About the Photos

In This Issue:

Two photos in this issue were submissions to NHPCO’s annual photography contest. Our cover photo was submitted by Avalon Hospice in Flint, Michigan, and captures the beauty of summer flowers on the grounds of its inpatient facility. In the photo on page 4, from Hospice of North Central Florida, we share a moment in the final days of one hospice patient who finds solace through painting. For details on the 2007 contest, visit nhpco.org > About NHPCO > Awards & Contests.
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**June 2007**

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Interdisciplinary Care: The Essence of Hospice
As hospice and palliative professionals, we know that quality care at the end of one’s life goes beyond meeting a patient’s very tangible medical needs. What has made hospice so special since its inception, and what has captured the hearts of so many Americans, has been our focus on healing the whole person—both patients and family caregivers—through the myriad of skills represented by the interdisciplinary team.

As hospice utilization grows, however, and more patients come to us with increasingly complex conditions, it’s often easier to address only their obvious, more visible needs. But as soon as we do, our services become no different than those of the more conventional care providers. Each hour, each day, and each week, a hospice team is challenged.

The theme of this Insights is a red flag of sorts—a reminder to be ever-mindful of the psychosocial, bereavement and spiritual services that set hospice care apart from home care. “While our eyes must certainly be cast toward our future, we can’t afford to forget where our success has been grounded,” NHPCO’s president/CEO, Don Schumacher, has said. “These services are very much the foundation of what we do.”

In the opening article of this issue, “A Day in the Life of a Hospice Patient,” NCHPP vice chair, Shareefah Sabur, gets to the very heart of whole-patient care when she writes, ”This article is a tribute to the hospice patient—patients who we have the honor of getting to know for only a short while, yet help us appreciate how much more there is underneath and deep inside.”

As you read Shareefah’s article and the many other pieces written by your colleagues in the field, ask yourself whether the staff of your own organization could have contributed to this issue? If the demands of today have distracted you from the most important aspects of your work, let this issue be your wake-up call.
In the Morning:
I usually get up around 8:00 a.m. I go into the kitchen and make espresso for myself. I have an espresso machine.

Every four hours I take my medicine, two puffs of Albuterol, Coumadin, and Tylenol 3 for cervical arthritis.

Midday:
Around 11:00 a.m., I eat fruit, meat and cheese. I eat another meal around 1:00 or 4:00 p.m. My hospice team comes three times a week. If I am tired, I take a nap. I work crossword puzzles that come to me weekly from Italy, and I can finish them.

Late Afternoon:
I watch television. I have an Italian satellite dish. I often watch programs in Italian and Spanish. I can speak three languages: Italian, Spanish, and English.

I get visits from friends and neighbors who offer to run errands as well.

Evening:
I usually go to bed at 9:00 p.m.

What you have read is a chronology of daily activities as recounted by Mr. Caticchio, but what we see in terms of daily activities is just the tip of the iceberg when it comes to really knowing him. There is so much more. There are experiences, thoughts, and feelings that we may never know, but with Mr. Caticchio’s permission, I will share my experience of spending a late afternoon with him and hearing him share bits and pieces of his life story.

First, I would like to thank Mr. Caticchio for allowing me into his home and agreeing to this article. I also would like to commend his excellent recall of dates and events. His welcoming and gracious hospitality can’t be put into words. Our conversations took place at the kitchen table as so many memorable conversations do. He insisted on preparing a meal, pasta with ragout sauce. Cooking is something at which Mr. Caticchio is quite adept. He even shared his Alfredo sauce recipe with me. When going back for the second visit to finalize the content of this article, I became privy to his Carbonara sauce recipe.

Mr. Caticchio lives alone in a two-story home, his wife of over 40 years having passed about five years ago. He is very close to his family; a number of them live in Minnesota, but some still reside in his native Italy. He shared a photo album of his family with me that included his siblings. He spoke with pride when he talked about the younger generations. He also shared a photograph of himself, strikingly handsome at age 19, and his lovely, tiny-waisted mother.

Mr. Caticchio was born in Italy in 1919, and has spent 48 years in the United States. As a young man, he joined the Italian navy. If you know your history, you realize that this would have been during the time of Mussolini and Hitler. During his military service, he was taken as a
prisoner of war, was sent to Massawa and Eritrea, and later spent six months in Sudan. He also spent time in Bhopal, India, and later on went to Calcutta, where he remained until 1946. It was in India that he saw the many hospitals filled with leprosy patients.

After leaving military service, he spent a year back home in Italy before taking off to South America. He settled in Venezuela, living there for 14 years. His mother’s encouragement is what set him in the direction of Cleveland, Ohio, where his brother was living. He ended up staying with his brother until he got married six months later.

Mr. Caticchio is quite a world traveler and has seen many changes in the world. The countries in which he has lived and worked are still very much a part of him, and he has continued to travel over the years. He had occasion to be in Rome in 1978 when a new pope was being selected. He has even maintained a residence in Italy. Due to his health, however, his last trip to Italy was very trying and quite expensive; alas, going back again would be quite a challenge.

Mr. Caticchio has helped to edit this article to determine what he wanted to share. There was so much rich detail in our conversations and I marvel at his ability to recall events and dates. He has invited me to come back any time and I would certainly like to take him up on that offer.

This article is a tribute to the hospice patient—patients who we have the honor of getting to know for only a short while, yet help us appreciate how much more there is underneath and deep inside.

Shareefah Sabur has been at Hospice of the Western Reserve (Cleveland, Ohio) since 1993, and serves as director of planning and evaluation. In addition to her role as NCHPP’s vice chair, and Section Leader for Performance Improvement/Quality Assurance, she serves on NHPCO’s Standards Committee and is co-chair of NHPCO’s Quality Advisory Council.
The pharmaceutical industry, with its constant stream of new medications, has become an ever-increasing force in healthcare. In fact, one can hardly turn on the television or open a magazine without seeing an advertisement for medications that will supposedly improve our quality of life. It is no wonder that we tend to migrate toward drug therapy as a first intervention for the treatment of suffering in hospice and palliative care.

One must thoroughly assess a patient’s complaint from a “whole person” perspective and, even though patients are terminally ill, strive to alleviate any reversible causes of suffering. Although medication therapy is a valuable and essential component of symptom management, in this “a pill for every ill” society, one must not overlook the importance of the non-pharmacological components of palliative care. Utilizing the expertise of the social workers, spiritual counselors, massage therapist, and volunteers, to name a few, can not only more appropriately address the suffering of individuals, but can also prevent iatrogenic distress resulting from overmedication and associated side effects.

Here’s one example:

A 24 year-old man with a glioblastoma multiforme and a history of seizures presented to the hospice team with headache pain which recently progressed to “all over” pain with agitation and confusion. He continually rates his pain at 20 on a scale of zero to 10 (0 = no pain, 10 = worst pain imaginable) with no signs of relief. The nurse and the patient’s physician are at a loss as they have been titrating his medications with no success. His current medications are 12 mg subcutaneous hydromorphone per hour with 6 mg hourly boluses which he uses frequently. Phenytoin, 200 mg twice a day, 2 mg lorazepam orally every four hours, 50 mg chlorpromazine every four hours, senna plus docusate twice a day, and 6 mg dexamethasone four times a day. The patient’s mother is frustrated and angry at the lack of symptom control and refuses to see the social worker or the spiritual counselor until her son is made comfortable.

Although the patient has been in significant pain, at this point, signs point to opioid induced neuron toxicity resulting in agitation, confusion and hyperalgesia. In an effort to control the agitation and confusion, albeit unknowingly partially drug induced, lorazepam and chlorpromazine were added and doses escalated. Lorazepam can worsen delirium while chlorpromazine, especially in high doses, may lower the seizure threshold in a patient with a history of seizures.

Stepping back, one might rethink where all the pain is coming from. No doubt physical pain exists. But, at 24 years of age with a terminal disease and an anxious, grieving caregiver, there is high probability that some of this young man’s suffering is also related to a psychosocial component. The question is how to manage this pain. In this case, drug therapy, particularly the high-dose opioid, complicated the picture. In retrospect, earlier intervention of the psychosocial team members may have helped the patient and his mother identify the impact of grief on the perception of pain. In order to address these non-physical symptoms, drug therapy is almost always necessary. It is when doses begin to escalate with little or no effect, however, that the interdisciplinary team needs to come together and formulate a new plan. In this particular case, the patient was switched off of hydromorphone to a low dose of methadone and much of the hyperalgesia went away. The agitation and confusion continued, however, most likely due to progression of his disease. Ultimately, this patient had to receive palliative sedation.
Caring for patients with life-limiting diseases requires that the healthcare team recognize the potential importance and act on the psychological and spiritual suffering in the lives of our patients and families. Too often clinicians fall into a unidimensional assessment approach to pain and symptom control. The table below illustrates the problems associated with unidimensional pain as seen in this patient.

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<th>Problems Associated with a Unidimensional Pain Assessment</th>
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<td>Assessment:</td>
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<td>“Pain is whatever the patient calls pain and has the intensity the patient reports.”</td>
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Phyllis Grauer has been a palliative care consultant pharmacist for over 20 years and is founder of the Palliative Care Consulting Group. Following PCCG’s recent merger with Hospiscript Services, Phyllis has assumed the role of vice president of clinical development. In addition to serving as NCHPP’s Pharmacist Section Leader, she is an assistant clinical professor at the Ohio State University College of Pharmacy.

References:

Not only is the “whole person” assessment of the patient critical to the appropriate management of symptoms, but as illustrated in the case noted in this article, the caregiver’s well being can often impact the patient’s emotional and spiritual welfare. Clinicians can learn a great deal by listening and trying to understand the patient and the family dynamics. The stress and sadness of the dying process undoubtedly brings up spiritual issues that should be addressed by involving the appropriate members of the interdisciplinary care team.

Could this young man have suffered less? One can only guess, but it was clear that the high-dose opioid therapy he received did not adequately manage his pain and may in fact have caused additional physical distress which resulted in the escalation of drug therapy. Assessment of psychosocial and spiritual issues, and understanding their contribution to the patient’s perception of pain and other symptoms, must be deliberate and ongoing. Early involvement of the appropriate team members may result in better patient outcomes and reduced medication complications.
As a 10 year-old riding in the funeral home’s “family car” on the way to my father’s service, I remember gazing out of the window, watching people we passed following their daily routines, the sun shining brightly that May afternoon.

“How are these people able to go about walking their dogs, casually talking to a neighbor, tossing a ball back and forth, so carefree, as if nothing has happened? Don’t they realize that my father has died suddenly, at age 43, from a heart attack? Why is the sun shining so brightly, when it seems so dark and forlorn inside of this immense vehicle?”

