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The Positive Impact of Individual Core Values

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Abstract

The role of values in organizations has been a highly researched topic (Collins, 2001; Collins & Porras, 1997; Frederick & Weber, 1990; Kouzes & Posner, 2007; Pattison, Hannigan, Pill & Thomas, 2010). However, little research has focused on values in health care settings. In addition, the research that has been done has focused on values from an organizational perspective, not from an individual perspective. Based on these two factors, in addition to the maturation and growth of the hospice industry, and the researcher's prior studies on hospice leadership and organizational practices; a research study was conducted to evaluate the core values of hospice professionals. Another key driver of the research were expressed difference identified by leaders within the hospice industry that values of individuals new to hospice were different than those who have worked in the industry longer. A web-based survey was utilized to gather core values and demographic data from hospice professionals. Data was collected over a one year period and involved 531 hospice professionals from 33 states. The demographic information collected was similar to comparative data from previous hospice studies. The top three core values identified in the study were family, faith and love and represented 76% of all responses. No statistically significant identifiable differences, based on demographic variables, were found. Based on the findings, no support was found for the perceived differences noted by leaders working in the hospice industry. However, it identified that hospice professionals regardless of demographic characteristics appear to hold similar values as being important. Based on the findings, core values appear to be an area of commonality versus difference among hospice professionals and could serve as a focal point for building a positive organizational culture. Further research is suggested to evaluate the unique meaning of the key values identified

by hospice professionals in the study. In addition, replication of the study in other health care settings would be suggested.

Introduction

The healthcare industry is a rapidly evolving business impacted by many outside forces. These diverse forces include changes in consumer demands, payer sources, government regulations, accreditation, the aging U.S. population and shortages of health care professionals (Dye, 2010; Fishman, Hornbrook, Meenan & Goodman, 2004; McConnell, 2000). Although, these external forces are significant and require health care executives to explore new and innovative ways to confront and manage them, there may be internal forces within health care provider organizations that may help the change process. One of these forces is the values held by professionals working within the healthcare industry. Although, prior research has identified that generational, occupational and personality differences (Fogg, 2008; Frederick & Weber, 1990; Holland, 1997; Sessa, Kabacoff, Deal & Brown, 2007) can impact an individual's values, little is known about differences in values between health care professionals and their effects on care or service delivery.

As a sub-grouping of the health care industry, the hospice industry appears to be a microcosm of the changes that have impacted the entire industry. The changes that the hospice industry has encountered include a 30% increase in patients served from 2005 to 2009, a 2.5% increase in Average Length of Stay (ALOS) and 5% increase in Median Length of Stay (MLOS) from 2007 to 2009 (NHPCO, 2010). An additional change to the industry is a change in the tax status mix of providers. The mix of Not for Profit to For Profit providers has shifted from 75%-25% to 50%-50% over the last decade (NHPCO)

Based on prior research on succession planning practices of hospices (Longenecker, 2009), it was identified that changing values of hospice professionals was seen as an obstacle for effective succession planning. This finding was supported by direct conversations with hospice

executives from across the U.S. This finding did not correspond with the researcher's previous research or personal experiences in the industry. Based on this information, a research project was conducted to explore differences in values between members of the interdisciplinary team involved in the delivery of hospice care.

Review of the Literature

Values

The study of values as a concept has existed for over 30 years following the seminal work by Milton Rokeach (1973). In his work, he identified two types of values: instrumental and terminal. Terminal values represented desirable outcomes like world peace, family security and happiness. Instrumental values were those values that allow people to achieve terminal values. Examples of these values are honesty, love, politeness and courage. Rokeach defined values as "a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end state of existence" (p. 5). Put into simple terms, values are a defined belief system that helps people differentiate right from wrong. In this process, values are placed in a hierarchy of importance.

Other research has helped expand the definition and scope of the study of values. Collins and Porras extended the definitions to include organizational values as "essential and enduring tenets – a small set of general guiding principles…" (1997, p. 73). Frederick and Weber (1990) identified that similar occupations tend to hold similar values and Holland (1997) identified a connection between personality, values and occupational preferences. To explore this connection further, Montrose & Sweeney (2010) found that values associated with specific professions may differ from personal values. In addition, the concept of generational impact on values has been

explored (Fogg, 2008, Sessa et al, 2007). These studies found that based on differing life experiences, each generation tends to adhere to different values.

