NATIONAL ASSOCIATION OF SOCIAL WORKERS

Practice Standards for Serious Illness Care

Hospice and Palliative Social Work

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ACKNOWLEDGMENTS

The Task Force gratefully acknowledges the work of the original Expert Steering Committee who developed the *NASW Standards for Palliative and End of Life Care* in 2004. This groundbreaking work provided a foundation for these standards. The Task Force also recognizes the National Consensus Project for Quality Palliative Care's *Clinical Practice Guidelines for Quality Palliative Care* (4th edition), which has provided a vision of interprofessional, quality care for individuals living with serious illness and the structure for these standards. The Task Force thanks Edgar Guedry and Doris Roman for their input and support in the standards development process.

INTRODUCTION

The current *NASW Practice Standards for Serious Illness Care: Hospice and Palliative Social Work* reflects the rapid growth and evolution of these fields. The stress and symptoms associated with a serious illness have an impact on the quality of life of not just the person living with the disease, but also those in their support system. Yet too often treatment and services are difficult to access or navigate. Social workers are uniquely, in fact ideally, positioned to identify and address inequities, structural racism, and barriers to access across all of healthcare. **These standards are meant to articulate and guide all health social workers (whether specialists or generalists), program leaders, researchers, academics, and policymakers in their efforts to improve the equitable delivery of quality care regardless of setting.**

Palliative care can be delivered in a hospital, a clinic, or the community, and is appropriate for people of any age or stage of illness. Palliative care services are appropriate from the diagnosis of a serious illness onward, through end-of-life and bereavement support, and may be delivered through a hospice program, which is a specialized area in the larger field of palliative care. Social workers are a core part of an interprofessional palliative care service that typically also includes doctors, nurses, chaplains, and others working closely together to ensure that symptoms are controlled and that treatments are aligned to provide quality, individualized care.

The primary principles of palliative care are applicable to social workers in any setting, as all social workers will inevitably encounter people coping with the impact of a serious illness. **These primary principles of palliative care are aligned with social work values and thus have applicability for all health social workers**. These primary principles include the following:

- Comprehensive attention to the multidimensional aspects of distress with a collaborative team approach that is relationship centered, recognizing the patient and family system as the primary unit of care.

- Provision of contextualized care to improve people's quality of life, which lays the foundation for the equitable delivery of care that is person centered, family focused, culturally congruent, and goal concordant.

In pursuit of these principles, palliative social workers provide support, education, and counseling to improve coping and enhance well-being as they:

- Identify what matters most to those they serve
- Remove barriers to health and improve access to quality healthcare
- Link people with needed resources and services
- Facilitate family meetings and lead advance care planning conversations
- Recognize, normalize, and address the impact of trauma, grief, and loss
- Help manage high-risk situations, provide crisis management, and use conflict resolution skills
- Streamline collaboration and communicate patient concerns with the healthcare team
- Create policies and programs that better serve diverse communities
- Navigate transitions in care
- Skillfully apply evidence to improve the delivery of care
- Provide emotional support to healthcare teams
- Advocate for health equity and social justice at the micro, mezzo, and macro levels

Social workers' access to practice standards supports initiatives from competency development in field education to academic research and provides the foundation for advocacy initiatives on behalf of the profession. The use of standards both guides best practice in hiring and developing role descriptions and provides a framework to measure quality practice. These standards illustrate social work's contributions to the delivery of serious illness care described by the National Consensus Project for Quality Palliative Care (NCP; 2018) in *Clinical Practice Guidelines for Quality Palliative Care*.

Table 1 highlights this alignment between social work practice and the NCP (2018) guidelines, demonstrating social work's vital role in

the provision of quality care to all of those impacted by serious illness. Social workers recognize that a person's experiences and cultural background impact each domain of care, and it is in the social work scope of practice to ensure that healthcare teams approach those they serve with cultural curiosity, humility, awareness, and sensitivity. Examples of how social work's commitment to social justice and the provision of contextualized, person-centered care are represented in each domain are articulated in Table 1.

TABLE 1 Application of National Consensus Project (NCP) Domains to Social Work Practice in Serious Illness Care

NCP Domain	Application to Social Work Practice in Serious Illness Care
NCP Domain 1: Structure and Processes of Care	• Promote standardized care planning using a collaborative interprofessional team approach. • Establish standardized policies and protocols for screening and biopsychosocial–spiritual assessment and for the use of evidence-informed interventions. • Provide system navigation while advocating for the seamless delivery of care regardless of setting. • Stay abreast of policy disruptions in healthcare's rapidly evolving environment. • Recognize that the fields of palliative care and hospice present a unique culture in the framework of Western medicine that arose from the dominant culture and includes their own distinctive values, practices, hierarchies, and language, and that in this setting, colleagues, patients, and families bring their own cultural beliefs, values, and patterns of behavior that must be assessed in the care plan. • Seek to mitigate the inherent power imbalances between healthcare teams, patients, and families. • Provide timely documentation. • Engage in quality assurance and performance improvement activities.
NCP Domain 2: Physical Aspects of Care	• Address physical concerns to improve function and quality of life. • Assess how culture plays a role in how pain and suffering are experienced and communicated by an individual and their family. • Recognize that patients may choose to decline certain pain medications for personal or cultural reasons (e.g., finding meaning and value in the experience of pain, preferring alternative treatments, prioritizing cognitive clarity, having an addiction history, and lacking access to medications), or have beliefs, traditions, and values that influence acceptance of caregiving from those outside of the family unit.

(*continued*)

TABLE 1 Application of National Consensus Project (NCP) Domains to Social Work Practice in Serious Illness Care (*Continued*)

NCP Domain	Application to Social Work Practice in Serious Illness Care
NCP Domain 3: Psychological and Psychiatric Aspects of Care	• Promote adjustment to illness. • Recognize that coping styles differ widely among people, as does comfort with addressing "mental health" concerns (e.g., fearing biases or stigmatization that may result from others for "needing" such treatment). • Collaborate with colleagues to ensure that complex mental and behavioral health concerns are integrated into care planning. • Assess for a history of trauma and skillfully provide a trauma-informed lens to interventions.
NCP Domain 4: Social Aspects of Care	• Develop a comprehensive interprofessional care plan to address the needs and goals of the patient and family and offer an ongoing exploration of caregivers' capacity to provide care using a strengths-based approach. • Assess and address the impact of unmet social drivers of health. • Facilitate family meetings, recognizing differences in family structure, social support, communication patterns, and decision making (e.g., individual versus collective decision making). • Explore how and with whom medical information is shared and encourage the involvement of each person's preferred support system and decision makers (noting that these may fall outside the typical nuclear family, such as faith leaders). • Honor neurodiversity and consider social preferences or social barriers to care, such as potential isolation, sensory overwhelm, social needs, or differences for people living with intellectual or developmental challenges.
NCP Domain 5: Spiritual, Religious, and Existential Aspects of Care	• Actively promote the integration of patient's/family's religious, spiritual, and existential beliefs into care delivery. • Collaborate with chaplains and community faith leaders to create meaningful rituals, support legacy building, and increase grief literacy. • Recognize how culture influences how spirituality, religion, and existential experiences impact and influence decision making (e.g., belief in miracles or that the circumstances of one's death are "in the hands of God"). • Pay attention to how people experience hope, express existential suffering, and search for meaning as they seek to make sense of their illness.

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TABLE 1 Application of National Consensus Project (NCP) Domains to Social Work Practice in Serious Illness Care (*Continued*)

NCP Domain	Application to Social Work Practice in Serious Illness Care
NCP Domain 6: Cultural Aspects of Care	• Promote social justice and advocate for the delivery of culturally congruent care. • Cultivate awareness of one's own cultural influences, history of trauma or privilege, and personal biases, and how these might impact the delivery of care. • Recognize that culture plays a role in all aspects of care, while avoiding overgeneralizations. • Strive to understand and share the effect of social drivers of health and structural racism that impact the access to and use of palliative and hospice care. • Recognize the impact of the cultural and ethnic makeup of teams, with attention to how this may impact the provision of care and patients' utilization of services. • Approach others with humility and cultural curiosity, respecting that individuals are their own "cultural experts."
NCP Domain 7: Care of the Patient Nearing the End of Life	• Promote shared decision making to support goal-concordant care. • Provide support and education regarding serious illness care. • Collaborate with the interprofessional team to cultivate prognostic awareness and offer anticipatory guidance to minimize future regrets. • Facilitate advance care planning conversations. • Provide grief and bereavement support and education and assess for risk factors associated with complicated bereavement. • Recognize how contextual and cultural factors may influence decision making and personal preferences at end of life and what might be considered a "good death." • Sensitively explore requests for hastened death with awareness of state and organizational guidelines. • Assess communication preferences regarding "disclosure" of diagnosis and prognosis, as well as the differing values that people place on autonomy and self-determination. • Assist teams as they navigate ethically challenging situations. • Actively assess the importance of rituals and attempt to incorporate cultural practices whenever possible. • Recognize the emotional toll it takes in caring for the seriously ill, and advocate for systemic changes that support families and staff in processing their grief and mitigating their moral distress.

(*continued*)

TABLE 1 Application of National Consensus Project (NCP) Domains to Social Work Practice in Serious Illness Care (*Continued*)

NCP Domain	Application to Social Work Practice in Serious Illness Care
NCP Domain 8: Legal and Ethical Aspects of Care	• Address the ethical, legal, and regulatory issues that impact care delivery. • Actively consider how the bioethical principles of social justice, beneficence, nonmaleficence, and autonomy are applied in practice with specific attention to those who have been politically, socially, or historically marginalized. • Integrate the core values of social work of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence into the provision of quality care. • Recognize the impact of social drivers of health and experiences of racism and oppression on both the providers of care and those served. • Regularly reflect on one's own biases and cultural worldview and how they impact delivery of care. • Seek to identify and maintain appropriate professional boundaries. • Use the NASW (2021) *Code of Ethics* to guide decision making regarding ethical dilemmas. • Advocate for comprehensive systemic improvement regarding inequitable access to palliative care and hospice services (e.g., socioeconomic disparities, racism, and other forms of discrimination) while also encouraging institutional and professional accountability in efforts to dismantle structural inequities in care.

Note: A variety of studies contributed to the development of this table by applying the NCP Guidelines to social work practice for serious illness care. They include the following (in alphabetical order): Becker & Cagle, 2022; Bullock, 2011; Crunkilton & Rubins, 2009; Desai et al., 2021; Glajchen et al., 2018; Glajchen et al., 2024; Kuo, 2013; NCP, 2018; Otis-Green, 2022; Pace & Mobley, 2016; Rogerson et al., 2022; Strang et al., 2004; Sumser et al., 2019; Zebrack et al., 2022.

As demonstrated, social workers are an integral part of an optimally functioning interprofessional team and are essential for the provision of quality serious illness care. Recognizing the burdens associated with the fragmented healthcare system in the United States, the NASW (2021) *Code of Ethics* compels social workers to promote workplace well-being and individual self-care. Comprehensive approaches to nurture well-being include a review of the systems, workloads, and mandates necessary to create safe practice environments—both emotional and physical. Occupational distress inherent in serious illness care increases the risk for empathic strain and secondary trauma in the workforce (Showalter, 2010).

Palliative social workers respectfully collaborate with others to reinforce relationships with the clinicians who have cared for the patient throughout the continuum of their illness. The social workers' social justice mandate calls for promoting antiracist practices to create accountable environments of care. Workplaces need intentional redesign to develop robust systems of peer support and a thriving culture of teaching, coaching, and mentoring to support the next generation of care providers (Toh et al., 2018).

Despite these very real challenges, a career in palliative social work offers opportunities for meaningful engagement and rich learning. Social workers are called to be lifelong learners committed to ongoing professional development. There is an obligation to seek mentorship and continuing education, as well as to provide mentorship and support to others. The tension between the need to standardize practice and the call for social workers to personalize care is inherent. These standards provide a benchmark for serious illness care, regardless of one's area of specialization or populations served.

Sumser and colleagues (2019) offer clinical guidance for health social workers seeking to build competence in caring for those with serious illnesses. Those working specifically in palliative care and hospice may find the *Oxford Textbook of Palliative Social Work* (Washington & Lero, 2022) valuable in deepening their understanding of the complexities inherent in the field. Each of these resources provide nuanced patient narratives and practice examples useful in increasing one's confidence in applying these standards in real-world situations. Whether through direct service delivery, policy work, research, or education, social workers are leading efforts to improve the nation's health and well-being.

LANGUAGE

Throughout these standards, language usage is intentional with the goal of creating a forward-facing document that reflects the nuances and rapidly evolving terms related to serious illness care.

BIOPSYCHOSOCIAL–SPIRITUAL CARE

A comprehensive biopsychosocial–spiritual assessment provides the foundation for the provision of person-centered, family-focused, culturally congruent, goal-concordant quality care that is tailored to each individual served. The social worker's strengths-based, contextualized perspective recognizes how these multidimensional aspects of a person's history and experience impact serious illness (see also **Intersectionality**). Personalized care plans recognize family dynamics and developmental stage. The sensitive exploration of an individual's suffering and trauma history lays the groundwork for building a therapeutic relationship and creating shared goals for care.

