The ACTive Intervention in Hospice Interdisciplinary Team Meetings: Exploring family caregiver and hospice team communication

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Abstract

This paper presents the theoretical framework and rationale for the ACTive intervention which proposes the use of video technology to facilitate patient and family participation in hospice interdisciplinary team meetings where plans of care are determined. It is surmised that patient and family involvement will improve communication and compliance in hospice care. An analysis of data from a pilot project of the ACTive intervention was conducted to explore active participation among family caregivers and the hospice team. Through the use of videophone technology caregivers participated in video-recorded team meetings. The actual communication behaviors of caregivers and team members were analyzed for active participation. Findings revealed that team–prompted caregiver participation was most common, however, team use of supportive talk in this context was considerably less frequent. The study also found that the team’s use of active participation behaviors elicits caregiver active participation behaviors. The results of this study suggest the intervention was an effective way to involve family caregivers as active participants in the designing of care for their loved one. Findings also suggest that hospice staff would benefit from education and training on best practices for communicating with caregivers in the team meeting setting.

In 2007, an estimated 1.4 million people received services from hospice, approximately 38.8% of all deaths in the United States (National Hospice and Palliative Care Organization, 2008). Hospice care is provided to people facing a life-limiting illness or injury and emphasizes quality of life rather than focusing on curing the disease/illness. Based on a team-oriented approach to care, hospice staff collaborate to provide expert medical care, pain and symptom management, and emotional and spiritual support. The majority of hospice care is provided in the patient’s home by family or friends who provide informal caregiving. Although the primary goal of hospice is to provide patient care in the comfort of the patient’s home, a majority of this care is provided by caregivers who have little or no training (Kazanowski, 2005).

Caregivers of hospice patients report a high degree of uncertainty, particularly as it relates to the responsibilities of handling pain management at home (AUTHOR, 2008,(Keefe et al., 2003). Caregiver pain management responsibilities include assessment of patient pain, preparing and administering medications, monitoring symptoms, trouble-shooting medication side effects, and communicating with medical staff (Keefe et al., 2003). Responsibilities related
to pain management can be overwhelming and caregivers report confusion about the various
types of medications to be administered, indications for their use, time for administration, and
the desired effect on the patient (Kazanowski, 2005). Not being able to handle pain management
practices creates distress for the caregiver, particularly near the end-of-life when patient pain
is likely to increase. The stress of decision-making impacts the caregiver’s well being and is
also dangerous for the patient as the untrained caregiver is often the person who self-selects
medication to administer when assistance is not available.

One of the most challenging aspects of the caregiver role is inadequate health professional
support (Aoun & Kristjanson, 2005; Lowey, 2008). Caregivers are often under-informed about
the patient’s prognosis, the hospice element and the daily challenges associated with caregiving
(Mangan, Taylor, Yabroff, Fleming, & Ingham, 2003). Under hospice care, staff coach family
caregivers on how to care for the patient, provide care when the caregiver needs respite time,
and provides bereavement care and counseling (National Hospice and Palliative Care
Organization, 2008). However, hospice volunteers brought in to aid with caregiving tasks are
less likely to provide instrumental support and more likely to provide emotional support (Egbert
& Parrott, 2003). Family caregivers continue to report an increased need for more information,
communication, and services and support from community services (Aoun & Kristjanson,
2005; Evans, Cutson, Steinhauser, & Tulskey, 2006; Hwang et al., 2003).

In the following, we describe a proposed framework and intervention for the inclusion of family
caregivers in the core of hospice services by utilizing video technology to enable patient and
family participation in routine interdisciplinary team (IDT) meetings conducted by hospice
staff. We argue that inclusion of the patient/family unit in IDT meetings has the potential to
improve communication between the team and patient/family, offering the opportunity to work
together on a patient/family driven plan of care, improving emotional support and caregiver
concerns related to pain management (AUTHOR, in press). We then provide findings from a
pilot intervention that explored the effectiveness of the video enabled participation of
caregivers in team meetings to facilitate communication and aid in decision-making.

