SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE
SSWLHC

VOLUME 14, ISSUE 1

WASHINGTON STATE NEWSLETTER

JANUARY 2012 CAUCUS EDITION

SSWLHC ADVOCACY, PRIORITIES, ISSUES & ACTIVITIES

- **SSWLHC WA CHAPTER**
  JAN 23, 2012 4:00 PM
  TELECONFERENCE: DISCUSSION OF CHAPTER DISENROLLMENT
- **SSWLHC WA CHAPTER**
  MARCH 2012
  VENDOR FAIRE & LECTURE
  DATE AND LOCATION TO BE ANNOUNCED
- **NASW LOBBY DAY**
  FEBRUARY 20, 2012
- **NASW WA CHAPTER**
  MARCH 23,2012 9:00—4:30
  NORTH SEATTLE COMMUNITY COLLEGE
  'GOOD ETHICS, GOOD PRACTICE: HOW RULES, LAWS, RISK MANAGEMENT AND CODES OF ETHICS RELATE TO THE DYNAMIC OF THE RERALITIES OF OUR DAY TO DAY WORK'

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SSWLHC WA CHAPTER CONSIDERS DISENROLLMENT FROM NATIONAL ORGANIZATION

SHOULD THE SSWLHC WASHINGTON CHAPTER CREATE A NEW ORGANIZATION TO SUPPORT WASHINGTON STATE HEALTHCARE SOCIAL WORKERS?

Members to Decide!

At the November 2011 Washington State SSWLHC board meeting, the Board approved a vote of the membership to decide whether to retain affiliation with the national SSWLHC organization or to create a separate Washington State healthcare social work organization.

Background on the board's decision to call for a membership vote:

The Washington State Chapter of SSWLHC has been in a two-plus year process of affiliating with national SSWLHC, which became a national organization requirement in 2009. In the summer of 2009, the Washington Chapter asked local members to vote on affiliation, resulting in 64% voting to affiliate (with 44% of the total membership voting).

In the transition period from January 2010 though June 2011, local members automatically became both national and local members, for the price of local membership. The Washington Chapter promoted the benefits of national membership, encouraging members to become familiar with the national SSWLHC publications, discussion forums and continuing education opportunities.

ALL CURRENT AND FORMER MEMBERS

Join the Teleconference Discussion on Disenrollment!

January 23, 2012
4:00 PM
1-800-444-2801
Conf # 6826158

In July 2011, all local members were required to pay national dues ranging from $90-$175 with $35 per member returned to the Washington State chapter (reduced to $25.00 per member, determined after our agreement to affiliate). While the affiliation process has increased the number of Washington State residents holding national membership from 13 to 61 local members, the local chapter has lost 101 members out of their former membership of 165. This has greatly reduced annual

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LOCAL CHAPTER CONSIDERS DISENROLLMENT FROM NATIONAL

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dues income for the local chapter. **Equally if not more importantly, the affiliation process has reduced the number of Washington State social workers staying connected to local issues and resources via the local chapter.**

In discussion with tax and legal experts, the national SSWLHC organization concluded that it would be a mutually beneficial financial arrangement for the chapters to file with the national organization as a group rather than as separate entities --this was a significant reason cited for unification. The Washington State chapter has experienced considerable lack of clear direction and conflicting counsel from the national organization related to legal documents needed for the affiliation process. The local chapter is still being given no clear direction on these issues, and is having to manage this independently, nullifying any anticipated fiscal and legal benefits to the affiliation.

Next steps:

Just as the Washington State chapter believed that membership needed to vote to approve affiliation, we are now asking members to vote on whether the Washington State Chapter should disaffiliate from the national SSWLHC organization and form a new Washington State healthcare social work organization. Current bylaws state that the local affiliate can be dissolved with a majority of the membership. Current members will receive a letter with a ballot to be returned by January 31.

Teleconference Jan 23, 4:00 PM

The Washington State Chapter will hold a teleconference call to answer member questions and discuss the pros and cons in further detail on January 23, 2012 at 4:00pm. The conference number is: 1-800-444-2801 Conference Code: 6826158. Former members are also welcome to participate and give input.

Annual Membership Meeting, March 2012

The annual Membership Meeting will be held in March in conjunction with the upcoming Vendor Fair. The final vote results and next steps will be addressed as a primary membership meeting topic.

