A ROLE DESCRIPTION FOR ADVANCED PRACTICE NURSES WITHIN THE HOSPICE CONSTRUCT

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A ROLE DESCRIPTION FOR ADVANCED PRACTICE NURSES WITHIN THE HOSPICE CONSTRUCT

By

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ABSTRACT

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There is an opportunity to improve the delivery and the quality of health care to the hospice population. The purpose of this project was to first identify the need for advanced practice nurses within the context of hospice care, and second, to develop a role description for utilizing such nurses. Thirdly, this project suggests a means by which the advanced practice nurse's effectiveness in patient/family satisfaction, patient outcomes, and cost effectiveness can be evaluated. A literature search has revealed that very little has been published on this topic. Therefore, this role description suggests a comprehensive outline and plan addressing the role, implementation, and effectiveness of the advanced practice nurse within hospice. This role description has the potential for adoption and implementation by any hospice team and may result in improved delivery and quality of end of life care for all.

This project is lovingly dedicated to my wonderful family: my grandparents, parents, brothers and sisters, husband, children, and grandchildren. Without their unconditional love, support, and faith in me, I would never have reached this goal. They all have played a vital part in my life, my focus, and my accomplishments. I love them all very much and owe them everything. I take this opportunity to thank them and to acknowledge their tremendous contributions to my life.

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INTRODUCTION

What do dying people need and want? What are some of the greatest fears and challenges that people at the end of life encounter? How are these needs, wants, fears, and challenges met? These and many other questions are especially relevant in 1997 because all people are faced with the dilemma of end of life care whether for themselves or their loved ones. The fact that we are all faced with the dilemma has not made it any easier for our society to realistically face, deal with, or agree upon the issues surrounding this phase of the life cycle.

Hospice is one approach to end of life care. This specialized holistic health care system, comprised of an interdisciplinary team, is capable of providing pain and symptom management in addition to psychosocial support for patients and families coping with an irreversible illness. "The primary concern of hospice is LIFE and living it to the fullest extent possible while allowing death to occur naturally...LIVING while dying may seem a contradiction in terms, but it is a very real aspect of hospice care"(Ekhart, 1988, p.9).

Advance practice nurses (APNs) are independent healthcare practitioners who work collaboratively with physicians. Their independence resides in their orientation and training. Most APNs' education includes a base of four years of college and an additional two years in a master's program. Nursing, the center of the orientation of APNs, emphasizes the total needs of the patient and family, counseling, teaching and maintaining health (DeAngelis, 1994).

Safriet (1992) states that APNs are capable of a wide range of nursing and medical functions that were traditionally performed by physicians. Assessing, diagnosing, ordering laboratory and other diagnostic tests, conducting physical examinations, prescribing some medications, developing and implementing treatment plans, monitoring patient status for acute and chronic illnesses, consulting, collaborating with and referring to other providers are some of the functions. APNs are educated to provide diagnoses, management of acute and chronic illnesses, and disease prevention education and health promotion.

Advanced practice nurses working within the hospice construct can enhance end of life health care by facilitating excellent case management, timely and sophisticated interventions, and by upgrading the awareness of the other providers. When the advanced practice nurse is the primary care agent, continuity, accessibility and comprehensive coordination are the elements most apparent (Ebersole & Enloe, 1983). The knowledge, expertise, and experience of an APN in holistic health care are all assets to a hospice organization in the delivery of care to the terminally ill patient. The hospice concept is a growing alternative in our country. Hospice patients in the United States have grown from the first patient in 1974 to more than 340,000 patients with more than 2,510 hospice agencies providing care through July, 1995 (Lubash & Dunn, 1996).

Health care costs are also an issue in the health care and hospice arenas. "Advanced practice nurses have been underutilized despite research evidence supporting their efficacy, cost-effectiveness, and value in providing quality primary health care services" (Sullivan, 1992, p. 236).

In order to remain major players in the current managed care environment, hospices are in need of cost-saving alternatives. The cost of the implementation of services must be attractive to third party payors if hospices are to continue to offer hospice care to patients and families at the end of life. Therefore, a role description for advanced practice nurses within the hospice construct may offer a cost effective, evaluative, and useful tool for hospice organizations throughout the nation.

BACKGROUND OF THE PROBLEM

There are currently more than one thousand hospice patients in a large not for profit hospice in the Midwest and 340,000 hospice patients nationwide (M.L. Huber, personal communication, March, 20, 1997 & Lubash & Dunn, 1996). These patients have complex needs, desires, fears, and challenges. In the present situation these needs, desires, fears, and challenges are at risk for remaining unfulfilled by hospices. This is because most of the reimbursement for hospice comes from the federal government through the Medicare hospice benefit. Seventy percent of the above mentioned hospice patients are Medicare patients (C. Casson, personal communication, February 11, 1997). Hospices are provided per diem payments for each patient. Out of this per diem, the hospice pays for everything that is directly related to the terminal diagnosis, including medications, equipment, and services such as nursing, social work, and home health aide visits.

With managed care now capitalizing on the market, and with the potential of restructuring Medicare into a managed care model, the hospice construct is at risk

because the dollar can be stretched just so far. Who will the managed care companies contract with to provide end of life care? Will they understand what quality end of life care is and how vital it is to patients and their families? Will they access people who are true hospice providers or will they access those who deliver less than comprehensive hospice care?

There are many hospitals, home care agencies, and other organizations that have not had any hospice education or training but yet are bidding for "hospice care" with the health maintenance organizations and winning contracts for delivery of hospice care. Some of these organizations have never given hospice care (C. Casson, personal communication, May 14, 1996). Advanced practice nurses within hospices offer a real opportunity to provide quality cost-effective end of life care within any of the constructs.

Currently there are no federal Medicare regulations or guidelines that address the use of or reimbursement for advanced practice nurses within hospice. The need to revisit the governmental guidelines for end of life care within the present health care arena has become quite evident.

Hospices are challenged to find a way to utilize APNs within their per diem reimbursement. Some suggestions for this may be to rewrite the Medicare hospice benefit guidelines, (a project that is currently underway), or to work within the guidelines by developing protocols with the medical directors, or simply contracting with the medical directors of hospice organizations. Another approach would be for the managed care organizations to list APNs as approved providers.

The current composition for the hospice team includes a physician (medical director) and/or an attending physician, the registered nurse, licensed practical nurse, social worker, spiritual advisor, home health aide, home service aide, and the lay volunteers. Each of these team members has a specific job description and regulations surrounding the specific role. Hospice agencies have many other specific regulations governing their operations, all dictated through Medicare and the state departments of Consumer and Industry services. With the need for change identified, the stage is set for the development and implementation of a role description for advanced practice nurses within the hospice construct.

PURPOSE

Because advanced practice nurses are currently underutilized but well equipped and available to provide expertise and cost effectiveness, the purpose of this project is to develop a role description for their participation within the hospice construct. The role description will be a specific job description, outlining qualifications, functions and services, roles and responsibilities.

