

Program Evaluation: Preferred Hospice

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Setting

Preferred Hospice is a Missouri-based hospice agency or “comfort care” that is offered to all terminally ill patients whom, according to a doctor, have a life expectancy of six months or less. Preferred Hospice has six offices all in Missouri: Ozark, St. Louis, Columbia, Dexter, Farmington, and Lexington. Each location serves many counties and are all a one hour radius from them. This paper presents a program implementation evaluation of the office in Lexington, Missouri. This agency provides care to the patients and their families with an Interdisciplinary Team composed of Administration, Physicians, Nurses, CNAs, Social Workers, Volunteers, Bereavement Coordinator, Volunteer Coordinator, and a Companion Care Sitter. When all positions are filled, the interdisciplinary team is also composed of a Director of Business Development, Admissions Coordinator, a dietician, an Assistant to the Volunteer Coordinator, Medical Records Technician, Staffing Scheduler, an Administrative Assistant, and a Receptionist. Preferred Hospice employs 35 people when all positions are filled. Currently, the Lexington office employs 27 people: one administrator, one director of clinical services, one office manager, seven Nurses, six CNAs, two social workers, two chaplains, zero dieticians, one bereavement coordinator who also assists the volunteer coordinator (the practicum student) and one Volunteer Coordinator who also assists the office manager. Hospice is paid for by Medicare, private insurance, or private funds. The Lexington office is located on Business 13 Highway within a strip mall next to a hair salon and an insurance agency.

Design and Method

For this implementation evaluation of Preferred Hospice, a multi-method design will be utilized that focuses through National Implementation Research 0, (NIRN) implementation

frameworks (Bertram, Blase, & Fixsen, 2015; Fixsen, et al, 2005). The data will include three data sets:

- The first data set reviews printed material, including training material, Policy and Procedure manual, pamphlets, booklets used within the interdisciplinary team such as the Chaplain's booklet called "Reflections," the Bereavement Coordinator's booklet called, "My Friend, I Care" and the Nurses' booklet called, "The Peaceful Crossing"; and a handout breaking down the disciplines and describing their responsibilities.
- The second set of data comes from semi-structured interviews of one representative from each discipline within the interdisciplinary team. This will include the administrator, the director of clinical services, the office manager, one nurse, one CNA, one social worker, one chaplain, and one volunteer coordinator. The administrator has been in the job for seven years, the director of clinical services has left the company and came back on multiple occasions. If she had remained employed at the office she would have been employed with the company four years, the office manager has been employed with the agency for almost five years, the nurse is the newest staff member that I will interview, having been at Preferred Hospice for 6 months. The social worker is one of the more senior employees at the agency, having been at Preferred Hospice for almost six years. The chaplain has been with Preferred Hospice for almost six years, and the volunteer coordinator has been with Preferred Hospice for almost four years.
- The third set of data comes from peer-reviewed literature pertaining to palliative care, the effectiveness on the hospice patient through utilizing an interdisciplinary team, and the effect of spirituality within hospice care.

All data will be compared and contrasted within and between data sets. I will note similarities, differences, congruence and incongruence.

NIRN Intervention Components

The NIRN framework include intervention components: target population characteristics (behavioral, demographic and other factors that align with the practice model), model definition (who should be engaged in what actives and phases of the service delivery), theory base(s) that support those elements and activities, the practice models theory of change (how those elements and activities create improved outcomes for the target population), and alternative models (the rationale for why the program rejects the use of other program models) (Bertram, Blase, & Fixsen, 2015). These intervention components along with implementation drivers and stages of implementation comprise the three NIRN frameworks, however this paper will not focus through stages of implementation.

Derived from a systematic review of over thirty years of empirical data from diverse endeavors across disciplines, implementation frameworks use multi-disciplinary knowledge bases to understand the complexity of human interactions within systems (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Implementation frameworks provide a conceptual basis for organizing an agency to best support its service delivery.

Target Population Characteristics

Each program model should be developed to work with a specific population. Target population characteristic could include a specific behavior or event of concern, culture, socio-economic status, and other specifically defined characteristics (Bertram, King, Pederson, & Nutt, 2014; Bertram, Blase, Shern, Shea, & Fixsen, 2011).

Written materials. A flyer produced for Preferred Hospice does not indicate a breakdown of the populations served, nor do any other site materials listed above show a breakdown of population characteristics. However, an African American man along with a Caucasian man are pictured together on the back of the pamphlet as the company's way of representing diversity. Before September of 2015, the primary ages served ranged from 65+ years and a variety of males and females. Now, all ages are served and services of the company are now being offered to the pediatric population. There is no representation of the pediatric population pictured within the flyer, but is pictured within the sub category titled "pediatric supportive care" within the "resources and support" tab on the website. Preferred Hospice obtains client records, produces annual reports, and maintains a database of who was served. However, I was unable to gain access to this information throughout the duration of this evaluation.

Semi-structured interviews. All staff members shared all ethnicities are welcomed. However, the agency primarily serves Caucasian individuals due to the agency serving a rural community. When asked specific questions regarding the demographics of the clientele staff were able to provide more details.

Each staff member had a different view on the characteristics of their clients, most of which were characteristics of the individual patients. The social worker stated that the patients served come from a Caucasian ethnicity from a rural community and differing economic status, from lower class to "almost wealthy." The social worker also said the majority of her patients were farmers and have "old money" and currently out of the sixty patients the agency is serving, all are Caucasian. Pediatrics has recently been implemented in Hospice care and that was only mentioned by the Administrator and the Director of Clinical Services. The Director of Clinical

Services stated Preferred Hospice “serves the community-every patient and every family member we have the privilege to walk their home, life limiting, disabling process where a doctor must say have a six month or less diagnoses, any age of patient in all walks of life. We have recently been approved to serve the pediatric population and if we are interested, those of us who would be okay with treating pediatric, we are in the process of getting a headcount of who would be okay with it and if we get a referral we would then receive further training from the Director of Operations.” The Administrator referenced the disproportionality of the race/ethnicity of clients, and racial makeup of the staff. The administrator, who is also the marketer for the company, shared an example where there was a time only Caucasian individuals represented throughout all advertisement for the agency. One day, she went to market in the downtown Kansas City area where she had a meeting with an Administrator. Their agency served a variety of ethnicities and once the administrator of that agency looked at the pamphlet, she immediately rejected doing any future business with Preferred Hospice until their marketing tools were more welcoming to all ethnicities instead of targeting one. The Administrator of Preferred Hospice immediately contacted corporate and the marketing tools were fixed and sent out for all offices to utilize in the future.

Peer-reviewed literature. Cohen (2008) discussed the racial/ethnic disparities in hospice care:

Access to hospice is a growing public health matter given that quality care at the end of life should be provided to all individuals regardless of race, ethnicity, or socioeconomic status. Health care disparities, particularly among racial and ethnic groups, have been well documented in the scientific literature. However, little is known about the demographics of hospice users or the use of hospice services by specific racial and ethnic groups (p. 763)

There was a study conducted to examine hospice utilization among racial and ethnic groups residing in mainly urban areas. The study was based on patient characteristics such as socioeconomic status, socio-demographic variables, geographic location, type of insurance, and year of death. The sample was collected from 13 studies found within online databases and included 170,136 patients aged 67 and older diagnosed with breast, colorectal, lung, or prostate cancer from 1991-1996 and died between 1991 and 1999. Within each racial and ethnic group, hospice services were used by 31% of non-Hispanic whites, 27.3% of blacks, and 26.7% of “other” ethnicities. Higher utilization was higher for non-Hispanic whites, those enrolled in managed care and those who were younger, married, female, living in urban areas, diagnosed with lung or colorectal cancer, and living in areas with higher education and income levels. The study showed that hospice use increased for both blacks and non-Hispanic whites over the study period, but the higher ratio of use by non-Hispanic whites compared to African Americans remained the same (Cohen, 2008).

Cort 2004 stated, “Ethnic and racial minorities represent only 5% to 7% of the hospice patient population, and African Americans in particular, are seriously underrepresented in this institution (p. 63).” The authors further explain that African Americans face barriers on the consideration of hospice care in particular. Within an African American family, community health care decisions are decided amongst the family members. “Therefore, many African Americans first consult their family circle in making decisions about where to seek help, and show a general reluctance to go outside of their family circle for help with medical caregiving (p. 63).” This culture often hesitates to welcome strangers into their homes, where many individuals from the hospice team would be entering their house throughout the coming months. The article

also describes a lack of knowledge about hospice services constitutes another barrier to hospice use for African Americans.

Cultural insensitivity and mistrust are engendered by a health care system that tends to be complex, busy, impersonal, and often brusque . . . hospice care which is not impersonal or brusque, may be viewed by minority families as intrusive, especially if they believe that unfamiliar caregivers will try to take over and change things.

Fischer, Sauaia, & Kutner explain the growing need for “patient navigation” in the care of underserved populations. Patient navigators, normally individuals whom hold a position within social work, case management, patient education and advocacy-work with patients and families to empower them to overcome barriers in the health care system and enjoy better health and better health care. The first program of patient navigation aimed at breast cancer and was designed by Dr. Harold Freeman in 1995. The program utilized community members to address barriers to screening, further diagnostic studies, and timely treatment by navigating the health care system, providing education and support, and assisting with child care, transportation, and scheduling appointments. Over the next 5 years, late-stage breast cancer rates dropped from 50% to 21% and the 5-year survival rates went from 39% to 70%. Patients with navigators had higher screening rates, were more likely to follow-up abnormal results, and obtain treatment. The authors introduce patient navigation as a growing need in palliative care. For example, in their preliminary work they found that few Spanish-speaking persons knew about hospice. “The very translation of the word, *hospicio*, was problematic-some translated it to mean an orphanage, a nursing home, or a mental institution. However, hospice care includes many aspects of care consistent with Latino values and preferences.” Furthermore, few minorities use hospice services due to the language and cultural barriers discussed above. A patient navigator program for palliative care can address these barriers and be applied independent of expected prognosis.

There is a significant body of literature that suggests that disparities in health care extend to care at the end of life. The National Institutes of Health 2004 State of Science report on the Quality Gap of End of Life Care, the National Quality Forum's Framework and Preferred Practices for Palliative and Hospice Care Quality, and the National Consensus Project for Quality Palliative Care all acknowledge the existence of disparities in end-of-life care for ethnic minorities and recommend culturally appropriate assessment and treatment at the end of life. However, practical strategies or models to eliminate disparities in end-of-life care are lacking (p.1024).

The authors suggest since hospice allows for care to take place in the home, with family members serving as the primary care givers; providing education about hospice care, using nonthreatening language, in person discussions with patient and family members in their home, and using personal testimonials would be examples of the culturally competent intervention strategies a navigator could use to address cultural barriers and increase hospice acceptance and utilization. To explain further:

A patient navigator for palliative care will incorporate some of the skills and services of a community health worker by doing outreach and palliative care education in the community, a case manager or social worker by problem solving barriers to palliative care, and directing patient and families toward community resources, and an advocate by empowering patients, families, and communities to achieve better health care at the end of life. In a linguistically and culturally appropriate manner, a palliative care patient navigator would serve as a liaison between the patients and the health care providers, as well as address logistical or tangible needs that can be significant barriers to obtaining care (p. 1024-1025).

Analysis. According to the semi-structured interviews and the site materials, there is statistical information produced breaking down the variety of populations served over a period of time. However, due to the factual information that currently all patients being served through the

Lexington office are Caucasian, there is no existing diversity within the patient population. This coincides with the articles on the racial makeup of older adults utilizing hospice in the US and describes the language and cultural barriers that withhold the minority populations from utilizing hospice care. In this article, the evident racial disparities among these minority groups in urban communities with more resources and lower financial need speaks to the ethnic disparities in rural communities that more commonly have significantly less resources and a higher financial need.

The third article describes the benefits of using patient navigators to alleviate the concerns and barriers of the minority populations when utilizing hospice. The calculations within the database regarding diversity is not readily available to staff. When interviewed about the diversity of the target population, the administrator and the Chaplain noted the issue of disproportionality. The remaining interviewees stated that they primarily serve the Caucasian population due to the rural communities the agency serves and did not indicate disproportionality. The third article highlights the major disproportionality among diversity receiving services through hospice care and the cultural mistrust occurring amongst the minority population(s).

Model Definition

In NIRN frameworks model definition refers the key elements of a program. The model definition details the elements and activities along with the participants and phases of service delivery. Even if an evidence-based practice model is not in use, the model elements and activities, participants and phases of service delivery should be clearly defined (Bertram, Blase, & Fixsen, 2015).

Written material. Although the practice model is not clearly written within the site materials, there is a clear practice model reported in the policy and procedure manual as well as the handout describing the responsibilities. These are congruent with the “Team-based Model.” Within the practice model, there are clear expectations for when activities occur and by which member of the team. Other site materials that support the practice model include the Chaplain’s booklet called, “Reflections of the Heart and Soul” and the Bereavement Coordinator’s booklet called, “My Friend, I Care.”

The policies for each discipline along with a description of the programs they are responsible for are as follows:

Once the agency receives a referral, the office manager will send the patient’s name, date of birth, and social security number into an eligibility form and emailed to the corporate office in Ozark, Missouri for their officer manager to find out what the potential patient’s payer source is (whether that is Medicare, Medicaid, and/or private insurance). Then the agency will need to get a physician’s order stating the patient has a terminal prognosis of six months or less and qualifies for hospice.

