ExCEL in Social Work: Excellence in Cancer Education & Leadership: An Oncology Social Work Response to the 2008 Institute of Medicine Report

Shirley Otis-Green · Barbara Jones · Brad Zebrack · Lisa Kilburn · Terry A. Altilio · Betty Ferrell

Abstract *ExCEL in Social Work*: *Excellence in Cancer Education & Leadership* was a multi-year National Cancer Institute (NCI)-funded grant for the development and implementation of an innovative educational program for oncology social workers. The program's curriculum focused upon six core competencies of psychosocial–spiritual support necessary to meet the standard of care recommended by the 2008 Institute of Medicine (IOM) Report: *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*. The curriculum was delivered through a collaborative partnership between the City of Hope National Medical Center and the two leading professional organizations devoted exclusively to representing oncology social workers—the Association of Oncology Social Work and the Association of Pediatric Oncology Social Workers. Initial findings support the feasibility and acceptability of this tailored leadership skills-building program for participating oncology social workers.

S. Otis-Green (✉) · L. Kilburn · B. Ferrell
Division of Nursing Research and Education, Department of Population Sciences, City of Hope National Medical Center, 1500 E. Duarte Rd., Duarte, CA 91010, USA
e-mail: sotis-green@coh.org

S. Otis-Green
e-mail: Shirley@CollaborativeCaring.net

B. Jones
School of Social Work, University of Texas at Austin, Austin, TX, USA

B. Zebrack
School of Social Work, University of Michigan, Ann Arbor, MI, USA

T. A. Altilio
Beth Israel Medical Center, New York, NY, USA

Overview

ExCEL in Social Work: Excellence in Cancer Education & Leadership (*ExCEL*) was a multi-year National Cancer Institute (NCI)-funded leadership skills-building educational program for oncology social workers. This program was developed in direct response to the 2008 Institute of Medicine (IOM) Report: *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs* [1]. *ExCEL* was designed to enhance oncology social worker's competence and confidence to address psychosocial issues using evidence-informed practice and knowledge. This paper provides background information on the delivery of psychosocial services for cancer patients in the USA, which served as the foundation for the development of the *ExCEL* program, and subsequently describes the *ExCEL* curriculum and implementation process with data supporting the program's feasibility and acceptability among participating oncology social workers.

The aims of *ExCEL* were to (1) develop an oncology social work-specific curriculum addressing the recommendations of the 2008 IOM Report on psychosocial health needs of oncology patients; (2) implement the curriculum through eight pre-conference courses offered in conjunction with the two leading oncology social work professional organization's annual meetings: the Association of Oncology Social Work (AOSW) and the Association of Pediatric Oncology Social Workers (APOSW); (3) provide evidence-informed education through the AOSW and APOSW websites and quarterly newsletters; (4) evaluate the impact of these efforts by measuring the process and outcomes of the various educational activities, as well as the self-reported change efforts conducted by participants by

means of institutional change goals; and (5) disseminate these findings through peer-reviewed publications, various professional organizations, and oncology networks.

The 2008 IOM Report summarized a growing body of scientific evidence that validates the effectiveness of addressing psychosocial problems created or exacerbated by cancer to reduce patient's suffering, help them adhere to prescribed treatments, support their return to health, and promote their well-being [1]. Unfortunately, there continues to be many barriers to clinician's ability to adequately and reliably attend to the psychosocial–spiritual health needs of cancer patients and their families [2]. Examples include the way in which clinical practices are designed, shortages of health personnel, the nature of payment, and the policy environment in which healthcare is delivered [3]. *ExCEL* was developed as a systematic approach to improving the delivery of these vital services through the enhancement of leadership skills for oncology social workers. *ExCEL* is unique in that it simultaneously educated oncology social workers on six selected core psychosocial–spiritual health competencies and provided mentorship to participants as they developed and implemented institutional change goals.

Background

The field of psycho-oncology was developed to address the multiple dimensions of the cancer experience [4–6]. Social workers practice in a wide array of settings and provide an extensive range of mental health services to both pediatric and adult oncology patients and their families [7, 8]. There has been an increasing focus on the urgent need to better prepare the existing workforce to more effectively meet the demands of a diverse and rapidly aging population [2, 9–11]. The 2008 IOM Report identified the following impediments to the provision of continuing education for psychosocial–spiritual health professionals: a lack of clarity about the competencies the workforces should possess, absence of well-developed curricula around clearly defined competencies, inadequate numbers of faculty qualified to teach and mentor psychosocial skills, and insufficient specificity in accreditation and licensing standards regarding competencies and curricula on psychosocial care [1]. Additionally, there continues to be a lack of institutional support for professional social work education due to constricted budgets, staffing shortages, and time constraints [12, 13]. This creates practice environments that do not routinely provide opportunities for social workers to engage in leadership development.

Compounding these issues are troubling reports of oncology workforce shortages due to an aging workforce and a lack of professionals to replenish the specialty in the near future [14, 15]. There is increasing awareness that the US healthcare system is facing a crisis that challenges the already over-burdened system for oncology professionals across all disciplines [2, 14, 16]. Oncology leaders are urgently needed with the competence and confidence to develop new programs in response to the rapidly evolving healthcare environment [17]. The development of a wide range of culturally congruent, person-centered, and family-focused services requires a cadre of professionals with an ability to quickly create, evaluate, disseminate, and replicate novel programs across settings and disparate systems of care [18].

