Order Number 8814886

The identification of competencies for hospice administrators in Michigan, emphasizing an organizational life cycle administration model

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THE IDENTIFICATION OF COMPETENCIES FOR HOSPICE ADMINISTRATORS IN MICHIGAN, EMPHASIZING AN ORGANIZATIONAL LIFE CYCLE ADMINISTRATION MODEL

By

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Family and Child Ecology

1988

ABSTRACT

THE IDENTIFICATION OF COMPETENCIES FOR HOSPICE ADMINISTRATORS IN MICHIGAN, EMPHASIZING AN ORGANIZATIONAL LIFE CYCLE ADMINISTRATION MODEL

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The purpose of this study was to identify Essential and Supplementary competencies as rated by hospice administrators in Michigan using a four-stage hospice life cycle administration model. The study focused on five major objectives: (a) to compile selective demographic and opinion data, (b) to identify what functions these administrators were performing and/or delegating, (c) to identify their perceptions of Essential and Supplementary competencies that met consensus under five administrative sections, (d) to identify demographic factors that affected the reported essentiality of competencies, and (e) to identify how the reported essentiality and/or delegation of competencies varies with organizational life cycle stages. A four-phase methodology was used including a two-round Delphi technique. The survey instrument contained 17 demographic and opinion questions and 201 competency statements under five major competency sections. These sections were also grouped according to administrative functions of Planning, Organizing, Directing, and Controlling.

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Seventy-eight hospice administrators were surveyed. Round I response rate was 65% (51), and Round II was 63% (49).

Significant demographic findings included: Age, education, hospice administrative experience, and salary were highly variable. Michigan hospice administrators were primarily female, middle aged, and working full time with additional role responsibilities. Their hospice service area population on average was less than 50,000, and they served predominantly white patients/families. In Michigan, 88% (43) of the hospice administrators endorsed a need for a hospice administration curriculum.

Overall, 132 Essential and 69 Supplementary competencies were identified. Of these, 37 reached consensus and were also the highest rated. Consensus items clustered in community and public relations and quality assurance. Supplementary competencies were delegated more than the Essential ones, and delegation occurred most frequently in patient and family relations.

Significant hospice life cycle findings were: (a) In Michigan four definable stages of hospice program development were evident, with notable increases in Essential competencies and delegation from Stage I through Stage IV; (b) 63% (32) of the hospices in this study were identified in Stage II; (c) administrative educational needs differed by stage of hospice development; and (d) the Controlling function was <u>not</u> significant across all stages of program development.

To "Schneids"

But a good leader, who talks little, when his work is done,
his aim fulfilled, they will say, "we did this ourselves."

Lao Tzu

ACKNOWLEDGMENTS

I would like to acknowledge the support and patience of my chairperson, Dr. Norma Bobbitt. Her continued emphasis on professionalism and excellence guided my research in a meaningful and organized manner. Also, I would like to acknowledge and thank Drs. Don Melcer, Rosemary Walker, Bill Hinds, and Bob Griffore. My appreciation is also extended to the Department of Family and Child Ecology for fellowship support and encouragement in meeting my educational goals.

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CHAPTER I

INTRODUCTION

The hospice concept, which speaks to a "quality of life until a person dies," has begun a revolution in the American health care system to improve care for the dying. This revolution has been called the "hospice movement," which emphasizes a program of care addressing medical, psychosocial, and spiritual needs of a patient and family experiencing terminal illness. The primary goal of hospice is to provide the terminally ill patient a death with dignity. This is accomplished by assuring physical, emotional, social, and spiritual support without the need of exhaustive curative efforts. While this seems a simple, basic right, it has become the philosophical cornerstone on which hospice is built.

A major focus in hospice care is pain and symptom control. It should be emphasized that hospice care is not merely counseling and hand-holding of patients. Rather, Saunders (1978) noted that it is impeccable medical and nursing care, delivered by practitioners of the highest competence. Therefore, adequate hospice training remains an essential, ongoing challenge.

In recent years, with the rapid expansion of hospice programs in the United States, interest has developed in the administration of such programs. While researchers are increasingly interested in

studying other aspects of hospice care, Richie (1984) noted that there is little information available on the nature of and career preparation for hospice administration. This paucity of research indicates a need to more carefully define and understand the skills and knowledge base required to function as a hospice administrator.

Currently, hospice administrators come from a wide range of fields: nursing, social work, health care administration, pastoral care, finance, and accounting. Each administrator brings a special blend of education and experience to the position, yet each does not have a "blueprint" of guidelines to follow in developing a particular set of knowledge and skills unique to hospice administration. Also, he/she has no basis for determining which administrative tasks should or should not be delegated. If tasks should indeed be delegated, to what extent? Regardless of varied educational backgrounds, hospice administration involves creating a context for effective care. That context can only be assured by effective individuals trained accordingly.

Five main questions about hospice administration are addressed in this study:

1. What are the demographic characteristics of hospice administrators in Michigan?

2. What functions are these administrators performing and/or delegating?

3. What are the Essential and Supplementary competencies hospice administrators in Michigan perceive as necessary for carrying out their role?

4. Do demographic factors differentially affect the reported essentiality of competencies?

5. Does the stage of the organization's life cycle influence the reported essentiality and/or delegation of competencies for hospice administrators?

It was anticipated that answers to these questions would help clarify the hospice administrator's role and perhaps guide interested professionals toward a program of study that would provide the skills needed to become a hospice administrator.

The next section of this dissertation presents the background for this study and enlarges on various hospice issues that support the need for this research.

Background of the Problem

Hospice care in the United States has grown rapidly during the past decade. Today there are approximately 1,600 hospice programs in operation with many different organizational structure models (Rooney, 1986). As the hospice concept gains widespread support, it is being challenged philosophically to validate its efficacy, to grow and develop according to regulations and standards of care, and to do so with primarily a voluntary effort. It has perhaps been the subject of more evaluative studies than most health care innovations in recent history. Therefore, background knowledge on four current issues seems essential for the reader. A brief discussion of each of these issues follows.

Issues of Professionalization

Just as hospice is beginning to validate its efficacy, it is also being challenged to "professionalize" itself at both the national and state levels. Nationally, the most immediate challenge to hospice administrators has been establishing hospice as a bona fide health care option. The enactment of Public Law 97-248 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1983 established hospice as a medicare reimbursement option.

More recently, Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). One provision of the law made hospice care a permanent part of the Medicare program. COBRA also raised Medicare hospice payment rates and gave states the ability to provide hospice services under the Medicaid program. In effect, this has shifted the hospice movement to a hospice "industry."

According to the Health Care Financing Administration (HCFA), 279 out of 1,500 hospices had obtained Medicare certification as of July 1986 (Fackelman, 1986). As of February 1987, Michigan had 21 hospice Medicare certified programs (Olson, 1987). Carolyn Fitzpatrick, chairwoman and president of the 2,000-member National Hospice Organization (NHO), also noted that Michigan was one of the leaders in the hospice field. Out of the 10 hospice regions designated by the HCFA, Region V (of which Michigan is a part) has the largest number of hospices, and the highest percentage of patients receiving care (Health Care Weekly Review, May 26, 1986).

Also, in concert with professionalization, three national organizations have evolved which focus on hospice care. The oldest,

the National Hospice Organization (NHO), was founded in 1977. NHO has approximately 703 member hospices, including 39 state organization members across the United States (Bates, 1986). It provides standards to evaluate the quality of hospice care being provided and sponsors numerous educational meetings for hospice professionals and nonprofessionals. NHO's educational goals for 1986 focused on hospice administration and hospice administrative skills. NHO stated that the single most important element in the overall success of a hospice program is the hospice administrator's ability to manage (Hospice Letter, May 1986).

As a supplement to the NHO, a second organization known as the American Society of Hospice Care (ASHC) emerged in 1985. The ASHC focuses on education, training, and research in hospice. The third organization to develop was the American Hospice Association (AHA), which was organized in July 1985. AHA developed from and is jointly supported by the National Association of Home Care (NAHC) and the Association of Community Cancer Centers (ACCC). This organization is committed to heightening public awareness on hospice issues, building a cohesive hospice movement, and enhancing the development of the hospice philosophy to ensure the inclusion of all aspects of terminal care. On behalf of many hospice programs affiliated primarily with home health agencies, the ACCC strongly advocates for increases in reimbursement levels for hospice care.

The evolution of these three national organizations has presented a professional quandary for the fledgling hospice

movement. Hospice administrators are being encouraged to participate in or become members of these various organizations. As yet, it is unclear which one would best represent their own program concerns.

Fiscal Issues

Two studies (Kane et al., 1985; Brooks & Smyth-Staruch, 1984) challenged the beneficial outcomes of hospice care. The Kane study revealed that there was no difference in length of survival of hospice and nonhospice patients and that there was no difference in terms of physical functioning, symptom control, pain, or mood state. Hospice patients, however, were more satisfied with the care they received. The Brooks study focused on cost savings. It indicated that over the last 24 weeks of life, payments were $9,362 for nonhospice patients and $9,651 for hospice patients (Mor, 1985, p. 82). It must be noted that both studies have been strongly contested by the hospice faction.

More recently, Smith and Veglia (1986) conducted a study at the Veterans Administration Medical Center, Wilkes-Barre, Pennsylvania. These researchers focused on comparing the utilization patterns of lab work, procedures, and special therapies between hospice and non-hospice subjects in the same setting. Through cost analysis they identified the total cost of all the variables for hospice care to be $33,291 as compared to $233,614 for the nonhospice patient. The study also revealed the mean number of diagnostic tests for hospice

patients was .94 as compared to 34.98 for nonhospice patients (Smith & Veglia, p. 1).

Many of the administrative adjustments that need to be made by hospices participating in the hospice Medicare benefit are driven by the legislative premise for cost containment of federal health care dollars. Central fiscal and professional management responsibilities in the hospice Medicare benefit were included to protect the interests of the patient and limit health care expenditures for the taxpayer.

As a participating provider under hospice Medicare, a hospice program has a clearly defined amount of money from which all payments for care related to the terminal illness of patients are drawn. The only exception is for reimbursement to the patient's personal physician. Thus, the hospice must prudently manage its hospice Medicare revenues.

Among hospice programs which began as a direct response to community needs, there is now a serious concern that reimbursement options will alter the philosophical essence of hospice care. Some hospice administrators believe that the shape and form their hospice program takes will be increasingly determined by third-party reimbursement rather than by the needs of the patient, family, and community.

Quality-of-Care Issues

About the same time the federal arm was defining hospice care for reimbursement, the private sector was developing standards for

quality care. The Joint Commission on Hospital Accreditation (JCAH) published Standards for Hospice Care in 1983. These standards continue to be used today as criteria for a voluntary JCAH survey of hospice programs across the United States. By the end of 1985, the number of JCAH accredited hospices totaled 100 (McCann, 1985). In addition, JCAH has mandated that any JCAH-accredited hospital offering hospice services must now be surveyed against the 1983 hospice standards. As of 1985, participation in this survey has been mandatory for JCAH-accredited hospitals offering a hospice program.

State Licensure Issues

There is a drive for hospice licensure in many states which centers on two issues: (a) truth in advertising and (b) legality. The first issue stems from the perception that organizations which advertise to the public that they provide a hospice program or offer hospice services should conform to certain minimum standards of care.

The second issue was prompted by the observation that many hospices grew out of community-based organizations unaffiliated with traditional providers of health care services. Rosen (1985) noted that when the programs began to provide nursing care and other professional services, they discovered no rubric under which to operate legally. Hospice licensure provides this legal rubric. As of March 1986, 17 states had hospice licensure and 7 more had licensure rules in draft form within their legislatures.

The statutory base for licensure hospices in Michigan is Public Law No. 368, section 21419 (as amended by 333.21411), which became effective October 31, 1984. For hospice administrators in Michigan, this means their programs must be surveyed yearly for compliance to state hospice rules unless they have met specific hospice licensure exemption criteria.

If a program is exempt from licensure it does not mean that those programs are not without their own special kinds of administrative concerns. Examples of unique problems which surface in the exempt hospice programs are: (a) primarily "all-volunteer" staff, including the administrator; (b) inconsistent funding support; and (c) delivery of professional skills in a predominantly rural area. Exempt hospice programs are also included in this study.

In summary, both state and national issues involving cost savings, professionalization, reimbursement, quality of care, and state licensure provide a backdrop for the environment in which a hospice administrator must function. The tasks are becoming more complex and often overwhelming, especially for individuals who do not have the experience or educational preparation.

Statement of the Problem

Because hospice is a relatively new health care model, it has not been extensively evaluated in the area of administration. The limitation of current literature as to competencies for hospice administration is apparent (Barton, 1977; Bohnet, 1982; Richie,

1984; Rossman, 1977; McDonnell, 1986; Story, 1983;). Often, individuals who become involved in hospice care because of their philosophical and clinical beliefs regarding death and dying practices find themselves in administrative roles lacking conceptual and technical skills needed for effective management.

McLaughlin (1983) stressed that a well-run hospice program requires effective management practices by the hospice administrator to manage people, staff, volunteers, finances, community relations, quality, patient care, change, growth, education and training, recruitment and retention, marketing, and resources for the future. This study identifies the competencies required to accomplish these management tasks.

In planning and managing hospice programs, Lamb (1985) also noted that hospice administrators, like other health care executives, must assess their base of community support, understand funding sources, have an extensive organizational committee structure in place, and have a clear idea of organizational goals and objectives. As hospice programs develop over time and become more involved with the traditional health care system, success will largely be determined by program management. For administrators, this means a thorough knowledge of the hospice market, a clear idea of costs involved, and a ready supply of resources and the flexibility to initiate programs capable of meeting community needs.

Most descriptions of health service organizations presume that they exist in a static state. In fact, however, these organizations are in constant evolution. Starkweather and Kisch (1971) suggested

that health service organizations have their own life cycle and that each phase brings new types of responsibilities for administrators. It can be said that hospice is evolving through its own "life cycle." As this is occurring, hospice administrators are struggling to define a base of conceptual knowledge and technical skills that will assist them in meeting the responsibilities of their evolving programs. This evolution, for example, is apparent in exempt hospice programs moving to licensure, and licensed programs moving to hospice Medicare certification or perhaps JCAH hospice accreditation.

In every facet of health care, successful clinicians are often promoted to administrative positions. They may not have the inclination for administration or possess the experience and academic preparation to enable them to be successful administrators. General administrative functions and theoretical approaches provide models from which the hospice administrator can develop insight. According to this researcher, however, hospice programs are in desperate need of an effective administrative educational model that meets their needs over the organizational life cycle.

Purpose of the Study

Specifically, this study focused on five major objectives: (a) to compile selective demographic and opinion data on hospice administrators in Michigan, (b) to identify what functions current hospice administrators in Michigan were performing and/or delegating, (c) to survey current hospice administrators in Michigan

on their perception of Essential and Supplementary competencies which meet consensus under five administrative categories, (d) to identify demographic factors which differentially affect the reported essentiality of competencies, and (e) to identify how organizational life cycle stages influence and differentially affect the reported essentiality and/or delegation of competencies for hospice administrators.

A preliminary survey instrument developed by this researcher consisted of two parts. Part One addressed administrative/hospice characteristics to include: age, sex, education, length of employment in hospice, prior employment history, administrative history, role responsibilities, salary range, employment status, hospice designation, hospice location, patient/family ethnic representation, type of program credentialing expected 1 year from the time of survey, and the administrator's perception of the need for educational programs in hospice administration. Also surveyed was the administrator's rating of the life cycle stage of hospice development.

Part Two consisted of a listing of 201 competency statements under five administrative categories. Current hospice administrators in Michigan in 1987 determined if the competency statements were Essential and/or Supplementary as well as which tasks represented by the competency statements were delegated.

Because no research had been done on hospice administrators in Michigan, the demographic data from this study provided initial

baseline information and offered implications for further research. Also, the identification of Essential hospice administrative competencies can be used as guidelines to assist hospice programs in determining their expectations for professionals filling the administrative role.

The identification of these competencies may also be useful in providing a basis for developing curricula and training for continuing education in hospice administration. Finally, the evaluation of competencies which are delegated may be an indicator of the hospice program's stage in the organizational life cycle.

Research Questions

The following research questions arose from Objective Number One: to compile selective demographic and opinion data on hospice administrators in Michigan.

A1. What is the mean age in years for hospice administrators?

A2. What are the proportions of male and female administrators?

A3. What is the most frequently identified educational background?

A4. What is the mean number of years experience in hospice administration?

A5. What is the most frequent type of prior employment history?

A6. What is the range of total number of years worked as an administrator?

A7. What percentage of administrators have additional role responsibilities?

A8. What is the most frequent salary range as a hospice administrator?

A9. What is the proportion of full- to part-time employment?

A10. What is the most frequent hospice program credentialing designation?

A11. What proportion of hospice administrators are in rural and urban locations?

A12. What were the percentages of patient/family ethnic representations for the hospice programs in 1986?

A13. What do hospice administrators project for their hospice program credentialing designation 1 year from this survey?

A14. What is the distribution of perceived state of development for hospice programs?

A15. What percentage of hospice administrators identify a need for an educational program in hospice administration?

A16. What is the most frequent educational need identified by hospice administrators in Michigan?

A17. What is the most preferred method of educational assistance identified by hospice administrators in Michigan?

The following research questions arose from Objective Number Two: To identify what functions current hospice administrators in Michigan were performing and/or delegating.

B1. What are the competencies by functions (planning, organizing, directing, and controlling) which hospice administrators in Michigan identify as Essential and Supplementary?

B2. To what degree are these Essential and Supplementary competencies delegated for each of the major administrative survey components (Ref. Design of the Study, Chapter III) and each of the functions of planning, organizing, directing, and controlling?

B3. Do significant differences exist in the frequency of Essential and Supplementary competencies which are delegated?

The following research questions arose from Objective Number Three: To survey current hospice administrators in Michigan on their perception of Essential and Supplementary competencies which meet consensus under five administrative categories.

C1. What are the competency statements which meet consensus under the five major administrative survey components?

C2. Will there be any convergence to consensus on the Essential competencies?

C3. Will there be any convergence to consensus on the Supplementary competencies?

The following research questions arose from Objective Number Four: To identify demographic factors which differentially affect the reported essentiality of competencies.

D1. Is there a significant difference in the mean rating of competencies based on the respondent's age?

D2. Is there a significant difference in the mean rating of competencies based on the respondent's sex?

D3. Is there a significant difference in the mean rating of competencies based on the respondent's educational background?

D4. Is there a significant difference in the mean rating of competencies based on role responsibilities of the administrator?

D5. Is there a significant difference in the mean rating of competencies based on salaried or nonsalaried status?

D6. Is there a significant difference in the mean rating of competencies based on employment status?

D7. Is there a significant difference in the mean rating of competencies between administrators of licensed programs and administrators of exempt programs?

D8. Is there a significant difference in the mean rating of competencies of administrators with differing sizes of populations served by hospice programs?

The following research questions arose from Objective Number Five: To identify how the reported essentiality and/or delegation of competencies varies with organizational life cycle stages.

E1. Do Essential and Supplementary competencies within the administrative functions of planning, organizing, directing, and controlling vary with stage of program development?

E2. Do Essential and Supplementary competencies that are delegated for each of the major administrative survey components and each of the administrative functions vary with stage of development?

E3. Is there a significant difference in the mean rating of competencies across stage of hospice program development?

E4. Do the mean ratings of competencies across the four administrative function areas of planning, organizing, directing, and controlling vary significantly with stage of program development?

E5. Is there a significant difference in the frequency with which competencies are delegated based on program stage of program development?

Theoretical Definitions

Concepts which are important in understanding the human ecological framework are as follows:

Ecology: the pattern of relations between organisms and their environment (Melson, 1980).

Environment: the totality of circumstances surrounding an organism. It is composed of three interrelated environments: the human behavioral environment, the human constructed environment, and the natural environment (Bubolz, Eicher, & Sontag, 1979).

The human behavioral environment (HBE): an environment of human beings and their biophysical, psychological, and social behaviors.

The human constructed environment (HCE): an environment altered or created by human beings.

The natural environment (NE): a product of nature with spatial-temporal, physical, and biological components. The concept of energy is also represented in the NE.

Adaptation: the process of establishing and maintaining a relatively stable reciprocal relationship with the environment (Melson, 1980).

Adaptation press: the demands of an environment exerted upon a system to encourage and/or force adaptation (Olson, 1988).

Conceptual Framework

In recent years a major transformation in the understanding of health and disease has taken place. According to Hancock (1985), the emphasis has shifted from a simplistic, reductionist cause-and-effect view of the medical model to a complex, holistic, interactive hierarchic systems view known as an ecological model. This shift may be so profound as to constitute a paradigm shift or a change in the collective mind set regarding what the rules are and what is possible in care for the dying. From a broad focus the hospice concept is consistent with this emerging paradigm that calls for human services to be delivered from an ecological perspective which focuses on the interaction between persons and their environment. Recent interest in the ways in which primary social networks exchange social support is based on consistent evidence that social support enhances individual well-being and aids in adaptation to a range of life stresses (Ell, 1984; Gottlieb, 1983). In this context, hospice can be characterized as a professionally devised support system that intends to maximize a comfortable fit between dying persons and their physical and social environments and, to the extent possible, accomplish this by improving the ability of the

primary network to engage in support provisions for the patient and family.

In a paper entitled "An Ecological Approach to the Family," Andrews, Bubolz, and Paolucci (1980) described an ecological system as having three organizing concepts: the environed unit, the environment, and the patterning of transactions between them. This ecological approach can be further delineated by examining the environment in depth. Bubolz, Eicher, and Sontag (1979) envisioned this environment as being composed of three interrelated environments: the human behavioral environment (HBE), the human constructed environment (HCE), and the natural environment (NE). In the ecological model, one assumes that the human organism, known also as "the environed unit," interacts with all environments, i.e., the physical, biological, psychological, social, and cultural environments, over space and time. This conceptual model can be applied to hospice administration as follows.

The environment is the total hospice program to include those administrative responsibilities relative to the natural, the human-constructed, and the human behavioral environments. The HBE involves the behavioral management of staff to include volunteers and interactions with the patient and family. This includes assuring that psychosocial needs of staff and patient/family are identified, that stress-related issues are addressed, and that a relative state of equilibrium within the environment is maintained for employees and volunteers. The HBE also includes a sharing of common values on death and dying, bereavement, the grief process,

and common goals and interests in providing "help" to families. Examples of individuals interacting with the hospice administrator in the HBE are: the volunteer coordinator, the bereavement coordinator, the social worker, volunteers, clergy, nurses, physicians, medical director, and perhaps a psychologist if the hospice program has access to support from this particular professional discipline. In the hospice program, an important psychosocial interchange among staff and volunteers occurs during the interdisciplinary team meetings which are most often held on a weekly basis.

The HCE involves major responsibilities for the hospice administrator in the areas of staffing and personnel management, community and public relations, program quality assurance, and fiscal management. The HCE also includes the hospice program's accessibility as a resource for the patient/family and community. If the family needs equipment such as a hospital bed, suction machine, or oxygen, the hospice administrator must arrange for those resources to be available. If the community requests a program presentation on hospice and/or grief issues, the hospice administrator must consider what outcomes these programs would have on the public and also on hospice staff in time allocated to organize materials and/or participate in the presentation. Individuals interacting with the hospice administrator in the HCE include the physician, the hospice program medical director, clergy, agencies, or individually contracted personnel who can provide

specialized services to the patient/family unit, nursing personnel, volunteers, community programs, and the patient/family.

The NE includes the rural or urban setting in which the hospice administrator is working. It also captures the energy expenditure required to sustain the hospice program operation as well as family energy expended in caring for a terminally ill family member. Just as there are times when families experience periods of growth, balance, integration, and stability, there are also periods when families experience stress and disorder. The intensity of stress can be so overwhelming that disruption in family system functioning occurs, especially when physical and psychic energy demands are too great. Bubolz and Whiren (1984) noted the following assumptions with regard to energy:

*Supplies of human energy-physical and psychic are limited.

*Any alteration in the flow of energy-matter, information, and other resources requires adaptive change.

*Behavior of individual family members may require additional energy inputs by other family members as well as energy outputs for obtaining these supports.

*High energy demands create "energy sinks" where adaptive creative behavior may not be possible. This results in still greater stress on the family.

These concepts may be applied to terminally ill family members being cared for at home. Their care often places excessive demands on energy levels as well as other resources the family uses to cope. Additional physical care which needs to be provided involves high

emotional demands usually over an extended period of time for everyone concerned. Hospice care seeks to provide families with the necessary energy input required to sustain them in coping with terminal illness as well as providing support through bereavement. Using an interactive team approach, the physical and emotional care as well as energy levels required to sustain that care become the province of all staff members and volunteers in the hospice program. The greater the integration of the staff's energy and services, the more successful hospice care will be for patients and families.

Adaptation is the ability of the hospice administrator to reorganize the hospice program to a state of equilibrium after change or some new input occurs. Demands of the environment are exerted on the hospice program in what this researcher refers to as an adaptation press. This press seems to be influential in moving hospice programs along through their organizational life cycle. Thus, from an ecological perspective, hospice can be described as a "family enabler system" which focuses on the needs of the terminally ill person and family as they themselves define those needs in the HBE, HCE, and NE. Services offered to the patient and family are planned and coordinated on the part of many to support and enable the family in providing care to terminally ill individuals in their own environment. This environment is hopefully enhanced by the interaction of hospice professionals and nonprofessionals addressing the holistic needs of the patient and family. Figure 1.1 presents an ecological model for hospice administration.

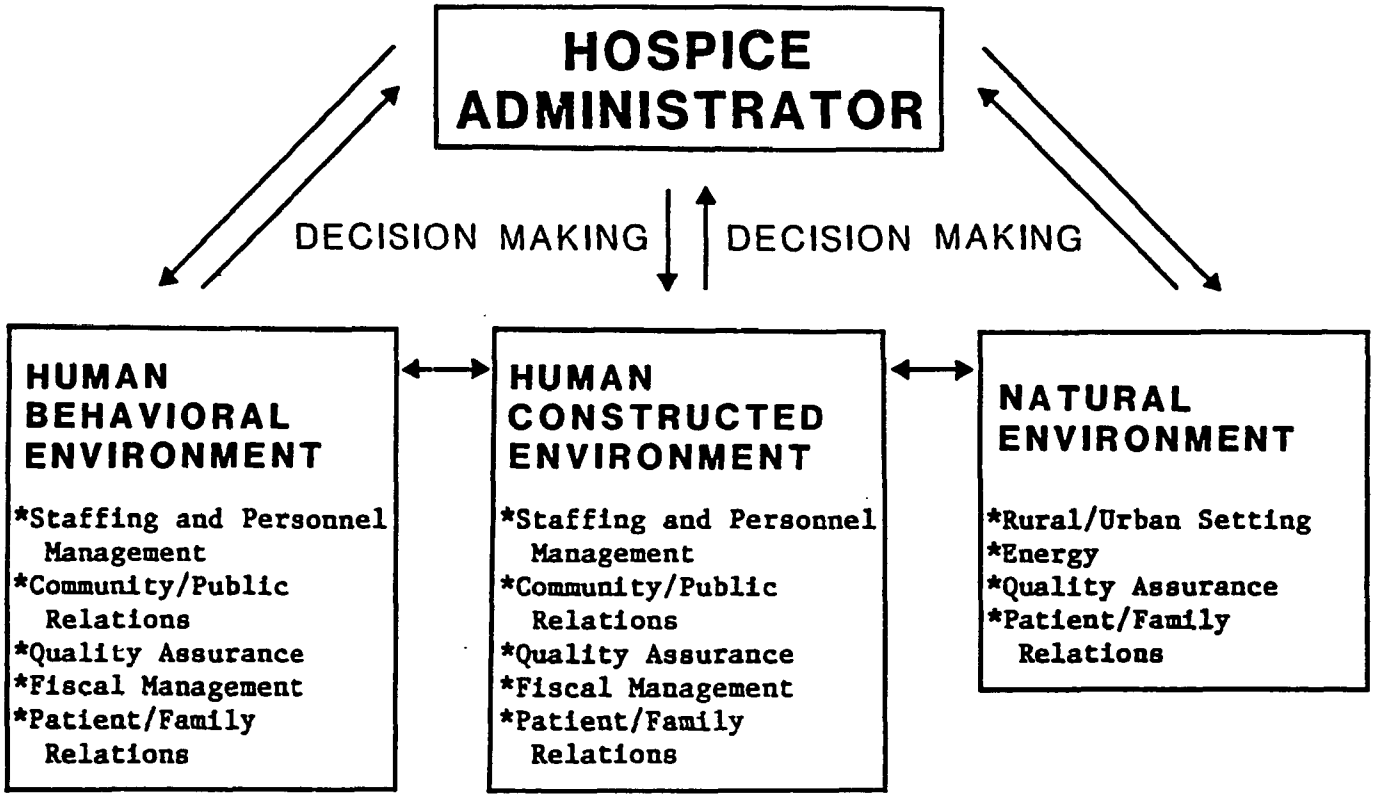

Figure 1.1.--An ecological model for hospice administration.

Basic Assumptions for the Study

The following assumptions were made in order to accomplish the objectives of this study.

