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Hospice Interdisciplinary Use of The Social Work Assessment Tool for Military Families

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Miranda L. Rankin

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Walden University
2020

Abstract

Hospice Interdisciplinary Use of The Social Work Assessment Tool for Military Families

by

Miranda L. Rankin

MA, Liberty University 2011

BS, Park University 2010

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Human Services

Walden University
November 2020

Abstract

The development of the social work assessment tool (SWAT) was an initiative designed by members of the National Hospice and Palliative Care Organization to move hospice and palliative care social workers into the arena of viewing the family as an extension of the patient. Of those dying in the United States, 1 out of 4 is a military veteran (vet) in need of assessments, culturally relevant interventions, and/or supports at the end of life. For military families, caring for vets at the end of life can prompt stressors that may require culturally unique assessments and/or interventions. Tsai's (2003) theory of stress served as the theoretical framework for this study; situated in an urban setting in the Southern United States explored how SWAT was used by hospice staff to address psychosocial, spiritual, emotional, and mental health needs of military families to corroborate SWAT use for militaries. Data collection included interviews of 7 staff members, observations of 2 interdisciplinary meetings, and 1 focus group, and analyses were thematic and propositional. When making sense of SWAT results to characterize the needs of military families, IDT members relayed 4 themes: (a) relinquishing some level of control to community-based hospice members, (b) a need for familial culture, (c) a need to be recognized for their service, and (d) the need to regain control after their loved one dies. IDT members appraised military caregiver needs in 11 subsets of SWAT. The findings for this study are significant, informed research questions, and illuminated SWAT use for military families as a viable tool for human service practitioners when providing culturally relevant interventions for military families.

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Dedication

This dissertation is dedicated to my mother… Caroline. Thank you, mom, for teaching me all that I know about perseverance and for pulling me up when life knocks me down. I love you.

Acknowledgements

Before I acknowledge anyone, let me acknowledge God for keeping me, watching over me, and saving me when I was lost. I thank Him daily for valuing my life enough to save it. I thank Him for reminding me that I can do ALL things through Him!

I want to thank my sweet children –Iyanna and Octavia. Everything I do, I do it with the two of you in mind. You are the air I breath and the greatest gifts I have ever received. I also want to thank my parents who are always in my corner, who always love and protect me, and who always push me to do my best. To my siblings -- Neil, you never make me feel small in life; you set the bar high because you knew your little sister could reach it. Tyrone, you gave me the blueprint to what hard work and drive looks like. Thank you for always challenging me to *go get it*! Shawn, thank you for your prayers and consistent positivity in my life. Finally, I would be remiss if I did not thank my husband Deon -- thank you for believing in me; thank you for cheering for me when I couldn’t cheer for myself; thank you for your patience, your kind words, and your strong arms that always catch me when I fall.

I would like acknowledged my committee: my chairperson, Dr. Heinrich, my committee member, Dr. Carpenter, and Dr. Scotten, my URR for their continued contributions and support.

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Chapter 1: Introduction to the Study

Introduction

Absent of diseases, motor vehicle accidents, suicides, or homicides, Americans can anticipate a life cycle of 78.6 years (Centers for Disease Control and Prevention, 2015). Death comes at the end of the life cycle, yet many individuals fear death due to the possibility of pain, suffering, and the unknowns that may accompany dying (Gwyther et al., 2008). Of those dying in the United States, one out of every four is a military veteran (vet) in need of assessments, culturally relevant interventions, and/or supports at the end of life (Fulton & Epstien-Lubow, 2011; Saban et al., 2016). Most service members are frequently reminded of mortality due to the possibility of combat-related death, yet vets who do not die in combat may require specialized care at the end of their life cycle (Prince-Paul, Peereboom, & Daly, 2016).

Hospice is specialized end-of-life care for those dying of advanced illness, aging, disease, and/or infection (Prince-Paul et al., 2016). Hospice providers offer terminally ill patient's comfort, dignity, pain management, and assessments at end of life (Fulton & Epstien-Lubow, 2011; Saban et al., 2016). For military families caring for a terminally ill vet can prompt stressors that may require culturally unique assessments and/or interventions (Antoni et al., 2012; Chakrawarty & Dhanaklashmi, 2013; Chang, Stein, & Skarf, 2015; Feldman, Sorocco, & Bratkovich, 2014; Fulton & Epstien-Lubow, 2011). Typically, community-based hospice social work (HSW) team members conduct assessments and provide family s opportunities to identify needs and obtain some relief from stressors. Most of what is known about end-of-life needs and preferences of vets comes from Veterans Affairs (VA) hospital data sources (Prince-Paul et al., 2016).

Wachterman et al. (2014) found that only 4% of vets who use the VA receive hospice assessments; subsequently, VA data sources do not capture the profile of non-VA home hospice assessments, such as the social work assessment tool (SWAT), for vets and family s. Therefore, further exploration may be warranted into the use of SWAT by community home hospice interdisciplinary teams (IDT) Gwyther et al., 2008; NHPCO, 2015; Rhondali, Burt,Wittenberg-Lyles, Bruera, & Dalal, 2013). In-patient hospice staff, VA medical staff, and/or military treatment facility staff may be largely unaware of how community home hospice IDT members use SWAT when caring for military families (Prince-Paul et al., 2016; Wittenberg-Lyles, Bruera, & Dalal, 2013). Thus, I conducted an explanatory case study to examine how community-based IDT members make sense of SWAT results to meet the needs of military family cos.

Problem Statement

One out of every four dying Americans is a U.S. military vet (NHPCO, 2010). Many vets rely on family members to act as s along with hospice providers at the end of life (Fulton & Epstien-Lubow, 2011; Saban et al., 2016). Of vets receiving hospice care, 17% have exacerbated symptoms such as service-related posttraumatic stress secondary to combat related traumas, moral injury, or survivor’s guilt for having survived catastrophic service related incidents, all of which can uniquely contribute to military family stress (Antoni et al., 2012; Chakrawarty & Dhanaklashmi, 2013; Chang et al., 2015; Feldman et al., 2014; Fulton & Epstien-Lubow, 2011). In response to the increasing number of families enrolled in home hospice care, the National Hospice and Palliative Care administrators developed standards for hospice providers (NHPCO, 2010). As a result of these standards, many home HSWs conduct assessments focused on the family as an extension of the patient (NHPCO, 2015). The National Institute of Health on End of Life Care (as cited in Mullane, 2009) emphasized the importance of considering family caregiver needs when preparing for the death of a loved one. However, there appears to be a gap in how home hospice IDT members use specific assessment tools to meet needs unique to military families. The intent of this explanatory case study research was to address this gap by exploring how SWAT is used by IDT members to address psychosocial, spiritual, emotional, and mental health needs of military family s enrolled in home-based hospice care (see Yin, 2017). The results of this study may include information helpful for hospice directors to identify how stakeholders make sense of and characterize military family support.

Purpose

For this explanatory case study, I examined the assessment practices of home-based IDT members who offer end-of-life services to vets, located in a Southwest U.S. urban area, in order to corroborate, extend, or refute the use of SWAT for military families. Most vets are likely to die in a hospital or a nursing home; therefore, many home-based hospice leaders have a limited understanding of the operational tools social workers use to assess the needs of military families enrolled in nonmilitary affiliated home hospice care (Condard, Allen & Armstrong, 2015; Weber & Clark, 2016; Zaider & Kaissan, 2009). Hospice directors are also largely unaware of how IDT members such as hospice nurses, chaplains, case managers, and volunteer coordinators incorporate SWAT results when caring for patients (Mullane et al. 2009). Gathering information about social work assessment practices appears important to sustaining hospice services; therefore, I aimed to fill a gap in the existing literature about how hospice IDT members make sense of SWAT to characterize support for military families.

Significance

The results of this explanatory care study include information that can inform directors, hospice IDT members, and administrators about how IDT members characterize the needs of veteran family hospice enrollees. Hospice IDTs who use SWAT can benefit from an extended understanding of the SWAT support mechanism. Subsequently, administrators who evaluate standards of care for hospice patients may be able to use the findings to promote or adapt supports. Directors may make sense of the results of this data and how such use may indirectly improve hospice services. In addition, the study includes information helpful for filling the gap in the literature by outlining how the use of SWAT illuminates the needs of home hospice enrolled military families.

Nature of the Study

In this explanatory case study, I sought to understand how and why hospice IDTs make sense of SWAT (see Dando & Chiverton, 2014; Kruse, Parker, Wittenberg-Lyles, & Demiris, 2013; Yin 2017). The unit of analysis were members of a hospice IDT: (a) one home hospice social worker, (b) two nurses and two nursing assistants, (c) one case manager, (d) one volunteer manager, (e) one hospice chaplain, (f) the director of patient services, and (e) one community coordinator ; these staff members typically participate in IDT meetings (see Pizzi, 2014; Yazan, 2015). Understanding the utility of SWAT from the users' perspectives provides useful information when determining how hospice providers make sense of, characterize, and communicate the support needs of military families enrolled in community-based home hospice care.

Tsai's (2003) Theory of Stress

Tsai's (2003) theory of stress served as the theoretical framework for this study. The theory of stress was derived from the Roy (1976) adaptation model. Tsai's theory offers a template for s of terminally ill relatives. The theory of stress is a middle range nursing theory and includes information that contains a context for understanding (a) how hospice providers assess burdens associated with caregiving (objective burden), (b) stressful life events, (c) social support, and (d) social roles of family s (Roy, 1976; Tsai, 2003). I used this lens as an organizing concept in the field of hospice care (see Waldrop & Meeker, 2014). In this explanatory case study, I examined how hospice IDT members made sense of SWAT when characterizing support needs to corroborate the use of SWAT for military families. I used Tsai's theory of stress to contextualize IDT members' use and how they made meaning of SWAT results (see Roy 1976; Tsai, 2003; Yin, 2003).

Tsai (2003) suggested that coping mechanisms for stress are either automatic responses to the environment or the manifestation of learned behavior through experiences (p. 138). Autonomic and learned responses can prompt s to seek available physical and psychosocial resources to manage any distress secondary to caring for dying loved ones (Tsai, 2003; Yazan, 2015). HSW team members routinely assess family caregiver stress by identifying tasks associated with caregiving (objective burdens) and offer resources that can lessen stress and improve coping (Pizzi, 2014; Tsai, 2003; Yazan, 2015). Therefore, I used the theory of cargiver stress as a basis for making sense of the data related to SWAT use when military family cos perceive stress related to caregiving.

Social Work Assessment Tool (SWAT)

One of the most critical elements of hospice care is to assess the needs of dying patients (Parker et al., 2012). However, HSW assessments and IDT interventions are just as critical for family members caring for dying patients (Gotea & Bodi, 2017). Reese et al. (2006) designed the SWAT for HSW team members to assess 11 individual psychosocial and spiritual issues. HSW members assess primary family s on 11 subsets (See Figure 1; Reese et al., 2006). Some SWAT goals are to (a) facilitate meeting the needs of dying patients or families, (b) provide measurable outcomes of social work interventions, and (c) contribute to collaborative practices with other hospice IDT members (Reese et al., 2006). The collaborative outcomes and interventions of IDT members was the primary focus of SWAT use in this explanatory case study. My intent in this study was to understand how hospice IDT members make sense of SWAT when characterizing the following 11 subsets:

1. End of life decisions,
2. Thoughts of suicide or wanting to hasten death,
3. Anxiety about death,
4. Preference about the environment,

5. Social support,

6. Financial resources,

7. Safety,

8. Comfort,

9. Complicated anticipatory grief,

10. Awareness of prognosis, and

11. Spirituality (Reese et al., 2006, p. 65)

Unit of Analysis

The unit of analysis was an inclusive hospice IDT of Blue Ocean home hospice[i] located in South Texas in an urban medical center. I collected data by observing two hospice IDT meetings, a focus group, and seven interviews with IDT members. I conducted this research during the summer of 2020 over the course of 10 days. Staffing for hospice IDTs included a director of operations, director of patient services, volunteer program manager, nurses, nursing assistants, case manager, chaplain, and social worker. The boundaries around the cultural system of action was defined by purposeful exploration of the 11 subsets of SWAT addressed by hospice IDT members.

Research Questions

I used the following questions to guide the research process:

Research question (RQ)1: How do hospice IDT members make meaning of SWAT when characterizing support needs for military families?

RQ2: How do hospice IDT members' SWAT-related activities corroborate, extend, or dispute SWAT for military family s?

Assumptions

In this explanatory case study, I assumed that participants understood the interview questions, answered honestly, participants participated in normal IDT meetings during this case study, and that my presence did not change usual interactions between staff members.

Scope and Limitations

For this explanatory case study, I examined Tsai's (2003) theory of caregiver stress in a community-based home hospice setting. The results lend dialogue to and analytic generalizability for understanding how hospice IDT members make sense of SWAT to characterize support needs (see Yin, 2017). The findings offer a holistic perspective of the use of this tool (see Yin, 2017).

Findings also contribute to an emerging body of knowledge about the relevance and use of SWAT to identify needs specific to military culture at the end of life. The results may not, nor are they intended to, represent optimal use and organizational practices that advance SWAT effectiveness across hospice organizations. Influenced by Tsai's (2003) theory of caregiver stress, I applied social research approaches to enhance achievement with the anticipation of contending interpretations, which may be inevitable yet important. Individual hospice IDT members and family members' experiences and knowledge concerning SWAT use may also be readily identified as a potential limitation (see Kettner, Moroney, & Martin, 2013; Reese et al., 2006; Schleicher, 2014; Yin, 2017): There may be covert participatory perceptions held as respective truths in this inquiry. My attention to words, associated meaning, and patterns in context could foster an understanding of Tsai's theory of caregiver stress when hospice IDT members use SWAT to assess and characterize military family caregiver needs.

Definitions

For the purpose of this study, the following definitions guided the research:

stress: Symptoms such as depression, social isolation, financial stress, and feeling overwhelmed because of providing informal care for patients with a chronic or terminal illness (Ahmed, N., Ahmedzai, S., Collins, K., & Noble, B. 2014).

Comfort care: Services provided by nursing staff with the goal of alleviating emotional or physical pain and minimizing psychosocial stressors associated with dying; or for those providing informal care for dying patients (Moore, Bastian & Aponteng, 2015).

Hospice: Specialized care for patients with a life expectancy of 6 months or less due to aging, chronic illness, disease, or infection (Hui et al., 2013).

Hospice interdisciplinary team (IDT)*:* A group of licensed clinical professionals, paraprofessionals, and chaplains who work collaboratively to ensure that a holistic care plan based on the patient’s wishes is implemented (Moore, Bastian & Aponteng, 2015).

Military family caregiver (cos): A family member living with and acting as an informal caregiver for a terminally ill veteran in conjunction with the formal care received from hospice staff (Kettner, Moroney, & Martin, 2013).

Summary

SWAT was developed by Reese et al. (2006) as an instrument used by social workers to assess the needs of hospice enrolled families and subsequently address problematic caregiver stress. This chapter contained information about an explanatory case study, including the problem, purpose for the study, significance, nature of the study, research questions, scope and limitations, and definitions. Chapter 2 comprises a review of literature pertaining to this study.

