Social Workers and Chaplains: Beyond Presence

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June 2022

GLAD YOU'RE HERE!

HOSPICE FUNDAMENTALS

Objectives

- Understand the current state of social work and spiritual care outcome measurement in hospice
- Identify barriers to quantifying the value of these clinicians in hospice
- Discuss existing and proposed regulations that effect social workers and spiritual care providers
- Identify ways to quantify these team members contribution to great clinical and financial outcomes
- Identify language that reflects professional intervention

What?

- Leaning into the non-nursing disciplines as professionals capable of evidence-based function

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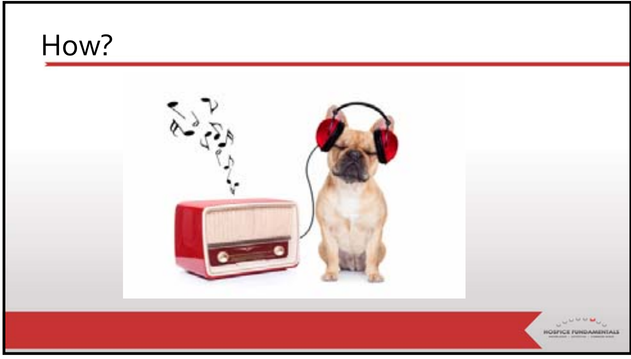
Why?

- All interdisciplinary team members can perform to a rigorous clinical standard and support one another and the patient and family
- Roles can be nebulous to nurse managers

When?

- Overdue!

How?



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Hospice Vignette

- Hospice social worker Douglas MacDonald wrote that he misses:

"the early days of hospice, when there was more time and fewer rules……..."

Times have changed

- The number of Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to over 1.5 million
- Medicare hospice expenditures have risen from $2.8 billion in FY 2000 to approximately $19 billion
- Fraud and abuse have muddied our reputation
- Technology is such that there is data everything we are doing, and even where our clinicians are at any given time

Times Have Changed

- Medicare and hospices now collect data on:
  - visits by discipline, location of care, length of visit, discharges and revocations, direct and indirect time, visits per week per clinician, visits per patient per week, cost per patient per day for everything, percentage of net patient revenue per cost area, burdensome transitions, unrelated costs, cost of care by day of care and level of care and location of care, discharge and revocation by length of stay
- AND these are juxtaposed with outcomes to assess value

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Value

- Meaningful outcomes: clinically, financially and experientially for the patient and family
- Delivery of the best outcome at the lowest cost
- Right care at the right time

Value

- Performance data on Hospice process is already available on line
- "Pay for Performance" incentives have already been successfully implemented by CMS in other settings
- The HOPE mandatory assessment ool for hospice is coming, standardizing metrics and allowing for the aggregation of outcomes nationally
- "The community loves us" is no longer the measurement of value for hospices
- "You are an angel" is no longer the metric for assessing the value of each discipline's contributions!

Value Metrics

- Patients Treated with an Opioid who are Given a Bowel Regimen
- Pain Screening
- Pain Assessment
- Dyspnea Screening
- Dyspnea Treatment
- Treatment Preferences
- Beliefs/Values Addressed (if desired by the patient)
- Hospice Visits when Death is Imminent
- Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission
- Hospice CAHPS Survey

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Tightening Our Belts

- Medicare has determined that hospices are making too much money, and has proposed rate cuts
- Medicare denies payment for services already rendered
- Medicare takes back money it has already paid
- “Virtually all” means “all, unless you can prove it isn’t”-but paying for too much can also be problematic
- All of the above are based on claims and medical record information
- Resource utilization is mentioned repeatedly in CMS communications
- Doing more with less can mean reduction in services and cuts to programming at some hospices

Vulnerabilities

- The employment of chaplains is not required by the COPs; 418.56 (a)(1) states that The interdisciplinary group must include a physician, a registered nurse, a social worker *and a pastoral* ***or other*** *counselor*
  - *418.64: there should be evidence in the clinical record that the hospice has offered and/or provided spiritual counseling……if a patient of family desires spiritual counseling, then the hospice should facilitate visits by local clergy, pastoral counselors or others to the best of its ability*
- In 2008, CMS allowed for the employment of BSWs or employees from a related field to serve in the social work function
- Med Pac on Hospice, March 2010, is now baked-in: *We do not have sufficient evidence to assess quality, as information on quality of care is very limited.* Quality information about social work and spiritual care is even more limited

