SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE

SSWLHC

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SSWLHC ADVOCACY, PRIORITIES, ISSUES & ACTIVITIES

·SSWLHC WA CHAPTER
Tuesday, March 25, 2014
5TH ANNUAL EDUCATIONAL CONFERENCE AND RESOURCE FAIR
(formerly VENDOR FAIR)
Mountaineers Club Headquarters
Magnuson Park, Seattle

•NASW WA CHAPTER
Wednesday, March 26, 2014
AWARDS DINNER
Museum of Flight, Skyline Room
Boeing Field, Seattle

•NASW LOBBY DAY
February 17, 2014

•CITY OF HOPE/EXCEL
April 21-22, Philadelphia PA
May 26-27 Baltimore, MD
'EXCEL in Social Work: Excellence in Cancer Education & Leadership' FREE

INSIDE THIS ISSUE:

THOMAS HOUSE WINS WSHA COMMUNITY LEADERSHIP AWARD

The Edward Thomas House Expanded Medical Respite Program in Seattle was awarded the Washington State Community Health Leadership Award for 2013. The award nomination came from the project's Steering Committee, chaired by Brian Giddens, Director of Social Work and Care Coordination at UWMC (and former SSWLHC WA Chapter President, 2011-2013), and Committee Members: Julie Jones, MSW/LICSW, Manager Social Services, Virginia Mason Medical Center, and Rachel Dieleman, Supervisor, Case Management, Swedish Medical Center. (and current SSWLHC WA Chapter President-Elect, 2013-2014)

The Thomas House located at Jefferson Terrace, is a Medical Respite Program providing recuperative care for homeless men and women who are too sick for the streets or shelters but not sick enough to be admitted to the hospital. This concept started with a problem—nowhere to send homeless patients, many of whom had drug abuse histories, who needed IV antibiotics. These patients did not need inpatient level care, but had nowhere else to go, and due to the homelessness and, in some cases, mental health and/or drug history, no facility would accept the patient. Their needs were too high for existing respite programs. In a brainstorming session with Brigitte Folz, MSW, Director, Psychiatry and Behavioral Health, and Clinical Instructor, School of Social Work, Harborview Medical Center, a call was placed to Janna Wilson of Public Health who agreed to initiate a planning group. This eventually led to more

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hospitals being involved and the creation of Thomas House. Initial planning and participating hospitals included UWMC, Harborview, Swedish, and Virginia Mason, who worked to quantify the need by tracking the number of homeless patients needing a discharge placement over a six week period, finding that 76% had significant barriers to discharge. In 2008 the Seattle Housing Authority expressed interest in repurposing some of the Jefferson Terrace public housing units, and public funding for the project became available. Hospitals agreed to contribute significantly to the cost based on anticipated number of referrals, and the project moved towards reality.

Other community collaborators included St. Francis Hospital, Evergreen Medical Center, Valley Medical Center and Northwest Hospital. In addition to the consistently strong presence of Public Health—Seattle and King Co., the respite and housing community, Downtown Emergency Services Center, the Committee to End Homelessness, Seattle Housing Authority and King County Mental Health, Chemical Abuse and Dependency Services (MHCADS) also assisted in the identification of need process and the various stages of planning and development.

Harborview was chosen to run the operations of Edward Thomas House, and reports to the Steering Committee, chaired by Brian Giddens, on a monthly basis, providing data on admissions, demographics of patients being referred, patient outcomes information and budget reports. Hospitals participating in the Steering Committee are those that are helping to fund the project, and the committee's role is to provide guidance and feedback on performance of the program and assure that the program is meeting its goals in a safe, effective and efficient manner. The group has expanded to include managed care organizations, and continues to have King County Mental Health, Chemical Abuse and Dependency Service representation as well as the ongoing presence of Seattle King County Department of Public Health.

RESULTS

During the first year of operation, 2011, Thomas House served 456 homeless persons living on the street or in shelters with complex needs, acute and chronic medical issues and high incidence (74%) of chemical dependency and/or mental health diagnoses. The most common admitting diagnoses were abscesses, post-op recovery, cellulitis/diabetes, and fractures.

Patients average a 2-3 week length of stay and are frequently connected to case management services prior to discharge. The results indicate that for the average respite patient with a 19 day length of stay, considerable inpatient costs are avoided and access to mental health and substance abuse services leads to longer term stability.

