# Hospice of the Chesapeake Learning and Development Analysis

Mary Lynn McPherson

University of Maryland University College

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### Introduction

Hospice is a model of care for patients with advanced, life-limiting illnesses who are likely to die within six months. Care is provided for the terminally ill patient with attention to their physical needs (e.g., pain, shortness of breath, nausea, etc.), psychological/existential needs, spiritual needs, financial needs, health care planning, and bereavement support for the family and caregivers. Some hospice programs also provide palliative care, which attends to the same patient and family needs, but the patient may have a prognosis greater than six months. The model of hospice and palliative care has grown exponentially over the past 40 years, with an accompanying growing need for skilled practitioners (e.g., physicians, nurses, social workers, pharmacists, chaplains, nursing assistants). Most hospice programs are experiencing a dearth of new hires with prior hospice and palliative care experience. To this end, programs must have a robust orientation and ongoing learning and development plan in place. This report is the result of a learning and development analysis that has been conducted at a local hospice known as Hospice of the Chesapeake (HOC).

### Description of the Organization

Hospice of the Chesapeake (HOC) is a not-for-profit service organization that provides both hospice and palliative care services in their catchment territory. HOC provides care to patients in Anne Arundel County (90 Ritchie Highway, Pasadena) and Prince George's County (9500 Arena Drive, Largo) in Maryland. HOC provides a full complement of care from a spectrum of practitioners including physicians, nurse practitioners, nurses, social workers, nursing assistants, chaplains, music therapists, consultant pharmacist, administrators, clerical support, education staff, Board of Directors, and volunteers. HOC has 267 staff members, of which 111 are nurses. There are approximately 30 hospice programs in the state of Maryland, and HOC is in the top three in terms of size. Size of a hospice program is judged by the average daily census (number of patients on service at a given time) and HOC has a census of about 460 patients (this would be considered a moderately large hospice program) (personal communication, October11, 2016). In 2015, HOC provided care for 2, 665 patients. HOC

provides care in the patient's home, an assisted living facility or long term facility if that's their residence, an inpatient hospice facility (located on the Anne Arundel County campus), and hospice and palliative care services at the two hospitals in Anne Arundel County (Anne Arundel Medical System and Baltimore Washington Medical Center).

The mission statement of HOC is "Caring for life throughout the journey with illness and loss" and is operationalized through the agency's goals and objectives, doing so with "courage, accountability, relationships and excellence" (personal communication, October11, 2016). The education department at HOC consists of two nurses, one who addresses organization-wide initiatives (e.g., Education Day) and one who teaches the face-to-face 2.5 week orientation every month. The face-to-face orientation is primarily for newly hired nurses; but all employees receive one day of orientation to the electronic medical record.

## Case Study Data

**Tools and Technology:**

Brenda Meyett (2016), Director of Education at HOC explained that the agency uses the Relias Academy as their learning management system. On further investigation, Relias Academy is an online training and development website that offers a wide range of asynchronous educational programs for health care organizations and individuals (Relias Academy, 2016). Reaching out to Relias Academy confirmed that they have developed their own learning management system ("powered by Relias Learning") and they are scorm conforment (Relias Academy, 2016). Scorn conformance refers to assuring that all e-learning content and learning management systems can work with each other (scorm stands for Sharable Content Object Reference Model) (SCORM Explained, 2016). Ms. Meyett stated, and Relias Academy confirmed, that member organizations may upload their own learning content, and restrict access to their own organization.

Although minimally qualifying as "technology", HOC has purchased a "SimMan" which is a mannequin used to teach staff how to perform physical assessment (e.g., take a blood

pressure, inspect a wound) and use for formative and summative competency assessments. HOC's SimMan model is very rudimentary; they have plans to upgrade in the future to a model with programmable options.

The only other "tool or technology" HOC uses in learning and development is the laptop computer issued to each clinician. They receive a day of training on how to access and document in the electronic medical record. While HOC does provide each employee with a smartphone, there has been no effort to deploy technology via the smartphone for learning and development to date.

