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The Newsletter of the New York State Society for Clinical Social Work, Inc. • A Founding Member of the Clinical Social Work Federation

# New Training Program in Palliative and End-of-Life Care

*By Marsha Wineburgh, DSW and Helen Hinckley Krackow, CSW*

*L. to r., Training Program leader Hillel Bodek, MSW, CSW, BCD, Chair, Committee on Palliative and End-of-Life Care; Cynthia X. Pan, MD, Assistant Professor of Geriatrics & Adult Development and Director of Education, co-facilitator of Pain Management Training Module, Hertzberg Palliative Care Institute of the Mount Sinai School of Medicine; and participants Bobba Jean Moody, MSW, CSW, BCD; Marsha L. Wineburgh, DSW, CSW, BCD; and, Karen Wong, Pre-Medical Student, Fordham University.*

We were fortunate to participate in the "Comprehensive Training Program in Palliative and End-of-Life Care: Working with Chronically Ill and Terminally Ill Patients," sponsored by the Society's newest practice committee, the Committee on Palliative and End-of-Life Care. The six-session, 32-hour training course was presented by Hillel Bodek, MSW, Chairperson of the Committee, to 25 clinical social workers in fall 2002, and to 19 in winter 2003.

Palliative care is holistic care that is provided to patients with the purpose of helping alleviate the physical, emotional/mental, social and spiritual pain and suffering of those who are ill and of the significant others in their lives. It can be provided concurrently with health care directed at curing or ameliorating the patient's illness. End-of-life care is only a segment of palliative care. Patients can require and benefit from palliative care

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# HIPAA Hysteria And HIPAA Shared Panic Disorder: *Is There a Cure?*

*By Hillel Bodek, MSW, CSW, BCD*
*Chairperson, Committee on Ethics & Professional Standards*

## History of the Present Illness

On August 21, 1996, Congress passed the Health Insurance Portability and Accountability Act (Public Law 104-191), affectionately known as HIPAA. Its purpose was to improve the portability and continuity of health insurance coverage in group and individual markets; to combat waste, fraud and abuse in health insurance and health care delivery; to promote the use of medical savings accounts; to improve access to long-term care services coverage; and to simplify the administration of health insurance.

By enacting this legislation, Congress unwittingly set the stage for the largest pandemic of hysteria and shared panic

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## IN THIS ISSUE:

# President's Message

By Helen Hinckley Krackow, CSW, BCD, Society President

# Society Withdraws from CSWF

It is with great sadness and concern for our profession that I have to inform you that the New York State Society for Clinical Social Work State Board voted on March 22nd to withdraw from the Clinical Social Work Federation (CSWF) for the next fiscal year, July 1, 2003 through June 30, 2004.

This action was modified by the decision to pay our dues to the CSWF on a voluntary basis, quarter by quarter, for the above-mentioned fiscal year, as long as the Federation works on restructuring itself in a manner we can support.

We feel that the CSWF must become more democratic and build in some checks and balances to offset the current trend toward centralized power. At the same time, our Board wishes to preserve the CSWF, which our Society helped to found, as it is preferable to any other national organization representing clinical social work.

Changes need to be made so that the CSWF will be able to fulfill its mission, which includes national advocacy. Over the last few years, our State Board has become increasingly dissatisfied with the CSWF because of the lack of national lobbying, the handling of the relationship with Guild No. 49 and the health insurance debacle, and the centralization of power, which gives the New York State Society only one vote, although we represent a third of the total members in the Federation.

Our distress was already mounting when the flash point came earlier this year as the CSWF disregarded our wishes by marketing a HIPAA conference in New York that would have left our members out of compliance with New York State laws and privacy regulations.

We have made our voluntary dues payments dependent on the participation of David Phillips and Allen A. Du Mont on CSWF's Restructuring Committee.

We fervently hope that we will be able to continue as members of the CSWF. ■



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**DEADLINES:** January 10, April 5 and September 1

| AD SIZE | MEASUREMENTS | 1 TIME | 3 TIMES |
|---|---|---|---|
| 2/3 Page | 4 15/16" W x 10" H | $325 | $295 |
| 1/2 Page Vertical | 3 5/8" W x 10" H | $250 | $225 |
| 1/2 Page Horizontal | 7 1/2" W x 4 7/8" H | $250 | $225 |
| 1/3 Page (1 Col.) | 2 3/8" W x 10" H | $175 | $160 |
| 1/3 Page (Square) | 4 15/16" W x 4 7/8" H | $175 | $160 |
| 1/4 Page | 3 5/8" W x 4 7/8" H | $140 | $125 |
| 1/6 Page (1/2 Col.) | 2 3/8" W x 4 7/8" H | $ 95 | $85 |

Display ads must be camera ready. Classified: $1/word; min. $30 prepaid.

## VENDORSHIP REPRESENTATIVES

| | | |
|---|---|---|
| **BROOKLYN** | ALICE GARFINKEL | 718-352-0038 |
| **CAP DISTRICT** | ALICE GARFINKEL | 718-352-0038 |
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| **QUEENS** | SHIRLEY SILLEKENS | 718-527-7742 |
| **ROCKLAND** | BETH PAGANO | 914-353-2933 |
| **STATEN ISLAND** | COLLEEN DOWNES | 718-816-0712 |
| **SUFFOLK** | ELLIE PERLMAN | 631-368-9221 |
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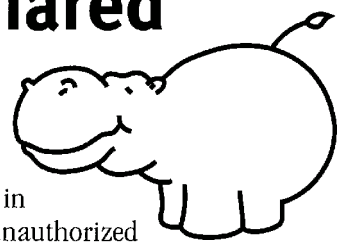
# HIPAA Hysteria and HIPAA Shared Panic Disorder: *Is There a Cure?*



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disorder in recorded history, a pandemic that would sweep rapidly through our nation's health care community.

