Making the Case for Social Workers as Integral Members of the Home-Based Palliative Care Team

Stephanie DePiano, MSW, LCSW, ACHP-SW
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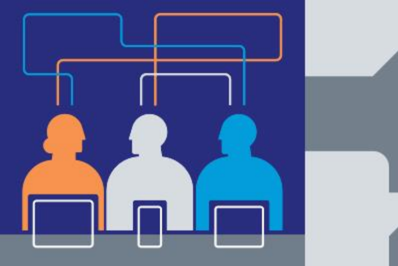
June 13, 2017



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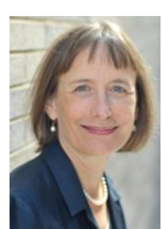
2017 SEMINAR THEMES

- Program design for all care settings
- High-functioning teams
- Health equity in palliative care
- Quality measurement

HIGHLIGHTS

- Interactive sessions on cutting edge topics
- Networking events to connect and share ideas
- Office Hours with Seminar faculty for deep dive Q&A
- Poster session and reception

KEYNOTE LINEUP



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Objectives

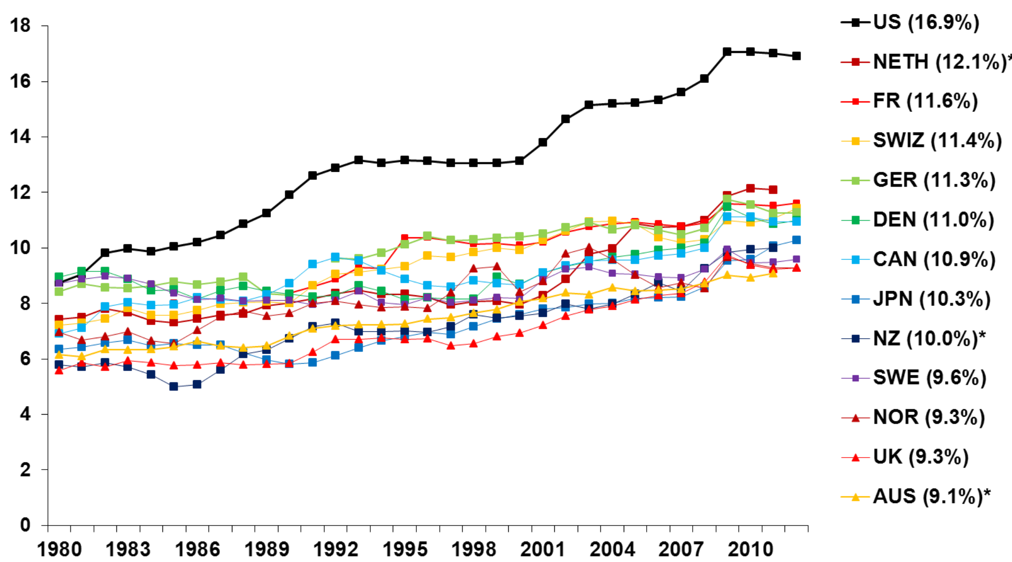
- Define the role of the social worker on the home-based palliative care team
- Understand the value-add of social work in health reform
- Review Hackensack Meridian's home-based palliative care program and the function of social workers on the team
- Identify barriers to social workers' leadership and empower social workers to overcome them

Health Care Reform

- Payment models are changing toward value-based care
  - Moving away from FFS model
  - Population health, bundles, shared risk
- Palliative care programs fit firmly in these new models

