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## Results of a nationwide hospice and palliative care social work job analysis

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### ABSTRACT



The role of the hospice and palliative social worker is often ambiguous and misunderstood by colleagues and fellow team members. One reason for this is the lack of identified, clearly delineated roles, skills, and tasks employed by these specialty social workers in their daily work. This article summarizes the first nationwide job analysis of hospice and palliative social workers. A contextual, cross-sectional survey design was used to identify current and relevant job tasks from practicing hospice and palliative social workers. A sample of 482 social workers representing 46 states responded to a survey that included demographic questions and ranking of 152 tasks and importance to the position. Tasks were categorized into four broad categories: assessment and reevaluation; planning and intervention; death, grief, and bereavement; and professionalism; which includes subcategories consisting of multiple tasks and skills. Respondents identified performing a psychosocial assessment from a patient/family centered care perspective, assessment of the patient's current and desired quality of life and of coping skills as the tasks most important to their role. This outline of the role of the hospice and palliative social worker was then used in the development of an evidence-based certification exam that may be required of those who want to receive specialty certification in the field.

### KEYWORDS

Hospice; job analysis; palliative care; social work competencies; social work roles

## Background

Since the hospice movement began in the United States in the 1970s, it has been characterized by its interdisciplinary approach to serving patients and families. Social work has provided essential services as a component of hospice and palliative care, though the field has had a more difficult time than their medical counterparts in clarifying, documenting, explaining and justifying their role on the interdisciplinary team.

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### ***Early efforts to describe the social work role in palliative and hospice care***

Kulys and Davis (1986) were among the first to collect data on how social workers function in hospices, analyzing the services provided, frequency of the services, and degree type of the social worker providing care. They found that social workers did not have an area of expertise that was specifically theirs but rather shared in providing services with nurses and volunteers. Social workers also did not often participate in program development, staff and volunteer support groups, or staff orientation and training, which might have further confused those trying to determine the role and value of social workers within the hospice setting.

Since the Kulys and Davis' (1986) study, social workers have been attempting to clarify and define their expertise and role and further characterize their participation as a valued and integral part of interdisciplinary team care. Palliative and end-of-life social work requires a high level of professional skill and knowledge (NASW, 2004), and brings a tremendous amount of value and benefit to patients and families; being able to demonstrate this expertise is of paramount importance.

### ***Primary roles and competencies identified***

Some tasks and roles for hospice and palliative social workers have been identified over the years, albeit on a smaller or more local scale as compared to the current nation-wide survey. The first comprehensive listing of roles and competencies for palliative and hospice social workers was compiled by Gwyther et al. (2005) as a result of the 2002 Social Work Leadership Summit on Palliative and End-of-Life Care. In fact, one of their objectives for reviewing the current literature at the time and compiling a list of required roles and competencies was to guide the future preparation and credentialing of social workers. Thus, their work laid the groundwork for this current study.

Primary roles and competencies identified by multiple authors over the years include: initial and ongoing psychosocial assessment of the patient and family; crisis intervention; individual and family counseling; developing a plan of care; making referrals to local resources and agencies; collaboration with other disciplines; facilitating effective family and team communication; patient/family education regarding palliative and end-of-life options; case management; legacy work; resolving ethical problems; financial counseling; grief counseling; bereavement care; spiritual assessment and interventions; and advanced care planning (Altilio, Gardia & Otis-Green, 2008; Altilio, Otis-Green & Dahlin, 2008; Gwyther et al., 2005; NASW, 2004; Quig, 1989; Reese, 2011; Sumser et al., 2015; Walsh-Burke & Csikai, 2005; Weisenfluh & Csikai, 2013; Wesley, Tunney & Duncan, 2004).

Other authors have contributed to defining social work's role in hospice and palliative care. Rine (2018) conducted an extensive literature review regarding the intersectionality of racial, ethnic, social and other differences in end-of-life care and reiterated the importance of hospice and palliative social workers' continuation of their longstanding commitment to cultural competence, which is constantly evolving to meet current needs as the population grows and shifts. Herman (2012) warned about the deprofessionalization of hospice and palliative social work and called for social workers to strengthen and promote the profession by the following methods: enhancing their palliative and hospice expertise, educating consumers and colleagues about the social work role within interdisciplinary teams, conducting and promoting research demonstrating the value of social work hospice and palliative care training and education, and advocating at both organizational and state levels.

