SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE MICHIGAN CHAPTER
Newsletter, Summer 2009

2009 Board Members

Dave Neal, President

Kathy Wade, President Elect

Sarah Allen, Secretary

John Carey,
Membership Recognition

Doug Dault, Nominations

Sarah Eisenberg, Membership

Chris Henrickson,
Michigan Continuing Education Collaboration Liaison

Sandra Iaderosa, Education

Ellen Kachalsky, Treasurer

Karen Neuman, Publications

Carrie Ross, NASW Board Liaison

President's Message – Dave Neal

The Board unanimously voted at its June Board meeting to begin actions necessary to affiliate with the National Society. We are the first state chapter to take official action to affiliate.

In many ways the Chapter will continue to function as well always have. EXCEPT, the Board is trying to take steps to be more active and to meet your needs. For the first eighteen months, January 1, 2010 – June 30, 2011 you will receive all of the benefits of National Membership at **NO ADDITIONAL COSTS.** Clearly beginning July 1, 2011 your dues will increase significantly depending on the type of membership you will be eligible for.

This period of time will allow **all of us** to evaluate the benefits of affiliation and determine whether the Chapter should renew its affiliation with the National Society. With this opportunity for an eighteen month affiliation at no cost to the membership and with our By–Laws saying that we are an affiliate with the National Society, the only rational decision was to move forward with a formal affiliation.

National is changing their fiscal year to July 1-June 30. All Chapters are required to do the same. The Board voted to extend everyone's membership through June 30, 2010. You will be asked to renew you membership in the spring of 2010 for 10-11 at the chapter rate of $35.

For the FY 10-11 National will require a $10 service fee for all state members. The Board voted to pay this and not ask members for it.

Sometime in the fall all members who are not national members, will be required to join the National Society. There will be no charge attached.

At this point it is not clear what will be required of those members who are currently National Members. These members have been paying a national and state membership fee. National can not waive their national membership fee and remain solvent. It is not certain how the transition will affect their dues.

The Chapter will retain our funds. We can raise money and continue to do business as we have. National will now be responsible to our non-profit status and make appropriate reports to the IRS. This is what the Michigan Hospital Association has been doing for us. This will require changing our By-Laws to be consistent with National. It is my understanding that Stephanie Peters has agreed to chair the By-Laws committee. We will need to adopt a new set of By-Laws at the fall conference.

This reorganization is really challenging the Society to stop up to the plate and become the organization which represents social workers in Health Care. This is a big task and we will evaluate in two years to see how well it has been accomplished. Remember that we are a Membership Organization. All members share the responsibility for success or failure.

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE MICHIGAN CHAPTER Newsletter, Summer 2009

President's Message – continued

This is not all that the Board has been focused on. The Health Care Policy Paper lead by Karen Newman; regional meetings are planned; a revised Newsletter format is developed, and there has been other advocacy work. See other articles in the Newsletter for information about these activities.

Congratulations to Jennifer Plarske who has had a new baby. Because of this, she has had to resign as Nominations Chair. Doug Dault, chair elect, has taken over and Nina Abney has replaced Doug as the Nominations Chair Elect. Many thanks to Jennifer for the work she did as Chair. We wish her well with her new child.

Senator Stabenow's Health Reform Hearings

Dave Neal, LMSW and Andrea Muldaore, LMSW

Senator Stabenow's health care staff held 6 hearings across the state. Andrea Muladore and David Neal represented the State Chapter at the Saginaw hearing.

Staff explained the process which will be occurring. The House has formed one committee to write the Health Care Bill. Representatives Pelosi and Waxman are basically controlling the writing of this legislation.

In the Senate separate bills will be written by the Health and Finance Committees. These will have to be reconciled and passed before a conference committee between the House and Senate will have to write the final bill. At this point it is anticipated that President Obama will become active in trying to have the final bill be something that he can support and get passed in both houses. This bill is either passed or rejected.

Through out the process the Budget Office and the Joint Committee on Taxation are very important players. The Budget Office is responsible to determining how much the new program will cost. The Joint Com on Taxation determines how much will be raised by new taxes that are needed.

There is general agreement that reform should costs no more than 1 trillion dollars. Coverage will need to be cut back to reach that amount. It will be a struggle to arrive at new taxes to reach 1 T. While there is hope that there can be savings, the Budget Office is not accepting significant savings from prevention, case management, chronic disease management, and evidenced based practices.

