Keeping Social Workers in Palliative Care: The Interdisciplinary Coleman Palliative Medicine Training Project

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“Inadequate numbers of palliative care specialists and too little palliative care knowledge among other clinicians who care for individuals with serious advanced illness, and

A fragmented care delivery system, spurred by perverse financial incentives, that contributes to the lack of service coordination” - (IOM, 2014)
Baseline data (N=21)

- Significant symptoms of PTSD in 1/3 of participants.
- 5-6 X national average
- PTSD was significantly associated with
  - Experiential Avoidance ($r_s=.62, p=.003$)
  - Believing one’s thoughts to be true ($r_s=.58, p=.006$).

One study reported that 39% of medical students felt unprepared to address patient/family issues related to dying, and

<18% of students & residents had participated in a formal EOL curriculum

-Sullivan, Lakoma, & Block SD, J Gen Intern Med, 2003

Institute on Medicine committee recommends that:

› educational institutions,
› professional societies,
› accrediting organizations, certifying bodies,
› health care delivery organizations, and medical centers

take measures to both increase the number of palliative care specialists and expand the knowledge base for all clinicians

- (IOM, 2014)
What is the situation of social workers, many of whom have received little specific education in their social work curricula on end-of-life care?

Some social workers now in the Coleman program were not able to take specialized courses in their graduate program, leaving them with only interest and on-the-job training opportunities.
Social work education in palliative care

- Social workers in medical facilities report inadequate training in end-of-life care, palliative care, and ethical dilemmas they regularly face. -Csikai & Bass, 2000; Christ & Sormanti, 1999

- Social workers overall have access to limited content on EOL care in social work education, if any. -Murty, Sanders, Stensland, 2015

- There has been even less available in terms of interdisciplinary education. . . .
What social work offers

 Psychosocial support to patients and their families
 Discharge planning that reflects the medical and psychosocial needs of patients and their families
 Bridges to improved collaborations across teams
 Skill in supporting interdisciplinary team members
What social work offers

- Users of palliative care have reported that social workers:
  - enhance the patient/family’s capacity to cope
  - help reduce social isolation,
  - increase support for loved ones,
  - minimize anxiety about practical problems and
  - support patient abilities to manage medical problems

- Agnew & Duffy, 2010; Beresford, 2007
What is the need?

- Families of patients seem to perceive the hospital social worker’s primary role as the practical aspects of care, such as:
  - discharge planning
  - coordinating services in the community
  - resolving financial problems

- Families may overlook social workers’ skill in addressing emotional problems
What is the need?

- Social work in palliative care is focused on identity losses and changes in expectation - Reith & Payne, 2009

- Social work is valued on interdisciplinary teams, but there has been role ambiguity and

- Lack of articulation of what social workers can do as well as permission to do it
Addressing the need for palliative care education and strengthening their role in care

The Coleman Palliative Medicine Training Program for Interdisciplinary Providers

- Co-directed by Sean O’Mahony MB BCh BAO, Rush University Medical Center & Stacie K. Levine, M.D., University of Chicago and program coordinator, Aliza Baron, A.M.
- Interdisciplinary faculty mentors and trainees: social workers, chaplains, advance practice nurses and physicians
Essentials for developing a regional program

- Administrative support, convinced of value
- Philanthropy, jump start with funding
- Local experts
- Knowledge of local climate/needs, how to obtain “buy-in,” ability to fluidly manage changing situations and respond to needs
Coleman Palliative Medicine Training Program Goals

- Improve the quality of and access to palliative care services for patients with cancer and other life threatening illnesses
- Train and build a supportive network of palliative care providers across Chicago and outlying areas; Social Work and Chaplaincy added for 2015-17
- Funding through the Coleman Foundation (two training cycles - three years)
- http://colemanpalliative.uchicago.edu
The Coleman Palliative Medicine Training Program

An educational initiative for physicians, nurses, social workers and chaplains across the Chicago area led by regional leaders in palliative care to improve the quality of and access to palliative care for patients with cancer and other life threatening illnesses.

- 2013-2017
- Supported by a grant from the Coleman Foundation

Meeting the Needs of Those with Serious Illness:
National Trends in Palliative Care and Business Plan Essentials

Resources for Hospital and Health Care Leadership
Interdisciplinary approach

- Training physicians, advance practice nurses, social workers and chaplains to grow the workforce in palliative medicine

- Involving all disciplines at a leadership, faculty, mentor, and fellowship level

- Looking at outcomes related to palliative care service utilization and patient satisfaction
Coleman Palliative Medicine Fellows represent 27 health systems across the Chicago region

Phase 1 (2013 - 2015)
35 Fellows:
- APNs (23)
- MDs (12)

Phase 2 (2015 – 2017)
29 Fellows:
- APNs (12)
- Social Workers (7)
- Chaplains (6)
- MDs (3)
- PA (1)
4.4% of patients admitted to an acute care hospital in the U.S. had a palliative medicine consultation in 2014 (range 0.3%-16.8%)