CULTURE AND CULTURAL COMPETENCE

The provision of culturally congruent care requires a commitment to social justice and recognition of how one's own cultural background influences the delivery of care. Cultural curiosity is a key component in the delivery of culturally accountable care. Social workers have an ethical responsibility to address disparities and to promote equitable access to quality care for those who have been historically, politically, or socially marginalized, and have a professional mandate to actively address racism and discrimination in all its forms. This requires reflective practice and ongoing attention to one's own areas of privilege. Social workers are called to develop expertise in advocacy and activism as effective change agents to confront and disrupt systemic and structural oppression (NASW, 2015). Attention to variances in health literacy, access to appropriately translated resources, and the skillful use of professionally trained medical interpreters are critical to the provision of culturally competent care.

FAMILIES AND CARE PARTNERS

Serious illness impacts not just the person, but also their family, care partners, and community. Palliative care sees the family as the unit of care and respects each person's right to identify "family" as they prefer. The understanding of the importance of social support has evolved from terms such as "caretakers" to "caregivers" or "loved ones." Those who are partners in a person's care may or may not share legal or biological ties with them or be currently providing direct patient care.

GRIEF AND BEREAVEMENT SUPPORT

There are numerous losses inherent in living with a serious illness, and grief is associated with each loss. The social worker normalizes these feelings, offering ongoing support and education related to the experiences of anticipatory grief and disenfranchised grief, assesses for risk factors associated with complicated bereavement, and provides guidance regarding postmortem services and funeral options. Social workers may partner with chaplains to participate in rituals and offer existential support for colleagues as they grieve patient deaths or cope with complex and emotionally challenging situations.

HEALTH SOCIAL WORK

Recognizing that all social workers will interact with people impacted by serious illness over the course of their careers, these standards were written to be applicable to all social workers, regardless of whether they have a specialization in palliative or hospice social work. Additional guidance for health social workers can be found in the NASW (2016) *Standards for Social Work Practice in Health Care Settings* and the various resources referenced throughout this document.

HOSPICE AND PALLIATIVE CARE

In the United States hospice programs are tightly regulated and restricted to those who are nearing the end of life, while palliative care is a broader concept and applicable to people from time of the diagnosis of a serious illness onward. Both share a team approach to care with exquisite attention to the physical, emotional, social, and spiritual aspects of a person's quality of life. Both offer services to people of all ages and in all settings and see the patient and family as their unit of care. There is

rapid growth in community-based palliative care with rich opportunities for palliative social work leadership to expand these models outside of traditional health settings.

INTERPROFESSIONAL PRACTICE

A collaborative team approach to care is a hallmark of palliative and hospice care. Interprofessional (or transdisciplinary) practice recognizes and values each discipline's unique skills and perspectives in the provision of whole person care. This flattened hierarchy allows the core palliative care team (consisting of physicians, nurses, social workers, and chaplains) to deliver a coordinated response to the multidimensional aspects of each patient's distress. Cross-training key competencies is also crucial. Effective communication, the de-escalation of distress, and the ability to address common myths and misperceptions related to pain management are examples of core skills that benefit all members of a palliative care team (Interprofessional Education Collaborative [IPEC], 2023). Shared leadership is demonstrated when the various disciplines intentionally learn with and from one another. For example, a social worker will provide training to the team on navigating complex family dynamics, while medical colleagues will provide team training on the basics of symptom management.

A high-functioning interprofessional team understands the limits of every member's skill set and each respective discipline's scope of practice while supporting one another in their shared efforts to work to the "top of their licenses." Establishing clarity regarding potentially overlapping roles (such as guidance about whether and when to refer to the psychologist, chaplain, community health worker, or social worker when a patient is experiencing distress, or how the palliative social worker might collaborate with the unit social worker) is needed to ensure that referrals are expedited when situations outside of one's scope or experience occur.

INTERSECTIONALITY

This term was developed by professor Kimberlé Crenshaw (1989) to describe how race, class, gender, and other individual characteristics "intersect" and overlap. The concept resonates with social workers, who are trained in systems theory to see how converging, interrelated, or interdependent elements may synergistically interact. Social workers'

understanding of how the delivery of care may be influenced by their perceptions about a person's identity is a valuable prerequisite to successfully addressing disparities in care.

LINGUISTIC COMPETENCE AND HEALTH LITERACY

Social workers advocate for the provision of readily available, culturally appropriate, oral and written language services to diverse populations, including those with limited English proficiency, and actively support the recruitment of bilingual/bicultural staff, trained medical interpreters, and qualified translators. The complexities and nuances of serious illness care require that family *not* be used as interpreters. Additionally, social workers serve individuals who are nonspeaking, Deaf, or hard of hearing, and seek to find ways to connect and decrease barriers that impede communication.

SERIOUS ILLNESS

These standards are intended to apply to the care of all those living with a serious illness, regardless of the patient's age or the stage of their disease. Palliative care services address the seriously ill person's quality of life, their functioning, and the impact of the illness on their social network. This contextualized approach normalizes the early integration of palliative care services from diagnosis onward and may be combined with disease-modifying treatment. The early integration of palliative care is associated with improved outcomes and is considered best practice for many health conditions.

SOCIAL DETERMINANTS, HEALTH-RELATED SOCIAL NEEDS, AND DRIVERS OF HEALTH

For over 100 years, social workers have sought to lower the social and economic barriers impacting people's health and well-being. Increased attention to how these factors contribute to disparities in health offers opportunities for social workers to exert their expertise. The language surrounding these concepts has recently evolved from "social determinants of health" to "social drivers of health" to "health-related social needs." The Centers for Medicare & Medicaid Services (2022) have issued a call to providers to more systematically address these factors related to disparities in health outcomes. The conditions in which people live are shaped by the distribution of money, power, and resources

and impacted by factors such as institutional bias, discrimination, and oppression, which influence well-being. The social work field's long-standing commitment to social justice demands continued advocacy to ensure that all people have equitable access to needed healthcare, quality education, stable housing, healthy food, and a safe and nurturing environment. These preventable differences create additional disparities in the degree of burden faced by the socially, politically, and historically marginalized communities served.

SPECIALIST PALLIATIVE SOCIAL WORKERS

Specialist palliative social workers are those who have sought additional training to hone their skills in caring for people who are seriously ill. Their expertise may be demonstrated by certifications or credentialing (e.g., Advanced Certified Hospice and Palliative Social Worker [ACHP-SW; NASW, n.d.] or Advanced Palliative Hospice Social Worker-Certified [APHSW-C; Hospice & Palliative Nurses Association, Hospice & Palliative Nurses Foundation, & Hospice & Palliative Credentialing Center, n.d.]), and they may work as part of a designated palliative care or hospice service with responsibilities for clinical care, education, and leadership. Further specialization may exist for those working in pediatrics (e.g., perinatal palliative social work) or with other patient populations (e.g., oncology social work). There is a growing movement to integrate primary palliative care skills for all clinicians, given that there are insufficient numbers of specially trained palliative care providers. These standards reflect that goal and are intended to be of relevance for all health social workers, regardless of their specialization or setting.

SPIRITUAL AND EXISTENTIAL CARE

Spiritual or existential care in the context of serious illness care includes attention to the experiences of hope, existential distress, and search for meaning as individuals make sense of life and death. Social workers assess the ways in which spirituality, religion, and existential concerns impact quality of life and influence decision making. As a facet of cultural competence, social workers seek to understand and support the beliefs and practices that are meaningful to patients and families, and work closely with chaplains, other spiritual care professionals, and community faith leaders to ensure that care is focused on what matters most to those they serve.

SUPPORTIVE CARE SERVICES

Palliative care services may be labeled differently in different settings. The term "supportive care services" typically identifies specialized programs that seek to provide comprehensive "whole person care." These programs may include a range of integrated services (such as the therapeutic use of the arts or various mindfulness practices), patient navigators, counseling (often with both psychologists and social workers), spiritual support, financial assistance, logistic support (such as transportation resources), as well as dedicated palliative care teams. Community health workers, child-life specialists, and rehabilitation professionals may also be housed under this broad umbrella of supportive care services.

STANDARDS

1. ETHICS AND VALUES

The values, ethics, and standards of both the profession and contemporary bioethics shall provide the foundation for all social workers providing serious illness care. The NASW (2021) *Code of Ethics* is one of several essential guides to ethical decision making and practice. Social work has an obligation to empower people receiving palliative and hospice care and advocate for their needs, decisions, and rights. Social workers engage in social and political action as advocates for equitable access to comprehensive quality serious illness care and the resources needed to minimize the impact of unmet social drivers of health.

INTERPRETATION

The responsibility to avoid or minimize harm to patients, families, communities, and colleagues through negligent or unethical behavior lies with each social worker regardless of the scope of their practice. Social workers are guided, and licensure is guarded, by adherence to the values, principles, and standards of the NASW (2021) *Code of Ethics* while simultaneously taking into consideration the unique circumstances around each interaction. Social workers must balance the need to negotiate with colleagues and respect their differing professional ethics while being bound by applicable federal and/or state laws, regulations, and agency policies. This section provides practical ethical applications and considerations for all health social workers practicing in serious illness care.

Ethical Responsibilities to Clients

- Provide goal-concordant care, extending cross-cultural respect and dignity through a lens of cultural humility that honors the patient-defined importance of beliefs pertaining to race, ethnicity, spirituality, social class, sexual orientation, and abilities (Foronda et al., 2016; Mathew, 2024).

- Practice critical self-awareness regarding countertransference.
- Address personal or societal biases to perform duties responsibly and positively.
- Actively engage in making the serious illness experience as seamless as possible.
- Support patients through ethical decision-making processes, such as discussing advance care planning, considering medical interventions to align with goals of care, and discussing medical aid in dying per governing statutes.

Ethical Responsibilities to Colleagues

- Social workers are responsible for being an active, engaged member of the interprofessional team, contributing pertinent knowledge that is based on current research findings for improving serious illness care.
- The NASW (2021) *Code of Ethics* emphasizes ethical responsibilities to highlight and address social justice issues impacting patient care and bring issues to the attention of the entire interprofessional team for discussion.
- Social workers are responsible for respecting the inherent dignity and worth of the person, advocating for people's decisions, and assisting the team to resolve differing opinions and agendas. For example, patients may express a desire to engage in disease-modifying or life-sustaining treatment options in the terminal phase of illness despite limited evidence of the efficacy of those interventions.
- Social workers have a responsibility to elevate the patient's wishes and goals despite personal or team feelings to the contrary.

Beware of thinking that palliative care and hospice are the exclusive hallmark of excellence in end-of-life care (Gawande, 2017). Racial differences in the utilization of these services abound. Research shows that Black patients are less likely than White patients to seek and receive hospice and palliative care services (Samuel-Ryals et al., 2021). Equitable access is a critically important ongoing process that holds the promise of improving the quality of care for all people (NASW, 2021). As a fundamental moral imperative, social justice posits that all people are entitled to have their basic human needs met; therefore, the principles of palliative care are crucial.

Regardless of disparities in class, gender, race, ethnicity, sexual orientation, religion, age, disability, or health status, quality care is customized, contextualized, and individualized. Although no one can know everything about every culture, social workers exercise cultural competence by recognizing the disparate impact of historical racism experienced by various racial and ethnic groups (Bullock et al., 2022; Carrion & Bullock, 2012). Therefore, establishing trusting relationships that build rapport lays the foundation for shared decision making and facilitates person-centered, goal-concordant care—which is at the core of ethics in palliative and hospice care.

Using ethical frameworks can highlight disparities in serious illness care and social work practice behaviors, which may help to close the gaps in racial inequities and other intersectional identities experiencing discrimination in healthcare. Ethically responsible agencies and organizations aim to create equity across a culturally diverse population in need of care through serious illness and at the end of life. It is critically important to consider the resiliency and strengths of historically marginalized and excluded populations from healthcare systems and settings, so the goal is to integrate person-centered, culturally competent approaches to caring for all people with serious illness. Practice, policy, and research are tools to help social workers engage in developing and promoting antiracist and other forms of inclusive care throughout serious illness and at the end of life (Rhodes et al., 2022).

Ethical Responsibilities in Practice Settings

- Social workers must advocate for adequate and equitable resources to meet the varied social realities of patients, families, and care partners in their communities. For example, those living in rural areas may face issues with choice, access, and/or transportation to services compared with people living in more urban areas (Washington & Lero, 2022).
- Similar barriers to service may exist for patients from politically or socially marginalized, underserved, or oppressed communities who may face barriers stemming from systemic bias and discrimination.
- Social workers must challenge organizational practices that sustain the inequity of the status quo and press for change in decolonizing the delivery of care (Schill & Caxaj, 2019). It is the responsibility of social workers to advocate for social justice regarding

social drivers of health impacting access to care through a lens of cultural humility in each practice setting to promote equity in the delivery of palliative and end-of-life services (Gottlieb, 2021; Kemp & Fisher, 2022).

