A National Role Delineation Study of the Hospice and Palliative Care Administrator

Conducted for the

National Board for Certification of Hospice and Palliative Nurses

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Introduction

The purpose of this study was to identify the responsibilities of hospice and palliative care administrators as a first step in the development of a job-related certification examination. The National Board for Certification of Hospice and Palliative Nurses (NBCHPN®) requested the services of Applied Measurement Professionals, Inc. (AMP) to design and conduct a study that would provide the support necessary to develop specifications upon which a content valid certification examination could be built.

The title of this study includes the use of the term role delineation study. However, other equally appropriate terms could be used to describe this study, for example, job analysis or practice analysis. A role delineation study suggests breadth of focus; however, the term role delineation has sometimes been used to describe a strictly judgmental process that does not make use of the data collection methodology used in the present study. While these three terms could be considered synonymous, there may be some subtle differences. Job analysis is the traditional technical term that is consistent with traditional standards of practice used to describe validation procedures for certification examinations. Practice analysis is a contemporary term that provides an appropriate description of the present study, as practice analysis suggests that the focus of a study is broader than a single job. Again, role delineation is the term primarily used in this report, although the terms should be considered to be interchangeable in relation to this study.

The NBCHPN® appointed a Role Delineation Study Advisory Committee (AC) to conduct the activities necessary to identify responsibilities of hospice and palliative care administrators and develop Examination Specifications. The AC was reflective of the hospice and palliative care administration professions in all relevant respects, for example: geographic, professional area, level of responsibility, educational background, gender, and work setting. All AC members had demonstrated expertise in their respective areas of specialization. AMP is grateful to these committee members for their guidance and expertise, as well as the time committed to this project. Without the AC's effort and expertise across the various specialty areas, this project would not have been accomplished. In addition, special mention should be made of the valuable contributions of NBCHPN® staff, especially Director of Certification, Sandra Lee Schafer RN, MN, AOCN®.

In the next section of this final report, the methodology of the study is discussed. In particular, the design of the survey instrument is described, including the method of defining tasks, professional issues, rating scales, and demographic questions. Also discussed in the methodology section is the sampling plan and distribution of the web-based survey. The results section of this report discusses the respondents and their demographics, the adequacy of the instrument, and a summary of the responses. The final section of this report discusses the development of the Examination Specifications based on these data.

Methodology

The AC considered various resource materials that could be useful in gaining an understanding of the responsibilities of hospice and palliative care administrators. The primary resource was the previous practice analysis survey and the Detailed Content Outline developed on the basis of the practice analysis completed by NBCHPN® with AMP's assistance in 2007. Other materials assembled prior to the first meeting of the AC included orientation materials, a draft of rating scales used for role delineation, and a timeline for conducting the study. Background information was provided regarding both the role delineation process (and its relationship to the examination development process) and NBCHPN®'s role in the continuing development of a hospice and palliative care administration certification examination. Seven major tasks were initiated during the AC meeting held in April 2012. These steps included:

1. Defining the target practitioner
2. Developing a sampling plan
3. Identifying tasks for the survey instrument
4. Identifying knowledge domains
5. Determining the rating scales
6. Determining the relevant demographic variables of interest
7. Integrating demographics, rating scales, and tasks into a survey instrument

A summary of each activity follows.

1. Defining the target practitioner

For the purposes of this study, the NBCHPN® adopted the following target practitioner definition of a CHPCA®:

> *The Certified Hospice and Palliative Care Administrator (CHPCA®) demonstrates competence in directing/managing a broad range of administrative activities for hospice and/or palliative care service entities. These activities include clinical, operational, financial and human resources, as well as the delivery of quality patient care for the organization or part of the organization. The administrator may have direct clinical responsibilities however, they are secondary to business oversight.*

2. Developing a sampling plan

The AC considered various methods of identifying individuals who consider themselves to be hospice and palliative care administrators, or who would be knowledgeable about the duties of hospice and palliative care administrators. It was determined that invitation e-mails containing a link to the online role delineation study would be distributed by NBCHPN® to hospice and palliative care administrators listed in the NBCHPN® and HPNA databases.

3. Identifying tasks for the survey instrument

The draft list was thoroughly discussed during the meeting held in April 2012. Tasks representing individual job responsibilities were modified, added, and removed, and all tasks

were verified as being appropriately linked to the associated knowledge domain (e.g., Leadership and Ethics). At the conclusion of this meeting, a draft list that included 110 tasks was developed by the AC. After the review of the draft task list, the AC authorized development of the final survey. The final survey included 110 tasks.

