VOLUME 13, ISSUE 4

WASHINGTON STATE NEWSLETTER

OCTOBER 2011 BEDBUG EDITION

SSWLHC ADVOCACY, PRIORITIES, ISSUES & ACTIVITIES

- **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
- **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 DECEMBER 3, 2011**
  LASW—LICSW LICENSURE EXAM PREPARATION
  HIGHLINE MEDICAL CENTER
  SOMERS AUDITORIUM

INSIDE THIS ISSUE:

HAYS ELECTED	1
DSHS HEALTH CARE UPDATE	1
REDUCING PREVENTABLE READMISSIONS,	2-3
BEDBUGS, A PUBLIC HEALTH PEST RETURNS	4-5
MEMBERSHIP MATTERS	6
PRESIDENT'S LETTER	7
SSWLHC NATIONAL MEETING	
AFFORDABLE CARE ACT TIMELINE	12

MIKE HAYS, MSW
ELECTED PRESIDENT-ELECT

Mike Hays is the new President-Elect effective August 1, 2011, elected in the special election held in July. He succeeds Linda Brandeis who resigned for personal reasons.

Mike is the Manager of Social Work at Group Health Cooperative of Puget Sound, with responsibility for social work practice from Olympia to Bellingham. He received his MSW in 1991 and a MHA in 2003 and has been a SSWLHC WA Chapter member since 2002. He holds licensure as an LICSW and LMHC. He previously held certifications as a Case Manager (CCM) and Professional in Healthcare Quality (CPHQ). Mike's clinical practice has ranged from inpatient hospital, outpatient clinics, home health and hospice, subacute and long term care, to management at GHC and The Community Health Plan of WA. Mike has also held office with NASW as Treasurer and Regional Representative.

Mike's particular interest as SSWLHC President-Elect is to help the WA Chapter complement clinical work with some leadership-oriented volunteer work to promote social work within health care settings.

DSHS HEALTH CARE POLICY UPDATE
SEPTEMBER 2011

By Tricia Mattson, SSWLHC Social Health Policy Chair

Following is a summary from the DSHS Stake Holders Meeting of September 2011:

CHANGES TO DISABILITY LIFELINE:

A new state law ends the Disability Lifeline cash program on October 31, 2011 and creates three new programs beginning November 1, 2011:

> Aged, Blind, or Disabled cash assistance program

> Pregnant Women Assistance program

> Housing and Essential Needs

Continued on Page 9

REDUCING PREVENTABLE READMISIONS:

By Carol Charles, LICSW, CCM

"Mrs. Jones, I reviewed your chart and see that you were here just 2 weeks ago. Could you tell me what you thought happened to cause you to be readmitted? I'm asking because we want to do the best possible job in preparing our patients to have a good recovery when they leave the hospital."

Have you started asking your patients this question? Have you learned anything that challenges the way you go about planning for transitions of care?

BACKGROUND

Experts estimate that as many as 20 percent of US hospitalizations are rehospitalizations within 30 days of discharge. These re-hospitlizations are costly, and potentially avoidable.

Under the Affordable Health Care Act, hospitals will be penalized for higher than expected Medicare 30 day readmission rates for diagnoses of heart failure, pneumonia and acute myocardial infarction. All causes of readmissions and readmissions to other hospitals will be included in determining a hospital's rate. While penalties are slated to start in 2012, we've just learned that the "look back" period will encompass the past 3 years. While most hospitals have started addressing readmissions, many of us already feel behind!

National demonstration projects have identified best practices for improving transitions of care, and reducing a patient's risk of readmission. These include:

- Identifying and communicating with the patient's PC (Primary Care Provider) on admission
- Performing medication reconciliation at admission and discharge
- Scheduling follow up appointments before the patient leaves the hospital
- Ensuring follow up appointments within 7 days
- Calling patients at home within 48 hours of DC
- Providing the discharge summary to the PCP promptly (and a provider to provider phone conversation is even better)
- Using the Teach Back Method to assess patient understanding
- Providing patient-friendly discharge instructions that clearly state signs and symptoms to watch for, when & who to call if those symptoms are experienced.

