VOLUME 13, ISSUE 3

WASHINGTON STATE NEWSLETTER

JULY 2011 ALOHA EDITION

SSWLHC ADVOCACY, PRIORITIES, ISSUES & ACTIVITIES

- **NASW WA SEPTEMBER 23, 2011, 'GOOD ETHICS, GOOD PRACTICE: HOW RULES, LAWS, RISK MANAGEMENT AND CODES OF ETHICS RELATE TO THE DYNAMIC REALITIES OF OUR DAY TO DAY WORK' JOAN GOLSTON, DCSW, LICSW**
- **SSWLHC OCTOBER 26-29, 2011 46TH ANNUAL NATIONAL MEETING AND CONFERENCE 'SOCIAL WORK IN HEALTH CARE: NAVIGATING OUR TROUBLED WATERS' THE SAN FRANCISCO FAIRMONT SAN FRANCISCO, CA**
- **NASW WA OCTOBER 20, 21, 2011 'THE DYNAMICS AND SKILLS OF CLINICAL SUPERVISION: AN INTERACTIONAL APPROACH' SWEDISH MEDICAL CENTER—CHERRY HILL LAWRENCE SHULMAN, MSW, ED.D**

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FELICITY BURDICK SELECTED 2011 SCHOLARSHIP WINNER

Felicity Burdick, 2011 SSWLHC Scholarship win-

Felicity Burdick of the UW SSW is the 2011 winner of the SSWLHC WA Chapter $2,000.00 student scholarship. She begins her MSW program in July 2011 with the goal of earning her degree in 2012 with specialization in gerontology and healthcare. Felicity's background indicates a variety of entrepreneurial and service experiences that have fueled her desire to work on a master's degree in social work.

Felicity was born in South Africa and raised by progressive parents during the Apartheid years. According to references, "Felicity had the unique opportunity to witness first-hand the ravages of a racist and very harsh political system but grew up in an open and accepting home environment where all ethnic groups were welcomed. The family was often

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LINDA BRANDEIS RESIGNS SSWLHC OFFICE SPECIAL ELECTION SCHEDULED

Linda Brandeis, 2011 WA Chapter President Elect, has resigned that office effectively immediately. Her letter to the Board follows:

"Brian Giddens, President

It is with difficulty that I write this letter. I am resigning from the President-Elect position on the Board. I have both personal health issues that require a cut back in my activities and commitments and I have had to take a hard look at myself and my expectations of what needs to happen to be successful in this role, and I do not have the ability to do that at this point.

See Board Nomination of Mike Hays Page 12 ***Continued on Page 12***

COMMUNITY HEALTH PLAN OF WASHINGTON

The Mental Health Integration Program in Washington State

By Betsy Jones, MBA, MSW and Stacy Heinle, LICSW

Since 2008 Community Health Plan of Washington (CHPW) has been working with DSHS to provide mental health treatment in the primary care setting for recipients of Disability Lifeline (DL) benefits. Prior to this, mental health benefits were not available to those receiving DL. In order to qualify for DL, DSHS must determine the individual has a limited income, limited resources and is mentally or physically incapacitated, leading to an inability to work for greater than 90 days. An evidence- and outcome-based model of collaborative stepped care, referred to as the Mental Health Integration Program (MHIP), was adopted and is now operating in all 39 counties of Washington State to provide care for DL recipients.

MENTAL HEALTH INTEGRATION PLAN

MHIP is a patient-centered model of care with mental health clinicians, referred to as care coordinators, working collaboratively with Primary Care Providers (PCP) and consulting psychiatrists to create treatment teams. The care coordinator is able to facilitate the sharing of medical and mental health information between team members in an effort to better serve their patients. Other members of the treatment team may include DSHS, chemical dependency treatment providers, vocational rehab providers and anyone else working with the client.

