405 Country Place
Longview, Texas 75605

September 10, 2007

CMS-Office of Strategic Operations & Regulatory Affairs
Division of Regulations Development-C
ATTENTION: Bonnie L. Harkless
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Received
SEP 17 2007

RE: Comment period-Document Identifier: CMS-R-249, CMS 10238, CMS-102, 105; CMS-10243 and CMS 10244 as it relates to Data Collection for Administering the Medicare Continuity Assessment Record and Evaluation (CARE) Instrument

Dear Ms. Harkless:

Enclosed per instructions in the Federal Register is our comment regarding the urgency of development of a standardized tool for medical social work to be used across post-acute settings in order to decrease unnecessary utilization of institutional and emergent care settings through appropriate utilization of medical social services. The additional benefit of this proposal would be to produce data to measure the benefits of medical social service interventions designed to reduce and/or resolve the economic, emotional, environmental and caregiving issues that impede the achievement of medical goals and stabilization of clients following acute episodes of care.

Our comments are discussed in detail in an article, *The Missing Link*, and we are enclosing a summary of our recently completed research project and resumes for introductory purposes.

We look forward to your response once you have had the opportunity to consider our comments.

Respectfully submitted,

Nancy McCaghren, LMSW
Shirley Walker, LCSW

THE MISSING LINK:
Medical Social Services in Health Care

Nancy McCaghren, LMSW

If the goal of the medical community at large is to decrease health care costs by reducing unnecessary utilization of emergent care, hospitals, and nursing facilities, then whenever possible **the HOME must be made a suitable venue for health care**. It is important to recognize that comparing a home setting with sterile, controlled, professionally staffed in-patient medical environments is comparing apples to oranges. Still, **homes can usually be made adequate for the delivery of intermittent health care *when the natural caregiving system and community resources are organized for the unique needs of the individual.*** The goal of most institutional care settings is to stabilize the medical condition toward return to the community if at all possible. However, many people are not aware of the many choices available to facilitate this choice. Clients and their families often need counseling on how to transition back into a home setting. Enter the skilled expert- **the medical social worker*** (page 6).

The contributions of nurses and therapists to improve client function are evident and widely understood. However, in many cases clients return unnecessarily to hospitals or stay longer than necessary in nursing facilities because they did not have skilled social workers accessing and coordinating complex community resources for short- and long-term financial, environmental, and caregiving needs in a community setting. Specially trained medical social workers are equipped to provide valuable counseling to the client *and the family* who must adjust to the impact of life-changing diagnoses that affect the entire family.

The proposed CARE tool should trigger social service referrals so that outcome studies can reflect these benefits. *In addition, there is an acute need for* ***a standardized social service assessment tool*** *that flows from CARE to follow up with appropriate questions that lead to interventions to ameliorate or resolve the socioeconomic obstacles to the achievement of medical goals.* The High Risk Assessment Tool, a Professional Practice Model published in the *Journal for Healthcare Quality*, March/April 2003, identified eight risk factors for hospitalization and emergent care; two were purely medical, i.e., dyspnea and urinary catheter. The other six high risk factors have significant socioeconomic ramifications and include: (1) discharged from hospital or skilled nursing facility; (2) low socioeconomic status, financial concerns, low literacy; (3) lives alone and/or inadequate support network; (4) assistance with medication management needed; (5) confusion; and (6) life expectancy less than six months and poor prognosis. All six of these high risk factors are red flags for further psychosocial assessment regarding caregiving arrangements, environmental safety, economic factors, and the emotional impact of life-changing diagnoses. V-codes should be reinstituted and included in the HHRGs with corresponding reimbursement to fund the provision of a social worker to

assess, address and measure these factors toward reducing the incidence of unnecessary institutional care.

The absence of a standardized social service assessment tool, complete with interventions, educational tools and outcome measures is precisely the reason why the impact of these issues has not been reduced. The problems have only been identified in the various assessment tools. Without standardized social service referral and intervention, the problems continue to resurface at tremendous cost.