### ***The role of certification in verifying competency***

One of the ways in which social workers can follow Herman's recommendations and demonstrate their competency in hospice and palliative care is by obtaining certification. Evidence-based certification is a profession's official recognition of expertise, clinical judgment, and achievement (NCCA, 2014). Certification indicates a high level of clinical competence and can enhance professional credibility.

Certification encourages and recognizes professional achievement and, in turn, advances the profession of social work. It assures patients, families, and workplaces that one has met professional standards of practice and demonstrates ones' commitment to the profession and continued learning to improve competencies and skills. Certification programs exist for a variety of social work specializations, including health care social work and oncology social work (Reese, 2011).

### ***Current status of palliative and hospice social work certification***

One way a certification can be granted is by review of a portfolio submitted by an applicant. A designated group or person reviews the portfolio and makes the certification decision. The National Association of Social Workers (NASW) began offering the opportunity to become credentialed as an Advanced Certified Hospice and Palliative Social Worker (ACHP-SW) and a Certified Hospice and Palliative Care Social Worker (CHP-SW) in 2008 and 2009, respectively (NASW, n.d.). These certifications are portfolio-based. Requirements for NASW certification include a degree from an accredited social work program (a bachelor's degree for the CHP-SW and a

master's degree for the ACHP-SW), 20 or more CEUs related specifically to hospice and palliative care, multiple years (2 for the CHP-SW, 3 for the ACHP-SW) of supervised social work experience in hospice and palliative care, a current state license and adherence to the NASW Code of Ethics and NASW Standards for End of Life Care. This type of certification based solely on a completed portfolio is a more subjective measure of competence in the field.

### ***Development of an evidence-based certification***

Currently, there is no scientifically developed, evidence-based certification program for hospice and palliative social workers. Evidence-based certification relies on verification of competency through examination. The examination is based on a thoroughly conducted scientific job analysis. Hospice and palliative social workers achieve evidence-based certification through specialized education, experience in hospice and palliative social work, and by passing a qualifying exam. Maintenance of the certification requires continued skill development and ongoing learning.

The first step in developing an evidence-based certification for hospice and palliative social workers is to complete a job analysis. The objective of a job analysis is to define a role in terms of the work behaviors necessary to safely and effectively perform the job at a specified level of expertise (AERA/APA/NCNE, 2014; NCCA, 2014). Prior to this study, an in-depth, nationwide job analysis had not been conducted. This analysis may provide the necessary evidence for the development of an entry-level certification exam.

As a result of mounting interest related to evidence-based certification among hospice and palliative social workers, the Social Work Hospice and Palliative Network (SWHPN) formed a Certification Committee in 2015 to explore funding sources for the development of a test-based certification program. The Committee developed a letter of intent to be shared with potential funders. A full proposal was invited by the Gordon and Betty Moore Foundation who agreed to fund the project through the University of Louisville. Dr. Barbara Head was appointed the Principal Investigator (PI) for the project and a program coordinator was hired. The University contracted with PSI Services, a company with over 70 years of experience conducting job analyses, developing tests and delivering testing services.

### ***Purpose of study***

The purpose of completing a job analysis was to determine the most important tasks included in the specialty practice of palliative and hospice social work; develop an outline inclusive of these tasks; and provide the

evidence needed for the development of an entry-level exam to be used for certification of social workers in this specialty practice.

## **Methodology**

### ***Method***

A contextual, cross-sectional survey design was used. With this design, data were gathered from a “cross-section” of respondents chosen to represent a particular target population within a relatively short period of time (Singleton & Straits, 2009). The design was contextual in that all participants shared the same social context (being employed as palliative/hospice social workers). Contextual designs sample a significant number of cases within a particular group or context with the goal of accurately describing selected characteristics of that context (Singleton & Straits, 2009). This design was selected in order to gather data from actual practitioners that was current and relevant.

### ***Survey development***

The first step in the process was to appoint an Advisory Committee (AC) to oversee the nationwide job analysis which would form the basis for the exam content. Committee members were recruited from the SWHPN general membership. Applications were reviewed by the SWHPN Certification Committee and 10 persons were selected to compose the AC based on their education, experience, and ability to serve as a content expert. Every effort was made to compose a committee representative of the field, including younger, as well as more seasoned, practitioners. The 10-person AC members had a range of 2–35 years of experience in hospice and/or palliative care. Eight members provided direct services or supervised social workers who provided direct service in hospice or palliative care, one was in academics who taught palliative and hospice care and one worked for a major palliative care membership organization. Seven members were employed in palliative care while the remainder worked in organizations providing hospice services.

