Our nation and our world will never be free of disasters. The United States was shaken again on October 29, 2012, by the powerful hurricane named Superstorm Sandy. According to the National Hurricane Center, this storm was the second-costliest U.S. hurricane since 1900; 24 states were affected, with severe damage particularly to New Jersey and New York. Federal Emergency Management Agency (FEMA) and government officials warn no matter how many programs they put in place, every institution, business, and household needs to be better prepared for disasters.

In this issue, authors Sedgwick and Siegel, who have firsthand experience with a major disaster, share their remarkable, thoughtful, and awe-inspiring account of how three hospitals and their social work staffs in New York City dealt with the aftermath of Superstorm Sandy. Their article, “New York City Hospital Social Workers Respond to Hurricane Sandy,” is a must-read for medical and mental health administrators and staff; it could be a springboard to fine-tune their own disaster preparedness.

This is an unusual Health newsletter in that it does not directly focus on day-to-day clinical services but on our preparedness. Another example is our treatment effectiveness when we feel we are working harder in our sessions than our clients. Authors Gombis and Gilliam offer a self-monitoring method, with specific steps, to guide the treatment process in a way that puts “the patient back in the driver seat.” They based their technique on neuroscience findings. The technique strives to foster the firing of our patients’ developing neuronal chains and to reinforce effectively positive neurotransmission (new learning) in therapy. Their article, “Neuroscience and The 49% Rule: How to Avoid Overworking the Therapist and Underworking the Patient,” offers their clear step-by-step method in a very readable style.

Social work in health care has become increasingly more complex—just as health care itself. Social workers incorporate the social, psychological, biological, and cultural (religious) beliefs of the patients and families into their treatment plans, which are often developed under limited time and resources. Creative program development and techniques, such as The 49% Rule, will augment our effectiveness.

Elizabeth H. Fung, PhD, ACSW
Chicago, Illinois
IT'S A FACT:
Although most research examining the effects of exposure, and harm are global phenomena.

Health Committee Members

Elizabeth H. Fung, PhD, ACSW, Chair
Wendy Auslander, PhD, LCSW
Shirley Otis-Green, MSW, LCSW, ACSW
Thomas W. Sedgwick, LCSW, ACSW, CCM
Kelly Ann Spangler, LCSW, MSW, MPA

In the book The Talent Code, author Daniel Coyle interviewed UCLA Professor of Neurology Dr. George Bartzokis. In the interview, Dr. Bartzokis described learning as a skill that boiled down to three simple facts:

1. **Inside the brain, every human movement, thought, or feeling is an electrical signal that moves through a chain of neurons;**
2. **Myelin is the cellular insulation that wraps the chain of neurons to increase strength, speed, and accuracy of that electrical signal;** and
3. **The more you fire the chain of neurons, the more myelin optimizes that circuit, making the electrical signal stronger, faster, and fluent** (Coyle, 2009, p.32).

The discovery that myelin wraps chains of neurons, thereby making the most used chains stronger, faster, and fluent, means that our patients can increase capability in any area by thinking, moving, or feeling more about that area.

As therapists, we may be taking on work that would be beneficial for our patients to handle. Whether it's learning to drive a car or learning to maintain a healthy weight, "every human movement, thought, or feeling" is part of a chain of neurons that can be automated when fired repeatedly. So, if our patients are more capable than we think—or than they let on—should that change how therapy is done? How well do we foster the firing of our patients' developing neuronal chains in therapy? And who is in the driver's seat? These questions led me to a strategy called The 49% Rule.

**NEUROSCIENCE AND THE 49% RULE: How to Avoid Overworking the Therapist and Underworking the Patient**

**STEPHAN GOMBIS, LCPC, MFMFT • DAWN GILLIAM, LCSW**

**SO, WHAT IS THE 49% RULE?**

**The Rule:** Regardless of the problems a patient faces, the therapist will not be in the driver's seat for them more than 49% of the time.