MENTAL HEALTH INTEGRATION TRACKING SYSTEM

Those working as part of the mental health and medical treatment team have access to the Mental Health Integration Tracking System (MHITS). This patient registry has been designed to record client information and uses evidence based screening tools such as the PHQ9, GAD7, GAIN SS and others, to assess patient progress toward goals. The information can then be transferred to the patients Electronic Medical Records. The MHITS tool also prompts care coordinators to make referrals to other supportive programs their clients may need. For example, if a care coordinator determines their client's incapacity may last longer than 12 months, a referral to facilitate their application for SSI can be made through MHITS. Another benefit of using this tool is reducing the number of times a client has to repeat the same information to multiple providers.

The majority of clients being served in MHIP have been diagnosed with Depression, Anxiety, or Post-traumatic Stress Disorder (PTSD), and can be effectively managed and treated in the primary care setting. There are times when the integrated care team feels a client would benefit from a higher level of stepped care. This level is typically provided at a Community Mental Health Center and includes a face to face appointment with a Psychiatrist and additional specialty services. There is a limit of six months to this level of treatment and specific goals are set by the primary care treatment team when the referral is made. Once the client enters this level of care, those providers also have access to/ add to client information in MHITS.

CARE COORDINATORS

Our care coordinators meet Department of Health criteria for mental health clinicians, and also receive additional and ongoing training to provide evidence based interventions, while working in a primary care setting. Clinical supervision and training for Motivational Interviewing, Behavioral Activation and Dialectical Behavioral Therapy's Distress Tolerance is available through or partnership with the University Washington Department of Psychiatry. Training on specific topics have included managing patients with chronic pain, supporting medication therapy, problem solving treatment are offered throughout the year. Roundtable support and discussion groups are held several times a year as an opportunity for care coordinators to give feedback to program managers about challenges and best practices.

EVALUATION FINDS ENCOURAGING RESULTS

In January 2011 the Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations (CHAMMP) published their evaluation of the MHIP pilot. The pilot ran from January 2008 through September 2009 in King and Pierce counties and included all the program elements described. Data related to the impact on state cost for managed medical/ mental health care, the health and well-being of enrolled members, and the use of other social services was analyzed. This same data was evaluated in the comparison counties of Whatcom, Skagit, Snohomish, Kitsap, Thurston, and Clark. Results of the evaluation included a reduction in inpatient medical admissions, smaller increase in inpatient psychiatric cost, a decrease in the number arrests, and a smaller increase in the proportion living in homeless shelters or outdoors, in the King and Pierce Counties, as related to the comparison counties. (1)

PERSONAL STORIES

The results of this early evaluation are certainly encouraging and indicate moving in a positive direction. But they are not nearly as powerful as hearing MHIP participants tell their stories. At the MHIP statewide meeting last fall the most powerful speaker was a woman who told her story which began with the loss of employment, relationships with family and friends, and her sense of stability. She talked about not being able to leave her apartment because the fear and anxiety was so great. She spoke of feeling worthless and hopeless, yet she continued to see her doctor. Once the connection with the care coordinator was made and she began to fully participate in MHIP, her life began to change. She spoke of receiving the tools she needed to deal with stress and began setting and meeting goals. Because clinical screening measures were taken regularly by the care coordinator she was able to see her progress, and this led to a fuller understanding of her triggers and cycles. There are many other stories like this across the state.

CHPW IS DELIVERED STATE-WIDE

Part of Community Health Plan of Washington's mission is to deliver accessible managed care services which meet the needs and improve the health of our communities, and we believe MHIP is doing just that. We have established a statewide program to treat the medical and mental health issues among some of our most vulnerable populations which has improved the lives of our clients and communities. Social workers by profession, Betsy Jones, MSW, MBA and Stacy Heinle, LICSW help continue to develop and implement this program throughout Washington. They welcome any calls or questions you may have regarding accessing these important services, Stacy can be reached at 206-613-8894. CHPW will continue to lead the way for the integration of all behavioral health issues in the primary care setting, not only for those receiving DL but for all vulnerable individuals.