1. Growth of hospice care in Michigan is inevitable.

2. Growth will require competent administrators who are prepared to adapt to changing responsibilities.

3. Hospice administrators are sufficiently informed to respond to statements of competency relative to their job requirements.

4. Internal and external environmental demands will require a conceptual knowledge and skill base in the areas of staffing and personnel management, patient and family relations, community and public relations, fiscal management, and quality assurance.

Limitations of the Study

1. The sample size of licensed hospices is small relative to the number of hospice exempt programs; however, it is anticipated that because of this researcher's visibility among licensed programs, the return rate should be sufficient.

2. The essentiality of each competency is only measured by the perceptions of those people in Michigan who respond to the survey. It remains for additional studies to determine the perceptions of other hospice administrators throughout the United States.

3. This study used a long questionnaire, however an effort was made to use succinct competency statements.

4. Survey responses were elicited a minimum of two times, and this may have decreased respondents' attention and the participatory response rate.

Summary

Chapter I introduced the problem for this study, general research questions, a human ecological conceptual framework applicable to hospice administration, theoretical definitions of terms, assumptions, and limitations. Chapter II contains the review of literature relevant to this study.

CHAPTER II

REVIEW OF LITERATURE

In this chapter the review of literature is divided into five parts:

1. Hospice Overview
2. Hospice Administrative Components
3. Administrative Theory
4. Competency Research
5. Research Methodology
   - Survey Methodology
   - Delphi Technique

Hospice Overview

Although the appearance of hospice programs in the United States began in 1974, the concept has existed for centuries. The word "hospice" originally meant a place of shelter or rest for travelers. During the medieval period, hospices were maintained by religious orders for individuals on pilgrimages to the Holy Land. For centuries, the idea of hospice signified a refuge where people could be cared for, nourished, and loved in the face of impoverishment, crisis, or impending death.

The modern hospice designed primarily for the care of terminally ill persons traces its roots directly to the Irish Sisters of Charity in Dublin. In the mid-1800s, Sister Mary Aikenhead opened a home in Dublin for the dying, calling it "hospice." Through her leadership, the Sisters established hospitals for the sick and refuges for the poor and homeless. This work eventually spread to London where the Sisters established St. Joseph's, the first British hospice. St. Joseph's also served as a model for other English hospices, the most notable of which is St. Christopher's Hospice, established in a London suburb by Dr. Cicely Saunders. It is to St. Christopher's Hospice and its founder that the United States hospice movement looked for guidance in the late 1970s.

The hospice concept is considered by some to be a human rights movement focusing not only on the terminally ill patient's rights but also on the failure of the existing medical care system in the United States to meet the needs of the dying (Finn-Paradis, 1985). The important aspect involved is giving the dying patient and his/her family the choice as to where he/she wants to die and then providing the "caring measures" needed to give a quality to the life remaining.

The National Hospice Organization defined hospice as "a program of palliative and supportive services which provides physical, psychological, social, and spiritual care for dying persons and their families. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers" (NHO, 1981).

All hospice programs are encouraged to ascribe to a common set of 16 standards developed by the National Hospice Organization in 1978 and patterned after Dr. Cicely Saunders's principles of hospice care. These standards were also utilized in developing the hospice Medicare certification requirements (1983) and the Michigan Hospice licensure rules (1984). They are as follows:

1. The hospice program complies with applicable local, state, and federal laws and regulations governing the organization and delivery of health care to patients and families.

2. The hospice program provides a continuum of inpatient and home care services through an integrated administrative structure.

3. The home care services are available 24 hours a day, 7 days a week.

4. The patient/family is the unit of care.

5. The hospice program has admission criteria and procedures that reflect: (a) the patient/family's desire and need for service, (b) physician participation, and (c) diagnosis and prognosis.

6. The hospice program seeks to identify, teach, coordinate, and supervise persons to give care to patients who do not have a family member available.

7. The hospice program acknowledges that each patient/family has its own beliefs and/or value system and is respectful of them.

8. Hospice care consists of a blending of professional and nonprofessional services, provided by an interdisciplinary team, including a medical director.

9. Staff support is an integral part of the hospice program.

10. Inservice training and continuing education are offered on a program basis.

11. The goal of hospice care is to provide symptom control through appropriate palliative therapies.

12. Symptom control includes assessing and responding to the physical, emotional, social, and spiritual needs of the patient/family.

13. The hospice program provides bereavement services to survivors for a period of at least 1 year.

14. There will be a quality assurance program that includes: (a) evaluation of services, (b) regular chart audits, and (c) organizational review.

15. The hospice program maintains accurate and current integrated records on all patient/families.

16. The hospice inpatient unit provides space for: (a) patient/family privacy, (b) visitation and viewing, and (c) food preparation by the family.

Using the umbrella of these standards, patient management is based on the principle of aggressive palliative care, which has as its primary objective to alleviate the distressing symptoms that occur during the advanced stages of terminal disease. This includes not only the clinical treatment of physical symptoms, but spiritual

and social as well. Because palliative care means total care for the patient, the "unit of care" becomes the patient and family.

Hospice Administrative Components

The work of all hospice administrators typically consists of coordinating the activities of various parts of the hospice program, relating the program to its environment, and integrating the performance of persons who work in the program so that there is adequate identification and commitment to the program goals. The hospice administrator also concurrently assumes the final responsibility for his/her hospice program in striving to meet the standards described in the previous section. It is a challenging responsibility to make judgments as to what is best for the individual hospice program and yet keep a perspective of future growth for hospice care in the broader context.

Kovner and Newhouser (1978) noted that both the formation and application of administrative judgment involve skills which can be improved. This researcher believes that once administrative competencies are identified, individuals can better identify ways in which their skills can be evaluated and polished. This may occur through an individual learning situation or through participation in a curriculum model for hospice administration.

Through a review of pertinent literature, hospice administrators' job descriptions, and regulatory statutes for hospice care from both the state and federal level, this researcher believes that there are five major "bedrock components" on which hospice

administrators should focus their conceptual knowledge and technical skills. These five broad competency areas are:

1. Staffing and Personnel Management
2. Patient and Family Relations
3. Community/Public Relations
4. Fiscal Management
5. Quality Assurance

The five competency areas are schematically represented through an ecological design in Figure 2.1. A discussion of each of these components follows.

Staffing and Personnel Management

Staffing requirements for hospices vary greatly. Factors such as stage of development of the organization, type of program, geographic area covered, rural or urban location, available community resources, funding support, and ethnic groups served are determining elements.

Relative to state of development, Petrosino and Weitzel (1984) noted that a new hospice generally requires proportionately more staff members per patient served than an established one because a greater amount of time is consumed in establishing procedures, refining recording and reporting procedures, and establishing community relationships. By contrast, most hospices in Michigan develop initially with "bare bones" staffing (Olson, 1986). One individual may be the hospice administrator, the volunteer coordinator, and the patient care coordinator. This multiple role concept

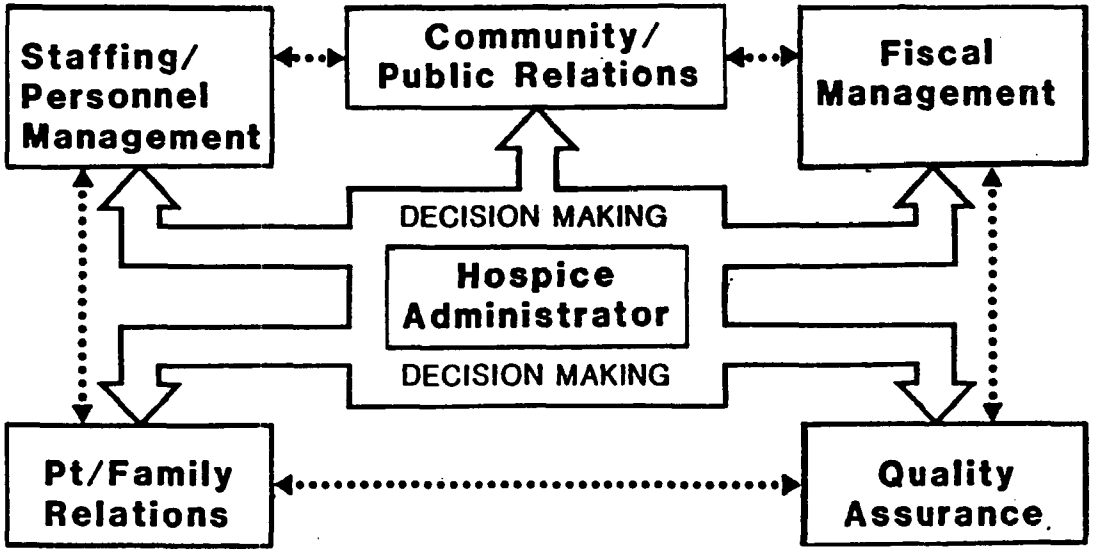

Figure 2.1: Hospice administrative competency areas.

may be beneficial in early program development, but unfortunately, as programs grow and increased staffing needs seem evident, personnel find it difficult to divest from their multiple roles.

As identified in organizational life cycle theory (discussed later), this researcher noted that most hospice programs in Michigan are perhaps in stage I and II of development.

The type of program certainly plays an important role in staffing. Both hospital-based and home-health-agency-based hospice programs seem to be more affluent in staffing availability, whereas the independent community-based and/or volunteer-intensive hospices must often work very hard to identify potential hospice personnel.

The geographic area served and location of the hospice are important considerations in determining staffing needs. The amount of travel time staff members require to make home visits determines how many home visits are feasible each day. With regard to location, an urban hospice generally has more well-established supportive services available to it, and therefore staff members can easily make referrals. By contrast, staff members in rural hospices frequently must provide more services themselves or spend more time training and coordinating volunteers to carry out support services.

Available community resources affect staffing to the extent that a hospice may be able to negotiate for staffing support. A small, volunteer-intensive hospice program may negotiate a contract with a local home health agency to provide nursing and/or home health aide support for the hospice patient and family.

There has not been extensive research in the area of ethnicity and hospice care, although hospice programs indicate an awareness of ethnicity needs. For example, a hospice program had difficulty communicating with and meeting the needs of a Polish patient. A volunteer who spoke Polish and was familiar with the "old country" made considerable strides with the Polish patient in assisting with hospice care.

Major responsibilities for the hospice administrator relative to staffing and personnel are: recruitment, orientation and retention of employees (including volunteers), management of the interdisciplinary team, volunteers, medical direction, reduction of staff stress, and maximization of staff energy inputs. A brief discussion of these responsibilities follows.

Recruitment, orientation, and retention. There remains an ongoing effort to orient new staff using an orientation program which is comprehensive enough to prepare staff to attend to the physical, psychological, spiritual, and social needs of the patients/families as well as to assist new staff in utilizing self-care strategies for themselves. According to Profitt (1985), staffing for hospice care is determined by two factors: (a) patients' average length of stay (ALOS) in the hospice program and (b) intensity of services required by the patient and family. A study of hospice patients in Cleveland, Ohio, in 1981 revealed an ALOS of 48.3 days with a median of only 27.0 days (Brooks & Smith-Staruch, 1984). Thus, many patients may be in the hospice program less than 1 month. For Michigan, Finn-Paradis (1983) indicated that

hospice programs are continuing to increase staffing levels. Her research indicated that the average staff size increased from 1.6 in 1979 to 8.8 in 1983.

The hospice administrator is also responsible for providing staff with educational inservices. These inservices may relate to current care issues such as admitting AIDS patients. Although NHO has encouraged programs to care for AIDS patients (NHO Policy Statement, November 1985), many program administrators are concerned realistically with staff attitudes, staff inservice training on caring for AIDS patients, and perhaps denied reimbursement for the care tendered (Hospice Letter, January 1986).

The interdisciplinary team. Certain staff comprise the interdisciplinary team, which meets most frequently on a weekly basis. According to Michigan hospice licensure, the team must consist of a nurse, physician, volunteer, spiritual counselor (when indicated by the family), and social worker. Home health aides; physical, speech, and/or occupational therapists; nutritionists; and pharmacists may also be included. Their major responsibility is to plan and coordinate the services provided. This interdisciplinary team function is also mandated by JCAH (1983), Medicare (Federal Register #48, 1983) and Michigan Hospice rules (Michigan Department of Public Health Code, Act #368, PA 1978). Fundamental to the team approach is the concept that no one person has all the answers and that total care is made easier by a variety of personnel, with a variety of resources, working together. The administrator monitors

the functions of the interdisciplinary team and in some programs in Michigan actually directs the team meetings on a regular basis (Olson, 1986).

Volunteers. Unique to the hospice concept is the practice of using extensive volunteer services to provide both support and direct patient services, which is mandated by both the Michigan Hospice Licensure Rules and hospice Medicare certification. This use of volunteers demands recruitment, retention, ongoing education, and coordination of volunteers by a volunteer coordinator. According to hospice Medicare Certification, volunteer staff must be managed as regular hospice employees; therefore, it is incumbent on the administrator to ensure orientation, inservice education, and supervision which matches that of salaried staff. Blum (1985) noted that administrators must also consider liability and legal sanctions appropriate for both salaried and voluntary staff.

Medical direction. Every hospice must have medical direction by a medical director who is currently licensed as a physician. This individual is considered an employee whether his/her services are provided by contract or in a volunteer capacity. In Michigan, many hospice programs have volunteer medical directors serving most frequently in a part-time capacity (Olson, 1986). Technically, the medical director answers to the hospice administrator. He/she is the hospice program's primary resource and support for appropriate pain management. The medical director also interacts with attending physicians who must determine, by virtue of admission criteria, the patient's 6-month terminal prognosis. The hospice administrator and

the medical director must be attuned to building physician support to assure continued patient referrals.

Staff stress. Vachon (1986) noted that the lack of definitions of clear professional roles is a major stress-inducing factor in the hospice work environment. However, McArdle (1985) noted that it is realistic to expect that a well-functioning hospice program will have staff tension. Hospice staff provide a wide range of services and perform many care-giving activities for terminally ill patients and their families. However, their work may also produce stress and affect their own emotional well-being. Research by Yancik (1984) revealed that there were three major stress-producing areas in hospice: staff support issues, emotional concern for patients and their families, and management of the disease process. Of these three, the lack of staff support proved to be the greatest overall producer of stress. Thus, Yancik indicated the need for hospice administrators to improve the working conditions of hospice staff and to increase communication with them.

Thus, one of the administrator's roles is to reduce employee stress. Setting aside specific time for support group meetings is important but also requires that staff have support sources in their daily activities. Ongoing support groups are a valuable asset to the staff within the hospice program. Meetings are often held when the majority of staff can attend with a group leader skilled in group communication techniques. Effective communication on the part

of the hospice administrator is perhaps the foundation for successful staff support efforts.

Energy inputs. Finally, energy requirements necessary to address staffing, personnel, and patient/family needs can be very demanding for the hospice administrator. Replenishing the "energy sinks" and fatigue that occur can be accomplished by having opportunities to meet with other hospice administrators not only to discuss programmatic issues but also to receive peer support. As one hospice administrator told this researcher, "It's a very lonely job when you have no other directors to talk with." Both the hospice administrator and his/her staff may expend phenomenal amounts of energy coordinating and delivering patient care, often covering large geographical areas in all types of weather conditions. The issue of "What is enough? What is too much?" remains an often unanswered question in providing hospice care.

Staffing and personnel management, therefore, are key elements in administering a successful hospice program. Major responsibilities of the hospice administrator focus on staff selection and assuring recruitment and orientation for both paid and volunteer staff. The hospice administrator also monitors the function of the interdisciplinary team while assuring overall medical direction for the program. Woven through these functions are issues involving staff stress and administrator fatigue. In addition, implicit in this component is knowledge of personnel evaluation, education, discipline, and motivation.

Patient and Family Relations

In the hospice program, family members most often assume primary care-giving responsibilities. Spouses, children, relatives, and friends may contribute to overall patient care. What is unique about hospice is that the care-givers are also cared for by hospice. The concept of "unit of care" as described by Buckingham and Lupu (1982) and required by Michigan hospice licensure clearly identifies that services must extend to and include the family. Bass and Garland (1985) noted that family members may be in more need than anyone else of the assistance a hospice program can offer. For the program administrator this means monitoring an environment that encourages families to become involved and stay involved. The delineation of specific tasks and activities for families, particularly by the nursing staff who visit the home setting on a regular basis, can be helpful. In addition, if the patient in a Medicare-certified hospice should need medical equipment, the hospice administrator must ensure that the equipment is available. Equipment may include a hospital bed, oxygen, suction machine, walkers, bedside commodes, and devices that assist in lifting the patient in and out of bed. In programs which are not hospice-Medicare certified, the administrator tries to posture the hospice program as a resource to refer the family to other agencies in the community which might be able to assist in securing the needed supplies or equipment.

Patient/family rights and confidentiality. Assuring patient/family rights and responsibilities as well as medical information

confidentiality is required by both Michigan licensure and hospice Medicare certification. Excerpts of Michigan hospice licensure rules (October 1984) are as follows:

R325.13110 Patient rights and responsibilities reads:

1. "A hospice shall develop, adopt, post in a public place, distribute, and implement a policy on the rights and responsibilities of hospice patient-family units in accordance with the requirements of sections 20201, 20202, and 20203 of the code."

2. "A hospice shall assure that information transmitted to a patient-family unit will be communicated in a manner that will reasonably insure that the information is understood by the patient-family unit."

R325.109 Development of policies and procedures reads:

(t) (ii) "Confidentiality of medical information."

(t) (iii) "Release of information or the provision of copies of the information to patient-family units or authorized persons upon the written consent of the patient or guardian."

Excerpts from the hospice Medicare benefit which also support these requirements are:

418.60 Continuation of care reads:

"The hospice does not discontinue or diminish care provided to a Medicare beneficiary because of the beneficiaries' inability to pay."

418.62 Informed consent reads:

"The hospice demonstrates respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual."

418.74 (b) Protection of information reads:

"The hospice safeguards the clinical record against loss, destruction and unauthorized use."

Continuity of care must also be assured to the patient/family as part of the rights accorded them in receiving hospice care. The patient's plan of care should not be interrupted for the patient moving from home to a hospital setting or hospital to home care.

Bereavement care. Formalized bereavement service within the hospice's organizational structure is a natural extension of responsibilities to the family. It is important to note that the provision of bereavement care is mandated (but not reimbursed) under current hospice Medicare legislation in the United States and also mandated as a requirement for Michigan licensure (Hospice Rule 325.13305, Michigan Department of Public Health, 1984). For hospice licensure in Michigan, administrators must ensure that bereavement follow-up to families is available for a minimum of 13 months following the patient's death. As bereavement preparation and care are part of regular hospice services, the hospice administrator must ensure that bereavement education, monitoring, and assistance begin early and continue in a coordinated fashion.

Respite care. Patient and family relations are also important in the provision of respite care. According to the hospice Medicare certification model, respite care accommodates the family or primary care-giver by providing an alternate place for the patient to stay when home care-givers need a rest from the everyday physical and emotional strain of caring for the terminally ill friend or relative. The administrator must be attuned to appropriate respite situations for families and to availability of staff in providing the needed respite care.

Thus, hospice care is for and about patients and families. The skills and knowledge base required by a hospice administrator to manage patient and family relations includes reference to admission/discharge criteria, patient/family rights, patient/family confidentiality, continuity of care, bereavement, and respite care.

Community/Public Relations

Lamb (1985) defined community support for hospice as the widespread belief that hospice is a viable health care option warranting promotion and development. As groups formally or informally organize to promote hospice care, increased community support is usually targeted as an administrative priority. One might argue that community relations and public relations are one and the same; however, they can be differentiated.

Community relations capture the community's investment in hospice as well as the hospice program's ability to meet the community's need for education in the area of hospice care, death

and dying, and grief/loss issues. The hospice program must be tailored to meet the needs of the individual local community. This can only be accomplished by knowing cultural, social, economic, and political influences in concert with a knowledge of the community profile and gaps in health care delivery. On-going public and professional education is critical to facilitate understanding and subsequently may provide funding support for hospice care.

Public relations, on the other hand, is often called "marketing" activity. It focuses on how hospice is "perceived" in the community. Marketing the hospice's services has to be a continuing effort, emphasizing the hospice's quality of care and special services. Health care professionals, public policy-makers, and the community are essential in developing both community and public relations for hospice care.

Community education. Historically, hospices usually have had small community beginnings. These hospices had to establish relations with the larger community. The public needs information about what hospice does and about the attitudes toward life and death that make hospice work. As hospices become more established in the community, they are being utilized as a resource for programs in grief and loss unrelated to terminal illness (Olson, 1986). The hospice administrator must be attuned to meeting these community needs within program staffing constraints. As indicated in the bureaucratic phase of the organizational life cycle (discussed later), if these needs are not met by responsible adaptation on the

agency's part, it can lead to reduced public concern and eventual diminution in the flow of public resources (Blau, & Scott, 1962).

Negotiation/communication. The "community" also includes other health care providers with whom the hospice program must interact. For hospice programs seeking hospice Medicare certification, the administrator is required to develop contractual agreements with acute-care or long-term-care hospitals in the community to provide for acute symptom control and respite care. In addition, other types of contractual agreements might be required to provide physical therapy, speech therapy, occupational therapy, and other counseling the patient and family may need.

To a great extent the reputation and credibility of a hospice are based on the communications that hospice personnel have with persons representing community resources. Maintaining effective communication must be a primary concern for the hospice administrator, especially when patient care is provided by various health care professionals. The combination of inpatient and home care, 24-hour staff availability (often by contract services), respite care, and volunteer placement requires a concerted effort to ensure the continuity of care so essential to the patient and family (Petrosino & Weitzel, 1984).

Competition. Competition in health care, particularly among providers of home care, to include hospice, is now a reality in most communities (Moga, 1985). Patients and referral sources do not always understand the distinction between traditional home care services which focus on curative nursing care, versus the holistic

palliative approach in hospice care. Frequently, the competitive environment in home health care prevents patients from hearing about hospice programs and knowing that a choice of types of care is available. The hospice administrator needs a knowledge of marketing techniques in order to assure that the hospice program message is effectively communicated to the public.

Competition has also developed among hospice programs within the same community. Consumers may have a choice between two hospice programs which may carry identical credentials. Thus, hospice administrators in this situation must increase their marketing efforts to assure that distribution of referrals is in their favor.

Governing board relations. Another community and public relations function requires interaction with the governing board. The board comprises a varied professional mix of people concerned with promoting hospice care in their community. The hospice administrator is accountable to the board for day-to-day operations of the hospice program. Therefore, communication is essential between his/her board and the hospice employees and volunteers. The hospice administrator in essence becomes the "linking pin" between these two groups of people.

In summary, the community/public relations component encompasses skills and knowledge required in the areas of communication, knowledge of available community resources and use of those resources, contractual negotiations, and work with a governing board.

Fiscal Management

Historically, hospices have not used ability to pay or insurance coverage as considerations for reimbursement. Care is provided regardless of ability to pay. According to Michigan Hospice Licensure Rule R325.13107:

> The hospice administrator shall implement financial policies and procedures, approved by the governing body, according to sound business practice, including, but not limited to, all of the following: (a) payroll, (b) budget, (c) accepting and accounting for gifts and donations, (d) keeping and submitting such reports and records as required by the department and other authorized agencies.

Reimbursement. As of January 1, 1986, legislation in Michigan now requires commercial health insurance companies to offer coverage for hospice care whenever they issue or renew policies which provide coverage for inpatient hospital care. The hospice Medicare benefit is a major reimbursement option although hospices say Medicare rules are burdensome and expensive to implement. Under the Medicare benefit, beneficiaries with a life expectancy of 6 months or less can elect hospice coverage. Patients must waive all other Medicare services except for physician care. Hospice programs are paid flat rates for four different levels of care: routine home care, continuous home care, inpatient care, and respite care. While hospices are struggling to make the changes necessary to qualify for Medicare reimbursement, they are also being forced to adjust to the competitive health care environment. Competition for community dollars may force noncertified hospices out of business entirely or may push them to make the changes necessary to qualify for federal dollars.

Fund raising. Community fund raising and grant writing appear to be important alternatives in securing additional funding for hospice services. Hospice administrators must be creative and take full advantage of community financial support. This includes aggressive fund-raising campaigns supported by donations from individuals and organizations. Owen (1985) noted that hospice care is a gift-generating program. These donations result from the donor's interest in hospice care, satisfaction with hospice services received, or direct solicitation by the hospice program.

While hospice programs cannot be expected to survive on gifts alone, some communities have found local agencies such as the United Way and various volunteer service associations as a resource for financial support. All the expected revenues from grants, contracts, and donations are forecast as part of the budget and overall financial management planning by the administrator and governing body.

Volunteer cost savings. The role volunteers play under the hospice Medicare benefit is also a fiscal consideration. A Medicare-certified hospice program is required to maintain volunteer staff sufficient to provide administrative or direct patient care that at minimum equals 5% of the total patient care hours of all paid hospice employees and contract staff. Although these requirements can be easily achieved, the time spent documenting, recording, and computing the figures is considerable (Tehan, 1985).

As hospice programs evolve through their organizational life cycle, fiscal management of hospice becomes more and more complex. Hospice administrators are now encouraged in current literature to review budgeting and fiscal practices and apply them to their specific programs (Lamb, 1985). The hospice administrator now has the opportunity to define a financial system that blends the delivery of service and practical skills needed to keep the organization alive. Silvers (1976) suggested there are no purely financial or organizational actions, but rather administrative decisions that, in reality, are expressed in financial or organizational terms. In summary, the knowledge and skills related to the fiscal component of a hospice program include knowledge of reimbursement modes, budgeting, fund raising, grant writing, and cost-containment strategies.

Quality Assurance

The "growing pains" and often inconsistent financial position of many hospice programs do not eliminate the need for a thorough quality-assurance program. Although hospice programs in Michigan vary in size and in scope of service, all programs purport to have a common mission of providing the best possible care to the dying patients and their families.

A quality-assurance plan. The hospice administrator is responsible for assuring the development and implementation of a quality-assurance plan. This plan should include specific standards of care, methods of data collection, a time frame for collecting

data, and methods for implementing any necessary revisions to the plan. A solid quality-assurance program can then provide a basis for a total program evaluation. A quality-assurance program designed to achieve the most desired effect for the patient and family considers program philosophy, policy, and procedural factors. To accomplish this, administrators must implement a planned and systematic process for monitoring and evaluating the quality of hospice service. Such input is garnered from clients, staff, and community in all environments which would include home care as well as inpatient care. The results are then used to adjust the organizational design of the program and shape the attitudes and practices of all individuals associated with hospice. Excellence is achieved by continual scrutiny against hospice standards of care. McArdle (1985) noted that a great deal of a hospice manager's energy is devoted to evaluation, which occurs on a daily basis.

Regulatory guidelines. Quality-assurance requirements are also mandated by JCAH, hospice Medicare, and Michigan hospice licensure as follows:

JCAH: There is an ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient/family care, pursue opportunities to improve patient/family care, and resolve identified problems.

Medicare: A hospice must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided including inpatient care, home care, and care provided under arrangement.

Michigan hospice licensure: Hospice programs must develop and implement, through an interdisciplinary committee, an ongoing quality-assurance program. Professional standards must also be developed or adopted in the following areas: (a) interdisciplinary team services, (b) patient and family as the unit of care, (c) symptom control, (d) continuity of care, and (e) home care services. These standards require that the administrator assure that individuals charged with quality-assurance activities in the program collect and analyze data, and recommend change and re-evaluation when necessary (Michigan Hospice Rule R325.13111).

As these requirements suggest, the quality-assurance program is self-directed, with each individual hospice tailoring its own specific quality-assurance program to meet quality-of-care principles. It is a process that provides useful information concerning the use and appropriateness of services, as well as the quality of care. The information gathered is such that it becomes useful to the hospice administrator in assuring: (a) competence of staff, (b) the appropriate and cost-effective use of resources, (c) compliance with federal and state regulations, and (d) provision of appropriate information to the governing body, i.e., if the program is providing good care and meeting designated goals (McCann & Enck, 1986).

In summary, quality hospice services must be delivered efficiently and appropriately in an ever-changing environment of government regulations, consumer activism, and budget limitations.

The hospice administrator must have knowledge and skills related to quality-assurance theory and practices, hospice regulatory and statutory requirements, utilization review, and program evaluation.

Administrative Theory

Planning, organizing, directing, and controlling are important features of administration. In addition, a review of general administrative functions and administrative approaches is cogent to this study. Dressler (1978) stated:

> Administration is a complex set of tasks requiring both the acquisition of technical skills and interpersonal competence. Unfortunately, most young administrators have received little formal preparation for this role. The problems encountered in performing administrative roles are both difficult and complex and require a high degree of ingenuity and persistence. (p. 360)

More recently, Dubrin (1984) noted an effective leader almost always has to be technically or professionally competent, particularly when leading a group of specialists. He stated:

> It is difficult to establish rapport with subordinates when you do not understand what they are doing and they do not respect your technical skills. At a minimum the manager of specialists has to be "snow-proof" (not readily bluffed by subordinates). It is not always necessary for the manger to display technical competence when first placed in the job. Employees will give their leader a reasonable period of time to become oriented, but they will lose respect for the manager who continually relies on others in the department to make decisions or provide guidance. (p. 259)

The role of the professional hospice administrator is reinforced by legal, regulatory, and accrediting agencies, a posture which many of the beginning hospice programs did not wish to undertake (McDonnell, 1986). Indeed, hospice administration cannot allow the hospice concept to become buried within the maze of the

already existing health care delivery system, thereby undermining the basic precept of quality care for the terminally ill. For this reason, the following four classic administrative functions are emphasized as they apply to hospice administration.