Family and Patient Participation in Hospice Care

Staff communication with family caregivers during end-of-life care can serve to promote
family communication, encourage advance care planning, support home care, empathy for
family emotions and relationships, and attend to family grief and bereavement (Rabow, Hauser,
& Adams, 2004). Likewise, family caregivers are an important communication source for
hospice staff about patient pain (Query, Wright, & Gilchrist, 2007). Although patients and
family members are considered the unit of care in hospice, they are rarely included in team
meetings where much of the decision-making regarding a patient’s plan of care takes place
(AUTHOR, 2005). Under the Medicare program which pays for 83% of hospice care in the
United States, hospice agencies are required to conduct routine IDT meetings (also known as
plan of care meetings) to facilitate collaboration and produce holistic plans of care (Centers
for Medicare and Medicaid Services, 2008; National Hospice and Palliative Care Organization,
2008). Hospice philosophy, as well as federal regulation, requires team members representing
medicine, nursing, social work, and chaplaincy to evaluate the patient and family and conduct
IDT meetings to collaborate and establish holistic plans of care. However, the caregiver’s time
demands, logistics, lack of financial skills/support and other restrictions related to
transportation needs inhibit caregiver involvement as well as contribute to caregiver burnout
(Razani et al., 2007).

Finding ways to overcome the challenges and support the involvement of caregivers in IDT
meetings is important to assure that hospice goals and plans of care are centered on both the
patient and the family (AUTHOR, in press). While preliminary research on hospice IDT
meetings has revealed that interdisciplinary collaboration does not always occur (AUTHOR, 2005; Bokhour, 2006), other evidence suggests that the use of person-centered comforting strategies in IDT meetings increases communication satisfaction and perceived satisfaction in the evaluation of the team’s success (Zimmerman & Applegate, 1992). We theorize that caregiver involvement is one way to improve the collaborative process by facilitating communication between the team and family. We propose an intervention model named ACTive: Assessing Caregivers for Team intervention through videophone encounters.

The ACTive Intervention in Hospice Care

The ACTive intervention relies on Saltz and Schaefer’s model for participation of family on health care teams as one context for interdisciplinary collaboration with the family (Saltz & Schaefer, 1996). Figure 1 illustrates the Saltz and Schaefer model as modified for this intervention. This model health care team collaboration includes families. Saltz and Schaefer identify four components of a collaborative model that includes family: Organizational context, which influences team structure, which in turn impacts team processes, which ultimately determine how teams evaluate outcomes (Saltz & Schaefer, 1996). This non-linear model includes feedback loops between all components. The context of organizational factors (such as little or no leadership) may encourage or discourage family involvement in teams. Team structures determine whether family members are viewed as “lay” team members (without detailed knowledge), or as “specialists” (with great knowledge of the patient/resident). Saltz and Schaefer suggest that family involvement can influence certain process elements of team functioning, especially assessment, care planning, and implementation of plans. This model maintains that lack of family input into problem-solving or decision making negatively damages interventions because staff make incorrect assumptions about patient/family perspectives, which influence the process.

Bronstein’s model for successful interdisciplinary collaboration in combination with the work of Saltz and Schaefer (1996) supports a theoretical understanding of team processes (AUTHOR, in press). The framework identifies five components to interdisciplinary collaboration: 1) interdependence; 2) newly created professional activities; 3) flexibility; 4) collective ownership of goals; and 5) reflection on process. The model intersects these components by stating that the interdependence (created by the synergy needed to complete necessary tasks) is combined with newly created professional activities or collaborative acts and structures, allowing for accomplishment that would not be possible without the other members. The success of interdependence and these newly created professional activities requires flexibility in traditional roles, leading team members to deliberately, yet appropriately blur roles. This collaborative process requires collective ownership of the goals of the team including shared responsibility for the design of care plans. Finally, integral to successful collaboration is a reflection on the collaborative process by the team members, focusing on the process of their work together, as well as the outcomes of their efforts (Bronstein, 2003).