At first glance the casual observer might surmise that there are plenty of private, government and charity organizations to get people the help they need; yet when faced with accessing said resources, most will reach a different conclusion. Services are geographically scattered and each comes with its own set of ever-changing eligibility criteria, scope of benefits, and application procedures. Resources range from state and federal programs to county-, faith- and locally-based services which fluctuate depending on budgets, grant monies, volunteer availability, and donations. Navigating the complex world of community resources can present a substantial challenge even to otherwise accomplished individuals who must arrange care for themselves or a family member facing a sudden or debilitating health crisis. Organizing a new routine to encompass increasing needs can be overwhelming taking into consideration costs, family work schedules, geographical complications and other critical factors.

A diagnosis that demands major alterations in lifestyle, compounded by limited family support, inadequate financial resources, and no knowledge of 'what's out there' in the form of community services and care options leaves a client at high risk for re-hospitalization or institutionalization. Individuals who have been sick enough to be hospitalized and quickly discharged in today's world of DRGs, or who have chosen to leave nursing facilities to return to their inadequate but 'home sweet homes' are in need of experienced medical social workers to assess and address problems related to environment, financial factors, and organizing caregiving resources outside the structured, professionally staffed institutions.

When a skilled, experienced home care social worker becomes involved with the client's medical care team, many of these high risk factors can be identified early and addressed successfully. The implementation of OASIS (Outcome Assessment and Information Set) to standardize assessment has improved access to data that identifies best practices in home care. Without standard forms, there is no way to measure the impact of interventions. For that reason it is urgent that a complimentary standardized form be created for social services.

The original form of OASIS included assessment of financial resources, environmental hazards, data on caregiving arrangements, and to some extent, the emotional state of the client on admission, if there were a diagnosis. However, *MO160-Financial Factors limiting the ability of client/family to meet basic health needs* was later eliminated. Clients who lack adequate financial resources for purchasing prescribed medications, not to mention basic food and housing, are unlikely to achieve their medical goals! Items MO360-380 note caregiving deficits, but there is no expressed referral for social services, the appropriate discipline to assess further and provide appropriate intervention. **With no reimbursement for social services flowing from the identification of those problems, Medicare beneficiaries' access to social workers has been significantly diminished.** Sadly, distressed clients and their families often comment to social workers, *"Thank you so much. I didn't know where or how to get help."*

Changes in reimbursement that failed to support social services in home care reduced utilization of the discipline and has deprived Medicare beneficiaries of the valuable professional best qualified to provide *psychosocial assessment and assistance* for the client in the context of family dynamics, financial issues, environmental factors, emotional impact of illness and potential for crisis when the natural caregiving system is inadequate to meet the client's needs. When specific OASIS items that drive reimbursement were selected, (HHRGs), psychosocial issues were largely overlooked. ***This error has resulted in the reduction of social services, although studies have repeatedly identified numerous psychosocial issues among high risk factors that contribute to emergent care, hospitalization and institutionalization.***

The *Briggs National Quality Improvement/Hospitalization Reduction Study* (January 2006) sponsored by Briggs Corporation and co-sponsored by National Association for Home Care & Hospice and Fazzi Associates, Inc., is only one of many research studies revealing psychosocial factors affecting client progress. This study identified strategies utilized by Best Practice Agencies which resulted in decreased incidence of hospitalization during the course of home care. ***Appropriate utilization of social services clearly impacts many of the fifteen identified strategies in the best practice agencies.***

Medicare regulations for home care recognize the distinct discipline of social services. The role of the social worker is to provide *psychosocial assessment* which goes beyond the medical and functional factors included in OASIS; ***counseling for long-term planning*** including but not limited to alternate living arrangements that prolong home settings whenever possible; ***coordinating community resources*** by addressing financial, environmental, emotional, and caregiving issues through education, access, advocacy, and linkage with appropriate services; ***short-term therapy*** to relieve the emotional

impact of illness; ***family counseling*** to address caregiving and related issues that impact the client's rate of recovery; and ***crisis management***.

