Sustaining the Role of Social Work in Hospice Care: Social Workers' Perceptions of Job Satisfaction, Interdisciplinary Collaboration and Organizational Leadership

by

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Abstract

Sustaining experienced and skilled hospice social workers is important for providing high quality services to hospice patients. Job satisfaction for social workers in health care and hospice settings is a key component for maintaining social workers in their employment. In previous research, hospice social workers have been found to have the lowest level of job satisfaction compared to other hospice professionals (Casarret, Spencer, Haskins, & Teno, 2011; Monroe & DeLoach, 2004). A better understanding of how hospice social workers experience their jobs is needed to improve working conditions. Social workers in hospice will experience their jobs as a member of a team. The use of an interdisciplinary team in hospice is recommended for effective end-of-life care and is part of Medicare Conditions of Participation for all hospices in the United States who accept insurance reimbursement. However, there appears to be a gap in the research literature as to how relationships on the interdisciplinary team may be related to hospice social worker job satisfaction. The purpose of this study was to examine how these relationships, along with perceptions of hospice leadership, may be associated with hospice social workers' job satisfaction.

This was an exploratory cross sectional study that used an online survey. Data came from 203 hospice social workers that participated in a web-based survey that measured individual and hospice characteristics, interdependence in interdisciplinary collaboration, perception of servant leadership and job satisfaction. Results indicated that interdependence and perception of servant leadership were positively associated with job satisfaction, while also showing very little changes in job satisfaction based on other

characteristics such as profit status of the hospice, experience of the social worker, caseload size and other individual and hospice characteristics. This exploratory study lends support for the argument that relationships in the hospice organization matter for hospice social workers' job satisfaction and that differences in workforce conditions do exist for social workers at different hospices. Despite differences in workforce conditions, social workers continue to experience satisfaction in their jobs. Suggestions for areas of improvement in job satisfaction are presented as well as possible directions for hospice leadership to consider to maintain experienced and satisfied social workers in their employment.

Dedication

This dissertation is dedicated to the loves of my life, the reasons I wake up each day and my two favorite people in the world, my children, Maria Roman and John Roman. Johnny-do, you are my heart and Maria my love, you are still who I want to be when I grow up.

And…I love you more.

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Chapter 1

Introduction and Study Aims

Introduction

Despite high levels of satisfaction expressed by hospice employees when compared to employees in other sectors of health care, hospice social workers have the lowest job satisfaction compared to other professionals on the hospice interdisciplinary team (Casarret, Spencer, Haskins, & Teno, 2011; Monroe & DeLoach, 2004). Job satisfaction amongst health care employees contributes to the retention or tenure of qualified and experienced employees (Fritzsche & Parrish, 2005; Head, Washington & Myers, 2013; Kobayshi & McCallister, 2013; Miller, 2008). High turnover has been shown to be associated with decreased job satisfaction among direct care hospice workers and has also been shown to compromise quality of care for hospice patients (Dill & Kagle, 2010; Miller 2008). Higher job satisfaction among health care workers has also been shown to contribute to reduced cost of training new employees, improved patient satisfaction, and better adherence to treatment (Miller, 2008; Weissman & Nathanson, 1985).

Interdisciplinary relationships with hospice team members including social workers, nurses, physicians, chaplains, as well as the collaborative work that emerges from these relationships, has been described as an essential component of hospice and palliative care (NHPCO, 2013; World Health Organization, 2002). Hospice social workers operate as members of this interdisciplinary team to meet the needs of terminally ill patients and their families. Evidence is lacking about whether the quality of relationships with other disciplines on the hospice team and administrative leadership affect job satisfaction of the hospice social worker. For the purpose of this study, work relationships with other interdisciplinary team members and

perceptions of leadership were the variables of focus in the work environment that were hypothesized to impact job satisfaction. The congruence of the fit between the hospice social worker and this aspect of the hospice work environment were hypothesized to contribute to job satisfaction in this study. The Theory of Work Adjustment (Dawis & Lofquist 1984; Fritzsche & Parrish, 2005) emphasizes the process of achieving correspondence between the employee and the work environment. Degree of job satisfaction is therefore, associated with a successful person-in-environment fit and the flexibility on the part of both the worker and the work environment to achieve this correspondence (Dawis & Lofquist, 1984). Consistent with the Theory of Work Adjustment, successful work relationships with interdisciplinary team members and leadership may be key components contributing to a successful correspondence between person-and-work environment fit, and thus, impact job satisfaction.

Social Work and the Interdisciplinary Hospice Team

The full integration of social work in hospice care is in accordance with the philosophy of hospice and palliative care, which calls for an egalitarian and integrative interdisciplinary team model (Parker-Oliver, Bronstein, & Kurzejeski, 2005; World Health Organization, 2002). In the hospice and palliative care interdisciplinary team model, each discipline is considered to be an equal contributor to the team and to lend their unique perspective and expertise to the complex and diverse needs of patients. Research with terminally ill individuals and their families have supported preferences for professional attention to a holistic model that places equal emphasis and attention on the physical, emotional, psychosocial and spiritual needs of patients and families in end-of-life patient care (Steinhauser et al., 2000). Social work scholars in hospice and palliative care have warned against a developing trend of primary focus being placed on the physical needs of patients in hospice care (Kulys & Davis, 1986; Reese, 2011;

2013; Reese & Raymer, 2004). This emphasis on physical care needs may contribute to a lower emphasis on the psychosocial needs of patients, which is the primary area of focus for the hospice social worker (Reese & Sontag, 2001). Social work scholars have warned against the possibility of social work becoming an "ancillary" service to nursing in hospices (Kulys & Davis, 1986; Reese, 2011; Reese & Raymer, 2004; Reese & Sontag, 2001) possibly leading to lower job satisfaction, role confusion and feeling less valued in the organization (DeLoach, 2003; Monroe & DeLoach, 2004; Kobayashi & McCallister, 2013; Reese & Raymer, 2004). Social work has been identified as one of the "core services" in hospices (CMS, 2005, 2008). Despite the Medicare hospice mandate for social work presence on a hospice interdisciplinary team, economic strains in the health care system have contributed to an environment of decreased use of social workers in end-of-life care decision-making and increased social work patient case load sizes in hospitals, long-term care facilities and hospices (Marmo, 2014; Munn & Adorno, 2008; NHPCO, 2013; Reese & Raymer, 2004).

Study Aims

The goal of this study was to better understand how relationships with co-workers and perceptions of leadership were related to job satisfaction of hospice social workers. The specific aims were to determine whether: 1) Job satisfaction was associated with a) interdisciplinary collaboration or b) perceptions of leadership in the hospice (specifically executive directors); and 2) whether these associations differed by whether the hospice is for profit or not–for-profit. Potential covariates included hospice characteristics including number of staff, number of patients served, social worker's caseload); b) Professional characteristics of social worker, including: years since receiving MSW, number of years in clinical practice, number of years in hospice social work, and type of professional degree; and c) personal characteristics, including age and gender.

Problem and Justification

Definition and Purpose of Hospice

There were 6,100 hospices operating in the United States in 2014 (NHPCO, 2015). Hospice programs provided services to 44.6% of all persons who died in the United States in 2012, with over 1.5 million patients receiving services from a hospice agency that year (NHPCO, 2012; 2013). Hospice is considered the model for quality and compassionate care for persons with a life-limiting illness. Referral to hospice care has been suggested to be an indicator of quality care for persons diagnosed with terminal illness (Earle et al., 2003; Kamal, Gradison, Maguire, Taylore & Abernathy, 2014). Patients admitted to hospice have been shown to have lower anxiety, better pain management and longer life expectancy compared to patients who were not admitted to hospice (Connor, Pyenson, Fitch, Spence & Iwasaki, 2007; Greer et al., 1986; NHPCO, 2014). Admission to a hospice results in improved coping and better health outcomes for decedent family caregivers (Christakis & Iwashyna, 2003).

Hospice is a type of palliative care that is provided to individuals who have a prognosis of six months or less and who are no longer pursuing curative treatment for their terminal illness (NHPCO, 2013). As a philosophy of care, hospice uses a holistic approach to end-of-life care designed to meet the physical, emotional, social and spiritual needs of patients and families. To meet those needs, hospice, as a system of care in the United States, has developed into diverse health care organizations that provide medical, nursing social services, home health care, and bereavement care, as well as medication and supplies specific to the needs of individual patients and families. The utilization and staffing ratios of these direct service providers are under the discretion of leadership in the hospice organization and great variation in staffing ratios and service provision have been noted across hospices (Aldridge et al., 2014; NHPCO, 2013).

History of Hospice in the United States

The rise of the hospice movement started in 1967 in England by Dame Cecily Saunders, a nurse who later trained as both a social worker and a physician. In a series of lectures at Yale-New Haven Hospital, Saunders and other advocates of the hospice movement, including Elisabeth Kubler-Ross, spread the idea of hospice in the United States as a supportive and interdisciplinary system of care for the patient and their family to cope with the dying process (Kastenbaum, 1975). The hospice movement served as an alternative philosophy and approach to a perceived death-denying culture and the medicalization of the dying process in hospitals (Cerminara, 2010). The first hospice in the United States, Connecticut Hospice, began in 1974. At that time, hospices focused on providing care in a patient's home with volunteer services to support the patient and family in providing this care. In the 1980's, hospices shifted away from being primarily volunteer organizations, to becoming health care market organizations, through advocacy and efforts to receive financial reimbursement for services provided (Buck, 2009; 2011). In 1978, a U.S. Department of Health, Education, and Welfare task force described the hospice movement as a "viable concept" that could provide compassionate care to terminally ill Americans while also reducing health care costs in end-of-life care (NHPCO, 2014). To explore this further, in 1980, Congress requested a demonstration project to test the feasibility of providing hospice under Medicare. In this demonstration project, 26 hospices provided care to end-stage cancer patients in their homes and showed increased quality of life outcomes with cost reduction in health care spending (Greer, Mor, Sherwood & Morris, 1983). The cost data and findings of this demonstration project helped design the funding structure of the Medicare Hospice Benefit (CMS, 2014). This reimbursement structure has remained, with little change, since the inception of the Medicare Hospice Benefit in 1982 (Iglehart, 2009).

In 1982, the Medicare Hospice Benefit was established under the Tax Equity and Fiscal Responsibility Act (TEFRA) (CMS, 1983). Eligibility for the Medicare Hospice Benefit included: 1) a referral, including self-referral, to an accredited hospice program; 2) a treating physician's certification of a six-month or less prognosis; and 3) a decision by the physician and patient to discontinue curative therapy (McGorty & Bernstein, 2006). In the hospice philosophy of care, treatment goals are changed from a curative system of care to one that focuses on alleviating suffering through symptom management. The 1982 Medicare Hospice Benefit received bipartisan support as both a compassionate approach to end-of-life care and considerable cost saving measure (Buck, 2011). Passage of TEFRA signaled a policy shift, transitioning end-of-life hospice care from a volunteer program dependent upon donations and with no set standards of care provision, to a federally funded benefit that provided reimbursement for hospices that provide interdisciplinary care to terminally ill patients on a per diem basis.

Hospice Funding

The hospice system of care is primarily funded in the U.S. by medical insurance and certified hospice agencies are reimbursed at a per diem rate (Ash & Arons, 2009; Carlson et al., 2012; CMS, 2005; 2008; NHPCO, 2012). It has been suggested that the provision of hospice care in the United States has moved away from the original philosophy of the founders of the hospice movement to one that has instead been defined by the health care market economy and need for organizational stability (Buck, 2009; 2012; Cerminara, 2010). Under the per diem rate of approximately $140 to $180 per day, hospices must provide all services, including nursing, social work, medical, home health care, chaplaincy, and volunteer and bereavement services, as well as provide medication and durable medical equipment. Critics of the funding structure note

an inherent disincentive to provide increased service and have advocated for changes to the reimbursement structure of hospice based upon individualized assessment of service needs. (Buck, 2009; Carlson et al., 2012; Cerminara, 2010).

Recent U.S. policy changes, including the Budget Neutrality Adjustment Factor (BNAF) have enacted cost cutting changes to Medicare that will permanently reduce hospice reimbursement rates by nearly 4.2% by 2016 (NHPCO, 2013). Additionally, the Affordable Care Act (ACA) introduced a productivity adjustment factor that is projected to reduce hospice payments by another 11.8% over the next ten years (NHPCO, 2013). A 40% growth of the privatization of hospice programs occurred from 2000 to 2007 and for-profit hospices represented the majority (63%) of hospices in operation in the U.S in 2012 (CMS, 2012; NHPCO, 2013). Examination of medical records has shown that this competitive health care market and the need for cost containment led to decreased direct service provision for patients, as indicated by fewer visits per patient in for-profit hospices (Aldridge et al., 2014; Carlson, Gallo & Bradley, 2004. Doherty, 2009; Unal, 2011). Health care reform measures have decreased reimbursement for hospice services and there are more patients who spend one week or less enrolled in hospice care, which results in a financial loss to the hospice (Ash & Arons, 2009; Raphael, Ahrens & Fowler, 2001). To attempt to alleviate this cost burden, as of January 1, 2016, hospices are now billing on a new two-tiered payment model and receive a rate of $183.17 per day for the first 60 days of patient's care and then $143.94 per day for days 61 and above (NHPCO, 2015). An added component of this payment reform, may show reinforcement of the importance of social work for effective end of life care as hospices are now eligible to bill for Service Intensity Add-On payments (SIA) which provide additional payments for Nurse (RN) or social worker visits in the last 7 days of life (NHPCO, 2015).