The Cost of Health Care

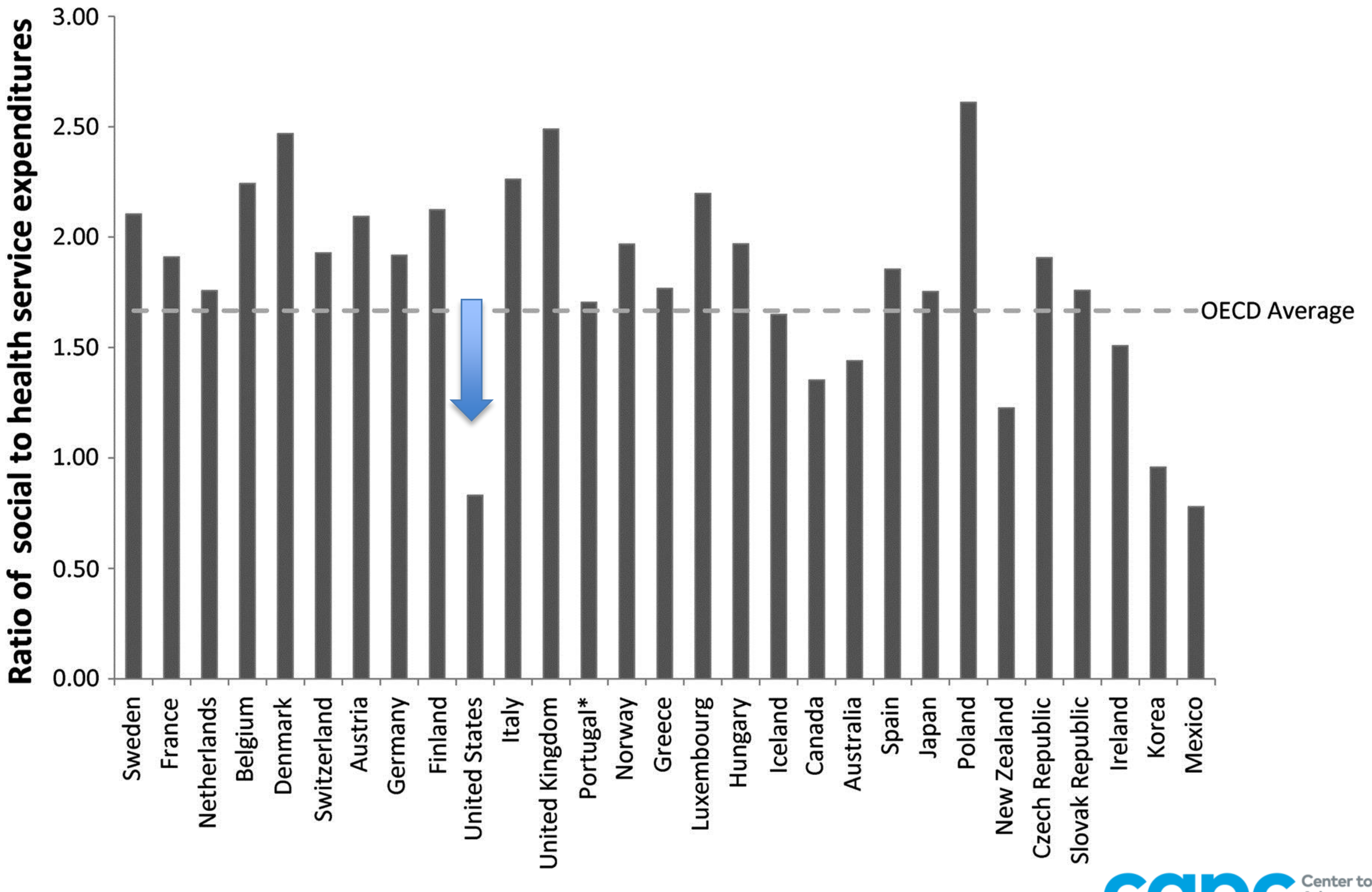
- Health Care Expenditures (2012)
  - 16.9% of GDP
  - $8,745 per capita
    - 2.5 times more than OECD average of $3,484



OECD Health Data 2014 http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT

Low Ratio of Social to Health Service Expenditures in U.S.

for Organization for Economic Co-operation and Development (OECD) countries, 2005.



Bradley E H et al. BMJ Qual Saf 2011;20:826-831

capc Center to Advance Palliative Care

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Social Workers Add Value

- How do we prevent needless ED visits and re-admissions?
  - Must adequately address social determinants to impact health outcomes
  - Must define goals of care
  - Must provide patients and families with emotional support and resources

The Most Comprehensive and Integrated Health Network in New Jersey

Hackensack Meridian *Health* Overview

Licensed Acute Beds
4,024

Hospitals
2 Academic
9 Community
2 Children's

Team Members
27,986

Home Care
Over 19,000 visits annually

Acute Admissions
153,185

Physicians
6,006

ER Visits
568,431

Medical Residents
503

Fitness Members
30,000

Rehab
16 Facilities

Net Revenue
$4.1B

Palliative Care Service

Navigational Key

Discharges and Transitions of Care

Quality Initiatives

Palliative Care Database

- Continuous reporting analysis
- Performance improvement
- Standardization of assessments and care
- Initial, follow-up, psychosocial, spiritual, and family conferences

Home-Based Program

- Serious Chronic or Advanced Illness
- Interventions: symptom management, ACP, psychosocial and spiritual support
- Team approach: NP, RN, SW, Chaplain, MD oversight
- Seen across continuum (home, ALF, SAR, etc.)