Vulnerabilities

- Social Work and spiritual care have not robustly quantified their contribution to healthcare within a medical model
- Interventions and outcomes can be vague
  - 418.56c: reflect patient and family goals and interventions based on the problems identified in the….assessments
  - What criteria are used to assess the needs?
  - Evaluation if services are continuing to meet the needs
  - Are the outcomes documented and measurable?
- Social workers, chaplains state that they wish their role were better understood and that they were called upon more appropriately
- Established metrics are predominantly medical
- Variability in caseload models

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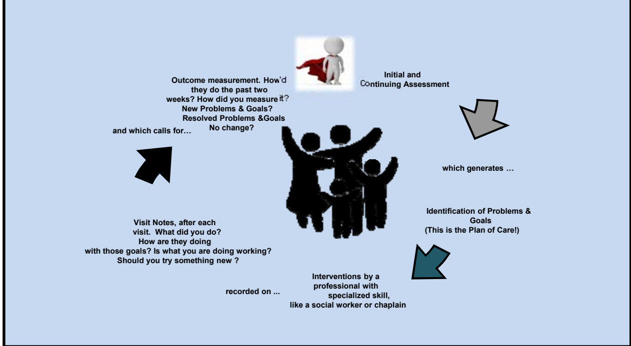
Care Planning: Problems, Interventions and Outcomes

- Get specific about issues like “Difficulty Coping” and “Spiritual Issues”
- Measure outcomes with validated tools or evidence based professional assessment
- Step right up into easily measurable outcome areas
- Support nursing within scope of practice

Care Planning

- Since the 2008 final rule, CMS has stressed that the intent of the plan of care requirements are to show a direct link between the needs identified in the comprehensive assessment and the plan of care developed by the hospice
- This means that anyone who visits a patient should be there for a reason, a reason related to a problem identified in the assessment of the patient and family



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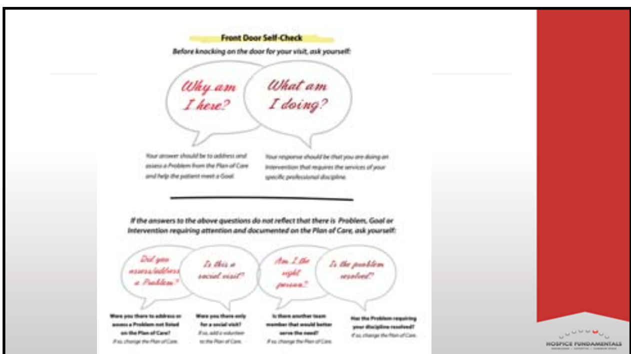
Pre-visit Check

- What am I doing here?
  - Addressing one of the problems or goals of care as identified by the patient and family
- What am I going to do while I am here?
  - Use my professional skills, to help the patient and family resolve the problem or meet their goal
- Is what I am doing helping?
  - I'll check, using a data collection tool
- If none of the above apply, this is a social visit

Wrong Answers

- I'm here because we get paid extra if I visit during the last seven days of life
- I am here because social workers are supposed to see each patient at least once a month
- I am here because this patient is on my caseload
- I am here because my supervisor said we have to be visible in facilities
- The family doesn't want a chaplain, but I have to get my assessment done within 5 days



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Social Work Interventions

- Screen for psychiatric illness
- Educate and assist with advance directives
- Provide education and manage expectations about care/benefit
- Ask for a pain, nausea and shortness of breath self-rating
- Recognize behaviors associated with these symptoms and document them/communicate with nurse
- Provide interactive and reflective listening
- Partialize, validate and prioritize concerns
- Assist with funeral planning
- Assist with resources and services (meals, benefits)
- Refer for legal and other guidance
- Facilitate transport
- Provide instruction in calming skills (breathing)
- Order DME