Kuebler (1997) believes that as advanced practice nurses move into the area of hospice, job descriptions, clinical protocols, standards of practice, specialized training, and education must be promoted and distributed to the consumer and to the health care system. This project will attempt to assist in that goal.

This role description will be based upon Hildegard Peplau's developmental model of nursing. The inherent values of this model include 1) people as unique individuals (equal partners in the care), 2) the necessity of a working, trusting relationship between

patient, family and nurse, and 3) the flexibility of application to different clinical settings. All of these values will be beneficial in applying this model to the participation of the advanced practice nurse within the hospice construct (Simpson, 1994, p. 94).

DEFINITION OF CONCEPTS

Role Description: Webster defines role as "a socially accepted behavior pattern usually determined by an individual's status in a particular society" (Mish, 1983, p 1021). The American Academy of Nurse Practitioners define the APNs' professional role as nurses serving as health care patient advocates, interdisciplinary consultants and resources (AAPN, 1993). They suggest that the APNs' role evolves in response to health care needs and changes and in response to the changing society in which they practice. The role description for this project will be defined as a descriptive framework outlining qualifications, functions and services, and roles and responsibilities.

Advanced Practice Nurse: An advanced practice nurse is a registered nurse who has completed a graduate level of education and/or is certified in an area of specialization (ANA, 1991).

> "Advanced practice nurses are primary health care providers. They provide nursing and medical services to individuals, families and groups, emphasizing health promotion and disease prevention, as well as the diagnosis and management of acute and chronic diseases. Services include but are not limited to ordering, conducting and interpreting appropriate diagnostic and laboratory tests, prescription of pharmacological agents and treatments and non-pharmacological therapies. Teaching and counseling individuals, families and groups are a major part of advanced practice nurses' activities"(AAPN, 1993, p. 1).

There are four categories of advanced practice nurses: (a) Certified Registered Nurse Anesthetists, (b) Certified Nurse-Midwives, (c) Clinical Nurse Specialists, and (d) Nurse Practitioners. More will undoubtedly emerge to meet future needs.

Hospice: Webster defines hospice as a "program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill" (Mish, 1983). Hospice is much more than that, however. Spector (1994) in her article, "What Makes Hospice Unique" for *Hospice Nursing Perspective*, describes hospice as a philosophy that provides empathetic, holistic, sympathetic, personal care to the dying and to their families. At the most critical phase of family life, hospice creates an atmosphere of spiritual meaning. It does not seek to cure, but to palliate. Hospice provides care in all settings, homes and institutions and does not end when the patient dies but provides bereavement care to the family and friends of the deceased.

Lebanowski (1997) describes hospice in much the same way. She states that it is an interdisciplinary program that provides pain and symptom management and supportive services to the terminally ill and to their families. She says that the essential characteristics of hospice include non-abandonment, willingness to bear witness, care management across settings, bereavement care for the family and care provided regardless of ability to pay (Lebanowski, 1997).

Hospice services include spiritual care for the patient and the family, volunteer hours for companionship and emotional support, and psychosocial support for death and dying issues, financial and legal concerns, and grief and mourning. Therapies such as

physical, occupational, and speech, and alternative therapies such as music, art, and massage are available. Dietary counseling, nursing assessments, support and teaching with twenty-four hour availability is also included. Home health aide services provide the patient with personal care and provide the caregiver with support and relief from the intensity and overwhelming tasks of caring for the terminally ill.

Hospice goals include affirming life, acknowledging death as a part of life, aggressively managing pain and symptoms, maximizing quality of life, alleviating suffering, and preserving the potential for human growth at the end of life (Lebanowski, 1997). Hospice neither postpones nor hastens death, it affirms life until death, emphasizing quality of life not the length of life. It empowers patients to live pain free with dignity and involves families in the care. A major goal is satisfactory mental and spiritual preparation for death (National Hospice Organization, 1997).

The definition of hospice must also include the levels of care and the reimbursement structure. Hospice provides for four levels of care: (1) home care, (2) inpatient care, (3) respite care, and (4) continuous care. Home care is the routine palliative, symptom management care that is provided in the home setting. However, home care can also include extended care facilities and adult foster care homes. These facilities are considered the patient's home. Inpatient care is provided for symptoms that may become out of control and for other situations not related to the life-limiting illness. The hospital contracts enable the hospice to provide for their patients within the inpatient setting.

Respite care is a level of care particularly designed for the caregiver. Arrangements are made with either extended care facilities or hospitals for the patient to stay for three to five days in the facility while the caregiver rests, travels out of town, or just regroups and adjusts the plan of care with the team. It provides a means by which a crisis can be defused and allows time for other alternatives to be put in place.

Continuous care is the ability of the hospice team to provide twenty-four hour coverage in the home or facility in support of the family and the patient. This can be done in the event of a medical emergency or the active dying process.

The Hospice Association of America (1997) states that hospice care is cost-effective. In 1995 the charges per hospital day were estimated at $1,810, $323 in a skilled nursing facility and $105 per covered day of hospice care. Ninety percent of hospice services are delivered in the home and that saves an estimated $2,884 over non-hospice users or $1.68 for every dollar spent in the last month of life (Hospice Association of America, 1997).

Reimbursement for hospice agencies comes from Medicare, Medicaid, and third party payors. These sources provide strict guidelines within which a hospice agency must practice. Michigan Department of Consumer and Industry Services surveyors, and focused medical review teams visit the agencies, review charts and decide on compliance to the regulations. They are empowered to make recommendations to the state based on their findings. Other sources of funding for hospices include memorials, gifts, and fundraisers. Most hospices provide care for patients regardless of their ability to pay.

Patient and Family: This concept is defined as a unit of care or the recipients of hospice services. In most cases, it is not possible to consider the patient without the family. The hospice philosophy helps preserve one of our country's most important social values: keeping families together and allowing family members to actively participate in the care of their loved one (Hospice Association of America, 1997).

The patient is the person with a life-limiting diagnosis, a disease process that cannot be cured and for whom the prognosis is approximately six months if the disease runs its normal course. This person is the focus of palliative medical care, and psychological, social, and spiritual support. This support is also provided to the patient's family, which is defined, as all those who are related to or provide for the patient.

CONCEPTUAL FRAMEWORK

A nursing model that provides a comprehensive framework for hospice nursing is Hildegard Peplau's Developmental Model (Figure 1)(Forchuk & Brown, 1989). The main theme of this model is the skill of interaction. Peplau "sees nursing as an educative instrument, a maturing force that aims to promote forward movement of the personality in the direction of creative, constructive, productive, personal and community living" (Forchuk, Brown, Crawford, Ide, Voorberg, & Bethune, 1989, p. 36). This fits with hospice nursing because so much of hospice involves relationships, interaction, trust building, and communication beyond the superficial level. Hospice patients are facing

one of the most important times in their lives, a time that requires much inner work, soul-searching, growth and development.

Nursing involves looking for suitable frameworks in which to practice, and assist clients to full recovery, assisted independence, or to a peaceful death (Simpson, 1991). Simpson states that Peplau's model provides nurses with a structure to direct their thinking, feelings, and actions and that the cornerstone of success is the nurse-patient/family relationship. The model also provides flexibility enough to be used in different clinical settings (Simpson, 1991).

