

# CHAPTER 12

## Social Work in Skilled Nursing Homes

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### CHAPTER OBJECTIVES

- Describe the role of a social worker in a nursing home setting;
- Assess the patient using a biopsychosocial framework;
- Identify the psychosocial interventions necessary to facilitate appropriate patient care;
- Comprehend and discuss how differing laws impact clinical practice.

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### CASE VIGNETTE

Mr. Anthony Jones is an English-speaking (primary language) 45-year-old single African American male with a prolonged history of homelessness. He is disabled. He currently receives Supplemental Security Income (SSI) and Medi-Cal insurance (or Medicaid). He was recently discharged from the local county general hospital (acute care hospitalization) for continued monitoring and stabilization from the following conditions: Human immunodeficiency virus (HIV), hypertension, muscle weakness, diabetes, Chronic Obstructive Pulmonary Disease, depression, Psychotic Disorder Not Otherwise Specified (NOS) and Poly-substance Dependence. Prior to being in the county hospital, Mr. Jones was living in the streets of Los Angeles because he had nowhere to turn. Mr. Jones has been a long-time resident in the Skid Row area of Los Angeles but refuses to enter a shelter because he was previously physically assaulted by another resident. Living on the streets has been a difficult lifestyle for Mr. Jones to manage, given the multitude of medical conditions he is grappling with.

Upon entering the Northwood Care Center in Los Angeles, Mrs. Adams, the social worker, completed the biopsychosocial evaluation in order to gather more information about the resident. The assessment revealed that Mr. Jones has been living with his medical problems for the last five years or more, since his heavy dependency on heroin, crack cocaine, methamphetamine, and alcohol overtook his life. From that point on, he began to "spiral out of control," and his physical health became impacted by his prolonged drug and alcohol dependency. Mr. Jones has been in and out of treatment facilities for the past couple of years but always seems to return to the hospital for stabilization. Mr. Jones believes the lack of support and housing assistance has caused him to remain in this "ping pong-like" situation where he enters the acute care hospital from the streets, then is discharged to a nursing facility, to be later discharged again back to the streets without a stable and permanent living environment. Because Mrs. Adams is a qualified mental health practitioner (master's prepared), her biopsychosocial evaluation will help her to create a case management treatment plan inclusive of discharge planning, to avoid rehospitalization. Understanding the problem will allow the worker to pair correlative interventions to meet the needs of the resident. Because Mr. Jones will require continued monitoring post-discharge from the nursing facility, he was amenable to a referral to a board and care facility. Mrs. Adams assisted Mr. Jones with the referral paperwork to the Windsor Recovery Home (a licensed board and care facility). Mrs. Adams received written consent for release of information from Mr. Jones so that she could advocate for him with the local Department of Public Social Services regarding his Medi-Cal (Medicaid) and the Social Security Administration regarding increasing his SSI benefits to the Board and Care rate in order to cover his stay at the Windsor Recovery Home. Mrs. Adams was also able to facilitate transportation and a site visit to the Windsor Recovery Home in order to successfully transition Mr. Jones.

## INTRODUCTION

Social work practice in nursing home settings is usually seen as an adjunctive service provided to patients and their support systems. Nursing facilities or skilled nursing facilities usually offer the patient skilled nursing services, and rehabilitation services inclusive of physical therapy (PT), occupational therapy (OT), and speech therapy (ST) as ordered by a physician. In California, for example, many nursing facilities employ Social Service Designees (SSD), who are usually paraprofessional staff with little to no specific training in social work who operate also as the Social Services Director of the facility. According to Byrd (2009), a physician must complete the initial history and physical (H&P) that will determine the treatment needs for the individual. Regarding social work practice in this setting, it is not uncommon for a nursing home chain to employ one licensed clinical social worker (LCSW) to supervise a few SSDs located at different facilities. These paraprofessional staff often refer to

themselves as social workers despite not having the clinical training or education.