Simultaneously, the PI and program coordinator requested job descriptions and course syllabi from SWHPN members and others working or teaching hospice and palliative social work and performed a literature search related to current hospice and palliative social work competencies and curricula in an effort to develop an exhaustive list of tasks required for specialist practice. Duplicate tasks were eliminated. These were shared with the PSI staff who in turn developed a draft definition of a hospice and palliative social worker and a task statement list. Tasks were specific to

specialist palliative and hospice social work as opposed to generalist social work practice although some tasks may overlap with those involved in generic health social work practice.

The AC adopted the following practitioner definition:

*A hospice and palliative care social worker provides psychosocial assessment and services to the patient/family/caregivers, facilitates patient-centered goal-setting and a plan of care. This social worker provides counseling and casework to meet the identified goals, and assists with decision-making and advance care planning throughout the trajectory of serious illness. A hospice and palliative care social worker seeks to improve patient/family/caregiver quality of life through education, addressing needs and referring clients to the appropriate resources.*

The Advisory Committee met for 2 days to review, edit and approve a draft task list and to recommend various demographic variables to be placed in the survey. Demographic variables were selected for their ability to describe social workers currently practicing palliative and hospice social work. The AC also assisted in the selection of the importance rating scale used in the survey. Participants rated each job task as: not applicable for my role (0); minimally important (1); somewhat important (2); quite important (3); or extremely important (4).

PSI staff placed the finalized lists into a survey format that was reviewed, pilot tested and approved by the Advisory Committee. PSI then enabled the survey for web-based administration.

### **Recruitment of participants**

Participants were recruited through a number of websites and databases. E-mail invitations were sent to all members of SWHPN ( $n = 630$ ), and the Social Work Network in Palliative and End-of-Life Care ( $n = 720$ ) databases. Invitations were included in the newsletters of SWHPN, the Association of Oncology Social Workers and the Hospice and Palliative Nurses Association. Web-links were posted on Facebook, LinkedIn and Twitter pages of related organizations. Participants were encouraged to share and forward the survey to colleagues, and members of the AC shared invitations with potentially interested organizations and individuals.

Recruitment notices included a link to the survey website. The study was submitted to the University's Human Subjects Protection Office and deemed exempt.

Respondents indicated which tasks they performed and rated the importance of those tasks performed in their practice. Participants were asked to respond based on their current practice rather than a specific period of their practice such as the past year or the past several months. Participants

could be employed either full or part-time as this variable was not included in the questionnaire.

### ***Statistical analysis***

Descriptive statistics were calculated for the percentage of candidates performing each task and for the task importance. The percentage of participants who perform each task was calculated by dividing the number of non-zero ratings (1–4) by the number of total ratings. The percent performing was sorted in ascending order for committee review. Responses to task importance included only those respondents who performed the task as task importance could not be realistically rated if the task was not performed. The mean and standard error of the mean on the 1–4 importance scale was calculated and sorted in ascending order for committee review.

Subgroup analyses for each task were also conducted for several demographic variables (i.e. geographic region, years of experience in social work, years of experience in hospice and palliative care, primary job role, social work license). For the subgroup analysis, the mean task importance rating was used as a decision rule by the Advisory Committee to ensure only tasks that are highly important to practice remained on the content outline.

### ***Application of decision rules and criteria to tasks***

The judgment of AC members was used to interpret the data gathered through the job analysis and develop the Detailed Content Outline (DCO). The DCO is a detailed listing of content in outline form that will serve as a guide for test development. The AC's role was to limit the content to only the broadly performed critical tasks emerging from the job analysis. The AC adopted the following decision rules to apply so that the resulting examination content reflected the tasks of hospice and palliative care social workers as judged by a demographically representative group:

1. Keep all tasks performed by at least 70% of practitioners.
2. Keep all tasks rated with a mean importance rating of at least 2.60.
3. Keep tasks rated with a mean importance rating of at least 2.40 by 3 of the 4 geographic-region subgroups (Northeast, South, Midwest and West).
4. Keep tasks rated with a mean significance rating of at least 2.40 by 4 of the 5 years-of-post-degree-work-experience-in-social-work subgroups (0–5 years, 6–10 years, 11–15 years, 16–25 years, and 26 or more years).
5. Keep tasks rated with a mean significance rating of at least 2.40 by three of the five years-of-experience-in-hospice-and/or-palliative care



- subgroups (0–2 years, 3–5 years, 6–10 years, 11–15 years, 16 or more years).
6. Keep tasks rated with a mean significance rating of at least 2.40 by 3 of the 4 primary-practice subgroups (hospice social worker, palliative care social worker, hospice and palliative care social worker, other).
  7. Keep tasks rated with a mean significance rating of at least 2.40 by both of the 2 social-work-license subgroups (Yes- I have a license, No- I do not have a license).