When Congress failed to pass legislation establishing HIPAA privacy standards by August 21, 1999, as required by the HIPAA, the responsibility for the highly politically sensitive determination of the privacy standards was passed from the legislative to the executive branch of government. There this task fell to the Department of Health and Human Services (HHS).

In order to implement HIPAA, HHS has promulgated various regulations, the three most important of which are the Transactions Rule, the Privacy Rule and the Security Rule.

The **Transaction Rule** established a single national standard for certain electronic transactions involving patients' health care information and a single national standard set of codes to be used in encoding health care information for these transactions. The compliance date for health care providers who are covered entities to comply with the HIPAA Transaction Rule was October 16, 2002. However, providers who applied, prior to that date, for an extension were automatically granted a year's extension, until October 16, 2003.

**By the time you read this article, the second edition of the Society's HIPAA Compliance Manual will be sent to our listserv and will be on our website, www.clinicalsw.org. Over the next few months, a library of over 60 forms to facilitate HIPAA compliance will be added as well.**

**The Privacy Rule** sets standards to protect the confidentiality of protected health information by establishing regulations that: (1) govern the use and disclosure of confidential health information and (2) outline the rights patients have with regard to access to those records, the right to correct perceived errors in health care records maintained about them, and the right to an accounting of how the health care information about them has been used or disclosed. If you are a covered entity, compliance with the Privacy Rule was required by April 14, 2003.

**The Security Rule** sets standards to protect the confidentiality, integrity and availability of protected health care information stored in electronic form from unauthorized access, alteration, deletion or transmission by establishing administrative, physical, and technical safeguards. If you are a covered entity, the compliance date for the HIPAA Security Rule is April 20, 2005.

### Etiology of This Pandemic

Commencing in early 2002, health care practitioners became increasingly aware of HIPAA. As the year progressed and the October 16, 2002 compliance date for the Transaction Rule approached, a nationwide frenzy ensued as health care providers scurried to apply for extensions of the compliance date at the very last minute. Shortly thereafter, as word of the April 14, 2003 compliance deadline for the HIPAA Privacy Rule began to be publicized in earnest, HIPAA hysteria began to develop. This hysteria was fueled to some extent by a lack of accurate information.

A more significant etiological factor was the mad rush by many entrepreneurial individuals, companies and organizations that saw HIPAA and the confusion about it as a way to make money. For instance, health care providers were told that even if they were not required to comply with the Transaction Rule because they were not covered entities, they still had to comply with the Privacy Rule. Providers were urged to take HIPAA classes, go to HIPAA support groups, and to purchase HIPAA materials to assure that they would be compliant with these complicated government regulations (which, it was implied, they would not be able to understand on their own). Some were encouraged to purchase HIPAA compliant computers (not merely HIPAA compliant software).

What better vehicle than fear to generate business? Some individuals, companies and organizations stressed potential penalties for non-compliance with HIPAA, including prison and substantial fines–from which they would rescue health care providers.

Some professional organizations, wanting to impress their members with the perceived risks of non-compliance with HIPAA, gave erroneous information. One example is the false advice that even if you don't transmit health information electronically to a health plan, if you receive that information, such as a computer generated fax, you must be HIPAA compliant in any case. And, since you cannot know if a fax is trans-

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# Five New Diplomates Chosen

*By Adrienne Lampert, MSW, BCD, Membership Committee Chair*

*(L. to r) Michael DeSimone, Debbie Kaplan and Andrew Daly.*

Diplomate status was awarded to five outstanding members at the Annual Meeting in January. Nominated by their chapters, these awardees have consistently supported the principles of the Society, and have demonstrated a sustained commitment to our profession. Each has contributed time, energy and creativity on the chapter and/or state level. We applaud them all for their achievements.

**Andrew Daly** joined the Society in 1981, shortly after the founding of the Staten Island Chapter. His loyalty and support has been unswerving. Andy has attended and participated in more chapter activities than any other member. He became Chapter Legislative Chair in 1982, beginning the long, arduous campaign, with Marsha Wineburgh, State Legislative Chair, and others to consolidate and protect our professional status. Tirelessly meeting with local legislators, making innumerable phone calls on our behalf, he has rallied others to do the same. He was a leader in the "P" and "R" legislation and the licensing bill battles. Andy enlivens our chapter by being welcoming, encouraging and considerate. As he continues to grow, he shares with us as a teacher, peer supervisor, mentor, guide and anchor.

**Michael DeSimone** has consistently demonstrated a commitment to the practice of clinical social work. He has been a member of the Staten Island Chapter for over 20 years. When Mike originally joined, he was very active in the efforts of the Society to gain recognition for the profession. He supported the Legislative Committee in the fight for passage of vendorship legislation and played a vital role on the local level in our interface with legislators.

Mike was chair of the Education Committee for five years, during which time he was responsible for raising the caliber of this component of our monthly meetings. He instituted a yearly calendar and developed an educational brochure outlining the monthly presentations to be mailed to all members. He encouraged colleagues to present their own clinical work, invited senior clinicians from other chapters, and shared his own work. Attendance at our monthly meetings increased by over 25 percent because of these efforts.

Mike's concern for training is also evidenced by his work on the State level. He has presented at three annual conferences. A well-respected member of the Staten Island Chapter, Mike's gift to us is the pursuit of excellence in education.

**Don Goldberg** was on the Board of the Nassau Chapter for many years, working on developing membership, organizing educational events and volunteering to do whatever needed to be done. His interest in the Society, both on the State and Chapter level, has been tremendous. He has been challenging and thoughtful in his tireless dedication to the needs of the profession. Unfortunately, he has had to resign his presidency of the chapter due to poor health. He well deserves diplomate status.