Other studies have demonstrated success using care coaches, home visits from advanced practice nurses, specialized post hospital clinics, community agency partnerships and telemonitoring.

IMPLICATIONS FOR SOCIAL WORKERS

Social workers play a key role in assessing, coordinating care, informing and empowering patients. We serve as advocates and case managers. Just as we worked for years to balance the hospital's need for appropriate length of stay with the patients' needs and safety issues, we can take a lead in efforts to reduce preventable readmissions in a collaborative, patient centered way.

One patient's wife shared her experience at discharge: "The nurses, doctors, everyone, emphasized so strongly that providing the right care for my husband at home was high stakes. It was vitally important that I knew what to watch for, what to do and when to call for help. Their attitude, their display of concern made all the difference to me". This genuine concern for a successful transition from the hospital goes a long way to make a complex discharge safe and sustainable. What a contrast to the comments we sometimes hear from patients that discharge felt rushed, little teaching occurred and concerns were minimized.

WHAT CAN SOCIAL WORKERS DO NOW? In addition to our assessments and referrals, consider the following:

ASK FOR DETAIL ABOUT THE FOLLOW UP VISIT.

Reducing risk of readmission can require some drilling down of our usual questions about the post hospital plan. Does the patient really intend to return to his

OPPORTUNITY FOR SOCIAL WORK

PCP of record? Does he need help to make a follow up appointment? What about transportation? Should the follow up appointment be made on a day when a family member can accompany?

At the UWMC we are piloting a Medical Team Assistant position. This Bachelor's level social worker is responsible for confirming the PCP with the patient or helping him to find a new one, notifying the PCP of admission, making follow up appointments and ensuring that discharge summaries get to the right post-hospital providers. Feedback from community providers about this enhanced communication has been great. As this role has evolved, the Team Assistant increasingly serves as an educational resource for medical residents about the system.

PRACTICE TEACH BACK – IT IS NOT JUST FOR NURSES!

Ask the patient to explain in his own words his understanding of his diagnosis and plan of care when he leaves the hospital. You may find important gaps that require providers to give clearer explanation. Pay extra attention to health literacy. Help the patient articulate and write down the questions for the provider.

USE MOTIVATIONAL INTERVIEWING TECHNIQUES.

Many readmitted patients have 2 or more chronic illnesses. Self-management can feel like a full time job. The patient's goals may not be expressed in health terms, like lowering blood sugars or maintaining dry weight. They may be instead to attend a family wedding or go for a walk with a grandchild; goals which still require self-management. Asking the patient about realistic steps to reach those goals and about his confidence to do so can put an overwhelming task into a meaningful, achievable perspective.

We are so fortunate to have a great resource through Senior Services of Seattle, the Living Well with Chronic Conditions program. This evidence-based program helps patients focus on their goals and learn self-management skills in a supportive environment.

In rounds, ask the team, "What can we do NOW to reduce this patient's risk of readmission?" This question raises everyone's awareness. Have the appropriate consults for patient education/therapy been completed to help this patient succeed in recovery?

STOP THE LINE!

The discharge day is set and the plan is moving forward. But the patient is saying "I'm just not feeling ready" and the social worker is concerned. It sometimes takes courage to ask the team to "stop the line" and relook at the plan. Of course we can't ignore criteria for continued acute care stay. But what is the value of a saved hospital day if the patient is readmitted within a week?

Ask the patient what happened. Listen carefully to the patient's own words. It can be humbling. Efforts to reduce readmissions provide an excellent opportunity to use social work skills and leadership.

I'd welcome your feedback.