4. Identifying knowledge domains

The committee identified 7 knowledge domains, under which the 110 tasks were categorized into subcategories. The AC unanimously agreed on the linkage of each task to the respective knowledge domain. The domains were as follows:

1. Leadership and Ethics
2. Operations
3. Fiscal Management
4. Human Resource Management
5. Quality Management
6. Community Outreach and Advocacy
7. Organizational Integrity and Compliance

5. Determining the rating scales

The committee discussed the advantages and disadvantages of various rating scales that could be used in responding to the tasks. AMP suggested the use of a single significance scale. This single scale is intended to solicit judgments that combine the importance of a task with the frequency with which it is addressed in practice, after first considering the extent to which it is necessary to the performance in practice. The significance scale adopted by the AC is shown below.

How significant is this activity to your work?

0 = Not Necessary for My Job
1 = Minimally Significant
2 = Significant
3 = Very Significant
4 = Critically Significant

6. Determining the relevant demographic variables of interest

The committee identified 20 relevant and important demographic survey variables. Since this was a national study, it was important to identify the respondents' geographic regions of employment. Other demographic questions were written to assess characteristics of the representativeness of the respondents, including highest degree, degree discipline, organization memberships, certifications held, years of experience, leadership level, responsibility, job title, service, program size, primary setting, primary empoyer, employer's tax status, community, age, gender, and racial and ethnic background.

7. Integrating demographics, rating scales, and tasks into a survey instrument

After the first meeting, all components of the survey (demographics, rating scales, and tasks) were combined and designed into a draft survey instrument. As a pilot test, this draft was distributed to the AC and other individual content experts via an e-mail message, which included a link to the survey. Following a review of the comments, the final survey was prepared and distributed via an e-mail invitation.

Results

The survey was accessible via the Internet through the response deadline of July 31, 2012. Of the 972 e-mail invitations distributed, a total of 307 respondents accessed the survey, resulting in a raw response rate of 32%. After reducing the sample size for participants who completed 0% of the survey (no ratings provided for any tasks, n=34) and participants who indicated not working as an administrator in hospice and palliative care (n=13), a total of 260 responses were considered to be valid responses, for a corrected response rate of 27%.

Demographic Information

Responses to some of the demographic variables are depicted in the following graphs.

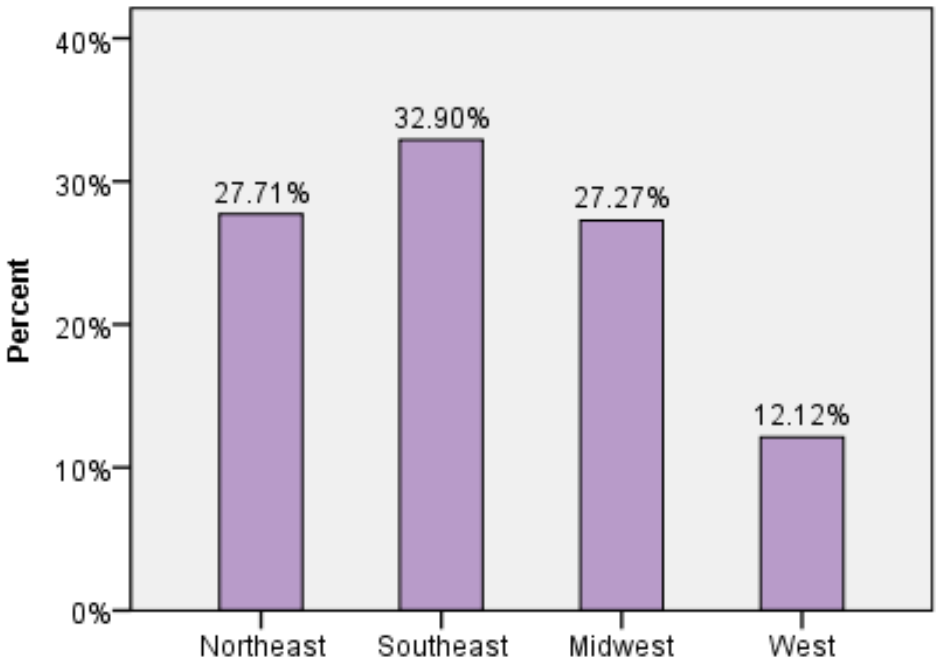

Figure 1. In what state do you work? (recoded)

- Northeast: CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VA, VT
- Southeast: AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, TX, WV
- Midwest: IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, OK, SD, WI
- West: AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY

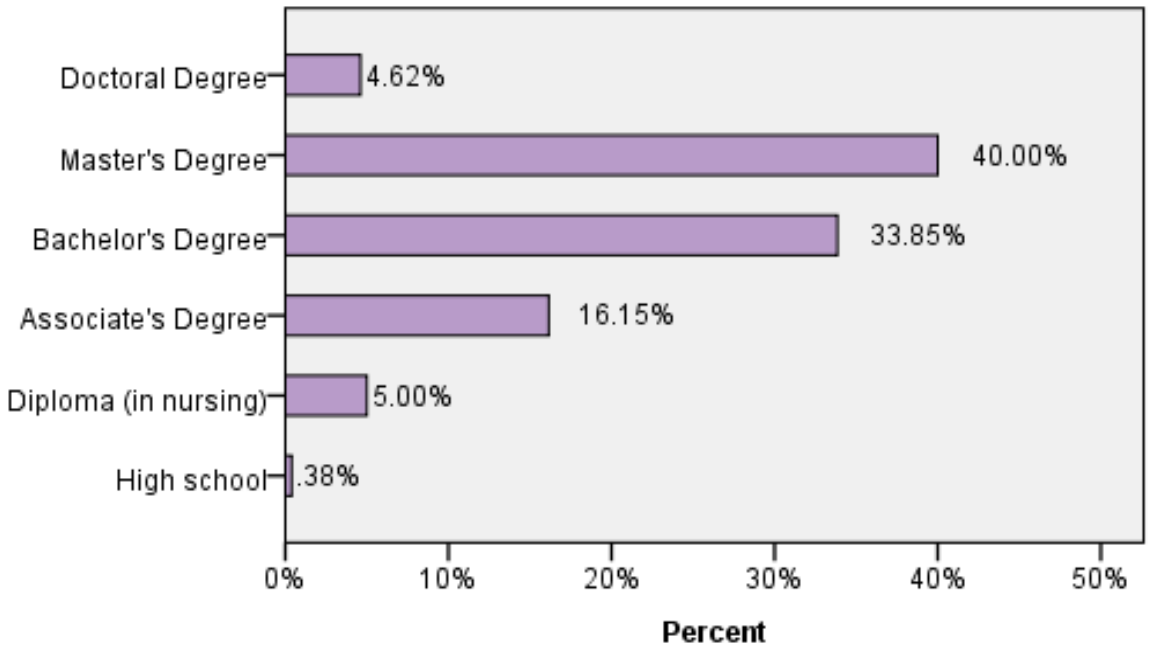

Figure 2. What is the highest degree you have completed?

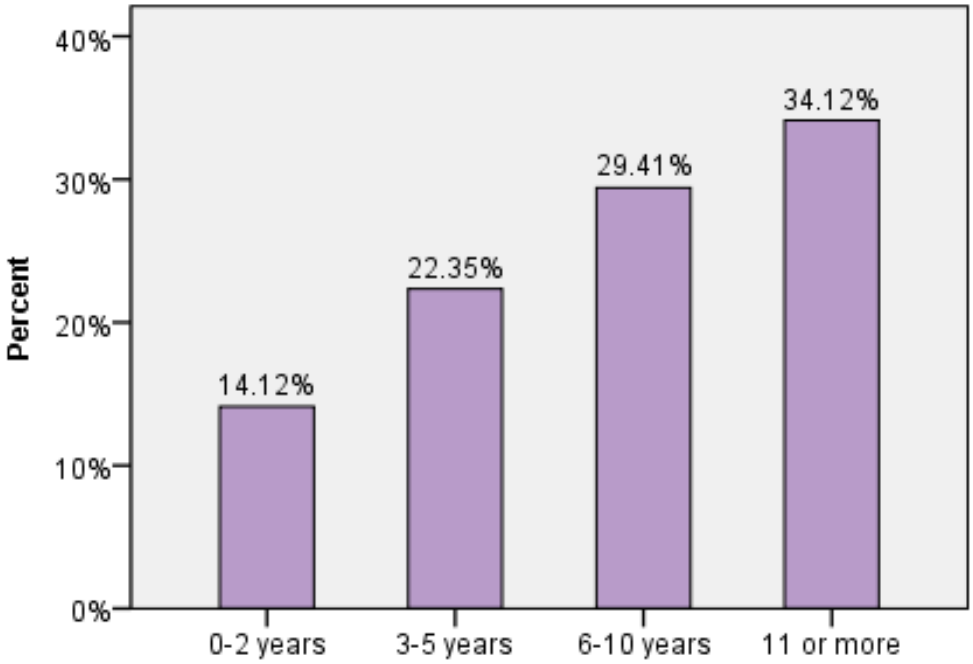

Figure 3. How many years have you been working in an administrative role within the field of hospice and/or palliative care? (recoded)