Once the physician’s order has been received, a nurse (when all positions are filled an admissions nurse would be in charge of this responsibility) will go where the patient resides to complete a head-to-toe assessment and ensure the patient meets hospice criteria. The hospice criteria are strict and rigid guidelines developed through Medicare in order for the patient to qualify. If the patient is appropriate, the nurse will then go back to her office and document an initial nursing assessment and the office manager will admit the patient. Then, the office manager will send out a text message through the agency’s paging system to alert everyone and who from each discipline are on that patient’s care team.

24 hours after the admission, the nurse will complete a follow-up visit to compare the measurements of pain upon admission and at the follow-up assessment to ensure the pain is controlled. If it is not, the nurse will reevaluate the medications and/or supplies needed to get the patient's pain under control. The nurse will then coordinate with the caregiver(s) and/or community (nursing home facility) to schedule their bed baths, showers, and all other nursing visits that are required at a minimum of two times a week.

Then the social worker will complete their psychosocial assessment within five days and the chaplain will complete their initial assessment within five days of the admission as well. The interdisciplinary team will then review each patient every fourteen days at the IDT meeting to ensure they are still hospice appropriate and to evaluate if there are any concerns within each discipline.

The administrator is also the marketer of the company (when all positions are filled, there is one administrator and one marketer). The administrator is responsible for covering nine counties, all an hour radius of the Lexington office and making phone calls to communities (nursing home facilities), assisted living facilities, clinics, doctors, hospitals to introduce herself and ask to complete a presentation of the programs and services offered through Preferred Hospice, then request a contract with them to begin receiving referrals and provide care to the qualified patients within the facility.

RN case managers see their patients a minimum of every fourteen days per Medicare regulation, LPNs provide additional nursing visits to comply with the company policy stating patients get two nursing visits a week. Company policy states CNAs visit at a minimum of twice a week, and social workers and chaplains will meet with patients once or twice a month unless declined by patient and family. RN case managers use a book created by the Director of

Operations called, “The Peaceful Crossing” to help educate the families on the dying process and what to expect as their loved one is approaching death.

CNAs have a contract with the patient, explaining the story of the goose, named Chance (essentially our mascot). This contract describes the V formation and makes a promise to the patient that they will be the lead goose in the care, and the CNA will follow them along with the rest of the interdisciplinary team to provide the best care to the patient. The story of the goose is as follows: “The V formation offers many benefits. Each bird has an unobstructed field of vision, allowing flock members to see each other and communicate while in flight. The goose at the head of the V is not necessarily the leader of the flock. Geese take turns leading. When one bird tires, it drops to the back of the formation and another takes its place. The birds do not fly close enough to realize the full benefit of that shape. The V also gives the geese the ability to watch each other and communicate about likely landing locations. They communicate regularly in flight. Geese are very loyal birds. A male and female mate for life. A family group will stay together even within the flock. If a bird in the flock becomes injured during migration and can’t keep up with the V, a few family members will go down with the injured bird to keep it safe while it recuperates. This is teamwork.” By choosing Preferred Hospice, the patient has become a member of their flock. The patient will be the leader of the flock and point the care team in the direction the patient wants the team to go with their healthcare decisions. The interdisciplinary team will communicate throughout the journey. When the patient gets tired and are unable to lead, the interdisciplinary team will continue in the same direction. The CNA tells this story to their patient at the initial visit and signs the contract to seal the promise they made to them. The goose is named Chance because Preferred Hospice only has one chance to make this process as comfortable as possible for as long as possible.

Social workers provide an aromatherapy-reflexology kit which includes three essential oils: lemon to increase appetite, peppermint to increase stimulation and help with nausea, and lavender to help with relaxation. The kit also includes reflexology socks that have a map on them with different pressure points to relieve pain in certain areas of the body. Social workers are required to visit their patients once a month (unless declined by patient) but will see their patients more often as needs change and/or requested by the patient, caregiver, or family member. Social workers will also use outside agencies as needed to fulfill the needs of their patient such as food stamps, utility assistance, etc.

The Chaplain provides a booklet called “Reflections” describing the spiritual path as well as a life review of the patient practices a faith or is spiritual in any way and is open to benefiting from this booklet. The booklet has a minimal amount of biblical scripture in it, but the booklet is made to be non-denominational and is used with all patients who are accepting of the Chaplain’s services. On the last page, at post-mortem there is a place for the chaplain to get hand prints and/or foot prints from the patient too frame and give to loved ones to keep forever. The Chaplain is required to visit his patients once a month (unless declined by the patient) and will see their patients more often as needs change and/or requested by the patient, caregiver, or family member. The website states, “Preferred Hospice is not associated with a particular religious group or church. In offering spiritual support, we honor different faith backgrounds and provide spiritual care and counseling to patients of all beliefs.”

The Bereavement Coordinator gives the bereaved families a “My Friend, I Care” booklet. The owner of this company and their wife lost their daughter over five years ago, and the wife said of all the advice and gifts that were given, this booklet is what helped her the most and requested the Bereavement Coordinator give to all the bereaved families. The booklet was

written by an RN who offers knowledge to patients and families to ease fear and misinformation about dying and death. The booklet is used at the 2 month mark of the death and is also offered to community members outside of the agency that come into contact with the Bereavement Coordinator through grief support groups and referrals by service providers in the communities we serve. The Bereavement Coordinator also has a children's program that has a booklet starring Chance as a cartoon and he explains the dying process in a way that children can understand it. This booklet recently won an Addy award. A coloring book goes along with the booklet for the children to use. For teens, there is a memory box with paint and a pamphlet explaining the program. The memory box promotes self-expression and the teens can paint the box in a way that best describes the teen and can place items in the box that will remind them of their loved one who has passed on.

When a patient passes away, the bereavement coordinator contacts the family within 72 hours to offer condolences, a visit, and the bereavement program and will complete an initial bereavement assessment. The Bereavement Coordinator of Lexington will then send an initial bereavement card with the staff's personal signatures and phone number. The bereavement coordinator will then contact the family at the 2 month mark from the death and the 5 month mark of the death to touch base and offer continued support as well as complete and document follow-up assessments. The bereavement coordinator offers home visits to the families and facilitates three support groups in the area.

Upon arrival at each requested home visit, a follow-up assessment is completed. The pre-generated assessment calls the bereaved client the "primary survivor" and asks for their name, address, phone number, the relation to the client, and their relationship with the client (good rapport, unresolved issues,/conflicts, relatively non-dependent, conflictual, resolved issues,

dependent and other). The rest of the family is noted within the same care plan (i.e. if the primary survivors are husband and wife, they will be listed on the same care care plan. If they are siblings, each will have a separate care plan)

Then the assessment asks to indicate the circumstances surrounding death: (i.e. attendance at memorial/funeral, unresolved issues at time of death, unusual events at time of death, functioned in caregiver role, death was prepared for (expected) and other-all choices have boxes next to each choice for the social worker to have more than one option they can choose).

The assessment then asks the physical/mental health of the primary survivor, again with multiple choice checkboxes (good health history, good self-care habits, history of depression, appropriate grief response, sleep changes, anxiety, health concerns, appetite changes, keeping overly busy, suicidal ideations, substance abuse, fatigue and other-then it has a box titled “Notes related to findings” to describe more in depth the choices that were selected. For example, the “fatigue” choice could mean the primary survivor is not getting any sleep throughout the night, or may be having dreams about their loved one that continues to wake them throughout the night, etc. Emotions related to grieving are indicated (appropriate, absence of emotion, difficulty expressing, anger, withdrawn, guilt, dependency, extreme reaction, unable to evaluate at this time), then social stressors are also indicated (none noted, financial, legal, relocation, role changes, unable to evaluate at this time).

Then loss history (multiple, other recent loss, concurrent life crisis, delayed grief reaction from previous loss, resolved grief from previous loss, unable to evaluate at this time). Then a box titled “notes” can be used to specifically describe the choice(s) selected. Then it asks the primary survivors current risk level and has the worker choose one: “Demonstrates HIGH risk-depression, anxiety, unable to function at daily tasks, suicidal; is in need of immediate

intervention by Hospice or professional staff, demonstrates MODERATE risk-able to function but struggling with feelings or decisions, demonstrates LOW risk-needs support but is able to recognize needs, seek and accept help, demonstrates NO risk-demonstrates healthy grieving and coping skills, and N/A”

Once that is completed, the assessment seeks a yes or no answer to the primary survivor’s willingness to accept continued support and contact by hospice and if the primary survivor needs immediate and/or intensive support from hospice. Then provides another box titled “notes related to findings” to discuss the setting of the visit, what occurred during the visit, what the primary survivor shared with the bereavement coordinator and what the bereavement coordinator did to support the primary survivor (used strengths perspective, used active listening, validation, and positive affirmations). Then it asks a yes or no question to see if a plan of care has been established.

The volunteers have a booklet they fill out with the patient called “Treasures of the Heart and Soul” where it guides the volunteer to ask patients about certain details of their life from their favorite color to their favorite sports team to letters they would like to leave behind for their loved ones. Once this journal is filled out in its entirety or as much as the volunteer can fill out in the time they have with the patient; when the patient passes the journal is given to the family as a gift to keep, look back on, and pass down to future generations forever.

Regarding team meetings, IDT meetings and Monday morning meetings are held to address any issues and concerns there may be with the individual patients and/or patient care. IDT meetings are to be held every two weeks to evaluate, review, and update the resident’s (patient’s) plan of care. The primary and mandatory members of the IDT consist of a physician (medical director, associate medical director), director of clinical services, registered nurse,

pastoral/counselor, and a social worker. The support members of the IDT consist of the volunteer coordinator, volunteers, certified home health aides (CNAs), registered dietician, pharmacist, DME provider, QA/care plan coordinators, licensed practical nurse, companion care, therapists, and medical records clerk. The Lexington office conducts their IDT meeting every other Tuesday at 9:00 a.m.

Within the Lexington office, the IDT has a team meeting every Monday morning at 9:00 a.m. to discuss weekend report, and to discuss any concerns regarding the patients in the upcoming week and works to resolve those concerns during the meeting.

Semi-structured interviews. All interviewees did not have a clear definition when asked about the practice model, except for the Administrator. The administrator described their practice model as a “team-based approach,” meaning all members within the interdisciplinary team come together to assess the needs of each patient and come up with a plan of how the team is going to address those needs (which would be congruent to the “Team-based model,” although it is not clearly written within site materials). Upon further probing when the interviewees were asked how the team complements one another; all team members described that all members within the interdisciplinary team use their expertise to address and fulfill the needs of the patient-which again, would be congruent to the “Team-based model.”

All interviewees had broad answers when describing the roles and responsibilities of each team member. Along with that, all interviewees did not explain the programs each discipline is responsible for when delivering services except for the Administrator. The Volunteer Coordinator mentioned the Chaplain’s program and the nurse stated that all team members were responsible for a program but was unwilling to go into the details of each program. Interviewees were asked how the team complements one another, and all team members stated “we all have

our own expertise that addresses the needs of the whole patient.” However, the nurse explained further and said that the team works together and can follow-up with one another to ensure the patient’s need(s) are being met (i.e. if the patient has a financial need the nurse can follow-up with the social worker). The nurse further explained this shows “continuity of care” and makes the patient feel more comfortable discussing their concerns with anyone since everyone is aware of the patient’s needs and are working together to fulfill those needs.

The Chaplain explained the roles and responsibilities of each team member by separating them as one side being the “clinical side” which includes the nurses, CNAs, and the doctors and on the other side being the “support side” which included the chaplains and the social workers. Although the chaplain did not define the programs each discipline is responsible for, both accurately defined the elements and activities of each discipline.

A key point the Chaplain explained he works in all types of faith, but is not experienced in all of them and will research materials in order to help support the patient within their faith. However, he “draws the line” when it comes to a faith or religion that compromises his values and belief system. For example if the patient were a “devil worshiper” he would not assist them in their faith, instead he would research material and request the patient’s family member to assist them in their faith. The Chaplain also stated the agency does not serve babies or children.

The Volunteer Coordinator was able to further articulate the elements and activities within the team.

The social worker, the office manager, and the CNA gave broad answers and stated the IDT includes nurses who monitor needs and any change in condition, and CNAs who take care of the physical well-being, social workers who provide resources and emotional support and the chaplains who provide spiritual support. However, the CNA and the Office Manager included

doctors within the IDT. The CNA stated their discipline visits the patient the most and do all their personal care. The Volunteer Coordinator and the CNA were the only disciplines who included Volunteers within the IDT.

Interviewees were asked about differences that may occur when a family requests something for their loved one (the patient) that the team does not agree with and gave varying answers when it came down to the individual who ultimately makes the final decision. However, all interviewees stated communication (regarding the differences between the family and the team) amongst team members occurs during the IDT meetings. All team members stated patient education is provided regarding use of alcohol and medication (i.e. the nurses will tell the patient and the family the harmful effects of consuming alcohol while taking certain medications and will educate the proper way to take the medications).

The Chaplain gave an unclear response when he said it depends on the specific requests the family is wanting for the patient (i.e., if the family is requesting more visits, the patient will get more visits-if the team disagrees it is “not up to them, it is up to the patient” whereas if it is a medication issue it is “up to doctor.” However, if the family and/or patient is requesting something that will cause death early and/or something that is unethical the team cannot follow through with those particular events).

The administrator, the CNA, and the social worker stated the team members meet the client where they are at within the dying process and as a team decide which needs are to be met and how they will each fulfill those needs. The social worker stated completing IDTs every two weeks helps to ensure all needs are being met (did not speak to the differences the family may have). The Office Manager stated the team will discuss the options and choose the best option that will “make the patient and the company happy.”