Carol Charles, LICSW, CCM
Project Manager
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Resources

Institute for Healthcare Improvement: http://www.ihi.org/knowledge/Pages/Tools/default.aspx

Project RED (reengineered discharge): http://www.bu.edu/fammed/projectred/

Society for Hospital Medicine: http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm

Teach Back Method: http://www.nchealthliteracy.org/toolkit/tool5.pdf

Ask Me Three: http://www.npsf.org/askme3/

Motivational Interviewing: http://www.motivationalinterview.org/clinicians/Side_bar/skills_maintenence.html

Senior Services of Seattle, enhance wellness programs: http://www.seniorservices.org/getting_assistance/all_programs/project_enhance/living_well_with_chronic_conditions.aspx

Care Transitions Model, Dr. Eric Coleman: www.caretransitions.org/

Brief Questions to Identify Patients with Inadequate Health Literacy, http://www.stfm.org/fmhub/fm2004/september/lisa588.pdf

A Public Health Pest Returns with a Vengeance

by Liz Dykstra and David Magby, Washington State Department of Health

Bed bugs, Cimex lectularis, are blood-feeding insects that feed on humans, usually while we are asleep.

Once a common part of life, bed bugs were eliminated from much of the developed world when pesticide use became common following World War II. In the past five years, however, bed bugs have once again become a common pest in the United States and throughout the world. The resurgence can be attributed to the ease of international travel, the second-hand furniture trade and the development of insecticide resistance in bed bug populations.

BED BUG PROTECTION TECHNIQUES

Tips for Home Health Care and Social Workers

Protect yourself and your clients by always wearing booties and protective coveralls when making home visits. Use a bed bug containment kit made up of the following items:

- ✓ A portable, hard surface chair or stool
- ✓ A fanny pack for holding personal items (identification card, cell phone, additional booties or gloves, etc.)
- ✓ A change of clothes and shoes (kept in your vehicle)
- ✓ A plastic storage container with a sealed lid that is large enough to hold the following items:
  - Protective booties and Tyvek type coveralls
  - Disposable gloves
  - A roll of duct tape (light colored)
  - Small plastic garbage bags
  - A roll of clear plastic 50-gallon garbage bags
  - Flashlight
  - Narrow banded spatula (for crushing bed bugs)
  - A fresh container of wet wipes
  - Plastic box-type clipboard containing paper and pens
- ✓ A second large plastic storage container with a sealed lid that can be used to hold items that might be infected

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Adult bed bugs are about 1/4 of an inch long, have flat, rusty-red, oval bodies, and look like an apple seed. They feed for 3–10 minutes, and their bodies swell and become bright red. Once they complete feeding, they crawl to a sheltered seam or crevice, where they will remain for several days digesting the meal. The life cycle takes four to five weeks (egg to egg) to complete under ideal conditions and there can be three or more generations in a year. Adult bed bugs can survive for several months without feeding. Females can lay 200–400 eggs during their lifetime, depending on food supply and temperature.

Bed bugs are attracted to people by their warmth and the carbon dioxide emitted from breathing. The bugs' flattened shape allows them to hide during the day in cracks and crevices, and along mattress and pillow seams. Headboards provide many hiding places. Bed bugs don't fly, but can quickly walk across floors, walls and other surfaces.

Diagnosis and Treatment

A bed bug infestation can be recognized by brownish or reddish spots from crushed bugs or their fecal spots on sheets, mattresses, bed clothes and walls. Fecal spots, eggshells and shed skins may be found in the vicinity of their hiding places. A sweet, musty odor may be detected when bed bug infestations are severe.

Bed bug bites are usually the first sign of an infestation and often occur in rows of three or more bites on exposed skin. Welts caused by bed bug bites do not have the red spot in the center that is characteristic of flea bites.

Bed bugs have never been shown to transmit disease pathogens. A variety of clinical reactions are attributed to their bites, including cutaneous and, rarely, systemic reactions. Reactions to bed bug bites may take a week or longer before appearing. The most common reaction to bed bug bites is the development of small inflamed, pruritic bumps where each bite occurs. These usually resolve within a week or two, but can persist for a longer time. Allergic reactions can result in urticaria at the bite site, which can evolve into a more widespread bulbous rash over the subsequent days and may become complicated by secondary bacterial infections.