- Additional practice setting considerations include outpatient versus inpatient care, home-based versus institutionalized care, and pediatric versus adult palliative and hospice care. The ease of planning, delivery, and quality of service, as well as access to staff by patients and families, should remain consistent across all areas regardless of setting.
- Social workers are called to advance equity in care by adhering to the ethical responsibility to remain knowledgeable on best practice interventions through the pursuit of continuing education and credentialing opportunities. Furthermore, the social worker should advocate for each person to ensure all individuals receive the highest level of services available (Bosma et al., 2009).

Ethical Responsibilities as Professionals

- As a core ethical principle, social workers' primary goal is to support those in need and address social problems (NASW, 2021). Medical decision making is addressed at the macro, mezzo, and micro levels of social work practice.
- Serious illness care is an area of practice in which culturally, socially, and economically diverse patients and families continue to experience inequities in care systems and settings (Richards, 2022). Social workers practice self-reflection to address areas of bias in themselves and their settings to promote equity and justice (Bussey et al., 2022).
- Professional colleagues need to consider the historical discrimination and legalized structural and systemic racism that Black, Indigenous, Latino/a/x, and Asian/Pacific Islander populations have experienced over the life course (Bullock et al., 2022). Since the COVID-19 pandemic, NASW's National Committee on Racial and Ethnic Diversity has issued a statement affirming the need for culturally competent social work practitioners to align with and strengthen support for the professional practice standard. The revised NASW (2021) *Code of Ethics* is a testament to the collective voice of social workers as proponents of evidence-informed practice supported by a set of skills, knowledge,

and investment in workforce development (at the macro, mezzo, and micro levels), leadership, and leverage that influence legislative change through policies that impact social work practice outcomes for professionals.
- Social workers have a responsibility to identify emerging ethical issues and advocate accordingly. For example, all social workers are required to increase their understanding of the implications of the use of generative artificial intelligence and how quickly it is impacting all aspects of healthcare.

Awareness and activism regarding healthcare access and policy disruptions are an inherent aspect of professional social work practice. There is a mandate to ensure that the voices of those who have been marginalized are heard, which requires social workers to develop and expand skills as effective advocates and change agents. Studies have documented the ethical challenges associated with creating equity in the provision of end-of-life care across diverse racial and cultural patient populations (Gawande, 2017; Starr et al., 2021).

Social workers recognize that structural racism leads to disparities in care (Rhodes et al., 2022), and that the hospice philosophy, which is a European model of care added to the U.S. system of healthcare in 1974 (Connor, 2008), may not align with the preferences, help-seeking behaviors, and cultural values of historically marginalized individuals and groups of the U.S. patient population (Bullock et al., 2022).

This can lead to underutilization of the standard of care for palliative and end-of-life care. In identifying racial differences in end-of-life care across groups, it is essential that social work professionals understand the influence of culture on care and that the perceptions of suffering across racial and ethnic groups vary. Moreover, cultural groups vary in opinions and preferences about how to treat those with "incurable" illnesses (Nedjat-Haiem et al., 2021). Culture is a driver in treatment selection and use of available disease-modifying and life-prolonging interventions for progressive terminal illness (Bullock-Johnson & Bullock, 2022).

Racial and ethnic populations that experienced the highest rates of morbidity and mortality during the COVID-19 pandemic (Black, Indigenous, Hispanic/Latino/a/x, Asian/Pacific Islander) were disproportionately affected by structural and systemic racism that existed long before the pandemic (Bullock et al., 2022; Jones et al., 2022). Social workers abhor all forms of racism in accordance with the ethical principle that social workers challenge social injustice and, in doing so, address racism

as a practice standard. Thus, social workers need a set of behavioral practices, knowledge, interest, leadership, and leverage to engage in effective and culturally congruent care.

Ethical Responsibilities to the Social Work Profession

- Social workers have an ethical responsibility to advocate for title protection. Not all states operate with adequate accountability and regulatory oversight for maintaining public safeguarding of the "social worker" title and recognition of the professionalism inherent in our field, limiting the usage to those who have the necessary education as indicated by a bachelor's, master's, or doctorate from an accredited school of social work.
- Social workers build on the core values of service, integrity, and competence to promote the unique skills of the profession to both patients and interprofessional teams (Blacker et al., 2016).
- Social workers uphold the integrity of the profession by supporting quality education and partaking in social work leadership opportunities through formal mentorships, staff education initiatives, field education placement experiences, and/or teaching each subsequent generation of practitioners (Gardner et al., 2015).
- Ethical social work practice must also include dedicating time and effort to research and evaluation of the contributions made by social workers in palliative and hospice practice settings. Distribution of this knowledge via publication and conference presentations contributes to the visibility and advancement of the social work profession, further promoting the advanced skills and perspectives of social workers practicing in end-of-life care (Cagle, 2022).

Ethical Responsibilities to the Broader Society

- Specialist palliative social workers handle macro-level ethical responsibilities by engaging with local and federal legislative policies to address social equity gaps in access to and provision of education to develop specialist palliative care and hospice services across the globe (Marmo & Lane, 2020; Rosa et al., 2022). Social workers advocate to address comprehensive systemic needs impacting communitywide access to palliative care and

hospice services such as socioeconomic disparities, racism, and other forms of discrimination, while also addressing institutional accountability in these efforts to dismantle structural inequities (American Medical Association, 2021; Wilkinson et al., 2017).

- Social workers disseminate knowledge to community members and stakeholders on local and national levels to endorse the value of conversations with respect to end-of-life planning, including the promotion of holistic specialized palliative and hospice services (Kwak et al., 2022; Otis-Green et al., 2019).
- Social workers have an ethical responsibility to respond meaningfully in their scope of practice to public emergencies, such as viral outbreaks and natural disasters that encompass significant loss of life. Social workers respond by building on existing strengths in the community; strategizing culturally responsive and equitable solutions to address holistic care needs; and providing emotional support to patient, families, and providers during these times of heightened stress and/or exhaustion (Altilio et al., 2021; Gibson et al., 2018; Jones et al., 2022).

Summary

Principles of bioethical considerations include social justice, beneficence, nonmaleficence, and autonomy. Coupled with these principles are the NASW (2021) *Code of Ethics* core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. To collaborate effectively with patients, social workers must consider all these to appropriately provide the care that patients and their families need.

2. CULTURAL AND LINGUISTIC COMPETENCE

Social workers shall have, and continue to develop, specialized knowledge and understanding about history, traditions, values, and family systems as they relate to practice in serious illness. Social workers shall be knowledgeable about, and act in accordance with, the NASW (2015) *Standards and Indicators for Cultural Competence in Social Work Practice*. Social workers shall demonstrate compassion and sensitivity to clients, respecting rights to self-determination and recognizing the impact of historical, political, and structural inequities on those who have been

marginalized. Social workers shall be aware of how their own beliefs, values, and place of power and privilege influence practice.

INTERPRETATION

All forms of discrimination, social drivers of health, and oppression must be examined with the understanding of the intersectionality of race, ethnicity, immigration, veteran or refugee status, religion and spirituality, sexual orientation, gender identity and expression, social class, and abilities. Social work practice in palliative and hospice care supports an interprofessional focus in which a part of the social worker's role is to ensure a clear understanding and recognition by the team of the unique and specific influences of a person's culture on their behavior, attitudes, preferences, and decision making.

The NASW (2015) *Standards and Indicators for Cultural Competence in Social Work Practice* defines *cultural competence* as the acknowledgment of the varied nuances of culture, noting that social workers must work to "recognize, affirm, and value the worth of individuals, families, and communities and to preserve the dignity of each" (p. 13). Social workers must meet each person and their families or care partners with cultural curiosity and humility and with awareness of the intersectionality of their identities, including recognizing forms of oppression and confronting disparities that may occur across the health continuum. Social workers also must demonstrate awareness of differing health literacy by being intentional about the use of language, understanding the impact of comprehension pertaining to informed consent and decision making when speaking to individuals, their families and/or care partners, or interprofessional team members (Otte et al., 2022).

Social Drivers of Health and Health-Related Social Needs

Social drivers of health are conditions in a person's environment that affect a wide range of health and quality-of-life outcomes and are responsible for most health disparities. These factors include income, housing, education, employment, access to health services, culture, and structural racism and discrimination (Mannoh et al., 2021). Social drivers of health are shaped by the distribution of resources, money, and power (Centers for Disease Control and Prevention, 2024). Using a person-in-environment framework, social workers explore and address these factors to improve people's well-being and access to needed resources.

Linguistic Competence

Linguistic competence involves the ability to communicate effectively to convey information in a manner that can be understood by the people seeking services including those with limited English ability or varying levels of health literacy. Social workers use multimodalities of communication to support effective practice and that seek to bridge cultural barriers (Neely-Barnes et al., 2020). The impetus is on clinicians to effectively communicate their skills and find ways to make patient and family voices heard (Giamportone, 2022). Additionally, social workers should recognize multiple forms of communication outside of spoken language and familiarize themselves with resources and tools for communication with nonspeaking, Deaf, or hard-of-hearing persons. They should also collaborate with and consult colleagues such as speech and occupational therapists who may help inform their tools and approaches.

Persons Receiving Care

Social workers ensure that all those with limited English proficiency have access to professional interpreter services and avoid using family members, including children, to translate, as mandated by federal law (Code of Federal Regulations, 2024). Social workers assist the team by ensuring that appropriately trained medical interpreter services are provided and medical information has been conveyed without the use of medical jargon (Goldhirsch et al., 2021). Written information, similarly, should be in the appropriate language and at the appropriate literacy level for the person, their family, and their care partners. Social workers assess for the unique challenges that may arise for some individuals due to sensory overload or social differences, recognizing the importance of using a person's preferred names and pronouns, and strive to create an environment where communication is tailored to individual needs, thereby fostering a supportive and inclusive atmosphere for all people receiving care.

Interprofessional Teams

Social workers collaborate with the interprofessional team and educate when needed to enable all team members to recognize how personal culture and biases may impact care (Borden et al., 2022), including the use of biased language (e.g., "noncompliant" or "difficult"). Further, social workers help to identify and encourage elimination of common phrases that may unintentionally perpetuate harm (e.g., "giving up," "she's a

fighter," "nothing more we can do") but are nonetheless often used by well-meaning families, care partners, and colleagues. Social workers can use these opportunities to model attention to word choice and provide examples of more appropriate language that seeks to reframe and improve communication while shifting the burden of outcome off the patient (Altilio & Kelemen, 2022).

Community

Social workers must strive to use a cultural humility lens and culturally appropriate tools to engage diverse groups in serious illness conversations (Anderson, 2021). Connecting with a wide representation of community and cultural leaders to improve communication and understanding, build trust, and improve community members' willingness to engage with social workers is an important goal aimed at increasing health literacy pertaining to goal-concordant care (Hendricks Sloan et al., 2016). This is particularly important when addressing the needs of those at the intersection of marginalization, such as older adults who may be isolated and individuals with intellectual and developmental disabilities who have historically faced barriers in accessing care and support (Shady et al., 2024).

Professional Growth

Social workers strive to continually foster professional growth and development in accordance with the NASW (2003) *Standards for Continuing Professional Education* and individual state licensing requirements. Avenues for growth include increasing one's knowledge about various belief systems, cultures, and identities through scholarly literature, as well as through a cultural humility practice of curiosity in learning from interactions with patients. This also includes ongoing and intentional self-reflection about one's own spaces of privilege and oppression to empathetically engage with clients and simultaneously strive to not impose one's subjective experiences and beliefs onto others (Rosa et al., 2022). Continuing education on well-being, boundaries, cultural humility, inclusivity, and cultural competence is therefore critical.

Racial and Ethnic Inequities in Access to Care

Quality practice concerns not only care for existing patients and families, but also ensuring access of services and resources for all people

eligible for hospice care. Research continues to highlight the public's gaps in education and knowledge about eligibility criteria, benefits, and availability of palliative and hospice care, advance directives, and other resources for care partners (Gerstorf et al., 2010; Hardy et al., 2010; Webb, 2015). There are known gaps in education about end-of-life support for people of racial and ethnically diverse backgrounds, particularly in rural communities or in marginalized urban communities (Hidaka et al., 2019; Hughes, 2013; Johnson, 2013; Richards, 2022). Hospice programs may not equitably provide services to areas most in need, with less availability in impoverished neighborhoods in inner cities or on city fringes (Elk et al., 2018).

It is important to note that while there may be less targeting of education and availability of access to some neighborhoods and populations, there are also cultural and spiritual differences pertaining to hospice care, with some people being more likely to care for loved ones at home without hospice services in place (Johnson et al., 2008; Markham et al., 2014). While social workers should honor and respect personal, cultural, and spiritual beliefs, they can work on improving education and helping everyone to exercise their right to self-determination.

