Update

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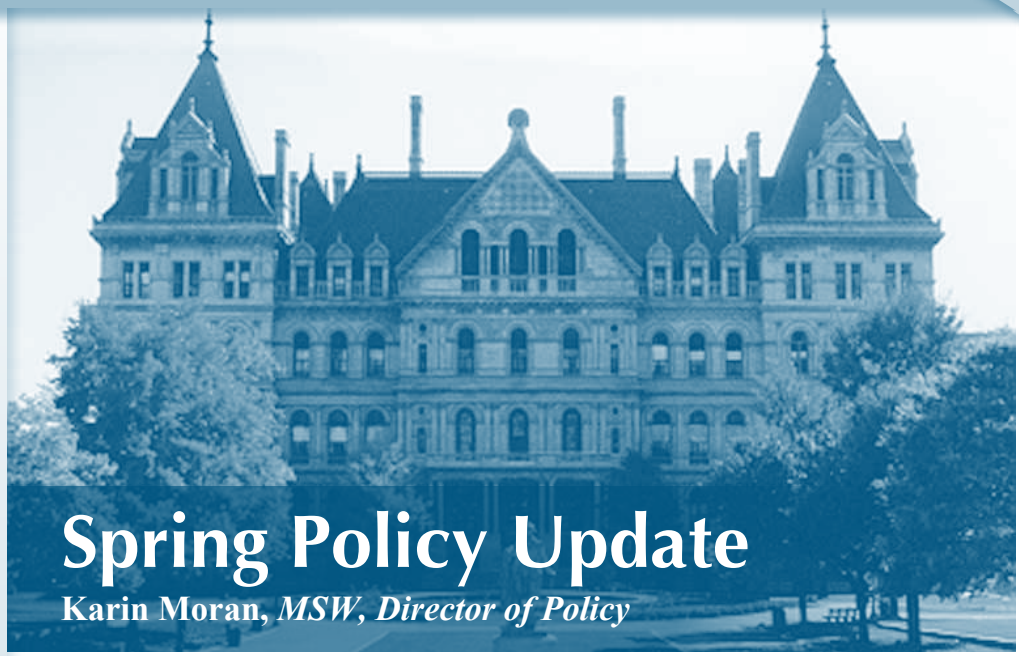

Spring Policy Update

Karin Moran, *MSW, Director of Policy*

NASW-NYS has been extremely busy this legislative session focused primarily on social work professional issues such as loan forgiveness, licensure implementation, reimbursement structures, workforce preservation, workforce development and broadening the arenas for social work practice. Our advocacy efforts also include a number of social justice issues such as access to healthcare and marriage equality.

Beginning in the fall of last year, the Chapter's policy staff began employing a legislative and political strategy to secure an extension of our Social Work Loan Forgiveness Program. Discussions/negotiations related to such efforts were a top priority for both the NYS and NYC Chapters and as such, the policy staff began meetings in late October that stretched throughout November and December with key staff in the out-going Paterson Administration as well as staff from the Division of Budget in both the Education and the Mental Health Departments, Senate Finance, Assembly Ways and Means, and eventually with Cuomo transition team members and ultimately, with new Cuomo staffers. In addition, we were again fortunate enough to have legislative champions, such as Senator Thomas Libous and Assemblyman Gary Pretlow, whose continued support and commitment to the profession of social work is immeasurably appreciated. Our longtime allies, 1199-SEIU provided support for the program as well. As a result of our combined efforts, a five year extension of the social work loan forgiveness program was in the governor's budget proposal and the resulting, final budget enacted on April 1. We thank all involved in this effort and greatly appreciate the support of our new governor, especially in light of our current fiscal crisis.

In the area of workforce development, we continue to work on securing funding for our Veterans' Mental Health Training Initiative. Due to large call volume from our membership, the Chapter developed a training program several years ago that focuses on the recognition and treatment of veteran's specific mental health issues. Year one was funded through a legislative grant and though we retain great support in such arena, given the state's current fiscal constraints, the program was left without a funding mechanism for its envisioned second year. Chapter policy

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staff consequently set to work on a number of strategies focused on securing funding for year two. Once again, we looked to the state legislature as a potential funding source and as mentioned above we were met with a great amount of support, however, dollars were not allocated for projects such as the VMHTI in this year's drastically reduced budget. We also worked with our federal representatives (Senators' Gillibrand and Schumer), however, the fiscal problems facing NY are also rife at the national level and again, the project garnered support from both representatives and their staff, however, a two year moratorium on federal earmarks was recently enacted and therefore no funding was available. As of the writing of this article, the Chapter's program staff has developed and submitted an application for a substantial grant to support year two of the project and hope to have news soon…stay tuned.

"As a result of our combined efforts, a five year extension of the social work loan forgiveness program was in the governor's budget proposal and the resulting, final budget enacted on April 1."

As we have communicated in previous policy updates, our work related to the implementation of Social Work Licensure remains ongoing. We have continued to spend a considerable amount of time ensuring the field is aware of recent statutory and regulatory changes that impacts social work professionals and practice. We continue to work closely with the Office of the Professions (at the State Education Department), most notably, David Hamilton PhD, LMSW, ACSW, Executive Secretary to the State Board for Social Work, regarding the implementation of the not for profit corporate waiver application and are grateful to Dr. Hamilton for the positive working relationship he has had with the Chapter and for his dedication and commitment to our profession. Most recently NASW-NYS partnered with Dr. Hamilton and the New York State Association of Deans of Schools of Social Work, who underwrote the projects, to produce two informational videos. The first video provides an overview of the corporate practice/ authorized settings issue and the waiver application process. We have engaged members of the Social Work Licensing Coalition, NY Council of Nonprofits, and the Schools of Social Work to disseminate the video as widely as possible to agencies who are potentially affected by this issue in advance of the June 18, 2011 application deadline. The second video focuses on licensure and licensed social work practice and incorporates the newest regulatory changes. Both videos are available through the chapter website (www.naswnys.org).

NASW-NYS has also continued to work with the Office of the Professions as they finalized and distributed a workforce study focused on all state agencies that are currently exempt from the licensing statute. We expect to be appointed to a Taskforce which will be charged with examining the results of such study and potentially offering further (final) recommendations on the licensing statute.

With regard to reimbursement issues, we have followed the work of the Governor's Medicaid Redesign Team (MRT), specifically, as it related to Medicaid Reimbursement. Of particular interest were the discussions and recommendations that mental health benefits provided under Medicaid for the seriously and persistently mentally ill population be subjected to Medicaid Managed Care. Anticipating the potential implications such a move could have on the reimbursement structure for mental health providers, the NASW NYS and NYC chapters gathered additional information on the issue and met with other stakeholders which resulted in the development a joint position statement which was disseminated to members of the MRT.

The following iterates the potential problem and our shared position…

The New York State and City Chapters of the National Association of Social Workers understand there is serious consideration being given to managing the behavioral health and substance abuse services provided under Medicaid to Seriously Mentally Ill adults and Seriously Emotionally Disturbed children. While we understand this is merely a consideration at this stage, we would like to bring to your attention a potential workforce issue such a transition could create.

As we understand it, the current NYS model contract only requires Medicaid Managed Care plans to reimburse for mental health services of an LCSW and above; whereas fee for service Medicaid reimburses all levels regardless of credential so long as they comply with scope of practice laws. Hence, many clinics currently bill for LMSWs and social work interns as well and can continue to do so under Part 599 of the clinic restructuring regulations. However, should there be a shift to a managed care model where behavioral health services are subject to the NYS Medicaid Managed Care model contract, neither LMSW's nor MSW interns will be reimbursable. Given the fact that the profession of social work is the largest group of mental health service providers, huge workforce and service delivery disruptions could be an immediate result of such a shift. Further, it has the potential to eliminate a vital pipeline for obtaining the LCSW in the future, hence, creating long-term disruptions and workforce shortages.