Practicing social workers continue to report a lack of adequate preparation for the specialized work they are expected to do and note this as a significant source of stress, increasing the risk for compassion fatigue, decreased job satisfaction, and often resulting in a premature exodus from the field [19, 20]. Commonly, oncology social workers are supervised by non-social work professionals and embedded in multidisciplinary departments or units, limiting access to seasoned social work colleagues as clinical supervisors, mentors, or role models. Yet, with adequate education and support, oncology social workers are ideally positioned in healthcare settings to fill the gaps identified in the 2008 IOM Report. *ExCEL* was developed in response to the IOM's [1] call to action for improved psychosocial oncology care through the development and implementation of a tailored curriculum specifically designed to enhance the clinical competence and leadership potential of oncology social workers.

Program Content and Implementation

The *ExCEL* curriculum focused on six core competencies identified in the 2008 IOM Report [1] as necessary for the provision of quality psychosocial–spiritual care for oncology patients and their families. Persons facing cancer require competent and compassionate care throughout the continuum of illness, across multiple and varied treatment settings, and throughout their lifespan. Yet, evidence indicates that few health care professionals and oncology care systems are adequately prepared for this task [21, 22]. Guided by professional standards of care and a code of ethics [8, 23], health social workers must personally and professionally embrace the imperative to deliver and sustain meaningful advancements in the delivery of quality psychosocial–spiritual care.

The *ExCEL* curriculum addressed these complex challenges through an evidence-informed curriculum using face-to-face education (two courses per year for 4 years, targeting 400 competitively selected participants), structured expectations for goal achievement, follow-up support at 6 and 12 months post-course, and a variety of distance communication methods. *ExCEL* was led by a team of expert oncology social work faculty. The investigative team and faculty collaborated in the development of the curriculum, delivered the program, and were available as mentors to offer support and assistance to participants as they worked toward achieving their institutional change goals. *ExCEL* participants were encouraged to see themselves as

part of a community of like-minded professionals with knowledge and experiences to share in support of one another.

Interested oncology social workers applied to attend *ExCEL* through a competitive process. Applicants completed an online application, which included questions asking them to describe their leadership potential, opportunities to implement institutional change as part of a clinical care team, and commitment to improving psychosocial care. *ExCEL* faculty and staff reviewed applicants and selected participants for each cohort group based upon their written application materials. Selection criteria included a commitment to personal and professional development (in the form of a personal leadership statement) and their ability to identify and articulate an institutional change goal (applicants with goals that addressed the needs of the traditionally underserved were more heavily weighted). Following selection, participants completed a baseline institutional needs assessment survey to further assist them in refining their goals.

In recognition that many social workers receive limited financial support from their institutions for continuing education, *ExCEL* partnered with AOSW and APOSW to offer this curriculum as "pre-conferences" to their annual organizational meetings. This strategy was designed to maximally leverage grant funds to subsidize course attendance by minimizing participant travel costs. This strategy also provided an immediate arena for dissemination, reinforcement, and discussion among large numbers of oncology social workers as *ExCEL* participants were able to share their renewed motivation and discuss their institutional change goals with colleagues at the subsequent AOSW and APOSW meetings. Steps were taken to encourage members of previous *ExCEL* cohorts to meet and support newer *ExCEL* participants (*ExCEL* participants wore identifying ribbons and pins to assist networking at the annual meetings). There were also *ExCEL* presentations and poster sessions at each year's AOSW and APOSW meetings to support community building among participants and to share *ExCEL* activities and information with a wider social work audience.

In addition to the face-to-face courses held each year, *ExCEL* content was delivered through print and web-based educational materials to further expand program impact and to reinforce key concepts. The virtual dissemination of information offered a timely response to the complex and rapidly changing US healthcare environment. Those not able to attend a pre-conference course benefited from this exposure to critical content areas through print and web-based efforts. *ExCEL* faculty and participants presented on *ExCEL* and the results of their goal activities through a variety of professional venues, furthering the impact of the program.

Participant Recruitment

ExCEL was advertised and marketed through AOSW and APOSW media channels (including dedicated space through their websites and quarterly newsletters, where course information and educational content was regularly shared), advertisements placed in professional journals, the City of Hope website, and other professional email channels serving social workers (e.g., National Association of Social Workers). Marketing and recruitment strategies also included mailings to attendees of previous City of Hope-sponsored professional education projects. Additionally, a dedicated *ExCEL*-specific newsletter and website (housed at the City of Hope: http://www.cityofhope.org/ExCEL) provided a wide array of program and curriculum information and updates, the course application materials, links to useful resources, and other educational opportunities and information highlighting successful participant goal work. A dedicated *ExCEL* *Facebook* page and *Twitter* feed also aided in marketing the program and created a venue for the growth of a robust "virtual" community.

ExCEL Curriculum

ExCEL in Social Work educational strategies were predicated upon established adult learning theories [24] that suggest that adult learners are self-directed, possess rich life experiences, and are concerned with solving relevant life problems. Curriculum content was presented through plenary sessions, faculty-facilitated small group workshops, and tailored goal refinement sessions. Video demonstrations and patient and family narratives were interwoven throughout the program to highlight awareness of the human impact of this important work. Interactive experiences were designed to encourage personal engagement and authentic professional reflection.

Courses began with an evening reception and were followed by a full day of material to leverage limited resources and minimize participant time away from work. Participants received a syllabus with module outlines, slide content, reference lists, and contact information. Participants also received a wealth of other resources including copies of the National Consensus Project *Clinical Practice Guidelines for Quality Palliative Care* [25], the 2008 IOM Report [1] and the *Oxford Textbook of Palliative Social Work* [26], a flash drive containing an electronic copy of the syllabus and IOM Report, the *City of Hope Pain and Palliative Care Resource Center* index [27] (http://www.cityofhope. org/prc, with links to hundreds of additional resources), and nearly 1,000 pages of supplemental material.