Chapter 2: Literature Review

Introduction

One out of every four Americans at the end of life is a U.S. military veteran (Chakrawarty & Dhanaklashmi, 2013). Of vets receiving hospice care, approximately 17% have exacerbated symptoms during the end of life, which may contribute to increased family stress (Antoni et al., 2012; Chakrawarty & Dhanaklashmi, 2013; Feldman et al., 2014, Fulton & Epstien-Lubow, 2011). Families enrolled in hospice care often perceive information related to managing practical and/or psychosocial issues at the end of life as helpful (Snyder, 2015; Zaider & Kissaine & Kissane, 2009). To provide information, support, and care to families enrolled in home hospice, a comprehensive assessment using standardized tools is necessary (Ahmed et al., 2014). SWAT appears to be needed for members of the hospice IDT to manage family expectations and to promote holistic care inimitable to military families (Zaider & Kissane, 2009).

Social work involvement is a major contributor to team functioning and promoting care unique to dying patients and families (Mullane et al. 2009; Reese et al., 2006). Although SWAT is administered by HSW team members, subsequent IDT members may incorporate SWAT recommendations when providing end-of-life care to patients (Nayer, 2014; Reese & Raymer, 2004). Improved medical and/or psychosocial support and lowered costs incurred by hospice agencies are just a few areas affected by HSW and hospice interdisciplinary member collaboration (Mullane et al. 2009; Reese & Raymer, 2004).

SWAT use appears to have increased across the social work discipline (Reese & Raymer, 2004), yet other hospice disciplines may have poor awareness of the relevance of SWAT issues in hospice outcomes (Reese & Raymer, 2004). Thus, I completed a comprehensive literature review that includes information about SWAT use by hospice IDT members. Subsequent sections of this chapter include an overview of the research strategy, history of hospice, hospice care, military families, family support roles and hospice care, military veterans and hospice use, family systems, military family cos, stress, social workers, SWAT, and hospice IDTs.

Literature Search Strategies

I performed an extensive literature review and used the following databases: The Walden Library, MEDLINE, EBSCHO, ProQuest, PubMed, Cumulative Index to Nursing and Allied Health, NHPCO, and Google Scholar. I completed a review of the literature using the following key words and phrases: *hospice, home hospice, hospice social workers, hospice IDTs, family meetings, family support roles and hospice care, military vets and hospice care, social work assessment tools, hospice IDT meetings, military family stress, burden, comfort*, and *family systems*. I combined these terms in various ways to help broaden the literature search. SWAT, military family s, and social work assessment tools as stand-alone terms did not provide a lengthy list of results. However, word combinations such as *social workers* and *hospice*, *IDTs* and *hospice care*, as well as *vets* and *military families* yielded increased numbers of available literature in the research database. I reviewed approximately 50 primarily peer-reviewed scholarly journals.

History of Hospice Care

Saunders (1978) pioneered the hospice movement during the first half of the 20th Century (Campbell, 1986; Hoffman, 2005; Paradis & Cummings, 1986). Hospice is patient-focused care with relief of multiple symptoms congruent with dying (Paradis & Cummings, 1986; Saunders, 1978; Stoddard, 1978). In 1948, Saunders offered specialized care for dying patients in a London resting place (as cited in Connor, 1998; Hoffman, 2005; Paradis & Cummings, 1986). Saunders designed this resting place to have a home-like feel, combined with skilled nursing services equivalent to what patients encounter in a hospital setting (Connor, 1998; Hoffman, 2005; Paradis & Cummings, 1986). Saunders founded St. Christopher in 1967 as the first institutionalized hospice facility where patients died in a care environment intended for nursing staff to promote comfort, pain management, clinical research, and education rather than curative measures (Connor, 1998; Hoffman, 2005; Saunders, 1978).

In the mid-1970s, Saunders used St. Christopher as a basis for the hospice philosophy and shared the concept of patient-centered compassion care with students and faculty assigned to the nursing department at Yale University (Connor, 1998; Hoffman, 2005; Paradis & Cummings, 1986). Florence Wald, dean of Yale University, and Elizabeth Kubler-Ross, author of the book, *On Death and Dying*, were inspired by the work Saunders accomplished at St. Christopher (Kubler-Ross, 1964; Saunders, 1978). Wald and Kubler-Ross (1964) expanded the use of hospice for dying patients to include home care with visiting staff as an alternative to institutionalized end-of-life care (as cited in Connor, 1998; Hoffman, 2005; Saunders, 1978). In 1972, Kubler-Ross advocated for aging and terminally ill patients before the Senate Special Committee on Aging (as cited in Hoffman, 2005; Saunders, 1978); subsequently, administrators of the U.S. Department of Health, Education, and Welfare formally established hospice care as a viable concept for terminally ill patients and their families (Chakrawarty & Dhanaklashmi, 2013; NHCO, 2015).

Physicians typically made house calls and assessments of patients perceived to be gravely ill; however, physicians offered little regarding psychosocial support, death education, and/or bereavement services to family s (Hoffman, 2005; Joyce, Berman & Lau, 2014; Saunders, 1978). The benefit of social workers and clergy for family s became prominent as the hospice movement expanded to include hospice homecare (NPHCO, 2015; Teixeira, Abreu, Correia, & Costa, 2016). In 1982, Medicare administrators designated social workers and chaplains as critical team members for hospice enrollees and their family s, which remains a modern-day contributor for hospice as a covered entity under Medicare (Hodges et al., 2015; NPHCO, 2015). With Medicare as a payor source and the expansion of home hospice, physician communication about patient preferences, death, dying, and family involvement at the end of life continued to gain momentum (Connor, 1998; Hoffman, 2005; NPHCO, 2015).

Clinical Transition to Home Hospice Care

Although physician communication about death, dying, and family involvement continues to gain momentum, Jackson (2013) discovered that physicians' shift from curative to palliative care is routinely introduced late in the continuum of treatment for terminally ill patients. Some physicians continue to offer aggressive measures for terminal disease, with a focus on prolonging the patient's life in contrast to the patient dying well (Jackson, 2013). Other physicians may not have training in end-of-life care or the proficiency to cope with responses of dying patients and/or family members (Gagle, et al., 2017; Jackson, 2013). Aggressive treatment for terminal disease has historically continued until the prognosis of impending death could no longer be ignored by the physician and/or the patient's family, at which point, some patients transitioned to home hospice care within weeks or days of dying (Jackson, 2013).

The benefit of family s became prominent as many hospital administrators pushed for low occurrences of in-patient mortalities (NPHCO, 2015). The home hospice movement continued to expand to include patients who were discharged from hospital settings with the expectation of rapid decline, often leading to death within weeks or days of discharge (NPHCO, 2015; Teixeira et al., 2016). Teno et al., (2013) reviewed patient decline within the last 180 days of life through random samples of over 800,000 adults and found, on average, that patients entered home hospice care with less than 1 week to live when discharged from inpatient hospital settings. In the context of hospital discharges, home hospice IDT members have a narrow opportunity to work with family cargivers on bio-psychosocial and spiritual stressors, which indicates the importance of social workers' assessment practices of informal s (Jackson, 2013; Reese, 2008).

Family Support Roles and Hospice Care

Roughly 60 million Americans identify as informal s (Joyce et al., 2014). Informal s are often laypersons, with little to no formal education in skilled nursing. However, informal care can be essential to quality of life and symptom management in the final days of life for home hospice enrollees (Given & Reinhard, 2017; Joyce et al., 2014). Many terminally ill patients identify family members as s in conjunction with skilled home hospice providers (Given & Reinhard, 2017; Joyce et al., 2014; Teixeira et al., 2016). Hospice providers strengthen family support roles by educating and providing informal skills training to cos (Hodges et al., 2015; Hoffmann, 2005).

Family cos have multifaceted support roles and frequently require collaboration with hospice staff (Given & Reinhard, 2017; Hoffmann, 2005). Hospice IDT members and advocates for the National Alliance for s recognize the benefits of family support roles as patients near death (Hodges et al., 2015; Teixeira et al., 2016). Patients who elect to die at home depend on cos to use skills at the bedside such as preventing aspiration, medication administration, wound care, prevention of pressure ulcers, and contamination precautions (Teixeira et al., 2016). Cos are informal hospice IDT members who communicate patient needs, adhere to medication regimens, and report and manage behavioral changes at the end of life (Hoffmann, 2005; Joyce et al., 2014).

As cos carry out varying tasks, compassion fatigue, sleep disturbance, as well as emotional, physical, and/or psychosocial distress can be barriers to the s' quality of life (Given & Reinhard, 2017; Tabler et al., 2015). Although family members routinely contribute as informal members of hospice IDTs, formal IDT members recognize the benefit of providing relief to cos (Given & Reinhard, 2017; Hodges et al., 2015). Hospice interdisciplinary members offer support as cos fulfill dual roles within their family systems as informal caretakers as well as family members of dying loved ones (Tabler et al., 2015).

Family Systems and Contemporary Hospice Care

Many home hospice providers underscore family as an extension of the patient (NHPCO, 2015). Contemporary hospice care includes family members as emotional units when presented with end-of-life decision making, crisis, and/or the aftermath of death (Henry, Morris, & Harrist, 2015; Joyce et al., 2014; NHPCO, 2015). Bowen (1978) described family systems as “individuals with automatic and often predictable behavior between family members” (p. 417). However, family cos may find generating automatic responses and/or behaving predictably difficult when caring for terminally ill loved ones, as dying is often a unique experience for patients and cos alike (Giles, 2014).

Hospice care includes meeting the needs of cos as they adjust to the developing needs of dying loved ones, complete tasks relevant to end of life preparation, and experience grief (Giles, 2014; Henry, Morris & Harrist, 2015). Contemporary hospice administrators may recognize that families are networks of relationships that do not necessarily include biological connections (Giles, 2014). Family cos can include members of the nuclear family, and or individuals ascribed as family based on shared experiences – such as groups of military service members and or service member dependents (spouses or children of vets) (Giles, 2014; Henry, Morris & Harrist, 2015; National Military Family Association, 2018). The inner workings of family systems can be difficult to understand; particularly in military families when death of a vet becomes imminent (Giles, 2014). Military families may also face unique challenges in the aftermath of death such as place of burial, military honors, dissolvement of veteran benefits and or who will receive the burial flag at the gravesite (Giles, 2014; Henry, Morris & Harrist, 2015).

Military Family Caregivers (cos)

Vets span multiple generations and eras of service, however, vets with post-traumatic stress, survivor's guilt, and or moral injury, have increased since 2001; largely due to fewer available troops serving multiple combat tours in Afghanistan and Iraq (Averill, et al., 2015; Ramchand, et al., 2014, p. 1). War and death, as well as line-of-duty injuries happen across most eras and branches of service and frequently result in wounded, ill, and or trauma-inflicted service members (Averill, et al., 2015; Ramchand, et al., 2014; NMFA, 2018). Over three million vets utilize medical benefits and receive compensation for disabilities or injuries incurred during duty; however, some vets receive compensation and utilize medical benefits for life-limiting illnesses caused by disease, infection, aging, and or catastrophic accident (Ramchand, et al., 2014). According to the Veteran Health Administration (VHA), vets enrolled in standard medical benefits packages can choose to elect non-government end of life care – including community home hospice care (Wachterman, Lipsitz, Simon, Lorenz, & Keating, 2014; VHA, 2017). Terminally ill vets who opt to die at home are typically motivated to do so in order to receive formal care from hospice s, in conjunction with: (a) informal care, (b) the familiarity of home, and (c) emotional support from most family cos (Empeno, Raming, Irwin, Nelesen, & Lloyd, 2013; NHPCO, 2015; Wachterman, et al., 2014).

Caring for vets at the end of life can come with unique costs for military family cos; terminally ill vets may relay unresolved service-related experiences at the end of life

- some for the first time (Empeno, et al., 2014; Ranchmand, et al., 2014; Prince-Paul, Peerboom & Daly, 2016). Often when vets recount service-related experiences, particularly traumatic experiences, symptoms such as anxiety, restlessness, and or hyper arousal can exacerbate as death nears (Prince-Paul et al., 2016; Ranchmand, et al., 2014, p. 1). Military cos may themselves recount military stressors such as frequent moves, deployments, separations from relatives, culture shock during overseas assignments, and or loneliness; which can exacerbate stress while making end of life decisions for dying vets (Prince-Paul et al., 2016). The act of caring for the can be a useful feature of home hospice care; particularly for military family cos who routinely acknowledge stress and report a need for emotional support more frequently than non-vet cos do (Empeno, et al., 2014; Prince-Paul, et al., 2016).

Family Caregiver Stress

Family members can encounter highly stressful experiences when caring for dying relatives; and may find caregiving particularly difficult to navigate when death is associated with advanced illnesses, disease and or aging (Quinn-Lee, McBride & Unterberger, 2014; van Gennip, et al., 2013). Symptoms of caregiving stress often manifest as psychosocial and psychological indicators such as anxiety, depression, uncontrolled worry, social withdrawal and or isolating behavior (Bevans & Sternberg, 2012; Kim, 2017). Psychosocial and psychological reactions are frequently related to the 's appraisal of the experience and can yield real and or perceived negative outcomes such as increased stress, feeling overwhelmed, and poor self-care while providing informal caregiving (Bevans & Sternberg, 2012, p. 401). For some, caregiving may be labor intensive and stressful experiences can be associated with formal or informal caregiving (Bevans & Sternberg, 2012; Quin-Lee et al., 2014). However, unlike many formal s, informal s may experience psychological, behavioral, and or physiological stress while assisting terminally ill loved ones with daily activities such as: (a) administering medications, (b) transportation, (c) preparing meals, (d) managing finances and or (e) making death preparations while simultaneously navigating emotions associated with loss (Bevans & Sternberg, 2012, p. 400; Prince-Paul, et al., 2016; Quin-Lee et al., 2014). Cognitive signs of stress are regarded by Bevans and Sternberg (2012) to be dire and can include emotional distress accompanied by impaired decision making, chronic fatigue, and or sleep impairment for s. Prolonged symptoms of stress can deteriorate the physical and mental health of family s, which could encumber the quality of end of life care given to terminally ill family members (Kim, 2017; NHPCO, 2017; Quinn-Lee, et al., 2014; Ramchand, et al., 2014).

Typically, military family members experience stress during encounters with deployments and combat-related deaths of service members (Paley, et al., 2013). Thus, Armed Service leaders make efforts to build stress-resiliency in military families through Department of Defense (DOD) resources and government affiliated agencies such as the American Red Cross and military family life counselors (MFLAC) when military families encounter stressful or catastrophic events (Kim, 2017; Paley, et al., 2013). Most combat-related deaths are typically associated with military service and require specialized amenities provided by DOD agencies such as casualty affairs and survivor outreach services. Yet, death due to illness, advanced disease, and or aging is not exclusive to service members and may require specialized end of life care by community hospice providers (Kim, 2017; Ramchand, et al., 2014). Military families who experience stress when caring for dying vets can be largely unaware of the severity of their own end of life support needs; and correspondingly have poor knowledge about restorative benefits that community hospice providers may offer to help manage stress (Bevans & Sternberg, 2012). While stressful events might be inevitable for cos; community hospice providers may be able to identify cos at increased risk for negative outcomes, assess the degree to which the 's life may be adversely affected, and recommend interventions that could attenuate negative caregiving experiences (Bevans & Sternberg, 2012, p. 402). Although co- stress is not unique to military family s, non-DOD hospice IDT members (community hospice IDT members) may utilize assessment tools and or modify interventions to lessen stressors relevant to military families (Kim, 2017).