1. Planning: involves identifying hospice goals and objectives, stating premises and assumptions, and developing specific detailed plans for hospice care. Levey and Loomba (1973) noted that planning is the process of making decisions in the present to bring about an outcome in the future. Wilson (1976) related that planning bridges the gap between where the program is and where it wants to go. It is the most fundamental administrative action which logically precedes all other management functions (McDonnell, 1986).

2. Organizing: involves how the hospice administrator groups, assigns, and coordinates activities needed to accomplish goals and objectives. It is providing mechanisms for how the job will be done.

3. Directing: involves being able to motivate, communicate, and lead hospice staff as well as teach, supervise, and integrate them into the organization. An important task in this administrative function is delegation. It is perhaps one of the most difficult administrative concepts to implement, and yet it is absolutely vital that it be done (Wilson, 1976). The important issue involves being realistic about one's own limitations, both in time and knowledge. According to Wilson, delegation does not

eliminate work; it simply changes it. As a person is able to delegate appropriately, a multiplier effect occurs. The time spent doing one job can be spent in enabling several people to do numerous jobs. This researcher used the concept of delegation to explore which functions hospice administrators in Michigan delegate and then determined if certain administrative competencies were indeed delegated.

4. Controlling: is the process of monitoring and evaluation. It is essential in determining if events have conformed to plans for providing quality care.

This researcher believes that hospice administrative leaders must be dynamic and eclectic while holding fast to hospice ideals and essential values. Individuals must be able to plan, organize, direct, and control as part of their role responsibilities. They must also be creative and discover how to tap staff resources through delegation. Each of the five hospice administrative components on the survey instrument included subsets of the four functions just discussed. This researcher analyzed to what degree these functions were used and to what degree they were delegated.

Administrative Strategies

Arnold et al. (1971) noted that the study of administrative organization has been eclectic. Concepts from sociology, political science, psychology, economics, and mathematics have been interchanged in the process. These fields have been a rich source of concepts for adding to the understanding of administrative

behavior. During the past several decades certain identifiable themes or conceptual modes have patterned the development of administrative knowledge and skills. Presented here is a brief overview of four major administrative strategies.

The structural approach. This approach to administration started with a focus on how work should be divided and how this division of labor could be made more rational. Weber (1957), Gulick and Urwick (1937), Mooney and Reiley (1939), and Taylor (1952) all emphasized structural rationality. The underlying assumption was that all tasks could be separated into discrete parts and that job functions could be delineated by clear-cut boundaries between positions. These tasks were to be coordinated through a hierarchical structure of authority.

The process approach. As the mechanistic management model was gaining popular acceptance, Roethlisberger and Dickenson (1939) introduced research that substantiated the need for social process to be taken into account. A flood of studies on social process appeared, and concepts such as human relations, participative management, and interpersonal communications became popular. The focus of administrative attention was on motivation and the resolution of conflict which is inherently present between the individual and the organization. Argyris (1957) also emphasized the social process with his theme of "job enlargement." He indicated that job content could expand to include a wider range of tasks and thus broaden the worker's control over his responsibilities.

The decision-making approach. Simon (1947) introduced a focus on the decision-making process as a new way of looking at the organization. Problem solving rather than specific kinds of tasks or activities was emphasized. This resulted in variations in the team concept within the organizational structure. Levey and Loomba (1973) noted that regardless of the nature or type of decision, the following elements of decision making must be consciously considered in the administrative process:

1. Who is the decision maker and what are the objectives?
2. What is the context and environment of the decision problem?
3. What are the alternative courses of action?
4. What are the assumptions regarding the future?
5. What are the consequences of alternative courses of action?
6. What is the choice according to a decision criterion?
7. How will there be implementation and control?

In actual practice, the decision maker identifies the problem and its hierarchical nature, states the objectives for which the problem is being perceived and formulated, tests the responsiveness of the environment in light of the stated objectives, identifies relevant relationships between the variables, specifies the constraints of the problem, and chooses a course of action according to a decision criterion. Since the decision-making process is usually dynamic in nature, the administrator exercises control over the implementation of decisions by continually observing the

outputs and making necessary changes in the inputs by using feedback channels.

The ecological approach. Melson (1980) noted that an ecological perspective emphasizes on different levels common themes, among them system-environment relations, interdependence, and reciprocal change. The five administrative competency areas used in this research are in reality based on system-environment relations adopted from the ecological framework described in Chapter I. It is important to recall that in this approach communication and decision making provide a means for assimilating and processing the flow of information from the identified competency areas as represented in Figure 2.1 presented earlier. In terms of the choice of a course of action from among many alternatives, the decisions made in any one component must be based on analysis of the patient/family as well as the state of the other components. The hospice administrator's decisions direct the hospice and ensure implementation of policies and procedures regarding all activities in all components. The administrator's role can be considered a circle of action in which he/she interacts to a greater or lesser degree with each component. It is critical that administrators monitor the program's environment to anticipate change and bring about the appropriate responses required from the adaptation press experienced by the hospice program.

In summary, this researcher has identified that the tasks of the hospice administrator are complex and often overwhelming, especially for individuals whose background is clinical and whose

training has not qualified them for managing such complex tasks. General administrative functions such as planning, organizing, directing, and controlling, in addition to theoretical administrative approaches, provide models from which the hospice administrator can develop insight. According to this researcher, hospice programs are in desperate need of an effective administrative model which meets their needs over the organizational life cycle.

Organizational Life Cycle and Administrative Dynamics

A review of organizational life cycle theory seems applicable to this review of literature because it uses an ecological model. Also, it is important to note that hospice programs in Michigan can be seen as evolving through their own life cycles and are in different stages of development relative to services they provide. Haire (1959) noted that organizations have life cycles analogous to those of individual and family structures. Organizations may be thought of as having strong wills to survive and having stages of development from birth to death. Some organizations have normal development while others apparently have arrested development. All are influenced by and have an influence on their environment. Starkweather and Kisch (1971) stated that the survival of an enterprise may become contingent on its readiness and ability to reorganize and adapt to changing conditions in society. The four

life cycle phases health service organizations may experience are as follows.

The search phase. In this phase of its life cycle, an organization is of course young and small, having been created in response to the pressure of social forces. Messinger (1955) noted that the organization is in ascendancy, when leaders and members in an organization identify that something needs to be done to transform social discontent into effective action. The rate of innovation is high, permitting policies or procedures to be quickly modified as personnel seek the proper approach to problems that first generated the organization's formation. Patients or their representatives are formally or informally included in the decision-making process, and their suggestions and criticisms are sought with genuine interest. The administrative structure of an agency at this phase is informal and open. The staff is growing, and there must be an opportunity for new members to be fully integrated. There is an egalitarian feeling between staff members, and policies are developed by sharing and pooling the perspectives and judgments of many.

In this phase the leadership element is crucial, but there is also a built-in dilemma. The leader in this stage must set a tone of flexibility and permissiveness if the organization is to make essential adjustments to its new environment. The agency also needs charismatic leadership, since public recognition can best be achieved at this early time by the personal visibility of the agency's chief official. Unfortunately, the qualities of charisma

and the qualities of participative leadership are not often found in the same individual. Another characteristic of the leadership element in this phase is that competence is usually more in subject matter rather than in administration. The small organization demands relatively little by way of management, and its resources flow in large measure toward its professional and patient service work. Another obstacle which must be surmounted before an organization can pass into the second or "success" phase has to do with organizational stress. There may be either too much or too little stress in an organization. If achievement comes so early that stress is low, March and Simon (1958) suggested that organizational apathy results. Under these circumstances the agency will not collapse, but its innovation and expansion will be slow. If aspiration remains well above achievement, stress will be too high and may result in frustration and burnout.

Whether an organization thrives depends largely on the degree of acceptance accorded it by the community. This is dependent in large part on the quality and appropriateness of the services rendered to patients. Maslow (1962) discussed the dilemma of the opposing pulls between growth and security as motivators. According to Maslow, when these pulls are equally balanced, security always dominates. Thus, a parallel issue may surface in which growth and change often lose out when an organization becomes concerned more about its survival than its impact.

The success phase. Starkweather and Kisch (1971) used the word "formalization" to describe the internal structural changes that occur in this phase. There is reduced dependence on the personal attributes of the founding leaders and an increase in more routine control. Jobs become specialized, and a hierarchy of authority and central administration develops, strengthening the management component. The staff's attention often becomes divided between immediate patient needs on the one hand and future-oriented requirements of securing the enterprise's financial base on the other. A satisfactory balance is usually achieved with enough administrative focus to avoid the risks to survival inherent in the search phase. There is still, however, enough client focus to foster the provision of needed services at adequate levels of quality.

This phase also includes a shift in the balance of the professional-administrative relationship in favor of increased administrative control. The desired personality specifications for the agency's leadership undergo change, and subject-matter specialists who led the organization in its early development are replaced by administrators with strong managerial skills. This change in the type of control seems inevitable even though one might wish that leadership patterns which encouraged both innovation and effective implementation could be preserved (Starkweather & Kisch, 1971).

The timing of the leadership transition is very important. It can come prematurely through overemphasis of the agency's need for

effective communication and command, thereby denying an organization innovative leadership at a time when it is still needed (Selznick, 1961). On the other hand, its occurrence can be excessively delayed, leaving the organization unprepared for the time when charismatic leadership eventually departs.

The change in character of leadership, sometimes arranged by design but frequently occurring ad hoc, largely dictates the future course of the organization and the rate of its advance into the much less productive phase that often follows the success phase. Few governing boards that make executive selections clearly see these implications. As a result the leadership in health service organizations frequently oscillates for a time between exclusively professional and strictly managerial types, with neither providing the combination of qualities the agency could ideally use. What does occur due to the shifting and reshifting of leadership is the expenditure of organizational energy. In this, a certain momentum and social force is lost that seldom is regained.

One final factor important to the success phase in the life cycle of organizations is the almost universal drive toward bigness. In many ways this interest is warranted, since the economic structure of society gives advantage to larger institutions. This advantage includes the most fundamental concept of a greater chance of "long-run" survival.

The bureaucratic phase. Blau and Scott (1962) noted that in general, as an organization becomes more complex in its internal

workings it also becomes increasingly differentiated from the larger social system. While the public may seem to suffer most by this development, the agency itself can be the ultimate loser. Changes in social forces that are not met by responsible adaptation on the agency's part lead to a lack of public interest in the agency's mission. Reduced public concern in turn eventually causes a diminution in the flow of public resources to the agency.

As the organization grows, its internal structure changes through the addition of staff necessary to assure adequate communication and coordination. Activities previously done informally and voluntarily are now done by a rising proportion of the total personnel complement given over to staff control functions. Such organizational maintenance work naturally drains energy from the agency's productive and creative capacity. Interestingly, at this point the more imaginative people begin to leave the organization. Also worth noting in this phase is that informal communications concerning patient needs often can no longer reach the higher levels, and no one lower in the organization is empowered to alter policy.

The succession phase. The impetus which triggers a large organization to spawn a new unit and thus start again the full organizational life cycle is in part a mystery, particularly as to time and detail; yet it also seems somewhat predictable. Frequently, a new unit will be established within the old organization to compete successfully for clients. Within health service organizations the transition appears to be caused more often

than not by the need for professionals within the organization to exercise more individual responsibility and identify new ways to serve patients (Starkweather & Kisch, 1971).

Thompson and McEwan (1961) noted that beneath the progression of organizations through the different life cycle phases there are some basic principles that perhaps set the limits or indirectly influence the course of events. One is the necessarily recurrent process of reappraising and evaluating program goals and of defining the desired relation between an organization and its environment. First, a change in either the organization or its environment demands reappraisal and probable alteration of organizational policies and goals. Second, leadership personnel well-suited to one stage are often ill-fitted to another. Third, mechanisms of review and self-evaluation are essential. To remain viable, hospice organizations must undertake such appraisals periodically if not continually to keep pace with this "inevitable change" life cycle theory. This researcher has adapted the life cycle theory to hospice programs by delineating stages of development in which hospice administrators in Michigan believe their program to be.

Competencies and Leadership Theory

In posing their theory on leadership behavior, Ross and Hendry (1957) listed the following main characteristics of a leader:

1. Empathy
2. Membership in the group
3. Consideration

4. Sergeancy (enthusiasm, expressiveness, alertness)
5. Emotional stability
6. Desire for and recognition of the leadership role
7. Intelligence
8. Competence
9. Consistency
10. Self-confidence
11. Ability to share the leadership role

What is the relationship between the characteristics listed above and competencies which an administrator should possess? The answer can be best stated by quoting Campbell, Corbally, and Ramseyer (1966):

> It becomes apparent that something more than possession of a prescribed set of traits characterizes the leader. This fact lets students of administration consider leadership behavior--the ways in which a leader or administrator (and we hope that these terms are synonymous) uses the traits and abilities he/she has. In turn, this has led to an emphasis on competencies rather than traits. A competency is related to the ability to do something; in the case of the administrator, it is the ability to behave in a way which research and our value criteria show is effective administration behavior. (p. 316)

Katz (1955) expanded the context of "way of behaving" to include technical, human, and conceptual skills. He defined a technical skill as the ability to have a proficiency in a special kind of activity, especially if it involves methods. Human skill was defined as the ability to work with others in a group or to build a cooperative team. Conceptual skill, according to Katz, is the ability to observe the enterprise as a whole. This researcher

blended all three definitions into the text of 201 competency statements in section II of the survey instrument.

Education plays its part in the development of competencies. Many times it is in high school that an individual becomes interested in a profession and a competency pattern starts to form. In an associate degree or undergraduate program, the competency pattern consists of accruing a conceptual knowledge base which might include: human growth and development, methods of teaching, group process, and many others. Experience is also important in developing technical skill patterns. The greater the variety of experiences to learn from, the more the administrator is able to develop his/her skills and knowledge base. Kovner and Neuhauser (1978) noted that experience is a tempering process that matures the administrator's judgment and provides it with the sort of dispositional control that produces consistency.

In reviewing literature on leadership theory, there seemed to be three broad classifications that overlap. They are: (a) the "great man" theory, (b) group function, and (c) situational function. The first theoretical construct is the "great man" theory of leadership, in which the leadership qualities are considered to be inherent in the individual. Borgatta, Bales, and Couch (1954) extended this theory to conclude that great men tend to make "great groups" in the sense that major factors of group performance and member satisfaction simultaneously increase.

The second theory of leadership concerns group functions. Leadership is defined as the performance of these functions in order

to achieve group goals. Cartwright and Zander (1953) made the following statement concerning this theory:

> Leadership consists of such acts by group members as those which aid in setting group goals, improving the quality of the interactions among members, moving the group toward its goals, building cohesiveness of the group or making resources available to the group. (p. 538)

The third theory of leadership emphasizes leadership as a situational function which contains four situation-specific elements:

1. The structure of interpersonal relations with the group.
2. Group characteristics.
3. Characteristics of the total culture in which the group exists and from which group members have been drawn.
4. Physical conditions and the tasks with which the group is confronted.

Ross and Hendry (1957) noted that the nature of any leadership pattern is determined by the social organization, the social climate within the organization, and the value system of that organization. The administrator does not have time to think of all the values to be matched in the decision-making process, yet there are controlling values of the particular environment which will shape administrative decisions and judgment (Kovner & Newhouser, 1978).

Dubrin (1984) noted that during the last two decades there has been a declining interest in understanding the traits, characteristics, and behaviors of leaders themselves. He suggested that substantial research has shown that leadership is best

understood when the leader, the followers, and the situation in which they are placed are analyzed. Nevertheless, the leader remains an important consideration in understanding leadership, and without effective leaders, most organizations cannot prosper.

Research On Competencies

From a review of literature it is evident that there has been considerable research concerning the competencies of knowledge, skills, values, interactions, and attitudes applied in various areas of administration, health-related professions, and educational curricula. Research done by McCleary (1973) outlined six steps for developing a program of competency-based administration. These steps are as follows:

1. Assess competency needs.
2. Specify competencies.
3. Determine competency components and performance levels.
4. Identify competency attainment.
5. Establish assessment of competency attainment.
6. Validate competencies, attainment procedures, and assessment system.

The procedures used in the McCleary study consisted of role-analysis methodology. First, an instrument was developed after the review of the literature on functions in leadership roles. Second, critical incidents were developed to reflect each function. Third, eight leaders were selected to be representative of the study population and interviews were conducted. Fourth, a panel of judges

reviewed a list of 46 activities, and an instrument was finalized and pilot-tested with a group of 10 career education persons. Finally, the instrument was revised and sent to 60 superintendents.

Competency Research in Health-Related Professions

In 1974-1975, the American Dietetic Association (ADA) conducted a role-delineation study for entry-level clinical dietetic personnel. This 15-month study was to delineate the actual and appropriate role functions, and requisite knowledge and skill statements (competencies). Competencies covering food service, clinical nutrition, and general skills were defined for the roles of communicator, facilitator, educator, manager, advocate, and professional. By consensus, skill and knowledge statements were formulated through group discussion (Baird, 1980). Products of the study included: (a) statements of major and specific performance responsibilities for each level of practice, (b) statements of requisite knowledge for each level of practice, and (c) a correlation of specific performance responsibilities with knowledge statements.

Another study by White (1980) researched essential, supplementary, and emerging competencies needed by occupational therapists (OTs). The study focused on defining competencies needed by OTs; validating the essential, supplementary and emerging competencies needed by OTs; and deriving an educational model for lifelong professional development. The questionnaire contained a list of 124 competency statements and a personal data section

containing 16 demographic variables. Findings of the study supported the conclusions of essential competencies at entry level for direct client service, occupational therapy theory, indirect client service, and OTs in the schools. White also found that the essential competencies did not represent technical changes in skills but reflected a response to social and political pressures.

Relative to hospice, Basiles (1982) collected data from a sample of 49 interdisciplinary team members from 6 hospices in the United States. Ten individuals represented a panel of experts in various fields of health care delivery, and 29 competencies related to the areas of emotional, interpersonal, and professional abilities were identified. The results of his study demonstrated that the panel of experts and the practitioners exhibited high positive intergroup agreement regarding the value of the competencies under study.

Richie (1984) conducted research on 68 hospice administrators to identify a list and ranking of the perceived top five administrative functions performed. He also generated a list and ranking of the perceived top five skills/competencies needed to carry out their identified role. To obtain a measure of the importance respondents placed on the functions (by ranking them from 1 = highest to 5 = lowest), average ranks were computed along with standard deviations. The data indicated that hospice administrators in an institutional setting were more likely to mention overall administration, patient care, and personnel work, whereas

independent administrators were more likely to mention personnel work, public relations, and fund raising. In both settings overall administrative functions and patient care ranked high (1.54, SD ±.28), but institutional hospice administrators placed higher value on leadership and coordinating activities, while independent hospice program administrators placed higher value on personnel work and fund raising. With regard to skills, institutional hospice administrators listed "ability to apply clinical nursing skills--particularly a knowledge of oncology--to patient care" as 1.9 (SD ±.75). The independent hospice administrators listed "ability to engage in general administrative activities, including problem solving, decision making, delegation of authority, planning, personnel administration, organization, and delivery of services" as 1.96 (SD ±1.02).

Competency Research in Educational Curricula

White (1980) noted that competency-based education is an approach having two primary characteristics: first, precise learning objectives defined behaviorally in assessable terms, and known to both the teacher and learner. Competencies are first identified as general goals, then stated as performance objectives which have a stated behavior to be changed, conditions for completing the learning effort, and a standard by which the learners' performance will be judged (Davis et al., 1974). The second characteristic is accountability. Each learner knows the learning expectation, accepts responsibility for doing the activity,

and expects to be held accountable for meeting the established conditions. Earlier, Elam (1978) had developed a list of essential elements of competency-based educational programs which included:

1. Competencies should be derived from the role of the practitioner, and should be specified in behavioral terms which are made public in advance.

2. Assessment criteria should be competency based and specify expected levels of mastery.

3. Assessment of learners should be based primarily on performance.

4. Learners' progress through the program should depend on demonstrated competency.

5. The instructional program should facilitate development and evaluation of competencies.

In a study focusing on competencies in adult education, Chamberlain (1960) asked 90 adult learners to list 45 statements of competencies in order of importance using the Q-sort technique. In the statement of findings, Chamberlain indicated that the respondents were sure of their ratings at the beginning and the end of the list but were uncertain of those ratings in the middle. For this reason he focused the greatest consideration in the analysis to the first 15 and last 15 statements. Q-sort methodology would not be appropriate to use in identifying hospice administrators' competencies because in this study, rank ordering of competencies was not applicable, and the competency items were too numerous to feasibly manage by Q-sort. Also this researcher wanted to ensure

that all items were equally considered rather than the first and last groups of items.

Competency-based professional education evolved in the area of home economics with the development of competencies at a national workshop in February 1974. As stated in their Competency-Based Professional Education in Home Economics publication (AHEA, 1974):

> Assessment of professional competence of the home economist is essential if systematic procedures are to be developed for determining effectiveness of home economics professional programs. Competency development must not end at the granting of the baccalaureate degree. The home economist needs continued professional growth. (p. 3)

Mokma (1975) completed a study of the assessment of the leadership role in emerging career education programs in Michigan. The literature review covered the analysis of roles for determining curriculum content using an approach called "function activities." Once these function activities were identified, the activities or tasks then served as a basis for identifying specific competencies i.e., skills, knowledge, and attitudes needed by personnel occupying the particular occupation. This approach has also been used in planning vocational education curricula.

Another study done by Howard (1978) used a three-phase methodology to identify and validate change agent competencies in education. Phase One consisted of a review of literature relative to change agent roles and duties, while Phase Two involved pilot testing the most important competencies that were relevant to the final investigation. Phase Three focused on validating those competencies through empirical testing of a 37-item list reviewed by

272 people. This researcher used a four-phase methodology modified to include the Delphi technique in the fourth phase.

In the area of social work education, Berkman (1985) noted that the number of social workers employed in health care in the United States has more than doubled since the early 1960s, with estimates of social workers now at approximately 45,000). With increasing numbers of health concentrations being developed in schools of social work, the challenge faced by social work faculties was to develop health curricula that integrated health-specific content with foundation content. There was clear agreement among faculty that the beginning social worker in health care required an understanding of the milieu of the system. To accomplish this, 13 knowledge base areas were identified with specific competencies in each area. The Massachusetts General Hospital Institute of Health Professions has implemented this program, aware that some of the content in the major areas must be continually reinforced at different levels of practice through continuing education. The perception was that this knowledge was <u>basic</u> for beginning social work practice in health care.

In the present study, the focus was on assessing competency needs, specifying competencies, and determining competency components in five broad competency sections for hospice administrators. It remains for future study to determine performance levels, competency-attainment criteria, and assessment

mechanisms as mentioned in the previous review of competency research.

Research Methodology

This section includes a review of survey methodology, the Delphi technique, advantages and disadvantages of the Delphi technique, and a review of studies using the Delphi technique.

Survey Methodology

Survey research has, as its primary focus, the goal of describing and predicting action, or explaining the relationship between two or more variables (Oppenheimer, 1973). Variables in survey research can be classified as sociological and psychological and are useful when researchers are interested in how sociological information such as demographic data relates to psychological variables such as opinions, attitudes, and behavior. Warwick and Lininger (1975) noted that the survey is an appropriate and useful means of gathering information under the following three conditions:

1. When the goals of research call for quantitative data.
2. When the information sought is reasonably specific and familiar to the respondents.
3. When the researcher has considerable prior knowledge of particular problems and the range of responses is likely to emerge.

According to Babbie (1983), survey research is probably the best method available to the social scientist interested in collecting data on a population too large to observe directly. The structural nature of the instrument also provides an opportunity to

collect comparable data from all respondents for use in quantitative analysis. It is also efficient and less costly than in-depth interviews, in which much time is spent talking to informants.

Further, Babbie (1973) noted that survey instruments are useful in secondary analysis by other researchers later on. The development of a survey instrument provides a mechanism for the re-examination of the original findings. In the case of this research, it provided an opportunity for listing identified competencies of hospice administrators which may lead to new programs of instruction in hospice administration. Babbie (1983) also noted that survey research is generally strong on reliability because of the standard instrument which eliminates unreliability in observations. To ensure reliability, he recommended several points. First, construct an instrument that asks relevant questions which the respondent is likely to be able to answer. Second, be clear on what is asked so the subject's own unreliability can be reduced. Third, incorporate specificity. Fourth, ask for the same information more than once by using the same or similar questions. Last, use rating measurements that have been proven reliable in previous research.

The rating mechanism used this survey was the Likert scale. It was selected because of its wide use as an attitude scale and for its dependability as a measuring instrument for quantifying research information (Ary et al., 1975). Research has indicated that as the number of positions in a rating scale increases, the usage of the neutral, uncertain, don't know option decreases (Matell & Jacoby,

1972). A five-level response was presented to the respondents in this study.

Strengths of survey research. There are strengths and weaknesses inherent in survey methodology. The strengths are that with the preplanned design of survey research, results are uniform and reliable, especially in comparison to the method of observation (Williamson et al., 1982). Survey research also enables flexible analysis of subjects and issues because many questions can be asked about a particular topic. Furthermore, the reliability of survey research measurement is high. Finally, the results of survey research can accurately describe the characteristics of a large population. Also, a large number of subjects can be surveyed cost efficiently through the use of the self-administered questionnaire.

Weakness of survey research. Babbie (1983) noted that because standardized questions are designed to be applicable to all subjects, superficial analysis may result because of the tendency of surveys to reveal a greater scope of information, as opposed to explaining in-depth relationships. Also since survey research must be restricted to questions respondents are likely to know, this may result in artificial findings since only self-reports are measured (Babbie, 1983). Williamson et al. (1982) noted that there is a question of accuracy concerning self-reports. A final weakness identified is that although they are flexible in one sense by the amount of information that can be obtained, surveys require that an initial study design remain unchanged and inflexible throughout the entire research.

The Delphi Technique

Rowland and Rowland (1984) noted that the Delphi technique is a simple and efficient method of assuring participatory decision making, policy setting, and planning. The review of literature presented here includes: (a) the history, purposes and philosophy of the Delphi Technique (hereafter referred to as Delphi); (b) the process of the Delphi, including modifications; (c) advantages of the Delphi; and (d) disadvantages of the Delphi.

This technique was developed over a decade ago at the Rand Corporation by Olaf Helmer as a way of predicting future events and was dubbed "Delphi" after the famous oracle of that ancient city. Helmer (1967) used the opinions of international experts to predict changes needed for the survival of man. In his research, he permitted the experts to revise their predictions on analysis of the future in three rounds. Helmer's method is based on an intermediary who obtains consensus from a panel of experts on the probability that future events will occur.

The process of the Delphi technique. The steps in the Delphi technique described by Helmer (1967) are summarized as follows:

1. Selecting a panel of experts.

2. Independent questioning of the experts.

3. Feeding information about the responses back to the respondents.

4. Inviting the respondents to revise their predictions.

Although Helmer suggested repeating the above process to a total of four rounds, Young (1977) found that in 49 dissertations she reviewed, 34 used three rounds and modifications to the Delphi technique included variations in selection of the panel of experts, format, number of rounds, and interval between rounds. Essentially, the Delphi technique uses a questionnaire to determine the views and attitudes of this panel of experts relative to the task before them and to delineate the areas of concern to the intermediary. Since the questionnaire is completed anonymously, a higher number of frank answers is likely, especially where identification of the opinion holder would result in reduced creativity, biased estimates, or constrained suggestions.

Usually the first round of questioning encourages the generation of new or additional problem statements, issues, or alternatives from the committee members. After sufficient discussion to insure that all participants understand what is being sought, each member receives a questionnaire. The participants are asked to respond to the questionnaire and to comment on the phrasing of the questions, and to add further questions/statements that they regard as significant. This is valuable in two respects. First, rephrasing, which is suggested, may translate the issues from a technical jargon to the normal vocabulary of the respondents, and second, the additional statements of the individuals involved are reflected.

Between each round of questionnaires the latest opinions of the panel members are analyzed, compiled, and pooled. This process of

recirculating the questionnaire for review is repeated until a consensus is reached. Chung and Ferris (1971) noted that the Delphi is an attempt to overcome influence of dominant personalities in face-to-face group interaction for decision making.

Selection of the panel of experts. Helmer and Rescher (1959) listed criteria for the use of experts in prediction, which included level of knowledge of the person about the topic. Characteristics of the panel of experts should also be matched to the nature and purposes of the Delphi study. Dalkey (1968) noted that each panelist must also be an expert in his/her own right in order to avoid creation of a situation in which someone's point of view is summarily accepted without question.

This study used the expertise of 78 current hospice administrators in Michigan whose backgrounds were heterogeneous relative to educational preparation and the type of hospice for which they were administratively responsible. Basically, they were experts on the administrative responsibilities for their own program.