Federal law (42 CFR 483.15) requires that all skilled nursing facilities provide "medically related social services to attain or maintain the highest practicable resident physical, mental, and psychosocial well-being." Nursing homes with more than 120 beds are required to employ a full-time social worker with at least a bachelor's degree in social work or "similar professional qualifications." Facilities with 120 beds or fewer must still provide social services, but they do not need to have a full-time social worker on staff. Although federal nursing home regulations have a general requirement that facilities use licensed personnel, this regulation has not been enforced in the case of social work. (Social Work Policy Institute, 2014)

The lack of geriatric social work competencies has been well documented, which led to the large disparity in knowledge and skills (Naito-Chan, Damron-Rodriguez, & Simmons, 2008). However,

the level of care provided by the facility social worker will dictate the level of training and education that is necessary to perform the duties of the position. For example, Institutes of Mental Disease are locked nursing facilities that have professional mental health services in addition to supervised nursing services. In these types of settings, it is common to have master's level practitioners (unlicensed/licensed) as the facilities often provide individual and group psychotherapeutic services. Most government agencies will require social workers to have either a bachelor's or master's degree, dependent upon the job function or "scope of practice" required of the position. According to Simpson, Williams, and Segall (2007), the social work specialization was developed to meet specific population needs (i.e., person-in-situation perspective).

Historically and societally, nursing homes were commonly thought of as places where older adults would live out the remainder of their lives. However, in clinical practice, this is often not a reality. Many nursing home clients are younger people (less than 65 years old) who may require recuperative or skilled nursing care services, usually after acute hospitalization, to further stabilize their medical and/or psychiatric conditions. This is evident in the case of Mr. Jones, who is in need of skilled nursing and rehabilitation services to prevent rehospitalization. Rehabilitation services (e.g. PT, OT and/or ST) may be ordered by medical providers to assist an individual with his or her abilities to perform activities of daily living such as bathing, dressing, grooming, and toileting, or instrumental activities of daily living such as budgeting, transportation, laundry, and cooking, among others. These services are usually ordered for several times per week and scaled down as the individual gains more functional independence. Social workers often work alongside nursing staff and the adjunctive rehabilitation services to provide a holistic approach to recovery.

## MICRO PERSPECTIVE

Social workers in care facilities provide a range of services: the coordination of external appointments for the individual, arranging for transportation

services, assisting with care planning and discharge planning, case management/linkage to various agencies, providing consultation, facilitating family meetings, performing psychosocial evaluations, and providing supportive counseling (depending upon education and licensure). Although LCSWs are trained and certified to perform psychotherapeutic services, their services are often underutilized, possibly due to the medical team's and/or facility's lack of understanding of the social workers' clinical abilities and scope of practice. Social workers with a master's degree are licensed to either practice at the general practice level or at the advanced/independent practice level, as specified by each state's licensing board. The advanced/independent practice level incorporates the ability to perform clinical work in the form of differing psychotherapeutic modalities (e.g., individual, family, and/or group psychotherapy) and the rendering of psychiatric diagnosis as per DSM-5 criteria. Although social work staff complete a biopsychosocial assessment on each patient who remains in the facility for at least three days (a requirement that may differ by state as well as by facility), assessment is generally utilized as a tool to determine psychosocial supports and augment information obtained from the medical team, rather than for purposes of determining a mental health diagnosis or treatment. Because the social worker usually has greater contact with residents in a given facility, it is customary for the social worker to provide feedback to psychiatrists and psychologists with regard to a resident's mental health functioning, in order to enhance treatment efficacy. It is not uncommon for nursing facilities to contract their mental health service needs to external providers (e.g., psychiatrists and psychologists as noted in the medical record) and, to a lesser degree, LCSWs practicing independently. This is also seen when perusing the physician's orders in the medical record that would explicitly state psychiatry and/or psychology consults to address the individual's mental health needs. Some clinicians speculate the lack of LCSWs providing mental health services in nursing facilities has a direct correlation with the lack of title protection for the clinical social workers (i.e., SSDs referring to themselves as social workers, as

