**Chapter 8: Becoming Policy Advocates in the Gerontology Sector**

***Policy Advocacy Learning Challenges and Exercises***

***Excerpted from the book***

**POLICY ADVOCACY LEARNING CHALLENGE 8.1**

**Connecting Micro, Mezzo, and Macro Policy Advocacy to Protect Patients’ Ethical Rights**

Social workers are often the healthcare professionals that family and patients reach out to when making end-of-life decisions. Social workers have an ethical obligation to advocate for the right to self-determination among competent patients with clearly executed advance directives and living wills indicating their preferences and instruc­tions for withholding and withdrawal of care, as well as among the surrogate decision makers they appoint, that is, individuals with power of attorney.

Mr. K was an 80-year-old Caucasian male who resided at his home with his spouse. He had advanced Parkinson’s disease and was dependent on a ventilator/ tracheotomy and artificial hydration/nutrition through a feeding tube.

Mr. K was bedbound and required total care. He was alert and oriented times four (person, time, place, situation) but was nonverbal. His only way of communicating was by writing on a whiteboard. Mr. K had a very active spouse and two adult children who were professionals. Mr. K received long-term home health care and had a visiting nurse. Mr. K had the financial resources to pay for around-the-clock 24-hour care. Mr. K identified his religious view of an afterlife as one source of hope and ability to cope. To Mr. K, the ability to communicate with loved ones and visitors via the white­board helped define his quality of life. He stated that once he could no longer write, he wanted life support discontinued. Mr. K had an advance directive which designated his spouse as his healthcare proxy/decision maker. In Mr. K’s advance directive, he requested that his life not be prolonged if he had “an incurable and irreversible condi­tion that would result in his death within a relatively short time.” About two weeks after the social worker met with Mr. K and his spouse, the spouse contacted the social worker, indicating that the time had come that Mr. K could no longer write on the whiteboard, that he wanted to be taken off life support according to his instructions in his advance directive, and that he wanted to die at home surrounded by his family.

**Learning Exercise**

1. How should the social worker proceed with a micro policy intervention?
2. Does Mr. K have a right to die at home?
3. What are the legal requirements or programs available?
4. What are the goals and timeline for executing the actions?
5. Should an interdisciplinary team meeting, bioethics consult, and/or psychiatric evaluation be requested to establish a plan of care and determine whether the patient still has the mental capacity to make such a decision?
6. How can the end-of-life options be best explored with the patient and family?
7. Assume that a physician insisted that all medical means be used to prolong this patient’s life. How might a social worker initiate a macro policy intervention at the organizational level to decrease the likelihood of incidents like this?

**POLICY ADVOCACY LEARNING CHALLENGE 8.2**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

Mrs. C is an 89-year-old resident in a skilled nursing facility, where she has resided for three years. Prior to entering the nursing home, she lived in her home with a pri­vate 24-hour caregiver. Once she required the assistance of a Hoyer lift, she decided she could not afford the extra caregiver to assist with transfers, and she made the decision to relocate to a nursing home. She is alert and oriented, suffers from no psychological disorders, has capacity to engage in all decision making, and signs all her own consents. She is obese, and had her left leg amputated four years ago due to complications with diabetes. She suffers from severe diabetic neuropathy and cannot ambulate without an assistive device and cannot transfer without assistance. Since entering the nursing home, she has required three attendants to assist with the use of a Hoyer lift to transfer her from her hospital bed to her wheelchair. You are the new social worker at this facility and are meeting with each resident to update psy­chosocial assessments and treatment plans. In your assessment interview, Mrs. C states that she would like to eat her meals in the dining room but is often brought her meals to eat alone in her room. She also reports that she would like to participate in the social activities such as bingo and music, but reports that when she asks the attendants, they say, “I’m too busy; I’ll come back,” but they “never come back, so I sit in my room watching television by myself.”

**Learning Exercise**

1. How should the social worker proceed with a micro policy intervention?
2. Does the long-term care ombudsman need to be notified?
3. What are the legal requirements for the nursing home?
4. What resident rights have been violated?
5. How can the resident’s rights be best addressed?
6. What policies may need to be updated at the organizational level to reflect state and/or national policies ensuring protection of residents’ rights?
7. Could state regulations governing nursing homes be modified to limit seniors’ isolation?