Too often, however, social services in home care have been reduced to contractors who are called only when situations are critical. **Many agencies have failed to invest in salaried social work positions that include ongoing involvement as well as training to keep social workers, like nurses and therapists, abreast of changes and emerging best practices to maximize clients' potential for managing their care in a home setting.**

Part of the problem is that social services is a unique discipline. While the client's diagnosis is an important consideration, social work is not diagnostically driven. OASIS and CARE are useful to help nurses and therapists identify issues that merit further psychosocial assessment. But once the problem is identified, ***the skilled social worker should be called to assess the specific strengths and deficits in the client's natural caregiving system and develop a plan to enable the client to remain in or return to a home setting with needed services and counseling. A home setting is a Win-Win-Win situation: almost every client prefers to be at home, studies show that most clients do better in a home setting, and home care is almost always the least expensive option. Clients need a social worker to coordinate services so that well-planned assistance on a scheduled basis is provided to meet their needs. With this kind of professional assistance many clients can manage well without full-time supervision. This goal can be accomplished by specially trained medical social workers who can organize appropriate community resources along with the natural support networks who often provide many hours of care and/or supervision at no cost.***

Home care is the future of health care. With an estimated 76 million baby boomers thundering toward Medicare and Medicaid health services, the looming challenge is enormous. **Medical social services must be reintegrated into the assessment process with the reinstatement of questions that have psychosocial implications acting as automatic triggers for MSS referral.**

When problems regarding financial resources, environmental hazards, inadequate caregiving, basic needs or emotional issues are identified, V-codes should be included in the HHRGs to fund social services with increased reimbursement, parallel to the way the functional assessment increases reimbursement for the provision of therapies. In its current form HHRGs do not support necessary funding for social services to address these issues. The CARE project can correct this problem to achieve better outcomes across all post-acute settings.

In a commentary on the Briggs Study regarding the role of social services in Case Management as one of the identified best practices this author wrote:

> Interestingly enough, interdisciplinary case conference originated at Massachusetts General Hospital in the early 1900s as a seminal idea proposed and led by the social work department working directly with physicians. In recent years health care has moved into the extremely competitive free enterprise arena. In today's climate it is quite clear that the language of health care is numbers and dollars. Therefore, it is possible that there are at least three reasons why social services did not maintain its strong leadership role.
>
> First, social workers are notorious for concentrating focus on direct care for clients to the neglect of research which is now necessary to produce the numbers that illustrate the tangible benefits of social services. In anticipation of IPS/PPS, [the prospective payment system driven by HHRGs, a diagnostically driven, bundled payment system] leadership for home care social workers emphasized preparing for change by delivering services more efficiently and effectively. However, the cutbacks across disciplines were disproportionately severe to social services. More emphasis should have been placed on research to equip the profession to demonstrate its effects in the new language of health care - numbers and dollars.
>
> Second, the challenge of measuring the intangible benefits of counseling to prepare and empower patients and their caregivers with the options and information needed to reorganize their lives to stabilize the caregiving, financial, and emotional effects of illness and disease, has not been adequately addressed.
>
> Third, the absence of a standardized medical social work assessment tool that can be used to identify best practices in social work and measure outcomes along with ongoing training is a significant factor. The Walker-McCaghren Study produced and proposes a form that flows from OASIS and is ready to be revised to be compatible with the new CARE instrument. The standardized form will include specific interventions and outcome measures to be programmed in a point-of-care laptop and self-contained social work station capable of producing documentation and reports related to social service intervention and outcomes. Adoption of this program would increase the incentive of agency leadership to support home-health specific education/orientation for social workers and obtain tools to equip the social worker whose interventions will result in better agency outcomes.

The Walker-McCaghren Study was completed in December 2006 with a grant from the University of Mary Hardin-Baylor, and in collaboration with my colleague, Shirley Walker, LCSW, ACSW, BCD and Professor of Social Work, we developed an additional tool for identifying best practices in home care social services that leads to measurable outcomes. It was tested with excellent results which were presented at the Regional Association for Home Care, Winter Legislative Conference, Owner's Forum in January 2007.