Access to Home Hospice Care

The number of terminally ill patients who accessed hospice care has increased in the U.S. since 2010 (Henry, Morris & Harrist, 2015; Joyce, et al., 2014; NHPCO, 2015; Wachterman et al., 2013). Most hospice enrollments were primarily non-vets who were Medicare recipients. Non-vets accounted for 83% of hospice care financed under the new 2010 Medicare Hospice Benefit (Teno et. al., 2013; Wachterman et al., 2013). VA administrators began multiple initiatives for vets in response to the disparity in hospice use by expanding access to end of life services, to include home hospice care covered under the Tricare benefit (Jackson, 2013). Tricare medical health benefit primarily utilized by military members, qualified vets and their dependents; and utilized by qualified terminally ill vets in order to access care outside of military treatment facilities (Wachterman et al., 2013).

Under the new comprehensive end of life initiative VA administrations proposed a system that allowed VA staff members to provide, or vets to purchase hospice care. VA nurses and physicians provided inpatient end of life care to accommodate vets facing institutional death; while vets who desired to die at home purchased community-based home hospice services using Tricare as the insurance payor (Wachterman et al., 2013). The concept of *provide or purchase* allowed vets to gain access to end of life care in settings outside of the VA hospital; yet Wachterman et al. (2014) noted access to care outside of VA hospitals contributed to some inconsistencies in supports family cos received.

Inpatient VA staff members provide direct care to terminally ill vets and are often familiar with protocols and service commitments of military families (Hoffmann, 2005). Care received while inpatient at VA hospitals is subject to VA policies and practices with routine oversight by those familiar with needs unique to vets and family members (Wachterman, et al., 2014). In contrast, vets who seek home hospice care are referred by VA physicians to community-based hospice agencies where hospice IDT members may deliver end of life care without guidance or oversite from VA social workers familiar with intricacies of military service, exacerbated symptoms unique to vets, and or stressors unique to military family cos (Hoffmann, 2005).

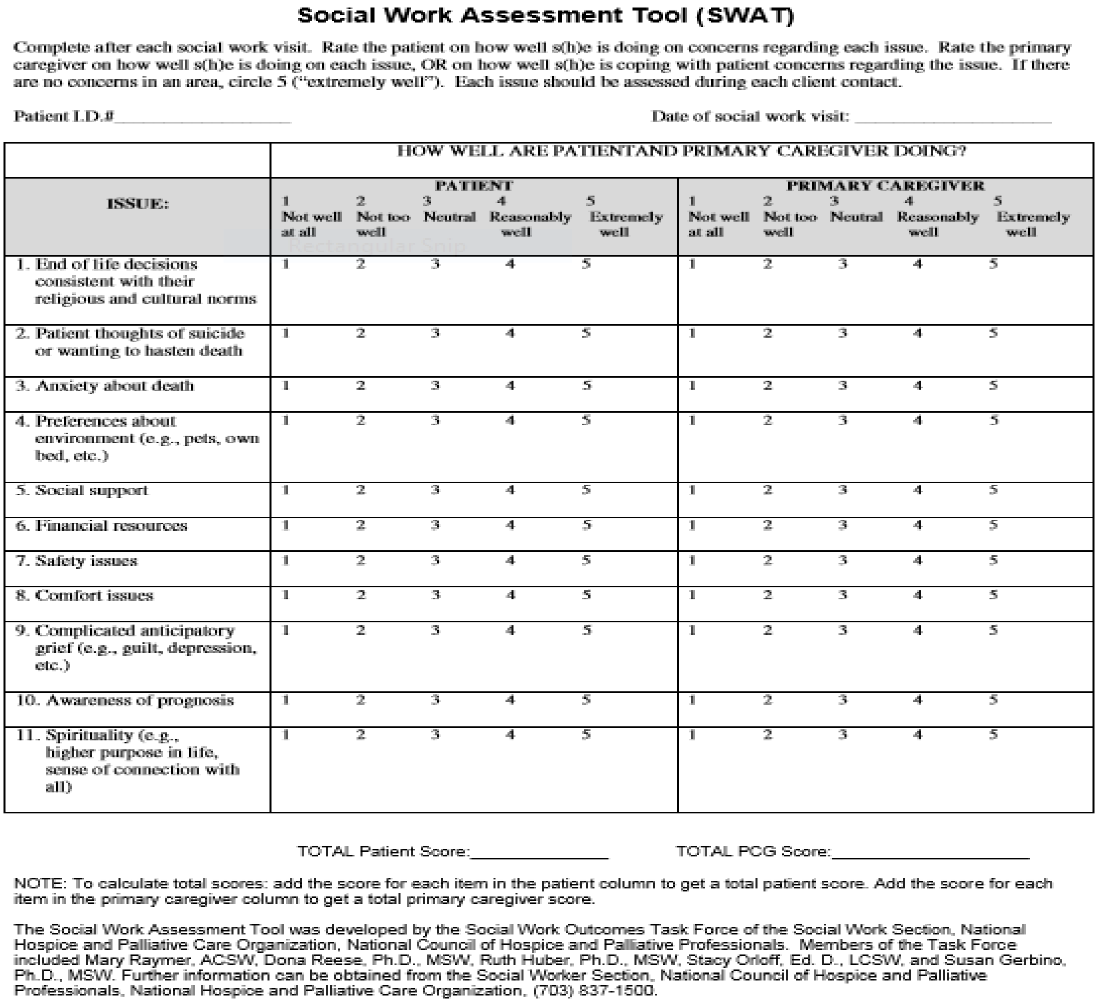
Home Hospice Social Workers

Over 700,000 patients die each year in a hospital setting; yet, when asked, terminally ill patients often express a desire to die in their usual place of residence. One presumable rational is the notion of familiarity at the end of life; thus, home comfort care may be appealing to families when making end of life care decisions (Bailey, et al., 2014; Coldrey, & Wilding, 2015). Home hospice administrators typically rely on HSW members to promote comfort care or hospice care that is patient-centered and holistic, along with the philosophy that the whole family unit is defined as the *hospice patient* (Coldrey & Wilding, 2015; Kim, 2017). Professionals, paraprofessionals, volunteers, and other formal hospice staff ordinarily work together to address needs of dying patients; while identifying co- goals, assessing family stressors, and developing a plan to meet psychosocial and or medical needs of cos are routine tasks specific to HSW team members (Coldrey, & Wilding, 2015).

HSW members frequently promote needs of enrolled families; however, for military families, needs may include obtaining legal, financial, and burial arrangements exclusive to military culture (Barat, 2015; Coldrey & Wilding, 2015). Military family cos who experience increases in stress may solicit support and articulate vet specific needs to HSW members (Barat, 2015). HSW members who understand VA insurance benefits, have some familiarity with military coverage limitations, and comprehend DOD and or VA regulations can help families navigate arrangements specific to dying vets and lessen stressors unique to the culture of military family cos (Barat, 2015; Coldrey & Wilding, 2015). Although the needs of most terminally ill patients and family cos are often related to emotional wellbeing and pain management; many terminally ill vets and family co-'s express needs that align with cultures, customs, and courtesies specific to military service (Barat, 2015; Coldrey & Wilding, 2015). Some military leaders promote the ideology that when military members serve, family members serve too. Thus, family cos may require hospice assessments that illuminate needs inclusive and unique to military families (Coldrey & Wilding, 2015).

Social Work Assessment Tool (SWAT)

Reese, et al., (2006) discovered, while developing the SWAT, that HSW members play a significant role in improving the quality of life (QOL) for hospice enrollees (NHPCO, 2007; Reese et al., 2006). Many HSW members identify interventions and make community or medical referrals for terminally ill patients, the initial steps often involve gathering information, making assessments, and clarifying patient goals (Coldrey & Wilding, 2015; Parker, et al., 2012). HSW members of the NHPCO created SWAT as a guide for HSW providers to identify stressors and subsequent needs of families enrolled in end of life care (Reese, et al., 2006). Reese, et al. (2006) recommended that SWAT be completed by HSW members after each visit with the patient or primary caregiver; scores on the initial visit can be compared with scores on subsequent visits (see Figure 1).



Social Work Assessment Tool (SWAT)

Complete after each social work visit. Rate the patient on how well s(h)e is doing on concerns regarding each issue. Rate the primary caregiver on how well s(h)e is doing on each issue, OR on how well s(h)e is coping with patient concerns regarding the issue. If there are no concerns in an area, circle 5 ("extremely well"). Each issue should be assessed during each client contact.

Patient I.D.#__________________ Date of social work visit: ____________________

	HOW WELL ARE PATIENTAND PRIMARY CAREGIVER DOING?									
	PATIENT					PRIMARY CAREGIVER				
ISSUE:	1 Not well at all	2 Not too well	3 Neutral	4 Reasonably well	5 Extremely well	1 Not well at all	2 Not too well	3 Neutral	4 Reasonably well	5 Extremely well
1. End of life decisions consistent with their religious and cultural norms	1	2	3	4	5	1	2	3	4	5
2. Patient thoughts of suicide or wanting to hasten death	1	2	3	4	5	1	2	3	4	5
3. Anxiety about death	1	2	3	4	5	1	2	3	4	5
4. Preferences about environment (e.g., pets, own bed, etc.)	1	2	3	4	5	1	2	3	4	5
5. Social support	1	2	3	4	5	1	2	3	4	5
6. Financial resources	1	2	3	4	5	1	2	3	4	5
7. Safety issues	1	2	3	4	5	1	2	3	4	5
8. Comfort issues	1	2	3	4	5	1	2	3	4	5
9. Complicated anticipatory grief (e.g., guilt, depression, etc.)	1	2	3	4	5	1	2	3	4	5
10. Awareness of prognosis	1	2	3	4	5	1	2	3	4	5
11. Spirituality (e.g., higher purpose in life, sense of connection with all)	1	2	3	4	5	1	2	3	4	5

TOTAL Patient Score:______________ TOTAL PCG Score:____________________

NOTE: To calculate total scores: add the score for each item in the patient column to get a total patient score. Add the score for each item in the primary caregiver column to get a total primary caregiver score.

The Social Work Assessment Tool was developed by the Social Work Outcomes Task Force of the Social Work Section, National Hospice and Palliative Care Organization, National Council of Hospice and Palliative Professionals. Members of the Task Force included Mary Raymer, ACSW, Dona Reese, Ph.D., MSW, Ruth Huber, Ph.D., MSW, Stacy Orloff, Ed. D., LCSW, and Susan Gerbino, Ph.D., MSW. Further information can be obtained from the Social Worker Section, National Council of Hospice and Palliative Professionals, National Hospice and Palliative Care Organization, (703) 837-1500.

Figure 1. Social work assessment tool. Rese, D., Raymer, M., Huber, R., Orloff, D., Gerbino, S. Social Work Assessment Tool, copyright © 2008, by Social Work Outcomes Task Force. Reprinted by Permission of National Hospice and Palliative Care Organization.

Reese, et al., (2006) conducted research in response to requests from HSW members throughout the nation for a tool to document social work effectiveness, provide measured results, and subsequently identify best practices in areas of major influence on end of life care outcomes - to include family member stress (Krepetis, 2017; NHPCO, 2007). According to Reese, et al., (2006) the hope for SWAT is to be used as part of routine quality assurance activities for hospice and palliative care programs' nationally (Kim, 2017; NHPCO, 2007; Reese et al., 2006). Psychosocial, mental health, and spiritual issues are included in the SWAT for the patient and the primary co- to consider and report to HSW members (Coldrey, & Wilding, 2015; Reese, et al., 2006).

Specific assessments such as SWAT, and how HSW members inform hospice IDT members of the need for intervention on behalf of military family cos may subsequently strengthen the care given to vets at home (Kim, 2017; Reese et al., 2006). During a narrative review of social work skills, Krepetis (2017) discovered an emerging need for qualitative case studies of HSW member techniques, skills, assessments and co-interventions. How hospice IDT members make sense of SWAT and establish collaborative populous specific outcomes can contribute to the effectiveness of an operational tool for vet cos (Coldrey, & Wilding, 2015; Kim, 2017; Reese, et al., 2016).

Hospice Interdisciplinary Teams (IDT)

Most HSW administrators commit to unobstructed access to nursing services as needed by dying patients; however, administrators require hospice patients to have access to registered nurses, as well as social workers, and chaplains (NPHCO, 2015; Weisenfluh & Csikai, 2013). Based on Medicare guidelines, one of the conditions for hospice agencies is that IDT consist of disciplines that differentiate hospice care from routine medical care (Damron-Rodriguez, 2013; NPHCO, 2015; Quinn-Lee, et al., 2014). Each

IDT member utilizes skills and competencies respectively in order to care for families enrolled in home hospice care; yet, the IDT is interdisciplinary by design, with each discipline depending upon the other to provide patient-centered and holistic care (Weisenfluh & Csikai, 2013).

Much of the focus during IDT meetings center on nursing outcomes such as treatment plans, lengths of stay, live discharges, and new admissions (Duner, 2013; Kobayashi & McAllister, 2014; Wesienfluh & Csikai, 2013). Furthermore, time during IDT meetings is seldom allotted to each discipline equally, yet HSW team members frequently contribute to nursing outcomes in tangible ways (Damron-Rodriguez, 2013; NPHCO, 2015; Weisnefluh & Csikai, 2013). HSW team members work within a unique scope of practice to include counseling and psychosocial assessments for patients enrolled in hospice care; yet HSW members' roles within the IDT are frequently blurred and or misunderstood. However, the use of SWAT provides HSW members a way to introduce interventions that could align with nursing outcomes (NHPCO, 2015; Weisenfluh & Csikai, 2013).

Assessment Tools for Military Families

SWAT instrumentation is relatively new - used since 2006 as a quality of care indicator and a measurement of social work outcomes; since 2012, Reese, et al., (2009) modified SWAT to also include a qualitative assessment of end of life needs of family cos (Reese, 2006; Wool, 2015; Weisenfluh, 2012). Thus, HSW members utilize the SWAT tool to assess patient and family physical, spiritual, emotional, and cultural needs (Wilson, et al., 2015; Wool, 2015). However, the integration of SWAT with military populations have been mixed regarding how HSWs and subsequent hospice IDT members make sense of SWAT results in order to meet holistic needs specific to military family cos in the United States (Nelson & Watson, 2013). A review and synthesis of the literature on hospice, military families, social workers, and hospice IDT illuminated the relevance of the need for further exploration of hospice provider assessments of military families (Reese, 2006).

Social work administrators have identified hospice IDT members' scope of practice related to psychosocial and spiritual assessments of veteran patients (Gagle, Sacco & Jacobson, 2017; Nelson & Watson, 2013). Gagle, et al., (2017) described psychosocial assessments conducted by HSW members as crucial components of the full interdisciplinary assessment of hospice IDT care planning; yet, there appears to be notable absence of studies related to the content of SWAT and how hospice IDT members make sense of SWAT results in order to provide culturally specific end of life care and resources for military family systems (Gagle, Sacco & Jacobson, 2017; Wilson, et al., 2015; Wool, 2015).