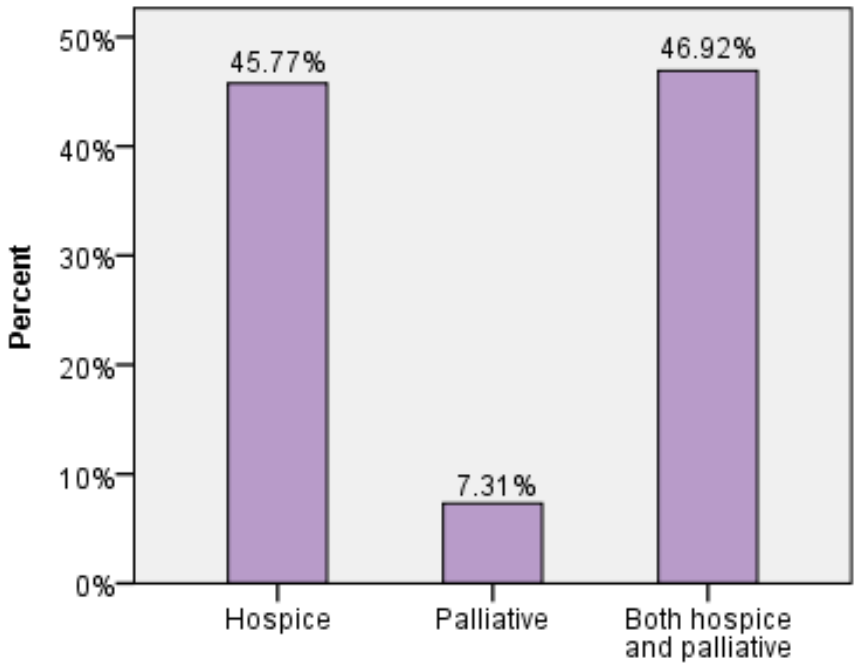

Figure 4. Which of the following best describes your service?

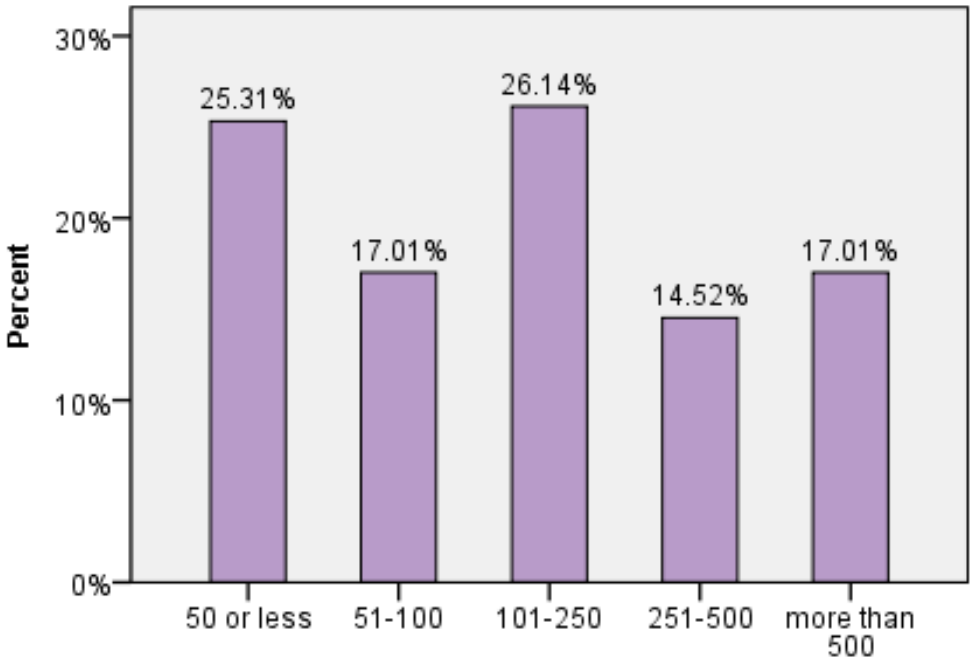

Figure 5. What is the average daily cesus for your program?