The Board's Commitment to You:

While the question to affiliate or not affiliate has been confusing and time consuming over the past several years, the Washington State SSWLHC board has never waivered in its mission to bring value to healthcare social workers in our state. We continue to prioritize avenues to 1) increase networking and mentoring 2) offer low cost continuing education and 3) advocate at the local level, keeping our members informed of policy issues impacting healthcare practice.

Your board wants to hear your thoughts on continued affiliation vs. a new local organization. We need your input about how the organization (SSWLHC affiliated or not) can meet your needs. Regardless of the affiliation outcome, our intent is to continue to serve healthcare social workers via the best methods possible.

Selena Bolotin, MSW, Membership Chair
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POINTS TO CONSIDER
NATIONAL AFFILIATION VERSUS LOCAL CONTROL

The table below summarizes issues cited at the time of the initial vote related to continued national affiliation vs. creation of a new local organization from July 2009 Newsletter:

POINTS FOR CONSIDERATION	AFFILIATION WITH NATIONAL SSWLHC	INDEPENDENT
NAME	Name remains the same: **SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTHCARE, WA STATE CHAPTER**	Create a new name. We will not be allowed to continue using the SSWLHC name unless we sign the affiliation agreement
LOGO	Continue using the SSWLHC logo	Create a n ew logo
AFFILIATION	Signing the affiliation agreement with National requires that future affiliations with other organizations would occur at the national level.	Sever our relationship with National SSWLHC. It would be possible to affiliate with another organization if mutually agreeable.
DUES	Dues were set at the national level starting July 2011; dues include a national membership fee plus a chapter membership fee of $35.00, which will be collected by the National SSWLHC and returned to the local chapter. **Current National Dues:** Management: $140/yr Direct Patient Care, $85./yr Transitional, Emeritus, Faculty: $85/yr Student: $55/yr **PLUS Chapter membership: $35/yr which is returned to the local Chapter.**	Dues will continue to be set and collected at the local level **Current Local Dues:** All members $30/yr All dues are retained by the local Chapter.
INCORPORATION	Incorporate as a 501 C3, Non-profit under National SSWLHC's non-profit ID number. No cost to local Chapter.	Incorporate as a 501 C3, Non-profit organization. (New IRS rules require that we either incorporate ourselves or become a part of another incorporated non-profit. There will be some one-time costs incurred to incorporate independently
COMMUNICATION	Provide the National organization with a list of our members, including contact information.	Continue to keep our membership list available only to local members.
BENEFITS	**Dues Include:** ***Publications including:** Journal of Social Work in Health Care, Social Work Leader (on-line Newsletter) *National networking opportunities, *Discount on annual National Educational Conference fee, *National website with access to tools such as salary survey, *Webinar series with member discussion forum, *24 hour access to Society information, resources and career opportunities through SSWLHC's official website. *Exclusive members' only discounts on educational programs, books and products	**Dues include:** ***Publications including:** Quarterly local Newsletter *Local Networking Opportunities *Discount on local seminars *Local website with statewide information *24 hour web access to local organization's information, resources, career opportunities, and conferences *Member and social work student discounts on WA Chapter educational programs.
CEUs	CEUs available to local chapter educational offerings without charge to local chapter	CEUs available to the Chapter through NASW for $200.00 per event or $300 for a two year certificate
BYLAWS	Some local changes required for national congruity.	Some local changes required to reflect lack of National affiliation.

Member Pros and Cons Statements from the July 2008 Newsletter

As a long-time national and local member, I have valued the benefit of having a national organization for access to educational events and colleagues around the country. I too, however, believe that the solution to national's declining membership is not by forcing individuals to pay national dues or lose the local connection. I would rather that we looked to coalitions with other national health care social work groups for mutual administrative and educational costs. I believe the local presence is far too valuable to risk diminishing its support by requiring national membership.

- Linda Batway

I am not sure how the national chapter would benefit me. The local chapter provides wonderful workshops and an outstanding newsletter plus more.

- Ann Pryich

I am a fairly new member of the local chapter and have enjoyed the updates on the local level. At this time, I do not think I would join the national chapter due to cost to myself or to our very limited budget at my organization. I daydream about attending a future national conference as well, but at this time, it is not in my immediate future due to cost.