Since the IDT plays a key role in care coordination, interviewees were also asked about differences within the team itself and all interviewees described that communication plays a key part in discussing the differences and it ultimately falls back on “what is best for the patient.” If that cannot be agreed upon, it ultimately falls to the competent patient or the incompetent patient’s power of attorney. The Administrator shared that team members have to “walk a fine line” when differences occur between the family and the team and shared when the nurses are being reprimanded by the DCS, she tries to ensure the nurses are okay after the fact and attempts to work with the DCS in helping her understand if “the shoe was on the other foot.” The Administrator also makes attempts to work with the DCS through helping her understand that every team member learns differently and are in need of more guidance instead of receiving punishment.

As far as personal differences between the team itself, some employees were unwilling to answer due to fear of suffering consequences. However, some team members shared the corporate office “sweeps things under the rug” when it comes to the issues occurring within the office (i.e. team members creating a hostile work environment) and issues they face out in the field (i.e. the competition amongst other hospices, and the lack of staffing and equipment to best deliver services).

Peer-reviewed literature. Crawford & Price (2003) describe the different models of interdisciplinary practice within palliative care. “Moreover, the origins of palliative care lie in the areas of religious care and nursing, rather than medicine, and palliative care draws heavily on a broad spectrum of disciplines, knowledge, skill, experience and creative thought (p. 32).” They explain that palliative care teams include nurses, doctors, social workers, volunteers, chaplains, allied health practitioners and a multitude of other therapists (p. 32) and medical science has

been more supportive lately in the development of multidisciplinary approaches in order to provide comfort to the “whole” person. The authors describe interdisciplinary as:

“Interdisciplinary function is generally the aim of specialist palliative care teams, with members contributing from their particular expertise. The team shares information and works interdependently. Leadership is task-dependent, with tasks defined by the individual patient’s situation (p.32).” Team conflict issues, role ambiguity, role overload, interpersonal conflict, inadequate communication and leadership dilemmas are discussed as well recognized challenges to creating good teamwork in the delivery of palliative care:

Team conflict and difficulties can develop because of internal or external stresses, individual issues or a corporate problem. Communication, both formal and informal, within a team is a major factor. A longstanding team may become self-sufficient, or resistant to new ideas. Underground communication (e.g., rumor, gossip) may destroy the trust and openness required to function as a team. Conflict between two team members and problems such as a dominant member, an isolated member, team factions and team secrets are all potent means of disrupting team equilibrium and function. Poor definition of authority and individual responsibilities and roles, poor performance feedback processes, and reluctance to cooperate, collaborate and compromise can all undermine a team’s capacity to achieve its goals (p. 33).

Despite the challenges, the core benefit to this model is that each team member can support one another and depend on one another based on their expertise to further support the patient.

Hearn & Higginson (1998) conducted a study to determine if multidisciplinary palliative care teams improve outcomes for cancer patients. The author considered a variety of outcomes when conducting the study such as aspects of symptom control, patient and family caregiver satisfaction, health care utilization and cost, place of death, psychosocial indices and quality of life. The authors found eighteen relevant studies and included give randomized controlled studies throughout their research. Improved outcomes were seen in the amount of time spent at home by

patients, satisfaction by both patients and their caregivers, symptom control, a reduction of in the number of inpatient hospital days, a reduction in overall cost, and the patients' likelihood of dying where they wished to for those receiving specialist care from a multi-professional palliative care team (p. 317)

Within this article, evidence suggests that poor communication amongst a multidisciplinary team is one of the most common reasons for litigation and complaint in the health service. Poor communication results in dissatisfaction and increased co-morbidity of both the cancer patient and their family or caregivers. The article also explains that the effectiveness in palliative care is judged in terms of the quality of life before dying, the quality of life at the time of dying, a 'good death' and the impact on the family or carers (p. 319). "An effective and communicative team is often espoused as an essential element for achieving these goals by specialist working in the field (p. 319)."

Hilliard (2005) suggests Music Therapy is an effective tool to use in engaging patients within the end-of life process. Preferred Hospice does not currently utilize Music Therapy within their agency, but according to the literature there is a dearth of empirical research literature supporting the use of music therapy in end-of-life care. For example, in a study of single-session music therapy, Krout (2001) studied the effects of music therapy on pain, physical comfort and relaxation among 80 hospice patients over a total of 90 sessions. Although there was a variety from one to four sessions per patient, there was an average of one session per patient. The patients had a wide variety of diagnoses and settings in which they resided. The results demonstrate there was a significant change and improvement as far as pain, physical comfort, and relaxation after the music therapy sessions.

Within this article there are also studies that show the impact music therapy has on the patient's spirituality and enhancing their quality of life (Hilliard 2005). However, since death is a complex experience, research needs to continue to be conducted in order to further support individuals with a terminal illness.

Research needs to be conducted to ensure a high quality of care and to provide for the best clinical interventions in meeting the needs of patients and families. Creating an evidence base in hospice and palliative care music therapy will assist music therapy clinicians in establishing best practices in end-of-life care (p.177).

Analysis. The written material does not clearly define a practice model used within the agency or a company as a whole. Although employees were unable to determine a practice model; the administrator was able to determine a "team-based approach." This is congruent to Team based model as the practice model the interdisciplinary team uses in serving clients and their families. The website states the interdisciplinary team includes: the patient's personal physician, hospice physician, nurses, home health aides, social workers, clergy or other counselors, trained volunteers and specialist such as speech, physical and occupational therapists. However, at the Lexington office all team members are included except there are no "clergy or other counselors" or "speech, physical and occupational therapists" within the interdisciplinary team. Within the interviews, all team members had varying answers when discussing the activities or responsibilities of IDT members.

The pre-generated assessment form is open for interpretation. For example, many components within the form ask the worker if the bereaved are grieving "appropriately." However, there is no scale to measure the "appropriateness" to ensure the Bereavement coordinator is assessing the bereaved client effectively.

The first article focused on the interdisciplinary team serving only the patient, and the second article focused on the well-being of the family/caregivers. This is congruent with the interviewees, as they also describe the importance of assisting everyone within the client system.

The literature also explains the importance of communication and establishing good relationships amongst the team because the palliative care team is so interdependent.

Throughout this evaluation, there is a consistent pattern where the interviewees state that communication could be improved upon in order to deliver more effective services.

The third article suggests Music therapy as an effective tool to implement within hospice care and overall resulted in a significant decrease in pain, significant change and improvement as far as pain, physical comfort, and relaxation after the music therapy sessions. Within Preferred Hospice, the website provides links to various music videos within the bereaved teen program as an important tool to express the agony and grief when the exact words are difficult to find. The website provided a specific music video in order to assure teenagers are never alone. The interviewees did not speak of or suggest music therapy within the interviews.

Theory Base

The theory base supports the selection and delivery of those elements and activities. There can be multiple theory bases, if they complement each other. Theory base(s) can help clarify what to measure or how to measure for fidelity in delivering the model (Bertram, King, Pederson, & Nutt, 2014; Bertram, Blase, Shern, Shea, & Fixsen, 2011).

Written materials. The written material did not define any clear theory base nor any approaches/perspectives the agency uses to guide their practice within each discipline. As part of their headliner on the front page of their website, it states: “If you are living with a terminal illness, caring for a loved one who is gravely ill, or grieving the impending loss of someone close

to you, Preferred Hospice can help you. We provide support with our compassionate medical, emotional and spiritual care to people of all ages who are coping with end-of-life challenges.”

Then it breaks up into the different tabs with each discipline and the services each can offer to the patient and the family as explained above. However, there is no indication as to the theory base they use to back the compassion they have to deliver services.

Semi-structured interviews. Interviewees had varied answers about the theory base(s) behind the way they support the patients and their families. All interviewees did not have knowledge of a theory base used when initially asked. However, I then explained a theory can be a tool to use in order to help measure the effectiveness of the services they are delivering within their specialty. I also explained that there are different theories that can be used to do this in all helping professionals. I gave all interviewees examples of various theory bases to choose from such as Kubler Ross, Psychodynamic Theory, Family Life Cycle Theory, Ecological Systems Theory, Solution-Focused Therapy, and Client-Centered Therapy. The interviewees chose all the theories they felt applied to their specialty and elaborated on their reasoning.

The Director of Clinical Services, the Nurse, and the office manager chose the Ecological Systems Theory as the theory base that “best fit” the agency. The Volunteer Coordinator chose the psychodynamic model. The CNA chose Solution-Focused Therapy. The Administrator and the Chaplain chose “all” the theories I gave examples to and reported that it depended on the needs of the patient. The social worker did not have knowledge of the theory bases, but chose all of them as well and for the same reasons as the Administrator and the Chaplain.

All interviewees were asked how Kubler-Ross literature made an impact on the dying patient and everyone except for the Administrator did not have knowledge of this individual. Once it was further explained who she was by sharing she wrote a book called, “On Death and

Dying” as well as discussed the five stages of grief, some team members shared that she sounded familiar and some team members shared they had not heard of her but are aware of the five stages of grief. However, the Chaplain defined the five stages of grief as anger, denial, blame, remorse, and did not name a fifth stage. The DCS stated the stages of grief are completed within a certain order that a grieving individual cannot move to the next stage without completing the next stage.

Peer-reviewed literature. The literature within Larson and Tobin (2000) suggests that “Client-Centered Therapy,” or how they title it, “Patient-Centered” is an effective theory base to use when applying it to practice with patients.

Research and theory on effective interpersonal care are identifying elements of patient-centered medicine characterized by mutual-participation relationships that encourage informed choice and patient autonomy. At the heart of the patient-centered approach is the need to understand the meaning of the illness for the patient, a central goal of any whole-person approach to end-of-life care (p. 1576).

Although the dying process depends on the individual, there is a “general agreement” that six categories of outcomes can define the quality of end-of-life care: the patient’s physical comfort (i.e. the acceptable physical distress) the patient’s spiritual and psychological well-being the patient’s and family’s access to information and control over treatment decisions, family psychological, spiritual, and social well-being, continuity of care across providers and care settings; and family adjustment after death. The importance of each domain is likely to change over a patient’s illness trajectory and will vary between individuals and cultures. Nevertheless, these domains provide a useful structure for measuring the quality of care that populations receive (David, Casarett, Teno, & Higginson, 2006, p.21-34). This piece of literature did not directly define a theory base, however the six categories described above are mostly congruent with “ecological systems theory.” The patient’s personal relationship with their own physical,

spiritual, psychological well-being is compared with their physical relationships with family members/caregiver(s), healthcare providers, and the environment(s) they are residing.

Considering these components, or “categories” the assessment tools, eco-map and culturagram, could further assist the worker in assessing these components as well as applying the patient and families culture(s) as well in working with hospice patients.

Dugan (2004) describes a growing appreciation for Elisabeth Kubler-Ross’ work within death and dying and how it can unify the disciplines in a shared understanding of the process of dying: “Kubler-Ross’s work and influence helped hospices and palliative care programs to emerge, define themselves, attain legitimacy, and become stable features of the healthcare topography (p. 25).”

Kubler-Ross’s work and influence helped two generations of nurses and physicians recognize and understand their own feelings about death and dying, and to move beyond their denial of their fears to increasing comfort levels and competencies in relating to dying patients, their families, and each other. Kubler-Ross says that she framed the “stages” as a lens, a tool to help professional caregivers, motivated by compassion for both: “My goal was to break through the layer of professional denial that prohibited patients from airing their inner-most concerns (p. 25)

The article also explains that Kubler-Ross’s work brought issues to light that remain important in many clinical settings with seriously ill and dying newborns, children, and adults (i.e. informed choice regarding CPR and other life-sustaining interventions, pain management, physician-assisted suicide, and organ transplantation). “From the work of Elisabeth Kubler-Ross, the contemporary disciplines of hospice and palliative care took form and established themselves in the healthcare system, re-orienting the focus of care to the experiences of dying patients, their families and their professional caregivers (p. 27).”

Overall, the literature used for this program implementation evaluation makes little direct reference to the use of theory base(s) for practice in working with these targeted populations other than the theory base revolving around Kubler-Ross.

Analysis. The written materials state no clear definition of the theory base, and the interviewees have varying understanding and choices as to which theory base would “best fit their agency. The first article suggests that “Client-Centered Therapy” and is an effective tool to use when applying theory to practice in helping hospice patients. The second article suggest six categories as a structured tool to use when measuring the effectiveness of the quality of care at the end-of-life. This specific piece of literature did not describe a specific theory base used, however, the categories were mostly congruent with “ecological systems theory.” Based on the pieces of literature found, multiple theory bases can apply in measuring the effectiveness of outcomes within palliative care. Results from searching for literature also suggest further studies are needed to evaluate the theory base(s) that would best fit the palliative care model in order to make the service delivery of the model more efficient from all disciplines. All interviewees did not have knowledge of who Elisabeth Kubler-Ross was and the direct impact she has made within hospice care and grieving individuals and families. The five stages of grief are: denial, anger, bargaining, depression, and acceptance. She also stated the stages of grief are not linear and do not go in any particular order, if at all. The Chaplain and the DCS had varying answers when defining and describing the stages of grief.

Theory of Change

Theory of Change describes how those elements and activities in the program model create improvements with the target population (Bertram, King, Pederson, & Nutt, 2014; Bertram, Blase, Shern, Shea, & Fixsen, 2011).