Everything was so out of whack.

When grieving children arrive at the Kids Path facility to begin the process of healing, it is our hope that before they enter the door, they are greeted by a landscape which embraces them—inviting them into a safe and caring place. We strive to create a stable, constant reminder that beauty and order are available in the midst of confusion, pain, and other bizarre, unfamiliar feelings.

A priority for me, as a horticultural therapist and gardener at Hospice and Palliative Care of Greensboro, is offering healing gardens that envelop not only our Kids Path building, but our Administrative Building and our 14-bed residential facility, Beacon Place.

In Green Nature, Human Nature, Charles A. Lewis explains why the inclusion of a healing landscape is so beneficial: “Plants are so effective in eliciting human responses....The garden is a safe place, a benevolent setting where everyone is welcome. Plants are non-judgmental, non-threatening, and non-discriminating....”

Simply viewing nature’s splendor may allow us to begin to relax, unwind and release a bit of anxiety. The plants invited into the hospice grounds have gentle smells, soft textures, and deep and vibrant colors that awaken the senses and draw attention to themselves.

The Beginning

The story of the horticultural therapy program at our hospice has a simple beginning, dating back to the late fall of 2000. Picture empty, lonely looking concrete planters that staff and visitors passed daily on the walk to the front door of the “main” building, and a volunteer who noticed how stark the planters looked and, more
importantly, how their emptiness made her feel.

"May I plant a few pansies and snapdragons in those pots leading up to the front door?" I asked, realizing how simple it would be to turn a dreary walk into a welcoming one.

Those sunshine-yellow pansies and rainbow-colored snapdragons got the attention of not only the staff, but also visitors and clients who felt uplifted by their beauty and perkiness. A few more pots were added at key spots around the grounds. Community volunteers interested in beautifying the grounds were gathered and then organized into groups charged with transforming stark spaces into reflective spots.

Over the next two years, the seven acres of property were gradually transformed into mini-oases with the help of hundreds of hands from the community. Now it was time to offer the residential patients living at Beacon Place the chance to do more than passively derive the benefits of viewing the landscape. During this two-year period, my interest in combining people and plants led me to Denver Botanic Gardens, where I received a certificate in horticultural therapy.

**Patient Care: the Horticultural Therapist’s View**

Recently there was a 48 year-old man in our hospice facility who had come from his home, unwillingly. Being a very large man, he was a “prisoner” in his bed; while he could move his legs slowly, his movement was labored. His illness also prevented him from successfully communicating most of the time. He understood what was being said to him and tried to verbalize his thoughts, but he was very hard to understand. He was, however, able to communicate to his wife that he just wanted to go back home, get his gun, and kill himself.

Each week, our Beacon Place team meets to discuss the condition and care of the residents. When I listened to this man’s story, I didn’t see myself walking into his room with a big bucket of fresh flowers and a big smile on my face. He had just arrived here, a place he didn’t want to be, in a condition from which he wanted to escape.

The following week, I learned that he had left our facility for a short stay in the hospital, but was back now. After his visit in the hospital, the staff who regularly interacted with him felt that he was thinking that even though he wasn’t home, at least this place was better than the hospital. Maybe now was the right time to approach him.

Not knowing how he would react, I wheeled my cart into his room. At the wholesale florist that day, I had him in mind as I picked out some “show stopper” plants—one-of-a kind, dramatic plants that tend to act as magnets because of their unusual shape, color and size.

When I go into the room of a patient who I feel has a chance to interact, I’ll often have on the cart a bucket of loose flowers, several vases, a lightweight watering utensil and some pruners.
As I entered his room and introduced myself as “the gardener,” I pulled the stem of a pale blue hydrangea from the bucket, its fluffy blossoms spreading five to six inches across. He made eye contact, first looking to me, then to the flower head. He was interacting; my foot was in the door. Coming closer to his bedside, I began to talk about the flower, reaching for others in the bucket, like the baby’s breath I had chosen for its soft fragrance. I asked if he would like to hold the hydrangea. He nodded yes. He carefully studied what he was holding. He was focusing on something pleasurable, something besides the heaviness of his condition.

The baby’s breath was his next new distraction. As he inhaled its calming fragrance, he closed his eyes—as if he were shutting out his illness—to be alone with the aroma. The horticultural therapy goal of allowing nature to intercede between the patient and his illness, experiencing pleasure within the reality of severe limitations, felt attainable.

The beauty of an interaction with nature and the senses is that, once experienced during an illness, one may return to that place of calm, without the plant literally present, much like the pleasure of reliving a favorite vacation or other pleasant memory. Unlike vacations and experiences that have become unattainable, the simple, soothing company of a fragrant blossom is available. New experiences are being created—realistic, simple, pleasing experiences.

Thanks to the staff at Beacon Place, the patient was later able to leave his bed for short periods. Once in his wheelchair, we were able to go outside on warm days to enjoy the sunshine and all of the spring flowers surrounding his “home.” On such an outing, he grasped the garden pruners and clipped a couple of holly sprigs that were encroaching as we went down a garden path. He firmly removed the obstacle, it was in his way and its points were sharp.

As Anne Frank once noted, “The best remedy for those who are frightened, lonely or unhappy is to go outside; somewhere they can be alone with the sky, nature and God....I firmly believe that nature can bring comfort to all who suffer.”

Sally Cobb has been employed as the horticultural therapist at Hospice and Palliative Care of Greensboro in North Carolina since 2003. In addition to publishing numerous articles on this topic for state and national publications, she has presented on the evolution of the hospice’s program at meetings of the American Horticultural Therapy Association.
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What is our spiritual life? I suppose we could answer that question and find that each answer leads to more questions. Is it our faith or where we go to pray or practice? Is it how we live in the world—the values that we bring to everyday experience? Or, is it how we nourish ourselves in times of crisis and in times of ease?

When we apply this to the context of the team, it may feel like we are doing something unnatural. How can such questions apply and why would we want them to? It may even feel that we are pushing the team to be something that it is not, that to speak of its spiritual life is to be a little too much in the realm of new age lingo. The team is just the team. We are here to help our patients and families. It is that simple.

There are many cultures in the world that feel community is an essential element to survival. Individuals, in and of themselves, are only one part of a more vibrant whole and to ignore the whole could cause difficulty. What also seems important to understand is that the health of the individual and the health of the community are connected. They directly impact each other and we could even say, are equal. If one is out of balance, so is the whole. If there is illness in the individual, there is illness in the community. We certainly see this with the patients and the families we work with every day. We rarely look just at the patient and their symptoms. We also look at the situation around them. If the environment is completely chaotic, it may directly affect the patient’s pain level and sense of anxiety. So, we cannot simply put blinders on and narrowly look at just one piece of the puzzle. We have to take a step back so that we can get a sense of the kind of picture we are trying to understand.

If we do this for our patients, it would seem essential to do this initially for ourselves as a team. How can we offer integrated care to our patients and families if we are unable to offer it to ourselves first? We promote the value of the team, yet my sense is that many teams function more like a collection of individual disciplines: I have my job, you have yours, and we work together. How often do we go further than that?

There seems rarely a time when the team meets to talk about the effects of the work and the impact it is having in their lives—a time when they meet, not because they are mandated to, but because they know they have to. Yet, it is essential—one might even say imperative. If we are not healthy as a group and as individuals, how can we be of service to others? If we are not able to know the heart of every member of our team, how can we truly see and know the hearts of those we care for? Are we simply fulfilling the regulations or are we making deeper steps?

Now, perhaps this is something that does happen at your hospice. If it does, then I apologize. I have just noticed that in the ever-quickening pace of our standardized world, we are becoming more at risk of missing the point of why we might even consider doing this kind of work. Somehow it feels our profession is separate to our life as a whole. Yet, this work in particular would seem to ask us to be even more aware of how they are connected. If we look at the history of hospice as a movement, we know this to be true. To care for the whole being in the other is to care for the whole being in ourselves. They are the same, whether it is our patient, a family member, or each other. If we do not do this, then we are only scratching the surface of what we are truly capable of doing.

I say all this in the context of knowing what it is like to do hours of charting every day. I say this in the context of hearing the struggles of hospice professionals around the country wondering how they can have a moment to grieve and share.
with their team and their colleagues, and not feel like they have to fight for that right. I know the reality of the context in which I offer this. Yet, it still feels important to say it. I am also not the first to express these sentiments. Far more noted minds have been speaking to this for years. I wonder why we have yet to fully listen? We have nothing to lose, except maybe our limitations.

All of this leads back to how we might look at the spiritual life of the team. To begin, perhaps it is best to simply look at just “the life of the team.” That practice alone might allow for some interesting discoveries. It is not a waste of time. We talk so much about quality these days and this is at the core of it. Quality life, quality care. Do we care for the members of our team as we care for our patients and families? Do we celebrate the lives of our team as we do the lives of our patients and families? This is not a new age conceit. It is about caring past my own responsibility to the room. It is about creating a situation in which each member of the team is valued regardless of rank or training. It is about fellowship. It is about connection. Just give it a try.

Carlyle Coash has been a hospice chaplain since 2000, in Boulder, Colorado and now California. He is board certified with the Association of Professional Chaplains and currently serves as NCHPP’s Spiritual Caregiving Section Leader.
Journaling as Therapy
By Cassandra Cotton, CHPNA

Journaling may mean a hundred different things to a hundred different people. Merriam Webster’s Dictionary defines journaling as “A personal record of occurrences, experiences and reflections kept on a regular basis; a diary; an official record of daily proceedings.” Although there are many definitions of journaling, one thing is clear: It is an unparalleled portal into the soul, and a chance to understand and heal emotions.

Reflecting on my own journey during a time of loss, I can share personal experiences on the value of journaling. I have learned that there is a need for individuals to care for the mind and soul, as well as the body. There are many therapeutic tools we can use and, though journaling is only one, it is a powerful one.

Following the loss of my mother from breast cancer, and a painful and unexpected divorce, I searched for creative ways to channel the grief and anxiety I was feeling. I felt powerless, fearful, and overwhelmed. I began to journal and found that it facilitated psychological healing and led me to a search for spiritual recovery. Journaling was a safe mode of expression that brought me peace and understanding, guiding me through many traumatic issues.

The art of journaling was simple: It was one person (me) and a piece of paper. There was no need for fancy writing or big words. It was just an opportunity to talk to myself by articulating my thoughts. The journal became my companion, a way to keep an account of the good things in my life as well as the painful issues. There were many times at night when I would read my journal like a novel, then stick it under my pillow and go to sleep.