Inpatient

- Any of MH's 5 Acute Care Hospitals
- Physician Order
- IDT Team: MD, NP, SW, Chaplain
- Daily care until discharge or transition

Skilled Nursing Facility

- Any of MH's 5 SNFs and 1 ALF
- Physician Order
- IDT Team: NP, SW, Chaplain, MD oversight
- Consultative service

Outpatient Practice

- Various locations "without walls" (e.g., CHF and cancer clinics)
- No referral required
- MD, NP, SW, Chaplain

Home-Based Program

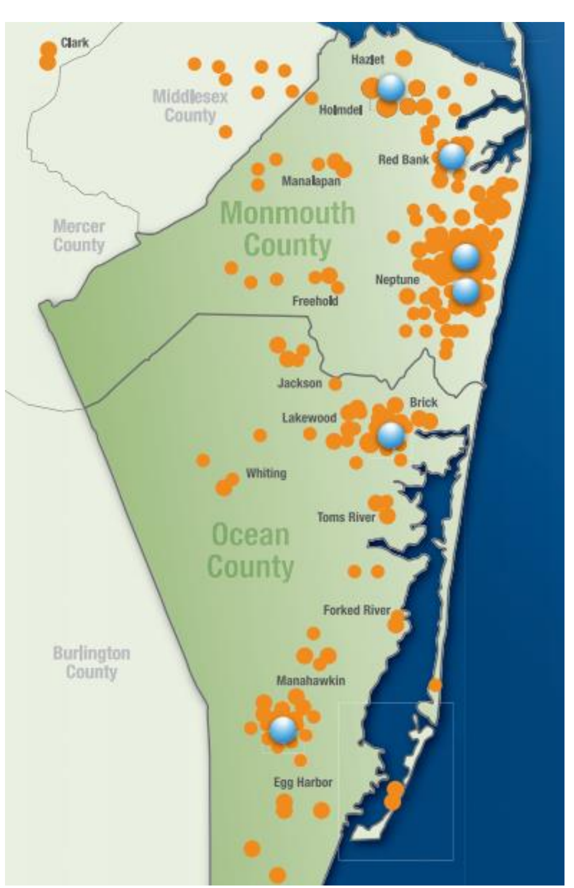
2012 to 2016

Meridian Care Journey

- A Medicare Demonstration Project set out to:
  - Improve quality of life of patients and families facing serious illness
  - Provide patients and families with education and emotional support needed to make informed decisions relative to end of life care
- Followed patients across care continuum
- Developed a program that is reproducible

Setting & Demographics

- Integrated health system in central NJ
- Monmouth and Ocean counties
  - Suburban
  - High percentage of elderly population
  - Socioeconomic diversity
- Patients followed at home
  - Independent residence
  - Assisted living
  - Long-term care facility



Enrollment Criteria

- Medicare Part A and B (without Managed Care)
- Age 65 or older
- Not on Hospice
- Discharged from one of three Meridian legacy hospitals with MS-DRGs representing seven specific disease states
  - Cancer, heart failure, COPD, dementia, stroke, end-stage renal disease, end-stage liver disease
  - Patients stratified to three levels by acuity to determine interventions

Interdisciplinary Palliative Care Team

- Began July 1, 2012
  - 2 APNs
  - 1 RN
  - 1 LCSW
  - MD oversight

- Staffing grew to
  - 3 APNs
  - 6 RNs
  - 5 social workers
  - 1 chaplain
  - MD oversight

Interventions

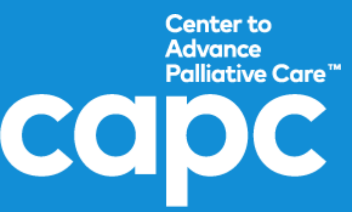
Touch	Total 48 Months	Touches by Provider	Total 48 Months	% by Provider
Touch Calls	37234	CC	15510	21%
		NP	8575	23%
		SW	**12743**	**34%**
Face-to-Face Visits	35683	CC	13261	37%
		NP	8585	24%
		SW	**13383**	**38%**
Additional Calls & Tasks	25318	CC	13599	58%
		NP	5175	21%
		SW	**4475**	**20%**