## Results

### *Sample*

A total of 623 persons responded to the survey. Six hundred and ten respondents (97.9%) stated that the practitioner definition of a hospice and palliative social worker described them. Responses were excluded for (a) stating the practitioner definition did not describe them (b) rating less than 25% of tasks and (c) failing the survey check item (an item embedded in the task statements for quality control purposes to identify careless respondent behavior). This resulted in 141 respondents being omitted from the analysis; 482 respondents provided usable data.

The sample of 482 was largely Caucasian (71.4%) and female (93.8%). Forty-six states were represented. Approximately one-half of the respondents practiced as hospice social workers; the remainder were either palliative care (28%) or hospice and palliative care social workers (14%). The sample was experienced: the average years of post-degree work experience was 16 years and the average years of experience in hospice and/or palliative care was 9 years. Most had masters' degrees in social work (90%). Further description of the sample can be found in [Table 1](#).

### *Selection of key tasks*

The Advisory Committee applied the decision rules described in the Methodology Section to develop the final list of key tasks to be used to guide the development of the content outline for the certification exam. Tasks with the highest mean rating of importance (3.74 or above) included:

- Perform psychosocial assessment from a patient/family centered care perspective
- Assessment of the patient's current and desired quality of life
- Assessment of the patient's coping skills
- Assessment of family/caregiver coping
- Identify support systems

**Table 1.** Demographics.

	Frequencies or Means Percentage or (Standard Deviation)	
Gender		
Male	21	5.6
Female	349	93.8
Genderqueer/Gender non-conforming	2	0.5
Race		
American Indian or Alaskan Native	1	0.2
Asian	4	0.8
Black or African American	8	1.7
Native Hawaiian or Pacific Islander	—	—
White or Caucasian	344	71.4
Multiracial	4	0.8
Hispanic		
Yes	18	4.9
No	350	95.1
Type of practice		
Hospice social worker	178	47.5
Palliative care social worker	104	27.7
Hospice and palliative care social worker	54	14.4
Other	39	10.4
Licensed in social work		
Yes	321	85.6
No	54	14.4
Mean years of experience		
Years of post-degree work experience	16.06	(10.52)
Years of experience hospice or palliative care	9.05	(6.94)
Primary work setting		
Urban	146	39.2
Rural	89	23.9
Suburban	137	36.8
Highest degree in social work		
Associate degree	1	0.3
Bachelor's degree	31	8.2
Master's degree	338	89.73
Doctorate degree	3	0.8
No SW degree	4	1.1
Interested in new evidence-based certification program		
Yes	315	84.7
No	57	15.3
Missing	110	—
Licensed to practice social work		
Yes	321	85.6
No	54	14.4
Missing	107	

- Provide emotional support
- Facilitate communication among patient/family/caregivers and team members
- Advocate for patient-centered care within the interdisciplinary team
- Provide individual/family counseling to assist the patient/family to cope with suffering
- Educate patient/family/caregivers regarding advance health care directives
- Conduct visits to home
- Collaborate with other professionals as part of the interdisciplinary team

- Practice self-care
- Maintain professional boundaries
- Identify and report abuse and neglect as mandated by law
- Adhere to requirement regarding confidentiality and release of information.

All tasks selected, their mean ratings, the standard of error, and number and percentage of respondents performing the task are displayed in [Table 2](#).

The list of tasks was reorganized using subtopics (organizer statements) to group tasks into a more logical framework. Four major topical areas were identified: assessment and re-evaluation; planning and intervention; death, grief and bereavement; and professionalism. Upon review of this outline, a number of tasks were added by the Advisory Committee because it became evident that some areas had been omitted. For example, tasks related to re-evaluation had been overlooked in the job survey but are tasks completed by social workers in this specialty field. Asterisked items indicate those tasks added by the Advisory Committee.

### ***Tasks not included***

Tasks that did not meet the inclusion criteria set forth by the Advisory Committee are displayed in [Table 3](#). Thirteen items fell below the inclusion threshold to be included in the examination specifications. Respondents ranked “Use DSM criteria to assess and interpret the patient’s needs” as the least important of the assessment and reevaluation tasks, ranking it only a 1.70 out of a possible 4 points. This was also the lowest-scoring task out of all 152 job tasks assessed in this study.