Social workers will meet not only barriers to access to care, but also resource barriers that may impact quality of life whether hospice services are in place. Those who are historically, socially, or politically marginalized, or those living in poverty, may have the most difficulty not only accessing hospice services and preparing for end of life, but also accessing the necessary resources needed for goal-concordant care to be provided in their preferred location (Oliver & Peck, 2006; Peres, 2016; Webb, 2015). An important benefit of hospice care is the agency for the patient to choose where to receive end-of-life care; however, this opportunity is not equitably accessible (Hughes, 2013; Jeurkar et al., 2012; Webb, 2015; Wheeler, 2018). Many individuals lack the resources needed to pay for private caregivers to assist with care in the home, and people in poverty may be caring for multiple generations (such as caring for parents and grandchildren simultaneously), making it difficult to provide full-time care at home for the dying person (Lewis et al., 2011; Webb, 2015).

These gaps in awareness and education, access, and services all compound to lead to vastly different end-of-life experiences for those who have been marginalized. It is the duty of social workers to educate, address sociopolitical barriers, strive for social justice, and advocate for improved access and quality of care for all individuals facing end of life.

Summary

Therefore, there is no final "achievement" of cultural competence as it is, rather, an ongoing commitment to reflexive practice. This practice stems from the NASW (2021) *Code of Ethics* and standards for practice and is respectful and intentional. It encompasses all levels of practice and manifests in everything from verbal and nonverbal communication to practice interventions to policy development and promotion (Agency for Healthcare Research and Quality, 2019). Its foundation is informed by social workers and the voices and experiences of those they serve (Swick et al., 2021). This practice also looks to confront disparities; to promote understanding and appropriate access to palliative care and hospice services; and to improve quality of life, and quality of dying, for all.

3. SCREENINGS, ASSESSMENTS, AND INTERVENTIONS

Social workers shall conduct screenings and assessments to identify and address patient needs through a wide range of evidence-informed interventions.

INTERPRETATION

Social workers develop patient-driven interventions and advocate for treatments that align with each person's values, beliefs, and preferences using their biopsychosocial–spiritual lens to cocreate goal-concordant care plans. Social workers incorporate health-related social needs into care planning for the essential contextual perspective required to recognize impact on access and care delivery. Social workers align care to enhance people's agency for individualized decisions in serious illness care. Social workers employ a holistic appraisal to discern people's strengths and understanding of illness with input from the patient, family, and care partners.

Screenings

Screening may occur through interprofessional partners' use of screening tools. For example, the Centers for Medicare & Medicaid Services (2022) developed a tool to provide standardization for assessment of health drivers that encourages all "patients 18 years and older [to be] screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety using a standardized health-related social needs screening" (p. 2).

There are diverse ways and various places in which to identify needs while prioritizing responses. Screening is conducted in emergency departments, acute and subacute units, clinics, homecare settings, and other points of entry for serious illness care, primarily for issues related to health literacy, trauma history, social support, food insecurity, and need for safe and sustainable housing (O'Brien, 2019). The screening phase also may identify specific needs that arise for a person living with a serious illness. Screening may be completed by social workers and those in other disciplines who activate a referral to a social worker for further assessment and follow-up.

Screenings for biopsychosocial–spiritual issues include but are not limited to the recognition and management of general patient concerns (e.g., a history of trauma, depression, anxiety, fear, developmental delays, disability, pain, and financial toxicity); the understanding of the physical health condition; the goals of the social support system; and the culture, language, and spirituality concerns unique to each person. Screening tools are most effective when they are designed to help culturally congruent formulations of care plans (Starr et al., 2021). Early identification of biopsychosocial–spiritual issues, through screening, may aid in effectively assessing and prioritizing attention to issues that may affect the patient's safety or social connectedness or that may restore hope in a patient living with serious illness.

Social workers should have education and training to ensure competency in the use of validated psychosocial screening tools (e.g., the nine-item Patient Health Questionnaire, the Distress Thermometer, or the Anticipatory Grief Scale) and strategies that promote racial equity to help address structural and systemic racism in healthcare. Social workers must be adept in using tools that assess pain or distress in nonspeaking individuals, people with cognitive conditions, and those with other social or communication barriers (International Association for the Study of Pain, 2021). Social workers provide leadership on interprofessional teams and committees that design, implement, study, and adjust psychosocial screening programs to further promote social equity in the delivery of palliative services.

Assessments

The assessment phase is guided by the social worker's knowledge and skills, in collaboration with input from the interprofessional care team. Social workers use theoretically based perspectives and competency-based skills to complete assessments that then lead to appropriate

recommendations for interventions and care plans. Patient, family, and care partner preferences may vary based on sex, religion, cultural beliefs, educational backgrounds, socioeconomic differences, age groups, background, sexual orientation, ethnicity, disability, and sociocultural factors.

Therefore, a person-centered approach to choosing an assessment that incorporates evidence-based tools such as those developed by Reese and colleagues (Reese & Csikai, 2018; Reese et al., 2006) is strongly recommended. Assessments are an iterative process done at diagnosis, changes in prognosis, during transitions in care or settings, and in response to treatment (Otis-Green, 2005). Assessments may be regulatory driven, with established intervals for reassessment based on policy, or payment-driven, with standardized rescreening and reassessment timeframes.

Interventions

The patient's plan of care addresses concerns identified during the assessment phase. This cocreated plan lays the foundation for the team delivery of goal-concordant care. Social workers are active members of interprofessional rounds and attend team meetings where they advocate for the values, goals, wishes, and preferences of the patient and family and assist the team in prioritizing what matters most. This collaborative team approach is a hallmark of quality palliative care and is associated with a more seamless delivery of care over time and across settings, resulting in increased patient satisfaction scores, improved patient reported outcomes, and more goal-concordant use of services.

Social workers providing serious illness care may act as care coordinators, system navigators, and behavioral and mental health providers. The core values of social work and the strengths-based perspective of social workers make their presence on the team especially valuable. Key social work roles include advocacy, care coordination, crisis intervention, psychoeducation, community organization, policy work, and research.

Because palliative care services are relationship-driven and communication-focused, social workers play an essential role in all aspects of care delivery. Table 1 (page 3) provides numerous examples of evidence-informed interventions that promote the patient's adjustment to living with a serious illness. Social workers are resource liaisons, making referrals to organizational and community supports. Social workers coordinate and facilitate family meetings, conduct advance care planning conversations, assist in the cultivation of prognostic awareness to minimize future regrets, address unmet social drivers of health, explore

sources of existential distress, and provide grief support (Altilio et al., 2022). Social workers may support care at the end of life through legacy-building activities and by providing dignity therapy, as well as culturally and spiritually sensitive postmortem guidance and support. Additional evidence-informed social work interventions include the provision of trauma-informed care, cognitive–behavioral therapy, and acceptance and commitment therapy (Altilio et al., 2022; Sumser et al., 2019).

Social workers address the myths and misperceptions that patients and their families have related to pain and symptom management and assist in managing the multidimensional sources of suffering associated with serious illness (Sharma et al., 2018). Social workers may also be called in complex care situations to assist those living with cognitive impairment or with an addiction history.

Summary

Social workers have a responsibility to advocate for policies and procedures that support the use of validated assessment tools and evidence-informed interventions critical in the delivery of quality, goal-concordant care.

4. DOCUMENTATION

Social workers document all practice activities in clinical records to foster clear communication and facilitate collaboration with patients and interprofessional teams, and to communicate findings and interventions clearly through timely documentation, with awareness that patients and team members have access to notes.

INTERPRETATION

Documentation of the social worker's assessment and interventions communicates quality-of-life goals of patients, families, and care partners to the broader team. Quality of life can be interpreted differently by each person, so a thorough biopsychosocial–spiritual assessment is critical.

Documentation highlights social work clinical practice theory and social work competencies used to guide practice. Together, theory and competency contribute to the overall plans of care that incorporate and implement social work perspective to enhance the patient, family, and care partners' quality of life (Fuentes & Pietrus, 2022). Documentation serves as a platform to build on common language used between

providers to reduce misunderstandings and enhance collaboration (Olsson et al., 2021).

Documentation is both a form of communication and foundational to successful collaboration. Quality documentation creates a meaningful narrative. Collaboration starts with the patient and extends to the interprofessional team. It includes validation of information for accuracy and confirmation that the language used does not perpetuate cultural racism and health inequities (Michaels et al., 2023). Objective and nonjudgmental documentation of conversations with patients facing serious illness in patient records supports the provision of goal-concordant care (King et al., 2022). Documenting and reviewing the impact of social work interventions with patients, families, and team members help the interprofessional team, and the entire profession as a whole, avoid malfeasance, uphold beneficence principles, and build on best practice techniques.

Reporting and documenting patients' records must be conducted in compliance with current federal and state laws, with an emphasis on confidentiality and privacy of medical information. Compliance with organizational and federal policies, particularly about the transfer of electronic records and the sharing of information, is an important component of quality practice.

Social workers can facilitate transparent and timely access for patients to view their electronic health information in accordance with the 21st Century Cures Act (P.L. 114-255, 2016), while also promoting policies to facilitate patients' communication with their care providers. The impact of movements advocating for transparent communication in healthcare such as OpenNotes (n.d.) is multidimensional and used by different stakeholders, inclusive of patients and care partners.

Ethical Considerations

The NASW (2021) *Code of Ethics* respects patient confidentiality and trust. Professionals must strive for accuracy, elimination of bias, and an attitude of respect.

Patient Empowerment: Informed patients are more likely to actively take part in their care plans, leading to improved treatment outcomes.

Therapeutic Alliance: Transparent communication can help foster trust, assuring patients that their privacy is respected, while encouraging open discussions about the implications of accessing their notes.

Cultural Sensitivity: Documentation may encompass deeply personal information that might be culturally sensitive or challenging for patients to process.

Communication: Documentation requires clear communication between providers and patients. Explaining the intention behind notes, the terminology used, and the potential emotional impact of reading them is crucial.

Patient Well-Being: Content in the electronic health record may be distressing, triggering, or misinterpreted without professional guidance. Best practice establishes mechanisms for patients to be involved in processes for inclusion or exclusion of data that may compromise their safety or privacy. It is imperative that social workers complete documentation in a prompt fashion. Documentation of every interaction, including in-person and via telephone, ensures continuity of care and transparency.

Summary

Holistic documentation is key to communication and maintenance of the therapeutic alliance. Cultural sensitivity integrates social work ethics and patient engagement and enhances collaboration. Documentation that informs and provides shared language enriches collaboration, enhances decision making, and builds trust. Transparent and timely patient access to health information has the potential to amplify patient empowerment and ultimately well-being.

5. COLLABORATION

Social workers are an essential part of an interprofessional team and shall respectfully collaborate with team members and other clinicians, recognizing the essential relationships with providers who may have cared for the patient throughout the continuum of illness. Social workers access a variety of roles to expand collaboration through formal leadership, mentorship, and clinical care, and by fostering and creating meaningful encounters. Collaboration with colleagues in policy, research, and education occurs across settings.

INTERPRETATION

Social work is collaborative by nature, building on the crucial importance of human relationships. Collaboration is the operational vehicle

for increased communication, enhanced empathy, and a critical catalyst for change. Healthcare has become progressively complex, requiring interprofessional collaboration, work distribution, joint decision making, and team members who understand the diverse roles needed to care for patients facing serious illness.

Collaboration through Communication

Communication occurs in myriad ways. One level is among patients, families, and care partners who have documented and discussed values and preferences for types of care at early stages of an illness. Another level of communication includes medical professionals seeking out previously executed advance directives, and communication aligned with the health literacy of that patient–family system. There is also communication among the interprofessional teams to address differing perspectives and identify when to seek consultation with specialty teams in palliative care or ethics to resolve differing assessments about patient care needs. Social workers are a vital member of the team to improve communication in all the micro, mezzo, and macro realms of care.

Patient and Family. Discussions with patients and families about the pursuit of life-sustaining interventions and transition into end-of-life care are often emotionally charged. Patients may be struggling to understand the implications of a poor prognosis paired with a social narrative that promotes death as the enemy, thus worsening their confusion and misconceptions regarding end-of-life services (Giamportone, 2021; Waldrop et al., 2016). Social workers can assume leadership positions to facilitate family meetings at key intervals in the continuum of care to aid comprehension of the information, clarify patient wishes, and promote shared understanding among all involved. Social workers may use these opportunities to introduce and discuss advance care planning to document an individual's values and preferences for care (Hage et al., 2022).

Healthcare Team, the Patient, and Their Family. Facilitating communication between patients, families, and team members is an integral part of the social work role in all hospice and palliative care (Giamportone, 2022; Head et al., 2019). Social workers aid in clarifying communication disparities to improve health literacy when medical information has not been clearly understood by patients and families, as well as to elevate patient voices regarding the psychosocial impact of intervention options (Curd

& Hong, 2024). This is a critical ability performed by social workers to advocate for care plans reflecting the person's emotional, sociological, and economic realities, and/or to elevate a perspective that may be contradictory to the team's noted objectives.