With regard to panel size, Weatherman and Swenson (1974) reported that previous studies using the Delphi had panels under 50 members. By contrast, White (1980) started with a random sample of 842 panelists and a 37% return rate in round one and 301 panelists in round two with a 77% return rate. This researcher used an initial mailing to 78 hospice administrators in Michigan with an expected return rate of approximately 60%. It was anticipated that

this researcher's extensive visibility in the field of hospice care in Michigan would encourage the higher return rate.

Interval between rounds. Another procedural question is related to the length of time between rounds. Helmer (1966) used 2 months between rounds for an international study, but recommended that the time be shortened to facilitate a better response rate. Gazzola (1971) used 5 weeks for a four-round study. Young (1977) noted that it is advantageous to plan to prevent time delays. This researcher planned 1 month between rounds.

Advantages and disadvantages of the Delphi technique. The combination of the Delphi technique and survey methodology was expected to improve both validity and reliability of this study. Some notable characteristics and advantages of the Delphi procedure were: (a) by use of the questionnaires there was anonymity and excessive influence of dominant individuals was reduced, (b) controlled feedback by a sequence of rounds between which a summary of the previous round results was communicated to each panel member, and (c) intuitive insights of the panel of experts enhanced the internal validity of the survey instrument (Helmer, 1967).

The early studies dealing with social issues noted that it was less costly to conduct a Delphi study than to assembly the panel of experts together at one time. Weatherman and Swenson (1975) observed that Delphi was considered an interesting task by panel members attributing the interest to information feedback. Cyphert and Gant (1971) observed that the Delphi technique can be a useful

method to mold opinion and to collect it, while Welty (1973) found that the Delphi method resisted manipulation.

Disadvantages of the Delphi technique included the critical problem of acuity in predicting the future and the time spent in completing the series of rounds necessary for consensus. Malone (1973) stated that consensus may be contrived, while Womble (1974) described Delphi as a "conformity movement" and requested respect for those who differ.

Research using the Delphi technique. In 1973, the American Home Economics Association involved members in a Delphi study of "The Future of Home Economics," which provided the framework for discussion for the Eleventh Lake Placid Conference for Home Economics in 1974 (Lee, 1973).

Rhodes (1976) found the Delphi method successful in determining which competencies were essential for teachers in the community college system of Tennessee. Seventy-four experts were used, resulting in three rounds of input and group feedback. Regarding the competencies under scrutiny, the investigator concluded that statewide consensus had been attained and that the Delphi method gained convergent expert opinion.

Copeland (1977) used the Delphi to identify and gain a consensus on competencies for evaluating industrial arts student teachers. Three groups of industrial art educators were used, with a high rate of agreement between each group on the ranking of each competency listing.

The Delphi technique was also used in a study done by Young at Michigan State University in 1977 on the development of a family studies program at the college level. One purpose of that study was to contribute to the theory of the Delphi method by comparing panels that had hierarchical, heterogeneous, and homogeneous sections, within specialist and generalist groups. A 15-member advisory committee evaluated the objectives and pilot-tested the questionnaire completed by 104 persons in six Delphi panels. Round one contained 123 items derived from the review of literature. Panelists' suggestions were added in rounds two and three. The study used a four-point Likert-type scale. Statistics reported to panelists were median and inter-quartile range. Results of this study showed that the Delphi method was suitable for the development of a program in family studies at the college level. Convergence to consensus on objectives was complete by round two.

White (1980) used the Delphi technique to determine the essential, supplementary, and emerging competencies needed by occupational therapists. She used a three-phase methodology that included: (a) phase one--identifying a list of competencies from a literature review, (b) phase two--pilot-testing the competency inventory with five American Occupational Therapy Association Fellows, and (c) phase three--obtaining responses from Fellows of the American Occupational Therapy Association, curriculum directors of programs for occupational therapists and assistants, and a random sample of graduates within 5 years of graduation. Opinions were obtained in two rounds. Feedback from round one was given as means

and frequency of responses in each of the five intervals of a Likert-type scale. Findings from this study revealed that across all panelists the proportions of competencies reaching an Essential consensus were 60%, 0% Supplementary (indicating 0 supplementary competencies obtaining consensus), and 28% Emerging.

In 1983 Basiles used the Delphi technique to identify and evaluate selected competencies needed by hospice team members. Through a review of literature, he selected competencies and then used the Delphi technique and the Likert scale to have 10 panel experts review the 29 competencies. His final step was to cross-validate the experts' responses with 49 hospice practitioners. These practitioners rated the competencies only once. Each of the 29 competencies was reviewed separately to facilitate analysis and discussion of the data. Statistical analysis consisted of a $\underline{t}$-test for independent samples, analysis of variance, and a paired $\underline{t}$-test ($\underline{p} < .05$).

Although the Delphi is not widely used, this researcher believes the technique will be extremely beneficial in defining competencies for hospice administrators in Michigan because it allows and encourages participatory decision making. As Elam (1978) noted, competencies "should be derived from the role of the practitioner," and through this research the practitioners themselves had input in defining their own competencies.

Summary

This chapter presented a review of literature, which included an overview of hospice care, hospice administrative components, administrative theory, organizational life cycle theory, competency research, and research methodology, including a review of survey methodology and the Delphi technique. Chapter III presents a detailed discussion on research methodology specific to this study.

CHAPTER III

METHODOLOGY

The purpose of this study was to identify the competencies needed for hospice administrators in Michigan. This chapter includes descriptions of the design of the study, operational definitions, hypotheses, sample, techniques of data collection, and procedures for data analysis.

Design of the Study

The research design involved a four-phase methodology described below. It included: (a) the development of a research instrument designed to assess competencies of hospice administrators through Phases I, II, and III; and (b) empirically validating the competencies using the Delphi technique in Phase IV. The decision to use the Delphi technique was based in part on the review of literature and also this researcher's viewpoint that hospice administrators need to be actively involved in defining their professional competencies.

Phase I

The purpose of this phase was to generate items for the instrument by identifying potential competencies according to the functions of planning, organizing, directing, and controlling which

are needed by hospice administrators. This was accomplished by reviewing:

1. Literature related to administration, competency theory, and leadership theory. Rationale: to develop a base of administrative theory and identify general leadership competencies.

2. Social policy legislation at the state and federal level. Rationale: to identify specific competencies required from a statutory base at both the state and federal levels.

3. Hospice administrator job descriptions. Rationale: to review and identify administrative job requirements from various types of hospice programs in both urban and rural settings.

4. To identify each competency statement as it related to the human behavioral, human constructed, and natural environment. Rationale: to assure that an ecological framework continued to be evident in the development of the survey instrument.

Phase II

To verify the five potential competency areas generated from both the review of literature and hospice administrator job descriptions, this researcher also compared the proposed competency areas with a list of competency areas submitted by the former hospice administrator of Hospice of Southeastern Michigan (HSEM), the largest freestanding hospice in Michigan.

Also, as Hospice Coordinator for Michigan, this researcher had the opportunity to observe 30 licensed hospice programs in Michigan and 25 hospice Medicare certified programs and to consult with

numerous exempt hospices. According to these observations, the competency areas used in this research were believed to be relevant and appropriate for hospice programs in Michigan.

Phase III

Based on a combination of Phases I and II, a preliminary two-part survey instrument entitled the Hospice Administrators Inventory was pretested by four former hospice administrators in Michigan. They evaluated the instrument and offered suggestions which helped promote clarity and specificity. The rationale for using this pilot group of former hospice administrators was to avoid contaminating the study sample. These four individuals were representative of the various organizational types of hospice programs in the state. Based on their suggestions, appropriate revisions were made in the questionnaire before Phase IV was implemented.

Phase IV

This phase focused on empirically validating the competencies identified from the revised Hospice Administrators Inventory. The Delphi technique for obtaining opinions of a panel of experts was used. This study used the expertise of 78 current hospice administrators as the panel of experts. Since the inventory was a long one, only two rounds were used to survey panelists.

Operational Definitions

Several definitions relevant to this study are included in this section. They are defined in the context in which they are used in this dissertation.

Hospice: A centrally administered program of palliative and supportive services which provides physical, psychological, social and spiritual care for dying persons and their families. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers.

Hospice administrator: A person who is responsible to a governing body, either directly or through the governing body's chief executive officer, for the administrative operation of a hospice program.

Hospital-based hospice: An acute care hospital with staff and beds designated for the provision of care for the dying.

Freestanding hospice A facility with all beds and staff assigned to providing care to the dying patient. It is an independent economic entity governed by its own administrative staff and board.

Home-health-agency-based hospice: An agency which coordinates nursing and related health care services to patients in their homes and includes, as one of its services, a hospice program of care for patients and families.

Community-based hospice: A program which provides and coordinates hospice services in the home for the community. It is a separate and economically autonomous program.

Interdisciplinary team: A group consisting of a physician, nurse, social worker, clergy, volunteer, and members of related disciplines who interrelate in an effective working relationship enabling the provision of hospice services to patients and families.

Functions: The planning, organizing, directing, and controlling activities in which a hospital is involved.

Planning function: The most basic of administrative functions. It is fundamentally choosing a future course of action from alternatives. It gives direction to future program growth.

Organizing function: Involves how the hospice administrator groups, assigns, and coordinates activities to accomplish goals and objectives.

Directing function: Involves being able to motivate, communicate, teach, as well as delegate and supervise hospice staff.

Controlling function: The process of monitoring and evaluation.

Competencies: Skills, knowledge, and attitudes which are identified as necessary to function in a professional role (Klemp, 1979).

Essential competencies: Those competencies which hospice administrators in Michigan rate on the average higher than or equal to 4.0 on the Hospice Administrators Inventory II.

Supplementary competencies: Those competencies which hospice administrators in Michigan rate on the average higher than 2.5, but less than 4.0 on the Hospice Administrators Inventory II.

Delegation: To commit to one's agent or representative.

Delphi technique: A set of procedures to elicit and refine the opinion of a group of people (Weatherman & Swenson, 1974). A simple and efficient method of assuring participatory decision making.

Panel of experts: Persons invited to form a Delphi panel who have expertise in the field of hospice administration. In this study, the panel comprised all current hospice administrators in Michigan as of December 1986.

Consensus: A degree of within-group agreement where over 50% is considered achievement of consensus (Gazzola, 1971).

Convergence to consensus: A degree to which respondents reach agreement on a given item. Using the Leik formula for ordinal consensus, respondents' within-group consensus as accepted when equal to or higher than 75% (Leik, 1966).

Licensed hospice: A hospice program which complies with all the hospice rules as defined by Michigan hospice licensure requirements R325.13101-R325.13307.

Exempt hospice: A hospice program which complies with all of the following requirements: (a) provides services to not more than seven patients per month on a yearly average, (b) does not charge or receive any fees for goods or services provided, and (c) does not receive third party reimbursement for goods or services provided.

Hospice Medicare-certified program: A licensed program in Michigan which maintains compliance with the Hospice Medicare Conditions of Participation 418.50-418.98 (Medicare [HCFA] Federal register #48, p. 45309-10).

Education: Seven response choices were included in the statement, "Please check the highest educational level achieved: (a) High school diploma, (b) Associate degree in _____, (c) Diploma in nursing _____, (d) Bachelor's degree in _____, (e) Master's degree in _____, (f) Ph.D. in _____, or (g) Other _____." Open-ended responses allowed the researcher to evaluate more specifically the type of degree attained rather than just knowing if the administrator had a degree.

Present employment: For purposes of this study, present employment related to how long the administrator had been in his/her current position. Responses were solicited in years and months to the statement: "Please identify the number of years/months you have worked as a hospice administrator in the program you are currently directing." As hospice is a new program of care in Michigan, this researcher was interested in how long administrators had been directing their programs.

Prior employment history: Five response choices were included in the statement: "Please check the statement which most accurately reflects your employment status 1 year prior to your current employment: (a) working in a health related field other than hospice, (b) working in a nonhealth related field, (c) working in a hospice program but not in an administrative capacity, (d) working

in a hospice program in an administrative capacity, or (e) not working."

Administrative history: Three response choices were included in the statement: "Please indicate the total number of years you have worked as an administrator: (a) in hospice, (b) in a health related field, or (c) in a nonhealth related field." Respondents were also asked to specify in which fields they had administrative experience.

Role responsibilities: Two response choices were included in the statement: "Please check the statement which most accurately reflects your role responsibilities: (a) I am only responsible for administering the hospice program, or (b) I am responsible for administering the hospice program and additional role responsibilities." If respondents replied to the second choice they were then asked to delineate their additional role responsibilities.

Salary range: Eight response choices were included in the statement: "Please check your current salary range: (a) volunteer --unsalaried, (b) under $10,000 per year, (c) $10,000-$15,000 per year, (d) $15,000-$20,000 per year, (e) $20,000-$25,000 per year, (f) $25,000-$30,000 per year, (g) $30,000-$35,000 per year, or (h) over $35,000 per year." This range selection was based on the knowledge that hospice is both a relatively young movement in Michigan and uses many volunteer administrators (Olson, 1986).

Hourly employment status: Two response choices were included in the statement: "Please check your employment status: (a) full

time, or (b) part time." If respondents replied to the second choice they were then asked to specify the number of hours worked per week.

Hospice designation: Four response choices were included in the statement: "Please check the statement which currently reflects the status of your hospice program: (a) licensed as a hospice, (b) exempt from licensure, (c) hospice Medicare certified, or (d) other _____." This last open-ended response allowed the opportunity for hospice administrators to indicate additional program status.

Hospice location: Two response choices were included in the statement: "Please check the population most appropriate to your hospice service area: (a) pop. < 50,000, (b) pop. > 50,000 but < 100,000, (c) pop. > 100,000 but < 250,000, or (d) pop. > 250,000.

Patient/family ethic representation: Five response choices were included in the statement: "Please indicate the number of patient/families in your program for 1986: (a) Black, (b) White, (c) American Indian, (d) Asian, and (e) Hispanic.

Program forecast: Four response choices were included in the statement: "What do you anticipate the status of your hospice program to be one year from now: (a) licensed as a hospice, (b) exempt from licensure, (c) hospice Medicare certified, or (d) other _____." The last open-ended response allowed the opportunity for hospice administrators to indicate any additional program status. This researcher believed program forecast is an important predictor

of anticipated program growth as well as stability within the program's organizational life cycle.

Program development: Four response choices were included in the statement: "Please check the stage of development you believe your hospice program to be in currently: (a) stage one, (b) stage two, (c) stage three, or (d) stage four.

Stage one hospice: The hospice program is newly organized, developing policies and procedures, developing and filling staff positions, and perhaps is highly volunteer intensive.

Stage two hospice: The hospice is becoming more established in the community, referrals are increasing, staff positions are being added, and administration is formalizing.

Stage three hospice: Administration is becoming more complex with the addition of more staff. The hospice is adding additional services and the census is remaining high. For Michigan, it is highly unlikely that a hospice program would reach stage three without meeting state hospice licensure requirements.

Stage four hospice: There is a highly complex organizational structure. Expansion is occurring through satellite operations, and a large number of employees is needed to accommodate increased service areas.

Hospice administration education forecast: Two response choices were included in the statement: "Do you believe there is a need for a hospice administration educational curriculum: (a) yes, or (b) no." If the respondents replied "yes" they were asked to

complete two more questions relating to hospice educational programs.

Hospice educational areas: Six response choices were included in the statement: "Which educational areas do you feel would be most helpful to you: (a) Staffing and Personnel Management, (b) Patient and Family Relations, (c) Community/Public Relations, (d) Fiscal Management, (e) Quality Assurance, and (f) Other _____." Respondents were asked to specify the area if they indicated (f) Other _____.

Educational assistance: Six response choices were included in the statement: "Please check which method of educational assistance is most preferable to you: (a) seminars/workshops for Continuing Education Units (CEU) credits, (b) seminars/workshops without CEU credits, (c) college/university certification/degree program, (d) college/university lifelong education courses, (e) adult continuing education programs, or (f) other _____." Respondents were asked to specify other educational assistance if they indicated (f).

Hypotheses

The following research objectives were generated with hypotheses specific to Objectives 2, 3, 4, and 5.

Research Objective 1: To compile selective demographic and opinion data on hospice administrators in Michigan. Demographic data for hospice administrators in Michigan included: (a) mean age, (b) proportion of male to female administrators, (c) most frequent educational background, (d) mean number of years experience in

hospice administration, (e) most frequently identified prior employment history, (f) mean total years worked as an administrator, (g) most frequent current salary level, (h) most frequently identified hourly employment, and (i) most frequently identified role responsibility designation.

Demographic data relative to the hospice programs included: (a) most frequent hospice service area by population, (b) most frequently identified current hospice credentialing, (c) percentages of patient/family ethnic representations for hospice programs in 1986, and (d) the most frequently identified stage of hospice development.

Opinion data from the hospice administrators included: (a) what credentialing the hospice program would have 1 year from this survey, (b) if there is a need for an educational program in hospice administration, (c) the most frequently identified educational area need, and (d) the most preferred method of educational assistance.

Statistics used for Objective 1 were mean, median, SD, and frequency. Note that Objective 1 is descriptive in nature and therefore no hypotheses were generated.

Research Objective 2: To identify what functions current hospice administrators in Michigan are performing and/or delegating. The research questions were:

1. What are the competencies by functions (planning [P], organizing [O], directing [D], and controlling [C]) which hospice administrators in Michigan identify as Essential and Supplementary?

2. To what degree are these Essential and Supplementary competencies delegated for each of the major administrative survey sections (A-E) and all functions (P, O, D, and C)?

A supplementary hypothesis postulated for this research objective was:

Ho 1: There is no significant difference in the frequency of Essential and Supplementary competencies which are delegated.

Statistics used for Objective 2 were mean, SD, frequency, and chi-square.

Research Objective 3: To survey current hospice administrators in Michigan on their perception of Essential and Supplementary competencies which meet consensus under five administrative sections (A-E).

Ho 2: There will not be respondent convergence to consensus $\geq$ 75% on the Essential competencies (mean = $\geq$ 4).

Ho 3: There will not be respondent convergence to consensus $\geq$ 75% on the Supplementary competencies (mean = $\geq$ 2.5 < 4).

The statistic used for Objective 3 was the Leik formula.

Research Objective 4: To identify demographic factors which differentially affect the reported essentiality of competencies. The following hypotheses were tested:

Ho 4: There is no significant difference in the mean rating of competencies based on the respondent's age.

Ho 5: There is no significant difference in the mean rating of competencies based on the respondent's sex.

Ho 6: There is no significant difference in the mean rating of competencies based on the respondent's educational background.

Ho 7: There is no significant difference in the mean rating of competencies based on role responsibilities of the administrator.

Ho 8: There is no significant difference in the mean rating of competencies based on salaried or nonsalaried status.

Ho 9: There is no significant difference in the mean rating of competencies based on employment status.

Ho 10: There is no significant difference in the mean rating of competencies between administrators of licensed programs and administrators of exempt programs.

Ho 11: There is no significant difference in the mean rating of competencies for administrators with differing sizes of populations served by the hospice program.

Statistics used for Objective 4 were ANOVA, and Scheffe procedure (when applicable).

Research Objective 5: To identify how the reported essentiality and/or delegation of competencies varies with organizational life cycle stages. The research questions were:

1. What are the competencies within each area of administrative functions (P, O, D, and C) that are identified as Essential and Supplementary in each stage of program development by hospice administrators in Michigan?

2. Which of these Essential and Supplementary competencies within each of the major administrative sections (A-E) and each of

the functions (P, O, D, and C) are delegated in each stage of program development? The hypotheses were:

Ho 12: There are no significant differences in the mean ratings of competencies when compared across stage of hospice program development.

Ho 13: There is no significant difference in the mean ratings of the four administrative function areas (P, O, D, and C) based on program stage of development.

Ho 14: There is no significant difference in the frequency with which competencies are delegated based on program stage of development.

Statistics used for Objective 5 were mean, SD, frequency, chi-square, ANOVA, and the Scheffe procedure (when applicable).

Description of the Sample

The sample for this study included all current hospice administrators in Michigan, as of December 1986, when there were 78 hospice programs in Michigan. Of these, 48 were exempt from licensure, 30 were licensed, and 25 were hospice Medicare certified (Olson, 1987). Table 3.1 provides a summary of hospices by type and participation in hospice Medicare certification.

Table 3.1: Summary of Hospices by Type and Participation in Hospice Medicare Certification (N = 78)

Hospice Type	N	% of Total	No. Hospice Medicare Cert.
Home health agency based	10	13%	9
Community based (ind.)	60[a]	77	9
Freestanding	1	1	1
Hospital based	7	9	6

[a]Forty-eight programs (61%) were classified exempt from licensure.

It should be noted that because the total population was used rather than a sample, the association among variables as measured was precise, due to the fact that there was no chance that the association could be due to sampling error (Babbie, 1973).

Techniques of Data Collection

The Hospice Administrators Inventory (HAI) consisted of Sections I and II. HAI I contained 17 demographic variables, and HAI II contained 201 competency statements which were categorized by administrative section (A-E) and administrative functions (P, O, D, and C). Table 3.2 provides a numerical summary of items within each area.

Together, the HAI I and HAI II consisted of 218 variables in Round I. The survey form was 15 pages, one of which was informal.

Table 3.2: Numerical Summary of Survey Items Within Administrative Sections (A-E) and Functions (P, O, D, and C)

Administrative Area	Planning	Organizing	Directing	Controlling	Total
A: Staffing and personnel	12	9	12	18	51
B: Patient/family rel.	11	12	8	12	43
C: Community/public rel.	9	10	9	11	39
D: Fiscal management	9	7	8	8	32
E: Quality assurance	10	11	6	9	36
Total	51	49	43	58	201

In HAI II, a Likert rating scale of 5 to 1 was used with 5 = absolutely necessary, 4 = highly necessary, 3 = useful, 2 = uncertain, and 1 = nonnecessary. Respondents rated each competency statement using the Likert scale to answer the statement, "In administering my hospice program I:" Appendix B contains Round I and Round II of the Hospice Administrators Inventory. Table 3.3 outlines the schedule which was used for obtaining and analyzing the data.

Table 3.3: Schedule for Obtaining and Analyzing the Data

Action	Date
Pilot testing	April 1987
Round I mailed	May 13, 1987
Follow-up letters	May 29, 1987
Round I data analyzed	June 1987
Round II mailed	July 29, 1987
Follow-up letters mailed	August 4, 1987
Round II data analyzed	Aug.-Dec. 1987

Data Analysis

Because many of the variables of interest being measured were ordinal, the researcher used nonparametric procedures when evaluating single competencies and the delegation function. The assumption of nonparametric qualities was necessary since it was expected that responses would not be normally distributed. All competency items were generated on the assumption that some of the respondents would consider the competency statements Essential (i.e., 4 or 5 on the Likert scale). Thus, the skewed nature of the expected response rendered parametric assumptions nonvalid for some aspects of this study.

Parametric analysis was used in examining the four administrative functions (P, O, D, and C) and five major administrative sections (A-E) by using mean ratings of the competencies. Five-factor analysis verified that the administrative sections were very reliable.

Ordinal Consensus

To develop a measure of consensus requires that the dispersion of responses be measurable. In the ideal case, perfect consensus implies no dispersion, whereas little consensus implies that responses will be widely dispersed over available options. The dispersion measure itself is a percentage and thus has ordinal properties. The researcher used the following formula developed by Leik (1966) to define an appropriate measure of ordinal consensus.

$$D = \frac{2\,\Sigma(d - 1)}{m - 1}$$

Where D is a percentage, a measure of ordinal dispersion, it becomes a percentage of consensus when subtracted from 1 (total consensus). The cumulative frequency of responses is d, and m equals the number of options in the scale.

This measure is free of limitations due to sample size and number of choice options, as well as concerns about skewness, central tendency, and assumptions about intervals between choice options; yet it accurately reflects the degree to which choices are spread over the set of options available. Furthermore, because the measure is a sum divided by its maximum possible value, D is a percentage, hence a ratio scale variable. Convergence to consensus indicates the degree to which the respondents reach unanimity on a given item. It is a nonparametric measure of error variance. According to Leik, complete consensus would be 1.0 while zero consensus would be complete dispersion of responses. This researcher used the score of .75 or greater as the minimal acceptable degree of convergence for both Essential and Supplementary competencies.

The Delphi process included feeding information about the responses back to the respondents. For this reason, the mean of each item was given as feedback to the respondents in Round II since it was a statistical average of responses and easily understood by those reading the competency statements. Table 3.4 provides a summary of the statistical analysis procedures used for this study.

Table 3.4: Summary of Data Analysis

Purpose	Data Used	Statistics
1. Feedback to panelists	Round I	Mean
2. To determine Essential and Supplementary competencies	Round I	Mean, SD, frequency, chi-square
3. To determine convergence to consensus	Rounds I and II	Leik formula
4. To determine internal relationship of the administrative sections (A-E) and the functions (P,O,D,C)	Rounds I and II	Factor analysis
5. To determine mean rating differences according to demographic variables	Round I	ANOVA, Scheffe
6. To describe demographic variable responses	Round I	Mean, median, SD, frequency
7. To determine the relationship between sections (A-E), function areas (P,O,D,C), delegation, and stage of hospice development	Round I	Chi-square, ANOVA, Scheffe

Summary

Chapter III included a discussion of the study design using a four-phase methodology, operational definitions, hypotheses, description of the sample, techniques of data collection, and methods for data analysis. Chapter IV contains the findings from this study.

CHAPTER IV

ANALYSIS OF RESULTS

This chapter contains the results relevant to the research objectives outlined in Chapter III. The data consisted of responses from hospice administrators in Michigan who participated in this research study. A two-part survey instrument used for data collection contained 17 demographic and opinion questions in the Hospice Administrators Inventory I (HAI-I) and 201 competency statements in the Hospice Administrators Inventory II (HAI-II). Appendix A contains the final version of the instrument used in this study.

Response Rate--Round I and Round II

Table 4.1 contains a summary of the rate of response to each of the two rounds of survey.

Table 4.1: Summary of Survey Instruments Sent and Returned

	Sent	Returned	Used
Round I	78	51	51
Round II	78	49	45[a]

[a]Three surveys were received after the data analysis had been completed, and one uncompleted survey was returned.

Overall, there was a 65% return rate for Round I and a 63% return rate for Round II. It is important to note that Michigan hospices are required by law to be either licensed or found exempt from licensure. These two divisions were used in this study. Licensed hospice programs must meet state licensing standards. Exempt programs, on the other hand, do not have to meet such standards, although many of them may be preparing to do so. When statistically possible, comparison was made on these two groups. It was expected that significant differences in rating and delegation of competencies could result from this difference.

In Round I of this study, respondents included 90% (27 or 30) of the licensed programs, 50% (24 of 48) of the exempt programs, and 85.7% (18of 21) of the hospice Medicare certified programs.

Use of Round I and Round II Data

The Delphi technique was employed in two rounds. This technique encouraged participative decision making by allowing input and re-evaluation on the competency statements. Round I included demographic and opinion questions. Respondents were asked for any additional competency statements they thought might have been omitted in each of the five major competency areas. The Round I survey did not generate additional competency statements for Round II. As specified in the Delphi procedure, the mean score on each competency statement was provided in Round II for the respondents.

Because the items generated for this survey were all potentially important competencies, consensus was more likely

to occur on items that were at the high end of the scale (Essential), weakening parametric assumptions of interval and normal distribution. However, the possibility also existed that there could be consensus on items that were rated lower on the scale. In this study, it was the highest rated items that reached consensus, supporting the necessity for ordinal statistical analysis when possible.

The Leik formula was applied to each competency statement in Round I and Round II as a nonparametric measure of consistency of response from one respondent to the next. Thirty-six competency statements reached consensus at a level of $\geq$ 75% in Round I. One additional competency statement reached consensus at that same level in Round II. Those competency statements that met consensus in Round I were omitted from Round II in order for the rater to focus on the remaining items. This eliminated 36 items which were also the highest rated items. In their absence, the responses became more normally distributed.

Very little change was noted in the overall ratings of the remaining items, indicating that ratings of items in Round I were reliable in spite of the presence of the 36 consensus items. Round I was then used as the principal source of information for the most generally agreed on Essential and Supplementary competencies. Also, Round I contained the demographic data used for those analyses of demographically related hypotheses.

Summary of Findings

Results of the analyses of the five research objectives are discussed in the following sections.

Research Objective 1

To compile selective demographic and opinion data on hospice administrators in Michigan.

Overall demographic data summary. Table 4.2 summarizes the overall demographic characteristics of the respondents, which included age, sex, educational background, present employment, prior employment history, administrative history, role responsibilities, salary range, employment status, hospice location, patient/family ethnic representation, and hospice designation.

This survey revealed that, overall, Michigan hospice administrators were primarily female, middle-aged, and working full time, with additional role responsibilities other than just administration. Fifty-six percent (31) had a bachelor's degree or beyond in education, and 54% came from a health-related background at least 1 year before being hired as hospice administrator. It is important to note that Michigan hospice administrators overall had an average of 27 months of current experience in hospice administration, which was highly variable (SD $\pm$ 23.9 months). Salary was also variable. Thirty-six percent (18) of the administrators were either volunteers or earning under $10,000 per year, whereas another 20% (10) clustered around an income of $20,000 to $25,000 per year.