referenced earlier). Social workers are also responsible for completing sections of the Minimum Data Set (MDS) that correspond with the discharge planning and psychosocial needs of the resident. However, some facilities may have a MDS coordinator (usually a RN) who is tasked with the completion of this required document. The reader is encouraged to check with the facility regarding internal policies and procedures, as this is not a standard practice across all facilities. The MDS provides a “multi-dimensional” snapshot of an individual’s overall functioning (Centers for Medicare and Medicaid Services, 2014). Performing social service–related duties may periodically require the practitioner to report suspected cases of abuse. Although elder and dependent adult abuse are the more typical forms of abuse that will be reported to authorities, it is not uncommon for social workers in nursing facilities to report suspected cases of child abuse. According to the California Advocates for Nursing Home Reform (2014), elder abuse can take differing forms and can be both civil and criminal offenses.

Criminal elder abuse occurs where any person who knows that a person is an elder and willfully causes or permits any elder to suffer, or inflicts unjustifiable physical pain or mental suffering on the elder. It also covers situations where a person willfully causes or permits the elder to be placed in a situation in which elder’s health is endangered. . . . Civil law defines elder abuse to mean physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment resulting in physical harm or pain or mental suffering. It also means the deprivation by case custodian of goods or services that are necessary to avoid physical harm or mental suffering. (Welfare & Institutions Code Section 15610.07)

In Los Angeles County, Adult Protective Services is the entity to which reports of alleged cases of abuse of older adults or dependent adults can be made (California Department of Social Services, 2014). Similarly, the Department of Child and Family Services is tasked with handling cases related to child abuse. Of special note, the local Ombudsman can also be contacted for any infractions or

suspected abuse issues in long-term care facilities. The contact information for the Ombudsman is required to be posted in designated areas in the care facility. Each region may have these departments listed under different names, so it is important to know your state laws that govern practice as well as the reporting agency in your jurisdiction.

## Assessment

Biopsychosocial evaluations, often referred to as psychosocial evaluations, are assessments to view the various domains or systems of an individual that assist the professional to deepen his or her understanding of how a person functions. It is critical for the clinician to have an accurate assessment so that the correlative treatment plan and interventions can be created and implemented. Therefore, a detailed review of a biopsychosocial evaluation will be provided to enhance your understanding. According to the Los Angeles County Department of Mental Health (2013), these biopsychosocial evaluations should include the following data: demographic data, presenting problems, medical problems, current medications, alcohol and drug usage, family constellation/primary supports, secondary supports, educational background, religion/spiritual considerations, and legal involvement, considerations, and issues.

### *Demographic Data*

Demographic data provides a snapshot of a client. This is information that should include the following: name, age, race/ethnicity, gender, preferred language, and marital status. Demographic information advises the treatment team how to address a client and the preferred language in which he or she would like to communicate. For example, if a patient is Spanish-speaking only, the provider would know that the patient only communicates in the Spanish language, so he or she may use a translator if the provider does not speak the same language. This is crucial so that the individual’s needs are properly communicated, understood, and supported, and it facilitates culturally sensitive practice.

### *Presenting Problems*

It is crucial to understand the “presenting problem” or the reason the individual is admitted to the nursing facility. This may incorporate both medical and mental health diagnoses. The presenting problem also justifies the need for nursing home placement for insurance reimbursement. Here are some questions to ask: What are his or her current diagnoses? Why is he or she seeking assistance currently? What has he or she done to resolve the problem in the past? What was effective and what was not? What are the current symptoms (looking at frequency, chronicity, severity of all symptoms, and how they impair his or her functional ability; this helps to justify medical necessity). Is there a history of suicidal or homicidal ideation or attempts for this individual or in his or her family? This information can be gathered by reviewing the MD orders, the History and Physical (H&P) in the chart, discharge information from an acute hospitalization, transfer summary, the MDS, nursing notes, and/or through the client’s self-report.