Rƒ¥¥x} v/Tsvt

https://hopkinspsychedelic.org/

Difficulty Coping

- As evidenced by:
- The professional intervention I am using to address this is:
- The desired outcome is:
- I will measure this by:

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Spirituality at the End of Life

- Patients and families voice a desire for basic spiritual care that includes active listening, empathic communicating and expressing compassion
- Sensitive and detailed spiritual assessment uncovers the spiritual and/or religious beliefs specific to the patient, and develops a strategy to address those in the plan of care
- Spiritual distress may occur in situations in which a patient is unable to ascribe meaning to an experience in a satisfying way
- Not just anyone can provide this

Spiritual Care Problems

- Anger
- Powerlessness
- Fear
- Meaning
- Ritual request
- Guilt
- Hope
- Acceptance
- Regret
- Final Arrangements

Spiritual Care Interventions

- Facilitate connection with clergy from faith tradition
- Exploration of spiritual beliefs
- Facilitation of meaning
- Open-ended questioning
- Reading from doctrine or other religious or spiritual publication
- Inquiry about beliefs and traditions
- Supporting and validating source of spiritual relief
- Memorial planning
- Obituary writing
- Joining patient and/or family in prayer
- Inquiry about important life events
- Advance Directives

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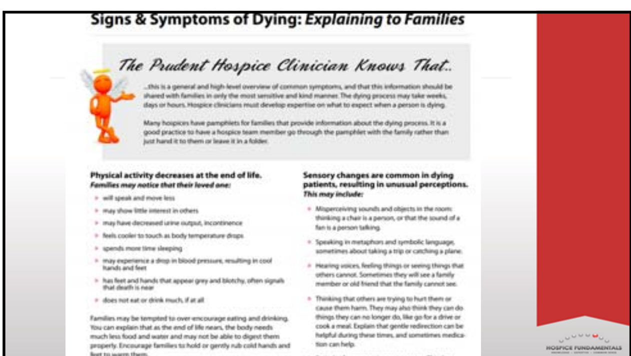

Signs & Symptoms of Dying: *Explaining to Families*

The Prudent Hospice Clinician Knows That..

...this is a general and high-level overview of common symptoms, and that this information should be shared with families in only the most sensitive and kind manner. The dying process may take weeks, days or hours. Hospice clinicians must develop expertise on what to expect when a person is dying.

Many hospices have pamphlets for families that provide information about the dying process. It is a good practice to have a hospice team member go through the pamphlet with the family rather than just hand it to them or leave it in a folder.

Physical activity decreases at the end of life.
Families may notice that their loved one:

- will speak and move less
- may show little interest in others
- may have decreased urine output, incontinence
- feels cooler to touch as body temperature drops
- spends more time sleeping
- may experience a drop in blood pressure, resulting in cool hands and feet
- has feet and hands that appear grey and blotchy, often signals that death is near
- does not eat or drink much, if at all

Families may be tempted to over-encourage eating and drinking. You can explain that as the end of life nears, the body needs much less food and water and may not be able to digest them properly. Encourage families to hold or gently rub cold hands and feet to warm them.

Sensory changes are common in dying patients, resulting in unusual perceptions.
This may include:

- Misperceiving sounds and objects in the room: thinking a chair is a person, or that the sound of a fan is a person talking.
- Speaking in metaphors and symbolic language, sometimes about taking a trip or catching a plane.
- Hearing voices, feeling things or seeing things that others cannot. Sometimes they will see a family member or old friend that the family cannot see.
- Thinking that others are trying to hurt them or cause them harm. They may also think they can do things they can no longer do, like go for a drive or cook a meal. Explain that gentle redirection can be helpful during these times, and sometimes medication can help.
- Periods of unresponsiveness or coma. This does

The Prudent Hospice Clinician Knows That...

the better he or she understands the hospice benefit and care delivery, the easier it is to speak with clarity and confidence to patients and families. Avoid using agency jargon and acronyms; the patient and family probably have no idea what a "team", IDT, GIP, "face-to-face", or "related" means until it is explained to them.