Meridian Care Journey Case Assignment

- Over the 4 years, nearly **3,700** patients were enrolled
  - 1,889 active patients at our highest point
- Social workers became lead case managers for **1/3** of patients
  - Empowered social workers
  - Even playing field
  - Social work skills identified as equally important as those of nursing
- Unique and valued aspect of the program

New Home-Based Program

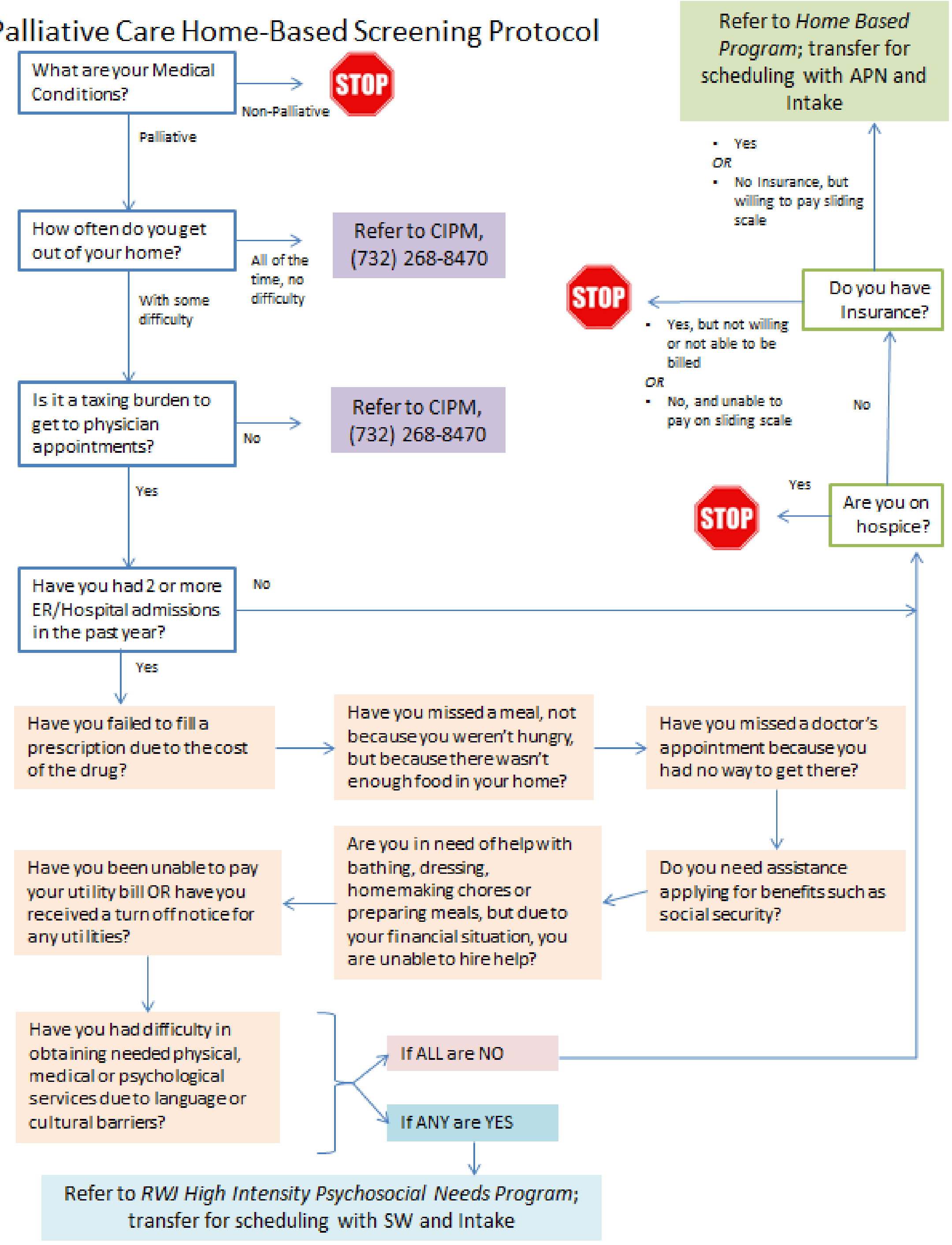
2017



Our Current Home-Based Palliative Care Program

- Two-pronged
  - Fee-for-service
    - 2 APNs, 2 SW, 1 chaplain
  - Robert Wood Johnson Foundation high intensity social work program
    - 2 RNs, 4 SW, 1 chaplain