**Sharon Greaney-Watt** is an intelligent, dedicated and skilled clinician. A member of the Suffolk Chapter, she has served as Secretary, Membership Chair, Member-at-Large, interim President, and Co-President, all with a high level of responsibility and creativity. Sharon has been more than willing to lend an extra hand to almost any endeavor, such as board meetings, planning for educational events and so on. Recently she put in many extra hours creating an e-mail list of our members. Sharon is a warm, sensitive and caring person, an invaluable member and leader. She is a true asset to the Society and to the field of social work.

**Debbie Kaplan** has been an exemplary leader of the Queens Chapter. She came forward at a low point in the chapter's history to give it new life. She is conscientious and thorough in all her endeavors. Her responsiveness to the interests, needs and concerns of members has set a new standard for Chapter Presidency. ■

# Vendorship & Managed Care

By Alice Garfinkel, ACSW/DCSW, Chair

The Vendorship & Managed Care Committee (VMCC) continues to function as a support for Society members in their dealings with managed care and third party payers. We assist members with difficulties in payment, non-payment or delayed payment of authorized sessions. We also help members obtain continued authorizations for patients, enroll or disenroll from panels, resolve dilemmas about confidentiality, and answer Medicare questions.

## OPENING NEW MARKETS: Self-Insured/Self-Funded Companies

The VMCC also markets to self-insured companies that do not recognize clinical social workers for independent reimbursement for mental health services. Our efforts continue to be successful: Daimler-Chrysler and Sun Chemical now have clinical social workers on their panels of mental health providers! We continue to market The Mark Hotels, Bedford School District, Nova Care, IIT Research Company and Chemed Corporation.

## Recent News

- A managed care list has been updated. Please contact your VMCC representative for more information.
- There are panels that attempt to contact providers and encourage them to join for a fee! Be very careful and cautious before paying money. Often, providers pay money with the hope of referrals and never get them.
- Oxford has done an extensive audit, basically to prove that therapists have had sessions. Hillel Bodek has been helpful to therapists in complying with the audit.
- Effective 10/01/02, the time limit to request a claim review for Medicare was reduced from six months to 120 days for claims finalized on or after 10/01/02.
- Providers must re-credential with Medicare if they have not submitted a claim for one year. The re-credentialing process has been taking 10-15 weeks due to backlog. To speed up the process, call 1-877-869-6504 and speak to a supervisor. Ask the supervisor to contact Mary Cook or Ronnie Houser in the enrollment area to have your application processed.■

## Medicare Clinical Social Worker 2003 Fee Schedule*

EFFECTIVE MARCH 1, 2003

| CODE | DESCRIPTION | LOCALITIES (see below) | | | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 |
| 90804AJ | Individual Psychotherapy (20-30 min.) | $56.91 | $54.87 | $49.93 | $54.15 |
| 90806AJ | Individual Psychotherapy (45-50 min.) | 84.82 | 81.81 | 74.64 | 80.75 |
| 90808AJ | Individual Psychotherapy (75-80 min.) | 126.57 | 122.22 | 111.43 | 120.62 |
| 90801AJ | Psychiatric Diagnostic Interview | 131.63 | 126.80 | 115.50 | 125.15 |
| 90846AJ | Family Psychotherapy (without pt) | 82.05 | 79.20 | 72.32 | 78.18 |
| 90847AJ | Family Psychotherapy (cojoint) | 100.31 | 96.80 | 88.31 | 95.55 |
| 90853AJ | Group Psychotherapy | 27.96 | 26.90 | 24.52 | 26.55 |

**LOCALITIES**

1. Manhattan
2. Brooklyn, Bronx, Westchester, Richmond, Rockland, Nassau and Suffolk Counties
3. Putman, Sullivan, Orange, Dutchess, Ulster, Columbia, Delaware and Greene Counties
4. Queens County

# Infant-Parent Psychotherapy

## *The Relevance for Psychoanalytic Practice and Thoughts About the Contributions of Clinical Social Work*

*By Miriam Pierce, CSW, BCD*

The model of psychoanalytically oriented infant-parent psychotherapy as an intervention was originally proposed in "Ghosts in the Nursery," by Fraiberg, Adelson, and Shapiro (1975). This seminal paper continues to be cited as the inspiration for the clinical work currently being done in infant observation and research.

In recent years, there has been a burgeoning of research in infant development. Attachment theory has been studied by psychoanalysts interested in understanding the potential for its application to clinical practice and research. Infant researchers Beebe, Stern, and Fonagy, to name just a few, have integrated psychoanalytic concepts with the findings of attachment theory. Environmental and socioeconomic concerns, as they impact on the infant's physical and psychological development, have been integrated into the thinking of infant researchers. Neuroscience has illuminated the development of the infant's brain. Shore directs our attention to the early months and the significance of the infant-mother interaction for right-side brain development in the first three months of life. As the brain continues to develop in subsequent months, the dyadic relationship is crucial for the infant's developing mind, a co-constructed endeavor. Ainsworth's "strange situation," based on attachment theory, is currently being applied to many different situations in the research of infant-parent relationships and child development.



Beebe, Lachmann, and Fonagy have applied the teachings of infant observation and research to adult treatment. Fonagy has developed the concept of reflective function and mentalization as deriving from the mother's ability to know her baby's mind as she interacts with, responds to, and makes meaning for her baby. Infant-parent psychotherapy, current theories of development, and the research of infant-parent dyads are now included in the curriculum of analytic institutes. I offer a brief review of the contributions to infant psychology.