Written materials. Within the site materials, the handout describing the responsibilities of each discipline describes how their role contributes to meeting the needs of the dying person and their family. The handout describes that the RNs and LPNs provide the patient with hands-on care to help ensure the patient is comfortable and functioning at the highest level, they discuss medication changes, special equipment and other concerns with the patient's physician and the agency's medical director, in addition to the patient, family and caregivers. The nurses are on-call 24/7 in case of an emergency and or pain crisis. Nursing visits occur two times a week or more frequently if necessary.

The handout also states the pharmacy helps meet the needs of the patient through hospice taking care of providing and paying for all hospice related diagnosis medications and instruct the patient or a caregiver on their proper use. The hospice agency will use the pharmacy of the patient's choice, and will have a 24 hour pharmacy available.

The CNAs contribute to meeting the needs of the dying patient through providing bathing, personal care, dressing, and companionship. Homemaker services are available and include vacuuming, dusting, cleaning bathrooms and kitchens, light meal preparation and errands.

According to the handout, the chaplains are well versed in multiple faiths and denominations. They are available to the patient and the family for spiritual counseling and guidance through this difficult time. Chaplains visit at least once a month, more if requested.

Social workers can help the patient identify and apply for pay sources such as Medicaid and Medicare, help with financial concerns, and provide emotional support to the patient and family. They can help write letters to family members and provide as communicators with family members. Social workers visit at least once a month, more frequently as requested.

The handout states an important part of hospice is a good bereavement program. Preferred Hospice's bereavement program continues for thirteen months after the patient passes. Phone calls, visits, letters, and informational mailings help family members cope with the passing of a loved one. Special events are not forgotten: birthdays, anniversaries, and other special days to your family will be commemorated with them and the feelings that may be present at such occasions are highlighted. Grief is a natural process, and each person handles it differently. Our chaplain, social workers, and volunteers are available to family at any time.

Within the handout, the volunteer program includes hospice volunteers who are trained to provide the patient and the family with additional support. Volunteers can provide relief for family members by sitting with a patient so that a family member may have some time off. Volunteers will also spend time just being a friend. Playing cards, reading to the patient, or just a shoulder to cry on, volunteers are the life blood of a hospice program.

Another indication of a theory change could possibly be found on the agency's home page of their website, and it states:

Preferred Hospice is dedicated to providing the highest quality of care to patients and families dealing with advanced illness, while honoring human dignity and personal choice. We offer comfort, strength and compassion to every individual as they fulfill life's journey.

Written information about how strengths-based or culturally competent help create change and positive outcomes with the client system is not addressed in agency written materials. Written information regarding satisfaction surveys are not addressed either within the agency written materials.

Semi-structured interviews. Within the interviews, the interviewees were asked how they engage the client. All interviewees explained they engage the client by introducing themselves, explaining their role, how often they would be visiting, and educating the patients and their families with the programs to provide further support. When asked, “What change should occur if everyone on the team functions in their role as intended?” all team members described that the patient would have a peaceful, painless death with all of their needs met. Then team members were asked the follow-up question, “so what does each team member do that contributes to that outcome, and how can that be monitored?” In summary, team members identified the same contributions for each discipline and that each element and activity are closely monitored through IDT. To be more specific, interviewees stated the social worker will meet the emotional needs through completing psychosocial assessments. This ensures that emotional well-being is closely monitored and communicated in the IDT as the patient is approaching death. The Chaplain will meet the spiritual needs of the patient through completing assessments. This ensures their spiritual well-being is closely monitored and communicated in IDT as the patient is approaching death. The nurse consistently assesses the physical needs/symptoms and reports these findings to the doctor. This ensures that pain and proximity of death are closely monitored and communicated with every patient during IDT as the patient is approaching death. The CNA will fulfill the physical needs of the patient through physical care and will report all findings to the nurse. This ensures the quality of physical care is closely monitored through the nurse and communicated with every patient during IDT as the patient is approaching death.

Peer-reviewed literature. Parker-Oliver, Bronstein, & Kurzejeski (2005) explains the importance of successful interdisciplinary collaboration within hospice teams in an effort to

improve teamwork and hospice care: “In hospice, teamwork is critical to the service and management of the entire person and his or her environment and is essential in providing a "good death" for the hospice patient (p. 279).” In order to create this desired outcome for the dying patient, the authors suggest that “management of pain for the dying person requires attention to the physical, spiritual, financial, and psychosocial needs of the patient and his or her family, none of which can be accomplished by only one "kind" of professional (p. 279).

Field & Cassel (1997) highlight the importance of the IDT utilizing their knowledge effectively to promote a painless death and to advocate for change when systems impede on best practice for patients:

Physicians, nurses, social workers, and other health professionals must commit themselves to improving care for dying patients and to using existing knowledge effectively to prevent and relieve pain and other symptoms. Patients often depend on health care professionals to manage the varying physical and psychological symptoms that accompany advanced illness. To meet their obligations to their patients, practitioners must hold themselves responsible for using existing knowledge and available interventions to assess, prevent, and relieve physical and emotional distress. When they identify organizational and other impediments to good practice, practitioners have the responsibility as individuals and members of larger groups to advocate for system change (p. 86).

Analysis. There is no clear defining theory of change in the written materials and the interdisciplinary team had varying responses as their definition of the theory of change when initially asked. However, when probed deeper, their defined contributions were essentially the same. The literature explains the importance of team collaboration and effective use of their knowledge within each discipline in order for the patient to have a “good death.” A deeper and clearer understanding of theory of change would vastly benefit this site. It would clearly state how each element and activity specifically contributes to improved experience of death and dying for the patient and their family.

Alternative Models

This involves a review of alternative program models for the target population.

Reviewing alternate options for service delivery creates a rationale for why a program is run in a particular way. This also documents why the program rejects other models (Bertram, King, Pederson, & Nutt, 2014)

Written materials. A review of the materials produced no acknowledgment of alternative models of providing services to patients in hospice care along with their families. However, before September of 2015, Preferred Hospice did not provide services to the pediatric population until now. The website has been updated and discusses the SOAR program and welcomes referrals to admit pediatric patients on service with the agency. The policy and procedure manual, the flyer, nor the handout provide information about serving the pediatric population. Since there is no record of alternative ways the team used to work with people facing death, there is no previous grant or contract on file.

Semi-structured interviews. The team could not produce an alternative model that was previously used in working with individuals facing death. However, the administrator and the DCS speak to the alternative model now used through serving the pediatric population. The DCS shared throughout her experience in the company the agency primarily served middle aged and elderly and have made strides through developing the programs to better support patients and families along with recognizing the need for hospice with children and including them as well. The Administrator expressed the fact the company is serving more patients than most commonly served (i.e. last year around this time the highest census was 29, currently the census is 62). All team members implied their approach is significantly better than the patient dying in a hospital. The nurse and the social worker further explained that upon admission, the social worker has a

discussion regarding hospitalization with the patient and the family. If the family feels the patient may need to be hospitalized, they are encouraged to contact the office first for nurses to assess and prevent future hospital bills. This also ensures the patient will have an increased (length of time with the nurse) and holistic, individualized care from more than one professional.

Peer-reviewed literature. There is a new model used in palliative care which is called, “Dignity-conserving care” to help the client feel more valued. This piece of literature was written by Chochinov, (2002). Chochinov states,

If the preservation of dignity is to be a targeted goal of palliation, the patient’s sense of dignity must first be thoroughly understood. Few studies have addressed this issue directly, although several have examined it from the vantage point of a “good death,” or a “quality of life” paradigm (p. 2254).

However, it is noted that further research is needed to evaluate the true effectiveness of this model:

One study asked members of the patient’s care team within 24 hours of the patient’s death to rate the deceased’s level of dignity during their last 3 days of life. A list of factors generated by the investigator and health care staff were used as criteria against which to make dignity score ratings. The authors concluded that they were unable to shed light on the deeper meaning and personal relevance of patient dignity, describing it as “an elusive concept” that needed to be studied from the vantage point of patients themselves (p. 2254) point of a “good death,” or a “quality of life” paradigm (p. 2254).

Zimmermann, C., Riechelmann, R., Krzyzanowska, M., Rodin, G., & Tannock, I. (2008) produced a systematic literature review of interventions and their effectiveness when finding the best way to help caregivers in cancer and palliative care. This piece of literature suggests that the current provision for informal caregivers (i.e. unpaid caregivers providing one or a combination of physical, practical, and emotional care and support) has been described as crisis intervention, in that services ignore successes and reward failure. To further elaborate, the caregivers who “appear” to be coping in their role and do not request services are assumed to have no unmet

needs, and it is only in the crisis situations of imminent or apparent breakdown of informal care that services respond. “Although the systematic psychosocial assessment of caregivers has been proposed, and comprehensive assessment schedules developed, it is not yet clear how to meet assessed need (p.63).”

This study show evidence of caregivers utilizing hospice care (n=83) reported a greater reduction in anxiety and higher satisfaction compared with conventional care (n=69) in a randomized control trial. However, this data does not distinguish between those using inpatient and home hospice care (p.64).

This article also focused on caregiver outcomes through group work. An RCT of a six-week stress and activity management group for patients and carers (n =26) versus standard management (n =25) found that spouses who had attended the intervention had significantly higher knowledge scores, achieved activity goals, coped better with medical situations and were more satisfied with the care provided. However, psychosocial adjustment did not alter between the two groups. (p. 70) On the contrary, a descriptive evaluation of eight weekly combined patients (n=73) and caregivers (n=54) group sessions in cancer care found that the provision of information and education promoted understanding and facilitated coping, and that familiarity with the facts and feelings involved reinforced confidence. Although anxiety was not reduced it was better recognized, therefore making it easier to deal with (p.70).

In conclusion, the growing bodies of evidence of caregiver’s needs in cancer and palliative care consistently call for the development and evaluation of targeted intervention and the evidence for unmet need is clear. Ethically, the time is overdue to apply this data and to build on what has been begun in the development of accessible and acceptable interventions. Carers interventions should aim to be grounded in the theory and evidence of interventions, acceptable

or seen as useful and appropriate by caregivers, accessible-caregivers must be able to access services should they wish to do so, and effective- shown to improve intended outcomes for caregivers using rigorous evaluation methods. Throughout these components, feasible and robust evaluation methods are needed. The unanswered questions that must be addressed are: which interventions (or combination of interventions) best meet caregiver needs, what outcomes might we hope to improve and what is the effectiveness of such services? (p.73)

Analysis. The written material produced no acknowledgement of alternatives and neither did most of the staff, except for the Administrator and the DCS who described the change in the populations the agency currently serves. The alternative models suggested within the literature suggest “dignity conserving care” and explicates interventions that suggested “best support” the caregiver(s) while supporting their loved one (the patient) through hospice care, group interventions, one-on-one interventions, etc.

Findings

The written material produced by the company did not clearly define nor provide clarity to the details within the target population and does not participate in activities that would welcome a more diverse population in need of hospice care and do not have a database that breaks down the ethnicities served.

The policy and procedure manual does not define a clear practice model, nor a clear theory base, or theory of change. However, throughout the findings within the policy and procedure manual as well as the interviews “Team-based Model” is defined as the practice model used when delivering services. The member from each discipline pulled from their existing

knowledge within their personal expertise to produce the best possible answer for each component.

The use of a more clearly defined program model would eliminate any inconsistencies with identifying who exactly they are serving and how they are going to serve them, and what evidence-base model they can utilize and follow to evaluate the effectiveness of the practice model to ensure all patients are getting the absolute best care every single time.

A robust amount of literature was found to support the findings through the intervention components, however, there were also many methodological limitations and inconsistencies amongst the data found amongst the literature, specifically evidence revolving around theory base(s) and theory of change.

Limitations

Due to time conflicts, I was unable to interview a physician, the Director of Operations, or a Volunteer. I was also unable to interview disciplines from other offices to compare and contrast as well as note similarities, differences, congruence and incongruences throughout the different offices.

NIRN Competency Drivers

Competency drivers comprise one of three sets of implementation drivers. Each set of drivers are integrated and compensatory, adjusting to support delivery of the program model. Competency drivers develop the competence and confidence of those delivering, and supervising the delivery, of the program model (Bertram, Blase, Shern, Shea, & Fixsen, 2011).

Staff Selection

This included who is qualified to carry out the program model and what are the methods for recruiting and selecting staff with those skills and characteristics. Qualified applicants have

the appropriate knowledge and skill set to deliver the elements and activities of the program model. This means that candidates not only have the necessary education requirements but also those skills needed to effectively be trained and coached to a higher level of understanding.

Written material. Within the written materials, there is no link to find employment opportunities on the Preferred Hospice website. However, open job positions are posted on the Preferred Hospice Facebook, within universities, on Indeed, and in community newspapers. Once an individual is interested in the position, they visit the office and request an application. If an individual contacts the office and cannot transport to the office for whatever reason, the Office Manager can email the application to the interested individual.

Within the policy and procedure manual, applicants for open positions must submit an application form and a resume or job history, which contains references to be contacted. Only applicants whose education, training, or skill matches those described on the job description can be considered for hiring. Personal interviews will be conducted with the top qualified candidates, and the preferred candidate will be selected. Before hiring is confirmed, background checks will occur and will include verification of license or registration and criminal history. If all checks of the candidate are clear, the hiring process may proceed. The new employee must also be registered, or has applied for registration with the Family Care Safety Registry and the positive results of a check of the Family Care Safety Registry has been received.

Job descriptions are found in the Office Manager's file at the office. According to the Job descriptions, for the Administrator "may" have experience as health care administrator, demonstrates ability to supervise, direct professional and administrative personnel, knowledge of corporate business management and a minimum of two years of supervisory or administrative experience in the health field, the Physicians.