### *Medical Problems*

It is important to know the specific medical problems for which the patient is receiving treatment. This domain is important to understand as medical illness often impacts overall mental functioning, which may be reciprocal and/or magnified. The practitioner should list all current physical health problems. You can find this information from the patient’s face sheet data, the MD orders, the MDS, or through the H&P. Some of this information can be solicited from the patient directly, but he or she may not be able to provide all the medical diagnoses for which he or she is being treated.

### *Current Medications*

Often patients are prescribed multiple medications to treat both physical conditions and psychiatric illnesses. It is important to list all current medications (i.e., the dose, the frequency, and the

response to the medications). Please note any side effects and cost/benefits from the medications. This information may be crucial to relay to the prescribing provider and the treatment team so that they can assist in monitoring the patient’s overall health and functioning.

### *Alcohol and Drugs*

It is important to obtain a complete list of all current and/or past alcohol and drugs used. Ascertaining the specific types of drugs used, duration, and any issues related to tolerance, withdrawal, or chronic use will assist you to make provisional diagnoses as appropriate, and it will give the provider a global understanding of an individual’s issues and how his or her substance use pattern may or may not be contributing to his or her clinical presentation. This data could also be utilized to understand how the patient attempts to self-medicate his or her symptoms. For example, an anxious client may opt to use alcohol to cope with his or her inability to self-regulate, without fully understanding how this substance may contribute to other physiological and psychological problems, as well as potentially amplify underlying depression.

### *Family Constellation/Primary Supports*

This domain is crucial to understand as it sheds light upon how the individual views his or her family structure, his or her connectedness with family members, and the likelihood he or she will seek assistance from them to aid in coping during difficult times. The practitioner should gather information regarding the family of origin, birth order, feelings toward family members, and how culture may have influenced his or her perception of the family dynamics. It is also important to gather information regarding the individual’s partner, spouse, girlfriend/boyfriend, relations, and any children. It is ideal to utilize support systems where and when possible to assist the individual to cope with stressors as well as reinforce therapeutic interventions that are implemented in the treatment process. Likewise, if the clinician identifies

the family system to be maladaptive or a source of great tension for the client, this would inform the practitioner to avoid them or gradually desensitize the individual from them, depending upon the mutually agreed upon treatment goals.

### *Secondary Supports*

It is important to gather information regarding the patient's friends and support system. This will aid the therapist in creating interventions to assist the individual with coping, similar to the use of primary supports. Some individuals may not have a primary support system in the form of biological family and/or extended kin, but they may view their support system to be inclusive of "close" friends. Whatever the scenario, it is ideal to have a firm grasp of the patient's support system to assist with pairing appropriate treatment interventions. This will also enable the therapist to understand how his or her client relates socially with others or to identify potential personality disorders.

### *Educational Background*

It is important to ascertain your patient's academic background (highest level of education, grades, IEP, academic probation, field of study). This will not only assist in tailoring individualized interventions to the person's level of cognitive functioning but inform of his or her academic interests as well as enable benchmarking his or her current functioning with previous ability.

### *Religion/Spiritual Considerations*

It is ideal to ascertain from the patient his or her religious and spiritual beliefs. This can be a tremendous source of coping for the infirm. Facilities usually have religious services to meet the spiritual needs of the residents. Social workers can also assist in coordinating religious/spiritual events and visits by religious practitioners or organizations. Having an understanding of the patient's religion, faith, or spiritual beliefs may also assist with potential discharge planning for the client. For example, if

a patient is of the Jewish faith, you may want to explore with the individual the faith-based services and/or placements that may be appropriate for him or her.