Staff believes that current employer programs will remain. You have probably heard President Obama says that everyone will be able to keep their current coverage. Medicare will remain and probably expanded. There will be increase access to Medicaid and the SCHIP program was recently expended to 300% of poverty.

This still leaves a significant number of folks generally those working without coverage. A new public program will be introduced. Everyone without health insurance will be required to participate. Because these individuals will have a range of income, it is not clear how their ability to pay will be determined. Also, whether their employers should contribute or pay a tax.

There is also some support to not have a government program but to allow co-ops to form to manage plans. This would be similar to credit unions. Participants would elect Boards to run the programs.

Congress is considering several options on how to raise taxes. A tax on pop or any beverage with sugar would bring in 60 billion; alcohol tax 50 B; tax on incomes over $250,000 250 B; and elimination of health savings accounts several billion. A tax on current health insurance benefits would raise 400 B. Since 1 T is needed, it is likely the tax on Health Insurance benefits will be utilized.

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE MICHIGAN CHAPTER
Newsletter, Summer 2009

Following discussion of these issues, those present discussed areas of concern to them. The Chapter's Health Reform Paper with our 10 essential elements were presented. Staff expressed appreciation for the paper and for having it written out so they could use it with others.

Everyone was encouraged to discussed health reform and why it is needed with their family, friends, colleagues, and others.

Health Care Reform Online Resource Center
www.stabenow.senate.gov/healthcare

- Copies of draft bills
- Transcripts of hearings and debates
- Background materials
- Reports and information from the White House
- Links to other information and resources

ESSENTIAL ELEMENTS FOR NATIONAL HEALTH CARE REFORM

National Association of Social Workers – Michigan Chapter
Society for Social Work Leadership in Health Care – Michigan

This paper is intended for broad distribution to inform and influence forums addressing health care reform, resulting in the incorporation of these essential elements in our nation's future health care system.

Across the country there is a growing demand for health care reform. It is being driven by an increasing number of uninsured citizens who lose health care benefits when they lose their jobs; increasing costs and disparities in care; provider manpower shortages; inadequate attention to preventative health care; and excessive and duplicative administrative costs. This is in addition to the nearly 50 million Americans who were either uninsured or underinsured before the current economic crisis.[1] The manufacturing base of this country can no longer compete with international companies who do not have to bundle the costs of employee health care into the prices of their products. The threat of job loss or benefit reductions with employer-based health insurance coverage is a matter of national concern. Individuals, families, businesses, governmental units and entire communities are being financially strained in unsustainable ways.

Nationally, citizens, health care providers, and leaders in business, labor, and government are finally voicing a need for comprehensive health care reform. States are beginning to experiment with forms of universal health care coverage. The country can no longer ignore the injustice, indignity, and expanding economic devastation caused by the inadequacies of the current health care system. A poll conducted by Harris Interactive for the Commonwealth Fund in 2008 found that 81 percent of Americans who were insured all year and 89 percent who were uninsured at some point in the year called for fundamental change or a complete rebuilding of the country's health care system.[2] Persons who previously have been unmoved by the plight of the uninsured are increasingly aware of the vulnerability of the underinsured, and the very real possibility that they may join this group. Broad consensus is emerging in Michigan and across the country to address the problems within America's health care system, which include disparities in access to care, lack of quality care, and unequal distribution of resources, ever increasing cost, and economic devastation for families and businesses, social justice inequities, provider manpower shortages and failure to promote prevention measures.

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE MICHIGAN CHAPTER
Newsletter, Summer 2009

This Health Care Reform Policy Position Paper presents ten essential elements that the National Association of Social Workers – Michigan Chapter (NASW-MI) and the Society for Social Work Leadership in Health Care – Michigan Chapter (SSWLHC-MI) believe must be included in the reform of our national health care system. It is the product of a collaborative effort between NASW-MI and SSWLHC-MI and has been endorsed by the National Board of the Society for Social Work Leadership in Health Care.

It is our belief that ultimately a publicly funded, single payer insurance program must be a principle component of a comprehensive and cost-effective plan to achieve universal coverage. Other models must be considered and endorsed but represent incremental improvement rather than the sweeping reform that is needed.