Psychoanalytically-informed "baby watchers" such as Spitz, Winnicott, Bowlby, Mahler, Bergman, Emde, and Stern credit the psychoanalytic theories of Sigmund Freud, Anna Freud, Klein, and Bion with providing a window into the developing mind of the baby. Brazelton describes the newborn as "amazing." In The Motherhood Constellation, Stern offers a dynamic understanding of motherhood and a treatment approach that derives from it. Focus upon development has increased exponentially since the work of Spitz, Mahler and Fraiberg.

Little if any mention is made of the contributions of clinical casework, where Fraiberg and her colleagues began their infant research. Social casework classics, such as Richmond's Social Diagnosis (1944), Towle's Common Human Needs (1945), Perlman's casework approach in Family Diagnosis (1950s), and Fraiberg's Every Child's Birthright: In Defense of Mothering (1970s), enlighten us about the family and environmental influences that impact on the developing infant.

Towle writes, "The infant's security depends on being loved and cared for by adults so that the wish to be cared for and to care is a central issue in life." Towle's views are consistent with Fonagy's attention to the way in which the baby becomes known to the mother and the mother gives that knowing back to the baby — the beginning of the process of mentalization — and to Bowlby's theory of attachment as a human need, focusing on family patterns of attachment. Bowlby

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# Relational Social Work in Action

## *Student-Centered Video as an Innovative Learning Tool*

*By Lora Sasiela, C.S.W., B.C.D., Chair, Membership Committee, Metropolitan Chapter*

"What do I say to the client?" is the most commonly uttered question social work students ask their supervisors, teachers, and fellow students. How does the social work professional go about engaging a mandated client or one who is seeking help due to the pressure of loved ones?

Drs. Caroline Rosenthal Gelman and Carol Tosone at New York University Shirley M. Ehrenkranz School of Social Work have responded by collaborating with Lynne McVeigh, an Associate Professor at NYU Tisch School for the Arts to develop **Why Am I Here? Engaging the Reluctant Client**, a training video for beginning practitioners.

As members of the National Study Group, the "think-tank" of the National Membership Committee on Psychoanalysis (NMCOP) in Clinical Social Work, Professors Rosenthal Gelman and Tosone worked in concert with their fellow study group colleagues to develop innovative learning tools which convey the relevance and centrality of psychoanalytic principles as practiced in clinical social work. Conceived as part of the work of the National Study Group and funded through an NYU Project and Development Curricular Enrichment Grant, the video depicts reenactments of interviews based on actual student process recordings which have been disguised to insure student and client confidentiality.

One of the most powerful ways of training aspiring social workers, in addition to the experiential component of field work, is to expose them to realistic examples of interventions with clients. This video resonates with their core anxieties and experiences in conducting client interviews.

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The fact that the roles of clients and student clinicians are played by actual M.S.W. and Ph.D. students helps observing students to recognize the situations as familiar and to appreciate how much they have learned or need to learn about the clinical process. Students have the opportunity to witness first hand their worst interview nightmares from the safety of their classroom seat.

In the initial scenario, they can identify with a young first-year M.S.W. student who is conducting her first session with a middle-aged patient in the psychiatric inpatient unit. The patient is a woman who is reticent to provide any information and distrusts all mental health professionals. The next scenario involves an older second-year female student who is frantically attempting to engage an African-American adolescent male who was coerced into attend therapy by his guardian aunt.

Each clinical reenactment is followed by a supervisory session with Carol Tosone, Ph.D, a recipient of the New York University Distinguished Teaching Award and a Distinguished Scholar in the National Academy of Practice in Social Work in Washington, D.C. Professor Tosone also serves as the First Vice President for the State Society. Both Dr. Tosone and the student actors offer a viable model of clinical supervision. As observed by her colleagues, Dr. Tosone embodies the essence of good supervision: listening to her student, empathically responding, and teaching in an interactive manner that is at once deeply instructive and supportive.

Each student, in turn, approaches the supervisory experience in an open, receptive manner, one in which she feels comfortable exposing "mistakes," acknowledging biases about the client populations, and reflecting on her countertransference reactions.

Both the supervisory sessions and the reenactments of clinical interviews that precede them reflect the reciprocal nature of clinical social work practice and supervision. The client and clinician mutually influence one another in the therapeutic process, as does the clinician and supervisor in the supervisory experience. Drs. Tosone and Rosenthal Gelman's approach to the clinical encounter and supervision reflects a synthesis of the core principles of relational psychoanalysis and

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# HIPAA Hysteria and HIPAA Shared Panic Disorder

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mitted by a computer or by a regular fax machine, you must be HIPAA compliant.

A second example is informing providers that they had to be HIPAA compliant if they were going to submit claims to Medicare after October 16, 2003, because those claims would have to be submitted electronically. Still other professional organizations, wanting to assure that their members understood the need for HIPAA compliance, instilled fear by placing headlines in their newsletters such as, "HIPAA Compliance Deadline Looms, Criminal Sanctions for Non-Compliance."

Compounding the problem, many of the HIPAA manuals and training classes either fail to mention that HIPAA requires providers to follow state privacy laws if those laws provide greater privacy protections than HIPAA does, a requirement referred to as "preemption." Or they only mention that such requirement exists. Most of the manuals and training classes that mention the preemption requirement provide little or no guidance on state-specific preemption. This leaves providers with inadequate guidance on HIPAA compliance, especially in a state such as New York, where state law preempts HIPAA in a variety of situations.

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To be sure, there is no logical basis for this pandemic to have occurred, particularly in the mental health community, where the majority of practitioners do not engage in electronic billing. But, such is often the case where human reactions are founded on hysteria and panic and are, as a result, grossly out of proportion to the reality of the environmental stressor.

