

Pittsburg State University

Pittsburg State University Digital Commons

Doctor of Nursing Practice Scholarly Project

Irene Ransom Bradley School of Nursing

Fall 12-15-2017

INPATIENT HOSPICE HOME: A NEEDS ASSESSMENT AND BUSINESS PLAN

Stacey Middleton

Pittsburg State University, smiddleton@gus.pittstate.edu

Follow this and additional works at: <https://digitalcommons.pittstate.edu/dnp>



Part of the [Public Health and Community Nursing Commons](#)

Recommended Citation

Middleton, Stacey, "INPATIENT HOSPICE HOME: A NEEDS ASSESSMENT AND BUSINESS PLAN" (2017).
Doctor of Nursing Practice Scholarly Project. 13.
<https://digitalcommons.pittstate.edu/dnp/13>

This Scholarly Project is brought to you for free and open access by the Irene Ransom Bradley School of Nursing at Pittsburg State University Digital Commons. It has been accepted for inclusion in Doctor of Nursing Practice Scholarly Project by an authorized administrator of Pittsburg State University Digital Commons. For more information, please contact digitalcommons@pittstate.edu.

INPATIENT HOSPICE HOME: A NEEDS ASSESSMENT AND BUSINESS PLAN

A Scholarly Project Submitted to the Graduate School
in Partial Fulfillment of the Requirements
for the Degree of
Doctor of Nursing Practice

Stacey Middleton

Pittsburg State University

Pittsburg, Kansas

December 2017

INPATIENT HOSPICE HOME: A NEEDS ASSESSMENT AND BUSINESS PLAN

Stacey Middleton

APPROVED:

DNP Scholarly Project Advisor

Dr. Kristi Frisbee, School of Nursing

DNP Scholarly Project Committee Member

Dr. Barbara McClaskey, School of Nursing

DNP Scholarly Project Committee Member

Dr. Stephen Horner, Department of
Management and Marketing

Acknowledgements

Special thanks to my committee members, Dr. Kristi Frisbee for reminding me that you can only eat an elephant one bite at a time and for allowing me to continually bounce ideas back and forth to make this project actually come to life; Dr. Barbara McClaskey whose smile always lit up the room when she saw me walk in a room; Dr. Stephen Horner who graciously met with me on several occasions to develop a workable business plan, something of which I had absolutely no understanding of in the beginning. Last but not least, thank you to my husband, Danny Middleton. Without his consistent support and understanding, I probably would not be standing where I am today. Thank you all from the bottom of my heart.

INPATIENT HOSPICE HOME: A NEEDS ASSESSMENT AND BUSINESS PLAN

An Abstract of the Scholarly Project by
Stacey Middleton

There are two constants that every person can count on in life, being born and dying. No amount of research is required, and there is no need to challenge the inevitable. When a child is born, people celebrate and congratulate the new parents and their family. When a person dies, people are saddened by the loss of a friend and loved one. Death comes to all and is either, fast and unexpected or a slow drawn out process. Every dying patient deserves to die with dignity, be free from pain, and be supported emotionally and spiritually. Currently, hospice programs offer each aspect. However, in the areas of Southwest Missouri, Southeast Kansas and Northeast Oklahoma the only options for hospice care are home hospice, hospice within a nursing care facility or in an acute care hospital none of which are able to provide long term 24/7 care for dying patients. This leaves a significant gap in services for patients with life-limiting and/or life-ending injury or illness in the tristate areas of Southwest Missouri, Southeast Kansas and Northeast Oklahoma. The goal of was to establish a need for inpatient hospice services in the local areas and develop a business plan to begin the process of establishing Care Plus Inpatient Hospice House and fill the gap in dying care services.

TABLE OF CONTENTS

CHAPTER.....	PAGE
List of Tables.....	vii
List of Figures.....	viii
Chapter I.....	1
Background and Significance.....	1
Clinical Problem/Issue.....	1
Significance of Project.....	3
Purpose of Project.....	4
Theoretical Framework.....	4
Roger's Diffusion of Innovation Theory.....	5
Kolcaba's Comfort Theory and Practice.....	7
Project Question.....	8
Definitions of Key Terms.....	8
Logic Model of the Project.....	9
Conclusion.....	11
Chapter II.....	12
Review of Literature and Evidence.....	12
History of Hospice Care.....	13
Current Hospice Options.....	14
Services and Reimbursement.....	16
Patient and Family Perceptions of Death, Dying and Hospice Care.....	18
Current Provider Knowledge and Attitudes towards Hospice Care.....	18
Conclusion.....	20
Chapter III.....	21
Methodology.....	21
Project	
Design.....	21
Sample/Target	
Population.....	23
Recruitment.....	24
Inclusion/Exclusion Criteria.....	24
Protection of Human Subjects.....	24
Instrument.....	25
Conclusion.....	27
Chapter IV.....	28
Survey Results and Business Plan.....	28

Survey Results.....	28
Demographic Data.....	29
Respondent Experience with Hospice.....	33
Respondents Attitudes about Inpatient Hospice	36
Business Plan.....	40
Product.....	40
Customers.....	40
What Drives Us?.....	41
Mission Statement.....	41
Principal Members.....	42
Legal Structure.....	43
Market Research.....	43
Industry.....	43
Customers.....	44
Competitors.....	44
Competitive Advantage.....	45
Regulations.....	45
Product /Service Line.....	45
Product or Service.....	45
Pricing Structure.....	45
Product/Service Life Cycle.....	46
Intellectual Property Rights.....	47
Research and Development.....	47
Conclusion.....	47
Chapter V.....	48
Summary, Conclusion and Recommendations.....	48
Relationship of Outcomes to Research.....	48
Observations.....	49
Evaluations of Theoretical Framework.....	50
Evaluation of Logic Model.....	51
Limitations.....	51
Implications for Future Projects and/or Research.....	52
Implications for Practice.....	53
Conclusion.....	
References.....	54
Appendix A.....	62
Appendix B.....	63
Appendix C.....	67
Appendix D.....	69

List of Tables

Table 1.....31

List of Figures

Figure 1. Logic model.....	10
Figure 2. Age of Respondents.....	30
Figure 3. Professional Background.....	30
Figure 4. Education Level.....	33
Figure 5. Years in Practice.....	33
Figure 6. Hospice Services Received.....	34
Figure 7. Length of Care.....	35
Figure 8. Overall Satisfaction.....	35
Figure 9. Likelihood of Utilization.....	37
Figure 10. Recommend Hospice Care.....	37
Figure 11. Need for Inpatient Hospice Facility.....	38
Figure 12. Importance of Services to be offered.....	38

Chapter I

Background and Significance

There are two constants that every person can count on in life, being born and dying. No amount of research is required, and there is no need to challenge the inevitable. When a child is born, people celebrate and congratulate the new parents and their family. When a person dies, people are saddened by the loss of a friend and loved one. Death comes to all and is either, fast and unexpected or a slow drawn out process. Many people fear dying, as there is always a fear of the unknown. “Will I have pain?” “What’s on the other side?” “Am I going to die alone?” Since the 1860’s, Florence Nightingale identified nurses as the one group of providers who could and would provide comfort and care to the sick and dying (Oliveira, 2013). Since that time, comfort care or hospice has evolved into a care partner that allows patients to die with a goal of minimal to no pain and discomfort, spiritual guidance and with someone always by their side.

Clinical Problem/Issue

Every dying patient deserves to die with dignity, be free from pain, and be supported emotionally and spiritually. Currently, hospice programs offer each aspect. However, in the areas of Southwest Missouri, Southeast Kansas and Northeast Oklahoma the only options for hospice care are home hospice, hospice within a nursing care facility

or in an acute care hospital. Though these options may seem ideal, there are a few obstacles that make each option less than desirable. Acute care beds need to be utilized for acute care patients. The goal of a hospice patient in an acute care bed is three days or less (National Hospice and Palliative Care Association, (NHPCO), Hospice Action Network, 2015). The next level of care is home or a nursing care facility while utilizing hospice benefits, and is covered by Medicare (NHPCO, Hospice Action Network, 2015). A patient may have another payer source that has been privately paid for, but are usually reserved for those in a higher social class.

The dilemma with transferring a hospice patient to a nursing care facility is, if a patient does not expire within seven days, the inpatient hospice benefit changes (NHPCO, Hospice Action Network, 2015) and the dying patient is moved to the long term care portion of the nursing home and the patient's long term care insurance, the patient or the family members are responsible for the actual "bed" in the facility which is approximately \$5600 a month (NHPCO, Hospice Action Network, 2015). Many people in Southwest Missouri, Southeast Kansas or Northeast Oklahoma are at or below the national poverty level and cannot afford many basic needs and do not have long term care insurance or cannot afford the cost of the long term care bed.

The final option is going home and utilizing hospice benefits. Medicare will cover all equipment and allow for skilled nursing visits, social work, as well as aide visits for personal care. What Medicare does not provide, is continuous care for a patient at home, who is qualified for hospice benefits. Most dying patients eventually need 24/7 care, leaving the responsibility to families who are unwilling or unable to provide the level of care required.

Unfortunately, the dying process is not influenced by Medicare hospice guidelines. As dying is not an exact time specific process, there is often a transitional period when a patient requires a level of care between the acute dying phase and the phase where the dying patient can still do things for themselves. This where the author's scholarly project begins.

Significance of the Project

This project is significant to the area of nursing practice due to the current gap in services for dying patients. Many nursing conversations surrounding hospice patients either discuss the occupation of an acute care bed for a dying patient or that a patient is being sent home to die in a situation that will not truly provide for dying with dignity. Neither aspect leaves a practicing nursing professional with a feeling of providing adequate care to the patient or their families.

As of October 2015, the Hospice Action Network notes that 35.7% of Medicare Hospice beneficiaries utilize the home hospice benefit and approximately 31% of the Medicare benefit is used for inpatient hospice care. According to Ortman, Velkoff, & Hogan (2014) the current elderly population is roughly 43 million. The prediction is that by the year 2050, that group of individuals will double to over 86 million. With such dramatic statistical estimation, individuals with chronic illnesses will be living longer and the need for comfort care in dying will be much more in demand.

The families of those elderly individuals will also be living longer with chronic illnesses and will be less likely to care for their loved one at home. The best option to fill the likely gap in care is to expand hospice benefits and care, including the expansion of hospice homes in several high demand areas in the United States. The Tri-State area is

one such area, as many families currently do not have the time, money or resources to stay home and provide continuous care for a loved one.

Purpose of the Project

The goal of this Doctor of Nursing Practice (DNP) Scholarly Project was to develop a business plan to create an inpatient hospice facility that will cater to individuals in the Southwest Missouri, Southeast Kansas and the Northeast Oklahoma areas who are facing the end of their lives and require continuous care. Southeast Arkansas would have been included in this study, however, there is an inpatient hospice unit located in Rogers, Arkansas that services the Northwest Arkansas region.

Theoretical Framework

The theoretical frameworks that were utilized to guide information collection and development centered on Roger's Diffusion of Innovation Theory and Kolcaba's Comfort Theory and Practice. Roger's Theory of Innovation guided the "understanding of how new ideas, processes, and products diffuse and spread within and across organizations" (Lundblad, 2003) and will continue beyond the scope of this project to guide the collection and distribution of information for development of an actual "Hospice House." Kolcaba's Comfort Theory connected the caring aspect, as that is the ultimate goal of all patient care which is "complicated, individualized and holistic" (Kolcaba, 2003, p. 1) at its finest hour. Combining the diffusion of innovation and caring allowed the author to combine principles that focused on allowing patients to die with dignity and not feel a burden to those who love them the most.

Roger's Diffusion of Innovation Theory

Change, in any aspect, is often difficult to accept due to the fear of the unknown. In 1962, Everett Rogers developed one of the oldest the social change theories, the Diffusion of Innovation (DOI). Rogers explained that an innovation is an idea, behavior or product and there are five stages of adopters across the continuum (NSW Agency for Clinical Innovation, 2015; & Behavioral Change Models, 2017; Orr, 2003):

1. Innovators: the first to try a new adventure or innovation, they are the first to try a new ideas and are willing to take risks with very little encouragement.
2. Early Adopters: the opinion leaders are often in leadership positions and are already aware that change needs to happen. Slightly more reserved than the innovator but still eager for change.
3. Early Majority: seldom hold leadership roles but once sufficient evidence is provided are easily persuaded to support an innovation.
4. Late Majority: Skeptical of change and support an innovation once it has provided successful outcomes.
5. Laggards: Conservative and bound by tradition, extremely skeptical of change and only conform due to social pressure or will continue to oppose an innovation.

Once the stages of adoption were identified, Rogers defined the five stages of adoption of an innovation (NSW Agency for Clinical Innovation, 2015; & Behavioral Change Models, 2017):

- Relative Advantage: the degree to which the idea, behavior or product is seen as better than what is currently available.

- Compatibility: the alignment with current perceived community needs and the ease of incorporation.
- Complexity: the ease of understanding and use.
- Trialability: the opportunity to trial or test before a commitment is made.
- Observability: the ability to provide tangible results.

Finally, Everett Rogers outlined the five phases of diffusion regarding the innovation-decision process (NSW Agency for Clinical Innovation, 2015; & Behavioral Change Models, 2017; Orr, 2003):

1. Knowledge: awareness of an innovation; new idea, behavior or product.
2. Persuasion: a favorable or unfavorable opinion or attitude is developed.
3. Decision: engagement in activities that support or reject the innovation.
4. Implementation: Utilization of the innovation.
5. Confirmation: evaluation of results from the innovation-decision already made.