The principles inherent within the hospice philosophy provide the organizational context for patient/family participation and a supportive structure that acknowledges patient/family feedback as valuable. With the inclusion of patients/families, the team will become interdependent with patient/family goals, and will create new activities and roles for patients/families within the team, requiring flexibility among individual members’ role definitions. The patient/family involvement will require collective ownership of all goals by all team members, and the care outcomes will be evaluated through a reflection on the team process, including feedback from patients/families. The videophone provides a logistical way to include family in that structure as a core team member.

Videophone technology is a communication medium that can facilitate caregiver involvement in hospice team meetings (AUTHOR, 06-08). Videophone technology holds promise as a tool
to overcome the current challenges to patient and family involvement and is offered as a potential way to solve many of the barriers currently preventing participation. Patients/families can be viewed as team members with important information and knowledge required for assessment, care planning, and evaluation. The use of telemedicine in home care, also known as telehomecare, is defined as the use of advanced technologies such as the Internet, monitoring devices and videoconferencing technologies, to enable patients and families at home to interact with health care providers at a clinical site. Such an interaction over the TV, monitor or videophone is called a virtual visit.

Recently, research has demonstrated the feasibility and suitability of using videophone technology in hospice to create a social presence between patients and their family members (Chilcoat & DeWine, 1985; Hensel, Parker-Oliver, & Demiris, 2007; Parker Oliver, Demiris, Day, Courtney, & Porock, 2006). The enhanced social presence created through the use of videophones can increase social support and reduce loneliness (Hensel et al., 2007). The use of videophone conference calls to facilitate involvement in the interdisciplinary team meeting provides family caregivers with an opportunity to actively contribute to decision-making about the care of their loved one as well as receive practical support from the hospice team. A preliminary report on the effectiveness of the ACTive intervention is provided by assessing the active participation of family caregivers and staff who participated in IDT meetings via videophone conference calls. Specifically we question:

RQ: To what extent do caregivers using videophones ask questions, express concerns, and engage in assertive behavior during their interactions with the hospice team?

The investigation of active participation in medical encounters has been developed by Street (2001, 2003, 2005) and colleagues. This framework will be used to explore the active contribution of family caregivers during videophone conference calls during a pilot study of the intervention. The next section will outline the active participation framework.

Assessing Active Participation

The main goal of the hospice IDT meeting is to foster collaboration among interdisciplinary team members so that holistic decisions regarding the patient’s plan of care can be best determined. In order for the inclusion of patients and family members to impact the decision-making process, motivation, knowledge, and communication skills need to be part of the interactive process (Street, 2007). First, communicators should be motivated by the belief that they are an important part of the process. In a hospice IDT meeting family caregivers need to feel that their perspective and role in patient care is valued by the team. The role of the team should focus on developing caregiver understanding of the clinical evidence of end-of-life care as it pertains to the patient’s values. Second, Street (2007) proposes that communicators should be knowledgeable. For family caregivers this includes being knowledgeable of the patient’s values and desires regarding end-of-life care. The goal of the hospice team is to elicit this knowledge from caregivers and facilitate decision-making in line with the patient’s wishes.

Communicative skills, defined by Street (2007) as active participation, are also required for effective decision-making. Street and colleagues (2001, 2003, 2005) operationalize that active participation consists of asking questions, expressing concerns and negative feelings (fear, frustration, etc.) and being assertive (stating opinions, preferences, etc.). Active caregiver participation allows caregivers to put their agenda into the conversation, thus facilitating patient/family-centered care by enabling relationship building opportunities that include communication about social issues (von Friederichs-Fitzwater & Gilgun, 2001). The active participation framework proposes that physician response to these types of participatory behaviors include being more informative, supportive and accommodating. Specifically, responses can be patient-centered through partnership building (e.g. asking the caregiver a
question) and supportive (e.g. telling caregivers they are doing a good job). Prior research on caregivers in hospice has revealed that caregivers don’t always ask questions (Hebert, Schulz, Copeland, & Arnold, 2008) and the ACTive intervention seeks to empower patients and family by including them in the IDT meeting.

