse practitioners to give short talks about their role on hospital teams. Activities such as these could provide educational opportunities to those who may want to pursue careers in hospital social work, even if their practicum placement was not in a hospital setting.

Final Conclusion

Though there are large numbers of students who chose the MSW programs for their formal education, many of those who work in hospital settings have shown they had not felt adequately prepared for their role. This study examined self-efficacy scores on the HSWSE scale and social workers were slightly more than moderately confident working with various populations in a hospital setting. The qualitative analysis results spoke to the type of training that social workers identified that would have been helpful to have learned in their MSW programs. Training desired was in areas such as medical terminology, dealing with grief and death, and managing emotions and interactions with members of interdisciplinary teams. This study examined the modified full mediation model for the relationship between preparedness and HSWSE. The results showed that the paths from preparedness to HSWSE, and from years of experience to HSWSE, were both positive and statistically significant. Research findings were that compared to years of on the job social work experience, preparedness had a stronger effect on self-efficacy. The results also showed professional self-efficacy had a positive effect on quality of life, as anticipated. This model showed professional self-efficacy fully mediated the relationship between preparedness and quality of life.

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Appendix

Hospital Social Work Self-Efficacy Scale

Likert type scale with possible responses from 1 to 9.

1= Not at all confident, 5 = Moderately confident, 9 = Totally confident

1. How confident are you that you can work successfully with the following groups in a hospital setting?
    a. Children with mental illness
    b. Children who have been abused (both counseling and ensuring they receive protection)
    c. Adolescents
    d. Elderly
    e. The families of patients who do not have a terminal illness
    f. Patients with a terminal illness (including AIDS)
    g. The families of patients who have a terminal illness
    h. Patients who have a mental illness
    i. The families of patients who have a mental illness
    j. Patients from a different culture who speak English
    k. Patients from a different culture who do not speak English
    l. Patients who abuse alcohol
    m. Patients who abuse substances other than alcohol
    n. Patients who are loud, threatening, abusive, or violent
    o. Patients who enter the hospital from jail/prison
    p. Patients who are the victims of domestic violence

q. Patients who are homeless

r. Patients with physical disabilities

s. Patients who are on life support systems

2. How confident are you that you can successfully…

   a. Write comprehensive, informative, and relevant chart notes

   b. Write comprehensive, informative, and relevant psychosocial histories

3. How confident are you that you can work successfully with…

   a. Other hospital social workers

   b. Your social work supervisor

   c. Non-social work hospital administrators\

   d. Clerical and support staff

   e. Nurses

   f. Physicians

4. How confident are you that you can successfully…

   a. Keep abreast of current hospital policies and procedures

   b. Keep abreast of current community aftercare resources for patients

   c. Keep abreast of current patient benefit information (e.g., Medicaid, Medicare, other insurances)

   d. Recognize the ethical dilemmas that will occur in your work

   e. Set up safe, appropriate discharge plans

5. How confident are you than you can successfully…

   a. Manage the stress that you will feel working in a fast-paced, high work load environment

b. Manage the frustration that you will feel working in a large bureaucracy
c. Manage the feelings that you will have working with patients wo are experiencing severe physical pain
d. Manage the feelings that you will have working with patients who die
e. Manage the feelings that you will have when patients or families blame you for things going wrong
f. Manage the feelings that you will have when team members from other disciplines blame you for things going wrong

Unique version of HSWSE scale using wording "preparedness."

Likert type scale with possible responses from 1 to 9.

1= Not at all confident, 5 = Moderately confident, 9 = Totally confident

6. Specifically considering your knowledge from your MSW curriculum classroom learning, bookwork), how adequately prepared do you feel to successfully work with the following groups in a hospital setting?
   a. Children with mental illness
   b. Children who have been abused (both counseling and ensuring they receive protection)
   c. Adolescents
   d. Elderly
   e. The families of patients who do not have a terminal illness
   f. Patients with a terminal illness (including AIDS)
   g. The families of patients who have a terminal illness

h. Patients who have a mental illness

i. The families of patients who have a mental illness

j. Patients from a different culture who speak English

k. Patients from a different culture who do not speak English

l. Patients who abuse alcohol

m. Patients who abuse substances other than alcohol

n. Patients who are loud, threatening, abusive, or violent

o. Patients who enter the hospital from jail/prison

p. Patients who are the victims of domestic violence

q. Patients who are homeless

r. Patients with physical disabilities

s. Patients who are on life support systems

7. How adequately prepared do you feel by your MSW training that you can successfully…

   a. Write comprehensive, informative, and relevant chart notes

   b. Write comprehensive, informative, and relevant psychosocial histories

8. How adequately prepared do you feel by your MSW training that you can successfully work with…

   a. Other hospital social workers

   b. Your social work supervisor

   c. Non-social work hospital administrators

   d. Nurses

   e. Physicians

9. How adequately prepared do you feel by your MSW training that you can successfully…
    a. Keep abreast of current hospital policies and procedures
    b. Keep abreast of current community aftercare resources for patients
    c. Keep abreast of current patient benefit information (e.g., Medicaid, Medicare, other insurances)
    d. Recognize the ethical dilemmas that will occur in your work
    e. Set up safe, appropriate discharge plans
10. How adequately prepared do you feel by your MSW training that you can successfully…
    a. Manage the stress that you will feel working in a fast-paced, high work-load environment
    b. Manage the frustration that you will feel working in a large bureaucracy
    c. Manage the feelings that you will have working with patients who are experiencing severe physical pain
    d. Manage the feelings that you will have working with patients who die
    e. Manage the feelings that you will have when patients or families blame you for things going wrong
    f. Manage the feelings that you will have when team members from other disciplines blame you for things going wrong