**POLICY ADVOCACY LEARNING CHALLENGE 8.3**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

Mr. A is a 66-year-old male referred to home health services by social work for crisis intervention and discharge planning; physical therapy for new DME (walker), strengthening and endurance, and gait training due to a fracture sustained to his hip when he fell; and nursing to monitor vitals and medication management/compliance. Mr. A was admitted via ambulance to the ER upon being found unconscious in a park. He flat-lined in the ambulance on the way to the ER but was brought back with CPR and chest compressions. He was admitted and transferred to the ICU, where he was on life support for three days. He was successfully weaned from the ventilator and transferred to the medical floor until he stabilized. The hospital social worker discovered that Mr. A had just been released from prison the day before he was brought to the ER. A Medicaid application was not completed at the hospital. Mr. A could not go to a shelter due to the change in his functional health. The hospital discharged Mr. A to a board-and-care facility, where his basic needs were met for 30 days, fully paid through a charity program by the hospital. He had no income, hous­ing, insurance, transportation, ID, clothing, or adequate social support. He had been a janitor for 15 years on and off in between times he was in prison.

Mr. A reveals to the home health social worker that he missed his parole officer meeting and has a diagnosis of schizophrenia. He asks the social worker for help in changing his life circumstances. He tells his life story, leading to his present state, of getting caught in a cycle of committing crimes, using drugs, going to prison, and returning back to the same environment to repeat the cycle. One of the home health providers labels Mr. A as a “drug dealer” unlikely to change, and the hospitalist refuses to provide pain medication beyond the discharge prescription, requesting that the patient find a primary care physician.

**Learning Exercise**

1. How might the social worker intervene as a case advocate?
2. What might the social worker’s plan of care look like?
3. What programs, services, and benefits is the client eligible for and in need of advocacy for in terms of coordination and implementation?
4. What state and national policies relate to this case?
5. How might the social worker advocate changes in policy at the organizational level?

**POLICY ADVOCACY LEARNING CHALLENGE 8.4**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

Mrs. G is a 61-year-old LEP female patient hospitalized after fainting. She has high blood pressure, a family history of type 2 diabetes, and a history of high cholesterol; is overweight; and does not exercise. Her educational level is sixth grade. You are asked by the hospitalist (a physician who speaks only English) to identify a clinic that will accept Mrs. G’s new PPO insurance that she received after September 23, 1010 (the date when the Affordable Care Act required new insurance plans to provide free preventive services for all new plans), for primary care follow-up of her hypertension. Mrs. G is instructed by the hospitalist to start exercising and modify her diet to a low-sodium diet (1,200 mg or less). You are brought in right at the time she is being discharged. You ask whether she was screened for diabetes, and she replies that she was not. She cannot recall her cholesterol levels from a test when she was 40. She indicates she does not know what type of exercise or diet to follow.

**Learning Exercise**

1. If you worked in this hospital and wanted to be an advocate for diabetes screening for this patient before discharge, what conflicts might arise, and how might you best mitigate them?
2. What procedures or protocols at the organization level should be in place to pre­vent a patient with risk factors for diabetes from not receiving screening tests before discharge?
3. How might you as the social worker best coordinate the patient’s linkage to an outpatient physician and/or other services necessary to ensure that the patient has access to a physician in her community?
4. What policies or programs exist in the community you work in for older adults with diabetes or hypertension? How might you link an older LEP patient to such services?
5. How would you advocate policy change at the organizational level?

**POLICY ADVOCACY LEARNING CHALLENGE 8.5**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

An affluent couple, who resided in a rural area, ran into financial difficulties when they encountered health problems that meant they could not perform many daily activities. The female member of this couple (Mary) became, in effect, the head of household because her husband (John) had been severely handicapped by a stroke. They found a woman (Joan) who had cared for others who had become, in effect, the head of their home health team. While a caring person, Joan had only a high school diploma and was often remiss in keeping the house clean or helping Mary and John to clean themselves because they could not ascend steps to the second floor to a bathroom with a shower. Joan recruited other younger women who also had not progressed beyond high school. She frequently had to recruit new people, as the women tended to leave this job due to the treatment they received from Mary, who viewed them as intruders in her house. Joan screened applicants by placing a $10 bill on the floor near John’s bed. If they picked it up and did not give it to Joan, she did not hire them. Little did they know it was a fake $10 bill inscribed with “Take Jesus Into Your Everyday Life” on the side facing the floor. Almost bankrupted by the cost of this home health team, Mary had to endure the visit of a realtor to her home, organized by her children, to appraise its value in the event that she exhausted her savings and could not obtain Medicaid-financed home health services.