Because I began journaling during a very critical time in my life, it was a way to ease anxiety. It became a remarkable tool that brought clarity during a dark period. On sleepless nights, writing in my journal helped me uncover feelings, let go of anxiety, sort out confusion, and gain understanding, all of which enabled me to move closer to peace and acceptance of the losses in my life. It helped me identify with my hopes and fears, and provided a safe, nonjudgmental opportunity to question God, to ask Him why.

During my mother’s illness, journaling was instrumental in helping me cope with her illness and then with her death. I was able to document her legacy and it was powerful. It showed me how she maintained her faith during her illness and, thus, her spiritual journey became mine. Even today, as I revisit that particular journal, I see the pages that hold my pain, frustrations, loneliness and fears. Nevertheless, those pages have helped me to gain meaning and purpose out of that painful experience. Journaling was the beginning of my spiritual exploration and eventually became the guide to a spiritual realm filled with many rooms, rooms that had not been opened. In those rooms, self-evaluation led to an evolved “me,” a person with changed behavior, personal growth and new health.

Since then, I have continued to use the art of journaling as an outlet for expression to reconnect with my innermost thoughts. And as I look back on journaling, I am able to see a clear path.

Therapy for Patients and Families
It is likewise vital for the hospice team to be participants in the healing process. As hospice providers, we offer patients support, encouragement, and genuine caring, but we can further assist families through journaling.

As a team, we help reconnect the patient or the bereaved person with the world at large. Offering to assist with journaling gives our patients and their loved ones another valuable tool to voice their feelings, enabling them to move forward through the process.
When offering journaling as a therapy, we can assure patients and families that journaling does not require special talent or skills. It is not necessary to be an experienced writer. The journal is not for publication—it’s simply a tool for comfort in a critical time. Here are some suggestions on how patients and families can begin this process:

- Ask the patient to write about his/her illness;
- Suggest the patient write a letter to the loved ones who will be left behind;
- Begin with a photo of a loved one and ask the patient to write about why this particular photo is important and what memories it holds;
- Suggest the patient write about a conversation that took place or one that never happened and probably should have;
- Encourage children to draw pictures or make collages to assist them in expressing their feelings, or to use the lyrics to their favorite songs, or lines from special prayers or poems to get in touch with their inner-most thoughts;
- Encourage patients and families to write about their peace, anger or strength;
- Remind them that journaling doesn’t have an expiration date;
- Make it a safe exercise—what they do with it after they write it is up to them.

As we encourage patients and families to explore the art of journaling, our job is not to tell them how to write or what to write, but to provide them with resources and support. Invite them to tell their own stories in their own way. The object of journaling is to write out the feelings without analysis, to let them flow freely.

Lisa Browder, a complementary therapist with the Bonnie Schreck Memorial Comfort Care Program at Nathan Adelson Hospice, likened journaling to the “butterfly effect” and explained its power this way: There’s an oft-paraphrased quote that says the soft beat of a butterfly’s wings can cause major climate changes on the opposite side of the world. The contention is that small actions have the power to snowball into major events. So it is with journaling. On the surface, journaling is a nice way for patients to leave a legacy to their families. It’s an effective means of providing focus and clarity to critical issues, concerns, conflicts and confusions. The reality is that the journal has the potential to be the first beat of the butterfly wings, the catalyst to a deeper understanding of why a family behaves the way it does. It’s easy to sweep unpleasant subjects under the rug, never to see the light of day, never to be discussed. Over time, those subjects become unapproachable topics that may or may not hold the key to communication, allowing insight and emotional healing.

**Therapy for Ourselves**
Journaling, of course, is for everyone—including staff. As we work to ensure
a peaceful, dignified death for our patients, it can be a remarkable tool for coping with emotional stress.

It begins with taking care of yourself and by seeking support. In order to care for people, you have to create and maintain your own balance, find meaning and purpose in what you are doing as hospice providers. And journaling may be one therapy that can help.

You never know what journaling can do for you until you try it. It will also be different for every person—even every culture. Take, for instance, the Buddhist perspective. It’s built on the concept of mindfulness. Mindfulness is about knowing where we are (being in the moment), maintaining an awareness of where we have been (reflection), and where we are going (having goals). A meditation journal can help with all of those areas of awareness, helping to have a more unified awareness of self.

For Buddhists, journaling is said to help one move toward “reorganization,” a willingness to start new goals, a desire to return to a more normal life, and to form new relationships. Where there was once disorganization, patterns can now emerge, leading the way to “reorganization.” Writing becomes a time of reflection in order to put life back into perspective. This can be achieved in a variety of ways:

- Write a letter to the person who died, saying things that were perhaps unsaid;
- Tell those who are alive that they are loved;
- Forgive yourself: Tell yourself over and over that you did the best you could;
- Forgive the person who died.

I still have the tear-stained journals that I have written over the years. I have decided to leave one of them to each of my granddaughters, not only as a memorial and a tool for encouragement, but also to provide proof of the blessing and grace that have been provided to me over the years. Through my willingness to open up, I gave away all the pain and found the inner peace that I’ve chosen to make a legacy to my grandchildren. I hope to provide encouragement, to let them know that it is not impossible to overcome obstacles or challenge barriers that may occur in life.

Although there are many ways to begin journaling, the impetus is to simply write from your heart. My advice to anyone who wants to begin journaling is that all that’s needed is the willingness and the desire to explore moments of ecstasy and moments of despair, critical illness, and crucial life choices. It has been said that you can’t exult in the highs if you don’t understand the lows. Journaling brings clarity and a vision of possibility.

Cassandra Cotton joined Nathan Adelson Hospice more than 15 years ago as a nursing assistant and currently serves as its community relations and outreach coordinator. In addition to her work as NCHPP’s CNA Section Leader, Cassandra devotes her time and expertise to educating the African-American community about hospice care.
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Hospice Journal Club
Feeding the Mind, Nourishing the Spirit

By Joan Harrold, MD, MPH, FAAHPM, and W. Thomas Dodge, ThM, BCC

“How do we join?”

That was not the question we expected to hear, but it was one of the indications that the Hospice Journal Club was a hit. Over the past three and a half years, what started as an academic endeavor to feed the mind and help maintain clinical excellence has also become a time to nurture the spirit and wrestle with many of the ethical, cultural, and spiritual issues encountered in hospice care.

In medical school, residency, and beyond, “journal club” is not a club per se, but a gathering for physicians to discuss new or important information from medical journals. It was this concept we chose as a model when we started a monthly gathering to review current literature. Knowing that the interdisciplinary team would be interested in more than medical aspects of care, we broadened our focus to include a variety of articles and topics pertinent to hospice and palliative care, often alternating between diagnosis or physical symptoms and emotional, social, or spiritual issues.

From the beginning, we have offered a mix of topics (see sidebar on page 21). Although some articles are sufficient for an hour of examination and conversation, we frequently juxtapose two articles written on the same or similar topics. While a current patient situation or prominent article in the media may be the basis for a topic, most topics are selected in advance in order to have a balanced series over the course of the year.

Initially, we began each session with an explanation of some of the basic guidelines for reading clinical literature (see page 21). We continue to assess each article using the guidelines that are applicable to the article. In addition to experimental research, we have discussed meta-analyses, review articles, case reports, and editorials. (Because attendance fluctuates with schedules, census, and changes in staffing, a handout on the guidelines is still available to attendees at every session.)

The review of literature in this way is continuing education for the different members of the interdisciplinary team. For example, physicians can claim Category 2 CME credits under the AMA guidelines. We have also pursued formal approval for our chaplains certified by the Association of Professional Chaplains. For each of the past two years, we have submitted the schedule of topics and received 12 certified continuing education credits per year. We will be pursuing continuing education units for our nurses as well. Social work credits have not been obtained thus far.

We remain committed to the goal of reviewing clinical literature for the purpose of supporting clinical practice. But along the way, we have recognized that Journal Club provides an opportunity for staff to grapple with some of the difficult issues that are part of our work. What do we know—and not know—about artificial nutrition and hydration in a patient who has suffered an acute stroke? How do we recognize and respond to spiritual pain? How do we support acceptance of end of life and hope at the same time? How do we find the words we need when we aren’t comfortable?

In one Journal Club, the group talked about missed opportunities to move beyond the expected benefits of complementary therapies and talk with patients about the meanings that these interventions had for them. This conversation inspired the Spiritual Care team to discuss how to recognize and utilize opportunities to help patients do even deeper spiritual work.
Thus, Journal Club led the chaplains to sharpen their skills in ways they had not previously considered.

In another Journal Club that focused on transitions for family caregivers, everyone engaged in the academic exercise of analyzing the article. Team members also offered a variety of deeply personal stories with their professional ones, opening themselves to the support offered by the group. At the end, ideas discussed for enhanced practice reflected the mix of personal and professional experiences. Later, many participants quietly noted how valuable it was to have been part of the conversation.

With the articles serving as catalysts, Journal Club has become an hour of information, examination, and creative exploration to enhance care in the areas of symptom management, diagnosis-specific topics, ethical dilemmas, patient and caregiver experiences, spiritual care, and underserved populations. It has also become a time to feed the mind and nourish the spirit with conversation, collaboration, and reflection.

The authors are grateful to Gail Smith and Becky Neimer for their efforts which are essential to the success of Journal Club.

Joan Harrold is medical director and vice president of medical services for Hospice of Lancaster County. In addition to serving as NCHPP’s Physician Section Leader, she is president of the Pennsylvania Hospice Network board of directors, a trustee of the American Board of Hospice and Palliative Medicine, and a faculty member for the NHPCO Physician Leadership Development Program.

Tom Dodge is a board-certified chaplain and the spiritual care coordinator at Hospice of Lancaster County. In addition to the six years he has worked in hospice, he served as a pastor for 16 years, and as a missionary for six years, during which time he and his wife Elizabeth worked with pregnant teens.

Basic Guidelines for Reading Clinical Literature

Is the topic USEFUL to my practice?
• Read the abstract for a brief overview.

Is the research GENERALIZABLE?
• Are my patients similar to the patients in the study?
• Is the setting similar to the setting in which I practice?
• Is there any reason to think that the differences would make this study less useful to my practice?

What are the METHODS?
• A randomized, controlled trial is the most scientifically rigorous type of study.
• A case control study has a study group and a control group for comparison.
• A pre-post study compares a patient or group to itself.
• A case report or case series (set of case reports) gives information, but no comparisons.
• Large studies have more power than small studies.

Is there an INTERVENTION? What is the INTERVENTION?
• Can you identify exactly what was done to try to create the desired effect?

What are the RESULTS?
• Are the results clearly defined in a measurable way?
• Are the results statistically significant?
• Are the results clinically significant?
• Do the results make sense?
Is the intervention DOABLE?
• In your practice, can you accurately replicate the intervention?