Interprofessional. The Institute of Medicine (2015) recommends that practicing healthcare professionals pursue ongoing interprofessional training (IPEC, 2023) to develop the skills needed to increase communication effectiveness. The ability to effectively communicate one's rationale behind assessment conclusions such that others on the interprofessional team can understand the social work perspective is a vital skill. Interprofessional communication is dependent on social workers having the confidence to contribute their knowledge and ability in conversations (Curd & Hong, 2022). Social workers' knowledge is a requisite part of the comprehensive approach to care services. Therefore social workers freely contribute to patient discussions rather than wait for an invitation to share their perspectives and expertise (Curd & Hong, 2024; Giamportone, 2022).

Interdepartmental and Interorganizational. Specialist services (e.g., oncology, pulmonology, cardiology) recognize that palliative and hospice care interventions are provided by interprofessional teams, but some departments or organizations may have misunderstandings about when to consult or involve the team to optimize collaborative supportive practices (Walter et al., 2021). Social workers actively seek opportunities to build bridges between healthcare departments in hospital networks and with community providers to highlight the benefits of early collaboration in providing layers of support to holistically address a variety of patient symptoms or to ease care transitions (Flierman et al., 2020).

Community. Social workers have an ethical responsibility to recognize the social justice issues and systemic barriers to receiving palliative care and/or hospice services faced by individuals who are politically, historically, or socially marginalized (Curd & Hong, 2024). Social workers have an obligation to communicate with network, city, state, and national leaders to advocate for changes in addressing social drivers affecting care (NASW, 2021). Additionally, social workers are encouraged to fulfill ethical responsibilities to the broader society by seeking opportunities to partner with community organizations to provide education and clarification about advance care planning, specialist palliative care services, and hospice care.

Transparency and Inclusivity. All members of the team need to feel heard and acknowledged and should be kept informed to build trust and maintain a truly collaborative environment. Creating conditions that promote a sense of psychological safety is crucial for productive collaboration; enhanced engagement; reduced stress; and improved team communication, effectiveness, and organizational performance (Mogård et al., 2023). All actions of the group need to include clearly designated responsibilities prior to implementation.

Knowledge. A collaborative leader acknowledges the diversity of education and backgrounds that an interprofessional team brings to the table. Knowledge of different disciplines and varied processes can remove obstacles to providing individualized care plans for patients and families.

Summary

Open, judgment-free communication offers positive reinforcement, and discussion of the expectations of all disciplines cultivates a collaborative environment. Collaborative leadership includes patience, self-awareness, and a sense of equality across the board that allows for open sharing of information and relationship building. Compromise may be necessary to provide quality care. Building and maintaining relationships requires the effort to understand others' points of view and identify personal similarities and common interests.

Interprofessional, interdepartmental, and interorganizational collaboration is a critical component of quality care. Collaboration occurs among the healthcare team and between the team, patient, and family. Communication reveals separate realities and builds inclusive relationships. Social work is called to expand collaboration via coaching, mentoring, and clinical care to promote and foster meaningful encounters.

6. EDUCATION, PROFESSIONALISM, AND PROFESSIONAL DEVELOPMENT

Social workers shall possess a bachelor's or master's degree in social work from a school or program accredited by the Council on Social Work Education and comply with state licensing requirements. Social workers shall possess the skills, knowledge, and experience necessary to provide quality care to individuals living with a serious illness; assume personal responsibility for their own continued professional development following the NASW (2003) *Standards for Continuing Professional*

Education and state requirements; and demonstrate a commitment to lifelong learning.

INTERPRETATION

Social work degree programs from accredited schools of social work provide the required education and training for foundational competency development. Increasingly, schools of social work are offering courses, internships, field placements, and other interprofessional learning opportunities that are specific to health social work or serious illness care and provide beneficial training to students interested in these areas of practice.

Social workers who work in palliative, hospice, and other healthcare settings are typically expected to have an active state license, though licensing requirements vary by setting and state. Additional post-master's graduate palliative and hospice social work training may be obtained through fellowship and certificate programs. Currently, two social work palliative care credentialing certifications exist for individuals with demonstrated experience.

Continuing Education

Social workers have an ethical responsibility to commit to career-long professional development per the NASW (2021) *Code of Ethics* in an effort to remain up to date in the best practices of palliative and hospice social work. Although continuing education is a requirement of most, if not all, state licensure boards, social workers, regardless of license or credentialing, must take responsibility for engaging in continuing education to promote and enhance their professional competencies (Apgar, 2021; Glajchen et al., 2018; Jonas et al., 2022). Opportunities for interprofessional learning enhance social work skills in general and elevate the role of palliative and hospice social workers on interprofessional teams (Wong et al., 2022). There are opportunities for lifelong professional development in the field of palliative social work through engagement with the various local and national professional palliative care and hospice organizations.

Additional intensive post-master's graduate palliative and hospice social work training can be obtained through fellowship and certificate programs. An increasing number of healthcare systems and university systems are offering one- to two-year palliative care social work fellowships either alongside their physician fellowships or independently,

dedicated to social work professional enhancement. These fellowships offer intensive training in the varied areas of practice—inpatient, outpatient, pediatric, community based, and hospice—allowing for an in-depth, well-rounded specialized educational experience. There are also national postgraduate certificate programs designed to foster education, leadership, and mentorship for palliative care social workers at all levels of experience. The certificates earned through successful completion of these programs demonstrate heightened skills and depth of knowledge, but are different from the credentialing certification discussed in the next section.

Credentialing Certification

Credentialing certification is authorized by a national organization after the candidate meets criteria and demonstrates competency in a specialized field via advanced-level examination. As of this writing, palliative social workers in the United States have two options for credentialing certification that demonstrate to patients, families, employers, colleagues, and the public that these specialized palliative care and hospice social workers meet the highest standards of professional training and practice.

NASW offers both master's- and bachelor's-level certifications that indicate social workers with sufficient experience and continuing education. The APHSW-C (Hospice & Palliative Nurses Association, Hospice & Palliative Nurses Foundation, & Hospice & Palliative Credentialing Center, n.d.) is the first evidence-based hospice and palliative care social work certification for which both MSW and BSW practitioners with two to three years of related experience are eligible to apply. This is a test-based certification like that in nursing or medicine, and renewal is offered every four years. Social workers are encouraged to obtain certification and to advocate with their employers for recognition of the value of their education, experience, and contribution to their care team. As with their physician and nursing colleagues, certification may provide social workers a pathway to promotion and increased compensation, as well as recognition by regulatory boards.

Supervision

Using social work–specific supervision allows workers the opportunity to enhance professional growth while building skills and knowledge to increase competence in providing high-quality services to patients and families. Supervision provides an avenue to sustain and nurture the

core values and ethics of the social work profession to promote learning and to develop resiliency and compassion while processing emotionally intensive and ethically complex case scenarios (Sewell, 2018). There continues to be limited research covering the topic of professional social work supervision practices; however, Mor Barak and colleagues (2009) found positive connections for workers when supervision sessions covered topics related to social and emotional support and navigating interpersonal interactions.

Seasoned social workers have opportunities to provide supervision to students through field placements, interprofessional colleagues through orientation training and on-boarding activities, and when in positions of leadership. Social workers may be tasked to supervise community health workers or hospice volunteers.

Mentorship

Mentorship, which can be either formal or informal, is critical throughout one's professional development. Formal mentorship may take the form of intentionally demonstrating the process of integrating theory into practice. For example, new social workers ideally have access to a professional mentor with more experience to glean guidance, advance clinical skills, address ethical issues, model documentation practices, and discuss opportunities in the interprofessional team to advance quality of care (Berkman et al., 2022). Formal mentorship may also refer to the professional administrative leadership roles inhabited by social workers occupying a variety of positions in organizations and who personify compassionate leadership qualities (Hewison et al., 2019).

Social workers with a minimum of two years postgraduate experience may also consider leadership development and give back to the profession by becoming practicum supervisors for social work students completing generalist or specialist-level training. Palliative social work mentors can leverage these standards to help students meet the competency requirements outlined in the Council on Social Work Education (2022) *Educational Policy and Accreditation Standards* to guide and cultivate the next generation of practitioners, ensuring they possess the necessary skills in areas like ethical decision making, cultural humility, and interprofessional collaboration as they learn to provide holistic support to patients and families facing serious illness.

Informal mentorship applies to everyday practice skills social workers bring to their role, whereas other disciplines may not have the same

level of knowledge. There is value in the contributions and assessment explanations that social workers can use to teach and model their practice skills for others on the interprofessional team, such as explaining behavioral cues or issues pertaining to social drivers of health, demonstrating cultural humility tenets, and most important, modeling skills related to improving communication and relationship building (Giamportone, 2022).

Summary

Social workers have an obligation to be lifelong learners who seek to expand their areas of expertise, so they can continually increase their effectiveness as professionals committed to the delivery of quality care. Identifying opportunities for continuing education, coaching, and mentorship is critical for professional growth and sustainable practice.

7. ADVOCACY AND LEADERSHIP

Social workers shall demonstrate commitment to providing the best care possible and advocating for effective and improved care for those served. Specialty-trained social workers in palliative and hospice care are uniquely qualified to lead educational, supervisory, administrative, research, and advocacy efforts with individuals, groups, and organizations.

INTERPRETATION

As shown in the NASW (2021) *Code of Ethics*, social workers are charged with advocacy and championing social justice on all levels of practice. Social workers advocate on behalf of people in their care during interprofessional team meetings, in the broader medical profession, and in communities and systems to address social inequities and promote well-being. They advocate for removal of barriers and use of antiracist techniques to address inequities in access and use of palliative and hospice care. They explore and promote policies that eradicate disparities in caregiving, resources, and other identified needs that potentially affect a person's dignity, peace, and quality of life throughout serious illness (Rosa et al., 2022). Advocacy for those who are vulnerable, marginalized, or oppressed is at the foundation of the social work profession and requires a commitment to broadening leadership skills to enhance clinical impact and effectiveness (Otis-Green, 2022).

Leadership

Social workers play an integral role as members of interprofessional healthcare teams and must be well prepared for the position of collaborative leader (Schaub et al., 2022). Collaborative leadership encompasses the purposeful actions taken to build relationships with all stakeholders, to act with transparency, to share knowledge, and to build both self- and collective efficacy (DeWitt, 2018). Self-efficacy is the belief one has in their own abilities to complete a task or achieve a goal, while collective efficacy is the group's shared belief in their capability to accomplish goals (Ganotice et al., 2022). The use of interprofessional collaboration is empowering, and transformative leadership fosters growth through the development of shared goals and visions with colleagues and clients alike (Otis-Green, 2022).

Social workers are key members of health-related interprofessional teams with awareness of the impact of social drivers of health (National Academies of Sciences, Engineering, and Medicine, 2019). Social workers' knowledge, skills, and abilities enhance the quality of life of patients and are instrumental in advancing the profession. There is a growing demand for care of older adults and those with chronic conditions, as well as an increased need for quality palliative and end-of-life care, and a shortage of palliative care practitioners and social workers trained to care for this population (Burke & Currin-McCulloch, 2019).

Professional Well-Being

Balancing Boundaries and Institutional Support. Working with patients and caregivers facing serious illness and end-of-life issues can be extremely stressful at times, requiring the use of multiple self-care practices, such as performing reflective self-compassion techniques (Miller, 2020), establishing professional boundaries (Sanders et al., 2012), and holding institutions accountable for their role in promoting wellness among workers (Lehto et al., 2020). Research has shown low job satisfaction among social workers in palliative care settings due to the high stress–high loss environment leading to moral distress and burnout (Taels et al., 2021). Organizations have a responsibility to provide space for personal well-being practices and to develop systemic occupational strategies that support workers in mitigating the stressors associated with caring for patients and families (Lehto et al., 2020; Mulkerin, 2022). Promoting practices and policies to support social workers' self-care is the role of social work organizations, agencies, and educational facilities (NASW, 2021).

Due to the high stress–high loss environment that is present in work with people with serious illness, social workers may potentially feel isolated and alone, especially in settings where they have no other experienced palliative social work colleagues. As is true in other disciplines, insufficient peer support is linked to job dissatisfaction and burnout. Social workers benefit from receiving clinical support from other social workers whenever possible. This allows them to process experiences that are unique to the social work role and perspective (Taels et al., 2021). Therefore, social workers may also benefit from seeking peer support outside of their department or field of practice. Developing connections with others across a variety of health departments, in local NASW chapters, or through other professional organizations (e.g., Social Work Hospice & Palliative Care Network, American Academy of Hospice and Palliative Medicine) may help to provide sustained opportunities for ongoing processing and feedback.

Team Dynamics and Culture. A social worker is an ideal team member to lead staff through reflective debriefing, allowing members to freely process moral distress, work-related issues, and other obstacles met in the course of daily work (Browning & Cruz, 2018). Facilitation of such meetings allows each member of the interprofessional team to feel included and able to verbalize issues, thus promoting health and wellness among the team. Social workers may partner with spiritual care colleagues to support wellness from a biopsychosocial–spiritual perspective (Burke et al., 2024).

Social workers can advocate for positive change on the systemic level in organizations on behalf of all team members. Efforts to mitigate the impact of toxic work environments, overwhelming caseload expectations, and unrealistic "productivity measures" reduce moral distress and enhance sustainability for all. Organizational administrators can positively impact job satisfaction and reduce burnout in departments by providing supervisory support and increased job autonomy, the latter of which is associated with lower levels of depression, anxiety, and burnout (Pala et al., 2022).