We may think we can do a better job than our patients of solving problems—and so may our patients. But solving problems for them prevents their neurons from firing. It tells them they can't do or be something they want, when really they just need more time in the driver's seat. Easy
of toxic exposure in children occurs in industrial countries, children’s risk,

enough, right? Even new therapists know not to jump in and directly fix a patient’s problem, but applying The 49% Rule can be tricky.

Here’s how to avoid missteps.

**STEP #1: IT’S REALLY A PRINCIPLE. THEY WORK; YOU GUIDE.**

It’s so critical, it bears repeating: no myelin grows if the patient isn’t thinking, feeling, and moving.

**STEP #2: BREAK IT DOWN.**

First, have patients identify an area of focus and then have them pick one simple action. How do you do this exactly?

- **Ask questions rather than give answers.** When we ask questions, we are helping to activate a patient’s mind. When we give answers, we activate our own minds. But sometimes we can feel like we’ve run out of questions to ask. So here are a few ways to keep them coming:
  - **Test your assumptions.** Ask your patient What, When, Where, Who, and How questions. **Note:** Avoid Why questions, which often create more assumptions than facts.
  - **Play dumb.** Ask the questions you think are SO simple you probably already know the answers. Your patient might surprise you.
  - **Be curious.** Imagine you’re an explorer and use your questions to discover new insights, different perspectives, and opposing views. Your genuine interest in who your patient is will make her or him more likely to fire those neurons.

**AN EXAMPLE OF STEP #2**

A patient recently decided to focus on weight loss as his desired outcome. He identified after-meal snacking as a barrier to his goal. So, we worked to isolate an action he could focus on for one week, and he decided to e-mail me if he ate anything between dinner and bedtime.

**STEP #3: WE LEARN BY FEEDBACK, SO CREATE FEEDBACK LOOPS.**

In the above example, the feedback loop was the e-mail to me; I have also used text messaging, posting on a blog, phone calls, and old-fashioned journaling. No matter what method you and your patient select, make sure that the simple action has a feedback loop between you and the patient so you can offer insight on whether the selected action works.

**STEP #4: MAKE SURE TO AVOID THE TWO BIGGEST TRAPS—DOING TOO LITTLE AND DOING TOO MUCH.**

I’ve seen two traps, missteps really, that can cause this process to break down. So, let’s look at each one.

**ASKING FOR TOO MUCH TOO SOON.**

Patients are often overwhelmed or inexperienced, so expecting them to go it alone is unrealistic. And if I had them attempt to take too much action before developing a process (a resourceful chain of myelinated neurons), then they would regress.

A slightly different way of doing too much too soon is when the patient wants to take on a complex action—say, working out four times a week—rather than a simple one—like just getting to the gym even if you only watch TV there.

The second action (just getting to the gym) seems less helpful to the patient, and so they avoid choosing this type of act as “too easy.” It is a mistake to think a small action is simple; after all, growing the myelin is what we’re after.

**NOT CHALLENGING PATIENTS TO DO ANYTHING.**

Patients come into therapy thinking their problems are too big and their ability to face them is too small. And if we never gave our patients the opportunities to challenge their own assumptions (by taking the lead themselves), then we would rob our patients of seeing their true capacity. By positioning them to take the lead with small steps that lead toward their goals, we’re helping them see what’s possible. And to me, this is what Dr. Bartzokis’s insight about firing chains of neurons is really all about. This process gives our patients hope. Now that we’ve covered the four steps of The 49% Rule, it’s time to head to the summary.

**The 49% Rule Summary:**

- **Step #1:** It’s really a principle. They work; you guide.
- **Step #2:** Break it down.
- **Step #3:** We learn by feedback, so create feedback loops.
- **Step #4:** Make sure to avoid the two biggest traps—doing too little and doing too much.