Only about 60% of respondent hospice and palliative social workers assessed patients who request medically-assisted dying. The fewest percentage of social workers (32.38) facilitate or refer for medically-assisted dying as appropriate. Because the legality of assisted death varies by state, the Advisory Committee felt it appropriate to omit these items.

Although tasks often performed by social workers, respondents indicated that assessing the patients’ gender identity, sexual orientation and sexuality were of low importance in their position.

For planning and intervention tasks, providing group counseling was ranked as least important, scoring just a 2.30 out of a possible 4 points. Referring to educational programs was a task often performed but not deemed to be of high importance.

The only task in the death, grief and bereavement group that scored lower than the threshold was assist in funeral arrangements and memorial

**Table 2.** Job tasks.

Item	N that responded	Mean Importance Score	Standard Error	% Performing
<i>Assessment and re-evaluation</i>				
Identify support systems	481	3.84	0.018	99.79
Assessment of the patient's current and desired quality of life	482	3.80	0.020	99.79
Assessment of patient's coping skills	480	3.79	0.021	99.79
Assessment of family/caregiver coping	480	3.79	0.021	99.79
Perform a thorough psychosocial assessment from a patient/family centered care perspective	480	3.78	0.023	99.79
Assessment of patient's understanding of illness and medical treatment plan	482	3.72	0.023	99.79
Assessment of family/caregiver understanding of the illness and medical treatment plan	482	3.72	0.023	99.79
Assessment of safety, abuse, and neglect	482	3.71	0.025	99.79
Provide psychosocial assessment for seriously ill patients	480	3.70	0.028	99.38
Assessment of family functioning	479	3.70	0.023	99.79
Assessment of patient's decision-making capacity	482	3.70	0.026	98.55
Identify strengths of the family	481	3.70	0.024	99.79
Identify strengths of the patient	480	3.69	0.024	99.79
Identify barriers that may impede biopsychosocial symptom management	482	3.67	0.026	99.79
Identify strengths of the caregiver	477	3.67	0.025	99.79
Assessment of communication patterns and challenges	481	3.59	0.026	99.79
Evaluate the psychosocial response to prognosis	480	3.59	0.028	99.58
Use clinical knowledge of psychosocial dynamics to gather biopsychosocial history	481	3.54	0.033	99.58
Assessment of cultural dynamics as they impact the illness or treatment	482	3.54	0.028	99.79
Use clinical interviewing and behavioral observation	481	3.50	0.034	99.17
Assessment of patient cognitive ability	481	3.49	0.031	99.38
Assessment of quality of caregiving	481	3.49	0.030	99.38
Evaluate the psychosocial response to treatment	478	3.46	0.032	99.58
Assessment of caregiver cognitive ability	480	3.41	0.032	99.17
Assessment of mental health symptoms that impact functioning as related to coping with illness	481	3.35	0.034	98.96
Assessment of family cognitive ability	482	3.35	0.032	99.38
Assessment of spirituality	479	3.33	0.034	98.33
Assessment of suicide risk	482	3.33	0.037	98.34
Assessment of spiritual dynamics as they impact the illness or treatment	481	3.31	0.034	98.13
Assessment of veteran status and eligibility for benefits	481	3.28	0.036	97.92
Assessment of socioeconomic status	481	3.21	0.038	99.17
Assessment of hospice eligibility	482	3.15	0.046	87.76
Assess hospice eligibility and/or recertification	482	3.15	0.046	87.76
Assessment of healthcare literacy	480	3.13	0.038	99.17
Integrate the diagnoses and treatment findings into the psychosocial assessment	479	3.07	0.042	98.75
Assessment of need for volunteer services	480	3.02	0.043	91.67
Assessment of appropriateness for palliative care referral	478	3.00	0.051	82.01
Identify physical, behavioral and emotional characteristics typical for the developmental stage	480	2.97	0.042	99.17
Administer validated assessment tools	478	2.42	0.048	90.38
Interpret results from validated assessment tools	480	2.41	0.048	89.38
Communicate changes in assessment to team*	—	—	—	—
Document changes in assessment*	—	—	—	—
Update care plan in accordance with the reevaluation of patient/family/caregiver*	—	—	—	—

