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Implementation outcomes of a dementia-focused intervention for family care partners and clinicians in home hospice care

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Abstract

Objectives. End-of-life care for persons living with dementia in home hospice relies heavily on coordination between family care partners (FCPs) and clinicians (e.g., hospice social workers and nurses). FCPs and clinicians have reported support and knowledge gaps in end-of-life dementia care. Interventions are needed to improve FCPs' support and clinicians' educational gaps.

Methods. A pilot randomized controlled trial was designed to examine implementation outcomes for a dementia-focused end-of-life intervention for FCPs ($n = 37$) and clinicians ($n = 15$). Data on survey completion and acceptability were collected at baseline, during 4 follow-up visits, and at the conclusion of the study.

Results. Twenty-eight (75%) caregivers completed the post-study survey, and 10 (27%) reported using the structured worksheet. Thirteen (87%) clinicians completed the post-training survey, 8 (53%) completed the post-study survey, and 8 (100%) used the worksheet. Clinicians ($n = 8$) were satisfied or highly satisfied with the instructional videos, and half (50%) used the information frequently with patients. Both groups reported the worksheet helpful, easy to use, and satisfactory, though clinicians rated helpfulness slightly higher (mean = 3.88 vs. 3.70 for FCPs). Clinicians liked the worksheet's structured guidance and the enhanced collaboration.

Significance of results. This study provides preliminary evidence for implementation outcomes of a dementia-focused end-of-life intervention in home hospice. Findings suggest the intervention can be implemented in a hospice setting, with moderate worksheet uptake and perceived value among FCPs and clinicians.

Introduction

Persons living with dementia (PLwD) are the fastest-growing group of hospice users (now accounting for over 50% of hospice enrollees in the United States) (De Vleminck et al. 2018; Aldridge et al. 2022; Centers for Medicare & Medicaid Service 2025). Home hospice care is a model of treatment designed to provide physical, psychological, and emotional support to individuals with a life expectancy of 6 months or less, as certified by 2 physicians, and to their families (Bhatnagar et al. 2023). Services are typically delivered in private residences, nursing homes, and assisted living facilities (Bhatnagar et al. 2023). Hospice care for PLwD is increasingly characterized by lengthier hospice stays with more days of routine home care and additional home health aide visits (Frank et al. 2025). PLwD often have limited capacity to advocate for their needs due to late-stage dementia symptoms (Hugo and Ganguli 2014), leaving family care partners (FCPs) responsible for making treatment decisions (Feinberg and Whitlatch 2002; Martin et al. 2019). FCPs frequently turn to clinicians, most often social workers and registered nurses in hospice care, for knowledge and support when making these decisions.

End-of-life care for PLwD relies heavily on coordination between FCPs and clinicians. For FCPs, this can exacerbate caregiver distress (Brodaty and Donkin 2009) by increasing decision-making uncertainty (Sellars et al. 2019), contributing to misunderstandings of clinical information (McWilliams et al. 2018), and reducing confidence in collaborative decision-making with clinicians (Sellars et al. 2019). In tandem, clinicians caring for PLwD near the end of life face competing clinical demands such as balancing time with the patient and the family (Edberg et al. 2008) and communication challenges ascertaining the wishes of the patient with dementia who has limited communication abilities and relies on their FCPs to relay their wishes (Abrahamson et al. 2009; Albers et al. 2014), underscoring the need for interventions

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that enhance clinician confidence and skills in medically complex settings. Critically, both FCPs and clinicians have reported knowledge gaps in end-of-life care for PLwD (Todd et al. 2021; McDarby et al. 2023, 2024). To better meet the needs of PLwD at the end of life, interventions are needed to better support FCPs and improve clinicians' educational gaps.

Prior research on FCP interventions has focused on general hospice or palliative care education (Chi et al. 2016). Notably, many caregiver interventions do not specifically target dementia-specific needs, with 1 systematic review (Chi et al. 2016) finding only 1 study focused on caregivers to those with dementia (Reinhardt et al. 2014). Similarly, interventions for clinicians have included palliative care training and educational modules (Anstey et al. 2016; Tjia et al. 2023), but largely lack hospice- and dementia-specific information. Other interventions include structured curricula and training programs to improve the delivery of end-of-life care (Chi et al. 2016). These interventions have ranged from psychosocial support to cognitive-behavioral approaches with mixed effectiveness and implementation results (Chi et al. 2016). Review of these interventions found increased awareness and knowledge of end-of-life care, but limited use in clinical practice over time (Anstey et al. 2016; Lassell et al. 2022). Additionally, rarely have interventions implemented a dyadic approach between FCPs and clinicians.