### *Legal Involvement, Considerations, and Issues*

Many clients are involved with the legal system in some fashion. This area is important to gather information about, especially regarding the decision-making ability of the individual. Is the client on probation or parole? Is the person conserved? Does he or she have a Durable Power of Attorney for Healthcare? Does he or she have an Advanced Directive on file? Are there any legal issues that need to be addressed to ensure the safety of the individual and/or the public? For example, in California, do any of the presenting issues warrant initiating a writ for a Welfare and Institutions Code (WIC) 5150 involuntary hold/observation, Tarasoff requirements (reasonable attempts at informing an identifiable party regarding threats of violence/death and imminent risk to his or her personal safety; *Tarasoff v. Regents of the University of California*, 1976), and/or mandatory reporting (e.g., child abuse, elder abuse, or dependent adult abuse)? Please check with your state laws governing social work and mental health practice, as this may differ by region. Has the person been involved with the justice system before? If so, in what capacity? Is he or she on probation or parole? If he or she has been arrested, what prompted his or her detention? Does the person exhibit remorse? Are there any behavior patterns to note? This information may assist you in considering a provisional diagnosis. It is common for the biopsychosocial evaluation to utilize diagnoses that are rendered by the medical team. This is especially useful if the worker is not master's-level prepared or independently licensed so that the scope of practice is maintained.

### *Application of the Biopsychosocial Evaluation to Mr. Jones*

In the case of Mr. Jones, it is imperative for the social work practitioner to have a thorough

biopsychosocial evaluation completed in order to fully understand how this client presents (functional ability based upon past and current life events, coping skills, and patterns of relating with himself and his external environment), the underlying issues for the client, and how best to intervene on behalf of the client to ameliorate barriers and/or stressors that may prevent him from optimal functioning. After completing the biopsychosocial evaluation, the social worker will be able to assist Mr. Jones with a mutually agreed upon treatment plan, which may include appropriate psychotherapies and/or targeted case management services. Having a well-rounded understanding of Mr. Jones's situation will provide the social worker with an understanding of the issues that placed Mr. Jones in his current predicament, enable her to pair culturally sensitive interventions, and may yield higher treatment adherence. For example, Mr. Jones has co-occurring conditions of depression, Psychotic Disorder NOS and Polysubstance Dependence, homelessness, and a history of assault while being a resident in a local shelter in the Skid Row area. It is important to have a comprehensive biopsychosocial assessment so that a more accurate provisional diagnosis can be rendered that directly correlates with the treatment plan. An accurate evaluation will cue the social worker to coordinate a feasible discharge plan that may address his issues without placing him back in the area where he was assaulted—possibly into a board and care facility in a residential community away from the Skid Row area that can address all his immediate needs regarding his medical and mental health conditions coupled with basic needs of food, clothing, and shelter. Therefore, a social worker must have a thorough understanding of the array of resources in the local area to assist clients as appropriate.

## Diversity Considerations

It is important for social work clinicians to consider all federally protected categories with regard to the clients they are serving: religion, sexual orientation, gender, race, ethnicity, religion,

age, as well as physical and/or mental disability. Having a comprehensive knowledge of these diversity considerations will afford the practitioner a better mental schema regarding an individual's possible clinical presentation, which may be substantiated via the clinical interview/assessment, collateral information, and medical chart information. It is crucial for the clinician to be flexible, empathic, and open to diversity as each case must be treated on an individual basis, allowing for the individual's history and current presentation to be fully evaluated and understood.

With regard to Mr. Jones, it would be useful for the social work clinician to have a comprehensive awareness of any pertinent diversity considerations as it will validate and respect the client's presentation as well as assist the worker to pair possible interventions that will have a greater applicability for him. As a result, this may yield higher treatment adherence by Mr. Jones as the correlative interventions have been tailored to his individual needs and circumstance. Mrs. Adams was able to validate Mr. Jones's presentation and afforded him the opportunity to share his personal story of how he became addicted to substances that led him down the path of homelessness and declining health. Mrs. Adams operated from a nonjudgmental stance and took care not to assume that she knew what was happening with Mr. Jones because she had dealt with prior patients who were living with HIV, substance abuse, medical problems, mental health issues, and homelessness. Rather, she allowed Mr. Jones to tell his unique story, which validated his experience and assisted in the process of developing therapeutic rapport.