For additional information, contact Brian Giddens, MSW, LICSW: bgiddens@uw.edu

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King County Releases the Equity and Social Justice Annual Report

This report, released October 3, 2013, indicates that King County is becoming more diverse, citing that King County is now 35% non-white compared to 17% in 1990. However, most of the diversity is concentrated in 10 zip codes. These 10 zip codes correlate to lower income and a life expectancy 10 years less than the rest of King County. The report is created to identify the inequality so that the county can focus efforts on eliminating inequities. From the report: "To eliminate the root causes of inequities, essential questions include: *What upstream pro-equity policies, structures and systems do we need to promote opportunity for all? Instead of looking at a simpler response to a complex problem, what is the comprehensive approach we need to get at the root causes? What other areas and sectors must we engage and work with to be part of the solution?"*

How can this information inform your social work practice and how can you be involved in addressing inequality? Read the full report here: ***http://www.kingcounty.gov/exec/~/media/exec/equity/documents/EquityReport2013.ashx***

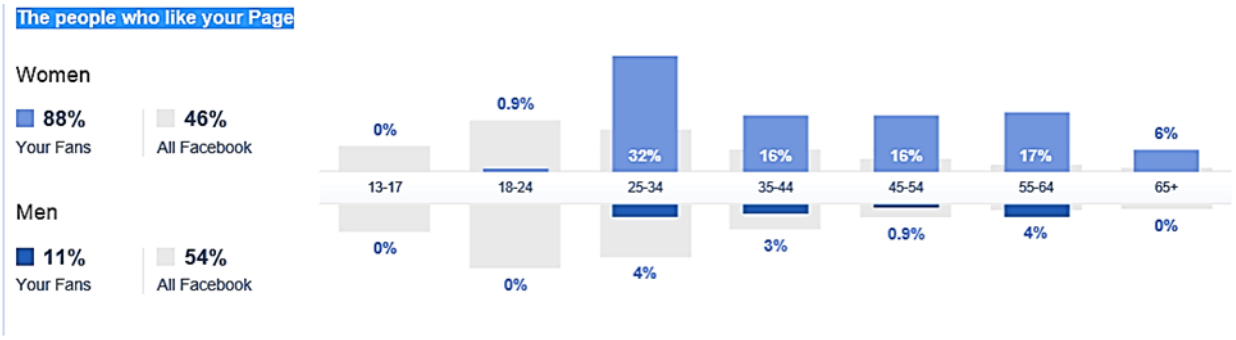
Contributed by Amber Wade, MSW, LICSW, izakbliss@gmail.com

SSWLHC WA CHAPTER MEMBERSHIP GROWING

Report from the Membership and Technology Chair
Tricia Matteson

As of the end of 2013, SSWLHC-WA has 116 active members, 14 of whom are new to the organization this membership cycle. Many of you took advantage of our online registration capability, which is also becoming a popular choice when signing up for continuing education offerings. We continue to offer a reduced rate to those who sign up for a two-year membership ($40 for one year, $75 for two). A goal frequently discussed by the Board is increasing SSWLHC -WA membership in Eastern Washington. We are interested in hearing from social workers east of the mountains. Let us know how we can better represent your interests and engage you in continuing education offerings and healthcare policy discussions.

We are continuing to expand and utilize various social media tools to increase membership engagement. We now have 113 Facebook "likes" (www.facebook.com/sswlhc.wa) with the following demographics:



In addition to posting about upcoming continuing education events, our Facebook page frequently features job openings in the Puget Sound area. The page also allows us to share fun and entertaining items of interest, such as the music video produced by the most recent UW SSW MSW graduating class:
"***Social Workin' 2013***" http://youtu.be/bMvFmKs8348

There are two things you can do to make sure the page continues to show up in your Facebook news feed. First, hold your cursor over the "Liked" button at the top of the SSWLHC-WA page and make sure "Show in News Feed" is checked in the drop down menu. Secondly, you can click on "New List" or "Add to Lists" in that same drop down menu to create a list including SSWLHC-WA as one of your favorite pages and make sure you never miss an update from us. Also, be sure to interact with the page. The more you "Like" and comment on pictures and status updates, the more you will see them in your Newsfeed!