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**NASW Tools & Techniques**

**A Quick Guide for Front-Line Social Workers to the Upcoming Changes in Health Care Coverage Mandated by the ACA**

For more details visit: SocialWorkers.org/assets/secured/documents/practice/quickguidetotheaca.pdf
At the end of October 2012, Superstorm Sandy devastated the Northeast. The storm surge and ensuing flooding forced the unprecedented closing of four major medical centers—Bellevue Hospital Center (BHC), New York University Langone Medical Center (NYULMC), the Manhattan campus of the Veterans Administration New York Harbor Health System (VA), and Coney Island Hospital—as well as the closing of many skilled nursing facilities, assisted living facilities, and adult homes throughout the metropolitan area. Thousands of patients were displaced and thousands of health care workers redeployed (including hundreds of social workers). What follows is an account of how NYULMC, BHC, and Metropolitan Hospital Center (MHC) dealt with the storm’s aftermath.

**NYULMC**
The campuses of NYULMC and BHC adjoin New York’s East River, within a flood zone. Sandy’s storm surge drove a significant amount of saltwater into three of NYULMC’s hospital buildings. As much as 12 feet of water ruined state-of-the-art equipment, including MRI machines, the Gamma Knife, and the Linear Accelerator; research areas, lab animals, and specimens were destroyed. Communication and information technology infrastructure also sustained major damage, closing down the Web site and e-mail systems as well as all telecommunication on Monday night, October 29, as the storm made landfall. Overall damage estimates at NYULMC were as high as $1 billion.

**Social workers at NYULMC**
were very involved in the emergency preparation during the three days preceding the storm. NYULMC established its incident command system, tasking social work and care management with discharging as many patients as possible. Approximately 200 patients were discharged, leaving the hospital with about 325 patients who were either too critical to move or too stalwart to leave—an unfortunate mix of patients left to evacuate in the middle of a storm, and, regrettably, this is exactly what

**REFERENCE**
happened. NYULMC’s evacuated patients were discharged home or were transferred to other hospitals or nursing homes.

NYULMC’s communication systems stopped working at about 8 p.m. the night of the storm, leaving many unaware of what was happening at the hospital, especially those who lost power during the storm. NYULMC social work and care management staff has hospital-provided BlackBerries; while cell phone coverage was inconsistent, staff was able to keep in fairly good touch by texting.

Starting the day after the storm, social work staff was deployed as needed, assisting with the discharge of more than 300 psychiatric patients at BHC, going to NYU’s Hospital for Joint Disease to assist with discharges and to make room for other NYULMC patients, and doing tasks such as carrying oxygen tanks and supplies up many flights of stairs for patients who had been discharged home to the apartment complex (without electrical power) directly across the street from the hospital. These assignments were challenging for many staff, as transportation in much of New York City was limited for several days; it took quite a while for the bridges to Brooklyn and Queens to reopen, subway service was limited or cancelled on several lines, and the lower third of Manhattan was without electricity for almost a week.

In the immediate aftermath of the storm, NYULMC social work staffers were used at lobby information tables and emergency call centers. They also accompanied teams of physicians and patient advocates to other facilities to visit evacuated patients. Of the 325 patients evacuated, 84 percent were reached by telephone, 27 percent were visited, and 19 percent received a visit and a call. Social work staff expressed concern about NYULMC patients—what they went through during the evacuation and how they were coping in the aftermath.

NYULMC remained closed for two months following the storm, with social work staff redeployed to other hospitals to help with the overflow caused by the closing of NYULMC, BHC, the Manhattan VA, and Coney Island Hospital. The weeks following the storm were a time of uncertainty and many workers struggled with redeployment and different workflows and physical worksites. In addition, many social work staffers were personally affected by the storm; some of them did not have electricity, heat, or hot water for quite a while. Others had their apartments and homes damaged or destroyed by the storm; their ability to continue working while dealing with these personal challenges was remarkable.