Treatment for bed bug bites is usually confined to symptomatic relief for pruritic bites using over-the-counter topical antihistamines or topical corticosteroids. Topical, oral or intravenous antibiotics may be required when secondary bacterial infections occur. Intramuscular injections of antihistamine, corticosteroids or epinephrine may be required for some individuals who develop a systemic allergic reaction to the bites.

Controlling the Problem

Bed bugs are very difficult to control because their small size and flattened shape allows them to travel in our belongings (clothing, luggage, furniture, electronics, etc.) without our knowledge. Once established in a residence or unit in a building, bed bugs can travel between rooms or apartments on their own or on people's clothing or other belongings. Items purchased at garage sales and thrift shops, especially mattresses, box springs, and bedding, should be carefully inspected for bed bugs before they are taken home.

Home health care workers should take precautions when working in clients' homes, and travelers should carefully inspect their hotel rooms before

continues

When Making Home Visits...

- ✓ Always wear simple clothing. Avoid shirts with buttons and pockets, cargo pants or pants with cuffs. Professional looking, long-sleeved, light-colored T-shirts work well. Wear simple shoes that can be thrown in a hot dryer and that have minimal tread. Do not accessorize with anything, particularly scarves, jewelry or handbags.
- ✓ Keep your belongings sealed in containers inside your vehicle.
- ✓ Minimize the number and type of items you bring into a home.
- ✓ If you bring items in, keep them sealed in a garbage bag or plastic bin when not in use.
- ✓ As much as possible, avoid contact with beds, couches and chairs. If you're required to sit, use your portable chair or stool to sit on.
- ✓ If you bring items in, do not place them on beds, couches or chairs.
- ✓ If your client needs to be transported, use the garbage bags in your kit to bag your client's clothes and personal items. Tie the bags closed and seal them in the plastic storage container prior to putting them in your vehicle.
- ✓ If bite marks you suspect were caused by bed bugs develop after you leave, notify the client.

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Continued on page 8

Membership Matters

SSWLHC DUES ARE DUE

In this year of SSWLHC membership change from local chapter to a national organization serving a number of local chapters, membership dues were to be paid by September 30. At this point in time, we have all been contacted by email and asked to pay via credit card or check.

As you know, the chapter dues and national association dues have been merged effective July 1, with a change in the organization's fiscal year to July 1 through June 30. Historically, the WA chapter collected dues on an annual calendar basis, January 1 to December 31. The WA Chapter last collected dues for the fiscal year 2010. National SSWLHC Membership during the first six months of 2011 has been provided to you by the local chapter.

If you have not paid your national dues, membership in both the national and local chapters will have ceased by September 30, 2011.

If you want to join or are in arrears, log on to: *www.sswlhc.org* and click on 'Membership'. If you have been a national member through the local chapter, your default user name is your email address, and your password is your last name and is case sensitive.

PLEASE RENEW NOW!!

2011 SSWLHC Scholarship Winner Thanks The Chapter

SSWLHC Scholarship Committee

It is with much gratitude that I write to thank you for the honor you have bestowed on me.

The SSWLHC student scholarship award will put a nice dent in the academic fees of the Advanced Standing MSW program.

I appreciate your support, and look forward to attending Board meetings in the near future.

Warm Regards,
Felicity Burdick

President: Brian Giddens, MSW
President Elect: Mike Hays, MSW
Past President : Selena Bolotin, MSW
Secretary: Carole O'Brien, MSW
Treasurer: Stacey Jones, MSW
Communications Coordinator, Jacqueline Durgin, MSW

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Stacia Fischer, MSW
Denise Katterhagen, MSW
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Letter From The President

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

This Service Sponsored By…..