Growth of the for-profit hospice market

The National Hospice and Palliative Care Organization (NHPCO) has reported the success and growth of hospice programs with the increase of hospice use by terminally ill persons in the U.S. (2013). Recent studies have critically examined the growth in the hospice industry in the current competitive health care market (Carlson, Gallo & Bradley, 2004; Doherty, 2009; Miller, 2008; Thompson, Carlson & Bradley, 2012; Wachterman et al., 2011). This has led to a critique of market-driven medicine at the end of life (Perry & Stone, 2011). Perry & Stone (2011) described this change in hospice delivery as a commercialization of hospice care. The growth of for-profit hospices has raised concerns about patient care outcomes and adherence to the original philosophy of the hospice movement (Iglehart 2009; Perry & Stone, 2011; Unal, 2011; Wachterman, Marcantonio, Davis & McCarthy, 2012). The growth of profit-making potential in the hospice health care market is evident in the increase of Medicare reimbursement for hospice expenditures that has risen from 2.9 billion dollars in 2000, 10 billion dollars is 2009 and 15.1 billion dollars in 2012 (Medpac, 2014; Unal, 2011). Additionally, the trend in health care consolidation has been observed in hospitals and hospices since the passage of the Affordable Care Act, with recent research showing that the most rapid growth is in multiagency hospice agencies (Dafny, 2014; Stevenson, Dalton, Grabowski, & Huskamp, 2015). Between 1989 and 2009, one in five hospices closed, with smaller hospices being more likely to close or merge with a larger hospice agency in order to remain in business (Stevenson et al., 2015; Thompson, Carlson, & Bradley, 2012). During this time period, over 40% of hospices changed from a nonprofit to a for-profit organization (Thompson, Carlson, & Bradley, 2012). Recent analyses of the National Home and Hospice Survey found that patients under the care of a for-profit hospice received fewer services such as nursing visits, social work visits, use of continuous

time care and lower medication expenses when compared to those under the care of non-profit hospices (Carlson, Gallo & Bradley, 2004; Doherty, 2009; Thompson, Carlson, & Bradley, 2012).

Unlike other health care billing on a fee-for-service model, hospice bills a per diem rate for each day the patient is alive and enrolled in hospice (MedPac, 2014). The incentive of the hospice benefit for hospice is the opposite of the traditional fee-for-service model of most health care services. The fewer services the hospice provides, the greater the profit. The National Hospice Survey collected data from a national random sample of 591 hospices between 2008 and 2009 and revealed that for-profit hospices were not only providing less service to patients than non-profit hospices, but were also less likely to provide service benefits to the community, such as serving as training sites, conducting research, providing charity care and providing expanded community bereavement services such as children's bereavement, specialized groups and 1:1 counseling (Aldridge et al, 2014). Patients with a greater need for intensive care have also been shown to be less likely to be enrolled in for-profit hospices than in nonprofit hospices, when compared to patients with other diagnoses (Aldridge et al., 2014; Carlson, Barry Cherlin, McCorkle & Bradley, 2015; Wachterman et al., 2011). Patients with non-cancer diagnoses, such as Alzheimer's Disease and congestive heart failure, as well as nursing home patients, have been recruited by for-profit hospices as they are considered to be more profitable and thereby financially advantageous for hospices seeking to generate revenue (Aldridge et al, 2014; Wachterman et al., 2011).

In addition to the recent focus on differences in patient populations for nonprofit and for-profit hospices, research has also documented that for-profit hospices employ fewer social workers then nonprofit hospices and the social workers at for-profit hospices make fewer visits

per patient then social workers at nonprofit hospices (Cherlin, Carlson, Herrin, Schulman-Green, McCorkle, et al, 2010).

Changing Work Conditions of the Hospice Social Worker

The mandate for social work presence on the hospice interdisciplinary team was first introduced into U.S. public policy in the original Hospice Medicare Benefit of 1982 and has continued to be reinforced in all updated versions of the CMS Hospice Conditions of Participation (CMS, 1983; 2005). Despite the mandate for social work presence on the hospice interdisciplinary team, the Medicare hospice law does not specify a social worker to patient ratio or the number of social workers employed in management or other positions at a hospice (CMS, 1983, 2005; Neigh, 2005). The professional to patient ratio is also not specified for other core disciplines, including medicine, nursing, and chaplaincy. The hospice leadership determines the number of social workers and other disciplines to employ, which has been suggested to be a contributing factor to great variation in staffing patterns in different hospices (Aldridge et al., 2014; NHPCO, 2013).

According to the latest update to the Medicare Hospice Conditions of Participation, patients are required to have a social work assessment as part of the comprehensive assessment, completed within five days of admission to hospice care (CMS, 2008). This assessment may be completed by a bachelor's level social worker if the state permits licensure at the baccalaureate level. In states without social work licensing laws, the social work assessment may be completed by a person without any social work degree (CMS, 2008; NHPCO, 2014). All social work services are mandated by the Medicare Hospice Benefit to be "under the direction of a physician," but this requirement is not included for other professions on the interdisciplinary team, including nursing and chaplains, nor does it include volunteers, bereavement workers, and

hospice aides (CMS, 1983, 2005)

The limited research on number of hospice social workers employed at individual hospices shows that there is great variability in social worker to patient ratio, availability of social work supervision, social work degree (BSW or MSW) and caseload size (NASW, 2004, 2012; NHPCO, 2012; Reese & Raymer, 2004; Social Work Policy Institute, 2010). Recent studies have shown that social workers are expected to carry increasingly larger caseloads and are seeing patients less often than they have in the past (Parker, Oliver & Peck, 2006; NHPCO, 2012; 2013; Reese & Raymer, 2004; Reese 2013). Hospice social workers' caseloads, on average, are more than double the number of patients when compared to nurses' caseloads (NHPCO, 2012; 2013; Reese 2013). Limited research exists exploring how often social workers are visiting hospice patients when compared to other disciplines. In a cross-sectional survey of 66 hospices, Reese & Raymer (2004) the median number of visits to hospice patients for a social worker was two, whereas for a nurse it was ten. A study of hospice workers assigned to nursing homes also found differences in the number of hospice visits by discipline. In 2009, the Office of Inspector General released a report on hospice beneficiaries in nursing homes and found that social workers provided considerably less service than nurses and home health aides (Department of Health & Human Services, 2009). In this 2009 report, based on a 2006 review of a of 450 hospice claims, medical social service visits occurred on a monthly or bimonthly basis, averaging about .4 visits per week, compared to nursing visits that averaged 1.7 times per week and home health aide visits that averaged 2.2 times per week (Department of Health & Human Services, 2009). Social work visits had a shorter mean duration of 43 minutes, compared to 53 minutes for nurses (Department of Health & Human Services, 2009).

Although mean lengths of stay for hospice patients has risen from 67.4 days in 2010 to

71.8 days in 2012 and to 72.6 days in 2014, the median length of stay decreased from 19.7 days to 18.7 to 17.4 days during the same time period (NHPCO, 2013; 2015). It has been suggested that the increased number of patients with shorter lengths of stay calls into question whether hospice social workers are able to provide meaningful service to terminally ill individuals and their families (Department of Health & Human Services, 2009; NHPCO, 2013; Reese & Raymer, 2004; Reese, 2013).

A survey of 146 hospices in Missouri found that some hospices employed only one social worker and that after the initial social work assessment, saw patients only when initiated by the patient's primary nurse (Parker-Oliver, Bronstein, & Kurzejeski, 2005). Reese (2013) describes this as problematic as other team members may not recognize the need for social work intervention with families until the problem has become a crisis situation. The reduction in social work involvement in patient care, larger caseloads, and requirement of a nursing referral in order for additional social work services to be provided, may be contributing factors to lower job satisfaction compared with other members of the interdisciplinary team (Casseret, Spencer, Haskins & Teno, 2011; Reese, 2013).

Relevance for Hospice Social Work

Reese (2007; 2013) has cautioned against a trend to lower costs by reducing social work services and recommends research to promote a more positive perception of the social work role and of the value of the contributions of social workers on the interdisciplinary team, including more positive outcomes for patients and families, as well as for organizational outcomes. More social work involvement in patient care has been shown to be associated with increased cost containment and higher family satisfaction (Mahar, Eickman, & Bushfield, 1997; Paquette, 1997; Reese et al., 2006; Reese & Raymer, 2004; Sherin, 1997).

The reduction in social work services and larger caseloads for hospice social workers may explain why hospice social workers have lower job satisfaction compared to other members of the interdisciplinary team (Casseret, 2011). Johnson (2014) suggested that the competition for sustainability in the crowded hospice care market places pressure to achieve greater cost effectiveness in the delivery of hospice services and increase the number of patients served, with less emphasis on patient and family outcomes. This may contribute to fewer visits per patient by social workers then in the past (Reese & Raymer, 2004).

As research has suggested, reduced number of visits to hospice patients, high volume of crisis intervention work and higher caseloads for hospice social workers may place added demands and stress to hospice social workers. Hospice and palliative care social work has been considered a specialized field of social work practice due to the complexity of working with this population, and the unique emotional and intellectual demands placed on the social worker (Parry, 2001). Newer social workers express heightened death anxiety when working with terminally ill patients and may experience difficulties maintaining professional boundaries (Reese, 2013; Simons and Park-Lee 2009). Social workers who specialize in death and dying often report feelings of grief and loss which may lead to compassion fatigue and increased likelihood to leave their employment (Puterbaugh, 2008; Reese, 2013).

The accumulation of the constant exposure to loss has been noted in the literature to put hospice staff at risk of distress and possible traumatic response (Blacker & Deveau, 2010; Lattanzi, 1981; Pereira, Fonseca, & Carvalho, 2011). Being unable to provide needed and quality care to patients due to large worker to patient ratio can complicate feelings of loss and distress when working with dying patients and this has been shown to lead to decreased job

satisfaction and difficulty serving patients and families as effectively as needed (Empeno, Raming, Irwin, Nelesen & Lloyd, 2013).

Chapter 2

Literature Review and Conceptual Model

Hospice Social Work and Job Satisfaction

Job satisfaction has been shown to be associated with high productivity, increased communication and cooperation with co-workers and leaders, as well as strength and stability to the organization as whole (Fritzsche & Parrish, 2005). Job satisfaction has also been shown to be associated with individual well-being outside of the workplace, higher life satisfaction, and increased length time a worker stays in a work environment or "tenure" (Dawis, 2005, p. 3). As is common in the majority of workplace environments, job satisfaction in health care has been shown to have an inverse relationship with intention to leave an organization as well as a positive relationship with perceptions by leadership of the role of social work in the organization (Fritzsche & Parrish, 2005; Gellis, 2002; Parker-Oliver, Bronstein, & Kurzejeski, 2005; Price & Mueller, 1986; Shier & Graham, 2013). Job satisfaction of health care workers is a widely researched variable in health care organization research and thus, its definition is at times defined as an overall attitude or feeling of satisfaction (considered a global definition) to a more complex understanding that incorporates a person and environment fit along with the different aspects (or facets) which may be more or less satisfying to the individual worker. For the purpose of this study, job satisfaction can be described as the way that the person (employee) engages with their environment. This conceptualization of job satisfaction is more process oriented and reflects an ongoing mutual and reciprocal relationship or correspondence of workers' personality and work environment (Dawis & Lofquist 1984; Farr & Ringseis, 2002). In this understanding of job satisfaction, the individual worker perceives a fit between their needs and the work

environment's reinforcers (satisfaction), while also incorporating how appropriate that individual is for the organization or how much they meet the needs of that work environment (satisfactoriness) (Dawis & Lofquist 1984; Fritzsche & Parrish, 2005).

According to the Theory of Work Adjustment, job satisfaction is a result of a worker's subjective assessment of how their work environment meets their individual requirements for continued employment and how well it contributes to a successful person-environment fit (Dawis & Lofquist 1984, 1994; Farr & Ringseis, 2002; Fritzsche & Parrish, 2005). There are two different kinds of job satisfaction considered in the theory of work adjustment, intrinsic and extrinsic job satisfaction (Dawis & Lofquist 1984; Fritzsche & Parrish, 2005). Intrinsic job satisfaction includes recognition, feelings of accomplishment, responsibility, perception of value, perceptions of shared values with co-workers and leaders. Extrinsic job satisfaction includes job security, salary, working conditions and work relationships.

In health care, job satisfaction has been considered an essential focus for managers, as motivational and commitment level of the health care employee has been shown to be associated with more positive patient satisfaction outcomes and contributing to human resource potential and health care organization's efficiency (Bhatnagar & Srivastava, 2012). Job satisfaction affects well-being of social workers and in turn, may impact their intentions to maintain employment at the organization, provide leadership to less experienced social workers, and provide quality patient care (Clark, 2007; Monroe & DeLoach, 2004; Shier & Graham, 2013). The retention of hospice and health care workers and professional job satisfaction have been shown to improve patient outcomes including continuity of caregivers, increased interdisciplinary collaboration and increased patient satisfaction in health care settings and hospice (Ablett & Jones, 2007; Bhatnagar & Srivastava, 2012; Clark, 2007; Csikal, 2006; Reese

& Raymer, 2004; Shier & Graham, 2013). Research on hospice social workers specifically has suggested that a lack of job satisfaction may lead to feelings of being devalued by the organization and may have an impact on the ability of social workers to successfully interact with other members on the interdisciplinary team and provide optimal service provision to their patients (Clark, 2007; Monroe & DeLoach, 2004; Shier & Graham, 2013).

Some research studies have examined social work's job satisfaction as compared to other disciplines on the hospice care team. Monroe & DeLoach (2004) surveyed 76 team members from 4 different hospice organizations in the Midwest and found that social workers scored the lowest on job satisfaction scores when compared to nurses and chaplains. Social Workers also scored lower than nurses on their perceptions of distributive justice, which measured how they felt they were rewarded or punished for their contribution to the organization (Monroe & DeLoach, 2004). Casarret et al. (2011) conducted an analysis of 8,495 hospice staff from 177 agencies using the Survey of Team Attitudes and Relationships (STAR) instrument which measures job satisfaction in the domains of individual work rewards, teamwork, management support, organizational support, workload issues, and global assessment of job satisfaction. Similar to findings in the Monroe and DeLoach study (2004), hospice social workers scored the lowest amongst core disciplines on job satisfaction on 5 of 6 domains measured (Casarret et al., 2011). Research by Weisenfluh & Csikal (2013) has suggested that social workers' role and expertise is not always fully utilized on the hospice team and the Kulys & Davis (1987) survey of hospice executive directors revealed that nursing leadership often considered nurses to be as qualified as social workers to perform psychosocial care. Given that the direct purpose of hospice and palliative care is to deliver services to terminally ill patients and their families through an interdisciplinary team model, the ability to successfully interact with other members

of the hospice team, and the value their input receives from both other team members and leadership, has been shown to be contributors to social work job satisfaction and may in turn, impact patient care outcomes (Monroe & DeLoach, 2004).