Want to know more? Medicare has a really nice pamphlet that explains this in more detail.
https://www.medicare.gov/Pubs/pdf/02154-medicare-hospice-benefits.pdf

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Measurement Tools for Chaplains and Social Workers

- Spiritual AIM, (Meaning and Direction, Self-Worth and Belonging to Community, and Reconciliation/to Love and Be Loved)
- Spiritual Distress Assessment Tool (Meaning, Transcendence, Values, and Psycho-Social Identity)
- iCARING Brief Assessment (Importance of spirituality/religion, Community, Assets, Resources, Influence, Needs, Goals (generalist)
- GAD 7 (Anxiety)
- Coping Self Efficacy (CSE)
- PHQ9: Depression

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Anger

- As evidenced by:
- The professional intervention I am using to address this is:
- The desired outcome is:
- I will measure this by:

Non-Pharmaceutical Pain Intervention

- Distraction
- Diversion
- Aroma
- Meditation
- Guided Imagery
- Gratitude therapy
- Spiritual readings/practices
- Simple massage
- Application of hot/cold
- Simple/mild exercise
- Emotional Interventions
- Active listening
- Journaling
- Hope instillation
- Hypnosis

Necessary but Not Sufficient

- Supportive presence
- Sensory stimulation
- Socialization
- Mental status (oriented x3)
- Opening mail, reading to patient, "life review" without documentation of a reason
- Review documentation with an eye for "Does this sound like the work of a specialized professional, or could a volunteer have written this?"

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The Bigger Picture

- Social workers can ask the patient and family at every visit about the "5 Ps":
  - Pain level
  - Product needs (briefs, other supplies)
  - Poop (last BM, changes)
  - Pill's (are there any running low?)
  - Have you seen any physicians or providers lately?
- These are common and avoidable reasons for after-hours "emergencies"
- Replies should be communicated to the appropriate team members

Productivity

- How big is a typical social worker or chaplain caseload?
- What is a caseload, anyway?
- What is the visit expectation each week?
- How are frequencies determined?

Doing the Math

- Census is the number of patients in a clinicians territory
- Caseload is the number of those patients engaged in interventions with the clinician
- Weight of the caseload is determined by frequency
- Visits per week per clinician is set by the agency; 20-25

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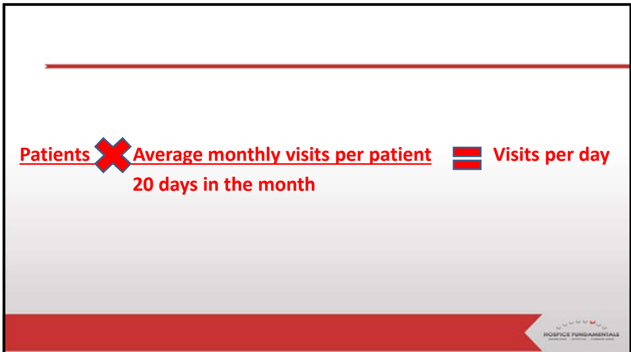
Doing the Math

- 20 days in a work month, 5 days in a week
- 45 minute visits

Chaplain:

- 45 patients in their territory, 20 are actively engaged with spiritual care
- Average visit frequency is 1 times a month
- This is a patient load that can be managed in 1 visit a day
- Change this patient load to 60, and it can be managed in 3 visits a day
- What is your agency's expectation each day/week for full time clinicians?



Doing the Math

Nurse:
12 patients x 8 visits a month each = 4.8 visits a day
20

Chaplain:
80 patients x 1 visit each month = 4 visits a day
20

Social Worker:
55 patients x 2 visits each month = 5.5 visits a day
20

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Variables

- Drive time
- Visit time
- Meeting time
- Admissions?
- Memorial services
- Weather

Myths/Excuses Impacting Productivity

- Every visit must take an hour
- Every patient must be seen at least monthly
- Every patient must see the chaplain at least once for an assessment
- I don't believe in rushing my patients
- It is rude to document at the point of care

Time Management and Caseloads

There is always discussion about how many patients should be in each staff members caseload. There is no universal magic number for caseloads; many things factor in.

As you manage your time, remember:

How many is too many?