Ira Byock, M.D., a well-known hospice physician and advocate, sees hospice as an agent to assist the patient in the resolution of life relationships and problems, in the achievement of growth and development in dying, and in understanding the human capacity to experience meaning and value within illness and dying (Byock, 1997). Peplau's model can assist the advance practice nurse in working toward this goal because the model views interactional dynamics as an avenue for exploring and understanding the patient's needs, feelings, attitudes, and beliefs within a relational partnership (Simpson, 1991).

The major concepts and their inter-relationships are depicted in Figure 1 (Forchuk & Brown, 1989). Within this model it is of major importance that patients learn about themselves, using their abilities to express themselves fully and freely to a nurse, thus maximizing their chances for further personal development (Simpson, 1991). Cheryl Forchuk, RN, MScN (1991), explained Peplau's major concepts in detail in her paper, "Peplau's Theory: Concepts and Their Relations (1991).

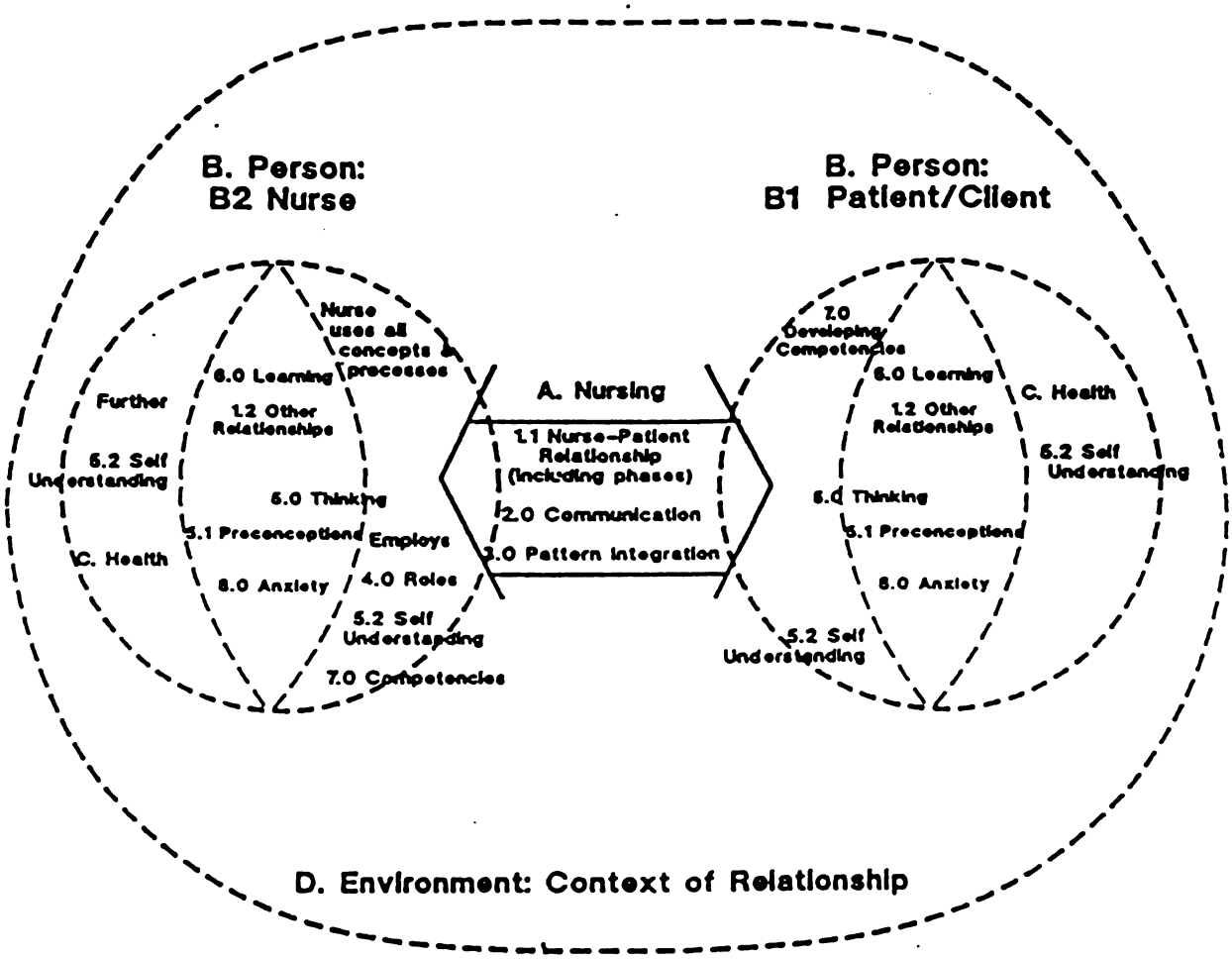

Figure 1.
Peplau's Framework: Major Concepts and Their Inter-Relationships (Forchuk & Brown1989)

The model is based on the assumption that people need support in retaining or achieving maximum potential to function within the society that influences their growth and maturation. Man is comprised of physical, psychological and social needs and when these needs are met, man grows and develops as human beings, seeking more mature ways to meet future needs (Simpson, 1991).

Nursing is the main transforming force that facilitates the growth of the patient and the nurse. Peplau characterized nursing as a propelling instrument toward productivity and fulfilled living both personally and within the community. Patient refers to those individuals, sick or well, that the nurse serves. The nurse is the "medium of the art of nursing" (Forchuk, 1991, p. 55). Health, the goal of nursing, is the symbol of productive living. According to the Peplau model growth is inherent in health. This coincides with the hospice philosophy that emphasizes growth, even at the end of life. Environment is defined as the context of the relationship, including physical and social aspects.

The nurse-patient relationship is the core in the Peplau model. The relationship develops as the nurse and patient spend time together and grows through interlocking and overlapping phases. These include the phase of orientation where initial trust is established, the phase of identification (exploring issues), the phase of exploitation (understanding of patient's needs), and the phase of resolution (plan for long term care or death). The roles that are described in the Peplau model are: the nurse as stranger, the nurse as a resource person, the nurse as a teacher, the nurse as a leader, the nurse as a

counselor, and the nurse as a surrogate (Simpson, 1991). These roles coincide with the characteristics of advanced practice nurses. Runtz (1983) described nursing roles, utilizing Peplau's model, as collaborator, educator, counselor and resource person. The American Academy of Nurse Practitioners (AANP) also lists these as roles of the advanced practice nurse (AANP, 1993).

"By using nursing roles effectively, the patients are encouraged to participate in their own care, to help formulate care plans and solve problems. It is through the phases of interaction that a nurse can identify how dependent a patient is likely to be, and this helps the nurse to predetermine the support that will be needed at various stages of the relationship" (Simpson, 1991, p. 20).

The phase of orientation is characterized by two factors, the felt need by the patient and the seeking of professional assistance (Fowler, 1994). This phase sets the tone for the following phases. It ensures that the patient understands the purpose and boundaries of the relationship (Martin, 1990).