Interdisciplinary collaboration

The interdisciplinary approach to patient care is an essential component in effective end-of-life care. Due to the complexity of care involved in caring for a terminally ill patient and their caregivers, the goal for effective hospice and palliative care provision is to utilize the unique perspective of each discipline, and specifically the work that is produced when these disciplines collaborate together in a professional relationship (Kobayshi & McAllister, 2013). The interdisciplinary team has been distinguished in the hospice and palliative care literature as different from a multidisciplinary team in that it is the interactions, and the work produced from these collaborative relationships, along with the patient care unit, that constructs the essential component of the team model (Bronstein, & Kurzejeski, 2005; Byock, 1997; Kobayshi & McAllister, 2013; Monroe & Deloach, 2004). Kobayshi & McCallister (2013) describe this work as essential for patient and family focused care and requires "a coordinated effort" that cannot be achieved as effectively with non-collaborative individualized efforts (p.1). The benefit of interdisciplinary collaboration has been shown to improve three areas of focus with complex populations in the health care organization research literature: client outcomes, cost containment and team member satisfaction (Connor, Egan, Kwilosz, Larson & Reese, 2002; Kobayshi & McCallister, 2013).

The value of an interdisciplinary team, and the specific contributions of social work as a member of this team, have been supported in the research literature and is recommended by the World Health Organization (2014) for effective end-of-life and palliative care (Bomba,

Morrissey, & Leven, 2011; Forrest & Derrick, 2010; Reese & Raymer, 2004). The use of an interdisciplinary team for hospice care has also been supported in United States public policy. In order to receive Medicare reimbursement, all services provided by hospices need to be provided through a plan of care developed by an "interdisciplinary group" or team (Abramson, Robinson, Hoyer, & Blackford, 2007; CMS, 1983, 2003). The core hospice interdisciplinary team mandated by Medicare consists of physicians, registered nurses, social workers, and pastoral care (Hoyer, 1998; CMS, 1983, 2003).

Despite the support and mandate for social work presence on the hospice interdisciplinary team, and research documenting positive outcomes such as cost containment & family satisfaction with increased hospice social work services, social work scholarship has continued to see hospice social work in danger of being labeled an ancillary service, secondary to medicine (Blacker & Deveau, 2010; James, 2012; Reese & Raymer, 2004; Reese & Sontag, 2001). Additionally, no requirements for patient to social worker ratio, nor specific job duties or roles and responsibilities are detailed in Medicare regulations. Neither size of caseloads nor frequency of contact with patients are suggested in public policy or hospice regulations, leaving individual hospice agencies in charge of making these determinations (NHPCO, 2013). Some social workers, in addition to carrying a patient caseload, also had additional responsibilities, such as bereavement counselor. Performing these additional duties was found to be predictive of less positive social work job satisfaction (Reese & Raymer, 2004). The NHPCO does not suggest staffing ratios, rather they have suggested that hospice programs can determine their own staffing ratios based on organizational and environmental characteristics such as patients' average length of stay, staff turnover, staff job satisfaction, staff travel time between patients, staff safety issues and percentage of patients with complex psychosocial issues (NHPCO, 2013).

There has been some limited amount of empirical research exploring the hospice social worker's experiences as a member of the interdisciplinary team and how social work is utilized, but with limited sample sizes and methodological limitations. In a survey of 77 hospice social workers in the state of Missouri, Parker-Oliver, Bronstein, & Kurzejeski (2005) found that social workers reported an overall positive perception of the level of interdisciplinary collaboration, but did not compare these results to the other disciplines (Parker-Oliver Bronstein, & Kurzejeski, 2005). Authors acknowledged that the overall philosophy of patient centered care in hospice is in line with inherent social work perspective and values, therefore, roles between professions may, at times, become "blurred" (Parker-Oliver, Bronstein, & Kurzejeski, 2005). This has been shown to be a potential contributor to role confusion and lack of acknowledgement of the expertise and contribution of social work to the interdisciplinary team (Blacker & Deveau, 2010; Kulys and Davis, 1986; Parker-Oliver, Bronstein, & Kurzejeski 2005; Reese, 2011).

In a study that examined social work collaborative communication amongst other disciplines, Wittenberg-Lyles, Parker-Oliver & Regehr (2010) conducted a qualitative analysis of 64 videotaped interdisciplinary team meetings at one Midwestern hospice. Results of this study found nurses and physicians to be much more likely to express collaborative communication when compared to social workers on the team. Of note in this study was the presence of only two social workers on the interdisciplinary team who participated in these meetings (Wittenberg-Lyles, Parker-Oliver & Regehr, 2010).

Kobayashi & McCallister (2013) surveyed 129 members of the four core hospice disciplines on the interdisciplinary team (social work, nursing, physicians and pastoral care). This study found positive perceptions of interdisciplinary collaboration expressed by all disciplines, however, among these disciplines, social workers felt the least connected and least

interdependent with other members of the interdisciplinary team (Kobayashi & McCallister, 2013).

The findings of the limited amount of research that include hospice social workers in this area seem suggestive of possible differences in perception of experiences of professional relationships on the interdisciplinary team and possible justification as an area of focus for future researchers to explore what may be contributing to social worker's feelings of less connection to other team members. Are social workers experiencing less connection to the team due to an interdisciplinary team dynamic or outside factors impacting this dynamic such as leadership characteristics in the hospice organization?

Leadership

An early study of hospice leaders' perception of social work's contribution was undertaken in 1986 and surveyed 34 hospice directors' attitudes about the value of the different disciplines in hospice care. In this study, it was reported that hospice executive directors felt that nurses were providing more of the psychosocial care to patients than social workers (Kulys & Davis, 1986). Hospice directors, in this survey, also perceived that nurses were considered as qualified as social workers, or at times better qualified, to provide services such as crisis intervention, advocacy, and case coordination (Kulys & Davis, 1986). Only in the areas of using community resources, making referrals to community resources, and providing financial information, did hospice directors consider social workers to be more qualified than nurses (Kulys & Davis, 1986). In this and other studies, it has been suggested that there has been a continued progressions towards a primarily medical model of hospice, as well as a strong focus placed on the primacy of physical needs of the patient (Reese, 2011). Reese (2011) replicated the Kulys & Davis study with a slightly larger sample (n=43) and did find a more positive

perception of social work contribution to the hospice interdisciplinary team amongst hospice leadership. This study involved a simple random sample of hospice executive directors in Michigan, however, hospice executive directors still viewed other disciplines, primarily nursing, as more qualified to perform over one-half of the activities that social workers typically claim as their own (Reese, 2011). The need for leadership skills on the interdisciplinary team, and the ability to collaborate effectively appears to be essential skills for every hospice social worker to possess to maintain meaningful presence and contribution to interdisciplinary collaboration (Blacker & Deveau, 2010; Reese, 2011; Weisenfluh & Csikai, 2013). Some discrepancies between hospice executive directors' perceptions of the social work role have been noted, but to date, there are no studies that have examined how hospice social workers perceive they are supported by leaders. More specifically, a gap appears to exist in the research literature to examine whether social workers perceive shared values, positive relationships and support from their leaders, and if this may contribute to job satisfaction of hospice social workers.

Theoretical Model

The job satisfaction of hospice social workers and their professional relationships in hospices will be examined using the Theory of Work Adjustment. In this research, the Theory of Work Adjustment will be combined with elements of Bronstein's conceptual model of interdisciplinary collaboration and the Theory of Servant Leadership.

Theory of Work Adjustment

The theory of work adjustment posits a connection between person-environment fit and job satisfaction (Dawis, 2005; Dawis & Lofquist 1984, 1994; Farr & Ringseis, 2002; Fritzsche & Parrish, 2005). According to this theory, job satisfaction is a predictor of continued employment or tenure, but achievement of job satisfaction is an ongoing and dynamic process accomplished

not just by the (worker) person and not just by the environment, but rather with the person-environment relationship, or fit (Dawis, 2005; Lyons, Brenner & Fassinger, 2005). Originally conceptualized as part of the Work Adjustment Project introduced by Rene Dawis, George England and Lloyd Lofquist in 1964, it describes a process of achieving correspondence, the meeting of requirements and needs, between the person (P) and the environment (E). The work environment demands specific tasks and roles to be performed, and the individual person brings to the job certain abilities needed to perform these tasks. The person, in return, requires compensation and complementary working relationships for their work performance. When there is a conflict between a person's needs or abilities and the work environment's needs or requirements, then change needs to occur, thus the need for a relationship between P and E to perform work adjustment (Dawis, 2005; Dawis & Lofquist 1984, 1994). In this theory, similar to systems theory, which emphasizes feedback loops to reinforce and explain positive or negative outcomes, job satisfaction is a process-oriented relationship between the person (P) and the environment (E) and how well that relationship continues to fit. Job satisfaction is therefore achieved and maintained when there is correspondence and P is satisfied with E (satisfaction), and when E is satisfied with P (satisfactoriness) (Fritzsche & Parrish, 2005).

The purpose of the Work Adjustment Project was to develop a more comprehensive measure of job satisfaction. Fritzsche & Parrish (2005) describe how traditionally, job satisfaction measures included global measures of affect or attitude, rather than cognition. Ironson, Smith, Brannick, Gibson & Paul (1989) and Dawis (2005) note that utilizing a sum of different domains of facet scores to measure job satisfaction may capture some aspects of job satisfaction that are more or less important to individual workers, and these need to be captured to better understand causes of job satisfaction. The Theory of Work Adjustment differentiates

between intrinsic satisfaction (within the individual) and extrinsic satisfaction (reinforcers provided by the work environment) and describes six different values that are necessary for achieving job satisfaction: achievement, comfort, status, altruism, safety and autonomy (Dawis & Lofquist 1984). A differential facet measure of job satisfaction will be able to determine which aspects of job satisfaction will be more or less important to hospice social workers.

Justification for utilizing facet measures for hospice social workers' job satisfaction

Previous research on job satisfaction of hospice social workers has utilized global measures of job satisfaction, but has not examined aspects of job satisfaction that may be more important for hospice social workers (Clark et al., 2007; Kobayshi & McCallister, 2013; Monroe & DeLoach, 2004). Facet or multi-dimensional measures may be more appropriate for complex organizations, such as hospices, in order to better evaluate such aspects of relationships with co-workers and leadership support on overall satisfaction of different workers. Previous research has utilized facet measures of job satisfaction with hospice nurses and nursing assistants, but have not yet provided a more comprehensive assessment of hospice social work satisfaction and how this may be impacted by leadership support and interdisciplinary collaboration (Head, Washington & Meyers, 2013; Miller 2008).

A component of the theory of work adjustment is the extent to which a person's values match those of the work environment's values (Dawis, 2005; Fritzsche & Parrish, 2005). According to this, employees are satisfied with their work environments when the values that they possess related to work correspond with the values of their work environments. In the case of the hospice social worker, a perception that co-workers and leadership share similar missions and values may contribute to overall job satisfaction. The National Hospice and Palliative Care Organization has recently recognized the need to uphold values similar to the founders of

hospice care and have developed a Hospice Executive Leadership Program which lists one of its goals as ensuring "values-based leadership for the future" (NHPCO, 2015). In describing the organization's values, NHPCO describes how leaders and employees should believe in: "service, respect, excellence, collaboration, and stewardship" (NHPCO, 2015).

Interdisciplinary Collaboration

The interdisciplinary approach to hospice extends health care provision from an individual sole practitioner model of behavior to a collaborative effort among professionals that incorporates aspects of care into one holistic team effort. The interdisciplinary team has been distinguished as different from a multidisciplinary team in that it is not only the different disciplines working individually in their skill set, but it is also the interactions and relationships between the different specialties in care planning, along with the patient care unit that comprises the essential components for this team model (Byock, 1997). The founder of the modern day hospice movement, Dame Cecily Saunders, was trained as a nurse, and then as a medical social worker, and finally became a physician. She has been described as the "role model" for interdisciplinary work in hospice care (Parker-Oliver, Bronstein, & Kurzejeski, 2005).

Bronstein (2002; 2003) proposed a model for interdisciplinary collaboration that describes the different components needed to make up optimal collaboration in working relationships. These components include interdependence, flexibility, reflection on process, newly created professional activities and collective ownership of goals (Bronstein, 2003). Interdependence has been described as synergy between professionals and is defined as "the occurrence of and reliance on interactions among professionals whereby each is dependent on the other to accomplish his or her goals and tasks" (Bronstein, 2003, p. 299). In this way, interdependence for the hospice professional can be described as the degree to which different

members of the group experience mutual dependence on each other in performing their work. Bronstein uses the concept of "interdependence' in the model of interdisciplinary collaboration and proposes a way to operationalize this concept on one subscale of the Index for Interdisciplinary Collaboration (Bronstein, 2002). The IIC has been used on a sample of hospice social workers and revealed an overall high perception of interdisciplinary collaboration, with some variability that was unable to be explained by education level, size of hospice or number of social workers on the team (Parker-Oliver, Bronstein, & Kurzejeski, 2005). The impact of different perceptions of interdependence may have on overall job satisfaction has also not been examined in the research literature.

Servant Leadership

Ethical leadership comprises several different theories and approaches to management styles that promotes and inspires values in an organization such as honesty, trust, fairness, and consideration. Different types of ethical leadership theories include Servant Leadership, Spiritual Leadership, Authentic Leadership and Transformation Leadership and have received much attention in the nursing literature to describe desirable leadership styles for health care organizations (Brown, 2010; Wagner and Seymour, 2007; Yuki, 2010). Goals of ethical leadership promote responsible personal behavior and interpersonal relationships to promote bilateral and equal communication, establish ethical standards, and make fair decisions. These humanistic leadership approaches have been shown to lead to increased staff satisfaction in health-care settings and has been suggested to be related to social learning theory in that the leader models effective and moral work behaviors for the greater good of the organization and the community it serves. (Brown, 2010; Wagner and Seymour, 2007).

Recent studies have identified hospice executives as perceiving themselves as transformational leaders (Longnecker, 2006; 2008), Burns (1978) introduced the concept of Transformational Leadership that emphasizes a higher level of leadership skills that may be most useful in complex organizations that serve high need patients. Transformational leaders need to able to do more than manage the daily transactions of managing a staff. Leaders, instead, need to be able to grow, adapt and enhance their followers, their organization, and themselves to a rapidly changing environment. Leadership is not just for those at the top, but can be at all levels. This mode of leadership has been shown to be effective during times of economic insecurity and change (Barker, 2000; Goldkind & Pardasani, 2014). Therefore, leaders who possess this quality may be most effective in a rapidly changing health care environment. The transformational leader motivates individuals to become "self-actualizing" through a desire to work for the greater good of the organization. Leaders empower followers and pay attention to their individual needs and personal development, helping followers to develop their own leadership potential.