Enrollment Criteria & Screening Protocol



Program differentiation

HbPC

- APN for medical management
- Billing for APN visits
- Billing for LCSW Psychotherapy
- APN visits ~1 / month (but as needed based off of APN clinical judgment)
- # SW visits/interventions determined by SW
- Co-management model

Both

- Palliative care diagnosis
- Taxing effort to get out of the home
- Social worker services including:
  - Psychotherapy
  - Applications (Medicaid, JACC, RX, etc.)
  - ACP
  - Emotional support to patients and caregivers
  - Chaplain PRN

RWJ

- High utilization (≥2 ED/inpatient admissions during past year)
- No billing
- RN for medical management
- Social work services at **high intensity** (multiple visits a month, going to Medicaid office attend outreach appointments etc.)
- Minimum 3 SW interventions monthly
- Minimum 1 RN visit monthly
- Recommendation based model (recommendations made to physicians)

Robert Wood Johnson Foundation Grant Enrollees

- High health care utilization
- High social need
  - Food instability
  - Home care
  - Insurance
  - Medications
- Minimum of three social work interventions monthly

Interventions – 1st Quarter

	Face-to-Face Visits	Phone Interventions	Total	% by FTE
HbPC				
APN	457	149	**606**	61%
RN		112	**112**	11%
SW	293	257	**550**	**28%**
RWJ Foundation				
RN	186	104	**290**	45%
SW	249	446	**695**	**55%**
Total				
APN	457	149	**606**	37%
RN	186	216	**402**	25%
SW	542	703	**1245**	**38%**

Social Work Palliative Care Role

The Social Work Role in Palliative Care

- Addressing concrete needs
  - Basic functional needs
  - Food instability
  - Medication assistance
  - Transportation
  - Utility assistance
  - Housing

The Social Work Role in Palliative Care

- Examples of concrete needs
  - Medicaid
  - NJ JACC and Statewide Respite
  - Medication (PAAD and RX assistance programs)
  - Utility assistance program
  - MOW and meal delivery services
  - Needed DME and skilled nursing
  - Transition patients to hospice
  - Transition patients to alternate levels of care- ALF, LTC

The Social Work Role in Palliative Care

- Addressing emotional needs
  - Adjustment to disease process and life changes
  - Physical limitations
  - Intimacy issues
  - Change of life roles
  - Loss of identity
  - Speaking with children about their ill parents
  - Anticipatory grief
  - Adjustment to illness & limitations
  - End of life counseling

The Social Work Role in Palliative Care

- Psychotherapy
  - Cognitive behavioral therapy
  - Meaning-centered
  - Solution-focused
  - Mindfulness
- Ability to generate revenue

The Social Work Role in Palliative Care

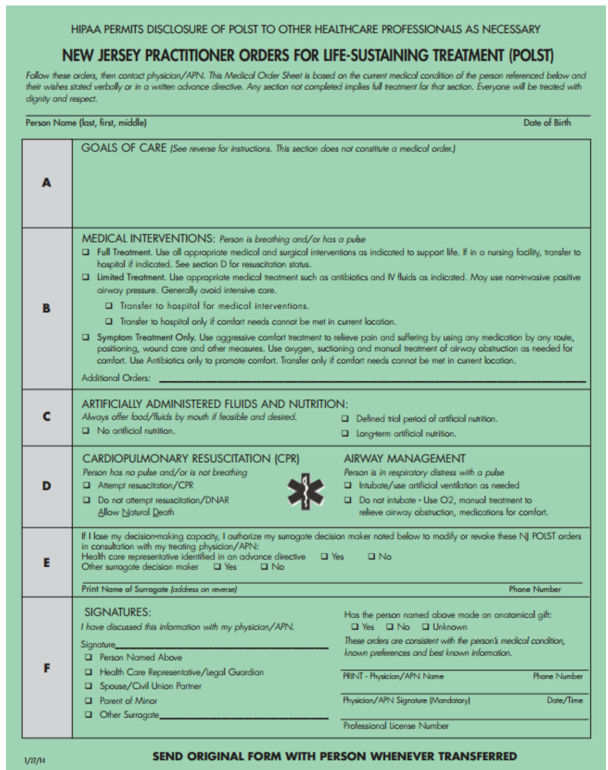
- Identify caregiver stress
  - Educate on self care
  - Brainstorm avenues for support
  - Facilitate a monthly dementia caregiver support group
- Ensure patients safety by working with outside agencies when needed
- Continuity of care