Essential Elements

1. Reform must provide coverage for all citizens of the United States.

According to the Institute of Medicine, "The growing number of uninsured Americans – totaling 45.7 million as of 2007– is taking a toll on the nation's health". [3] Further, the Institute finds that each year 18,000 Americans die needlessly because they lack access to care.[4] In 2008, the average annual premium for family health insurance was $12,680, an increase of about 5% from the 2007 average premium. Since 1999, average premiums for family coverage have increased 119%.[5] Such huge increases in coverage premiums are making access to private health plans impossible for many working families and virtually all families facing unemployment or under employment. Only the federal government has the capacity, resources, and experience necessary to build an adequate framework for health care for all citizens. This does not mean that individual consumers of health care should not bear some cost considering "ability to pay", but the inability to pay should not be a barrier to necessary health care.

2. Reform must monitor and cap administrative costs.

Social workers support a single payer system. This appears to be the most cost effective way to reduce administrative costs. If a single payer, publicly funded plan is not feasible, oversight and coordination of any and all private, for-profit insurers must be implemented. Further, consideration must be given to capping the administrative costs of any plan, whether public or private, to a maximum of 15%. Over 31% of every health care dollar goes to administrative expenses such as paperwork, overhead, CEO salaries, profits, and other non-clinical costs.[6] Data, including report cards, indicating the amount of administrative cost, salaries for top executives, and profit earned by a particular insurer must be made easily accessible to the public to assist in their plan selection process.

3. Reform should require the integration of physical and behavioral health care services, including parity for mental health and substance abuse services.

There is ample evidence that behavioral health issues affect quality outcomes for physical health disorders. A study published in 2006 by the National Association of State Mental Health Program Directors reports that persons with serious mental illness die 25 years younger because of physical health disorders that are not adequately treated.[7] As noted in the Michigan Commission on Aging Advisory Council 2006 Annual Report addressing Mental Health for Older Persons, studies have found that depression is a risk factor for chronic illness and contributes to higher symptom burden, complications and mortality.[8] Chronic illness is a risk factor for depression and each factor complicates the other. These findings are supported by the U.S. Surgeon General's Report on Mental Health (1999)[9] and the President's New Freedom Commission on Mental Health (2003)[10]. Programs across the country that truly integrate physical and behavioral care are achieving better outcomes and reducing costs. Health care reform efforts must provide incentives to systems of care that integrate physical and behavioral care services.

4. Reform must include provisions that improve the quality, safety, and outcomes of health care services.

Despite having the highest per person cost for health care in the world, in 2000 the United States was ranked 37th in the world by the World Health Organization for overall health system performance and 72nd for level of health .[11] Requiring providers to implement evidence based practices is a first step in improving health care outcomes. The establishment and funding of national research centers and national data bases to develop and disseminate best practice standards is also essential. This improvement will also include ensuring that all care is culturally appropriate. The professional social worker is an expert in this area.

5. Reform should reward providers who achieve quality outcomes in efficient cost-effective care.

The United States spends 16 percent of its gross domestic product (GDP) on health care.[12] The Congressional Budget Office projects that, without changes in the law, total spending on health care will rise to 25 percent of the GDP by 2025 and 49 percent in 2082.[13] While most major industrialized nations spend only 8 percent to 10 percent of their GDP on health care[14], they achieve significantly better health outcomes in life expectancy, infant mortality, and other conditions.[15] Our current system of financing creates incentives for overuse of health services in some cases and the denial of needed care in others. Realigning incentives for providers to offer the right amount and kind of care when it is needed is critical.

6. Reform must provide coverage and adequate services for catastrophic care.

More than half of all personal bankruptcies in the United States are precipitated by the costs associated with a health care crisis.[16] Families who are caring for a severely disabled child or elder should not be driven into poverty as a consequence of providing that care. Financing for care must keep pace with technological advances that save and improve the quality of lives of the severely disabled and chronically ill.

7. Reform must include greater use of information technology which allows providers to coordinate care, reduce costs, avoid errors, and eliminate unnecessary redundancies.

The development of electronic medical records is a first step in providing quality care through the coordination of treatment plans and the reduction of errors. As portable electronic records evolve, adequate protections for securing the patient's record must be assured.