- Laura Cardinal

I do think you would see a drop-off in local chapter membership if one has to join national as well. I am actively involved in another social work health organization, the Council of Nephrology Social Workers. We have local chapters as well as the national organization, and there are at least 2,000 local members who are not members of the national organization. We have done some fairly extensive outreach and surveying to find out why people are not joining the national organization. One consistent reason is the cost. Most local chapters either don't charge any dues or have very minimal charges, while the national membership is $70. Personally I have a hard time seeing $70 a year as being a barrier, but apparently it is quite a barrier for many members. I think if our organization required local members to join the national that we would see a lot of local chapters fold.

-Jeff Harder, MSW, LICSW

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realize that $70 may seem like a significant amount of money to belong to an organization that you may not feel any connection to, but I believe that this money is very well spent when we are all looking at having some sort of voice or mechanism for advocacy for ourselves and our clients on a larger scale. The Society is attempting to link with other organizations that do have a voice in funding and lobbying arenas. The federal government has cut back programs and funding in many areas that have affected the patients that are served throughout this area. The Society maintains a connecting and link to the advocacy through the American Hospital Association. They are looking to connect to other groups that have links to issues that we are involved with. The society has joined the Family Violence Prevention Fund with other organizations urging Congress to provide money to fund the Violence Against Women Act in FY 2009. The Society has been asked to participate in MedPac (HCFA) focus groups in the past that deal with Medicare and Medicaid funding of hospitals and outpatient activities. There used to be rules that in order to be a recognized Chapter of the National Society, a certain percentage of the members were required to be National members. That rule was eliminated in the 1990s. In 2001 our current organization separated from the AHA and became a free standing organization.

Over the years the Society has worked hard to grow and become a responsive National presence. This is a critical time for all of us here in Washington to look at our commitment to our profession and our future in health care and support a national entity that has healthcare as a focus. I pay NASW over $200 each year for the honor of having an ACSW. It only cost me $70 to belong to an organization that is supporting healthcare and issues that are critical to the care of the patients here at Harborview.

- Linda Brandeis, LICSW, Past President, National SSWLHC

You are correct - it is expensive and I would think twice about joining the national. If recruitment into the Washington chapter is already an issue, this won't help.

- Bunny Hirschmann, MSW

I share the concerns of the other members that is, the requirement of National membership may reduce Chapter membership. currently belong to the National organizational. , there have been times that I've let the membership lapse. have always found great value in belonging to my local Chapter. I've not had this same experience with the

National organization.

I understand what the National organization is attempting to do. , it is my belief that National membership will not grow, while local membership declines.

- Roosevelt Travis, Jr., MBA, LICSW

I agree that if the fee structure changes to where one needs to join the National SSWLHC in order to also belong to the local chapter, that membership will drop significantly. find the information I receive from the local chapter to be valuable and if such changes were to occur, would have to end my membership due to the cost change. hope this helps in advocating for our local chapter!

- Rachel Ogrodowski

Thanks for the opportunity to comment. I am retired and a recent member and doubt I would join the national during the "twilight" years of my life/career.

-Rena Merithew

I think there would be a loss of members with higher yearly dues. I have not joined NASW over the years because of the dues.

- Selena Bolotin

As I understand it, the National SSWLHC is proposing a dues structure similar to NASW, in which one pays national dues which then includes dues to the local Chapter.

I think this poses some concerns for us. First, there is no way that we could get our Chapter membership, somewhere between 50 and 100, to pay dues at the level that would be required. Our dues, pegged at $20.00/year are reasonable and probably too low. A National dues would come in somewhere between $100.00 and $150.00. With most of our membership now in clinical positions, the strength of our organization comes from our focus on clinical symposiums and the reduced fees for CEUs that membership offers. The current membership will not see national membership as a program that can address their needs. And without national membership, there would not be a local organization.

Secondly, it appears to me that NASW WA Chapter has difficulty here in gaining and keeping membership. The complaint that I hear is (1) 'cost', and (2), 'relevance'. I noted in the last ballot for the WA State NASW Board, that many positions went without nomination. People feel they are not able to step up to fill positions due to time and cost constraints.

Thirdly, I believe that many employers no longer pay membership fees to professional organizations for their employees, so many have dropped out from NASW. And I would be surprised if employer organizations are in a position to pay SSWLHC National dues. 98% of our membership pay their own dues.