Is the BENEFIT WORTH THE BURDEN to change your practice?
• For patients, families, organization, self
  ◦ Time
  ◦ Effort
  ◦ Cost
  ◦ Possible complications

Journal Club Topics
• Patient Refusal of Care
• Net Worth and Symptom Burden
• Use of Methadone
• IDT Communication Skills
• Artificial Nutrition/Hydration
• Physician-Assisted Dying
• Hospice Use of Dobutamine
• Palliative Sedation
• Transitions in Family Caregiving
• Competency at the End of Life
• Fatigue
• Opioid Neurotoxicity
• Spiritual Pain
• Palliative Care for Muslim Patients
• Parenteral Nutrition in Advanced Cancer
• Pediatric Palliative Care
• In Patients’ Own Words
• Complementary Therapies
• Mental Status Examinations
• Miscommunication at End of Life
• Hope and Spiritual Transformation
• Cultural Mistrust
• Professional Boundaries
• Self-Care for Hospice Staff
• Bereavement Care for Long Term Care
• Ethnic Experiences and Disparities
• Lewy Body Dementia
• Goals of Care
• Meaning and Growth at End of Life
This article is as much about process as it is about product. It is a reflection on companionsing, community, and the formation of a presentation that provided me the opportunity to gain new insights into this remarkable work we are privileged to do.

In the fall of 2005, I was asked to present at a conference entitled “Spiritual Perspectives on Dying Well, Caregiving & Healing Grief.” While the conference was being sponsored by Nalanda West, a Buddhist meditation center, the overall scope of the event was ecumenical in nature. My topic was “Healing Grief from a Spiritual Perspective.” From the beginning, I thought that I was clear about the direction this particular presentation would take. Clear that is, until I heard the “voice.” (Note: The following italicized sections are portions of the presentation.)

As we get started today, I would like to say that I have a confession to make. I love PowerPoint. Perhaps my affinity for this particular piece of software began with a previous work incarnation as a stage director, reminding me of the creative process of producing a show for the stage. When I was first approached about speaking today, one of my initial thoughts was “What would my PowerPoint presentation look like? What imagery would I use to encourage you to consider a topic that we all live with on a daily basis and yet sometimes don’t consciously fully engage?” And before the echo of those questions could subside, a rather soft inner voice I had heard before simply said, “This time, you don’t get to do PowerPoint.” When that voice speaks to me, I have been known to argue a bit. “Why not?” I shot back. “Think of the beautiful images that I could use as a background for whatever words I would deliver. Not to mention the ready-made handouts that a PowerPoint presentation provides.” And I waited for an answer. And the silence that followed my well-made arguments was my answer. I realized what I had to do was simply speak from my heart. Without the bells and whistles, without the noise of well-intentioned imagery—just my experience would have to do.

We all know that grief has physical, psychological, emotional and spiritual components. Yet when I consider these, I am aware that sometimes I don’t listen to my “inner chaplain.” I knew that to be successful in this presentation, I needed for that voice to speak with clarity; I knew that I needed a “touchstone.” Someone who could walk with me as this presentation developed and offer me some insights and guidance as I relinquished my hold on technology and listened to my heart. So I emailed my friend and colleague Larry Crawley-Woods in West Virginia, solicited his help, and soon found myself in a conversation that would not only shape the presentation, but offer me opportunities for growth along the way.

After an initial series of emails, it became clear that the three primary areas of focus in this short one-hour presentation were found in its title: healing, grief and spiritual. As Larry and I wrestled with these BIG concepts, the area of focus for each began to slowly emerge.

Because spirit and spirituality are words that come laden with a variety of meanings, for the purposes of my time with you today I would ask you to think of spiritual as that which is connected.

That sense of connectedness is well illustrated by a story that Geri Haynes tells about her
grandchildren. Geri is a remarkable nurse who one day found herself playing in her backyard with her grandchildren, ages 5 and 8. As she played with the youngest, David, he said to her, “La-low (Geri’s name of endearment), God broke.” A bit taken aback by this statement, Geri asked David to repeat what he just said. “God broke, La-low,” was his instant reply. And so Geri sat with David a moment and then said, “David, where did you hear that?” And David’s short pudgy finger was immediately pointing toward his older brother Mark. After a time, Geri approached Mark and knelt next to him in his play and softly queried, “Mark, your brother tells me that you told him that God broke. Is that true?” Mark replied while intent in his play, “That’s right La-low.” Geri asked him what he meant by that. “Oh you know La-low. God broke......into all of us.”

If you need to, you can substitute whatever word you like for God. And no matter what word you choose, it is this connection that I want to focus on today. For if grief is integral to who we are, then it is impossible to have a grief response that doesn’t touch that place of connection in us and ripple out to touch all others in the process.

So if the focus for spirituality was to be connection, where to focus on this thing called grief? Conversation with Larry distilled that focus into a single word—integral. Grief is an instinctual response to loss and is therefore integral to us as human beings. First by definition, and then by exercise, those attending this session would have the opportunity to begin to look at this instinctual response.

Change is the fundamental building block of the human experience. Biologically, each one of you has changed since you entered this room this morning. Some cells have died, others have been born—an ongoing process of change.

I would suspect that if each of you were given the opportunity to define the word “change,” we would get varying definitions and varying emotional comfort levels to describe the process. I would also suspect that the comfort level of change would often correlate to whether the change was perceived as primarily positive or primarily negative.

Take a moment and consider a positive change that has happened in your life in the last six months. Perhaps you have married, or secured a new job. Now consider what the losses were that came with that change. The losses are there; sometimes we just have to look closely to see them. For with every change, no matter how positive, comes loss, and each loss has grief attached to it.

I began to feel that Larry and I had somehow navigated through the large “waters” of spirit and grief and now we were faced with the concept of healing. I knew that each individual’s definition of healing would be as different as their definitions of love. So I returned to the etymology of the word “healing” to find an old English word meaning “whole.” Here Larry also reminded me that this was the same root for “holy.” To heal is to become whole and by extension holy.

continued on next page

With every change no matter how positive, comes loss, and each loss has grief attached to it.
So what is the “healing” here? We heal by fully embracing the totality of who we are and that includes this process called grief.

And how does one accomplish that? While much has been written and discussed about the efficacy of varying methods, for today I want to focus briefly on two—storytelling and ritual.

Research and literature in the field of grief and loss points to the idea of “seeking meaning” as central and integral to working with change in our lives, and in my work I have found that to be true. A primary way of seeking meaning comes through the telling of story.

The origin of the word “story” comes from Latin and Greek derivatives meaning “to inquire” and “of the learned man.” Thus, when we tell story, or when we listen to story, we are inquiring of the wisdom that it holds for us.

In storytelling there are at least two—the teller of the story and the one who bears witness to it. And since those who are grieving may feel that they are no longer “heard,” it becomes the role of the witness to allow the storyteller the opportunity to tell the story he or she needs to tell. The clean slate of the witness offers the storyteller the opportunity to have their story reflected back to them and in doing so, the storyteller begins to “hear” their own story and begins to access for themselves its innate wisdom.

We had explored concepts and ideas and now came the time for practice. Years ago, with the blessings of a local rabbi, I had adapted the Jewish ritual of keri’ah as part of another presentation that I had done. For this conference, I returned to that ritual as a means of giving the participants an opportunity to honor a loss in their lives.

Historically, keri’ah is the ritual tearing of garments upon hearing of the death of a loved one, for it was believed that the heart had been wounded and needed space for healing. Upon entering the room that day, each participant was given a small piece of fabric about 15 inches square. After a brief reflective exercise, each individual was given the opportunity to tear the fabric as the others in the room silently supported them. For about five minutes nothing was heard but the tearing of fabric, and the sometimes quietly uttered name of a person, relationship or life experience.

With the completion of the ritual, I invited the participants to once again close their eyes, focus on the loss they had just named, and participate in a meditation that had been written by the Buddhist, Lama Surya Das:

Trust the wisdom of your heart and ask yourself these questions:

- What did I really lose?
- Why did I lose it?
- Have I healed from this loss?
- Do I want to heal from this loss?
- If I have healed, what lessons have I learned about myself?
- What lessons can I apply to current or future loss?

And finally, if change brings loss, and loss brings grief, what is the growth that has been the gift of that grief?

I invite you now to find a partner and tell your story. If telling a partner feels too vulnerable, then journal your insights on the back of your handout. I will ring a bell when it is time for the storyteller to become the witness and ring it again to draw us to conclusion.

As the participants began to be joined in dyads, the quiet room began to reverberate with sobs and laughter as stories were witnessed and held. And as the energy of the room spiraled upward, I knew that the stories being told were shaping both the teller and the witness—from that place of connectivity that we all share, some level of healing was occurring.

Months after the presentation, I continue to reflect on the lessons of this opportunity. Perhaps the largest has been the reminder to always listen for that point of connectivity. Years ago, a small inner voice nagged at me to contact my friend Mark. Days turned to weeks and weeks turned to months and still the voice urged the contact, yet I continued to occupy myself with the “important” matters of my day-to-day life. When finally I picked up the telephone, an un-
Seeking meaning is central and integral to working with change in our lives.

familiar voice at the other end of the line informed me that Mark had died a few days prior to my call. It was at that point in time I decided I would do my best to listen for that small inner voice and what it might have to say to me. I am grateful that it spoke to me again, grateful for its guidance to a gifted colleague, and grateful for the opportunity to open my heart and speak passionately about this remarkable thing called grief.

Rex Allen has worked in the field of loss and grief as a professional and volunteer for over 18 years. He is currently the grief support services supervisor for Providence Hospice of Seattle in Washington, and is a member of the NCHPP Bereavement Steering Committee.

Larry Crawley-Woods is the bereavement coordinator at Hospice of the Panhandle in Martinsburg, West Virginia. While he has held that position since 1994, he has worked in hospice since 1980. He also serves as an NCHPP Bereavement Steering Committee member.
Interdisciplinary thought and practice is a hallmark of hospice and palliative care because it improves quality of life for patients and families, and supports consumer-driven care. Educators can support and guide interdisciplinary thought and practice with staff and volunteers through a planned approach to learning. This article examines approaches for integrating interdisciplinary practice into all aspects of education and training throughout the “service lifespan” of all staff and volunteers.

Philosophy in Action: Foundation for Orientation

Unfortunately, in many healthcare settings, staff and volunteer orientation usually consists of a review of policies and procedures, rules and regulations, and a briefing on the organization. It is also commonplace that new learners will experience a distinct division of disciplines throughout most learning experiences demonstrated by use of divided classroom settings and separate course content. This foundational learning experience often guides how one practices and is generally a reflection of the culture of the organization.