The evening reception provided an overview of the standard of care as recommended by the IOM Report and introduced the "S.M.A.R.T." approach (see competency number 6, below) to crafting effective change efforts [28]. The evening session ended with a small group session and the opportunity for attendees to further discuss their goals and network with other social work professionals and the *ExCEL* faculty.

The full-day curriculum addressed the six core competencies necessary to improve practice and reliably deliver quality person-centered and family-focused psychosocial–spiritual services. The following six core competencies composed the foundation of the *ExCEL* curriculum: (1) interdisciplinary collaboration and teamwork, (2) person-centered and family-focused screening and assessment, (3) family–caregiver support and family-conferencing, (4) culturally sensitive communication, problem-solving, and decision-making, (5) evidence-informed psychosocial interventions, and (6) advocacy and leadership (see Fig. 1: curriculum framework). These six core competencies were deliberately selected to be inter-related and synergistic. Plenary sessions were interspersed with interactive workshops and a series of faculty-facilitated small group sessions designed to assist in the further refinement of participant goals (see Table 1: course agenda).

The *ExCEL* program focused on the refinement of skills in each area to enhance oncology social worker's overall effectiveness. Results of post-course 6- and 12-month follow-up surveys each year helped identify barriers to goal implementation and allowed curriculum content to be annually updated to maximize the effectiveness of the program. The six competencies are described in greater detail below.

1. Interdisciplinary collaboration and teamwork

    Social workers have been identified as key members of interdisciplinary healthcare teams for decades [29] and frequently serve as members of ethics committees [30], palliative care services, pain teams, and other committees and projects [26]. Oncology social workers play a critical role in advocating for patients and reducing barriers to patient outcomes, particularly with disenfranchised and vulnerable populations. Social workers bring crucial skills in contextualizing patient needs and offering insight into factors that impact patient quality of life and health decision-making. Yet, lack of specific team-building skills may impair cross-discipline collaboration which in turn directly impedes team effectiveness and impacts patient care. Although oncology social workers may be well-versed in the importance of communication, they benefit from support to refine these specialized skills to enhance team practice and effective case collaboration in oncology settings [31, 32].

    A transformation in oncology care delivery must include integration of psychosocial services with medical care. Interprofessional (or transdisciplinary) care improves quality health outcomes for patients and reduces health-related distress and other psychosocial barriers to health outcomes [1, 33–35]. Providers, however, are too often unclear about the role social workers play on the health care team [36].

    Oncology social workers benefit from targeted education designed to enhance team functioning and collaborative communication. Reinforcing oncology social worker's inherent collaborative skills promotes improved communication with team members and enhances effectiveness in implementing effective psychosocial services.

2. Person-centered and family-focused screening and assessment

    Oncology social workers are at the forefront in providing systematic psychosocial screening and assessments and communicating this information to the healthcare team [37]. New standards of oncology care related to distress screening place oncology social workers in a visible and potentially more powerful position to enhance oncology care system's response to patient and family needs [38]. Doing so requires skill in the implementation of distress screening protocols, selection of appropriate instruments, and evaluation of patient outcomes [39–42]. Participant goals have focused heavily on the need to develop robust screening strategies to address recommended IOM [1] and *Commission on Cancer* [43] guidelines for identifying patients most at risk for distress.

3. Family–caregiver support and family-conferencing

    Evidence suggests that family-conferencing is a potent and effective intervention for family decision-making and establishing shared goals of care [44–48]. Family-conferencing is most successful when the interdisciplinary team and oncology care professionals strategize together to make a plan to enhance the effectiveness of the meeting [49–51]. Oncology social workers serve an important role in family-conferencing as translators of medical information, coordinators, and advocates for the patient and family [47].

    Social workers have the ability to help patients and their families better understand and cope with diagnosis and treatment and assist in communicating this information. Specifically, social workers use their considerable skills in engagement, negotiation, family dynamics, interpersonal communication, empathy, assessment, and cultural understanding to facilitate family conferences. Further refining these competencies for oncology social workers empowers them to take leadership roles in facilitating family conferences and to improve patient provider communication and ultimately patient care [52, 53].

4. Culturally sensitive communication, problem-solving, and decision-making

    Despite advances in cancer prevention, early detection, and cancer treatment in the USA, the provision of the full range of medical, psychological, social, and spiritual support services are not yet accessible to all persons diagnosed with cancer [1, 2, 25, 54]. Access to necessary

Fig. 1 Curriculum framework

**Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs
A Social Work Education Response to Meet the Recommended Standard of Care**

Effective Patient-Provider Communication

Patient/Family — Patient/Family Provider Relationship — Provider Team

Six Core Competencies for Oncology Social Workers
1. Interdisciplinary Collaboration & Teamwork
2. Person-Centered & Family-Focused Psychosocial Screening & Assessment
3. Family-Caregiver Support & Family Conferencing
4. Culturally-Sensitive Communication. Problem Solving & Decision Making
5. Evidence - Informed Psychosocial Interventions
6. Advocacy & Leadership: Quality Improvement and Performance Measures

Identification of Psychosocial Needs

Development and Implementation of a Plan for Psychosocial Health Services that:

Links patient/family with psychosocial services

Supports patients by:
• Providing personalized information
• Identifying strategies to address psychosocial needs
• Providing emotional support
• Helping patients manage their illness and health

Coordinates psychosocial & medical care

Follow-Up & Re-Evaluation

medical and psychosocial support services is a function of having health insurance mediated by socioeconomic status influenced by individual and family attitudes and beliefs about the need and efficacy of such care and affected by personal and institutional attitudes and practices of care providers and facilities. Differential access to societal resources and institutionalized bias/discrimination lead to inequalities and variation among these factors, resulting in an unequal burden of cancer in the USA [55, 56].