Luth and colleagues developed the "Enhancing Dementia Instruction and Tool in Home Hospice Care" (EDITH-HC) intervention (Geisser et al. 2025; Tamer et al. 2025), a 2-pronged approach for clinicians and FCPs. The parent study (Geisser et al. 2025; Tamer et al. 2025) focused specifically on Black and White FCPs of PLwD in home hospice to allow a focused evaluation of these 2 populations, given the increased risk of poor hospice outcomes for Black PLwD (Luth et al. 2020, 2024) and limited research on Black–White racial differences in dementia caregiving burden (Black et al. 2013; Miranda-Castillo et al. 2013; Chi et al. 2016). EDITH-HC includes educational modules for clinicians on dementia-specific end-of-life care and a structured worksheet for clinicians and FCPs to complete together to identify and address FCP stressors. The intervention aims to enhance dementia care quality in home hospice settings by tailoring support for FCPs.

Following stage 1B of the National Institutes of Health (NIH) Stage Model for Behavioral Intervention Development (Research Centers Collaborative Network 2025), this study evaluates the implementation and acceptability of the pilot randomized controlled trial of EDITH-HC. This study provides an overview of the strengths and limitations of this intervention and guidance on intervention adjustment for future evaluation.

Methods

Study design

This pilot randomized controlled trial employed a 2-arm design with repeated measures at baseline, up to 4 subsequent clinical visits, and a final survey at study completion to assess intervention implementation and acceptability outcomes. Participants completed surveys electronically via Research Electronic Data Capture (Harris et al. 2009). For participants who did not complete the surveys online, trained study staff conducted follow-up data collection by telephone. The study utilized a non-blinded, adaptive randomization strategy to balance participant numbers across study arms. This protocol was approved by the VNS Health (1805421) and the Rutgers (Pro2021001817) Institutional Review Boards. This trial was registered on www.clinicaltrials.gov (NCT05719077).

Recruitment and participant eligibility

Participants were recruited from a New York City hospice agency between October 2023 and March 2025. The agency is a nonprofit healthcare program with an average daily census of 1,100 hospice patients. All participants provided oral informed consent before enrollment.

Eligible clinicians were hospice social workers or nurses providing home hospice care to PLwD. Eligible FCPs met the following criteria: 18 years or older; provided care to a family member, friend, or significant other with dementia enrolled in home hospice for at least 2 weeks; able to complete data collection in English; self-identified as Black or White to the study screener; provided at least 8 h of care per week for a minimum of 1 month; and scored 15 or higher on the Animal Naming Test, a validated cognitive screening measure assessing verbal fluency and cognitive function (Henry and Crawford 2004).

Intervention

Clinicians completed 5 educational modules delivered flexibly via videoconference in 30–60-min sessions to accommodate schedules. These modules included 4 videos addressing dementia-specific end-of-life care challenges: eating and feeding, pain assessment and management, documenting caregiver burden in the electronic health record (EHR), and instructions on using the Needs and Strategies Worksheet, a 1-page intervention worksheet. The worksheet employs problem-solving therapy (Nezu et al. 2013) strategies to systematically identify and address dementia-related stressors faced by FCPs, facilitating tailored support within diverse socioeconomic and cultural contexts. Clinicians used the worksheet during routine hospice visits to guide ongoing caregiver support.

Measure

Participants completed study-developed, self-reported questionnaires at baseline, after each educational module (for intervention clinicians only), after each visit (up to 4 times), and at the end of the study.

Sociodemographic information

We used structured questionnaires to collect sociodemographic data from clinicians and FCPs (e.g., age, gender, race, education). Clinicians were asked about their professional role. FCPs provided their relationship to the PLwD and the average number of hours spent providing care per week.