The state of Pennsylvania maneuvered through similar territory and included both levels of social work licensure within their reimbursable provider structure. While we understand a shift to Medicaid Managed Care for behavioral health is not a foregone conclusion in NY State, we simply felt it incumbent upon us to raise this potential concern as a prelude to more substantive conversations should we move toward such a model.

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Since issuing the above position, the legislature acted on many of the MRT recommendations, however, with regard to this specific area, there will be a two year implementation period and as such, NASW will continue to work on behalf of the profession as such reforms transpire.

NASW-NYS has again taken up our pursuit of legislation to include social workers as authorized providers in NYS' Workers Compensation program. We are currently engaging and strategizing with other stakeholders on the issue and will again work toward passage of the bill. In another access issue relevant to our profession, we are working with the NYS Conference of Local Mental Hygiene Directors to advance an initiative that seeks to include licensed clinical social workers, as well as licensed nurse practitioners in psychiatry, as psychiatric examiners for the purpose of determining a defendant's mental capacity to proceed to trial in a criminal proceeding. Under the current Criminal Procedure Law, a court may order a psychiatric examination to determine if a defendant possesses the capacity to understand the proceedings against them, or if the defendant is unable to assist in their own defense by cause of mental illness or developmental disability. When a psychiatric examination is ordered, two psychiatric examiners, currently defined only as a "qualified psychiatrist" or a "certified psychologist," are delegated to conduct the examination. The current definition of psychiatric examiner prevents licensed clinical social workers from conducting psychiatric examinations in criminal proceedings, even though the functions of the examination lie directly within their scope of practice. The counties contend there is shortage of currently authorized examiners, especially in many rural counties; therefore we will work in partnership with the Conference to advance this initiative.

In another workforce related issue, NASW-NYS has received dozens of calls from School Social Workers whose positions were in danger of being cut from their school district's proposed budget as districts across the state proposed such actions in light of an unprecedented $1.2 billion dollar cut in education funding. NASW-NYS sent an alert on this issue to our members and have been in communication with school social workers in more than 20 districts with social work jobs at risk. The Chapter developed and issued a position statement supporting the retention of school social workers to the Boards of Education in the identified districts. The Chapter has also set to work on advocating for a bill mandating that districts employ School Social Workers (to provide mental health services). While we certainly understand the difficulties districts face given the steep cuts, we contend that services provided by school social workers are not interchangeable with those provided by other professions (such as guidance counselors) and as such should not be provided by pupil personnel staff not qualified to provide mental health services.

Marriage Equality has been gaining a lot of attention at the capitol once again this year and given the fact that our new Governor has committed to passing such legislation in NY, hopes have been renewed. In 2009, the marriage equality bill was defeated on the Senate floor 38 to 24. While the defeat was discouraging, advocates regrouped, realigned and set about strengthening their ranks. Pro-equality groups including the Empire State Pride Agenda, Freedom to Marry, Human Rights Campaign, Log Cabin Republicans, and Marriage Equality New York, have unified under the banner "New Yorkers United for Marriage."

On May 9, members of our Northeast Division and NASW-NYS policy staff joined over a thousand LGBT and allied New Yorkers who participated in "Equality and Justice Day," Empire State Pride Agenda's annual advocacy day. They rallied at the Capitol and engaged in a full day of legislative advocacy in support of issues ranging from marriage equality, transgender rights, and health service issues. Marriage equality has been identified as an issue of priority for our National Office and the State Chapter, and we will therefore continue to monitor and weigh in when and where appropriate.

Since passage of the Affordable Care Act (ACA), we have been peripherally involved in implementation efforts at the state level. Full enactment of this federal initiative requires several legislative initiatives be passed, starting with the creation of a statewide health insurance exchange. As such, the NASW-NYS Policy staff has been asked to work with members of the Timothy's Law Campaign and Health Care for All New Yorkers (TLC and HCFANY, respectively) on such initiatives. To date, we have had several meetings with members of each group and continue to keep abreast of developments and opportunities to engage. On May 11, with only six legislative session weeks remaining, over 85 organizations, including NASW-NYS, signed onto and released a letter to Governor Cuomo, Senate Majority Leader Dean Skelos and Assembly Speaker Sheldon Silver at a press conference, urging them to take swift legislative action to establish New York's insurance exchange as prescribed in ACA. In addition, we have joined HCFANY's Children, Youth, and Families Task Force, a group dedicated to addressing the issue of uninsured children in New York, and to ensuring that the state adopts children and family friendly policies during the implementation of ACA. We will continue to work with stakeholders to shepherd in affordable high quality healthcare for all.

Clients with Chronic Illness:
Guidelines for Mental Health Professionals

Joanne Bobes, MA, LMSW

Introduction

Connecting with a mental health practitioner can be an invaluable part of a person's growth when managing chronic illness. How can mental health professionals help clients to manage chronic illness? This article provides guidelines (from a health professional's vantage point) to understand common feelings associated with illness, and to help clients learn how to talk about illness and consider alternative (or non-medicinal) approaches. Providing support and hope for wellness is an invaluable part of the therapeutic relationship. When clients have more hope, they typically feel more in control and happier. "To hope under the most extreme circumstances in an act of defiance that… permits a person to live his life on his own terms." (Groopman, 2004). Support, education and resources can provide a greater sense of control as well as hop fulness towards wellness. Fears, sadness or frustration associated with illness can lessen over time through dialogue, education, and support.

Chronic Illness & Common Feelings

Common feelings associated with many chronic illnesses include:

- Feeling unable to be social when not feeling well
- Feeling isolated, with a lack of support resources
- Feelings of frustration with medication and its side effects
- Feelings of stigma
- Uncertainty about how to talk about illness when it impacts work life

Talking About Illness – Tips for Clinicians

- **Ask Clients:** ***How does it feel to talk about your illness?*** A mental health professional might be the first person to provide a safe place to talk about illness, which can provide an immediate relief of anxious feelings relating to illness. As a dialogue continues, client's can sort through the myriad of feelings associated with illness.
- **Ask Clients:** ***Do you like your doctor?*** If your client isn't happy with a doctor, support your client to network and find a doctor who better meets their needs. Patients should feel that their doctor is accessible, easy to talk to, and open to listening and answering questions.
- **Ask Clients:** ***What do you do to manage your illness?*** It's important to explore both medicinal and non-medicinal approaches to manage chronic illness. There are numerous types of mind, body, or mind-body approaches to manage health. Benson & Stuart (1992), note that "the awareness that mind and body interact has important implications for the way we view illness…" Further, Benson & Stuart suggest that the mind/body relationship implies that addressing and treating both internal (bodily functions) and external (social connections) factors simultaneously can impact health more positively than by only treating one in isolation.