These shortcomings speak to social work's ethical commitment to social justice and serve as rationale for integrating activities into oncology social work that will increase the likelihood that the care all patients and families receive is safe, efficient, effective, person-centered, timely, culturally congruent, and equitably delivered. Pediatric and adult oncology social workers are ethically obligated to offer support to the vulnerable populations they serve [23, 57, 58]. Patients and families rely upon oncology social workers to be a voice for psychosocial–spiritual concerns and to be system advocates on their behalf [59].

Oncology social workers are well trained in understanding how barriers to health are impacted by culture, community, discrimination, and disenfranchisement [60].

Using their skills in cultural humility and awareness, social workers support patients and families as they communicate treatment issues to team members and talk with children, schools, extended family, friends, or co-workers. There is tremendous variability regarding communication styles and decision-making across cultures; therefore, attention to these differences by skilled practitioners is a necessary component of competent healthcare in a diverse society.

5. Evidence-informed psychosocial interventions

Oncology social workers are guided by a set of professional values and ethics that emphasize service, the dignity and worth of individuals, the importance of human relationships, social justice, and professional competence [61, 62]. The ethic of competence suggests that oncology social workers maintain and apply clinical skills that are known to enhance patient's and families' abilities to cope with the myriad of practical, interpersonal, emotional, spiritual, and existential challenges posed by cancer and its treatment. Although there is emerging evidence regarding the effectiveness of many social work interventions, there remains a significant lag in the translation of research findings to clinical practice. The field of social work (like other healthcare professions) is challenged to

Table 1 *ExCEL in Social Work* course agenda

Monday	Opening reception agenda
4:00–5:00	Sign-in and dinner reception (course material distribution and networking)
5:00–6:00	Welcome, faculty introduction and overview of course curriculum, resources, and responsible conduct of research
6:00–7:00	A call for heightened leadership, accountability, and professionalism Overview of *IOM Report* and recommended psychosocial standard of care
7:00–7:30	Making goals S.M.A.R.T.~ Enhancing your effectiveness as a change agent
7:30	Evaluations, dessert, and networking
Tuesday	Full-day agenda
7:30–8:00	Sign-in and continental breakfast
8:00–9:00	Interdisciplinary teamwork and collaboration: the oncology social worker in context: identifying strengths, limitations, and barriers making
9:00–10:30	Making goals S.M.A.R.T. (continued) Enhancing your effectiveness as a change agent (9:00–9:30) Applying content and refining goals: facilitated small groups (9:30–10:30)
10:30–10:45	Break
10:45–12:00	Person-centered and family-focused psychosocial screening and assessment
12:00–1:00	Luncheon
1:00–2:00	Culturally sensitive communication, problem-solving, decision-making
2:00–3:00	Workshop (choose one workshop, a or B): A. Evidence-informed practice/interventions B. Family–caregiver support and family-conferencing
3:00–3:15	Break
3:15–4:00	Facilitated small group goal refinement
4:00–4:45	Professionalism in action: strengthening our commitment to advocacy and leadership—achieving quality care for our patients, communities, profession, and ourselves
4:45–5:30	Enhancing institutional change: applying lessons learned Evaluation and goal collection

demonstrate that clinical practice is informed by research.

ExCEL participants were reminded of the importance of critically engaging the literature and encouraged to identify interventions that are known to be effective in changing patient/family behaviors, reducing institutional barriers to care, and improving patient and family outcomes. A plenary presentation the first evening on the responsible conduct of research provided the foundation for the workshop focused upon evidence-informed practice the next day.

Participants were encouraged to consider how their work contributes to building a more robust and culturally sensitive evidence base and offered mentorship to disseminate their work through professional publications and presentations.

6. Advocacy and leadership/quality improvement projects and performance measures

Quality psychosocial practice requires professionals with a personal commitment to provide evidence-informed care, yet few oncology social workers have been trained to negotiate the complex political climate so as to maximize their leadership role as advocates for institutional change [17]. *ExCEL* specifically called on social workers to increase their leadership roles in their institutions and in their professional organizations with a focus on increasing their effectiveness as advocates for patients, caregivers, and the profession itself. Many clinicians are unfamiliar with organizational change principles [63–65] and may not see themselves as having the responsibility or power necessary to create robust and sustainable institutional change.

A foundational principle of *ExCEL* was that all healthcare professionals have a duty to improve the delivery of care. Regardless of one's job title, participants were reminded that patients and families rely upon all healthcare providers to have a commitment to continuously seek to improve the quality of care provided. A key component of the curriculum was to encourage social workers to see themselves as healthcare change agents with the necessary skills to create meaningful organizational change within their area of influence.

The *ExCEL* curriculum emphasized the importance of identifying oncology leaders with the courage to speak out for change and with the skills to create new programs to better meet patient and family needs. Participants were reminded of the importance of collecting evidence to provide a strong foundation for their proposed change efforts. Mentorship was offered throughout the course to support participants in the further refinement of their goals using the "S.M.A.R.T." model [28]. "S.M.A.R.T." is an acronym used by many organizations to provide structure and practical guidance in the formation of goals. "S.M.A.R.T." goals are *s*trategic, *m*-easurable, *a*chievable, *r*ealistic, and *t*ime-framed. Participants were introduced to the concept of developing "S.M.A.R.T." goals during the course application process and refinement of this process occurred through faculty-facilitated small group sessions.