Implementation and acceptability

We assessed the acceptability of educational modules using a combination of Likert-scale (ranging in scores from 1 to 5 with higher values indicating more positive ratings), multiple-choice, and short-answer questions. Likert-scale items captured clinicians' and FCP perceptions on the ease of use, helpfulness, satisfaction,

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and likelihood of continued use of the intervention components. Responses for the Likert scales ranged from "very difficult" to "not at all difficult," "very unhelpful" to "very helpful," or "very dissatisfied" to "very satisfied." Multiple-choice questions on intervention implementation collected data on preferences, frequency of use, and settings. Some multiple-choice items permitted multiple responses to capture the full range of participant experiences and opinions. Open-ended, short-answer questions invited participants to provide qualitative feedback on the intervention, elaborating on helpful or challenging aspects and suggestions for improvement. An example of a quantitative question includes "How helpful was the video on the Needs and Strategies Worksheet to you?" while a short-answer item was "Please indicate what you found helpful about the video." These varied question formats enabled a comprehensive quantitative and qualitative evaluation of implementation and acceptability.

Data analysis

Descriptive statistics summarized participant characteristics, implementation, and acceptability using SPSS version 31 (International Business Machines Corporation 2025). Free-text responses to acceptability items were examined and summarized to provide exemplar quotes.

Results

Participant characteristics

FCP average age was 58.2 years (SD = 13.5), and most identified as female (83.8%). About half of FCPs identified as White (51.4%), followed by Black/African American (35.1%). Most FCPs were daughters (59.5%) of the PLwD. Many of the FCPs reported spending 24 h a day, 7 days per week (32.4%) providing care to the PLwD. Table 1 presents the demographic data for all FCPs.

Clinicians' average age was 43.8 years (SD = 11.4), and most identified as female (66.7%). Most clinicians identified as White (46.7%), followed by Black/African American (40%). Half (53.3%) had graduate school education, 60% were nurses, and 40% were social workers. Half of clinicians visited the PLwD a few times a month (53.3%). Table 1 presents demographic data for all clinicians.

Enrollment and retention

FCPs: Thirty-seven FCPs enrolled in the intervention, of whom 28 (75.7%) completed the post-intervention survey; 3 did not receive the survey due to leaving the study, while the 6 other participants did not complete the survey after they were contacted. In post-visit assessments, 12 FCPs reported using the worksheet.

Clinicians: Fifteen clinicians enrolled in the intervention group. Two clinicians discontinued participation before completing the educational component. The remaining 13 clinicians completed each educational module and post-training survey. Of these 13, 12 matched with an FCP during this study. Of these 12, 8 clinicians (75%) completed the post-intervention survey. The remaining 4 clinicians could not be reached by the study team.

Implementation and acceptability for clinicians

Clinicians reported high levels of engagement and satisfaction across all 4 educational modules: Eating & Feeding Support,

Table 1. Participant characteristics for 37 family care partners and 15 clinicians

	Family care partners		Clinicians	
	n	**%**	***n***	**%**
Total	37	–	15	–
Relationship to PLwD				
Daughter	22	59.5	–	–
Other family	7	18.9	–	–
Son	4	10.8	–	–
Spouse	2	5.4	–	–
Non-family	2	5.4	–	–
Role				
Nurse	–	–	9	60.0
Social worker	–	–	6	40.0
Age (mean/SD)	58.2	13.5	43.8	11.4
Sex				
Female	31	83.8	10	66.7
Male	4	10.8	4	26.7
Missing	2	5.4	1	6.7
Race				
Black	13	35.1	6	40.0
White	19	51.4	7	46.7
>1 race	1	2.7	1	6.7
Other race	1	2.7	–	–
Prefer not to answer	1	2.7	–	–
Missing	2	5.4	1	6.7
Hispanic				
No	32	86.5	14	93.3
Yes	3	8.1	0	0.0
Missing	2	5.4	1	6.7
Education				
Some graduate school/graduate degree	9	24.3	8	53.3
College	14	37.8	6	40.0
HS or less	8	21.6	–	–
Some college	4	10.8	–	–
Missing	2	5.4	1	6.7
Hours of weekly caregiving				
24 h/day, 7 days/week	12	32.4	–	–
>30 (less than 24/7)	12	32.4	–	–
8–30	7	18.9	–	–
Less than 8	2	5.4	–	–
Missing	4	10.8	–	–
Patient encounter				

(*Continued*)

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Table 1. (*Continued.*)

	Family care partners		Clinicians	
A few times a month	–	–	8	53.3
Monthly	–	–	4	26.7
Other	–	–	2	13.3
Missing	–	–	1	6.7

PLwD = persons living with dementia; SD = standard deviation; *n* = number.

Pain, EHR, and Needs and Strategies Worksheet. Across modules, most clinicians watched the entire videos (Eating & Feeding: 92.9%, $n = 13$; Pain: 92.9%, $n = 13$; EHR: 100%, $n = 14$; Needs and Strategies Worksheet: 92.9%, $n = 13$) and reported minimal difficulty understanding the content (92.9–100% across modules).