There are three important characteristics of the active participation framework. First, active participation is characterized by mutual influence (Street, Krupat, Bell, Kravitz, & Haidet, 2003). In medical encounters, if the physician uses more patient-centered responses then patients have more active responses (Street et al., 2003). Similarly, if a patient has more active participation in the interaction the physician responds with more patient-centered responses. Prior research on active participation in medical encounters found that the more the physicians used partnership-building and supportive talk, the more the patients actively participated in the communication (Street, Gordon, Ward, Krupat, & Kravitz, 2005). Likewise, in the hospice team meeting context we would expect to see active participation among caregivers when the team engages in partnership-building and supportive talk.

Second, much of the quality of communication between patients and physicians rest on the physician’s side (Street et al., 2005). If the physician has a facilitative communication style, this will enhance the interaction greatly. If the physician has a more controlling communication style, the patient’s interactions and input will be discouraged and marginalized. According to Street (2005) physicians have one of two communicative style orientations: (1) towards shared control with the patient or (2) towards physician control. The control style is characterized by the dominant role of the physician which encourages passivity from the patient. In these encounters, the patient is presented with selective medical information and the physician promotes a specific treatment. On the other hand, shared control style is centered around shared decision-making, characterized by the physician’s role as teacher or friend who helps the patient make care decisions. Similarly, the communication style of the hospice team is likely to influence videophone interactions with family caregivers.

Third, active participation in medical encounters is contextually influenced (Street et al., 2005). During short visits with little immediate health needs it is less likely that the patient will be able to contribute much in the way of active communication and more likely the physician will exert control over the communication for expediency’s sake. Additionally, care setting has been found to be a significant predictor of physician communication, with physicians more likely to use partnership-building and supportive talk with lung cancer patients (Street et al., 2005). Given the relationship between the physician’s communication style and patient communication in medical encounters, we posit the following hypothesis about communication between hospice team members and caregivers:

H: Caregiver active participation behaviors will be positively correlated with the team’s use of partnership-building and supportive talk during videophone IDT meetings.

**Method**

**Procedure**

Data for this study were gathered from a pilot project on the ACTive intervention funded by the National Cancer Institute (RA-CA-05-013). Following referral by hospice staff, a graduate research assistant (GRA) visited the family caregiver’s home for consent to participate in the study and installed a videophone. Family caregivers were provided a designated time and date to use the videophone to participate in a hospice team meeting. Videophones were not used in any other capacity. Hospice team meetings that involved a family caregiver videophone conference call were videotaped. Meetings took place in the hospice office room where a video
camera was set up in the corner. The GRA provided a seating chart of the participants, identified only by their profession. The study was approved by both the Institutional Review Board at the supporting university and the hospice. A total of 70 videophone conference calls comprised the data set. Video-recordings were transcribed for 20% of the data to assist in training coders and comprised 56 single-spaced pages.

Technical Quality

We assessed the quality of the video calls using a previously developed instrument for assessing the technical quality of a ‘virtual visit’ in home care (Demiris, Speedie, Finkelstein, & Harris, 2003), a video-based interaction between health care providers and patients or caregivers. The form includes identification of the caregiver, date, starting and ending time of the video-call. The main section of the form contains five items regarding the technical quality of the video-call. The first two items refer to the observations made by the GRA in regard the frequency of difficulties with audio and image at the team’s site. The next two items address problems with video and sound at the caregiver’s end, as reported to the team during the video-call. The last item addresses possible disconnection(s) and their frequency of occurrence. This section allows for the definition of a score for the overall technical quality of each video-call. This instrument has been tested for reliability and validity and used to rate the technical quality of video-calls in home care settings (Demiris, Speedie, & Finkelstein, 2001; Demiris et al., 2003).