  While mental health professionals are not an expert on these approaches, offering ideas for exploration can provide more healthcare options and also a greater sense of control. Non medicinal or alternative approaches, depending on the illness, may include:
  - ❍ acupuncture
  - ❍ biofeedback
  - ❍ bodywork
  - ❍ dietary changes
  - ❍ meditation
  - ❍ nutritional supplements
  - ❍ relaxation techniques
  - ❍ tai chi

- Ask Clients: How do you find information? There are numerous associations, support groups, online resources and publications that provide information about traditional (medicinal) and alternative (non-medicinal) ways to manage most chronic illness. Some suggestions for client discussions:
  - ❍ Explore your client's current source of information and education.
  - ❍ Help your client to identify what information they want.
  - ❍ Discuss ways to get information and learn about resources, which may include researching at a library or online, locating association's websites for information or locating a support group

- Ask clients: "Do you talk about your illness with family members or friends?" Does your client feel comfortable talking about illness? Why or why not? People suffering from chronic illness are often isolated and lonely and may not feel understood by family, friends or colleagues. Therapy and support groups provide ideal settings to talk about illness, move towards acceptance, and have a greater comfort level talking to family and friends about the illness.

- **Ask clients:** ***"Do you know who to talk to about your illness if it's impacting your work life?***

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It is important that clients know their rights when it comes to managing their health while at work, or if they need time off or ask for an accommodation. Clients should be guided to:

- talk to their Employee Assistance Program (EAP) if they need time off or need an accommodation at work.
- review their rights on the ADA (American Disabilities Act)
- if an EAP program does not exist, clients should talk to Human Resources after consulting with the ADA

Managing Pain & Stress Naturally

There are a number of ways that people with chronic illness can manage pain and symptoms naturally. Diet, rest, stress, exercise, bodywork, mindfulness techniques, and alternative medicine may help to reduce symptoms, manage what triggers symptoms, or maintain a stronger constitution.

A mental health practitioner can help clients explore natural ways to manage pain and stress. Guide clients to seek information from online resources from reliable sources (i.e., WebMD), trade publications, and certified health practitioners. Clients should always be encouraged to tell their medical practitioners about any alternative methods of self-care they are trying out.

- Do you have a nutrient-rich **diet** appropriate to the condition?
- Do you get enough **rest**, including a good night's sleep and rest during the day?
- Do you manage your **stress level**, i.e., find time for yourself, slow down when needed?
- Do you have **mental health** supports, for example, friends and family to lean on for support, support groups, etc.?
- Do you get ample **exercise**?
- Can you use any form of **bodywork** to support your circulation and overall health? This could include massage, gyrotonics, tai chi or stretching.
- Do you use **mindfulness techniques** to help you to relax? This may include meditation, visual imagery, breathing exercises, biofeedback, or prayer.
- Are there any **alternative medicine** approaches that could help your condition? Such approaches could include acupuncture, Chinese herbs, or nutritional supplements. Make sure to encourage clients to check with their physician before using alternative approaches to consider potential contra-interactions with prescription medication.

In closing, it is important to note that a dialogue about illness is not linear, and that any of the topics raised in this article can be tabled at the appropriate time. The therapy setting can provide an opportunity to reflect, develop acceptance and hope, and receive support to develop stronger coping strategies to manage chronic illness.

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Learn more about:	Resource:
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Nutrition and Diet	• Balch, J.F. and Bach, P.A. (2010). Prescription for nutritional healing. USA: Penguin Group. • Pitchford, Paul (2002). Healing with whole foods. California: North Atlantic Books. • The World's Healthiest Foods is a very good resource base for healthy eating plans and a special section on food sensitivity resources, digestion, and organic foods (http://whfoods.org/)
Mind/Body Resources	• H. Benson, MD and E.M. Stuart, RN, C, MS (1992). The wellness book – the comprehensive guide to maintaining health and treating stress-related illness. New York: Fireside. • Mathew, R. (2009). The relaxation response: equipping patients with a self-care tool for life, *Advance for Occupational Therapy Practitioners*, Vol. 25, Issue 4, p 26. • The Center For Mind-Body Medicine is a great resource for resources, professional training, D.C.-based services, and referrals for nationwide similar centers (http://www.cmbm.org/)
Alternative Medicine: Acupuncture & Chinese Medicine	Beinfield, H and E. Korngold (1991). Between heaven and earth: a guide to chinese medicine. New York: Ballantine Publishing Group. • Kaptcuk, Ted J. (2000). The web that has no weaver. New York: McGraw-Hill Companies.

The Ethics Corner

The Ethical Dilemma That Gifts Present To Social Workers

By Jed Metzger, PhD, LCSW

Social work justly and proudly proclaims ethics as the cornerstone of our profession. As such, ethics help us understand and frame the very context of our helping relationships. Interestingly however, unlike some of our more closely related professions (Marriage and Family Therapy, 2001, Counseling, 2005), our code of ethics does not have a clear standard related to receiving gifts from the people we work with as social workers. This article, using direct experience from the author's professional practice, shall attempt to illuminate the ethical dilemmas that gifts present and offer a framework to clarify on how to proceed when presented with a gift by a client.

Honesty requires that I start at my beginning. I received my MSW in 1987 from a clinical program and had the good fortune of excellent clinical supervision while in internships and upon graduation. Among the many things I learned in graduate school and in supervision was about gifts. I learned a fairly simple rule and strategy. This was that I was to not accept gifts, but I was to respectfully explore the gift- the meaning, perhaps transference rich, and then to move forward, again sans gift. What I discovered was while this worked well for me, it did not work so well for the people who were trying to give me a gift. Several of these individuals let me know that I was failing to meet the *NASW Code of Ethics* (1999), specifically the principle of valuing our relationship. I wish to confidentially give credit and thank Ms. V. and Ms. P.- both many years my senior and coming from different ethnic backgrounds than myself. In the end the real gift that they gave me, one that I gladly accepted, is a greater understanding of the nuances that are at the core of this particular ethical dilemma.

I learned pretty quickly that my clients understood fairly rapidly that they should not give me money- they got the ethical position that money put us both in. My clients could say that money (or more recently gift cards) probably should be professionally prohibited. To that end I want to stress that we as social workers should never accept gifts of money as this compromises our relationships and violates the *Code*. In fact I call to attention the fairly high profile license suspension in 2008 of a social worker in Virginia who was routinely accepting gift cards from clients (Day, 2008). At the same time my clients also let me know that gifts were complex, that they also had the "right" to show me appreciation. They told me, "we understand that you cannot accept money or items of great value but we want to acknowledge good service".

Value then is an important subject to tackle. The American Association of Marriage and Family Therapists (2001) goes as far as using the term "substantial value" when discussing prohibited gifts. On one hand this issue may seem self-explanatory- in essence an expensive gift is what is prohibited. Clearly an expensive gift would be out of bounds. Where value gets more complex is when we move away from the money question for a moment. Here is where meaning becomes important. Several years ago I supervised a young lesbian social worker who came to me perplexed with a gift that an older female client had given her of a silk undergarment. She had refused the gift but was clearly flustered in what appeared to be a sexualized gift. I directed her to return to the client (who was still in her office) and explore the issue. The client informed her that she had observed the social worker frequently wore silk and wanted to get her something she would like. The meaning the client wanted to convey was to be thoughtful, armed with this knowledge the social worker relaxed and was able to respectfully decline the gift based on the value of the gift.