Summary

Chapter two contained a review and synthesis of the literature on hospice, family systems, and military families, social workers, SWAT, and hospice IDT. The next chapter includes the purpose of the study, research rationale and design, the research question, truth value, unit of analysis, role of the researcher, researcher bias, methodology, sampling, data gathering protocol, data analysis plan, method validity, triangulation, ethical considerations, and the social change implications of the study.

Chapter 3: Research Method

Introduction

A case study was an appropriate approach to explore Tsai's (2003) theory of caregiver stress, which was derived from Roy's (1976) adaptation model as prototypical for family cos. I incorporated Yin's (2017) holistic, explanatory case design in response to a contemporary phenomenon within its real-life context. From a co stress prevention prospective, SWAT emerged in 2006 to assist HSW members to identify and evaluate interventions to enhance caregiver coping when navigating tasks associated with caregiving (Reese, 2006, 2008). Tsai (2003) posited that objective burdens are "duties or tasks associated with caregiving of a person with chronic [and/or terminal disease], such as hours of care and making final arrangements, which may either activate or suppress coping" (p. 139). Suppressed caregiver coping may be tantamount with stress, while activation of coping can be tantamount with resiliency (MacArtney et al., 2014).

I used Tsai's 2003 theory of caregiver stress to guide my data collection and analysis while exploring how hospice IDT members make sense of SWAT results (Yin, 2017). The cultural system of action under scrutiny involved a home hospice agency with hospice IDT members who incorporate SWAT for military families. Using this theoretical lens, in this chapter, I provide a detailed description as to how participants were selected, including the population and sampling strategy used for recruitment and participation in this study. I outline the instrumentation for this study and describe how data were collected through (a) interviews, (b) observations, and (c) a focus group, and I outline how data were analyzed and stored and how they will be destroyed. I also provide a description of how participants were debriefed to include follow-up protocols once interviews, observations, and focus group were completed. I describe the purpose of the study, research design and rationale, research question, truth-value, unit of analysis, role of the researcher, ethical considerations and issues regarding trustworthiness of data, including saturation, validity, and data analysis, and I describe the potential social implications of this explanatory case study.

Purpose of the Study

For this explanatory case study, I examined the assessment practices of home-based HSW members located in a Southwest U.S. urban area. Receiving information related to the end of life as well as support in managing practical and psychosocial issues are often perceived by family members as helpful (Condard, Allen & Armstrong, 2015; Weber & Clark, 2016). The social work assessment is essential to promote end-of-life care that meets the needs of hospice enrollees (Mullane et al. 2009). Because most vets are likely to die in a hospital or a nursing home (Nayer, 2014;), many in-home hospice leadership roles have a limited understanding of the operational tools social workers use to assess the needs of military families enrolled in community home hospice care (Condard, Allen & Armstrong, 2015; Weber & Clark, 2016). Hospice directors are also largely unaware of how hospice IDT members such as hospice nurses, chaplains, case managers, and volunteer coordinators incorporate SWAT results when caring for patients (Mullane et al. 2009). Gathering information about social work assessment practices was important to sustaining hospice services; therefore, I aimed to fill a gap in the literature outlining how hospice IDT members make sense of SWAT to characterize support for military families.

Research Design and Rationale

Quantitative and qualitative research are two types of designs used in various fields such as education, social science, and health science (Antwi & Hamza, 2015). Quantitative studies are appropriate for examining relationships between and among variables, describing trends, attitudes, or opinions of populations, as well as for testing the outcomes of a treatment or intervention (Yates & Leggett, 2016). The role of the researcher in a quantitative study is to remain distant and independent of what is being researched; conversely, in qualitative research designs, the researcher is aware of the socially constructed nature of reality and is embedded intimately in the context of the study (Yates & Leggett, 2016). I considered quantitative research such as survey, correlational, and experimental designs; however, these did not align with purpose of this study. I discovered that although quantitative analysis allows for a high degree of precision in research, Yates and Leggett (2016) suggested that quantitative designs represent a 2-D view of findings as compared to rich, deep descriptions offered by a qualitative approach. Other important differences include sample size, methods of data collection, analysis, and interpretation (Yates & Leggett, 2016).

Yin (2017) suggested explanatory case study to explain presumed casual links (or propositions) that are too complex for surveys or experimentation. Baskarada (2014) described the explanatory qualitative approach as “the preferred research method when *how and why* questions are posed, the investigator has little control over events, and the focus is on an existing issue within a real-life context" (p. 3). In view of this approach, I conducted seven interviews, made two observations of IDT meetings, and conducted a focus group to gather themes and patterns as they emerged related to casual links (propositions) concerning hospice IDT members' use of SWAT for military family cos. I explored how hospice IDT members make sense of SWAT through thematic and propositional analyses to build inferences about the data. I sought to gain an understanding by looking for themes and patterns and used propositional analysis to answer the research questions.

Research Questions

I used the following questions to guide the research process:

RQ1: How do hospice IDT members make meaning of SWAT when characterizing support needs for military families?

RQ2: How do hospice IDT members' SWAT-related activities corroborate, extend, or dispute SWAT for military family Caregivers?

Research Tradition

For this study, I used a qualitative approach with an explanatory case study design. Yin (2017) relayed that case studies can be useful in capturing everyday practices within organizations, emergent and/or changing priorities, and participatory meanings. Explanatory case studies should be accurate, and a conclusion should be drawn based on explanations that appear congruent with the facts (Yin, 2017). Thus, I used Tsai's (2003) theory of stress as a basis for gathering information to address the gap in literature related to nonmilitary home hospice assessment practices and to answer the research in the context of how hospice IDT members make meaning of SWAT results when characterizing needs of military family cos. To do so, I sought information from hospice IDT members regarding their experiences with SWAT use to understand how and why hospice IDT members determine, offer, and/or provide support in order to make referrals unique to military family cos in a real-world setting (see Yin, 2017). Researchers use the explanatory case study method to increase understanding of presumed casual links rather than to give conclusive evidence (Yin, 2017), which supported my rational for the use of an explanatory case study to illuminate how and why decisions regarding end-of-life supports were made and implemented by IDT members who used the 11 elements of SWAT (See Figure 1).

Yin (2017) suggested that an explanatory case study be used to explain presumed casual links (or propositions) that are too complex for surveys or experimentation; thus, I acted as the research tool during this study and used multiple data collection methods. I conducted interviews, made observations, and conducted a focus group to gather themes and patterns as they emerged related to SWAT use on broader and under similar circumstances (military families) in order to answer my research question (see Yin, 2017).

According to Baskarada (2014), an important strategy is to follow the theoretical propositions that lead to the case study, therefore, I used propositions and alternate propositions to focus on relevant data and organized my study, which aligned with Yin's (2017) intent for an explanatory case. However, Castleberry and Nolen (2018) suggested that data cannot speak for themselves and should be interpreted, and analytical conclusions are drawn from data first as codes, then as themes. As the analyst, I also used a thematic analysis through common occurrences of ideas, words, sentences, and phrases. Baskarada (2014) postulated that “any meaningful patterns and categories in explanatory qualitative data need to first be identified by the analyst…and scholars should express strong caveats about any use of computer-assisted tools” (p. 15). For this explanatory case study, I interpreted themes according to propositions and alternate propositions. Castleberry and Nolen suggested that “qualitative data analysis software is particularly useful in developing data visualizations in the form of code clusters” (p. 812).With that in mind, I used NVivo software as an automated aid to (a) search for themes, (b) categorize propositions, and (c) identify code clusters (patterns) as they emerged from interview transcripts, observations, and focus groups.

Propositions

Propositions are necessary and “the most important strategy is to follow the theoretical propositions or hypotheses that led to the case study” (Baskarada, 2014, p. 15). Tsai’s (2003) theory of caregiver stress included the explanatory basis for the following propositions:

HSW member assessments should

1. Characterize objective burdens, stressful life events, social supports, and social roles of family cos.
2. Include barriers faced by family members when caring for a chronically ill vet.

Some alternative propositions that arose in this study about Tsai’s (2003) theory of caregiver stress are as follows:

1. scope of practice informed the cognitive appraisal of objective burdens, stressful life events, social supports, and social roles.
2. The relationship between hospice IDT members and military service influenced the response and or services offered.

The appraisal of stress is an individualized response and a multifaceted concept in the context of caregiving (Leung, 2015; Yazan, 2015). Yin (2009, 2017) suggested that an explanatory case study should benefit from prior development of theoretical propositions. I used existing literature as a foundation for guiding the truth-value of the data.

Truth Value

The truth value refers to the practical application of the lens I used to make sense of the research data about SWAT use for military family caregivers. Yates and Leggett (2016) offered that qualitative researchers should be aware of the socially constructed nature of reality, be reflective practitioners, be aware of their own cultural perspectives, and be willing to engage in self-questioning and self-understanding. By using a pragmatic worldview, my assumption was that first-hand experiences of hospice IDT members may add meaning to and shape the reality of SWAT assessments used for military family cos (see Yates & Leggett, 2016). For this explanatory case study, I sought to understand the pragmatic application of SWAT for military family cos in order to corroborate, extend, or refute SWAT use for military cos (see Zambrano, Chur-Hansen, & Crawford, 2013).. My pragmatic ontology affected the analysis and interpretation of data and modulated how I, as the sole searcher-analyst, made sense of the research data.

Self-proclaimed pragmatists, Sullivan and Miller (2015) posited that significant and healthy relationships are rewarding when reciprocal and mutual; yet caregiver stress occurs when there is an unequal exchange of assistance among people who stand in close relationship to one another. Llanque et al. (2016) posited that caring for someone with a chronic illness can lead to decreased quality of life and psychological health, and increased stress. Over time, caregiving can be daunting, emotionally, physically challenging and isolating (Llanque et al., 2016). Cos who take care of other adults, are most often parents or spouses of aged, disabled, and or ailing family members; yet cos differ in their perceptions of caregiver stress (Llanque et al., 2016). Further, Llanque et al. (2016) posited that attributes of stress are related to "decreased levels of cognition in the care receiver, changes in behavior, poor support for the and the routine needs of the care receiver over time…along with socially embarrassing problems associated with caregiving" (p. 25). The following section contains the unit of analysis for exploring a program intended to assess co- needs.

Unit of Analysis

This explanatory case study included ten members of the home hospice IDT located at Blue Oceans Hospice[1]. Further, the boundaries around the unit of analysis include staff members who participate in IDT meetings and use SWAT as an assessment tool. (Pizzi, 2014; Yazan, 2015). This home hospice agency is in an urban city in Midwest Texas. Staffing for the hospice IDT included: (a) home hospice social worker

(b) nurses and nursing assistants (c) a case manager (d) a volunteer manager, (e) a hospice chaplain, and (f) the director of patient services. The staff focused on meeting medical, mental, spiritual, and psychosocial needs of patients and family cos during hospice IDT meetings. The utility of SWAT from the users' perspectives provided useful information as hospice providers made sense of, characterized, and communicated the support needs of military families enrolled in home hospice care.

Role of the Researcher

I acted as an instrument of data collection during this explanatory case study (Bahrami, Soleimani,Yaghoobzadeh, & Ranjbar, 2015; Yin 2017). As the researcher, I had little control over events; yet my focus was on trends, patterns, and inferences that occured within a real-life context until I reached inductive findings (Baskarada, 2014; Yin, 2014). I gathered findings in a real-world setting of participants; and I analyzed data gathered, offered findings, and debriefed participants according to ethical standards (Bahrami, Soleimani,Yaghoobzadeh, & Ranjbar, 2015; Yin, 2017). As researcher-participant I asked questions, then listened, then asked additional questions to build deeper conversations and I explored ideas, perspectives, and experiences (Bahrami et. al, 2016; Cope, 2014).

Researcher Bias

Bias is a crucial factor to be aware of when acting as the data collection tool (Cope, 2014). As researcher-scholar, I exerted little control over events, and I focused on trends, patterns, and inferences that occurred without manipulating results (McLachlan & Garcia, 2015). I sought to remain objective as I analyzed data, avoided diverging relationships, and I avoided conflicts of interest with participants during the study and when offering a debrief of the study.

Explanatory Case Study

Yin (2017) defined an explanatory case study design as a contemporary phenomenon within its real-life context relevant to how and or why questions, and relies on multiple sources of evidence, and data needing to converge in a triangulating fashion. The choice of methodology is appropriate for answering research questions, and the research design is valid for the methodology (Lueng, 2015). With this in mind, the research questions and the design of the study aligned to support Yin's suggestion that an explanatory case study be a method of inquiry, bounded by time, in which I offered propositions and alternate propositions in order to examine in depth a program over the course of three weeks (Dando & Chiverton, 2014). Yates and Leggett (2016) proposed qualitative researchers are embedded intimately within the study, to include the research setting and when collecting data. I, as the sole data analyst, was embedded within each data collection type; therefore, in the subsequent sections, I addressed the data gathering protocol and sampling. Each data collection type is different and required a predetermined protocol for gathering information to corroborate, extend, or dispute SWAT use for military cos.

Sampling

For this explanatory case study, I utilized criterion sampling in order to explore how hospice IDT members make meaning of SWAT when characterizing support needs for military families enrolled in home hospice care (Marrelli, 2015; Yin, 2017). Criterion sampling involved selecting cases that meet predetermined criteria (Guetterman, 2015; Yin, 2009). Palinkas, et al. (2015) defined criterion sampling as purposeful and widely used in qualitative research, particularly with case studies, to identify and select information-rich cases related to the phenomenon of interest. I used criterion sampling for this explanatory case study, and I included members of a IDT who participated in IDT meetings and use SWAT during HSW assessments with military families enrolled in home hospice care as the criterion of importance for the unit of analysis (case sample). Criterion for family cos included participants who resided with and provided care for terminally ill vets enrolled in home hospice (Pizzi, 2014; Yazan, 2015). For the purpose of this study, a vet was someone who previously served on active duty, reserve, or National Guard in the military; a service member retiree; or active duty service member enrolled in home hospice. The sampling of this explanatory case study included: (a) a home hospice social worker (b) four nurses and two nursing assistants (c) a case manager (d) a volunteer manager, (e) a hospice chaplain, and (f) the director of patient services as outlined in Table 1.