LPN's fulfill the requirement of obtaining a current license by the State of Missouri as a Licensed Practical Nurse, "must" have a minimum of two years' experience as a Licensed Practical Nurse, professional or personal experience in death and grief, with an ability to recognize both the positive and negative aspects and exhibits a thorough knowledge of the holistic approach toward patient care and the nursing processes that applies to Hospice patients and families.

Nurses fulfill the requirements by obtaining a current license by the state of Missouri as a Registered Nurse, must have a minimum of two years' experience as a registered Nurse, and has professional or personal experience in death and grief, with an ability to recognize both the positive and negative aspects and exhibits a thorough knowledge of the holistic approach toward patient care and the nursing processes that apply to Hospice patients and families.

CNAs or Home Health Aides fulfill the requirement of obtaining a current certification by the State of Missouri as a CNA or attend CNA classes and pass certification or Health care experience related to personal care and exhibits a thorough knowledge of the holistic approach toward patient care and the nursing processes that apply to Hospice patients and families.

Chaplains must be ordained, commissioned or credentialed according to the practices of an organized religious group and has completed one unit of clinical pastoral education or has a minimum of a bachelor's degree with emphasis in counseling or related subjects. Training in grief and bereavement counseling and have at least one year experience in pastoral care related to the dying process and bereavement.

Social Workers must be a graduate of a school of social work approved by the CSWE (Council of Social Work Education) with a Master's degree (a previous job description stated Bachelor or Master's degree, but that job description was outdated)

Bereavement Coordinator must be an ordained, commissioned or credentialed according to the practices of an organized religious group and has a minimum of a bachelor's degree with emphasis in counseling or related subjects, and has training in grief and bereavement counseling and has at least one year experience in pastoral care related to the dying process and bereavement (the other job description included a requirement of a Bachelor's degree in psychology, counseling, pastoral ministry, social work, sociology or related field and/or equivalent education and work experience, knowledgably in cultural, ethnic, and spiritual diversity, ability to work independently and within a IDT, demonstrate excellent oral, written, and interpersonal communication ability, ability to work a flexible schedule and interact with a variety of different groups, must have reliable transportation, current driver's license and current automobile insurance, and has excellent organizational skills but was all taken out and updated recently to the job description above).

Volunteer Coordinator must have a high school diploma, and must have a minimum of three years' experience working with the public in either a volunteer or employment capacity. Companion Care Sitter qualifications include a desire to provide companionship to dying patients, belief in the hospice philosophy at the end of life, and are willing to make self-available on short notice and a dietician fulfills the requirement of the job through obtaining a degree/certificate in nutritional care for the State of Missouri and one year experience in nutritional care, intervention or counseling for the terminally ill patients.

The website states the company has “professional staff with experience in pediatrics,” however, there are currently no staff members within the Lexington office trained within the SOAR program and as stated in the interview with the DCS, team members will not be trained within the program unless they feel comfortable and upon receiving a referral at the office. The website also tells viewers that “all staff is certified through EPEC (Educating providers on End-of-Life Care) and EDNA (End-of-life-Education for Nurse Assistants.) Staff members also participate in In-Service Training through the Community Alliance for Compassionate Care at End-Of-Life.” However, at the Lexington office it is reported that not all staff members are certified through these programs.

Semi-structured interviews. All staff members identified the Facebook page, the Indeed website, the universities, newspapers and personal references (i.e.; a trusted employee recommending a certain individual be hired due to personal knowledge of the potential employee) as main forms of recruitment to inform potential candidates about the open positions. The Office Manager indicated it would be more beneficial if the applications were available online for accessibility purposes and to relieve her of taking the time to individually send them when needed.

Once the employee submits an application, it is reviewed by the Administrator and the DCS. The DCS noted she typically reviews the nursing applications. Applicants whose resumes correlate with the job description are invited to set up an interview. If it is a nursing position, the DCS will interview along with a panel of 2-3 nurses on the team and allows for them to see if they would be a good fit for the agency. If it is another discipline, the Administrator will interview along with 1-2 members of the same discipline already on the team and also allows for them to see if they would be a good fit for the agency. The Volunteer Coordinator (initially

interviewed for a CNA position) and the nurse indicated that the DCS interviewed them. The Volunteer Coordinator did not undergo a second, panel interview but the nurse did experience one. The purpose of the second panel interview was to ensure she would be a good fit for the position and that her “personality” would be a good fit for the team. All team members stated they were asked how much experience they had, how they would benefit hospice patients (if they have little experience within a hospice setting, this component is added to the question), and team members who experienced a panel interview were asked why they want to work for hospice.

The remaining team members were interviewed by the Administrator through the same process. No matter who is interviewing, the questions are the same each time, a background check is ran through the corporate office once an interview is completed and before hiring is confirmed. The staff members are also tested through urination for drugs and alcohol. All team members felt the questions that were asked were fair.

The social worker indicated her father was on services with the company prior to her gaining employment there. Once her father passed away, she was asked to fill out an application. Three weeks later, she was hired. The social worker indicated when she interviews students she asks them if they have ever experienced a significant loss in their life. The social worker believes individuals who have experienced a significant loss have a better understanding of the patients and families being served.

When asked about what background, educational and/or experience, makes for an ideal candidate staff had differing responses. The Administrator, office manager, and volunteer coordinator stated different backgrounds prepare you for different aspects of the job. The DCS, Chaplain, Social worker, and Nurse stated an educational background is required to complete the

work they do.” However, applicants are being hired on prior to receiving their degree due to limited applicants looking for employment in rural communities.

The DCS also stated, “Not everyone (nurse) has the hospice heart and is truly a servant.” When asked to elaborate, how one knows who has the “hospice heart and is truly a servant.” The DCS described the qualifications as someone who has good leadership, has critical thinking skills, and is autonomous and dependable (i.e. the DCS stated, “do they call in, or have small children? We cannot discriminate individuals who have children but we can filter through and find individuals who are reliable”).

All team members indicated it is beneficial to hire someone who has experienced the death of a family member, but it is not required. As mentioned above, the social worker stated, “As far as hiring goes, team members who have experienced the death of a family member have an insight of exactly what the (hospice) patient’s family members may be thinking and feeling throughout the end-of-life process. However, it does not mean that someone who has not had that experience could not do the work.”

Peer-reviewed literature. Wright (2002) was in support of essentially researching “the hospice heart” by finding the qualities of hospice nurses. This article explains within the beginnings of the hospice movement, members of the interdisciplinary team were researched and found that nurses were the essential professionals on the hospice team. Focused ethnography was the method used to identify and describe qualities of hospice nurses. The research was conducted in a freestanding, community-based hospice agency. The results included twelve specific descriptions that emerged that seemed to capture the essence of hospice nurses. The most prominent description was “attending or being humanly present with.” The other eleven qualities were to: be independent, be compassionate, be entrepreneurial, have appropriate technological

knowledge, be spiritual, be confident, be interdisciplinary team players, have a sense of calling, be humble, be intuitive, and have a sense of humor.

Smith and Bohnet (1983) suggest that staff should be chosen carefully on the basis of experience, ability to deal with dying patients and their families, and personal insight into how one deals with stress and makes use of a support community. An applicant in the first year of mourning is not appropriate. Very young nurses with little life experience may not be ready to handle the emotional load of such a unit. Our experience indicates that there are no hard and fast rules in these areas, but caution should be exercised. More importantly than loss history or age is the sense one obtains from the candidate as to how this person would function on a team, including evidence of flexibility and openness. Some degree of philosophical or spiritual development as well as a sense of humor have been found to be important to staff stability. It is extremely important that the potential staff member recognize the need for a balanced personal life, and have sources of satisfaction outside of work (p. 14).

Analysis. Current hiring processes are not accessible on the agency's website, and applicants are not as thoroughly reviewed compared to other surrounding agencies. Some staff addressed that holding a specific degree does not make you more qualified to do the work. However, the educational background one gains shapes the individual's world view and this qualification is what sets the individual apart from the rest of the applicants. Other staff members agree that holding a specific degree does make you more qualified to do the work, and should also be compensated as such.

Team members also indicated a significant benefit in hiring individuals who have experienced the loss of a family member, however it did not mean team members who have not had that experience could not complete the work they do with passion and care. It would be

interesting to implement this topic into a research study to measure the similarities, differences, congruencies and incongruences between employees who have endured the experience and employees who have not. This would also be potential information to implement into training material(s) for newly hired employees when working with family members of the patient.

Research found twelve prominent qualities of a hospice nurse whom would be fully qualified to deliver services to patients and their families, supporting the DCS' personal qualification of one who "has a hospice heart, and is truly a servant." Smith and Bohnet (1983) suggest staff selection is a component of an organization where the employees should be chosen carefully and consider many qualifications about the person personally and professionally. These qualifications were parallel with some members of the team during the interviews.

Training

Training includes that of new hired and ongoing training for employees. Training includes information about the client population, theory, values, and the components and rationales of key practices. Training also provides opportunities to practice new skills and receive feedback (Bertram, King, Pederson, & Nutt, 2014).

Written material. The policy and procedure manual indicates that each employee will receive training specific to the position into which he/she has been hired. Such training may include but would not be limited to: review of the position description, review of the performance evaluation to set expectations for performance, cognitive training specific to the position, hospice philosophy, goals and services, confidentiality, hospice policies and procedures, IDG group function, communication skills, plan of care, universal precautions, documentation, levels of hospice care, and facility resident care.

As far as procedure for training, the administrator or designee is responsible for identifying the specific training needed to bring the new employee to Preferred Hospice competency standards, the administrator or designee designs or plans the needed training, and the training will include a pre-test and a post-test to evaluate the effectiveness of the training. The policy and procedure manual also states that all employees and volunteers of Preferred Hospice will receive training on the system for reporting, investigating, implementing appropriate procedural responses, assessing outcomes, tracking, and documenting all incidents. There are specific policy and procedures for training registered nurses and CNAs, and training of new managers, as well.

During the orientation process, the policy and procedure manual states a basic course content for all professional staff training will be accomplished with the employee handbook, policy and procedure manual and orientation manual, and will address the following topics: Definition, history, philosophy of hospice and its concepts of care, IDT group function and responsibility, pain and symptom control, psychosocial and spiritual issues surrounding dying and death, family dynamics, communication skills and techniques, the process of grief, infection control, plan of care, universal precautions, patient and family rights, documentation, concept of grief and loss, facility resident care, levels of hospice care.

In addition each employee will receive orientation and training as appropriate to the position description in the following areas: principles of information management, patient/family rights, infection control and universal precautions, safety (personal, home, fire safety, electrical safety, environmental safety and mobility, and bathroom safety), office, identifying, handling, and disposal of hazardous wastes, medication handling, administering, teaching, and disposal,

use of equipment and supplies, disaster plans and procedures, admission policies and procedures, and discharge policies and procedures.

For volunteers, there is an extensive training process. When a potential volunteer is interested, they come into the office and receive an application. The volunteer application is a lengthy packet. Once they are cleared through a background check and have a positive result through the Family Safety Care registry, they can then begin the orientation process and receive a thick, lengthy, volunteer training manual. All volunteers will receive training in: hospice philosophy, goals and services, the volunteer role in hospice, confidentiality, instruction in the volunteer's particular duties and responsibilities, and documentation. Within orientation, the volunteers will be oriented on the concepts of death and dying, communication skills, care and comfort measures, psychosocial and spiritual issues related to death and dying, the concept of the hospice patient and family as a unit of care, procedures to follow in an emergency or following the death of a patient, concepts of grief and loss, universal precautions, safety, patient/family rights, and hospice and the nursing home.

Semi-structured interviews. All staff except for the Office Manager mentioned that training is not as thorough and specific as they would like it to be. Some team members stated they did not receive adequate training within their specific position and claims that what they know is "self-taught" and "asking questions as they ran into certain situations they were not sure how to handle." Some team members also expressed frustration with the inconsistencies of procedures between offices. All team members are trained through "shadowing" and feel they were still not fully prepared once they were out on their own, except for the Office Manager who felt she was fully prepared through shadowing. None of the team members reported completing pre and posttests during the training process.

The DCS stated training consists of putting the new nurses out with the nurses in the field to train, and the length of time a nurse is in training is on a case-by-case basis and depends on the comfortability of the nurse. However, typically training normally lasts 2-3 weeks. The DCS shared if training lasts 4-6 weeks, she finds the nurses get too dependent which “doesn’t do them any good, either.”

Peer-reviewed literature. Sperlazza and Cangelosi (2009) describe the impact of teaching with simulation and the process of developing an end-of-life laboratory simulation for first year students in an associate degree nursing program. The article suggest that most nurses have a story to tell about their first experience with a dying patient and is usually surrounded with anxiety, guilt and confusion. Due to the fact that nurses are the essential part of the hospice care team, they need to be better equipped to manage and interpret the dying process not only for their own emotional health, but also for the well-being of their patients.

As the proportion of older adults increases in this country, the number of dying patients will also increase. However, there is evidence to suggest that teaching end-of-life care is done poorly or inadequately in schools of nursing and in rural and underserved communities. Caton and Klemm revealed that in 2002, only 3% of nursing programs had end-of-life courses and only 2% of nursing texts contained topics related to end-of-life care. (Sperlazza and Cangelosi, 2009, p.1-4)

Another way to address this large amount of education in end-of-life care is through the ELNEC (End-of-Life Nursing Education Consortium), where more than 5,425 nurses in the United States have received this education. This project provides education in end-of-life care to nursing faculty and clinical nurses so they can teach this information to nursing students and practicing nurses. However, clinical instruction in a simulated setting may produce greater understanding of the specialized knowledge and skills essential in the provision of quality end-of-life care (p. 4-8).