Verbal behavior coding

Utterances were categorized into mutually exclusive categories of Street and colleagues’ (2001,2003) active participation verbal behavior coding scheme. Utterances are the oral analogue of a simple sentence (Street & Gordon, 2006;Street et al., 2003). Active caregiver participation was assessed on three specific forms of speech: asking questions (“should I make an appointment for that?”), expressing concerns (“I’m worried that she [patient] might be getting too much [pain medication]”), and assertive utterances (“I’d like to get your opinion on that”). The sum of utterances in these three categories comprised the caregiver’s active participation score.

In addition, the team’s participation was coded for utterances that included partnership building (e.g. asking the caregiver a question) and supportive talk (e.g. telling caregivers that they are doing a good job). We also coded for Team-prompted caregiver participation which involved direct caregiver responses to team partnership-building or supportive talk. Finally, Caregiver-initiated active participation was characterized by caregiver’s behaviors independent of the team’s partnership building and supportive talk.

The data were analyzed by two coders, a graduate student in communication and a health communication researcher, who conducted six hours of training. This training involved independent coding of five transcribed cases, a discussion to reach consensus and agreement, followed by independent coding of seven transcribed cases to assess for intercoder reliability and to discuss disagreements. During this first intercoder training session it was decided that courtesy communication such as greetings and good-byes would not be included in the data set. Technical adjustments concerning use of the videophone technology were also not considered in the assessment of active participation. In all cases, reliability was sufficient for caregiver active participation behaviors (.79) and physician’s facilitative communication (.83). A second intercoder training session involved coding from videotapes. The coders repeatedly viewed the videotaped discussions and coded the data. For each taped discussion, the unit of analysis was each participant’s talking turn. After an initial training period, the coders came to 100% agreement on the number of turns by talking through the differences. Overall, 25%
of the data was used to establish reliability and the remaining data set was coded independently by the two coders.

**Results**

Participants in this study consisted of family caregivers of hospice patients and two hospice interdisciplinary teams, comprised primarily of nurses, chaplains, social workers, and medical directors. Hospice staff consisted of a total of 43 hospice interdisciplinary team members, 36 females and seven males. There were 17 nurses, three social workers, three chaplains, two medical directors, and 18 other members such as volunteer coordinators and medical students. Table 1 illustrates the demographic factors for the 25 caregivers who were involved in this study. Caregivers participated in at least one hospice team meeting (range 1 – 8 videophone conferences).

The average technical quality score was 41 out of 50 (range 37-50) indicating good technical quality during the interactions. The research question asked to what extent caregivers actively participated in videophone communication with hospice team members. Descriptive statistics were used to answer research question one. Table 2 displays the descriptive statistics of caregiver and team responses. Consistent with similar research on patient-provider communication (Street & Millay, 2001), caregivers’ active participation varied, with some merely participating in the act of using the videophone and not asking questions, while others were more engaging by expressing concern and being assertive.

On average, caregivers asked 1 question per videophone conference (range, 0-5), produced at least 1 act of assertiveness (range, 0-10), and at least one expression of concern (range, 0-9). Regarding team communication, the team engaged in partnership-building behavior an average of 3 times per videophone conference (range, 0-11), but produced considerably less supportive talk averaging 1 supportive act per conference call (range, 0-7). Active caregiver participation was 3 times more likely to have been team-prompted (mean, 2.96, range, 0-5) than self-initiated (mean, .93; range, 0-5).

The hypothesis posited caregiver active participation behaviors would be positively correlated with the team’s use of partnership building and supportive talk. To ascertain this relationship, the correlation between total caregiver participation behaviors and total patient-centered team responses was computed. There was a significant correlation between the two scores, evidencing that the team’s use of active participation behaviors elicits caregiver active participation behaviors (r [13]=.712, p<.01). Hospice team meetings where staff used partnership building and supportive talk (patient-centered responses) had caregivers who were more assertive, expressed concern, and asked more questions. This finding supports preliminary results published by Street & Millay (2001) that documented a cycle of collaboration that emerges between healthcare provider and recipient.

The following examples between nurses (RN), social workers (SW), Caregivers (CG) and Medical Director (MD) illustrate the mutual influence of team –prompted and caregiver-initiated participation.