The Social Work Role in Palliative Care

- Advance care planning discussions
  - Help patients identify values and goals
  - Complete LW and HCP documents
  - Initiate POLST discussions
  - Support patient and family in making difficult decisions

Social Work and Advance Care Planning

- During **72%** of all psychosocial visits, advance care planning was addressed
  - Living wills were discussed, initiated and completed
  - POLST documents were reviewed and discussion about goals of care conducted
- When restricting to patients who we followed for at least 90 days, ACP addressed **99%** of the time



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, then contact physician/APN. This Medical Order Sheet is based on the current medical condition of the person referenced below and their wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

Person Name (last, first, middle) — Date of Birth

A — GOALS OF CARE *(See reverse for instructions. This section does not constitute a medical order.)*

B — MEDICAL INTERVENTIONS: *Person is breathing and/or has a pulse*
- ❑ Full Treatment. Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.
- ❑ Limited Treatment. Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ❑ Transfer to hospital for medical interventions.
  - ❑ Transfer to hospital only if comfort needs cannot be met in current location.
- ❑ Symptom Treatment Only. Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use Antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

Additional Orders: ______

C — ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:
Always offer food/fluids by mouth if feasible and desired.
- ❑ No artificial nutrition.
- ❑ Defined trial period of artificial nutrition.
- ❑ Long-term artificial nutrition.

D — CARDIOPULMONARY RESUSCITATION (CPR)
Person has no pulse and/or is not breathing
- ❑ Attempt resuscitation/CPR
- ❑ Do not attempt resuscitation/DNAR
  Allow Natural Death

AIRWAY MANAGEMENT
Person is in respiratory distress with a pulse
- ❑ Intubate/use artificial ventilation as needed
- ❑ Do not intubate • Use O2, manual treatment to relieve airway obstruction, medications for comfort.

E — If I lose my decision-making capacity, I authorize my surrogate decision maker noted below to modify or revoke these NJ POLST orders in consultation with my treating physician/APN:
Health care representative identified in an advance directive ❑ Yes ❑ No
Other surrogate decision maker ❑ Yes ❑ No

Print Name of Surrogate *(address on reverse)* — Phone Number

F — SIGNATURES:
I have discussed this information with my physician/APN.
Signature______
- ❑ Person Named Above
- ❑ Health Care Representative/Legal Guardian
- ❑ Spouse/Civil Union Partner
- ❑ Parent of Minor
- ❑ Other Surrogate______

Has the person named above made an anatomical gift:
❑ Yes ❑ No ❑ Unknown
These orders are consistent with the person's medical condition, known preferences and best known information.

PRINT - Physician/APN Name — Phone Number
Physician/APN Signature (Mandatory) — Date/Time
Professional License Number

1/27/14

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

Social Work and Advance Care Planning

- Advance care planning is a process
  - Establishing relationships
  - Goals and values translated to treatment interventions
  - Allowance for the ACP process to evolve

Case Study

Background Information

- Joyce is a 70 year-old female with a medical history of:
  - COPD - O_2 dependent
  - Chronic DVTs
  - Chronic arthritic pain
  - Anxiety and Depression
  - Actively smokes two packs per day
- She lives in a home that had significant water damage from Hurricane Sandy

Background Information

- She is a hoarder and has small pathways in the home
- She has not paid her mortgage in 5 years, her home had been in foreclosure for about a year
- Her son and his s/o reside in the home; however, offer no support
- She utilizes a walker and wheelchair for mobility
- Independently manages her ADLs
- Her daughter fills her pill box

Nursing Interventions

- Initial visit completed by RN
- RN coordinated with physicians to get patient back to their office for regular visits
- RN helped to establish a safe pain regimen
- RN coordinated bloodwork for INR check
- RN scheduled LCSW to meet with patient for support and to address "social needs"

Care Coordination

- Coordinated with outpatient psych for management of anxiety and depression
- Worked with water and electric companies to have services resumed so she could remain at home
  - Applied for utility assistance programs
  - Assisted with developing a payment plan

Resource Connection

- Referral made to Meals on Wheels and local food pantry
- Applied for prescription assistance program
- Initiated Medicaid process
- Worked with the sheriff's office to hold off on sheriff's sale of the home until safe housing could be established

