National Hospice Social Work Survey

Summary of Final Results

Dona J. Reese, Ph.D., M.S.W., University of North Dakota, Principal Investigator

Mary Raymer, M.S.W., A.C.S.W., Chair, Social Work Section, Coinvestigator

Joan Richardson, M.S.W., L.C.S.W., Coinvestigator

March 2000
Dear Colleague,

I am enclosing a summary of the results of the National Hospice and Palliative Care Organization’s Social Work Research Project. I believe it will be of interest to your organization.

As we all continue to seek ways to improve hospice and palliative care in our country it is important to address all forms of pain and suffering. The psychosocial arena is an area where we have less hard data to document the benefits of competent clinical care. This study was in response to that lack of data. The results are intriguing particularly in the arenas of cost savings, pain control, client satisfaction and team functioning. You will be reading more about this study as we are currently in the process of writing several articles for publication, however, we thought a “sneak preview” would be warranted due to our mutual mission to raise the standards of palliative care.

Thank you for your continuing good work.

Sincerely,

Mary Raymer M.S.W, A.C.S.W.
NCHP Social Work Chair
National Hospice and Palliative Care Organization
PROBLEM

Hospice programs have encountered external challenges over the last few years. Reimbursement cuts, mergers, managed care, focused medical review and other external and internal factors have forced many hospices to examine their business practices even more closely. In an effort to maintain financial viability, some programs have tried to cut costs by reducing social work involvement on the interdisciplinary team. We believe this decision was compromising patient and family care, as well as costing hospices both financially and organizationally. The trends revealed by pre-existing studies suggested that consistent social work involvement produces improved financial, clinical, and organizational outcomes. Our project was designed to be broader in scope than these studies and to investigate the effect social work has on hospice outcomes.

PREVIOUS RESEARCH

Four recent studies have demonstrated that increased social work services in hospice and home health are related to reduced costs (Mahar, Eickman, & Fry, 1997; Paquette, 1997; Sherin, 1997, Silberstein, 1998). The effects on hospice outcomes included decreased hospitalizations, on-call visits, and nursing visits, with reduced hospice costs due to the reduced nursing hours. Effects also included lower costs for pain medications, lower use of IV’s, increase in physician and patient satisfaction, higher quality of life for patients, and decrease in staff turnover due to greater job satisfaction for both nursing and social work. Home health effects from increased social work involvement included reduced length of stay, reduced visits made by the agency as a whole, and better nurse job satisfaction.

NATIONAL HOSPICE SOCIAL WORK SURVEY RESULTS

The National Hospice Organization selected a stratified random sample of the NHO membership, with 76 hospices responding, and a sample of 347 patient cases. The study included two phases: a cross-sectional survey of hospices, and a longitudinal bereavement evaluation study. Within each hospice, the director and a social worker each completed a questionnaire, and the social worker assigned to the case completed a chart review form for each of the five most recently discharged cases. For the bereavement followup study, the bereavement coordinator filled out a questionnaire, along with a chart review form for each of the cases selected for the original study. Information was collected about social work services and hospice outcomes. Measures were selected from the literature or developed by the researchers with input from expert social workers in the field.
PERCENT OF SOCIAL WORKERS PROVIDING INPUT TO THE TEAM RE:

- Psychosocial issues: 100%
- Emotional support/counseling other team members: 100%
- Advocacy for self-determination: 92.8%
- Cultural diversity issues: 83.2%
- Systems perspective: 73.6%
- Spiritual issues: 69.2%
- Other input: 76%

SOCIAL WORK ASSESSMENT OF TEAM FUNCTIONING

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>DMA</th>
<th>AMD</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff morale is good</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team communicates effectively</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team is supportive of each other</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All disciplines are valued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>There is trust on the team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Team members’ expertise is fully utilized</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>All members have input</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team has good conflict resolution strategies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

SD = Strongly disagree, D = Disagree, DMA = Disagree more than agree, AMD = Agree more than disagree, A = Agree, SA = Strongly agree

CONFLICTS THAT SOCIAL WORKERS HELPED THE TEAM TO RESOLVE

- Differences in professional boundaries: 76%
- Differences in approach to self-determination: 71.2%
- Turf issues: 62%
- Lack of knowledge of the expertise of other disciplines: 49.5%
- Differences in the use of the biomedical model: 45.2%
- Differences in professional ethics: 42.3%
- Differences in theoretical perspectives: 39.9%
- Differences in perspective on confidentiality: 38.5%
- Differences in interventions used: 38%
- Differences in approach to diversity issues: 35.6%
- Differences in status: 27.9%
- Other: 31.3%
SOCIAL WORK EDUCATION ROLE

Volunteer training  90.9%
Public education     88%
Outreach to the medical community  69.2%
Outreach to the AIDS community  35.6%
Outreach to the minority community  26.4%
Other        55.3%

BEREAVEMENT FOLLOWUP RESULTS

35 hospices replied to the bereavement followup survey
questionnaires returned regarding 167 patient cases

The primary caregiver’s bereavement risk was significantly lower at the one year followup
than at the time of the patient’s death:

Mean pretest bereavement risk:    9.36
Mean posttest bereavement risk:  8.57

    t = 2.121, df = 92, Sig = .037

SUMMARY OF PATH MODEL

Overall hospice costs

1. If the social worker participates in the intake interview, there are lower overall hospice
costs (B = -.108).

2. If the social worker has more experience since his/her social work degree, there are lower
overall hospice costs (B = -.082).