**Example 1:**

RN: Now, I checked with the pharmacist about flushing the pick line, and it does have to be flushed every day. But she’s thinking it needs to be flushed (medical term). Anyway, she’s going to check into it and get it all set up for me to bring to the house.

CG: We’ve been doing it [flushing the patient’s pick line] every day since last October. The same line has been in.
RN: Yeah.

CG143: It’s pretty unusual, isn’t it? [caregiver-initiated participation; asking question]

RN: Yes it is. Yes it is.

CG143: He’s (pharmacist) taking good care of us.

Researcher: (Name), we can’t see you right now. Would you like to move the camera back?

CG143: Where do you want to go with it?

RN: Little more to the back. There you go.

MD: (Caregiver’s Name), does (Patient’s name) have a favorite pain medicine? [partnership-building; team-prompted participation]

CG143: She has (medicine name) and (medicine name), and that generally will hold her if I’m consistent with it – if I don’t let too many hours go in-between.

MD: Okay.

CG143: But it’s all on the PRN basis, so in the beginning, we started out with the one liter and every hour……..One of the nurses, when I wasn’t doing too well with it, said add that and it sort of enhances the medication, and that triple combination seems to help her.

MD: Well, good. You’re doing a very good job. I can see. [supportive talk]

RN: Yes, she is. I don’t see how she does it for her age.

CG143: My biggest problem is trying to keep her awake and pain free at the same time. It just doesn’t seem possible, but I have to have one or the other. [expression of concern]

As the conversation came to a close:

SW: We want to thank you for being with us today.

CG143: You said something that I want to ask you about. [caregiver-initiated participation; assertive utterance] Um, we were on (medication)……and you have to have a glass of (inaudible) with it. So, [I] took her off the (medication) and put her on the (medication), and I wonder if you ever mix those two?

MD: If that’s what you think you’d like to try, we’d be happy to help. [supportive talk] It’s very difficult from a scientific standpoint to understand, um, how the medicines are working for (name). So, I’m thinking of it as a trial and error situation.

CG143: Well, yeah….And also, I want you to know about the (medicine). . [caregiver-initiated participation; assertive utterance] Since she hasn’t been eating and it can cause very little #x2026;..

MD: She still needs the (medicine) because even though you don’t eat, you still make stool.

Noticeably, as the following examples illustrate, there were many negative cases where the team failed to respond to caregiver active behavior. Consequently, self-initiated caregiver participation was not reciprocated by the staff.

Example 2: [patient at home]

RN: She’s very frail.
CG147: I know it. I know. I can’t handle her any more. I used to be able to help her go to the bathroom. And I can’t do it anymore…. She doesn’t have strength of her own. I don’t know what to do. [caregiver-initiated participation; expression of concern]

RN: I got her some medicine ordered today for the swelling in her legs.

CG147: The what in her legs?

RN: swelling.

CG147: Yes, she’s got a lot of swelling and their ice cold.

RN: We’ll try to get that down with the medication.

Example 3: [same caregiver as above example, patient now in a nursing home]

CG147: She wouldn’t even touch it (food).

RN: Yes, I noticed, her appetite has really went [sic] down and it’s….she’s really declined.

CG147: and her weight is down to 125.2.

RN: (caregiver’s name), you know it’s getting close for her.

CG147: I didn’t catch that.

RN: I said you know, she’s really getting close to the end [partnership-building]

CG147: I’m afraid yes. I don’t want to admit it, but I’m afraid yes. [team-prompted participation; expression of concern] Because today she was talking and I said ‘who are you talking to?’ and she said I don’t know. So she’s not making sense.

RN: Do you think she needs a visit from the chaplain?

In this interaction, the nurse prompts the caregiver to share her understanding of the situation, however, staff fail to follow up with supportive talk or more partnership-building once the caregiver has shared her concern.

Discussion

This data represents the first experiences of hospice teams in communicating in a group setting and in using the technology. Conclusions from these data are offered here as a future comparison which can assess the effect of maturity and experience in communicating long term in these situations. These results offer the opportunity to explore the ACTive intervention as well as explore potential training needs for teams and should therefore not be generalized at this point.