This brings me to the lessons from my two teachers, Ms P. and Ms. V. Ms P. had been born into a country formally occupied by the British and began a habit of bringing me a small amount of curried goat most every week when she came for session. This type of gift had low monetary value. With discussion we came to understand the gift was what has been described as an "homage" type of gift (Spandler et. al., 2000). What was I to do? Did it matter that I was a vegetarian? Here then is the dilemma. Ms. P. had listened to me about the nature of our relationship and my professional code and clearly seemed to understand both. At the same time she felt a need to communicate to me by way of gift. There seemed to be important cultural considerations at play. As social workers, I contend that we need to always be mindful if accepting a gift will have the potential to harm the client in any way including altering our relationship. At the same time we

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need to consider what the impact is of rejecting a gift as well. In this way Ms. V. was also a strong teacher to me. I was to work with her and her family for around four years. Towards the end of December of our first year of working together she gave me a holiday card that contained some cash. This I could not accept, she informed me that she would have gotten me something but did not know what I would like so wanted me to get myself something, hence the cash. A fairly lengthy discussion resulted in her grudgingly accepting the cash back (I kept the card as a gift). A year later it was a fine pair of leather gloves. Again a considerable amount of discussion that while the gift was very thoughtful and useful; it clearly had too large a value for me to accept. The next year she knit me a scarf. She gave it to me with admonishment, "I have listened to you the past two years, now you will listen to me, I did not spend any money on this, I had the yarn, I just spend my time, in the same way you spend your time, l and I am pretty certain that you don't get paid for all the time you spend with us, so you will take this scarf". I did accept the gift with as much humility and appreciation as I could. The gift was seasonal (Spandler et. al., 2000), but I did accept it in the same way that I accepted Ms. P's cooking. In both cases we had spent considerable time discussing the gifts and the nature of our professional relationship. Both women had listened to me and I had listened to them. We came from different ethnic backgrounds, genders, ages, economic classes; all of these factors played a role in the importance of the gift, in valuing them I needed to understand that as well.

Recently Reamer (2003) has framed the gift question under the larger "dual relationship" ethical considerations. Reamer indirectly discusses the gift question framed as an "altruistic gesture" concern. While some may argue that receiving gifts is not a dual relationship issue and hence an incorrect placement of the concern (Saer, 2011), it does seem that gifts do present us with some subtle or not so subtle boundary and dual relationship dilemmas. As such we need to attend to this boundary seriously and with care. As in all ethical considerations then, this requires a consistent strategy to successfully attend to the ethical considerations presented (Dolgoff, Harrington & Loewenberg, 2012).

In order to best address ourselves to any ethical dilemma, always first begin with the *NASW Code of Ethics* (1999) and the specific standard (Congress, 1999, Reamer, 1998). In this case it is suggested that section 1.06 *Conflicts of Interest* is the most appropriate section. Again while there is no specific mention of gifts, it is contended that this is the specific section that addresses this concern. Following use of the *Code*, it is advised that you ask yourself what rights do the clients have and what responsibilities do you have then look at the ethical implications for each course of action. Third, if you work in an agency or organization, consult that agency's policy manual to see if the issue is addressed. Fourth use professional supervision and/or consultation. Following these steps will best protect you and the people you work with to maintain the highest standards of professional social work practice.

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Genesee Valley Division Hosts 2011 Awards Dinner

Submitted by Brenda L Barkley, LMSW, Awards Dinner Coordinator

The Genesee Valley Division held their annual *Social Worker of the Year* Awards Dinner at the Burgundy Basin Inn on Tuesday, April 5, 2011. In attendance were over one hundred Professors, Alumni, family and friends of Award winners. Five colleges represented were; University of Buffalo-Rochester Extension, Greater Rochester Collaborative, SUNY Brockport, Roberts Wesleyan and Nazareth.

We enjoyed networking and learning more about how ***Social Work in the Digital Age*** affects our profession. This presentation was by our keynote, Nancy J. Smyth, PhD, Dean of Social Welfare and School of Social Work from the University of Buffalo. Her presentation included topics such as; Blogs, Podcasts, Social Media Evolutions, Twitter, etc. Contact information for more details can be found at LinkedIn: http://www.linkedin.com/in/njsmyth or Twitter: http://twitter.com/njsmyth.

The Genesee Division presented the following awards:

Shirley Reiser and Shirley Sharp - *Lifetime Achievement Awards*
Cynthia Lewis - *Social Worker of the Year*
David Fiedler - *Public Citizen of the Year*

Social Work Students of the Year

Paul Tucker - *University at Buffalo, Rochester MSW Program*
Daryl Staneck- Roberts Wesleyan College, MSW
Shameka Collins - Greater Rochester Collaborative MSW Program
Courtney Etherton - Roberts Wesleyan College, BSW
Dellena Harper - Nazareth College, BSW
Shermeeka M Mason - SUNY Brockport, BSW

Special Recognition

Ms. Mary Hannick
Newly Inducted NASW Social Work Pioneer

Our evening ended with the NASW Social Work Pioneer Award presentation by NASW-NYS Executive Director Ray Cardona to Mary Hannick (now 102 yrs old) for her decades of service and contributions to the social work profession.

Special thanks to the Dinner Committee for all of their efforts:

Julie Cataldo, Lenora Colaruotolo, Cynthia Eygabroad, Tammy Franklin, Debra Fromm Faria, Cathy Harris, Nancy Kusmaul, Angela Oddone, Janice Putrino

Social Workers and Health Care Reform

Introduction

The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (hereinafter collectively referred to as the "The Health Care Reform Act" or "Act") was signed into law by President Obama in March of 2010. The Act aims to reduce the number of uninsured Americans in the United States by making health insurance more affordable and available. As signed into law, its provisions will have a significant impact on access to health care for social workers and their clients. This Legal Issue of the Month article provides highlights of the reforms contained in the Act, identifies relevant provisions for social work practice as well as provisions facing legal challenges and discusses NASW's involvement.

Implementation Timeline

The Health Care Reform Act established a staggered timeline for implementation over a period of years. In summary, some of the most significant elements of the Act, are that it provides for incentives for expanded group plans through employers, affords tax credits for low-income individuals and families, extends Medicaid, and increases federal subsidies to state-run programs. The Act also prohibits insurance companies from denying coverage to those with pre-existing medical conditions, setting eligibility rules based on medical factors or claims experience, or rescinding coverage other than for fraud or misrepresentation *(Thomas Moore Law Center v. Obama,* 720 F.Supp.2d 882, 886 (E.D. Mich. 2010) (internal citations omitted)).

Effective in 2010, the Act provided an expansive array of reforms, including:
Small business health insurance tax credits, states to provide Medicaid for more people, relief for millions of seniors who hit the Medicare prescription drug donut hole, expanded coverage for early retirees, a national program for uninsured Americans with pre-existing conditions, information online, expanded coverage for young adults, free preventive care, prohibiting insurance companies from rescinding care, a way to appeal insurance company decisions, eliminating lifetime limits for insurance coverage, regulating annual limits of insurance coverage, prohibiting coverage of children based on preexisting conditions, holding health insurance companies accountable for unreasonable rate hikes, a larger primary care workforce, consumer assistance programs in the states, a prevention and public health fund, strengthening community health centers, and payment of rural health care providers (U.S. Department of Health and Human Services, 2011).

Effective January 1st, 2011, the Act requires:
Prescription drug discounts for seniors, free preventive care for seniors, reduced health care premiums, strengthening of Medicare advantage plans, a center for Medicare and Medicaid innovation, and a community care transitions program for seniors.

By October 1st, 2011, the Act will require:
The Independent Payment Advisory Board to begin operations and develop and submit proposals to Congress and the President on how to extend the life of the Medicare Trust Fund, and a new community first choice option for in-home care for disabled individuals through Medicaid.

By March 2012, the Act will require:
A new plan to understand and fight health disparities.
By no later than October, 2012, the Act will require:
Voluntary long-term insurance plans to provide cash benefits to adults who become disabled, a series of changes to reduce paper records and administrative costs, and a hospital value based purchasing program (VBP) in original Medicare.