More recently, Servant Leadership has been compared to transformational leadership, but extends the theory of transformational leadership with an added dimension of service to not just the organization, but for the overall good of the people who work for the organization and the community it serves. Servant Leadership is a theory first introduced by Robert K. Greenleaf (1977) as a theoretical framework that describes a leader's primary motivation and role as service to others. Rather than focusing on advancing "glorification" of leader, the servant leader instead focuses on followers' development and performance (Van Dierendonck, 2011; Winston & Fields, 2015). The servant leader is perceived as motivating and mentoring individuals to become self-actualizing through a desire to work for the greater good and has been described as a

"person-oriented" leadership style that motivates leaders and their followers to serve and use the organization as a means to do so (Winston & Fields, 2015). Leaders empower followers and pay attention to their individual needs and personal development, helping followers to develop their own leadership potential. Servant Leadership Theory predicts that organizational leaders who use a particular set of leadership behaviors will impact employee perceptions and behaviors through a process of reciprocal relationships (Van Dierendonck, 2011; Winston & Fields, 2015). Also based on Social Exchange Theory that posits that relationships are formed by negotiated exchanges, and a cost benefit analysis between interested parties, Servant Leadership extends Social Exchange Theory and stresses the personal commitment of the leader and creates a relationship where all are collectively supporting organizational goals and values (Liden, Wayne, Zhao & Henderson, 2008). Unlike leadership approaches with a top-down hierarchical style, Servant Leadership instead places emphasis on collaboration, trust, empathy, and a value based ethical use of power within the organization to meet employee's needs (Liden et. al, 2008; Winston & Fields, 2015).

A limited amount of research comparing the congruence of leader and staff members' perception of leadership style has appeared in the nursing literature, but to date, no study appears to exist examining perceptions of hospice leadership in the organization from the perspective of the hospice social worker. Barker (2000) suggested that the best evaluation tool of leadership effectiveness is a subordinate rating of leaders, and thus, for a full assessment of leadership in an organization, both leaders and staff, need to be surveyed. Given the recent research literature that has shown that social workers experience the lowest job satisfaction when compared to other members of the interdisciplinary team (Casarret et al, 2011; Monroe & DeLoach, 2004), as well as the lowest perception of interdependence on the interdisciplinary team (Kobayashi &

McCallister, 2013), an examination of perceptions of leadership in the hospice organization may assist with examining the causes of this dissatisfaction.

Chapter 3

Methods

Study Design

A cross-sectional study design was used. An online survey was conducted.

Sampling Plan

The target population was hospice social workers in the U.S. Three different samples were selected. There were no data on the number of hospice social workers employed in the United States, so it was not possible to estimate a sample size possible for this study. Three different sampling methods were used due to the lack of an ideal study population and the lack of a sampling frame. The purpose of using three different sampling strategies was to invite the largest and most diverse sample of hospice social workers possible, thereby increasing the representativeness of the study sample to the target population.

Sample #1: Certified Hospices in Three States

A two-stage sampling plan was used for the first sampling strategy. Stage 1 was the selection of hospices. The study population for this stage was all certified hospices in New York, Connecticut and New Jersey. A sampling frame of all hospices in New York, Connecticut and New Jersey was be created by using the National Hospice Locator compiled by Hospice Analytics, Inc. and was available on the website: http://www.hospiceanalytics.com/. The National Hospice Locator geo-maps and provides information about hospices in the United States. According to the National Hospice Locator, during data collection months of September 2015 to November 2015 there were 68 hospices in New York, 56 in Connecticut and 82 in New Jersey. Hospice Analytics also identified websites for hospice organizations, which was used to

obtain contact information for hospice social workers if available. If contact information for individual hospice social workers was available, the researcher contacted those individuals directly by email or telephone. If that information was not available, the next choice was the director of social work. If information was not available for either of these, another administrator at the hospice was be contacted by either email or telephone. If a social worker or social work manager were not available at time of contact, the researcher left a message requesting a call back. Upon establishing contact, the researcher explained the purpose of the study as an exploratory study to examine the experiences of job satisfaction for hospice social workers and requested permission to contact hospice social workers with a study invitation by email. The researcher made it clear that the purpose of the study was not to evaluate individual hospices, and that data will be reported in the aggregate, making it impossible to identify individual hospices. All hospices in New York, Connecticut and New Jersey were considered for stage one of this sampling plan to establish the sampling frame for this stage.

In the second stage, social workers were selected. The study population for this stage was social workers at the selected hospices. A probability-sampling plan was used, selecting all eligible social workers in the sampling frame. Inclusion criteria were: 1) over 18 years of age; 2) on the payroll of the hospice for over 30 days; 3) self-identification as a social worker at a hospice or called a social worker at a hospice. After gaining permission to contact the social worker by email, the researcher sent an email invitation with a link to the online questionnaire to each individual in the sampling frame, or to a social work manager to disseminate to his or her social workers if they were not willing to release the email addresses of individual social workers at their hospice. All social workers that responded to the email or U.S. mail invitation were part of sample #1.

Sample #2: Professional Organizations and Interest Groups

The study population for this sampling strategy was social workers who were members of a hospice professional organization or interest group. In order to reach the highest number of potential respondents, respondents were recruited through several social work professional listservs and websites, including those who follow or are members of: 1) Social Work Hospice and Palliative Care Network (SWHPN) LinkedIn discussion group ; 2) the Association of Oncology Social Workers (AOSW) Facebook page; 3) Hospice Recruitment LinkedIn discussion group and 4) the Social Work Network in Palliative and End-of-Life Care (SW-PALL-EOL) listserv. There was no sampling frame available for this sample.

The sampling strategy was to select a volunteer sample by posting announcements about the study on the websites, discussion boards, Linked in pages or Facebook pages of the above listed organizations. The announcement included an invitation to participate in the study and a link to the online questionnaire. The inclusion criteria were the same as for Sample #1. A similar sampling method was used in a study of educational needs of hospice and palliative care social workers and yielded over 1,169 responses (Weisenfluh & Csikai, 2013).

Sampling Strategy #3: Known Associates

The study population for this sampling strategy was hospice social workers known to the primary researcher or identified by one of her colleagues. The sampling frame was compiled using snowball sampling. The researcher sent an email invitation with a link to the online questionnaire to each individual in the first round of sampling. Inclusion criteria were the same as for Sampling Strategy #1. Participants were asked to provide the researcher with the names and contact information of other eligible social workers, or to forward the email invitation to those individuals, regardless of whether the recipient of the invitation to participate in the study. The researcher sent an email to any social workers whose contact information she received from

the first round of invitations, inviting them to participate and to either send the researcher names of eligible social workers or forward the invitation to them. This continued throughout the data collection period.

Follow-up Invitations

Follow-up emails were sent out 10-14 days after the initial email for all three sampling strategies in order to increase the response rate.

Anonymity

The identity of study participants was anonymous. No contact information was requested as part of the online questionnaire. Participants were asked to provide the name of the hospice in order to obtain publically-available information on the hospice, including its non-profit or profit status. Participants were informed about the reason for asking for the name of the hospice, and were assured that: 1) no attempt will be made to identify the study participant, which would be possible at very small hospices; and 2) the name of the hospice will not be used in any reports.

Subject Incentive

All participants who opted to participate were entered into a raffle to win one of three $40 gift cards. Participants were asked to provide their name and email address in a separate link to the raffle if they wanted to receive the incentive. Since the raffle was a separate data collection accessed at the end of the primary survey, neither the email address nor the name of the hospice could be linked to responses on the questionnaire in order to protect anonymity.

Measures

Independent Variables

Perceptions of interdisciplinary collaboration

Perceptions of interdependence in interdisciplinary collaboration was measured using the Interdependence subscale in the Index for Interdisciplinary Collaboration (IIC) (Bronstein, 2002). In previous research, the IIC has been used to measure the extent of perceived collaboration in relation to their other interdisciplinary team members (Bronstein, 2002, Parker-Oliver, Bronstein, & Kurzejeski, 2005). The IIC has five subscales to measure the five theorized components of interdisciplinary collaboration: interdependence, flexibility, newly created professional activities, collective ownership of goals, and reflection on process. The modified ICC has 42 items and has been used to assess aspects and levels of interprofessional collaboration in an organization and had an alpha coefficient of .92 in a sample of 462 social workers (Bronstein, 2002). The Interdependence subscale of the ICC was selected because it was the most conceptually relevant to the theoretical model proposed for this study. Choosing only this subscale reduced the time necessary to complete the online questionnaire, for the purpose of increasing the response rate and having less missing data. Bronstein (2002) reports that the most support is for the use of the scale as a single construct, but also suggests moderate support for its use to measure the different components of collaboration with internal consistency of the 13 item subscale of interdependence at a reported Cronbach's α of .78 in that same sample of 462 social workers. In another study of hospice social workers specifically, the interdependence subscale had a Cronbach's alpha of .87 in a sample of 77 (Parker-Oliver, Bronstein, & Kurzejeski, 2005).

Sample items include: 1) I utilize other (non-social work) professionals for their particular expertise; 2) my colleagues from other disciplines believe that they could not do their

jobs as well without the assistance of social workers. Each item in the subscale is measured using five-point Likert response categories from strongly disagree (= 1) to strongly agree (= 5). The theoretical range of the scale is 13 to 65.

Perceptions of Leadership

Servant leadership was chosen to measure social worker's perceptions of leadership in this study, because it appeared to be most salient and theoretically relevant to study aims. Servant leadership scales have attempted to measure the extent to which an employee perceives their leader to be a servant leader or someone whose primary purpose for leading is to promote the common good (Liden et al., 2008; Page & Wong, 2000; Winston & Fields, 2015). Perception of servant leadership was measured using the Essential Servant Leadership Survey (Winston & Fields, 2015). This 10-item scale was very strongly correlated (r = .83) with a previously validated multi-dimensional measure of servant leadership (Liden et al., 2008; Winston & Fields, 2015). Each item represents essential servant leadership behaviors. This scale had a Cronbach's alpha = .96 in a sample of 433 adults employed in commercial firms, government entities, education, religious organizations, community non-profit organizations, and the healthcare field (Winston & Fields, 2015). Sample items include: How much do you believe that the behavior of the executive directors of your agency reflects…: 1) serving as a mission of responsibility to others?; 2) that they are genuinely interested in employees as people?; 3) promotion of values that transcend self-interest and material success?.

Each item is measured using five-point response categories ranging from definitely no (=1), no (=2), neutral (=3), yes (=4), and definitely yes (=5). The theoretical range of the scale is 10 to 50.

Dependent Variable

Job satisfaction was measured using the Minnesota Satisfaction Questionnaire – Short Form. The MSQ (short form) has been used widely in job satisfaction research and consists of 20 items that assess job satisfaction facets (Fields, 2002). The MSQ (short form) was shown to be very strongly correlated (r = .87) with a previously validated 100 item version developed in 1967 and contain the items that best represent each of the original subscales (Fields, 2002; Schrieshem et al., 1993). In addition to using the MSQ to measure overall job satisfaction as a composite score of 20 items, two subscales were used: the Intrinsic Satisfaction subscale (12 items) that measured intrinsic motivation and the Extrinsic Satisfaction subscale (6 items) that measured extrinsic motivation (Vocational Psychology Research, 2002). There are two items in the MSQ (short form) that are not included in either subscale. These two items assess how satisfied the respondent is with: 1) the working conditions; and 2) the way their coworkers get along with each other. (Weiss, Dawis, England, & Lofquist, 1967; Schriesheim, et. al, 1993). Cronbach's α for the MSQ was .85 in a probability sample of 150 professional work-experienced MBA students and .80 in a sample of 100 hemodialysis nurses (Ross, Jones, Callaghan, Eales & Ashman, 2009; Schriesheim, et. al, 1993). Intrinsic satisfaction is concerned with feelings about job tasks. Cronbach's α was .98 for the Intrinsic Satisfaction scale in a probability sample of 150 professional work-experienced MBA students (Schriesheim, Powers, Scandura, Gardiner & Lankau, 1993). Sample items on the Intrinsic Satisfaction subscale are how satisfied the respondent is with this aspect of his/her job: 1) the chance to do different things from time to time; 2) the chance to do something that makes use of my abilities.

Extrinsic satisfaction is related to aspects of the job that are separate from work. For the Extrinsic Satisfaction scale, a Cronbach's α of .97 was found in a probability sample of 150 professional work-experienced MBA students (Schriesheim, et. al, 1993). Sample items on the

Extrinsic Satisfaction subscale are how satisfied the respondent is with this aspect of his/her job: 1) my pay and the amount of work I do; 2) the competence of my supervisor in making decisions.

Each item has five-point response categories ranging from Extremely satisfied (=5) to Not satisfied (=1). The theoretical range of the Intrinsic subscale is 12 to 60, the Extrinsic subscale is 6 to 30, and for the entire scale is 20 to100 (Dawis & England, 1967; Schriesheim, et. al, 1993).

Moderating Variables

Profit Status of the Hospice

The profit status of the hospice was used as a moderating variable and was measured by asking participants if they were currently employed at a profit or a non-profit hospice. This information was confirmed from Hospice Analytics, Inc. database if the participant provided the name of the hospice.

Covariates

Hospice characteristics

1. Number of social workers included all social workers employed at the hospice. This measure was obtained by asking the participant for this information.
2. Average Caseload: This was the mean number of patients that the social worker is responsible for each day. This was measured by asking respondents to estimate their mean caseload size.
3. Roles at the hospice was measured by asking participants to check all that apply to the following question: What roles do you perform at the hospice you are currently working

for? a. direct patient and family care with active hospice patients and families; b. administrative/supervisory; c. bereavement; d. marketing/recruitment; e. education f. other.

4. Perceptions of being valued by other members of interdisciplinary team was measured by asking the extent of agreement or disagreement with four statements: As a social worker operating as a member of an interdisciplinary team, to what extent do you agree or disagree with the following statements: 1) I feel valued by the hospice nurses I work with; 2) I feel valued by the hospice doctors I work with; 3) I feel valued by the hospice chaplains I work with; and 4) I feel valued by the other social workers I work with. Each item will be measured using four-point Likert-response categories ranging from strongly disagree (=1) to strongly agree (=4).