Hospice

Hospice as a health care delivery model has seen significant growth since its formal introduction in 1983 when established as a Medicare approved service. Hospice care is focused on end-of-life care and works with individuals, with life-limiting illnesses and a projected life expectancy of 6 months or less, and their families. It has seen the number of individuals served grow from 1,000 patients to over 1.6 million in 2009 (NHPCO, 2010). In addition to growth in patient numbers, hospice has seen growth in number of providers, type of providers, payer sources and type of patient diagnosis (NHPCO). As part of this evolution, the professionals involved in hospice care have grown and changed. As is common in "grassroots" organizations and movements, the founding hospice leaders were focused on making changes in end of life care, creating a new healthcare provider identity, advocating for dying Americans and creating a cohesive identity (Smith, 1999a; Smith, 1999b).

With the many changes that occurred; hospices have taken on more of a business model. This is reflected by the increase of for-profit providers from 13% in 2001 (OHPCO and Perforum, 2003) to 50% in 2009 (NHPCO, 2010). In addition, the average age of hospice executives is early to mid-50's (Longenecker, 2009; Longenecker, 2008; Longenecker, 2006) representing an impending transition in leadership within the industry.

Hospice and Values

Comment [P1]: Research on values & health care

No prior research or publications focusing on values and hospice was found during the review of the literature. Anecdotal findings would suggest that values of family and faith would

be association with hospice providers and professionals related to their strong connection to end-of-life issues.

Research Focus

Based on the findings from prior values research, the hypothesis for this study was "Differences in core values would be identified based on demographic variables". The research question for the study was, "Do hospice professionals have expressed differences in their core values based on demographic variables"?

Methods

Participants

Potential participants for the study were all hospice professionals in the U.S. Participants were identified through their state hospice associations and accessed through each state's annual conference. All state hospice associations (44) were invited to be part of the study through the distribution of an "Invitation to Participate" letter to attendees at their annual state conference. Thirty-seven state associations accepted the invitation to assist in the study. The study data collection period ran for a one year period (September1, 2008 to August 31, 2009) to accommodate each state's planned conference.

Instrument

The study utilized a descriptive survey approach using a web-based tool. The study survey instrument consisted of two parts. The first part was based on an instrument entitled "Core Values Assessment (CVA)" developed by the Center for Ethical Leadership (CEL, 2002). Consent for use of the instrument was obtained through e-mail contact with CEL. The instrument was selected based on the researcher's familiarity with the tool from utilizing it with graduate leadership students and prior application of the tool in leadership training programs. The tool

was modified to accommodate a web-based model by eliminating the ability of participants to add values and a "faith" value option was added based on findings from use of the tool with graduate leadership students. Faith related values presented approximately 20% of values added when the CVA was completed by the graduate students.

The instrument required participants to review a list of 19 values and reduce the list to eight values based on their significance to the participant. Participants were then instructed to reduce the list to four values then finally to two core values. As the participants worked through the elimination process, the website automatically moved the selected values to a new page for the next step. A list of the values can be found in Table 1. The second part of the survey collected key demographic data relevant to hospice professionals; position, education, years of hospice experience, age, and gender; and their organizations; tax status, service area, and state.

Data Collection

Two to three weeks prior to each state's conference, copies of the invitation letter and a script for inviting attendees to participate in the study was sent to the organizational contact. The invitation letters were to be distributed with materials provided to each conference attendee. In addition, each state was asked to announce the project daily during their conference to increase awareness. Based on the recommendation of a state hospice director; a follow-up e-mail with an electronic copy of the invitation letter was sent to each state's contact person one week after the completion of their conference asking them to forward the letter to their member hospice organizations for distribution to staff.

The invitation letter described the study and its purpose and directed participants' to the study website. The website explained the study in more depth and sought their consent to

participate in the study. Participants needed to consent prior to accessing the study survey. The research study was approved by the Institutional Review Board of Lourdes University.

Upon completion of the data collection period, the data file from the website was loaded into SPSS for analysis. Descriptive statistics were run on value data and demographics. Correlation analysis was completed to examine significant relationship between values and demographic data. Level of statistical significance was conducted at the $p < .01$and $< .05$ levels.