### The Extent of the Pandemic

The Society's Committee on Ethics and Professional Standards ordinarily receives approximately 500 inquiries each year relating to a variety of ethical and practice issues, about ten inquiries each week. In the 21-week period between Thanksgiving 2002 and the end of April 2003, the Committee received more than 1,200 phone and e-mail inquiries about HIPAA, approximately 60 each week. These came from Society members, from clinical social workers and health care providers from other disciplines, from agencies, from other Societies for Clinical Social Work and from New York and other states.

Even in early May, after the Society had sent out several clear advisories about HIPAA, when providers read a new warning or information, they were nonplussed. One e-mail that was widely circulated by a social worker who opposes HIPAA indicated, without giving the context of the ruling, that a Federal Appeals Court had ruled that the HIPAA Privacy Rule applies to both paper and electronic records. A number of providers erroneously interpreted this as requiring them to comply with the HIPAA Privacy Rules, even if they do not engage in electronic transmissions of health care information to health plans. This is one of many indicators that the level of confusion and anxiety that is still being experienced about HIPAA by various health care providers from all disciplines, throughout the country, remains significant.

### The Cure

Early in 2001, the Society decided to develop a HIPAA Compliance Manual for distribution, without charge, to clinical social workers. After the Privacy Rules were finalized in August 2002, we began the Herculean task of comparing the HIPAA Privacy Rules to New York law in order to identify areas where state law would preempt HIPAA. This analysis was undertaken by the Committee on Ethics and Professional Standards in conjunction with the Society's counsel. The result of this effort was the first edition of a manual that was distributed by e-mail to members on the Society's listserv in early April, followed by ten basic forms needed for HIPAA compliance (some of which are also useful for compliance with current New York law which preempts HIPAA). This material was also placed on the Society's website.

By the time you read this article, the second edition of the Society's HIPAA Compliance Manual will be sent to the Society's listserv and will be on our website, www.clinicalsw.org. Over the next few months, a comprehensive library of over 60 forms that will facilitate HIPAA compliance, as well as compliance with New York State privacy laws and regulations, will be added to the website and sent to those on the listserv. The second edition of the manual corrects two minor technical

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# Public Relations

By Sheila Peck, LCSW, Committee Chair

## *The Profession Needs You!*

Originally, when I formulated this report, I thought I'd tell you about our redesigned and ever-expanding Web site (clinicalsw.org). Just before I began, and with typical procrastination, I made myself a cup of tea and turned on CNN to watch the news. Casually sipping while trying to develop a catchy first sentence, I saw something that made me change my mind.

There was a segment about "compulsive shopping" and similar behaviors. A guest "expert" told the audience that with any such disorder, the first step toward effective treatment was to obtain a correct diagnosis. So far, no problem. Then, however, he recommended that in order to do so, "one should seek out the professional assistance of a "psychiatrist or psychologist."

We – members of the newly-licensed profession of clinical social work, were left out – again.

I immediately fired off an e-mail. It said, in part, "your guest omitted the largest segment of the mental health professional population – clinical social workers. Our profession provides more than 60% of mental health services nationwide. Furthermore, its clinicians are licensed to diagnose and treat in every state. Should a patient require medication, such professionals have physicians with whom they hold working relationships in order to make medication referrals."

I got back boilerplate e-mail, but that's okay. It's a response. Having contacted media on other occasions, I find that sometimes the results are surprisingly effective. I've received phone calls or e-mails in response, and recently one psychologist, Georgia Witkin, made an on-air correction.

It occurred to me that all of can us do this. We all watch television or listen to the radio or read the newspapers. We all hear such omissions on a variety of occasions. In these days of e-mail, we can easily make our voices heard. The media and the public need to be educated about who we – and our now-official profession – are.

There are more than 2,000 members of the State Society. If each of us, upon noticing such omissions, dashed off a quick e-mail or made a simple phone call, think of all the positive publicity we could generate. What a great public relations offensive! What a wonderful opportunity to educate the media and the public (and what terrific media exposure you'd receive)!

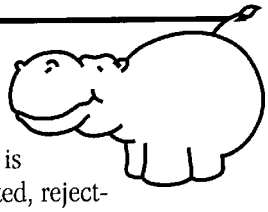
If we're proud of our profession, it's time to let everyone know about it. Let's not allow ourselves to be left out. We need your help to do this.

So, although we still urge you to visit it, I'll be delaying writing about our Web site until the next issue of *The Clinician*. I'll tell you more then.

If you contact media, please tell me. Send an e-mail to Sheila2688@aol.com ■



## HIPAA Hysteria and HIPAA Shared Panic Disorder



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errors in the first edition and adds material that will be helpful in dealing with some situations about which we have received inquiries. The Society hopes that providing accurate information in an easy-to-understand format can facilitate training about HIPAA and related New York State laws, as well as serve as an ongoing reference, and reduce the pandemic confusion, anxiety, hysteria and panic that have been unnecessarily generated about HIPAA.

### Palliative Care

Reduction in the discomfort many providers experience in relation to HIPAA can best be addressed by accurate information. The following are a few basic facts that one should keep in mind about HIPAA.

The most crucial fact, that is often erroneously ignored, doubted, rejected or misunderstood is that unless a provider is a covered entity, he or she is not required to be HIPAA complaint with any portions of HIPAA. For clinical social workers, a covered entity is a clinical social worker who:

(1) transmits health information (or has someone do so on his or her behalf, such as a billing service);

(2) electronically – that is by computer, a fax sent from a computer – [materials sent by traditional fax machine, through the telephone orally or by sending data by using the telephone's touch-tone keypad are not electronic transmissions];

CONTINUED ON PAGE 13

# Fantasy Death Exercise

By Sheila Felberbaum, CSW, APRN

*Sheila Felberbaum, CSW, APRN, has a private psychotherapy, consulting and supervision practice called "Healing Connections," which specializes in bereavement and the treatment of life challenging illnesses. She is the mental health consultant for the VNS Hospice of Suffolk and teaches Death and Dying at Nassau Community College.*



My recent teacher, Hillel Bodek, generously shared his expertise in his dynamic course on palliative and end of life care. Prior to our first class we were instructed to complete a "Fantasy Death" exercise. The instructions were as follows:

Consider for a moment the most wonderful death you can imagine for yourself, as though you were in a play. It doesn't have to be realistic; it can be quite fantastic. You might not have thought about this before. Give it your best shot. The only caveat: as in life, you must die. There is no way out.