According to Roger's Diffusion of Innovation Theory, the decision process, (Sanson-Fisher, 2004) begins by determining that there is a need in the community. For the purpose of this project, the author focused on the relative advantage and the perceived need in the local Tri-State area to develop a business plan and assessed the communities' knowledge and willingness to consider the innovation of a hospice house within the Tri-State area. Next, determine if the community healthcare entities (Health systems, hospice agencies, private providers and community members) have similar knowledge and if they believe that the development of such a facility would benefit the local community.

Following the data collection via the Needs Assessment Questionnaire, the author has

determined that the overall attitude towards the development of an inpatient hospice facility is accepted and encouraged. Education will continue to be vital to all parties who accept and oppose the project. Finally, now that the concept has been embraced, it will be within the best interest of all involved to move forward with the project and communicate the next steps in Roger's Diffusion of Innovation.

Kolcaba's Comfort Theory and Practice

The hospice concept is not new to nursing practice, but has only been funded by Medicare since 1983 (NHPCO, Hospice Action Network, 2016). It was vitally important to evaluate the level of knowledge that local communities had concerning actual hospice care. Kolcaba outlined the Care Plan for community Comfort Care and this plan was adapted to assess the viability of establishing an inpatient hospice facility that can provide continuous end-of-life care services to those in the three state area.

The first step in creating an inpatient hospice facility was completing a review of literature regarding the history of hospice care, current hospice options, services and reimbursement and current perceptions of hospice care. Step two involved the development of a project design or business plan that outlines the important aspects of creating a healthcare entity that caters to the community, the dying patients' and their loved ones. The third step included completing a community assessment to determine the amount of knowledge that the local community had about hospice care, specifically inpatient hospice. During the assessment, the author assessed the current needs (physical, spiritual, emotional and cultural) and whether the community members believed the needs of the dying patients were being met. The final step in the process was to meet with current hospice agencies and leaders of local health entities to determine the level of

partnership that could be established and whether or not these agencies considered an inpatient hospice house a viable option for the local areas and the surrounding communities. Currently, the author is considering an independent venture that will not require partnership with local healthcare entities. Lastly, this particular “care plan” was to consider the intervening variables that may positively or negatively affect the Hospice House development. All variables have been considered and the response has been significantly positive.

Kolcaba (2003) recommended the establishment of outcomes to be re-evaluated in the three months following the conclusion of a study. Upon completion of the project and the Hospice House has been established, it will be important to reassess the positive and negative effects in the local communities related to having an inpatient hospice resource in the area. Focus can then be to facilitate positive effects, as well as remedy any negative.

Project Questions

- What are the necessary elements in a successful business plan for a hospice home in the tristate area?
- What is the feasibility of opening a hospice home in the Tri-State Area?

Definitions of Key Terms

- Hospice care; Palliative care; Supportive care; End-of-Life care have been used interchangeably since the early 1960’s and have evolved from a philosophy of care to a professional discipline that concentrates on the care of dying patients. Many, many definitions are available in professional literature, however, the

ultimate definition is the “holistic care of the dying patient and their families” (Hui, D., et al., 2013).

- “Hospice is a patient centered, cost-effective philosophy of care that utilizes an interdisciplinary team of professionals to provide compassionate and expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient’s needs and wishes” (NHPCO, Hospice Care, 2015, p. 1).
- Comfort care: is the interrelationship between: (1) Symptom management, (2) Family care, (3) Interpersonal relationships, (4) Complementary between interdisciplinary roles (Waldrop & Kirkendall, 2013, p. 719).
- “Comfort” for the patient and family is the ultimate goal and a core value of nursing (Oliveira, 2013).
- Tristate area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma) includes the Missouri counties of Jasper and Newton; Kansas Counties of Cherokee and Crawford; and Oklahoma counties of Delaware and Ottawa.

Logic Model of the Project

The development of an inpatient “Hospice House” in the area of Southwest Missouri, Southeast Kansas and Northeast Oklahoma will likely alleviate the stress both nurses and providers feel when they believe a patient may be going into a less than adequate situation to live out their last living days and will give family members the peace of mind, knowing that someone is available to provide 24/7 care for their loved one, especially if they are unable. Initially, review of current literature guided the project direction and allowed for preparation to interview established hospice homes, allowing the author insight into the regulatory, financial and professional requirements required for

developing a “dying” business. Speaking with stakeholders at local facilities allowed the author to receive input from community leaders who possess insight into the level of support that is needed for the development of the actual inpatient hospice facility.

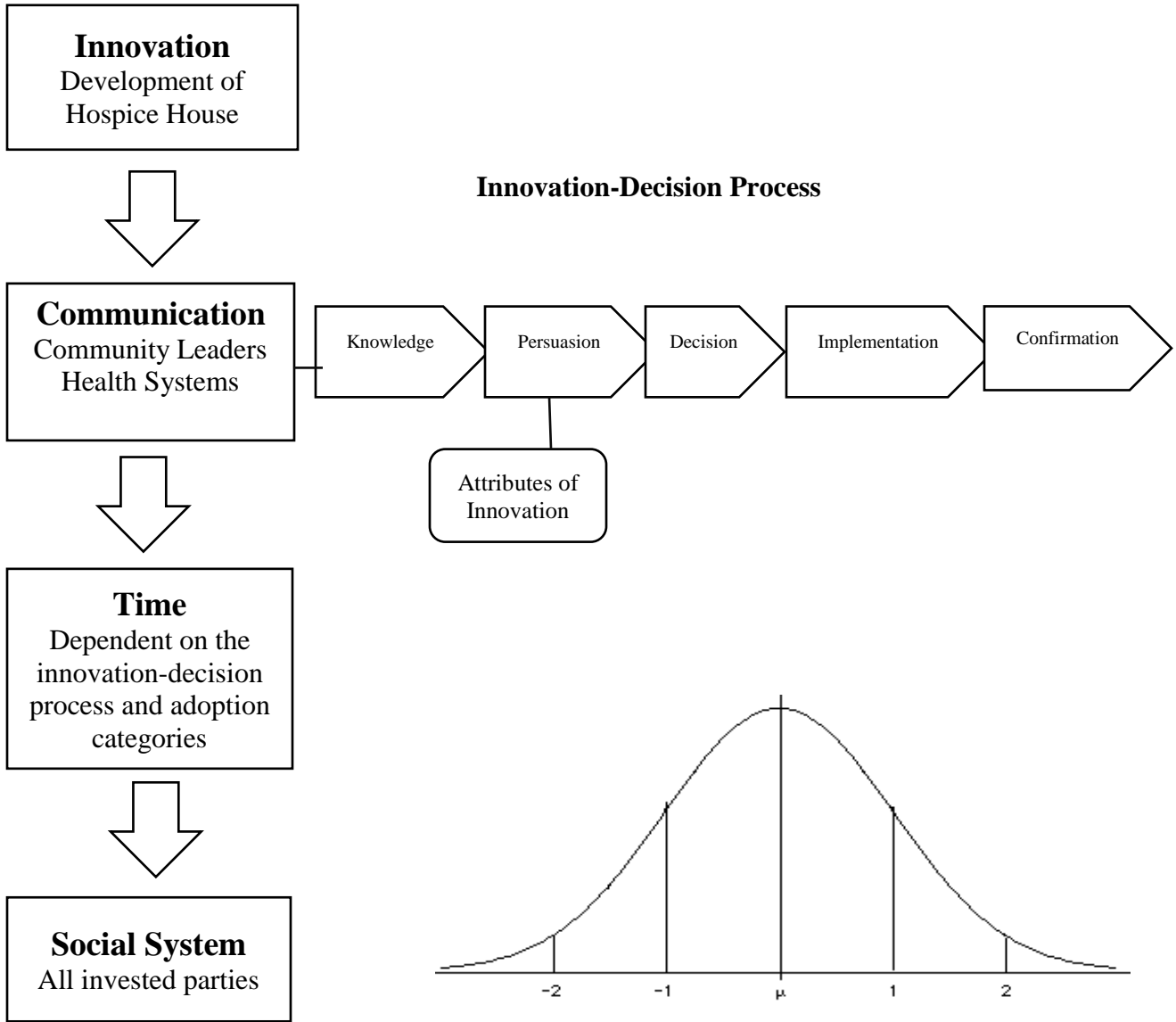


Figure 1. Logic model

Conclusion

Most patients will require continuous 24/7 care at some point in the dying process. Because death is inevitable, there will always be dying patients and there will always be a demand for end-of-life care and services. Development of a business plan served as an outline for future involvement of the actual inpatient hospice house facility. A community assessment enabled for collection of information and evaluation of current needs, knowledge, and beliefs within the community. The presentation of a business plan to key healthcare and community leaders will provide a visual interpretation of the inpatient hospice facility concept. Now that the community assessment has been completed, the author can determine the next steps in the process of opening an inpatient hospice facility, including approaching key community players who may have a vested interest in an inpatient facility.

Chapter II

Review of Literature and Evidence

A comprehensive review of literature was performed utilizing multiple databases including PubMed, Pro Quest Nursing and Allied Health Source, MEDLINE and the Cumulative Index of Nursing and Allied Health Literature (CINAHL). Seventy-six articles were reviewed for specific and detailed information. Several key words and terms were utilized in the literature search including comfort care, hospice care, inpatient hospice care, palliative care, supportive care, and end-of-life care. Actual literature reviewed was limited to English and non-English (translated) published from 2007-2017. Key websites were utilized as well, including Hospice Action Network, Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control (CDC). While many areas should be considered when gathering information, the author identified several aspects of hospice care information that were pertinent to the literature review. The progression of information begins with the history of hospice care and proceeds to issues regarding current hospice options, the latest service and reimbursement available, and patient and family perceptions of hospice care. The final area of information collected will speak to the current healthcare provider knowledge and attitudes toward hospice care.

History of Hospice Care

Death is inevitable. Every person will eventually die and of the 73% of people who accept that fact and want to die at home, only 53% are actually able to die in the environment that they are most comfortable, at home (Fisher, & Colyer, 2009; Hurley, Strumpf, Barg, & Ersek, 2014). According to Hurley, Strumpf, Barg, & Ersek, (2014), dying at home is the “gold standard” of where patients would choose to die. The average life span for a male in the United States prior to 1900 was less than 50 years old. The average age for a male in 1990 was 72.3 (CDC, 2017). The most recent information provided by the Centers for Disease Control is that the male life expectancy in 2017 is 84.3 years. Prior to the medical and technological advances in the 20th century, patients died at home surrounded by family and it was a truly personal experience. Families provided care to their own dying family members.

As medicine progressed and antibiotics were discovered, patients began seeking care in acute care hospitals to prolong their lives. The trend then became that patients who could not be cured were dying in acute care settings where they received 24/7 care by licensed personnel and providers. The first hospice program was initiated in the United Kingdom in 1967 and the first hospice in the United States was started in 1974 (NHPCO, Hospice Action Network, 2015b). As the new concept of hospice agencies were developed and utilized, end-of-life care moved back into the home setting. The Centers for Medicare and Medicaid Services (NHPCO, Hospice Action Network, 2015b) began reimbursement for hospice care in 1983.

Current Hospice Options

Currently, there are 6100 operating hospice agencies in the United States (NHPCO, Hospice Action Network, 2015b). “Hospice care is one of the fastest growing service categories in the American healthcare system” (Stevenson, Huskamp, Grabowski, & Keating, 2007, p. 1040). Though hospice agencies are seemingly nationwide, the majority of the hospice care for a patient falls to the families of those approaching the end of life. The typical hospice organization will set up home equipment needs, provide an initial admission visit, educate the family regarding the process and a nurse aide will come in approximately one hour a day or every other day to provide bathing and other personal hygiene tasks (Harrlod, Byhoff, Harris, Szolarova, Bender, Craig, & Casarett, 2014). A social worker and a nurse will make intermittent visits, otherwise all other care is provided by the family. Unless patients and families have had experience with hospice before, many are extremely disappointed to learn that the bulk of care is the responsibility of the family. The reality is that most patients in the Southeast Kansas, Southwest Missouri and Northeast Oklahoma do not have a person or family member they can depend on to provide care, the knowledge and skill (Newman, Thompson, & Chandler, 2013) or financial resources to stay at home and care for their loved one until they make the transition from this lifetime (Chung, & Burke, 2012).

Long-term care facilities can accommodate a hospice patient for a short period of time, however, once a patient has outlived the original seven-day stay, billing changes. The change includes the daily rate of a long-term care bed if a patient cannot transition to another level of care (Gozalo, Platzke, Mor, Miller, & Teno, 2015). Medicare will continue to provide the daily flat rate reimbursement and if a patient does not have long-

term care insurance or Medicaid, they or their family will be required to cover the cost of the bed. In the tristate area the cost is approximately \$166.00 a day (Missouri Department of Social Services, 2017).

The demand for hospice care continues to increase with the continued aging populations and those who are afflicted with terminal illnesses. Hospice referrals are being made earlier in the treatment of chronic illness, therefore increasing the number of patient who are receiving hospice care (Amano, Morita, Tatara, Katayama Uno, & Takagi, 2015). According to Baernholdt, Campbell, & Yan (2015), 1.65 million people utilized hospice care in 2011 and 44.6% died while on hospice care. Currently, more than one million people who are eligible and would have found benefit with hospice care did not receive it.