In January of 2013, the Act will provide:
New funding to state Medicaid programs that cover preventive services at little cost, increasing Medicaid payments for primary care doctors, and expanded authority to bundle payments.
By October of 2013, the Act will provide:
Two more years of additional funding for the Children's Health Insurance Program.

By January 1st, 2014, the Act will provide:
Health Insurance Exchanges, a minimum coverage requirement for those who are not exempted, increased access to Medicaid, tax credits to help middle class families pay for coverage, cover-

age for individuals participating in clinical trials, elimination of annual limits on insurance coverage, strong reforms that prohibit insurance companies from discriminating based on preexisting conditions or gender, and the second phase of the small business health insurance tax credit.

By January 1st, 2015, the Act will provide:
A new provision that ties physician payments to the quality of care provided (U.S. Department of Health and Human Services, 2011).

Challenges to the Health Care Reform Act

Essential to the legislation, and also arguably its most controversial aspect, is the minimum coverage provision. The provision "requires that every United States citizen, other than those falling within specified exceptions, maintain minimum essential coverage for health care for each month beginning in the year 2014. If an individual fails to comply with this requirement, the Act imposes a penalty to be included with a taxpayer's return" *(Thomas Moore Law Center v. Obama,* 720 F.Supp.2d 882, 886 (E.D. Mich. 2010)).

Congress found that without the Individual Mandate, the reforms in the Act, such as the ban on denying coverage based on pre-existing conditions, would increase the existing incentives for individuals to wait to purchase health insurance until they needed care, which in turn would shift even greater costs onto third parties. Conversely, Congress found that by "significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums. Congress concluded that the Individual Mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold (Id. at 886-887 (internal citations and quotations omitted)).

Congress has found the minimum coverage provision to be crucial to the Bill's success; however some have found it to be an intrusion on individual rights. Several lawsuits have been brought challenging the legality of the Health Care Reform Act and much of the litigation has been focused on the minimum coverage provision. To date, eleven suits have been brought by plaintiffs in federal courts claiming Congress did not have the authority to pass the Act, and/or that the minimum coverage provision and penalty were unconstitutional.

In seven of the cases the plaintiffs' actions were dismissed *(Baldwin v. Sebelius,* 2010*, Bryant v. Holder,* 2011*, Liberty University v. Geithner,* 2010*, Mead v. Holder,* 2011*, NJ v. Obama,* 2010*, Shreeve v. Obama,* 2010*, Thomas Moore Law Center v. Obama,* 2010*)*. In two of the cases, the defendants' motions to dismiss were denied, however the merits of the cases have not been decided *(Goudy-Bachman v. U.S. Dept. of Health and Human Services,* 2011*; U.S. citizens Ass'n v. Sebelius,* 2010*)*. Finally, in two cases, *State of Florida v. U.S. Dept. of Health and Human Services* (2011) and *Commonwealth of Virginia v. Sebelius* (2010), both parties moved for summary judgment, and the court granted the plaintiffs' motions. The courts held that Congress did not have the authority to pass the minimum coverage provision or impose its penalty, making the provision unconstitutional. In Sebelius, the court found the unconstitutional provision severable, leaving the remainder of the Act to be enforceable. In State of Florida, the court held that the entire Act was unconstitutional.

NASW's Involvement

NASW has a long standing commitment to universal access to healthcare. NASW continues to support "a national health care policy that ensures the right to universal access to a continuum of health and mental health care throughout all stages of the life cycle" (NASW, 2009, p.169). NASW has advocated for "policies and practices requiring that mandated medical social work services be provided by qualified social workers in all healthcare settings . . . [and for the] active participation of social workers on public and private health care policy and planning bodies" (NASW, 2009, p. 169). NASW is committed to the "efforts to increase health care coverage to uninsured and underinsured people . . . and [to the] efforts to eliminate racial, ethnic, and economic disparities in health service access" (NASW Brief at 11, *Commonwealth of Virginia v. Sebelius*). NASW also has a longstanding commitment to end discrimination against women, as stated in the NASW Code of Ethics, §§4.02, 6.01, and 6.04. For these reasons NASW strongly supported the passage of the Health Care Reform Act, and has expressed strong opposition to its repeal (NASW, 2011).

NASW has filed amicus curiae (e.g. "friend of the court") briefs in two of the above mentioned cases, *Liberty University v. Geithner*, and *Commonwealth of Virginia v. Sebelius*. Both cases have been appealed to the United States Court of Appeals for the Fourth Circuit, and in both cases NASW has filed similar amicus curiae briefs in support of the federal government defendants.

The briefs argue that Congress does have authority under the Commerce Clause to enact the Health Care Reform Act, including its mandatory coverage provision, penalty, and exceptions. The briefs also highlight the current crisis in the health insurance markets, and one of the Act's major purposes of "improving women's access to health care and health insurance [,] and eliminating insurance practices that discriminate against and disadvantage women" (NASW Brief at 4, *Liberty University v. Geithner*).

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Social Workers and Health Care Reform

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By eliminating insurance companies' ability to deny coverage based on pre-existing conditions, . . . [the Act] remedies long-standing insurer practices of refusing to sell insurance to women with "pre-existing conditions" such as pregnancy, a previous Caesarean section, or a history of having survived domestic abuse. Moreover, the Act explicitly targets practices that discriminate against or disadvantage women, such as charging women more for insurance coverage based solely on their sex and refusing to cover or overcharging women for essential services such as maternity care (NASW Brief at 2-3, *Commonwealth of Virginia v. Sebelius*).

Analysis and Conclusions

For many years NASW has advocated for universal access to healthcare, and supports the Health Care Reform Act as an important step towards reaching the goal of reducing the number of uninsured Americans. NASW's amicus briefs have also identified as significant the Act's progress toward eliminating "insurance practices that discriminate against and disadvantage women" (NASW Brief at 2-3, *Commonwealth of Virginia v. Sebelius*).

Social workers are an important part of health care teams, and NASW believes this "new law contains many key provisions that address critical changes social workers believe are needed to improve the public's health, and, specifically, to start moving towards a system that focuses on keeping people healthy and is affordable for all" (NASW, 2011). NASW has specifically emphasized the importance of certain provisions of the Act in its communications with leaders in Congress, including: health plan benefits that include mental health, substance abuse, rehabilitation, and preventive services; the integration of health services using interdisciplinary health teams to support primary care; extending Medicaid to include coverage for more low income Americans; and the strengthening of the health care workforce, including beginning to address the education and training needs of social workers. Workforce development programs in mental health and behavioral health education will assist social work students specializing in and providing services to special high needs populations such as children, the aged and underserved minority populations (NASW, 2011).

As a major piece of federal legislation with the ambitious goal of overhauling the nation's complex health care system, it not surprising that the Health Care Reform Act has received a great deal of praise and criticism. Some have commended the government for aiming to improve health care, while others find the Act's Individual Mandate to be a violation of individual rights and have brought suit against federal officials to declare the Act unconstitutional. The Act is vulnerable to amendments due to political changes that may occur during the protracted phase-in of its multiple provisions. It is important for social workers to be informed about the significant provisions of the Act in order to effectively advocate that they be fully implemented. As more Americans experience the advantages of health reform the Act may become more resistant to political pressure and social workers can have a significant impact by assisting those who were previously excluded to access their new benefits.

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The Medical Home Model:
What Is It And How Do Social Workers Fit In?