**Analytics:**

HOC actually uses all four levels of Kirkpatrick's evaluations in their program. At the end of the 2.5 week orientation, all staff complete a Level 1 "smile sheet" evaluation, assessing participant impression of having met the learning objectives, efficacy of the nurse educator, and so forth. They also administer a Level 2 paper and pencil quiz at the end of orientation to determine if the orientee retained key concepts.

Interestingly, HOC does track Level 3 and Level 4 outcomes. Level 3 evaluations determine if the employee is doing things differently, such as using skills that will lead to improved patient care. Level 4 evaluation data determines if the target population is doing better as a result of the educational intervention.

There is a federal mandate that all hospice programs publicize their outcomes data starting in 2017, based on a survey sent to the surviving family two months after the patient's death. There are two questions – rate the overall hospice experience (0-10) and would you recommend this hospice to friends and family members? The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Commission has given hospice programs significant notice that this was afoot; data will be made public within a year. In preparation for this move, HOC has been tracking Level 3 outcomes, but not by specific employee. Rather, they track metrics such as pain relief 48 hours after admission, resolution of constipation, etc. It would be interesting to track this by employee, which is completely possible, but they have not chosen to

do this. To be a true Level 3 evaluation, it would be useful to track an individual employee's performance, offer additional learning and development as appropriate, and then track performance after the intervention. Unfortunately, this is not the case at this time.

HOC has had access to Level 4 data (based on the two questions above) as compared to other hospice programs in Maryland who use the same vendor who administers the survey, and to all the hospices nationwide who use that vendor (over 1,000). Their performance is "middle-of-the-pack" at this time. Since family responses are confidential on this survey, they are unable to track this data to individual staff members.

HOC also tracks specific Level 4 data including percentage of patients who screen positive for poorly controlled pain on admission and receive a comprehensive assessment for pain within 24 hours, and pain rating at 48 hours post-admission. While HOC could sort this data based on individual nurses, they have not done so at this point.

In the Relias Academy coursework, HOC has determined which courses must be completed (e.g., different courses for nurses vs. social workers, vs. nursing assistants, etc.). Each course has a quiz at the end which the learner can take as many times as necessary to pass (which Relias sets at 80% but HOC requires 90% correct). These scores all go into the gradebook.

**Competencies with Job Roles and Responsibilities:**

Unfortunately, given the severe shortage of highly qualified, experienced, hospice professionals at this time, giving preference to more qualified potential hires is not a feasible option. Certainly the determination of potential competency is a bit more than "a pulse and a nursing license" but not by much. Ms. Meyett (personal communication, 2016) stated the interviewer determines "how smart the potential hire is" through the interview conversation. There is no formal assessment of competency as part of the hiring decision.

When asked about how HOC management values potential employee competence vs. capacity, the answer was "about equally" (personal communication, 2016). Of course it would

be optimal to identify new hires that were both competent and capable, but in this "seller's market" hospice programs are lucky to find a capable employee, and train them.

There are a few ongoing competency demonstrations that are mandated by HOC or their accrediting organization. For example, the clinical manager makes a home visit at 90 days post-hire, and annually thereafter to assess hands-on skills such as handwashing, infection precautions, patient interviewing skills, etc. They also plan to hold an annual "skills assessment" in house with various "stations" so staff can demonstrate a skill (e.g., how to program an IV pump), and receive formative feedback and education on the spot.

**Future Planning**:

Per the education team at HOC, future plans include consideration of moving away from Relias Academy (because much of their content is outdated) and possibly to adopt their own learning management system (they mentioned HealthStream) (personal communication, 2016). As mentioned above, there has been discussion about purchasing the programmable components for SimMan to make the model more realistic and to allow a greater breadth of training.

Last, HOC is switching to a new pharmacy provider as of November 1, 2016. Instead of using a local pharmacy, they will using a pharmacy benefits manager/distributor that works on a national level. This will allow the nursing staff to order medications online instead of having to call the pharmacy. However, this author pointed out that the pharmacy provider they are switching to offers the capability for physicians to prescribe medications from their smartphone, and for nurses to reorder medications in a similar fashion. The education team was unaware of this option, but speculated that would not be an option for them.

