“Social Work Leadership on Interprofessional Health Care Teams”

Collaborating Across Borders V

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CASE 1: Care Transition

Jason is a 32-year-old, white man born with congenital heart disease. He has been cared for by pediatric cardiac specialists all of his life. His primary heart specialist is retiring soon, and the family and team have decided this is a good time to transition his care to from a pediatric to an adult cardiologist. Jason is married and his wife is pregnant with their first child. His family of origin consists of his parents, married, and a sister, age 37, who is single and lives nearby. Jason works as an IT specialist. Jason has interviewed a couple of potential new cardiologists, but has not made a final decision. At his last check-up one year ago, his pediatric cardiologist noted an arrhythmia. He did not seem too concerned, but did tell Jason he wanted to monitor the situation. Jason trusts his cardiologist a lot, and was not too worried when his doctor did not seem to be. When Jason went to third adult cardiologist for a check-up and interview, that doctor noted the arrhythmia as well, but in fact seemed quite concerned. He wanted to order more tests and even wanted to admit Jason to the hospital for observation. This specialist tells Jason that this type of arrhythmia is associated with heart failure, and he may require a pacemaker, or worst case: a heart transplant. Jason’s wife, Elizabeth, was very concerned when Jason told her about this. She had always assumed his heart condition was well under control because Jason, and in fact his whole family, seemed to downplay any real concerns, and Jason always seemed to be in good health. While Jason has adequate private insurance through his employer, he is potentially eligible for Medical Assistance should he become disabled relative to his heart condition.

CASE 2: Disruption of Community-based Care

Bao is a 63-year-old Hmong woman with intellectual disability resulting for a brain injury as a young child. She speaks Hmong, has basic English language skills (oral/written), and has been assessed to have the mental age of a six year old. She has lived in a group home for intellectually disabled adults for the past 13 years. Her parents are deceased. Bao has never married and has no children. She has a niece, Mau, age 38, who is her legal guardian and holds a durable power of attorney to make decisions on her behalf. Mau visits her aunt weekly and takes her out to lunch. Mau is married and has two small children. Bao works in a sheltered workshop. Recently, Bao has experienced shortness of breath and sometimes feels anxious because she cannot catch her breath. The staff at the group home took her to the doctor, and she was admitted to the hospital for evaluation. It was discovered that she has developed emphysema as a likely consequence of many years of smoking cigarettes. She has significant lung damage, and her condition is not reversible. In fact, her breathing difficulties are likely to become progressively worse. She is able to breathe more easily now after starting medications and also being placed on oxygen through a nasal cannula. She has to have the oxygen at all times, and have the portable tank with her. She doesn’t like the nasal prongs, and has pulled it off in frustration sometimes, though she also states she does feel better with the help of the oxygen. The team has started to discuss discharge plans. The group home staff stated that Bao’s increased medical needs make her ineligible to continue living there. This has come as a complete surprise to Mau, who was not anticipating any issues because Bao had lived there as long as she could remember. Bao receives SSI and is on Medicare. She also receives Medical Assistance, which supplements her Medicare coverage. Her room and board has been covered by Minnesota Supplemental Assistance (MSA).

Discussion Questions

1. What should the social worker prioritize in the situation?
2. How might the social worker exercise leadership?
3. How would social work intervention affect patient outcomes?
4. How does the social worker strengthen the interprofessional team?

Overview of Social Work Contributions to Interprofessional Practice and Education

Practice

- The primacy of client-centered care
- Evidenced-based intervention strategies to improve client outcomes
- Core systems orientation (ecological perspective)
- Facilitate collaboration and communication across disciplines
- Use social determinants of health to understand and inform care plans
- Client empowerment
- Client advocacy
- Develop relationships in the service of client needs
- Mental health expertise

Education

- Teach health care team the range of knowledge, skills, and attitudes that operationalize the client-centered approach
- Inform health care professionals about the difference between BSW and MSW in terms of knowledge, skills and scope of practice
- Focus on the social determinants of health
- Build opportunities for social workers and other health care professionals to learn together because each discipline responds to information in different ways
- Prepare for health care reform, changes in reimbursement (e.g., bundled payments, outcomes-based payments), and new funding strategies for service delivery
- Inform members of the health care team that social workers perform key (interstitial) tasks that are not billable or easily identified, but are clinical and essential to client care and outcomes
- Teach ways to evaluate practice: measure the social work contributions to team efforts
- Understand shift from patient compliance to adherence to self-management