Advanced Palliative Hospice Social Worker – Certified
Examination Specifications[1]

a. Assessment and Reevaluation

A. Assessment
1. Use clinical interviewing and behavioral observation.
2. Use clinical knowledge of psychosocial dynamics to gather biopsychosocial history.
3. Administer validated assessment tools.
4. Interpret results from validated assessment tools.
5. Perform psychosocial assessment from a patient/family-centered care perspective.
6. Provide comprehensive psychosocial assessment for seriously ill patients which includes assessment of:
   a. Healthcare literacy
   b. Safety, abuse and neglect
   c. Socioeconomic status
   d. Veteran status and eligibility for benefits
   e. Spirituality
   f. Spiritual dynamics as they impact the illness or treatment
   g. Family functioning
   h. Cultural dynamics as they impact the illness or treatment
   i. Communication patterns and challenges
   j. Patient's understanding of illness and medical treatment plan
   k. Patient's decision-making capacity
   l. Patient's current and desired quality of life
   m. Patient's coping skills
   n. Suicide risk
   o. Appropriateness for palliative care referral
   p. Hospice eligibility
   q. Need for volunteer services
   r. Cognitive ability
   s. Mental health symptoms that impact functioning as related to coping with illness
7. Provide assessment of family/caregiver including assessment of:
   a. Family/caregiver coping
   b. Family/caregiver understanding of illness and medical treatment plan
   c. Quality of caregiving

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[1] This outline was developed based upon the results of a national survey of Hospice and Palliative Social Workers. The work was funded by the Gordon and Betty Moore Foundation and conducted by the University of Louisville. For further information contact Barbara Head, Principal Investigator. barbara.head@louisville.edu

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d. Family/caregiver cognitive ability

8. Identify support systems.
9. Identify barriers that may impede biopsychosocial symptom management.
10. Identify physical, behavioral, and emotional characteristics typical for the developmental stage.
11. Identify the strengths of the:
    a. Patient
    b. Family
    c. Caregivers
12. Integrate the diagnoses and treatment findings into psychosocial assessment.
13. Evaluate the psychosocial response to:
    a. Treatment
    b. Prognosis

B. Reevaluation

1. Provide ongoing assessment of patient/family/caregiver
    a. Communicate changes in assessment to team
    b. Document changes in assessment
    c. Update care plan in accordance with reevaluation of patient/family/caregiver
2. Assess hospice eligibility for recertification

b. Planning and Intervention

A. Planning

1. Use therapeutic techniques to help patients and families understand options and participate in healthcare decision-making.
2. Use assessment data to plan, coordinate, and follow-up with patient care.
3. Use problem-solving skills to assist patient/family/caregiver in setting goals.
4. Develop psychosocial, patient-centered plan of care.
5. Ensure continuity of care across practice settings working with changing medical teams.
6. Apply psychosocial theory to practice situations.
7. Integrate the findings and recommendations concerning diagnoses and treatment into a care plan.
8. Facilitate patient/family meetings for goal setting and care planning.
9. Establish measurable goals.

B. Intervention

1. Provide psychosocial interventions based on evidence-based practice and clinical assessments/diagnoses including:
    a. crisis intervention
    b. emotional support
    c. case management
    d. interventions that facilitate coping
    e. follow-up
    f. interventions that promote dignity
    g. non-pharmacological interventions to enhance quality of life
    h. activities that enhance the patient's desired quality of life