Table 1

IDT Participants

Sample	Data collection	Purpose
Nurse, nursing assistant, volunteer manager, chaplain, director of patient care services, and case manager	Interviews & observations	To determine how and why participants make sense of SWAT-related activities
Nurse, nursing assistant, volunteer manager, chaplain, director of patient care services, and case manager	Interviews	To explore activities of daily living offered by support staff to support military family cos.
Nurse coordinator, nurse, community coordinator	Focus group	Develop themes and patterns associated with SWAT use to determine how and why nurses make sense of SWAT-related activities

Data Gathering Protocol

I gathered data from multiple sources to capture the complexity and entirety of case study findings. I included multiple sources of evidence, and converged information in a triangulated fashion (Yazan, 2015; Yin, 2017). Yin (2017) advocated for the use of qualitative evidentiary sources as instrumental. The data sources I used to answer research questions in this explanatory case study included open-ended interviews with hospice administrators and staff; a nurse focus group; and observations of two hospice IDT meetings. Therefore, I utilized the following data gathering protocol:

- Step 1: I obtained a list of local community base home hospice agencies located in an urban city in Midwest Texas; with the understanding that hospice is specialized end of life for those dying of advanced illness, aging, disease, and or infection (Prince-Paul, Peerboom & Daily, 2016).
- Step 2: I reached out via email to hospice directors and inquired if they had staff members who (a) provide end of life services to vets, (b) participate in IDT meetings and (c) use SWAT as a needs assessment tool (See Appendix A).
- Step 3: Once I located a hospice staff who met the criteria outlined in steps 1 and 2, I gained permission by obtaining a digitally singed letter of cooperation via email (See Appendix B) for the hospice agency to participate in the study via interviews, observation of two hospice IDT meetings, and a focus group.
- Step 4: Once I receive the letter of cooperation, I provided a letter of confidentiality where I outlined the (a) use of the research data, (b) publications, (c) sharing, (d) safeguarding personal identifiable health information (PHI), (e) archiving, and (f) the destruction of research data (See Appendix D).

- Step 5: I posted two flyers concerning research interviews and the focus group in a conspicuous area to inform participants of the purpose and questions to be asked. (See Appendix D).
- Step 6: Once permission was granted, and the research flyers were posted, I coordinated dates for observations to be made during the weekly hospice IDT meetings.
- Step 7: I observed 2 weekly hospice IDT meetings (See Appendix I).
- Step 8: Once observations of both meetings were made. I consolidated the names of potential interview and focus group participants; and I provided consent forms for those who wish to participate in interviews and focus group (See Appendix B).
- Step 9: Once consent forms were received, I scheduled telephone interviews, and a face to face focus group.
- Step 10: I conducted interviews by phone (See Appendix C).
- Step 11: I facilitated a focus group using zoom technology (See Appendix F).
- Step 12: I analyzed the data collected from each method.

Data types for recruiting, sampling and analysis differed, thus the following sections include the considerations I utilized for recruitment, sampling, and analysis. Since each data collection type was different and required a predetermined protocol for gathering information, I included the following sections to outline the protocol I used for: (a) participant observations, (b) interviews, and (c) a focus group.

Participant Observations

Participant-observation refers to observation where the researcher is “not purely a passive observer, but an active participant in the events being studied” (Baskarada, 2014, p. 9; Yin, 2017). Observation is a chance for the observer-participant to gain insight into an organization or social group (Yazan, 2015; Yin 2017). Observation involves participating in a situation, while simultaneously recording what is being observed (Yazan, 2015; Yin, 2017). For this explanatory case study, I acted as observer-participant by attending two hospice IDT meetings via zoom technology. I took notes on a pre-printed observation log to address 11 sub-categories associated with SWAT use in order to address the research question pertaining to how hospice IDT members make sense of SWAT when characterizing the support need of military families (Reese, et al., 2006).

Observation Sampling

The unit of analysis (case sample) included home hospice providers from one organization located in an urban area of the Southwest United States. Participants were designated hospice IDT members routinely involved in IDT meetings and examine the 11 SWAT subsets outlined during HSW assessments with military families enrolled in home hospice care.

Permission

Proceeding participant observations, I obtained access to observe hospice IDT meeting activities by sending an email to the executive director of Blue Oceans Hospice[1] outlining the nature and purpose of the study, along with a request to conduct two formal observations of hospice IDT participants (See Appendix A). Once permission was granted, I was given an access codes to attend both hospice IDT meetings and made observations, which took place over the course of 6 hours. Proceeding my initial observation, I drafted and posted a flyer describing the research for Blue Oceans Hospice[1] staff and I offered an overview letter about the research purpose. The flyer and letter were emailed to the research coordinator (assigned by the executive director). The flyer and letter were emailed to all participants prior my observation of both hospice IDT meetings. My intent of providing the letter and memo was to inform participants of my presence during the hospice IDT meetings.

Observation Data Collection

Prior to the start of each hospice IDT meeting I arrived in the zoom meeting room 5 minutes prior to the start time. I greeted participants as they arrived in the zoom meeting room. Once everyone arrived, I offered a formal introduction and a reminder that I was seeking to simply observe during their meeting. During observations, I filled in my pre-printed observation log and I categorized discussions as they aligned with each of the 11 SWAT subsets. I paid attention to the perceptions expressed and actions taken across categories related to SWAT use for military families as outline in Appendix I. I acted as observer-participant by executing the form. In addition, I made notes on routine occurrences, perspectives, and patterns that were not categorically congruent with the pre-printed log as they emerged.

Interviews

Interviews provide information through the perceptions of the interviewees or informants (Fusch & Ness, 2015; Yin, 2017). Open-ended interviews include procedures associated with using lived experiences as evidence (Peter & Holcomb, 2015; Yin, 2017). For this explanatory case study, I elicited insight, opinions, and perceptions from hospice IDT member informants to address the research question pertaining to how hospice IDT members make sense of SWAT when characterizing the support need of military families. Interview participants included two certified nursing assistants, a social worker, a chaplain, a volunteer manager, a case manager, and a director of patient services. (See Table 1).

Interview Sampling

The unit of analysis (case sample) includes home hospice providers from one organization in an urban setting, located in the Southwest United States; who are designated hospice IDT member participants in routine IDT meetings and use SWAT during HSW assessments with military families enrolled in home hospice care. Once permission was granted from the executive director, I emailed potential staff participants, using a standard script (See Appendix B) and I outlined the nature and purpose of the study prior to the start of each interview. Interviews occurred over the phone for those who agreed to participate.

Informed Consent

I proceeded each interview by consenting each interviewee to act as a research participant. As the researcher-analyst, I protected anonymity and participant confidentiality by assigning pseudonyms and developing codes indeterminate to others. I provided the purpose of the research, potential benefits, harm, and right to opt out at any time without consequence. I obtained written acknowledgement prior to starting the interview and participants had the chance to ask questions and seek clarification prior to the interview. Afterwards, I invited interviewees to review the transcripts for accuracy, and I modified the transcripts to promote anonymity and confidentiality of all interviewees. Each participant received a signed copy of their consent.

Interview Data Collection

I was the instrument obtaining information with the use of an audio tape recorder to promote accuracy. I asked informants to characterize the use of SWAT when caring for military families utilizing semi-structured *how and why* interview questions (See Appendix D). Interviews allowed for interactive dialogue, which was transcribed before data analysis (Fusch & Ness, 2015). Data collected during interviews contained originating dialog from the interview related to the use of SWAT relevant to staff member roles and or responsibilities.

Focus Group

Focus groups allow researcher-facilitators to collect information, facilitate interactions among designated group members within the context of lived experiences and perceptions (Yin, 2014). Findings in case studies are “more likely to be more convincing and accurate if they are based on several different sources of information, to include focus groups” (Baskarada, 2014, p. 9). For this explanatory case study, I facilitated a focus group and collected in-depth descriptions that included information for addressing the research question pertaining to how hospice IDT members make sense of SWAT when characterizing the support need of military families.

Focus Group Sampling

The criterion of importance for the unit of analysis (case sample) included a home hospice nurse, a community liaison, and a nurse coordinator from one home hospice organization located in an urban area of the southwest United States. Fucsh and Ness (2015) recommended that a focus group be small enough for members to talk comfortably yet represents diversity. Group participants for this study included a nurse, a nurse coordinator, and a community liaison – all who routinely incorporate the 11 subsets of SWAT when caring for community-based home hospice care. Fucsh and Ness (2015) posited that "a focus group interview is a flexible, unstructured dialogue between the members of a group and a facilitator/moderator that meets in a convenient location" (p. 1410). Thus, I promoted unstructured dialoged I conducted the focus group utilizing face to face zoom technology as designated by the executive director of operations at Blue Oceans Hospice[1]

Informed Consent

Prior to facilitating a focus group, I contacted participants via email and offered a flyer that outlined a brief overview of the study (See Appendix D). Prior to the start of the focus group I offered informed consent to group participants, gave participants an opportunity to ask questions about the study and addressed any concerns about their participation in the group. Each participant received a signed copy of their consent.

Data Collection

I acted as researcher-facilitator for one focus group. The focus group lasted approximately 60 minutes and consisted of a home hospice nurse, a community liaison, and a nurse coordinator. The focus group took place using face to face zoom technology as requested by at Blue Oceans Hospice[1] executive director. The first 15 minutes consisted of introductions, a brief overview of the study, and purpose of the focus group. During the next 15 minutes the elements of SWAT were introduced as the primary focus for discussion (See figure 1) (Fusch & Ness, 2015; Reese, et al., 2003; Yin, 2014). As researcher- facilitator I used the remainder of the time to facilitate a flexible discussion of each element of SWAT. I utilized the outline at Appendix K as an outline to the steps I took as the data emerged. I sought accuracy of focus group dialogue by encouraging participants to type their responses in the zoom chat box after discussing each element. in zoom to categorize and extract data. Participants were asked about: (a) activities associated with their role; (b) most common need unique to military family cos; and (c) interventions offered according to their respective scope of practice. During the final 5 minutes I used member checking to seek verification of meaning from group members by inviting them to review their contributions in the chat box for accuracy. Once member checking was complete, I copied and pasted the transcribed answers into a separate sheet to use during data analysis.

Data Analysis

Castleberry and Nolen (2018) suggested that data cannot speak for themselves and should be interpreted and analytical conclusions drawn from data - first as codes, then as patterns, and ultimately as themes. Thus, as the analyst, I used a thematic analysis through common occurrences of ideas, words, sentences, and phrases. Baskarada (2014) postulated that “any meaningful patterns and categories in explanatory qualitative data need to first be identified by the analyst…and scholars should express strong caveats about any use of computer-assisted tools" (p. 15). Yet, Castleberry and Nolen (2018) proposed that "qualitative data analysis software is particularly useful in developing data visualizations in the form of code clusters" (p.812).With that in mind, I utilized NVIVO software to search for and code patterns as they emerge from verbatim transcripts, observations, and focus groups; yet I was the instrument to interpret emergent themes according to my propositions and alternate propositions. I incorporated pattern matching analysis to build inferences about the data, and I identified themes, patterns, and used propositional analysis when coding. I teased out themes and patterns and listed them vertically. I replicated this process until (a) no new themes or patterns emerge, (b) no further coding is feasible (thematic analysis), (c) emergent information related to my propositions and or alternate propositions are exhausted. After the fourth run of NVivo no new themes or patterns emerged, no further coding was feasible (thematic analysis), and emergent information related to my propositions and or alternate propositions were exhausted, (propositional analysis); which informed my conclusion that the study can be replicated.

Method Validity

Leung (2015) proposed that validity in qualitative research means appropriateness of the tools, processes, data; and the choice of methodology be appropriate for answering the research question. Furthermore, Yazan (2015) proposed that method validity be offered through multiple sources of information or triangulation, along with member checking. However, Leung (2015) relayed that " any work of qualitative research, when read by the readers, is always a two-way interactive process, such that validity and quality has to be judged by the receiving end too and not by the researcher end alone" (p.327). I demonstrated soundness of the research findings through triangulation of data, data saturation techniques, replicability of my study, and I offered strengths and weaknesses for each data collection method to include: (a) open ended questions, (b) participant observations, and (c) a focus group. The following section includes strengths and weaknesses of each data collection technique.

Open-Ended Interviews

Yin (2009; 2014) offered documentation such an interview is "one of the most important sources of case study information" (p. 106). As noted by Alshenqeeti (2014), interviews should "flow naturally, and be rich in detail" (p. 41). Yet interviews pose both strengths and weaknesses for this explanatory case study as outlined in Table 2.

Table 2

Open-Ended Interviews Evidence

Strengths	Weaknesses
Targeted directly on case study topics	Bias due to poorly articulated questions
Bias due to poorly articulated questions	Potential for subconscious bias
Insightful casual inferences and explanations	Never 100% anonymous
Potential for subconscious bias	Potential for inconsistencies
Never 100% anonymous	Time-consuming
Potential for inconsistencies	
Time-consuming	
Fewer incomplete answers	
Controlled answering order	
Relatively flexible	

(Alshenqeeti, 2014; Dornyei, 2007; Ho, 2006; Yin, 2009)

Open-ended interviews provide additional strength to this explanatory case study through accessing information such as opinions and perceptions of informants (Alshenqeeti, 2014; Yin, 2014). For case studies, the most important use of interviews was corroboration in a natural and socially acceptable way to collect information. I used semi-structured interviews and I asked multiple participants the same questions. Furthermore, I used informant-participant opinions and perceptions obtained during this explanatory case study to corroborate and augment evidence from other sources (Yin, 2014).

Reliability

This study was replicable, in that a third party can conduct this study in my absence. The interview protocol was replicable and able to be utilized by a third party. Thus, the study is reliable (Yin 2017).

Participant Observations

Yin (2009) offered that case studies "should take place in the natural setting in order for the observer to create the opportunity for direct observation" (p. 109) and analyze non-verbal components of observations (Cope, 2014). Yet, during participant observations there are strengths and weaknesses as outlined in table 3.

Strengths	**Weaknesses**
Reality – covers events in real time	Time consuming
Contextual – covers context of the "case"	Selectivity – Observers often act in roles that may interfere with the natural progress of events
Insightful into interpersonal behaviors and motives	Reflexivity – Event may proceed differently because it is being observed.
	Interviewee gives what the interviewer wants to hear
	Cost – Hours needed by human observation
	Bias due to participants and observer's manipulation of events

(Yazin, 2015; Yin, 2009)

Table 3 *Participant Observation Evidence*

Participant observation process contributed to scientific understanding of individuals, groups, and organizational behaviors (Cope, 2014). Observation involves participating in a situation, while simultaneously recording what is being observed

(Yazan, 2015; Yin, 2014). Yet, I as the participant-observer was mindful of the difficultly to enter the observation with a mental blank slate; therefore, I followed a set protocol to include being aware of any bias I has prior to the observation; I identified expectations based on prior research; I set aside personal experiences as a nurse, and I acknowledged my pre-existing assumptions (Cope, 2014).

I also utilized participant observation logs to address Tsai's (2003) theory of caregiver stress. I used observation as a supplement to interviews, which allowed me to investigate participants' external behaviors, internal beliefs, and practices related to SWAT use. Participant observations, unlike interviews, were used to offered information suitable for discovering and developing theoretical inferences. In response my propositions- as participant-observer I kept subjectivity to a minimum while I collected data (Mclachlan & Garcia, 2015).

Reliability

This study was replicable. The use of an observation protocol was readily replicable; therefore, the study was reliable (Yin,2017).

Focus Group

Researcher-facilitators use focus groups to facilitate interactions among designated group members within the context of lived experiences and perceptions while managing existing relationships with strengths and weaknesses as outlined in table 4. (Ochieng, Wilson, Derrick & Mukherjee, 2018; Yin, 2017).