It is our vision to combine the results of our efforts into a single standardized Medical Social Service assessment form, **PALMSS: Practical Assessment & Logical Maps for Social Services** with **MIMSS: Medical Impact of Medical Social Services** ***which includes interventions that result in measurable outcomes for social services.***

We are aware, however, that the best tools will be under utilized until they are standardized by CMS and followed by the necessary support and training for medical social workers to apply in health care venues. Honestly, how many agencies would have voluntarily adopted OASIS and participated in data submission if mandated utilization had not been anticipated? Just as HCFA required OASIS which made ongoing training imperative for nurses and therapists, ***medical social services should be brought back to the table with a mandated, standardized form and best practice training to supply the benefits of social services.***

This pervasive issue can be corrected with savings of substantial Medicare dollars by recognizing the need to standardize medical social service assessment with a CARE-compatible tool and best-practice interventions to compliment the nursing and therapy services, thus reintegrating social services to complete the continuum of care. ***Specially trained medical social workers can make the connections to achieve this goal.***

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*It is important to identify the ideally qualified medical social worker in today's health care community. Regulations vary from state to state; however the person occupying this position should have certain distinguishing characteristics. S/he should have a degree from an accredited School of Social Work, preferably a master's degree (which is required in a number of states for various health care settings). The master's degree in social work entails an average of sixty post-graduate hours including a one-year practicum, in addition to the one-year internship in a different setting in the bachelor's level social work program. The curriculum for a master's degree in social work includes multiple classes in psychopathology, individual counseling and group therapy, as well as numerous courses that address specific populations such as geriatrics, substance abusers, and maternal and child health, plus studies in administration, public health, and social problems. In addition to social work degrees, the home care or hospice social worker should be licensed according to State laws and have at least one year of experience in a health care setting as additional preparation for the isolated practice of social work in a home setting which is performed away from the luxuries of structured, sanitary, secure institutional settings and with limited peer support. ***Beyond these basic credentials a qualified medical social worker in any health care setting should have training specific to that setting and its unique practice with continuing education.***

CARE Demonstration Project
September 6, 2007

PALMSS/MIMSS

Co-Project Researcher: Shirley A. Walker, LCSW, ACSW, BCD
University of Mary Hardin-Baylor
Shirley.walker@umhb.edu
Co-Project Researcher: Nancy McCaghren, LMSW
Good Shepherd Home Health

Our goal is to share the results of our study that produced an instrument that measures the impact of medical social services, *MIMSS, in the home care setting and the assessment component, PALMSS, for consideration of inclusion in the *CARE* Demonstration Project across all post acute care settings.

Study Sample and Results:

After creating the Medical Impact of Medical Social Services (MIMSS) tool based on common interventions home care social workers make, outcomes that are commonly achieved, and a measurement scale, the study packets were sent to

- Six home care agencies/six social workers representing all the geographic regions of the United States, based on the U.S.Census Bureau (83%, five out of six packets, were returned). All were full-time salaried master's level social workers.
- The sample also represented a variety of home care agency structures from private, for profit (proprietary) both free-standing and institutional-based to public, institutional-based.
- Fifty (50) patient cases (10 per home care social worker) were included in the sample
- Patients represented a variety of living locations, mostly town dwellers
- Youngest patient was 1 year old; oldest patient was 93 years old
- Average age was 70; median age was 71
- Average length of stay in home care was 5.7 weeks
- The range of primary and other diagnoses was within the expected range for the kinds of conditions typical of the older, frail home care patient population in America.
- There were fewer initial referrals for long-term planning and short-term therapy than were indicated upon social work assessment of the patient situation, suggesting that our colleagues may need to assess the need for more referral cues of their patients in these two areas.
- Thirty per cent (30%) of the study sample (15 patients) had home care Aides involved in their care. This number seemed to be rather low.
- There appeared to be a need for home care agencies to track and provide easier worker access to patient data on hospitalizations and ER visits pre and post home care admission
- The pre-test MIMSS tool was found to be somewhat time consuming and not easy to understand, but we addressed these issues with our revised tool and added an assessment component, Practical Assessment and Logical Maps for Medical Social Services (PALMSS) that was developed over several years by Nancy McCaghren.
- All (100%) of the study participants believed that the tool measured the interventions the workers used on a regular basis, measured the desired psychosocial outcomes for their patients, and was helpful to them in performing their work at their respective agencies.