## Interventions

It is important for the social work clinician to understand the various evidence-based practices. Evidence-based practices are treatment approaches that have been validated via a body of research data. Because the length of nursing home stays fluctuates based upon the functional ability (medical need and/or safety) of the individual coupled with

payment reimbursements from various funding sources such as Medicare, Medicaid, long-term care insurance, and so on, it is crucial for providers to use evidence-based approaches as these are generally time bound, regimented, and efficacious. For example, cognitive behavioral therapy (an evidence-based approach) has been proven to be effective in the treatment of depression. Please ensure that you receive proper education, supervision, and/or consultation when implementing a new treatment approach as it would be unethical to render such services without this training.

During the assessment process, Mrs. Adams was able to uncover concurrent underlying depression that Mr. Jones felt comfortable in divulging. Mr. Jones informed Mrs. Adams that he was unable to share this previously with other providers as he did not feel safe. Because Mrs. Adams took the time to develop rapport and a therapeutic alliance with Mr. Jones, he felt that it was safe space for him to share his life experience. Via cognitive behavioral therapy, Mrs. Adams aided Mr. Jones to decrease his cognitive distortions regarding his situation that resulted in his self-medication with drugs and alcohol (maladaptive coping skills). Mr. Jones was able to decrease his automatic thoughts that he was a “failure,” and he realized that his situation was in part due to circumstance and partly due to his untreated mental health condition. With regard to his diagnosis of Psychotic Disorder NOS, she was able to assist him in grounding his pattern of thinking and used their clinical sessions as a “sounding board” where he was able to verbalize his thoughts and perception of issues in order to receive feedback. Mrs. Adams diligently monitored his mental health condition and often consulted with his psychiatrist to assist in stabilizing his symptoms of psychosis. Through the therapeutic process, Mr. Jones was able to develop trust in his relationship with Mrs. Adams to where he felt comfortable in letting her know that his voices (auditory hallucinations) were telling him that others were “out to get him.” Mrs. Adams was able to convey in an emphatic fashion that his paranoid delusions were solely internal to his experience. She was also able to provide him with psychoeducation regarding

the deleterious effects of substance abuse and its impact upon mental health functioning. During the treatment process, Mrs. Adams was successful at linking Mr. Jones to support groups in the community and securing a sponsor he can readily access upon discharge.

## Transference and Countertransference Issues

Social work practitioners need to understand the various competing transference and countertransference dynamics that may impede the therapeutic rapport and process with a client. According to Hughes and Kerr (2000), transference is a phenomenon whereby individuals unconsciously transfer or project feelings and attitudes from a person or situation in their past to a person or situation in the present. Likewise, countertransference is the direct converse of transference whereby the practitioner is undergoing a parallel process of unconscious reenactment and/or projection of thoughts, feelings, and/or attitudes from prior experiences onto the client. Therefore, it is important for the clinician to be as cognizant as possible when these competing issues may be at play so they can be processed and worked through.

Mr. Jones reported to Mrs. Adams that he felt comfortable sharing his issues with her because she reminded him of his mother. This positive transference enabled Mr. Jones to project his issues upon Mrs. Adams during their clinical dialogue. Mrs. Adams was able to use this transference to clinically bond with the client, and it allowed her to subtly intervene without the client feeling threatened. It is important for the social work clinician to understand issues related to transference and countertransference as well as recognize that this can be used either positively or negatively, depending upon the clinical presentation by the client in conjunction with the skill level of the therapist. Mrs. Adams was able to manage her thoughts and feelings regarding the multiple issues faced by Mr. Jones. She often consulted with colleagues both internal and external to her agency, which afforded her greater perspective of the issues



Mr. Jones was grappling with. Unbeknownst to Mr. Jones, Mrs. Adams also had family members and close friends who experienced mental health problems and substance abuse. Because she was cognizant of these issues and readily sought consultation, Mrs. Adams was able to gain greater perspective and not allow potential countertransference reactions to compromise her professional relationship with Mr. Jones.

## Legal and Ethical Concerns

The National Association of Social Workers (NASW) *Code of Ethics* provides a guide to professional conduct for social workers. It is crucial for social work practitioners to have a working understanding of these ethical guidelines as it ensures safety for the client, the general public, and the profession. It is important for the social worker to abide by all applicable local, state, and federal laws governing clinical practice. For example, the social work practitioner should be knowledgeable regarding issues of child abuse, elder abuse, dependent adult abuse, and the scope of practice, to list a few.