It seems that in the world of politics, there always has to be a target. There have been many over the years, including racial and ethnic groups, gays and lesbians, “welfare queens”, and immigrants. Targeting links all possible societal ills to one unfortunate category of people, thus leaving everyone not in that group blameless. Attacking a specific group deflects attention from other issues in society and rallies dissatisfied people to a fevered pitch. This then is exploited by our increasingly lazy media for the surface-level sensationalism such attacks produce.

Lately I have noticed that there is a big bullseye on the back of government, and it is being vilified on several fronts. Government in all forms is being labeled as bloated, bureaucratic, self-serving, unnecessary, expensive, and ironically, unconstitutional. As a state employee, I am beginning to think I need to don dark glasses and flee to Canada.

Clearly I may be biased, given where my paycheck comes from, but I happen to like government. Frankly, I think we need more government. I have seen what happens in the absence of government services. Because of the lack of zoning restrictions I have seen beautiful towns turned into dumping grounds for rows of big box stores and parking lots. I have permanently damaged my car driving on roads that have more potholes than one would find in third-world countries. My partner gets nervous when I join him for dog-walks in the park, because I cannot stop myself from pulling out the morning glory that is strangling the azaleas.

Call me crazy, but I see the need for a societal structure that ensures order, public safety, and access to basic services for all. I value the role of government in bringing together communities with diverse interests and needs to make a plan for improving programs and services for those communities. I like the fact that government has no financial conflicts of interest and is required to be transparent in the work they do. And I believe that government is the only social structure that can fill the gaps in our society, when volunteers, faith communities, businesses and others do not have the desire or means to address such gaps. Ron Paul, in one of the recent debates was asked what he would do about a young person with life-threatening medical needs who had not purchased insurance. He mentioned that when he was a doctor, churches would help in such situations. I wonder just how long it’s been since Mr. Paul practiced medicine?

Brian Giddens, MSW,

I don’t think that government has to do everything. But it certainly has to be at the table with private businesses and community groups, ensuring that all Americans receive basic services. We have seen the effects of de-regulation. I don’t know about you, but I’m not feeling as if my phone or cable service is any better than it was when it was more heavily regulated, and it is certainly not less expensive. I could go on and on about airline deregulation, but I have heard that the airlines may soon be charging a fee for complaining. And de-regulation of the financial services industry has really done wonders for the bankers.

Perhaps what government needs is a good public relations team. Since it appears that there is confusion over what is actually government-run (i.e., the famous anti-government plea of “keep your hands off

Continued on Page 9

unpacking their luggage (see sidebar for tips on avoiding bed bugs while traveling).

Getting Rid of Bed Bugs

1. Proper identification of bed bugs in the home
2. Education
3. Thorough inspection of infested and adjacent areas
4. Implementation of both chemical and non-chemical control measures
5. Follow-up to evaluate the success of the treatment

The Health Systems Quality Assurance Division (HSQA) of the Washington State Department of Health is responsible for licensing, inspecting and responding to complaints about transient accommodations (any facility offering three or more units for rent for 30 days or less). In 2009, HSQA received 23 bed-bug related complaints related to transient accommodations. Three of the complaints (13 percent) were substantiated. In 2010, 39 bed bug-related complaints were received; 12 (almost 31 percent) were substantiated. The HSQA attributes the increase in filed complaints to the higher media attention and greater public awareness about the problem. They expect this trend to continue in the next few years. ■

Additional information on bed bugs can be found at www.doh.wa.gov/ehp/ts/zoo/bedbugs.htm.

Liz Dykstra, PhD, is the Public Health Entomologist with the Washington State Department of Health's Zoonotic Disease Program.

David Magby is the Director of the Washington State Department of Health's Investigation and Inspection Office.