Many participants initially found that their original goals were too vague and had difficulty concisely articulating their hoped for change. Time was built into the curriculum to assist participants in creating and tailoring an "elevator speech" to describe their goal in clear and compelling language. Participants were required to create specific written steps of what they hoped to accomplish by 6 and 12 months post-course with reminders that their goals would continue to evolve over time. They were encouraged to identify "champions" in their home environment with whom they could partner to achieve

their goals. Participants were also invited to reach out to their faculty mentors and to other course participants post-course for on-going advice as their goal work progressed.

Following *ExCEL*, participants have successfully facilitated quality improvement projects, developed new support programs, established screening procedures, revised policies, mentored colleagues, joined a range of interprofessional committees, and more consciously integrated evidence into their clinical practice. To recognize outstanding goal achievement and identify emerging leaders, the *ExCEL* team selected two participants (an individual or team from each preconference course) annually to receive national recognition (Awards of Excellence) and $1,500. Monetary awards provided an important incentive to maintain commitment and were

Table 2 Examples of participant goal themes

Goal themes	Goal examples
To develop screening strategies/tools	1. Develop a comprehensive screening and assessment program called "Getting Connected" in which all new oncology patients will have a complete biopsychosocial assessment and treatment plan as part of their new patient visit 2. After 1 year, 40 patients (20 in-patients and 20 out-patients) will be screened for psychosocial distress in a pilot project. The project will be evaluated for effectiveness 3. To develop practical guidelines and procedures for implementing a caregiver screening program in accordance with the Commission on Cancer recommendations on distress screening (Standard 3.2)
Educate staff/patients/families/community partners	1. Develop and implement a psychosocial education curriculum for pediatric oncology team members, focusing on the fellowship program, pediatric house staff, and parent consultation 2. Develop a clinical skill building resource plan for pediatric oncology, hematology, and BMT social workers 3. Develop an MSW internship program that trains and educates students how to be a dynamic member of a multi-disciplinary team, complete full biopsychosocial–spiritual assessments in the oncology setting, and incorporate the 2008 IOM Report into their clinical practice
Quality improvement/process improvement/ research	1. Establish a patient- and family-centered care council within 12 months of completion of *ExCEL* course 2. Change the culture for peds oncology care to consistently include brothers and sisters in overall family care through strategic integration of Supersibs! S.M.A.R.T.-based consulting
Develop support program/resources	1. All geriatric patients with advanced cancer will have been met and assessed by the geriatric social worker and offered referral to the geriatric palliative care clinic to discuss advanced care planning 2. Every patient that is given a new, end-stage cancer diagnosis while hospitalized will receive a support/resource folder and will know who to contact if they need assistance
Comply with CoC standards (or other) to ensure patient-centered care	1. Create a caregiver program to include: kick-off caregiver day including massage, Reiki, reflexology, resources, assessment of needs, and possible interest in support groups; caregiver program to offer education, information, and support programs; pastoral care; presentation on palliative care, patient transition from inpatient to outpatient; and expand integrative medicine program to include caregivers
Professional development	1. To research and write a comprehensive literature review using at minimum 20 articles, less than 10 years old, focusing on adolescent oncology patient needs 2. Create a special interest student group at my hospital for those interested in oncology (specifically social work, but other fields could be included as well). The group will partner with university faculty and administration to host workshops and/or presentations by professionals in local hospitals. Create a mentoring relationship for students and professionals
Improve access to psychosocial services/ Interventions	1. To research the appropriate screening tools to help determine psychosocial needs of patients–breast cancer patients 2. To develop by June, 12 therapeutic letter templates. To pilot with 24 patients/caregivers who receive care at our cancer center. To evaluate use of a therapeutic letter and to determine the most effective format for use in navigation services
Survivorship care	1. After 1 year, 50 % of patients seen on an annual basis in a long-term follow-up clinic will have a consult assessment with a clinical social worker in pediatric oncology to assess and address psychosocial needs in survivorship 2. Informed by patient and family identified needs and the evidence available in the literature, we will have developed, tested, and implemented a comprehensive psychosocial educational curriculum and support program for cancer survivors (defined as patients who are finished with treatment)
Other	1. Develop a dedicated training position for MSW's in medical/oncology social work which will incorporate addressing the needs identified through psychosocial distress screening done in the cancer center. This will train MSW's in the community for oncology social work positions and provide service for the cancer program

used to subsidize costs for participants to attend further professional meetings to present their work. Additionally, several Merit Award recipients were recognized each year for their excellent work. Recognizing participant's outstanding achievements in these ways was designed to promote the IOM [1], recommended standard of care, disseminate successful strategies useful in creating change, and foster an identification of leadership among oncology social workers.

Preliminary Program Evaluation

Feasibility and Acceptability

Evaluation of a program's feasibility and acceptability is necessary before establishing its level of effectiveness. The City of Hope National Medical Center's Institutional Review Board reviewed the proposal and granted an educational exemption for the study prior to implementation of these activities. Feasibility and acceptability were determined through a variety of measures, including by the extent to which program goals for recruitment and participation (as specified in the original NCI grant proposal) were attained. Investigators intended to recruit a geographically representative sample of 400 oncology social workers from across the USA over 4 years. Participation exceeded initial recruitment goals with over 400 oncology social workers participating in the *ExCEL* program (representing 47 states and the District of Columbia). Additionally, 13 guests from five foreign countries (Australia, Canada, Singapore, New Zealand, and South Africa) paid to participate. By the last year, the application process became highly competitive as there was a nearly a 2:1 ratio of applicants to available participant spots.