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Background

The "medical home" concept dates to the late 1960s and has, until recently, been confined largely to the pediatric community. However, in the health reform era, the concept is being embraced as a model of health care delivery that is comprehensive and cost efficient, particularly for people with complex health conditions. Medical home programs are growing rapidly, fueled by interest from both the public and private sectors. The hallmark of the medical home is integrated, multi-disciplinary care that meets a patient's physical and behavioral health needs. The Affordable Care Act of 2010 advances a systems-level manifestation of the medical home—the "accountable care organization" (ACO)—a health care delivery model intended to promote shared accountability for improving patient care and controlling costs for a defined population. Social workers are well positioned to participate in these health delivery models – and have demonstrated their value in many of the medical home demonstrations projects currently underway throughout the nation.

What is a medical home?

At its most fundamental, a medical home suggests an on-going relationship between an individual and his or her primary care team. A medical home provides care that is patient-centered, team-based, comprehensive and coordinated. The Agency for Healthcare Research and Quality (AHRQ) suggests that a medical home is not just a place, but a model for organizing primary care that meets the large majority of a patient's physical and mental health care needs, including prevention and wellness, acute and chronic care (AHRQ, 2010). A medical home provides care through an interdisciplinary team, composed of physicians, advanced practice nurses, physician assistants, nurses, social workers, and pharmacists. Some medical homes will employ diverse teams directly; others will build virtual teams, linking themselves and their patients to providers and services in their communities. Medical homes vary in size from small (physician practices) to mid-size (safety net providers such federally qualified health clinics and free clinics) to large scale (e.g., non-profit health systems and the Department of Veterans Affairs).

Unique Features of The Medical Home Model

■ Use of Meaningful Performance measures

Current medical home demonstration projects – as well as payment models for ACOs - are using key performance measures to gauge their effectiveness. These include:

- Reducing 30 day hospital re-admissions
- Delaying permanent nursing home placement
- Reducing avoidable emergency room visits
- Increasing access to primary care
- Improving patient satisfaction
- Decreasing health disparities.

Early evidence suggests that medical homes have the potential to improve quality and reduce costs. Among vulnerable populations, medical home programs are showing improvement in access to primary care and reductions in avoidable emergency department utilization (Grumbach, 2009). Demonstration projects involving social workers (see below) are also showing positive trends on many of these measures.

■ Emphasis on Care Coordination and Interdisciplinary Teams

An essential feature of the patient-centered medical home is care coordination. AHRQ defines care coordination as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services" (AHRQ 2010). Care coordination is central to the shift in orientation away from a focus on episodic acute care to a focus on managing illness and facilitating preventative self-care, especially for those living with chronic health conditions (NCCBH, 2009). Within a medical

home, teams of health care professionals from different disciplines and practice areas share responsibility for managing key components of patient care.

The interdisciplinary team approach offers opportunities to improve care and lower costs, especially for patients with depression, physical disabilities, and other conditions that have proven difficult to treat in primary care settings (Commonwealth Fund, 2010). Team-based care also frees up physician time—as responsibilities shift to other staff members—and promotes a work environment where all staff can practice at the highest level their licensure or certification allows.

■ Integration of Behavioral Health into Primary Care

Most mental health problems first emerge in primary care settings; for many vulnerable populations, primary care is often the only source of mental health treatment. Rates of mental health problems are significantly higher for patients with certain chronic conditions (e.g., diabetes, heart conditions, asthma). Failure to treat both physical and mental health conditions yields poorer outcomes and higher costs. (NCCBH, 2009). Although not consistently integrated into all medical homes, behavioral health—through co-location or referral protocols—remains an important component of the medical home model (Blount, 2011).

> **Care coordination is central to the shift in orientation away from a focus on episodic acute care to a focus on managing illness and facilitating preventative self-care, especially for those living with chronic health conditions.**

What do social workers offer to the medical home team?

Social workers can provide valuable functions on a medical home team, including:

- comprehensive assessment and case management, especially for high-risk patients
- care coordination/patient navigation
- health promotion and disease self-management education
- transitional care
- patient and family support
- linkages to community services
- psychotherapy/clinical intervention
- advance care planning/end of life assistance

The inclusion of social workers on the team ensures an awareness of the non-medical factors that impact patient well-being – namely, environmental and psychosocial needs. Moreover, the social work profession's ecological framework promotes intervention on both individual and systemic levels. As a result, patients and caregivers are better supported and more able to navigate the complexities of the health care system with the social worker's assistance (Golden, 2011). The presence of a social worker who can address a patient's non-medical concerns also allows other members of the interdisciplinary health care team to focus on their specific areas of expertise.

Social work involvement in medical home initiatives

Geriatric Resources for Assessment and Care of Elders

The GRACE (Geriatric Resources for Assessment and Care of Elders) medical home project includes a nurse practitioner/social worker care coordination team, which works closely with primary care physicians and a geriatrician. The program, situated at an urban system of community clinics affiliated with the Indiana University School of Medicine, enrolls low-income seniors with multiple diagnoses. Data from the project show decreased use of the emergency department and lower hospitalization rates among seniors receiving the GRACE intervention, compared with those in control groups (Counsell, et.al., 2007).

Enhanced Discharge Planning Program

Rush University Medical Center's Older Adult Programs and Case Management Department have created the social work-based Enhanced Discharge Planning Program (EDPP). In this intervention, social workers phone patients and caregivers after discharge to ensure they are

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receiving the services detailed in their discharge plan. Social workers help patients avoid adverse events, encourage follow-up with primary care providers, and connect patients and caregivers to community-based resources (AHA, 2010). Data from the project show statistically significant increases in seniors' understanding of their medications, decreased stress over managing their health care needs, and improved communication with their physicians post-discharge. In addition, older adults schedule and attend their follow-up medical appointments more than peers not receiving this intervention (Golden, 2011)

OU School of Community Medicine — Patient-Centered Medical Home Project

The University of Oklahoma School of Community Medicine is shaping its teaching clinics on the medical home model, to provide patients with better access to primary and specialty care, increased access to medical advice, and more efficient and effective treatment for chronic conditions. New services to achieve this goal include placing social work staff in care coordination roles, forming integrated care teams and improving screening for mental and behavioral health concerns (PCPCC, 2010).

Commonwealth Care Alliance (CCA)

CCA - a Boston-based HMO serving seniors and medically fragile individuals on Medicaid, uses nurse practitioner-lead teams in 25 communitybased medical practices. These teams, which include social workers, are largely responsible for the ambulatory care needs of patients assigned to each practice. Teams provide intake and assessment, on-going care coordination and in-home assistance with activities of daily living. The physicians on the team focus primarily on inpatient care. CCA's data are promising. The number of hospital days per year per CCA member who is dually eligible for Medicare and Medicaid is 2.0, compared to 3.6 days per dually eligible patient enrolled in the Medicare fee-for-service program. Also, the percentage of nursing home–certifiable patients permanently placed in the nursing home per year is 8.5 percent, compared with the overall Massachusetts rate of 12 percent (Commonwealth Fund, 2010).

Genesys Health System: Health Navigator Self Management Support Model

Genesys, a large, integrated health system in Michigan with 59,000 covered lives, employs health navigators to work with primary care patients on chronic disease self management. Navigators have varied backgrounds, including social workers, health educators, dieticians, and nurses. The health system has seen improvement in management of diabetes, chronic pain, and depression among patients assigned to navigators.

Preventive Health Education and Medical Home Project for children (PHEMHP)

PHEMHP is a program to address both the financial and nonfinancial aspects of health care access and health status for low-income urban children and families in South Central Los Angeles. Through educational and case management strategies, the program is designed to reduce low levels of health services utilization and improve preventive health techniques and disease self-management, with the ultimate goal of attaching each child to a medical home (Tataw, 2010).