The phase of exploitation is the phase in which the patient makes full use of all the available resources in his environment. In this phase, the relationship is one of mutual processes. Both the nurse and the patient are planning, establishing means of implementation of plans, and setting goals. It is a working through the issues, a cooperative effort based on the dynamic relationship (dependence/interdependence) (Simpson, 1991).

The nurse-patient relationship is a temporary one. It is service oriented and therefore has an ending. The resolution phase is known as the letting go phase, the "freeing process" (Simpson, 1991, p. 13). It is during this phase that a hospice patient

can look back over the course of the relationship, understand the growth and development that has occurred, and move more preparedly toward death.

In implementing Peplau's model within the environment of hospice care, (1.2 of Figure 1), "Other Relationships" will be considered family relationships. "Since nurses' interactions with their patients' relatives and friends are seen as a central part of their role, Peplau's model would not only involve the patient but also important friends and relatives, and the nursing process relationship would develop with the patient and relatives" (Fowler, 1994, p.196).

Communication includes nonverbal and verbal exchanges from both participants. This is the avenue that information is exchanged, understanding occurs, and growth is promoted. Pattern integration explains or portrays how individuals interact. This interaction can be complementary, antagonistic, or shifting back and forth. It is developed over time with each interaction and can be productive or nonproductive for the patient and the nurse (Forchuk, 1991).

To further explain the roles of the nurse in Peplau's model, Fowler (1994) states that the nurse, in role of stranger, must be accepting of patients and treat them as if they are able strangers until discovered otherwise (Fowler, 1994). The resource nurse brings expertise and knowledge; the teaching nurse incorporates instruction as an integral part of all roles; the leader must have previously examined her own leadership style and its implications to the nurse-patient relationship; the counselor plays a very active role in ongoing therapeutic interactions; and the surrogate role is a building block (Forchuk, 1991).

Thinking is the "process by which experience is incorporated, stored, organized, and recalled. By way of thought, events that are observed and conceptualized are linked, revised, and used in other experiences" (Forchuk, 1991, p. 56). This concept includes preconceptions, and self-understanding. Preconceptions are the thoughts and feelings of each participant prior to any interaction and self-understanding, to Peplau, is a requirement for effective nursing practice (Forchuk, 1991). Learning is an active process utilizing understanding, perceiving, and thinking. It can include the acquisition of new knowledge, enabling change, and problem-solving. It moves each of us from one step to another.

Competencies are developed skills that have been used and practiced. According to Forchuk (1991), they are categorized as intellectual, interpersonal, and problem solving.

Anxiety is something that everyone experiences. It is felt when the security of an individual is threatened. The effects of anxiety can be constructive or destructive, leading individuals toward or away from productivity. Simpson (1991) implies that in the care of the patient, it is the central theme when applying Peplau's theory.

All of the major concepts are interrelated. Participants bring their sphere of self to the nurse-patient relationship which occurs within the context of the environment. As with any humanistic model, there are potential difficulties. The nurse must be confident and competent in her skills for therapeutic support. She must have highly developed communications skills, educative skills, technical knowledge, and the ability to understand herself in depth. She must also be able to recognize when to assume the

appropriate role. Thus, one limitation to this model could be the nurse herself. In Peplau's model, the nurse must have the skills of listening, speaking, questioning, and reflecting. It goes without saying that not all nurses, advanced practice or not, possess these skills in completeness.

Another variable or limitation might be the concept of time. A "relationship" takes time to develop. It is something that evolves over time as the nurse and the patient work together. In the hospice setting, it is ideal that the team has at least six months with the patient and family. This, of course, is not always possible. On some occasions, the time together is just a few weeks or even days. The nurse must be able to make the most of every minute.

The Peplau model does not specifically address the communication between the nurse and the organization that employs him/her. The lines of communication must also extend to co-workers or in the hospice setting, team members. It is essential for the APN to be able to communicate effectively with all care providers.

Because of the emotional demands that are placed on the nurses, they will need support. This is ideal for the hospice setting as the team functions as a network of staff support. Nursing support is especially needed when using humanistic skills within a model. An advanced practice nurse would be ideal for this support for the primary care nurse and other team members. The highly developed skills and expertise of the APN lend themselves to this role.

Fowler (1994) sees similarities between Kubler-Ross and Peplau, thus further substantiating the use of Peplau's model in hospice care. Kubler-Ross has done extensive writing on the terminally ill and death and dying. In her book, *Living With Death and Dying*, (Kubler-Ross, 1981), her dedication is to those who courageously fight negativity both within themselves and society. The idea of fighting negativity can be compared to Peplau's idea that anxiety leads to either "positive growth or negative regression" (Fowler, 1994, p. 196). Both Kubler-Ross and Peplau believe that the nurse-patient relationship determines whether the patient's journey through illness is positive or negative, (Fowler, 1994).

Peplau's model lends itself to a means of evaluation, but this means would have to be developed by the researcher. According to Simpson, feelings are a major tool that nurses can use to assess patient's needs, and they can be measured by methods of self-assessment and self-awareness. He suggests the use of a psychological scale of patient dependency integrated with a scale of physical dependency. He concludes however that, the measurement of nursing using an interactional approach, where parameters of care are ever-changing, is a difficulty which has not yet been overcome (Simpson, 1991). Fowler (1994) also believes that Peplau's model gives structure on which to evaluate care.

REVIEW OF LITERATURE

The review of the literature exploring the utilization and evaluation of APNs within the hospice construct revealed that this idea is very new to hospices and has not been extensively researched and documented.

Hospice

There is an abundance of information available explaining hospice, its philosophy, structure, services, goals and benefits. The National Hospice Organization, individual state hospice organizations and agencies, practitioners and researchers have provided coverage for the depth and breadth of hospice care. Dr. Cassell succinctly states the need for hospice.

> "As sickness progresses towards death, measures to minimize suffering should be intensified. Dying patients require palliative care of intensity that rivals even that of curative efforts, even though aggressive curative measures are no longer indicated. Professionals and families are still called on to use intensive measures, extreme responsibility, extraordinary sensitivity, and heroic compassion" (Cassell, 1991).

Byock (1997) believes that hospice is a vehicle by which people can die well. He believes that people who are dying, journey through stages of adjustment, discovery, and insight as they adapt to changing circumstances in their person and in the ways that others react to them. He further states that "as a dying person reaches developmental landmarks such as experienced love of self and others, the completion of relationships, the acceptance of the finality of one's life, and the achievement of a new sense of self, despite one's impending demise, one's life and the lives of others are enriched" (Byock,

1997, p. 33-34). Hospices are becoming increasingly adept at helping the dying work toward meaningful goals (Byock, 1997).

Beresford (1997) states that hospice, for many facing the unique problems in coping with a terminal illness, is a compassionate but highly skilled and specialized response to those specific needs. He further explains what usually happens to patients after they enroll in a hospice program. The patient and the family are accompanied at their pace, encouraged to make the most of the time left, motivated to be autonomous, facilitated in personal growth at the end of life, and assisted in refocusing their energies toward living the days that remain (Beresford, 1997). People in the midst of the greatest crisis of their lives are given a specialized kind of hope.