Table 4.2: Overall Demographic Data Summary

	Overall (51 of 78)	SD
1. AGE	44 years N = 50	(± 10.4)
2. SEX		
Female	88% (45)	
Male	12% (6)	
	N = 51	
3. EDUCATION		
High school diploma	2% (1)	
Associate degree	8% (4)	
Diploma in nursing	18% (9)	
Bachelor's degree	30% (15)	
Master's degree	26% (13)	
Doctoral degree	6% (3)	
Other	10% (5)	
	N = 50	
4. CURRENT HOSPICE ADMINISTRATOR EXPERIENCE: Total number of months worked as a hospice administrator.	27 months N = 49	(± 23.9)
5. PRIOR EMPLOYMENT: Employment 1 year prior to current employment.		
Health/not hospice	54% (27)	
Nonhealth	14% (7)	
Hospice/not administrator	12% (6)	
Hospice administrator	12% (6)	
Not working	8% (4)	
	N = 50	
6. TOTAL NUMBER OF YEARS IN ADMINISTRATION		
In hospice	2.3 years	(± 2.14)
In health related	3.2 years	(± 4.63)
In nonhealth	1.7 years	(± 5.94)
	N = 49	
7. ROLE RESPONSIBILITIES		
Only administrative	40% (20)	
Additional roles	60% (30)	
	N = 50	

Table 4.2: Continued

	Overall	SD
8. SALARY RANGE		
Volunteer	16% (8)	
Under $10,000	20% (10)	
$10,000-15,000	8% (4)	
$15,000-20,000	4% (2)	
$20,000-25,000	20% (10)	
$25,000-30,000	8% (4)	
$30,000-35,000	8% (4)	
Over $35,000	16% (8)	
	N = 50	
9. EMPLOYMENT STATUS		
Full time	60% (29)	
Part time	40% (19)	
	N = 48	
10. HOSPICE SERVICE AREA: The population most appropriate to the hospice's service area.		
Under 50,000	55% (28)	
50,000-100,000	19% (10)	
100,000-250,000	14% (7)	
Over 250,000	12% (6)	
	N = 51	
11. PATIENT/FAMILY ETHNIC REPRESENTATION, 1986 (incomplete data reported)		
Black	1.4%	
White	38.0%	
American Indian	.1%	
Asian	.1%	
Hispanic	.3%	
	N = 40	
12. HOSPICE DESIGNATION: Of 51 (65%) hospice programs in Michigan that responded:		
Licensed	27 (90% of a possible 30 programs)	
Exempt	24 (50% of a possible 48 programs)	
Hospice Medicare cert.	18 (72% of a possible 25 programs)	

Overall, the most frequently mentioned hospice program service area was less than 50,000 population. Also, according to this study, hospice programs served patients/families of primarily white ethnic origin. It should be noted that the data reported on patient/family ethnic representation were incomplete and therefore not considered by this researcher to be reliable for analysis.

Fifty-three percent (27) of the administrators who responded to the survey administered a licensed hospice program, while 47% (24) administered an exempt program. Sixty-seven percent (18) of the licensed programs were also hospice Medicare certified.

Overall opinion data summary. Table 4.3 summarizes the overall opinion data, which involved the following types of questions: (a) What did the hospice program anticipate its status to be 1 year from survey? (b) What stage of development was the hospice in? (c) Was there a need for hospice administration educational curricula? (d) Which educational areas would be most helpful to the administrator? and (e) What method of educational assistance was preferred?

Of those administrators who responded to the survey, 71% (35) anticipated their hospice program would become licensed, 29% (14) anticipated they would remain exempt, 49% (22) anticipated they would become hospice Medicare certified, and 10% (5) indicated their program would apply for JCAH accreditation for hospice care. For Michigan, the majority of hospice administrators (63%) believed their hospice to be in Stage II of program development. The significance of this finding for the data analysis is discussed further in Chapter V.

Table 4.3: Overall Opinion Data Summary

		Overall
13.	PROGRAM FORECAST IN 1 YEAR: What does the hospice program anticipate its status to be 1 year from survey:	
	Licensed	71% (35)
	Exempt	29% (14)
	Hospice Medicare cert.	49% (22)
	Other	14% (7)[a]
		N = 49
14.	PROGRAM DEVELOPMENT: Hospices indicated the stage of development they believed their hospice to be in.	
	Stage I	16% (8)
	Stage II	63% (32)
	Stage III	13% (7)
	Stage IV	8% (4)
		N = 51
15.	EDUCATIONAL FORECAST: Is there a need for hospice administration educational curricula?	
	Yes	88% (43)
	No	12% (6)
		N = 49
16.	EDUCATIONAL AREAS: Educational areas that would be most helpful.	
		Rank
	Quality assurance	1 79% (34)
	Staffing/personnel	2 74% (32)
	Fiscal	2 74% (32)
	Community/PR	4 58% (25)
	Patient/family	5 33% (14)
	Other	18% (8)
		N = 43
17.	EDUCATIONAL ASSISTANCE: What method of educational assistance is preferred?	
	Seminars/workshops for CEUs	59% (26)
	Seminars/workshops no CEUs	27% (12)
	College/univ. cert./degree	27% (12)
	College/univ. lifelong ed.	23% (10)
	Adult continuing ed.	25% (11)
		N = 44

[a]Five will be JCAH accredited for hospice care.

Overall, 88% (43) of the hospice administrators reported that there was a need for a distinct hospice administration educational curriculum and that the educational area of Quality Assurance would be most helpful to them. Fifty-nine percent (26) of the administrators who responded to the survey preferred to have educational assistance provided through seminars and workshops for continuing education units (CEUs).

Licensed/exempt demographic data summary. Table 4.4 summarizes the reported demographic data by licensed and exempt hospice programs. As noted previously, there were 27 administrators from licensed programs and 24 administrators from exempt programs who responded to the survey. When examined separately, no differences were found in age, sex, education, and current hospice administrative experience. However, administrators from exempt programs tended to have less health-related prior employment experience (44%) when compared with administrators from licensed programs (63%). Also, exempt programs had the highest percentage (22%) of administrators with nonhealth-related experience 1 year prior to employment.

Over half of both the exempt and licensed hospice program administrators had additional role responsibilities. The most significant difference in role responsibilities was for licensed programs in Stage II of development ($X^2 = 9.20$, $df = 3$, $p < .05$).

Table 4.4: Licensed and Exempt Programs Demographic Data Summary

	Licensed (27 of 30)	SD	Exempt (24 of 48)	SD
1. AGE	43 years N = 26	± 9.39	44 years N = 24	±11.61
2. SEX				
Female	93% (25)		83% (20)	
Male	7% (2)		17% (4)	
	N = 27		N = 24	
3. EDUCATION				
H.S. diploma	--		4% (1)	
Assoc. degree	4% (1)		12.5% (3)	
Dip./nursing	23% (6)		12.5% (3)	
Bach. degree	23% (6)		38% (9)	
Master's degree	31% (8)		21% (5)	
Doctoral degree	7% (2)		4% (1)	
Other	12% (3)		8% (2)	
	N = 26		N = 24	
4. CURRENT HOSPICE ADMINISTRATION EXPERIENCE: Total number of months worked as a hospice administrator.				
	29 mos.	(±28.5)	22 mos.	(±16.8)
	N = 26		N = 23	
5. PRIOR EMPLOYMENT: Employment 1 year prior to current employment.				
Health/not hosp.	63% (17)		44% (10)	
Nonhealth	7% (2)		22% (5)	
Hospice/not admin.	7% (2)		17% (4)	
Hospice admin.	19% (5)		4% (1)	
Not working	4% (1)		13% (3)	
	N = 27		N = 23	
6. TOTAL NUMBER OF YEARS IN ADMINISTRATION				
In hospice	2.8 years	(±2.35)	1.7 years	(±1.72)
In health rel.	4.4 years	(±5.35)	2.0 years	(±3.37)
In nonhealth	.7 years	(±1.59)	3.0 years	(±8.86)
	N = 27		N = 22	
7. ROLE RESPONSIBILITIES				
Only admin.	37% (10)		43% (10)	
Additional roles	63% ;(17)		57% ;(13)	
	N = 27		N = 23	

Table 4.4: Continued

	Licensed (27 of 30)	SD	Exempt (24 of 48)	SD
8. SALARY RANGE				
Volunteer	--		35% (8)	
Under $10,000	3.5% (1)		39% (9)	
$10,000-15,000	3.5% (1)		13% (3)	
$15,000-20,000	--		9% (2)	
$20,000-25,000	33% (9)		4% (1)	
$25,000-30,000	15% (4)		--	
$30,000-35,000	15% (4)		--	
Over $35,000	30% (8)		--	
	N = 27		N = 23	
9. EMPLOYMENT STATUS:				
Full time	89% (24)		24% ;(5)	
Part time	11% (3)		76% (16)	
10. HOSPICE SERVICE AREA: The population most appropriate to the hospice's service area.				
Under 50,000	33% (9)		79% (19)	
50,000-100,000	19% (5)		21% (5)	
100,000-250,000	26% (7)		--	
Over 250,000	22% (6)		--	
	N = 27		N = 24	
11. PATIENT/FAMILY ETHNIC REPRESENTATION, 1986 (incomplete data reported)				
Black	2.4%		.2%	
White	55.0%		23.0%	
Amer. Indian	.1%		--	
Asian	.2%		--	
Hispanic	.2%		.3%	
	N = 21		N = 19	
12. HOSPICE DESIGNATION: Of 51 (65%) hospice programs in Michigan which responded:				
Licensed = 27 (53%)				
Exempt = 24 (47%)				

Seventy-four percent (17) of the exempt administrators were either volunteers or receiving salaries under $10,000 per year. Ninety-three percent (25) of the licensed program administrators were receiving salaries equal to or above $20,000 to $25,000 per year.

Licensed/exempt opinion data summary. Table 4.5 summarizes the responses to the opinion items by licensed and exempt hospice programs. The responses to the program forecast revealed that 43% (10) of the exempt programs expected to move to licensure 1 year from survey, while 56% (13) expected to remain in the exempt status. Also, 77% (20) of the administrators of licensed programs expected their programs to apply for hospice Medicare certification.

A majority of both licensed and exempt program administrators saw their hospice programs in Stage II, and both groups endorsed a need for hospice administration educational curricula. Most striking was the 91% (21) endorsement by the exempt hospice program administrators.

Regarding educational areas, 82% (18) of administrators from licensed programs identified Quality Assurance and Fiscal Management as the highest educational needs, while 81% (17) of the administrators from exempt hospice programs identified Staffing and Personnel Management as the highest educational need. Both licensed and exempt program administrators preferred educational assistance in the form of seminars and workshops for CEUs.

Table 4.5: Licensed/Exempt Program Opinion Data Summary

	Licensed	Exempt
13. PROGRAM FORECAST IN 1 YEAR: What does the hospice program anticipate its status to be 1 year from survey:		
Licensed	--	43.0% (10)
Exempt	--	56.0% (13)
Hospice Medicare cert.	77% (20)	.9% (2)
Other	23% (6)	.4% (1)
	N = 26	N = 23
14. PROGRAM DEVELOPMENT: Hospices indicated the stage of development they believed their hospice to be in.		
Stage I	7% (2)	25% (6)
Stage II	52% (14)	75% (18)
Stage III	26% (7)	--
Stage IV	15% (4)	--
	N = 51	N = 24
15. EDUCATIONAL FORECAST: Is there a need for hospice administration educational curricula?		
Yes	85% (22)	91% (21)
No	15% (4)	9% (2)
	N = 49	N = 23
16. EDUCATIONAL AREAS: Educational areas that would be most helpful.	Rank	Rank
Staffing/personnel	1 56% (15)	1 81% (17)
Patient/family	5 26% (7)	5 33% (7)
Community/PR	4 44% (12)	4 62% (13)
Fiscal	1 82% (18)	2 67% (16)
Quality assurance	1 82% (18)	2 67% (16)
Other	22% (5)	14% (3)
	N = 43	N = 21
17. EDUCATIONAL ASSISTANCE: What method of educational assistance is preferred?		
Seminars/workshops for CEUs	69% (16)	48% (10)
Seminars/workshops no CEUs	30% (7)	24% (5)
College/univ. cert./degree	26% (6)	29% (6)
College/univ. lifelong ed.	26% (6)	19% (4)
Adult continuing ed.	35% (8)	14% (3)
	N = 23	N = 21

Research Objective 2

To identify what functions current hospice administrators in Michigan are performing and/or delegating.

Operational definitions. The following operational definitions are restated for review in the analysis of this objective.

Essential competencies are those competencies that hospice administrators in Michigan rated on the average higher than or equal to 4.0 on the Hospice Administrators Inventory II.

Supplemental competencies are those competencies that hospice administrators in Michigan rated on the average higher than 2.5 but less than 4.0 on the Hospice Administrators Inventory II.

1. What are the competencies by functions (Planning [P], Organizing [D], Directing [D], and Controlling [C]) which hospice administrators in Michigan identify as Essential and Supplementary?

Findings. Table 4.6 identifies the number and percentage of Essential and Supplementary competencies as they relate to the administrative functions (P, O, D, and C). Of the 201 variables, 100% overall were rated as either Essential or Supplementary. Sixty-six percent (132) were rated as Essential competencies, and 34% (69) were rated as Supplementary. Within all four functions (P, O, D, and C), more than half of these items were found to be Essential. The Planning function demonstrated the highest number of Essential competencies (75), whereas the Directing function had the least (53%).

Table 4.6: Ratings of Essential and Supplementary Competencies by Administrative Functions (P, O, D, C)

Function	Total Possible	Essential	% of Total	Supplementary	% of Total
Planning	51	38	75	13	25
Organizing	49	32	65	17	35
Directing	43	23	53	20	47
Controlling	58	39	67	19	33

2. To what degree are these Essential and Supplementary competencies delegated for each of the major administrative sections (A-E) and each of the administrative functions (P, O, D, C)?

Findings. Table 4.7 presents the percentage of competencies delegated across all administrative sections (A-e) and all functions (P, O, D, C). While not tested for statistical significance, Patient and Family Relations tended to have the highest percentage of Essential and Supplementary competencies that were delegated (45%), with Quality Assurance being the lowest (20). The Directing function overall was also most likely to be delegated.

Table 4.7: Percentage of Competency Delegation by Administrative Sections (A-E) and Functions (P, O, D, C)

Section	Planning	Organizing	Directing	Controlling	Ave. %
A: Staffing/personnel	.22	.34	.31	.22	.26
B: Patient/family	.29	.50	.60	.44	.45
C: Comm./public rel.	.16	.30	.31	.17	.23
D: Fiscal management	.31	.33	.34	.21	.30
E: Quality assurance	.20	.22	.31	.10	.20
Ave. %	.24	.33	.37	.22	

A supplementary hypothesis postulated for this research objective was:

Ho 1: There is no significant difference in the frequency of Essential and Supplementary competencies which are delegated.

Findings. Table 4.8 presents the findings from the chi-square analysis of the Essential and Supplementary competencies and the extent to which they were delegated. The analysis indicated that the Essential competencies were not as likely to be delegated as the Supplementary competencies. In this case the null hypothesis was not accepted. A complete listing of the Essential and Supplementary competencies for Sections A-E and the percentage for which each of the P, O, D, and C functions were delegated is presented in Appendix B.

Table 4.8: Chi-Square Analysis of the Delegation of Essential/ Supplementary Competencies

	Total Cases Observed	Expected	Mean % Delegated
Essential Competencies	1,883	2036.60	28
Supplementary Competencies	1,105	951.40	32

$X^2 = 36.38$, $df = 2$, $p < .001$

Research Objective 3

To survey current hospice administrators in Michigan on their perception of Essential and Supplementary competencies which meet consensus under five administrative sections (A-E).

Operational definition. The following operational definition is restated for purposes of review in the analysis of this objective: Convergence to consensus is the degree to which respondents reach agreement on a given item. Using the Leik formula for ordinal consensus, respondent within-group consensus was accepted when equal to or higher than 75%.

Findings. Thirty-six competency statements met consensus on Round I, and one competency statement met consensus on Round II. These were also the highest rated variables. Forty-six percent (17) of the consensus items fell within the Planning function. Clustering of the competencies occurred most heavily in the administrative section of Community/Public Relations (31%) and in Quality Assurance (36%). Table 4.9 provides a listing of consensus items by Sections A-E.

Ho 2: There will be no respondent convergence to consensus $\geq$ 75% on the Essential competencies (mean $\geq$ 4.0).

Findings. Table 4.10 summarizes the findings of variables that met consensus. All 37 competencies (100%) that met consensus ($\geq$ 75) also had a mean of $\leq$ 4.0. The lowest mean score of the competencies reaching consensus was 4.48. Therefore, the null hypothesis was not accepted.

Ho 3: There will be no respondent convergence to consensus $\geq$ 75% on the Supplementary competencies (mean $\geq$ 2.5 < 4.0).

Findings. Of the 69 competencies that were identified as Supplementary, none reached consensus. Therefore, the null hypothesis for Supplementary items was accepted.

Table 4.9: Competencies Reaching Consensus by Competency Sections

Section A: Staffing and Personnel Management
Apply effective communication skills.
Function as a liaison between the governing board and hospice staff.
Total = 2; Percentage of Section A = 4%
Section B: Patient and Family Relations
Develop confidentiality policies.
Develop bereavement policies.
Develop continuity of care policies and procedures.
Provide confidentiality for the patient/family.
Provide an ongoing bereavement program.
Communicate the hospice philosophy to the patient/family.
Total = 6; Percentage of Section B = 13%
Section C: Community/Public Relations
Plan hospice services which meet the needs of the community.
Plan strategies to increase community awareness/participation in hospice.
Plan strategies to increase physician awareness/participation in hospice.
Plan strategies to increase clergy awareness/participation in hospice.
Plan strategies to increase governing board awareness/participation in hospice.
Provide program status reports to the governing board.
Coordinate hospice care with other community health agencies/facilities.
Speak to interested groups about hospice.
Communicate the hospice philosophy to the community.
Communicate to the governing board about current hospice trends/issues.
Be accountable to the governing board for the hospice's day-to-day operations.
Maintain effective communication with community resource agencies.
Total = 12; Percentage of Section C = 31%
Section D: Fiscal Management
Develop a mechanism to account for gifts and donations to the hospice.
Provide for accurate accounting of gifts and donations to the hospice.
Monitor hospice expenditures.
Assure accurate accounting of gifts and donations.
Total = 4; Percentage of Section D = 12%
Section E: Quality Assurance
Understand quality assurance.
Plan for appropriate use of resources.
Plan a quality assurance reporting mechanism to the governing board.
Develop hospice standards of care.
Develop a plan for quality assurance.
Develop a program evaluation.
Plan an organizational design which reflects quality hospice care.
Provide competent staff.
Provide for evaluation of all services.
Communicate quality assurance issues to the governing board.
Assure competence of staff.
Monitor compliance with state hospice regulations.
Assure appropriate and efficient use of resources.
Total = 13; Percentage of Section E = 36%

Table 4.10: Leik Scores and Mean Ratings of All Items Reaching Consensus

Item No.	Variable	Leik	Mean
063	Provide confidentiality for the patient/family.	88.04	4.75
0111	Provide program status reports to the governing board.	87.50	4.74
P54	Develop confidentiality policies.	86.95	4.73
C131	Be accountable to the governing board for the hospice's day-to-day operations.	86.45	4.72
0176	Provide competent staff.	85.87	4.71
C45	Function as a liaison between the governing board and hospice staff.	83.33	4.66
D119	Communicate the hospice philosophy to the community.	83.33	4.66
C196	Assure competence of staff.	82.60	4.64
D122	Communicate to the governing board about current hospice trends/issues.	82.29	4.63
0177	Provide for evaluation of all services.	81.52	4.62
P100	Plan strategies to increase community awareness/ participation in hospice.	81.25	4.63
064	Provide an ongoing bereavement program.	81.11	4.61
C159	Monitor hospice expenditures.	79.78	4.58
P171	Develop hospice standards of care.	79.39	4.57
D116	Speak to interested groups about hospice.	79.16	4.57
P101	Plan strategies to increase physician awareness/ participation in hospice.	79.16	4.52
P55	Develop bereavement policies.	78.88	4.59
C162	Assure accurate accounting of gifts and donations.	78.40	4.56
C167	Plan for appropriate use of resources.	78.40	4.55
C197	Monitor compliance with state hospice regulations.	78.26	4.55
C199	Assure appropriate and efficient use of resources.	78.26	4.55
D33	Apply effective communication skills.	77.66	4.56
P168	Plan a quality assurance reporting mechanism to the governing board.	77.38	4.53
P96	Plan hospice services which meet the needs of the community.	77.08	4.53
0112	Coordinate hospice care with other community health agencies/facilities.	77.08	4.53
P172	Develop a plan for quality assurance.	76.66	4.52
P166	Understand quality assurance.	76.59	4.52
[a]D79	Communicate the hospice philosophy to the patient/family.	76.19	4.52
P57	Develop continuity of care policies and procedures.	76.08	4.53
P141	Develop a mechanism to account for gifts and donations to the hospice.	76.08	4.51
P187	Communicate quality assurance issues to the governing board.	76.08	4.51
P103	Plan strategies to increase governing board awareness/ participation in hospice.	76.04	4.51
P174	Plan an organizational design which reflects quality hospice care.	75.55	4.50
P102	Plan strategies to increase clergy awareness/participation in hospice.	75.00	4.51
C132	Maintain effective communication with community resource agencies.	75.00	4.48
0148	Provide for accurate accounting of gifts and donations to the hospice.	75.00	4.48
P173	Develop a program evaluation.	75.00	4.48

[a]Round II consensus item.

Research Objective 4

To identify demographic factors which differentially affect the reported essentiality of competencies.

Ho 4: There is no significant difference in the mean rating of competencies based on the respondent's age.

Findings. ANOVA by the variable age was not significant (F = .69, df = 4). The null hypothesis for age was accepted.

Ho 5: There is no significant difference in the mean rating of competencies based on the respondent's sex.

Findings. ANOVA by the variable sex was not significant (F = .56, df = 1). The null hypothesis for sex was accepted.

Ho 6: There is no significant difference in the mean rating of competencies based on the respondent's educational background.

Findings. ANOVA by the variable educational background was not significant (F = .92, df = 3). The null hypothesis for educational background was accepted.

Ho 7: There is no significant difference in the mean rating of competencies based on role responsibilities of the administrator.

Findings. ANOVA by the variable role responsibility was not significant (F = .08, df = 1). The null hypothesis for role responsibilities was accepted.

Ho 8: There is no significant difference in the mean rating of competencies based on salaried or nonsalaried status.

Findings. Table 4.11 presents the means and standard deviations of the competency items based on the reported salary level of the hospice administrator findings for salary. Significant differences (one-way ANOVA: F = 3.62, df = 4, $p < .01$) showed a trend for higher-paid administrators to rate competency items higher

as well. Further statistical analysis using the Scheffe procedure revealed no two groups were significantly different ($p < .05$). The null hypothesis for salary was not accepted.

Table 4.11: Overall Means and Standard Deviations for Rating of Competencies by Salary Grouping

Salary Level	N	Mean Competency Rating	SD
Volunteer	6	3.78	± .59
Under $10,000	10	3.73	± .66
$10,000-20,000	6	3.97	± .38
$20,000-25,000	10	4.24	± .54
Over $25,000	16	4.44	± .45

$F = 3.62$, $df = 4$, $p < .01$

Ho 9: There is no significant difference in the mean rating of competencies based on employment status.

Findings: Table 4.12 presents the results for full-time and part-time status. One-way ANOVA indicated that hospice administrators who were employed full time rated their competency statements significantly higher than did hospice administrators who were employed part time ($F = 8.48$, $df = 1$, $p < .01$). The null hypothesis was not accepted.

Ho 10: There is no significant difference in the mean rating of competencies between administrators of licensed programs and administrators of exempt programs.

Findings. Table 4.13 presents the results of the mean competency ratings for administrators of licensed and exempt programs.

ANOVA findings indicated that administrators of licensed hospice programs rated their competency statements significantly higher than did administrators of exempt hospice programs (F = 10.71, df = 1, $p < .01$). The null hypothesis for program status was not accepted.

Table 4.12: Means and Standard Deviations of Competency Ratings by Full/Part-Time Status

Employment Status	N	Mean Competency Rating	SD
Full time	29	4.31	± .49
Part time	18	3.85	± .56

F = 8.48, df = 1, $p < .01$

Table 4.13: Means and Standard Deviations of Competency Statements for Exempt and Licensed Program Administrators

Program Status	N	Mean Competency Rating	SD
Exempt	24	3.82	± .59
Licensed	27	4.33	± .48

F = 10.71, df = 1, $p < .01$

Ho 11: There is no significant difference in the mean rating of competencies for administrators with differing size of population served by the hospice program.

Findings. Table 4.14 presents the means and standard deviations of competency items based on size of population served by the hospice program. ANOVA findings indicated that as the

population service area increased, hospice administrators demonstrated a significant increase in their overall means of the competency statements ($F = 5.81$, $df = 3$, $p < .001$). Further statistical analysis using the Scheffe procedure indicated that Group 1 (under 50,000) and Group 3 (100,000-250,000) were significantly different ($p < .05$). The null hypothesis for population service area was not accepted.

Table 4.14: Means and Standard Deviations of Competency Items and Size of Population

Population Size	N	Mean Competency Rating	SD
Under 50,000	26	3.84	± .56
50,000-100,000	10	4.21	± .45
100,000-250,000	7	4.57	± .37
Over 250,000	6	4.53	± .48

$F = 5.81$, $df = 3$, $p < .001$

Research Objective 5

To identify how the reported essentiality and/or delegation of competencies varies with organizational life cycle stage.

1. What competencies within each area of administrative functions (P, O, D, C) are identified as Essential and Supplementary according to stage of program development by hospice administrators in Michigan?

Findings. Table 4.15 presents summary data of Essential and Supplementary competencies by stage of program development. Within

Table 4.15: Numerical and Percentage Summary of Essential and Supplementary Competencies by Program Stage of Development and Administrative Functions

Function	Stage I				Stage II				Stage III				Stage IV			
	Essen.		Supp.		Essen.		Supp.		Essen.		Supp.		Essen.		Supp.	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Planning	24	(47)	25	(49)[a]	36	(71)	15	(29)	45	(88)	6	(12)	49	(96)	2	(4)
Organizing	26	(53)	22	(45)[a]	33	(67)	16	(33)	46	(94)	3	(6)	47	(96)	2	(4)
Directing	22	(51)	20	(46)[a]	18	(42)	25	(58)	38	(88)	5	(12)	38	(88)	5	(12)
Controlling	28	(48)	28	(48)	39	(67)	19	(33)	47	(81)	10	(17)[a]	47	(81)	11	(19)
Total	100	(50)	95	(47)[a]	126	(63)	75	(37)	176	(87)	24	(12)	181	(90)	20	(10)

[a]Percentages do not total 100 across rows due to items that were not rated as either Essential or Supplementary.

the functions of Planning, Organizing, Directing, and Controlling, Essential competencies increased for hospice administrators, whereas Supplementary competencies decreased as the program stage increased. Statistical analysis of differences in the mean rating of competencies by program stage of development and the administrative functions are reported under Ho 12 and Ho 13.

2. Which of these Essential and Supplementary competencies are delegated for each of the major administrative sections (A-E) and each of the functions (Planning [P], Organizing [O], Directing [D], and Controlling [C]) by stage of program development?

Findings. Table 4.16 provides a summary of the percentage of competencies that were delegated for all sections (A-E) and all functions (P, O, D, C) by stage of program development. Delegation tended to increase as the program moved from Stage I to Stage IV. Overall, Patient and Family Relations (Section B) demonstrated the highest percentage of delegation across all stages of program development, while Quality Assurance (Section E) demonstrated the fewest delegated items. Tests of significance on delegation by program stage of development are shown in Table 4.19.

Essential and Supplementary competencies with the percentage each item was delegated were compiled for each life cycle stage.

> Ho 12: There are no significant differences in the mean ratings of competencies when compared across stage of hospice program development.

Findings. Table 4.17 summarizes the means and standard deviations of the ANOVA analysis for mean scores of competencies

Table 4.16: Summary of Percentage of Competencies Delegated, by Sections A-E and P, O, D, C.

Function	Stage I	Stage II	Stage III	Stage IV
Section A--Staffing and Personnel Management				
Planning	4%	22%	29%	41%
Organizing	8	36	47	47
Directing	16	33	27	54
Controlling	11	22	24	43
Sec. % Del.	10	27	30	43
Section B--Patient and Family Relations				
Planning	7	27	38	59
Organizing	15	48	77	79
Directing	23	60	75	100
Controlling	14	41	64	89
Sec. % Del.	14	43	63	80
Section C--Community/Public Relations				
Planning	2	18	23	13
Organizing	7	31	45	32
Directing	8	30	50	55
Controlling	7	17	18	20
Sec. % Del.	6	24	34	30
Section D--Fiscal Management				
Planning	18	32	31	41
Organizing	17	36	32	42
Directing	17	36	41	34
Controlling	7	21	34	15
Sec. % Del.	15	31	35	33
Section E--Quality Assurance				
Planning	1	23	18	37
Organizing	1	23	29	45
Directing	6	33	45	41
Controlling	0	12	9	16
Sec. % Del.	1	22	24	35

across program stage of development. Hospice administrators rated the competency statements significantly higher as the program increased in stage of development ($F = 3.11$, $df = 2$, $p < .05$). Further statistical analysis using the Scheffe procedure identified Groups I and III & IV as significantly different ($p < .05$). The null hypothesis for mean score of competencies compared with program stage of development was not accepted.