*(continued)*

**Table 2.** Continued.

Item	N that responded	Mean Importance Score	Standard Error	% Performing
<i>Planning and intervention</i>				
Provide emotional support	424	3.94	0.012	99.53
Advocate for patient-centered care within interdis- ciplinary team	424	3.79	0.022	99.76
Conduct visits to home	420	3.77	0.034	73.10
Report suspected abuse and neglect as mandated by law	423	3.77	0.027	99.76
Facilitate communication among patient / family/ caregivers and team members	423	3.76	0.025	99.76
Assist the patient /family / caregiver to cope with suffering	423	3.75	0.023	99.53
Educate patient/family/caregivers regarding advance healthcare directives	423	3.74	0.027	99.53
Provide interventions that facilitate coping	424	3.69	0.026	99.53
Provide interventions that promote dignity	423	3.68	0.027	99.53
Develop psychosocial, patient-centered plan of care	423	3.67	0.029	99.76
Facilitate completion of advance health- care directives	424	3.67	0.030	98.58
Conduct visits to assisted living facility	423	3.64	0.043	71.87
Collaborate with the care team in patient/fam- ily meetings	423	3.63	0.030	99.53
Use problem-solving skills to assist patient/family/ caregiver in setting goals	422	3.61	0.027	99.76
Conduct visits to skilled nursing facility	423	3.61	0.048	69.74
Provide follow up	424	3.59	0.033	97.88
Ensure plan of care is communicated clearly with patient/family/ caregivers, staff and support- ing agencies	423	3.59	0.033	98.58
Facilitate patient/family meetings for goal setting and care planning	423	3.51	0.035	99.29
Modify interventions and plans based on fam- ily dynamics	424	3.51	0.031	99.53
Assure patient understanding of medical language	423	3.50	0.036	97.40
Address barriers and risk factors identified in the assessment	423	3.50	0.032	99.53
Use therapeutic techniques to help patients and families understand options and participate in healthcare decision making	423	3.47	0.034	99.05
Facilitate processing and integration of information	424	3.46	0.033	99.29
Educate patient/family/caregivers regarding hos- pice benefits	421	3.45	0.039	97.15
Provide crisis intervention	423	3.41	0.039	97.87
Identify suspected intimate partner abuse cases and refer to appropriate resources	421	3.41	0.043	96.44
Identify ethical dilemmas in patient care and refer as appropriate	423	3.40	0.036	98.58
Modify interventions and plans based on changes in the patients' status	422	3.39	0.037	97.63
Ensure continuity of care across practice settings working with changing medical teams	423	3.38	0.039	96.22
Provide non-pharmacological interventions to enhance quality of life	421	3.38	0.037	97.15
Provide activities that enhance the patient's desired quality of life	423	3.37	0.039	97.40
Refer to specialty services (e.g. chaplain, art therapy, massage therapy)	423	3.36	0.037	97.40
Conduct visits to outpatient facilities	418	3.34	0.064	55.50
Support patients transition and identification of the 'new normal' after surviving serious illness	422	3.33	0.041	93.60

(continued)

**Table 2.** Continued.

Item	N that responded	Mean Importance Score	Standard Error	% Performing
Conduct visits to hospital	421	3.33	0.054	80.52
Refer to community programs	423	3.32	0.040	99.05
Use assessment data to plan, coordinate and follow up with patient care	422	3.28	0.042	97.63
Educate patient/family/caregivers regarding disease trajectory	423	3.27	0.041	97.40
Provide individual counseling	423	3.26	0.042	91.25
Modify interventions and plans based on patient age-specific needs and responses to treatment	420	3.26	0.040	96.90
Provide psychosocial interventions based on evidence-based practice and clinical assessments/diagnoses	423	3.24	0.043	98.82
Provide individual/family counseling to help manage existential issues and find meaning	424	3.21	0.042	97.64
Provide case management	421	3.19	0.049	88.36
Assist with transfer, discharge or other care transitions	424	3.19	0.047	89.62
Educate patient/family/caregivers regarding reinforcement of education provided by medical/nursing staff about treatment and side effects	421	3.17	0.044	97.62
Prepare patient/family/caregivers for discharge from hospice or palliative services	421	3.14	0.049	91.92
Integrate the findings and recommendations concerning diagnoses and treatment into a care plan	423	3.13	0.044	96.22
Provide family counseling	423	3.12	0.044	91.02
Refer to volunteer services	424	3.08	0.048	92.45
Tailor information about treatment and side effects to patients and families	422	3.08	0.048	88.39
Assist patient to navigate insurance, entitlement and financial programs	422	3.06	0.046	94.31
Provide funeral pre-planning	423	3.02	0.050	90.78
Apply psychosocial theory to practice situations	424	2.97	0.047	97.64
Provide legacy building and memory making	422	2.93	0.045	97.39
Monitor patient progress according to measurable goals described in treatment and care plan	422	2.85	0.049	94.79
Order and arrange for transportation, meals, medical supplies and/or equipment, etc.	422	2.84	0.056	82.23
Establish measurable goals	422	2.78	0.052	93.84
<i>Death, grief and bereavement</i>				
Identify and respect cultural and spiritual customs/practices related to death	399	3.69	0.030	99.50
Identify and respect cultural and spiritual customs/practices related to grief and bereavement	399	3.69	0.030	99.50
Facilitate dignified death	396	3.63	0.036	91.16
Support patient/family through preparatory grief process	399	3.62	0.032	97.74
Assess family / caregiver for anticipatory grief	399	3.61	0.032	98.75
Assess patient for preparatory grief	399	3.56	0.033	98.25
Assess family/caregiver for risk factors for complicated grief	399	3.54	0.036	97.24
Balance patient and family's preference for place of death	399	3.53	0.035	94.99
Support family and caregivers at the time of death	399	3.50	0.041	92.73
Provide patient/family/caregiver education about signs and symptoms of impending death	399	3.47	0.041	95.49
Assist with coping related to grief, loss, and bereavement	398	3.41	0.042	91.71
Assess family/caregiver for ambiguous loss and disenfranchised grief	399	3.38	0.039	95.99