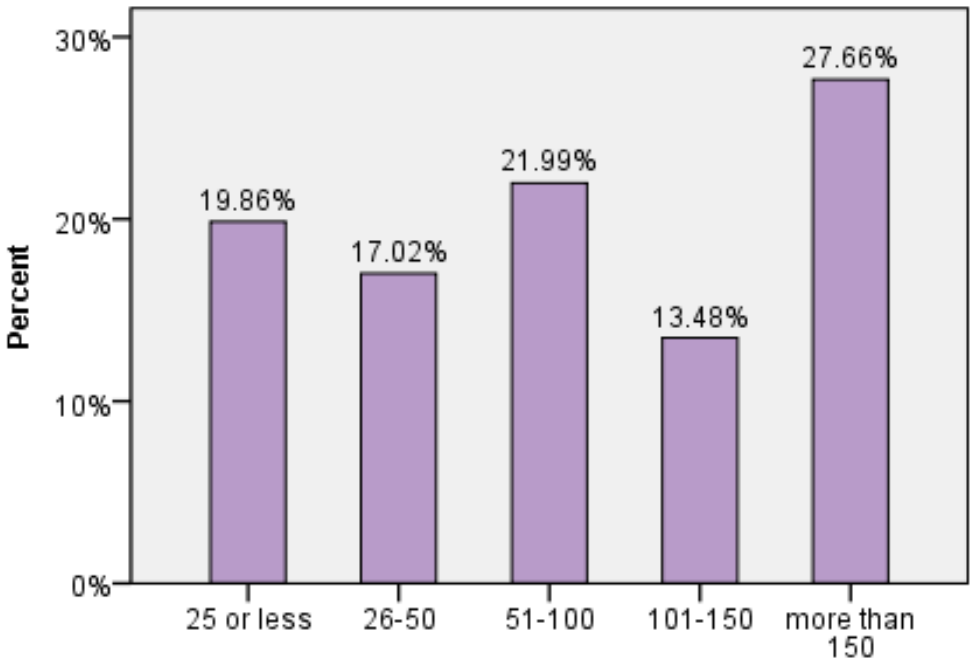

Figure 6. What is the average monthly referral rate?

Based on discussion with the AC, the demographic results were generally as expected, and judged to be representative of the profession. In addition to ensuring that the respondent group was representative, it was important to evaluate whether responses were received in ppropriate numbers from relevant subgroups. The AC determined that a sufficient response was received from relevant subgroups for subsequent analysis.

Although some of the analyses documented later in this report will investigate differences among various demographic groups, a description of the typical respondent may be of interest. This individual could generally be described as follows:

> The typical respondent is a female Caucasian from the Southeast in her 50s with a Master's Degree in Nursing, CHPN® Certification, HPNA and NCHPP/NHPCO memberships, and more than 11 years of experience in an administrative role within the field of hospice and/or palliative care. She works for a hospice provider with a daily census of 101-250 patients and an average referral rate of more than 150 patients. The organization is not for profit and has a mixture of patients in their own home and/or facility in a mixed urban and rural setting. She would describe herself as a full-time Director in upper management/executive level without responsibilities in other areas outside of hospice/palliative care.

The AC concluded that this information is consistent with the population of hospice and palliative care administrators, and a sufficient number of responses in relevant subgroups were received to facilitate subsequent analysis.

Adequacy of the Instrument

Approximately 98% of those responding to the survey felt that the role delineation study at least adequately addressed the responsibilities of hospice and palliative care administrators. Thirteen

(13) survey respondents did not answer this question. Another aspect of the adequacy of the instrument relates to its reliability. Task reliability and rater reliability were both evaluated.

Task reliability estimates show to what extent each scale "hangs together." A high task reliability value may indicate that the scale represents a consistent collection of tasks. Rater reliability estimates are more important and indicate the degree to which raters agree on the significance of an item. Overall, the calculated reliability estimates are quite acceptable.

Task Ratings

Descriptive data for each of the 110 tasks were reviewed. While relative comparisons of the data are appropriate (e.g., when comparing tasks, the task with the higher mean rating could be said to be more significant to practice), it is important to consider the absolute meaning of the ratings. The reader should bear in mind that the response options (also known as anchors) for the significance scale were: 0) Not Necessary for My Job, 1) Minimally Significant, 2) Significant, 3) Very Significant, and 4) Critically Significant.

The mean of the ratings is based on all ratings of significance and does not include the zero (i.e., Not Necessary for My Job) ratings. Therefore, the mean significance ratings represent the level of significance judged by the respondents who believed that the task was necessary to practice.