Professional Characteristics

1. Number of years in social work practice was measured by asking how many years the participant reported practicing as a professional social worker after receiving the degree that they obtained that permitted them to perform a social work role at the hospice.
2. Educational attainment was measured by asking which social works degrees the participant has earned: BSW, MSW, PhD or DSW, or a Bachelors or Masters degree in another discipline.
3. Number of years in hospice social worker was measured by asking how many years the participant has been employed as a social worker at the hospice.
4. Salary status was measured by asking if they were salaried or per-diem employees

Personal characteristics:

1. Age was measured by asking respondents how old they were based on age rages provided: 18 – 24 years; 25 – 34 years; 35-44 years; 45-54 years; 55-64 years and 65 + years.
2. Gender was measured by asking what gender they most identify with. The response categories were: male; female; transgender; other.
3. Ethnicity was measured by asking: What race do you consider yourself. The response categories were: Black or African American; Asian; Native American or Pacific Islander; White; other

Data Analysis Plan

Univariate statistics were obtained to assess degree of missing data. Frequencies for categorical variables were used to assess the degree of missing data and where categories needed to be collapsed to avoid very small cell sizes. This included frequency distributions on all categorical variables and measures of central tendency and variability obtained for all continuous variables, including assessing normality.

Bivariate analyses were conducted to determine the association or correlation between each of the independent variables and the dependent variable, as well as between each independent and dependent variables with each of the covariates and the moderating variable. Tests of chi-square, *t*-test, ANOVA, and correlation analysis were used.

Hierarchical multiple linear regression analyses were conducted by regressing each of the job satisfaction scales on the other study variables. In the first model, the independent variables were entered. The final model was be estimated by including the main effects of the independent variables. Profit status was considered theoretically important and was entered in

the model, regardless of whether it was significant in the earlier models. In addition, any of the other study variables that were significant in the prior models were included in the final model.

Chapter 4

Results

Description of Sample

There were 217 hospice social workers who participated in the study. Table 1 displays the sociodemographic characteristics of participants and the hospice at which they work. Most participants were age 25 to 64 years, with the majority age 45 or older. The vast majority of the sample was female (92.2%) and non-Hispanic white (87%). Almost all participants had an MSW. On average, participants were employed at their current hospice for 5.6 years (sd=.54). The majority of participants were salaried (85.6%).

The mean number of social workers employed at hospice was 10.5 (sd=11.1) and the mean caseload size was 28.8 patients (sd=14.1). The majority were employed at non-profit hospices (70.4%). More than half of work activity was in direct practice, with administration being a distant second in work activities. Two thirds of participants reported strong agreement with feeling valued by other hospice social workers. Participants were the least likely to strongly agree with feeling valued by doctors.

Main Study Variables

Table 2 shows descriptive statistics on the Essential Servant Leadership Scale, Interdependence in Interdisciplinary Collaboration Subscale, and Job Satisfaction Scales. These scales were not skewed and had very good to excellent internal reliability. Most participants viewed their leader as possessing servant leadership characteristics, with at least 48-93% answering yes or definitely yes to the individual servant leader items on the scale. The Cronbach's alpha for this scale was .95. Perception of interdependence in relationships with co-workers at their hospice was relatively high, with the mean score falling just 10.1 points below the maximum possible score. The Cronbach's alpha for this scale was .79. Responses to the Job

Satisfaction Scale (general) suggest that participants' overall job satisfaction was somewhat positive; The Cronbach's alpha for this scale was .89. Scores for the Minnesota Job Satisfaction (intrinsic) Subscale were relatively high with the mean score falling just 13.8 points below the maximum possible score. Mean subscores for the Minnesota Job Satisfaction (extrinsic) Subscale were relatively lower when compared to the possible range of scores on both subscales. The Cronbach's alphas for these subscales were .82 for intrinsic satisfaction and .83 for extrinsic satisfaction.

Table 3 presents percentage of dissatisfied responses for each item in the Minnesota Job Satisfaction Scale. All of the items on the extrinsic scale had higher percentages of dissatisfied ratings. Salary and the workload had the highest percent dissatisfied, followed closely by chance for advancement. All of the intrinsic items had much lower percentage of dissatisfaction responses.

Bivariate analyses

Pearson correlation among the five scales used to measure perception of the executive director, collaboration with co-workers, and job satisfaction are shown in Table 4. Perception of servant leadership had a strong positive correlation with general and extrinsic job satisfaction, and a moderately strong positive correlation with intrinsic job satisfaction. Interdependence in interdisciplinary collaboration also had a strong or moderately strong positive correlation with the three job satisfaction scales.

Table 5 displays the bivariate analyses between individual characteristics and hospice characteristics with job satisfaction. There was a moderate correlation between percent of time doing administration and with general job satisfaction and with extrinsic job satisfaction. None of the other characteristics were correlated with any of the job satisfaction measures.

Profit Status

Table 6 displays the bivariate associations between profit status and individual and hospice characteristics. Participants at non-profit hospices worked longer at the hospice when compared to those at a for-profit hospice. Number of social workers employed at hospice was associated with profit status of the hospice, with hospice social workers employed at non-profit hospices having 7.64 more social workers employed at their hospice when compared to social workers employed at for profit hospices. Average patient caseload for hospice social workers was also associated with the profit status of the hospice, with hospice social workers employed at non-profit hospices having 9.46 more patients on their caseload when compared to social workers employed at for profit hospices. Participants at non-profit hospices were 31% less likely to report that they strongly agreed with feeling valued by nurses at their hospice than those who worked at for-profit hospices. No other individual or hospice characteristics were associated with the profit status of the hospice.

Perceptions of Value by Discipline

Table 7 displays the correlation between perception of value by each of the professionals on the hospice team with perception of leadership, collaboration with co-workers, and job satisfaction. Perception of leadership was weakly correlated with perception of value by nurses, doctors, and chaplains and was not correlated with perception of value by other social workers. There were moderate to strong positive correlations between perception of value by the members of the interdisciplinary hospice team with collaboration with co-workers, and with each of the job satisfaction measures.

Regression Model

The final regression models for each of the job satisfaction scales are shown in Table 8. Regression diagnostics were assessed to ensure that assumptions were not violated. None of the

variables entered in the model were highly correlated with each other and Tolerance and VIF were all within accepted limits. Profit status of the hospice was included in the model regardless of significance level because it was theoretically important and for comparability with other studies. Other variables were retained in the model if they were at least borderline significant ($p \leq .10$).

Each of the Job Satisfaction scales were regressed on the Essential Servant Leadership Scale, Interdependence in Interdisciplinary Collaboration Subscale, number of social workers and perception of feeling valued by doctors. Perception of Servant Leadership and Interdependence in Interdisciplinary Collaboration were significant in models for all three of the job satisfaction scales. However, relative to the range of the three job satisfaction scales, Perception of Servant Leadership and Interdependence in Interdisciplinary Collaboration had a small effect on job satisfaction. Servant Leadership had a greater effect in the model for extrinsic job satisfaction as compared with intrinsic job satisfaction. Interdependence in interdisciplinary collaboration had a greater effect in the model for intrinsic job satisfaction as compared with extrinsic job satisfaction.

Feeling valued by hospice doctors was significant in all three job satisfaction models. Those who strongly agreed that they were valued by hospice doctors had higher scores on job satisfaction scales as compared with those who did not agree strongly. The perception of value by hospice doctors was also significant in the models for intrinsic and extrinsic job satisfaction, but the magnitude of effect was higher in the model for intrinsic satisfaction as compared with extrinsic satisfaction.

Number of social workers at the hospice was significant in the models for extrinsic job satisfaction and was borderline significant in the model for general job satisfaction, however the

magnitude of the effect was very small. Profit status of the hospice was not significant in any of the models.

Chapter 5

Discussion

The first research aims were to determine whether job satisfaction was associated with interdependence in interdisciplinary collaboration and perception of servant leadership. All three job satisfaction measures were positively correlated with interdependence in interdisciplinary collaboration and perception of servant leadership in both bivariate and multivariable analyses. Interdependence was more strongly correlated with general and intrinsic job satisfaction, while perception of servant leadership was more strongly correlated with general and extrinsic job satisfaction. Profit status of the hospice was not directly associated with any of the job satisfaction measures, nor did it moderate the associate with either interdependence in interdisciplinary collaboration or perception of servant leadership and any of the three job satisfaction measures.

Main Hypotheses of Study: Work Relationships, Perception of Leadership and Job Satisfaction

The job satisfaction measure used in this study provided a more complex understanding of job satisfaction and provided a better description of person and environment fit, including subscales of intrinsic and extrinsic job satisfaction. According to the Theory of Work Adjustment, job satisfaction is process-oriented and this study attempted to fill a gap in the research literature to use this conceptualization of job satisfaction with hospice social workers, and attempt to examine which aspects or parts of hospice social workers' jobs might be more or less satisfying. The main hypotheses of this study sought to examine whether relationships with co-workers and the executive director were associated with each of the three types of job satisfaction for hospice social workers.

Individual item analysis of the MSQ showed higher levels of dissatisfaction for items on

the Extrinsic Job Satisfaction Subscale when compared with items on the Intrinsic Job Satisfaction Subscale. Because perceptions of the hospice executive director were more strongly correlated with extrinsic job satisfaction, it may be useful to examine the measure used in this study that assessed a specific leadership style, servant leadership. Although this measure has not been used in previous research on hospice social work, servant leadership may be an effective leadership style for service-focused organizations, such as hospice. It may be useful for improving external aspects of the work environment and promote a better fit between the hospice social worker and the work environment. Servant Leadership, with its focus on the leader serving the needs of team members and the community, has been suggested as an effective leadership approach in service based organizations, faith based organizations and health care organizations (Schwartz & Tumblin, 2002).

Previous research suggests that leaders who have a Servant Leadership style may be well suited to lead a complex service-based organization like hospice (Carrol, 2005). More specifically, service-oriented professionals within the organization, such as social workers, may respond better to this leadership style that promotes values in congruence with the ethics of the social work profession, although we were not able to assess this given that only one leadership style was measured in this study. Fisher (2009) addressed the need for leaders in human service agencies to move away from viewing social workers as individuals motivated to simply "help people," to a better understanding of the aspects of their social work jobs that may contributing most to job satisfaction and job retention, such as meaningful work and service to the community. Fisher (2009) also noted that traditional methods of leadership in social work organizations have relied on wisdom and experience to guide leadership, but this may not be adequate for effective leadership in complex organizations. This study used Servant Leadership Theory to assess hospice social workers' perception of the executive director and showed that

most had a positive perception of their leader. However there was much variability in responses, with some extremely low scores and some respondents reporting that their executive director did not possess any of the servant leadership behaviors measured in the scale.

The hallmark of servant leadership is to train others to lead and empower employees to share in the success or failure of the organization, while also serving the interests of the community (Russell & Stone, 2002). Values and leadership styles of hospice executive directors that are high on servant leadership may be an effective leadership-training model. At this time, The National Hospice and Palliative Care Organization (NHPCO) has not endorsed a specific leadership style nor training program for hospice executive directors, but has offered servant leadership education for hospice physicians. The NHPCO promoted servant leadership education in its physician leadership skills development program in 2007. This study may provide further justification for this as a desirable leadership approach to create a work environment conducive to achieving satisfaction in the work environment. This may also better serve hospice patients and families.

The finding that interdependence in relationships with co-workers was associated with job satisfaction, particularly with intrinsic job satisfaction, was supported by findings from a previous study of hospice social workers (Kobayshi & McAlister, 2013). These finding support and extend the World Health Organization's recommendation for interdisciplinary team collaboration for effective palliative care by suggesting that not only are hospice social workers practicing on an interdisciplinary team in order to achieve better patient outcomes, but also that these interdisciplinary relationships result in higher job satisfaction for hospice social workers.

There were differences in how perception of value by co-workers of different disciplines was associated with job satisfaction. Despite lower ratings of being valued by hospice doctors, perception of value by hospice doctors was the only co-worker measure that was significant in

the regression models. This is possibly due to the disproportionate influence of the hospice doctor on the interdisciplinary team, which is supported by previous findings in end–of-life care research (Abramson & Mizrahi, 2002; Casarrett, 2011; Gordon & Daugherty, 2003; Levetown, Hayslip, & Peel, 2000; Marmo, 2014). The power differential between doctors and social workers, and the lower perception of value that social workers experience from doctors has been shown to decrease collaboration and communication in previous research (Abramson & Mizrahi, 2002). Although the present study did not assess physician's own perception of value or collaboration with other team members, improved physician and social worker perception of value and collaboration, may improve job satisfaction for hospice social workers.

Profit Status

In bivariate analyses, job satisfaction was not significantly different between for-profit and non-profit hospices, nor did profit status moderate any of the associations between relationships with co-workers or perception of leadership with job satisfaction. No research has been conducted to examine differences in hospice social workers' job satisfaction based on profit status, but it has been suggested that certain working conditions at hospices (such as higher caseload size and number of social workers employed) might contribute to dissatisfaction of hospice social workers (Cherlin, 2010). Previous research has shown that patients at for-profit hospices receive fewer visits from hospice social workers and less social work intervention when compared with non-profit hospices (Carlson et al, 2004).

There was a significant difference in duration of employment for for-profit and non-profit hospices, with social workers at for-profit hospices having a mean of 2.6 fewer years of employment compared to social workers at non-profit hospices. This could be suggestive of decreased tenure or lower intention to remain with the for-profit organization, or it could be reflective of newer hospices being more likely to be for-profit hospices (Aldridge et al., 2014;

NHPCO, 2013). Therefore, due to the newer status of for-profit hospices, social workers have had less opportunity to be employed at one of these.

The mean number of social workers employed at for-profit hospices was 7.6 fewer than at non-profit hospices. The smaller number of social workers employed at for profit-hospices could suggest that there may be a greater emphasis on the biomedical model, which places primacy on physical needs, and therefore nursing, at for-profit hospices (Reese, 2013). In an era of cost containment, the lower mean number of social workers at for-profit hospices could reflect a focus on meeting the physical needs of hospice patients and not adequately providing services for the psychosocial needs, as has been suggested in previous research (Buck, 2009). Thefewer mean number of social workers at for-profit hospices also needs to be understood in the context of the size of the hospice. We were not able to assess this because we did not have a measure of total caseload at each hospice. Lower overall staffing patterns for cost containment has been suggested in previous research that showed less staff to patient ratio at for-profit hospices, but to date, no information about differences in number of social workers relative to hospice agency size has been available (Cherlin et al., 2010).