Another communication tool we are using now is the SSWLHC-WA Google Group. To send a message to the entire membership, address your email to sswlhc-wa@googlegroups.com. Feel free to use this group messaging platform to pose questions to your fellow SSWLHC-WA members, discuss challenges, announce job openings, or celebrate professional successes.

Let me know if you have ideas or concerns about membership, social media, and technology used by SSWLHC-WA. We hope to use these tools to create a vibrant and engaged community of healthcare social workers across the state.

Tricia Matteson: trimatt@comcast.net

WHEN GOOD PATIENTS MAKE "BAD" DECISIONS ALLOWING FOR PATIENT AUTONOMY

By Norma J. Cole, MSW, LICSW

This is a synopsis of an interactive paper presented at the October 3, 2013 Society for Social Work Leadership in Healthcare Conference, in Philadelphia, Pennsylvania.

The presentation was developed and presented by Norma Cole, LICSW, Associate Director, Social Work, Harborview Medical Center, Seattle, Washington and Pam Haithcox Eggleston, MSW, MBA, Director Rehab Services, St. Anthony Hospital, Oklahoma City, Oklahoma, and previous Director of Social Work at Harborview.

As social workers in healthcare settings we have all been faced with situations where our patients are making seemingly "bad" decisions about their care, discharge plans, life decisions, etc.

That said, it is often the social worker who gets the referral to "make the patient go to the SNF", or "make the patient take their medication", etc. As a discipline that is geared towards advocating for patient autonomy and independence, these issues often fall squarely in the lap of the social worker.

So the question is, when do patients get to decide? Is it ever ok to override their decisions? What if they have decisional capacity but are still making "bad" decisions?

What if the patient's decision would put them in harm's way?

These are questions that many of us face daily. In this article I will explore the issue of patient autonomy and patient centered care in the face of unhealthy/unsafe choices, and present scenarios where ethical and practical dilemmas were placed in front of the treatment team.

Two very significant reports are the cornerstone of informed consent in the practice of medicine today. The first is the Nuremberg Code, 1949. This is a set of principles that were developed after World War II. This code came as a result of physicians who conducted medical research on individuals in concentration camps during that war. The physicians were brought to trial, found guilty and these guidelines were developed to prevent a similar atrocity from occurring again. There are 10 points to this code that include voluntary consent, free power of choice, knowledge of procedure, the capacity to make a decision, etc.

The second is the Belmont Report which came out in 1979. It was the result of the Tuskegee Syphilis Experiment conducted by the US Public Health Service from 1932-1972. This study followed the natural progression of untreated syphilis in rural African American men in the south. The men were told they were being given free healthcare and were never informed

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that they had syphilis. In the 1940's when it was determined that penicillin could cure syphilis, none of the participants in the study were given the lifesaving treatment. In 1966 Peter Buxton, who was working for Public Health, brought it to the attention of his superiors who refused to look into it and said the study needed to go forward. In 1972 Peter, who was a social worker, went to the press and the story broke wide open. Senator Edward Kennedy demanded congressional hearings which resulted in the Belmont Report. The Belmont Report essentially promotes respect for persons, with the acknowledgement of autonomy and protection of those with diminished capacity.

As a result of these two reports, and what is ethically and legally "right", informed consent is essential in today's healthcare settings.

A patient must have the following in order to be capable of informed consent:

The ability to understand the nature of their condition;

The ability to understand the risks and benefits of treatment or non-treatment;

And the ability to make a reasoned decision based upon this information.

The patient does not necessarily need to make what the provider would consider a wise decision, just a decision based on rational cognitive process appropriate to the situation.

HOW DO WE DETERMINE WHEN A PATIENT IS CAPABLE OF INFORMED CONSENT? WHAT IF WE ARE QUESTIONING IT?

First we need to differentiate between competency, decisional capacity and incapacitation. These terms are often confusing and unclear to members of the treatment team.

Competency is a legal term. The courts decide if someone is competent to make overall decisions. When we hear a team member report that a patient is not competent, our next question is, "in regard to what?" We do not decide competency, it is decided by the courts.