How many National SSWLHC members does WA State have? I can think of only about six or seven local people who belong. I believe this move by the national SSWLHC would absolutely decimate our chapter. Our current yearly expenditures run about $4,000/yr., funded largely by dues and educational activities

I am aware of previous arguments that local chapters where the majority of members do not belong to the national group use national resources such as salary surveys and other educational materials. There used to be a requirement that 50% of the local chapter members needed to be national members in order to have national affiliation. (However in this scenario, the local chapter established and collected the local dues.) Perhaps proportionate membership could be required again, however at an approximate 10% rate. Those national dues are hefty when one pays out of pocket.

- Jacqueline S Durgin, Newsletter Editor, SSWLHC-WA, and Past President, National SSWLHC

IN FOCUS: LEADERSHIP PROFILE

MIKE HAYS,
MSW, ACSW, LICSW, MHA, LMHC

Mike Hays has been a social worker since 1991, and has been in active social work practice in Washington State since 1993. He has been a member of SSWLHC since 2002 (when he first learned of the organization), and is a recent addition to the Board as Member-at-Large and now, President-Elect.

EDUCATION Mike started his work in human services as a volunteer on the California State University, Northridge suicide prevention helpline for five years. That work as a listener, supervisor and ultimately lead trainer led to his decision to complete his BA in Psychology in 1988. With the original intent of going into private practice, he then applied for and was accepted in to the Master's in Social Work (MSW) program at California State University, Long Beach, graduating in 1991. He worked during his MSW program schooling as a chemical dependency counselor in several different residential programs in Los Angeles and the San Fernando Valley. He was hired from his second year MSW practicum into his first social work job, working Emergency, Intensive Care Unit, and Neurosurgery at Good Samaritan Hospital in downtown Los Angeles. It was in the ER and ICU that he fell in love with medical social work.

PROFESSIONAL LIFE In October of 1991, he moved to the Portland area and worked for two years as a psychiatric social worker in a supported employment community-based case management program for the chronically mentally ill. During that time he also moonlighted in a court-diversion treatment program combining chemical dependency counseling and acupuncture for Multnomah County Courts.

In 1993, Mike moved to Seattle and started his employment in Washington State, working as a medical social worker for Group Health in Home Health & Hospice in Pierce, Kitsap, Mason, and Thurston counties. After driving 60,000 miles in two years (and running his truck into the ground), he transitioned to the Group Health-owned nursing home, The Care Center at Kelsey Creek (since closed) and worked on the Medicare rehabilitation floor, the in-patient Hospice Unit, and ultimately became the Social Work Manager for the facility. It was here that he started working with the University of Washington as a practicum instructor, and by 2000, he was selected as the Practicum Instructor of the Year (Health & Mental Health concentration.) Many of the students with whom he worked have gone on to become valued and highly

experienced colleagues of his today.

It was also during this time that he became an active member of the National Association of Social Workers – Washington State Chapter. He has been a member since 1988, and since 1994, he has served in a number of roles on the NASW board (Treasurer, Region Representative, and other roles.)

In 2001, he became the Psychosocial Clinical Specialist for the Group Health Home Health & Hospice program. During his three years in this position, he completed his Master's in Healthcare Administration (MHA) in the Executive MHA program at the University of Washington. In 2004, he led the move to reinstate a social work manager for the clinic and hospital social work staff within the Care Management department.

In 2005, Mike moved to Community Health Plan, where he was responsible for the Care Coordination functions of the health plan. During his time there, he was instrumental in developing the pilot site for integrating the Patient Review and Coordination program into health plan function. The Patient Review and Coordination program (known as the Member Review and Intervention Program at Community Health Plan) is a Medicaid required health and safety program to help coordinate medical care for patients with excess utilization issues. It developed out of a pioneering study in Washington State in 2004 as a way to address excessive prescription narcotic utilization which had started to lead to debilitation and death in many Washington communities. The work Mike did on developing this program resulted in a Best Practice Commendation by the Department of Social and Health Services.

Also at Community Health Plan, he instigated nursing Utilization Management, concurrent review, revised and enhanced the Children with Special Health Care Needs (CSHCN) program, as well as developing Behavioral Health services, and the Patient Navigator program for Medicare Advantage members.