Additional information can be found on the internet: http://integratedcare-nw.org/ or http://chammp.org/

Reference:

Evaluation of the General Assistance Managed Care Pilot in King and Pierce Counties for the Period January 2008 through September 2009, Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations 2011, 25.

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Stacy J. Heinle, LICSWS, Program Manager, CHPW can be contacted at:: stacy.heinle@chpw.org

FELICITY BURDICK

2011 SSWLHC SCHOLARSHIP WINNER

Continued from Page 1

ostracized by their Caucasian peers. This pivotal experience has deeply enriched her understanding and valuing of cultural, racial and socioeconomic differences. It has provided Felicity with a strong foundation to understand oppression and an abiding desire to work for social justice.

Felicity graduated from the University of South Africa in Cape Town with a bachelor degree in social science in 1974 For more than 25 years she engaged in multi-cultural community work including crop picking in an Israeli Kibbutz, the African Children's Feeding Scheme, the education of students on Diversity, and in the spring of this year, interning at St. Luke's Hospice in South Africa.

Felicity moved to the Pacific Northwest in 1987 from Denver Colorado, due to the economics of the time. Her work continued to be in the area of service to others but was taking an entrepreneurial bent. By 1995, she took some classes in Early Childhood Education at Bellevue Community College and earned a Montessori Teaching Certificate. She was the founder of the Children's Garden Learning Center in Bothell, WA. This work included developing the business plan, obtaining the necessary licenses for the new school, designing the Montessori curriculum for 3 – 7 year olds, recruiting the teaching staff, and conducting parent-teacher counseling to ensure a successful school experience.

In the year 2000, Felicity changed career paths and joined Alaska Airlines in Seattle as a Crisis Management Representative, representing the airline as a CARE team member. Her responsibilities included notifying families of the loss of loved ones, relaying information from the Federal Aviation Administration (FAA) National Transportation and Safety Board (NTSB) and the Red Cross to families of victims. She also provided direct customer service to mileage plan members.

In 2005, she became the co-owner of Quest Motors, Inc., of Lynnwood WA, a car dealership. She managed a team of independent wholesale representatives, designed and implemented a new bookkeeping system, and ensured bottom-line accountability increasing sales by 50%. In 2007, she worked as the Director of Customer Satisfaction for One Command of Cincinnati, Ohio, an organization offering multi-channel marketing and communication tools for car dealerships. In this capacity, she worked to resolve customer issues through mutually beneficial agreements, and coordinated several diverse teams to achieve intra company dialogue.

In 2009, Felicity began working for Merrill Gardens, an Assisted Living Facility organization, as a customer service specialist. She assisted the General Manager with administrative duties and provided customer service to senior residents.

By the mid 2000's, Felicity realized that her interests were pointing her in the direction of a social work degree. In discussions with the School of Social Work, she discovered that to realize her dream, she would have to start with an admission to the undergraduate program at the University of Washington to work on an undergraduate BSW. She began that work in 2008, with practicum placements as a Hospice intern at Evergreen Hospital and clinical social worker in the Mercer Island Senior Health Center outpatient program. She has now achieved that goal and has been admitted to the highly competitive advanced standing MSW program beginning this month.