The *Standards of Hospice Nursing Practice and Professional Performance* from the Hospice Nurses Association (1995) will also serve as a guide for the development of the role description. These standards are similar in presentation to the American Nurses Association Standards (1996). The hospice nursing standards, of course, pertain specifically to the specialty.

Advanced Practice Nurse Role

There is much written about the advanced practice nursing role since the nurse practitioner role originated in 1965. Advanced practice nurses have greatly impacted quality of care, provided cost-effective health care, and have increased accessibility of services for years. They need support for the increased patient needs in the diverse health care settings (Sellards & Mills, 1995).

The characteristics and competencies of APNs are listed and explained by Davis & Hughes (1995). The list of characteristics includes: risk-taking, vision, flexibility, articulateness, inquisitiveness, and leadership ability. APNs have the capacity to be self-directed, to adapt theory to practice implementation, to develop new theories from their knowledge and experience, and to provide new learning for the public (Davis & Hughes, 1995). The defined competencies (which fit with Peplau's theory) are listed as: "clinical expertise, critical thinking and analytical skills, clinical problem solving, collaboration, education and research, and program development" (Davis & Hughes, 1995, p. 158-159).

A case for the nurse practitioner movement gaining momentum is that APNs can be found in many clinical and geographic areas, including rural areas and inner cities and that they deliver high quality care to people of all ages (Davis, 1994). Davis (1994) continues to explain that the role blends both medical and nursing components, and in rural settings, APNs can provide care autonomously, without immediate assistance. Sullivan (1992) asserts that despite much research evidence supporting APN's efficacy, cost-effectiveness, and value in providing quality primary health care services, APNs are underutilized and if payment for services are not reimbursed comparable with physicians, serious financial disincentives would occur.

The American Academy of Nurse Practitioners (1993) provides a comprehensive outline for the APN standards and scope of practice. They define the APN role as primary nursing and medical providers for individuals, families and groups. APN services of teaching, counseling, diagnosis and management of disease processes, diagnostic and laboratory testing, health promotion and disease prevention along with

prescription of pharmacologics and therapies, are done autonomously or in collaboration with other health care providers. APNs are interdisciplinary consultants, patient advocates, and health care resources. The American Nurses Association has published the *Scope and Standards of Advanced Practice Registered Nursing* (1996) which will also guide the role description development. It is the guide for all roles of advanced practice nursing.

The managed care environment offers another unique role for the APNs. Madden & Ponte (1994) offer some thoughts on the APN in the managed care environment.

> "The role of the advanced practice nurse is based on expert clinical knowledge and skill and is practiced in multiple settings. They deliver care, manage patients and families, teach, consult, research, and do a range of other activities based on the needs of patients and the environment in which they practice...generally in an area that requires technical sophistication, in-depth knowledge, or complex decision-making...(they) will continue to be the lifeblood of the managed care organization and an asset that we cannot do without (Madden & Ponte, 1994, p. 56, 62).

Madden & Ponte (1994) feel that APNs are leaders in the following areas: reducing costs and enhancing quality of care by their impact on patient outcomes, providing new knowledge through research, and applying nursing research to nursing practice. Managing complicated patients and families, teaching, coaching and mentoring other nurses, impacting ethical decisions with their in-depth knowledge of clinical practice, and applying systems and financial knowledge to patient care decisions and nursing practice are other areas where APNs excel (Madden & Ponte, 1994).

Advanced Practice Nurse Within Hospice

Two correspondences received in the literature search stated that little information is available about the role of APNs in hospice (L. Powell & B. Mulich, personal communication, February 18, 1997). It has been suggested that the federal regulations surrounding hospice are in part responsible for this lack of literature (S. Solomon, personal communication, March 7,1997). APNs and hospice agencies are not finding reimbursement for the practice. Another factor could be the apparent lack of APNs who are interested in working in the hospice and palliative care field. However, since the movement of patient care out of acute care into home care, more and more APNs are likely to become involved.

Ebersole & Enloe (1983) present a case for the utilization of geriatric nurse practitioners (GNPs). This would apply to hospice because the greater percentage of hospice patients are elderly.

> "Considering that ninety percent of the population we serve is over sixty-five years old, we recognize the need for the additional geriatric expertise and the improved assessment skills of a geriatric nurse practitioner. We expect a GNP will facilitate better case management, more timely and sophisticated interventions, and upgrade all our nurses' awareness of the special aspects of aging"(Ebersole & Enloe, 1983, p. 48)

A certified family nurse practitioner in an Oklahoma hospice sees her responsibilities as a primary nurse, consultant, case manager, and coordinator for staff development, and provider of in-services for nursing homes and hospitals regarding hospice (Eckhart, 1988). A 1993 and a 1996 hospice job description for a nurse

practitioner listed the purpose or role as utilizing clinical expertise, expert knowledge, and diagnostic judgement to provide education, research, and consultation and to develop inpatient professional practice (Hospice of Michigan, 1993, 1996).

Another hospice, Dover House, has challenged the conventional roles in palliative care by implementing nurse practitioners into their structure. Their objectives were to provide their patients with more immediate access to care, provide increased continuity of care, and to unburden physicians. They developed protocols and identified five key areas for role development: remaining up-to-date with pain and symptom management, teaching others about pain and symptom management, researching palliative care issues, assuming a central clinical role by taking on extra responsibilities (guarded by protocols), and developing and maintaining a liaison role to link outside groups and hospice (Scott, 1995). Some advantages that this group enjoyed were the ability to expediently readmit patients to their unit, quick and easy access to the APN for pain and symptom management orders that enabled team members to be proactive rather than reactive, improved continuity of care and screening for potential problems, earlier access to blood test results and the elimination of delayed medical call backs. The staff benefited from the APN's presence by the reassurance of consultation, suggestions for patient care, teaching aids, and staff development (Scott, 1995).

APNs are viewed as underutilized but ideal practitioners for home care and hospice settings because of their outstanding assessment and interactional skills. They can coordinate the care of the dying patient, and can assist the family through the

grieving process (Solheim, et al, 1995). Home visits by the APN facilitate access to care for this particular population.

Weggel (1997) presented an extensive work on the role of the APNs in palliative care. This author presents evidence for the creation of a role of advanced practice nurse in palliative care. "The terminally ill are a specialized patient population that increasingly needs the expanded skills and knowledge of advanced practice nurses" (Weggel, 1997, p. 43). The APN's leadership skills, in-depth knowledge base, problem-solving abilities, and capability to negotiate in a complex integrated health care network uniquely qualifies the APN for the expanded role in comfort care. Further, the APNs can use their knowledge and skills in teaching and interaction. They can use their clinical competence and decision-making abilities to make decisions based on a holistic viewpoint. This makes significant contributions to palliative care (Weggel, 1997).

Weggel (1997) also contends that the studies that she has reviewed indicate that APNs have decreased costs and have improved the quality of care for the hospice clientele and states, "it is logical to assume that APNs could provide and oversee the provision of quality palliative care to patients, coordinate their care between home, hospital, clinic, or nursing home, and do so in a cost-effective way" (Weggel, 1997, p. 49).