Data analysis of active participation in the ACTive intervention suggests that caregiver’s are comfortable communicating with team members when using videophone technology. Although caregiver participation varied, the majority of active participation included verbally assertive responses and expressions of concern. Videophone technology was not seen as an inhibiting factor to communication between caregivers and team members. Rather, the use of videophone equipment enhanced the communicative process. This finding indicates that caregivers felt comfortable initiating topics and highlights the communicative needs of hospice family caregivers. Prior research has found that caregivers of terminally ill patients report feeling comfortable asking most questions but still do not discuss them with staff (Hebert et al., 2008). Further analysis is needed to determine if the videophone component and IDT setting ameliorate caregivers’ ability to seek information.
The majority of caregiver participation was in response to team-initiated participation. Team members were successful in stimulating caregiver responses by engaging in both partnership-building and supportive talk. The team’s communication approach and reciprocal turn taking demonstrate that the mutual influence of communication in these interactions was not impacted by videophone technology (Street et al., 2003). The mutual influence of communication in these encounters was found to be statistically significant, as the communication of the hospice team positively influences the likelihood of caregivers’ expressing concern, asking questions, and being verbally assertive. Caregivers in this study averaged at least one of these acts per interaction. These findings suggest that videophone technology does not negatively influence these interactions when high technical quality is achieved. Technology aside, the context of the team meeting setting appears to have influenced communication in these encounters.

Overall, there was a lack of supportive talk which suggests that perhaps that the team felt less comfortable with the interaction. Findings regarding caregiver participation behaviors indicate that this is likely not related to the use of videophone technology, but rather may be a product of the staff’s limited experience communicating with caregivers in the context of an interdisciplinary team meeting setting (AUTHOR, in press). The limited amount of supportive talk produced by team members in this study suggests that regardless of medium, team members are not clear about the role and function of communication with family caregivers in the team meeting context. This finding is in concert with earlier research that although family member involvement in healthcare meetings have yielded high family member satisfaction, an unclear agenda for these meetings has been found to be problematic by patients, staff, and family members (Griffith, Brosnan, Lacey, Keeling, & Wilkinson, 2004).

While team participation was predominantly aimed at partnership-building, it was accomplished mainly by asking the caregivers questions about the patient’s status. By remaining centralized on the patient’s care they neglected to provide care for the family caregiver by providing supportive talk. The use of supportive talk as a communication strategy could ultimately influence the caregiver’s decision to participate in bereavement services as well as facilitate additional opportunities for staff to assess caregiver burden and offer respite care. The data suggest that training hospice providers to be supportive to caregiver concerns may be appropriate and warrant standard assessment.

While patient and family participation in IDT meetings is not currently the standard of practice in hospice (AUTHOR, 2005), our analysis suggests that the ACTive intervention enables caregiver active participation. The technology is successful in overcoming physical and financial obstacles to patient and family participation. Although it adds to an understanding of the practical benefits of utilizing technology in this setting, future research is needed to understand how the technology may impede or facilitate the content and structure of these interactions. The social presence facilitated through videophone communication is not as rich as face-to-face interactions. Future research should seek to assess whether mediated communication inhibits or facilitates caregiver involvement as little is known about the impact of the technology on the interaction.

Similar to findings related to the context of physician-patient encounters (Street, 2007; Street & Gordon, 2006; Street et al., 2005; Street et al., 2003), the context of the IDT setting contributed to the frequency of team-initiated participation and lack of supportive talk. Future training is needed to teach hospice team members how to optimize communication with caregivers in these types of interactions. We would recommend staff education on the importance of supportive talk in these interactions, especially for caregiver social support and as an early bereavement care intervention, and staff training on how to facilitate caregiver-initiated talk in the IDT setting. Further research regarding implementation of this type of
training is needed. This study provided insight into an innovative way to engage and potentially empower caregivers in the hospice care and decision-making process.

