VOLUME 15 ISSUE 1

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE

SSWLHC

WASHINGTON STATE NEWSLETTER

JANUARY 2013
WASHINGTON CHAPTER LEGISLATIVE EDITION

SSWLHC ADVOCACY, PRIORITIES, ISSUES & ACTIVITIES

•NASW WA CHAPTER
February 18, 2013
LOBBY DAY
Governor Hotel, Olympia, WA

• NASW WA CHAPTER
March 8, 9, 2013 12 CEUs
"COGNITIVE BEHAVIOR THERAPY FOR ANXIETY AND PANIC"
Presented by James Shenk, Ph.D
Red Lion Hotel, Bellevue, WA

•NASW WA CHAPTER
March 22, 2013 6 CEUs
"FROM PRINCIPLES TO PROBLEM-SOLVING: ETHICS FOR SOCIAL WORKERS", Presented by:
Brian Giddens, ACSW, LICSW
North Seattle Community College, Seattle, WA

INSIDE THIS ISSUE:

STACY HEINLE, MSW SSWLHC NEW PRESIDENT ELECT

Stacy Heinle, MSW, elected SSWLHC WA Chapter 2012-2013 President-Elect

Stacy Heinle, LICSW, SSWLHC WA Chapter Board Member, has been elected to the office of President-Elect. In that capacity, she will be responsible for the 2012—2013 Chapter educational schedule as well as preparing herself for the 2013—2014 Chapter Presidency which begins July 1.

Stacy is Program Manager of Integrated Health Services for the Community Health Plan of Washington, a not for profit health plan founded by local community health centers. Today, that agency is one of the contracted organizations for the new Managed Medicaid programming.

Stacy is also an agency supervisor for UJIMA, a Washington State licensed child placement agency working primarily in King,

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UNIFIED SUPPORT PRESENT FOR SOCIAL WORK LICENSURE CHANGES

Representatives from SSWLHC have stayed at the table for the 2012 Licensure Stakeholder meetings at NASW. At the capstone meeting on November 8th, there was consensus to move forward with a bill that will include the following FINAL revisions to the current licensure process for social workers in Washington:

Adding a grandfathering clause to the licensure rules. "Only rules in effect on the date of submission of a completed application of an associate for her or his license shall apply. If the rules change after a completed application is submitted but not before a license is issued, such new rules shall not be a reason to deny the application."

Extending the associate license renewal limit from four renewals to six renewals. This extension will give social workers seven years to achieve full licensure (LICSW) after they have declared the path by obtaining an associate license.

Continued Page 2, Column 2

Heinle New President-Elect For 2012-2013

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Snohomish and Pierce counties specializing in identifying, recruiting, training, licensing, and supporting families for foster care adoption and kinship care of children in Washington State.

"In my current position I have the privilege of traveling across our amazing state working with social workers in many areas of health care. It is clear our work is unique, requiring specific skills, knowledge, and professional relationships. SSWLHC is a great forum for us to do just that: build relationships, skills and knowledge as well as have some fun."

Public Health Reserve Corps (PHRC) Opportunity

The King County PHRC is seeking Medical Social Work volunteers to help during a public health emergency or disaster. Social workers with behavioral health, case management, or discharge planning experience preferred. If a group of 10 or more SSWLHC members is interested, we can have a special orientation which may be eligible for CEUs.

You can find information about PHRC at: http://www.kingcounty.gov/healthservices/health/preparedness/phreservecorps.aspx

Interested, or want to hear more? Contact Angel Dawson (Chair, Social Health Policy Committee) at: angeld2020@gmail.com or 206-351-7521.

Social Work Licensure

Continued from Page 1

SSWLHC is still interested in expanding the renewal limit even further, as we believe an open-ended timeline would meet professional standards; and that time limits do not serve to protect the public, and may favor social workers in certain practice setting who have access to financial resources and opportunities. However, we are pleased with the improvement of 4 to 6 renewals, and will continue to advocate for the interest of our membership.