Where are you?

Who is with you?

What are you doing?

Are you experiencing any physical or emotional symptoms?

How long have you known you are dying?

I responded: I am in my own home, my children, husband and closest female friends are present. The women have bathed me using essential oils that are relaxing and comforting. I am able to look outside to watch the trees, birds, sun, leaves or snow, depending on the season. I can hear the sounds of my grandchildren and, perhaps, great-grandchildren playing.

As my death becomes imminent, I hear the melodic strains of Rosa Mystica, a CD that I played for my mother when she was dying. I am enjoying the physical closeness and yet am also separated from everyone. I'm aware of observing the scene around me. There is a feeling of anticipation; any fear that might have been present is gone. It is very much like the experience I had of being in labor and knowing I was in "the home stretch."

My breathing is labored, my body is cold, but I have begun to feel light, without weight. I hear my mother's voice; she has been waiting a very long time for me to come. I have known that I was going to die all my life, but not in a real sense, until my mother died on January 28, 1999.

Working with patients and their families as they deal with end of life issues engenders a variety of affects in all who are involved – sadness, wonderment, laughter and tears – to name a few. Practitioners are not exempt or uninvolved in this life long process. Confronting their own mortality allows them to be more fully present with their patients, their own friends and family members during an incredibly rich moment in time.■

## New Training Program

CONTINUED FROM PAGE 1

even if they are not terminally ill.

The training consisted of presentation of the palliative and end-of-life curriculum developed by the Education for Physician's in End-of-Life Care [EPEC] project, as well as three training modules Hillel developed: (1) "Psychosocial Aspects of Chronic and Terminal Illness: Taking Care of Our Patients and Ourselves," a module that reviews the topic from the perspective of the patient/family as well as the health care providers; (2) "Teamwork and Interdisciplinary Collaborative Practice," and (3) "Grief, Loss and Bereavement," a primer.

The Society's training program is the widest presentation of the EPEC curriculum to groups of clinical social workers. The program was provided at cost primarily by Hillel, who volunteered his time. Cynthia Pan. M.D., Director of Education; Daniel Fischberg, M.D., Medical Director; and Liz Hurwitz, MSW, Bereavement Coordinator, all from Mount Sinai Hospital's Palliative Care Service, joined Hillel to co-present some of the training modules. In return, Hillel presented the module he developed on Teamwork to members of Mount Sinai's Palliative Care Service and the one on Psychosocial Aspects of Chronic and Terminal Illness at Mount Sinai's annual EPEC training for its Geriatric Medicine fellows. Bellevue Hospital Center generously donated the space for the second clinical social work training sessions.

The training program was very well received by the participants. We received such comments as: a wonderful program, invaluable; the best post-MSW training I ever had; comprehensive and inspiring, challenging, stimulating, thought-provoking; interactive, well-organized, focused; well-conceived with clear goals; rigorous, sensitive, and compassionate. Two-thirds of the participants indicated that the program exceeded their expectations.

Despite the length of the sessions and the significant

# Life and Death, A Labor of Love

*By Sheila Felberbaum, CSW, APRN*

My earliest memory concerning death is of my mother crying over the loss of her youngest sister. I didn't know my Aunt Dottie. It was my mother's anguish that swept me into her pain and, at the age of seven, I began to learn how to comfort others.

By the age of 20, I had graduated from nursing school and witnessed many deaths first hand – at the bedside, speaking to my patient one moment, and performing post mortem care an hour later; sudden deaths from car crashes; and slow deaths due to various medical conditions.

In those days, nurses were not encouraged to analyze what they were experiencing. A good nurse worked hard at not showing her feelings. I recall a young woman my age remarking after she asked me what I was studying, "RN, that means real nurse. You see people die and it doesn't even bother you."

Twenty three years later I earned my MSW, began analysis and subsequently attended the New York School for Psychoanalytic Psychotherapy and Psychoanalysis. My defensive walls were awash with years of tears. Psychotherapy with individuals who were facing their mortality remained a challenging, rewarding and spiritually fulfilling experience for me, as was long term, ongoing treatment with those who had not yet confronted death directly. I believed that I knew a great deal about dying, and yet my best teacher turned out to be my very first one, my mother.

After many months of chemotherapy and radiation treatments, my mother's lung cancer metastasized to her brain and she was no longer safe living alone. I spent the last five days of her life with her in an inpatient hospice in Florida. The staff supported me as well as my mom, allowing me to be her daughter, instead of her nurse.

My mom taught me not to be afraid of dying. Each night she raised her arms up and called out her mother's name; she was convinced her mother was waiting for her. My sister, Maralyn, and I heard and watched her labored breathing. Medication (Atavan) administered by the hospice nurses helped her to be more peaceful, but even so, mom needed to work hard to be able to leave this world. We were both at her bedside when she took her last breath and died.■



amount of information presented, Hillel, an experienced clinician-educator who has provided many educational programs for the Society and for other groups, was able to hold our attention throughout and impart a significant amount of clinical knowledge and skills. A number of participants have indicated they have already used in their practices the information and skills gained in the course. Some have noted that they have taught or will be teaching some of this material to colleagues at the agencies where they work.