Strengths	Weaknesses
Targeted – focuses directly on "case" study topics	Selectivity
Useful for exploring ideas	Availability
Quick turnaround time of information	Reflexivity – Interviewee gives what the interviewer wants
Insightful – Provides perceived casual inferences and explanations	Inaccuracy due to poor recall
	Analysis of data can be time consuming
	Group think

(Baskarada, 2014; Ochieng, Wilson, Derrick & Mukherjee, 2018; Yin, 2017)

Table 4 *Focus Group Evidence*

Focus groups can generate ideas formed within a social context and require time and attentiveness from the facilitator-researcher (Ochieng, Wilson, Derrick & Mukherjee, 2018; Yin, 2014). The focus group added another source for data collection that led to discoveries of perspectives and lived experiences not explored during the one on one interviews or observations (Baskarada, 2014, p. 9; Yin, p. 116, 2009).

Reliability

This study was replicable. The use of a focus group protocol was easily replicable; therefore, it was a generally reliable source of data collection (Fusch & Ness, 2015; Yin, 2017).

Triangulation

I obtained an in-depth understanding of an issue, event, or phenomenon in a natural real-life context to answer the research questions which increased the internal validity of this explanatory case study (Yin, 2014). I employed data triangulation through the use of difference sources of data, which included collecting data at different times, in different places, and I observed, interviewed, and facilitated a focus group with different participants who hold different credentials. Data triangulation allowed me to compare information generated from multiple data sources (Wilson, 2014). I took notes throughout the research process; and I collected multiple sources of evidence using qualitative techniques (Yin, 2014). Furthermore, I conducted member checking with respondents to promote accuracy of interview transcripts and the focus group to increase the internal validity of this explanatory case study (Yin, 2017).

Ethical Considerations

Once IRB permission was granted and I obtained my IRB number (2020.05.2920:03:13-05 00) I sought permission from the executive director of my research partner prior to conducting observations of hospice IDT members. For interviews and focus groups, participants were consented and informed that they could withdraw from the study at any time. Participants in interviews were encouraged to check transcripts for accuracy. I modified names and other identifying data using role substitutes to protect the identity of participants (e.g. Participant 1, Participant 2). For written documentation, I did not seek personally identifiable health information of hospice enrollees and redacted or obscured any PHI at every stage of my study. I used role substitutes to maintain confidentiality of individuals and entities. For observations, I modified identifying information in case study notes and reports using role substitutes. Furthermore, I processed data on my password protected personal laptop and maintain the study along with focus group transcripts, observation logs, and any personal notes on a removable thumb drive. I secured research data in a lockable home cabinet in which only I have access. I secured audio recordings in a lockable home cabinet in which only I have access. I notified participants that I will destroy analytical notes, recordings, and transcripts three years after publication of this study. I also conducted an exit debriefing via email to interview and focus group participants (See Appendix H). Finally, I offered a summary of the findings to the executive director once I concluded the study.

Social Change Implications

The potential implications for positive social change that are consistent with and bounded by the scope of this study include (a) increase hospice administrators' understanding of the operational tools social workers use to assess the needs of military families enrolled in community-based hospice care, (b) inform community-based HSWs of unique needs associated with end of life care for military family cos and aide HSWs to increase, sustain, or implement relevant holistic care for vets at the end of life, (c) aide HSWs and nursing staff to characterize objective burdens, stressful life events, social supports, and social roles of military cos, and (d) provide references for hospice IDT members to identify barriers faced by family members when caring for a chronically ill relative (Condard, Allen & Armstrong, 2015; Weber & Clark, 2016).

Summary

This chapter contained the purpose of the study, research rationale and design, the research question, truth value, unit of analysis, role of the researcher, researcher bias, methodology, sampling, data gathering protocol, data analysis plan, method validity, triangulation, ethical considerations, and the social change implications of the study. Chapter four contains findings and the results of this study.

Chapter 4: Results

Introduction

This chapter contains findings of an explanatory case study along with my interpretations and analytical conclusions drawn from thematic analysis of common occurrences of ideas, words, sentences, and phrases within the data; along with propositional analysis that I derived from Tsai’s 2003 theory of stress. Yin (2017) defined an explanatory case study design as a contemporary phenomenon within its real-life context relevant to how and/or why research questions. Therefore, the purpose of this explanatory case study was to understand how hospice IDT members make sense of SWAT to characterize the needs of military families and to corroborate, extend, or refute SWAT use for military co-s. This chapter contains (a) results, (b) setting (c) demographics, (d) data analysis, (e) evidence of trustworthiness, and (f) summary.

Setting

Each interview, one focus group, and an observation of two IDT meetings took place face during normal business hours. Interviews were conducted by phone, and the focus group as well as my observation of two IDT meetings took place using Zoom face-to-face technology. Participants were hospice IDT members who provided care to military families enrolled in community-based home hospice. No participant indicated that they had any conditions that would influence their responses. There were no barriers to accessing participants for the study.

Demographics

Participants were staff members of Blue Oceans Hospice[1] located in a rural southeast region of the United States. Demographics for observations included Blue Oceans Hospice[1] IDT meetings where military families enrolled in home hospice care are discussed by healthcare members. The demographics for interviews included (a) one social worker, (b) two nursing assistants, (c) one registered nurse (RN) case manager, (d) one volunteer coordinator, (e) one hospice chaplain, and one RN director of patient services. The focus group included (a) one community liaison, (b) one RN intake coordinator, and (c) two RNs.

Data Collection

I gathered data from multiple sources to capture the complexity and entirety of case study findings. I included multiple sources of evidence and converged information in a triangulated fashion (see Yazan, 2015; Yin, 2017). Yin (2017) advocated for the use of qualitative evidentiary sources as instrumental. The data sources I used to answer the research questions in this explanatory case study included open-ended interviews with hospice administrators and staff, a nurse focus group, and observations of two hospice IDT meetings. Therefore, I used the following data gathering protocol:

- Step 1: I obtained a list of local community-based home hospice agencies located in a rural southeast area in the United States, with the understanding that hospice is specialized end of life for those dying of advanced illness, aging, disease, and/or infection (see Prince-Paul et al., 2016).

- Step 2: I reached out via email to hospice directors and inquired if they had staff members who (a) provided end-of-life services to vets, (b) participated in IDT meetings, and (c) used SWAT as a needs assessment tool (See Appendix A).
- Step 3: Once I located a hospice staff who met the criteria outlined in Steps 1 and 2, I gained permission by obtaining a digitally singed letter of cooperation via email (See Appendix I) for the hospice agency to participate in the study via interviews, observation of two hospice IDT meetings, and a focus group.
- Step 4: Once I received the letter of cooperation, I provided a letter of confidentiality where I outlined the (a) use of the research data, (b) publications, (c) sharing, (d) safeguarding personal identifiable health information, (e) archiving, and (f) the destruction of research data (See Appendix C).
- Step 5: I posted two flyers concerning research interviews and the focus group in a conspicuous area to inform participants of the purpose and questions to be asked. (See Appendix D).
- Step 6: Once permission was granted and the research flyers were posted, I coordinated dates for observations to be made during the weekly hospice IDT meetings.
- Step 7: I observed 2 weekly hospice IDT meetings (See Appendix I).
- Step 8: Once observations of both meetings were made, I consolidated the names of potential interview and focus group participants, and I provided

consent forms for those who wished to participate in interviews and a focus group.

- Step 9: Once consent forms were received, I scheduled telephone interviews, and a face-to-face focus group.
- Step 10: I conducted interviews by phone (See Appendix D).
- Step 11: I facilitated a focus group using Zoom technology (See Appendix G).

Data Analysis

I used a thematic and propositional analysis of different data collected from multiple sources. I triangulated sources from interviews, observations, and a focus group collectively to establish emerging themes and test propositions as well as alternate propositions. For thematic analysis, I ran a cyclical analysis and cycled data four times until no new themes emerged and no new pattern matching was feasible. Tsai's (2003) theory of caregiver stress included the explanatory basis for the propositions, which informed my decision that SWAT use is corroborated by HSW member assessments.

NVivo Software

I used NVivo software to help sort, code, and retrieve themes and patterns related to open-ended interviews, observations, and the focus group. I integrated NVivo software into the research process as an automated tool across information sources.

Evidence of Trustworthiness

I promoted trustworthiness of this study through multiple methods of engagement with participants or triangulation. Yin (2017) posited that case studies have analytical generalizability and include eight tactics to judge the trustworthiness of research findings:

1. Use multiple sources of evidence,
2. Establish chain of evidence,
3. Have key informants review the draft case study report,
4. Do pattern matching,
5. Do explanation building,
6. Do time-series analysis,
7. Use case study protocol, and
8. Develop case study data base.

I promoted credibility of this study by incorporating techniques to enhance the likelihood that the findings were credible, and multiple sources of evidence included (a) different perspectives during a focus group; (b) lived experiences during semi-structured interviews, and (c) observations of IDT members within a real-life context. I showed soundness of research findings through the triangulation of data, data saturation techniques, and replicability of my study, and I offered strengths and weaknesses for each data collection method to include (a) open ended questions, (b) participant observations, and (c) a focus group.

Yin (2017) proposed that qualitative researchers could promote dependability by being consistent through the research process. I used audio recordings, observation logs, and member checking to promote dependability. Interviews were recorded and then transcribed, and member checking was offered to all interview participants. Five of seven participants approved the transcripts without changes. Two participants made minor adjustments by clarifying information in the initial interview. For example, P3 clarified the term “soul wounds,” and P1 offered an expansion on how vets were honored for their service. I encouraged members of the focus group to answers questions within a text box using Zoom face-to-face technology, and I transcribed free-flow conversations in a text box during the focus group. I asked each participant to verify the transcript at the end of focus group. There were no changes requested by focus group members. The transcripts were printed and used during data analysis. During observations, I used an observation log (See Appendix I) to keep track of SWAT subsets discussed during the IDT.

Transferability occurs when researchers provide a comprehensive and detailed report of demographics, data gathering techniques, and data analysis. I offered a comprehensive and detailed description of the unit of analysis and provided lock-step data gathering protocol (Yin, 2017). Finally, I outlined the data analysis plan to promote confirmability and transferability. I employed these measures so that the study can be replicated by other scholars who examine comparable units of analysis and conduct similar explanatory case studies and answer research questions.

Results

Yin (2017) defined an explanatory case study as a design that is used within its real-life context to explain presumed casual links (or propositions). Therefore, I conducted interviews to gather themes and patterns as they emerged to answer the following RQ: How do hospice IDT members make meaning of SWAT when characterizing support needs for military families? The resulting themes that informed this research question include (a) relinquishing control, (b) familial culture, (c) recognition of service and (d) regaining control, as outlined in Figure 2.

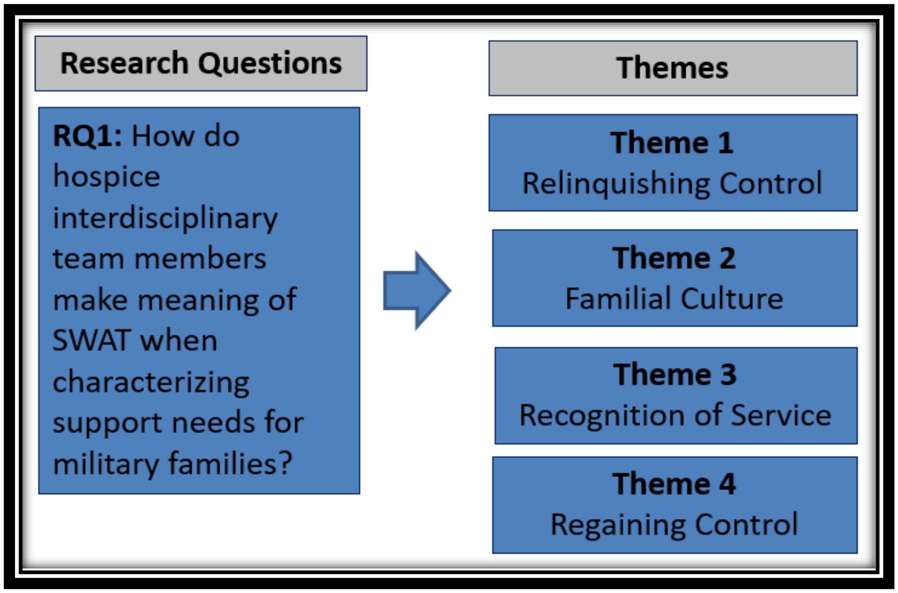


Figure 2. RQ1 development of themes.

Research Question 1

RQ1 was as follows: How do IDT members make meaning of SWAT results when characterizing the needs of military families? According to Reese et. al (2006) the use of SWAT serves as a reminder of issues to be routinely addressed with families – to include needs specific to different cultural groups. Military families are often considered a unique cultural group. When making sense of SWAT results to characterize the needs of military families, IDT members relayed: (a) relinquishing some level of control to community based hospice members; (b) a need for familial culture, (c) a need to be recognized for their service, and (d) the need to regain control after their loved one dies as prominent needs of military families based on HSW assessments.

Theme 1: Relinquishing control. In my review of the literature in chapter two terminally ill vets who opt to die at home are typically motivated to do so in order to receive formal care from hospice s, in conjunction with: (a) informal care, (b) the familiarity of home, and (c) emotional support from most family cos (Wachterman, et al., 2014). Yet, navigating the emotional and spiritual landscape at the end of life can take a toll on any family – particularly surrounding the idea of transitioning from the knowns of military support services to the unknowns of non-military services (Tracy, 2016). I found when interviewing seven IDT members that military families share a common theme related to relinquishing control. Patterns emerged related to relinquishing control of military health systems; relinquishing control at the time of death; and relinquishing control of post traumatic memories. All were common patterns that informed the development of *relinquishing control* as theme 1. The following narratives offer insight into how this theme was developed when IDT members made sense of SWAT results to characterize military family needs:

P1: The burden of caregiving for people who are vets is extreme because they can't control what's happening, especially if the co- was in the military as well; and if they were an officer (vs. enlisted member). It is hard to give up control. They can't control what's happening.

P2: Some military family s will not open up about their needs at first because it means that they are no longer in control…they feel like they have to give up some control. Non-military families want us to tell them what to do… what to expect.

P3: Non-military families are more accepting of someone outside of their families telling them how things are going to work. For military families, it is hard to give up that control.

P4: Some military cargivers want to go outside of their military community [for care and services] and others have a really hard time letting go of that control. So, we let them know that they can still use the VA [Veteran's Affairs] hospital for certain things if they still want to.

P5: Military families have a hard time letting go of their military system. We have to respect that about them because if they have served for consecutive years and have adapted to the military lifestyle, then it is the system they know and trust… they are really dependent on their system.

P6: Vets have a harder time transitioning at the end of life compared to non-vets. It can be hard for the caregiver to predict, hard to understand …often because the vet has experiences during their time in the service that they have never shared with the , and they are reliving those experiences at the end of life. We call that delayed onset PTSD. That is something the vet and caregiver cannot control.

Theme 2: Familial culture. Those who have served in the military represent a distinct cultural group whose perception of family is often influenced by factors specific to military culture (Meyer & Wynn, 2018). Military families who have adapted a military lifestyle due to an extended amount of time in the service hold the military as their primary source of identity; which is a stark contrast to families who only served a short time, or families who have never served. Meyer and Wynn (2018) posited that familial culture is how you express culture as a family through traditions, beliefs, roles, religion, and the community around you.