- **Problem areas:** Patient/caregiver lacked adequate caregiving, adequate finances, education/community support, adequate food/nutrition, financial resources for prescription drugs/supplies/medical equipment, transportation to medical appointments, knowledge of or access to medical directives, coping skills related to anxiety/depression and other emotional challenges
- **Interventions:** Social workers provided teaching and access with advocacy and appropriate assistance with financial resources, resources to remove barriers to safety in the home environment, caregiving resources, prescription drugs/supplies/DME resources, long-term care planning/alternate placement, and skills for management of various emotional and problematic behaviors
- **The Cumulative Outcomes score** was 50 (100%), meaning that all 50 patients utilized the options provided by the social workers to some degree and the problem/need was partially or completely resolved.
- **Validity/Reliability:** Due to the small sample size, these measures were not assessed. However, one question in the participant survey indicated a validity stat which was that all (100%) of the participants believed that the MIMSS instrument was very helpful to them in performing their jobs as medical social services workers in their respective agencies.

Implications for Home Care:

- Medical Social Services can now demonstrate the value of their services in home care, including contributing to patient safety of using medications by first assisting with the acquisition of prescribed medications and reducing the risk of patient harm from falls by arranging for installation of wheelchair ramps, stair rails, grab bars, and durable medical equipment that is not covered by Medicare or insurance, as well as impacting Home Health Compare scores. **The national average cost of a one-day stay in a PPS general acute care hospital in 2006 was $952.00. The study identified seven cases that indicated a clear connection to reduced hospital stays due partly to the interventions of medical social services. Thus, the minimum amount of health care costs saved was $6,664.**
- The "Medical Social Work Patient Care Survey" provides data on MSS contribution to patient/family satisfaction of care provided by the agency
- Social workers can produce outcomes that affect the bottom line by stabilizing caregiving situations in the home setting through various interventions as outlined in the Conditions of Participation (COPs)
- ***Social workers who have home health training and experience can produce these results; on the other hand, social workers who have not had the benefit of mentoring by experienced home health social workers are less likely to produce these outcomes***
- Agencies must support their social workers with the necessary training to enable them to produce these outcomes
- Agencies have much to gain by hiring social workers who have been educated in an accredited school of social work, are licensed by the state and who have the desire to serve home health patients if the agency is willing to provide the appropriate training and support they need to do the job
- OASIS does not currently adequately address the impact of interventions and outcomes medical social services have on patients and families.

PALMSS/MIMSS is the missing link! It is critical that this instrument be included in testing across all post acute care settings.

***This project was sponsored by a research grant from the Faculty Development Fund at the University of Mary Hardin-Baylor, Belton, Texas**

Two Dozen Samples of Medical Social Work Outcomes

Reflecting Contributions of Licensed and Trained Social Workers in Home Care Agencies

- Stabilized caregiving/supervision schedule using community resources to support/supplement natural caregiving system
- Reduced risk of hospitalization with increased commitment and involvement of natural caregiving system
- Reduced patient/caregiver anxiety by establishing/arranging for alternate housing plan to meet long-term care needs
- Increased knowledge of and access to community resources for assistance with costs of basic needs
- Decreased caregiver stress/anxiety with increased knowledge and access to resources to prolong and support caregiving in home setting
- Decreased risk of patient/caregiver overexertion due to improved/organized caregiving arrangements
- Improved management of finances with budget counseling
- Empowerment of patient/caregiver to pursue financial benefits with knowledge of, access to and advocacy with resources
- Increased patient ability to prepare medical directive with agent named
- Increased awareness of and access to emergency resources
- Reduced risk of falls through access to community resources for remodeling environment
- Increased compliance with plan of care meds/supplies/equipment through access to community resources
- Decreased anxiety for patient when alone with application/assistance with emergency response system
- Increased knowledge of and access to support/education network to prolong safe care in home setting
- Increased compliance to plan of care through access to community resources to provide nutritional needs*
- Increased likelihood of compliance with medical appointments with increased knowledge of and access to medical transportation**
- Increased knowledge of and access to primary medical care
- Increased recognition of triggering events and techniques to reduce symptoms of anxiety/panic attacks, depression, and problematic behaviors
- Reduced effects of symptoms of depression/anxiety/problematic behaviors through teaching patient to utilize management skills
- Increased access to resources through protective services
- Increased patients' access to and understanding of benefits of short-term in-patient care with goal of returning to home setting
- Decreased risk of injury in the home with fire safety equipment
- Increased knowledge of and access to resources for dental care and resources for visually and/or hearing impaired
- Increased compliance with plan of care with improved knowledge of and access to resources through the VA