Tips for Travelers

- ✓ Upon entering your hotel room, immediately place your luggage and other items in the bathroom.
- ✓ Thoroughly inspect the entire hotel room before unpacking.
- ✓ Carefully inspect the bed linens and mattress for the presence of bed bugs. Pull back bed sheets and inspect mattress seams, particularly the corners, for brownish or reddish spots. Bed bugs can also be found in box springs and behind headboards, baseboards, electrical switch plates, picture frames, wallpaper, and in upholstery and furniture.
- ✓ Never put your luggage on the bed. Luggage can be placed on racks, the ironing board or even in the bathtub to help keep bed bugs from accessing them. Do not store clothing in dressers unless the clothing is sealed in plastic bags or containers.
- ✓ If changing rooms within the same hotel because of a bed bug problem, ensure the new room is not adjacent to the possibly infested room.
- ✓ Pack a couple of large garbage bags and bag all of your clothes (whether worn or not) prior to leaving the hotel. Separate the laundry as you would if you were normally laundering items. Separating the clothing permits easy loading of the washing machine.
- ✓ Upon returning home, all clothing should go directly to the laundry room and be washed or run through the dryer on the hot setting for at least 20 minutes before being put away.
- ✓ Inspect and vacuum suitcases before bringing them into the house.
- ✓ If you suspect an infestation in your own home, contact a licensed pest management professional with experience treating bed bugs to inspect the property.

If bite marks you suspect were caused by bed bugs develop after you leave, notify the hotel manager.

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Letter from the President, Brian Giddens, Cont.

Continued from Page 7

my Medicare”), maybe there should be some insert on the social security checks-“brought to you by your government. Yes, you did contribute, but you have long since outlived your contribution-AND WE ARE STILL PAYING YOU”. Or add language to stop signs: “STOP and think about who paid for and put up this sign”. How about adding to the public school graduation program a message that says: “Congratulations on your child’s graduation. You just saved $25,000 per year for the last four years in not having to send your child to private high school, thanks to public education.”

As social workers who depend on “government” services on a daily basis, and who work with people who clearly are not in the top 10% tax bracket, we need to counter these attacks. Sure, these are very hard times, and everyone, including government, needs to stretch their dollars as far as possible. But I feel much more abused by the inequities in our society than I do by the societal structures upon which this country has flourished. Some Americans are forgetting that our country is unique in that it truly has the aim of ensuring a decent and fair life for all citizens-that’s what makes it a democracy. The true “patriots” are the ones that defend a government that stands for all people, not just a chosen few.

Brian Giddens, *bgiddens@u.washington.edu*

HEALTH CARE POLICY UPDATE

Continued from Page 1

Medical assistance eligibility and coverage will not be affected by the termination of the Disability Lifeline cash program. Medical Care Services and Medicaid coverage will continue unchanged. There will be no change in mental health or any other health services on November 1, 2011. Clients enrolled in managed care will continue to receive medical care from the Community Health Plan of Washington (CHPW) providers.

Monthly cash grant assistance programs for the Aged Blind and Disabled as well as the pregnant women program have been reduced 42% to $197/mo. About 19,000 people will lose their DL-U cash grant but will continue to receive medical assistance.

GOOD SOURCES OF INFORMATION:

http://www.dshs.wa.gov/onlinecso/disability_lifeline.shtml

http://www.workfirst.wa.gov/resources/pdf/Power%20Point%20Posted%207-26-11%20(2).pdf

Powerpoint used by DSHS at shareholder’s meeting: *http://www.dshs.wa.gov/ppt/ea/biennialbudget.pptx*

AFFORDABLE CARE ACT (SEE PAGE 12 FOR TIMELINE)

Next phase: Under the federal Affordable Care Act, by January 2014, states must be operating a health insurance exchange or implementation will fall to the federal government. The exchange will serve as a marketplace for individuals and small businesses (up to 100 employees) to purchase qualified health insurance. The exchange will allow individuals with incomes up to 400 percent of the federal poverty level to receive subsidized health insurance. **In Washington State, as many as 400,000 people could be served by an exchange.**

With bipartisan support, the 2011 Washington State Legislature enacted Senate Bill 5445, establishing a health insurance exchange. The Washington