(continued)

**Table 2.** Continued.

Item	N that responded	Mean Importance Score	Standard Error	% Performing
Refer families for bereavement counseling	397	3.37	0.044	94.21
Support family/caregivers through ambiguous and/ or disenfranchised loss	398	3.34	0.042	94.22
Screen families for bereavement counseling	396	3.34	0.048	87.88
Provide family/caregiver education about healthy and unhealthy grief and bereavement	399	3.20	0.045	91.48
Assess family/caregiver for somatic and/or emotional manifestations of grief	399	3.18	0.045	94.49
Apply grief and bereavement theories and best practices	398	3.13	0.050	90.20
Provide bereavement follow-up after death as deter- mined by the social work assessment	399	3.11	0.061	72.18
Provide grief counseling	398	3.04	0.067	61.06
Advocate for patient's after-death preferences (e.g. rituals, care of the body)	399	3.01	0.055	87.72
Provide patient/family/caregiver education about options for care of the body after death	399	2.99	0.058	82.46
Identify survivor benefits	398	2.61	0.058	79.90
Support family/caregiver through anticipatory grief process*	—	—	—	—
<i>Professionalism</i>				
Adhere to requirements regarding confidentiality and release of information	385	3.92	0.015	100
Maintain professional boundaries	384	3.88	0.018	100
Collaborate with other professionals as part of an interdisciplinary team	384	3.87	0.019	99.74
Identify and report abuse and neglect as mandated by law	385	3.84	0.024	99.48
Practice self-care	381	3.74	0.028	99.74
Ensure compliance with NASW standards and codes of ethics	385	3.69	0.032	99.48
Document ongoing patient/family/caregiver assess- ments, progress and response to treatment	384	3.65	0.032	99.48
Communicate social work assessments, goals and plan of intervention with the team and other staff to improve patient quality of care	384	3.62	0.032	98.96
Pursue ongoing professional development activities	384	3.62	0.031	99.48
Educate team members about the social work role	385	3.62	0.032	99.48
Identify ethical dilemmas and conflicts of interest	384	3.54	0.034	99.74
Develop cultural awareness in self and others	383	3.54	0.034	99.74
Develop self-awareness and acknowledge signs of compassion fatigue, burnout, vicarious trauma, and moral distress	385	3.52	0.040	98.70
Maintain knowledge of state laws and regulations related to end-of-life care	385	3.40	0.04	98.96
Participate in activities that promote team wellness	384	3.16	0.046	95.31
Cultivate and maintain community partnerships and relationships	384	3.09	0.048	96.09
Serve as liaison to community health, welfare, and social agencies	384	3.06	0.051	89.84
Inform policy regarding social work best practices (e.g caseload, patient volume)	385	3.05	0.051	91.17
Train social work students, interns, and allied professions	385	3.00	0.054	87.01
Use quality improvement process to identify improvement opportunities	385	2.88	0.051	92.47
Participate in quality improvement activities	384	2.86	0.051	94.27
Provide debriefings for end-of-life and death issues to physicians, residents, interns, nurses, and other providers	384	2.63	0.063	74.22

\*Item added by the Advisory Committee after survey.