Weissman, D. E. (1998) introduces a faculty development course for the hospice care team. The program included an 8 week, 12 contact hour course that was designed to provide up to 15 faculty members training in the practice and teaching of end-of-life care. Fifteen faculty members registered, but only 10 attended at least three of the eight sessions. Members took self-evaluation pre and post tests, and indicated poor or fair pre-course knowledge and self-confidence in most areas in end-of-life care. However, significant improvement in end-of-life knowledge and self-confidence was noted for eight of 11 content areas and in self-assessed education skills in six of seven content areas. Although there was a very low attendance rate, faculty members who attended at least three of the eight sessions reported significant improvement in many aspects of end-of-life clinical care, as well as in self-confidence and education skills, and were able to use the educational material to train a range of learners.

Cort (2004) suggests a curriculum for training health care workers in cultural competence should include certain components and should target both administrative and lower level workers:

- Understanding one's own cultural and social location. As part of the effort to reduce ethnocentrism, health care workers should be brought face to face with the fact that they are themselves part of a cultural/racial group, with their distinct culture patterns. "The multicultural perspective requires an understanding of the significance of social location in shaping human experience, including valuing one's own cultural heritage . . . acknowledging the importance of one's own culture helps one recognize its importance to others." Without seeing one's own position, it is impossible to really grasp the position of others.

- Gaining knowledge of other cultures. Gutierrez et al. argues that knowledge includes awareness of the history, traditions, and values of other groups. A cultural competence curriculum aimed at African Americans as a target group, should include a reasonable view of the historical experience of blacks that helped to shape their cultural mistrust. (The film media has done a reasonable job in documenting some of these historical experiences. Film is therefore a good medium to use for such activities.) All cultures have cultural context, therefore an opportunity to become aware of this context will greatly enrich a cultural competence curriculum.

Recognizing cultural competence as a dynamic experience rather than a state of accomplished expertise. The challenge of becoming culturally competent involves mastering skills in many areas of a foreign culture. This is the work of a lifetime of dedication. Cultural competence involves learning to speak other languages; immersing oneself in other cultures; and understanding the history, food, and lifestyles of another country and its people. Cultural competence is “an ongoing process in which we continuously strive to achieve the ability to work effectively within a community’s cultural context.”

Analysis. The policies and procedures revolving around training have notable differences between the training experiences among team members. The policy and procedure manual states the employees will be given a pre and posttest to measure the effectiveness of the training, however, none of the team members report ever taking a pre and posttest. Volunteers also do not get trained on the system database (MUMMS), as it says they do in the policy and procedure manual. The manual also states the Administrator plans and designs the training needed for the new employee. However, the DCS plans and designs the training needed for the new nurses. The

length of time a nurse, LPN, and/or CNA or any other discipline is trained along with the details of the training process is not included within the manual.

The literature suggests developing and utilizing a simulation laboratory in order to teach nurses about end-of-life care. This simulation could also benefit the rest of the IDT as well and inform them on what to expect, how to handle the situation, and could simulate working with the families as well. The literature also suggests participating in a faculty development program in order to gain the confidence and skills needed to work in end-of-life care programs. Perhaps if the faculty development program had incentives of attending and completing the program, attendance would increase and the program would have an even higher success rate.

The third article is a fantastic article demonstrating the importance of cultural competence and specific ways to implement this important and essential training into hospice settings.

Coaching/Supervision

Training never produces a full set of necessary knowledge and skills. Coaching is the process by which staff skills and knowledge, pertaining to the program model, are developed from a foundation provided by model pertinent training. Coaching formats, frequency and focus should vary and should always include direct observation of practice along with conference time that uses case data to evaluate practice fidelity (Bertram, King, Pederson, & Nutt, 2014).

Written material. The only information identified as coaching/supervision is within the “continuing education for staff and volunteers” and “continuing education for management personnel” located in the policy and procedure manual. There is no documentation that would indicate formal coaching and/or supervision policies reported within the manual.

Semi-structured interviews. All interviewees reported they do not receive any formal coaching or supervision within their positions. The nurse stated the DCS monitors her documentation to ensure she is doing her job correctly and will correct her with any changes that need to be made.

The social worker trains and supervises the other social work students and trains newly employed social workers. The social worker, the Chaplain, the DCS and the nurse reported she did not receive any training, coaching, and/or supervising to be the coach she is today, it was all “self-taught” and “trial and error.” The CNA trains other CNAs and reports she takes something that helped her become a better employee from each person who trained her and implements it into the training she does with the new CNAs. The Administrator had pre-managerial experience and training prior to being employed with Preferred Hospice. However, she does not conduct any training other than teaching the new staff about all of the programs and which discipline they are responsible for when delivering services to patients and families.

Peer-reviewed literature. Staff coaching and supervision includes direct observation, modeling, feedback, instruction and debriefing (Collins-Camargo et al., 2007). They go on to say that staff that are provided with ongoing coaching are more likely to applying skills learned in training/ from supervisor. Skills can be introduced in training but are solidified on the job with sufficient coaching (Fixsen, Blase, Naoom, & Wallace, 2009). Coaching is a way to guide staff as they gain skills and reframe thinking in order to implement the practice model.

Brunero, S., & Stein-Parbury, J. (2008) conducted an evidence-based literature review to find available evidence regarding the effectiveness of CS (clinical supervision) in nursing practice. The results concluded that clinical supervision provides peer support and stress relief for nurses (restorative function) and as well as a means of promoting professional accountability

(normative function) and skill and knowledge development (formative function). Kim, H., & Lee, S. Y. (2009). Present a studying revolving around different types of supervisory communication on burnout and turnover intention among health social workers. The three major typed of supervisory communication are: job-relevant communication, upward communication, and positive relationship communication. This study suggests that job-relevant communication embraces performance feedback, information about rules and policies, work schedules and assignments, task-specific instructions, and goals. Previous studies have suggested that effective job-relevant communication between supervisees and their supervisors can increase professional knowledge or skill levels. Job-relevant communication with supervisors has even been found to be the key predictor of social workers' performance (p.367).

“With upward communication, the literature on social work supervision has emphasized that the relationship between supervisor and social workers should be less hierarchical and more one of mutual influence (p.368).” The authors suggest that this type of communication allows the supervisor to create a trustworthy bond between the supervisor and the supervisee and feels as though both parties can offer their opinions and listen to one another.

With positive relationship communication, supervisors interact with social workers in an informal and supportive manner:

Supportive personal relationships lead workers to believe that they are valued by others, and having a supportive supervisor has been identified as an important condition for lowering levels of job stress. For example, evidence suggests that having a supportive supervisor is significantly related to higher levels of job satisfaction and that perceived supervisory support in the work place decreases the likelihood of worker burnout and turnover intention (p.368).

Analysis. There is a strong disconnect between the policy and procedure manual and the coaching/supervision each team member gives and receives. There is no discussion of

coaching/supervision within the manual so therefore no formal coaching/supervision is expected to occur unless informally completed (i.e. training is delegated through the DCS and the administrator) and training is not measured to evaluate its effectiveness. The majority of the team state their coaching and supervision is mainly “self-taught” and “trial and error.”

The literature suggests job performance is enhanced and solidified through coaching, and clinical supervision is effective to assist the nurse in delivering services to patients and families. Also, supervision in a social work setting is organized into three different types of communication and is effective in enhancing overall job performance, and decreasing burnout. Within clinical supervision, further evidence is needed when finding the relationship between clinical supervision and patient outcomes. If positive results are found within that study, the results could be used to help implement clinical supervision within the policy and procedure manual at the agency. The positive results within social work supervision could also be parallel to the coaching/supervising that could occur with the nursing team along with all other disciplines as well. Utilizing evidence-based literature could develop an effective coaching and supervision program for the IDT.

Performance Assessment

Performance assessments evaluate the outcomes of the skills that identified in the hiring process taught in training, and reinforced and expanded in supervision/ coaching. NIRN describes two forms of performance assessment. The first is at the direct service level, and is a reflection of how well the organization supports fidelity to the model. The second is on an organizational level, and examines how data is used to look at overall performance. This organizational data is used to improve service delivery (Bertram, Blase, & Fixsen, 2014).

Written material. In a review of the written materials I found one indication of performance assessment. In the policy and procedure manual, there is a form used during Quality Assurance meeting that assesses both at the direct service level, and at the organizational level.

Once a month, the team comes together (usually comprised of a social worker, a chaplain, a nurse, the DCS, and the Administrator) and at the beginning of each meeting the team will review previous month's assessment with patient-specific information such as how many falls, catheters, wounds, etc. have occurred and if the plan of action resolved those issues. Within the Lexington office, the Quality Assurance Team is made up of four teams: the green team, the yellow team, the red team and the white team and the blue team: The green team is in charge of monitoring workman's comp, initiating in-services on different things where the team, patients, and families are in need of educational training. The white team is responsible for grievances and ethical issues occurring amongst the team and within clientele. The blue team is in charge of monitoring the number of admissions, referrals and deaths throughout the month as well as break down if all of these events occurred in the HSI facilities, in the home, and if the company missed any deaths through the duration of that month, as well as if a potential patient did not meet a requirement for admission. The notes taken throughout the assessment are then all typed up and write all it up with a plan of action for each issue by the 5th of the month it is faxed to corporate. Any issues where it can be addressed used to have pagers didn't always go off and constantly reviewing what we could do improve.

Preferred Hospice also goes through State and Federal Audits. This is a state and federal review and occurs at random times (the last state and federal audit occurred three years ago). This process includes case file reviews and the follow-up documentation for all disciplines. The

auditors ensure all documentation is current, accessible, and consistent. If there is an inconsistency, a piece of documentation is not evident, or follow-up documentation is not completed (i.e. a bereaved client is at “moderate” risk and the plan of care does not include interventions to support that) then the agency will receive a “tag” and the agency suffers monetary consequences.

The state submits ADRs (Additional Development Review) into the agency on a consistent basis. This is where the patient has been on service with the agency for over 180 days and Medicare is requiring more information about the patient to prove they are still hospice appropriate in order to still continue to cover services. The DCS and the Volunteer Coordinator (who assists the office manager with these medical regulations) have to submit all documentation through all disciplines showing evidence that the patient still qualifies for hospice services.

A QA (quality assurance) meeting occurs once a month. The QA team consists of a QA nurse, a social worker, the Administrator, a Chaplain, and the Director of Clinical Services. According to the policy and procedure manual, this team is called the “Quality Assurance Committee” and are responsible for measuring the effectiveness of the QA program on an on-going basis. The policy and procedure manual also states the QA program will be designed at a minimum to measure and monitor the following: risk management, legal compliance, certification compliance, adherence to corporate policies and procedures, personnel issues including performance, access to care, ethical issues, surveillance, control and prevention of infection, safety issues for patients/families and hospice personnel, responsible and reliable management of information, overall performance of the hospice and its leadership, and inpatient care, home care, and care provided under arrangements. In developing the QA committee, the policy and procedure manual states the administrator is responsible for appointing appropriate

members including one member not affiliated with the hospice to serve on the QA committee. The manual also states the committee should also meet at least quarterly with signed minutes of the meeting. For the quarterly report, the QA nurse will collect and factor in information received from the following sources: Communication reports, family evaluation forms, long term care facility satisfaction surveys, variance reports, and QA action plans. The QA committee will review the deficiency percentage for each category and determine which exceed normal practice standards, then a quarterly action plan will be developed for those categories identified as requiring improvement, then the top three categories with the highest deficiencies will receive corrective action plans each quarter. The action plans will be monitored daily by the QA variance and DCS and adjusted as needed. Progress on the action plans will be reported to the governing body at each quarterly meeting. The manual also states that the minutes from the meeting should be available for review within the hospice office.

At the Lexington office, the Quality Assurance Meeting is held within teams: Red team, green team, yellow team, blue team and white team. The red team is responsible for identifying the patients who are using nutritional supplements, wounds and evaluate the wounds based on stages (i.e. stage 1-a reddened area, stage 2-open area, stage 3-open wound to muscle, stage 4-bone, unstageable-vascular wounds such as poor circulation; comorbidities), personal alarms, geri chairs versus broda chairs, side rails, and foley catheters, tube feeders, patient using incontinent products, care plan meetings attended by hospice staff, pain on admit (yes, no, excluded). The green team is responsible for surveillance, prevention and control of infection (UTI, URI, other, Employee illnesses/injuries). The yellow team is responsible for falls that have occurred. The blue team is in charge of performance improvement: satisfaction surveys (how many were sent out and how many were returned), business growth (how many admissions came from HSI

facilities, home, other, the average daily census, and home patient average census, discharges-number of deaths, revocations, denial of service, live discharge, and transfers and Referrals-same day (i.e. the agency admitted the patient the same day they received a referral), next day, 2-5 days, 7 days. White team is responsible for ethics, grievances, and quality of life (no trends noted, no issues noted related to advanced directives, grievances, problems identified) information from referral source tracking tool (area hospitals, HSI facilities, community/family, physicians) and time frame for admit nurse notification after receiving referral.