NYULMC social work and care management leadership collaborated closely with their counterparts in these other hospitals to plan for a smooth transition and a quick orientation of staff. In an effort to provide ongoing support to staff working at other hospitals, the leadership team visited these employees at the other sites on a weekly basis and kept in daily telephone/e-mail contact. NYULMC also offered integrative health services (mindful meditation, yoga, massage, etc.) as well as peer support groups to help staff cope with these unprecedented conditions.

**BELLEVUE AND METROPOLITAN HOSPITAL CENTERS**

Next door to NYULMC is BHC, the country’s oldest public hospital and the flagship of the largest municipal hospital system in the United States. Initially able to weather the storm and care for patients in place, BHC eventually experienced flooding on its basement level, and the resulting damage to fuel and water pumps forced the hospital to evacuate the day after the storm. Many BHC patients—medical and psychiatric—were sent to MHC. Within a day or two of the evacuation, BHC staff was redeployed to MHC as well. Although there were no formal prepared plans for either of these processes, social work leadership at both BHC and MHC quickly adjusted and adapted. There were several lessons learned as patients and staff shifted from one hospital to another.

**FOR THE STAFF**

The challenge for social work leadership at MHC was to quickly develop a process for welcoming BHC staff into its culture, orienting them to core processes, deploying them based on expertise, and supervising and supporting them during the transition. Most of this process was conducted via cell phones.

The first group of BHC social work staffers—mostly a cohesive unit from BHC’s outpatient psychiatric clinic—was deployed to MHC on the Friday following the storm, and minimal notice was given to the respective social work directors. These BHC social workers and psychiatrists were oriented briefly to MHC’s systems, obtained access to the hospital’s electronic health records, and were introduced by a social work manager to the staff on
the unit where they were assigned. The redeployment process was finalized over a 10-day period, following the procedures above. BHC and MHC social work managers tried to acknowledge the stress and trauma BHC staff had experienced, such as walking up and down 15 flights of stairs in order to care for patients prior to their evacuation and being sent to work in a different hospital without familiar supervisory support and without a designated work space.

ISSUES TO RESOLVE
Existing BHC social work structure was integrated in the blended department whenever possible. This worked particularly well with the psychiatric programs transferred from BHC; a BHC inpatient psychiatry social work manager supervised the BHC staff placed at MHC. On the medicine side, staff reporting was integrated into the existing MHC structure.

Initially, areas that needed improvement were communication, coordination, and consistent command between the MHC and BHC social work leadership. For example, some confusion existed about whether BHC staff placed at MHC would work just with patients transferred from BHC or with all patients. Job assignments had to be determined—a situation that at times caused frustration for BHC staff. It was resolved when leadership of both departments focused on the common goal of meeting patients’ and hospital needs.

Unfortunately, something that should have been a positive step—the return of BHC staff to BHC—became an area of stress. Initially, insufficient notice was provided to allow for a well-organized process for backfilling at MHC for the work that the BHS staff had been doing. This led to insufficient time to “sign-out” patients to colleagues, especially around the Thanksgiving holiday. This challenge and others was met through close communication between the social work directors from each institution.

SUPPORTING STAFF AND FOSTERING INTEGRATION: INITIAL CHALLENGES AND STEPS TAKEN
In order to foster cohesion among the social work staff and to provide a positive environment for communication, BHC social work staff were given time to meet together to debrief; MHC social work managers joined several of these meetings, which helped to blend groups and enhanced the opportunity for the staff to learn from and support each other. During the first week of deployment of BHC social workers to MHC, BHC leadership went to MHC to connect with staff, to offer support, and to collaborate on a plan for moving forward.

HEALTH CARE SOCIAL WORK LEADERS RESPOND
Social workers in the New York metropolitan area are becoming increasingly familiar with having to respond quickly to natural and manufactured disasters, such as terrorist attacks (World Trade Center attacks in 1993 and 2001), hurricanes (2011 Hurricane Irene), and blackouts (2003). Much can be learned from our colleagues in Australia, who for decades have been instrumental in the response to terrorist attacks (2002 Bali bombing), cyclones (1974 Cyclone Tracey), tsunami (2004 Indian Ocean tsunami), and mass causality road/rail accidents (1977 Granville Sydney commuter train crash). In Australia’s disaster response, social workers have been relied upon for their advocacy skills, their ability to act as liaisons with government/nongovernment agencies, their propensity for community development, and their keen understanding of the needs of individuals and families impacted by social dislocation (Pickett, 2006).