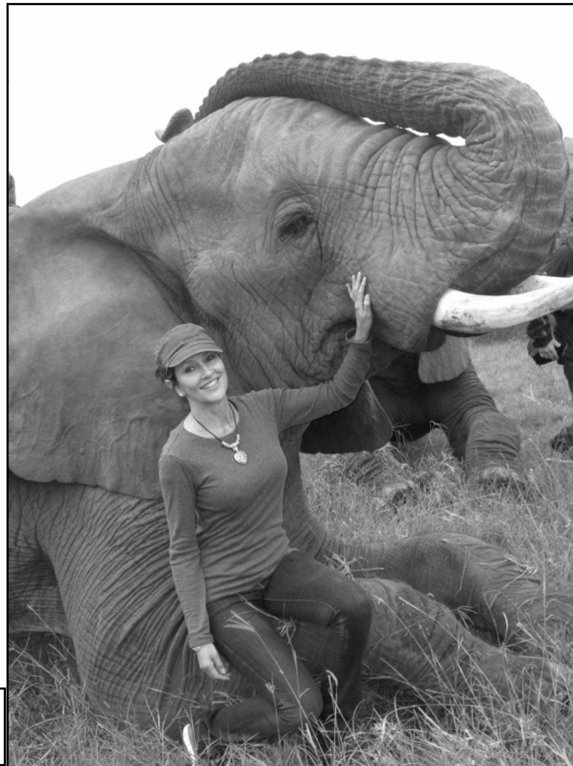
"As a result of adverse life circumstances I find myself reinventing my career in a field that I am passionate about – gerontology. Social work is a

natural fit for me . I have been a community volunteer all my life and as an adult with two independent children, I was finally in a position to fulfill a lifelong goal of obtaining credentials in a field that I enjoy.

I returned to college in my mature years to pursue a Masters' degree in social work with the intention of specializing in senior health care. The support of faculty member Professor Nancy Hooyman, University of Washington, and the inspiration of Karin Miller, geriatric social worker Overlake hospital, has empowered me to pursue the goal of working with seniors in the field of health care.

Personal experience with hospice introduced me to the critical psychosocial role that social workers fill in the medical setting. After shadowing an MSW hospice worker in Mount Vernon, Washington, I knew this would be a good fit for me. In order to meet an undergraduate community service learning requirement I interned at Evergreen hospice. My duties included hands-on inpatient care, bereavement counseling and respite care in the community. During my senior undergraduate year my field placement was at Overlake hospital senior health center where I conducted patient assessments, facilitated caregiver support groups and worked with clients in the community on resource management and intervention. I am currently interning at St Luke's hospice Cape Town, South Africa - a cancer inpatient center.

I am a strong believer of the importance of interdisciplinary team work in the medical setting. Specialization is critical to serve patients well. In order to be effective a high level of communication between the disciplines is of paramount importance. During my experience in various hospital settings I have noticed that the role of medical social worker is often misunderstood and not highly valued. I believe that this should be changed. I intend to advocate for medical social workers and encourage my peers to promote the importance of their role and earn respect for our profession."



Felicity and Friend in
Cape Town, South Africa

NATIONAL MEMBERSHIP EMAIL RENEWAL COMING SOON

There have been some changes in terms of renewing National Dues. As you may recall, the chapter dues and national association dues are being merged as of July 1st, and ***annual dues to be a full-fledged member of the SSWLHC will be $85.00 at the direct care level ($140.00 for members who are in management positions). This includes all the benefits of national as well as local chapter membership.***

BENEFITS

Benefits include reduced rates for continuing education (workshops, conferences, as well as webinars and publications), weekly "e-blasts" on topics relating to health care social work, an upcoming member-only list-serve, access to the online journal of "Social Work in Healthcare", the quarterly "The Leader" newsletter and the ongoing newsletters that our local chapter produces. While the rate is higher than many of you who are local members have been paying, we hope that you examine the benefits and join with many of us who have long been national members as well as local chapter members.

NOTIFICATION BY EMAIL

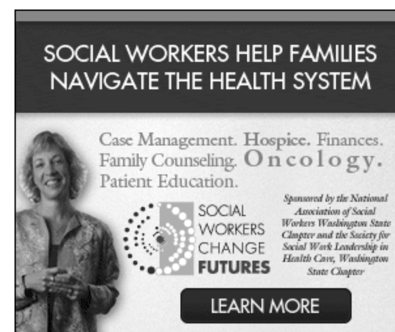
In order to be most efficient with the dues dollars, ***renewals will be sent online via email, in the month of June.*** National is in the process of setting up an improved software system for processing memberships, so even though the membership dues are due in July, there will be a "grace period" due to the delay in sending out the notices. The advantage of the new software is that it will allow new members to automatically be linked to all the features of membership as soon as the sign-up occurs.