There are a multitude of reasons that hospice care was not utilized including lack of education regarding hospice care, a local service provider, and challenges surrounding the care in rural areas and/or lack of knowledge or education regarding hospice care. A common misconception is that hospice care is only for cancer patients, however, more and more patients are living longer with heart failure, COPD, multiple sclerosis and many other life limiting illnesses. All of the above factors provide a path to an alternative means of providing care for the dying patients, inpatient hospice. Not all dying patients can die at home, in a nursing home within seven days or in the hospital.

The latest trend in end of life care is the development of inpatient hospice units and homes that allows patients to die comfortably and surrounded by family and friends with 24/7 care, adequate pain control and a holistic care approach that cares for the patient, families and friends. “The United Kingdom hospice system is the most

developed system in the world and has served as a model for provision of palliative care globally” (Sleeman, Davies, Verne, Gao, & Higginson, 2016). In England, approximately 55% of admissions are for end of life care, the other 45% of admissions are for symptom control and respite care and 35% of reimbursement comes from the government (Sleeman, Davies, Verne, Gao, & Higginson, 2016). The first inpatient hospice facility in the United States was opened in New York State in 1995 and provided a home-like facility for the benefit of its patients who did not have caregivers at home (Chung, & Burke, 2012).

Services and Reimbursement

The overall goal of providing care to patients in an inpatient hospice setting is to provide not only physical comfort, but also psychological, social and spiritual support to patients and their families (Kolcaba, 2003). Hospice care not only improves the end of life for patients and families but is also a cost effective measure to reduce the amount of emergency department visits and hospital admissions for patients with terminal illnesses. According to Kirolos, Tamariz, Schultz, Diaz, Wood, & Palacio (2014), patients who are admitted to an inpatient hospice facility can save approximately 40% of health care costs just in the last month of a person’s life.

Reimbursement rates from Centers for Medicare and Medicaid (NHPCO, Hospice Action Network, 2015a) for hospice care are slightly higher in urban areas, but in Southwest Missouri, Southeast Kansas and Northeast Oklahoma the rates are very similar. Reimbursement for routine home hospice care for days 1-60 are reimbursed at approximately \$164.00 daily, days 61 and beyond are approximately \$129 a day. Continuous home care is reimbursed at \$34.65 an hour and inpatient respite care is paid

at approximately \$152 a day. If a hospice patient is admitted to an acute care facility, the daily rate for home care is halted and the inpatient facility is paid at \$641 a day (NHPCO, Compliance Tip Sheet, 2012). No rates are listed for inpatient hospice care facilities. Reimbursement is vital to the continuation of care and will need to be addressed further at a later time.

End of life care in an aesthetically pleasing environment can be easily accomplished when focusing on the total care of patients and those they care about the most. Several factors can be addressed within an inpatient hospice facility that cannot be dealt with swiftly in the home care environment. Within the hospice facility, a team approach is recommended to provide well-rounded quality care (Zanartu, & Matti-Orozco, 2012). The team should consist of a minimum of a provider, a pharmacist, social worker, nurse, unlicensed assistive personnel, pastoral care and volunteers. A well-rounded team can approach every aspect of the patient and family's needs and support a caring and safe environment (Sandsdalen, Grondahl, Hov, Hoye, Rystedt, & Wilde-Larson, 2016). Providing frequent, scheduled family and support staff meetings as well as impromptu meetings will keep the lines of communication open and encourage the patient and families the opportunity to be and feel more involved in care decisions or changes in the patients status (Meeker, Waldrop, & Seo, 2015; Moir, Roberts, Martz, Perry, & Tivis, 2015). Education of potential patients, families and the local communities will be vital to the establishment and maintenance of an inpatient hospice facility.

Patient and Family Perception of Death, Dying and Hospice Care

When patients anticipate death and dying, the greatest fear is that of the unknown. Death is perceived as either a “good death” or a “bad death” (Ko, Kwak, & Nelson-Becker, 2015). A good death can be classified as “dying peacefully, not suffering, experiencing a spiritual connection, and making amends with significant others and a bad death consists of experiencing death by accident or violence, prolonging life with life support, becoming dependent while entering a dying trajectory and dying alone (Ko, Kwak, & Nelson-Becker, 2015). Given the choice, most people would choose to reach the end of their lives in a peaceful state surrounded by loved ones. Hospice care is a wonderful benefit to those who are willing to accept that they have reached the end of their life. Unfortunately, acceptance of an impending death is very hard for patients and families to accept and providers often look at consulting hospice as a failure to provide the best care to their patients (Sheward, Clark, Marshall, & Allan, 2011). Every year, the number of patients enrolled in hospice care continues to grow but continues to be underutilized in the United States and many other civilized countries (Dembinsky, 2014). Education regarding hospice care will play a vital role in ensuring that patients, families and caregivers receive sufficient end-of-life care.

Current Provider Knowledge and Attitudes towards Hospice Care

Of the 97.5% of physician who expressed comfort of discussing palliative or hospice care, only 43% reported that they actually had the discussion with their patients (Bakanic, Singleton & Dickinson, 2016; McCann & Adames, 2012; Snyder, Hazelett, Allen & Radwany, 2012). Currently, there is an underutilization of palliative and hospice care associated with primary care physicians (PCP’s) (Snyder, Hazelett, Allen, &

Radwany, 2012). There are two options in providing care to patient with a life-limiting disease or injury, palliative care and hospice care. Current research indicates that only 20% of PCP's believed that palliative care is appropriate only for patients with six months or less to live (Snyder, Hazelett, Allen, & Radwany, 2012). A somewhat common misconception is that palliative and hospice care are one and the same (Bakanic, Singleton & Dickinson, 2016; McCann & Adames, 2012; Snyder, Hazelett, Allen & Radwany, 2012). The definition of hospice care is the pursuit of optimizing quality of life with pain control and comfort while forgoing curative treatment and usually occurs at the very end of a patients' illness or injury (Snyder, Hazelett, Allen, & Radwany, 2012). Palliative care is defined as the optimization of quality of life at any time during the illness process, while providing aggressive symptom control and continuing to pursue treatment for a life-limiting disease or illness such as chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF) (Snyder, Hazelett, Allen & Radwany, 2012).

Among the issues that primary care physicians cite as reasons for not referring patients are the reluctance that patient is a good candidate, inability to distinguish between palliative and hospice care, lack of training, lack of knowledge regarding advance directives and fear of causing patient and families to give up hope (Snyder, Hazelett, Allen, & Radwany, 2012). According to McCann & Adames, (2012, p.289) "the dominant culture of the healthcare system views death as a failure of modern medicine, an event of unspeakable terror and taboo." Physician education is focused on curative care and they are trained to treat patients and make them better, while nursing education is focused on the caring aspect (Bakanic, Singleton & Dickinson, 2016).

Because of the differences in education, physicians and nurses often see death and dying from different perspectives (Snyder, Hazelett, Allen, & Radwany, 2012).

Conclusion

There is a significant amount of research available covering several aspects of hospice care. Hospice care has continued to evolve since its inception in 1983 and will continue to change and improve with more research and advances in technology. Current trends were identified along with services currently available and reimbursement options. As hospice care continues to evolve, hopefully provider perceptions will also convert from failing patients to providing the best care at the end of a person's life. Perceptions will continue to improve with continued hospice education and exposure.

Chapter III

Methodology

There is currently not an inpatient hospice facility within 90 highway miles of Southwest Missouri, Southeast Kansas and Northwest Oklahoma and the need for inpatient hospice services is not likely to decline with the aging of baby boomers and the incidence of chronic illness and injury. This chapter will focus on the development of a business plan for the establishment of an inpatient hospice facility. It will also describe the sample/target group, the instrument used and statistical analysis. The methods utilized for this project are a healthcare provider survey regarding previous experiences with hospice and the development of a business plan to establish an inpatient hospice facility. The goal of this project was to establish a needs assessment for an inpatient facility and develop a workable business plan.

Project Design

The first step in developing the business plan is accessing the Small Business Administration website and utilizing the outline for the developing a small business plan (SBA.gov, 2017). The name selected for the inpatient hospice unit is Care Plus Inpatient Hospice House. The location of the facility has yet to be identified, but will service Southwest Missouri, Southeast Kansas and Northwest Oklahoma. There are currently

several home hospice agencies, but no inpatient facilities are currently available in those areas.

The product being offered is an inpatient hospice facility, providing end of life care and services. The customers will be the patients and their loved ones to whom we will offer services. The main goal behind servicing the local area is to provide an inpatient end of life service and to provide quality compassionate care to those who utilize our service. To determine a needs assessment of an inpatient hospice facility in the tristate area, a needs assessment survey (Appendix A) was distributed via email to healthcare providers and caregivers in the Southwest Missouri, Southeast Kansas and Northwest Oklahoma areas. A mission statement was developed to guide the development of the project and the daily operation of Care Plus Inpatient Hospice House and key players, who will be the principal members of the organization were identified. Currently, the author is planning to move forward with an independent not for profit facility that will negate the need for partnerships with local healthcare entities.

Market research indicated and supported the need for inpatient hospice services in the local area. Customers were identified as providers and caregivers who treat patients with life limiting illness or injury. Competitors were identified as local acute care facilities that offer inpatient hospice services when no other option is available; nursing care facilities that also offer end of life care but for a limited time only; and outpatient hospice agencies who service a large number of patients who are at the end of their lives, but are unable to offer consistent 24/7 care if indicated for a dying patient. Care Plus Inpatient Hospice has the competitive advantage in the local area, as the next closest

inpatient hospice facility is almost 100 miles away. The inpatient facility will be regulated by Centers for Medicare and Medicaid Services.

Products and services to be offered to our customers are continuous end of life care; symptom and illness management; assisting with emotional, psychosocial, and spiritual needs of patients and families; provide medications, medical supplies and equipment for patient care; coach and guide families in terminal patient care; delivery of special services, physical and occupational therapy; respite care; and bereavement care (NHPCO, 2015a). Pricing structure will be developed following CMS guidelines and the most current reimbursement rates and currently run at a rate of \$275.00 to \$290.00 a day.

Sample/Target Population

This project included two target populations local healthcare professionals and patients and their families. Local healthcare professionals are the providers, administrators, nurses, social workers and case managers in the Southwest Missouri, Southeast Kansas and Northwest Oklahoma areas who work to transition patients from one level of care to the next. The second targeted groups were the patients and families who have either been exposed to or utilized hospice services in the local area. Recruitment of survey participants included face-to-face interaction and an online survey through Survey Monkey to obtain views of healthcare professionals regarding inpatient hospice services. Networking with local providers allowed for significant exposure to providers and their input regarding inpatient hospice care development. Due to the possible vulnerability of patients and families, and the inability to foresee personal experiences and assess coping mechanisms of former patients and families, this population was not surveyed at this time.

Recruitment

Recruitment of the sample or target population consisted of one-on-one contact to request participation in the “Inpatient Hospice Home Needs Assessment Questionnaire” and an email address was obtained. The survey link was emailed to each person along with a cover letter (Appendix A) summarizing the rationale for the survey and the needs assessment for an inpatient hospice facility in the local area. Along with the survey (Appendix B), the cover letter included directions for assessment that included a statement that by completing the survey participants were consenting permission to use and publish the data obtained. Generalized demographic information was requested including age, gender, professional background, level of education and years in healthcare practice.

Inclusion/Exclusion Criteria

Inclusion criteria required that individual respondents work within the primary care arena at some point in the previous ten years and included any person who willingly answered and returned the surveys, and could understand the English language. Exclusion criteria included any individual who was 18 years or younger and those who were unable to provide an answer to the questions that were asked. Protection of human subjects was obtained by collecting minimal participant information and only included age, gender, and diagnosis. No further identifying information was collected or maintained.

Protection of Human Subjects

Prior to the distribution of the cover letter and the online assessment survey, IRB approval was received from the Irene Ransom Bradley school of Nursing IRB review

board and the Pittsburg State University IRB review board for an exempt review. Risks of participation in the study included emotional recollection of loved one. Benefits of collected survey data was used to determine that local providers believe there is a need for an inpatient hospice facility in the local tristate area.

Instrument

This project utilized an online survey (Appendix A). Participants who personally requested the authors contact information and requested the survey implied consent. The survey included demographic data as well as questions regarding education level, current practice, knowledge and previous experiences with hospice care. The decision was made to survey healthcare workers who may or may not have had exposure to hospice care either professionally or personally. The providers included in the survey were physician's (MD, DO) advanced practice nurse's (APRN), physician assistants (PA), nurses, social workers or case managers in the tristate (Southwest Missouri, Southeast Kansas and Northwest Oklahoma) area. Demographic data about survey participants was collected including: age, gender, professional background, level of education and years of practice.

An instrument specific to the research question was not identified, so a survey tool was developed and approved by the IRB committees prior to administration. The instrument was developed following a review of current literature and based on the needs of hospice patients according to Clinical Practice Guidelines for Quality Palliative Care (National Consensus Project, 2013). The first question was a qualifying question and if the provider had not practiced in any type of primary care in the last ten years, they were not able to continue with the survey. The next six questions were about personal experiences with hospice care. The next set of five questions sought data about the

professional opinions of the providers regarding hospice needs in the three state area (Southwest Missouri, Southeast Kansas and Northwest Oklahoma). The final set of five questions focused on the collection of demographic data. The test included a variety of question types including multiple choice questions, 5-point Likert scale responses that included very important to very unimportant, very likely to very unlikely and strongly agree to strongly disagree. The survey also gathered qualitative data for a descriptive study of the research topic.