8. Reform must provide for preventative care and other health promotion services.

Our current health care system lacks incentives for the patient and the provider to engage in disease prevention and health promotion strategies. An examination of spending on preventive services, health promotion, and health protection estimates that 3 percent of national health spending and 0.7 percent of GNP (Gross National Product) was spent on wellness activities, an increase of just 1.4 percent since 1929.[17] Services designed to prevent or delay the onset of disease are far less costly that the expense of care once disease has occurred. Structuring economic incentives to motivate providers, payers, and consumers to use preventative measures should be included in health care reform. For example, implementing obesity prevention programs can reduce treatment costs resulting from obesity related conditions such as diabetes ($98 billion current health care cost) and hypertension ($4.1 billion). Obesity leads to 62.7 million related physician visits and 39.3 million days of lost work per year.[18] Structuring economic incentives to promote prevention will reduce overall health care costs.

9. Reform must promote the patient and family as the center of all care and decision making and assure the protection of patient rights.

There is ample research documenting that patients do better when they are informed, educated and included in the decision making process. Providers should be knowledgeable of, and inform patients of, their rights and options, including compassionate end of life options, and must be supported in their efforts to educate, counsel, and fully engage patients and families in a shared decision making process. Standards ensuring patient rights should be established, including access to a fair and independent appeals process if care is denied.

10. Reform must promote coordination of health services and service integration to address the total needs of the patient, her or his family, and life environment.

While providers of health care services in a reformed system should be licensed and credentialed in their respective professions and enjoy some level of professional independence, each provider in a reformed system must work as a part of a team that recognizes the interrelationship of health care to other factors affecting the patient's health. This will require moving beyond treating each episode of illness as an isolated incident and focusing on long term needs and the prevention of undesired health conditions. As essential members of the health care team, social workers provide important services to the patient and family including case management; advising and educating regarding care options; coordinating care between patient and provider(s); and facilitating the development of the patient's ability to assume more responsibility for disease prevention and health promotion.

Action Alert

The membership of the Michigan social work organizations responsible for this Health Care Reform Policy Position paper welcome comments and reaction from readers. Our membership intends to use this paper as a basis for future discussions on health care reform and participation in health care reform efforts.

Those wishing to comment or invite social workers to forums addressing health care reform may contact: Linda Burghardt, Governmental Relations Director, NASW – MI Chapter (Lburghardt@nasw-michigan.org) or David Neal, Chairperson, SSWLHC-MI (dneal@med.umich.edul).

Healthcare Reform: Legislative Update from National

House representative, Dingell (Michigan) recently introduced H.R. 3200, a.k.a. America's Affordable Health Choices Act of 2009. It has been passed through the House Ways and Means Committee, the Education and Labor Committee and the Committee on Education and Commerce. The bill will come to the Floor of the House for a vote in September. Some of the key provisions of the bill as set forth are:

• A Health Insurance Exchange that enables comparison shopping and "affordability" credits to help individuals and families purchase insurance.
• A public health insurance option that healthcare consumers can purchase and is sustained by consumer premiums.
• Guaranteed coverage including coverage for pre-existing conditions and limit on the ability of insurance companies to raise premiums bases on health risk factors.
• A "basics benefit package" based on standards that will be established by law. (The package includes preventative services without cost sharing, mental health services, oral health and vision for children and individual and family monetary annual spending caps.)

• Expanded Medicaid eligibility coverage to individuals and families with incomes at or below the 133% of the poverty level.
• Improvements to Medicare by filling the donut hole over time in the Part D drug program and elimination of out of pocket expenses for preventive services.
• Placement of responsibility on individuals to obtain and maintain health insurance. (Except for hardship cases, those who elect not to obtain coverage will pay a financial penalty.)
• Employers will have the option of either providing health insurance coverage to employees or contributing funds on their behalf. (Employers who chose to contribute will pay an amount based on 8% of their payroll.)

This legislation's goal is to expand healthcare coverage to almost all Americans while at the same time controlling health care costs. There are provisions that increase the number of community health and wellness centers, prohibit cost sharing for preventative services, provide federal funding for training of primary care physicians and identify and address health disparities. The AMA, NASW and Families USA are in support of this legislation.