In the case of Mr. Jones, the social worker clinician, Mrs. Adams, completed a comprehensive biopsychosocial evaluation and determined that the client was not in danger of suicide, homicide, or grave disability. Implicit in the evaluation process, Mrs. Adams also evaluated Mr. Jones for any potential red flags, such as abuse issues, in efforts to maintain the safety of the client and the general public.

## MEZZO PERSPECTIVE

Social workers in care facilities often provide training to the clinical team in order to broaden their understanding of psychosocial factors that impact a resident's functioning as well as to keep team members abreast of differing social service programs and resources. Social workers may also be required to facilitate various groups (psychotherapeutic, educational, and/or socialization) depending upon the needs of the particular facility. In California, for example, it is important for the social worker to

understand California Law Title 22, which applies to laws, regulations, and services that are rendered in residential care facilities. Mr. Jones was referred to Windsor Recovery Homes, a board and care facility that is subject to Title 22 requirements. Please check with your regional and/or state jurisdiction for applicable laws governing social work practice to ensure legal and ethical compliance. It is important for the social worker to understand the difference between a licensed and unlicensed residential care facility, in order to provide the most appropriate referral for aftercare placement. Facilities can be licensed or registered on the local or state level as well as via Joint Commission accreditation. Because nursing facilities are considered health care facilities, they must meet local, state, and federal regulatory measures with regard to the types of services offered, who may provide services, and how services may be reimbursed.

Nursing homes in California are licensed, regulated, inspected, and/or certified by a number of public and private agencies at the state and federal levels, including the California Department of Public Health (CDPH) Licensing and Certification Division (L&C) and the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). These agencies have separate—yet sometimes overlapping—jurisdictions.

California Department of Public Health (CDPH) is responsible for ensuring nursing homes comply with state laws and regulations. In addition, the CDPH has a cooperative agreement with the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to ensure that facilities accepting Medicare and Medi-Cal (in California, Medicaid is referred to as Medi-Cal) payments meet federal requirements. Of California's 126,800 nursing home beds, on any given day approximately 68% are occupied by a Medi-Cal beneficiary. (California Health Facilities Consumer Information System, 2014)

In the case of Mr. Jones, it may be import to provide inservice training to staff on homelessness, mental health diagnoses, and available community resources such as the local Department of Social

Services, vocational rehabilitation, and board and care facilities. Because many nursing facilities do not have mental health providers on staff, the various disciplines may turn to the social worker for this support. Please remember your scope of practice based upon your level of education and correlative licensure status as appropriate, as this may require you to seek external providers to consult. In addition, it is critical for the social work practitioner to have a fundamental knowledge of applicable local, state, and federal laws governing practice. Please check with your licensing boards for more information and to ensure compliance in efforts to maintain safety.

## MACRO PERSPECTIVE

As the need arises, social workers may be asked to complete outreach services for the facility as well as perform marketing to the community, network providers, and other hospitals/care facilities. Because social workers are usually familiar with the core services offered by the program, knowledgeable regarding various funding streams, and have an affinity for connecting with people on a personal level, they are often asked by facility administrators to use these skills to market the facility to generate additional residents. The social worker may also be utilized to provide facility tours to potential clients (e.g., family members, potential residents, and other agency care providers). The Nursing Home Reform Act of 1987 assisted to clarify required patient services that culminated in a Residents' Bill of Rights as well as a method for ongoing monitoring/survey of facility compliance with the law.

