Domain 4: Social Aspects of Care

Practice Examples

**Practice Example D4-A**

A community hospital recognizes the need to integrate palliative care into the care of patients with serious illness. The hospital is served by independent physician practices and also has employed intensivists and emergency department staff. To support the needs of the patient population, the hospital pays for palliative care training for all inpatient and outpatient social workers, and three achieve advanced certification. Seriously ill patients are screened at admission to identify those with high-risk and high utilization patterns; these patients receive a more in-depth social work assessment. Out- and inpatient social workers are asked to do a joint visit at the end of the hospitalization for these patients to facilitate continuity. The hospital conducts a biweekly care conference to review all palliative care patients – the conference is expanded to include hospitalists, advanced practice providers, registered nurses, spiritual care, and emergency department leaders. The emergency department recruits a physician trained and certified in palliative care.

**Practice Example D4-B**

A children’s hospital has recognized the need to expand palliative care integration beyond the current inpatient palliative care team. Social workers and child life therapists in the outpatient setting already conduct an in-depth psychosocial assessment of every new patient and family within 14 days of the start of outpatient care. This information is recorded in the outpatient medical record and has not been available to inpatient teams, yet it has great importance in managing transitions of care. The hospital commits to implementing a single electronic medical record for inpatient and outpatient care. Representatives of the psychosocial outpatient team begin attending the inpatient palliative care interdisciplinary team meetings to enhance communication and information sharing. Patients admitted who will not be seen in follow-up in the hospital clinics receive the in-depth psychosocial assessment while hospitalized. A process to routinely identify these patients and to share this information with the healthcare providers who will be seeing the patient and family after discharge is under development.

**Practice Example D4-C**

A community hospital has its own medical group including disease specialists. The hospital’s strategic plan includes improving care for patients with advanced heart failure, as these patients represent the highest utilizers and greatest expense to the health system. The hospital endorses the creation of a specialty heart failure clinic and asks clinical leadership to guide the development, including the integration of palliative care services. Although the heart failure clinic team has physicians, advanced practice registered nurses, nurses, a therapist, a social worker, and a chaplain, there is little direct communication and collaboration between team members. The heart failure clinic social worker identifies caregiver stress as a key driver of hospital re-admission and collaborates with the palliative care advanced practice registered nurse to develop an assessment of caregiver capacity and distress. Poor family member understanding of what to expect in progressive heart failure and lack of confidence in handling after hour emergencies emerge as central themes. The social worker and advanced practice registered nurse work with all members of the heart failure team to create patient and family teaching materials in multiple languages. The chaplain initiates a weekly family support group for caregivers that includes a telephone option for those who can’t leave the house. A regular heart failure team meeting is established to review the needs of patients and their caregivers and identify those patients eligible for hospice services. These changes in the clinics’ function lead to improvement in utilization patterns and the hospital invests in a new telehealth system.
to further enhance monitoring and communication in support of high-risk heart failure patients and their caregivers.

**Practice Example D4-D**

An independent rural community dialysis center serves a broad geographic area and recognizes high levels of distress and ED and hospital utilization among its patients and their family caregivers. The dialysis staff (its nephrologists and nurses) have pursued palliative care training and the practice has hired a physician assistant with several years’ experience working in palliative care at one of the tertiary hospitals that serves the same geographic area. The dialysis center team discusses the worrisome connection between caregiver strain and patient outcomes and decide to target family caregiver support as a quality improvement project. Led by the dialysis center social worker, two initiatives are launched: a recurring instructional session for patients and family caregivers on symptom management at home; and a monthly peer support group for family caregivers. The center also recognizes many adult children of the dialysis patients have moved away from the rural area. The social worker arranges web-based technologies to allow participation of remote family members in care conferences with the interdisciplinary team, which are now held routinely and with any changes in patient status or goals of care.

**Practice Example D4-E**

A social worker in a community hospice has a particular interest in perinatal loss and has studied how programs across the country provide support for mothers and extended family members anticipating such a loss. With leadership support, she and others in the hospice reach out to the hospital-based obstetrics practice to see if there is an interest in co-creating a palliative team to serve these patients and their families. These conversations lead to a collaborative service that provides early access to grief support for expectant mothers and their families while the woman are pregnant, and bereavement follow-up after the loss. The hospice identifies and coordinates with other programs if the women do not live locally or if family members from out of town request grief and bereavement support.

**Practice Example D4-F**

A hospice program affiliated with a critical access hospital recognizes a high number of its patients prefer not to die at home. After exploration of the cultural norms of the community the hospice decides to build a hospice house to provide an alternative home-like setting. The house is well received and supported by the community. Soon, the hospice house begins receiving calls from community members who have a variety of needs unrelated to a terminal condition. The hospice utilizes the NCP Guidelines to develop a community-based palliative care program focused on the social determinants of care needs of community members. The hospice medical director oversees the work of a registered nurse, and the registered nurse collaborates with the hospice social worker as needed. The registered nurse facilitates the work of a trained group of volunteers to facilitate advance care planning and connect people to services within the community. The primary care physician receives visit documentation when applicable. The program tracks completion of advance directives and connections to various services to demonstrate the need for and value of the program to the local hospital and the community.