Table 4.17: Mean Competency Ratings and Standard Deviations Across Program Stage of Development

Stage of Development	N	Mean Competency Rating	SD
I	7	3.73	± .31
II	31	4.08	± .63
III & IV[a]	11	4.40	± .41

$F = 3.11$, $df = 2$, $p < .05$

[a]Stage III and Stage IV were collapsed to represent one group; thus $df = 2$.

Ho 13: There is no significant difference in the mean ratings of the four administrative function areas (P, O, D, C) based on program stage of development.

Findings. Table 4.18 summarizes the ANOVA findings of this hypothesis. The Planning, Organizing, and Directing functions were significantly different across hospice program stages of development ($p < .05$). The Scheffe procedure indicated that Groups I and III & IV were also significantly ($p < .05$) different in the Planning,

Organizing, and Directing functions. The Controlling function was not significant across program stage of development (F = 1.59, df = 2), nor did the Scheffe procedure identify significantly different groups within the Controlling function. The null hypothesis was not accepted for the Planning, Organizing, and Directing functions; however, the null hypothesis was accepted for the Controlling function.

Table 4.18: ANOVA of Program Stage of Development by Administrative Functions

Function	Means by Program Stages I (N = 8)	II (N = 32)	III & IV (N = 11)	Overall Mean	F-Value
Planning	3.68	4.17	4.44	4.16	4.27*
Organizing	3.73	4.09	4.48	4.13	3.75*
Directing	3.62	3.96	4.40	4.01	3.30*
Controlling	3.80	4.09	4.32	4.10	1.59

*Significant at the .05 level.

Ho 14: There are no significant differences in the frequency with which competencies are delegated based on program stage of development.

Findings. Table 4.19 presents the findings of the chi-square analysis of frequency of competencies that were delegated by stage of program development. Delegation significantly increased as the program advanced in stage of development (X^2 = 311.13, df = 2, p < .001). The null hypothesis was not accepted.

Table 4.19: Chi-Square Analysis of Delegation and Program Stage of Development.

Stage of Development	Cases Observed	Expected	X^2	df	p
I	158	468.71	311.13	2	<.001
II	1,927	1874.82			
III & IV[a]	903	644.47			

[a]Stages III and IV were collapsed for this analysis; thus df = 2.

Summary

This chapter included the findings related to each research question. The next chapter presents the overall summary of the study, discussion and conclusions by research objectives, followed by implications and recommendations.

CHAPTER V

SUMMARY, DISCUSSION, IMPLICATIONS, CONTRIBUTION TO HOSPICE ADMINISTRATION, LIMITATIONS OF THE STUDY, AND RECOMMENDATIONS

This chapter presents the overall summary of the study, a discussion of the findings, the implications of the findings, the contribution this study has made to hospice administration, the limitations of the study, and the recommendations.

Summary

Hospice programs are a relatively new phenomenon in American health care. Their philosophical emphasis on "care" rather than "cure" has frequently come from grass-root sources outside of traditional medical settings. As the programs increase in number and mature, it becomes necessary to identify the administrative competencies which are essential for the continued viability of these programs. This study explored the perceived competencies rated as Essential and Supplementary by Michigan hospice administrators in the late 1980s. The purpose for such identification was to determine not only the need for administrative hospice education programs but also to formalize general educational content areas. At present such educational programs are not likely to exist based on a competency model.

The purpose of this study was to examine hospice administrators' perceptions of Essential and Supplementary competencies for hospice administrators in Michigan. The following objectives were identified as a result of the intent of the study:

1. To compile selective demographic and opinion data on hospice administrators in Michigan.

2. To identify what functions current hospice administrators in Michigan indicate they are performing and/or delegating.

3. To survey current hospice administrators in Michigan on their perception of Essential and Supplementary competencies which meet consensus under five administrative categories.

4. To identify demographic factors which differentially affect the reported essentiality of competencies.

5. To identify how organizational life cycle stages influence and differentially affect the reported essentiality and/or delegation of competencies for hospice administrators.

A four-phase methodology was used to accomplish these objectives and to answer the research questions. Phase I consisted of generating items for the instrument using state and federal social policy legislation, hospice administrators' job descriptions, and literature related to administration, competency theory, and leadership theory.

Phase II involved grouping the competencies into relevant areas and delineating them according to the administrative functions of planning, organizing, directing, and controlling for a survey instrument entitled the Hospice Administrators Inventory. Part I of

this instrument contained 17 demographic and opinion questions, while Part II contained 201 competency statements.

Phase III involved pilot testing the Inventory by four former Michigan hospice administrators representing the various hospice organizational program types. Revision of the Inventory followed to prepare it for dissemination in Phase IV.

Phase IV used the Delphi technique in a two-round survey process of 78 hospice administrators in Michigan. Round I collected the demographic and opinion data in Part I of the Inventory in addition to the responses on the competency statements in Part II. Round II provided feedback with the mean score of each competency statement and asked the administrators to again rate the competency statements excluding those which reached consensus in the first round. Of 78 administrators surveyed, 51 (65%) responded to Round I and 49 (63%) responded to Round II. Hospices in Michigan are required by law to be either licensed or found exempt from licensure. This study involved responses from 27 (90%) of the licensed programs of which 18 (72%) were also hospice Medicare certified. Twenty four (50%) of the administrators who responded were from exempt hospice programs.

For Michigan, it was important to consider the cross-section of responses by licensed or exempt status and the organizational stage of development because programmatic operations vary with program size, complexity, and accountability. Exempt programs tend to be "grass roots" programs which are highly volunteer intensive and are

not required to meet statutory requirements for the type and quality of hospice care they provide. These programs are considered to be Stage I or Stage II hospices in terms of organizational life cycle development. However, licensed programs are guided by state (and perhaps federal) requirements for the type and quality of hospice care delivered. These programs are considered Stage II or beyond in their stage of organizational development.

Generally, programs in Stage I are small and volunteer intensive. As they progress through the stages, they are likely to become complex, with increasing numbers of salaried employees, regulated by state and/or federal guidelines and enmeshed in third-party reimbursement for services rendered. Such factors may profoundly affect responses to what items might be considered as Essential or Supplementary as well as which items are delegated.

Respondents of licensed programs carried a higher overall return rate. Two factors may have affected the return. First, by nature of this researcher's employment, each licensed hospice had been personally visited for licensure and/or hospice Medicare survey. Second, within these programs there seemed to be keen interest for program evaluation and assessment of job function.

The number of administrators from exempt programs did represent at least 50% of their programs overall. As noted on one returned survey instrument which was not complete, the exempt hospice program administrators might have been discouraged by the lengthy survey instrument requiring two rounds of involvement as well as by the

content of the survey, which may have seemed too sophisticated for their "grass roots" program.

The time for completing both rounds was 4 months with 2 months passing from the first round to the second. Follow-up letters were mailed approximately 2 weeks after the initial mailings for both rounds.

Data analysis focused on four research questions and 14 hypotheses using parametric and nonparametric testing. Since the nature of the scaling for competency items did not adhere to parametric assumptions, the Leik formula was incorporated in this study to measure ordinal consensus among the respondents on their responses to the items. Thirty-seven competency statements, which clustered around community and public relations and quality assurance, reached consensus. These items were also the highest rated.

Discussion

A discussion of the findings for each of the five research objectives follows.

Research Objective 1

To compile selective demographic and opinion data on hospice administrators in Michigan.

This was the first study to compile demographic and opinion information on hospice administrators in Michigan. It revealed that hospice administrators in Michigan are primarily female, middle aged, and working full time with additional role responsibilities

other than administration. These additional role responsibility findings are important when viewed from the organizational stage of development. Most hospices surveyed were in Stage II. This means that additional salaried staff most likely have been added but not to the extent that it totally frees up the administrator to focus primarily on directing the program. Consequently, more and more energy is required to meet the multi-faceted program responsibilities at a time when patient census is also increasing.

One question which was not answered by this research was: Are additional role responsibilities related to such factors as job stress, resignations, difficulties and/or the ease with which administrators are able to delegate?

Current hospice administrative experience was highly variable with an overall average of 27 months (SD $\pm$ 23.9). This implies very high turnover for some programs and relative stability for others. One could ask why so many hospice administrators have not been in their jobs longer. The researcher posits that this may relate to the finding that the majority of hospice programs have been identified as Stage II in their development. It is usually during the transition from Stage I to Stage II that an administrative change occurs (Olson, 1988). Leadership suited for the first stage may be ill-suited for another. Also one must consider the possibility that administrators who responded to the survey were from very newly organized hospice programs. What can be done to assist Michigan hospice administrators to develop their competencies in order that they might stay in their administrative positions

longer? This will be more fully explored in the discussion of Research Objective 5.

Another finding was that 27 (54%) of the respondents had prior health (but not hospice) experience. This indicates that not only are administrators learning administrative skills specific to hospice, but they may also be learning the hospice philosophy as well. Overall, only six (12%) were working in the hospice setting (but not in administration) 1 year prior to their current employment. Again, the hospice movement is relatively young, but a concern of this researcher is that hospice administrators are typically not coming from within the ranks of hospice. Why? Is this a trend? Is it increasing? Could it be that this is just the outcome of not having any programs which specifically train professionals in hospice administration? Since the hospice philosophy in many ways is the opposite of the one found in traditional health care settings (e.g., emphasis on "care" over "cure," person-oriented rather than institutional, holistic rather than segmented) the numbers of administrators whose principal background is traditional health care poses major concerns. How do they make the transition? Does their traditional administrative focus override the hospice philosophy? Are the competencies they identify as important truly related to hospice, or do they reflect the competencies necessary to blend hospice programs into mainstream health care?

Additional questions which cannot be answered from this research are: Has hospice opened up a new employment opportunity for health care administrators in general? Do governing boards tend to equate previous health care administration or perhaps no health administration experience as sufficient for hospice administration? How will this affect hospice administration in the future?

Overall, only 36% of the respondents earned an income of over $25,000 per year. These findings can be compared with a National Hospice Organization Hospice Personnel Compensation Study, which revealed that the mean salary for hospice administrators across the nation was $25,700 (NHO, 1987). In Michigan, salaries have tended to be variable and lower perhaps because there have been no data on what administrators have been paid, program stage of development, and hospice location. In Michigan, 28 (55%) of the hospice programs have a service area of less than 50,000.

Program forecasts of status 1 year from this survey indicated that only eight of the exempt programs that responded to the survey expected hospice licensure, four programs expected hospice Medicare certification, and five programs expected JCAH accreditation. This would indicate some conservative shifts for the exempt programs in the forthcoming year and takes into consideration that hospice licensure is still a relatively new option in Michigan. It also takes considerable time and effort to groom a program for regulatory survey.

Finally, although incomplete data were reported, hospice programs in this study tended to care for primarily white

patients/families. This supports (not favorably) the observation that hospice currently tends to be a white/middle-class phenomenon. It has been noted that some minority groups which have strong family and religious ties may be providing hospice-like care for themselves and not perceive a need for hospice. Many others who are in low socioeconomic categories may not have access to the health care system in general, much less hospice. More specific ethnic studies are needed for hospice at both the state and national levels.

Research Objective 2

> To identify what functions current hospice administrators in Michigan are performing and/or delegating.

This study found that hospice administrators in Michigan identified 132 Essential competencies and 69 Supplementary competencies. Of all the questions devised for this study, every one had a mean score of higher than 2.5. This finding can be explained in several ways. First, the respondents could have had a strong response bias toward rating everything as important. A second possibility provides validation of the investigator's process of generating competency statements that were applicable. To determine which of these two factors is most likely, "foil" items would have to be included in a future study. For the purpose of this study, it was assumed that the differences between ratings of Essential and Supplementary items represented both reliable and valid findings.

Of the five administrative sections (staffing and personnel management, patient and family relations, community/public relations, fiscal management, and quality assurance), 81% of the items within quality assurance were considered Essential. Quality assurance represents an evaluation of the quality of the hospice program and how well services are provided. When examined by organizational stage of development, the number of Essential items remained high because a prime factor in remaining a viable hospice program is the quality of services provided. These findings also demonstrated that administrators in Michigan placed high value on the administrative area of quality assurance across all stages.

The lowest number of Essential competencies overall within sections occurred in staffing and personnel management (47%). However, a progressive increase occurred in Essential competencies for this area as programs advanced in stage of organizational development.

Within the functions of planning, organizing, directing, and controlling, the planning function contained 38 (75%) of the Essential competencies while the directing function had the lowest number identified as Essential (23). These findings seem reasonable when one considers that planning is a critical administrative function while directing involves a high degree of delegation of tasks.

The respondents' ratings also indicated that the Essential competencies were less often delegated than were the Supplementary ones. Overall, the administrative area of patient and family

relations carried the highest delegation (45%), followed by fiscal (30%), staffing and personnel (26%), community and public relations (23%), and finally quality assurance (20%). The highest delegated function was directing (60%) in the area of patient and family relations. As stated in the above paragraph, the directing function had the lowest identified Essential competencies but now was also the highest delegated.

Of all areas, competencies in patient and family relations were most likely to be delegated by the hospice administrator. This area in particular requires a high degree of tracking and involvement (e.g., assuring 24-hour on-call availability of all services provided and attending to patient/family crises). Consequently, if the administrator was absorbed in trying to manage patient and family relations, there would be no time to attend to other administrative areas. Hospice administrators who have additional role responsibilities for patient care often find it very difficult to abdicate that additional role (Olson, 1988).

The function to be delegated the least was controlling (10%) in the area of quality assurance. One could conclude again that as quality assurance had the highest percentage of Essential competencies, these would not be delegated as frequently. Also, the administrator must assume final responsibility for the day-to-day quality of care being provided. Consequently, it seems plausible that controlling would be more cautiously delegated than perhaps the other functions.

Research Objective 3

To survey current hospice administrators in Michigan on their perception of Essential and Supplementary competencies which meet consensus under five administrative categories (Sections A-E).

Thirty-six competency statements met convergence of $\geq$ 75% on Round I, and one competency statement met convergence on Round II. These competencies were also the highest rated and therefore considered Essential.

Highest clustering of these Essential and reliable items occurred in the areas of community/public relations (12 [32%]) and quality assurance (13 [35%]). In the area of community/public relations, hospice administrators agreed that planning strategies to increase community awareness for hospice was important as well as their ability to communicate. They agreed that they needed to communicate with the community, with the hospice governing board, and with other community resource agencies. Responsiveness to what this researcher refers to as the "adaptation press"[1] from the community involves, to a large extent, free-flow communication to assess the community needs. The hospice program's success depends on it. Nonresponsiveness by the hospice program to this "adaptation press" results in decreased interest in and concern for the hospice program and reduced availability of resources (Olson, 1988).

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[1]Adaptation press: the demands of an environment exerted upon a system to encourage and/or force adaptation.

In the area of quality assurance, hospice administrators in Michigan agreed that knowledge of quality assurance was Essential as well as developing standards of hospice care, providing and assuring competent staff, evaluating all services, and planning and assuring appropriate and efficient use of resources. Again, viability of any health care program in the 1980s depends on systems of accountability.

The lowest area of important and consensus items was staffing and personnel management (4%). This researcher posits that stages of hospice development with varying personnel needs and issues could perhaps account for the low number of items which reached consensus. Hypothetically, staffing needs in a Stage I hospice caring for an average of five patients a month is considerably different from those in a Stage IV hospice caring for 30 patients on any given day of the month. Stage I hospices may not even have personnel policies or written job descriptions, whereas Stage IV hospices may be staffing more than one hospice location.

Research Objective 4

To identify demographic factors which differentially affect the reported essentiality of competencies.

Statistical analysis of demographic factors which differentially affected the reported essentiality of the mean of the competencies was significant ($p < .01$) with regard to salary/nonsalaried status, full-time/part-time status, licensed versus licensure-exempt programs, and population service areas. It was not significant for sex, education, or age.

From this study, hospice administrators who earned higher salaries, worked full time, administered licensed programs, and whose programs served increasingly larger service areas tended to rate all competencies higher in degree of importance. It is important to note that these factors correlate highly with increased program stage of development as well. Independent of this study, the researcher has observed the following sequence of events: the hospice program grows, the administrator becomes a full-time employee, he/she earns a higher salary, and the hospice program becomes licensed and eventually serves a wider population as staffing capacities increase.

Research Objective 5

To identify how the reported essentiality and/or delegation of competencies varies with organizational life cycle stages.

Hospices have been observed to be evolving through their own organizational life cycle. The investigator suggested four stages of organizational development for hospices with indicators within each stage, which include: motivation, leadership style, and community involvement (Olson, 1988). Life cycle stages of development was a theoretical construct applied and adapted to hospice programs by this researcher based on her observations of hospice programs through her work and on organizational theory. Thirty-two (63%) of the hospice programs in this study identified themselves as being in Stage II of development. There are several concerns related to this finding.

First, the proposed life cycle model may or may not be helpful in self-reporting of programs in different life cycle stages. Self-reporting may need to be compared to an external assessment of the program as well. Based on this investigator's position at the time of the study as State Hospice Coordinator for Michigan, such a large proportion of programs identifying themselves as being in Stage II seems accurate. Most programs in Michigan are relatively new and have been licensed within the past 3 years. In this instance, self-reporting seemed reliable.

Second, assuming that self-reporting of program stage of development is accurate, then the general results of this study are overrepresented by programs in Stage II of development. Several factors may contribute to this. For instance, it may be that of all the programs in Michigan, the ones which responded were likely to be in Stage II. This might be because programs in Stage II were more likely to have direct contact with this investigator as licensing surveyor. Given that over 90% of the licensed programs responded, person-to-person contact by this investigator with Stage II, III, and IV hospices may have been a factor in their response. Also, Stage II programs may be overrepresented because of heightened awareness of the need to assess competencies as a result of regulatory surveys on their programs.

Third, it is likely that, since the largest proportion of nonrespondents from the total population were exempt programs, Stage I was the most underrepresented of the stages in this study. Finally, because of the relatively limited number of programs

identified as Stage III and IV (for purposes of statistical analysis), these two stages were often combined. The findings may not accurately represent the range of competencies and degree of delegation which takes place. Future studies may need to take place at a time when a greater proportion of Stage III and IV hospice programs are available.

Figure 5.1 indicates that as hospices increased in stage of development, the percentage of Essential competencies increased while the Supplementary competencies decreased. What may have happened in this study is that many items were rated lower in early program stage of development because the issues relating to the competency had yet to be encountered. To examine the stability of these findings, it would be useful to repeat this study in approximately 5 years. Would the same competencies emerge as Essential by stage of program development? Would hospices in Michigan be more evenly distributed across the stages of development?

As total item pool for Essential competencies increased, this finding suggests that the administrative role increases in complexity as the program progresses in development. Thus, more mature programs require more complex administrative competencies.

This increasing shift in Essential competencies can also be examined in terms of potential educational needs. Table 5.1 identifies the educational needs of hospice administrators in

Table 5.1: Rank Ordering of Administrative Educational Needs by Program Stage of Development

Rank	Stage I	Rank	Stage II	Rank	Stage III/IV
1	Staffing/personnel mgt.	1	Quality assurance	1	Staffing/personnel mgt.
1	Patient and family	2	Fiscal management	2	Quality assurance
1	Community/public rel.	3	Staffing/personnel mgt.	2	Fiscal management
2	Fiscal management	4	Community/public rel.	3	Community/public rel.
2	Quality assurance	5	Patient and family	4	Patient and family

Michigan by program stage of development. Stages III and IV were collapsed because of the small number represented.

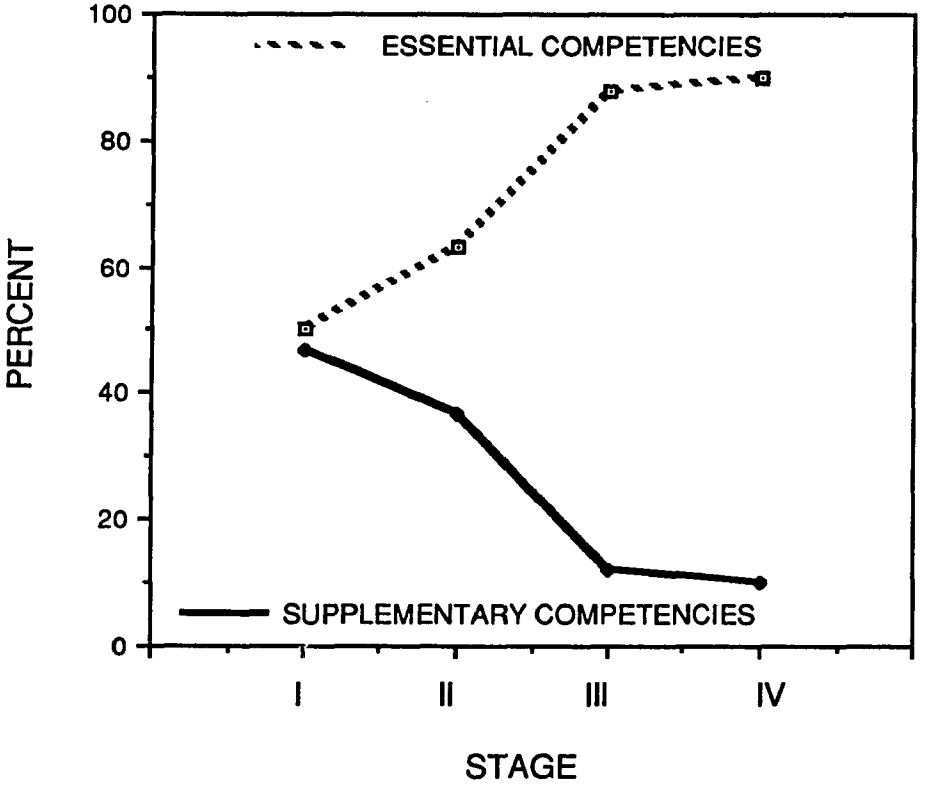

Figure 5.1: Percentage of Essential and Supplementary competencies by stage of program development.

According to the hospice life cycle model, educational programs could be planned which meet the needs of hospice administrators in all stages of hospice development.

Also, this study found that the need for hospice administrators to delegate within the administrative sections (A-E) increased as the hospice developed. Specifically, they were more likely to

delegate within patient and family relations and not to delegate within quality assurance. From this study one can identify those areas that increased in delegation as the hospice program increased in stage of development and those areas that tended to remain fairly constant. This is significant because hospice administrators can begin to evaluate their own delegation skills and anticipate their delegation effectiveness or limits in certain administrative sections. Figure 5.2 identifies the administrative sections and the average percentage delegated by stage of program development.

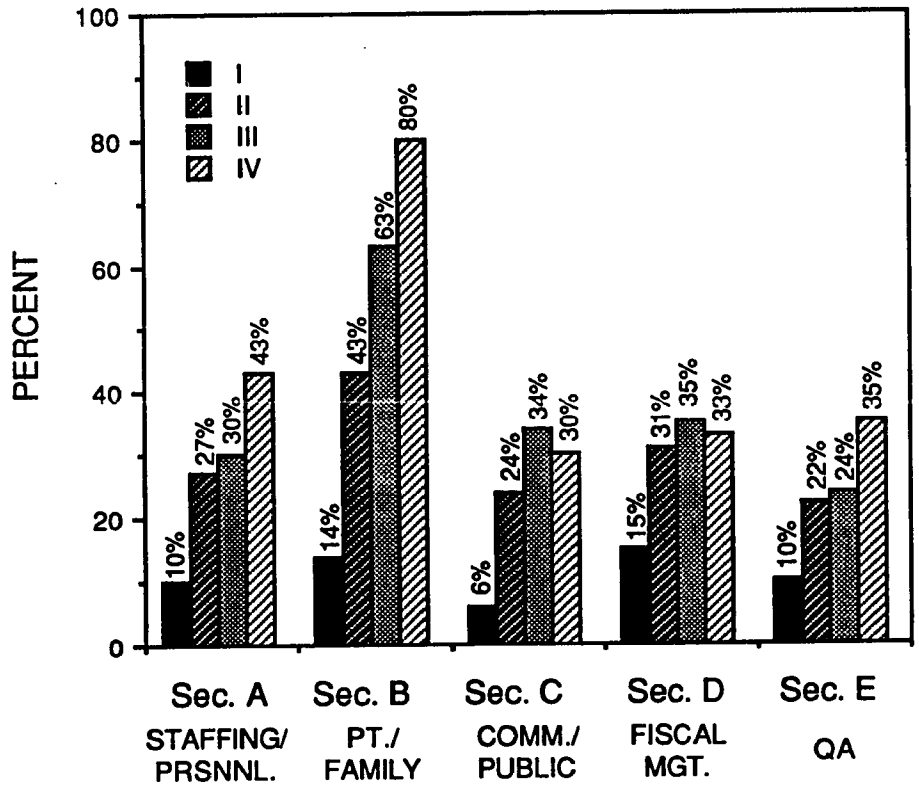

Figure 5.2: Administrative sections and average percentage delegated by program stage of development.

Finally, delegation can also be evaluated according to the administrative functions of planning, organizing, directing, and controlling by program stage of development. Figure 5.3 demonstrates that in this study, delegation increased in all four administrative functions as the hospice increased in stage of development.

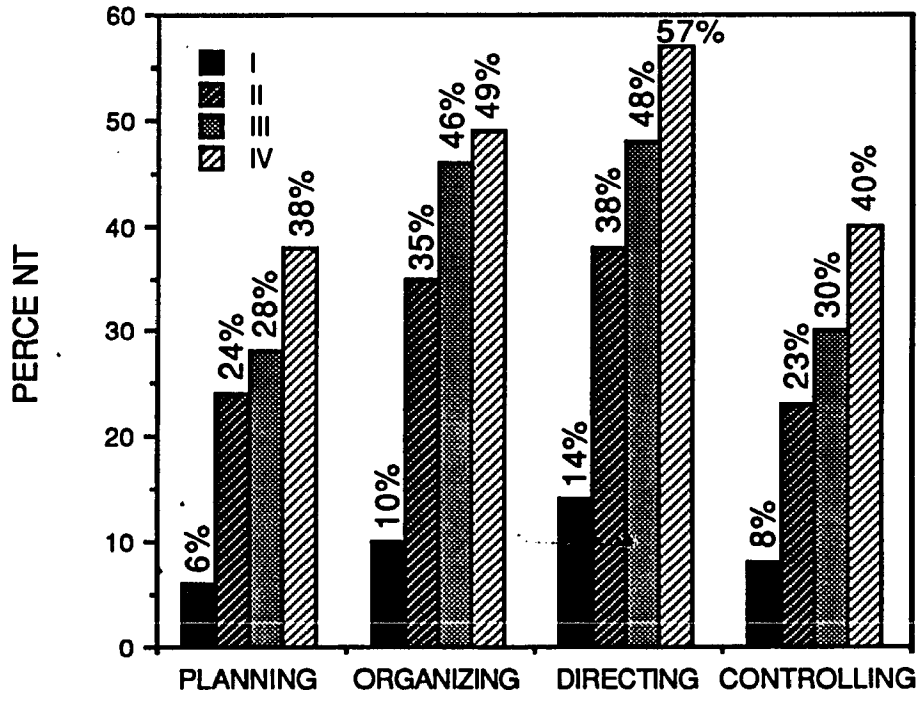

Figure 5.3: P, O, D, C functions and delegation by program stage of development.

As noted in Chapter IV, planning, organizing, and directing functions were significantly different by stage of development ($p < .05$), while the controlling function was not. This suggests that the administrative controlling functions not only remain the lowest

delegated but also remain fairly consistent throughout the hospice's development. A basic tenet for hospice administrators across all stages of development is to control and assure the quality of care provided.

Implications

In addition to the discussion of the research objective findings, five general implications will be discussed.

1. What are the implications for differentiating program stages of development in hospice?

2. What is the significance for educational programs based on the five administrative sections suggested in this study?

3. What are the implications of the relative lack of hospice administrative experience?

4. What are the implications of the ethnic composition of hospice patients on future program development?

5. What are the implications of an organizational life cycle approach to teaching strategies?

First, definable stages in hospice program development require significantly different administrative competencies. In many instances four determinants have been significant in the transition from one stage to another. They are: (a) the on-going evaluation process, (b) self-care strategies of staff, (c) stability of a funding source, and (d) the leadership competencies of the administrator. The implications of this organizational life cycle model reach beyond hospice and can be applied to many types of

organizations. Courses in Life Cycle Administration would be applicable to a wide range of professions as well as to members of the hospice's Board of Directors.

Second, this study identified five major administrative sections in which 134 (67%) of the competency statements statistically supported a high congruence in five factors. This is significant in statistically validating the competency items under the sections of: staffing and personnel management, patient and family relations, community/public relations, fiscal management, and quality assurance.