Correcting a language error in RCW 18.225.090 that has confounded applicants for licensure. The existing section states that an associate must have a "minimum of four thousand hours of experience, over a three year period…." This has been widely misinterpreted by licensure applicants and the Department of Health. The proposed amendment to the language is: "Applicants must be post-Masters for at least three years prior to being eligible for LICSW status. Applicants must also have a minimum of four thousand hours of supervised post Masters experience." Thankfully, the language will now be changed to parallel the intent.

SSWLHC members are proud to have participated in this process, and we hope the changes positively support the next generation of social workers on their journeys to licensure. Next steps include identifying legislators to introduce the bill, and developing a strategy to have it passed! SSWLHC social policy committee members will have an opportunity testify in Olympia in support of this bill. Because of the broad collaboration in this process we hope things will move along smoothly.

Contributed by Angel Dawson, MSW,
Chair, Social Health Policy Committee
SSWLHC, WA Chapter

AFFORDABLE CARE ACT UPDATE

BY AMBER WADE, MSW

The Affordable Care Act (ACA) was voted into law on March 23, 2010 and the Supreme Court upheld it in June. According to the Congressional Budget Office, the projected revenue increases and the cost reductions of the bill will "yield a net reduction in federal deficits of $130 billion over 2010-2019 period."

Currently in effect:	**Going into effect January 2014**
• Insurance policies have limited ability to cancel policies, deny children coverage due to pre-existing condition or to charge men more than women. • Insurance companies now offer preventive care free of charge (mammograms/well visit). • Those in Medicare's "donut hole" are only paying 50% of cost of prescriptions instead of 100%. New provisions strengthen Medicare by protecting against fraud. • The law allows children to stay on their parent's plan until they are 26 years old.	Create Insurance Exchanges that will offer array of affordable private insurance plans to individuals who are currently uninsured. This is projected to help Medicare recipients receive more affordable plans (see Medicaid chart below). Provide security of coverage for pre-existing conditions. Offer middle class/small business tax credits to ensure that health insurance is affordable. For individuals that do not qualify according to the chart below, the tax credit is designed to help ensure ability to purchase coverage. See: http://healthreform.kff.org/subsidycalculator.aspx U.S. citizens and legal residents will be required by law to have health insurance.

Affordable Care Act Changes to Washington Medicaid to Occur January 1, 2014

	Eligibility	Application	Renewals
Newly eligible, pregnant women, children, families	MAGI*- 138% of federal poverty level or $1238/mo individual, no asset limitation	Streamlined, automated data linking to IRS, SSA. Apply through Insurance Exchange (where you also apply for Advanced Premium Tax Credit)	Automated renewal with data linking every 12 months if data available
SSI recipients, Medicare qualified (seniors/disabled)	Same as current. $698/mo individual, $2000 asset limitation. Spend downs etc.	Same as current. Washington Connect Website	Same as current. Every 6 months.

* Modified Adjusted Gross Income (MAGI), mirrors the IRS calculation of adjust gross income, removes Medicaid's multiple previous income disregards and allows one 5% income disregard. No assets are considered. For more information:

- ACA see: http://www.helpstartshere.org/tag/affordable-care-act

- ACA and Washington Medicaid see: http://www.hca.wa.gov/hcr/me/faq.html#new15d
- Requirements for individual insurance mandate: http://healthreform.kff.org:80/the-basics/Requirement-to-buy-coverage-flowchart.aspx

EMERGENCY DEPARTMENT: SEVEN BEST PRACTICES

by Stacia Fisher, MSW, LICSW

History of the Issue:

In an effort to satisfy the state's desire to lower costs incurred by inappropriate ED visits of Medicaid patients, the Medicaid Health Care Authority created a rule stating they would not cover ED visits for a wide-range of conditions – many of which are appropriate for the ED. The result of this rule would be that hospitals would be subject to non-payment for these visits – even though patients are covered under Medicaid.

The Washington State Hospital Association (WSHA), Washington State Medical Association (WSMA) and the Washington Chapter of the American College of Emergency Physicians (ACEP) came together to develop an alternative approach which focuses on "7 ED Best Practices" in the hopes that coordinating with other community hospitals and implementing these practices will result in decreased inappropriate ED usage.