Decisional Capacity is not an all-inclusive concept; it is often on a continuum and capacity can change over time and in relation to specific questions. "Can the patient understand the pros and cons of the medical decision to be made, and relate those back to you? If a physician describes a surgical procedure to a patient and they understand it and can deliberate its major risks and benefits, and then decide based on this deliberation, they have decisional capacity in making that decision.

If a patient says they will not go to a skilled nursing facility, but are unable to grasp that they need nursing level care, the team feels they cannot make it on their own at home, and the patient is unable to describe how they will get their needs met at home, then perhaps that individual does not have the decisional capacity to make discharge plans.

If a patient is incapacitated it could be a temporary situation due to medication, drugs, delirium or sedation. In this case, the incapacitation will likely clear and the patient will be able to make decisions. If decisions need to be made in the interim, that falls to legal next of kin.

HOW OFTEN HAVE YOU BEEN CONSULTED TO EVALUATE A PATIENT'S DECISIONAL CAPACITY WHEN THE PATIENT WAS AGREEING WITH THE MD AND THE TREATMENT TEAM?

It is very frustrating for members of the treatment team to observe patients making poor choices that will further

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OCTOBER LEGISLATIVE SESSION A SUCCESS

Cassie Sauer, MSW, WSHA

Issues confronting the WA State Legislature's 63rd session were outlined in a discussion led by Cassie Sauer, MSW, Senior Vice President, Advocacy & Government Affairs for the WSHA. She discussed the political issues confronting the legislators and the WSHA budget priorities for protecting current important programs, funding for Medicaid outreach, mental health and primary care providers in Medicaid.

Mary Kay Cluines-Ross, MA, WSHA

Mary Kay Clunies Ross, MS, WSHA Vice President of Publications and Public Affairs, discussed the implementation of the Affordable Care Act and its implications for WA State residents and the medical settings that will serve these new enrollees.

This October seminar garnered a 4.39 in overall ratings, attended by 33 social workers. Overall, the comments about the workshop were strongly positive: "Cassie Sauer is a very engaging speaker and very knowledgeable of political environment. Very helpful to get overview of big picture. Appreciate 'non-medical' approach from Mary Kay." "Loved the venue. Always enjoy and appreciate Cassie's info. Well prepared and timely and articulate—understood the SW concerns in the legislature." I appreciate the comprehensiveness of presentation! Identified strengths/challenges for care coverage with current change model; learning more about the role of WSHA." "Friendly speakers/staff: excellent choice of refreshments. Registration fee was affordable. Clean building, clean bathrooms."

Critical comments included: "Would have liked more detailed information about the ACA in WA State—more nuts and bolts." "Not an ideal location, easy parking but far South." "Ms. Clunies-Ross handout depended a lot on color for the information to be fully understood." (These handouts were in black and white).

Suggestions for additional workshops included 'Regular Updates on the Affordable Care Act' during the first year", 'How to Help Undocumented Immigrants', "Continue discussion on healthcare mergers and the effect on 'Death with Dignity' and women's reproductive issues", "Address mental health: outpatient, inpatient, for all types of insurance".

The venue location/time generated these comments: "a neutral location—not Seattle—maybe Federal Way, Auburn, Renton, Tacoma, Olympia". "I like the idea of early evening workshops." "Not missing work would be helpful."

For additional information and/or if you would like to volunteer to assist in the presentation of our seminars, contact Carol Charles: ***carolc6@uw.edu***

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LETTER FROM THE PRESIDENT

From Stacy Heinle

Stacy Heinle, MSW,
SSWLHC Board President

January 2014, we made it!

It's finally here, the date where millions of uninsured now have access to medical and behavioral health services. In Washington State this means the discontinuation of Medical Care Services, also known as GAU and Disability Lifeline. These recipients should now meet eligibility for Medicaid, have continued access to medical coverage and have full access to mental health coverage paid by Medicaid for the first time.

Of course there are many other changes to Medicaid in Washington, including the name. No longer will we see Health Options, Medicaid is now Apple Health, not to be confused with Apple Health for Kids witch still exists. I'm almost certain it will take quite a while with forms and systems to catch up with the name change, so don't be confused Apple Health is Medicaid.

Changes to the Medicaid benefits have also been made; recipients now have access to dental services for adults, unlimited mental health visits from an expanded pool of licensed providers, oral contraception, Naturopathic Physicians as primary care providers, screening of children for autism as well as others. For addition information check out the Health Care Authority web page (www.hca.wa.gov/medicaid/Pages/benefit_changes.aspx).