For more information on H.R. 3200, a summary prepared by the House Committees on Ways and Means, Energy and Commerce and Education and Labor can be found at
http://energycommerce.house.gov/Press_111/20090714/hr3200_summary.pdf

Mental Health Parity Legislation

As you may know, House Bills 4597, 4598, 4599 and 4600 were introduced by Representatives Rebekah Warren (D-Ann Arbor), Tom Pearce (R-Rockford), Bert Johnson (D-Detroit) and Pam Byrnes (D-Chelsea) respectively, on March 17, 2009 and immediately referred to the House Committee on Health Policy. These bills would prohibit health insurers from imposing cost-sharing requirements and benefit or service limitations for mental health and substance abuse services.

Specifically, House Bills 4597 and 4598 would amend the Insurance Code to apply to hospital, medical, or surgical policies of commercial health insurance companies and health maintenance organizations (HMOs) providing inpatient and outpatient medical services. House Bills 4599 and 4600 would amend the Nonprofit Health Care Corporation Reform Act to apply to inpatient and outpatient hospital medical services of Blue Cross and Blue Shield of Michigan.

I have received a large volume of correspondence on this issue with many people expressing their disappointment with the House of Representatives voting on Autism Spectrum Disorder legislation (HB 4476 and 4183) without addressing mental health parity. Please know that an agreement has been reached and House Bills 4597 - 4600 will be brought to the House floor for debate and vote in the near future. Rest assured I will keep your views in mind.

You may monitor the status of these bills at www.michiganlegislature.org.

Again, thank you for your correspondence.

Regards,
Andy Dillon
Speaker of the House
District 17

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE MICHIGAN CHAPTER
Newsletter, Summer 2009

MICHIGAN NASW UPDATES

Carrie Ross, SSWLHC – NASW liaison

Greetings SSWLHC Michigan members! I recently took on the role of the liaison from our SSWLHC Michigan Board to the NASW Michigan Board. In addition to monthly SSWLHC board meetings and quarterly NASW meetings, part of my responsibility will be to represent us on the Legislative and Social Policy (LSP) committee through the NASW. This is the body responsible for coordinating legislative and policy recommendations to the Michigan legislature on behalf of NASW membership/interests. I hope to continue to be a voice for our interests as health care social workers in this role. I would like to take this opportunity to let you know about several pending bills and actions in which the NASW (and therefore SSWLHC) is involved.

The LSP committee has spent quite a bit of time discussing the current financial situation in Michigan. In order to approach a balanced budget, the governor recently issued an executive order calling for budget cuts to offset our 1.3 billion dollar deficit. Examples of cuts (which many of us are already noticing in our work): $10 million from community mental health programs, 4% decrease in Medicaid HMO reimbursement, $800,000 decrease in substance abuse prevention funds, $16.7 million decrease in child support enforcement programs. There is also concern that the state is using current federal stimulus funds to balance the budget rather than to create new programs or work toward long range financial solvency—these stimulus funds will expire in 2012.

The NASW is also at the forefront of various legislative efforts. Members have advocated at length in support of current mental health parity legislation and have urged that all mental health diagnoses be awarded parity rather than singling out one or two diagnoses. The NASW has also stood firmly in support of second parent adoption which, among other benefits, will have significant insurance and health care access benefits for the children of Michigan. The SSWLHC and the NASW are joining together to support a push from Senator Debbie Stabenow to increase the federal block grant for substance abuse and mental health services which has not been increased in 10 years. Given current fiscal realities it is unclear that this will be successful.

The legislative session following the summer break will have many items of interest to watch out for. Once again, the Michigan Blue Cross companies will be advocating for a compromise to allow the Blues to retain non profit status but be able to compete better with for profit companies. NASW did not take an official position on this matter during its last iteration as we were then in negotiations about expanded Blue Cross coverage of social work services. There is some concern that such "individual market reform" would jeopardize the position of Blue Cross as an insurer of last resort for many Michiganders.

If there are legislative items you believe should be taken up, pro or con, by the SSWLHC due to potential impact upon our patients/clients or our jobs, please let me know. Please also let me know if you see opportunities for intensified partnership between the SSWLHC and the NASW about specific matters. I will do my best to keep the membership u to date through the newsletter and be responsive to your

For more information about the Society for Social Work Leadership in Health Care – Michigan Chapter please visit our website at www.sswlhc-mi.org

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE MICHIGAN CHAPTER Newsletter, Summer 2009

Michigan State Loan Repayment Program Opportunity

The MSLRP has advised Bd. Association offices that FY09 funding is still available to support loan assistance payments to health care providers. The Michigan State Loan Repayment Program (MSLRP) provides loan repayment assistance to medical, dental and mental health care providers who enter into MSLRP service obligations. These service obligations require participants to provide full-time, primary health care services at an eligible, non-profit practice site, located in a Health Professional Shortage Area (HPSA) for a period of two to four years.