The 1987 Nursing Home Reform Act requires each nursing home to care for its residents in a manner that promotes and enhances the quality of life of each resident, ensuring dignity, choice, and self-determination. All nursing homes are required "to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care that . . . is initially prepared, with participation, to the extent practicable,

of the resident, the resident's family, or legal representative" (Dementia Today, 2015, para. 2). This means a resident should not decline in health or well-being as a result of the way a nursing facility provides care. The following are the central tenets regarding the Residents' Bill of Rights: "(a) the right to freedom from abuse, mistreatment, and neglect; (b) the right to freedom from physical restraints; (c) the right to privacy; (d) the right to accommodation of medical, physical, psychological, and social needs; (e) the right to participate in resident and family groups; (f) the right to be treated with dignity; (g) the right to exercise self-determination; (h) the right to communicate freely; (i) the right to participate in the review of one's care plan and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and (j) the right to voice grievances without discrimination or reprisal" (Klauber & Wright, 2001, para. 5).

In the case of Mr. Jones, it may be ideal to provide him with a list of all these rights upon admission and have him sign a form acknowledging receipt and/or have them posted in a visible location throughout the facility, such as on bulletin boards where other facility information is provided. Having these issues addressed upon admission may give the resident a greater sense of empowerment and may increase likelihood that he will feel included in the nursing home setting. Should Mr. Jones or other residents have difficulty reading these rights, they should be read to them and noted as part of the informed consent process. Likewise, it may be ideal for the social worker to provide Mr. Jones with a tour of any board and care facilities that the team is considering for discharge planning, as a way to have greater "buy in" from the client as well as strengthen the working relationship between facility entities.

## CONCLUSION

Social work in nursing home settings is a challenging but rewarding journey. It is important for practitioners to have a working understanding of the different levels of social work practice and the legal and ethical considerations. Depending upon

the size of the nursing facility (in terms of number of residents), often there may be only one social work professional to provide the psychosocial care necessary. It is important for social workers to have a firm understanding of how to complete a psychosocial evaluation; create treatment and/or care plans; have a working understanding of the MDS assessment tool; and provide case management services, crisis intervention, and counseling/psychotherapy (per licensure status of the provider). Many nursing home residents have both medical and mental health conditions that they are trying to manage simultaneously. Therefore, an effective social work clinician would need to understand both the medical and mental health conditions of their patients and the interplay between them. It is important for the social work practitioner to have a fundamental understanding of the different local, state, and federal laws and regulations that govern clinical practice. Social workers in nursing home settings often provide inservice trainings to staff regarding various psychosocial topics as well as community resources. The facilitation of support groups, the provision of outreach services, marketing, and networking with various providers may be a requisite part of the duties of a social worker in this type of setting. It is important for practitioners to familiarize themselves with the various local, regional, and state resources available in their jurisdiction.

## INTERNET RESOURCES

- Alzheimer's Association: <http://www.alz.org>
- California Adult Protective Services (APS): <http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm>
- Centers for Medicare and Medicaid Services: <http://www.cms.gov>
- ICD 9 Codes: <http://www.icd9data.com/2014/Volume1/default.htm>
- Medicare Nursing Home Coverage: <http://www.medicare.gov/nursinghomecompare/search.html>
- National Association of Social Worker Code of Ethics: <http://www.socialworkers.org/pubs/code/default.asp>

- National Long-Term Care Ombudsman: <http://www.ltombudsman.org/>
- Nursing Home Quality Initiative Minimum Data Set: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/>
- Social Security Administration: <http://www.ssa.gov/>
- Social Work Policy Institute: <http://www.socialworkpolicy.org>
- Tarasoff Law: [http://en.wikipedia.org/wiki/Tarasoff\\_v.\\_Regents\\_of\\_the\\_University\\_of\\_California](http://en.wikipedia.org/wiki/Tarasoff_v._Regents_of_the_University_of_California)

## DISCUSSION QUESTIONS

1. As a social work clinician, what would your biopsychosocial assessment entail?
2. With regard to Mr. Jones, what is known about the case and what is not known? How would you go about ascertaining this information if you were the assessing social worker?
3. What interventions would you perform to assist Mr. Jones? If you were doing therapy with Mr. Jones, which perspective would be most appropriate? Justify your rationale. How would that look in practice?
4. What case management activities would you perform? Make sure that each problem identified has correlative interventions to offset the stress.
5. What are some of the ethical and legal considerations for this case?

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