ARE YOU RECEIVING EMAILS FROM NATIONAL?

For those of you not receiving emails from National, such as the weekly "eblasts", please go to the website www.sswlhc.org, and check to see if the email listed for you is correct. To find your member information, go to the "members" section, enter your user ID and password, and click on your member profile. If your email information is correct, it may be that the emails are being received as spam. There is a spam filter guideline on the site (home page-at the very bottom of the screen on the right hand side) that can help you to clear any blocks to your email system.

LOCAL CONTACT

If you have any questions about membership, please contact Selena Bolotin, at: selenab@qualishealth.org



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SSWLHC

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Published Quarterly by SSWLHC, WA Chapter, Seattle, WA
January, April, July, October
1620 43rd Avenue East, Suite 4B, Seattle, WA 98112

Letter From The President

By Brian Giddens, MSW, LICSW,
WA State Chapter President

Harm Reduction for Hospitals

Hospitals and health care systems are increasingly feeling effects from two significant forces. One is the decline of public dollars used to help cover some of the costs of health care. The other is the increasingly tight reimbursement environment, from public and private funders, that requires hospitals to be more creative than ever before. In such an environment, the social work profession, with its problem-solving skills, community-based perspective, and ability to bring groups together, has much to offer.

Let's first look at the forces that are motivating change. Washington State has restricted access to the Basic Health Program for some time to come. Medicaid funding for several programs has either been eliminated or decreased. Community Health Centers, recipients of referrals from hospitals seeking follow-up care for uninsured or under-insured patients, have been hit with more cuts. The mental health and chemical dependency services that already felt grossly underfunded are absorbing yet more reductions in state funding.

At the same time as these cuts to hospitals and the services they depend on are occurring, hospitals are being asked to justify to funders to an even greater degree that patients need the care that they receive, and that the costs are reasonable. CMS is contracting with external organizations that are aggressively auditing health care systems to ensure that their billing is legitimate (the aggression is in part due to the external contractors receiving a percentage of money returned to CMS by the hospitals). CMS is also setting up a financial penalty plan for hospitals that have high rates of readmissions. The penalty will not just be related to the specific readmission, but to all readmissions within 30 days.

Brian Giddens, MSW,

In times of stress, it is best to understand one's scope of control. Looking at shifting patient mix has been one solution for some hospitals, but identifying and securing the "ideal" patient is unrealistic in these constantly changing times (and raises significant ethical questions). If the hospital cannot change the patient mix, the hospital needs to change course and move away from the traditional model of care. "Harm Reduction" is a term long associated with reducing adverse consequences of drug use and other high risk behavior. Hospitals are in a "high risk" situation, and while we cannot eliminate the consequences of the current health care pressures, we can take steps to reduce the harm by thinking "out of the box." Here are some ideas on how hospitals can move to a harm reduction model:

Look outside to save dollars inside. We have heard a lot about "silos" and inpatient care is a mammoth silo in itself. We can spend millions treating people with the latest equipment and technology, but disconnect the patient once they leave our doors. If we are to be responsible for readmissions, we need to work with the organizations to which we refer, to make sure that they are able to follow the plan. We also need to partner pre-admission, to see if we can prevent unnecessary admissions. This means engaging with community programs, collaborating on patient hand-off's, increasing our accessibility so that if problems occur once discharge happens, the organization accept

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STATE OF WA POLICY UPDATES

After a 105-day regular session and a 30-day special session the Washington State Legislature adjourned the 2011 legislative session on May 25. As expected the final budget includes significant cuts impacting healthcare and the most vulnerable in our state, although it was ultimately better than the initial proposals. Some of the most significant cuts and changes:

Basic Health: The new budget limits eligibility to those who will be covered by the 2014 Medicaid expansion; disenrolls immigrants; and further reduces enrollment in the subsidized health insurance program from the current level of 38,475 to 33,000 people by 2013.