Further evidence for the use of APNs in palliative care was substantiated by Rich, Beckman, Wittenberg, Leven, Freedland, & Carney (1995). These researchers found that a multi-disciplinary team, directed by a nurse, provided education, consultation, and

follow-up, for elderly patients with congestive heart failure and was able to reduce hospital usage and medical costs and improve the quality of life for this group (Rich et al., 1995).

METHODOLOGY

The purpose of this project is to develop a role description for utilizing APNs within the hospice construct and to suggest a means by which the effectiveness of the role description can be measured or evaluated. The role description will evolve from the review of current literature, the standards of practice for APNs and hospice nurses, and from information hospice organizations have provided that currently employ APNs. Aspects of Peplau's developmental theory will guide the pivotal concepts used in the development of the role description.

One of the first steps would be to define the roles and responsibilities, outline the qualifications, and then describe the functions and services of the APN within the hospice construct. Peplau's major concepts and their inter-relationships will guide this outline. Flexibility will be key in allowing individual hospice agencies the ability to implement the role description. The role description will incorporate *the Scope and Standards of Advanced Practice Registered Nursing* from the American Nurses Association (1996), and the role characteristics of an advanced practice nurse, the *Scope of Hospice Nursing Practice and Professional Performance* from the Hospice Nursing Association, and the *Scope of*

Practice for Nurse Practitioners from the American Academy of Nurse Practitioners (1993).

PROCEDURE FOR IMPLEMENTING SERVICES

The implementation of the following role description could occur within any hospice organization. It will allow enough flexibility for adaptation to any setting. The development of the role description will be guided by the previously referenced works of Peplau, the *Scope and Standards of Practice Registered Nursing* (1996), the *Scope and Practice for Nurse Practitioners* (1993), and the *Scope of Hospice Nursing Practice and Professional Performance* (1995).

The advanced practice nurse in this role description could a part of the organizational chart or be an independent contractor to the hospice agency and work in collaboration with the medical director. The APN would then be evaluated by the medical director, the patients/families, and peers.

Role Description

Job Title: Advanced Practice Nurse Within Hospice

General Summary: The Advanced Practice Nurse within hospice is a registered professional nurse prepared in a formal graduate educational nursing program. The practice builds on: (a) previous knowledge and skill in utilizing the nursing process, (b) knowledge of hospice philosophy and functioning, and (c) encompasses the roles, scope, and standards of both hospice and advanced practice nursing. The APN possesses the following characteristics: leadership, vision, inquisitiveness, flexibility, risk-taking, and articulateness. The roles of patient advocate, consultant, and resource person will be emphasized.

Qualifications:

1. The APN must have a current state registered nursing license in the resident state, (Michigan), have completed a graduate program for advanced practice nurses, and hold a clinical certification in a specialty field.
2. The APN must possess clinical expertise in all aspects of palliative care and hospice nursing concepts and principles, and must be able to apply concepts and principles from the behavioral and biological sciences.
3. The APN must demonstrate proficiency in pain management.
4. The APN must have worked for a least two years as an advanced practice, one year in palliative care.
5. The APN must be able to demonstrate competencies in the following areas: critical thinking, analytic skills, clinical problem solving, and organizational skills.
6. The APN must have the verbal, written, and interpersonal communication skills to easily develop a nurse-patient relationship.
7. The APN must maintain continuing education programs as outlined by the state and organizational guidelines.

Roles and Responsibilities:

1. Act as patient advocate for hospice patients.
2. Be a consultant for peers, the community, and other health care agencies.
3. Assume liaison role between hospice and all other health care providers.

4. Be an identified resource person for all questions regarding palliative care. Collaborate with physicians and others on the health care team.
5. Assume responsibilities for education of co-workers and the community regarding palliative care.
6. Conduct research as applicable to current practice.
7. Assume responsibility for a part in program development as mentor and/or administrator of specific aspects of the agency.
8. Participate in the evaluation process for care delivery (health care outcomes), patient and family satisfaction and cost effectiveness.
9. Advance the role of nursing and the APN while assuring that the standards of the nursing profession are maintained.
10. Maintain contact with professional organizations and involvement in health care on the local, state, and national levels.
11. Adhere to all established nursing and hospice standards, procedures, and guidelines.
12. Maintain confidentiality regarding health information other than conditions that are required to be reported by law.

Functions and Services:

1. Performs admission history and physical examinations and assessments,

periodic and on-going re-assessments, and acts as consultant for other nurses who are doing exams.

2. Utilizes the nursing process by forming nursing diagnoses, intervention and treatment plans, prioritizing needs, establishing goals, and monitoring and evaluating care progression.
3. Writes prescriptions, administers, and adjusts dosages of medications within guidelines of organizational protocols or in collaboration with physicians.
4. Orders diagnostic tests, interperts and evaluates results, and adjusts treatment plans as necessary. Collaborates with physician as needed with diagnostic testing.
5. Secures referrals for organization by explaining hospice to patients and families and developing a care management plan with them and their physician.
6. Makes home visits as necessary for continuity of care and follow-up monitoring.
7. Presents seminars or in-services about hospice to the community agencies, service programs, and other health providers.
8. Performs all necessary clinical procedures according to standards and guidelines.
9. Regularly consults with organizational nurses regarding patients' and families' needs and challenges and provides them with information and education.
10. Conducts research projects, disseminates and integrates findings.
11. Facilitates change through written protocols utilizing research findings.
12. Mentors nursing students and acts as role model to all nurses to promote nursing and especially palliative care nursing.

13. Participates in organizational committees and policy-making processes.
14. Assumes partial responsibility for the implementation, maintenance, revision, and evaluation of such.
15. Facilitates positive relationships with patients, families and co-workers understanding individual uniqueness and the phases of a working relationship.
16. Develops methods to evaluate the effectiveness of interventions or programs based on desired outcomes and objectives.
17. Maintains and reviews medical records for compliance with organizational and state regulations.

Supervision: Guided by organizational chart.

Working Relationships:

Internal: On-going contact with organizational employees in all departments.

External: On-going contact with referral sources, community members, health care providers and facilities.

EVALUATION OF SERVICES

The advanced practice nurse should be evaluated yearly on the performance within the role description and on specific nurse sensitive outcomes related to patient care, for example, patient/family satisfaction with APN performance/services. This evaluation would include not only the personal attributes of the APN but the overall effectiveness and value of the fulfillment of the expectations involved in the components of the role description.

The APN roles of collaborator, educator, resource person, and counselor, can be evaluated by using Peplau's model. This is accomplished by evaluating the mutual goals in relationship to expectations, time limits, success/failure of interventions (Runtz & Urtel, 1983). "According to Peplau's model the goal of action is the forward movement of personality and other ongoing human processes in the direction of creative, constructive, productive personal and community living" (Runtz & Urtel, 1983, p. 38). The ultimate goal is the transformation from anxiety to resolution or acceptance. If this has occurred for the patient and family, some success of the nurse-patient relationship has been accomplished. Identifiable sources of difficulty might be a conflict of goals between APN and patient and family, frustration on either part, or unmet needs. This is not to say that there are not varying stages of success and that all sources of difficulty can be overcome. But the general feeling of success/failure is definitely measurable.