Initial analysis of the first three cohorts ($N=308$) and 12-month follow-up data from the first two cohorts ($N=165$) is

reported here. Participants from 45 states and five foreign countries attended the courses from 2011 to 2013. Acceptability and feasibility of the project were also measured by the extent to which participants provided 6- and 12-month follow-up reports describing the activities they implemented at their institution to achieve the goals they created. To date, 92 % of participants from the first three cohorts have reported 12-month follow-up activities. Table 2 provides a sampling of the thematic areas reflected in participating oncology social worker's goals for change. Additionally, acceptability was measured with a question regarding whether participants would "recommend the course to colleagues." Ninety-nine percent reported that they would recommend *ExCEL* to others.

Preliminary Evaluation

The overall program was rated as well as each session using a 1–5 scale (5=excellent). The overall program was rated 4.9 and the overall sessions were rated 4.8. As part of the course evaluation, participants are asked to retrospectively report their confidence in each of the six core competency areas (see Table 3: pre- and post-course self-reported competency rating). Table 3 indicates a reported improvement and suggests that participants experience moderate to large improvements in their self-rated competencies.

In follow-up surveys, participants reported that they maintain increased confidence over the 12-month period and that a great deal of effort is made to accomplish goals. Participants report successes and barriers to goal implementation at 6 and 12 months post-course and actively reach out to *ExCEL* faculty or other participant mentors for guidance. Initial data analysis demonstrates that 35 % of participants developed screening and assessment goals, 20 % identified educational goals, and 19 % were devoted to developing support

Table 3 Pre- and post-course self-reported competency rating

Pre- and post-course self-reported competency rating

$N=308$ (scale: 1=minimally effective, 5=very effective)

Core competencies	Interdisciplinary collaboration		Screening and assessment		Culturally sensitive communication		Evidence-informed interventions		Family caregiver support and conferencing		Advocacy and leadership	
	Before	After	Before	After	Before	After	Before	After	Before	After	Before	After
2011	3.7	4	3.5	4	3.6	4	3	3.8	3.6	4	3.4	4.2
2012	3.9	4.4	3.7	4.4	3.8	4.4	3	4.2	3.8	3.9	3.6	4.4
2013	3.7	4.4	3.4	4.3	3.8	4.3	3	4.3	3.7	3.9	3.3	4.3
Mean	3.8	4.3	3.5	4.2	3.7	4.2	3.0	4.1	3.7	3.9	3.4	4.3
Reported improvement	0.5		0.7		0.7		0.4		0.2		0.9	

programs and the balance reflect quality improvement projects. A future publication will report more detailed evaluation responses.

Conclusion

The *ExCEL* project was designed to increase the leadership skills and confidence of oncology social workers as healthcare change agents, by supporting participants in their efforts to identify opportunities and create goals to improve the delivery of care within their area of influence. Participant goals covered a wide variety of areas, including creating more culturally tailored support services to meet the needs of non-English speaking patients within their institution, implementing more comprehensive screening strategies, and educating colleagues about the need for psychosocial support.

The voice of oncology social work is crucial in the development and implementation of sustainable and robust psycho-oncology services to meet the needs of an aging population. In the current climate of healthcare reform, oncology social workers are urgently needed who can provide quality culturally congruent, evidence-informed, person-centered, and family-focused care. This transformation in service delivery offers tremendous opportunities for oncology social work leadership.

The initial evaluation of this project suggests feasibility and acceptability among a self-selected portion of oncology social workers in the USA. Combined, AOSW and APOSW have over 1,500 active members with more than a quarter attending an *ExCEL* course over 4 years. The findings here reflect that oncology social workers are interested in and will attend and participate in training designed to increase their skills in leadership and evidence-based psychosocial interventions in cancer care. Yet, like any new program or clinical intervention, adoption occurs in waves, with these first 407 *ExCEL* participants representing early to mid-level adopters. *ExCEL* was recognized in 2014 by the American Psychosocial Oncology Society with an *Outstanding Education and Training Award* further affirming the value of this innovative educational approach.

The *ExCEL* project was created to re-ignite oncology social worker's commitment to ensure quality psychosocial–spiritual care is provided to all of those whose lives are impacted by cancer. The *ExCEL* project's positive evaluations and robust participation rates attest to the interest and need for advanced professional education among oncology social workers. The structure and network created through participation in the *ExCEL* program supported and reinforced oncology social worker's efforts to implement changes in their institutions to improve patient care for cancer patients and families.