Before you ask your supervisor for help because your caseload seems high, apply this formula to your work load:

In any given timeframe:
Active Patients x Frequency = Visits

A few examples:

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Established Metrics

- Treatment Preferences
- Beliefs/Values Addressed (if desired by the patient)
- Hospice Visits when Death is Imminent
- Hospice CAHPS Survey

Treatment Preferences

- Chaplains and social workers should be the agency experts on explaining and facilitating the execution of advance directives
  - State law
  - Various forms and options
  - Dissemination of the information
  - Involving the physician or RN
  - Family discussion

Beliefs/Values

- Train admission, nursing and home health aide personnel to ask about this when cued by family and patient behavior, and/or the absence of spiritual care involvement
- Ensure that your chaplains have a patient/family centered and driven approach to spiritual care delivery

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Hospice Visits When Death is Imminent

- Measurement is visits by an RN or SW on two of the last 3 days of life
- Discuss ways of providing this support in a manner that is meaningful to families
  - Established relationship is important
  - Specialized interventions
- Priming the expectation for this support in advance; "part of my role is to be here for you if you need it when….."

CAHPS

- 5: Help weekends evenings and holidays
- 9: Informed about patient's condition
- 11: Treated with dignity and respect
- 27: Help for feelings of anxiety or sadness
- 31: What to expect while patient is dying
- 35: Listening carefully
- 36: Support for religious beliefs
- 37: Emotional support
- 38: Emotional support after death

Actions of the Prudent Hospice™

- Review your social worker and chaplain documentation
  - Does assessment link to care planning, and are interventions linked to measurable outcomes?
  - Do interventions reflect the work of a specially trained professional?
- Run reports on visit frequency and average visits per week
  - Is frequency individualized or rote?
  - Are your social workers and chaplains busy?

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Actions of the Prudent Hospice™

- Review your hospices process for involving spiritual care
  - Is it automatic, or patient and family-centered (if desired!)
- Ask your teams about interdisciplinary functioning?
  - Is there good understanding of each team members role?
  - Are team members behaving in mutually supportive ways
- Educate
  - Advance directives
  - Documentation
  - Cross functional scope of work

Actions of the Prudent Hospice

- Subscribe to local and federal updates regarding innovations in social worker-supported pharmaceutical interventions to alleviate end-of-life suffering.

References

- MacDonald, D. (2001). Thank you, I'm sorry, and goodbye. *American Journal of Hospice and Palliative Care*, *18*(6), 417–419.
- Spiritual Care and Social Work: Integration into Practice at https://www.healthcarechaplaincy.org/docs/about/spiritual_care_and_social_work.pdf
- Five Steps to Proper Hospice Chaplain Documentation at https://hospicechaplaincy.com/2019/04/01/five-steps-to-proper-hospice-chaplain-documentation/

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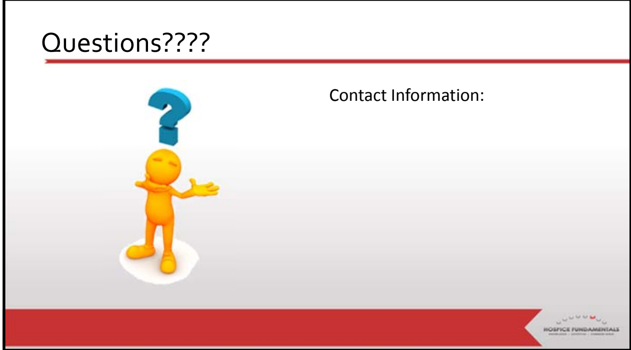
References

- 2020 Proposed Wage Index at https://www.federalregister.gov/documents/2019/04/25/2019-08143/medicare-program-fy-2020-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting
- Byock, I. (2022) Psychedelics for Serious Illness: Five Things Clinicians Need to Know at CAPC Clinical Care: https://www.capc.org/blog/psychedelics-for-serious-illness-five-things-clinicians-need-to-know/
- Parker, J. (2021) Psychedelics Could be the New Frontier in End-of-Life Care at Hospice News:
- https://hospicenews.com/2021/11/05/psychedelics-could-be-new-frontier-in-end-of-life-care/



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