Advance Care Planning

- Supportive counseling to help patient cope with multiple life stressors, as well as disease progression
- Completed LW (trusting relationship)
- Completed POLST document with PC APN
- Coordinated the transition into a LTC
- Eventually transitioned to Hospice

Summary

- Joyce began with the Meridian Care Journey program in December 2013
- Transitioned to Hospice April 1, 2016
- The palliative care team, led by the social worker, walked this **3 year** journey with her

Social Work Leadership

Leadership Attributes

- Effective communication
- Education
- Oversight
- Team support

Institutional Barriers to Social Work Leadership

- Used as support or administrative staff
- Doctors and nurses are in charge
- No administrative time is given
- Not invited to attend key meetings or committees
- Do not have a voice

Self-reported Barriers to Social Work Leadership

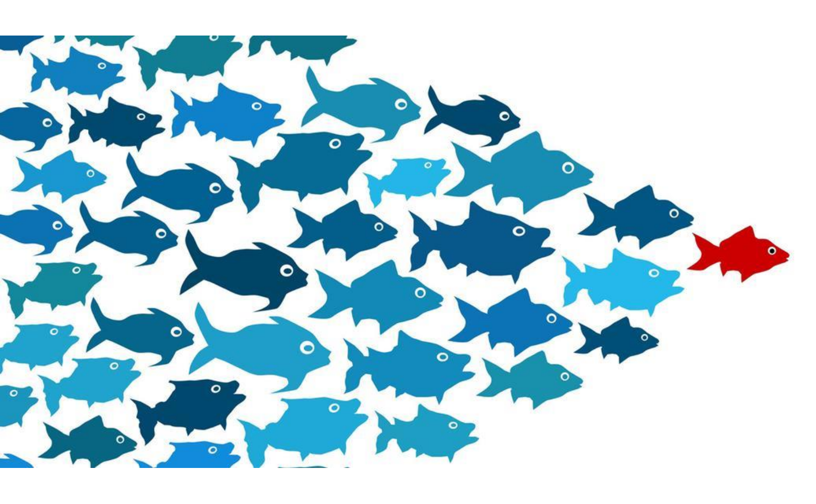
- I am *"just"* the social worker
- I do not feel trained to be a leader
- I am too young
- I am over-worked
- I don't have enough time
- I'm not interested/trained in research
- I can't speak in public

Haynes 2016

Leadership Qualifications

- Appropriate educational background
- Strong palliative care knowledge base
- Excellent interpersonal skills
- Advocacy skills
- Viewed as a leader by **entire** team and the **system at large**

Social Work Activities



- Monthly lectures at nursing orientation
- Educational series at skilled nursing facilities
- Hospice and Palliative Care Month
- National Healthcare Decisions Day
- Compassion Fatigue

System & Community-Wide Initiatives

- POLST education to EMS providers
- OREC (regional ethics committee)
- Support and educate other clinicians

Promoting Self Care

- Compassion Fatigue Day for entire team to encourage self-care
  - Started with Palliative Care only
  - Expanded to hospital staff
  - Now system-wide initiative
- Code Lavender
  - Ongoing research

I'm not bossy!
I have skills...leadership skills!!
Understand?

How to Become a Social Work Leader

- Be your own advocate
  - Highlight your skills and achievements
  - Volunteer for new opportunities
- Teach others
- Support colleagues
- Give presentations
- Conduct research
- Join committees
- Network
- Speak up

Social Work Leadership in Palliative Care

- ➔ Demonstrate your financial value
- ➔ Obtain clinical licensure
- ➔ Advocate for social work reimbursement platforms
  - *Reimbursement streams, such as the development of new CPT codes that reflect the role of the interdisciplinary team (including social workers) in advance care planning*
- ➔ It is up to us to become leaders as both palliative care and the role of social workers grows

(NASW Recommendations for the 2015 WHCoA Theme: Healthy Aging June 12, 2015)

References

- Altilio, T. Otis-Green, S. (2011 March 28). *Oxford Textbook of Palliative Care Social Work*. New York, New York. Oxford University press.
- Haynes, K. (2016). Social Workers as Leaders. *Social Worker Today*. Retrieved from: http://www.socialworktoday.com/archive/exc_040714.shtml
- Morgan, L. (2014, September). Palliative Care Growth Trend Continues, According to the Latest Center to Advance Palliative Care. *CAPC*. Retrieved from: https://www.capc.org/

Be the kind of leader that you would follow.
-WALLPAGO-

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