Self-Care. Professional self-care and well-being are critical issues for social workers in any field. The 2021 amendments to the NASW *Code of Ethics* specify professional self-care as being paramount for competent and ethical social work practice. Social workers have a heightened risk of developing moral distress and burnout due to increased stressors resulting from exposure to death, dying, and complex family structures (Pelon, 2017). Social workers who examine death anxiety and take time for reflection to process feelings and attitudes about their own mortality

and that of people in their personal lives may appreciate the work ahead for patients and families. Through this process the social workers have the potential to bolster protective mechanisms that guide compassion satisfaction. Reflecting on mortality provides a countermeasure for fear and anxiety to openly discuss dying with empathy and compassion.

Additional improvement strategies that an organization can use to decrease burnout and increase professional fulfillment among social workers include providing clarity in the scope of their roles and upholding a manageable workload, providing clear leadership support, encouraging licensure practice, and providing opportunities for professional development (such as career ladders, protected time for academic growth, recognition for exemplary practice, and promoting avenues for the practice of self-compassion and wellness; Chan et al., 2021).

Summary

Social workers are leaders and advocates in many aspects of serious illness care. This ranges from clinical care to academic and research environments. Advocacy and leadership promote the unique contributions of social work in serious illness care. Ultimately social workers are called to advocate for professional well-being through healthy team dynamics, promoting a culture that balances the responsibility to serve without self-harm and a culture that supports healthy boundaries. Resilience, self-care, and well-being are vital ingredients to nurture and sustain this work.

8. COMMITMENT TO QUALITY PRACTICE

Social workers shall function within guidelines for excellence using evidence-informed practice approaches, data collection, and efficient evaluation for rapid-cycle improvement to ensure representation in planning and implementing best practices.

INTERPRETATION

Social workers contribute to the literature in the field by using evidence to inform practice and practice to inform and address gaps in the literature. Social workers providing care to seriously ill patients and families function within the guidelines for excellence outlined by the NCP (2018), the American Academy of Hospice and Palliative Medicine's (n.d.) Palliative Care Measures Project, and the standards of care in the respective setting in which they practice. Social workers' commitment to quality practice is supported by the NASW (2021) *Code of*

Ethics, which articulates the basic values, principles, and standards to guide ethical practice behaviors.

Tools are available to facilitate rapid-cycle quality improvement and conformance to standards for high-quality palliative care that are continuously measured and regularly shared among clinicians (Kamal et al., 2015). Using human-centered design strategies, social workers can promote efforts to make healthcare more equitable by centering user involvement (Sherman et al., 2024). Social workers are integral to the planning and implementation of strategies identified as best practices. Goals that are set by interprofessional teams, inclusive of social workers, often focus on collective quality measures and discipline-specific measures or outcomes (NCP, 2018). Social workers have a responsibility to attend to family dynamics, assess and support treatment planning and address social drivers of health, identify and facilitate access to resources, mediate conflicts, and uphold a host of other demonstrative values with the team (Marmo & Berkman, 2020).

These outcomes may be measured at the patient, organization, and community levels (Taels et al., 2021). The metrics set by the team measure quality by systematically collecting and analyzing data on care processes and outcomes specific to the patient population and the priorities of the organization. Continuous review of outcomes and adjustment of targets, planning, and implementing change are essential to quality care. This cycle is repeated in an iterative and ongoing fashion (NCP, 2018).

Staying abreast of contemporary models and frameworks for engaging patients and families that have been historically excluded from fair access to care is a quality care issue. Continuing education is necessary to end disparities in serious illness care that have resulted in inequities across historically, politically, and structurally marginalized groups. Perpetuating the use of dominant care models may worsen the racial divide in access to hospice and palliative care (Silvers et al., 2022). Social workers' commitment to quality practice should include an examination of culturally incongruent methods for validation and assessment of application to and with those who are marginalized.

Research and Dissemination of Knowledge

Social workers elevate the profession as contributing authors and lead investigators conducting quantitative and/or qualitative research covering topics aimed at intra- and interprofessional audiences. Social workers also play a vital role by taking part in the research efforts conducted by

others or partnering with academic colleagues to support the research process (Buck et al., 2023).

Research is needed that seeks insight into social worker perspectives and evaluates the effectiveness of intervention methods and strategies, which would result in the development of more nuanced staffing standards and more effective policies, programs, and procedures that ultimately improve services for patients, families, and care teams (Cadet, 2022). Social workers also gain useful experience using theory-informed interventions and anecdotal observations from practice experiences that may help others working with similar subpopulations or issues. Rigorous research, publishing reflective essays, and conference presentations are all routes for social workers to share their clinical knowledge with their peers.

Additionally, social workers can increase the visibility of the profession and share their perspectives by engaging in active public debate on social policy through respectful social media platforms and contributing opinion pieces to newspapers or other mainstream publications (Lundalv, 2019). These options will serve to advance the profession of social work within the care continuum.

Summary

Social workers play a critical role in enhancing the quality of care by improving patient outcomes, reducing hospital readmissions, lowering overall healthcare costs, and fostering greater coordination and cohesion within care teams. Evidence-informed knowledge adds another layer of legitimacy to the social work profession's role as critical partner on the interprofessional team. Social workers, as members of a practice-based profession, have a responsibility to continually reflect on and assess the validity of intervention methods to uphold their ambitious standards leading to these multiple benefits of inclusion on the care team. Social workers demonstrate their professional skills and value via consistent engagement in a range of areas from clinical practice to policy development, research, and other leadership roles.

Palliative social workers bring humanity to healthcare, ensuring that individuals and families facing serious illness are seen, heard, and supported. By addressing emotional, social, cultural, and systemic barriers to care, palliative social workers promote dignity and improved quality of life, and are essential in the delivery of compassionate, person-centered, family-focused, culturally congruent, and ethically grounded healthcare.

REFERENCES

Agency for Healthcare Research and Quality. (2019, July). *Planning culturally and linguistically appropriate services.* https://www.ahrq.gov/ncepcr/tools/cultural-competence/planclas.html

Altilio, T., & Kelemen, A. (2022). The power of language: Inviting attention and intention to word choice. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *The Oxford textbook of palliative social work* (2nd ed.; pp. 52–64). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Altilio, T., Kelemen, A., & Leff, V. (2021). Designing and implementing a COVID language resource guide as a response to an acute need. *Journal of Social Work in End-of-Life & Palliative Care*, *17*, 146–157. https://doi.org/10.1080/15524256.2021.1940420

Altilio, T., Otis-Green, S., & Cagle, J. G. (Eds.). (2022). *The Oxford textbook of palliative social work* (2nd ed.). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

American Academy of Hospice and Palliative Medicine. (n.d.). *The Palliative Care Measures Project.* Retrieved September 10, 2025, from https://aahpm.org/research-qi/quality-initiatives/

American Medical Association. (2021). *Embedding racial justice and advancing health equity: AMA's Organizational Strategic Plan 2021–2023.* Author.

Anderson, G. T. (2021). Let's talk about ACP pilot study: A culturally responsive approach to advance care planning education in African American communities. *Journal of Social Work in End-of-Life & Palliative Care*, *17*, 267–277.

Apgar, D. (2021). The great divide between social work, educational policy and licensure examinations: Differing approaches to identifying competency that are challenging the profession. *Journal of Social Work Education*, *57*, 519–533. https://doi.org/10.1080/10437797.2019.1671273

Becker, T. D., & Cagle, J. G. (2022). The importance and impact of culture in palliative care. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 26–38). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Berkman, C., Genereux, C., & Front, A. (2022). Supervision and mentoring for social workers in palliative and end-of-life care. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 888–896). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Blacker, S., Head, B. A., Jones, B. L., Remke, S. S., & Supiano, K. (2016). Advancing hospice and palliative care social work leadership in interprofessional education and practice. *Journal of Social Work in End-of-Life & Palliative Care*, *12*, 316–330. https://doi.org/10.1080/15524256.2016.1247771

Borden, E., Leimena, M. L., & Sumser, B. (2022). Centering the lens of social justice. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *The Oxford textbook of palliative social work* (2nd ed.; pp. 3–13). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Bosma, H., Johnston, M., Cadell, S., Wainwright, W., Abernethy, N., Feron, A., Kelley, M. L., & Nelson, M. (2009). Creating social work competencies for practice in hospice palliative care. *Palliative Medicine*, *24*, 79–87. https://doi.org/10.1177/0269216309346596

Browning, E. D., & Cruz, J. S. (2018). Reflective debriefing: A social work intervention addressing moral distress among ICU nurses. *Journal of Social Work in End-of-Life & Palliative Care*, *14*, 44–72. https://doi.org/10.1080/15524256.2018.1437588

Buck, G., Whiteside, N., Newman, A., Jones, H., Stanley, S., Feather, J., & Millard, W. (2023). Promoting practitioner research through a social work teaching partnership. *Practice*, *35*, 57–73. https://doi.org/10.1080/09503153.2022.2128324

Bullock, K. (2011). The influence of culture on end-of-life decision making. *Journal of Social Work in End-of-Life & Palliative Care*, 7, 83–98. https://doi.org/10.1080/15524256.2011.548048

Bullock, K., Gray, T. F., Tucker, R., & Quest, T. E. (2022). Race roundtable series: Structural racism in palliative care. *Journal of Pain and Symptom Management*, *63*, e455–e459. https://doi.org/10.1016/j.jpainsymman.2022.01.015

Bullock-Johnson, R., & Bullock, K. (2022). Advance directives and the influence of cultural dynamics. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 580–587). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Burke, C., Clark, S., Gholson, K. L., & Mazur, J. (2024). We care: A wellness intervention project for palliative care physicians. *Journal of Pain and Symptom Management*, *67*, e90–e93. https://doi.org/10.1016/j.jpainsymman.2023.08.027

Burke, C., & Currin-McCulloch, J. (2019). Educating our future colleagues: Creating an MSW palliative care practicum. *Journal of Social Work in End-of-Life & Palliative Care*, *15*, 7–15. https://doi.org/10.1080/15524256.2019.1586806

Bussey, S. R., Thompson, M. X., & Poliandro, E. (2022). Leading the charge in addressing racism and bias: Implications for social work training and

practice. *Social Work Education*, *41*, 907–925. https://doi.org/10.1080/02615479.2021.1903414

Cadet, T. (2022). Merging research and clinical practice. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 527–536). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Cagle, J. (2022). Advancing the social work profession within palliative care. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 853–856). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Carrion, I. V., & Bullock, K. (2012). A case of Hispanics and hospice care. *International Journal of Humanities and Social Sciences*, *2*, 9–16.

Centers for Disease Control and Prevention. (2024, January 17). *Why is addressing social determinants of health important?* U.S. Department of Health and Human Services. https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html

Centers for Medicare & Medicaid Services. (2022, November). *Screening for social drivers of health*. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_487_MIPSCQM.pdf

Chan, G., Kuriakose, C., Blacker, A., Harshman, J., Kim, S., Jordan, L., & Shanafelt, T. (2021). An organizational initiative to assess and improve well-being in advanced practice providers. *Journal of Interprofessional Education & Practice*, *25*, Article 100469. https://doi.org/10.1016/j.xjep.2021.100469

Code of Federal Regulations, 45 CFR § 92.201 (2024, October 1). https://www.govinfo.gov/app/details/CFR-2024-title45-vol1/CFR-2024-title45-vol1-sec92-201/summary

Connor, S. R. (2008). Development of hospice and palliative care in the United States. *OMEGA: Journal of Death and Dying*, *56*, 89–99. https://doi.org/10.2190/OM.56.1.h

Council on Social Work Education. (2022). *Educational policy and accreditation standards (EPAS)*. https://www.cswe.org/accreditation/policies-process/2022epas/

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1*, 139–167.

Crunkilton, D. D., & Rubins, V. D. (2009). Psychological distress in end-of-life care: A review of issues in assessment and treatment. *Journal of Social Work in End-of-Life & Palliative Care*, *5*, 75–93. https://doi.org/10.1080/15524250903173918

Curd, J., & Hong, M. (2022). "We are all just walking each other home": Exploring the lived experiences of rural hospice social workers in "companioning" the dying. *Journal of Social Work in End-of-Life & Palliative Care*, *18*, 252–272. https://doi.org/10.1080/15524256.2022.2093313

Curd, J., & Hong, M. (2024). Exploring the lived experiences of rural hospice social workers in navigating "cracked" systems. *Journal of Social Work in End-of-Life & Palliative Care*, *20*, 26–47.

Desai, M. U., Paranamana, N., Restrepo-Toro, M., O'Connell, M., Davidson, L., & Stanhope, V. (2021). Implicit organizational bias: Mental health treatment culture and norms as barriers to engaging with diversity. *American Psychologist*, *76*, 78–90. https://doi.org/10.1037/amp0000621

DeWitt, P. M. (2018). *School climate: Leading with collective efficacy*. Corwin.