Results

Demographics

A total of 37 state hospice associations agreed to assist in the data collection process by disseminating the information about the study. During the data collection process, 531 hospice professionals from 33 states participated in the study. In addition, 43 partial surveys were completed and 123 visits to the study website occurred without any information being provided. Only completed surveys were used in the analysis. The demographic information on the participants can be found in Table 2. The predominant characteristics of participants and their organizations were as follows:

Nursing	34.6%
Bachelor Degree	36.7%
Years of Hospice Experience (mean)	8.5
Age (Mean)	49.7
Female	92%
Employer – Not for Profit	84%
Service Area – Urban & Rural	59.7%
Region of the US – Great Lakes	40.6%
State – Ohio	23.4%

Values

In evaluating the values selected at the three stages of the process, *Family* was the highest rated value at each stage. Respectively chosen, 45.5% (top eight), 39% (top four) and 33% (top two). The other four highest rated values selected were *Faith*, *Love*, *Integrity* and *Peace*. These values were the top five values from the initial cut to eight down to the final two. The only thing that changed was their ranking on the list. In the elimination process, all 19 values were selected by at least one participant in the cut to eight values, 15 values at the cut to four values and 12 values at the cut to two values. The summary of the top five values can be found in Table 3.

No statistically significant correlations were identified between any of the values and the demographic characteristics. In evaluating correlations with and between values as the elimination process occurred, several statistically significant findings were identified. For *Family* at the final stage, a strong correlation (P = .69) was found with *Family* at the second stage. In addition, weak correlations were found with Level of Education (P = -0.09) and Years of Hospice Experience (P= 0.058). For *Faith* at the final stage, four strong negative correlations were found from values selected at the second stage; *Peace* (P = -0.83), *Integrity* (P = - 0.82), *Love* (P = -0.79) and *Truth* (P = -0.71).

Discussion

Based on the findings, it would appear that hospice professionals regardless of their demographic characteristics expressed having similar core values although no statistically significant findings were found based on age, gender, years of hospice experience, profession, type of employer, service area or location in the U.S. The finding of *Family* as an important value correlates well with other research studies on values (Frederick & Weber, 1990; Allicock,

Sandelowski, De Vellium & Campbell, 2008**).** The hypothesis for the study that differences would be found in values based on demographics was not supported.

In evaluating the comparability of the research sample to the population of hospice professionals in the U.S., the participants would appear to provide a good representation. When looking at the various professions within hospice, the sample closely mirrored prior demographic analysis (NHPCO, 2007). Nursing in the study represented 34.6% compared to 33.8% in the NHPCO data. The only category not closely matched was Hospice Aides with 1.7% compared to 19.8% (NHPCO). This difference could be explained by the low number of Aides who attend state conferences. The other notable differences in the demographics were fewer Masters prepared and more Associate Degree participants and fewer years of hospice experience. These findings could be explained by prior comparative hospice studies being conducted on executives (Longenecker, 2009; Longenecker, 2008, Longenecker, 2006). However, the demographics of the current study would appear to be a better representation of the general hospice profession population than prior studies since it involved representation from all hospice professional categories.

Two areas where differences existed in the organizational demographics were Tax status and Regional representation. Not for profit employees represented 84% of the sample as compared to 48.6% in NHPCO data (2010). This difference in For Profit representation has been noted in other studies (Walston, Chou, & Khaliq, 2010**)**. This disparity may negate the significant of the findings since For Profit professionals were under represented in the study. However, as reflected in the findings, although For profit and Not for profit responses were analyzed for statistical differences, no significant findings were identified.

For regional representation, the Great Lakes region was over represented while the Southeast and Northeast regions were under represented. This difference could be explained by the two states (Ohio and Minnesota) with the highest level of participation represented 36.6% of the sample was both in the Great Lakes region. Similar to tax status, the disparity in regional representation may minimize the significance of the findings since the study population was not a proportionate representation of hospice across the U.S. However, no statistically significant findings were identified between states or regions.

A key relevant finding of the study was the study population represented all levels of hospice personnel; executive, management and front line workers; in addition to both clinical and business operations; making the findings more generalizable to the entire hospice industry. In addition, participants represented 33 different states.

Recommendations

Based on this cross-representational population, the commonality of values across the hospice team continuum would appear to represent a key building block for organizational success. As noted in the introduction, prior research identified that expressed differences in values was seen as being an obstacle for succession planning, team development and personnel development (Longenecker, 2009). Based on the study findings, support for the opposite would appear to be true. With Family, Love, Faith, Integrity and Peace, the top five values, representing 92% of all responses; strong support for building a cohesive hospice team would appear to be present. Instead of values being an area that pulls a team or organization apart, it would appear that it is an area that can bring them together. Using values as the common thread among the hospice interdisciplinary team would allow the organization to develop a strong core

on which to build all team activities and functions. This approach would be building on positive attributes of the team not perceived differences between team members.