Forty-three (88%) of the surveyed hospice program administrators in Michigan identified a need for hospice administration educational curricula. Twenty-six (59%) preferred to received this information through seminars and workshops for continuing education credits. Respondents identified that overall their educational needs were rank ordered as follows: (1) quality assurance, (2) staffing and personnel management, (3) fiscal management, (4) community/public relations, and (5) patient and family relations.

Additionally, this study identified educational needs by hospice stages of development. An educational model which takes into account the stages of hospice development can greatly enhance the effectiveness of teaching modules. As shown in this study, hospice administrators need to be continually learning Essential competencies to keep pace with their hospice program's

organizational changes. This can be accomplished through an educational program which specifically addresses programmatic issues by stage of organizational development. State hospice organizations working with colleges and universities could establish hospice administrative curricula, and/or the National Hospice Organization could develop a hospice administration certification curriculum.

Third, this study identified that hospice administrators in Michigan had on average a little more than 2 years of experience in hospice administration at a time when over half the hospice programs in Michigan were considered to be in Stage II of hospice development. This means that hospice administrators with essentially very little administrative experience were trying to cope with very difficult administrative issues unique to Stage II such as: identification of stable funding sources, staff expansion, licensing, and hospice Medicare certification (Olson, 1988). This lack of previous hospice administrative experience implies that a concerted effort should be in progress to assist and support new administrators through their tenuous program growth.

In addition, a large percentage of these administrators came from health (not hospice) experience. This has implications for hospice administration perhaps 10 to 20 years from now. Additional longitudinal research is needed which can address these questions: Will hospice administrators tend to have a diluted administrative base of knowledge which is not specific to hospice? Will a general health administration degree suffice? Over time, how will

administrators with specific hospice administration skills fare compared to administrators with no hospice experience?

Fourth, although the data collection on ethnicity of the patients/families being cared for in this study was incomplete, it still supported other research which has identified that hospice in America may be primarily an option for white families. Survey items related to planning, developing, and organizing staff training on ethnicity issues were only rated as Supplementary by the administrators. The implications of these items remaining Supplementary in the future may delay a wider use of hospice by various ethnic groups.

Finally, this study identified <u>overall</u> Essential and Supplementary competencies for hospice administrators in Michigan. Educational programs could be based on these general findings; however, it is likely that they would miss the specific needs of administrators. As noted, Essential competencies in Stage I hospices are proportionally less than for a Stage IV hospice. The implications of this are that an overall categorization of Essential and Supplementary competencies is not accurate if one chooses to define the hospices by stage of development. Rather, if generalizations are made, it is only the consensus items which have applicability overall. This researcher supports an organizational life cycle approach to teaching strategies which is more specific and better meets the needs of the administrators.

Potential Contributions to Hospice Administration

Potential contributions from this study to hospice administration are:

1. The identification and categorization of hospice administrative competencies. Such a listing can be useful for program and educational development.

2. The identification of consensus items on which all hospice administrators in Michigan agree. As these items were the highest rated, they were also the most Essential.

3. The identification of organizational stages of development as applied to hospice (see page 94 for stage definitions). Such identification can aid hospice administrators, hospice boards of directors, and staff in understanding program growth and change.

Limitations of This Study

This study was limited in its broader application because of a relatively small N and its limitation to Michigan. Also, programs in Stage I were underrepresented. Would this be a problem nationally if the survey was replicated on a larger scale? If so, one should consider how the programs could be more effectively surveyed.

Relatively little data was also available for Stage III and IV hospices in Michigan. However, it is possible that programs in these stages of development nationally could be surveyed individually to build a larger data base.

Finally, survey instrument questions on administrative history (total number of years in administration) and patient/family ethnic representation did not elicit accurate data for statistical analysis. The questions would have to be revised if the survey instrument is used again.

Recommendations

This study of hospice administrative competencies represents an initial investigation in the field. Clearly, further research is encouraged and needed in the area of hospice administration. For Michigan, this study has provided an initial demographic and empirical data base from which to expand knowledge of the complex tasks required to administer a hospice program. It is recommended that Michigan continue to build its data base on hospice administrators through its state hospice organization.

Also, it is recommended that research continue in the areas of hospice life cycle stages as well as a more in-depth analysis of hospice administrative functions (planning, organizing, directing, and controlling). Longitudinal studies could be done on hospice programs to assess the validity of the hospice life cycle model. This study could also be replicated in Michigan to evaluate shifts in stages of development. For example, 5 years from now will the majority of hospices still be in Stage II?

Additionally, delegation of competencies needs to be more clearly defined under the five major administrative sections developed in this study. It is recommended that this survey be

used in other states by hospice state organizations to evaluate its accuracy in identifying Essential and Supplementary competencies including those which are delegated.

Finally, program administrators have clearly identified life cycle educational needs. It seems risky to rely on general health care administrative models to carry us into tomorrow. Califano (1986) noted that the health care industry of tomorrow is going to be unrecognizably different. He noted, "whether it will be better depends on how we shape it" (p. 10). It is recommended that colleges which support and teach an ecological framework consider course offerings which address health care life cycle administration. Hospice programs are a small example of the holistic approach needed in the larger arena where organizational life cycle issues occur.

Rogers (1971) noted that a broader ecological approach is needed in order to fully understand and recognize the need for holistic analysis in administration. He stated:

> Since a broader ecological approach is needed in order to fully understand man's relationships with his environment, it follows that many existing, well-intended organized patterns and programs which were formulated in the context of a more limited viewpoint are likely to prove inadequate, perhaps even dangerous in the long run. Expediential decisions will always remain a practical necessity. But expediency as a way of life is quite different from expediency taken as a necessary, but recognized incomplete, interim measure. (p. 206)

APPENDICES

APPENDIX A

ROUND ONE AND ROUND TWO HOSPICE ADMINISTRATORS INVENTORY

HOSPICE ADMINISTRATORS INVENTORY

Please complete Sections I and II of the Inventory and return in the enclosed envelope by JUNE 1, 1987.

SECTION I: BACKGROUND INFORMATION

1. _____ Age

2. _____ Female _____ Male
(1) (2)

3. EDUCATION Please check ( ) the highest educational level achieved.
code:
(1)_____ High School Diploma
(2)_____ Associate degree in _____
(please specify)
(3)_____ Diploma in Nursing
(4)_____ Bachelor's degree in _____
(please specify)
Minor: _____

(5)_____ Master's degree in _____
(please specify)
Minor:_____

(6)_____ Doctoral Degree in _____
(please specify)

Minor:_____

(7)_____ Other _____
(please specify)

4.PRESENT EMPLOYMENT Please identify the number of years/months you have worked as hospice administrator in the program you are currently directing.
_____ (years)

_____ (months, if newly hired)

5. PRIOR EMPLOYMENT HISTORY Please Check ( ) the statement which most accurately reflects your employment status one (1) year prior to your current employment.
code:
(1)____ Working in a Health related field OTHER THAN hospice
please specify:_____
(2)____ Working in a non-Health related field
please specify:_____
(3)____ Working in a hospice program but not in an administrative capacity.
(4)____ Working in a hospice program in an administrative capacity.
(5)____ Not Working

6. ADMINISTRATIVE HISTORY Please indicate the TOTAL number of years you have worked as an administrator.

code:

(1)_____ in hospice
(2)_____ in a health related field (please specify)_____
(3)_____ in a non health related field (please specify)_____

7. ROLE RESPONSIBILITIES Please Check ( ) the statement which most accurately reflects your role responsiblities.

code:

(1)____ I am ONLY responsible for administering the hospice program.
(2)____ I am responsible for administering the hospice program AND other roles. Please specify other roles:_____
_____

8. SALARY RANGE Please check ( ) your current salary range.

code:

(1)____ Volunteer-Unsalaried
(2)____ Under $10,000 per year
(3)____ $10,000- $15,000 per year
(4)____ $15,000-$20,000 per year
(5)____ $20,000-$25,000 per year
(6)____ $25,000-$30,000 per year
(7)____ $30,000-$35,000 per year
(8)____ Above $35,000 per year

9. EMPLOYMENT STATUS Please check ( ) your employment status.

code:

(1)____ Full-time
(2)____ Part-time (please specify # of hours per week) _____

10. HOSPICE DESIGNATION Please check ( ) the statement which currently reflects the status of your hospice program.

code:

(1)____ Licensed as a hospice
(2)____ Exempt from Licensure
(3)____ Hospice Medicare certified
(4)____ Other: (please specify)_____
_____

11. HOSPICE LOCATION Please check ( ) the population most appropriate to your hospice service area.

code:

(1)____ (pop. less than 50,000)
(2)____ (pop. greater than 50,000 but less than 100,000)
(3)____ (pop. greater than 100,000 but less than 250,000)
(4)____ (pop. greater than 250,000)

12. PT/FAMILY ETHNIC REPRESENTATION Please indicate the number of pt./families in your program for 1986.(January 1986- Dec.1986)

(1)_____ Black
(2)_____ White
(3)_____ American Indian
(4)_____ Asian
(5)_____ Hispanic

13. PROGRAM FORECAST What do you anticipate the status of your hospice program to be ONE year from now?
Please check ( )
code:
(1)____ Licensed as a hospice
(2)____ Exempt from Licensure
(3)____ Hospice Medicare certified
(4)____ Other:(Please specify)_____

14. PROGRAM DEVELOPMENT Please check ( ) the stage of development you believe your hospice program to be currently in.
code:
(1)_____ STAGE ONE: perhaps newly organized, developing policies and procedures, developing and filling staff positions, perhaps highly volunteer intensive.

(2)_____ STAGE TWO: established in the community, referrals are increasing, staff positions being added, administration formalizing.

(3)_____ STAGE THREE: administration becoming more complex, adding more staff, adding additional services, census remaining high.

(4)_____ STAGE FOUR: highly complex organizational structure, expansion through satellite operations, large number of employees to accomodate increased service area.

15. HOSPICE ADMINISTRATION EDUCATIONAL FORECAST Do you believe there is a need for a hospice administration educational curriculum?
Please check ( ):
code:
(1)___ yes
(2)___ no

If you indicated a YES answer please complete the two questions on the next page.
If you indicated a NO answer please continue on to SECTION II.

16. HOSPICE EDUCATIONAL AREAS Which educational areas do you feel would be most helpful to you.(You may check more than one area)
code:
(1)_____ Staffing and Personnel Management
(2)_____ Patient and Family Relations
(3)_____ Community/Public Relations
(4)_____ Fiscal Management
(5)_____ Quality Assurance
(6)____ Other:_____
(please specify)

17. EDUCATIONAL ASSISTANCE Please check ( ) which method of educational assistance is most preferrable to you.
code:
(1)_____ Seminars/Workshops for CEU credits
(2)_____ Seminars/ Workshops without CEU credits
(3)_____ College/ University certification/degree program
(4)_____ College/University Lifelong Education courses
(5)_____ Adult Continuing Education Programs

PLEASE CONTINUE ON TO SECTION II

SECTION 11
HOSPICE ADMINISTRATORS INVENTORY

Please circle the number to the right of each statement which best represents YOUR response as to how essential each statement is for YOUR particular hospice program then indicate whether the statement is delegated.

5=Absolutely Necessary 3 = Useful
4=Highly Necessary 2= Uncertain 1=Not Necessary

SECTION A
STAFFING AND PERSONNEL MANAGEMENT

(This section INCLUDES volunteers)

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
In administering my hospice program I:						
P1. plan staff development.	5	4	3	2	1	( )
P2. understand motivational theories.	5	4	3	2	1	( )
P3. plan recruitment strategies.	5	4	3	2	1	( )
P4. develop staffing patterns.	5	4	3	2	1	( )
P5. develop personnel policies and procedures.	5	4	3	2	1	( )
P6 understand stress management theories.	5	4	3	2	1	( )
P7. develop personnel grievence procedures.	5	4	3	2	1	( )
P8. develop staff contracts.	5	4	3	2	1	( )
P9. plan staff assignments.	5	4	3	2	1	( )
P10. develop staff training for pt/family ethnicity needs.	5	4	3	2	1	( )
P11. plan 24 hour staff availability.	5	4	3	2	1	( )
P12. plan resource support for staff.	5	4	3	2	1	( )
O13. organize personnel policies and procedures.	5	4	3	2	1	( )
O14. provide stress management programs for staff.	5	4	3	2	1	( )
O15. provide training on ethnicity issues.	5	4	3	2	1	( )
O16. provide support resources for staff.	5	4	3	2	1	( )
O17. coordinate patient care assignments.	5	4	3	2	1	( )
O18. provide for medical direction.	5	4	3	2	1	( )
O19. provide communication inservices.	5	4	3	2	1	( )
O20. take on-call assignments.	5	4	3	2	1	( )
O21. provide on-call availability of staff.	5	4	3	2	1	( )
D22. teach inservices.	5	4	3	2	1	( )
D23. direct all personnel activities.	5	4	3	2	1	( )
D24. conduct performance reviews.	5	4	3	2	1	( )
D25. conduct staff recruitment.	5	4	3	2	1	( )
D26. hire qualified personnel.	5	4	3	2	1	( )
D27. conduct staff meetings.	5	4	3	2	1	( )
D28. teach the hospice philosophy to staff.	5	4	3	2	1	( )

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
D29. lead the Interdisciplinary team meetings.	5	4	3	2	1	( )
D30. counsel staff.	5	4	3	2	1	( )
D31. conduct stress reduction classes.	5	4	3	2	1	( )
D32. negotiate staff contracts.	5	4	3	2	1	( )
D33. apply effective communication skills.	5	4	3	2	1	( )
C34. initiate disciplinary action.	5	4	3	2	1	( )
C35. monitor recruitment.	5	4	3	2	1	( )
C36. monitor staff orientation.	5	4	3	2	1	( )
C37. supervise home visits.	5	4	3	2	1	( )
C38. monitor staff stress levels.	5	4	3	2	1	( )
C39. monitor the on-call schedule.	5	4	3	2	1	( )
C40. supervise the Interdisciplinary team.	5	4	3	2	1	( )
C41. monitor personnel contract renewals.	5	4	3	2	1	( )
C42. resolve staff issues/complaints.	5	4	3	2	1	( )
C43. monitor support resources for staff.	5	4	3	2	1	( )
C44. attend the Interdisciplinary team meetings.	5	4	3	2	1	( )
C45. function as a liaison between the governing board and hospice staff.	5	4	3	2	1	( )
C46. assure 24 hour availability of staff.	5	4	3	2	1	( )
C47. schedule staff meetings.	5	4	3	2	1	( )
C48. document staff meetings.	5	4	3	2	1	( )
C49. engage in research relative to staffing and personnel.	5	4	3	2	1	( )
C50. monitor the personnel files.	5	4	3	2	1	( )
C51. monitor disciplinary action.	5	4	3	2	1	( )

Comments and/or additions to the competencies in this section:

_____

_____

_____

SECTION B
PATIENT AND FAMILY RELATIONS

In administering my hospice program I:	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
P52. develop pt/family admission and discharge criteria.	5	4	3	2	1	( )
P53. develop pt/family complaint mechanisms.	5	4	3	2	1	( )
P54. develop confidentiality policies.	5	4	3	2	1	( )
P55. develop bereavement policies.	5	4	3	2	1	( )
P56. understand grief/loss theories.	5	4	3	2	1	( )
P57. develop continuity of care policies and procedures.	5	4	3	2	1	( )
P58. plan for ethnicity needs of the pt/family.	5	4	3	2	1	( )
P59. plan for acute symptom control procedures.	5	4	3	2	1	( )
P60. develop a pt/family rights policy.	5	4	3	2	1	( )
P61. develop respite care options for the family.	5	4	3	2	1	( )
P62. develop a comprehensive needs assessment for the pt/family.	5	4	3	2	1	( )
O63. provide confidentiality for the pt/family.	5	4	3	2	1	( )
O64. provide an ongoing bereavement program.	5	4	3	2	1	( )
O65. provide for ethnic needs of the pt/family.	5	4	3	2	1	( )
O66. coordinate pt/family transfers.	5	4	3	2	1	( )
O67. provide for continuity of care.	5	4	3	2	1	( )
O68. provide for resolution of pt/family complaints.	5	4	3	2	1	( )
O69. provide for acute symptom control.	5	4	3	2	1	( )
O70. provide respite care for the family.	5	4	3	2	1	( )
O71. make home visits.	5	4	3	2	1	( )
O72. provide for the spiritual needs of the pt/family.	5	4	3	2	1	( )
O73. provide for the physical needs of the pt/family.	5	4	3	2	1	( )
O74. provide for the emotional needs of the pt/family.	5	4	3	2	1	( )
D75. direct the bereavement program.	5	4	3	2	1	( )
D76. communicate confidentiality policies to the pt/family.	5	4	3	2	1	( )
D77. communicate their rights to the pt/family.	5	4	3	2	1	( )
D78. communicate admission/discharge criteria to the pt/family.	5	4	3	2	1	( )

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
D79. communicate the hospice philosophy to the pt/family.	5	4	3	2	1	( )
D80. discuss grief/loss issues with the pt/family.	5	4	3	2	1	( )
D81. make bereavement visits.	5	4	3	2	1	( )
D82. do the initial pt/family assessment.	5	4	3	2	1	( )
C83. monitor pt/family confidentiality.	5	4	3	2	1	( )
C84. resolve pt/family complaints.	5	4	3	2	1	( )
C85. monitor continuity of care.	5	4	3	2	1	( )
C86. monitor bereavement follow-up.	5	4	3	2	1	( )
C87. assure pt/family physical needs are met.	5	4	3	2	1	( )
C88. assure pt/family spiritual needs are met.	5	4	3	2	1	( )
C89. assure pt/family emotional needs are met.	5	4	3	2	1	( )
C90. monitor family involvement in the patient's care.	5	4	3	2	1	( )
C91. assure pt/family rights are respected.	5	4	3	2	1	( )
C92. monitor pt/family visits.	5	4	3	2	1	( )
C93. monitor pt/family admissions and discharges.	5	4	3	2	1	( )
C94. engage in research relative to the pt/family.	5	4	3	2	1	( )

Comments and/or additions to the competencies in this section:

_____

_____

_____

SECTION C
COMMUNITY/PUBLIC RELATIONS

In administering my hospice program I:	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
P95. understand current community needs for health care.	5	4	3	2	1	( )
P96. plan hospice services which meet the needs of the community.	5	4	3	2	1	( )
P97. develop marketing strategies.	5	4	3	2	1	( )
P98. develop contracts with community health care agencies/facilities.	5	4	3	2	1	( )
P99. develop bereavement education programs for the community.	5	4	3	2	1	( )
P100. plan strategies to increase community awareness/participation in hospice.	5	4	3	2	1	( )
P101. plan strategies to increase physician awareness/participation in hospice.	5	4	3	2	1	( )
P102. plan strategies to increase clergy awareness/participation in hospice.	5	4	3	2	1	( )
P103. plan strategies to increase governing board awareness/participation in hospice.	5	4	3	2	1	( )
O104. provide hospice orientation to community groups.	5	4	3	2	1	( )
O105. identify individuals to potentially fill governing board vacancies.	5	4	3	2	1	( )
O106. provide ongoing marketing activities.	5	4	3	2	1	( )
O107. communicate pain management protocals to physicians.	5	4	3	2	1	( )
O108. provide inservices for clergy.	5	4	3	2	1	( )
O109. provide inservices for physicians.	5	4	3	2	1	( )
O110. provide hospice orientation to the governing board members.	5	4	3	2	1	( )
O111. provide program status reports to the governing board.	5	4	3	2	1	( )
O112. coordinate hospice care with other community health agencies/facilities.	5	4	3	2	1	( )
O113. provide bereavement support for the community.	5	4	3	2	1	( )
D114. implement marketing strategies.	5	4	3	2	1	( )
D115. contact physicians in the community.	5	4	3	2	1	( )
D116. speak to interested groups about hospice.	5	4	3	2	1	( )
D117. contact clergy in the community.	5	4	3	2	1	( )
D118. meet with other hospice administrators.	5	4	3	2	1	( )
D119. communicate the hospice philosophy to community.	5	4	3	2	1	( )

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
D120. lead bereavement support groups.	5	4	3	2	1	( )
D121. write media articles on hospice care.	5	4	3	2	1	( )
D122. communicate to the governing board about current hospice trends/issues.	5	4	3	2	1	( )
C123. monitor marketing strategies.	5	4	3	2	1	( )
C124. evaluate the community's perception of hospice care.	5	4	3	2	1	( )
C125. monitor all public relations strategies.	5	4	3	2	1	( )
C126. review all media articles before publication.	5	4	3	2	1	( )
C127. oversee all promotional activities sponsored by hospice.	5	4	3	2	1	( )
C128. monitor community issues/trends which may affect the hospice program.	5	4	3	2	1	( )
C129. schedule governing board meetings.	5	4	3	2	1	( )
C130. document governing board minutes.	5	4	3	2	1	( )
C131. be accountable to the governing board for the hospice's day to day operations.	5	4	3	2	1	( )
C132. maintain effective communication with community resource agencies.	5	4	3	2	1	( )
C133. engage in research relative to community/public relations.	5	4	3	2	1	( )

Comments and/or additions to the competencies in this section:

_____

_____

_____

SECTION D
FISCAL MANAGEMENT

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
In administering my hospice program I:						
P134. plan the hospice budget.	5	4	3	2	1	( )
P135. develop fund raising strategies.	5	4	3	2	1	( )
P136. plan grant proposals.	5	4	3	2	1	( )
P137. develop cost containment strategies.	5	4	3	2	1	( )
P138. plan financial statements.	5	4	3	2	1	( )
P139. develop a staff benefits plan.	5	4	3	2	1	( )
P140. develop reimbursement policies and procedures.	5	4	3	2	1	( )
P141. develop a mechanism to account for gifts and donations to the hospice.	5	4	3	2	1	( )
P142. develop liability coverage for staff and board members.	5	4	3	2	1	( )
O143. utilize computer programing assistance.	5	4	3	2	1	( )
O144. provide ongoing funding support.	5	4	3	2	1	( )
O145. provide liability coverage for staff and board members.	5	4	3	2	1	( )
O146. interpret financial statements.	5	4	3	2	1	( )
O147. provide for a balanced budget.	5	4	3	2	1	( )
O148. provide for accurate accounting of gifts and donations to the hospice.	5	4	3	2	1	( )
O149. provide for salary increases.	5	4	3	2	1	( )
D150. direct grants that are awarded to the hospice program.	5	4	3	2	1	( )
D151. conduct fund raising.	5	4	3	2	1	( )
D152. communicate fiscal issues to staff and governing board.	5	4	3	2	1	( )
D153. prepare financial statements.	5	4	3	2	1	( )
D154. compute volunteer cost savings.	5	4	3	2	1	( )
D155. recommend salary increases.	5	4	3	2	1	( )
D156. write grant proposals.	5	4	3	2	1	( )
D157. prepare/issue payroll checks.	5	4	3	2	1	( )
C158. monitor revenue resources.	5	4	3	2	1	( )

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
C159. monitor hospice expenditures.	5	4	3	2	1	( )
C160. monitor insurance claim processing.	5	4	3	2	1	( )
C161. monitor liability insurance renewal.	5	4	3	2	1	( )
C162. assure accurate accounting of gifts and donations.	7	4	3	2	1	( )
C163. assure continued cost savings by volunteers.	5	4	3	2	1	( )
C164. engage in research relative to fiscal management.	5	4	3	2	1	( )
C165. monitor cost containment.	5	4	3	2	1	( )

Comments and/or additions to the competencies in this section:

_____

_____

_____

SECTION E
QUALITY ASSURANCE

In administering my hospice program I:	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
P166. understand quality assurance.	5	4	3	2	1	( )
P167. plan for appropriate use of resources.	5	4	3	2	1	( )
P168. plan a quality assurance reporting mechanism to the governing board.	5	4	3	2	1	( )
P169. plan for re-evaluation of quality care issues.	5	4	3	2	1	( )
P170. plan quality assurance inservices.	5	4	3	2	1	( )
P171. develop hospice standards of care.	5	4	3	2	1	( )
P172. develop a plan for quality assurance.	5	4	3	2	1	( )
P173. develop a program evaluation.	5	4	3	2	1	( )
P174. plan an organizational design which reflects quality hospice care.	5	4	3	2	1	( )
P175. develop utilization review mechanisms.	5	4	3	2	1	( )
O176. provide competent staff.	5	4	3	2	1	( )
O177. provide for evaluation of all services.	5	4	3	2	1	( )
O178. provide for concurrent medical record reviews.	5	4	3	2	1	( )
O179. provide reviews of all hospice standards.	5	4	3	2	1	( )
O180. provide for review/evaluation of all contracted services.	5	4	3	2	1	( )
O181. provide an ongoing evaluation of services.	5	4	3	2	1	( )
O182. provide for re-evaluation of quality care issues.	5	4	3	2	1	( )
O183. provide quality assurance inservices.	5	4	3	2	1	( )
O184. function as a member of the quality assurance committee.	5	4	3	2	1	( )
O185. provide for quality assurance studies.	5	4	3	2	1	( )
O186. provide for retrospective medical record reviews.	5	4	3	2	1	( )
D187. communicate quality assurance issues to the governing board.	5	4	3	2	1	( )
D188. communicate the importance of quality assurance to staff.	5	4	3	2	1	( )
D189. lead the quality assurance committee meetings.	5	4	3	2	1	( )
D190. do quality assurance studies.	5	4	3	2	1	( )
D191. do the program evaluation.	5	4	3	2	1	( )
D192. teach quality assurance inservices.	5	4	3	2	1	( )
C193. assure sufficient data collection to support quality assurance studies.	5	4	3	2	1	( )
C194. monitor the quality assurance plan.	5	4	3	2	1	( )
C195. assure re-evaluation of quality care issues.	5	4	3	2	1	( )

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated
C196. assure competence of staff.	5	4	3	2	1	( )
C197. monitor compliance with state hospice regulations.	5	4	3	2	1	( )
C198. monitor compliance with federal hospice regulations.	5	4	3	2	1	( )
C199. assure appropriate and efficient use of resources.	5	4	3	2	1	( )
C200. engage in research relative to quality assurance.	5	4	3	2	1	( )
C201. monitor contracted services.	5	4	3	2	1	( )

Comments and/or additions to the competencies in this section:

PLEASE RETURN THE HOSPICE ADMINISTRATOR3 COMPETENCY INVENTORY BY----------

MAIL TO:
Sharon Olson R.N. M.S.
2117 Rolling Brook Lane
East Lansing, Mi.48823

ROUND TWO
HOSPICE ADMINISTRATORS INVENTORY

Please circle the number to the right of each statement which best represents YOUR response as to how essential each statement is for YOUR particular hospice program then indicate whether the statement is delegated.

