Palliative Care in Rural Communities: Social Workers and Spiritual Providers

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Overview

• Case Story
• Palliative Care – General Information
• Assessment
• Intervention Areas
• Resources
• Questions/Discussion

Case Study

• “Dorothy” - 84 year old, Caucasian, female
• Lifelong resident – western MN, rural community, 2,000 (approx) residents.
• She and her husband were farmers for 50+ years on their land before moving to town.
• Raised six children, had grand and great grandchildren.

Case Study

• Her husband died about 2 years after moving to town from leukemia, did not remarry.
• She was active in her local Lutheran congregation, which she attended from birth.
• Socially very active and connected.
• Knitted and gave slippers and afghans to relatives.
Case Study

- Experienced two strokes at age 83. Acute hospitalization in Sioux Falls, SD.
- Her six children urgently arrived to be at her bedside and a family conference was held.
- She had a health care directive.
- She was offered a potentially aggressive surgical intervention that would have led to a longer hospital stay possibly involving being vented, sedated in the ICU, then long rehab.

Case Study

- Unable to communicate with family due to her deficits including an inability to speak. She also had lost much capacity on her right side.
- Family disagreed on how to proceed.
- Surgery was declined by her health care proxy (daughter) based upon her interpreted, stated desires in her health care directive.

Case Study

- Once stabilized she was transported to her town’s nursing home.
- She was not enrolled in hospice, but the decision was made to not pursue aggressive care for her disease.
- She lived for about another year and died surrounded by her family.

Hallmarks of Palliative Care

- Holistic view
- Transdisciplinary
- Symptom management
- Goals of care
Building Interdisciplinary Care in Rural Settings

- Using community resources
  - Pastors, chaplains, lay pastoral volunteers
  - Parish nurses
  - Social Workers in various settings

Rural Communities

- Potentially “broad base” of support
- Community centered
- Informal, often rapid transmission of information

Cautions

- Cannot “fix” serious mental illness in patient/family and/or entrenched family dysfunction
- We all operate from our own frame of reference
- Self awareness is critical

Cautions

- Confidentiality can be challenging and is important
- The “good death” doesn’t always happen
- Compost happens
Assessment

- First step for all disciplines
- Dynamic, ongoing process

Assessment - Spiritual

- Spiritual Screen
- Spiritual History
- Spiritual Assessment (Chaplain or Spiritual Care Provider)

Assessment - Spiritual

Story – The Medical Picture

- Evolving Situation
- Pt & Family
- Medical & IDT Staff

Continual Reshaping
Spirit (Consensus Definition of Spirituality, Puchalski et al, 2009)

<table>
<thead>
<tr>
<th>Elements of Definition</th>
<th>Possible Intervention Examples</th>
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</thead>
<tbody>
<tr>
<td>Meaning – sought &amp; expressed</td>
<td>Scripture reading/exploration</td>
</tr>
<tr>
<td>Purpose – sought &amp; expressed</td>
<td>Reflective conversation</td>
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<td>Connectedness to the moment</td>
<td>Breath attention and awareness; “By-heart” prayers</td>
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<tr>
<td>Connectedness to the self</td>
<td>Nearing death ritual</td>
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<td>Connectedness to others</td>
<td>Bed-side journal; after death ritual</td>
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<td>Connectedness to nature</td>
<td>Ritual – Blessing of the senses</td>
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<td>Connectedness to significant/sacred</td>
<td>Contemplative prayer</td>
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Psychosocial Assessment

- Social Work is holistic, strengths based
- Purpose is generally to support and strengthen within the Palliative Care context

Psychosocial Assessment

- Family
- Support System
- Financial
- Coping/Mental Health Issues
  - Clinical Depression versus Grief
- Concurrent Stressors

Psychosocial Assessment

- Symptoms
- Understanding of Disease/Progression
- Understanding of Cause of Disease
- Hope
- Spiritual
Goals of Care

- Spectrum of Interventions/Timing
- Health Care Directives
  - Educate
  - Encourage Completion
  - Encourage Discussion
- Health Care Agents

Care Conferences

- Involvement of community support people (pastor, social worker)
- Solicit from patient/family who should be there
- Value of provider preconference

Caregiver Needs

- Recognize losses for family caregivers
  - Change in roles/relationships
  - Change in how the patient is perceived by family/others
- Additional responsibilities
- Barriers to caregivers getting their own needs met

Patient and Caregiver Support

- More apparent when patient is in hospital or other facility
- Often more need for support when patient is at home
- Importance of community networks recognizing support needs
- Special needs of children
Symptom Management

• Coping (Patient/Family)
  – Support strengths
  – Refer for mental health expertise when needed (LICSW Clinical Social Worker, Psychologist)

Symptom Management

• Physical/Emotional
  – Simple Massage (Patient should be able to consent)
  – Distraction
  – Textures
  – Story Telling
  – Prayer
  – Using Family/Supportive Others

Family Dynamics/Conflict

• What’s the problem?
• What’s the goal?
• Pastors may have valuable knowledge.
• Social workers have skills for facilitating.

Life Legacy Work

• Creating something to pass on to others
• Can include
  – Life story
  – Lessons learned
  – Values and beliefs
  – Hopes and dreams for loved ones
Life Legacy Work

- Educate
- Provide opportunities
- Time to do this is when the person has time and energy
- Booklet availability

Bereavement Follow-up

- Assessing bereavement risk
- Death is an event. Grief is a process.
- Sudden death versus death preceded by illness.

Resources/Reference

- Resources – See separate handout
- Reference for slide # 17

Questions/Discussion