Disability Lifeline: Continues the medical portion of this temporary safety net for the disabled poor, but changes the cash grant program into a housing assistance program.

Apple Health for Kids: Continues current eligibility. Immigrant children with family incomes above 200% of the poverty level must pay the full cost of their premiums. Also establishes a new Disproportionate Share Hospital (DSH) program to provide $2.8 million for inpatient and outpatient services for children not eligible for Medicaid or the Children's Health Insurance Program.

Regional Support Networks: Cuts funding for state patients receiving mental health services through a $17 million cut for Medicaid services and an $8.7 million cut for non-Medicaid services.

Maternity support services: Cuts funding by 30 percent for services that improve birth outcomes for at-risk pregnant women.

"Non-emergency" visits: Limits payments to three per year for "non-emergency" emergency room visits for Medicaid patients. Of concern is that many of these non-emergency conditions could be life threatening or lead to permanent disability.

DSH payments: Preserves the indigent assistance DSH program, but reduces payments for both the indigent assistance and low income DSH programs by 40 percent.

The following bills have direct impact on healthcare services:

State health insurance exchange: Senate Bill (SB) 5445. The exchange will offer government subsidies for health insurance to anyone not on Medicaid with income up to 400 percent of the federal poverty level. This makes Washington the fourth state in the nation to start implementing a state-based health insurance exchange, and will ensure that our state's Exchange is up and running by January 1, 2014, a major milestone established by the Affordable Care Act. The expectation is the exchange could provide health insurance for 400,000 to 500,000 people.

Mental health information: SB 5187. This bill requires hospital emergency departments and mental health units to provide treatment information to parents seeking mental health care for their children. The Washington State DSHS is tasked with creating an informational document to give to parents.

Vaccines: SB 5005: This bill requires parents to talk to a health care provider before they are allowed to refuse to immunize their children. The policy goal of the bill is to ensure parents make an informed decision, having received medically accurate information about the benefits and risks of immunization. The bill sponsors also hope to decrease the number of "convenience" opt-outs, signed by parents who chose to opt out instead of tracking down vaccination records or visiting a provider to ensure their child's immunizations were up to date.

For additional information, contact:;Tricia Mattson, MSW, Social Health Policy Chair, trimatt@comcast.net

Letter from the President, Brian Giddens, Cont.

Continued from Page 7

ing the hand-off has a chance to confer with the hospital about resolving the problem in the community, not by sending the patient back to the ED.

Spend money to facilitate the ongoing plan. Traditionally, hospitals discharged to services that were on their own in terms of finding reimbursement. For some needed services, that model just doesn't work anymore. After four years, a partnership between King County hospitals and Seattle King County Department of Public Health has led to the opening of an expanded medical respite program this summer. The program will accept referrals of homeless patients with medical needs from participating hospitals and long-term care facilities, and provide nursing care, access to social services, and connection to mental health and chemical dependency programs. For the first time, hospitals will be paying for respite referrals, but the gain is that the funds support a program with the capacity to serve homeless patients with medical needs, beyond traditional medical respite. The expected savings of reduced length of stay and lowered readmissions are expected to be significant, but at the same time, the care is at a more appropriate level, and provided by people who understand the needs of this population. This is one example of where the hospital may need to help build, or support programs that can help meet the patient's needs post-discharge.