As things began to return to normal at NYULMC and BHC, a panel discussion—“Health Care Social Workers Respond to Superstorm Sandy: Lessons Learned; A Call to Action”—was held on December 4, 2012, at New York’s Hospital for Special Surgery. The event was sponsored by the New York City Chapter of the National Association of Social Workers (NASW) in conjunction with the New York Metropolitan Chapter of the Society for Social Work Leadership in Health Care (SSWLHC).

This panel of health care social work leaders was convened and moderated by the SSWLHC president Carol Dejesus, LCSW, CCM. Each panelist discussed how the storm impacted his or her respective facilities; how social workers were deployed during the storm preparation, duration, and immediate aftermath; and how staff were deployed post-storm. The panel included Robin Blumenthal, LCSW, assistant director of social work and home care at Beth Israel Medical Center; Susan Conceicao, LCSW, director of psychosocial services for Metropolitan Jewish Health Systems; Tom Sedgwick, LCSW, CCM, director of social work at NYULMC; Ines Suarez, LCSW, director of social work at BHC; and Phyllis Eribaum-Zur, PhD, LCSW, director of Metropolitan Jewish Health System–Kittay House Hospice (representing Menorah Center for Rehabilitation).

Ms. Dejesus called “to action” the audience of about 50 health care social workers. It was nearly a standing-room-only crowd, evidence of the subject’s importance to the health care social work community. The group identified communication challenges during Superstorm Sandy and discussed ways that SSWLHC and NASW might collaborate in the future to facilitate better communication and support during a major crisis.

Madelyn Miller, LCSW, chair of New York City NASW’s Disaster Trauma Committee, reminded the group to be conscious of supporting self-care among health care social workers who help patients and families impacted by Sandy. Health care social workers affected by Sandy, either directly or through vicarious exposure, are at risk for experiencing “shared trauma” as they help their patients most harmed by the storm.

Through self-care and a chance to process the event, these workers also have the opportunity to experience posttraumatic growth (Phelps et al., 2009; Michalopoulos & Aparicio, 2012). Robert Schachter, executive director of New York City NASW, invited
the group to become more involved with NASW’s Disaster Trauma Committee.

The panel spoke about exploring whether opportunities exist for social work to be more involved with the New York City Department of Health Emergency Preparedness Coordinators group and with the City’s Office of Emergency Management, where the Greater New York Hospital Association and Health and Hospitals Corporation have representation. The group ended the evening by agreeing to form a subcommittee to further explore how the SSWLHC can respond to future disasters.

Thomas W. Sedgwick, MSSW, LCSW, ACSW, is the Director of Social Work at New York University Langone Medical Center in New York City. He can be contacted at Thomas.sedgwick@nyumc.org.

Richard A. Siegel, MSSW, LCSW, ACSW, is the Director of Social Work/Discharge Planning at Metropolitan Hospital Center in New York City. He can be contacted at Richard.Siegel@nychhc.org.

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NASW invites current social work practitioners to submit brief articles for our specialty practice publications. Topics must be relevant to one or more of the following specialized areas:

- Administration/Supervision
- Aging
- Alcohol, Tobacco, and Other Drugs
- Child Welfare
- Children, Adolescents, and Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social and Economic Justice & Peace
- Social Work and the Courts

For submission details and author guidelines, go to SocialWorkers.org/Sections. If you need more information, email sections@naswdc.org.

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Did You Know?

A person may choose to delegate end-of-life decisions, with or without an advance directive, depending on an individual’s capacity to do so.