If our goal is to ingrain interdisciplinary thought and practice throughout an organization, it is best to support “inclusive” initial learning experiences where all new staff and volunteers participate equally. Interdisciplinary practice requires new staff to immediately understand and embrace core values, such as: all staff and volunteers have value; all contribute equally to quality patient and family care; and mutual respect is non-negotiable. Teaching these core values begins to create a norms process by which the expectations for behavior include: respect, trust, and collaboration. These are essential elements to interdisciplinary thought and practice.

We All Make a Difference

One day over lunch, a chaplain was speaking to a staff member from the accounting department. The chaplain inquired “How do you like it here at hospice?” The accounting professional stated “I love it! I get so much purpose and meaning from my work.” The chaplain smiled and asked “How so?” The accounting professional stated “I have had a long history in banking and finance. In those days when I saw numbers on a balance sheet it was about the money. Now when I see numbers I see the lives of people. My efforts help provide them with a better quality of life. I feel blessed to be a helping professional. I feel blessed to be part of the team.”

A strong focus on honoring the physical, functional, social, emotional, and spiritual aspects of patients and families, as discussed in The Experience Model of Care (Labyak, 2002), promotes a framework to understanding broader aspects of hospice and palliative care philosophy and the importance of everyone’s role in the interdisciplinary care process. Heavy emphasis on this Experience Model of practice is a very effective learning strategy that should be utilized when new learners are making the shift from traditional healthcare practice to interdisciplinary practice.

Utilizing this model of care when developing core course content will automatically expose new learners to interdisciplinary thought and practice. In addition, class course design is important and should be based on the learning outcome desired, utilizing traditional learning methods such as knowledge-based learning, discussion, demonstration, role-play practice, and performance feedback. For example, interdisciplinary care-planning exercises in the classroom setting are very effective in challenging new staff to think differently and providing them an opportunity to demonstrate new knowledge and skills that reflect interdisciplinary thought.
Transition to Interdisciplinary Practice:
Mentor or Preceptor Programs

Leaving the safety of a classroom-based orientation program and successfully integrating into practice requires a comprehensive approach that generally involves job-specific shadowing with gradual work or caseload transition, one-on-one learning, and performance feedback and review.

Ideally a mentor or preceptor will guide this learning approach and constantly infuse the initial orientation core themes. In addition, as long as the core culture is one of interdisciplinary thought and practice, the new learner will see this role-modeled throughout by all team members, and will see it anchored into all practice. Mentor and preceptor programs foster interdisciplinary awareness through coaching, feedback and customized approaches based on individual learner needs over the first several months on the job.

Mentors and preceptors should be selected that role-model excellent interdisciplinary practice and healthy balance while compassionately guiding the new employee or volunteer to learn and grow. All of these methods combined result in anchoring interdisciplinary thought and practice with all new learners.

Interdisciplinary Practice and the Seasoned Professional

To support interdisciplinary thought and practice throughout the service lifespan of staff and volunteers, continuity and consistency are key. To assure continuity and consistency in education, three elements must be considered.

*Do all instructors embrace and demonstrate interdisciplinary thought and practice?*

Educators can help to address this by assuring that all intermediate and advanced course content is driven by interdisciplinary thought and practice and that this is delivered in a consistent manner. In addition, instructional methods should include “IDT like” formats such as case study presentations, panel discussions, and mock IDT round tables. These learning design approaches constantly reinforce interdisciplinary thought and practice and require demonstration of learning by the participants.

*Do all training and reference materials, and instructor guides reflect interdisciplinary thought and practice?*

The creation of concise, easy-to-access training and reference materials reflective of interdisciplinary thought and practice provides an added complement to any classroom-based or field-based training. Hard copy manuals, handouts, digital files (e-learning) or clinical reference tools (on laptop computers) are resources that reinforce best practices in interdisciplinary care and provide continuous job aids for “just in time” or as needed learning.

*Is all educational planning dynamic, inclusive of all staff across the service lifespan, and reflective of the current body of knowledge?*

The selection of experienced instructors is essential in promoting interdisciplinary thought and practice. This type of training challenges instructors to transcend the basic foundations of their “discipline of origin” and embrace a “transdisciplinary” approach to curriculum and instruction. This requires a
deliberate approach to ongoing training and constant collaboration with practitioners, educators, and content experts all offering diverse perspectives.

**Final Thoughts**

Interdisciplinary thought and practice is a hallmark of hospice and palliative care because it improves quality of life for patients and families and supports consumer-driven care. If this is a core philosophy, it follows that interdisciplinary thought and practice must be a cornerstone of the overall educational planning process. This process is dynamic and must respond to competing and complementary influences. Educators need to be supportive of all staff and volunteers (direct care, administrative, support) across the service lifespan and provide ongoing opportunities for professional growth and development.

Similarly, as people and organizations develop, so does the field of hospice and palliative care. Advances in the hospice and palliative care field require educators to be ever-vigilant to assure that practice reflects the current body of knowledge. It also requires educators to creatively integrate new approaches within an interdisciplinary context.

There exists many opportunities for educators to support interdisciplinary thought and practice in hospice and palliative care settings. A planned approach to initial and continuous development of all staff and volunteers will continue to drive the ultimate learning outcome which is the delivery of consumer-driven quality, competent, and compassionate care to the patients, families and communities we serve.

Robert Arnold is the professional development coordinator for The Hospice of the Florida Suncoast in Clearwater, Florida, where he has worked since 1993. He currently serves on the NCHPP Research/Academics/Education Steering Committee.

Judy Crown has worked for The Hospice of the Florida Suncoast since 2000, and is currently director of professional development.
The inspiration for this article comes from overhearing a conversation. A new staff nurse was asking her mentor to explain just what social workers did as part of the team. The mentor did an excellent job of outlining the social worker’s ability to help families apply for Medicaid, sign the patient up for community programs, and so on. I kept listening, hoping to hear something about counseling, the family, helping the patient deal with the grief they might be experiencing, or explaining advance directives, however, the conversation drifted into other areas.

Explaining the job duties of any professional is a difficult task. I can remember participating in a number of team-building exercises that included one discipline explaining the duties of another discipline. At the end of the exercise, we would go back and let the nurse, social worker and chaplain talk about their own job responsibilities and then compare what each thought the other did. It was always an enlightening experience, and helped to clarify and broaden the way team members viewed each other.

So exactly what is it that social workers do? The first category of duties is the easiest to identify and describe. Social workers provide concrete goods and services for patients and families. I have explained and hooked up baby monitors so a family member could hear a patient call from another room. I arranged for smoke alarms to be installed, lifeline units to be hooked up and, when needed, helped get a patient’s utilities turned back on. All tangible, easily understood social work interventions that are needed and usually appreciated by families and team members. Hospice programs can and should expect social workers to be experts on community resources, and how and where to get items to improve a patient’s quality of life.

Job duties however, should move beyond tangible interventions. Social workers also need to be responsible for assessing and intervening with complex family dynamics such as abuse, neglect, or exploitation. Suicide ideation must also be assessed, a level of risk assigned, and appropriate actions taken. Additionally, the issue of substance abuse, drug dependency and drug diversion are areas of responsibility.

Social workers are trained to assess patient and family strengths. By asking questions that help determine past coping measures, social workers can help the patient and team focus on existing strengths. Social workers are trained to look at the patient/family from a systems approach and to understand the level of support that exists from other family members or friends. Understanding how the patient and family communicate or interact is also important and can provide the team with insight on how best to educate or instruct on patient care.

continued on next page
A social work job description usually includes responsibility for helping prepare a patient/family for what to expect as death approaches. Skilled social workers are capable of guiding conversations into difficult areas and listening for an opportunity to answer questions that linger just under the surface. Purposeful, goal-directed interventions can greatly assist patients and family members in expressing fears or anxieties.

These examples are by no means exhaustive, but seek to broaden the reader’s view. The ability to articulate what social workers do sometimes requires the social worker to expand their clinical vocabulary. Given the size and structure of many hospice programs, I realize that many social workers do not directly report to another social worker. Mentors, however, can be found at colleges, universities and within peer groups. A clinical thesaurus, research articles, and numerous Web sites can be accessed to improve the ability to describe psychosocial interventions.

Advocating for our role can be enhanced by our ability to clearly and plainly explain what it is that social workers do. Without the language to describe what we do, how can we train the next generation of professionals? I hope someday to overhear another conversation that indicates team members have a broader view of psychosocial interventions.

*Sherri Weisenfluh is the associate vice president of counseling for Hospice of the Bluegrass in Lexington, Kentucky, a position she has held for 15 years. In addition to her service as NCHPP’s Social Work Section Leader, she teaches part-time at the University of Kentucky.*
An Emerging Synergy: Pain and Social Work

By Terry Altilio, LCSW, and Shirley Otis-Green, MSW, LCSW, ACSW, OSW-C

While the following article was written in celebration of Social Work Awareness Month in March, its message is especially fitting in the context of Sherri Weisenfluh’s piece (page 29) about understanding and utilizing the full scope of the hospice social worker’s expertise.

It’s important to call attention to the emerging, yet unrealized potential for skilled social workers to contribute to the lives of persons living with pain. For years, a small cadre of practitioners has demonstrated the relevance of social work training to many aspects of pain management. More recently, there is an increased presence of the profession within leading educational, leadership and advocacy organizations, such as the American Pain Foundation and the Alliance of State Pain Initiatives, and through the Mayday Fund’s Pain & Society Fellowship Project. Many social work conferences and curriculums involving end-of-life and palliative care now include pain and symptom management as a core competency; yet the role of the profession in chronic pain is largely untapped. The historical commitment of social work to the underserved, to social justice, and to the relief of suffering provides a context that naturally applies to the tragedy of undertreatment of pain.

There are more than 100,000 healthcare social workers across the country. These skilled professionals provide the first and, in some instances, the only mental health contact for patients with chronic pain, particularly in institutional settings. Social workers practice in hospitals, extended care facilities, hospices, senior centers, advocacy agencies and policy venues.

For patients with chronic pain, social workers may function as advocates, care managers, clinicians, educators and coordinators of their treatment plan. They are often instrumental in ensuring access to appropriate pharmacotherapy and other pain treatments, and may become the major support for patients, family and caregivers. Fears about addiction and other barriers to adequate pain management, including issues with child care or transportation to appointments, are often vetted by socials workers. These clinicians can also teach skills and strategies to enhance pain relief, such as relaxation, breathing exercise, and goal setting.