THE 7 ED BEST PRACTICES ARE OUTLINED BELOW:

A – Electronic Health Information – Adoption of an electronic health information system integrated across all state emergency departments to exchange patient information among Emergency Departments. Participating hospitals have adopted a program called EDIE (Emergency Department Information Exchange) which allows ED providers to see a report of a patient's ED usage if they meet set visit criteria (such as 4 ED visits in 60 days or a Medicaid patient with 5 ED visits in 12 months) and view or upload any Care Guidelines developed for the patient.

B – Patient Education – Hospitals are required to actively disseminate educational materials about appropriate use of the Emergency Department to all patients. WSHA has created brochures available at http://www.wsha.org/files/82/ERBrochure.pdf. Many hospitals are posting or handing out information in the ED and incorporating them into their instructions when appropriate. For frequent ED users, in person discussion between the patient and ED MD or MSW may be necessary to further reinforce appropriate places to seek care.

C – PRC Client Information – Designation of hospital personnel and ED Physician personnel to receive and appropriately disseminate information on Medicaid clients including a list of clients enrolled in the Patient Review and Coordination (PRC) program and monthly utilization reports for those clients.

ED: SEVEN BEST PRACTICES

D – PRC Care Plans – Hospitals are required to create a process to assist Medicaid PRC patients with their care plans. The process must include substantial efforts to make an appointment for a PRC client to see the assigned primary care provider within a maximum of 72-96 hours of the client's ED visit when follow up is appropriate.

E – Narcotic Guidelines – Implementation of narcotic guidelines that incorporate the state agency medical directors' group and Washington American College of Emergency Physicians (ACEP) guidelines.

F – Prescription Monitoring – Hospitals must enroll ED Physicians in the state's Prescription Monitoring Program (an electronic online database used to collect data on patients who are prescribed controlled substances).

G – Use of Feedback Information – Hospitals must designate staff responsible for reviewing and monitoring the state's Medicaid utilization management feedback reports and taking appropriate action in response to the information in the feedback reports. The Hospital must have a system of Quality Assurance and can routinely identify, report, and correct cases of noncompliance with best practice.

While this project was born out of the Health Care Authority's desire to decrease costs associated with inappropriate Emergency Department admissions, it presents Medical and Emergency Department Social Workers with a unique opportunity to be part of an effort to coordinate care beyond the confines of the Emergency Department and to facilitate micro and macro level change. The Social Work role is naturally a good fit to work with high utilizers of emergency services and provide information and education on the appropriate settings for receiving care. It is also an opportunity for us to advocate for the availability of primary care for those who lack access to resources.

We as Social Workers may also be involved in crisis intervention, brokering services or assessing the motivation behind noncompliance or patterns of inappropriate usage. We can utilize our skills to identify what is important to the patient and what will engage them in change. This project has also (in my own health system at least) initiated a renewed focus on the importance of Emergency Department Social Work and the vital role that we play in providing care and preventing inappropriate admissions which will not only benefit the Health Care Authority but ultimately, the health care system as a whole.

Next Steps:

An impressive 100% of Washington Hospitals have signed on to participate in the ED 7 Best Practices project. The test will be to see if together we have effectively reduced inappropriate Medicaid Emergency Department visits by 1/15/2013.

For more information, please go to www.wsha.org

Stacia Fisher, MSW, LICSW,
Treasurer, SSWLHC WA Chapter,
Emergency Department Social Work Supervisor, Swedish Medical Centers
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Membership Matters

LICENSURE ALERT –

The Department of Health is implementing online renewals for state licensed professions. Social Workers, LASW and LICSW, are now able to renew electronically. Instructions will be provided with your next 'NOTICE TO RENEW' sent by the WA Department of Health. If you can't wait,

Renew Online -- http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/LicenseRenewals/RenewalsOnline.aspx

Scroll down to the link - Create an account with Secure Access Washington (SAW)

There is a $2 convenience fee to help cover the cost of the online system and credit card processing.

You will not be able to renew online if:

→ Your credential has expired.

→ Your credential status is currently Military, Inactive, or Retired.