Within the QA meeting, the Lexington office does not have a member within the QA committee who is not affiliated with hospice. The minutes are also not posted within the hospice office to be available for review. Preferred Hospice also offers around the clock sitting for patients who are in their last 72 hours of living and all staff/volunteers assign themselves a minimum of a four hour time slot. The written materials nor the interviews describe this component within the services the agency provides. The agency also provides respite services, aimed to give the caregiver a break through placing the home patient within a nursing home for five consecutive days, and all disciplines will visit the patient within the nursing home and the nurse will make a visit there every day to ensure the patient's needs are met, alleviating the caregiver.

The social workers are in charge of distributing the family satisfaction surveys. The satisfaction surveys consist of broad questions requesting the family to rate on a scale their satisfaction with overall service they received from various team members. The random surveys are sent back to the corporate office in Ozark, Missouri. However, the Lexington office is unable to receive the feedback from the surveys, therefore are unable to get data on satisfaction and do not further pursue any data on family satisfaction.

Semi-structured interviews. The Administrator, the DCS, and the social worker all explained performance assessments were completed within the process of the quality assurance meetings as well as employee reviews (that are completed annually). The DCS stated that employee reviews are not sufficient enough to effectively measure the job performance within each competency. The DCS stated, “They (corporate) give you the ratings you are supposed to use, but they do not give you a tool for what the ratings mean and how you are supposed to grade them.” The Administrator stated she has a trusting relationship with her employees and trusted how they are all doing their jobs. However, the Administrator periodically monitors the documentation from all disciplines and hears from administrative staff in HSI facilities regarding the performance of the employees. When asked more about how administration knows they are doing their job through the writing, both stated “if they are documenting to the diagnoses, they are doing their job correctly.” The nurse gave an example of asking for help with the DCS, to ensure her documentation is done correctly and is documented to the diagnoses of the patient.

Regarding differences between the team itself, the office manager and the DCS spoke to performance assessments when addressing these issues. The office manager stated, “A QA (quality assurance) meeting occurs once a month and we try to resolve any issues then-if it cannot be solved amongst one another or with the Administrator, it is then taken up to corporate to handle the situation.” The DCS provided a specific example and shared the team recently experienced a situation revolving around a specific patient who had been on service with the agency for over three years. This meant that all visits marked past 180 days Medicare was not paying for them which in turn, the agency was not getting paid either. During an IDT meeting this issue was discussed with a plan to discharge the patient, and the social worker immediately began to advocate for the patient about the importance of keeping them on service. The DCS

then stated, “Being a patient advocate is great and all, but we were not getting paid for any visits after 180 days.”

Peer-reviewed literature. The most important use of fidelity assessment information is to help staff gain understanding on how to improve skills to help clients (Fixsen et al., (2009). Performance assessments should identify practices that represent the model’s core components and activities. Blase and Fixsen (2013) state that if performance assessment measures do not examine the core components of the program model then achieving outcomes may not be realistic.

Hasson, H. (2010) systematically evaluated implementation fidelity and possible factors influencing fidelity of complex interventions in health and social care. “Implementation fidelity has been used as a measure for the degree to which an intervention was implemented as was intended (p. 12).” This study suggests that previously developed and validated instrument, Supported Employment Fidelity Scale is used to evaluate implementation fidelity. According to this study “the extent to which the program was implemented as planned” is also defining fidelity.

Other studies have focused more precisely on the concept of implementation fidelity and suggested that it can be defined in terms of five elements regarding to what extent the delivered intervention correspond to the designed intervention (adherence), amount of an intervention received by participants (exposure or dose), quality of the program delivery, participants' engagement in the program activities (participant responsiveness), and presence or absence of the critical program elements (program differentiation) (p. 10-13).

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Blase and Fixsen (2013) state that if performance assessment measures do not examine the core components of the program model then achieving outcomes may not be realistic.

Analysis. As a team, the Quality Assurance Committee meets monthly to assess and ensure model fidelity. The Administrator also added that employee reviews also ensure model fidelity within direct service, as well as the literature that shared that a “Supported Employment Fidelity Scale” is used to evaluate the implementation fidelity. However, in other studies fidelity is can be defined upon in terms of five elements regarding to what extent the delivered intervention correspond to the designed intervention (adherence), amount of an intervention received by participants (exposure or dose), quality of the program delivery, participants' engagement in the program activities (participant responsiveness), and presence or absence of the critical program elements (program differentiation). This tool could also be used to help measure the effectiveness the program(s) have on the patient and their overall well-being.

Organization Drivers

Organizational drivers, as previously mentioned, are one of three components that comprise integrated implementation drivers. As a whole implementation drivers ensure that programs are of high quality and are sustainable. Organization drivers specifically focus on creating a hospitable administration, sufficient funding, and an environment that ensures that competency drivers are effective. The organizational drivers also provide continuous quality monitoring and needed improvements (Bertram, Blase, Shern, Shea, & Fixsen, 2011).

Facilitative Administration

Facilitative administration includes leadership that makes use of data inputs to inform decision making, provides supports for the overall processes, and keeps staff focused on

improving their delivery of the practice model. This may include making adjustments to policies, procedure, and job responsibilities to effectively implement the practice model, as well as monitoring and adjusting competency drivers (Bertram et al., 2015).

Written material. Reviewing the written materials, the policy and procedure manual is comprised of many, many components. There are 20 sections: Section 1 discusses the governing body, section 2 is the “Admissions and Patient/Family rights,” section 3 is “levels of care,” section 4 is “scope of services,” section 5 is “contracted services,” section 6 is “nursing services” section 7 is “psycho-social/counseling services,” section 8 is “spiritual care/bereavement services,” section 9 is “volunteer services,” section 10 is “nutrition services,” section 11 is “quality assurance program,” section 12 is “medical records,” section 13 is “human resources,” section 14 is “environmental safety,” section 15 is “infection control,” section 16 is “education,” section 17 is “access to care,” section 18 is “death, discharge, or revocation of the hospice patient,” section 19 is “exposure control, safety, and disaster plan,” and section 20 is “handling of client cash.”

There is a mandatory requirement that 5% of the IDT’s overall patient contact hours is to be filled with volunteer time. Also the ADRs that are consistently submitted to the office promote consistent productivity to ensure the model is being carried out effectively.

Regarding caseload, the policy and procedure manual states: “a corporate planning process will define for each program the number and the mix of staff approved for that location. The annual plan will be issued to the administrator each year for planned growth in that location along with number and mix of staff that will be required to achieve the goals for program development.”

Semi-structured interviews. All team members except for two reported the Administrator or the DCS do not check in with them to ask how their caseload is going. However, those team members who reported administration does not check in with their caseload feel supported when they are in need of hiring another member of their discipline when they feel their caseload is too high (although census has to support that decision; i.e. if census is low, the team member will not get the support needed until census is going at a higher rate). Team members indicate this has to be approved through corporate, they personally assess if there is need or not-there is no known tool to measure this specific need.

All team members except for one say that the nurses and the social workers do not have all the equipment needed to deliver effective services (i.e. computers within the office for documentation rather than having to purchase their own).

All team members noted disproportionality between their current caseload and the caseload stated within policy except for the CNA. However, the team members note they do receive more support when they feel their caseload is too high through other coworkers and/or administration hiring more people. However, recently schedules have been changing consistently with the new hires and the “continuity of care” piece is not being carried out-causing frustration to the patients, families, and among staff members.

The administrator within the Lexington office also holds the responsibility as the marketer for the company. Within the interview, the administrator solely focused on the responsibilities as the marketer, not the responsibilities as the Administrator. As the Administrator, she explains being in charge of hiring, firing, staffing, finances, maintaining census and working with the patient, caregiver, and the family by addressing and resolving any concerns they may have at any given time. The Administrator explained the variety of programs

each discipline is responsible for and shared each program was developed by the Director of Operations, whom is also her sister.

Peer-reviewed literature. Facilitative administration makes use of data inputs to inform decision making and keep staff focused on the desired intervention (Fixsen et al., 2009).

The ability of staff to remain focused on the intervention is to key for successful interactions with clients. Agencies with facilitative administration have policies, procedures, and organizational culture that support the development of staff (Fixsen et al., 2009).

In relation to the key findings within the interviews, the needed equipment and support is not fulfilled unless the money (from Medicare) is there to provide those needs.

As mentioned above, Casey, Moscovice, Virnig & Durham, S. B. (2005) describe specific challenges hospice face in serving rural communities the Medicare program is noted: “As the largest payment source for hospice care in the United States, the Medicare program has a significant influence on hospice use and the financial status of hospices (p. 363).” This indicates the Medicare program is a key player in funding the needed services in hospice care, especially in rural communities.

Medicare per diem rates are consistently lower for rural hospices than urban hospices because they are adjusted using a hospice wage index. However, the rates are not adjusted for other differences in costs that may be significantly higher for rural hospices, such as travel to patient’s homes (p.363).

“Recent studies, including an actuarial analysis of hospice costs and revenues, suggest that many hospices, especially small rural hospices, are likely to have costs that are not adequately covered by the current Medicare payment system (p. 363).”

Casey, Moscovice, Virnig & Durham, S. B. (2005) describe challenges in hospice staffing, to be considered by administration:

Home-based hospice care is labor intensive. The task of recruiting and retaining staff is complicated by the need to accommodate fluctuations in patient census and to provide coverage 24 hours a day, seven days a week. For rural hospices, staffing challenges are exacerbated by shortages of nurses, social workers, and other health professionals. Rural hospices with low patient volumes are often unable to fund full-time positions, and those that cover large geographic areas may have difficulty finding staffing willing to travel to remote areas. Hospice workers may be at particular risk for burnout and compassion fatigue in resource-poor rural areas, especially when the boundaries between their work and personal lives are blurred (p. 363)

This article also provides a variety of strategies to address staffing needs:

- “One strategy is to employ hospice staff from a parent agency, which provides the employees with salaries and benefits comparable to similar positions in the larger organization (p. 366).” For example, “the staff members of Kanabec County Hospice are county employees, and Lower Columbia Hospice staff members are hospital employees. A related strategy is sharing staff across programs. The Kanabec County Public Health Agency jointly staffs its hospice program and its much larger home health program; nurses have both hospice and home health patients in their caseloads. The chaplain at Lower Columbia Hospice ministers to both hospice and hospital patients. Joint staffing can help an agency deal with fluctuations in hospice census and help to even out caseloads geographically, thereby reducing staff travel. It also can reduce staff burnout by providing variety in patient caseloads and spreading responsibility for on-call coverage over a larger number of workers (p. 366).”

- Another strategy is that “some of the staff members at the three smaller hospices perform multiple roles. For example, volunteer coordinator responsibilities are part of

a social work, nursing, or home health aide position. These hospices also employ part-time medical directors, nurses, and social workers. The part-time staff are either semi-retired, seeking to balance work time with family needs, or have other practice interests. Hospice of North Central Florida's larger organizational structure allows it to provide competitive salaries and benefits, such as health insurance and retirement benefits, which facilitate recruitment. It also achieves efficiencies related to centralized administration and shared on-call coverage for nurses and social workers (p.366).”

Overall, “The Medicare program still needs to evaluate hospice payment rates to ensure that they are consistent with the costs of providing appropriate care in rural areas (p. 368).”

Analysis. The material produced by Preferred Hospice addresses policies, however they are broad and are not specific to supporting the development of staff. The first piece of literature provides the importance of facilitative administration and the duties this driver carries out in order to keep the staff focused on the desired invention when delivering services. The second article produces significant findings of providing hospice care in a rural setting. The article also addresses the challenges in staff members in a rural hospice and provides suggestions on addressing staffing needs. The majority of team members do not get asked how their caseload is going nor is the size of caseload defined within the policy and procedure manual.

Decision Support Data Systems(s)

This organizational driver assesses overall performance of the organization and provides data to support decision making to assure the implementation of the practice model. Decision support data systems use “model-pertinent data to guide decisions about adjustments to

implementation drivers as well as to evaluate fidelity outcomes for quality improvement of the program's practice model" (Bertram, King, Pederson, & Nutt, 2014. P 204).

Written material. Within the written materials, there is no indication of decision support data systems. The written materials do not include a way the organization tracks their success in hiring the right people. However, they do include family satisfaction surveys as a way to assess overall performance. The results of the family satisfaction surveys are reported to the office in Columbia are not made aware to the office in Lexington.

Semi-structured interviews. According to the Administrator, there is no database tracking the success of hiring the right people, or on staff collection at all. However, there is a database that tracks overall performance through tracking the PPD (per patient per day) and overall census.

The social worker, the Chaplain, and the Administrator spoke about using the data they find in the assessments during Quality Assurance meetings to develop a plan of action.

All team members feel they could be better supported through administration and corporate.

Peer-reviewed literature. Decisions made for the agency should be driven by data. Frequent, user-friendly reports provide the necessary support for informed decision making (Fixsen et al., 2009). By making decisions in this manner the agency will continue to make quality improvements that fit within the program model.

Data reports should not only be user-friendly but also accessible to all levels of the organization (Bertram, Blase, et al., 2011). This data should not only be aggregate but also

individual. This break down allows administration to see patterns in the overall adherence to the practice model but then looks at what individual staff need more support.

Analysis. It appears there is no systematic way of tracking data that supports the practice model, it appears to be anecdotal, instead. There is a strong disconnect to allow for the administration to see patterns in overall performance and see which individual staff needs support. Instead they get support if their caseloads are high, but not necessarily if they are low. Tracking data in hiring the right people, implementing a systematic way of tracking the data used to support the decisions made that assist the delivery of the program model, as well as making other data forms easily accessible to all levels of the organization will also will help keep the staff focused on the desired intervention.