In a review of existing literature in chapter two, Cos are informal hospice IDT members who communicate patient needs, adhere to medication regimens, as well as report and manage behavioral changes at the end of life (Hoffmann, 2005; Joyce et al., 2014). However the findings and patterns that emerged during the data analysis inform the conclusion that familial culture for military families present obstacles for cos when communicating patient needs due to cultural stressors such as frequent moves, separation of families during childhood developmental years, deployments, post-traumatic stress, culture shock during overseas assignments, and or loneliness resulting in infidelity; which can exacerbate stress while making end of life decisions for dying vets (Prince-Paul et al., 2016). All were common patterns that informed the development of *familial culture* as theme 2. The following narratives offer insight into how this theme was developed when IDT members made sense of SWAT results to characterize military family needs – particularly those that contribute to familial culture:

P1: Women s share a lot more than men do, for example, I was asking a vet's son questions about end of life decisions and preferences… he passed the phone to his wife – the veterans daughter-in-law. I was shocked because I was asking questions about *his* dad. Some military families know little about their loved one vs. nonmilitary families, they seem know each other well.

P2: Military families are more prepared with advanced care planning; they have better access to financial and legal resources. The military culture of deployments and leaving their loved for long periods of time require that type of planning because [vets] can be separated from their families at any given moment. Nonmilitary families rarely have to worry about that time apart like that.

P3: For those who have seen combat and is also a co- there is some survivors guilt and anxiety over beating death once. When they watch a loved one die and not being able to save them - it really does something to the caregiver. Cos who have also served are trying to make sense of the death because military culture has taught them to never leave anyone behind… you can save them. So, the needs of military families look different as far as anxiety about death and spirituality.

P3: Military cos often do not know about the vet's experiences while in the military, and [s] struggle to understand the delayed onset of behaviors at the end of life. Sometimes [s] find out things about the military member that they did not know about. Because of deployments and time away from the family, some vets have fathered children outside of the marriage, and the burden of caregiving is complex because there are dynamics within the relationship that may not be healed. That was a big part of the culture for vets who served in the Vietnam era, and I still see it from time to time now. Military families have gaps in experiences based on deployments or times when they were separated, and this can complicate grieving.

P5: s Caregivers want to be heard. They may not have had the opportunity to be heard while the vet was actively serving their country, it was part of the culture, so now, they want to know that we hear them and are able to pass on information to IDT members and help them get resources or support.

P6: When some vets are at the end of their life the caregiver themselves may struggle because of unresolved service-related issues like PTSD. So, it may take the veteran more time to pass because of their history of service-related trauma. Usually when this happens cos may require more psycho-social and spiritual support because they are not always familiar with the specifics of the trauma the vet went through.

P7: Military family cos are often overwhelmed, information seeking and sometimes confused. They are trying to sort our parts of the veteran's life before they pass; and they become extended beyond their ability to handle the situation, which relates to comfort issues, grief, and anxiety about death.

Theme 3: Recognition of service. In a review of previous literature vets span multiple generations and eras of service, however, vets with post-traumatic stress, survivor's guilt, and or moral injury, have increased since 2001; largely due to fewer available troops serving multiple combat tours in Afghanistan and Iraq (Averill, et al., 2015; Ramchand, et al., 2014, p. 1). War and death, as well as line-of-duty injuries happen across most eras and branches of service and frequently result in wounded, ill, and or trauma-inflicted service members (Averill, et al., 2015; Ramchand, et al., 2014; NMFA, 2018). I discovered an emerging pattern while analyzing the data that informed the theme related to recognition of service. According to most of the IDT members interviewed, vets who served during the Vietnam era were never thanked for their service and suffer invisible wounds, which can contribute to exacerbated pain and delayed post traumatic reactions. In a review of the literature in chapter two, the vets psychosocial and psychological reactions can yield real and or perceived negative outcomes for the family such as increased stress, feeling overwhelmed, and poor self-care while providing informal care All were common patterns that informed the development of *recognition of services* as theme 3. The following narratives offer insight into how this theme was developed when IDT members made sense of SWAT results to characterize military family needs:

P1: I ask about military service, what they did in the military and if they are open to sharing their experiences. Some vets don't want to talk about their experiences, especially those who came back from Vietnam. Many of them feel like they were never recognized for their service, so I ask about honoring their service through a special ceremony we have for vets and we recognize the sacrifice of the spouse caring for them at the end of life.

P2: I make a clear distinction between someone who has served in the military for a few years in comparison to what I consider a military family who has served for multiple years and have adapted to a military lifestyle. They can be quite different when you compare the two. For those who have adapted a lifestyle. Many of those who adapted the lifestyle were honored, but there are those that were never really honored for their service and their families certainly were never honored for their sacrifices. We try to bring closure to some of that by offering a special ceremony to military families.

P3: Military cos hear the veteran say thank you and forgive me at the end of life. Vets have soul wounds due to military service, whereas the co- has relational wounds. That plays into it for a lot of military families – recognition of service and sacrifice at the end of life. It is important for both the caregiver and the vet to heal some of that before the vet dies. I help a lot of them get that closure.

P4: When it comes to the end of life military cos want and need different support. Recognition of service before they die, even the burial and what the patient looks like as far as military honors and stuff like that.

P5: What I notice is that military families are about protocol and recognition and we let them know that in our positions that they can trust us.

P6: We do a ceremony for military families, so we go to wherever the patient is living and we pin, not only the patient but we pin the spouse or and we do this little ceremony with them as a way to honor their service. A lot of the struggle for military family depends on what era, or war they war in; so you have to think, so you have to think whatever the public response was during that time, they may go through something different. Vets from Vietnam era were never thanked or honored, they were spit on, so a lot of them have never closed that chapter in their lives. A lot of them do not like to talk about their experience, and they didn't feel like an American. A lot of times its about thanking them and helping them close that chapter, in comparison to someone who came back from Iraq. The situation was quite different for the vet and their caregiver…more support and recognition for service and sacrifices for those who served in Kuwait, Iraq and Afghanistan.

P7: For me when I have a military family who has been long term career military family, their mindset is a bit different from those who have no military affiliation. The main thing is to honor their service and the sacrifices of the family.

Theme 4: Regaining control. A review of existing literature outlined the benefit of IDT members who seek to understand the cultural backgrounds of their patients, which equips them to better provide more effective care (Sanghera, 2017). Military families may also face unique challenges in the aftermath of death such as place of burial, military honors, dissolvement of veteran benefits and or who will receive the burial flag at the gravesite (Giles, 2014; Henry, Morris & Harrist, 2015). The need to regain control and become re-embed within the military culture at the end of life are tasks that inform the fourth theme of *regaining control*. The following narratives offer insight into how this theme was developed when IDT members made sense of SWAT results to characterize military family needs:

P1: Key questions to ask military cos is to ask about military service, what they did in the military and if they are open to sharing their experiences. It is a way of regaining control for them because there are so many things at the end of life that they cannot control. when I ask the questions of cos, they are happy to share… with military families you have to ask the right questions.

P2: I pull back the layers of the onion and look at the 's understanding of the diagnosis and prognosis. I asked about family support, finances, caregiver burnout, and I look at if the caregiver understands what they may see, will experience, and help them through the anxiety of impending death. The goal is for the family to have the education and understanding of what we do and have some sense of control.

P3: What I found in difference between the family members of nonmilitary and military is that military families are used to giving orders, and are less likely to take orders, especially if they were an officer. In the military they are used to things being given and or supplied for them, and not used to waiting or depending on a system that is foreign to them. For example, don't tell them that their hospital bed is coming tonight, because they want to know what time, how, where those are things that they can oversee so they ask for specifics.

P4: Military families are more into detail; they have more concerns about the care and they like specifics. They ask more questions and are interested in every detail of what we are doing.

P5: I think the biggest difference is military families wanna know up front what it is we're going to do for them and once they know that up front the cos are more accepting of us being there.

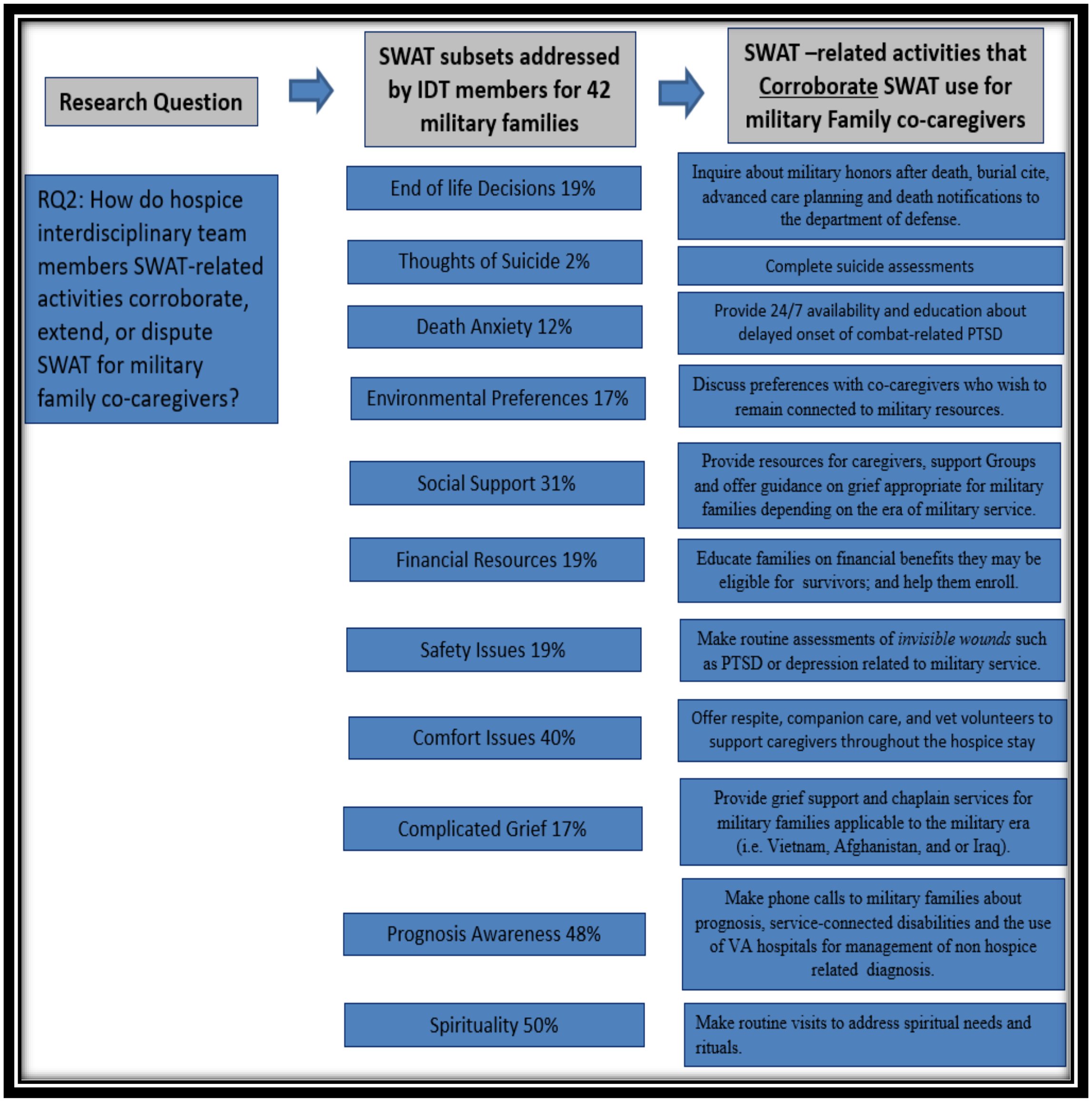
P6: So typically, if you have a military family, then timing and schedules are everything. So, for example we typically cannot promise that you will be seen every single Monday at 8 o'clock because we take care of so many patients, but with our military families we try really hard to schedule their visits at a time when we might have a better chance to keep the visit time. Military families seem to live and die by their schedules. So, we work hard to allow them to keep control over their day by coming on time when we can.

P6: Another example is we have a lot of patients who have been exposed to agent orange, and have VA benefits tied to that, so that has to be on the death certificate and whatever the VA diagnosed them with is related to agent orange, they will have a date of exposure onset, so that has to be on the death certificate so that the spouse or family that is left can capture those benefits. For some military s left behind that can be significant as far as having the funeral arrangements paid for and ongoing financial support. They can continue to receive money even after the veteran has died. They really watch those things closely to maintain control over their finances.

P7: the important thing for military families is the continued partnership with the VA. I make sure that I explain and give them the leeway to still see their doctor at the VA for their medications if they want to, and for non-hospice related care. I respect that about them because that is the system they know, and trust and they are dependent on their system.

Research Question 2

RQ2 was as follows: How do IDT SWAT related activities corroborate, extend, or dispute SWAT use for military family co-caregivers. I observed two IDT meetings and facilitated a focus group to make inferences related to my propositions that informed the answer to RQ2. I determined IDT members appraised military co- needs in all eleven subsets of SWAT (see Figure 1). I obtained contextual information during a focus group with a separate set of IDT members. During the focus group, SWAT-related activities were discussed. I subsequently determined interventions by IDT members strengthen support for military family cos. Therefore, I concluded SWAT related activities performed by Oceans Hospice IDT corroborate the use of SWAT for military families as outlined in figure 3.



Research Question	SWAT subsets addressed by IDT members for 42 military families	SWAT –related activities that Corroborate SWAT use for military Family co-caregivers
RQ2: How do hospice interdisciplinary team members SWAT-related activities corroborate, extend, or dispute SWAT for military family co-caregivers?	End of life Decisions 19%	Inquire about military honors after death, burial cite, advanced care planning and death notifications to the department of defense.
	Thoughts of Suicide 2%	Complete suicide assessments
	Death Anxiety 12%	Provide 24/7 availability and education about delayed onset of combat-related PTSD
	Environmental Preferences 17%	Discuss preferences with co-caregivers who wish to remain connected to military resources.
	Social Support 31%	Provide resources for caregivers, support Groups and offer guidance on grief appropriate for military families depending on the era of military service.
	Financial Resources 19%	Educate families on financial benefits they may be eligible for survivors; and help them enroll.
	Safety Issues 19%	Make routine assessments of *invisible wounds* such as PTSD or depression related to military service.
	Comfort Issues 40%	Offer respite, companion care, and vet volunteers to support caregivers throughout the hospice stay
	Complicated Grief 17%	Provide grief support and chaplain services for military families applicable to the military era (i.e. Vietnam, Afghanistan, and or Iraq).
	Prognosis Awareness 48%	Make phone calls to military families about prognosis, service-connected disabilities and the use of VA hospitals for management of non hospice related diagnosis.
	Spirituality 50%	Make routine visits to address spiritual needs and rituals.

Figure 3. RQ2 SWAT use for military cos.

Summary

Chapter 4 contained findings of seven semi-structured interviews focused on the lived experiences of home hospice IDT members; findings from a focus group concentrated on discussions about SWAT use and military families; and direct quotes from interviews and focus group to answer research question 1: How do hospice IDT members make meaning of SWAT when characterizing support needs for military families? Themes that informed the answer to RQ1 included (a) relinquishing control, (b) familial culture, (c) recognition of service and (d) regaining control. Findings related to propositions and alternate propositions to answer research question 2: How do hospice IDT members SWAT-related activities corroborate, extend, or dispute SWAT for military family cos? I concluded SWAT related activities performed by Oceans Hospice IDT corroborate the use of SWAT for military families.