Elk, R., Felder, T. M., Cayir, E., & Samuel, C. A. (2018). Social inequalities in palliative care for cancer patients in the United States: A structured review. *Seminars in Oncology Nursing*, *34*, 303–315. https://doi.org/10.1016/j.soncn.2018.06.011

Flierman, I., van Seben, R., van Rijn, M., Poels, M., Buurman, B. M., & Willems, D. L. (2020). Health care providers' views on the transition between hospital and primary care in patients in the palliative phase: A qualitative description study. *Journal of Pain and Symptom Management*, *60*, 372–380. https://doi.org/10.1016/j.jpainsymman.2020.02.018

Foronda, C., Baptiste, D., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing*, *27*, 210–217. https://doi.org/10.1177/1043659615592677

Fuentes, B., & Pietrus, M. (2022). Connecting the dots between theoretical knowledge and clinical practice: A palliative care social worker process improvement project in an acute hospital setting. *Journal of Social Work in End-of-Life & Palliative Care*, *18*, 22–33. https://doi.org/10.1080/15524256.2021.1984368

Ganotice, F. A., Chan, L., Shen, X., Lam, A. H. Y., Wong, G. H. Y., Liu, R. K. W., & Tipoe, G. L. (2022). Team cohesiveness and collective efficacy explain outcomes in interprofessional education. *BMC Medical Education*, *22*, Article 820. https://doi.org/10.1186/s12909-022-03886-7

Gardner, D. S., Gerbino, S., Walls, J. W., Chachkes, E., & Doherty, M. J. (2015). Mentoring the next generation of social workers in palliative and end-of-life care: The Zelda Foster studies program. *Journal of Social Work in End-of-Life & Palliative Care*, *11*, 107–131. https://doi.org/10.1080/15524256.2015.1074142

Gawande, A. (2017). *Being mortal: Medicine and what matters in the end*. Holt & Company.

Gerstorf, D., Ram, N., Goebel, J., Schupp, J., Lindenberger, U., & Wagner, G. G. (2010). Where people live and die makes a difference: Individual and geographic disparities in well-being progression at the end of life. *Psychology & Aging*, *25*, 661–676.

Giamportone, K. E. (2021). A journey to hospice: Reflecting on one patient's barriers to service. *Journal of Social Work in End-of-Life & Palliative Care*, *17*, 246–249. https://doi.org/10.1080/15524256.2021.1977762

Giamportone, K. E. (2022). Expectations of social workers for interprofessional practice in healthcare: Qualitative insights from practicing physician, nurse, and social work professionals. *Social Work in Health Care*, *61*, 516–529. https://doi.org/10.1080/00981389.2022.2154887

Gibson, A., Walsh, J., & Brown, L. M. (2018). A perfect storm: Challenges encountered by family caregivers of persons with Alzheimer's disease during natural disasters. *Journal of Gerontological Social Work*, *61*, 775–789. https://doi.org/10.1080/01634372.2018.1474158

Glajchen, M., Berkman, C., Otis-Green, S., Stein, G. L., Sedgwick, T., Bern-Klug, M., Christ, G., Csikai, E., Downes, D., Gerbino, S., Head, B., Parker-Oliver, D., Waldrop, D., & Portenoy, R. (2018). Defining core competencies for generalist-level palliative social work. *Journal of Pain and Symptom Management*, *56*, 886–892. https://doi.org/10.1016/j.jpainsymman.2018.09.002

Glajchen, M., Otis-Green, S., Berkman, C., & Portenoy, R. K. (2024). Educating social workers in palliative and end-of-life care: Development and implementation of a new national training program. *Journal of Palliative Medicine*, *27*, 638–643. https://doi.org/10.1089/jpm.2023.0516

Goldhirsch, J., Halpenny, B., Scott, N., Ma, Y., Rodriguez, M. S., & Abrahm, J. L. (2021). What's lost in translation: A dialogue-based intervention that improves interpreter confidence in palliative care conversations. *Journal of Pain and Symptom Management*, *62*, 609–614. https://doi.org/10.1016/j.jpainsymman.2021.02.027

Gottlieb, M. (2021). The case for a cultural humility framework in social work practice. *Journal of Ethnic & Cultural Diversity in Social Work*, *30*, 463–481.

Hage, M., Nelson, E., Bocchino, A., Ginsberg, J., & Potter, J. (2022). A model for standardized and proactive advance care planning. *Journal of Social Work in End-of-Life & Palliative Care*, *18*, 34–45. https://doi.org/10.1080/15524256.2021.2015737

Hardy, D., Chan, W., Liu, C., Cormier, J., Xia, R., Bruera, E., & Du, X. (2010). Racial disparities in the use of hospice services according to geographic residence and socioeconomic status in an elderly cohort with nonsmall cell lung cancer. *Cancer*, *117*, 1506–1515.

Head, B., Peters, B., Middleton, A., Friedman, C., & Guman, N. (2019). Results of a nationwide hospice and palliative care social work job analysis. *Journal of Social Work in End-of-Life & Palliative Care*, *15*, 16–33. https://doi.org/10.1080/15524256.2019.1577326

Hendricks Sloan, D., Peters, T., Johnson, K. S., Bowie, J. V., Ting, Y., & Aslakson, R. (2016). Church-based health promotion focused on advance care planning and end-of-life care at Black Baptist churches: A cross-sectional survey. *Journal of Palliative Medicine*, *19*, 190–194. http://doi.org/10.1089/jpm.2015.0319

Hewison, A., Sawbridge, Y., & Tooley, L. (2019). Compassionate leadership in palliative and end-of-life care: A focus group study. *Leadership in Health Services*, *32*, 264–279. https://doi.org/10.1108/LHS-09-2018-0044

Hidaka, T., Endo, S., Kasuga, H., Masuishi, Y., Kakamu, T., Kumagai, T., Saito, K., Abe, K., & Fukushima, T. (2019). Disparity in pre-emptive end of life conversation experience caused by subjective economic status among general Japanese elderly people: A cross-sectional study with stratified random sampling. *Geriatric Medicine*, *9*, Article e031681.

Hospice & Palliative Nurses Association, Hospice & Palliative Nurses Foundation, & Hospice & Palliative Credentialing Center. (n.d.). *APHSW-C*. Retrieved September 10, 2025, from https://www.advancingexpertcare.org/hpcc/credentials/aphsw-c/

Hughes, A. (2013). Poverty and palliative care in the US: Issues facing the urban poor. *International Journal of Palliative Nursing*, *11*, 6–13.

Institute of Medicine. (2015). *Dying in America: Improving quality and honoring individual preferences near the end of life*. National Academies Press.

International Association for the Study of Pain. (2021). *IASP curriculum outline for pain in social work*. https://www.iasp-pain.org/education/curricula/iasp-curriculum-outline-for-pain-in-social-work/

Interprofessional Education Collaborative. (2023, November 20). *IPEC core competencies revision: Version 3*. https://www.ipecollaborative.org/2021-2023-core-competencies-revision

Jeurkar, N., Farrington, S., Craig, T. R., Slattery, J., Harrold, J. K., Oldanie, B., Teno, J. M., & Casarett, D. J. (2012). Which hospice patients with cancer are able to die in the setting of their choice? Results of a retrospective cohort study. *Journal of Clinical Oncology*, *30*, 2783–2787. https://doi.org/10.1200/JCO.2011.41.5711

Johnson, K. S. (2013). Racial and ethnic disparities in palliative care. *Journal of Palliative Medicine*, *16*, 1329–1334.

Johnson, K. S., Kuchibhatla, M., & Tulsky, J. A. (2008). What explains racial differences in the use of advance directives and attitudes toward hospice care? *Journal of the American Geriatrics Society*, *56*, 1953–1958.

Jonas, D., Patneaude, A., Purol, N., Scanlon, C., & Remke, S. (2022). Defining core competencies and a call to action: Dissecting and embracing the crucial and multifaceted social work role in pediatric palliative care. *Journal of Pain and Symptom Management*, *3*, e739–e748. https://doi.org/10.1016/j.jpainsymman.2022.02.341

Jones, T., Nedjat-Haiem, F., & Bullock, K. (2022). Health equity in palliative care. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 14–25). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Kamal, A. H., Harrison, K. L., Bakitas, M., Nicholas Dionne-Odom, J., Zubkoff, L., Akyar, I., Pantilat, S. Z., O'Riordan, D. L., Bragg, A. R., Bischoff, K. E., & Bull, J. (2015). Improving the quality of palliative care through national and regional collaboration efforts. *Cancer Control*, *22*, 396–402. https://doi.org/10.1177/107327481502200405

Kemp, A. H., & Fisher, Z. (2022). Wellbeing, whole health and societal transformation: Theoretical insights and practical applications. *Global Advances in Health and Medicine*, *11*. https://doi.org/10.1177/21649561211073077

King, S., Douglas, M., Javed, S., Semenchuk, J., Ghosh, S., Dunne, F., Moledina, A., Fassbender, K., & Simon, J. (2022). Content of serious illness care conversation documentation is associated with goals of care orders: A quantitative evaluation in hospital. *BMC Palliative Care*, *21*, Article 116. https://doi.org/10.1186/s12904-022-01006-2

Kuo, B. C. (2013). Collectivism and coping: Current theories, evidence, and measurements of collective coping. *International Journal of Psychology*, *48*, 374–388.

Kwak, J., Jamal, A., Jones, B., Timmerman, G. M., Hughes, B., & Fry, L. (2022). An interprofessional approach to advance care planning. *American Journal of Hospice and Palliative Medicine*, *39*, 321–331. https://doi.org/10.1177/10499091211019316

Lehto, R. H., Heeter, C., Forman, J., Shanafelt, T., Kamal, A., Miller, P., & Paletta, M. (2020). Hospice employees' perceptions of their work environment: A focus group perspective. *International Journal of Environmental Research and Public Health*, *17*, Article 6147. https://doi.org/10.3390/ijerph17176147

Lewis, J. M., DiGiacomo, M., Currow, D. C., & Davidson, P. M. (2011). Dying in the margins: Understanding palliative care and socioeconomic deprivation in the developed world. *Journal of Pain and Symptom Management*, *42*, 105–118.

Lundalv, J. (2019). The challenges of writing opinion pieces in social work: A national online survey of Swedish social workers' experiences of influencing public opinion. *British Journal of Social Work*, *49*, 1395–1414. https://doi.org/10.1093/bjsw/bcz058

Mannoh, I., Hussien, M., Commodore-Mensah, Y., & Michos, E. D. (2021). Impact of social determinants of health on cardiovascular disease prevention. *Current Opinion in Cardiology*, *36*, 572–579. https://doi.org/10.1097/HCO.0000000000000893

Markham, S., Islam, Z., & Faull, C. (2014). I never knew that! Why do people from Black and Asian minority ethnic groups in Leicester access hospice services less than other groups? A discussion with community groups. *Diversity and Equality in Health and Care*, *11*, 237–245.

Marmo, S., & Berkman, C. (2020). Hospice social workers' perception of being valued by the interdisciplinary team and the association with job satisfaction. *Social Work in Health Care*, *59*, 219–235. https://doi.org/10.1080/00981389.2020.1737306

Marmo, S., & Lane, S. R. (2020). Social justice and advanced cancer patients: An analysis of key policies. *Journal of Policy Practice & Research*, *1*, 37–54. https://doi.org/10.1007/s42972-020-00003-0

Mathew, L. (2024). Racism is life-threatening and continues the cycle of racial trauma: What can clinicians do to interrupt this cycle? *Clinical Social Work Journal*, *52*, 265–273. https://doi.org/10.1007/s10615-023-00913-y

Michaels, E. K., Lam-Hine, T., Nguyen, T. T., Gee, G. C., & Allen, A. M. (2023). The water surrounding the iceberg: Cultural racism and health inequities. *Milbank Quarterly*, *101*, 768–814. https://doi.org/10.1111/1468-0009.12662

Miller, J. (2020). Building competency in self-care for social work students: A course-based case study. *Social Work Education*, *39*, 256–269. https://doi.org/10.1080/02615479.2019.1620722

Mogård, E. V., Rørstad, O. B., & Bang, H. (2023). The relationship between psychological safety and management team effectiveness: The mediating role of behavioral integration. *International Journal of Environmental Research and Public Health*, *20*, Article 406. https://doi.org/10.3390/ijerph20010406

Mor Barak, M., Travis, D., Pyun, H., & Xie, B. (2009). The impact of supervision on worker outcomes: A meta-analysis. *Social Service Review*, *83*, 3–32. https://doi.org/10.1086/599028

Mulkerin, C. (2022). Professional self-care, resilience, and well-being. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 897–902). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

National Academies of Sciences, Engineering, and Medicine. (2019). *Integrating social care into the delivery of healthcare: Moving upstream to improve the nation's health*. National Academies Press. https://doi.org/10.17226/25467

National Association of Social Workers. (n.d.). *Advanced Certified Hospice & Palliative Social Worker (ACHP-SW)*. Retrieved September 20, 2025, from

https://www.socialworkers.org/Careers/Credentials-Certifications/Apply-for-NASW-Social-Work-Credentials/Advanced-Certified-Hospice-and-Palliative-Social-Worker