Clinician evaluation of educational modules (Table 2)

Across all modules, clinicians reported high perceived helpfulness, strong likelihood of use in practice, and high satisfaction, with mean ratings in the range of 4.31–4.54 (helpfulness), 4.38–4.69 (likelihood of use), and 4.33–4.69 (satisfaction). The Eating & Feeding Support and EHR modules demonstrated the strongest overall ratings (≥92.9% acceptability across outcomes), while the Needs and Strategies Worksheet also showed consistently high acceptability (92.9% across domains). Although still favorable, the Pain module showed comparatively lower ratings, particularly for likelihood of use (78.6%) and satisfaction (85.7%). Short-answer feedback highlighted requests for additional detail, such as information on feeding tube interventions (Eating & Feeding), non-pharmacologic pain management strategies (Pain), ways to more specifically document concerns from FCPs (EHR), and more examples for using the worksheet during visits (Worksheet). Themes reflected both appreciation for the clarity of the materials and suggestions for expansion of content to support clinical practice.

Comparison of clinician responses from post-training to post-intervention (Table 3)

Clinicians reported similar levels of satisfaction across both surveys. There were slight decreases in levels of helpfulness, use in practice, and intent to use information after application in clinical visits.

Implementation and acceptability for FCPs

Twenty-eight FCPs completed the post-intervention survey. The sample was split between FCPs who reported using the worksheet ($n = 10$) and FCPs who reported not using the worksheet ($n = 18$). Among FCPs who used the worksheet, 70% reported using it 2–4 times, found it moderately helpful ($M = 3.20$, SD = 0.919), and were moderately satisfied ($M = 3.70$, SD = 0.823). Most reported minimal difficulty using it. Short-answer responses indicated that guidance and steps were helpful. Next, FCPs who reported not seeing or using the worksheet ($n = 18$, 100%) indicated that they were unaware of the worksheet.

Comparison of post-intervention responses from clinicians and FCPs who used the worksheet (Table 4)

Completion of the Needs and Strategy Worksheet was evaluated for clinicians and FCPs from the post-intervention survey. All 8 clinicians who completed the post-intervention survey reported using the worksheet with at least 1 FCP during a visit. Ten (35.7%) FCPs reported using the worksheet with their clinicians. Both groups reported the worksheet as generally helpful, not difficult to use, and satisfactory, though clinicians rated helpfulness slightly higher ($M = 3.88$ vs. $M = 3.70$ for FCPs). Time to use the worksheet was longer for clinicians than for FCPs during initial use, but follow-up times were comparable. Short-answer responses showed that both groups valued the structured guidance and collaborative aspects of the worksheet.

Discussion

Findings from this pilot randomized controlled trial of EDITH-HC among FCPs and clinicians found high acceptability and promising implementation outcomes. The results suggest the intervention may serve as a helpful tool for FCPs caring for PLwD and hospice social workers and nurses.

Clinicians consistently rated education modules highly regarding helpfulness, satisfaction, and usability following training and indicated that the information applied to clinical practice. Content was described as clear, practical, and relevant to patient care. These findings suggest that the education modules may enhance the perceived preparedness of clinicians supporting PLwD and their FCPs. This perceived utility is particularly important given that clinicians, specifically social workers and nurses in hospice, often have limited time to learn and implement new interventions (Abrahamson et al. 2009; Albers et al. 2014). Prior educational interventions for clinicians have not focused on dementia and end-of-life information (Anstey et al. 2016; Tjia et al. 2023). Therefore, EDITH-HC may help address this gap by integrating these domains into an evidence-based training approach (Nezu et al. 2013; Geisser et al. 2025; Tamer et al. 2025).

Modules emphasizing direct clinical strategies (e.g., the Eating & Feeding Support and Pain modules) were particularly valued for their actionable content. Nutrition and pain are often challenging to manage in PLwD due to communication difficulties (Sachs et al. 2004; Tarter et al. 2016; Fetherston et al. 2018). Clinicians providing evidence-informed guidance (Tarter et al. 2016; Volkert et al. 2024) on these symptoms may lead to more effective symptom management for patients and potentially reduce caregiver strain. However, future research is needed to evaluate whether the EDITH-HC intervention leads to measurable improvements in patient and caregiver outcomes.