The importance of peer support networks when working in hospice and palliative care has been supported by NASW to better assist social workers in coping with the demands of working with terminally ill patients and their families, (NASW, 2011). NASW recommends peer support networks of other hospice social workers, and hospices often promote interdisciplinary staff support groups to improve job satisfaction and prevent compassion fatigue and burnout (Wenzel et al., 2011; Le Blanc et al., 2007). Findings from this present study suggested that peer support at for-profits differed from non-profits. Social workers at for-profit hospices were more likely to perceive being valued by nurses than those at non-profit hospices. One possible explanation for this may be that when there are fewer social workers available to

provide peer support, social workers seek out nurses to assist with difficult psychosocial issues and cope with the demands and stress of hospice work. In addition, the smaller number of social workers employed at the hospice may also be an indicator of the size of the hospice, which could also be a factor in interdependence and feeling valued by co-workers. However, at this time, while there has been some research exploring differences in type of illnesses, length of stay, staffing patterns and the likelihood of disenrollment from hospice between for-profit and non-profit hospices, no research has been conducted to determine differences between the mean number of patients enrolled overall at for-profit and non-profit hospices.

Previous research on job satisfaction

The mean level of job satisfaction for social workers in this study was only slightly higher than that found in a previous study of hospice social workers, although that was a small study (n=52) and they used the Michigan Satisfaction Questionnaire (MIQ), which is a weaker measure of job satisfaction (Coopman, 2001). The present study used a more complex measure with three facets of job satisfaction, which has not been used in previous research with hospice social workers. When compared with dialysis health care professionals, the mean level of job satisfaction of hospice social workers in the present study was higher on intrinsic and lower on extrinsic satisfaction (Ross et al., 2009). While some minimal differences in job satisfaction were found between this earlier study and this present study, due to a small sample size (50) and methodological weaknesses in the earlier study, the comparison may not be meaningful. A study of 302 hospice nurses found a lower mean level of job satisfaction than for hospice social workers in the present study, especially for intrinsic job satisfaction (Miller, 2008). This study of hospice nurses included a sample from multiple states from 60 different hospices. (Miller, 2008) That study, along with the other studies that measured job satisfaction using weaker measures, have found hospice social workers to have lower levels of job satisfaction when compared with

nurses (Casarret et al., 2011; Miller, 2008; Monroe & DeLoach, 2004). This study, and the previous research mentioned, provides additional evidence on the differences in job satisfaction levels of hospice nurses and social workers. The reasons for these differences are not clear and warrant additional research.

The individual item analysis of the job satisfaction scale revealed that the item on the MSQ scale, which may indicate an internal feeling of accomplishment: "the chance to do things for other people", was the item with the highest satisfaction and least dissatisfaction in the sample. This may suggest that participating in work that is meaningful, provides service and is congruent with social work values may contribute the most to job satisfaction of hospice social workers and may be a possible motivator to remain in the work environment. "Meaningful work", as an indication of job satisfaction has been shown to be an important contributor not to only job satisfaction, but also to social workers' intention to stay at nonprofit organizations (Bright, 2008; Haley-Lock, 2008). Feelings of accomplishment obtained through work that advances a social cause (in the case of hospice social workers, advocating for the rights and providing service to the terminally ill) may therefore be positively linked to job satisfaction. This concept of meaningful work and public service motivation (PSM) has received some attention and support in organizational nonprofit research literature, but seems to be a gap in the hospice care research literature (Haley-Lock, 2008; Light, 2004). In this understanding of job satisfaction, individuals tap a unique source of job satisfaction linked to feelings of achievement, because they make a difference, a preference for this type of work may be seen as advancing a social cause and perhaps linked to job satisfaction for hospice social workers.

Caseload Size

There is limited research that measures caseload size for hospice social workers. One study of caseload size of hospice social workers was conducted with over 1,000 hospice and

palliative care social workers and found that 50% of respondents reported a caseload size of between 21-50 patients (Weisenfluh & Cskiai, 2013). Another nationwide study conducted by NASW Center for Workforce Studies found that 12% of the 51 hospice social workers that responded to their study had caseloads of 50 or more (2006). The present study had a mean caseload size of 28.8 (sd=14.1). The mean was 35.5 patients (sd = 15.9) for for-profit hospices and 26.0 patients (sd = 12.3) for non-profit hospices.

Caseload size was not associated with job satisfaction in this study, contrary to what has been found in previous research with social workers in a range of human service settings, including child welfare agencies, mental health agencies and in a randomized sample of 500 licensed social workers (Cole, Panchanadeswaran & Daining, 2004; Thomas et al., 2014). A previous study of job satisfaction of mental health and child protective social workers found that higher caseload size was negatively correlated with job satisfaction, but also suggested that organizational support may be able to override the stress associated with caseload size and contribute to job satisfaction (Thomas et al., 2014). Relationships with co-workers and perception of the hospice executive directive as a servant leader in the current study were associated with job satisfaction. These associations and previous research suggests that there may be other contributing influences that promote job satisfaction for hospice social workers, even when there are higher workload demands.

A study of 500 licensed social workers found a negative correlation between perceived workload and job satisfaction, however, this relationship was mediated by perceived efficacy and meaningful work (Cole, et al., 2004). While potential effect modifiers of efficacy and meaningful work were not measured in this current study, there were items on the job satisfaction scale about being good at your job, opportunity to use skills, chance to do things for other people, and feelings of accomplishment. While these items have not been validated as

single-item measures of these concepts, they may be reflective of different facets of job satisfaction (Brown & Lent, 2012; Dawis, 2005). Responses to these items indicated very minimal dissatisfaction amongst the hospice social workers in this study and this could be meaningful and worthy of further exploration. Hospice work providing an opportunity for meaningful work has been documented in previous research (Sanders & Swail, 2011; Qaseem et al., 2007). Meaningful work, along with relationships with hospice co-workers, may have influenced social workers' job satisfaction level.

Study Limitations and Strengths

This study had several limitations. The cross-sectional study design does not allow us to establish causality. It is not possible to determine whether the conditions that resulted in higher job satisfaction both influenced the leadership style of the executive director and fostered better relationships with co-workers. Additionally, since this is a cross-sectional study, social workers' perception of leadership, relationships with co-workers and job satisfaction may change over time and under different situations, or be influenced by outside factors that were not measured in this study. Unfortunately, there are no studies that used a longitudinal design to assess this.

Selection bias is also a limitation. It is not known whether there was a disproportionate representation based on personal or professional characteristics of the study population, or of the hospice. Study participants may not be representative of the study population on their perceptions of the executive director, perceptions of interdependence with co-workers, feeling valued by co-workers, and/or job satisfaction. Participants who responded to social media and listserv invitations may be different than others in the study population because they were already connected to social work networking organizations. This may impact the findings if study participants were more open and interested in reporting on this topic than were non-participants. Previous research on web-based surveys suggests that the validity and reliability of data obtained online are similar to those obtained

by traditional survey methods, however results should be interpreted with the understanding of this possible selection bias (Eisenbach & Wyatt, 2002). The researcher also contacted every hospice in three states to attempt to reach hospice social workers not connected to professional organizations or on social networking sites, but these were three states in the northeastern United States and may not be fully representative of the target population.

The sample was not diverse. It was predominantly Caucasian (87%) and female (92%). Data on the sociodemographic characteristics of hospice social workers is limited. In a study of 1,169 hospice and palliative care social workers, 89% were female, but no information on ethnicity was reported (Weisenfluh & Csikai, 2012). The very limited variability of ethnicity and gender in the present study prevented inclusion of these variables in data analyses.

This study also had some strengths. It is the only study that examined the association between perception of the executive director and relationships with co-workers with job satisfaction of hospice social workers. An additional strength of the study was that job satisfaction was measured as a multidimensional and process-oriented concept with three subscales, which contributed to the assessment of this variable.

Three different sampling strategies were used, mitigating the weakness of any single strategy, however, percentage of respondents from any of the three different sampling strategies was unable to be estimated due to survey being accessed from a common link in all study invitations. The sample had a wide geographical distribution, drawing participants from at least 32 states. However, inability to estimate the response rate, together with a high likelihood of selection bias, limits generalizability of the findings, which might be based on only a subgroup of hospice social workers.

Inclusion of multiple measures of the professional and sociodemographic characteristics of the hospice social workers, as well as of the hospice characteristics, was another strength. The

measure of perception of value from different core team members contributed further to examining the experience of interdependence in interdisciplinary collaboration.

Future Research

The purpose of this study was to examine the perspective of hospice social workers. Future studies should also examine how job satisfaction is associated with patient outcomes, including family and patient satisfaction as well as other indicators of patient care such as stress level of the patient and family members, perception of patient and family members of support from staff, and pre- and post-death bereavement outcomes. Skillful psychosocial support provided by social workers during the patient's dying process is key to the family's healing after the death occurs and may improve patient and family outcomes. A study including both hospice social workers and patients may help to better understand whether aspects of the social workers' employment conditions and job satisfaction impact these types of patient care outcomes. Longitudinal studies should be conducted to examine the causal relationship between job satisfaction, tenure of staff, and quality of patient care.

Leadership style should be measured not only based on the perception of the employee, as was measured in this study, but also by the leader, to determine whether there is congruence in these descriptions, and whether degree of congruency in perception of leadership style is associated with social worker job satisfaction.

Future research should also include more sensitive measures of workload. The present study measured only caseload size to assess workload. Workload is a much more complex concept, and the worker's perception of their workload should be measured in order to identify risk and protective factors for job satisfaction and burnout (Cole et al., 2004). Intention to stay employed at the hospice should also be included in future studies to further assess whether job satisfaction of hospice social workers fosters tenure of hospice social workers.

Although the present study did not assess physician or other team members' perception of value or perception of interdependence by other team members, research with all core team members in hospice is necessary to determine whether improving the perception of value of the physician, nurse, chaplain and social worker by the other members of the hospice team and the degree of collaboration with hospice team members, improves job satisfaction for all hospice workers.

Implications for Social Work Policy

The profession and specialization of hospice social work in the United States is a relatively new one. Since the implementation of the Hospice Medicare benefit in 1983, and particularly in the last decade, the hospice industry has grown in the number of hospices and the number of patients served (NHPCO, 2015; Weisenfluh & Csikai, 2012). Within this climate of growth and change, hospice social workers have had to adjust to increased work demands and adjustments to changes in the health care market economy.

A major problem identified in the current billing structure for Medicare reimbursement is inadequate payment to fund all services provided to patients; especially in the first and last week of a patient's hospice stay (Reese, 2003). Recent policy shift of allowing hospices to bill retroactively for enhanced nursing and social work services seven days prior to a patient's death is promising in that Medicare appears to recognizing an equal value of the need for social work and ability to bill for enhanced services. However, due to the unpredictability of a terminal patient's death, this may not always be possible if the patient does not die within 7 days of enhanced services. Perhaps incorporating enhanced billing in first 7 days in the program may also assist with increasing addressing psychosocial needs of a patient earlier in the hospice enrollment period and increase social work presence in this time frame.

Implications for Social Work Practice

A goal of this study was to better understand job satisfaction among hospice social workers making it possible to increase longevity in this area of practice. Longevity of hospice social workers in this area of practice is important to provide opportunities to serve as role models for emerging hospice social workers and to promote better representation of the social worker on the hospice team. To improve job satisfaction and promote sustainability of hospice social workers in their jobs, improving extrinsic factors seems to be a need for hospice leadership. It was shown in this study that hospice social workers were most dissatisfied with their salaries and chance for advancement. Hospice leadership should consider higher salaries and reorganization of administrative roles to include more social work opportunities for advancement to increase hospice social work job satisfaction.

Hospice social workers face challenges due to time, staffing, and financial limitations and are also required to provide services to patients in very complex and high stress practice settings (Csikai and Raymer, 2003; NASW, 2003). In light of these challenges, it is important to understand which aspects of hospice social work employment provides the most job satisfaction in order to support social workers who choose to do this type of work. This study explored different individual and organizational characteristics of hospice social workers and their job satisfaction in order to better understand the process of achieving job satisfaction for the hospice social worker. It suggested that social workers' relationships with co-workers contribute to job satisfaction. Intrinsic job satisfaction was greater than extrinsic satisfaction.

The Theory of Work Adjustment describes six values that are important in understanding different components of job satisfaction: achievement, altruism, autonomy, comfort, safety and status (Brown & Lent, 2012). Each item on the MSQ measures different work needs that are

reflective of these values. If the work environment provides opportunities to meet these needs, then workers will be more likely to be satisfied in their jobs, indicating a goodness of fit or congruence between worker and work environment (Brown & Lent, 2012; Dawis, 2005; Dawis & Lofquist 1984). In a qualitative study of 48 hospice social workers, Cabin (2008) suggested a "match" between the values of hospice and the values of social work, describing this as professional altruism. Cabin (2008) further suggested that hospice work provided an opportunity to "actualize altruism" and this may help hospice social workers achieve both job satisfaction and better service to patients (p. 474). The present study found that "providing service to others" was the item that was ranked the highest in job satisfaction amongst the individual items on the MSQ. This item is reflective of the work value of altruism (Brown & Lent, 2012). This type of service-oriented satisfaction may be worthy of further examination to better understand the experiences of hospice social workers and possible motivators to remain in hospice social work employment (Dawis, 2005; Dawis & Lofquist 1984). Understanding hospice social workers' job satisfaction can serve to promote a better fit between the hospice social worker and her or his work environment. Better understanding this process should increase the tenure of social workers in hospice and promote the highest possible quality of care to terminally ill patients and their families.