With the increasing number of elderly and the strides in medical care that have allowed people to live with chronic illnesses for many years, palliative care and end-of-life care are becoming areas in which clinical social workers, both in agencies and in private practice, will increasingly be called upon to become involved. Clinical social workers will not only be working with chronically and terminally ill patients, but, also with the families and significant others of these patients, who struggle to care for and deal with their needs and their own responses to the patient's illness.

The Society hopes that Hillel will be able to present this program to members on Long Island, the Hudson Valley region, and the upstate region during the coming year. We hope to provide this program several times a year in the future to train clinical social workers in this increasingly important area of clinical practice.■

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might have benefited from Richmond's book, Social Diagnosis, when he was working with and studying the families of delinquent boys. The clinical applications of attachment theory took hold when Ainsworth's "strange situation" research offered predictability of secure and insecure patterns of attachment. The contribution of Main's adult attachment interview and the correlation to the infant's pattern is impressive, telling us that these patterns are learned. Beebe's face-to-face split screen research with four-month-old infants demonstrates this learning as the infant adapts to its mother's affective state. Towle wrote that love, care, and a chance to learn are the three sources of security that are essential needs for the infant's development. In Maturational Process and the Facilitating Environment, Winnicott describes the holding environment as "father, mother and infant all three living together. The term 'holding' is used here to denote not only the actual physical holding of the infant, but also the total environmental provision prior to the concept of living with."

When Stern writes about the significance of the grandmother's mothering of the mother who is mothering her infant, I connect to Fraiberg's book, Every Child's Birthright, in which she writes about a system of caring that is transgenerationally transmitted. The "ghost in the nursery" might be the uninvited guest, the unfriendly intruder who interferes with mother and infant establishment of the mother-infant bond that encourages security and growth-promoting development. Infant-parent psychotherapy, as a method of early intervention, offers treatment and prevention. The therapy might be supportive or educational and can, in addition, focus on unconscious fantasy, conflict, and unresolved trauma. It is a therapy that integrates environmental influences, psychoanalytic understanding, and concepts derived from infant observation and research. I will offer a short clinical vignette to demonstrate the treatment approach.



## Clinical Vignette

Ms. B. telephoned when her infant was one month old. She was referred to me by a friend. Ms. B. was quite distraught. Her son had a reflux condition and was vomiting frequently after feedings, which left her feeling inadequate and overwhelmed. There was no available family to turn to for help. She was born in another country and her husband's family lived out of state. There were medical mishaps in the course of her delivery that required uncomfortable medical procedures.

I decided to offer home visits to the parents that would include the baby, Ms. B., and her husband. The parents felt supported during these visits. I was able to observe this baby and his parents in their home environment, and particularly to observe him as he was being bottle-fed by both mother and father. He was a difficult baby to feed, calm, and comfort. As I joined with the parents in "the bond of not knowing," a concept derived by Hirsch, Pierce, and Smith (2002), we were able to make space and discover the ways in which this baby could communicate his needs; thus, the intensity of his distress diminished. The baby began to respond to the parents' ministrations, and they began to respond to his cues. With the improvement of the reflux condition, mother felt more effective and her survival fears and anxieties abated. By the time the baby was six months old, Ms. B. joined a mothers' group and entered individual therapy with me.

It was a while before I learned that this mother had been abused as a child. She felt safe enough to reveal the abuse only after her baby "survived" and was developing in a normal, healthy way. She felt she might have damaged him and feared she could do to him what had been done to her. She had been a protective, though anxious mother and now that the baby was developing well, she experienced rage when she encountered hostile rivalry with other members in the mothers' group. This sibling rivalry was the precipitant for the breakthrough of her traumatic history. I believe her murderous rage could only be revealed to me because she had experienced me as a benign, non-judgmental "grandmother" who could be her ally during the initial phase of motherhood. Stern describes this dynamic in The Motherhood Constellation.

In this abbreviated vignette I have attempted to demonstrate a treatment approach that includes support, education, and interpretation. Home visiting is a casework approach that has been incorporated into infant-parent psychotherapy. The Anna Freud Centre at the Hampstead Clinic and The Tavistock Centre in London include home visits as part of the treatment. Winnicott's concept of the holding environment and Bion's concept of the container function of the analyst are relevant and applicable here. Home visits can facilitate the holding and containment functions. Psychoanalysis is "talking" to other disciplines. Interaction between the disciplines has benefited and expanded our views and understanding. Social casework was an early contributor to work with the individual in the context of the family system. Infant-parent psychotherapy is a systems approach to treatment.■

*Miriam Pierce, CSW, BCD, is Program Chair for the NMCOP 2004 conference. She is Vice President of the New York School for Psychoanalytic Psychotherapy and Psychoanalysis and Chair of its Child and Adolescent Program. She is a member of the New York Freudian Society, where she graduated from its Infant Toddler Program and is currently a supervisor. Ms. Pierce is also a member of the Institute for Psychoanalytic Training and Research, and the International Psychoanalytical Association. She is in the private practice of psychoanalysis and psychotherapy with infants, toddlers, and their parents in New York City.*

## Relational Social Work in Action *Student-centered Video as Innovative Learning Tool*

CONTINUED FROM PAGE 7

clinical social work. They employ key concepts from relational psychoanalysis, such as a postmodern approach to issues of gender, class, and ethnicity, as well as the importance of the client's narrative, the two-person perspective, and the subjective nature of truth. They also artfully blend these concepts with the fundamental principles of social work practice, such as empathy, professional use of self, "starting where the client is," and respecting the client's right to self-determination. They effectively demonstrate through video illustration the similarities and compatibility of these models, as well as the centrality and import of relationships in all therapeutic work. Hence, Drs. Tosone and Rosenthal Gelman employ the term relational social work to describe their approach to clinical social work practice.