→ You want to change your license status from Active to Military, Inactive, or Retired.

→ You have an address change.

→ You have a legal name change.

License renewals for social workers may still be completed by US Mail, in-person at the DOH counter in Olympia, via the DOH After-Hours Drop Box in Olympia, or via the Capitol Courier Service. DOH will continue to mail courtesy renewal notices.

Board Meetings are Open to SSWLHC WA Chapter Membership

The SSWLHC WA Board meets regularly on the 3rd Wednesday of each month from 6:00 to 8:00 PM. All members are welcome to attend. Schedule for the second half of our fiscal year is:

January 16	February 20
March 20	April 17
May 15	June 19

For information on Board meeting location, contact:

Carole O'Brien, Secretary at:
carolemsw@hotmail.com

or

Jacqueline Durgin, Communications Coordinator at:
jackiedurginbeck@comcast.net

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BREAKING INTO MEDICAL SOCIAL WORK
ADVICE FOR JOB SEEKERS

By Sarah Crane O'Neill, MSW

"Be prepared to come in through the back door," say established medical social workers to new graduates and other job seekers.

One director at University of Washington Medical Center describes a new medical social worker he knew who unsuccessfully tried the front door. She couldn't find a fulltime job in medical social work upon earning her MSW, so she took a job in a different field to pay the bills and worked short-term assignments (usually known as "per diem") in different medical settings on the side. She became a stronger social worker in the process, and as soon as a fulltime position opened, she was hired.

I surveyed four managers/supervisors at hospitals and medical centers in Seattle, Issaquah, and Bellingham to find out how job seekers can set themselves apart in this competitive niche.

Second best to graduate school practicums or per diem work in medical settings, they say, is experience in a similar role or setting. "I want to see that you are really interested and not just saying that to get into the field," says Denise Katterhagen, Social Work Manager at PeaceHealth St. Joseph Hospital Medical Center. "If you want to work in the ED, perhaps you could show that you were an ED volunteer in high school or maybe you could show that you did some fire fighter 'ride along' work. That would show me that you are not afraid of fast, quick work that may be trauma-based."

Relevant experience is more than a badge for your resume, it's proof to yourself and a potential employer that you know what you're getting into and you thrive in this type of setting. Brian Giddens, Director of Social Work and Care Coordination at University of Washington Medical Center, gives the example of discharge planning, a large part of all inpatient jobs. If you haven't done discharge planning in the past, he says, it's very difficult for an employer to know that you will enjoy it or be good at it.

Did I mention that medical social work is fast paced? I asked what aptitudes or skills are important to have, and everyone emphasized a comfort with working quickly. They also listed strong clinical and crisis intervention skills, good communication and documentation skills, and the ability to work on an interdisciplinary team. Stacia Fisher, Social Work Supervisor at Swedish Hospital, adds that her best new social workers aren't afraid to ask questions when they don't know how to do something, and they seek out feedback on their work.

Experience is more important than particular coursework, though one supervisor recommends classes or workshops on clinical assessment (the DSM), brief intervention, documentation, grief and loss, death and dying, and other relatable topics.

One respondent to my survey cautioned job seekers that hospitals are expecting social workers to take weekend and holiday shifts. Approach new positions and interviews with this in mind, she advises.

If you want to be a medical social worker, understand the niche on its unique terms, and be willing to "meet it where it is," just as you would a client. Spend some time getting experience in the field, pick up per diem work if nothing else is available, and eventually the right job will come.

Sarah Crane O'Neill, MSW is an Adoption and Foster Care Specialist with AMARA. Sarah has another passion, nonfiction writing. Having previously worked in a medical setting, this topic linked to some of her personal experiences. This is her first article for the SSWLHC WA Chapter Newsletter. She can be located at: sarah.crane.oneill@gmail.com

ESSENTIAL HEALTH BENEFIT
SSWLHC WA Chapter Sends Suggestions and Comments on Basic Requirements for Private Health Insurers

ESSENTIAL HEALTH BENEFITS FOR WAState (CR-102, June 2012, WAC 284-43-877)