The timeline of action for the development of a business plan for an inpatient hospice facility was separated into several phases of action. The first phase was the collection and analysis of survey data. The second phase of the timeline was the development of the business plan. The third phase of the project is to apply for a 501c3 non-profit designation and approach possible benefactors who have expressed an interest in the development of an inpatient hospice facility. Once a non-profit designation is obtained and financial backing can be secured, the next step will be finding a lease property and making the location handicap accessible. Once renovations have been completed and public education has been provided, the facility move through the final phase of opening its doors and offering care to patients and families in the local tristate area.

The resources required to complete this project were personnel, technology and personal time commitment for the development and distribution of surveys, survey analysis and the development of the business plan. Two personnel worked to develop, administer, and tally survey data. Two personnel also worked to develop a functional business plan. Four personnel met to evaluate the results of the study and provided

information and guidance for completion of the project. Current technology required the use of computers to email cover letters and survey links, to take surveys and to tally survey data. Active Internet service was vital to the collection and distribution of information. Personal commitment of time and effort by the author and the three committee members and survey participants was also required for project completion and success.

Participants of the survey were either personally requested or a notice was placed on the authors' Facebook page asking friends to share the project and goals. A private message was requested containing a contact email to send the survey cover letter and the survey link to each individual. All contact was made personally by the author and directly to each participant. Subjects were identified as health care professionals (MD, DO, APRN, PA), nurses, social workers or case managers in the tristate area (Southeast Kansas, Northwest Oklahoma and Southwest Missouri).

Conclusion

The Inpatient Hospice Needs Assessment Questionnaire (Appendix B) was distributed among healthcare providers who possessed experience in primary care within the last ten years. Each individual read the English language and was over the age of 18 years old. Recruited professionals were directly contacted by the author and completed the survey without coercion. Exempt IRB approval was received from the Irene Ransom Bradley School of Nursing IRB Committee and the Pittsburg State University IRB committee. A developed survey tool was not available for the assessment therefore; the author developed and distributed the electronic survey.

Chapter IV

Survey Results and Business Plan

The following chapter will present the results of the Inpatient Hospice Home Needs Assessment Questionnaire and provide a balance sheet with the business plan details for the development of an inpatient hospice facility in Southwest Missouri, Southeast Kansas and Northwest Oklahoma. The goal of an inpatient hospice facility is to provide the local communities with a service that allows patients the opportunity to die with dignity, without the worry of whom will provide care for them in their last days. Currently, hospice practices in these areas provide exceptional care, but none are geared toward providing 24/7 care to individuals with life-limiting illness or injury. Partnership with established healthcare entities will ensure an open door to community connections and allow the compassionate, expert, holistic care provided to establish a solid reputation in a very short period of time.

Survey Results

The Inpatient Hospice Home Needs Assessment Questionnaire (Appendix B) surveyed local healthcare professionals who had been involved in primary care of patients at some point within the last ten years. If respondents did not meet the qualifying question, they were not allowed to continue with the survey. The survey collected

demographic data including age, gender, professional background, level of education and years in practice. Information regarding personal experiences was covered in five questions and information regarding professional exposure and opinions was assessed in four questions along with opinions regarding which services would be the most important in an inpatient hospice facility. The collected data was largely supportive to the development of an inpatient hospice facility. One respondent identified being “very dissatisfied” regarding overall satisfaction with hospice services received and later noted that lack of communication with the hospice service provided a less than stellar personal experience. Otherwise, collected data was supported and encouraged.

Demographic Data

The demographic data collected from the participants included age, gender, professional background, level of education and years in healthcare practice. This data is presented in Figures 1-4. The first question asked respondents for a yes or no response regarding having primary provider experience within the last ten years, a no answer thanked the respondent for their time and did not allow them to finish the survey. Seventy-two respondents were able to proceed and complete the survey. Of the 65 respondents who started and finished the entire survey, the prominent age range for responses was 26-33 years of age and 92% (N=60) identified themselves as the female gender. The largest majority of respondents were nurses-not caseworkers 43% (N=28) and 36% (N=24) were bachelor’s prepared nurses. While the age range of experience was zero to greater than 20 years, the average years in practice was less than ten years.

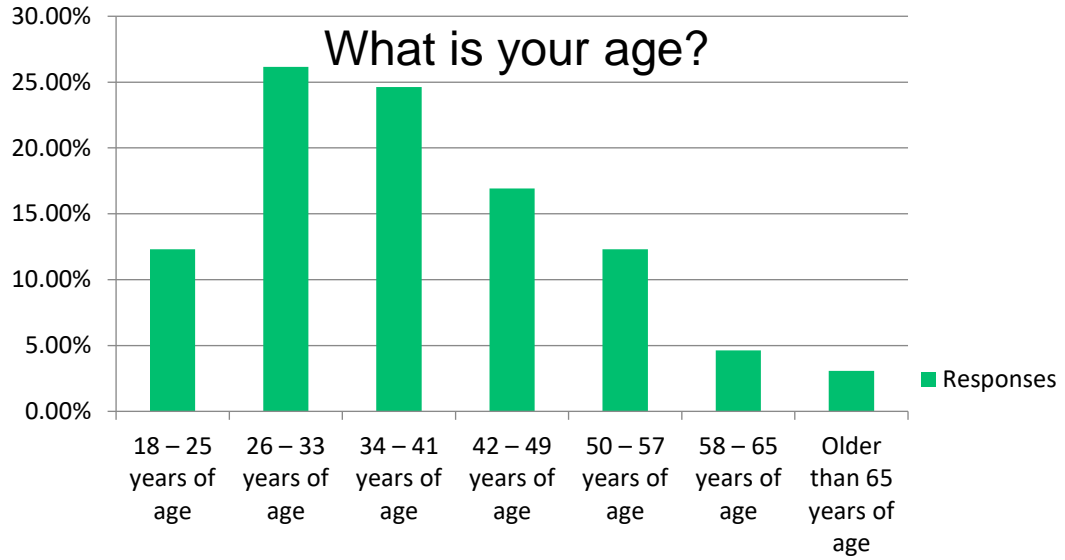


Figure 2. Age of Respondents

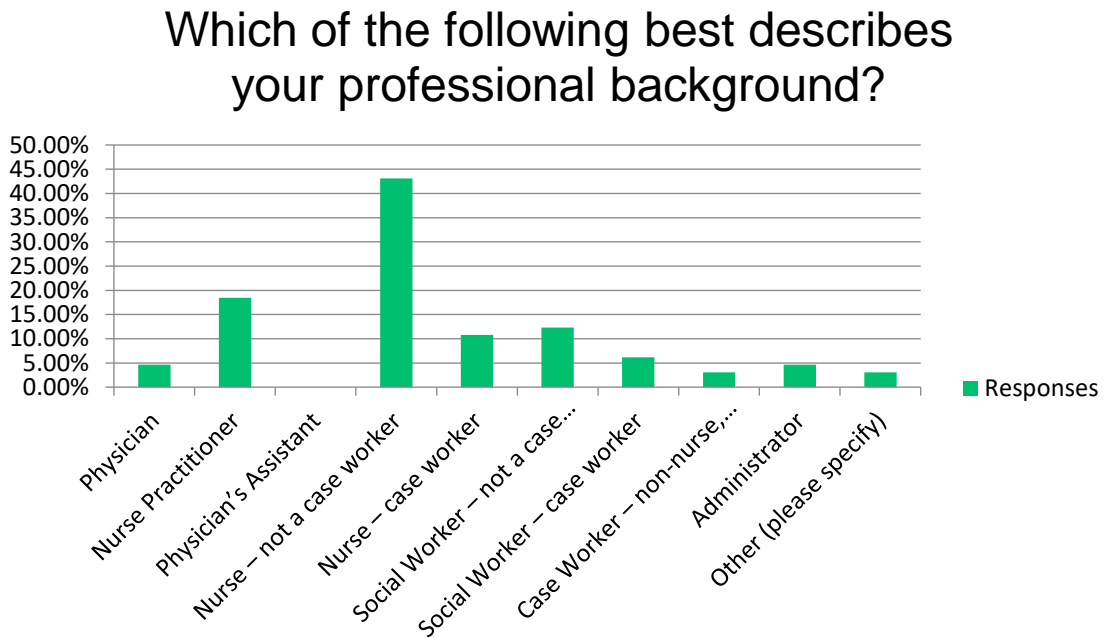


Figure 3. Professional Background

Table 1. Demographic Information

Gender (N) = 65	Overall %
Male (3)	5%
Female (62)	95%
Age of Respondents	N = #
18-25	8
26-33	17
34-41	16
42-49	22
50-57	8
58-65	3
Older than 65	2
Professional Background	N = #
Physician	3
APRN	12
Nurse	28
Social Worker/Case Worker	21
Administrator	3
Other, not specified	2
Level of Education	N = #
Certificate	0
Associates Degree	4
Diploma	0
Bachelor's Degree	24
Master's Degree	21
Doctoral Degree	6
Years in Healthcare Practice	N = #
0-5 years	15
6-10 years	21
11-15 years	8
16-20 years	6
More than 20 years	15

What is your highest level of education?

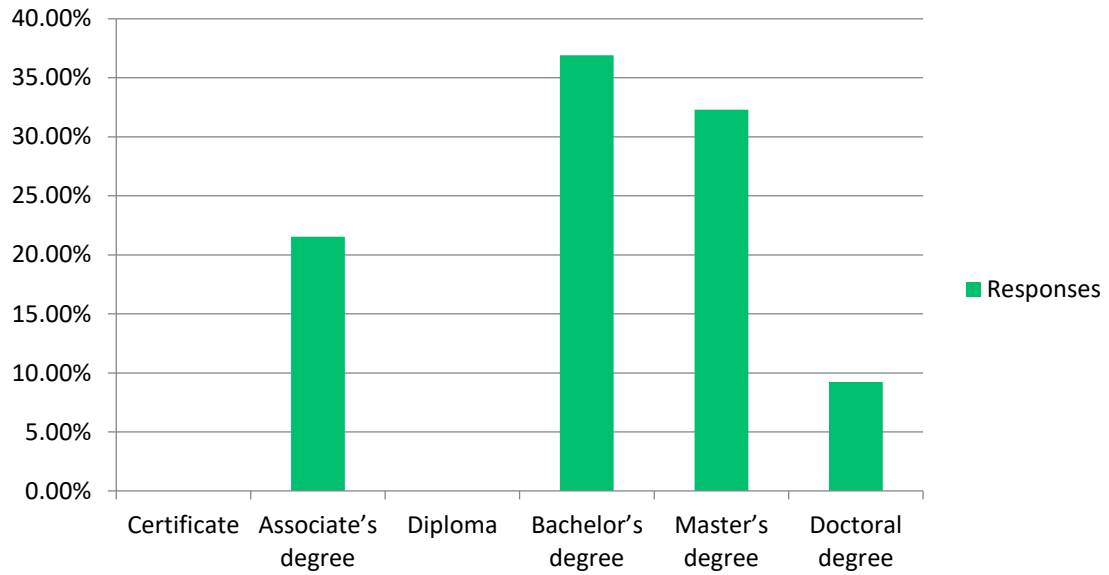


Figure 4. Education Level

How many years have you been in healthcare practice?

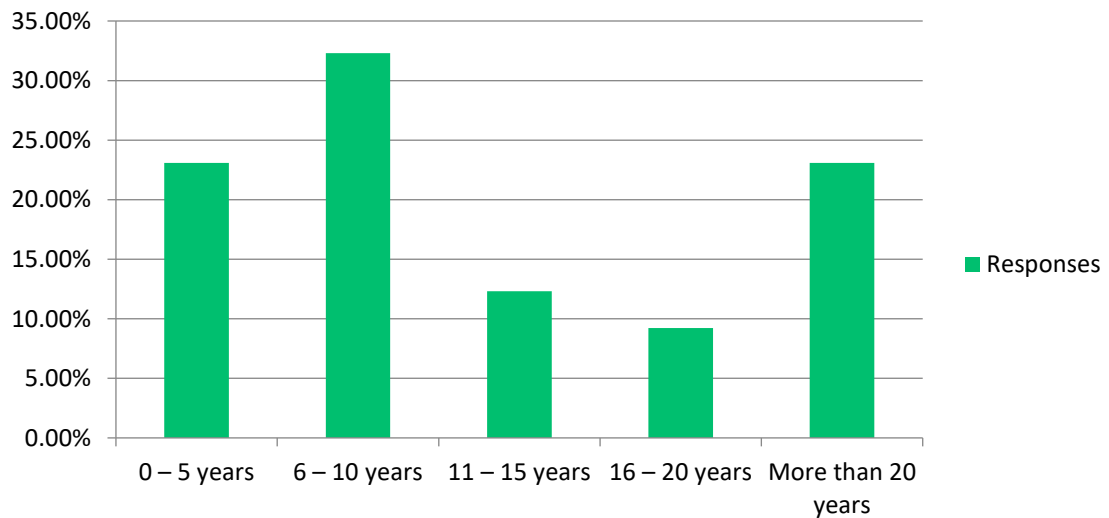


Figure 5. Years in Practice

Respondent Experience with Hospice

Participants were asked to respond to multiple questions regarding personal and professional experiences with hospice care in the Tristate area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma). Eighty-six percent of respondents (N=58) had experience with a family member, friend or patient for whom hospice services were recommended. Of those with personal experience, 93% actually received hospice services. Those who declined hospice service cited worry about cost, not ready to admit that the end of life was near, unsure of local availability and one stated that the patient had to choose between receiving Medicare coverage or going on hospice care.