3. If labor costs are higher, there are higher overall hospice costs (B = .998).

4. If team functioning is better, there are lower overall hospice costs (B = -.091).

5. If the average pain cost per patient is higher, there are lower overall hospice costs
(B = -.123).

6. If client satisfaction is higher, there are lower overall hospice costs (B = -.189).
Nights of Continuous Care

1. If the social worker has a position in addition to the social work position, there are more nights of continuous care (B = 1.260).

2. If the social worker has more experience since his/her social work degree, there are fewer nights of continuous care (B = -.004).

Average cost per patient

1. If the social worker has more experience since his/her social work degree, there is a lower average cost per patient (B = -.375).

2. If team functioning is better, there is a lower average cost per patient (B = -.229).

Labor costs

If team functioning is better, there are lower labor costs (B = -.332).

Average pain cost per patient

1. If there are higher labor costs, there is a lower average pain cost per patient (B = -.478).

2. If there is better team functioning, there is a lower average pain cost per patient (B = -.327).

3. If there is a higher beginning salary for MSW’s, there is a lower average pain cost per patient (B = -.497).

Client Satisfaction

If there is a higher beginning salary for MSW’s, there is higher client satisfaction (B = .279).

Nights in Inpatient Care

If there is a higher ratio of social workers to patients, there are fewer nights in inpatient care (B = -9.918).
NATIONAL HOSPICE SOCIAL WORK SURVEY
EFFECTS OF SW SERVICES ON HOSPICE OUTCOMES
Path Analysis Using Multiple Regression

B = -.108

Whether SW Participates in Intake

Whether SW Has Additional Duties

Social Work Experience

Nights of Continuous Care
B = 1.260*
B = -.004*

B = .200
SW to Pt Ratio

B = .082

Team Functioning
B = -.332

B = -.375

Average Cost Per Patient
B = -.292

B = .200

Labor Costs
B = .998
B = -.091

B = -.327

B = -.478

Beginning Salary for an MSW
B = -.497

Average Pain Cost Per Patient
B = -.123

B = .279

Client Satisfaction
B = -.189

B = -.300

Nights in Inpatient Care
B = -.918*

* Results of logistic regression
PRACTICE AND POLICY IMPLICATIONS

All the various disciplines are crucial to creating and maintaining sound palliative care. Unfortunately, social work has been slow to empirically measure its contribution to hospice and palliative care. Patients, their families, hospice programs and the social work profession have suffered the consequence of this oversight. While there is limited research in this area, there is a consistency in the findings of this particular study and the pre-existing literature. Enough of a consensus exists to comfortably offer the following conclusions for hospice policy and practice.

Hospice programs will benefit by hiring the best qualified and most experienced social workers available. While this will cost more initially, a truly seasoned clinical social worker will positively impact cost savings and quality of care.

Skilled social workers need to interview potential social work applicants for hospice programs. Historically in hospice, non-social work disciplines have hired social workers. This poses problems unless the interviewer is intimately aware of the variety in social work education and/or the various skills to expect and explore.

Social work caseloads need to be reasonable and at a level which ensures that social work visits can be made on a consistent basis with all families in hospice care. Programs need a sufficient number of full-time social workers dedicated to patient care only and not wearing too many different hats in the organization.

Social work is not a “crisis or as needed only” service. Regular and consistent social work intervention reduces crisis and facilitates smoother team function.

Initial assessments done jointly by social workers and nurses yield on-going dividends. Joint visits present hospice as a team from the very start of service and allows for smoother teamwork internally. Productivity for both disciplines is enhanced.

Seven days a week, twenty-four hour availability of social work is crucial. Psychosocial needs are frequent triggers for hospitalization or other inpatient stays. Expert psychosocial interventions will insure that all other options are explored. Frequently anxiety management is the true need during after hours calls.

Appropriate clinical supervision is essential for social workers. Like any other profession, social workers require supervision by seasoned social work practitioners to continue to grow into high quality skilled professionals.
REFERENCES

Previous Studies


Measures


AUTHORS’ ACKNOWLEDGEMENT

The authors would like to thank the hospice directors and social workers who kindly participated in this study. We would also like to thank Mary-Ann Sontag for her participation in planning the study, data collection, data entry, and provision of the Team Functioning Scale. We would like to thank the expert social workers, nurses and directors who provided input and advice. Finally, we would like to thank the National Hospice Organization and Hospice of the Florida Suncoast for their generous support of the study.