Continued on Page 10

HEALTH CARE POLICY UPDATE

Continued from Page 9

State Health Care Authority (HCA) received a $23 million federal grant to begin implementation work. The HCA will use the grant to create operational plans, develop the technical infrastructure, and analyze key policy decisions critical to establishing an exchange. (from Washington State Hospital Association)

NEWS:

The 4th Circuit Court recently dismissed constitutional challenges to the Affordable Care Act's "individual mandate." Here's why: The mandate requires most Americans to either carry health insurance or pay slightly more income taxes. Because the law does not take effect until 2014, however, no one has actually paid this tax yet and no one will for a few years. This matters because the Tax Anti-Injunction Act does not permit plaintiffs to sue in order to prevent a tax from being collected. They can only wait until after they have paid the tax and then sue claiming they are entitled to a refund. Because the mandate is a tax, and because no one has paid the tax yet, Judge Motz held that the Tax Anti-Injunction Act prevents anyone from challenging the mandate.

More info here: http://thinkprogress.org/justice/2011/09/08/314962/how-to-read-the-fourth-circuits-affordable-care-act-decisions/

CONTINUED STATE BUDGET CHALLENGES

> Eliminate cost-based reimbursement for Critical Access Hospitals ($19.1 million cut); and

> Reduce Certified Public Expenditure hold harmless for low income and medically indigent Disproportionate Share Hospital payments ($13.9 million cut).

> Elimination of state-subsidized insurance programs:

> Basic Health Plan ($70.4 million cut; 35,000 newly uninsured working adults);

> Medical care for Disability Lifeline and ADATSA ($110.0 million cut; 22,000 newly uninsured people with disabilities); and

> Children's Health Program for non-citizen children ($34.0 million cut; 25,000 newly uninsured children.

> Elimination of specific benefits:

> Adult pharmacy benefits in Medicaid ($127.5 million cut; services to 500,000 people lost);

> Maternity Support Services ($21 million cut; services to 54,000 women lost);

> Non-emergency adult dental services ($11.7 million cut; services to 123,000 patients lost);

> School-based medical services ($5.9 million cut; services to 22,000 children lost); and

> Interpreter services ($4.8 million cut; services to 70,000 people lost).

SPECIAL SESSION ANNOUNCED

Governor Gregoire has announced she will convene a special session of the Washington State Legislature beginning November 28, 2011 with the goal of cutting the state budget. Her budget proposal will be ***an all cuts budget*** based on the proposals she received from her state agency directors.

Some legislators are calling for a more balanced approach that would include a revenue package. Likely, any revenue package would need to go to the public for a vote in the spring. Whether the legislature will be able to reach a consensus or have the votes to put a revenue option on the ballot remains unclear.

TAKE-AWAY

Continue to encourage our membership to contact legislators ***with real-life impacts***

Refer members to the website, which has links for finding and contacting your legislators.

SOCIAL WORKERS IN HEALTH CARE NAVIGATING OUR TROUBLED WATERS

IT IS NOT TOO LATE TO REGISTER!!!

October 26 through 29, 2011
Pre-Conference Intensives, Oct 25, 2011
Fairmont Hotel
San Francisco, CA

Welcome to San Francisco for the 46th Annual SSWLHC Meeting and Conference, October 25 through 29, 2011. This year's conference title represents the sign of the times, state of our country, and the current health care environment. Social workers have preserved and helped health organization, patients, and families navigate through these precarious times. This conference will provide tools for social work leaders and clinicians to thrive despite the current uncertain climate. 26.5 Total CEUs are offered.

This year, the SSWLHC is celebrating the fourth year of the Leadership Institute! This is a day and a half interactive intensive workshop, held on October 25th, designed for healthcare social workers that want to further demonstrate their individual leadership talents in their organization, regardless of position or title through structured conversations with peers and veteran leaders of our Society. A 2010 graduate stated that the training was "the best conference experience in my professional life".