The FY 2009 first-come, first-served application period remains open. Employers may still take advantage of combining their contributions equally with available federal program funds to double their resources intended for provider loan repayment contracts. Remaining federal funds must be committed no later than August 31, 2009, or be returned to the Health Resources and Services Administration (HRSA). Interested providers and employers should apply as soon as possible: Participants receive these loan repayment benefits tax-free. Contracts are awarded to eligible providers on a first-come, first-served basis, regardless of priority status. Contracts may start as soon as the month following application and employment. Application forms are available on the MSLRP Website at: www.michigan.gov/mslrp (http://www.macmhb.org/MAIN/Friday%20Facts/2009/www.michigan.gov/mslrp). These contracts are not affected by the State's budget situation, because no state funds are involved. Call Ken Miller at 517 241-9946 for further details.

The MSW Student Intern's Point of View

Beginning with this newsletter we hope to feature an article or editorial statement from one of the many MSW interns working in our facilities. They will be asked to write about some convergence of field and classroom, something they have learned in their training, or thoughts about the trajectory of health care social work. This month we hear from Amber Lewandowski, a student at the University of Michigan School of Social Work who is placed in the adult liver transplant clinic at the U of M Hospital. A particular interest of Amber's is social justice as it pertains to health care delivery.

If you know of a student who would like to contribute to the newsletter (or who could be persuaded!!), please let me know. carross@umich.edu thanks, Carrie Ross

When asked to write this piece on social justice from a social work intern's perspective, the first thought that came to my mind was "differential treatment." As competent and compassionate professionals, we strive to provide equitable care; and for many of us, it is a central part of our identity. Whether a provider or a patient, we are all aware of the common perception that the medical profession is guided by objective realities and decisions. While this is largely true, I challenge us to critically evaluate our implicit biases that contribute to current health disparities.

In the prominent study, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare," by the Institute of Medicine (2003), it is posited that disparities in care, including those based on race/ethnicity, poverty, and low socioeconomic status, result from, "structural, economic, environmental, political, and [provider] attitudinal" factors (p. 598). Diverse social characteristics, such as social class, social status, employment, age, and appearance, influence our interactions with patients. For instance, consider how a professor reporting pain would be treated by providers, in comparison to an unemployed patient on Medicaid reporting pain. Even though both individuals have the potential to abuse pain medications, who is more likely to initially be identified as a "pain-seeker?"

Conversely, patients can receive preferential treatment when they share social characteristics with providers. All we need to do is think back to conversations with patients who identify themselves as a social worker, as graduated from our alma mater, or as growing up in the same town. Then imagine interactions with individuals, who are unpleasant, have poor social support, and have low-income. Now, enter alcohol abuse into each of these situations.

Often, I have seen the former received positively by providers, who have stated, "you know, that could have been any of us here." Whereas, I have seen the latter approached with much less empathy. These responses, however, are normal human reactions. We are naturally drawn to spend more time and effort with individuals who are pleasant and similar to ourselves, even though these may not be the individuals who most need our help.

Taking a look at myself, I can also identify when my implicit biases have surfaced in my work. My view on what I believe constitutes a "healthy" partnership has been a bias that I have had to self-monitor, as well as explore through supervision. I have had patients with a range of partnership styles, from patients who remain with an unsupportive partner to have a caregiver, to patients who have a significant other that has a wife and children. In these situations, I have had to remind myself that my purpose is to help meet patients' needs. I have had to remind myself that my job is not to make value judgments, but to respect patients' lives and decisions, in order to work toward patient-centered and practical goals.

As we enter into a period where the number of uninsured is increasing, healthcare needs are expanding, and services and social programs are being reduced because of budget cuts, it is expected that healthcare disparities will continue to grow. Social workers must strengthen their advocacy efforts for patients, including partnering with our interdisciplinary colleagues to implement strategies for working together to eliminate health disparities.

Educational programs should be first on our agenda. Programs centered on cultural competency and health disparities, should be a requirement for all providers in the medical setting during their educational experience, as well as throughout their professional careers. To be effective, these classes should also include experience with diverse populations, and be comprised of providers from various disciplines.