## Analysis of Learning and Development Maturity

To assess HOC's learning and development (L&D) maturity, a four stage system will be utilized. The four stages include:

- Stage 0 – The organization has no formal, consistent L&D activities (Stages of Learning and Development Capability/Maturity, 2013).
- Stage 1 – Separate or sporadic L&D activities have occurred (Stages of Learning and Development Capability/Maturity, 2013).
- State 2 – The organization's technological capability and people can support L&D activities. When L&D activities occur, they are replicated through a team which responds to staff and management inquiries and recommendations regarding L&D (Stages of Learning and Development Capability/Maturity, 2013).
- Stage 3 – The organization has established L&D policy and planning. This means a stable and predictable process is in place to facilitate the activities. L&D has been institutionalized with policy communication, and practice aligned so that business objectives are being addressed. The organization has established a L&D identity and conduct systematic assessment of L&D with an organizational perspective (Stages of Learning and Development Capability/Maturity, 2013).
- Stage 4 – L&D is part of the organization's DNA. Enterprise learning is the philosophy used by C-level management to determine the learning and training needs of the organization. It is aligned to the business goals and mission of the organization and focuses on business management, project management, and L&D management processes. Learners use innovation and resourcefulness in the way they learn and solve problems. The organization's culture is one where learners can get what they want, when and where they want it, regarding learning. Additionally, metrics, processes, and systems are put into place as needed that track and measure learning initiatives and align them with business goals (Stages of Learning and Development Capability/Maturity, 2013).

Hospice of the Chesapeake is a moderately-large hospice and palliative care program in Maryland that enjoys enormous respect from the community. They have an education department that meets all the accreditation mandates (e.g., The Joint Commission, Medicare, State of Maryland). They currently subscribe to Relias Academy for selected online training activities, and have a consistent 2.5 week face-to-face orientation for nursing staff, and a one

day training program for the laptop and electronic medical record for all staff. They have regularly scheduled assessment activities, and formative and summative assessments that are also scheduled regularly.

Leadership of HOC proclaims, at least in philosophy, that education is critically important, drives their mission and goals, and likely affects overall agency performance (if only from the perspective of the upcoming publicly shared performance results). However, the education department is understaffed and finances are always an issue, particularly in a not-for-profit institution. Confounding the issue is the dearth of skilled, experienced potential hires. There is a shortage of nurses altogether, particularly nurses with hospice experience.

Considering the Stages of Organizational L&D Maturity Matrix, I would rate HOC as a Stage 2 regarding the use of tools and technology. They have access to a learning management system that is populated with content available through their subscription, and they have the capability to add their own content. They are entertaining switching to their own LMS, but are likely concerned about recreating all the content currently provided by Relias (albeit a bit out of date). HOC has started to make a little progress in performance and knowledge management, but it is not consistently applied or implemented.

Regarding jobs/roles/competencies, I would also rate HOC as Stage 2. They have established a curriculum that all staff must successfully complete, but again, not quite to the level of consistent and deliberate talent and performance improvement. Their primary analytics are mostly checklist (completed, not completed) but they are making some progress based on the looming CAHPS initiative. I would also rate HOC as a Stage 2 in this arena. Regarding the primary drivers, I would rate HOC as Stage 2.5 – they have already taken steps to meet federal mandates, and they believe that better trained staff absolutely drives business results.

I would rate HOC as Stage 2 for their current learning process. Their curriculum, as stated above, is planned, but not particularly strategic nor agile. If a nurse or other staff member has a need for “just in time” education, it’s hit or miss if the orientation nurse is available to provide on the spot training. I would also rate their business structure focus as Stage 2; their educational plan is consolidated and consistent, but doesn’t necessarily foster a

learning culture. It actually feels more than a task to be completed. Last, I would rate their decision support as Stage 2 – they provide a significant amount of information, but I do not believe they are to the point of embracing that learning culture and knowledge/performance management.

## Conclusion

Hospice of the Chesapeake is a thriving hospice and palliative care, not-for-profit entity in Maryland. Their learning and development program has definite structure and meets the minimum bar for establishing competence in staff. Based on their current level of learning and development, I would rank them as Stage 2 in the Maturity Matrix. They have some plans for L&D changes for the future, and I hope that leadership agrees with these changes and funds the employees and technology necessary to take their L&D to the next level.

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