Again, this year, the conference will offer two standard pre-conference Intensive Workshops along with two new half-day Intensives. The Pediatric and Home Care Intensives have been great opportunities for veterans as well as new Social Workers in Pediatrics and Home Care to network and make connections as well as learn new and helpful information. For the first time, a half day Ethics Intensive will be presented titled "Ethical Practice: A Social Worker's Best Defense Against Malpractice" for those seeking ethics CEU's for their state licensing requirements together with "Building the Business Case: Critical Skills for Leadership". This second half day intensive is designed for social work leaders wanting to learn critical leadership skills needed to develop new programs and/or demonstrate the value social work adds to quality, safe patient/client care in a language that administrators, especially CFOs understand.

The conference beginning October 26, will feature opportunities for learning and peer interaction. The workshops and posters have been researched and developed by SSWLHC members and have been accepted for presentation by a panel of peers.

WA STATE CHAPTER MEMBERS PRESENTING at the 46th Annual Meeting and Conference include:

Selena Bolotin, Care Transitions Project Manager, Qualis Health; **Linda Brandeis**, Social Worker, Community Living Center, VAMC of Puget Sound; **Bonnie Conley**, Associate Director of Social Work, Harborview Medical Center; **Pam Haithcox Eggleston**, Director of Social Work Harborview Medical Center; **Kathy Hagar**, Social Work Clinical Specialist, St. Joseph Medical Center, Bellingham; **Denise Katterhagen**, Social Work Manager, Peace Health—St. Joseph Medical Center, Bellingham.

OTHER NORTHWEST PRESENTERS that you may know include:

Normal Cole, Harborview Medical Center, **Kris Ann Schmitz,** Talaria, Inc., **Erica Taylor**, VAMC of Puget Sound, and **Rachelle White**, Harborview Medical Center.

AFFORDABLE CARE ACT

Implementation Time Line

A REMINDER !!

2010

- Insurance companies can no longer refuse coverage of children because of pre-existing conditions.
- Health plans that cover dependent children must extend that coverage up to age 26.
- Lifetime limits on benefits and rescissions of existing policies because of customers' illness are banned.
- Medicare recipients caught in the Part D prescription drug coverage gap—the doughnut hole—will receive a $250.00 rebate.

2011

- Brand-name drugs in the Medicare Part D coverage gap are discounted by 50 percent.
- Medicare Advantage payments are frozen at the 2010 level.
- Medicare beneficiaries begin receiving free annual wellness visits and certain other preventive care benefits without incurring co-payments.

2012

- A phased-in reduction of Medicare Advantage payment benchmarks relative to current levels begins.

2013

- Contributitons to health Flexible Savings Accounts are limited to $2500 per year.

2014

- Most individuals are required to get health insurance or face a penalty that starts at $95.00 in 2014 and will increase to $325 in 2015 and $695 or up 2.5 percent of income (maximum of 2,085 for a family) in 2016 and subsequent years.
- State based health insurance exchanges are established to allow individuals and small businesses to compare and purchase standardized private insurance plans.
- Premium tax credits become available through the exchange for people who cannot get acceptable coverage elsewhere and whose incomes are above the level for Medicaid eligibility and below 400 percent of the federal poverty level (up to $88,000 for a family of four).
- Group insurance plans are banned from excluding pre-existing conditions.
- Employers with 50 or more workers who opt not to provide health coverage, and who have at least one employee who is receiving a tax credit for buying insurance, will pay an annual fee of $2,000 for each full-time employee. However, the first 30 employees will not be counted in the calculation of the fee.

2018

- An excise tax on high-cost health plans kick in. The tax applies to insurance that costs more than $27,500 annually for a family and $10,200 for an individual. For retirees and workers in high-risk professions, the thresholds rise to $30,950 for families and $11,580 for individuals.

2020

- The pharmaceutical manufacturer's discount on brand-name drugs for Medicare recipients rises to 75 percent, thus completely closing the "doughnut hole".

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