References

1. Institute of Medicine (IOM) (2008) Cancer care for the whole patient: meeting psychosocial health needs. National Academies Press, Washington
2. Institute of Medicine (IOM) (2013) Delivering high quality cancer care: charting a new course for a system in crisis. National Academies Press, Washington
3. Zebrack B, Walsh K, Burg MA, Maramaldi P, Lim JW (2008) Oncology social worker competencies and implications for education and training. Soc Work Health Care 47(4):355–375. doi:10.1080/00981380802173954
4. Fobair P, Stearns NN, Christ G, Dozier-Hall D, Newman NW, Zabora J, Desonier M (2009) Historical threads in the development of oncology social work. J Psychosoc Oncol 27(2):155–215. doi:10.1080/07347330902775301
5. Holland JC (1998) Societal views of cancer and the emergence of psycho-oncology. In: Holland JC, Breitbart W (eds) Psycho-oncology. Oxford University Press, New York, pp 3–15
6. Holland JC (2003) American Cancer Society Award lecture. Psychological care of patients: psycho-oncology's contribution. J Clin Oncol 21(23 Suppl):253s–265s. doi:10.1200/JCO.2003.09.133
7. Kazak AE, Rourke MT, Alderfer MA, Pai A, Reilly AF, Meadows AT (2007) Evidence-based assessment, intervention and psychosocial care in pediatric oncology: a blueprint for comprehensive services across treatment. J Pediatr Psychol 32(9):1099–1110. doi:10.1093/jpepsy/jsm031
8. Otis-Green S (2008) Health care social work. In: Mizrahi T, Davis L (eds) Encyclopedia of social work, 20th edn. Oxford University Press, New York, NY, pp 348–353
9. Otis-Green S, Ferrell BR (2010) Professional education in psychosocial oncology. In: Holland JC, Breitbart WS, Jacobsen PB, Lederberg MS, Loscalzo MJ, McCorkle R (eds) Psycho-oncology, 2nd edn. Oxford University Press, New York, NY, pp 610–616
10. Weisenfluh SM, Csikai EL (2013) Professional and educational needs of hospice and palliative care social workers. J Soc Work End Life Palliat Care 9(1):58–73. doi:10.1080/15524256.2012.758604
11. Whitaker T, Arrington P (2008) Professional development. NASW Membership Workforce Study. National Association of Social Workers, Washington
12. Christ GH, Sormanti M (1999) Advancing social work practice in end-of-life care. Soc Work Health Care 30(2):81–99
13. Jones BL (2005) Pediatric palliative and end-of-life care: the role of social work in pediatric oncology. J Soc Work End Life Palliat Care 1(4):35–61
14. Bunnell CA, Shulman LN (2010) Will we be able to care for cancer patients in the future? Oncology 24(14):1343–1348

15. Messner C (2010) Impending oncology social worker shortage? Oncol Issues, (Sept/October 2010), 46–47

16. Bodurka DC, Huang M, Sun CC (2010) Caring for cancer patients in the future: a perfect storm on the horizon? Oncology 24(14): 1351–1352

17. Otis-Green S, Yang E, Lynne L (2013) ACE Project—advocating for clinical excellence: creating change in the delivery of palliative care. Omega: J Death Dying 67(1–2):5–19

18. Otis-Green S, Ferrell B, Spolum M, Uman G, Mullan P, Baird RP, Grant M (2009) An overview of the ACE Project—advocating for clinical excellence: transdisciplinary palliative care education. J Cancer Educ 24(2):120–126. doi:10.1080/08858190902854616

19. Arrington P (2008) Stress at work. How do social workers cope? NASW Press, Washington, DC, 15

20. Simon CE, Pryce JG, Roff LL, Klemmack D (2005) Secondary traumatic stress and oncology social work: protecting compassion from fatigue and compromising the worker's worldview. J Psychosoc Oncol 23(4):1–14

21. Ferrell BR, Virani R, Grant M, Rhome A, Malloy P, Bednash G, Grimm M (2005) Evaluation of the End-of-Life Nursing Education Consortium undergraduate faculty training program. J Palliat Med 8(1):107–114. doi:10.1089/jpm.2005.8.107

22. Grant M, Hanson J (2002) Issues and opportunities in quality end-of-life care. J Oncol Manag 11(2):22–24

23. National Association of Social Workers (2008) Code of ethics. Retrieved on 6/16/2014: http://www.socialworkers.org/pubs/code/code.asp

24. Knowles MS (1990) The adult learner: a neglected species, 4th edn. Gulf Pub. Co., Houston

25. National Consensus Project for Quality Palliative Care (2013) Clinical practice guidelines for quality palliative care, 3rd edition. Pittsburgh, PA. Retrieved 6/16/2014: http://www.nationalconsensusproject.org

26. Altilio T, Otis-Green S (Eds.). Oxford textbook of palliative social work. Oxford University Press, New York

27. City of Hope Pain & Palliative Care Resource Center. Quality of life models. Retrieved on 6/16/2014: http://prc.coh.org/qual_life.asp

28. Conzemius A, O'Neill J (2002) The power of SMART goals: using goals to improve student learning. Solution Tree Press, Bloomington

29. Sheldon FM (2000) Dimensions of the role of the social worker in palliative care. Palliat Med 14(6):491–498

30. Csikai EL (2004) Social worker's participation in the resolution of ethical dilemmas in hospice care. Health Soc Work 29(1):67–76

31. Azoulay E, Pochard F (2003) Communication with family members of patients dying in the intensive care unit. Curr Opin Crit Care 9(6): 545–550

32. Baile WF, Kudelka AP, Beale EA, Glober GA, Myers EG, Greisinger AJ, Lenzi R (1999) Communication skills training in oncology. Description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. Cancer 86(5): 887–897

33. Blacker S, Deveau C (2010) Social work and interprofessional collaboration in palliative care. Progress Palliat Care 18(4):237–246

34. Interprofessional Education Collaborative Expert Panel (2011) Core competencies for interprofessional collaborative practice: report of an expert panel. Interprofessional Education Collaborative, Washington

35. Reeves S, Lewin S, Espin S, Zwarenstein M (2010) Interprofessional teamwork in health and social care: partnership working in action, 7th edn. Wiley-Blackwell, Oxford