5=Absolutely Necessary 3 = Useful
4=Highly Necessary 2= Uncertain 1=Not Necessary

SECTION A
STAFFING AND PERSONNEL MANAGEMENT

(This section INCLUDES volunteers)

ASTERICKS (*) INDICATES THAT YOU DO NOT NEED TO RESPOND TO THAT ITEM	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	
In administering my hospice program I:							mean
P1. plan staff development.	5	4	3	2	1	( )	4.18
P2. understand motivational theories.	5	4	3	2	1	( )	3.85
P3. plan recruitment strategies.	5	4	3	2	1	( )	3.89
P4. develop staffing patterns.	5	4	3	2	1	( )	3.76
P5. develop personnel policies and procedures.	5	4	3	2	1	( )	4.08
P6 understand stress management theories.	5	4	3	2	1	( )	4.02
P7. develop personnel grievence procedures.	5	4	3	2	1	( )	3.68
P8. develop staff contracts.	5	4	3	2	1	( )	3.27
P9. plan staff assignments.	5	4	3	2	1	( )	4.07
P10. develop staff training for pt/family ethnicity needs.	5	4	3	2	1	( )	3.04
P11. plan 24 hour staff availability.	5	4	3	2	1	( )	4.17
P12. plan resource support for staff.	5	4	3	2	1	( )	4.04
O13. organize personnel policies and procedures.	5	4	3	2	1	( )	4.08
O14. provide stress management programs for staff.	5	4	3	2	1	( )	3.63
O15. provide training on ethnicity issues.	5	4	3	2	1	( )	2.89
O16. provide support resources for staff.	5	4	3	2	1	( )	3.95
O17. coordinate patient care assignments.	5	4	3	2	1	( )	4.29
O18. provide for medical direction.	5	4	3	2	1	( )	4.23
O19. provide communication inservices.	5	4	3	2	1	( )	4.04
O20. take on-call assignments.	5	4	3	2	1	( )	3.63
O21. provide on-call availability of staff.	5	4	3	2	1	( )	4.19
D22. teach inservices.	5	4	3	2	1	( )	3.97
D23. direct all personnel activities.	5	4	3	2	1	( )	3.89
D24. conduct performance reviews.	5	4	3	2	1	( )	4.10
D25. conduct staff recruitment.	5	4	3	2	1	( )	3.83
D26. hire qualified personnel.	5	4	3	2	1	( )	4.15
D27. conduct staff meetings.	5	4	3	2	1	( )	4.35
D28. teach the hospice philosophy to staff.	5	4	3	2	1	( )	4.46

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	mean
D29. lead the Interdisciplinary team meetings.	5	4	3	2	1	( )	3.80
D30. counsel staff.	5	4	3	2	1	( )	4.13
D31. conduct stress reduction classes.	5	4	3	2	1	( )	3.23
D32. negotiate staff contracts.	5	4	3	2	1	( )	3.39
*D33. apply effective communication skills.	5	4	3	2	1	( )	4.56
C34. initiate disciplinary action.	5	4	3	2	1	( )	3.82
C35. monitor recruitment.	5	4	3	2	1	( )	3.65
C36. monitor staff orientation.	5	4	3	2	1	( )	4.15
C37. supervise home visits.	5	4	3	2	1	( )	3.66
C38. monitor staff stress levels.	5	4	3	2	1	( )	4.04
C39. monitor the on-call schedule.	5	4	3	2	1	( )	3.53
C40. supervise the Interdisciplinary team.	5	4	3	2	1	( )	4.04
C41. monitor personnel contract renewals.	5	4	3	2	1	( )	3.54
C42. resolve staff issues/complaints.	5	4	3	2	1	( )	4.28
C43. monitor support resources for staff.	5	4	3	2	1	( )	3.89
C44. attend the Interdisciplinary team meetings.	5	4	3	2	1	( )	3.81
*C45. function as a liaison between the governing board and hospice staff.	5	4	3	2	1	( )	4.66
C46. assure 24 hour availability of staff.	5	4	3	2	1	( )	4.37
C47. schedule staff meetings.	5	4	3	2	1	( )	4.26
C48. document staff meetings.	5	4	3	2	1	( )	3.95
C49. engage in research relative to staffing and personnel.	5	4	3	2	1	( )	3.15
C50. monitor the personnel files.	5	4	3	2	1	( )	3.95
C51. monitor disciplinary action.	5	4	3	2	1	( )	3.97

CONTINUE ON TO NEXT PAGE

SECTION B
PATIENT AND FAMILY RELATIONS

ASTERICKS (*) INDICATES THAT YOU DO NOT NEED TO RESPOND TO THAT ITEM	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	mean
In administering my hospice program I:							
P52. develop pt/family admission and discharge criteria.	5	4	3	2	1	( )	4.34
P53. develop pt/family complaint mechanisms.	5	4	3	2	1	( )	4.38
*P54. develop confidentiality policies.	5	4	3	2	1	( )	4.73
*P55. develop bereavement policies.	5	4	3	2	1	( )	4.56
P56. understand grief/loss theories.	5	4	3	2	1	( )	4.43
*P57. develop continuity of care policies and procedures.	5	4	3	2	1	( )	4.53
P58. plan for ethnicity needs of the pt/family.	5	4	3	2	1	( )	3.33
P59. plan for acute symptom control procedures.	5	4	3	2	1	( )	3.97
P60. develop a pt/family rights policy.	5	4	3	2	1	( )	4.44
P61. develop respite care options for the family.	5	4	3	2	1	( )	4.14
P62. develop a comprehensive needs assessment for the pt/family.	5	4	3	2	1	( )	4.04
*O63. provide confidentiality for the pt/family.	5	4	3	2	1	( )	4.75
*O64. provide an ongoing bereavement program.	5	4	3	2	1	( )	4.61
O65. provide for ethnic needs of the pt/family.	5	4	3	2	1	( )	3.31
O66. coordinate pt/family transfers.	5	4	3	2	1	( )	3.76
O67. provide for continuity of care.	5	4	3	2	1	( )	4.26
O68. provide for resolution of pt/family complaints.	5	4	3	2	1	( )	4.42
O69. provide for acute symptom control.	5	4	3	2	1	( )	3.97
O70. provide respite care for the family.	5	4	3	2	1	( )	3.97
O71. make home visits.	5	4	3	2	1	( )	3.86
O72. provide for the spiritual needs of the pt/family.	5	4	3	2	1	( )	4.23
O73. provide for the physical needs of the pt/family.	5	4	3	2	1	( )	4.25
O74. provide for the emotional needs of the pt/family.	5	4	3	2	1	( )	4.20
D75. direct the bereavement program.	5	4	3	2	1	( )	3.70
D76. communicate confidentiality policies to the pt/family.	5	4	3	2	1	( )	3.95
D77. communicate their rights to the pt/family.	5	4	3	2	1	( )	4.07
D78. communicate admission/discharge criteria to the pt/family.	5	4	3	2	1	( )	4.04

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	mean
D79. communicate the hospice philosophy to the pt/family.	5	4	3	2	1	( )	4.18
D80. discuss grief/loss issues with the pt/family.	5	4	3	2	1	( )	4.02
D81. make bereavement visits.	5	4	3	2	1	( )	3.79
D82. do the initial pt/family assessment.	5	4	3	2	1	( )	4.00
C83. monitor pt/family confidentiality.	5	4	3	2	1	( )	4.00
C84. resolve pt/family complaints.	5	4	3	2	1	( )	4.30
C85. monitor continuity of care.	5	4	3	2	1	( )	4.13
C86. monitor bereavement follow-up.	5	4	3	2	1	( )	4.14
C87.assure pt/family physical needs are met.	5	4	3	2	1	( )	4.27
C88.assure pt/family spiritual needs are met.	5	4	3	2	1	( )	4.30
C89.assure pt/family emotional needs are met.	5	4	3	2	1	( )	4.25
C90. monitor family involvement in the patient's care.	5	4	3	2	1	( )	4.12
C91. assure pt/family rights are respected.	5	4	3	2	1	( )	4.47
C92. monitor pt/family visits.	5	4	3	2	1	( )	4.05
C93. monitor pt/family admissions and discharges.	5	4	3	2	1	( )	4.26
C94. engage in research relative to the pt/family.	5	4	3	2	1	( )	3.22

CONTINUE ON TO NEXT PAGE

SECTION C
COMMUNITY/PUBLIC RELATIONS

ASTERICKS (*) INDICATES THAT YOU DO NOT NEED TO RESPOND TO THAT ITEM	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	
In administering my hospice program I:							mean
P95. understand current community needs for health care.	5	4	3	2	1	( )	4.34
*P96. plan hospice services which meet the needs of the community.	5	4	3	2	1	( )	4.53
P97. develop marketing strategies.	5	4	3	2	1	( )	4.14
P98. develop contracts with community health care agencies/facilities.	5	4	3	2	1	( )	4.17
P99. develop bereavement education programs for the community.	5	4	3	2	1	( )	3.95
*P100. plan strategies to increase community awareness/participation in hospice.	5	4	3	2	1	( )	4.63
*P101. plan strategies to increase physician awareness/participation in hospice.	5	4	3	2	1	( )	4.59
*P102. plan strategies to increase clergy awareness/participation in hospice.	5	4	3	2	1	( )	4.51
*P103. plan strategies to increase governing board awareness/participation in hospice.	5	4	3	2	1	( )	4.51
O104. provide hospice orientation to community groups.	5	4	3	2	1	( )	4.48
O105. identify individuals to potentially fill governing board vacancies.	5	4	3	2	1	( )	4.10
O106. provide ongoing marketing activities.	5	4	3	2	1	( )	3.91
O107. communicate pain management protocals to physicians.	5	4	3	2	1	( )	3.78
O108. provide inservices for clergy.	5	4	3	2	1	( )	3.55
O109. provide inservices for physicians.	5	4	3	2	1	( )	3.54
O110. provide hospice orientation to the governing board members.	5	4	3	2	1	( )	4.36
*O111. provide program status reports to the governing board.	5	4	3	2	1	( )	4.74
*O112. coordinate hospice care with other community health agencies/facilities.	5	4	3	2	1	( )	4.53
O113. provide bereavement support for the community.	5	4	3	2	1	( )	4.08
D114. implement marketing strategies.	5	4	3	2	1	( )	4.06
D115. contact physicians in the community.	5	4	3	2	1	( )	4.20
*D116. speak to interested groups about hospice.	5	4	3	2	1	( )	4.57
D117. contact clergy in the community.	5	4	3	2	1	( )	4.19
D118. meet with other hospice administrators.	5	4	3	2	1	( )	4.34
*D119. communicate the hospice philosophy to community.	5	4	3	2	1	( )	4.66

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	mean
D120. lead bereavement support groups.	5	4	3	2	1	( )	3.35
D121. write media articles on hospice care.	5	4	3	2	1	( )	4.11
*D122. communicate to the governing board about current hospice trends/issues.	5	4	3	2	1	( )	4.63
C123. monitor marketing strategies.	5	4	3	2	1	( )	3.97
C124. evaluate the community's perception of hospice care.	5	4	3	2	1	( )	4.20
C125. monitor all public relations strategies.	5	4	3	2	1	( )	4.19
C126. review all media articles before publication.	5	4	3	2	1	( )	4.29
C127. oversee all promotional activities sponsored by hospice.	5	4	3	2	1	( )	4.31
C128. monitor community issues/trends which may affect the hospice program.	5	4	3	2	1	( )	4.33
C129. schedule governing board meetings.	5	4	3	2	1	( )	3.86
C130. document governing board minutes.	5	4	3	2	1	( )	3.79
*C131. be accountable to the governing board for the hospice's day to day operations.	5	4	3	2	1	( )	4.72
C132. maintain effective communication with community resource agencies.	5	4	3	2	1	( )	4.48
C133. engage in research relative to community/public relations.	5	4	3	2	1	( )	3.29

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SECTION D
FISCAL MANAGEMENT

ASTERICKS (*) INDICATES THAT YCU DO NOT NEED TO RESPOND TO THAT ITEM	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	mean
In administering my hospice program I:							
P134. plan the hospice budget.	5	4	3	2	1	( )	4.41
P135. develop fund raising strategies.	5	4	3	2	1	( )	4.04
P136. plan grant proposals.	5	4	3	2	1	( )	3.62
P137. develop cost containment strategies.	5	4	3	2	1	( )	4.08
P138. plan financial statements.	5	4	3	2	1	( )	3.82
P139. develop a staff benefits plan.	5	4	3	2	1	( )	2.85
P140. develop reimbursement policies and procedures.	5	4	3	2	1	( )	3.28
*P141. develop a mechanism to account for gifts and donations to the hospice.	5	4	3	2	1	( )	4.51
P142. develop liability coverage for staff and board members.	5	4	3	2	1	( )	4.26
O143. utilize computer programing assistance.	5	4	3	2	1	( )	3.04
O144. provide ongoing funding support.	5	4	3	2	1	( )	4.25
O145. provide liability coverage for staff and board members.	5	4	3	2	1	( )	4.20
O146. interpret financial statements.	5	4	3	2	1	( )	4.15
O147. provide for a balanced budget.	5	4	3	2	1	( )	4.33
O148. provide for accurate accounting of gifts and donations to the hospice.	5	4	3	2	1	( )	4.48
O149. provide for salary increases.	5	4	3	2	1	( )	3.51
D150. direct grants that are awarded to the hospice program.	5	4	3	2	1	( )	3.50
D151. conduct fund raising.	5	4	3	2	1	( )	4.04
D152. communicate fiscal issues to staff and governing board.	5	4	3	2	1	( )	4.40
D153. prepare financial statements.	5	4	3	2	1	( )	3.70
D154. compute volunteer cost savings.	5	4	3	2	1	( )	3.58
D155. recommend salary increases.	5	4	3	2	1	( )	3.62
D156. write grant proposals.	5	4	3	2	1	( )	3.48
D157. prepare/issue payroll checks.	5	4	3	2	1	( )	3.20
C158. monitor revenue resources.	5	4	3	2	1	( )	4.09

		Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary		Delegated	mean
*C159.	monitor hospice expenditures.	5	4	3	2	1	(	)	4.58
C160.	monitor insurance claim processing.	5	4	3	2	1	(	)	3.54
C161.	monitor liability insurance renewal.	5	4	3	2	1	(	)	4.09
*C162.	assure accurate accounting of gifts and donations.	5	4	3	2	1	(	)	4.55
C163.	assure continued cost savings by volunteers.	5	4	3	2	1	(	)	4.00
C164.	engage in research relative to fiscal management.	5	4	3	2	1	(	)	3.19
C165.	monitor cost containment.	5	4	3	2	1	(	)	4.14

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SECTION E
QUALITY ASSURANCE

ASTERICKS (*) INDICATES THAT YOU DO NOT NEED TO RESPOND TO THAT ITEM	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	mean
In administering my hospice program I:							
*P166. understand quality assurance.	5	4	3	2	1	( )	4.52
*P167. plan for appropriate use of resources.	5	4	3	2	1	( )	4.55
*P168. plan a quality assurance reporting mechanism to the governing board.	5	4	3	2	1	( )	4.53
P169. plan for re-evaluation of quality care issues.	5	4	3	2	1	( )	4.47
P170. plan quality assurance inservices.	5	4	3	2	1	( )	4.14
*P171. develop hospice standards of care.	5	4	3	2	1	( )	4.57
*P172. develop a plan for quality assurance.	5	4	3	2	1	( )	4.52
P173. develop a program evaluation.	5	4	3	2	1	( )	4.48
*P174. plan an organizational design which reflects quality hospice care.	5	4	3	2	1	( )	4.50
P175. develop utilization review mechanisms.	5	4	3	2	1	( )	4.07
*O176. provide competent staff.	5	4	3	2	1	( )	4.71
*O177. provide for evaluation of all services.	5	4	3	2	1	( )	4.62
O178. provide for concurrent medical record reviews.	5	4	3	2	1	( )	4.33
O179. provide reviews of all hospice standards.	5	4	3	2	1	( )	4.39
O180. provide for review/evaluation of all contracted services.	5	4	3	2	1	( )	3.93
O181. provide an ongoing evaluation of services.	5	4	3	2	1	( )	4.41
O182. provide for re-evaluation of quality care issues.	5	4	3	2	1	( )	4.34
O183. provide quality assurance inservices.	5	4	3	2	1	( )	3.97
O184. function as a member of the quality assurance committee.	5	4	3	2	1	( )	4.35
O185. provide for quality assurance studies.	5	4	3	2	1	( )	4.09
O186. provide for retrospective medical record reviews.	5	4	3	2	1	( )	4.19
*D187. communicate quality assurance issues to the governing board.	5	4	3	2	1	( )	4.51
D188. communicate the importance of quality assurance to staff.	5	4	3	2	1	( )	4.43
D189. lead the quality assurance committee meetings.	5	4	3	2	1	( )	3.58
D190. do quality assurance studies.	5	4	3	2	1	( )	3.91
D191. do the program evaluation.	5	4	3	2	1	( )	3.90
D192. teach quality assurance inservices.	5	4	3	2	1	( )	3.64
C193. assure sufficient data collection to support quality assurance studies.	5	4	3	2	1	( )	4.15
C194. monitor the quality assurance plan.	5	4	3	2	1	( )	4.39
C195. assure re-evaluation of quality care issues.	5	4	3	2	1	( )	4.38

	Absolutely Necessary	Highly Necessary	Useful	Uncertain	Not Necessary	Delegated	Mean
*C196. assure competence of staff.	5	4	3	2	1	( )	4.64
*C197. monitor compliance with state hospice regulations.	5	4	3	2	1	( )	4.55
C198. monitor compliance with federal hospice regulations.	5	4	3	2	1	( )	4.31
*C199. assure appropriate and efficient use of resources.	5	4	3	2	1	( )	4.55
C200. engage in research relative to quality assurance.	5	4	3	2	1	( )	3.42
C201. monitor contracted services.	5	4	3	2	1	( )	4.04

PLEASE RETURN ROUND TWO OF THE HOSPICE ADMINISTRATORS COMPETENCY INVENTORY BY ***AUGUST 10, 1987***

MAIL TO:
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APPENDIX B

ESSENTIAL AND SUPPLEMENTARY COMPETENCIES AND PERCENTAGE DELEGATED SECTIONS A-E AND P, O, D, C

ESSENTIAL AND SUPPLEMENTARY COMPETENCIES AND PERCENTAGE DELEGATED SECTIONS A-E AND P, O, D, C,

Section A: Staffing and Personnel Management

	% Delegated
Essential Competencies (Planning)	
Plan staff development	.20
Plan 24-hour staff availability	.47
Develop personnel policies and procedures	.20
Plan staff assignments	.35
Plan resource support for staff	.20
Understand stress management theories	.04
Supplementary	
Plan recruitment strategies	.25
Understand motivational theories	.02
Develop staffing patterns	.20
Develop personnel grievance procedures	.24
Develop staff contracts	.14
Develop staff training for pt./family ethnic needs	.35
Content Mean = 3.85	Ave. % Del. = 22%
Essential Competencies (Organizing)	
Coordinate patient care assignments	.57
Provide for medical direction	.37
Provide on-call availability of staff	.33
Organize personnel policies and procedures	.22
Provide communication inservices	.35
Supplementary	
Provide support resources for staff	.24
Take on-call assignments	.37
Provide stress management programs for staff	.37
Provide training on ethnic issues	.25
Content Mean = 3.89	Ave. % Del. = 34%

Essential Competencies (Directing)	
Apply effective communication skills	.04
Teach the hospice philosophy to staff	.35
Conduct staff meetings	.14
Hire qualified personnel	.24
Counsel staff	.22
Conduct performance reviews	.24
Supplementary	
Teach inservices	.49
Direct all personnel activities	.49
Lead the Interdisciplinary team meetings	.63
Negotiate staff contracts	.33
Conduct stress reduction classes	.49
Conduct staff recruitment	.24
Content Mean = 4.00	Ave. % Del. = 31%

Essential Competencies (Controlling)	
Function as a liaison between the governing board and hospice staff	.08
Assure 24-hour availability of staff	.24
Resolve staff issues/complaints	.18
Schedule staff meetings	.14
Supervise the Interdisciplinary team	.29
Monitor staff orientation	.22
Monitor staff stress levels	.20
Supplementary	
Monitor disciplinary action	.10
Document staff meetings	.33
Monitor personnel files	.27
Monitor support resources for staff	.20
Initiate disciplinary action	.20
Attend the Interdisciplinary team meetings	.12
Supervise home visits	.55
Monitor recruitment	.14
Monitor personnel contract renewals	.22
Monitor the on-call schedule	.41
Engage in research relative to staffing and personnel	.06
Content Mean = 3.94	Ave. % Del. = 22%
Section Mean = 3.92	Sec. % Del. = 26%

Section B: Patient and Family Relations

	% Delegated
Essential Competencies (Planning)	
Develop confidentiality policies	.12
Develop bereavement policies	.33
Develop continuity of care policies and procedures	.25
Develop a pt./family rights policy	.20
Understand grief/loss theories	.16
Develop pt./family complaint mechanisms	.16
Develop pt./family admission and discharge criteria	.25
Develop respite options for the family	.27
Develop comprehensive needs assessment for pt./family	.51
Supplementary	
Plan for acute symptom control procedures	.53
Plan for ethnic needs of the pt./family	.35
Content Mean = 4.27	Ave. % Del. = 29%
Essential Competencies (Organizing)	
Provide confidentiality for the pt./family	.27
Provide an ongoing bereavement program	.57
Provide for resolution of pt./family complaints	.27
Provide for continuity of care	.43
Provide for the physical needs of the pt./family	.65
Provide for the spiritual needs of the pt./family	.67
Provide for the emotional needs of the pt./family	.63
Supplementary	
Provide for acute symptom control	.65
Provide respite care for the family	.47
Make home visits	.45
Coordinate pt./family transfers	.57
Provide for ethnic needs of the pt./family	.35
Content Mean = 4.15	Ave. % Del. = 50%

Essential Competencies (Directing)	
Communicate the hospice philosophy to the pt./family	.53
Communicate their rights to the pt./family	.59
Communicate admission/discharge criteria to the pt./family	.57
Discuss grief/loss issues with the pt./family	.59
Do the initial pt./family assessment	.65
Supplementary	
Communicate confidentiality policies to the pt./family	.57
Make bereavement visits	.65
Direct the bereavement program	.63
Content Mean = 3.99	Ave. % Del. = 60%

Essential Competencies (Controlling)	
Assure pt./family rights are respected	.45
Resolve pt./family complaints	.29
Assure pt./family spiritual needs are met	.57
Assure pt./family physical needs are met	.57
Monitor pt./family admissions and discharges	.37
Assure pt./family emotional needs are met	.55
Monitor bereavement follow-up	.45
Monitor continuity of care	.37
Monitor family involvement in the patient's care	.59
Monitor pt./family visits	.45
Monitor pt./family confidentiality	.31
Supplementary	
Engage in research relative to the pt./family	.29
Content Mean = 4.14	Ave. % Del. = 44%
Section Mean = 4.15	Sec. % Del. = 45%

Section C: Community/Public Relations

	% Delegated
Essential Competencies (Planning)	
Plan strategies to increase community awareness/ participation in hospice	.18
Plan strategies to increase physician awareness/ participation in hospice	.16
Plan hospice services which meet the needs of the community	.06
Plan strategies to increase governing board awareness/participation in hospice	.06
Plan strategies to increase clergy awareness/ participation in hospice	.20
Understand current community needs for health care	.04
Develop contracts with community health care agencies/facilities	.12
Develop marketing strategies	.18
Supplementary	
Develop bereavement education programs for the community	.51
Content Mean = 4.37	Ave. % Del. = 16%
Essential Competencies (Organizing)	
Provide program status reports to the governing board	.02
Coordinate hospice care with other community health agencies/facilities	.20
Provide hospice orientation to community groups	.37
Provide hospice orientation to the governing board members	.37
Identify individuals to potentially fill governing board vacancies	.18
Provide bereavement support for the community	.45
Supplementary	
Provide ongoing marketing activities	.24
Communicate pain management protocols to physicians	.55
Provide inservices for clergy	.41
Provide inservices for physicians	.43
Content Mean = 4.12	Ave. % Del. = 30%

Essential Competencies (Directing)	
Communicate the hospice philosophy to the community	.35
Communicate to the governing board about current hospice trends/issues	.02
Speak to interested groups about hospice	.35
Meet with other hospice administrators	.02
Contact physicians in the community	.35
Contact clergy in the community	.37
Write media articles on hospice care	.43
Implement marketing strategies	.24
Supplementary	
Lead bereavement support groups	.73
Content Mean = 4.24	Ave. % Del. = 31%

Essential Competencies (Controlling)	
Be accountable to the governing board for the hospice's day-to-day operations	.02
Maintain effective communication with community resource agencies	.14
Monitor community issues/trends which may affect the hospice program	.06
Oversee all promotional activities sponsored by hospice	.16
Review all media articles before publication	.14
Evaluate the community's perception of hospice care	.16
Monitor all public relations strategies	.10
Supplementary	
Monitor marketing strategies	.12
Schedule governing board meetings	.25
Document governing board minutes	.59
Engage in research relative to community/public relations	.10
Content Mean = 4.14	Ave. % Del. = 17%
Section Mean = 4.21	Sec. % Del. = 23%

Section D: Fiscal Management

	% Delegated
Essential Competencies (Planning)	
Develop a mechanism to account for gifts and donations to the hospice	.31
Plan the hospice budget	.31
Develop liability coverage for staff and board members	.27
Develop cost containment strategies	.22
Develop fund raising strategies	.41
Supplementary	
Plan financial statements	.53
Plan grant proposals	.27
Develop reimbursement policies and procedures	.22
Develop staff benefits plan	.25
Content Mean = 3.90	Ave. % Del. = 31%
Essential Competencies (Organizing)	
Provide for accurate accounting of gifts and donations to the hospice	.41
Provide for a balanced budget	.31
Provide ongoing funding support	.31
Provide liability coverage for staff and board members	.29
Interpret financial statements	.35
Supplementary	
Provide for salary increases	.33
Utilize computer programming assistance	.33
Content Mean = 4.01	Ave. % Del. = 33%

Essential Competencies (Directing)	
Communicate fiscal issues to staff and governing board	.16
Conduct fund raising	.41
Supplementary	
Prepare financial statements	.63
Recommend salary increases	.20
Compute volunteer cost savings	.39
Direct grants that are awarded to the hospice program	.14
Write grant proposals	.29
Prepare/issue payroll checks	.49
Content Mean = 3.72	Ave. % Del. = 34%

Essential Competencies (Controlling)	
Monitor hospice expenditures	.12
Assure accurate accounting of gifts and donations	.22
Monitor cost containment	.16
Monitor revenue resources	.24
Monitor liability insurance renewal	.25
Assure continued cost savings by volunteers	.25
Supplementary	
Monitor insurance claim processing	.29
Engage in research relative to fiscal management	.14
Content Mean = 4.04	Ave. % Del. = 21%
Section Mean = 3.91	Sec. % Del. = 30%

Section E: Quality Assurance

	% Delegated
Essential Competencies (Planning)	
Develop hospice standards of care	.24
Plan for appropriate use of resources	.08
Plan a quality assurance reporting mechanism to the governing board	.22
Develop a plan for quality assurance	.31
Understand quality assurance	.04
Plan an organizational design which reflects quality hospice care	.10
Develop a program evaluation	.22
Plan for re-evaluation of quality care issues	.22
Plan quality assurance inservices	.33
Develop utilization review mechanisms	.31
Supplementary	
None	
Content Mean = 4.45	Ave. % Del. = .20
Essential Competencies (Organizing)	
Provide competent staff	.10
Provide for evaluation of all services	.16
Provide an ongoing evaluation of services	.24
Provide reviews of all hospice standards	.25
Function as a member of the quality assurance committee	.12
Provide for re-evaluation of quality care issues	.20
Provide for concurrent medical record reviews	.31
Provide for retrospective medical record reviews	.33
Provide for quality assurance studies	.22
Supplementary	
Provide quality assurance inservices	.33
Provide for review/evaluation of all contracted services	.20
Content Mean = 4.32	Ave. % Del. = 22%

Essential Competencies (Directing)	
Communicate quality assurance issues to the governing board	.12
Communicate the importance of quality assurance to staff	.12
Supplementary	
Do quality assurance studies	.35
Do the program evaluation	.27
Teach quality assurance inservices	.49
Lead the quality assurance committee meetings	.53
Content Mean = 4.01	Ave. % Del. = 31%

Essential Competencies (Controlling)	
Assure competence of staff	.10
Monitor compliance with state hospice regulations	.10
Assure appropriate and efficient use of resources	.06
Monitor the quality assurance plan	.14
Assure re-evaluation of quality care issues	.08
Monitor compliance with federal hospice regulations	.10
Assure sufficient data collection to support quality assurance studies	.22
Monitor contracted services	.10
Supplementary	
Engage in research relative to quality assurance	.08
Content Mean = 4.28	Ave. % Del. 10%
Section Mean = 4.29	Sec. % Del. 20%

APPENDIX C

CORRESPONDENCE

ROUND-ONE LETTER

Dear Hospice Administrator,

For the past four years I have been a doctoral student in Family Ecology at Michigan State University, and I am now at the dissertation stage. As I have traveled to many hospice programs in Michigan and shared administrative program concerns, it seemed essential that research be pursued which would help to better define what skills and competencies were needed to establish hospice administration as a credible professional option in health care. What you do matters, and yet no one really understands all that you do. Therefore, I am asking you to work together with me on a study that will define hospice administration in Michigan. My dissertation is entitled: "The Identification of Competencies for Hospice Administrators in Michigan."

With your help this two-round study will bring us to consensus on the competencies as you identify them for hospice administrators in Michigan. Round One will give you the opportunity to rate competency statements as to how essential you feel they are. It will also provide the opportunity to add competency statements which you feel this researcher has inadvertently omitted.

In Round Two you will receive the revised survey to rate the competency statements again. The goal is to obtain consensus on the competencies under five broad administrative categories. Every administrator's response is critical to make this a valid study!

Important points to remember are:

1. This survey is not sponsored by, or related to, the Michigan Department of Public Health Hospice Coordinator position.
2. Participation in this survey is voluntary; respondents remain anonymous, and there is no penalty for nonparticipation.
3. The duration of participation in this survey extends from May 1987 (Round One) until June 1987 (Round Two).
4. A summary of the survey research will be sent to all respondents.

Please complete the enclosed Hospice Administrators Inventory (Round One) and return it to me in the enclosed self-addressed, stamped envelope by _____. DO NOT IDENTIFY YOUR HOSPICE PROGRAM OR YOUR NAME. Demographic data will only be requested on the first round.

Thank you very much for your support in this important research project.

Most Sincerely,

Sharon Olson, R.N., M.S.
2117 Rolling Brook Lane
East Lansing, MI 48823

ROUND-TWO LETTER

July 29, 1987

Dear Hospice Administrator,

Thank you for completing the Hospice Administrators Inventory (Round One). For your information, I have indicated the mean scores of each item after the "delegated" column on the right. If the item has an asterisk (*) to the left of the number it means that as a group you have reached consensus on that item and you do not need to score it again. There were 33 items which reached consensus in Round One.

Your final contribution on Round Two is critical to this research. Please complete the Hospice Administrators Inventory Round Two and return it to me in the enclosed self-addressed, stamped envelope by August 10, 1987.

Again, I appreciate your support in this study.

Sincerely,

Sharon Olson, R.N., M.S.
2217 C Stonehedge
East Lansing, MI 48823

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