The Essential Health Benefits for Washington State are being finalized. This is very important because it will set a floor for what all private health insurance in Washington will cover. SSWLHC Board and Social Health Policy committee membership had the opportunity to review the current draft for Essential Health Benefits for Washington State. Based on membership feedback, SSWLHC submitted the letter below to the Office of the Insurance Commissioner on December 10th, 2012:

"*The Society for Social Work Leadership in Health Care (SSWLHC), Washington Chapter appreciates the opportunity to comment on the Essential Health Benefits (EHB) for Washington State. Medical social workers recognize the key impact the essential health benefits package will have on patient care. The SSWLHC board asks you to consider the following suggestions to the current draft document. These suggestions are based on the direct practice experience of our membership.*

***Accessibility for Patients**: Although we appreciate the necessary complexity of this document, some changes to the organization of the document may help patients to understand their health care rights. Most importantly it is confusing how the document switches continuously back and forth between services that are covered and excluded. It would be helpful if the document could be clearly separated into two distinct sections of services that are covered and excluded. Also anything that could be done to simplify language and lower the reading level needed for comprehension would be helpful to patients.*

***Children's Care**: Concerns about cost shift to public schools: (pg8, 5-a-ii) Excludes treatment for diagnosis codes 302-302.9 in DSM-IV or V codes excluded except for a list of medically necessary services for children age 5 or younger. This will shift costs to school districts. Also it is problematic for families that are not a part of services for their child at school, for example in cases of parent-child relational problems or cases of abuse/neglect.*

*(**pg14, xviii-i) Neurodevelopmental therapy to age 6.** This is another shift to the schools which can't do enough as it is. There are lots of autistic spectrum kids who need intensive individual services past age 6.*

*(**pg11, 7-g-ii) Exclusion of "habilitative services and devices** delivered pursuant to federal individuals with disabilities education act of 2004 (IDEA) requirements or other habilitative services delivered in an educational setting." Again, another cost shift to schools which are not able to fund these key health services.*

***Dental Services:** **(pg4, 1-a-iii)** the policy should include restorative surgery for traumatic injury. Also services for patients with malnutrition due to dysphagia.*

***Diabetes Care:** Routine foot care: (pg 4, 1-a-ii) the policy should include routine diabetic foot care. We weren't sure if this might have been addressed in another section.*

***Obesity or weight reduction:** (pg 5, 1-a-vii) the policy should contain options for bariatric surgery as an option for treating diabetes.*

***Hearing Care: (pg11, c-i)** Hearing aid devices are limited to cochlear implants. Cochlear implants are not for everyone. Why would cochlear implants be covered and not more basic hearing aids? Does this mean even a hearing impaired pediatric patient cannot get a hearing aid?*

***Injectable Medication: (pg9, 6-c-i)** Why are prescriptions for self-administrable injectable medications limited to 30-day supplies at a time? Is there a medical reason? It seems counterintuitive since 90-day prescriptions*

ESSENTIAL HEALTH BENEFIT
SSWLHC Comments to the Insurance Commissioner's Office

are seen as more affordable to the patient and the health care plan.

Teaching doses of self-administrable injectable medications *are limited to three doses per medication per lifetime,(pg9, 6 –c-ii) . This seems unreasonable for pediatric patients like teens who are learning to do their own injections or for parents who are fearful of giving injections, or parents from other cultures for whom this would be a very new idea. This could become a barrier to discharge, needlessly increasing patient length of stay.*

Mental Health Care*: It was confusing that (pg8, 5) "mental health and substance use disorder services including behavioral health treatment" is covered, but not (pg8, 5-a-i) "counseling in the absence of illness." Please elaborate of the nature on the definition of this exclusion, as it would appear (pg9, d-i) Mental Health Parity statues would override all other specifications.*

EAP: (pg8, 5-b-i) *Why would the plan limit Employee Assistance Program counseling? And if it is limited does this refer to an incident/issues/calendar year etc.? Is this typically even covered by insurance, as it is an employee based program documented to increase workforce productivity?*