Clinicians reported that documentation and structured communication modules (e.g., EHR and Needs and Strategies Worksheet modules) supported workflow efficiency, standardization, and family engagement. Workflow efficiency is critical in high-demand settings such as hospice, where clinicians face significant time and workload constraints (Gesner et al. 2022; Jang et al. 2024; Sloss et al. 2024). These findings suggest that EDITH-HC may help streamline aspects of workflow, with potential downstream benefits (Sloss et al. 2024) that warrant future research.

Despite high satisfaction with content and training, implementation in practice was variable. Retention in research with

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Table 2. Clinician evaluation of education modules: quantitative and qualitative integration

Module	Sample size (*n*)	Helpfulness (*M* ± SD)	Satisfaction (*M* ± SD)	Likelihood of use (*M* ± SD)	Representative quotes
Eating & Feeding Support (EFS)	13	4.54 ± 0.66	4.69 ± 0.48	4.69 ± 0.48	"Good information, very practical for families." "Reinforced what I already knew and gave actionable steps." "Could include more detail on PEG tube care."
Pain	13	4.31 ± 0.86	4.33 ± 0.65	4.38 ± 0.96	"Helpful for assessing non-verbal patients." "Non-pharmacologic strategies were useful." "Would like more examples for pain management."
Electronic Health Record (EHR)	14	4.36 ± 0.75	4.57 ± 0.51	4.64 ± 0.63	"Clarified documentation for caregiver burden." "Increased confidence in EHR entries." "Helpful for understanding reporting requirements."
Needs & Strategies Worksheet (WKST)	13	4.31 ± 0.63	4.46 ± 0.52	4.54 ± 0.52	"Guided structured conversations with families." "Useful for problem-solving with pros and cons framework." "Could include more examples for different patient situations."

Helpfulness, satisfaction, and likelihood of use were measured on 5-point Likert scales (1 = very unhelpful/very dissatisfied/very unlikely, 5 = very helpful/very satisfied/very likely). Representative quotes were selected to illustrate common themes from short-answer responses.

Table 3. Comparison of clinician post-training and post-intervention survey responses

Domain	Question	Post-training results	Post-intervention results	Change over time
Perceived helpfulness and use of materials	Overall helpfulness and use of videos and worksheet	Most clinicians rated materials as highly helpful (78.6%)[a]	Half reported main points of specific materials were used (50%)[c]	Initial high perceived helpfulness decreased slightly with real-world use
Satisfaction with videos	Overall satisfaction with educational videos	Majority reported high satisfaction across modules (85.7%)[b]	Majority reported high satisfaction (100%)[c]	Satisfaction with videos remained high with real-world use
Use in clinical practice	Likelihood of using videos and worksheet in practice	Majority reported high likelihood across modules (78.6–92.9%)[a,b]	Half reported frequent use (50%)[c]	Anticipated use exceeded actual reported use
Understanding and using worksheet	Difficulty using worksheet	Majority reported no difficulty understanding information (92.9%)[b]	Majority reported worksheet was not difficult to use (75%)[c]	Ease of use for the worksheet remained high during implementation
Worksheet implementation	Helpfulness of Needs and Strategies Worksheet	Rated as helpful or very helpful (92.9%)[a]	Rated as helpful or very helpful (62.5%)[c]	Perceived helpfulness declined slightly with real-world use
Continued use intentions	Likelihood of continued worksheet use	Majority reported high likelihood anticipated (92.9%)[a]	Half reported anticipated continued use (50%)[c]	Intent to continue use declined post-study

Sample size varies across items due to item-level non-response:
[a]$n = 13$,
[b]$n = 14$,
[c]$n = 8$.
Likert-scale items were rated on 5-point scales, with higher scores indicating less difficulty or greater perceived helpfulness, as appropriate.

hospice and end-of-life participant groups is a documented challenge (Sherman et al. 2005; Wiegand et al. 2008; Fischer et al. 2012). While this study retained 61% of the clinicians for the post-intervention survey, additional research is needed to understand and decrease study attrition. Among clinicians, half reported using the videos in clinical encounters, and 70% reported using the worksheet with 2–4 FCPs. While most of the clinicians used the worksheet at least once with the FCP, the clinicians reported that FCP engagement during visits and patient needs limited their ability to fully review the worksheet and evaluate FCP stressors. These findings align with prior literature highlighting limited clinician time (Hoffstädt et al. 2023; Hughes et al. 2024; McAndrew et al. 2025) and competing demands for caregivers (Bijnsdorp et al. 2022; Sullivan et al. 2022) in hospice settings. Although the EDITH-HC intervention demonstrated strong acceptability with clinicians, these implementation challenges suggest the need for further refinement to enhance scalability. Clinicians may have integrated aspects of the intervention based on individual workflow and clinical priorities, as observed across behavioral health interventions (Kendall and Frank 2018; Bennett and Shafran 2023). However, add-on training with hospice clinicians may be required to facilitate consistent use.