The vast majority, 77% (N=44) utilized home hospice services (Figure 5) and 19% (N=11) were placed in a long-term care facility with hospice services. The national average for where patients receive hospice care is home at 56% and 41.3% receive hospice care in a long-term care facility (NHPCO, Facts and Figures, 2017a). The highest national average of patients in hospice care is 22.8% at 1-7 days (NHPCO, 2017a) whereas; those who have personal experience in the local area, 30% of those hospice recipients (N=21) were in hospice care for 8-30 days (Figure 6).

If yes, what type of hospice services did they receive? (Select all that apply)

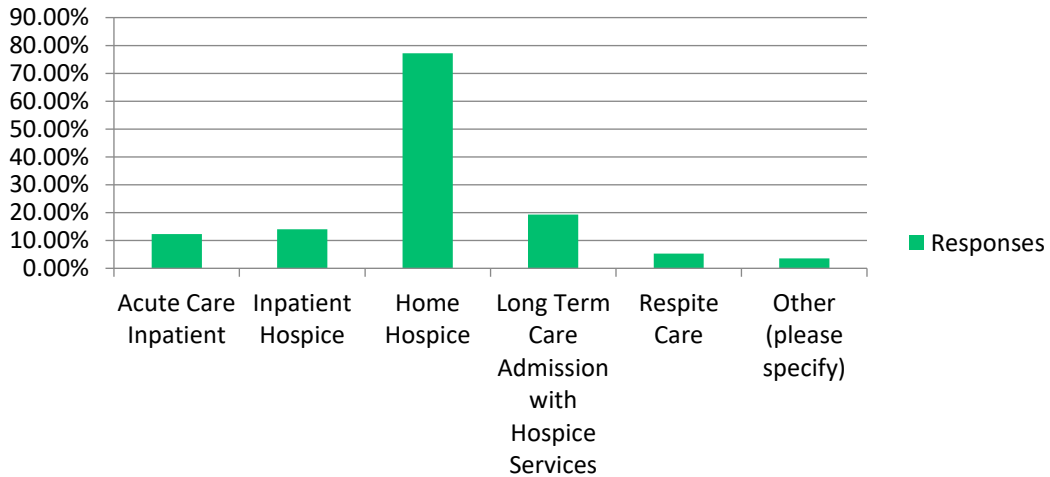


Figure 6. Hospice Services Received

How long did your family member/friend receive hospice care?

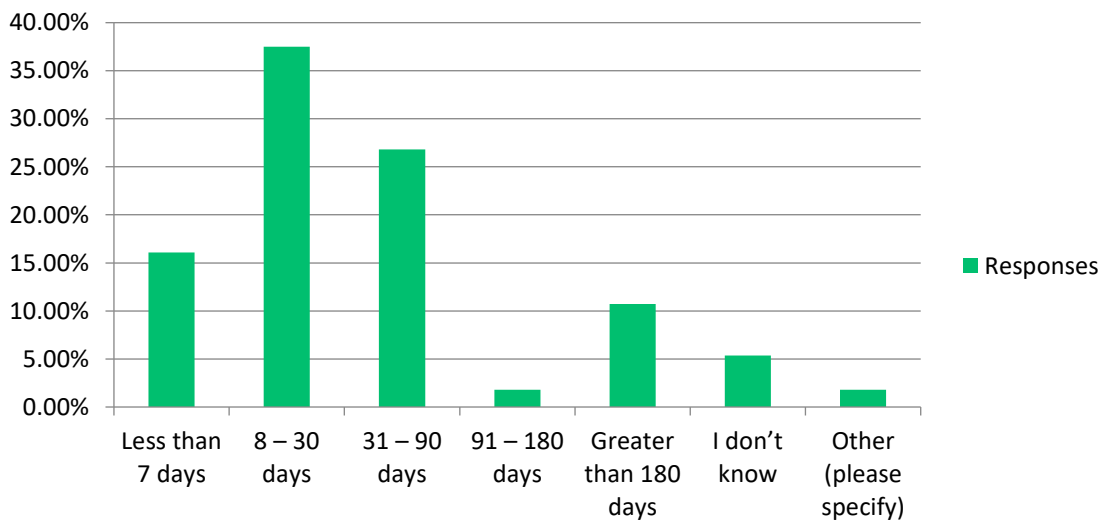


Figure 7. Length of Care

How satisfied were you/they with the overall hospice services?

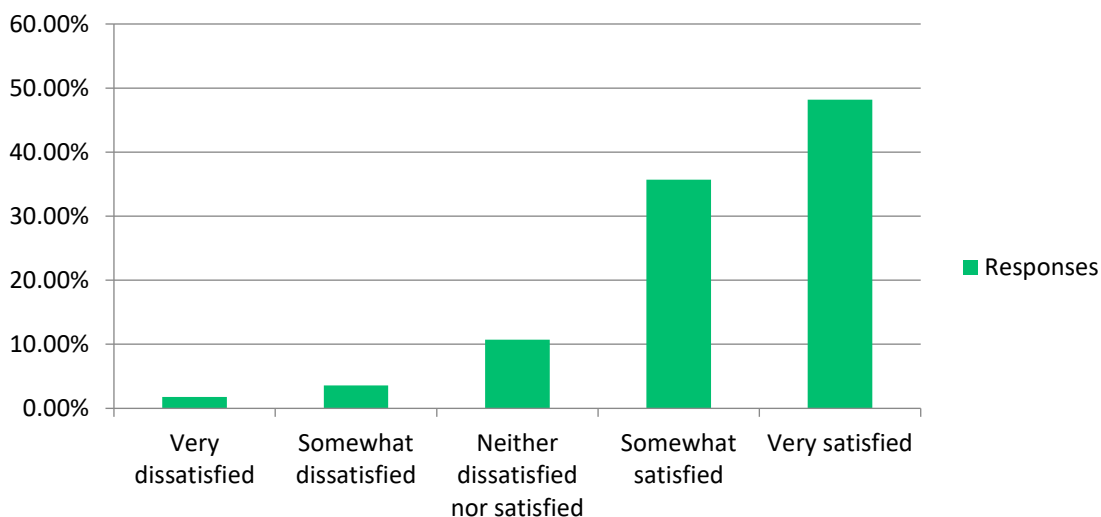


Figure 8. Overall Satisfaction

Respondents Attitudes About Inpatient Hospice

Eighty-three percent (N=47) of respondents noted somewhat satisfied or very satisfied with hospice services received (Figure 7). Professionally, 70% of respondents (N=43) identified that their patients would have been somewhat likely and very likely to utilize inpatient hospice care if a facility had been available in the area (Figure 8).

Further, 86% (N=56) indicated that they would somewhat likely and very likely to refer patients (Figure 9) to an inpatient hospice facility if it were made available in the tristate area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma). Of the respondents, 95% (N=62) somewhat agree or strongly agree that an inpatient hospice facility would meet a need in Southwest Missouri, Southeast Kansas and Northeast Oklahoma (Figure 10).

A table of questions was provided asking the respondents to rate the importance

of individual services, including continuous patient care by healthcare professionals; symptom and illness management; emotional, psychosocial and spiritual support; medication administration; availability of medical supplies; providing functional equipment; terminal patient guidance for families and loved ones; delivery of special services including, physical and occupational therapies; respite care; and bereavement counseling. As anticipated, each item other than the provision of special service items was rated by 90% (N=57) or higher as somewhat important or very important to provide in an inpatient hospice facility (Figure 11).

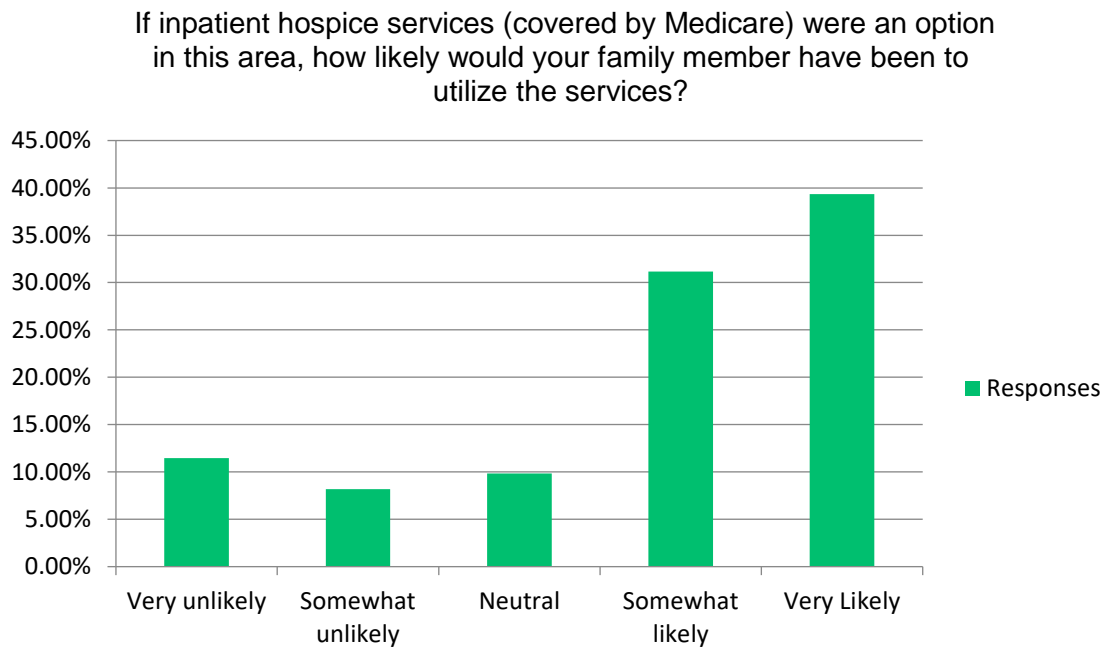


Figure 9. Likelihood of Utilization

How likely would you be to recommend inpatient hospice services to your patients?

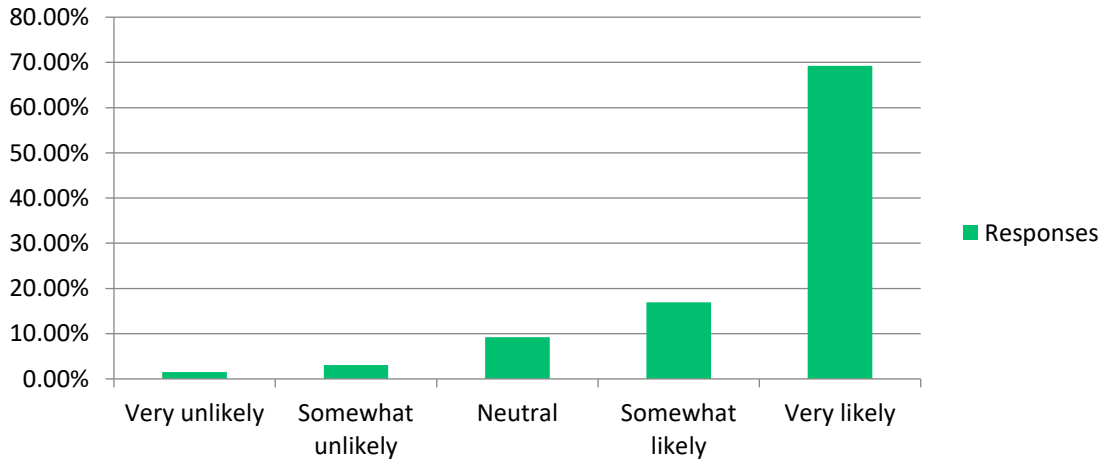


Figure 10. Recommend Hospice Care

Please rate your agreement with this statement: An inpatient hospice facility would meet a need for patients and their families in the three state (Southwest Missouri, Northeast Oklahoma, Southeast Kansas) area that is not currently being met.

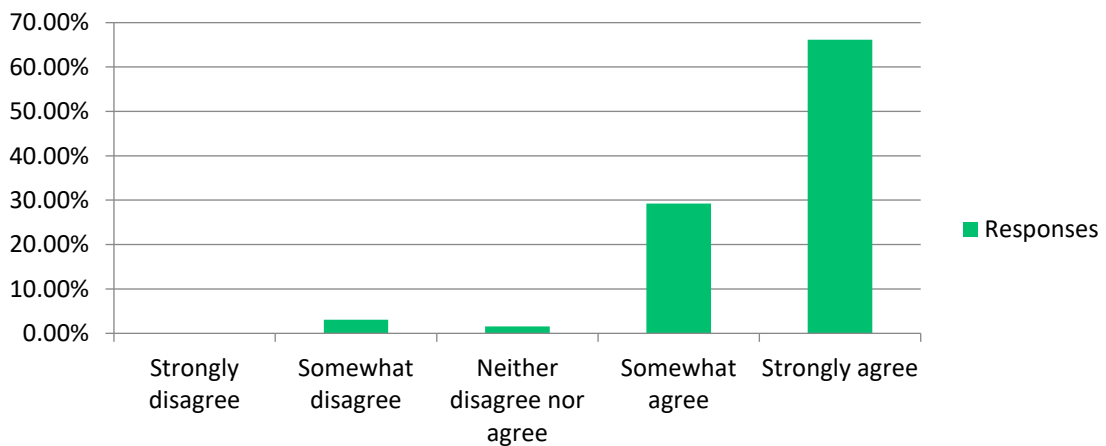


Figure 11. Need for Inpatient Hospice Facility

If an inpatient hospice facility were to be developed in the three state (Southwest Missouri, Northeast Oklahoma, Southeast Kansas) area, how important is it to include each of the following services?