Pregnancy Care: (pg7, 4) *As a mother's heath during pregnancy is related to long-term health and well-being for her and her child, medical social worker in this practice area offered the following recommendation for essential benefits during pregnancy: The addition of coverage for routine and medically indicated dental care, and unlimited nutrition counseling, acupuncture, and or massage with provider referral.*

Transplant services: (pg6, 3-d-i) *housing for patients and caregivers when required by the transplant agency for patients travelling more than 50 miles from own home for treatment.*

Treatment Related to Gender Identity: *Related to (pg6 3-a-i) - Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy; The benchmark base plan's exclusion of cosmetic or reconstructive services makes an exception for cosmetic breast reconstruction following a medically necessary mastectomy. This exception is made with the intent of maintaining bodily integrity related to a patient's gender identity. Similar exceptions should be considered for individuals who would benefit from surgical interventions which align physical sexual organs with a patient's gender identity. At least partial coverage of such surgical interventions would have a very real benefit to patients, similar in nature to the benefits of breast reconstruction. As such, please consider omission or revision of (pg 6, 3-a-iv), exclusion of sexual reassignment treatment and surgery."*

Contributed by Angel Dawson, MSW,
Chair, Social Health Policy Committee
SSWLHC, WA Chapter

THE AFFORDABLE CARE ACT'S FEDERAL BASIC HEALTH OPTION: INSURANCE FOR LOW-INCOME INDIVIDUALS AND FAMILIES

We all know how expensive health care can be and the particularly devastating impact the cost has financially on low-income individuals and families. Thankfully, the Affordable Care Act is providing many opportunities to reduce the financial hardships experienced through health care costs and Washington State is actively working to put the new programs into action. However, our state is still on the fence about the Federal Basic Health Option. As those members who were at the SSWLHC Legislative Update heard from Cassie Sauer, right now "it is not going to happen." Although it may not be implemented with the rest of the health care reform programs, it is important to still be educated about the FBHO and keep it in mind for future legislative advocacy.

What is it?

A program, modeled after our current Basic Health plan, which would offer subsidized insurance to over 160,000 low-income individuals and families in Washington State.

Who is eligible?

Adults who are age 65 or under, between 133% -200% of federal poverty level, are not eligible for Medicaid, do not have access to affordable employer-sponsored health insurance, and are U.S. citizens or legally present immigrants or refugees.

Reasons to support the FBHO (outlined by WashingtonCAN!)

- It will be more affordable for low-income individuals and families with premiums as lows as $10 a month.
- It will be more cost-effective for Washington State and taxpayers.
- It will work more efficiently with other health coverage options.

It will provide better benefits for people who enroll.

Arguments against the FBHO

- It will lead to more churning between insurance programs.
- It will further complicate our state's health insurance system.
- Lack of support and guidance from the Department of Health and Human Services leaves an uncertainty to whether our program will be approved.

The above arguments are valid, but we must keep in mind the people who need this program. With them in mind, we can overcome the issues and arguments against the FBHO. As changes occur in our health care system, be aware of how this program would positively impact the health of the individuals and families we serve. Remember those stories we hear of the heart-breaking financial hardships caused by expensive insurance plans and exorbitant health care costs and its adverse effect on low-income individuals and families' health. And, when the time is right, let us take action and advocate for the FBHO.

WashingtonCAN!, NOHLA, and Statewide Poverty Action Network have all voiced their support for the FBHO. To learn more about how the FBHO will benefit our State, please contact the above agencies or visit their websites.

By Jeanese Hime, MSWc
Jeanese is a UW SSW graduate student. She can be contacted at: Janese.Hime@swedish.org

SUICIDE ASSESSMENT, TREATMENT AND MANAGEMENT TRAINING ACT OF 2012 TO BECOMES A SW LICENSURE REQUIREMENT ON JANUARY 1, 2014

By Mollie Forrester, MSW

Update on WA ESHB 2366:

There is a new law in Washington that aims to help lower the suicide rate in our state. It requires certain health professionals to complete training in suicide assessment, treatment, and management as part of their continuing education, continuing competency, or recertification requirements. Washington State House Bill (ESHB 2366) will go into effect January 1, 2014, and will require certain health professionals, including advanced social workers or independent clinical social workers licensed under Chapter 18.225 RCW, to complete six hours of continuing education in suicide assessment, treatment and management every six years.