The importance and the appropriateness of the APN roles as well as the role description itself would be potential aspects to evaluated. As APNs expand into hospice and palliative care and their roles expand, more opportunity for evaluation will exist.

Patient satisfaction is currently being measured by many health care agencies, including hospices. Anyone of these measurement tools, such as the Edmonton Symptom Assessment System (ESAS) (Bruera, et al, 1991) or the Missoula –Vitas (Byock & Merriman, 1994) would offer insight into the success of the APN practice. However, the outcome measurements must relate to the roles, responsibilities, functions, and services as outlined above. Besides patient satisfaction, cost effectiveness and pain and symptom management (all nurse sensitive outcomes) could be measured and evaluated. A hospice

in Michigan is currently measuring pain relief and will be evaluating patient satisfaction in the areas of dyspnea and nausea relief.

Hospices themselves are developing and utilizing evaluation tools that are adding much needed information to the overall nursing database. One challenge is the appropriate documentation tools to record the interventions that are implemented. If nurses find it too difficult or time consuming to record their findings or interventions, they probably won't record them.

Performance evaluations or reviews done by supervisors and peers can be an effective means of evaluation of an APN. If the peers are satisfied with the services and feel that the APN is contributing to their quality of care and/or personal growth, then the APN is being effective in the described role.

The APN's clinical competencies could be evaluated by using the measurement criteria that the American Nurses Association presents in their publication, the *Scope and Standards of Advanced Practice Registered Nursing,* and the criteria that the Hospice Nurses Association present in their written scope and standards. These criteria are specific and objectively measurable criteria.

One hospice, Hospice of Michigan, is tracking pain levels on admission, pain levels after twenty-four hours and pain levels after forty-eight hours. The next step will be to record and identity specific interventions to see which has been most effective in reducing pain (M. L. Huber, personal communication, May, 1997).

The impact of evaluation of services on nursing is great and far-reaching. It reaches into the realm of funding for programs as well as APN positions and

reimbursement level. If the role is scientifically proven to be effective in patient and family satisfaction, pain and symptom control and cost-effectiveness, the APNs' place in the health care team is solidified.

IMPLICATIONS FOR ADVANCED PRACTICE

The introduction of advanced practice nurses into the hospice setting is relatively novel and challenging. This venture will expand the utilization and scope of practice for APNs and will provide leadership in research and practice in palliative care. It will enhance the body of knowledge and the practice of all nurses.

Since APNs' roles and responsibilities include that of educator, mentor, and change agent, practicing in hospice would provide ample opportunity to fulfill these roles and responsibilities. The APN would have the opportunity to educate peers, community members and agencies, and other health care providers regarding hospice philosophy, goals, and services. The APN would then be a change agent because fewer dying persons would die in pain and more would be allowed to die in comfort, peace, and dignity surrounded by those they love.

As patient advocates and counselors, the APNs would direct efforts towards patient self-actualization, promoting a meaningful completion of life. Patients and families would have the opportunity, knowledge, and tools they needed to make a comfortable transition from futile aggressive interventions to comfort care.

As clinicians, APNs would play key roles in the assessment of the patient's response to a particular disease process, diagnosing the patient status, developing and

implementing treatment plans, and evaluating the care that is provided. It is within the clinical scope of APNs to manage and direct the care of this population.

Other implications of the APNs in hospice care would be that of collaborators, coordinators, and consultants. They would be an essential link between the community, health care facilities, community and health services, physicians, and funding agencies. There is much work to be done on this level. As previously discussed, the dying have special needs and challenges and only a small percent of the dying are now served by hospices (Lubash & Dunn, 1996).

The benefits of APNs within hospice are far-reaching. APNs are an untapped resource. Care providers, patients and families, and the entire health care system would all benefit from APNs in this capacity.

IMPLICATION FOR EDUCATION

The implications for education are many. First, there is an opportunity to educate nurses and health care providers at all levels regarding end of life care. The expansion of APNs into hospice provides ample avenues for knowledge expansion. APNs can participate in many educational opportunities such as providing in-services, workshops, seminars, or lectures on end of life care to fellow health care providers.

There is also the opportunity for APNs to educate the public. One of life's greatest challenges is getting the word out to people regarding their choices, the

implications of their choices, their rights, and the availability of services. The health care system is continually changing and the challenges of keeping up can be overwhelming, especially to the terminally ill population.

Another area of education implication would be in APNs' education itself. It is now important that palliative care be a part of the APNs' curriculum. By introducing them to palliative care and teaching them the existing knowledge, they in turn can expand that knowledge base and share with others.

The governing bodies whose power and influence regulate the delivery of health care are also in need of education on palliative care. Only by sharing with them the data gathered in actual cases can they understand the needs and challenges of the terminally ill. APNs are capable of gathering and disclosing numbers, statistics, and new knowledge. This gathering and sharing can only benefit all as it adds to our body of knowledge and understanding of a unique group of people.

IMPLICATIONS FOR RESEARCH

Hospice nursing research is growing and evolving, but since hospice began in the United States in 1974, it is a relatively new concept. It is also a concept that changes with legislation, funding, societal moods, and health care changes. There is much to learn from the terminally ill as seen in Dr. Ira Byock's book, *Dying Well*. Published this year, Dr. Byock writings offers a refreshing and insightful glimpse into the lives of people facing death. In each instance, the people he writes about have taught those

caring for them a great deal about life, humanity, individual uniqueness, and death and dying.

There is ongoing research on specific topics such as pain control, patient and family satisfaction, caregiver stress, and cost-effectiveness. The Missoula-Vitas Quality of Life Index and the Edmonton Symptom Assessment System (Byock, 1994 & Bruer, et al, 1991) are examples of such research. There are many more opportunities that await us, such as successful symptom management for nausea and dyspnea. APNs in hospice are ideally equipped and positioned to conduct research to add to the body of knowledge surrounding end of life care.

Conway-Welch (1996) states, "our research efforts, which continue to be directed at clinical problems, need to embrace health services research in outcome-focused areas, including quality of patient care, population-based care management, and cost effectiveness" (Conway-Welch, 1996, p. 290). Outcomes are the focus of much of health care today. We must all assist in providing hard evidence that APNs can and do make a difference in the health care arena.

The establishment of the APN role with the hospice construct is challenging. Conducting research on that role will also present its own obstacles (L. Selandars, personal communication, August 18, 1997).

CONCLUSION

The development of a role description for advanced practice nurses in hospice is only a small contribution to the field. It is however, worthy of consideration because of

the newness of the concept and the implications for the promotion of well being and comfort of mankind. We all face death. It is a fact no one will escape. It is important to explore all possibilities in working toward a death with comfort, peace, and dignity. Hospice is a viable alternative to many other health care choices. Hospice works. It works in controlling pain and symptoms, resolving family conflicts, dying peacefully, and in dealing with grief. Advanced practice nurses can and will make a tremendous impact in this field.