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Tables

Table 1. Sample Characteristics

Characteristic	n	M (sd) or %
Age	195	
18 – 24 years	1	.5
25 - 34 years	35	17.9
35 – 44 years	42	21.5
45 – 54 years	46	23.6
55 – 64 years	61	31.3
65 + years	10	5.1
Gender	192	
Female	177	92.2
Male	15	7.8
Ethnicity	192	
White	167	87.0
Hispanic	10	5.2
Black (non-Hispanic)	5	2.6
Other	5	2.6
Asian	4	2.1
Native Hawaiian, Pacific Islander	1	.5
Years at current hospice	195	5.6 (5.4)
Degree	195	
BSW	2	1.0
MSW	189	96.9
PhD or DSW	3	1.5
Does not have a SW degree	1	.5
Payment Type	194	
Salary	166	85.6
Per diem	28	14.4
Work at more than one hospice	195	
Yes	4	2.1
No	191	97.9
Number of social workers at hospice	186	10.5 (11.1)
Caseload Size	177	28.8 (14.1)
Profit Status of hospice	189	
Non-profit	133	70.4
For Profit	51	27.0
I'm not sure	5	2.6
Percent of time spent in direct practice	189	54.1 (26.6)
Percent of time doing Administration	187	16.5 (17.6)
Percent of time doing Supervision	186	6.3 (11.0)
Percent of time doing Bereavement	189	8.9 (13.9)
Percent of time doing Marketing	189	2.3 (7.0)
Strongly agree feel valued by:		
Nurses	189	44.4
Doctors	188	37.2
Chaplains	189	54.0
Social Workers	183	67.8

Table 2. Descriptive Statistics on Servant Leadership Scale, Interdependence in Interdisciplinary Collaboration Subscale, and Job Satisfaction Scales

Scale	*N*	*Theoretical Range*	*Actual Range*	*Median*	*M*	*sd*	*Cronbach's alpha*	*Skewness*
Servant Leadership	203	10 - 50	1050	38.0	36.7	8.5	.95	-.4
Interdependence in Interdisciplinary Collaboration	196	13 - 65	37- 65	55.0	54.9	5.8	.79	-.4
Job Satisfaction (general)	195	20 - 100	48 – 100	76.0	75.6	10.4	.89	-.3
Job Satisfaction (intrinsic)	195	12 - 60	35 – 60	50.0	49.2	5.3	.82	-.2
Job Satisfaction (extrinsic)	195	6 - 30	6 - 30	20.0	18.9	5.1	.83	-.4

Table 3. Percent dissatisfied with aspects of the job as measured by the MSQ.

Job satisfaction item	n	% dissatisfied	Job Satisfaction Scale
My pay and the amount of work I do.	90	46.2	Extrinsic
The chance for advancement on this job	85	43.6	Extrinsic
The way company policies are put into practice	71	36.4	Extrinsic
The way my boss handles his/her workers	49	25.1	Extrinsic
The competence of my supervisor in making decisions	37	19.0	Extrinsic
The praise I get for doing a good job	37	19.0	Extrinsic
The working conditions	30	15.5	General
The chance to tell people what to do	30	15.4	Intrinsic
The way my co-workers get along with each other	24	12.3	General
Being able to do things that don't go against my conscience	21	10.8	Intrinsic
The way my job provides for steady employment.	8	4.1	Intrinsic
The chance to use my own methods of doing the job	8	4.1	Intrinsic
The freedom to use my own judgment	8	4.1	Intrinsic
The chance to be "somebody in the community"	6	3.1	Intrinsic
The chance to work alone on the job.	5	2.6	Intrinsic
Being able to keep busy all the time	4	2.1	Intrinsic
The feeling of accomplishment I get from the job	3	1.5	Intrinsic
The chance to do something that makes use of my abilities	3	1.5	Intrinsic
The chance to do different things from time to time	1	.5	Intrinsic
The chance to do things for other people	1	.5	Intrinsic

Table 4. ***Correlation between Servant Leadership Scale, Interdependence in Interdisciplinary Collaboration, and Job Satisfaction Scales***

Scales	*M* (*SD*)	2	3	4	5
1. Servant Leadership	36.7 (8.5)	.35*	.58*	.39*	.63*
2. Interdependence in interdisciplinary collaboration	54.9 (5.8)		.59*	.62*	.41*
3. Job Satisfaction (general)	75.6 (10.4)			.88*	.87*
4. Job Satisfaction (intrinsic)	49.2 (5.3)				.56*
5. Job Satisfaction (extrinsic)	18.9 (5.1)				

Table 5. ***Bivariate analyses between individual characteristics and hospice characteristics with job satisfaction***

Characteristics		n	Job Satisfaction (General)		Job Satisfaction (Intrinsic)		Job Satisfaction (Extrinsic)	
			M (sd) or Pearson *r*	p value	M (sd) or Pearson *r*	p value	M (sd) or Pearson *r*	p value
Individual Characteristics of Social Worker								
Age	18 - 34 years	36	75.02 (9.67)	.35	48.72 (4.32)	.26	18.58 (4.98)	.67
	35 - 44 years	42	76.37 (10.25)		49.40 (4.73)		19.40 (5.32)	
	45 - 54 years	46	76.24 (10.61)		49.35 (5.67)		19.28 (5.11)	
	55 - 64 years	61	75.86 (10.67)		49.66 (5.63)		18.87 (5.07)	
	65+ years	10	69.10 (11.40)		45.70 (5.27)		16.90 (5.10)	
Gender	Female	177	75.63 (10.50)	.84	49.21 (5.42)	.63	18.94 (4.99)	.85
	Male	15	75.06 (10.48)		48.53 (3.68)		19.20 (6.06)	
Years at current hospice		191	.001	.99	.02	.82	.01	.95
Type of pay	Salary	166	75.68 (10.32)	.54	49.14 (5.23)	.86	19.02 (5.05)	.44
	Per diem	28	74.37 (11.13)		48.94 (5.40)		18.21 (5.43)	
Characteristics of hospice								
Number of social workers at hospice		186	.08	.31	-.02	.82	.14	.056
Caseload		177	-.11	.16	-.09	.22	-.10	.19
Profit status of hospice	Non-profit	134	76.24 (10.34)	.26	49.46 (5.34)	.28	19.17 (5.02)	.36
	For profit	54	74.32 (11.09)		48.54 (5.25)		18.41 (5.57)	

Characteristics	n	Job Satisfaction (General)		Job Satisfaction (Intrinsic)		Job Satisfaction (Extrinsic)	
		M (sd) or Pearson *r*	p value	M (sd) or Pearson *r*	p value	M (sd) or Pearson *r*	p value
Percent of time spent in direct practice	189	-.11	.14	-.12	.10	-.09	.21
Percent of time doing administration	187	.18	.01	.17	.02	.14	.06
Percent of time doing supervision	186	.08	.25	.08	.30	.08	.26
Percent of time doing bereavement	189	.03	.66	.09	.23	.01	.91
Percent of time doing marketing	189	.06	.44	.04	.60	.06	.42

Table 6. Hospice employment characteristics by profit status

HOSPICE CHARACTERISTIC	PROFIT STATUS						p value on *t* test
	Non-Profit			For-Profit			
	n	M	SD	n	M	SD	
Years at Current Hospice	131	6.42	5.67	54	3.82	4.19	.001
Number of Social Workers at Hospice	131	12.73	12.09	54	5.09	5.34	<.001
Average Caseload	124	26.00	12.31	52	35.46	15.93	<.001
Percent of work time spent on:							
Direct Patient Care	134	53.82	27.50	54	54.35	24.42	.90
Administration	132	16.36	17.24	54	16.65	18.73	.92
Supervision	132	7.10	11.59	53	4.45	9.43	.11
Bereavement	134	8.84	14.97	54	9.16	10.82	.88
Marketing	134	2.19	7.86	54	2.46	4.58	.81
Feel valued by:							
	Total n	% strongly agree Non-Profit		Total n	% strongly agree For-Profit		p value on chi square
Social Workers	129	65.9		53	73.6		.31
Chaplains	134	52.2		54	59.3		.38
Nurses	134	39.6		54	57.4		.03
Doctors	133	36.8		54	38.9		.79
Type of pay	n	% Non Profit		n	% Profit		p value on chi square
Salary	111	83.5		49	90.7		.29
Per diem	22	16.5		5	9.3		

Table 7. ***Correlation between perception of value by different disciplines with Servant Leadership, Interdependence in Interdisciplinary Collaboration and Job Satisfaction scales***

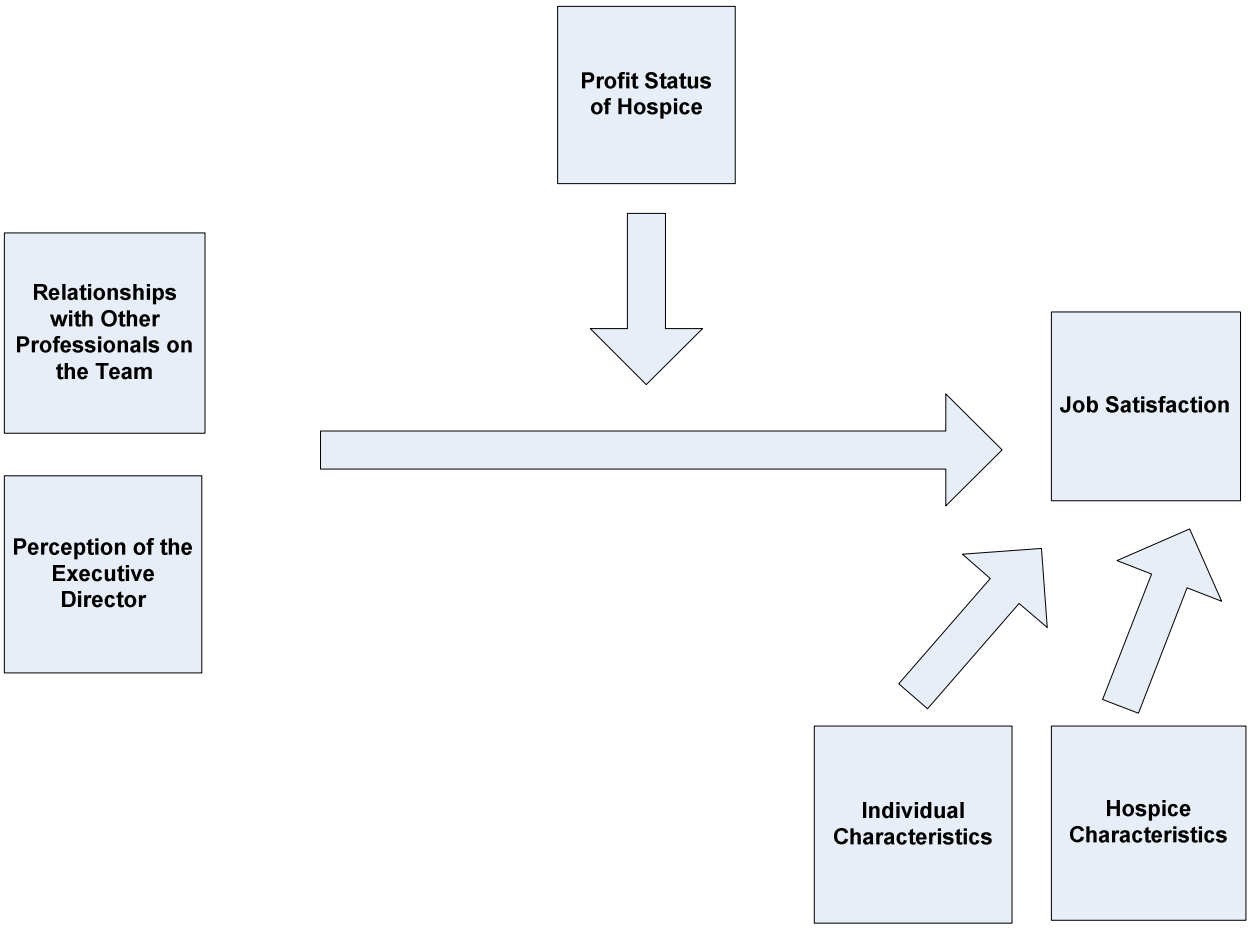
Perception of value by discipline	Servant Leadership r_S	Interdependence Interdisciplinary Collaboration r_S	Job Satisfaction (General) r_S	Job Satisfaction (Intrinsic) r_S	Job Satisfaction (Extrinsic) r_S
Nurses	.19*	.56**	.44**	.46**	30**
Doctors	.18*	.49**	.45**	.49**	.32**
Chaplains	.16*	.38**	.37**	.43**	.22**
Other Social Workers	.06	.22**	.28**	.37**	.10

*p < .05; **p < .01
Range of n for each Spearman correlation is 183-189

Table 8. Final linear regression models for each of the job satisfaction scales.

Variable	General Job Satisfaction n= 182			Intrinsic Job Satisfaction n= 182			Extrinsic Job Satisfaction n= 182		
	β	*p*	Adjusted R^2 p value	β	*p*	Adjusted R^2 p value	β	*p*	Adjusted R^2 p value
Servant Leadership	.58	<.001	.57 .001	.15	<.001	.48 .001	.34	<.001	.49 .02
Interdependence in Interdisciplinary Collaboration	.63	<.001		.42	<.001		.13	.02	
Perception of Value by Doctors (strong agreement with feeling valued compared with not strong agreement	4.52	<.001		2.38	<.001		1.52	.02	
Number of Social Workers	.12	.06		-.02	.59		.11	.001	
Profit Status (For Profit as compared with Non-Profit)	-.59	.63		-1.04	.12		.48	.46	

Figure 1. Theoretical Model



Appendices

Appendix A. Data Collection Instrument

Servant Leadership

Winston, B. & Fields, D. (in-press). Seeking and measuring the essential behaviors of servant leadership. Leadership and Organizational Development Journal.