***/** meals on wheels not available in some rural areas/other arrangements required; some transportation applications are up to 12 pages long and require submission by physician or licensed social worker**

Resume

Shirley A. Walker, LCSW, ACSW, BCD

Master of Social Work (M.S.W.)
Ohio State University
Clinical Social Work Concentration
June, 1973

University of Texas at Austin: BA in Sociology/Social Welfare Studies (1970)

University of Mary Hardin-Baylor:
Associate Professor
Belton, Texas
August, 1996-Present

Position 1
Methodist Home Children's Guidance Center
Psychiatric Social Worker
Waco, Texas
August, 1973-August 1976

Position 2
Pikes Peak Family Counseling and Mental Health Center
Psychiatric Social Worker
Colorado Springs, Colorado
August, 1976-August, 1978

Position 3
Child and Family Service
Clinical Social Worker
Austin, Texas
April, 1979-August, 1980

Position 4
University of Texas at Austin, Graduate School of Social Work
Field Unit Supervisor Instructor
Austin, Texas
August, 1980-June, 1982

Position 5
Austin Diagnostic Clinic-Renal Out Patient Center
Dialysis/Nephrology Social Worker
Austin, Texas
June, 1988- August, 1992

Position 6
Scott & White Hospital
Medical/Clinical Social Worker
Temple, Texas
August, 1992-August, 1996

Adjunct Faculty
University of Mary Hardin-Baylor Social Work Program
August 1993-August 1996

Founder and Co-Chair of the Social Work Special Interest Group of the Texas Association for Home Care (1993)

Private Clinical Social Work Practice
Full and Part-Time, 1983-Present

Current Professional Memberships

National Association of Social Workers/Texas Chapter
North American Association of Christians in Social Work, (Mentor Program)
Society for Social Work Leadership in Health Care (2006 annual conference program planning committee member, and Coordinator of the pre-conference Home Health Intensive for 2006), (2004 program planning committee member for the 2005 pre-conference Home Health Intensive in Houston, Texas)
Texas Chapter of the Society for Social Work Leadership in Health Care, Nominations Committee Member (2006-2007)
Academy of Certified Social workers (ACSW)
Board Certified Diplomate in Clinical Social Work (BCD)

Community Service Activities

Family Promise Agency, Advisory Board Member (Temple, Texas) 2007-Present
Supporter of Hill Country Community Ministries (Leander, Texas)
Round Rock Christian Academy School Board (2005-2006 Secretary)
Columnist for the *Villager*, a local weekly community newspaper in Austin, Texas: *"Ask Shirley"* (1985-1988)
Executive Producer and Host of a Cable Access Television Program: *Christ Evangelistic Ministries* (1980s)

Awards, Fellowships, Grants

Who's Who Among America's Teachers (2003-2004, 2004-2005, and 2005-2006)
Paid Faculty Development Leaves, based on my research proposals (Summer 2003 and 2004)
National Association of Social Workers/Texas Chapter: Chairperson of the Committee on Social Workers in Health Care, Plaque for service 2001-2003
Social Worker of the Year Award (2006), National Association of Social Workers/Texas Chapter, Central Counties Branch
Empire Who's Who of Women in Education, 2006/2007 "Honors Edition" Registry
Recipient of the UMHB Faculty Development Fund Grant (2006-2007) for my proposal to develop the tool: "Measuring the Impact of Medical Social Services" with co-project leader, Nancy McCaghren, LMSW