The law is named after Matt Adler, a Seattle attorney suffering from depression and anxiety disorder who killed himself in February 2011. His widow, University of Washington social work professor Jennifer Stuber, urged passage of the law, saying early detection and competent care in the treatment of suicidal thoughts could have saved her husband's life.

On November 2, 2012, the Washington State Mental Health Counselors, Marriage and Family Therapists, and Social Worker Advisory Committee conducted a teleconference during which an update on ESHB 2366 was discussed. The following is a summary of that meeting and information from the draft bill based as of that date.

Per the WA State Department of Health (DOH), a "Training program in suicide assessment, treatment and management" means empirically supported training program approved by the appropriate disciplining authority that contains the following elements: suicide assessment (including screening and referral), suicide treatment, and suicide management. A qualifying program must be approved by the AFSP; the SPRC; an industry recognized local, state, national, or international organization as listed in WAC 246-809-620; an institute of higher learning; or an association which approves training programs based on empirically supported or best available practices. The DOH hopes to have a model list of training programs reported to the legislature no later than 12.15.13.

As things stand now, the first training must be completed during the first full renewal period after initial licensure or the effective date of the act, whichever is later. A person is exempt from the first training if they can demonstrate completion, no more than six years prior to initial licensure, of a six-hour training program in suicide assessment, treatment, and management on the best practices registry of the American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC). The hours spent in these trainings do count towards the total 36 hours of CE required for social work licensure every two years.

Of note, a state or local government employees, or employees of a community mental health agency or a chemical dependency program, are exempt from the training requirements if they have at least six hours of training in suicide assessment, treatment, and management from his or her employer; the training may be provided in one six-hour block or in shorter segments at the employer's discretion.

There will be one more public comment session mid to late winter 2013. The DOH hopes to have the entire bill finalized by spring 2013. You can receive notice of the rule-making process by subscribing to the DOH professions Listserv via the WA DOH website:

http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/SocialWorker.aspx.

Molly Forrester, MSW, is an Assistant Director of Social Work at Harborview Medical Center. She can be located at: mglosson@uw.edu

2012 LEGISLATIVE SEMINAR PROJECTS CURRENT LEGISLATIVE ISSUES

The WA Chapter's 8th Annual Legislative Update was held on December 12, 2012, at the Qualis campus at Northgate with 40 attendees participating. This annual event is positioned to provide our membership with an up to date look at the coming legislative session and the issues they will be discussing as well as an opportunity, to review in detail, local or federal regulations that will impact social work practice.

We were again fortunate to hear from Cassie Sauer, MSW, Senior Vice President for Advocacy and Government Affairs, Washington State Hospital Association and honorary SSWLHC WA Chapter member. She discussed the context of state government politics and leadership. She also described the health care issues at stake in the 2013 legislative session, including a once-in-a-generation opportunity for forward movement on health care coverage.

Cassie Sauer, MSW

For additional information, contact Cassie Sauer at: ***cassies@wsha.org***

The 2nd half of the 2012 program featured a presentation based on a paper written by Selena Bolotin, LICSW, Director WA Care Transitions & Patient Safety for Qualis Health and Carol Charles, MSW, LICSW, CCM, Project Manager for the University of Washington Medical Center's Initiative to Reduce Readmissions and presented at the 2012 National Society for Social Work Leadership in Health Care conference in Denver, Co., in October 2012. The presentation outlined the process, problems and solutions found while working on the initiative underway at the UWMC.

Carol Charles, LICSW

The Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154)..

The UWMC experience has focused initially on cardiology but will expand to more diagnosis related groups.

For additional information, Contact Carol Charles at : ***carolc6@u.washington.edu***

Over 35 members and their colleagues attended the 2012 Legislative Update featuring Cassie Sauer, MSW, Senior Vice President of the Washington State Hospital Association and Carol Charles, MSW, Project Manager, UWMC Initiative to Reduce Readmissions.