In 2010, he returned to Group Health in a direct service role, and in 2011 he returned to his previous role as Manager, Social Work Services for 21 Primary Care clinics throughout Puget Sound, four Specialty Care centers, six Urgent Cares, and Group Health's Central Hospital. He continues to operate a private practice, in which he only works as a clinical supervisor for MSWs seeking licensure – with most of that work pro bono or very low cost.

Personal Life Mike lives in West Seattle where he is caretaker for his elderly mother, Mary (although if you asked her, she would say she takes care of him.) He has a wonderful rescue dog, Baxter, who loves to howl when the phone rings and other than that sleeps a lot. Mike is a competitive bridge player (C-level, and not quite a Life Master yet, but only needs a few more national wins to reach that goal) and is a very active patron of the arts (he says he is not allowed to go to art galleries, animal shelters or nurseries, as he comes home with art, dogs or plants, whether they are needed or not.)

Mike says, "Several members of SSWLHC have been instrumental in my development as a manager and as a clinician. I owe a debt of gratitude to Lynn Carrigan and Jackie Durgin, my two SSWLHC mentors here in Washington State. I am the talented clinician, insightful clinical supervisor and compassionate manager that I am today because of these two women. Thank you Lynn & Jackie."

Membership Matters

SOCIAL WORK LOBBY DAY, 2012

February 20, 2012
The United Churches
110 11th Ave. SE
Olympia, WA 98501
8:30 AM—3:00 PM

Join your social work colleagues for NASW-WA Chapter Lobby Day, February 21, 2012. Lobby Day is an opportunity for the social workers across the state to speak one on one with their state legislators and voice support for legislation that impacts children, families, health care, the profession of social work, and many other social justice issues. The last several years, approximately 200 social workers participated in the WA Chapter Lobby Day.

Lobby day will be held at the United Churches of Olympia, 110 11th Ave. SE, Olympia WA 98501. The events will begin at 8:30 AM and run until early afternoon with your visits to your state legislators. Come together on February 20, 2012, and support the profession of social work and the clients we serve.

2012 LOBBY DAY CONTEST FOR SCHOOLS OF SOCIAL WORK

The college or university with the greatest participation in Lobby Day will receive a plaque honoring their efforts. Two prizes will be given—one for the largest numbers of participants, and one for the greatest percentage of students attending.

Contact NASW-WA at 1-206-706-7084 for more information and contest rules!

NATIONAL CALL FOR NOMINATIONS

The SSWLHC at the National level is calling for nominations to the Board and Nominations Committee. Being a part of the Board provides the opportunity to influence the future direction of the organizations. Elections will be held in the Spring of 2012 with the positions to take effect July 2012. Position descriptions are available at:
http://www.sswlhc.org/docs/SSWLHC-Job-Descriptions.pdf

Nominate yourself or a colleague for the positions of President-Elect, Board Member at Large, or Member of the Nominations Committee by sending an email to Past President Carol Maxwell at:
maxwellcf@archildrens.org

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE
SSWLHC

President: Brian Giddens, MSW
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Letter From The President

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

Not "Just" a Discharge Planner

The other day I heard from a colleague who was frustrated by a situation they had encountered at their hospital. This social worker was training a social worker new to the health care field, and was explaining the herculean efforts being made to find placement for a patient who was way past his expected length of stay, due to complex and costly medical treatments. To this trainee, these efforts were perceived as "selling" the patient, demeaning to the patient and the profession.

HIGHER LEVEL ROLE?

Arguments and misperceptions about the value of social workers doing discharge planning go way back. Before the advent of DRG's (remember those days?), there were social workers advocating for a "higher level" role within hospitals. This role would leave discharge planning to nurses or assistants, while social workers would focus on counseling and support work-certainly needed in health care institutions. Social Work departments in some cases successfully negotiated their way out of discharge planning, and into more "meaningful" roles. But then DRG's came forth, followed many years later by a focus on length of stay, and unless social work was involved in helping to discharge the patient, the other roles disappeared, as did many other positions perceived as "fluff".