Chapter 5: Discussion, Conclusions, and Recommendation

Introduction

The purpose of this explanatory case study was to examine the assessment practices of community-based hospice IDT members when characterizing support needs for military families. I conducted the study using a qualitative explanatory research method to examine how IDT members make meaning of SWAT results and how SWAT-related activities corroborate SWAT use for military families. According to NHPCO members (2015) and Reese et al. (2006), SWAT use contributes to collaborative practices of hospice IDT members. I obtained information-rich data from IDT staff members regarding their experiences that supported the use of SWAT for military cos and aimed to inform how and why hospice IDT members provide support to military families at the end of life. This chapter contains the (a) research findings, (b) interpretation of the findings, (c) limitations, (d) recommendations (e) implications, and (f) conclusion.

Interpretation of Findings

The results of this study include information helpful for hospice directors to identify how stakeholders make sense of and characterize military family co support. IDT members make sense of SWAT results to characterize the needs of military families, which include (a) relinquishing some level of control to community based hospice members, (b) a need for familial culture, (c) a need to be recognized for their service, and (d) the need to regain control after their loved one dies. I also interpreted through this explanatory case study that IDT members appraised military co needs in all 11 subsets of

SWAT. Therefore, I found that SWAT-related activities performed by the IDT corroborated the use of SWAT for military families.

In Chapter 2, I focused on an extensive review of existing literature prior to conducting this study, and when interpreting the findings of this study, I applied them to areas of the literature review. Findings of the study were used to examine emerging themes and patterns and to corroborate, dispute, or extend the use of SWAT for military families. Some of the major areas of the literature review included (a) family systems and hospice care for military families, (b) family caregiver stress, and (c) social work assessment tools.

At the time of this study, there appeared to be no literature related to SWAT use to identify culturally relevant stressors of military family populations. Because of this, I found it useful to incorporate existing literature along with Tsai’s (2003) theory of caregiver stress during data analysis. Participants in this study consistently identified patterns that ultimately resulted in four themes related to caregiver burden in military culture. The themes outlined were stressors related to leaving military systems for community-based hospice care (relinquishing control), burden relevant to broad military family dynamics (familial culture), the burden associated with military service (recognition of service), and the need for military families to access systems congruent with military life such as the VA, military burials, and access to survivor outreach services (regaining control). Ultimately, data obtained from my study corroborated the use of SWAT for military families when identifying culturally relevant stressors.

Limitations of the Study

The findings from this study may not represent experiences of every home-based hospice agency; therefore, the findings may not be applicable to some home-based hospice agencies who use SWAT as an assessment tool for military families. Yin (2017) suggested that an explanatory case study be used to explain presumed casual links (or propositions) that are too complex for surveys or experimentation. Due to the qualitative nature of this explanatory case study, findings are largely presumed casual links rather than conclusive evidence used to answer the research questions. Finally, this study did not include other experiences and perspectives from IDT members such as physicians, nurse practitioners, and administrators.

Recommendations

Future researchers should consider conducting a mixed methods program evaluation research to assess SWAT use with military clients to measure the number of interventions offered by IDT members and to explore military caregiver experiences with SWAT related activities. This research design may be useful to expand and combine elements of qualitative and quantitative research approaches for the broad purpose of breadth and depth of understanding SWAT use.

Future researchers should also consider a subsequent phenomenology qualitative study exploring the lived experiences of military family co needs specific to military culture throughout the hospice length of stay. The goal of phenomenology is to describe the meaning of this experience—in terms of *what* was experienced and *how* it was experienced (Neubauer, Witkop, & Varpio, 2019). This phenomenological study could address SWAT results through the lens of the dying vet. This research design is aimed at the commonality of a lived experience within a particular group. Through a phenomenology approach, the researcher may construct a universal meaning of the experience of SWAT for vets and arrive at a profound understanding of the phenomenon.

Implications

Social change is the change of sociological norms secondary to organic or artificial stimuli (see Prince-Paul et al., 2016). Potential implications for positive social change are consistent with the scope of this explanatory case study and may strengthen the care given to military family cos. This study may help to sustain, modify, or dispute community-based social work assessment practices for community-based home hospice workers. This study may also contribute to social change by informing home hospice team members of the need for intervention on behalf of military family cos in culturally relevant ways.

Finally, the implications for positive social change relevant to the scope of this study include (a) increasing hospice administrators' understanding of the operational tools social workers use to assess the needs of military families enrolled in community-based hospice care; (b) informing community-based HSWs of unique needs associated with end-of-life care for military family cos and aiding HSWs to increase, sustain, or implement relevant holistic care for vets at the end of life; (c) aiding HSWs and nursing staff to characterize objective burdens, stressful life events, social supports, and social roles of military cos; and (d) providing references for hospice IDT members to identify barriers faced by family members when caring for a chronically ill relative (Condard, Allen & Armstrong, 2015; Weber & Clark, 2016).

Conclusion

At the inception of this study, I sought to understand how IDT team members make sense of SWAT results when characterizing the support needs of military family cos. I also set out to determine if SWAT related activity by Hospice IDT team members corroborate, extend, or dispute SWAT use for military families. Through a qualitative explanatory case study design, the data obtained throughout this study informed my research questions and lent to an understanding of SWAT use for military family cos. Prior to this study, there was a gap in the literature concerning the use of SWAT for military families enrolled in home-based hospice care. This study helps fill the gap in the literature related to SWAT use, invites further study of supports offered to military families at the end of life, and corroborates the use of SWAT for populations with unique cultural needs. One thing is clear at the conclusion of this explanatory case study: SWAT use by HSW members in community-based home hospice helps to illuminate and characterize the needs of veteran families in culturally relevant ways.

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Appendix A: Administrator Approval

From: Miranda Rankin

Sent: Monday 3/9/2020

To: [redacted]

Subject: Hospice Dissertation Research Approval Request

Good Day Ms [redacted]:

First, let me thank you in advance for your time. My name is Miranda and I am currently in the dissertation phase for my PhD in Human Services at Walden University. I am also a Texas licensed nurse and behavioral health specialist.

I noticed that you have [redacted] program, and I wanted to reach out to seek approval to conduct an inquiry at [redacted] Hospice Care.

The purpose of my study is to explore how hospice team members (nurses, CNAs, chaplains etc.) make sense of the social work assessment tool (SWAT) for military vets - basically, I am looking to explore how community based hospice staff members go about meeting the end of life , psyco-social, emotional, and spiritual needs of vets.

I will NOT need access to your patients or patient records, only your staff members. My goal is to collect data over the course of 5 days. The publication of my dissertation will NOT include: names of staff members, name of patients, or the name of [redacted] hospice agency. As a student I am bound by the National Institute of Health, the Walden University Internal Review Board, and HIPPA guidelines to protect and omit the identify of ALL participants in my study upon completion of the dissertation.

Ms. [redacted], would it be possible to meet with you or your representative about my request? The meeting would only take 15 to 20 minutes. If time is of the essence, we can even discuss via teleconference.

A good contact number for me is [redacted].

Thank you in advance,
Miranda L. Rankin, PhD Candidate

Appendix B: Standard Script for Participant Recruitment

I wanted to reach out to inquire about your possible participation in a study that I am conducting at [redacted] hospice agency.

I am looking to explore your utilization of assessment tools to determine the needs of military families enrolled in end of life care. My goal is to collect data over the course of one month through collection methods such as interviews with staff, 1 focus group, and observation of 2 multidisciplinary meetings. Per the university protocol and the National Institute of Health (NIH) regulations I will take the following steps to safeguard your identity and the identity of [redacted] hospice care:

Findings related to [redacted] will be confidential and the [redacted] healthcare name, staff names, and names of patients will NOT be published in any way.

If you are willing to participate, I would like to email a consent form for you to read, sign and return via email at the end of our discussion today.

Appendix C: Open-Ended Interview Questions with Administration and Staff

1.) Given the many assessment tools utilized by IDTmembers, which tool(s) best help you to determine needs for military families?

2.) How well does the social work assessment tool help you to interpret differences in the needs of military vs. non-military family cos?

3.) How do your experiences with SWAT align with the intended use of SWAT for hospice-enrolled military families?

4.) How do you make sense of SWAT results when determining co- psychosocial and or spiritual needs?

Appendix D: Participation Flyers

Research Study: Focus Group

(What): *A group interview to focus on how interdisciplinary teams make meaning of social work assessments for military families.*

Date /Time/ Location (When):

__________ / ______________ / room # __________

Purpose (Why):

To gather information and generate ideas about how hospice interdisciplinary team members make sense of social work assessment tools to characterize support for military families.

Nature of the Study (Who & How):

RNs, and Hospice Consultants are welcome to participate!

NOTE: *This is a group interview that will take place on campus and will last 30 minutes. Others within the group will have a chance to hear your responses, which will help to generate a dialogue in order to explore your ideas and experiences! Prior to the start of the focus group, we will discuss a few ground rules. The group interview will* ***NOT*** *be audio or video recorded.*

Focus Group participants will be asked to:

(a) List activities associated with their role in providing support to cos

(b) List the most frequent social work recommendations for military families

(c) List interventions used to assist with military co- stress.

(d) Offer 3 ways you confirm that an intervention was helpful/ not helpful for military cos.

If you would like to participate, please reach out to:

Miranda L. Rankin

[redacted]

Research Study: Interviews

(What): *How Hospice Interdisciplinary team members utilize the Social Work Assessment Tool (SWAT).*

Dates & Location (When):

6/10/2020 @ 11:30am

Purpose (Why):

To gather information about how hospice IDT members make sense of social work assessments to characterize support for military families.

Nature of the Study (Who & How):

IDT members are welcome to participate!

Interview participants will be asked:

a.) which tool(s) best help you to determine needs for military families.

b.) to interpret differences in the needs of military vs. non-military family cos.

c.) about your experiences with assessments involving hospice-enrolled military families.

d.) how you determine co- psychosocial and or spiritual needs.

Interviews will last between 10-20 minutes.

If you would like to participate, please reach out to:

Miranda L. Rankin

[redacted]

Appendix E: SWAT Use Approval

From: [redacted]

Sent: Thursday, July 5, 2018 10:41 AM

To: Miranda Rankin

Subject: RE: Approval for SWAT use

Miranda,

Thank you for reaching out to us at National Hospice and Palliative Care Organization regarding the use of the Social Work Assessment Tool that is publicly available on the NHPCO website, http://www.nhpco.org/social-work-assessment-tool.

This resource tool was created by several NHPCO's members who are part of our National Council of Hospice and Palliative Professionals. NHPCO is pleased to make this resource available to the public, particularly those who may need a social work assessment tool involving care at the end of life.

Please consider this as NHPCO's permission to use this document in your dissertation. Proper credit would be NHPCO's National Council of Hospice and Palliative Professionals.

If you have other questions, or need additional information, please let me know.

Best wishes as you move forward with your career,

[redacted]

[redacted]

Vice President, Communications

National Hospice and Palliative Care Organization

[redacted] King Street, Suite 100

[redacted], VA 22314

Direct: [redacted]

From: Miranda Rankin [mailto:XXX@waldenu.edu]

Sent: Thursday, July 05, 2018 11:26 AM

To: [redacted]

Subject: Approval for SWAT use

Good Day Dr. [redacted]:

Thank you so much for taking my call today. My intent was to follow up on my request for approval to incorporate the social work assessment tool (SWAT) as a figure within my dissertation. I am proposing a study to explore how hospice IDT members' make sense of the SWAT for military families.

I reached out to Dr. Dona Reese a few weeks ago. Dr. Reese offered support and additional literature for the study, however she suggested that I seek formal approval since the NHPCO owns the copyright for SWAT; therefore, I would like to do so in this forum. If possible, I would love the opportunity to explore my research topic utilizing the SWAT, and I am seeking approval to do so.

I appreciate your time,

Miranda L. Rankin

Appendix F: Focus Group Data Collection Protocol

____ Briefly introduce the study and disclose the purpose for the focus Group.

____ Obtain Informed Consent.

____Participants will be asked to clarify three areas of SWAT use verbally:

(a) activities associated with their role as a nurse

(b) interpretations of results for four military family cos

(c) interventions according to their respective scope of practice.

_____ Ask participants to transcribe the information in the Zoom chat box as answers are shared to categorize and extract data.

____ During emerging dialogue, seek accuracy, ask clarifying questions if needed

____ At the end of the focus group invite participants to review the chat box and ask them if their answers are accurately represented.

Appendix G: Debriefing Script

Thank you so much for your time today. The purpose of my study is to understand how hospice IDTs make sense of assessments when characterizing the needs of military family cos.

To preserve the privacy of your responses and protect the privacy of Hope Hospice care, only aliases and pseudo names will be written in my Dissertation. Your name will **NOT** be published in my dissertation. Any audio recording will be secured and stored in a locked file cabinet in my home office. Finally, all data that I collect pertaining to my study will be destroyed upon 3 years after the publication of my dissertation.

Below you will find my contact information, as well as the Institution review Board ethics office information:

Miranda Rankin
[redacted]
XXX@waldenu.edu
Office of Research Ethics and Compliance
Walden University
100 Washington Avenue South, Suite 900
Minneapolis, MN 55401
Email: irb@[redacted]

Appendix H: Letter of Cooperation

Letter of Cooperation

[redacted] Hospice

[redacted]

[redacted] TX 78130

March 20, 2020

Dear Miranda L. Rankin PhD candidate, MA

Based on my review of your research proposal, I give permission for you to conduct the study entitled [redacted] IDTs' us of Social Work Assessment Tools. As part of this study, I authorize you to conduct interviews with staff members, hold one 30-40-minute focus group, and make observations of two team meetings. Individuals' participation in interviews and focus groups will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: Onsite access to two team meetings, a designated space to conduct one 30-40-minute focus group, and onsite access to conduct interviews with staff members.

As a guest at [redacted] Hospice, you will be asked to sign a letter of confidentiality prior to onsite access. Leadership at [redacted] Hospice reserves the right to offer and arrange the dates/times and locations for data collection when it is most convenient and safe for us to do so, and we may withdraw from the study at any time if our circumstances change.

I understand that Miranda L. Rankin will not be naming our organization or any participants in the doctoral report published by Walden University. No patient information or any information that could be used to identify a patient will be included in the research nor be discussed outside of

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization’s policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student’s supervising faculty/staff and a debrief will be offered to the executive director as per Walden University internal review board protocol. No patient information or any information that could be used to identify a patient will be included in the research nor be discussed outside of these parameters stated.

Sincerely,

Authorization Official

// [redacted]//

Contact Information [redacted] [redacted]@[redacted]e.net

[redacted], TX 78130

Walden University policy on electronic signatures: *An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person’s typed name, their email address, or any other identifying marker.*

Appendix I: Observation Log

SWAT Issue Discussed by Staff	**Observation Notes:**
1. End of life decisions	
2. Patient thoughts of suicide	
3. Anxiety about death	
4. Preferences about environment	
5. Social support	
6. Financial resources	
7. Safety issues	
8. Comfort issues	
9. Complicated anticipatory	
10. Awareness of prognosis	
11. Spirituality	

____