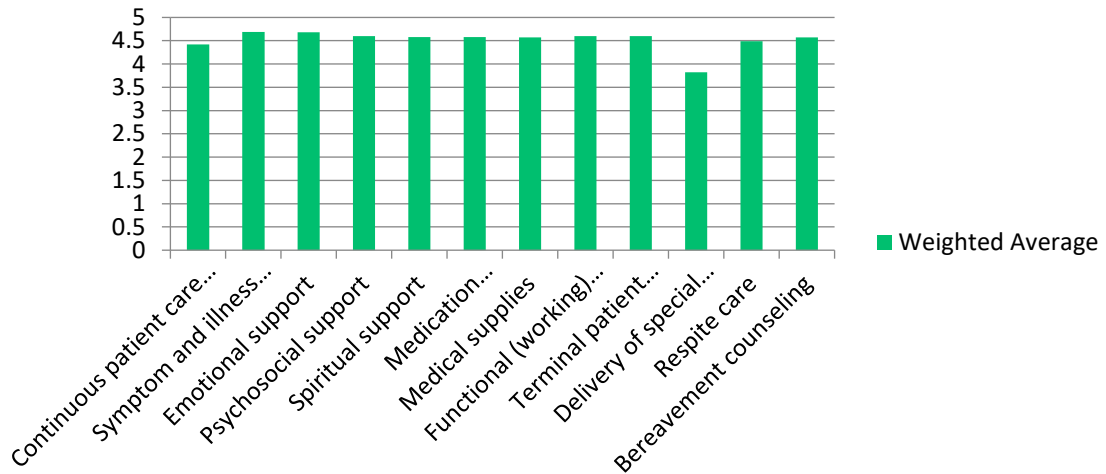


Figure 12. Rating the Importance of Services to be offered

An opportunity was provided for respondents to write in recommendations for services they felt should be provided within or associated with an inpatient hospice facility. Respondents recommended an aesthetically pleasing environment where large families can come together at one time including pull out couches for overnight guests and areas for families to eat together at meal times. Other recommended community opportunities for involvement were pet therapy or the ability for families to bring in the patients animals from home; education and counseling in regards to personal care of families and loved ones; financial support relating to insurance questions, financial complexities and making final arrangements for loved ones. One person recommended bereavement counseling groups for those who have been left behind. Provide opportunities for community involvement in regards to volunteering, such as singing,

meal preparation, yard work, as well as Boy Scout and Girl Scout troops interacting with patients.

Further comments support the desire to open an inpatient facility in the area as the local area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma). One respondent stated that the local area is currently underserved and some families lack resources to care for a dying loved one at home. Another respondent stated that she often carries a caseload of twelve patients with one-half of those who would benefit from inpatient care. An inpatient provider stated that very often there are hospice patients who do not have the support or resources to go home with hospice services, but cannot afford to go to a long term care facility for end-of-life care, and do not meet the criteria for general inpatient (GIP) care therefore cannot stay in the hospital.

Though the sample size was small (N=83), there appears to be overwhelming support for the development of an inpatient hospice unit in the local area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma). Attitudes seem to support the perceived idea that the area would benefit patients and their families. In response to the strong indications of support for an inpatient hospice facility, a business plan was created to guide further project development.

Business Plan

Product

Care Plus Inpatient Hospice (CPIH) will be an inpatient facility created to cater to the holistic needs of patients and their loved ones who are faced with a life-limiting illness or injury. Compassionate and caring healthcare professionals and local healthcare entities will join hands to provide the highest quality care to patients and their families

who would otherwise require long inpatient hospital stays, nursing home placement or significant out of pocket expenses for home hospice care. CPIH will provide 24/7 licensed care to patients who require or desire end-of-life services.

Customers

The target populations for Care Plus Inpatient Hospice will be individuals who are facing life-limiting illness or injury regardless of gender, age, race, ethnicity, or religion. Many individuals in the local areas, Southwest Missouri, Southeast Kansas and Northeast Oklahoma, with life-limiting illness or injury require 24/7 care at the end of their lives. Currently, the options are home hospice agencies that provide frequent visits, but are not set up to provide 24/7 care; local nursing care facilities that allow for 7 days of hospice care before reimbursement changes require significant financial contributions from patients, their families and acute care facilities that are not set up to care for long term patients with life-limiting illness or injury.

What Drives Us?

The Care Plus Inpatient Hospice will become the hospice choice for Southwest Missouri, Southeast Kansas and Northeast Oklahoma area.

1. To make Care Plus Inpatient Hospice, the leader in hospice care, we will offer expert, quality, compassionate patient care and education to patients and loved ones. We will consistently provide professional patient care and through community relationships and our commitment to service.
2. To be an active community participant, leader and supporter of community education, support groups, and bereavement counseling to family and friends of

those who are no longer with us. [L]
[SEP]

3. To achieve a consistent referral base for future hospice care.

Mission Statement

Care Plus Inpatient Hospice will provide quality, compassionate, holistic care 24 hours a day/ 7 days a week to patients and their loved ones in an aesthetically pleasing environment when faced with life-limiting illness or injury. The goal of Care Plus Inpatient Hospice will be to consistently meet the physical, spiritual and emotional need or needs of those in Southwest Missouri, Southeast Kansas and Northeast Oklahoma areas that are unable to return home for end-of life care.

Principal Members

Several key players will be utilized in the care of patients with life-limiting illness or injury. Each member of the multidisciplinary team will provide a service or skill that will be detrimental to the professionalism and efficient function of the care team.

- Owner/Administrator will provide the guidance for day-to-day operations of the facility while ensuring compliance with local, state, regional and national regulations (Top Master's, 2017).
- Medical Director is a staff physician who will provide oversight of day-to-day patient care, develop treatment guidelines and protocols, certify and recertify hospice patients (Hospice Patients Alliance, 2017).
- Director of Nursing will assist with overall facility operations, manage nursing staff within budgetary guidelines, develop and provide staff education. Work to

ensure growth and profitability of the facility (Washington Regional, 2017).

- Pharmacist consultants will assess the appropriateness of medication orders and ensure the timely administration of medications, educate hospice staff regarding treatments and medications, address financial concerns, ensure safe and legal disposal of all medications, establish and maintain effective communication with regulatory and licensing agencies (Demler, 2016).
- Social worker will provide counseling, and psychotherapy to patients and their loved ones, provide psychological education, lead community education workshops, provide crisis intervention, mediate conflicts, and advocate on behalf of patients and families (NASW, 2010).
- Registered nurses (RN) or licensed practical nurses (LPN) will provide hands on, compassionate, expert end of life care ensuring that patients' needs are fully met. Assess and treat patients for comfort and pain control, provide education to patient and their loved ones and be a patient advocate (Nurse Journal, 2017).
- Certified Nursing Assistants will provide basic patient care under the direction of the nursing staff. Duties will include bathing, dressing, feeding, grooming and moving (U. S. Bureau of Labor Statistics, 2017).
- Volunteers will provide support for patients and families, bereavement counseling, fundraising and administrative work, along with facility maintenance and surrounding grounds (Hospice Foundation of America, 2017).
- Pastoral care will provide spiritual support and bereavement counseling for patients and families (NHPCO, 2017b).

Legal Structure

Care Plus Inpatient Hospice is currently considering pursuance of a not-for-profit designation to 501(c) (3) thereby negating the need for partnership for continued project development. Legal advice will be sought to ensure proper completion of paperwork and zoning of a business in the City of Joplin, Missouri.

Market Research

Industry. Care Plus Inpatient Hospice is a future healthcare entity being developed to provide healthcare services and supplies to those who are facing life-limiting illness or injury and require continuous care. Care Plus Inpatient Hospice will provide expert, professional, compassionate, holistic care to patients and their loved ones.

Customers. The Care Plus Inpatient customers will be the patients who have a life-limiting illness or injury and require 24/7 care. Referrals will be provided by local acute care facilities, physician offices and outpatient hospice agencies that cannot provide continuous patient care.

Competitors. Local competitors will include:

- Acute care hospitals-Freeman Health System and Mercy Joplin, Joplin, Missouri; Mercy Carthage, Carthage, Missouri; Freeman Neosho, Neosho Missouri; Girard Medical Center, Girard, Kansas; Mercy Maude Norton, Columbus, Kansas; Via Christi, Pittsburg, Kansas; Integris Baptist, Miami, Oklahoma and Integris Grove, Grove, Oklahoma. These facilities are set up to take care of patients with acute illness or injury, not long-term hospice patients.

- Nursing care facilities- 27 nursing homes in the tristate area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma) can accommodate acute hospice patients for 7 days and if the patient does not reach the end of life by day 8, they are then required to go home with home hospice services, pay out-of-pocket for a long term care bed or apply for Medicaid benefits to cover the long term care bed cost.
- Outpatient hospice agencies-Twenty-seven outpatient hospice agencies are utilized by a large population of dying patients who do not currently require continuous care however, when a patient requires 24/7 care, the responsibility lies on the family members, many of whom are unable to take off work or lack the skills to provide seamless patient care.

Competitive Advantage. The advantages that Care Plus Inpatient Hospice has over all the competition in the local area are that there are no inpatient hospice facilities within a 95 miles radius. The closest inpatient hospice facility providing 24/7 care is in Rogers, Arkansas. Once a patient is accepted and admitted, they will not be required to change status and the cost of care will not change.

Regulations. Care Plus Inpatient Hospice will be regulated by the Centers for Medicare and Medicaid Services.

Product/Service Line

Product or Service. Care Plus Inpatient Hospice will provide (NHPCO, 2015):

- Continuous inpatient end-of-life care. ^[1]_{SEP}
- Symptom and illness management.

- Assist with emotional, psychosocial and spiritual need or needs of the patient and families. [L] [SEP]
- Provide medications, medical supplies and equipment for patient care.
- Coach and guide families in care of terminal patient. [L] [SEP]
- Deliver special services, physical therapy, and occupational therapy.
- Respite care. [L] [SEP]
- Bereavement and counseling.

Pricing Structure. According to the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, Medicare Program; FY2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements the daily reimbursement rate for inpatient hospice patients will be based on days within the facility (CMS, 2017). Rates for general inpatient care (GIP) first seven days - \$957.08 a day; Days 8-60 - \$188.98 a day (equal to routine home care rates); Days 61+ - 148.41; Respite care - \$169.36 a day (eligible for five days each quarter). The cost of care at Care Plus Inpatient Hospice will be \$280 a day and will not vary with Medicare and Medicaid or commercial insurance reimbursement.

Product/Service Life Cycle. Care Plus Inpatient Hospice is currently in the growth stage, meaning that the need for healthcare services is growing faster than the economy. In 1982, 25,000 patients received hospice services and in 2014, that number had exploded to 1,656,000 patients receiving end of life services (NHPCO, 2015b). The average annual growth for hospice and palliative care centers from 2012 to 2017 was 4.0% and is

expected to increase to 4.5% from 2017 to 2022 (IBISWorld, 2017). The current trend in elderly population growth is expected to increase two fold from 2010 to the year 2050 (Ortman, Velkoff & Hogan, 2014). Hospice growth has been astronomical from its inception in 1974, starting out with one hospice agency to now over 5800 hospice agencies nationwide (NHPCO, 2015a). The current trend is moving toward inpatient hospice care according to the National Hospice and Palliative Care Organization (2015b). According to IBISWorld (2017) revenue from 2,678 hospice and palliative care centers in 2016 was \$36 billion, with a profit of \$3.9 billion. The average U.S. household income is \$53,889 with the average in the tristate areas of Southwest Missouri, Southeast Kansas and Northeast Oklahoma below the national average at \$39, 359 per household (U. S. Census Bureau, 2017). Families in the tristate area cannot afford to stay home and care for their loved ones who are living longer with significantly more co-morbidities that require more complex end of life care.

Intellectual Property Rights. Currently no intellectual property is being utilized.

Research & Development. The collection of current literature and the positive results of the Inpatient Hospice Home Needs Assessment Questionnaire support the development of an inpatient hospice facility in the local area. A business plan has been developed and can be reviewed in Appendix C.

Conclusion

The business plan development for Care Plus Inpatient Hospice outlined many steps and important details of creating an inpatient hospice facility. Further details and

financial statements can be found in the Appendix. The product/service has been outlined, customers identified and the why behind project development. The mission to provide care for end-of-life patients has been described as well as the team members and their important functions. The establishment of a community relationship is vital to the program inception as well as a working relationship with the local healthcare community. The local market and patients will likely benefit from inpatient care services and the stress of not being able to meet such detrimental needs alleviated. The development and opening of Care Plus Inpatient Hospice House will hopefully fill a gap in current dying services in the local area and become a welcomed business entity and a staple in the local healthcare community.

Chapter V

Summary, Conclusions and Recommendations

The study obtained data from an online survey of health care professionals (MD, DO, APRN, PA), nurses, social workers or case managers in the tristate area (Southwest Missouri, Southeast Kansas and Northwest Oklahoma) who at some point had been involved in primary care in the last ten years. The survey focused on personal and professional experiences with hospice services as well as the collection of professional opinions and recommendations regarding the development of an inpatient hospice facility with in the tristate area. The study focused on two elements:

1. What are the attitudes of healthcare professionals in the tristate area regarding the development of an inpatient hospice facility?
2. What professional and personal recommendations would other healthcare providers offer for the success of an inpatient hospice facility?