In the healthcare setting, you find a unique group of individuals who share a common concern for the welfare of others. Every day, we try to work toward some measure of social justice. Initiating efforts to critically evaluate and address our implicit biases that contribute to current health disparities, will take each of us one step closer to providing equitable care and ensuring social justice within the healthcare setting. – **Amber Lewandowski**

Reference

Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.* The National Academics Press: Washington, D.C.

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE MICHIGAN CHAPTER
Newsletter, Summer 2009

Membership Recognition 2009

John Carey, LMSW – Membership Recognition

Each year, the Society for Social Work Leadership in Health Care – Michigan Chapter recognizes members who have displayed leadership qualities reflective of our Mission and Vision. Our mission is to be a primary professional organization which promotes, develops and supports social work practice in health care settings and offers its members ongoing educational opportunities to increase practice skills. Our vision is to model and promote excellence in social work practice and leadership in all areas of practice in health care.

Especially this year – with our challenges and changes both as a state and a nation, social workers are continually working on the edge, challenging, developing and caring for persons throughout our health care settings.

Nominate a colleague for the following awards to be presented at our annual conference this fall.

Emerging Social Worker of the Year: This award recognizes an exceptional member of the Society for Social Work Leadership in Health Care - Michigan Chapter who has been in the field five years or less who has made noteworthy contributions to patient services and project involvement.

Social Worker of the Year: This award recognizes an exceptional member of the Society for Social Work Leadership in Health Care who has been a leader in his/her individual program, department or health care agency and has demonstrated skills and outcomes considered exceptional.

Career Achievement Award: This award recognizes a member, retired or currently working, who has made an impact in Michigan and/or Nationwide on the field of Social Work in Healthcare. Nominees should be persons who have displayed ongoing leadership qualities reflective of the Society for Social Work Leadership in Health Care - Michigan Chapter's Mission and Values. The Society seeks to promote, develop and support social work practice in health care settings through education, networking and advocacy.

SOCIETY FOR SOCIAL WORK LEADERSHIP IN HEALTH CARE MICHIGAN CHAPTER
Newsletter, Summer 2009

Membership Recognition Nomination Form

Use one form for each award, checking the award and writing the nominees name where indicated on the bottom of the form.

_____ **Social Worker of the Year:** This award recognizes an exceptional member of the SSWLHC-MI Chapter who has been a leader in their individual program, department or health care agency and has demonstrated skills and outcomes considered exceptional. Characteristics of the Social Worker of the Year include:

- Professionalism, integrity and commitment to healthcare social work
- Well developed clinical expertise in the delivery of patient care services
- Knowledge of community resources and skills in advocating for the fulfillment of patient and family needs
- Collaboration skills which facilitate the development and implementation of programs, services or policies impacting patient care
- Commitment to the mission and vision of the SSWLHC

_____ **Emerging Social Worker of the Year:** This award recognizes an exceptional member of the SSWLHC-MI Chapter who has been in the field five years or less and who has made noteworthy contributions to patient services and project involvement. Characteristics of the Emerging Social Worker of the Year include:

- Professionalism, integrity and commitment to healthcare social work
- Ongoing development of clinical expertise in the delivery of patient care services
- Willingness to continuously expand upon knowledge of community resources and skills in advocating for the fulfillment of patient and family needs
- Collaboration skills which foster participation in development and implementation of programs, services or policies impacting patient care
- Commitment to the mission and vision of the SSWLHC

_____ **Career Achievement Award**: This award recognizes a member, retired or currently working, who has made an impact in Michigan and/or Nationwide on the field of Social Work in Healthcare. Nominees should be persons who have displayed ongoing leadership qualities reflective of the Society for Social Work Leadership in Health Care - Michigan Chapter's Mission and Values. The Society seeks to promote, develop and support social work practice in health care settings through education, networking and advocacy.

Nominee's Name, Title, and Agency:
Nominated by: _____ daytime phone: _____
Please explain nomination rationale (use additional pages if necessary):

Complete this form and mail or email to:
John V. Carey, LMSW
Suite 4001, 5333 McAuley Drive
Ypsilanti, MI 48197
careyj@trinity-health.org
(734) 712-8742

For more information visit our website at www.sswlhc-mi.org