IMPACT Model

IMPACT (Improving Mood – Promoting Access to Collaborative Treatment for Late-Life Depression) is a research-based approach to treating depression in primary care settings. IMPACT is a collaborative care model, in which the individual's primary care physician works with a care manager (usually a nurse, social worker or psychologist), to develop and implement a treatment plan. The care manager and primary care provider consult with a psychiatrist to change the treatment plan if the individual's depression does not improve. IMPACT Model data have shown improvements in depression management, physical functioning, and pain status for participants (NCCBH, 2009).

What can Social workers do to Promote Medical Homes?

- Work with NASW state chapters to ensure social work involvement in state-level Affordable Care Act medical home demonstration projects, especially medical homes for Medicare/Medicaid enrollees with chronic conditions
- Insist that medical home projects include prevention and treatment of mental illness and substance use disorders, along with chronic disease management

- Partner with key stakeholders – state Medicaid and Medicare programs, provider and payor organizations, patient advocacy organizations and other groups – on medical home implementation efforts
- Provide expertise on the unique needs of vulnerable populations in the development and implementation of medical home demonstration programs
- Engage families and consumers in the work of promoting and advancing the medical home concept.

Resources

The AHRQ Patient Centered Medical Home Resource Center. This web site provides policymakers and researchers with access to evidence-based resources about the medical home model. www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483

The Certificate Program in Primary Care Behavioral Health is a training program for behavioral health professionals seeking to practice in primary care settings. This training is particularly targeted to prepare behavioral health professionals for the patient centered medical home model. This program is approved for CEs through NASW. http://umassmed.edu/fmch/pcbh/welcome.aspx National Center for Medical Home Implementation, sponsored by the American Academy of Pediatrics, is a web-based resource center for health professionals and families interested in medical home information for children and adolescents. http://medicalhomeinfo.org/

Patient-Centered Primary Care Collaborative (PCPCC). The mission of the PCPCC is to strengthen the primary care delivery system in the US and to advance the patient centered medical home model. Sponsored by provider groups, large employers and insurance organizations, the PCPCC plays an active role as a convener and supporter of medical home demonstration projects and pilot programs. Currently, 27 multi-stakeholder PCPCC projects are underway in 18 states. The program website includes a host of materials on advancing the medical home model. www.pcpcc.net/

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Members in the News

W. Brian Barr, LCSW, CASAC of Albany has been selected from among 18 finalists as a candidate for a Jefferson Award. Barr was one of seven medalist level finalists from the capital region who were recognized at a reception Monday April 4th at the Century House in Latham, NY. Barr was then chosen as the finalist to represent the Capital Region at the national level on June 21 and 22 in Washington D.C.

The Jefferson Award is an annual recognition of public and community service around the nation. Brian has been volunteering in the Capital Region for more than 35 years with service organizations such as the Neighborhood Resource Center in Albany, Rotary Club of Albany, United Way of the Greater Capital Region and Senior Hope. Since his 18-year-old son Kevin committed suicide in 1984, Barr has been educating the public about suicide prevention by speaking at schools, churches, community organizations and in the media. Barr, now retired, was the clinical and community service director at La Salle School in Albany and associate deputy commissioner for the state Office of Children and Family Services. He was the 2009 recipient of the NASW-NYS Chapter Lifetime Achievement Award.

Welcome New NASW-NYS Members

Lindsay Ferguson
Melanie Foxx
Shelly Luttman, MSW
Daniel Mansfield

Central
Alicia Aiken
Renee Julia Blujus, M.S.W.
Nicole Ann Humphrey
Kasi Jeanne Jones
Martha Ann Keesler, LMSW
Alexandrina Marie MacPherson
Katie Lyn McQuaide
Heather Anne Savastano
Emily E. Stowell
Aarin Trombley

Genesee Valley
Jamie M. Bond
Scott Arnold Newman

Hudson Valley
Hannah Marie Byrnes
Jessica L. Calzareth
Danielle N. Dier
Tania M. Hammock
Eileen L Hayes, LCSW-R
Tiffany Hotaling
Anna Martin
Meaghan Elizabeth McGrath
Michael J. Murphy
Wanda Nieves, LMSW, CT
Folasade Omidiji
Jennifer Povill
Tara Stukes
Jessica Lynn Weeden

Mohawk Valley
Karrie Crippen, LMSW

Nassau
Candida Spano Cucharo
Joan Marie Determann, LMSW
Andrea Fagan
Ryan Paul Fleischmann
Liza Rose Goldberg
Katie L. Klieber
Maria Nigoghossian
Sophia Saint-Louis
Anne Tuszer
Shirley White, MSW

Northeast
Royal G Brown, Jr., LMSW
Linda Louise Carter, BSW, CASAC
Megan E. Clair
Kirk Matefy
Sharon Dawn Mattsson, LCSW, CASAC
Kevin O'Connor, MSW
Jessica Bonnie Putman, LMSW
Heather E Rich, MSW
JoAnn Theresa Waldmann, LCSW

Southern Tier
Carol Aronowitz
Emma K Atwood
Caitlin Bango
Tricia L Carman
Jim Inthanongsak
Nicole Ann Krause
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Ashley Mae Sargent
Trisha Marie Suhadolnik
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Raine Keegan Baker
Heather Boyle, MSW
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Mee-sha Chan, MSW
Kristyn DeMartinis
Rebecca Dziadowicz
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Kristin Nicole Halter
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Cara Elizabeth Meidenbauer, MSW
Teresa O'Connor, MSW
Laura Anne Russell Ricci
Susan Weinstein, LCSW

Approved Continuing Education Programs/NASW CERP

The following programs have been accredited for the listed number of Category I contact hours by the NASW-NYS Chapter Continuing Education Recognition Program (CERP). The CERP both accredits programs for continuing education credits and provides NASW members with an opportunity to have their credits recorded. Members who accumulate 90 contact hours of credit in a three-year period are eligible for a continuing education certificate.

Program providers who wish to have their programs accredited should submit an application form, the program schedule, the resumes/vitae of all the presenters and the review fee. The fees for providers are: $100 per program, $150 for multiday events, $350 for five programs in a 12-month period or $900 for unlimited programs in a 12-month period. NASW members wishing to participate in the CERP must register with the program. The service is free for NYS Chapter members; for all others, there is a $60 fee, for one three-year registration period.

For additional information, or to obtain application or registration forms, please contact the NYS Chapter office at (800) 724-6279 ext. 17, (518) 463-4741, or e-mail at james_koonce@naswnys.org. For information on a particular program, please call the contact number found in the listing.