Relationship of Outcomes to Research

Upon survey analysis, even with a small sample size, the author established that the need for an inpatient hospice facility would benefit the tristate area (Southwest Missouri, Southeast Kansas and Northwest Oklahoma). According to a vast majority of survey respondents there is an attitude of support for such a facility to fill a gap in care

for patients and families in the area. Of all the participants, only one professional indicated that they would not likely recommend inpatient hospice care to their patients. Unfortunately, we are unable to determine the background of that respondent and will move forward with the significant positive response from the survey.

The results of the survey support the authors' initial thought that there is a gap in services to patients in the area regarding patients who are facing the end of their life and desire to die at home, but do not have the family support to resources to do so. The average age of hospice participants is older than 84 years old (NHPCO, 2017) and according to Ortman, Velkoff, & Hogan (2014) the current elderly population is approximately 43 million and is expected to double to 86 million by 2050. There is already a significant gap in dying care in the local tristate area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma) there is a good possibility that the crisis will reach epic proportions if we are unable to develop a plan for filling the gap in dying care in the near future. Community and professional education along with the development and establishment of an inpatient hospice facility would likely help to fill the current gap.

Observations

Providers and healthcare workers appeared eager to fill out the survey and offer their opinions once the author explained the reasoning behind the collection of data. Many respondents offered words of encouragement and commented that the inpatient hospice service would be a wonderful benefit to the area. The author found support of the project to be overwhelmingly positive and can take an attitude of support from the local healthcare community. The survey was fairly broad in scope and upon completion and analysis; it would have been a good choice to reword the qualifying question that didn't

primarily focus on primary providers, but also those who deal with hospice patients in the community. This option may have provided the author with a larger sample size and a broader scope of recommendations for the plans success.

Evaluation of Theoretical Framework

The theoretical framework utilized for this project was a combination of Roger's Diffusion of Innovation Theory and Kolcaba's Comfort Theory and Practice. Roger's Theory provided guidance for data collection and distribution of information for the development of the Inpatient Hospice Home Needs Assessment Questionnaire as well as the development of the initial business plan, while considering the levels of support a developer may encounter throughout the process. Roger's further allowed the author to understand the stages of adoption of an innovation and the five phases of diffusion in regards to a new innovation, the Inpatient Hospice Facility. Following the recommendations of Roger's the community attitude and the perceived need has been established. The next step in the process would be the presentation of the business plan to local healthcare entities to determine their level of interest in an inpatient hospice facility.

Kolcaba's Comfort Theory and Practice outlined that the community be evaluated for the current level of knowledge regarding hospice care. Literature was reviewed to determine the history of hospice care and to determine what levels of care are being offered at the current time. According to the Inpatient Hospice Home Needs Assessment Questionnaire a significant sample of individual healthcare providers believe there is a gap in dying care in the community. Now that the positive attitude regarding the development of an inpatient hospice facility has been established, as will Roger's theory,

the next step is to present the information to local healthcare entities to attempt support of the local healthcare organizations.

Evaluation of Logic Model

The Innovation-Decision Process Logic Model was utilized in the development of the survey, Inpatient Hospice Home Needs Assessment Questionnaire and allowed the author to determine the positive attitudes towards the innovation of developing an inpatient hospice facility. The survey allowed the author to communicate with local healthcare providers regarding the idea that a hospice facility may be beneficial to the area. While evaluating survey responses, the author was able to identify the attributes that will aid in the success of the innovation of the hospice facility development and allowing the author to make the decision that the current “idea” is one that warrants continued development. Unfortunately, the time constraints of the current project do not allow for further time or evaluation of all invested parties. The next step in the project was the development of a business plan that will be presented to local healthcare entities that may have a vested interest in filling the current gap in dying care.

Limitations

The survey may have gathered a larger sample size if the author had not limited the qualifying question to primary providers and included acute care providers and those community individuals who work with hospice care but do not consider themselves to be primary providers. The sample size was limited to a particular geographic location therefore was specific to the local tristate area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma) and the local facilities. Including questions regarding where respondent had practiced and where they lived may have aided in further validating

responses. The project instrument was developed by the author along with the lead project advisor and provided a broad spectrum of answers regarding current hospice care and the needs that other local healthcare professionals indicate may allow an inpatient hospice facility to be successful (Appendix B). The amount of time available for data collection was more than adequate. The limiting factor was the author attempting to complete a job transition and experiencing personal issues while collecting data and attempting to complete the project. Presenting to local facilities and provider clinics would likely have resulted in a larger sample size and a perhaps a greater amount of positive or negative feedback regarding the perceived gap in dying care in the local area. Another option to allow for a possible greater participation group would have been to include the use of distribution through social media on the IRB requests to the Irene Ransom Bradley School of Nursing and to the Pittsburg State University IRB committees.

Implications for Future Projects and/or Research

Following the analysis of current data in regards to data collection via the Inpatient Hospice Home Needs Assessment Questionnaire, there is an overwhelmingly positive community attitude towards the development of an inpatient hospice facility. If the author, or another entity would choose to move forward with a detailed business plan and find the right financial support, an actual inpatient hospice facility that provided well rounded supportive care to patients and families would greatly benefit the community. If the author would choose to repeat the project, a larger sample size would be sought after and a greater amount of time would be spent on the development of the actual hospice house business plan.

Implications for Practice

Analysis of survey data indicates that there is a gap in dying care in the local tristate area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma) and that many local providers who deal with hospice patients support the idea of developing an inpatient hospice facility. The recommendation for Advanced Practice Nurses and nursing as a whole is that if you truly feel that there may be a gap in patient care, there are opportunities to fill those gaps through caring, research and innovation. As a former nursing instructor, the analysis of current and previous data and possessing a desire to provide the best care for patients would be a good leadership topic.

Conclusion

This project was focused on identifying the gap in dying care in the local area (Southwest Missouri, Southeast Kansas and Northeast Oklahoma). The current practice with hospice care is home with home health where family and friends will provide end of life care or placement in a nursing care facility that can financially devastate patients and their families. Healthcare providers are often left feeling defeated when they are unsure if a dying patient will be allowed to die with dignity. A survey was developed and distributed among local health care professionals to determine the attitude toward development of an inpatient hospice facility. The gap in dying care was confirmed with the survey and the response to such an entity was largely met with positive responses and encouragement to proceed toward development. A business plan was initiated and can be reviewed in Appendix C.

References

- Amano, K., Morita, T., Tataru, R., Katayama, H., Uno, T., & Takagi, I., (2015). Association between early palliative care referrals, inpatient hospice utilization, and aggressiveness of care at the end of life. *Journal of Palliative Medicine*, 18(3): 270-273. doi: 10/1089/jpm.2014.0132
- Baernholdt, M., Campbell, C., & Yan, G. (2015). Quality of hospice care: comparison between rural and urban residents. *Journal of Nursing Care Quality*, 30(3): 247-253.
- Bakanic, V., Singleton, M., & Dickinson, G. (2016). Hospice attitudes of physicians and nurses: A pilot study. *American Journal of Hospice and Palliative Medicine*, 33(1): 34-40.
- Behavioral Change Models, (2017). Diffusion of innovation theory. Retrieved from: <http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories4.html>
- Centers for Disease Control (CDC), Life expectancy at birth at 65 years of age and at 75 years of age by race and sex: United States, selected years 1900-2007. Retrieved from <https://www.cdc.gov/nchs/data/hus/2010/022.pdf>
- Centers for Medicare and Medicaid Services (CMS). (2017). FY 2018 Hospice payment rate update (CMS-1675-P). Retrieved from <https://www.gpo.gov/fdsys/pkg/FR-2017-05-03/pdf/2017-08563.pdf>

- Chung, K., & Burke, S. (2012). Characteristics of hospice patients utilizing hospice inpatient/residential facilities. *American Journal of Hospice and Palliative Medicine*, 30(7): 640-647. doi: 10.1177/1049909112469717
- Demensky, M. (2014). Exploring Yamatji perceptions and use of palliative care: An ethnographic study. *International Journal of Palliative Nursing*, 20(6): 387-393.
- Demler, T. L. (2016). Pharmacist involvement in hospice and palliative care. *US Pharmacist*, 41(3), HS2-HS5.
- Fisher, S., & Colyer, H. (2009). Making decisions about care: What it means for hospice inpatients with terminal progressive disease. *International Journal of Palliative Nursing*, 15(11): 548-553
- Gozalo, P., Plotzke, M., Mor, V., Miller, S., & Teno, J. (2015). Changes in Medicare costs with the growth of hospice care in nursing homes. *The New England Journal of Medicine*, 372(19): 1823-1831. doi: 10.1056/NE/Msa1408705
- Harrold, J., Byhoff, E., Harris, P., Szolarova, R., Bender, L., Craig, T., & Casarett, D. (2014). All Hospice patients are not equal: Development of a visit-based acuity index. *Journal of Palliative Medicine*, 17(2): 135-140.
- Hospice Action Network, (2016). *The Medicare hospice benefit*. Retrieved from http://www.nhpco.org/sites/default/files/public/communications/Outreach/The_Medicare_Hospice_Benefit.pdf
- Hospice Foundation of America. (2017). Become a Volunteer. Retrieved from <https://hospicefoundation.org/Volunteer>

Hospice Patients Alliance. (2017). Hospice medical director and attending physician: At your service. Retrieved from <http://www.hospicepatients.org/hospic13.html>

Hui, D., De La Cruz, M., Mori, M., Parsons, H. A., Kwon, J.H., and Torres-Vigil, I., (2013). Concepts and definitions for "supportive care," "best supportive care," "palliative care," and "hospice care" in the published literature, dictionaries, and textbooks. *Supportive Care in Cancer* (21)3. DOI: <http://dx.doi.org/10.1007/s00520-012-1564-y>

Hurley, S., Strumpf, N., Barg, Ersek, M., (2014). Not quite seamless: Transitions between home and inpatient hospice. *Journal of Palliative Medicine*, 17(4): 428-434.

IBISWorld, (2017). OD4952 Hospices and palliative care centers. Retrieved from: <https://www.ibisworld.com/industry-trends/specialized-market-research-reports/life-sciences/health-practitioners/hospices-palliative-care-centers.html>

Kirolos, I., Tamariz, L., Schultz, E., Diaz, Y., Wood, B., & Palacio, A. (2014). Interventions to improve hospice and palliative care referral: A systematic review. *Journal of Palliative Medicine*, 17(8): 957-964. doi: 10.1089/jpm.2013.0503.

Ko, E., Kwak, J., & Nelson-Becker, H. (2015). What constitutes a good and bad death?: Perspectives of homeless older adults. *Death Studies*, 39.422-432

Kolcaba, K., (2003). *Comfort theory and practice: A vision for holistic health care and research*. New York, NY: Springer Publishing.

Lundblad, P., (2003). A Review and Critique of Rogers' Diffusion of Innovation Theory as it Applies to Organizations. *Organization Development Journal* 21(4), 50-64

- Mccann, C. J., & Adames, H. Y. (2012). Dying other, dying self: Creating culture and meaning in palliative healthcare. *Palliative and Supportive Care, 11*: 289-293.
- Meeker, M., Waldrop, D., & Seo, J., (2015). Examining family meetings at the end of life: The model of practice in a hospice inpatient unit. *Palliative and Supportive Care, 13*: 1283-1291. doi: 10.1017/S1478951514001138
- Missouri Department of Social Services, (2017). Nursing facility rate list. Retrieved from <http://dss.mo.gov/mhd/providers/pages/nfrates.htm>
- Moir, C., Roberts, R., Martz., Perry, J., & Tivis, L. (2015). Communication with patients and their families about palliative and end-of life care: Comfort and educational needs of nurses. *International Journal of Nursing, 21*(3): 109-112.
- National Association of Social Workers (NASW). (2010). Social workers in hospice and palliative care: Occupational profile. Retrieved from <http://workforce.socialworkers.org/studies/profiles/Hospice.pdf>
- National Consensus Project for Quality Palliative Care, (2013). Clinical practice guidelines for quality palliative care. Retrieved from: www.nationalconsensusproject.org
- National Hospice and Palliative Care Organization, (2012). Compliance tip sheet: Managing general inpatient care for symptom management. Retrieved from: https://www.nhpco.org/sites/default/files/public/regulatory/GIP_Tip_GIP_Sheet.pdf
- National Hospice and Palliative Care Organization. Hospice Action Network. (2015a). The Medicare Hospice Benefit. Retrieved from www.hospiceactionnetwork.org

National Hospice and Palliative Care Organization (NHPCO). (2015b). Hospice Care.

Retrieved from <https://www.nhpc.org/about/hospice-care>

National Hospice and Palliative Care Organization (NHPCO). (2017a). Facts and figures:

Hospice care in America. Retrieved from

https://www.nhpc.org/sites/default/files/public/Statistics_Research/2016_Facts_Figures.pdf

National Hospice and Palliative Core Organization (NHPCO). (2017b). Medicare hospice conditions of participation spiritual caregiver. Retrieved from

https://www.nhpc.org/sites/default/files/public/regulatory/Spiritual_tip_sheet.pdf

Newman, A., Thompson, J., & Chandler, E. M., (2013). Continuous care: A home

hospice benefit. *Clinical Journal of Oncology Nursing*, 17(1), 19-20.

NSW Agency for Clinical Innovations, (2015). Change management theories and models-Everett Rogers. Retrieved from:

https://www.washington.edu/research/rapid/resources/changeModels/mc_diff_innov.pdf

Nurse Journal. (2017). What are the pros and cons of hospice nursing? Retrieved from

<http://nursejournal.org/hospice-nursing/what-are-the-pros-and-cons-of-hospice-nursing/>

Oliviera, I. (2013). Comfort measures: A concept analysis. *Research and Theory for*

Nursing Practice: An International Journal, 27(2), 95-114.