Be humble, and listen. For years, organizations have been courting hospitals for referrals-isn't it about time hospitals recognized the value of community organizations in keeping their patients healthy? Hospitals are amazing-big, bright boxes of activity, filled with smart people and lots of action. There is a reason why shows like "ER" exist, and shows depicting Home Health or Day Health are not seen on even the lowest rated cable channels. But health care is more than the hospitalization. A hospital is a momentary blip on the screen for most individuals-it's the community that provides ongoing care. What can we do to make the progression of care go more smoothly for these organizations, so that they are spending more time with the patient and not in pleading for discharge plans or trying to make marketing calls?

Expand the concept of internal system case management. Currently at UWMC, we are beginning a review of patients who have utilized multiple services within the UW Medicine system. We are finding that in some of these cases, the patients did not show up as "problems" in the regular ways. They did not have long lengths of stays, or unnecessarily high cost procedures. They were not referred to social work as individuals with multiple needs or behavioral issues. But they did consume an enormous amount of service by going from clinic to clinic, in and out of the ED, and having multiple admissions over time. What we found was that there was no central case management role to ensure that a plan was in place for these patients that coordinated the work of all the providers, and was available to review at every access point in the system. Just as we have silos between inpatient and outpatient care, health systems have silos between services and clinical areas. The experience for the patient resembles a health care version of the film, Groundhog Day-each visit recreates a new assessment and a new plan, with no continuity or shared planning from site to site.

While challenging, this is also an exciting time for health care. The focus on shared responsibility for patient outcomes makes it essential to try new approaches, and the limits on funding will require increased creativity. It is times like these when our work and skills become even more valuable in the health care arena, as we lead the way towards harm reduction for our organizations.

Brian Giddens, MSW, can be reached at: bgiddens@uw.edu

VENDOR FAIRE A RESOUNDING SUCCESS

SSWLHC CELEBRATES SOCIAL WORK MONTH

The Washington Chapter of the Society of Social Work Leadership in Health Care, CHOICE Advisory Services and The Chateau at Bothell Landing celebrated social work month by inviting all Medical Social Workers in WA state to a Vendor Faire and lecture. CHOICE Advisory Services assisted the Chapter in the organization of the affair, and the Chateau at Bothell Landing, a retirement and assisted living facility hosted the event and provided a delightful buffet lunch for the attendees.

The objective of the annual Vendor Faire is to provide community resource information to social workers that is specific to their work. We had more than 30 vendors in attendance, most of whom offered door prizes in addition to valuable information. These vendors also provided raffle items.

A session on Self-Care was presented by Stephanie Wichmann, MSW, that carried a free CEU. Stephanie is a graduate of Portland State University and is a social worker specializing in weight management, body image and eating disorders.

Stephanie Wichmann, MSW, LSWAIC

With a history in professional theater and comedy, Stephanie provided a very entertaining hour-long session that helped us cultivate our inner-comic.

Stephanie stressed the importance of using humor for on-going self-care, getting more humor and laughter in your life as well as using humor with clients.

More than 50 people attended the session on self-care with Stephanie Wichmann.

More than 30 Vendors set up tables and provided social workers with information. The vendors represented businesses addressing everything from residential care options to transportation, DME, medical and alcohol rehab programs, nutrition, home care, and other services to the elderly.

The Society wants to express their thanks for the work and hospitality provided by Choice Advisory Services and Chateau Retirement Communities. Your work in our behalf is deeply appreciated.

TITLE PROTECTION - - IT'S THE LAW

On Friday, April 15, 2011, Governor Christine Gregoire signed SB 5020, which will protect professional social workers and consumers by assuring persons using the title of social worker have graduated with a degree in social work from an accredited educational program. The legislation becomes effective January 2, 2012.

Summary:

A person may only use the designation of social worker if the person is licensed by DOH as a social worker, or has graduated with at least a bachelor's degree from a social work educational program accredited by the Council on Social Work Education.