Social workers collaborate with other members of the healthcare team and play an increasingly important role in addressing chronic pain. They help patients suffering with chronic pain navigate the healthcare system and optimize access to pain care. During Social Work Awareness Month—and throughout the year—let us both celebrate our profession and challenge ourselves to call attention to the tragedy of the undertreatment of pain.
Bringing Relevance, Relationships, and Value to Your Community

By Craig Dresang

Attitude drives behavior. It’s a simple truth. When applied to a communication strategy, it can move public understanding of, and support for, an intangible concept like psychosocial care in hospice. If someone is unclear about the value of something, they aren’t likely to support it.

Effective communication has little to do with glossy brochures, email blasts, slick Web sites and mass mailings. It does, however, have everything to do with building relationships, bringing value to your client base and demonstrating relevance.

A good communication/PR strategist will keep challenging their work with these three questions:

- Does the process for creating and delivering communication foster strong relationships (internally and externally)?
- Is the communication bringing value to the recipient?
- Is the information presented in a way that makes it relevant?

Don’t follow traditional communication practices—generating lots of newsletters, advertisements and emails in order to rain messages down on your community. Instead, become a facilitator of understanding, not just a messenger of information.

Good communication will foster collaboration and creative problem-solving. Begin this process by first identifying your audience and talking with some of them as a group. If the goal is to demonstrate the relevance of psychosocial care in order to drive referrals and financial support, then you will need to collect the ideas and views of those who both use and deliver psychosocial care. Talk to the social workers, bereavement counselors, chaplains and therapists. Talk to the people who have benefited from those areas of care and to those who financially support it. Ask all involved to identify any communication barriers. Have them talk about the value of their work, and provide tangible examples of how it has impacted a specific patient and/or family. And then, find a way to make the staff part of a communication strategy. This will move the ownership for effective communication from a single person or department to an entire organization.

Making It Relevant

Relevance begins at home. Research shows that people who believe in the importance of the psychosocial aspects of patient care are more effective in communicating its relevance to families, funders and agency friends.

Communicating the range of benefits that hospice provides is especially challenging since the concept of caring for the mind, body and spirit can seem intangible, even invisible. It’s easy to take a picture of a nurse or massage therapist caring for a patient and describe the relevance of what they do, but how do you capture the essence of a social worker’s day or demonstrate the value that a chaplain brings to a patient and family?

Oftentimes, an agency may assume its frontline staff has the language and tools needed to clearly make a case for the value of psychosocial care. Usually, that’s not true. Each frontline staffer, from the receptionist to the admission nurse and from the development officer to the marketing representative, needs to articulate, with passion, the same case for support. Training needs to be continuous, probably monthly, if an agency is going to be sure its staff is comfortable talking about and promoting the value and scope of care that hospice brings to a patient and family.

For the trainers and PR professionals, remember that logical, compelling content is the basis for all successful communication, written or spoken. It’s
impossible for anyone to develop compelling content if they are not interviewing and talking with the people who deliver psychosocial care. The best person to articulate the value of social work in hospice is a social worker. Get your raw content from the content experts and keep asking questions until you become a believer.

Once the frontline and PR staff are on the relevance trail, it will become easier to answer “Why does it matter?” in a more public way. Last fall for example, our agency pitched story ideas to the local press related to managing grief during the holidays—the idea grew out of a brainstorming session around ways to make the mind/spirit part of hospice relevant to the general public. The effort resulted in a front-page, full-color news story titled “Seeking a New Sense of Normal” that featured one of the agency’s bereavement counselors and her client. The article was an interesting feature story, but it also gave readers practical tips and information.

Adding Value
In today’s hustle-bustle business environment, few people will have time to listen to you unless you can provide some value to their day-to-day work. Good education and community relations programs are among the best ways for an agency to provide value. Most organizations—from nursing homes to social service agencies—welcome the opportunity for an outside educator to come in and provide free professional education or training for their staff. Finding ways to develop an education program that can be flexible enough to address the education needs of other organizations will pay big dividends down the road. In addition, a community relations program can bring visibility to an agency, build an understanding of concepts like psychosocial care, and provide broad community value. Chambers of commerce, Rotary clubs, churches, synagogues, high schools and colleges are always looking for meaningful partnerships. Universities with social work and nursing programs need internship and clinical rotation placements for their students, many churches need speakers to address their congregations during special months like National Hospice/Palliative Care Month, and social/service clubs are always open to learning more about and even funding the agencies in their community.

Building Relationships
There’s an old Italian saying, “If you marry my sister you marry the whole family.” The same concept holds true for hospice agencies and the communities where they reside. A strong relationship with other community leaders or organizations can help magnify your message with greater clarity and credibility. By definition, a relationship infers dialogue, mutual understanding, and some level of commitment. One of the most potent ways for an organization to communicate with its surrounding community is to develop relationships and partnerships with different parts of that community.

The collaborative possibilities for a hospice organization are limitless. There are natural collaborations that can be explored with other healthcare providers, communities of faith, and social service organizations. And then there are less obvious but equally meaningful partnerships that can be explored with schools, youth organizations, and local artists.

continued on next page
One example of a nontraditional partnership drew the collaborative support of a photo journalist and a local author. Together, they accompanied hospice staff to 20 patient homes, snapping pictures and collecting stories. During the course of their visits and interviews, they captured poignant images and tales that clearly show the value of each discipline—social work; nursing; counseling; massage, art, music; Reiki therapies; volunteerism; and spiritual care. The resulting photos and word portraits were beautifully framed and showcased at a local gallery that hosted an opening for the exhibit, drawing 200 people and lots of media attention. The exhibit, titled “The Gift of Knowing,” now travels to other galleries, schools and hospitals. It is both an educational tool and good art. It has also become a community-wide effort instead of an agency-only program.

Another unusual collaboration garnered the pro-bono participation of 10 different well-known musicians and dance groups for a combined fundraiser and showcase of music and dance. The event proved to be both great entertainment and a successful fundraiser. It also served as an effective platform for the agency to showcase the relevance of hospice—including the benefits of psychosocial care. Though many people purchased tickets for the entertainment value, they left with a deeper appreciation for hospice care and a clearer sense of community.

Finally, a more traditional collaboration with a community college resulted in the two organizations co-hosting a venue for the National Hospice Foundation of America’s Grief Teleconference. For Hospice of Northeastern Illinois, the partnership provided a natural way for the agency’s social workers and bereavement counselors to participate on a local panel for participants of the teleconference.

Every organization has the ability to turn its grunts into words, but developing meaningful communication, especially as it relates to the value of psychosocial care, has more to do with process than the actual words printed or spoken. Because an organization’s ability to raise dollars and serve more patients is directly tied to an ability to communicate with relevance and clarity, it is worth investing in a sound process before printing one more brochure.

Craig Dresang is director of business development/communications for Hospice of Northeastern Illinois, based in Barrington. He has worked in the fields of public relations, marketing, communications, and development for nearly 20 years, and has received numerous awards in recognition of his expertise.
Yes,
you can maintain relationships with your community pharmacy!

Hospice Pharmacia utilizes a pharmacy network of more than 60,000 pharmacies nationwide for medication access. So, YES, you can partner with HP for comprehensive medication management services and still maintain relationships with your preferred community pharmacies!
I have always been very proud to identify myself as a nurse and even more so as a hospice nurse. To my mind, hospice has allowed me to practice the art and science of my profession in a way that I had not found in other areas of nursing. I became a nurse to be with and help people who were ill. At many times in my career prior to hospice, it was very difficult to “be with” people; it seemed as if something technical was always getting in the way. Once in hospice, I was able to articulate what was missing in my prior experiences. What was missing was the ability to be with someone and be present to their pain, fears, hopes, wishes and all the emotions that confront a patient and family at the end of life.

This issue of Insights focuses on caring for the mind, body, and spirit. Nurses certainly use their mind, body, and spirit to care for those who are ill or need care. Their focus, in conjunction with the entire hospice team, is caring for the mind, body, and spirit of the patient and family. The coming together of these two concepts is the art and science of nursing—and especially hospice nursing.

As hospice staff we have the opportunity to enter one of the most intimate, private, and vulnerable times of a person’s life. Hospice nurses are frequently called upon to orchestrate the closure of a person’s life. In fact, hospice nurses have been referred to as “midwives of the dying.” From managing the plan of care to solving complex symptom management problems to being a quiet presence at the bedside, hospice nurses have the unique experience of practicing the art and science of their profession in a way few may realize.

In Making a Difference—Stories from the Point of Care, author Sharon Hudacek presents stories of nurses and nursing. She captures what I consider to be the “C’s” or core components of the art and science of nursing practice—caring, courage, comfort, competence, critical thinking, creativity, crisis intervention, and compassion. Each of these qualities speaks to nursing at its best and, when we look at hospice nursing, these qualities allow us to work at the highest level of our ability to meet the needs and desires of our patients and families.

As hospice nurses, these eight “C’s” should serve as our guideposts:
1. Caring—Listening to the desires, goals, and wishes of the patient and family, and helping them to be achieved;
2. Comfort—Providing a quiet presence at the bedside or to the caregiver to offer support.
3. Crisis Intervention—Intervening when the situation is fraught with anxiety and disappointment;
4. Creativity—Doing something never before tried that solves a problem;
5. Courage—Acting on beliefs and going out of the way for the patient when it may be hard to do so;
6. Competence—Performing bold and fearless acts for the benefit of the patient;
7. Critical Thinking—Attempting something that others have failed to accomplish;
8. Compassion—Providing humanistic care when there is no hope for cure.

All of these interventions are in the daily armamentarium of a hospice nurse and we use them effortlessly as we care for our patients and families. Our bodies allow us to come to work each day and be a physical presence to all whom we encounter. We have the honor to touch bodies in our caregiving—to touch and be touched both physically and spiritually. Our minds work tirelessly to solve problems, and our critical thinking affords us the opportunity to help families achieve goals only they can define.

There has been great fear voiced by many that palliative care/palliative medicine will “medical-
We must have the courage to maintain the creativity that brought us to this point in our practice for the benefit of our profession, and our patients and families.

The following is a letter that the staff of Beacon Place received from the daughters of a former hospice patient. I feel their words speak to who we are and why we do what we do:

For the past month since our mother’s death, we have attempted to put into words the gratitude we have for each of you. Finally, we decided that there were simply not words to express the depth of feeling. Enclosed is a list of only a few of the many ways you cared for our lovely mother and for us as well. Most of all we thank you for the countless things that you did that you did not have to do and we thank you for loving her during her stay with you. You will never know the comfort you brought to all of us.