Professional Presentations

Poster Session Presentation at the NASW/TX State Conference, October, 2004: Women Without Children, Forgotten People
Presentations (readings and book discussions) at The Writers' Festival at the University of Mary Hardin-Baylor, January 2005 and the Langdon Week-End Literary Conference in Granbury, Texas in September, 2005
Book discussion presentation in April, 2005 in Austin, Texas at Mitchie's Gallery
Staff In-Service Presentation to Park Place Manor Nursing facility in Belton, Texas in May, 2005
Developed and facilitated a five week talk/support group series in Austin, Texas in August, 2005: WomenWithout Children Fellowship

Coordinator/Facilitator of the Home Health/Hospice Intensive Workshop at the Society for Social Work Leadership in Health Care National Conference in San Diego, California, April 2006

Wrote a presentation for the UMHB Book Club, Spring 2006 read by Dr. Janene Lewis in my absence

Professional Publications

Women Without Children, Who Are They?: A Life Journey, January 31, 2005, Frederick, Maryland (1-4137-4883-X)

Service to the University

Assistant Marshal, Representing the University (Spring 2004-Present)
Faculty Assembly Professional Growth and Development Committee Member
Past Secretary of Faculty Assembly (2000-2001)
Represented Dr. Bawcom and the University at the Paul Quinn College Anniversary function in Dallas, Texas, 2003
Faculty Advisor to the Social Work Club (1996-Present)
Faculty Advisor to BASICS (Brothers and Sisters in Community Schools) (1997-Present)
Member of the Social Work Program Reaccredidation Committee (CSWE)
Participant in the Crusader Gospel Choir programs and Faculty Chapels

Church Related Service

Member of Central Baptist Church, Round Rock, Texas:
Member of the Choir, Greeter Ministry, and Prayer Ministry
Out-Reach leader for my Sunday School Class
Team Leader of the "Connection Team" (Prayer Ministry)

Nancy McCaghren, LMSW
405 Country Place
Longview, Texas 75605
903-663-6591 or 903-235-4436
www.jerrymac@cablelynx.com or nancy.mccaghren@LHCGroup.com

EDUCATION

Masters of Social Work from the University of South Carolina (1992)
Bachelor of Social Work from Winthrop University (Cum Laude 1991)

CAREER

- **Speaker and writer on medical social work topics; conferences and presentation titles attached**
- **Medical Social Worker for Good Shepherd Home Care (1999-present) and Marshall Regional Home Care (2005-present); home visits providing psychosocial assessment, interventions with appropriate resources, individual and family counseling, and crisis management**
- **Director of Medical Social Services for LifeLine Home Nursing Services; developed department; hired, trained, and supervised social workers for seven branch offices (1993-1998)**
- **Program Director and Social Worker in long-term care; designed and implemented specialty care unit for patients with dementias with emphasis on Alzheimer's care (1992-1993)**
- **One year counseling internship with Marshall Pickens Psychiatric Hospital including psychosocial assessment, patient histories, individual and group therapy sessions**
- **One year counseling and social service internship with Family Services at Shriner's Hospital with emphasis on developing and indexing resources in five state area to serve patient and family needs**
- **Graduate research assistant in Maternal & Child Health Project**

AUXILIARY EXPERIENCE

***Created Friendship Fund, a 501(c)3 charity for emergency patient assistance**
***Gregg County Advisory Board for Adult Protective Services**
***Area Agency on Aging REACH Planning Committee**
***Alpine Church Special Care Ministry, Counseling Ministry, and Family Life Ministry serving the church and community with counseling, social services, and educational programs**
***Two terms as Texas State Chair for the Social Work Special Interest Group for the Texas Association for Home Care**
***Certified Instructor for Walk Thru the Bible Seminars**
***Guest speaker and teacher for retreats, classes, lectureships, workshops**
*** Administrator for Hugo Project Relief through Northeast Church co-leading national fundraising project resulting in distribution of over a million dollars for emergency assistance and social support for hurricane survivors**