Why Am I Here? Engaging the Reluctant Client is envisioned as the first installment of a ten-part series entitled, The Relational Social Work Series. The Council on Social Work Education (CSWE), the national accrediting body for social work education, has recognized the value of such educational videos as effective teaching tools. CSWE has contracted with Professors Rosenthal Gelman, McVeigh, and Tosone to market and distribute the existing video, and to help them locate foundations and other sources of grant funding to develop future videos in the series. Planned for the series are subjects related to client populations such as the elderly, the severely and persistently mentally ill, substance abusers, and trauma survivors, as well as social work modalities such as group and family therapies, and topics such as the use of self-disclosure in treatment and phases of the clinical process.

### Training 4,000 Crisis Counselors Statewide

In addition to their ongoing project with CSWE, the three principal investigators have received a grant from Project Liberty Federal Emergency Management Agency to develop a training video for the New York State Crisis Counseling and Training Program. The video utilizes the same format of two clinical interview reenactments, each followed by supervisory sessions with Dr. Tosone. It will be used in the training of more than 4,000 Project Liberty Crisis Counselors statewide, and will also be available for national use in mental health disaster relief training. Both crisis counselors and M.S.W. students were used to play the roles of trauma victims and counselors, so it insures that the video provides accuracy, clinical sensitivity, and emotional relevance.

As an outgrowth of their fruitful collaboration and the intermingling of students from the Ehrenkranz School of Social Work and Tisch School of the Arts, Professors McVeigh, Rosenthal Gelman, and Tosone have received another NYU Project and Development Curricular Enrichment Grant to develop an inter-school production course for the design of community service media benefiting social work clients. Students from both schools will work side by side, learning the essential tools of the others' practice to enhance their own disciplines, and to develop psychoeducational and other community service videos to assist social work populations-at-risk.

The use of videos addresses a pressing need in social work education and practice; that is, how to demonstrate the significant contribution of psychoanalytic ideas to everyday clinical work, both for students and seasoned clinicians in agency-based practice. This medium can also be used to effectively communicate to other disciplines outside the field the response to the question "What do social workers do?" It shows in a direct way that "clinical social work works."■

## HIPAA Hysteria

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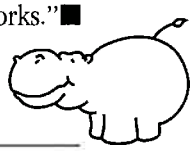

(3) in connection with a HIPAA covered transaction [transmission of information between two parties to carry out financial or administrative activities related to health care] which, in terms of transmissions by clinical social workers, means a transmission of health information from the clinical social worker (or someone acting on his or her behalf) to a health plan [a plan that provides, or pays the cost of, medical care - i.e., Medicare, a health insurance company, an HMO, etc].

Receiving electronic transmissions from a health plan does not make you a "covered entity," nor does a clinical social worker (or someone acting on his or her behalf) sending health care information electronically other than to a health plan. There is no basis for the erroneous belief that you have to be compliant with part of HIPAA (i.e., just the Privacy Regulations) even if you are not a covered entity. The bottom line is:

IF YOU ARE A COVERED ENTITY YOU ARE REQUIRED TO BE HIPAA COMPLIANT (with all of HIPAA's requirements as they apply to your practice).

IF YOU ARE NOT A COVERED ENTITY, YOU ARE NOT REQUIRED TO BE HIPAA COMPLIANT (with any of HIPAA's requirements).

With regard to fear of federal enforcement, the federal government has made it quite clear that its goal is to assist health care providers and others who must become HIPAA compliant to do the things needed to comply, not to penalize individual practitioners who are making a good faith effort to comply during the initial period of implementation of this new nationwide program. Also, criminal sanctions only apply in cases

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# HIPAA Hysteria

CONTINUED FROM PAGE 13

where persons knowingly violate patient privacy by improperly obtaining or disclosing protected health information, by improperly obtaining protected health information under "false pretenses," or by improperly obtaining or disclosing protected health information with the intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm.

If you are a covered entity, there is no cause for panic. Much of what the privacy regulations require, in substance, are things health care professionals in New York State, particularly mental health professionals, should have already been doing throughout their careers. The HIPPA regulations add some requirements, many of which are paperwork or administrative in nature, and some of which are substantive provisions that add confidentiality protections (i.e., providing special protections for psychotherapy session notes in addition to the general protection for health care records). Whereas compliance for hospitals, group practices, clinics, insurers, health care plans and healthcare organizations will be more burdensome, FOR INDIVIDUAL MENTAL HEALTH PRACTITIONERS WHO ARE COVERED ENTITIES COMPLIANCE SHOULD BE A RELATIVELY SIMPLE MATTER.

## Prognosis

Learning about HIPAA and becoming HIPAA compliant is relatively simple. But, like complying with any other new standard or legal mandate (such as learning a new treatment technique, or transitioning from the old DSM-II to the DSM-III), it takes time and effort to review and understand the pertinent background and context surrounding its passage, and then to become familiar with the methods, standards and steps to be taken to come into compliance. If you invest the time to read carefully the Society's HIPAA Compliance Manual and, in some instances, perhaps to re-read portions of it in order to prepare yourself to be HIPAA compliant or to address, in the future, certain HIPAA issues that may arise in your practice, you should be able to recover fully, without ongoing sequelae, from your exposure to or suffering from this disorder, without additional care and treatment.■

**For Information and to Prevent "Flare-Ups"**

**Public Health Prophylaxis:** If you have not yet done so, please provide your e-mail address to Sheila Peck (sheila2688@aol.com), the Director of our listserv, so that updates can be sent to you promptly about HIPAA and other information. Please be assured that the Society does not give out its e-mail list, and you can be on the listserv without having your e-mail published in the Society's membership directory.

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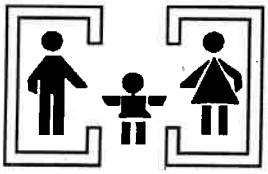

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