Demographic questions

11. Age in years

Drop down menu selection beginning with age 19 and ending with age 67

12. My gender identity

0=female, 1=male, 2=non-binary, 3=other

(If other, please identify gender identity in space provided)

13. Years in current social work role

Drop down menu selection beginning with 1 and ending with 20

14. MSW program type

0=in-person study, 1=fully online study, 2=combination of in-person and online

15. Please describe your practice focus during your MSW program

0=clinical, 1=community organization, 2=school social work, 3=administrative, 4=substance abuse, 5=older adults, 6=other

16. Please describe your practice focus in employment

0=hospital inpatient, 1=outpatient health care, 2=inpatient mental health, 3=outpatient mental health, 4=children, 5=adolescents, 6=older adults, 7=substance abuse, 8=skilled nursing facility, 9=research organization, 10=higher education institution

17. Have you had any prior mental health concerns?

0=All of the time, 1=Most of the time, 2=Some of the time, 3=A little of the time, 4=None of the time

18. What is your practice setting?

0 = Urban – area with over 50,000 population, suburbs with at least 2500 people to 50,000 people, 1 = rural – area with less than 50,000 people and no suburbs with over 2500 people

Quality of Life scale (QOL)

7 = Delighted, 6 = Pleased, 5 = Mostly Satisfied, 4 = Mixed, 3 = Mostly Dissatisfied, 2 = Unhappy, 1 = Terrible

19. Please read each item and circle the number that best describes how satisfied you are at this time. Please answer each item even if you do not currently participate in an activity or have a relationship. You can be satisfied or dissatisfied with not doing the activity or having the relationship.
    a. Material comforts, home, food, conveniences, financial security
    b. Health – being physically fit and vigorous
    c. Relationships with parents, siblings & other relatives- communicating, visiting, helping
    d. Having and rearing children
    e. Close relationships with spouse or significant other
    f. Close friends
    g. Helping and encouraging others, volunteering, giving advice
    h. Participating in organizations, and public affairs
    i. Learning – attending school, improving understanding, getting additional knowledge
    j. Understanding yourself – knowing your assets and limitations – knowing what life is about
    k. Work – job or in home
    l. Expressing yourself creatively
    m. Socializing – meeting other people, doing things, parties, etc.

n. Reading, listening to music, or observing entertainment

o. Participating in active recreation

p. Independence, doing for yourself

Uniquely designed questions to correlate with scores on section of HSWSE scale:

Answers are in Likert format with 4 = *Very high degree, 3 = A high degree, 2 = Somewhat, 1 = Low degree, 0 = Very low degree.*

20. I feel comfortable working with my social work manager.

21. I feel comfortable interacting with social work colleagues.

22. I feel supported by social work colleagues.

23. I feel comfortable working on an interdisciplinary team.

24. I feel supported by my hospital administration

25. I feel my workload is burdensome.

Uniquely designed question

0 = To a very high degree, 1 = To a high degree, 2 = Neutral, 3 = To a low degree, 4 = To a very low degree

26. Please share the degree to which you felt prepared to perform your job duties by

    a. Your MSW education

    b. Your practicum experience

    c. Continuing education/CEU's

    d. Your mentor

    e. Your manager

Open ended response questions

The next questions ask for your thoughts on preparation and working in the role of social worker.

27. What prompted you to choose to enter the social work profession?
28. How well did your didactic course(s) in the SW program prepare you for your current work role in the hospital setting?
29. How well did the fieldwork experiences in the SW program prepare you for your current work role in the hospital setting?
30. What types of skills did you learn on the job that you wish you had learned in your MSW program?
31. Did you take a course in your MSW program or have a specialization track in medical social work? If so, what was the most important skill you learned?
32. Describe any barriers you encountered in owning your social work role in the hospital setting.
33. Describe any sources of encouragement as you assumed your social work role in the hospital setting.
34. Please share the extent to which you feel your opinion is valued in your social work role on a team.
35. Please share with whom (what other professions) have you felt the need to define the profession of social work.
36. Please share what you do for self-care.
37. Please share any other pertinent information that you feel is important related to the preparation for hospital social work.

VITA

Alison Lloyd graduated from Michigan State University with a Bachelor of Social Work degree. She worked as a Social Worker and also obtained a Master of Business Administration degree from Saginaw Valley State University. Alison worked as a Social Worker and wanted to translate research into practice in order to increase the understanding of the role of hospital Social Workers. Alison worked as an Oncology Social Worker concurrently with completing her dissertation. Her research interests include hospital social workers' perceptions of their roles on an interdisciplinary team, along with the health and well-being of social workers. After graduation, she will continue her research agenda as part of the Oncology Social Work team with The Ohio State University Wexner Medical Center, James Cancer Center and Solove Research Institute.