Thank you for making her feel treasured.
Thank you for holding her hand when she was afraid.
Thank you for hugs and kisses you shared with her daily.
Thank you for putting on her make-up and combing her wisps of hair.
Thank you for sharing laughter and making her smile.
Thank you for making her comfortable and waiting patiently for her to swallow her pills.
Thank you for handling her gently, for touching her with affection, and making her feel feminine and talking with her when she could not say a word.
Thank you for your guidance, strength, and patience as we struggled.
Thank you for crying when she left us.
Thank you for your humanity and compassion.

Sincerely,
Sybil’s Daughters

Science and technology will continue, as it should, and it is our responsibility to make sure that the art of our practice remains just as important in the care of those we serve. As Sybil’s daughters remind us, “you will never know the comfort you brought.”

Pat Gibbons is director of Beacon Place, the 14-bed hospice facility operated by Hospice and Palliative Care of Greensboro in North Carolina. She currently serves as NCHPP’s Nurse Section Leader.

References:
Setting the Bar for Pastoral Care

By Martha Rutland, DMin, BCC, ACPE

What is the best way to support a chaplain? How can a non-chaplain evaluate the clinical competence of a chaplain? Isn’t an open, affirming spirit at bedside enough?

As the new liaison between NHPCO and the Association for Professional Chaplains, I’d like to address these questions—and the best way to begin is by example:

Lisa is 26 years old, developmentally disabled, and dying in an inpatient unit in the care of VITAS Innovative Hospice Care.® Her mom left her at a group home 13 years ago and has had no further contact. The care plan upon admission calls for chaplain intervention to facilitate this relationship.

When the chaplain first met with the mother, she wept as she described how she missed her daughter and how lost she was in her own life after leaving her daughter in a group home. The staff was angry with this mother for deserting her child without a birthday card or call or anything. The daughter couldn’t speak, but her gaze, her breathing, and her calm reflected her appreciation of her mom’s presence.

The chaplain made the team aware of the transition that occurred as mom grieved the lost years, found herself and her child, and renewed her own faith. The chaplain initiated a call to the priest on behalf of the family. A sacramental ritual gave opportunity for confession, for forgiveness, for healing. As the staff watched mother and child for a final few days together, the chaplain brought a perspective that moved beyond the fury at all that went wrong in these lives—to the newly emerging dynamics. The reality of a peaceful death and a hopeful future became possible.

New Standardized Competencies

After years of collaboration, six cognate groups (see References on page 41) have come together to standardize chaplain competencies—an accomplishment that can help guide chaplains and their colleagues toward higher-quality spiritual care for all patients and families. These “Common Standards” are grouped into four sections: Theory of Pastoral Care; Identity and Conduct; Pastoral; and Professional. This article will examine the competencies that comprise the section, Theory of Pastoral Care.

The first competency is to “Articulate a theology of spiritual care that is integrated with a theory of pastoral practice.” When a chaplain can communicate in practical ways the theory of spiritual care provided, respect for the role and responsibility of the chaplain grows. Describing how a spiritual assessment has been made, what interventions are proposed, and what outcomes are anticipated requires both a theory and a practice that is integrated. When the team understands how pastoral care occurs for patients and families, the team feels spiritually supported.

In Lisa’s case, the chaplain helped the mother and the team to recognize the beauty in the receptivity of Lisa to her mom. Lisa is not angry; she is ready for her mom’s attention. Part of pastoral practice is acknowledging Lisa’s responsiveness. This observance led mom to describe Lisa’s early development. Sitting at bedside, mom began to tell stories about Lisa’s early life. She told about how strange sounds made Lisa happy. She remembered her daughter’s giggles. She made these sounds while Lisa listened and sighed with contentment. Mom moved from sobbing relentlessly to the joy of finding her daughter again. The team could see the difference. Tension eased. The situation demonstrated “amazing grace.”
The second chaplain competency is also at work here: “Incorporates a working knowledge of psychological and sociological disciplines, and religious beliefs and practices in the provision of pastoral care.” In Lisa’s case, the chaplain acknowledges the psychological and sociological limitations the mother brought to child raising as well as the poverty of resources. The chaplain also brought in a sacramental blessing that reconnected mom to her own faith roots. This broader view gave all involved a wider understanding of the factors that led to years of neglect, and it brought about meaningful reconciliation.

While other team members reinforce spiritual care, patients and families give clergy the privilege not only of hearing feelings, but also of allowing these feelings to become a bridge. In this case, the entire team participated in rebuilding the relationship. The chaplain provided a critical link to faith traditions, with symbols for contrition, confession, forgiveness, assurance and hope. The chaplain loosened the throes of pain, walked through this valley and heard the joy of laughter in a relationship reclaimed. Documenting this process confirmed the effectiveness of spiritual care.

Chaplain certification is a central facet of professional pastoral care. Certified chaplains undergo rigorous review. Written responses to each identified chaplain competency must accompany an oral description for a committee. A CD–with-workbook is completed by committee members to demonstrate that they have been educated in how to interview candidates. The process is thorough and intense.

When reviewing resumes, candidates sometimes will say they are “certified,” or that they are “members” of a certifying group. These categories do not represent full “certification.” This endorsement is a high standard. NHPCO’s “Spiritual Care Guidelines” recommend the standard credentials of each certifying group. Setting this standard in hospice pastoral care is possible.

For five years, VITAS Innovative Hospice Care® has offered units of study through the Association for Clinical Pastoral Education, Inc. Appreciation for the value of the staff chaplain has risen as interdisciplinary staff have experienced the breadth of chaplain education and realized the competency expectations for chaplains. Levels of pastoral care have changed not only at the bedside, but also within the work of the team and throughout the community.

When a chaplain can communicate in practical ways the theory of spiritual care provided, respect for the role and responsibility of the chaplain grows.

Florence is 92 and lives in an Adult Living Facility on the same block with her son and his family, which includes two young grandchildren. Florence is sitting at a seasonally decorated table with the manager of the ALF, an aide and another resident. Florence does not raise her head when the chaplain enters. She does not respond as the aide encourages her to eat. The care plan proposes pastoral support for the patient and family for anticipatory grief.

The third chaplain competency is “Incorporates the spiritual and emotional dimensions of human development into the practice of pastoral care.” Religion can be maligned as fostering an immature dependency. Religious leaders can take advantage of those who are vulnerable. Death is a time of extreme vul-

continued on next page
nerability. Part of my work as a supervisor with the Association for Clinical Pastoral Education is to shadow chaplains and observe their clinical practice.

During a visit with Florence, I watched how, in response to patient neediness, a condescending manner arose. When a chaplain responds without respect for a patient’s maturity in the face of dwindling capacity, I cringe at the unconscious judgment. Learning to honor the sacredness of this time at the end of life requires professional pastoral practice.

The aide was encouraging the patient to eat—just a bite. The student chaplain slipped into a similar stance. The aide had mentioned that the patient was Roman Catholic. I asked if the patient received the sacrament regularly. When the aide said no, I asked the patient, “Would you like the priest to bring you the sacrament?” The patient had made no previous response, was not eating, nor making eye contact, just sitting with head bowed. She looked up at me and stated definitively, “No! That would be too sad.” She again lowered her head and made no further response. The patient’s declaration, however, defined her feeling state. She was sad and angry about the finality of her situation. The aide described how the patient could not enjoy her visitors, the season, or her grandchildren who came by each morning on their way to school. She was too sad.

A new care plan could now be developed with this information in mind. Sadness permeated her life. Could some new understanding through the cloud of her dementia bring meaning to the last days? Is there a way to listen, assimilate and respond with empathic attunement? How are the grandchildren supported? What age-appropriate resources are offered? Since the family is active in a neighboring congregation, how is that community invited to participate in the patient’s and the family’s care? These questions represent the considerations of a professional chaplain for Florence and her family.

The fourth competency is “Appropriates a working knowledge of ethics appropriate to the pastoral context.” Five primary ethical principles are highlighted in the 2005 Hospice Foundation of America resource, Living with Grief: Ethical Dilemmas at the End of Life. In a series of cases, ethical principles in practice evolve: nonmaleficence, beneficence, autonomy, justice, and fidelity. The first ethical principle, nonmaleficence, “is typically viewed as the most important.” (p.8)

Consider Florence’s outcry in the previous case to the question of the sacrament: “No, that would be too sad!” Hearing her sadness and her anger, the temptation is to back away from such strong feelings in order to cause no harm. And yet isn’t there harm in ignoring these feelings? Can the specific contours of her feelings be named? Can the family be invited to hear and reflect together on how to hear and understand Florence’s feelings, as well as to share their own feelings? Sometimes families may miss each other—even when they see one another. The role of the chaplain is to facilitate relationships. When a family is involved in a religious community, the rituals, symbols and traditions can be a shared source of comfort.

Florence’s first response to the sacrament is that it is too sad. To stop with this declaration is to miss the passionate investment that is held in her pain and anger. Can the chaplain slow down engagement to allow a different kind of meeting?

The final chaplain competency is “Articulate a conceptual understanding of group dynamics and organizational behavior.” In a group home and in healthcare, a need for compliance can obscure personal needs. The hospice movement grew out of the need to be more personally responsive to people at the end of life. Watching Florence, who is not willing to eat, is it possible to respect her resilience? Could this patient be maintaining self-respect and independence in a challenging situation? How does her faith sustain her?

In the Association for Clinical Pastoral Education group I currently supervise, I find resistance to learning the most basic skills. For those supporting someone who is different, it may seem like a betrayal of personal values held most dear. Teaching chaplain competencies, I experience the tension that occurs between supporting a diverse populace and remaining faithful to beliefs at the
heart of personal faith. How can a student move through this tension? What I love is watching patients and families tenderly leading the way, opening doors and guiding these chaplains with persistence and perseverance to broaden their vision and see that faith lives in many ways.

**Supporting the Hospice Chaplain**

In a recent chaplain job interview, I invited an applicant to talk about his work in another hospice. As he scrambled to tell me how he never quite understood it, I knew he still wouldn’t quite get it. What is “it”? The five competencies just discussed are part of “it.”

Look up all the common chaplain competencies determined by the six cognate groups at the professional chaplains’ Web site (professionalchaplains.org). Review other essential foundations for pastoral care also listed: Common Standards for Pastoral Educators/Supervisors, Common Code of Ethics, and Principles for Processing Ethical Complaints. Become knowledgeable about the breadth of pastoral care.

Support chaplains by becoming aware of standardized chaplain competencies. Discuss these expectations with chaplains. Watch for practical feedback regarding implementation. Encourage continuing education accredited by chaplain credentialing groups. Learn about these groups from the web pages listed below. Plan now to incorporate chaplain recognition during Pastoral Care Week in October, using resources at pastoralcareweek.org Maximize pastoral care resources by expecting chaplains to be certified. Support them in this process. While current chaplain staff may be adequate, remember these standards when hiring. Now is the time to begin.