36. Back A (2000) Communication between professions: doctors are from Mars, social workers are from Venus. J Palliat Med 3(2):221–222. doi:10.1089/10966210050085322

37. Stewart AK, McNamara E, Gay EG, Banasiak J, Winchester DP (2011) The Rapid Quality Reporting System—a new quality of care tool for CoC-accredited cancer programs. J Registry Manag 38(1): 61–63

38. Zebrack B, Burg M, Vaitones V (2012) Distress screening: an opportunity for enhancing quality cancer care and promoting the oncology social work profession. J Psychosoc Oncol 30(6):615–624. doi:10.1080/07347332.2012.721485

39. Kayser K, Acquati C, Tran TV (2012) No patients left behind: a systematic review of the cultural equivalence of distress screening instruments. J Psychosoc Oncol 30(6):679–693. doi:10.1080/07347332.2012.721489

40. Loscalzo M, Clark KL, Holland J (2011) Successful strategies for implementing biopsychosocial screening. Psychooncology 20(5): 455–462. doi:10.1002/pon.1930

41. Parry C, Padgett LS, Zebrack B (2012) Now what? Toward an integrated research and practice agenda in distress screening. J Psychosoc Oncol 30(6):715–727. doi:10.1080/07347332.2012.721486

42. Rohan E (2012) Removing the stress from selecting instruments: arming social workers to take leadership in routine distress screening implementation. J Psychosoc Oncol 30(6):667–678. doi:10.1080/07347332.2012.721487

43. Commission on Cancer (2011) Cancer program standards 2012: ensuring patient-centered care. American College of Surgeons, Chicago

44. Billings JA (2011) The end-of-life family meeting in intensive care part I: indications, outcomes, and family needs. J Palliat Med 14(9): 1042–1050

45. Billings JA (2011) Part II: family-centered decision making. J Palliat Med 14(9):105–1057

46. Fineberg IC (2010) Social work perspectives on family communication and family conferences in palliative care. Progress Palliat Care 18(4):213–220

47. Fineberg IC, Kawashima M, Asch S (2011) Communication with families facing life-threatening illness: a research-based model for family conferences. J Palliat Med 14(4):421–427

48. Powazki R (2011) The family conference in oncology: benefits for the patients, family and physician. Semin Oncol 38(3):407–412

49. Altilio T, Otis-Green S, Dahlin CM (2008) Applying the National Quality Forum Preferred Practices for Palliative and Hospice Care: a social work perspective. J Soc Work End Life Palliat Care 4(1):3–16. doi:10.1080/15524250802071999

50. Lautrette A, Ciroldi M, Ksibi H, Azoulay E (2006) End-of-life family conferences: rooted in the evidence. Crit Care Med 34(11 Suppl): S364–372. doi:10.1097/01.CCM.0000237049.44246.8C

51. Yennurajalingam S, Lockey M et al (2008) Characteristics of family conferences in a palliative care unit at a comprehensive cancer center. J Palliat Med 11(9):1208–1211

52. Hannon B, O'Reilly V, Bennett K, Breen K, Lawlor PG (2012) Meeting the family: measuring effectiveness of family meeting in a specialist inpatient palliative care unit. Palliat Support Care 10(1):43–49. doi:10.1017/S1478951511000575

53. Hudson P, Thomas T, Quinn K, Cockayne M, Braithwaite M (2009) Teaching family carers about home-based palliative care: final results from a group education program. J Pain Symptom Manag 38(2):299–308. doi:10.1016/j.jpainsymman.2008.08.010

54. Wiener L, McConnell DG, Latella L, Ludi E (2013) Cultural and religious considerations in pediatric palliative care. Palliat Support Care 11(1):47–67. doi:10.1017/S1478951511001027

55. Haynes MA, Smedley BD (eds) (1999) The unequal burden of cancer: an assessment of NIH research and programs for ethnic minorities and the medically underserved. Institute of Medicine, National Academy Press, Washington, DC

56. Kagawa-Singer M, Dadia AV, Yu MC, Surbone A (2010) Cancer, culture, and health disparities: time to chart a new course? CA Cancer J Clin 60(1):12–39. doi:10.3322/caac.20051

57. Corey G, Corey MS, Callanan P (2003) Issues and ethics in the helping professions. The University of Michigan: Brooks/Cole/Thomson Learning

58. Dahlin C (2004) Ethics in end-of-life care. J Hosp Palliat Nurs 6(1):2–3
59. Lauria MM, Clark EJ, Fife M, Marcusen C, Walsh-Burke K, Hedlund S (2001) Oncology social work toolbox: building advocacy skills. Association of Oncology Social Work
60. Otis-Green S, Rutland C (2004) Marginalization at the end of life. In: Berzoff, Silverman (eds) Living with dying: a handbook for end-of-life healthcare practitioners. Columbia University Press, New York, pp 462–481
61. National Association of Social Workers (2004) NASW standards for social work practice in palliative and end of life care. Retrieved on 6/16/2014: http://www.socialworkers.org/practice/bereavement/standards/default.asp
62. National Association of Social Workers (2005) NASW standards for social work practice in health care settings. Retrieved on 6/16/2014: http://www.socialworkers.org/practice/standards/naswhealthcarestandards.pdf
63. Burnes B (2009) Managing change, 5th edn. Pearson Education Limited, Essex, England
64. Fullan M (2008) The six secrets of change: what the best leaders do to help their organizations survive and thrive. Jossey-Bass, San Francisco
65. Periyakoil VS (2009) Change management: the secret sauce of successful program building. J Palliat Med 12(4):329–330. doi:10.1089/jpm.2009.9645