The mean significance ratings ranged from 2.12 to 3.81. The mean rating of significance, calculated across all 110 tasks, was 2.95, with a standard deviation of 0.35. A grouped frequency distribution of the overall mean task ratings for the 110 tasks is shown in Table 1.

Table 1. Distribution of Mean Task Ratings

Mean Rating	*N*	%
Greater than 3.49	9	8.18%
3.25-3.49	10	9.09%
3.00-3.24	33	30.00%
2.75-2.99	27	24.55%
2.50-2.74	18	16.36%
2.25-2.49	12	10.91%
Less than 2.25	1	0.91%
Total	110	100.00%

Ratings of Various Demographic Groups

The demographic questions were included in the survey to provide descriptive information about the respondents. For some demographic questions, however, it is important to ensure that individuals from different subgroups view the tasks required of hospice and palliative care administrators similarly, and that the ratings exceed a level of significance sufficient to warrant inclusion on a national examination.

Examination Specifications

In developing Examination Specifications (or a Detailed Content Outline), committee judgment must be used in interpreting the data gathered through the role delineation study. For purposes of this report, the Examination Specifications will be defined as the confidential document that is used to guide the examination development process, and includes sufficient detail to ensure the development of comparable examination forms. The Detailed Content Outline can be defined as a subset of the Examination Specifications; it is a document that includes a detailed listing of content available in outline form for candidates and item writers. Every examination item must be linked to the Detailed Content Outline as a first step in meeting the Examination Specifications during the examination development process.

Of particular importance to a national certification examination program is that the Examination Specifications must appropriately reflect the responsibilities of all groups who will participate in the certification program. Therefore, it is important to ensure that neither the Examination Specifications nor the resulting examinations include tasks that are not considered to be important responsibilities of the individuals for whom the examination is intended.

Application of Decision Rules and Criteria

Several decision rules were proposed for consideration by the AC in determining criteria by which tasks should be considered *ineligible* for assessment, and therefore excluded from the Detailed Content Outline. The general areas for consideration were discussed by the AC during web meetings held in September 2012, and were based on a variety of the demographic characteristics included in the survey.

The decision rules adopted by the AC, the order in which they were applied, and their impact on exclusion of tasks are summarized in Table 2. Applying the decision rules ensures that the resulting examination reflects the responsibilities of hospice and palliative care administrators, as judged by a demographically representative group of hospice and palliative care administrators.

As a result of implementing the decision rules, 17 tasks were removed from the task list, and 1 task was shifted to another category. A very small group of respondents who indicated their service as palliative only provided limited validity of responses with lower average ratings. Consideration should be given to advising examination candidates to carefully evaluate the examination specifications, since all tasks on the CHPCA® may not be applicable to administrators in an exclusively palliative care setting. The remaining 93 tasks out of the original 110 tasks (85%) were eligible for assessment, from which a Detailed Content Outline and Examination Specifications could be generated. Following discussion, it was decided that no additional tasks were needed to appropriately reflect practice or would be needed to construct CHPCA® examination forms. The final Detailed Content Outline is shown in Appendix A.

Table 2. Decision Rules and Criteria to Remove Tasks

Decision Rule *The task must be:*	Criteria	Number of Tasks Eliminated
• part of practice	More than 69.5% of the respondents reporting a non-zero rating	14
• significant to practice	Overall mean rating at least 2.43	1
• significant throughout the United States	Mean rating at least 2.36 in 3 out of 4 US regions	No additional tasks
• significant regardless of educational preparation	Mean rating at least 2.36 in all 3 subgroups	No additional tasks
• significant regardless of HPNA membership status	Mean rating at least 2.36 in both subgroups	No additional tasks
• significant regardless of NCHPP / NHPCO membership status	Mean rating at least 2.36 for both subgroups	1
• significant regardless of CHPCA® certification status	Mean rating at least 2.36 for both subgroups	No additional tasks
• significant regardless of years of experience (if more than 2 years)	Mean rating at least 2.36 for 3 subgroups with more than 2 years of experience	No additional tasks
• significant for middle and upper level of management	Mean rating at least 2.36 for subgroups of middle and upper management	1
• significant regardless of hospice average daily census (if 500 or less patients)	Mean rating at least 2.36 for 4 subgroups with 500 or less patients	No additional tasks
• significant regardless of palliative monthly referral rate	Mean rating at least 2.36 for 3 out of 5 subgroups	No additional tasks
• significant regardless of community type	Mean rating at least 2.36 for 2 out of 3 subgroups	No additional tasks
• significant regardless of service provided	Mean rating at least 2.36 for 2 out of 3 subgroups	No additional tasks
• significant regardless of tax status of the organization	Mean rating at least 2.36 for 2 out of 3 subgroups	No additional tasks

Confirmation of the Link between Tasks and Knowledge Domains

When developing the survey, the AC determined that each task was clearly linked to the associated knowledge domain. During the meetings in September 2012, the AC reconfirmed

that linkage. Item writers will be instructed to classify items according to a specific task, and to ensure that the item is associated with the major knowledge domain. When approving items, the Examination Development Committee (EDC) will similarly confirm that linkage.