**Table 3.** Items not included, listed in order of mean importance score.

Item	N that responded	Mean Importance Score	Standard Error	% Performing
<i>Assessment and re-evaluation</i>				
Assess patients who request medically-assisted dying	482	2.89	0.064	59.96
Assess gender identity	479	2.35	0.047	93.53
Assess sexual orientation	481	2.23	0.045	92.72
Assess sexuality	475	2.08	0.046	91.58
Assess immigration status	477	2.11	0.051	83.86
Use DSM criteria to assess and interpret the patient's needs	480	1.70	0.045	75.42
<i>Planning and intervention</i>				
Facilitate or refer for medically-assisted dying as appropriate	420	2.63	0.093	32.38
Refer to educational programs	421	2.43	0.050	95.49
Provide group counseling	424	2.30	0.065	59.20
<i>Death, grief and bereavement</i>				
Assist in funeral arrangements and memorial services	397	2.60	0.061	77.08
<i>Professionalism</i>				
Provide training and education in hospice and palliative care at the organizational, local, state or national level	384	2.81	0.064	74.74
Engage in social policy and community development	385	2.56	0.058	82.08
Participate in research	384	2.12	0.059	71.88

services. This scored a 2.60 out of a possible 4 points, with 77.08% of social workers performing this task.

Participating in research was the lowest ranked task under professionalism, scoring just 2.12 out of a possible 4 points. Just 71.88% of social workers reported performing this task. Engaging in social policy and community development and providing training in hospice and palliative care were also ranked lower than the threshold to be included in the final list of job tasks.

## Discussion

This job analysis provides a substantiated description of the tasks required for practice in this specialty. Results are based on a nationwide survey of social workers employed in hospice and palliative care practice. The process used was that recommended by experts in the field of certification and related test development. Therefore, the results of the survey can be used to develop an objective, psychometrically sound certification program for palliative and hospice social workers. This process is the same as that used to develop certification programs for hospice and palliative nurses at all levels of licensure and hospice medical directors.

The number of social workers who responded indicates substantial interest from the field. When asked about their interest in an evidence-based



certification program, 85% of the participants responded they would be interested.

The results of this job analysis provided the framework for the development of an entry-level exam to be required for certification. The four subcategories of tasks and the list of tasks were used to develop items. The percentage of questions in each area was determined by the frequency and importance of the tasks included in that subcategory. While not perfect, the test will provide an objective measure of competence. Passing the exam, experience in the field, related social work education, attestation regarding ethical practice, and licensure will all be required for certification. Unlike the NASW program that has separate credentials for BSW and MSW candidates, this certification will include both degrees while requiring more supervised experience from BSW candidates; this is possible because passing the exam verifies that the BSW candidates have the same knowledge base as those candidates with a masters' degree.

The resulting framework and list of tasks offer other benefits to the field. The outline can be used as a curricular guide by academic programs preparing social workers for this specialty practice. The list of tasks can be helpful when developing job descriptions, performance appraisals, and orientation content for social workers employed in palliative and hospice care.

The findings of this job analysis did not contradict previous studies or efforts to delineate the palliative and hospice social work role. All previously identified tasks were included and several areas (i.e. death and grief and professionalism) were detailed in more depth. Every effort was made to present an exhaustive list of tasks to respondents from which they selected the tasks they performed and the importance of each task to practice. Using the decision rules to further delineate tasks to be included assured that demographic characteristics were considered in developing an inclusive list.

Strengths of the study include the large sample size, the inclusion of respondents from across the nation, and the rigor with which the study was conducted using psychometrically sound procedures. Additional strengths include the expertise of the testing agency and the Advisory Committee and the respondents' agreement with the definition of the target practitioner developed by the Advisory Committee.

The study is not without limitations. One limitation of the study is the convenience sample which recruited respondents connected to membership groups, listservs or social media. This may not be an accurate representation of all hospice and palliative care social workers as those not belonging to membership groups or utilizing social media were excluded. Unfortunately, 141 respondents were excluded from the data analysis for

failing the survey check, noncompletion of 25% or more of the survey, or disagreement with the target practitioner definition.

Another limitation lies in the nature of the task list used to compose the survey. Tasks were selected based on the literature and submitted job descriptions; therefore, more contemporary thoughts or descriptions may not be included. Respondents were invited to contribute tasks not included in the survey list in an effort to overcome this deficit.

## Conclusion

This job analysis accurately reflects the tasks of palliative and hospice social workers. It not only provides a content outline for an entry-level certification exam; it also identifies content and criteria for preparation, ongoing education, and evaluation of social workers in this specialty practice.

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