Please describe how much you feel that your hospice organization's top executive:

	Definitely No 1	No 2	Neutral 3	Yes 4	Definitely Yes 5
1. Practices what he/she preaches	1	2	3	4	5
2. Serves people without regard to their nationality, gender, or race	1	2	3	4	5
3. Sees serving as a mission of responsibility to others	1	2	3	4	5
4. Genuinely interested in employees as people	1	2	3	4	5
5. Understands that serving others is most important	1	2	3	4	5
6. Willing to make sacrifices to help others	1	2	3	4	5
7. Seeks to instill trust rather than fear or insecurity	1	2	3	4	5
8. Is always honest	1	2	3	4	5
9. Is driven by a sense of higher calling	1	2	3	4	5
10. Promotes values that transcend self-interest and material success	1	2	3	4	5

Interdependence and Team Collaboration

Bronstein (2002), Index for Interdisciplinary Collaboration (IIC)

	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 4
1. I utilize other (non-social work) professionals for their particular expertise.	1	2	3	4	5
2. I consistently give feedback to other professionals in my setting.	1	2	3	4	5
3. Other (non-social work) professionals in my setting utilize social workers for a range of tasks.	1	2	3	4	5
4. Teamwork with professionals from other disciplines is not important in my ability to help clients.	5	4	3	2	1
5. My colleagues from other professional disciplines and I rarely communicate.	5	4	3	2	1
6. The colleagues from other disciplines with whom I work have a good understanding of the distinction between my role and their role(s).	1	2	3	4	5
7. My colleagues from other disciplines make inappropriate referrals to me.	5	4	3	2	1
8. I can define those areas that are distinct in my professional role from that of professionals from other disciplines with whom I work.	1	2	3	4	5
9. I view part of my professional role as supporting the role of others with whom I work.	1	2	3	4	5
10. My colleagues from other disciplines refer to me often.	1	2	3	4	5
11. Cooperative work with colleagues from other disciplines is not a part of my job description	5	4	3	2	1
12. My colleagues from other professional disciplines do not treat me as an equal.	5	4	3	2	1
13. My colleagues from other disciplines believe that they could not do their jobs as well without the assistance of social workers	1	2	3	4	5

Job Satisfaction

Minnesota Satisfaction Questionnaire (MSQ short form), Vocational Psychology Research (1977),

Ask yourself: How satisfied am I with this aspect of my job:

	Very Dissatisfied 1	Dissatisfied 2	Neutral 3	Satisfied 4	Very Satisfied 5
1. Being able to keep busy all the time	1	2	3	4	5
2. The chance to work alone on the job.	1	2	3	4	5
3. The chance to do different things from time to time	1	2	3	4	5
4. The chance to be "somebody in the community"	1	2	3	4	5
5. The way my boss handles his/her workers	1	2	3	4	5
6. The chance to do things for other people	1	2	3	4	5
7. The chance to tell people what to do	1	2	3	4	5
8. The chance to do something that makes use of my abilities	1	2	3	4	5
9. The way company policies are put into practice	1	2	3	4	5
10. My pay and the amount of work I do.	1	2	3	4	5
11. The chance for advancement on this job	1	2	3	4	5
12. The freedom to use my own judgment	1	2	3	4	5
13. The chance to use my own methods of doing the job	1	2	3	4	5
14. The working conditions	1	2	3	4	5
15. The way my co-workers get along with each other	1	2	3	4	5
16. The praise I get for doing a good job	1	2	3	4	5
17. The feeling of accomplishment I get from the job	1	2	3	4	5
18. The competence of my supervisor in making decisions	1	2	3	4	5
19. Being able to do things that don't go against my conscience	1	2	3	4	5
20. The way my job provides for steady employment.	1	2	3	4	5

Personal Characteristics

1. What is your age?

2. What gender do your consider yourself?
    a. Male
    b. Female
    c. Transgender
    d. Other_____

3. How many years have you been working at the hospice you are currently employed at?

4. What is the highest social work degree you have earned?
    a. BSW → Next section
    b. MSW → Next section
    c. PhD or DSW → Next section
    d. I do not have a social work degree

5. What is the highest degree you have earned?
    a. Associate or two-year degree in another field *specify field:*
    b. Bachelor's degree in another field *specify field:*
    c. Master's degree in another field *specify field:*
    d. Doctorate degree in another field *specify field:*

Characteristics of Your Hospice

1. Approximately how many social workers are employed at your hospice?

2. Does your hospice operate as a profit or not-for-profit hospice?
    a. For profit
    b. Not-for-profit
    c. I'm not sure

3. What is the name of your hospice agency? PLEASE BE ASSURED THAT THIS INFORMATION WILL BE USED ONLY TO OBTAIN PUBLICALLY AVAILABLE DATA ON THE CHARACTERISTICS OF YOUR HOSPICE. IT WILL NOT BE USED IN ANY REPORTS, NOR WILL IT BE USED TO TRY TO DETERMINE YOUR IDENTITY.

As a social worker operating as a member of an interdisciplinary team, To what extent do you agree or disagree with the following statements:

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4
1. I feel valued by the hospice nurses I work with	1	2	3	4
2. I feel valued by the hospice doctors I work with	1	2	3	4
3. I feel valued by the hospice chaplains I work with	1	2	3	4
4. I feel valued by the other social workers I work with	1	2	3	4

5. What roles do you perform at the hospice you are currently working for (PLEASE CHECK ALL THAT APPLY)
    a. direct patient and family care with active hospice patients and families
    b. administrative/supervisory
    c. bereavement
    d. marketing/recruitment
    e. education

SCORING GUIDES:

MSQ (short form)
Scoring Key to Which Questions Fall into Which Subscales

IS = Intrinsic Satisfaction subscale (12 items)
ES = Extrinsic Satisfaction subscale (6 items)
GI = General items (2 items, plus all other items)

Ask yourself: How satisfied am I with this aspect of my job?

5=extremely satisfied
4=very satisfied
3=satisfied
2=somewhat satisfied
1=not satisfied

IS 1. Being able to keep busy all the time.
IS 2. The chance to work alone on the job.
IS 3. The chance to do different things from time to time.
IS 4. The chance to be somebody in the community.
ES 5. The way my boss handles his/her workers.
ES 6. The competence of my supervisor in making decisions.
IS 7. Being able to do things that don't go against my conscience.
IS 8. The way my job provides for steady employment.
IS 9. The chance to do things for other people.
IS 10. The chance to tell people what to do.
IS 11. The chance to do something that makes use of my abilities.
ES 12. The way company policies are put into practice.
ES 13. My pay and the amount of work I do.
ES 14. The chances for advancement on this job.
IS 15. The freedom to use my own judgment.
IS 16. The chance to try my own methods of doing the job.
GI 17. The working conditions.
GI 18. The way my coworkers get along with each other.
ES 19. The praise I get for doing a good job.
IS 20. The feeling of accomplishment I get from the job.

IS = Intrinsic Satisfaction subscale (12 items)
IS 1. Being able to keep busy all the time.
IS 2. The chance to work alone on the job.
IS 3. The chance to do different things from time to time.
IS 4. The chance to be somebody in the community.
IS 7. Being able to do things that don't go against my conscience.

IS 8. The way my job provides for steady employment.
IS 9. The chance to do things for other people.
IS 10. The chance to tell people what to do.
IS 11. The chance to do something that makes use of my abilities.
IS 15. The freedom to use my own judgment.
IS 16. The chance to try my own methods of doing the job.
IS 20. The feeling of accomplishment I get from the job.

ES = Extrinsic Satisfaction subscale (6 items)
ES 5. The way my boss handles his/her workers.
ES 6. The competence of my supervisor in making decisions.
ES 12. The way company policies are put into practice.
ES 13. My pay and the amount of work I do.
ES 14. The chances for advancement on this job.
ES 19. The praise I get for doing a good job.

GI = General items (2 items, plus all other items)
GI 17. The working conditions.
GI 18. The way my coworkers get along with each other.

Interdisciplinary Collaboration

Bronstein (2002), Full Index for Interdisciplinary Collaboration (IIC)

Key to Subscales:

SUBSCALE	ITEMS
Interdependence	1 - 13
Newly Created Professional Activities	14 - 19
Flexibility	20 - 24
Collective Ownership of Goals	25 - 32
Reflection on Process	33 - 42

With regard to your current primary work setting/organization, please indicate the extent to which you agree or disagree with each of the following statements:

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	Strongly Disagree 1
1. I utilize other (non—-social work) professionals for their particular expertise.	1	2	3	4	5
2. I consistently give feedback to other professionals in my setting.	1	2	3	4	5
3. Other (non-social work) professionals in my setting utilize social workers for a range of tasks.	1	2	3	4	5
4. *Teamwork with professionals from other disciplines is not important in my ability to help clients.	1	2	3	4	5
5. *My colleagues from other professional disciplines and I rarely communicate.	1	2	3	4	5
6. The colleagues from other disciplines with whom I work have a good understanding of the distinction between my role and their role(s).	1	2	3	4	5
7. *My colleagues from other disciplines make inappropriate referrals to me.	1	2	3	4	5
8. I can define those areas that are distinct in my professional role from that of professionals from other disciplines with whom I work.	1	2	3	4	5
9. I view part of my professional role as supporting the role of others with whom I work.	1	2	3	4	5
10. My colleagues from other disciplines refer	1	2	3	4	5

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	Strongly Disagree 1
to me often.					
11. Cooperative work with colleagues from other disciplines is not a part of my job description.	1	2	3	4	5
12. *My colleagues from other professional disciplines do not treat me as an equal.	1	2	3	4	5
13. My colleagues from other disciplines believe that they could not do their jobs as well without the assistance of social workers.	1	2	3	4	5
14. Distinct new programs emerge from the collective work of colleagues from different disciplines.	1	2	3	4	5
15. Organizational protocols reflect the existence of cooperation between professionals from different disciplines.	1	2	3	4	5
16. Formal procedures/mechanisms exist for facilitating dialogue between professionals from different disciplines (i.e., at staffings, inservice, rounds, etc.)	1	2	3	4	5
17. *I am not aware of situations in my agency in which a coalition, task force, or committee has developed out of interdisciplinary efforts.	1	2	3	4	5
18. Working with colleagues from other disciplines leads to outcomes that we could not achieve alone.	1	2	3	4	5
19. Creative outcomes emerge from my work with colleagues from other professions that I could not have predicted.	1	2	3	4	5
20. I am willing to take on tasks outside of my job description when that seems important.	1	2	3	4	5
21. I am not willing to sacrifice a degree of autonomy to support cooperative problem solving.	1	2	3	4	5
22. I utilize formal and informal procedures for problem solving with my colleagues from other disciplines.	1	2	3	4	5
23. *The professional colleagues from other disciplines with whom I work stick rigidly to their job descriptions.	1	2	3	4	5
24. My non-social work professional colleagues and I work together in many different ways.	1	2	3	4	5

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	Strongly Disagree 1
25. Professionals from other disciplines with whom I work encourage family members' participation in the treatment process.	1	2	3	4	5
26. *My colleagues from other disciplines are not committed to working together.	1	2	3	4	5
27. My colleagues from other disciplines work through conflicts with me in efforts to resolve them.	1	2	3	4	5
28. When colleagues from different disciplines make decisions together, they go through a process of examining alternatives.	1	2	3	4	5
29. My interactions with colleagues from other disciplines occur in a climate where there is freedom to be different and to disagree.	1	2	3	4	5
30. Clients/patients/students participate in Interdisciplinary planning that concerns them.	1	2	3	4	5
31. Colleagues from all professional disciplines take responsibility for developing treatment plans.	1	2	3	4	5
32. *Colleagues from all professional disciplines do not participate in implementing treatment plans.	1	2	3	4	5
33. Professionals from different disciplines are straightforward when sharing information with clients/patients/students.	1	2	3	4	5
34. My colleagues from other disciplines and I often discuss different strategies to improve our working relationships.	1	2	3	4	5
35. My colleagues from other professions and I talk about ways to involve other professionals in our work together.	1	2	3	4	5
36. *My non-social work colleagues do not attempt to create a positive climate in our organization.	1	2	3	4	5
37. 1 am optimistic about the ability of my colleagues from other disciplines to work with me to resolve problems.	1	2	3	4	5
38. I help my non-social work colleagues to address conflict with other professionals directly.	1	2	3	4	5
39. My non-social work colleagues are as likely as I am to address obstacles to our	1	2	3	4	5

	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4	Strongly Disagree 1
successful collaboration.					
40. My colleagues from other disciplines and I talk together about our professional similarities and differences, including role, competencies, and stereotypes.	1	2	3	4	5
41. *My colleagues from other professions and 1 do not evaluate our work together.	1	2	3	4	5
42. I discuss with professionals from other disciplines the degree to which each of us should be involved in a particular case.	1	2	3	4	5

Appendix B. Invitations to study

Email invitation

Dear_____,

Thank you for agreeing to help me distribute my survey. Please feel free to cut and paste this study invite to your staff or any hospice social worker you know. You are also a hospice social worker, so you are invited to participate in the survey as well. I thank you in advance for your help!

Are you a social worker who works in hospice?

If you are, you are invited to participate in a research study about the experience of hospice social workers. We hope that what we learn from you will help improve the practice of social work in hospice.

The study is being conducted by Suzanne Marmo, an experienced social worker in end of life care and doctoral candidate at Fordham University Graduate School of Social Service.

The questions on this survey are about issues that social workers may have feelings and opinions about, such as relationships with co-workers, leadership support and working conditions. The survey will be completed online and you will be anonymous. It will not be possible to know who participated.

All participants who complete this survey will be entered in a raffle to win one of three $40 Amazon gift cards. If you are at least 18 years old, and are employed at a hospice as a social worker for at least 30 days, you are invited to participate. If you are interested in learning more about this study, please click this link to connect to the survey. There is more detailed information about the study after you click on the link. After reading that information, you can decide whether you want to participate.

https://fordham.qualtrics.com/SE/?SID=SV_cwCST4HumByMNxj

Thank you very much, should you have any questions, please feel free to email me at smarmoroman@fordham.edu or call me at 516-819-5804.
--Suzanne
Informed Consent/Landing Page for Qualtrics survey

Fordham University
GRADUATE SCHOOL OF SOCIAL SERVICE

You are invited to participate in a research study that I am conducting to explore hospice social workers' perceptions of job satisfaction, interdisciplinary collaboration and organizational leadership. The research study is being conducted by Suzanne Marmo, a doctoral candidate at

Fordham University Graduate School of Social Service who has also been a practicing medical social worker with over 20 years of social work practice experience in working with terminally ill individuals.

The questions on the survey will concern questions about your job as a hospice social worker and various aspects of that job which you may find satisfying or not satisfying. Additional questions about your experience as a hospice social worker and your perceptions of interdisciplinary collaboration and leadership support will also be asked. This survey is expected to take approximately 15-20 minutes to complete.

Your participation in the study is voluntary. Your anonymity is completely ensured. You are not asked to provide your name or any other information that could identify you. In addition, information that could identify the computer you are using is not collected. It will not be possible for anyone to know who participated in the study and who chose not to participate.

There are very minimal risks to participating in this study. The risks associated with participating in this study are no greater than what would occur in a professional conversation about your knowledge and attitudes towards your job as a hospice social worker. If you do decide to participate, you may skip any questions you don't want to answer or answer or to stop filling out the questionnaire at any time and leave the survey website.
All participants who complete this survey will be entered in a raffle to win one of three $40 Amazon gift cards. I hope that this study may lead to a better understanding of enhance understanding of factors which may lead to improved job satisfaction and improved staffing for hospice social workers.

If you have any questions about this research study, you may contact me, Suzanne Marmo, at smarmoroman@fordham.edu or 516-819-5804. You may also contact my faculty sponsor/dissertation chair, Cathy Berkman at berkman@fordham.edu or 212-636-6662. If you have any questions about your rights as a participant in a research study, you can contact the Fordham University Institutional Review Board by email at irb@fordham.edu to discuss or write Fordham University Institutional Review Board, 113 West 60th Street, Room LL203C, New York, New York.

By clicking on the "Next" button below, you indicate your consent to participate in this study and that you are at least 18 years old.