Another addition to the Apple Health benefit is the establishment of Health Home services. These are a standard set of services designed by the Health Care Authority (HCA) in collaboration with DSHS to provide care coordination across service domains. What this means is a recipient having access to a single person who will work to develop a single plan of care, based on what the recipient's goals are, use evidence based screening tools to measure progress. The care coordinator then shares the plan with other service providers, with consent of the recipient, to make sure everyone has needed information.

For example a 55 year old homeless man, diagnosed with COPD, diabetes, and depression could agree to work with a care coordinator who could contact his service providers, make sure they understood the recipient's motivation/ goals, and had the appropriate information to provider treatment. The primary care provider would be provided information on what medications are being prescribed by the behavioral health practitioner and vice versa. This sharing of information pertinent to treat the recipient is no longer the sole responsibility of the recipient.

This service is only available to those who qualify as determined by the Health Care Authority and there are far more details than can be covered in this article. The best place to get additional information is on the Health Care Authority web page (www.hca.wa.gov). There are many links to information related to Medicaid expansion and individual coverage.

It is also very important for those working with patients who have had Basic Health and Washington Health programs, which ended December 31, 2014. These folks should be directed to Washington Health Plan Finder (www.wahealthplanfinder.org). They will need to get medical coverage through the exchange.

May you all have a healthy and happy New Year!

Stacy can be located at: *stacy.heinle@chpw.org*

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impact their health in a negative way. As Social Workers we place a high level of importance on patient autonomy and independence as well as the legal and ethical implications of free choice. That's not to say that those "bad choices" don't impact us as well, as we do know that we cannot get in the way of patient choice, if they are making informed, but not so wise decisions.

Below are a few questions to consider and examples of patients making what we feel are "bad" decisions:

Domestic Violence

Even though there is a risk, can we send the victim home to a violent situation if she/he is refusing help? We can do our best to provide resources, options, etc. but in the end we cannot force someone to accept our help.

Vulnerable Adults

Can we send someone home alone if we think they will not be safe? Maybe they are a fall risk or won't take their critical medications. At my facility we see this frequently. It is very difficult for individuals to give up independence. One of my staff was consulted by an MD to start guardianship paperwork on an 82 year old diabetic female who lived alone with no family. She had a history of not regularly taking her insulin or checking her blood sugar level. The MD felt she needed to be in a skilled nursing facility, but she wanted to remain independent in her own home. Since she had decisional capacity on the question, we were able to beef up home supports so that she could remain in her home.

Substance Abuse

The patient has already overdosed and become critically ill twice – can we discharge him/her and let them do it again? We cannot force someone to get treatment. We can present drug treatment options each time the patient is admitted, offer support for that choice, and if they don't take you up on it this time, perhaps their next admission will be the time they are ready for treatment.

Mental Illness

There are approximately 60 million people in the US who have a diagnosable mental illness. Mental illness does not automatically equal lack of decisional capacity.

Can patients with mental illness make their own treatment decisions even if it leads to harm or death? A 25 year old female with a history of schizophrenia was admitted with a broken ankle. The surgeons repaired the ankle, but the patient refused to use crutches or a wheelchair and insisted on walking on the casted foot. The surgeon's recommendations were that she be non-weight bearing for 6 weeks. The social worker was consulted to talk with her about using her crutches and/or to see if we could put her on a hold and place her on the psychiatric unit until her foot healed. It was determined that the patient did have decisional capacity on this topic and had made the choice to walk on the cast. This was not a wise choice, but the patient had the right to make that choice.

As social workers in healthcare we all face patients who make "bad" decisions every day. These decisions are complex and include legal and ethical implications for our patients, our staff and our institutions.

The impact of these "bad" decisions continues to grow and have an impact on our patients, the healthcare system, readmissions and increased healthcare costs.

While good patients who make "bad" decisions are frustrating to the healthcare professionals working with them, it is still comforting to know that social workers will always be there to make sure the patients voice is being heard and the decisions patients make are their own, good or bad.

Norma J. Cole, MSW, LICSW, is Associate Director of Social Work at Harborview Medical Center. She can be reached at: njcole@u.washington.edu