# Examination Content Outline

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| **1** | **Assessment and Reevaluation** | **25** |
| A | Initial Comprehensive Assessment of Patient & Family/Caregiver | |
| 1 | Use clinical interviewing and behavioral observation | |
| 2 | Gather biopsychosocial history | |
| 3 | Administer and interpret results from validated assessment tools | |
| 4 | Assess for suicide risk | |
| 5 | Identify support systems and strengths of the patient and family/caregivers | |
| 6 | Identify barriers and social determinants of health that may impede delivery of care | |
| 7 | Identify physical, behavioral, emotional, cultural, and spiritual characteristics of patient/family/caregiver | |
| 8 | Assess developmental stage of patient/family/caregiver | |
| 9 | Integrate the diagnoses and treatment findings into psychosocial assessment | |
| B | Ongoing Assessment and Reevaluation | |
| 1 | Evaluate the psychosocial response to treatment and prognosis | |
| 2 | Update plan of care in accordance with re-evaluation of patient/family/caregiver | |
| 3 | Participate in ongoing assessment for program eligibility | |
| **2** | **Planning and Intervention** | **50** |
| A | Planning | |
| 1 | Use therapeutic techniques to help patients and families understand options and participate in healthcare decision-making | |
| 2 | Use assessment data to plan, coordinate, and follow-up with patient care | |
| 3 | Assist patient/family/caregiver in setting measurable goals | |
| 4 | Promote and protect patient autonomy and self-determination in decision making | |
| 5 | Develop a patient-centered treatment plan of care appropriate for the diagnoses | |
| 6 | Ensure continuity of care across practice settings | |
| 7 | Facilitate patient/family meetings for goal setting and care planning | |
| B | Education | |
| 1 | Ensure patient understanding of medical language | |
| 2 | Tailor information about treatment and side-effects to patients and families | |
| 3 | Facilitate processing and integration of information provided | |
| 4 | Educate patient/family/caregivers regarding disease trajectory | |
| 5 | Educate patient/family/caregivers regarding hospice benefits | |
| 6 | Educate patient/family/caregivers regarding advance healthcare directives | |


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| 7 | Educate patient/family/caregivers about transfer, discharge, or other care transitions | |
| 8 | Educate patient/family/caregivers about options for end-of-life care (e.g., palliative sedation, medical aid in dying) | |
| C | Coordination of Care/Case Management | |
| 1 | Refer to other community programs, specialty services, and volunteer services | |
| 2 | Order and arrange for transportation, meals, medical translation/interpretation, medical supplies and/or equipment, etc. | |
| 3 | Assist patient/family/caregiver to navigate insurance, entitlement, survivor benefits, and financial programs | |
| 4 | Prepare and assist patient/family/caregivers with transfer, discharge, or other care transitions | |
| 5 | Facilitate completion of advance healthcare directives | |
| 6 | Facilitate communication among patient/family/caregivers and team members | |
| 7 | Monitor progress and modify interventions and plans based on patient/family/caregiver needs | |
| 8 | Ensure plan of care is communicated clearly with patient/family/caregivers, staff, and supporting agencies | |
| 9 | Advocate for patient-centered care within interdisciplinary team | |
| 10 | Collaborate with the care team in patient/family meetings | |
| 11 | Refer to other community programs, specialty services, and volunteer services | |
| D | Counseling and Support | |
| 1 | Facilitate interventions that promote dignity, quality of life, coping, meaning making, and legacy building | |
| 2 | Provide psychosocial interventions based on evidence-based practice and clinical assessments/diagnoses | |
| 3 | Provide crisis intervention | |
| 4 | Support patient's identity after experiencing serious illness | |
| 5 | Provide individual and family counseling | |
| 6 | Apply psychosocial theory to practice situations | |
| 7 | Address barriers and risk factors identified in assessment | |
| **3** | **Death, Grief, and Bereavement** | **28** |
| A | Death Preparation and Death | |
| 1 | Assess and support patient through preparatory grief | |
| 2 | Assess and support family/caregiver through anticipatory grief | |
| 3 | Provide patient/family/caregiver education about signs and symptoms of impending death | |


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| 4 | Provide patient/family/caregiver education about funeral pre-planning | |
| 5 | Provide patient/family/caregiver education about options for care of the body after death | |
| 6 | Support family and caregivers at time-of-death | |
| 7 | Identify and respect cultural and spiritual customs/practices related to death (e.g., rituals, care of the body) | |
| 8 | Identify patient and family's preferences for place of death | |
| B | Grief and Bereavement | |
| 1 | Screen and/or refer families for bereavement counseling | |
| 2 | Provide bereavement follow-up after death as determined by the social work assessment | |
| 3 | Provide family/caregiver education about grief and bereavement | |
| 4 | Assess and support family/caregiver through complicated grief | |
| 5 | Assess and support family/caregiver through ambiguous loss or disenfranchised grief | |
| 6 | Assess and support family/caregiver through somatic and/or emotional manifestations grief | |
| 7 | Identify and respect cultural and spiritual customs/practices related to grief and bereavement | |
| **4** | **Professionalism** | **32** |
| A | Quality Improvement | |
| 1 | Use quality improvement process to identify and participate in improvement opportunities | |
| 2 | Communicate social work assessments, goals, and plan of intervention with team and other staff to improve patient quality of care | |
| B | Collaboration | |
| 1 | Cultivate and maintain community partnerships and relationships with health, welfare, and social agencies | |
| 2 | Collaborate with other professionals as part of interdisciplinary team | |
| 3 | Provide debriefings for end-of-life and death issues to physicians, residents, interns, nurses, and other providers | |
| 4 | Model respect for privacy | |
| C | Personal, Professional, and Ethical Competence | |
| 1 | Develop self-awareness and acknowledge signs of compassion fatigue, burnout, vicarious trauma, and moral distress | |
| 2 | Practice self-care | |
| 3 | Maintain professional boundaries | |


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| 4 | Pursue ongoing professional development activities |
| 5 | Identify ethical dilemmas and conflicts of interest |
| 6 | Participate in activities that promote team wellness |
| 7 | Develop cultural awareness and humility in self and others |
| 8 | Address biases that may affect justice, equity, diversity, and inclusion |
| D | Knowledge of laws, regulations, policies, and standards at the organizational, local, state, or national level |
| 1 | Maintain knowledge of state laws and regulations related to end-of-life care |
| 2 | Ensure compliance with NASW standards and codes of ethics |
| 3 | Identify and report abuse and neglect as mandated by law |
| 4 | Adhere to requirements regarding confidentiality and release of information |
| 5 | Inform policy regarding social work best practices (e.g., caseload, patient volume) |
| 6 | Document ongoing patient/family/caregiver assessments, progress, and response to treatment |
| E | Provide training and education in hospice and palliative care at the organizational, local, state, or national level |
| 1 | Train and supervise social work and allied profession learners |
| 2 | Educate team members about social work role |
| 3 | Advocate for the unique skills and expertise social workers provide in hospice and palliative care |

# Secondary Classifications

| Cognitive Level | Number of items |
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| Recall | 35 |
| Application | 100 |


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