I never saw those "higher level" roles as "fluff" but then I never perceived discharge planning as being less important. In fact, in my twenty years of working in hospitals, I see the need for MSW-level "discharge planners" more than ever. There is nothing simple about helping a patient transition from an acute care setting to a long-term care facility or back to their home. There are multiple skills required to manage this work. Social workers need to be able to quickly assess a situation, weighing multiple perspectives-those of the patient, family members, and the clinical team. A strong health care social worker needs to know enough about a variety of psychosocial issues to identify "red flags" that could impede a discharge or ongoing adherence to a plan. This means an understanding of mental health, substance abuse, domestic violence, and family dynamics, as well as a host of other psychosocial issues. They need to engage with the patient/ family member in a setting that does not afford uninterrupted periods of 1:1 time, in order to build a relationship of trust and open communication. The social worker needs to be attuned to both the needs and goals of the patient and those of the clinical team members, which often can be at odds with one another. Social work in health care settings serves as the liaison between the patient and the clinical team, "interpreting" the perspectives of both the provider and the patient, so that the plan can move forward.

Brian Giddens, MSW,

ADJUSTING TO A NEW REALITY!

A successful health care social worker does not see arranging a discharge as a matter of just moving a person from one bed to another. They realize that the person they are working with is coping with either a new diagnosis or an exacerbation of an existing illness, and that the condition is serious enough to require hospitalization and post-discharge services. Besides the trauma of the

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2011 LEGISLATIVE CONFERENCE OUTLINES DIFFICULT BUDGET CHOICES ON THE HORIZON

2011 Legislative Update

Cassie Sauer, MSW, WSHA, VP, Public Affairs

On December 16, 2011, SSWLHC welcomed speakers Cassie Sauer, VP for Public Affairs at the Washington State Hospital Association (WSHA), and Molly Belozer Firth, Director of Public Policy at Community Health Plan of Washington, for the annual legislative update. This well-attended conference was an opportunity to focus on state and federal budget challenges and policies impacting healthcare. The speakers educated the crowed and inspired lively discussion during the forum.

Cassie Sauer brought us up to date on current legislative issues at the state level, first reviewing the basic impact of a recession: Demand for state services increases, while revenue decreases. In June 2011 the forecast estimated a $570 million shortfall to the state budget. By September 2011 that estimate was for an **additional** $1.4 billion shortfall, leaving Washington state with an estimated $2 billion shortfall.

Cassie described that the legislature has two avenues available to address this huge budget shortfall: Cuts and Revenue. Governor Gregoire submitted an all-cuts budget proposal (note that the governor is required to submit a balanced budget). Proposed healthcare reductions would decrease payments to critical access hospitals, cut funding for community mental health, and eliminate Disability Lifeline, Basic Health, and funding for hospitals with high numbers of uncompensated care and Medicaid. These cuts are multiplied because we would also lose federal matching funds. On the plus side, the Governor's proposal does ***not*** cut adult pharmacy benefits, premium support for Apple Health, health coverage for immigrant children, or maternity support services.

The revenue proposals at this point include a temporary increase in sales tax of $0.005 (0.5 cents), which Gov. Gregoire would like to put to a public vote in hopes of raising $494 million. The governor is also asking the legislature to vote for additional revenue through increases in some small taxes and fees, and closing of loopholes, which together would raise $341 million. Healthcare would be the largest recipient of buy-back services from this revenue, including Basic Health, Disability Lifeline, and Community Mental Health services. However, critical access hospitals and safety net hospitals are not on this buy-back list.

Lastly, Ms. Sauer raised a call to action for social workers in healthcare to provide testimony , in person or on paper, to legislators detailing personal stories of the impact of these budget cuts

Molly Firth, MPH, CHNW, Director, Public Policy

Our second speaker, Molly Belozer Firth, Director of Public Policy at the Community Health Pplan of WA, provided an overview of federal perspective on current healthcare issues, budget cuts, and policies, and also reviewed what is happening on the local landscape. An example of the many striking facts she provided: Only 35,000 people remain enrolled on Basic Health, down from a high of almost 107,000 in January 2009. In March, the state disenrolled undocumented immigrants, legal permanent residents, seniors, and those over 133% of the federal poverty level. While some of these Washington residents have since been re-enrolled because of lawsuits challenging the changes, many are left without adequate options. And re-enrollment has a negative impact on a state budget that is already in crisis. Molly also discussed changes to Disability Lifeline ("Medical Care Services") and Apple Health, as well as Joint Procurement (RFP) with

2012— BUDGET CHOICES GRIM

contracts going out for bid Healthy Options (Medicaid), Basic Health, and the Blind and Disabled program. She explained that a number of plans nationwide are clamoring to get in on providing this care in WA state, while three current plans did not submit bids.