Development of Final Detailed Content Outline and Examination Specifications

For the CHPCA® examination, a Detailed Content Outline can be defined as a detailed listing of content available in outline form for candidates and item writers. The final 93 tasks were organized into the Detailed Content Outline, which may be used by candidates for preparation for the examination. The Examination Specifications remain confidential and are only used for examination development purposes. The Examination Specifications incorporate the detailed content of the Detailed Content Outline, and also include other information needed to ensure the development of comparable examination forms, as discussed in this section.

The AC determined that the remaining 93 tasks could be appropriately assessed by way of a total of 135 multiple-choice examination items to ensure appropriate content coverage. Item writers will be advised that any knowledge area underlying a task may be appropriate for assessment, and that the item should be directly related to the task, at an appropriate level of cognitive performance.

The AC determined that all items would be classified as requiring recall, application, or analysis on the part of the candidate. For purposes of such classification, the AC adopted the definitions shown in Table 3.

Table 3. Cognitive Level Definitions

Level	Definition
Recall	Requires recall or recognition of specific facts or concepts which generally does not vary relative to the situation.
Application	Requires the comprehension, interpretation, or manipulation of concepts or information to a given situation.
Analysis	Requires integration or synthesis of a variety of concepts or information to problem solve, integrate or make judgments about a situation (i.e., evaluating and rendering judgments on complex problems with many situational variables).

After agreeing on the number of items on the examination, the AC discussed how these items should be distributed across the knowledge domains. Based on the significance of the task ratings, the breadth of content within each major knowledge domain, and suggestions of survey respondents, the committee members used an iterative process to determine the number of items for each knowledge domain. The Detailed Content Outline with percent of items for each knowledge domain is shown in Appendix A.

During the present study, a variety of approaches were considered to establish the cognitive level distributions within the minor domains. The unanimous agreement of the AC was reached during the September 2012 meeting regarding the cognitive level distribution targets adopted for the Examination Specifications.

Appendix A

Detailed Content Outline

Certified Hospice and Palliative Care Administrators (CHPCA®) Detailed Content Outline	%
1. Leadership and Ethics	**19%**
A. Leadership 1. Design an organizational culture to support the hospice and palliative care philosophy and core values 2. Foster a positive work environment which enhances the organizational culture, mission and values 3. Promote effective interdisciplinary team building 4. Ensure a system to promote access to quality hospice and palliative care 5. Demonstrate effective leadership by serving as a role model 6. Establish an organizational climate to encourage mentoring 7. Monitor emerging trends that could impact hospice and palliative care operations, programs, practices, and services 8. Facilitate management of change within the organization 9. Promote service and performance excellence 10. Develop a long term strategic plan that is aligned with organizational mission and vision 11. Collaborate with the governing board to facilitate oversight and decision making 12. Provide input to facilitate succession planning B. Ethics 1. Participate in establishing a code of ethical conduct (e.g., professional boundaries, scope of practice) 2. Follow the code of ethical conduct 3. Develop a process of monitoring and addressing biomedical ethical issues (e.g., advance directives, assisted suicide, withholding and withdrawing life support or life sustaining procedures/treatments, informed consent) 4. Develop a process of monitoring and addressing ethical issues related to business practices (e.g., sales and marketing practices) 5. Encourage system-wide processes surrounding advance care planning	
2. Operations	**21%**
A. Staff Management 1. Ensure clinical staffing to meet patient and family care needs 2. Ensure administrative staffing to meet organizational needs 3. Provide regular and effective communication with staff members 4. Provide direct supervision to staff members 5. Establish productivity guidelines consistent with available resources (e.g., NHPCO, CAPC) 6. Support recruitment and retention of volunteers	