Additional refinement may also be needed to optimize engagement among FCPs. While many FCPs reported meaningful discussions, some FCPs did not fully engage in visits or complete the worksheet. Engaging FCPs in hospice care is inherently challenging due to caregiver stress (Wittenberg-Lyles et al. 2011; Hughes et al. 2024) and time limitations (Sherman 2019; Thomas Hebdon et al. 2023). These findings suggest that alternative or supplementary formats of intervention delivery for FCPs may require a different

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Table 4. Comparison of the post-intervention survey for clinicians and FCPs who used the worksheet

Question	Clinicians post-intervention ($n = 8$)	FCPs who used worksheet post-intervention ($n = 10$)
How often have you used information from the educational videos/worksheet?	Frequently: 4 (50%), sometimes: 2 (25%), rarely: 2 (25%)	Used worksheet 2–4 times: 7 (70%), once: 3 (30%)
Worksheet first-time use (minutes)	20–40 min: 4 (50%), 5 min: 1 (12.5%)	10 min: 5 (50%), 15–45 min: 5 (50%)
Worksheet follow-up time use (minutes)	10–30 min: 5 (62.5%), 5 min: 1 (12.5%)	5–15 min: 7 (70%)
Worksheet/videos helpfulness	Helpful or very helpful: 5 (62.5%), neutral to unhelpful: 3 (37.5%), $M = 3.88$, SD = 1.07	Helpful: 8 (80%), not helpful: 2 (20%), $M = 3.20$, SD = 0.919
What did you find helpful? (Short answer)	Guidance for discussions: 3, collaboration: 2	Entire worksheet: 2, dual aspect care: 2, steps to provide care: 2
Worksheet difficulty	Not difficult: 6 (75%), $M = 4.50$, SD = 1.07	Not difficult: 7 (70%), $M = 4.60$, SD = 0.699
Overall worksheet satisfaction	Satisfied: 6 (75%), $M = 3.88$, SD = 0.99	Satisfied: 7 (70%), $M = 3.70$, SD = 0.823
What could be changed to increase use? (Short answer)	Incorporated into conversations: 2 (25%), structure for discussions: 2 (25%)	No change: 8 (80%), different clinician/expand topics: 2 (20%)

Helpfulness, satisfaction, and likelihood of use were measured on 5-point Likert scales (1 = very unhelpful/very dissatisfied/very unlikely, 5 = very helpful/very satisfied/very likely).

approach, such as audio-based materials (Thomas Hebdon et al. 2023), to improve intervention implementation for caregivers.

Limitations and future directions

This study comes with limitations. First, this was a pilot randomized controlled trial designed to assess feasibility and acceptability. Therefore, conclusions about efficacy and effectiveness cannot be determined. Future powered randomized controlled trials should be conducted for further intervention evaluation. Next, participants reported variability in educational module and worksheet use in clinical settings, which may dilute implementation; additional training may be needed to improve implementation, especially worksheet use. This study encountered methodological limitations due to non-response among participants. While this provides important insights regarding study design, it may introduce response bias in the data and limit the interpretation of implementation outcomes. Future research should identify study retention barriers and incorporate strategies to improve response and engagement. This study recruited Black/African American and White participants from a large metropolitan hospice agency. Therefore, generalizability may be limited to participants from urban healthcare infrastructures. Future work should recruit from other hospice agencies, such as rural settings. Finally, this intervention was designed specifically for PLwD receiving hospice care. Not all PLwD have access to hospice care, and future research should consider community-based settings for additional intervention implementation assessment. Overall, future work should consider larger, adequately powered trials in diverse settings and populations to focus on efficacy and scalability outcomes to advance this intervention.

Conclusion

The present study constitutes a promising, practical educational intervention to better support hospice clinicians and FCP caring for PLwD. This study found preliminary evidence for the acceptability and implementation of the EDITH-HC intervention. Future studies are needed to enhance educational interventions that address the needs of clinicians and FCP caring for PLwD at the end of life.

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