National Association of Social Workers. (2003). *Standards for continuing professional education*. https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Standards-for-Continuing-Professional-Education

National Association of Social Workers. (2015). *Standards and indicators for cultural competence in social work practice*. https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/Standards-and-Indicators-for-Cultural-Competence-in-Social-Work-Practice

National Association of Social Workers. (2016). *Standards for social work practice in health care settings*. https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/NASW-Standards-for-Social-Work-Practice-in-Health-Care-Settings

National Association of Social Workers. (2021). *Code of ethics of the National Association of Social Workers*. https://www.socialworkers.org/Code-of-Ethics

National Consensus Project for Quality Palliative Care. (2018). *Clinical practice guidelines for quality palliative care* (4th ed.). National Coalition for Hospice and Palliative Care. https://www.nationalcoalitionhpc.org/ncp

Nedjat-Haiem, F. R., Cadet, T. J., Parada, H., Mishra, S. I., & Bullock, K. (2021). A national survey of social workers: Focusing on attitudes, knowledge, and practice implications during COVID19. *American Journal of Hospice & Palliative Medicine*, *39*, 737–744. https://doi.org/10.1177/10499091211038503

Neely-Barnes, S. L., Kirk, B. G., Elswick, S. E., Taylor, L. C., Delavega, E., Pettet, F. L., & Landry, M. (2020). Training second year MSW students to improve cultural and linguistic competence. *Research on Social Work Practice*, *30*, 392–398. https://doi.org/10.1177/1049731519874397

O'Brien, K. H. (2019). Social determinants of health: The how, who, and where screenings are occurring; a systematic review. *Social Work in Health Care*, *58*, 719–745. https://doi.org/10.1080/00981389.2019.1645795

Oliver, D. P., & Peck, M. (2006). Inside the interdisciplinary team experiences of hospice social workers. *Journal of Social Work in End-of-Life & Palliative Care*, *2*, 7–21.

Olsson, M. M., Windsor, C., Chambers, S., & Green, T. L. (2021). A scoping review of end-of-life communication in international palliative care guidelines for acute care settings. *Journal of Pain and Symptom Management*, *62*, 425–437. https://doi.org/10.1016/j.jpainsymman.2020.11.032

OpenNotes. (n.d.). *About*. https://www.opennotes.org/about/

Otis-Green, S. (2005). Psychosocial pain assessment form. In K. K. Kuebler, M. D. Davis, & C. D. Moore (Eds.), *Palliative practices: An interdisciplinary approach* (pp. 462–467). Elsevier.

Otis-Green, S. (2022). Building a legacy: Reflections on transformative professionalism. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 926–935). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Otis-Green, S., Thomas, J., Duncan, L., Walling, A., Lieto, C., Kung, J., Pietras, C., & Wenger, N. (2019). Advance care planning: Opportunities for clinical social work leadership. *Clinical Social Work Journal*, *47*, 309–320. https://doi.org/10.1007/s10615-019-00709-z

Otte, R., Roodbeen, R., Boland, G., Noordman, J., & van Dulmen, S. (2022). Affective communication with patients with limited health literacy in the palliative phase of COPD or lung cancer: Analysis of video-recorded consultations in outpatient care. *PLOS One*, *17*, Article 0263433. https://doi.org/10.1371/journal.pone.0263433

Pace, J. C., & Mobley, T. S. (2016). Rituals at end-of-life. *Nursing Clinics*, *51*, 471–487. https://doi.org/10.1016/j.cnur.2016.05.004

Pala, A. N., Chuang, J. C., Chien, A., Krauth, D. M., Leitner, S. A., Okoye, N. M., Costello, S. C., Rodriguez, R. M., Sheira, L. A., Solomon, G., & Weiser, S. D. (2022). Depression, anxiety, and burnout among hospital workers during the COVID-19 pandemic: A cross-sectional study. *PLOS One*, *17*, Article e0276861. https://doi.org/10.1371/journal.pone.0276861

Pelon, S. B. (2017). Compassion fatigue and compassion satisfaction in hospice social work. *Journal of Social Work in End-of-Life and Palliative Care*, *13*, 134–150. https://doi.org/10.1080/15524256.2017.1314232

Peres, J. (2016). A time and place: The role of social workers in improving end-of-life care. *Journal of Social Work in End-of-Life & Palliative Care*, *12*, 185–194.

Reese, D. J., & Csikai, E. L. (2018). Social work assessment and outcomes measurement in hospice and palliative care. *American Journal of Hospice & Palliative Medicine*, *35*, 1553–1564. https://doi.org/10.1177/1049909118788342

Reese, D. J., Raymer, M., Orloff, S. F., Gerbino, S., Valade, R., Dawson, S., Butler, C., Wise-Wright, M., & Huber, R. (2006). The Social Work Assessment Tool (SWAT). *Journal of Social Work in End Life and Palliative Care*, *2*, 65–95. https://doi.org/10.1300/J457v02n02_05

Rhodes, R., Ejem, D., Barrett, N., Smith, C., Bullock, K., Bethea, K., Hasan, M., & Johnson, K. (2022). Association and causation without adequate representation: An evaluation of the reporting of race and ethnicity of study participants in hospice and palliative medicine research (GP751). *Journal of Pain and Symptom Management*, *63*, Article 1140.

Richards, N. (2022). The equity turn in palliative and end of life care research: Lessons from the poverty literature. *Sociology Compass*, *16*, Article e12969. https://doi.org/10.1111/soc4.12969

Rogerson, C. V., Prescott, D. E., & Howard, H. G. (2022). Teaching social work students, the influence of explicit and implicit bias: Promoting ethical reflection in practice. *Social Work Education*, *41*, 1035–1046. https://doi.org/10.1080/02615479.2021.1910652

Rosa, W. E., Gray, T., Chambers, B., Sinclair, S., Knaul, F. M., Bhadelia, A., Lee, E., Kamal, A., Johnson, K., & Smith, C. B. (2022). Palliative care in the face of racism: A call to transform clinical practice, research, policy, and leadership. *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20220207.574426

Samuel-Ryals, C. A., Mbah, O. M., Peacock Hinton, S., Cross, S. H., Reeve, B. B., & Dusetzina, S. B. (2021). Evaluating the contribution of patient-provider communication and cancer diagnosis to racial disparities in end-of-life care among Medicare beneficiaries. *Journal of General Internal Medicine*, *36*, 3311–3320.

Sanders, S., Bullock, K., & Broussard, C. (2012). Exploring professional boundaries in end-of-life care: Considerations for hospice social workers and other members of the team. *Journal of Social Work in End-of-Life & Palliative Care*, *8*, 10–28. https://doi.org/10.1080/15524256.2012.650671

Schaub, J., Hewison, A., Haworth, S., & Miller, R. (2022). A leadership model for social work: Drawing on health care to inform social work leadership. *British Journal of Social Work*, *52*, 2911–2930. https://doi.org/10.1093/bjsw/bcab185

Schill, K., & Caxaj, S. (2019). Cultural safety strategies for rural Indigenous palliative care: A scoping review. *BMC Palliative Care*, *18*, Article 21.

Sewell, K. M. (2018). Social work supervision of staff: A primer and scoping review (2013–2017). *Clinical Social Work Journal*, *46*, 252–265. https://doi.org/10.1007/s10615-018-0679-0

Shady, K., Phillips, S., & Newman, S. (2024). Barriers and facilitators to healthcare access in adults with intellectual and developmental disorders and communication difficulties: An integrative review. *Review Journal of Autism and Developmental Disorders*, *11*, 39–51. https://doi.org/10.1007/s40489-022-00324-8

Sharma, S., Abbott, J. H., & Jensen, M. P. (2018). Why clinicians should consider the role of culture in chronic pain. *Brazilian Journal of Physical Therapy*, *22*, 345–346. https://doi.org/10.1016/j.bjpt.2018.07.002

Sherman, B. W., Stiehl, E., Gupta, R., & Pratap, P. L. (2024). The importance of human-centered design in equitable health promotion initiatives.

American Journal of Health Promotion, *38*, 427–447. https://doi.org/10.1177/08901171241232057

Showalter, S. E. (2010). Compassion fatigue: What is it? Why does it matter? Recognizing the symptoms, acknowledging the impact, developing the tools to prevent compassion fatigue, and strengthen the professional already suffering from the effects. *American Journal of Hospice & Palliative Medicine*, *27*, 239–242. https://doi.org/10.1177/1049909109354096

Silvers, A., Sinclair, S., Curseen, K., Chambers, B., Bullock, K., & Bowman, B. (2022). How Medicare advantage could address pain inequities for Black patients living with serious illness. *Health Affairs Forefront*. https://doi.org/10.1377/forefront.20221206.976112

Starr, L. T., Bullock, K., Washington, K. T., Aryal, S., Parker-Oliver, D., & Demiris, G. (2021). Anxiety, depression, quality-of-life, caregiver burden, and perception of caregiver-centered community among Black and White hospice family caregivers. *Journal of Palliative Medicine*, *25*. https://doi.org/10.1089/jpm.2021.0302

Strang, P., Strang, S., Hultborn, R., & Arnér, S. (2004). Existential pain—An entity, a provocation, or a challenge. *Journal of Pain and Symptom Management*, *27*, 241–250.

Sumser, B., Leimena, M. L., & Altilio, T. (Eds.). (2019). *Palliative care: A guide for health social workers.* Oxford University Press.

Swick, D. C., Dyson, Y. D., & Webb, E. B. (2021). Navigating a pandemic, racial disparities, and social work education through the lens of the NASW code of ethics. *Reflections: Narratives of Professional Helping*, *27*, 84–93.

Taels, B., Hermans, K., Van Audenhove, C., Boesten, N., Cohen, J., Hermans, K., & Declercq, A. (2021). How can social workers be meaningfully involved in palliative care? A scoping review on the prerequisites and how they can be realised in practice. *Palliative Care and Social Practice*, *15*, 1–16. https://doi.org/10.1177/26323524211058895

Toh, Y. P., Karthik, R., Teo, C. C., Suppiah, S., Cheung, S. L., & Krishna, L. (2018). Toward mentoring in palliative social work: A narrative review of mentoring programs in social work. *American Journal of Hospice and Palliative Medicine*, *35*, 523–531. https://doi.org/10.1177/1049909117715216

Waldrop, D. P., Meeker, M., & Kutner, J. S. (2016). Is it the difference a day makes? Bereaved caregivers' perceptions of short hospice enrollment. *Journal of Pain and Symptom Management*, *52*, 187–195. https://doi.org/10.1016/j.jpainsymman.2016.03.006

Walter, J. K., Hill, D. L., Schall, T. E., Szymczak, J. E., Parikh, S., DiDomenico, C., Carroll, K. W., Nye, R. T., & Feudtner, C. (2021). An interprofessional team-based intervention to address barriers to initiating palliative care in

pediatric oncology: A multiple-method evaluation of feasibility, acceptability, and impact. *Journal of Pain and Symptom Management*, *62*, 1135–1144. https://doi.org/10.1016/j.jpainsymman.2021.06.008

Washington, K., & Lero, C. (2022). Palliative social work in rural communities. In T. Altilio, S. Otis-Green, & J. G. Cagle (Eds.), *Oxford textbook of palliative social work* (2nd ed.; pp. 434–442). Oxford University Press. https://doi.org/10.1093/med/9780197537855.001.0001

Webb, W. A. (2015). When dying at home is not an option: Exploration of hostel staff views on palliative care for homeless people. *International Journal of Palliative Nursing*, *21*, 236–244.

Wheeler, M. (2018). Indiana's community and home options to institutional care for the elderly and disabled (CHOICE) program. *The Reporter*, *22*. https://www.iidc.indiana.edu/irca/articles/indianas-community-and-home-options-to-institutional-care-for-the-elderly-and-disabled-choice-program.html

Wilkinson, E., Randhawa, G., Brown, E., Da Silva Gane, M., Stoves, J., Warwick, G., Mir, T., Magee, R., Sharman, S., & Farrington, K. (2017). Time, timing, talking and training: Findings from an exploratory action research study to improve quality of end of life care for minority ethnic kidney patients. *Clinical Kidney Journal*, *10*, 419–424. https://doi.org/10.1093/ckj/sfw151

Wong, K. T. C., Chow, A. Y. M., & Chan, I. K. N. (2022). Effectiveness of educational programs on palliative and end-of-life care in promoting perceived competence among health and social care professionals. *American Journal of Hospice & Palliative Medicine*, *39*, 45–53. https://doi.org/10.1177/10499091211038501

Zebrack, B., Doherty, M., Grignon, M., Guan, T., Miller, N., Nelson, K., Otis-Green, S., Rayton, M., Schapmire, T., Wiener, L. (2022). Oncology social work competencies, opportunities, roles and expertise (CORE): Results from a role delineation study. *Journal of the Society for Social Work and Research*, *15*. https://doi.org/10.1086/719560

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