The provisions of this act do not apply to:

- persons employed by the state of Washington with the job title of social worker, so long as the person remains employed
- persons employed in Washington on the effective date of the act with the job title of social worker, so long as the person remains employed with the same agency;
- persons employed by the state of Washington with the job title of social worker, so long as the person remains employed with the state;
- individuals employed by the government of the United States while engaged in the performance of duties prescribed by the laws of the United States ; or
- persons providing services as an educational staff associate who are certified by the Washington Professional Educator Standards Board.

Educational Reference:

References to the term social worker throughout the RCW are modified to reference the educational requirements for a qualified social worker depending on the setting or persons being served as follows:

- a person must have a master's or other advanced degree in social work to use the designation of social worker when: providing services to those with mental illness, and supervising court ordered contact between a child who has been sexually abused by a parent and the offending parent;
- a person must have a bachelor's degree in social work to use the designation of social worker when providing rehabilitative services in nursing homes;
- a person must have a bachelor's degree in social work or meet the federal qualifications for a social worker in order to use the designation of social worker when providing services to those in home health or hospice care; and
- job titles previously designated as social worker but for which there is no educational requirement in social work have been removed and are replaced with the term department employee.

For purposes of mandatory reporting of abuse, the term social worker includes anyone who has a bachelor's degree in social work or who is engaged in a professional capacity working with vulnerable adults during the regular course of his or her employment.

Engaging in the improper practice of social work is an unfair trade practice and unfair method of competition under the Consumer Protection Act.

Full text: http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Session%20Law%202011/5020-S.SL.pdf

Tricia Matteson: ***trimatt@comcast.net***

SSWLHC BOARD NOMINATES HAYS FOR PRESIDENT-ELECT

Mike Hays has been nominated by the SSWLHC Board to run for the office of WA Chapter President-Elect to complete the term recently vacated by Linda Brandeis. Mike was nominated as President Elect in this last election and lost to Linda Brandeis by 3 votes. Subsequently, Mike was appointed to the Board as Board Member at Large beginning in January 2011. He has good knowledge of the workings of the Board, and an interest in continuing the educational programming that is an important part of Board activity.

Mike has been a SSWLHC member since 2002 and an officer in NASW. Following is Mike's statement:

MIKE HAYS, MSW, LICSW, MHA

I am interested in helping the SSWLHC complement clinical work with some leadership-oriented volunteer work, for the promotion of the social work profession within health care settings.

As a member of the WA Chapter SSWLHC since 2002, I have written several management articles for the Chapter Newsletter. I have also been an active member of NASW since 1988, volunteering as Treasurer, Region Rep. and other roles. I am a Licensed Independent Clinical Social Worker and Licensed Mental Health Counselor—with private practice focused solely on supervision of clinicians toward licensure. Currently this private practice work is pro bono.

In addition, I was recently promoted to Social Work Manager at Group Health Cooperative, managing a staff of social workers whose practices are from Olympia to Bellingham. I have 20 years of prior social work experience receiving my MSW in 1991, and an MHA in 2003.

I previously held certifications as a Case Manager (CCM) and Professional in Healthcare Quality (CPHQ).

BRANDEIS RESIGNS

Continued from Page 1

I have talked with Brian about my situation and it is my understanding that he has talked to Michael Hays who has agreed to step in (for the nomination). I want to thank Mike for taking this on and appreciate his willingness to step up at this time. I will work with (the new President-Elect) to make sure that the (Education) committee and the thoughts that we have been formulating can be moved forward smoothly.

Thank you for your support with this decision. I look forward to working with you all and support the chapter in any way that I can.

Sincerely,

Linda Brandeis.

Current WA Chapter SSWLHC By-laws, Section 11, Vacancies, Rev. 3/05, require a special election to fill that office.

"In the event of a vacancy in the office of President Elect a special election by the membership shall be held.."

To fulfill that requirement, the Board has nominated Mike Hays to the post. This Newsletter is your formal notification of the resignation and subsequent Board nomination.

Enclosed is a postcard for your vote. Please return your vote by July 31, 2011.