In 2012, 3.6% of patients had palliative medicine consultations

Source: National Palliative Care Registry sample of ~10% of US hospitals
<table>
<thead>
<tr>
<th>Provider</th>
<th>2012 FTEs Median (25 – 75%)</th>
<th>2014 FTEs Median (25 – 75 %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>0.9 (0 – 2.3)</td>
<td>1.1 (0.2 – 2.7)</td>
</tr>
<tr>
<td>Advanced nurse practitioner</td>
<td>1.0 (0.8 – 1.0)</td>
<td>1.0 (0.8 – 2.0)</td>
</tr>
<tr>
<td>Social worker</td>
<td>0.3 (0 – 0.5)</td>
<td>0.4 (0.1 – 1.0)</td>
</tr>
<tr>
<td>Chaplain</td>
<td>0 (0 – 0.5)</td>
<td>0 (0 – 0.5)</td>
</tr>
<tr>
<td>Other</td>
<td>0.2 (0 – 1.0)</td>
<td>0.2 (0 – 1.3)</td>
</tr>
<tr>
<td>Measure</td>
<td>2012 Median (25 – 75%)</td>
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<tr>
<td>Total inpatient visits</td>
<td>218 (30 – 969)</td>
<td>840 (320 – 4268)</td>
</tr>
<tr>
<td>Total inpatient visits per FTE</td>
<td>246 (117 – 440)</td>
<td>282 (145 – 522)</td>
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</table>
Proportion of Hospitals with Each Provider Type in the Palliative Care Program (N = 11)

- Physician: 83%
- Advanced nurse practitioner: 83%
- Social worker: 75%
- Chaplain: 42%

--- Interprofessional Teams ---

- At least 2 types of providers: 92%
- At least 3 types of providers: 75%
Palliative Care Consults as a Percent of Total Discharges

National: 4.4%
Coleman Fellowship Hospitals: 8.0%

Within the Coleman Fellowship Hospitals
Range: 1.0% - 24.4%

N = 9 hospitals reporting the number of palliative care consultations for 2014
Discharges to Hospice by Team Composition: Percent of hospital discharges to hospice versus in-hospital death

- With SW and APN both on team (n = 16,349)
- Without SW or APN on team (n = 10,830)

- With social worker on team (n = 17,353)
- Without social worker on team (n = 8,460)

- With SW and APN both on team (n = 16,349)
- Without SW or APN on team (n = 10,830)
Palliative Care Consults and End of Life Outcomes, 2013 - 2014, Rush University Medical Center

- Without Palliative Care Consult
  - Hospice: 97
  - In-Hospital Death: 332

- With Palliative Care Consult
  - Hospice: 280
  - In-Hospital Death: 160

23% discharged to hospice

64% discharged to hospice
2-Year Training Program Components

- Attend bi-annual live program workshops and 3 social work seminars/year
- Complete pre and post tests, surveys
- Complete 20 hours of self-directed, e-learning curriculum
- Submit *Intent to Change* contract describing a practice improvement project (PIP)
- Initiate and schedule monthly meetings with a program mentor
- Complete 40 hours of direct observation of designated mentor’s palliative care practice
- Collect baseline data for practice improvement projects
- Implement and evaluate practice improvement project
- Present project at Poster Walk
Practice improvement projects

- Focused, attainable, small project
- Initiated in response to a need
- Supported by institution & leadership
- Meaningful and measurable
- Resources & potential barriers identified
- Feasible, able to be adjusted if needed
- Project goals, actions plans, evaluation methods and timeline are set forth in an Intent to Change Contract

- Commitment!
<table>
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<th>Chaplain</th>
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<tr>
<td>Establish a palliative care survey to determine if patient’s primary caregiver(s)’ (identified by patient/family) needs were met while in the hospital</td>
<td>To assess needs for spiritual care in patients at a palliative care outpatient clinic and determine staffing to provide spiritual care to patients and families</td>
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<td>To develop a formalized bereavement program for families of La Rabida Children’s Hospital patients and staff</td>
<td>Develop and implement a teaching module on self-care for the ICU nursing staff to reduce job-related stress and build resiliency as they care for patients</td>
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<td>Comprehensively assess all patients diagnosed with stage 3 lung cancer for palliative care needs from a multidisciplinary perspective</td>
<td>Same project as social worker -team based collaborative project</td>
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<td>Improve palliative care for homeless patients with serious chronic illness by: conducting goals of care conversations and collecting Advance Directives</td>
<td>Increase patient access to spiritual care and care planning based upon their values, beliefs, and traditions for the patient’s future life following a diagnosis of serious disease or life threatening condition.</td>
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Social work mentors

- Represent academic medical centers, community-based hospitals, and hospices
- Variable practice settings – inpatient, clinic, home-based, SNF

Responsibilities

- One-on-one project consultation
- Direct observation of their practice
- Teach/facilitate at workshops
- Quarterly check-ins with program directors
- Supportive resource for Fellows’ hospital leadership
5 month delay in scheduling observations at one location due to hospital sensitivity to HIPAA regulations

One Fellow became pregnant with twins, chose to drop out of formal program, but continue attending workshops

One Fellow lost institutional support when key physician champion changed facilities

At one site, hospital legal department had concerns about data sharing—wanted a formal agreement.
Kirkpatrick learning evaluation model

- Assess learner’s reaction to educational experience. Is it positive?
  - Workshops/Conference evaluations
- Assess changes in attitudes, knowledge, and skills after new exposure
  - Changes from pre-test assessed at post test
- Assess application of learning and behavior changes in practice; and
  - Qualitative participant reports and other outcome data
- Assess results to trigger change at the levels of the learner and the organization
  - Hospital leadership engaged at all levels, separate conference held

-Model cited in Sanchez-Reilly & Ross, JPM, 2012
Social work embedded in interdisciplinary training approach

Able to both share expertise in large and small group sessions, and

Learn in 360 degree format

Intensive process leads to ongoing engagement, help with problem solving, network building