Orr, G. (2003). Diffusion of innovations, by Everett Rogers (1995). Retrieved from:

<https://web.stanford.edu/class/symbys205/Diffusion%20of%20Innovations.htm>

- Ortman, J., Velkoff, V., & Hogan, H. (2014). An aging nation: The older population in the United States. Retrieved from <http://www.census.gov/prod/2014pubs/p25-1140.pdf>
- Sandsdalen, T., Grondahl, V., Hov, R., Høy, R., Rystedt, I., & Wilde-Larsson, B., (2016). Palliative units in nursing homes, and home care a cross-sectional study. *BMC Palliative Care*, 15(79): doi: 10.1186/s12904-016-0152-1.
- Sanson-Fisher, R. (2004). Diffusion of innovation theory for clinical change. *The Medical Journal of Australia*, 180. Retrieved from <https://www.mja.com.au/journal/2004/180/6/diffusion-innovation-theory-clinical-change>
- Sheward, K., Clark, J., Marshall, B., & Allan, S. (2011). Staff perceptions of end of life care in the acute care setting: A New Zealand perspective. *Journal of Palliative Medicine*, 14(5): 623-630.
- Sleeman, K., Davies, J., Verne, J., Gao, W., & Higginson, I., (2016). The changing demographics of inpatient hospice death: Population-based cross-sectional study in England, 1993-2012. *Palliative Medicine*, 30(1): 45-53. doi: 10.1177/0269216315585064
- Small Business Administration (SBA). (2017). Writing your business plan. Retrieved from <https://www.sba.gov/starting-business/write-your-business-plan>
- Snyder, S., Hazellett, S., Allen, K., & Radwany, S. (2012). Physician knowledge, attitude, and experience with advance care planning, palliative care, and hospice: Results of a primary care survey. *American Journal of Hospice and Palliative Medicine*, 30(5): 419-424.

- Stevenson, D., Huskamp, H., Grabowski, D., & Keating, N., (2007). Differences in hospice care between home and institutional settings. *Journal of Palliative Medicine, 10*(5): 1040-1047.
- Top Masters in Healthcare Administration. (2017). Rankings of the best MS in healthcare administration programs. Retrieved from <http://www.topmastersinhealthcare.com>
- U. S. Bureau of Labor Statistics. (2017). Occupational employment and wages, May 2016. (31-1014 Nursing Assistants). Retrieved from <https://www.bls.gov/oes/current/oes311014.htm>
- United States Census Bureau (2017). American Fact Finder. Retrieved from: <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>
- Waldrop, D., & Kirkendall, A. (2013). Comfort measures: A qualitative study of nursing home-based end-of-life care. *Journal of Palliative Medicine, 12*(8), p719-724.
- Washington Regional. (2017). Nursing Director of Hospice Services. Retrieved from http://wregional.force.com/careers/ts2__JobDetails?jobId=a0I2A00000YbFOuUAN&tSource=&bID=1702
- Zanartu, C., & Matti-Orozco, B., (2012). Comfort measures only: Agreeing on a common definition through a survey. *American Journal of Hospice and Palliative Medicine, 30*(1): 35-39. doi: 10.1177/1049909112440740

APPENDIX

Appendix A

Dear Healthcare Provider, Nurse, Social Worker or Case Manager,

I invite you to participate in a research study entitled: Inpatient Hospice Home Needs Assessment Questionnaire. I am currently enrolled in the Doctorate of Nursing Practice program at Pittsburg State University in Pittsburg, KS, and am in the process of writing my scholarly project.

The enclosed questionnaire has been designed to collect information on: primary care provider (MD, DO, APRN, PA), nurse, social worker or case manager employed or previously employed in a healthcare organization in the three state (Southwest Missouri, Northeast Oklahoma, Southeast Kansas) area?

Your participation in this research project is completely voluntary. You may decline altogether. If a question is not applicable to your practice please select that response.

There is no compensation for completing this survey, nor are there any known risks. Your responses will remain confidential and anonymous. Data from this research will be private and reported only as a collective combined total. No one other than the researchers will know your individual answers to this questionnaire.

If you agree to participate in this project, please answer questions in the questionnaire as honestly as you can. It should take approximately 10 minutes to complete. Your prompt completion of this survey is greatly appreciated.

Thank you for taking the time to assist me in my educational endeavor. If you would like a summary copy please complete the request for information form at the end of the survey. Completion of the survey indicates your willingness to participate in this survey.

If you have any questions about this project, feel free to contact [REDACTED], FNP-BC at [REDACTED]. If you have any complaints in regards to this study please contact the Pittsburg State University via the contact information listed.

Information on the rights of human subjects in research is available through the Pittsburg State University Institutional Review Board at Pittsburg State University 1701 South Broadway Street Pittsburg, KS 66762; website:

<http://www.pittstate.edu/office/grants/research-involving-human-subjects.dot>, [REDACTED], [REDACTED], [REDACTED].

Thank you for your assistance in this educational endeavor.

Sincerely,

[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]

Appendix B
Inpatient Hospice Home Needs Assessment Questionnaire

Qualifying Question

1. Are you now or in the last 10 years been a primary care provider (MD, DO, APRN, PA), nurse, social worker or case manager employed in a healthcare organization in the three state (Southwest Missouri, Northeast Oklahoma, Southeast Kansas) area?
 - a. Yes
 - b. No

Personal Experience with Hospice Services

2. Have you ever had any experience with a family member or a friend for whom hospice was recommended?
 - a. Yes
 - b. No
3. If you answered yes to question number 2, did the family member or friend utilize hospice services? If you answer no to this question, what was the reason?

 - a. Yes
 - b. No
4. If so, what type of hospice services did they receive? (Select all that apply)
 - a. Acute Care Inpatient
 - b. Inpatient Hospice
 - c. Home Hospice
 - d. Long Term Care Admission with Hospice Services
 - e. Respite Care
5. How long did your family member/friend receive hospice care?
 - a. Less than 7 days
 - b. 8 – 30 days
 - c. 31 – 90 days
 - d. 91 – 180 days
 - e. Greater than 180 days
 - f. I don't know
 - g. Other, please specify
6. How satisfied were you/they with the overall hospice services? (Please rate your satisfaction according to the following scale:
 - a. 1 = Very dissatisfied
 - b. 2 = Somewhat dissatisfied
 - c. 3 = Neither dissatisfied nor satisfied
 - d. 4 = Somewhat satisfied

- e. 5 = Very satisfied

Professional Opinion About Hospice Needs in the Three State Area (Southwest Missouri, Northeast Oklahoma, Southeast Kansas)

7. Although hospice services are available in most places on the United States, there are many places where **inpatient** hospice is not available. If **inpatient** hospice (covered by Medicare) were an option in this area, how likely would your family member of friend have been to use it?
 - a. Very unlikely
 - b. Somewhat unlikely
 - c. Neutral
 - d. Somewhat likely
 - e. Very Likely
8. How likely would you be to recommend inpatient hospice services to your patients?
 - a. Very unlikely
 - b. Somewhat unlikely
 - c. Neutral
 - d. Somewhat likely
 - e. Very likely
9. Please rate your agreement with this statement: An inpatient hospice facility would meet a need for patients and their families in the three state (Southwest Missouri, Northeast Oklahoma, Southeast Kansas) area that is not currently being met.
 - a. 1 = Strongly disagree
 - b. 2 = Somewhat disagree
 - c. 3 = Neither disagree nor agree
 - d. 4 = Somewhat agree
 - e. 5 = Strongly agree
10. If an inpatient hospice facility were to be developed in the three state (Southwest Missouri, Northeast Oklahoma, Southeast Kansas) area, how important is it to include each of the following services?

Service	1 – Very unimportant	2 - Somewhat unimportant	3 - Neutral	4 – Somewhat important	5 – Very important

Continuous patient care by healthcare professionals	1	2	3	4	5
Symptom and illness management (pain control)	1	2	3	4	5
Emotional support	1	2	3	4	5
Psychosocial support	1	2	3	4	5
Spiritual support	1	2	3	4	5
Medication administration	1	2	3	4	5
Medical supplies	1	2	3	4	5
Functional (working) equipment such as lifts, commodes, wheelchairs	1	2	3	4	5
Terminal patient guidance for families and loved ones	1	2	3	4	5
Delivery of special services including physical and occupational therapy	1	2	3	4	5
Respite care	1	2	3	4	5
Bereavement counseling	1	2	3	4	5

11. What other services would be important to include in an inpatient hospice facility? (Free text.)

12. Please add any additional comments you would like the surveyors to know about a potential inpatient hospice facility in the three state (Southwest Missouri, Northeast Oklahoma, Southeast Kansas) areas. (Free text.)

Demographic Items

13. What is your age?
- a. 18 – 25 years of age
 - b. 26 – 33 years of age
 - c. 34 – 41 years of age
 - d. 42 – 49 years of age
 - e. 50 – 57 years of age
 - f. 58 – 65 years of age
 - g. Older than 65 years of age
14. What is your gender?
- a. Male
 - b. Female
 - c. Prefer not to answer
15. Which of the following best describes your professional background? (Select all that apply)
- a. Physician
 - b. Nurse Practitioner
 - c. Physician’s Assistant
 - d. Nurse – not a case worker
 - e. Nurse – case worker
 - f. Social Worker – not a case worker
 - g. Social Worker – case worker
 - h. Case Worker – non-nurse, non-social worker
 - i. Administrator
 - j. Other, please specify
16. What is your level of education?
- a. Certificate
 - b. Associate’s degree
 - c. Diploma
 - d. Bachelor’s degree
 - e. Master’s degree
 - f. Doctoral degree
17. How many years have you been in healthcare practice?
- a. 0 – 5 years
 - b. 6 – 10 years
 - c. 11 – 15 years
 - d. 16 – 20 years

Appendix C

Pro Forma Balance Sheet for Care Plus Inpatient Hospice

CURRENT ASSETS		
Cash in Bank	110,879.28	
Accounts Receivable		
Inventory		
Prepaid Expenses		
Deposits		
Other Current Assets		
<hr/>		
TOTAL CURRENT ASSETS	110,879.28	
FIXED ASSETS		
Machinery & Equipment (a)	5700.00	
Furniture & Fixtures (b)	4583.76	
Medical Equipment (c)	3836.96	
Land & Buildings		
Other Fixed Assets		
<hr/>		
TOTAL FIXED ASSETS (net of depreciation)	14,120.72	
OTHER ASSETS		
Intangibles		
Other		
<hr/>		
TOTAL OTHER ASSETS		
TOTAL ASSETS	125,000.00	
Liabilities & Equity		
CURRENT LIABILITIES		
Accounts Payable (see Appendix D)		0
Interest Payable		
Taxes Payable (30% of 320,000 salaries)		0
Notes, Short-term (due in 12 months)		
Current part, long-term debt		
<hr/>		
TOTAL CURRENT LIABILITIES		0

LONG-TERM DEBT	
Bank loans payable	100,000
Notes payable to stockholders	
LESS: short-term portion	11,474.72
Other Long-term portion	
TOTAL LONG-TERM DEBT	88,525.28
<hr/>	
TOTAL LIABILITIES	100,000
<hr/>	
OWNERS EQUITY	
Capital	25,000.00
Drawing	
TOTAL OWNERS EQUITY	25,000.00
TOTAL LIABILITIES & EQUITY	125,000.00

				Notes				
(a). Machinery & Equipment				(c). Medical Equipment				
Refrigerator	3500	Lift slings (4)	384					
Stove	1000							
Microwave	250	Recliner/lift chairs	2796					
Dishwasher	250	Transfer belts (4)	31.96					
Washing Machine	600							
Dryer	600							
	<hr/>							
	5700.00							
<hr/>								
(b). Furniture & Fixtures								
Dining room table & chairs	1500							
Living room furniture	2500							
Bedside tables (4)	183.80							
Dressers (4)	399.96							
	<hr/>							
	4583.76							

Appendix D

<u>Revenue & Expenses</u>	
Revenue	408,800/year*
<u>Expenses</u>	
Salaries	320,000/year**
Bank loan repayment	18,111.24/year**
Operating Expenses	33,024/year***
<u>Revenue – Expenses</u>	<u>Total Yearly Income</u>
	37,664.76

*Revenue - \$408,800

Using the average daily rate of inpatient facilities in Kansas City, KS, Rogers, AR, and Tulsa, OK ranging from \$275 daily to \$290 daily. The daily rate of services will be \$280 daily for inpatient stay. With an average of 4 patients x 7 day average stay, income has been figured for 28 paid days a month for 4 patients. \$ 280 x 4 patients x 365 days = \$408,800 yearly income

**Salary - \$320,000/year

Staff physician \$ 60,000 year
Director of Nursing/Administrator \$60,000
Registered nurses x 3 fulltime \$120,000 (40,000 each), x 2 part-time 20,000/each
Unlicensed assistive personnel x4 part-time 10,000/each

**Insurance - \$7,200

Estimated insurance facility coverage and malpractice insurance at \$600 monthly

**Bank loan - \$100,000

7 year loan with a 7% fixed interest rate, monthly payment \$1509.20

*** Operating Expenses

<u>Expenses</u>	<u>Monthly</u>
Medical Supplies	500
Kitchen Supplies	150
Cleaning Supplies	100
Food	600
Repairs and maintenance	300
Accounting	250
Insurance (liability and property)	600
Legal Fees	250
<hr/>	
Total initial Expenses	\$2750