RESEARCH AND WRITING

Medical Impact of Medical Social Services (MIMSS) Research project completed in December 2006 with colleague, Shirley Walker, LCSW, ACSW, BCD, through a grant from the University of Mary Hardin Baylor, demonstrating positive outcomes resulting from appropriate utilization of medical social services in home health care. Initial presentation of results made at the Regional Conference for Home Care in Austin, January, 2007 to the Owner's Forum. Additional presentations are planned for upcoming conferences through the Society for Social Work Leadership in Health Care and the National Association of Social Workers.

Caught In The Middle – The Sandwiched Generation, an article specifically solicited to highlight the research results and benefits of social services by the Texas Association for Home Care published in the Summer (2007) edition of *Home Care Journal* which is targeting TAHC members, legislators, congresspersons and discharge planners to further education regarding the benefits of home care.

PALMSS – Practical Assessment and Logical Maps for Social Services:
The Medical Social Worker's Handbook for Understanding and Working with OASIS (Outcome Assessment and Information Set, Medicare mandated, standardized assessment tool for Medicare-certified home health agencies) for training medical social workers in home care to participate in the new format shaping the future of home health.

Care Plans, Forms, and Educational Materials to supplement the practice of social work in home care and empower patients and their families to utilize community resources, evaluate options to plan for long-term care needs, and utilize coping skills to manage the effects of illness and aging while prolonging safe independence at home.

PRESENTATION VENUES

National Association of Social Workers (several national and state conferences)
American Network of Home Health Care Social Workers (four national conferences)
Society for Social Work Leadership in Health Care (national and state conferences)
Area Agency on Aging Regional Education on Aging, Caregiving, and Health Care (several REACH conferences)
Texas Association for Home Care (several state and regional conferences)
New Jersey Home Care Association (state conference)
Kansas State Home Care Association (state conference)
Buckner's Annual Celebration of Social Work Month with Social Work Education
Senior Expo - Longview
Numerous in-service presentations for local groups including hospice, civic clubs, church groups, medical supply companies, graduate nurse orientations, support groups, and staff programs

SELECTED PRESENTATION TITLES

SOS. . .Call the Social Worker!
Orientation to Medical Social Services for Health Care Staff

Proof Positive: Medical Social Workers Get Results!
Measuring Outcomes in Home Health Care

Maximum Impact:
Effective Assessment and Social Work in Health Care

What's Out There?
Locating, Creating, & Organizing Community Resources

Embracing the Challenge of OASIS
Identifying Indicators for Social Service Intervention

Focus on Medicare Part D
What You Need to Know (for beneficiaries and their families)

Protecting Our Client
The Role of Adult Protective Services

Patient Rights
Remembering them for JACHO – Integrating them in Practice

Who Will Make My Medical Decisions if I Can't??
Medical Directives with Emphasis on Texas laws and forms

Ethics: The Right to Know
Making and Discussing End of Life Decisions

Tool Time for Medical Social Workers
Creating and Utilizing Forms and Educational Materials

What Do Medical Social Workers Do?
Especially for physicians and other health care professionals

After the Diagnosis: Picking Up the Pieces
Entering the Grief Experience with Patients and Families with Hope

Staying Independent: What Are My Options?
Counseling Patients and Families on Long-Term Care Planning

Mrs. Jones Is Upset: Short-Term Therapy in Home Care
Addressing Symptoms of Anxiety, Depression, and Maladjustment

Shall We Dance?
Learning to Communicate through the Veil of Dementia

PIGIN' OUT for Success—
A Model for Efficient Documentation in Medical Social Work

Let Go. . .Move On!
Moving Social Work into the Brave New World of OASIS

I Want to Honor My Father & Mother, But HOW?
Organized and coordinated 7-week ElderCare series for seniors & families
Presented at the Alpine Church of Christ for the community