    i. legacy building and memory making
    j. funeral pre-planning
2. Refer to other services:
    a. community programs
    b. specialty services (e.g., chaplain, art therapy, massage therapy)
    c. volunteer services
3. Order and arrange for transportation, meals, medical supplies and/or equipment, etc.
4. Assure patient understanding of medical language.
5. Assist patient to navigate insurance, entitlement, and financial programs.
6. Facilitate completion of advance healthcare directives.
7. Assist with transfer, discharge, or other care transitions.
8. Address barriers and risk factors identified in assessment.
9. Facilitate communication among patient/family/caregivers and team members.
10. Advocate for patient-centered care within interdisciplinary team.
11. Facilitate processing and integration of information.
12. Provide individual and family counseling to:
    a. Assist the patient/family/caregiver to cope with suffering
    b. Help manage existential issues and find meaning
13. Collaborate with the care team in patient/family meetings.
14. Monitor patient progress according to measurable goals described in treatment and care plan.
15. Tailor information about treatment and side-effects to patients and families.
16. Support patient's transition and identification of the "new normal" after surviving serious illness.
17. Prepare patient/family/caregivers for discharge from hospice or palliative services.
18. Educate patient/family/caregivers regarding
    a. Disease trajectory
    b. Hospice benefits
    c. Reinforcement of education provided by medical/nursing staff about treatment and side effects.
    d. Advance healthcare directives
19. Modify interventions and plans based on:
    a. Patient age-specific needs and responses to treatment
    b. Changes in the patients' status
    c. Family dynamics
20. Identify ethical dilemmas in patient care and refer as appropriate.
21. Conduct visits to:
    a. Home
    b. Assisted-living facility
    c. Skilled nursing facility
    d. Hospital
    e. Outpatient facilities
22. Ensure plan of care is communicated clearly with patient/family/caregivers, staff, and supporting agencies.
23. Report suspected abuse and neglect as mandated by law.
24. Identify suspected intimate partner abuse cases and refer to appropriate resources.

c. Death, Grief, and Bereavement

A. Death Preparation and Death
1. Assess patient for preparatory grief
2. Assess family/caregiver for anticipatory grief
3. Support patient/family through preparatory grief process.
4. Support family/caregiver through anticipatory grief process
5. Support family and caregivers at time-of-death.
6. Provide patient/family/caregiver education about:
    a. Options for care of the body after death
    b. Signs and symptoms of impending death
7. Advocate for patient's after-death preferences (e.g., rituals, care of the body).
8. Identify and respect cultural and spiritual customs/practices related to death
9. Balance patient and family's preferences for place-of-death
10. Facilitate dignified death.

B. Grief and Bereavement (post-death)post-death)
1. Provide bereavement follow-up after death as determined by the social work assessment
2. Support family/caregivers through ambiguous and/or disenfranchised loss.
3. Provide family/caregiver education about healthy and unhealthy grief and bereavement
4. Assist with coping related to grief, loss and bereavement.
5. Apply grief and bereavement theories and best practices.
6. Assess family/caregiver for:
    a. Risk factors for complicated grief
    b. Ambiguous loss and disenfranchised grief
    c. Somatic and/or emotional manifestations of grief
7. Provide grief counseling
8. Screen and/or refer families for bereavement counseling.
9. Identify survivor benefits.
10. Identify and respect cultural and spiritual customs/practices related to grief and bereavement

d. Professionalism

A. Quality improvement
1. Use quality improvement process to identify improvement opportunities.
2. Participate in quality improvement activities.
3. Communicate social work assessments, goals, and plan of intervention with team and other staff to improve patient quality of care.

B. Collaboration
1. Serve as liaison to community health, welfare, and social agencies.

2. Cultivate and maintain community partnerships and relationships.
3. Collaborate with other professionals as part of interdisciplinary team.

C. Provide debriefings for end-of-life and death issues to physicians, residents, interns, nurses and other providers.

D. Personal/professional issues
1. Develop self-awareness and acknowledge signs of compassion fatigue, burnout, vicarious trauma, and moral distress.
2. Practice self-care.
3. Maintain professional boundaries.
4. Pursue ongoing professional development activities.
5. Identify ethical dilemmas and conflicts of interest.
6. Participate in activities that promote team wellness.
7. Develop cultural awareness in self and others.

E. Inform policy regarding social work best practices (e.g., caseload, patient volume)

F. Knowledge of laws, regulations, and standards
1. Maintain knowledge of state laws and regulations related to end-of-life care.
2. Ensure compliance with NASW standards and codes of ethics.
3. Identify and report abuse and neglect as mandated by law.
4. Adhere to requirements regarding confidentiality and release of information.

G. Provide training and education in hospice and palliative care at the organizational, local, state, or national level.
1. Train social work students, interns, and allied professions.
2. Educate team members about social work role.

H. Document ongoing patient/family/caregiver assessments, progress, and response to treatment.