Peplau's conceptual framework was beneficial in the development of the role description as it offered ideas of nursing as an educational interactive avenue that promotes the development of constructive relationships which enables both patient, family and nurse to bring their uniqueness and perceptions together to work towards mutual goals. The nurse offers her skills, knowledge, and expertise while the patient and family offers themselves and their goals. Communication is the key to all of life and so it is in the nurse-patient relationship. The APN's skill in communicating acceptance and knowledge to others is of great impact and importance.

Hospice and palliative care offers a tremendously challenging platform for APNs. Are advanced practice nurses up to the challenge?

REFERENCE LIST

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American Academy of Nurse Practitioners (1992). Scope of practice for nurse practitioners. *Standards of Practice.* Washington DC: American Academy of Nurse Practitioners.

American Nurses Association (1991). Nursing agenda for health care reform. Kansas City, MO: American Nurses Association.

American Nurses Association (1996). *Scope and standards of advanced practice registered nursing.* Washington DC: American Nurses Association.

Beresford, L. (1997). Is hospice too depressing? *Hospice Manager's Monograph, 3*(Whole No. 1).

Bruera, E., Kuehn, N., Miller, M., Selmser, P., & Macmillan, K. (1991). The Edmonton symptom assessment system (ESAS): A simple method for the assessment of palliative care patients. *Journal of Palliative Care7*(2), 6-9.

Byock, I. (1997). *Dying well: The prospect for growth at the end of life.* New York: Riverhead.

Byock, I., & Merriman, M.P. (1994). *Missoula-Vitas quality of life index.* NHO Annual Symposium, Washington D.C.

Cassell, E. J. (1991). *The nature of suffering and the goals of medicine.* New York: Oxford University Press.

Conway-Welch, C. (1996). Who is tomorrow's nurse and where will tomorrow's nurse be educated?. *Nursing and Health Care Perspectives on Community, 17*(6), 286-290.

Cronenwett, L. (1995). Molding the future of advanced practice nursing. *Nursing Outlook, 43*(3), 112-118.

Davis, A. (1994). Nurse practitioners today and tomorrow [Letters to the editor]. *Nurse Practitioner, 19*(1), 74-76.

Davis, B. & Hughes, A.M. (1995). Clarification of advanced nursing practice: Characteristics and competencies. *Clinical Nurse Specialist, 5*(3), 156-160.

DeAngelis, C.D. (1994). Nurse practitioner redux. *Journal of American Medical Association, 271*(11), 870-871.

Ebersole P. & Enloe, C.H. (1983). Geriatric nurse practitioner-vital to hospice & home health. *Caring, 6,* 48-50.

Eckhart, D.J. (1988). Expanding horizons: The nurse practitioner and hospice. *Oklahoma Nurse, 33*(1), 9.

Forchuk, C. (1991). Peplau's theory: Concepts and their relations. *Nursing Science Quarterly, 4*(2), 54-60.

Forchuk, C., Beaton, S., Crawford, L., Ide, L., Voorberg, N., & Bethune, J. (1989). Incorporating Peplau's theory and case management. *Journal of Psychosocial Nursing, 27*(2), 35-38.

Forchuk, C. & Brown, B. (1989). Establishing a nurse-client relationship. *Journal of Psychosocial Nursing, 27*(2), 30-34.

Fowler, J. (1994). A welcome focus on a key relationship: Using Peplau's model in palliative care. *Professional Nurse, 10*(3), 194-197.

Fowler, J. (1994). Taking theory into practice: Using Peplau's model in care of a patient. *Professional Nurse, 10*(4), 226-230.

Hospice Association of America (1997). *Information About Hospice*. Washington DC: Hospice Association of America, 1-40.

Hospice of Michigan (1993, 1996). Job descriptions.

King, J.E., Lancaster, L, Pierce, J., Norman, L.D. (1996). Removing the walls and expanding the boundaries: A curriculum model for acute care nurse practitioners. *Nursing & Health Care Perspectives on Community, 17*(6), 304-307.

Kubler-Ross, E. (1981). *On death and dying*. London: Macmillan.

Kuebler, K. (1997). Signs of a change in seasons: Hospice and palliative care nurse practitioner. *FANFARE, 11*(2), 1, 8.

Kuebler, K. & Berry, P. (1997). The advanced practice nurse in hospice and palliative care. *Abstract*, unpublished.

Lebanowski, J. (1997). Hospice and palliative care. *OMEN/OMEN-TV, Ohio Medical Education Network*, February.

Lubash, B. & Dunn, S. (1996). The growth of hospice services in a managed care environment. *The Remington Report, 4*(4), 28-31.

Maddon, M.J. & Ponte, P.R. (1994). Advanced practice roles in the managed care environment. *Journal Of Nursing Administration, 24*(1), 56-62.

Martin, P. (1990). Peplau's interpersonal model: clinical applications. In: Reynolds, W. & Cormack, D. (Eds). *Psychiatric and Mental Health Nursing.* London: Chapman and Hall.

Mish, F.C. (1983). *Webster's ninth collegiate dictionary.* Springfield: Merriam-Webster, Inc.

National Hospice Organization (1997). *Hospice, 8*(1), 1.

National statistics on death and hospice (1994). *Thantos, 19*(3), 35.

Peplau, H.E. (1952). *Interpersonal Relations in Nursing.* New York: G.P. Putnam's Sons.

Rich, M., Beckham, V, Wittenberg, C., Leven, C., Freedland, E., & Carney, R. (1995). A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. *The New England Journal of Medicine, 333*(18), 1190-1195.

Runtz, S. & Urtel, S. (1983). Evaluating your practice via a nursing model. *Nurse Practitioner, 8*(3), 30-40.

Safriet, B.J. (1992). Health care dollars and regulatory sense: the role of advanced practice nursing. *Yale Journal on Regulation, 9*(407), 450.

Scott, G. (1995). Challenging conventional roles in palliative care. *Nursing Times, 91*(3), 38-39.

Sellards, S. 7 Mills, M.E. (1995). Administrative issues for use of nurse practitioners. *Journal Of Nursing Administration, 25*(5), 64-70.

Simpson, H. (1991). *Peplau's model in action.* London: Macmillan Education.

Solheim, K., Mirr, M., & Snyder, M. (1995). Setting for care. In: Snyder, M., & Mirr, M. (Eds) *Advanced Practice Nursing: A Guide to Professional Development.* New York: Springer.

Smith, M. (1995). The core of advanced practice nursing. *Nursing Science Quarterly, 8*(1), 2-3.

Spector, R.E. (1984). What makes hospice unique? *Hospice: The Nursing Perspective.* New York: National League of Nursing.

Sullivan, E.M. (1992). Nurse practitioners reimbursement. *Nursing & Health Care, 13*(5), 236-241.

Weggel, J.M. (1997). Palliative care: New challenges for advanced practice nursing. *The Hospice Journal, 12*(1), 43-56.