Acknowledgments

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References

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Table 1
Demographics of caregivers who participated in videophone conference calls

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<tr>
<th>Caregiver Demographics</th>
<th>Category</th>
<th>N (%)</th>
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<td>Age&lt;sup&gt;ab&lt;/sup&gt;</td>
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<td>Education</td>
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<td>Race/ethnicity</td>
<td>Caucasian</td>
<td>25 (100)</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>4 (16)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>21 (84)</td>
</tr>
<tr>
<td>Marital status</td>
<td>Never married</td>
<td>2 (8)</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>2 (8)</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>4 (16)</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>17 (68)</td>
</tr>
<tr>
<td>Employment</td>
<td>None outside home</td>
<td>15 (60)</td>
</tr>
<tr>
<td></td>
<td>Full time worker</td>
<td>8 (32)</td>
</tr>
<tr>
<td></td>
<td>Part time worker</td>
<td>1 (4)</td>
</tr>
<tr>
<td></td>
<td>Volunteer worker</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Caregiver relationship to patient&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Spouse/partner</td>
<td>9 (36)</td>
</tr>
<tr>
<td></td>
<td>Adult child</td>
<td>10 (40)</td>
</tr>
<tr>
<td></td>
<td>Parent</td>
<td>1 (4)</td>
</tr>
<tr>
<td></td>
<td>Sibling</td>
<td>1 (4)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Caregiver residence&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Outside the home</td>
<td>7 (28)</td>
</tr>
<tr>
<td></td>
<td>Living with patient</td>
<td>17 (68)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Age: Median = 49.96 y.

<sup>b</sup> Three caregivers did not respond.

<sup>c</sup> One caregiver did not respond.
Table 2

Descriptive Statistics of Caregiver and Team Responses

<table>
<thead>
<tr>
<th>Behavior</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caregivers’ participation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asking question</td>
<td>.79</td>
<td>1.08</td>
<td>0-5</td>
<td>55 (19%)</td>
</tr>
<tr>
<td>Expressions of concern</td>
<td>1.77</td>
<td>1.81</td>
<td>0-9</td>
<td>124 (43%)</td>
</tr>
<tr>
<td>Verbally assertive responses</td>
<td>1.54</td>
<td>2.50</td>
<td>0-10</td>
<td>108 (38%)</td>
</tr>
<tr>
<td><strong>Total active participant responses</strong></td>
<td>4.10</td>
<td>4.17</td>
<td></td>
<td>287</td>
</tr>
<tr>
<td>Caregiver-initiated participation</td>
<td></td>
<td></td>
<td></td>
<td>65 (23%)</td>
</tr>
<tr>
<td>Team prompted caregiver participation</td>
<td></td>
<td></td>
<td></td>
<td>222 (77%)</td>
</tr>
<tr>
<td><strong>Team patient-centered responses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnership building</td>
<td>3.67</td>
<td>3.07</td>
<td>0-11</td>
<td>257 (74%)</td>
</tr>
<tr>
<td>Supportive talk</td>
<td>1.29</td>
<td>1.59</td>
<td>0-7</td>
<td>90 (26%)</td>
</tr>
<tr>
<td><strong>Total patient-centered responses</strong></td>
<td>4.95</td>
<td>3.95</td>
<td></td>
<td>347</td>
</tr>
<tr>
<td>Caregiver-initiated participation</td>
<td></td>
<td></td>
<td></td>
<td>140 (40%)</td>
</tr>
<tr>
<td>Team prompted caregiver participation</td>
<td></td>
<td></td>
<td></td>
<td>207 (60%)</td>
</tr>
<tr>
<td>Team-prompted caregiver participation</td>
<td>2.96</td>
<td>2.45</td>
<td>0-10</td>
<td>207 (76%)</td>
</tr>
<tr>
<td>Self-initiated caregiver participation</td>
<td>.93</td>
<td>1.27</td>
<td>0-5</td>
<td>65 (24%)</td>
</tr>
</tbody>
</table>

*Mean scores represent the average frequency of the behavior for each interaction.*