Systems Level Interventions

Preferred Hospice functions as part of a larger system of services to families, most notably the communities (nursing homes). Systems level intervention includes strategies to work with external systems to secure that the agency can to their work. Financial means is also considered in systems level interventions (Fixsen, et al., 2009).

Written material. As Preferred Hospice considers many external systems as their community partners, they are not included within their written materials. The funding source, Medicare has specific guidelines that the program manual is working towards supporting. The agency has organized specific policies and procedures to best ensure reimbursement. The agency goes beyond Medicare guidelines to ensure guidelines are met. However, there are inconsistencies present in Medicare supporting the overall program model.

Semi-structured interviews. Preferred Hospice staff interface with a variety of entities: HSI facilities (nursing homes) hospitals, doctor's offices, Veteran's homes, senior centers,

assisted living facilities, and other hospice companies when a patient is traveling and/or is moving to a different location outside of the service area.

Regarding the HSI facilities, the owner of Preferred Hospice also owns the surrounding nursing homes the agency provides services to. In this aspect, the interviewees feel as though there could be a better support system between companies (i.e. the team suggests that the owner close the campuses and the nursing homes only refer out to Preferred Hospice). In November of 2015, the request was granted and campuses were closed, however ESNR (Excelsior Springs Nursing and Rehab) lost 12 admissions from the Clay County public administrator due to the nursing home taking away the freedom of choice, and were granted permission to open the campuses back up again.

All team members included HSI facilities, hospitals, and assisted living facilities as community partners with the agency. The Chaplain also included churches, however he stated Preferred Hospice does not have established relationships with surrounding churches. The nurse included pharmacies as one of our community partners, and the social worker along with the office manager included the Veteran's home and the senior centers. All team members also stated the funding sources (Medicare, Medicaid, and private pay) are all fully aware of the services being delivered.

The Administrator explained her responsibilities as a Marketer: "I cover all nine counties that surround Lexington, I make calls on communities (nursing homes), assisted living facilities, clinics, doctors, hospitals, and participate in network communities within the city." Within all of these locations, when she makes the phone calls, she asks for contact information to get patients in place, she asks if she can give a presentation of the services provided along with all of the

programs, and provides activities for additional support of their staffing (such as root beer floats, crafts, etc.-carried out by the volunteers and employees).

When asked what further resources are needed to do their job best, the Chaplain stated that all nursing homes and hospitals in the community would reach out the Preferred Hospice first instead of rotating with other hospice companies, have stronger relationships with partners, being more hands on with facilities (spoke more to a desired outcome he would like to have achieved). The Volunteer Coordinator would like a qualified individual to take over the Volunteer Coordinator piece so she can solely be responsible for the Assistant to the Office Manager position, more money to support the volunteers and recruit volunteers as well. The social worker stated computers should be provided to all staff members and all staff members would have a manageable caseload (i.e. depending on the patients, if they demand more care than they would have less patients). The social worker also stated the resources she could also benefit from are enough staff members to prevent overtime and burnout, everyone pulling together as a team, and “corporate having a better understanding of exactly what we do and how long it takes to do it.” The office manager shared more corporate training would be beneficial, that all offices’ procedures do things differently and it would help if everyone was on the same page, if roles were broken down among team members everyone would know exactly what they are supposed to do, and that the agency would benefit from corporate taking the time to make sure everyone is on the same page as well as updating all job descriptions so everyone is aware of their exact roles and responsibilities. The DCS stated better training, although changes occur in hospice on a consistent basis, more concrete plans would be beneficial, and having the team’s voices be heard. The Nurse stated having a nurse sit at bed site more often, medications be more available and for the patient to have the same nurse 24 hours a day, 7 days a week.

Peer-reviewed literature. Fixsen et al. (2009) state that the agency must align with the external systems to support their work. Agencies where interface with multiple stakeholders, like Preferred Hospice, need to have systematic ways of having conversations. This includes within and between systems examination of data to improve services (Bertram et al., 2014). This implies that each stakeholder has a common understanding of family systems and shares a desired outcome. These similar characteristics would allow the agencies to work together to improve services.

Analysis. Preferred Hospice has many community partners, and the main funding source is Medicare. All the interviewees feel as though Medicare is fully aware of the services Preferred Hospice provides (the program model). However, there are only certain types of medications Medicare will cover and ADRs can intrude within a family who depends on Medicare and hospice services to take care of their loved one. If a patient is discharged, the social worker will make sure the family has everything in place. But there is no follow-up plan to ensure the family's needs are met unless the patient qualifies for hospice again and is readmitted.

The interviewees all made suggestions of resources they could benefit from that would allow them to do their job to the best of their ability. A major trend I found within these suggestions is that the team would benefit from a systematic way of making decisions, training, and gaining clarity of roles amongst the team members. A major suggestion of how these suggestions could be implemented other than monetary were the administration taking responsibility and finding patterns of the inconsistencies going on within their offices and appropriately addressing those issues.

Medicare will never perfectly support any program model. But when there are discrepancies between what funders fund and whatever the program model is, the question remains how administration will address this issue with the funding source.

The literature highlights the importance of the agency align with the external systems to support their work. Preferred Hospice creating a systematic way of having conversations with the HSI facilities would allow for both parties to better understand one another and support one another in the services they are both delivering. Also, there is an intense competition in the marketplace amongst other hospice companies when all do the same thing: helping dying loved ones and their families. Developing partnerships with other hospice companies, and looking at their way of doing things may be beneficial to implement in this agency.

Limitations

A major limitation I had in completing this evaluation were my skills when pursuing the interview. Due to time constraints and the length of time to obtain all the information needed made it difficult to develop an effective analysis for the review of competency and organizational drivers. However, after further probing at a later time when team members were off duty and not under as much stress, I was able to obtain deeper information relevant to competency and organizational drivers. Written material with information regarding Systems level interventions was nonexistent, resulting in a heavy reliance on the semi-structured interviews for analysis within data sets.

If I had more time, this program evaluation would be more effective if I interviewed a representative of each discipline from the other offices of Preferred Hospice to analyze the

similarities, differences, congruencies and incongruences. I would have also interviewed the Director of Operations to gain further insight on the development of the programs.

Results

Based on a comparison between written material and staff interviews, there is an evident disconnect. There is no systematic way of tracking the selection of staff, the success of hiring the right staff members. The training procedures within the policy and procedure manual do not align with the training experiences of the staff members. For example, the manual states staff members will take a pre and posttest to measure the effectiveness of their training, however, all staff members reported not completing a pre and posttest. The manual has an abundant amount of information, however the information is broad and open to interpretation for all staff members. The inconsistencies between the manual and the interviews, as well as the lack of data collection does not properly address fidelity to a model. Lack of clarity in the program model creates the inability to measure fidelity. Without data found in fidelity assessments the agency is unable to determine if the program model is resulting in changes for the desired outcome in patients and families.

The strain between the Administrator and the DCS as well as with Corporate was evident in the interviews. Team members that discussed the issue expressed frustration regarding the impact this has on their work as a team and the negative “trickle-down effect” this fact has on their overall attitude when delivering services. Team members feel as though they are not receiving the appropriate support needed (i.e. equipment, adequate staffing, and appropriate action to concerns about the work environment).

There are significant inconsistencies between the training occurring on site and the training presented within the policy and procedure manual. The desired outcome for the patient and their family cannot effectively occur if staff members are not trained on the clear roles, responsibilities and activities of their position. Team members also need to be taught the roles, responsibilities, and activities of all other team members in order to collaborate with the team and address the needs of the patient effectively and efficiently. This will help the site clearly define theory of change and make a significant positive impact on service delivery. If all team members are aware and understand the elements and activities of their position as well as their team members, the intended desired outcome can occur for every patient in a hospice setting.

Disconnect between direct service staff, supervisors/ management, training staff and the written material results in a breakdown in understanding of the purpose of the agency. Without more clarity, specifically the ability to identify how what Preferred Hospice does creates a change in patients and their families, Preferred Hospice is not working as a united force. Changes in training and coaching would support staff development, and clear roles and responsibilities, diminishing the disconnect.

In the policy and procedure manual, the administrator is in charge of/ delegating the training of the staff. However, the Administrator does not train, nor does not complete coaching with staff members. The social worker is the only staff member that gives coaching (to practicum students). However the coaching and training given by other disciplines is “self-taught” and “trial and error.” This type of coaching is not skill based and is not effectively measured.

Within performance assessment, the DCS stated that employee reviews are not sufficient enough to effectively measure the job performance within each competency. The DCS stated, “They (corporate) give you the ratings you are supposed to use, but they do not give you a tool

for what the ratings mean and how you are supposed to grade them.” It is important to implement an employee review that is specific to the position along with an effective measurement tool to grade them. This can ensure the time used to focus on the individual’s performance can address any gaps in service delivery and develop a clear, concise, and measurable action plan in order to effectively carry out their intended elements and activities.

Regarding organization drivers, there are also significant inconsistencies between the manual and the interviews. Within facilitative administration, it is an interesting finding that when an employee feels overwhelmed with their caseload, they can only be supported through hiring another staff member if the census “supports” this decision. Although it is understood that business matters are needed to be taken in consideration, the main priority should be on delivering effective services to the patient and adequately staffing the location (office) in order for the team to carry out their roles and prevent any possible gaps in service. It is the responsibility of administration to address the issues presented with the funding source.

As mentioned above, the interviewees all made suggestions of resources they could benefit from that would allow them to do their job to the best of their ability. A major trend I found within these suggestions is that the team would benefit from a systematic way of making decisions, training, and gaining clarity of roles amongst the team members. A major suggestion of how these suggestions could be implemented other than monetary were the administration taking responsibility and finding patterns of the inconsistencies going on within their offices and appropriately addressing those issues.

Recommendations

Although it is evident within the written materials, Preferred Hospice does have an evident program model. However, it is not clearly defined nor purposefully selected. It is recommended that the agency implements the Team Based Model into the program manual and the components of the program model. The use of a clearly defined model would allow Preferred Hospice to measure fidelity.

The programs that set Preferred Hospice apart from other hospice companies are exquisite, thoughtful, and driven with passion. However, there is currently no tool to measure the effectiveness or fidelity of these programs have on the dying patient and their families. It is recommended to find and/or pursue research where it is evident these types of programs create change for the patients and their families.

Within the policy and procedure manual, it is recommended to clearly define the policies and procedures within each section of the manual. This will clarify roles and expectations for each team member and will eliminate opportunity for interpretation. This will clearly define theory of change for the site. Clearly defined roles and expectations ensures all staff are delivering services to create the desired outcome as intended.

It is also recommended to create a more effective training program. The lack of staffing does not support the quality of training needed to fulfill the responsibilities in the field once training is “completed.” All staff members felt they did not receive adequate training to fulfill all their duties within their position. Implementing a better training program will diminish the disconnect between team members. Specifically, the nurses and their knowledge within their duties of delivering services. This would allow them to have a shared understanding with the DCS instead of getting reprimanded for something they may have never learned during the training process.

While a more effective training program is being implemented, cultural competence training among all team members is important when working with diverse patients and families. Although the agency primarily serves rural white patients and families, it is important to continue to work towards cultural competence in order to effectively treat diverse patients and families based on their culture, customs, and attitudes towards hospice care overall. It is the responsibility of administration to ensure a diverse staff is present to support a diverse clientele; and to initiate and participate in activities welcoming diversity into hospice care.

Coaching can sustain the improvements desired from the training through ensuring learned skills are being properly used by other team members in the field. The implementation of clinical supervision and upward communication across all disciplines would improve the quality of supervision/ coaching moving from minimal case consultation (i.e. the DCS “coaching” documentation with the nurse on a case-by case basis) into mentorship/ skill building. Needed skills would be identified and specifically targeted for improvement. Coaching that is skill based supports staff development, which is not evident nor formal across all disciplines in current practices.

It appears there is no systematic way of tracking data that supports the practice model, it appears to be anecdotal, instead. There is a strong disconnect to allow for the administration to see patterns in overall performance and see which individual staff needs support. Instead they get support if their caseloads are high, but not necessarily if they are low. It is recommended for the agency to develop a systematic way of tracking data. Tracking data in hiring the right people, implementing a systematic way of tracking the data used to support the decisions made that assist the delivery of the program model, as well as making other data forms easily accessible to

all levels of the organization will help keep the staff focused on the desired intervention and sustain the improvements desired from the improved training.

Communication amongst team members could be improved overall. It is recommended the team receive coaching around communicating in an IDT effectively. It is also recommended that the team be exposed to case by case data to evaluate team clarity and cohesiveness to improve communication. It is important to understand that although all disciplines have a different worldview and all bring something to the table, it is important that all disciplines carry out their responsibilities with a non-judgmental attitude, empathic skills, and treat each and every patient as the expert in their own lives and with dignity and worth.

Regarding performance assessment, it is recommended that effective measurement tools are given to leadership in order to effectively grade employee reviews. It is also recommended that not only is the review of the staff member's individual performance is completed, but their training be evaluated as well. This gives leadership an opportunity to coach the team member around training and a specific guideline to follow (assuming all training and coaching procedures were clearly defined in the manual). It is also recommended for the employee and the Administrator/DCS to create an action plan together to address the gaps in service delivery and in the training the staff member completes. This action plan would be clear, concise, and measurable. Then a follow-up appointment would be scheduled to ensure the action plan is carried out. This would allow for the Administrator/DCS to give coaching and better support their team. This also helps the Administrator/DCS have a better understanding of whether or not their team is doing exactly what they have been trained to do.

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