Certified Hospice and Palliative Care Administrators (CHPCA®) Detailed Content Outline	%
B. Staff Education 1. Assure implementation of best practices in all areas of hospice and palliative care operations 2. Encourage staff to apply clinically-based research findings into practice 3. Strive to achieve certification of hospice and palliative care staff 4. Assess staff educational needs 5. Create an education plan based on needs assessment 6. Ensure job-specific orientation 7. Foster continuing competence for all staff 8. Lead staff development initiatives 9. Provide opportunities for professional development of staff 10. Evaluate effectiveness of staff development C. Business Continuity 1. Assist with development of policies and procedures 2. Recommend an operating structure to ensure achievement of organizational goals 3. Develop and implement project management plans 4. Establish and implement an internal communication plan 5. Provide input to the development of emergency preparedness plans 6. Ensure staff have resources and tools to support job performance (e.g., technology) D. Operations Management 1. Engage in problem solving activities and conflict resolution 2. Establish workflow systems (e.g., flow of information, maintenance of records, delivery of medications) 3. Direct and manage day-to-day business operations 4. Establish delegation of operational decisions 5. Encourage innovative models of care delivery	
3. Fiscal Management	**13%**
A. Budget 1. Develop and provide input for the development of the budget 2. Manage resources efficiently within the allocated budget 3. Approve financial expenditures 4. Monitor and address budget variances 5. Maintain responsibility of financial areas and cost controls 6. Participate in cost reporting activities 7. Monitor targeted revenue to expense ratio 8. Monitor data related to reimbursement (e.g., utilization, median length of stay) 9. Maintain knowledge of cost reporting requirements, issues and practices	

Certified Hospice and Palliative Care Administrators (CHPCA®) Detailed Content Outline	%
10. Determine acceptable balance of reimbursable and non-reimbursable services (e.g., complementary therapies, community bereavement services, anticipatory grief services) 11. Ensure preparation of data for routine audit and assessment B. Contract Management 1. Negotiate with vendors of goods and services (e.g., DME, pharmaceuticals, biological, providers, facilities) 2. Monitor delivery of goods and services provided according to contractual terms	
4. Human Resource Management	**10%**
A. Staffing 1. Evaluate the marketplace to ensure workforce excellence 2. Participate in recruitment activities for staff 3. Participate in staff retention activities 4. Provide mechanisms to obtain employee feedback 5. Ensure general orientation of new staff 6. Conduct performance appraisals and provide feedback to employees 7. Participate in hiring, termination, and status changes (e.g., promotion, full-time to part-time, leave of absence) 8. Ensure compliance with licensing and credentialing of staff B. Policies and Procedures 1. Ensure compliance with employment laws (e.g., EEOC, OSHA, practice acts, worker's compensation) 2. Ensure compliance with human resources policies	
5. Quality Management	**15%**
A. Participate in the strategic and tactical review of the organization's performance with the governing body B. Participate in implementation of the quality management program C. Participate in the development of a data-driven quality assessment and performance improvement program using a methodology that guides the services of the organization to address: 1. patient safety 2. adverse events 3. infection control D. Integrate data-driven performance improvement projects into practice E. Evaluate quality management data related to outcomes F. Measure satisfaction of internal and external customers	

Certified Hospice and Palliative Care Administrators (CHPCA®) Detailed Content Outline	%
G. Oversee development, implementation, and evaluation of standards of practice in hospice and palliative care clinical areas	
H. Promote excellence in the patient and family experience	
I. Participate in national quality initiatives	
J. Apply National Quality Forum preferred practice standards	
6. Community Outreach and Advocacy	**8%**
A. Participate in development of community outreach plans	
B. Participate in community outreach activities (e.g., education, support groups, memorial services)	
C. Establish relationships with local, state, and national health and human service groups	
D. Participate in advocacy activities to influence public policy	
E. Develop relationships to assure consistency and growth of referral sources	
F. Determine market share and areas for development	
7. Organizational Integrity and Compliance	**14%**
A. Ensure organizational adherence to a code of conduct	
B. Ensure processes are in place for reporting violations related to inappropriate conduct	
C. Incorporate industry standards and guidelines into organizational practice (e.g., NHPCO Standards for Hospice Programs, National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, CAPC, NQF, discipline specific guidelines)	
D. Maintain current knowledge and interpretation of regulations that currently or potentially impact the organization's program goals and objectives (e.g., Medicare Hospice Benefit, Conditions of Participation/Interpretive Guidelines, Local Coverage Determination (LCDs)	
E. Follow applicable Federal regulations (e.g., Patient Self Determination Act, HIPAA, Anti-kickback laws, Stark law)	
F. Implement a compliance plan to ensure adherence to regulatory standards	
G. Ensure compliance with accreditation standards (e.g., The Joint Commission, CHAP)	
H. Participate in the development and integration of a risk management program	