**Learning Exercise**

1. Millions of additional seniors will need home health teams in coming years. What does this situation tell us about the relative preparedness of the U.S. for this situation?
2. If a relatively affluent couple encountered this situation, what additional hardships would many less affluent couples encounter?
3. What macro policy initiatives might social workers consider in the state’s capitol to shape programs offered by the state’s Medicaid program?

**POLICY ADVOCACY LEARNING CHALLENGE 8.6**

**Connecting Micro, Mezzo, and Macro Policy Advocacy**

Anna Gorman contended in a *Los Angeles Times* article on September 5, 2011, that “ERs are becoming costly destinations for mentally disturbed patients: Budget cuts are creating added safety risks at hospitals and placing a burden on already crowded emer­gency rooms.” She noted that many hospitals discharge patients with unaddressed mental health disorders into local communities. (By contrast, hospitals in affluent areas often have psychiatric services available.) The outcome is that many mentally ill people are released homeless into communities without their mental health needs being addressed, posing a danger to themselves and the local community.

Imagine you are a social worker who works in the emergency room of the local hospital and there is no staff psychiatrist. Mr. S is a 70-year-old homeless male who is brought to the emergency room by a police officer after he threatened to harm a street vendor in the local community. The police officer reports that Mr. S displayed “bizarre behavior” and threatened to harm the officer as well. The patient presents in the emergency room with auditory hallucinations, is disheveled in appearance, and has poor hygiene. He is able to report his name, the date, and the city he is in (ori­ented times three). The attending physician requests a social work consultation. You identify a county hospital that can take this patient, because he cannot be admitted to this hospital. The patient has an identification card and no insurance. You find out that he has been homeless for over 15 years. The patient states he does not want to go to a shelter and denies that he needs help with his psychiatric symptoms.

**Learning Exercise**

1. How might this social worker intervene to provide case advocacy to address the mental health needs of this patient?
2. What policies and/or procedures/protocols exist in the agency you were in for intervening with homeless older adults with unaddressed mental health needs?
3. What programs and services (inpatient vs. outpatient) are available in the com­munity you work in that can take uninsured older adults?
4. What local, federal, or state policies can help inform policy changes at the organiza­tion to improve services to older adults with unaddressed mental health needs?

**POLICY ADVOCACY LEARNING CHALLENGE 8.7**

**Connecting Micro and Macro Policy Advocacy**

You are a home health social worker who is referred by the primary care physician for information on community resources for your 62-year-old single female patient, who has just undergone a mastectomy and will be receiving chemotherapy for three months. She was working full time up until the time of her surgery, and her doctor has informed her that she will be unable to work while she is receiving the chemo­therapy. She was working as an engineer at a large aerospace organization and has no children. She does not have affiliations with religious or social supports beyond her co-workers, as she reports she worked 60 hours per week. She was not seen by a social worker at the hospital and has no help coming into the home with the excep­tion of the nurse, physical therapist, and you, the social worker. She is now ambulat­ing with a walker due to postoperative weakness and having had a prolonged hospital stay of five weeks as she underwent testing, surgery, and postoperative complications. There was a delay in the home health referral, causing the social worker not to make the first home visit until two weeks after the patient was already discharged. She has been ordering cabs to get to her chemotherapy and reports she fell getting out of the cab coming into her home because the cab was too low. Now that she is home, she reports she can barely make it to the bathroom, she has diffi­culty preparing food and has a low appetite, and she cannot drive to run errands, go shopping, or make it to her chemotherapy and doctor’s appointments. She ran out of food yesterday and has prescriptions that needed to be picked up from the pharmacy.

**Learning Exercise**

1. How might the social worker intervene?
2. What home and community-based services might this patient need?
3. What programs are relevant for this patient?
4. What state or federal benefits might this patient be eligible for?
5. How would you advocate policy change at the hospital organization that dis­charged her without having her see a social worker?