Molly described for the group numerous innovations being proposed to access federal monies and/or increase savings, such as pursuing Medicaid flexibility with the "Health Innovation for Washington" proposal. This zeroes in on health homes and care coordination, dual eligibles and payment reforms. There is also talk of prescription drug co-pays and more individual responsibility in the future, and local groups are pursuing Innovation Center funding opportunity.

On the federal landscape, the recent failure of the super committee has resulted in required budget cuts due to start in January 2013, with sequestration reductions of $1.2 trillion over 10 years, 50% of which must come from defense. Medicaid and CHIP are protected, with Medicare cuts limited to 2%, which will come from from payments to providers/plans, with no direct cuts to benefits. The committee's failure also impacts individual states. While many low-income programs are exempted, reductions are expected in maternal and child health funding, education, community policing, and defense. The latter will disproportionately affect Washington state due to the presence of Joint Base Lewis McChord.

Molly finished up her presentation with a discussion of what's next with Health Care Reform. She reminded the group that although there are federal challenges to the Health Care Reform act, we must to continue moving forward with implementation, as it's currently the law. Our current budget deficits complicate the inherent difficulty involved in implementing the new infrastructure.

With the continued implementation of Health Care Reform, Medicare is set to cut physician reimbursement by 27.4%. This is particularly worrisome in WA state where Medicare reimbursement is already very low. It appears

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Letter from the President, Brian Giddens,

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illness, there is the adjustment to a new way of living, the loss of one's independence, the change in self-image, and the grief that comes with such significant life changes. A health care social worker recognizes that the person they are helping is being asked to make decisions at a time of crisis, which requires empathy, support and extensive education.

FEW GOOD CHOICES INCREASES COMPLEXITY

In the case of my colleague, it also means working in an environment of few good choices. What hospitals can do medically and surgically has become increasingly complex and expensive, while the reimbursement for long-term care and other post-discharge options has not kept pace. This creates a gap between the escalating cost of care and the availability of post-discharge options. The more expensive the ongoing care is forecast to be, the less choices are available. Thus, to put it bluntly, there is a need to "sell" the patient, in hopes of trying to find someplace for that patient to go. But if social work does not do this, who will, and how will it be done? At least with a social worker in the picture, there is someone advocating for the best possible choice, while keeping the patient informed and supported throughout the process. While these aspects of the work certainly do speak to the reality that health care is also a business, having social work involved ensures that the process stays as patient-centered and respectful as possible.

I have often said that if the world was ideal, we would not need social workers. If everyone raised their children in a loving environment, if resources for individuals and families were available at time of need, if everyone had access to food and housing and health care, and if we could provide everyone with the best follow-up care, respecting their choices and their dignity…..

NEXT BEST THING, WE HAVE SOCIAL WORK.

SSWLHC Legislative Conference:
Grim budget choices for 2012

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that there is almost unanimous agreement that a fix to this issue is necessary, but finding the funding for the fix is proving nearly impossible. An excise tax will be levied on health plans to help pay for healthcare reform, based on a percentage of premium revenue, with for-profit plans paying on 100% a higher assessment than nonprofits.

Next up for Health Care reform is the initiation of new coverage options in 2014. These include a Medicaid option for those at or below 133% of the federal poverty level (FPL), the Federal Basic Health Plan for those at 133-200% FPL, and an Exchange Plan for those above 200% (with premium subsidies if between 200- 400% FPL).

Molly finished up her talk with a quick overview of Health Care Homes. She explained that this is a trend here because they are able to provide comprehensive case management, care coordination, health promotion, patient/family support, and culturally/linguistically appropriate care. The goal would be for all plans to reimburse if a medical group delivers care as a "health care home."

LAST MINUTE UPDATE

The recent special legislative session ran for 17 days, closing on December 14, and addressed approximately $480 million of the $2 billion deficit. The budget bill included some cuts, transferred funds, delays in some state payments, and the addition of some new federal funds, as well as a recapturing of more than $80 million that was budgeted but not spent last year. The 60-day regular session will reconvene in January, and a top priority will be addressing the remaining $1.5 billion deficit.

More than 30 conferees attended the SSWLHC WA Chapter December Legislative Workshop at the Exeter House in Seattle. Our sincere thanks to the Exeter and their staff for a beautiful meeting room, great continental breakfast and valet parking.