June – August 2011

21 June, 2011 — **Workplace Violence Prevention: Interacting with Difficult Clients NASW NYS Chapter/Central Division**
Syracuse (518) 463-4741 2. CEUs

21 June, 2011 — **Workplace Violence Prevention/ Interacting with Difficult Clients NASW NYS Chapter**
Central, NY (518) 463-4741 2. CEUs

22 June, 2011 — **Mistakes and Misgivings: Advancing the Analysis While Protecting the Analyst Center for Modern Psychoanalytic Studies** New York City (212) 260-7050 3. CEUs

22, 29 June, 2011 — **Couples Workshop Center for Modern Psychoanalytic Studies**
New York City (212) 260-7050 3. CEUs

23, 24 June, 2011 — **Art Therapy for Grief and Loss Cross Country Education**
Buffalo, Syracuse, A lbany, (615) 331-4422 6 CEUs

23, 30 June, 2011 — **When Space Shrinks and Time Stops: A Clinical and Theoretical Investigation Center for Modern Psychoanalytic Studies** New York City (212) 260-7050 3. CEUs

24, 25, 26 August, 2011 — **Providing Social Skill Instruction for Kids with ASD, ADHD and Other Social Emotional Issues Health Ed**
White Plains, NY (715) 552-9517 6. CEUs

27 July, 2011 — **Undoing Depression: A CBT Approach Jewish Board of Family and Children Services, Inc**
New York City (212) 632-4642 3. CEUs

29 June, 2011 thru 2 July, 2011 — **Changing Psychoanalysis for a Changing Society, Relational Perspectives IARPP**
New York City (917) 658-9846 25. CEUs

30 June, 2011 — **Pathways to Motherhood Center for Modern Psychoanalytic Studies**
New York City (212) 260-7050 1.5 CEUs

Clients with Chronic Illness

Continued from page 6

References

- American Disabilities provides federal resources and publications on the American Disabilities Act (http://www.ada.gov/).
- Benson, H. & Stuart, E.M. (1992). The wellness book: the comprehensive guide to maintaining health and treating stress-related illness. New York: Fireside.
- Groopman, J., M.D.(2004). The anatomy of hope: how people prevail in the face of illness. Canada: Random House.
- WebMD is a great educational website (http://www.webmd.com/).

Joanne Bobes, MA, LMSW, is a clinical social worker in private practice, a health educator and training consultant. Ms. Bobes facilitates workshops on Holistic Wellness for Chronic Illness, Talking About Illness, and Accepting Chronic Illness. Prior publications include Single Male Caregivers, The Source, National Abandoned Assistance Resource Center, Spring, 2009; http://aia.berkeley.edu. She can be contacted at JBobes@gmail.com

Office Space

Delmar: Large, attractive, well-furnished office with lots of windows, suitable for family and group work as well as for working with individuals, available for sublet in a long-established (40+years) group practice in Delmar. The office suite includes an art-filled waiting room, small kitchen, and room with fax and copier. Bus and handicapped accessible. We are especially looking for people who work with children and adolescents and who do assessment. Tremendous opportunity for referrals. Call Bethlehem Counseling Associates at 518-439-0090.

Garden City: Part-time office for rent – Professional Building – Shared waiting room – Furnished – Opportunity for cross-referrals – (516) 742-2479

Garden City: Professional Psychotherapy Suite – Immediate space available in newly renovated office suite: Furnished/Unfurnished, well established suite with opportunities for cross referrals, supervision and consultation. Intercom system: full services provided: Please call 516-510-5190 or 516-741-8111.

Huntington (25A): Well maintained 8 Room office Bldg (3000 sq. ft.) $850,000 - or rental $550 per month ground floor office or part-time furnished office space $12.00 per hour – owner/broker Panettieri 631-477-8526

Mineola/Williston Park: PT totally rebuilt, fully furnished, beautiful offices. Second floor, professional building. Centrally located. Waiting room. Full facilities. Warm, welcoming atmosphere. **Suffolk office also available.** Call Manny Plesent (516) 747-1344.

Plainview: Only few P/T offices left in suite with other successful LCSWs, LMFTs, Psychologists, Psychiatrist and other healthcare professionals. Modern, very attractive all-medical building decorated. Networking & supervision available. Dr Schuster, djschuster@aol.com, 516-931-5060.

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Pomona: Spacious, sunny attractively furnished office in 3 room psychotherapy suite. Includes use of waiting room and play area. Professional building with parking. Located off exit 12 on Palisades Parkway. Potential for referrals. Reasonable rates, hourly or daily. 845-354-7535

North Tonawanda: (Gateway Park, on the Erie Canal) Monday mornings, Tuesdays, Thursdays, Saturdays

ALSO

Buffalo: (Franklin Street) Monday afternoons
Michael Moses, Ph.D. (716) 695-0008

Roslyn Heights: Attractively decorated psychotherapy office suite near L.I. Expressway in professional building. Private waiting room. Share with experienced therapists. Available Mon•Thurs•Sat•Sun at $150 per month each. Call Richard at 631-757-5555.

Wantagh: F/T & P/T offices for rent in modern, furnished suite ideal for psychotherapists. Rent includes group therapy space, utilities, waiting area, cleaning svcs, parking, signage, storage, refrig/micro, 24/7 access. Great location, 1 block to LIRR. Immediate occupancy. Call **Sophia 917-566-4491**.

Elmhurst

Several luxurious, spacious therapy offices and group/conference rooms available for rent. Fully furnished, welcoming reception area. All under one roof in sunny location. Terms, conditions and price negotiable. Clerical and billing services available. Easy access to public transportation. Walking distance from Queens Center Mall. Licensed and Insured Mental Health Counselors, Social Workers and Psychologists encouraged to respond via e-mail qcpc9001@hotmail.com

Smithtown

2-3 days available for rent in Smithtown, New York. Fully furnished and nicely decorated on first floor office with a waiting room. This is suitable for counseling and therapy practice. The space has three windows with a lot of light. Monday/Friday- for 375.00 a month. 1 year lease and security deposit is required. Please call Jeanne at 631-455-9123.

Ads for the Supervision of Clinical Social Work in NYS: NASW-NYS advises all individuals providing/receiving clinical social work supervision services in NYS to be aware of and in compliance with the laws, rules and regulations governing such practice which are outlined on the NYS Education Dept.-Office of the Professions Social Work website: www.op.nysed.gov

Employment

The Center for Psychotherapy located in Garden City, NY (next to Roosevelt field) is a psychotherapy practice. We have been in business since 1983. Immediate Openings: Psychotherapist for individual, couple, and family psychotherapy with all age groups. Minimum 15hrs/ week, evenings or Saturdays required. Need licensure for independent practice (only LCSW-R, PsyD or PhD need apply). We have a great team and we are looking for some new additions. Work from your or our private offices (throughout Nassau county). Unique group supervision: strives to be nonjudgmental and values use of humor; strong emphasis on analysis of transference/counter-transference to improve efficacy of therapy. Great opportunity to develop your acumen and grow as a professional. Send Resumes via e-mail employment@thecfp.org or fax to 516-625-0821.

Wanted: Experienced psychotherapist (need licensure for independent practice LCSW-R) interested in starting a part-time private practice at Life Center Counseling & Health Services in Huntington, NY. Newly constructed office available in a medical building. Reception coverage. For more info call (631) 673-5433. www.LifeCenterli.com

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Highest fees on Long Island. Minimum of 6 years clinical experience. R# required. See clients in your own private office (Nassau and Suffolk). Please fax resume and cover letter with office location to Nassau Guidance and Counseling Centers: 516-785-5698 or e-mail to Nguidance@nassauguidance.com.

Long Island Catholic faith based therapy center needs professional with 3-5 years clinical experience for fee for service practice at our location in Melville. The center was founded in 2000 and is looking for dynamic individuals to share their clinical skills with their spiritual base. Supervision provided. E-mail resume to LWRESUME@verizon.net

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A Law Practice Emphasizing Mental Healthcare Law, Healthcare Law And General Civil Practice

An attorney with 28 years of experience, Bruce formerly practiced as a psychologist. He represents mental health practitioners for all their legal needs, including risk management, professional disciplinary proceedings, and business, insurance and regulatory issues. Bruce is listed in the Bar Register of Preeminent Attorneys in Healthcare Law.

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