In applying these findings to other industries and setting, the perception of differences between individuals, personally and professionally, would seem to be common. The question of the difference between perception and reality is directly addressed by this study. If the findings from the study can be viewed from a "big picture" perspective, the commonalities between individuals are greater than the differences. With this as a starting point; building relationships between individuals and within groups, organizations, and communities would be much easy. Creating a strong foundation on which all other blocks are laid.

Limitations

The study utilized state hospice organizations to help disseminate information on the research and may have resulted in bias or inaccurate information being shared with potential participants. Minor differences in the study sample demographics compared to other studies findings may limit the ability to generalize the findings although the study appeared to mirror comparable studies closely.

In addition, the interpretation of the meaning of the values could have been different related to defined meanings for the values were not provided for study participants. Each participant was allowed to define the meaning of each value based on the individidual perspective.

Future Research

Based on the results of the study, three areas of future study are recommended. First, no identifiable differences were noted in core values between the different hospice professionals, so it is suggested that an evaluation of the unique meaning of the top values; Family, Faith, Love,

Integrity and Peace; be explored. The differences between hospice professionals may not be in the values chosen but the unique meaning of the values to the different hospice professions. Further evaluation would help in clarifying this question. Research by Kouzes and Posner (2007) and Pattison et al (2010) would support this type of study since they identified that values can have different meanings for different people.

A second area of study related to the meaning of the values would be to provide participants with definitions of each value to help them frame their meaning and create a common meaning between participants.

A third and final area of future study would be replicating the study in other health care settings; hospitals, home care, long term care, outpatient settings; as a few examples. Although, there are perceived differences between health care professionals in the variety of health care settings that exist, there doesn't appear to be empirical support for these perceptions.

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Table 1

Core Values

- Peace
- Wealth
- Happiness
- Success
- Friendship
- Fame
- Authenticity
- Power
- Influence
- Justice
- Integrity
- Joy
- Love
- Recognition
- Family
- Truth
- Wisdom
- Status
- Faith

(CEL, 2002)

Table 2

Demographics of Study Participants

Current position	**% of sample**	**Comparative data (NHPCO, 2007)**
Nursing	34.6	33.8
Management	23.25	
Administration	19.1	
Social Work	11.15	8.2
Bereavement	2.5	4.2
Chaplain	2.5	4.2
Volunteer	2.3	
Hospice Aide	1.7	19.8
Business Operations	1.3	
Medicine	1.0	3.4
Therapy	0.75	

Education	**% of sample**	**Comparative data***
Bachelor	36.7	25-36.7
Associate	28.7	7-10
Masters	24.8	43.3-68
High School	7.2	0-3.3
Doctorate	3.0	0-3.3

*(Longenecker, 2009; Longenecker, 2008: Longenecker, 2006)

Years of Hospice Experience	**Sample**	**Comparative data***
Mean	8.5	12.1-13.9
Median	6	12-14
Mode	3 (9.25% of sample)	5-20
Range	<1 to 32	

*(Longenecker, 2009; Longenecker, 2008: Longenecker, 2006)

Age	**Sample**	**Comparative data***
Mean	49.7	51.1-52.1
Median	52	52-54
Mode	56 (5.5% of sample)	43-55
Range	22-78	

*(Longenecker, 2009; Longenecker, 2008: Longenecker, 2006)

Gender	**% of Sample**	**Comparative data***
Female	92	71.7-86.7
Male	8	13.3-28.3

*(Longenecker, 2009; Longenecker, 2008: Longenecker, 2006)

Organizational Profit Status	**% of Sample**	**Comparative data (NHPCO, 2007)**
Not-for Profit	84	48.6
For-Profit	16	47.1

Service Area	**% of Sample**	**Comparative data***
Both Urban & Rural	59.7	44.6-64.2
Rural	28.2	21-34.2
Urban	12.1	6.7-21.2

*(Longenecker, 2009; Longenecker, 2008: Longenecker, 2006)

Region of U.S.	**% of Sample**	**Comparative data (NHPCO, 2007)**
Great Lakes	40.6	23.5
West	22	18.2
Central Plains	14.9	13.8
Southeast	13.5	26
Northeast	8.8	18.2

Table 3

Summary of Value Results

Top Eight		**Top Four**		**Top Two**	
Family	45.5%	Family	39%	Family	33%
Love	43.5%	Love	28%	Faith	21%
Peace	42%	Faith	26.5%	Love	13%
Integrity	41%	Integrity	21.5%	Integrity	11%
Faith	35%	Peace	19.5%	Peace	5%
19 values selected		15 values selected		12 values selected	