Martha Rutland is the director of clinical pastoral education at VITAS Innovative Hospice Care® in Miami, Florida. While she has worked for VITAS for seven years, she has also spent 14 years in hospice, and was a parish pastor for 17 years. She is an ordained United Methodist minister, a certified supervisor with the Association for Clinical Pastoral Education, and a board-certified chaplain. She also makes time to serve as an NCHPP Spiritual Caregiving Steering Committee member.

**References**

Chaplain Cognate Groups and Web sites:

- Association for Professional Chaplains (professionalchaplains.org)
- American Association of Pastoral Counselors (aapc.org)
- Association for Clinical Pastoral Education, Inc. (acpe.edu)
- National Association for Catholic Chaplains (nacc.org)
- National Association for Jewish Chaplains (nacj.org)
- Canadian Association for Pastoral Practice and Education (cappe.org)
Data from NHPCO’s Family Evaluation of Hospice Care (FEHC) survey provides us with valuable information from families to help identify areas where quality improvements are called for. Likewise, the way to ensure the best possible outcomes for bereavement clients is through program evaluation and quality improvement. NHPCO’s new survey tool, the Family Evaluation of Bereavement Services (FEBS), will help us do that.

About FEBS’ Development

Kim Mooney, a member of the NCHPP Bereavement Professional Section, planted the seed for the FEBS in a question she raised during the summer of 2003. Recognizing the need for an industry-wide tool to measure hospice bereavement services, Dr. Stephen Connor, NHPCO’s vice president of research and international development, offered NHPCO’s support in developing one. An expert panel was formed based on NHPCO’s accepted methods for survey development. Experienced professionals comprised the panel, including many with a high level of expertise in delivery of bereavement services in the hospice setting (see sidebar on page 43).

Panel members began the project by collecting and reviewing sample surveys that hospices were currently using. They found there was much variation in the questions that were asked as well as how the surveys were administered. A fair number of hospices were not evaluating bereavement services. Those that were had been discouraged by low response rates and narrative comments that were often added. The comments usually referred to the hospice care they had received rather than the bereavement care. The need for a means to gather information in a way that would allow for evaluation and comparison across hospices was obvious.

As the next step, NHPCO requested the assistance of the survey research specialists at the University of Massachusetts (U Mass). With their guidance, under the leadership of Brian Clarke, PhD, the panel began the arduous—but eventually gratifying—process of FEBS’ development.

Over the course of a full day, panel members reviewed past and current bereavement services, evaluation efforts, and the NHPCO Bereavement Standards, and received instruction on the principles of survey design. They considered what general content domains to measure, the specific content areas within the domains, made plans for cognitive and field-testing, and established a timeline.

After the meeting, the U Mass researchers developed the first survey draft and distributed it to the panel for review. This was another first step in the long process of review and revision of survey drafts. After many months, the panel reached agreement on the survey’s design. The U Mass researchers then conducted cognitive testing, which engendered further review and revision. The survey was then ready for field-testing, which NHPCO conducted with the help of over 30 hospices during the summer of 2006. Based on results from the field-testing, they made a few more changes to the survey, and the final version became available for hospices to start using in January 2007.

Observations About the Final Content

There are two general assumptions about hospice bereavement services that serve as the foundation for the survey content: (1) services are intended to match the bereaved person’s need for support, while recognizing that not all individuals will have the same needs; and (2) services have the goal of assisting the bereaved person to manage the impact of loss.

Because hospices offer services based on their particular experience and resources, wide varia-
tion exists in the number and nature of bereavement services offered. Thus, the survey design had to be comprehensive and, at the same time, consider the dissimilarity of the configuration of bereavement services among hospices. Therefore, the panel decided to include questions on a wide range of services, with instructions to respondents to skip those questions that do not apply to their experience.

The panel wanted to be sure family members would clearly understand they are being asked about bereavement services after the time of death. To address this, there is a reminder of this at the beginning of each section of the survey.

The first section asks about the role hospice played during the year after the death by asking questions about the information that was provided and how helpful it was. The second section asks about hospice mailings, types, their timing, and how they were or were not helpful. Similarly, the section on phone calls asks about the frequency with which there was contact by phone, how accessible bereavement staff were if they made the call, and overall satisfaction with all phone calls.

In-person bereavement visits is another section, followed by questions about groups—whether they attended any and whether they derived satisfaction from them. There are also questions about memorial services and other special programs or activities.

The survey ends with a few questions about overall satisfaction, followed by questions regarding the types and amount of support they received, whether they had experienced other loss(es), the types of loss(es), and demographic information.

Because the quality of a bereavement program cannot be evaluated based on where its clients “are” in the grieving process, FEBS does not include an assessment of respondents’ progress. While grief assessment may be useful for bereavement staff in screening and planning interventions for individual clients, individual grief assessment has little utility in reporting and interpreting comparative program evaluation data nationally. A screening question has been included, however, to identify people who may need additional follow-up and assistance.

To review a copy of the FEBS survey, as well as information on implementing it, visit nhpco.org/febs.

Members of the FEBS Expert Panel:
Stephen Connor, PhD
Patti Homan, PhD, LPC, FT
Robin McMahon, LCSW, MSW
Kim Mooney, BA, CT, CTR
Stacy Orloff, EdD, LCSW
Shareefah Sabur, MNO
Carol Spence, RN, MS

Patti Homan is program director for the PATHways Center for Grief & Loss at Hospice of Lancaster County in Lancaster, Pennsylvania. She is currently serving her second three-year term as the NCHPP Bereavement Professional Section Leader.

Carol Spence is director of research for NHPCO, overseeing research activities related to performance measurement, including the planning and implementation of ongoing and new data collection initiatives.
Although Chinese-Americans make up just 25 percent of the Asian-American population, they are in fact the largest segment within this incredibly diverse and growing community. In 2004, there were over 3.4 million Chinese people living in the United States, an increase of more than 500,000 since Census 2000.

As part of its outreach work, NHPCO’s consumer-engagement program, Caring Connections, has been developing culturally diverse end-of-life resources for hospices and coalitions to better reach underserved populations. In October 2006, a Latino Outreach Guide was developed (NewsLine, 10/06) and now a Chinese-American Outreach Guide is available.

As a first step in the development of this Guide, a series of focus groups was held which provides insight into the attitudes and behavior of Chinese-Americans.

About the Focus Groups
In May 2006, Caring Connections sponsored four focus groups with Chinese-Americans to help determine their views on various end-of-life issues. The focus groups were conducted by Lake Research Partners and yielded some interesting preliminary findings:

Advance Care Planning
While some participants were comfortable talking about death and others were not, there was agreement that talking about death, especially with elders, is taboo and disrespectful. Yet most said they would not want to be kept alive on life support because they didn’t want to become a burden to loved ones.

End-of-Life Caregiving
Participants explained that dying peacefully is important to Chinese people. “We Chinese say, we don’t expect to have a good life, but we’d rather have a good death. It’s a good fortune to have a good death,” one participant shared. Chinese are divided about withholding life support from a loved one. Because of the importance of filial duty and respect, it is difficult to remove a parent from life support.

Hospice
While the central tenets of hospice resonated with respondents, hospice was a novel concept to most. Some were also confused about the specifics, and some thought hospice was nursing home care. In addition, some respondents did not believe that Medicare, Medicaid, and most private insurance will cover hospice.

Other Issues
Eastern religious beliefs were very relevant to many participants, while Chinese Christians
tended to use their religion as a basis for viewing end-of-life issues. Participants described the importance of having respect for doctors, and because of this, doctors may have a very significant role to play in end-of-life care decisions.

**About the New Outreach Guide**

Caring Connections’ new Chinese-American Outreach Guide was developed with the assistance of the Chinese-American Coalition for Compassionate Care (CACCC) of California, and HomeReach Hospice of Columbus, Ohio (see page 46 for profiles of these two organizations). The Guide, which is available to hospices and coalitions, can be downloaded from caringinfo.org (go to ‘Community’).

The Guide includes:

- A summary report from Caring Connections’ Chinese focus groups;
- Key facts and cultural concepts about Chinese-Americans;
- Case examples of the Chinese-American Coalition for Compassionate Care and HomeReach Hospice’s outreach initiatives;
- Tips for building partnerships with the Chinese-American community;
- Outreach strategies to engage the Chinese-American community;
- A Chinese-English glossary of end-of-life terms;
- PowerPoint presentations with speaker notes (in Chinese and English).

Because of the variety of languages and cultures among Asian-Americans, it was necessary to focus specifically on the largest population, the Chinese. However, the intention is that hospices and coalitions which also serve Japanese, Koreans, Vietnamese, Hmong, and Cambodians will gain new ideas and build on some of the broad cultural and religious similarities across Asian communities that are important factors in end-of-life care.

**Ashley Hammarth is NHPCO’s manager of partner programs and services.**


**Did You Know That...**

- In the United States, people identified as Chinese are either from the People’s Republic of China (mainland China), or from Taiwan (Republic of China), which is an island nation off mainland China. People from both countries share a similar racial, ethnic, and religious background.

- Chinese-Americans have lower average birthrates than whites and other groups, which means their population is aging relatively quickly.

- Despite lower birthrates, Chinese-American households tend to be larger due to the common practice of multiple generations and extended family living together.

*Source: U.S. Census Bureau*
Chinese-American Coalition for Compassionate Care
CACCC (caccc-usa.org) is based in California and is the only coalition in the country devoted to end-of-life care for Chinese-Americans. Sandy Chen Stokes, RN, MSN, founded CACCC and serves as its chair. She also serves on Caring Connections’ National Advisory Committee. Sandy has a wealth of experience in end-of-life issues which began with her career as a geriatric nurse specialist. In 1999, she began to focus on the end-of-life needs of Chinese-Americans in the San Francisco Bay Area. “I saw that people wanted information to do the right thing, but they really needed information in Chinese,” she recalls.

Before long, Sandy began doing community education on advance directives with Chinese elders. She attracted a great deal of interest in advance care planning, and this success led to a series of other projects, including the translation of the California Advance Health Care Directive into Chinese, and implementation of campaigns in the Chinese-language media.

CACCC, which Sandy founded in December 2005, is the culmination of her many previous efforts. In just one year, CACCC’s membership grew to more than 100 people, representing over 40 organizations, including the American Cancer Society, Alzheimer’s Association, California Transplant Donor Network, and Tzu Chi Foundation USA. To minimize the initial costs associated with establishing a new coalition, CACCC receives operational support from the California Coalition for Compassionate Care.

In August 2006, CACCC organized a training for volunteers who offer respite to caregiving families at the request of the American Cancer Society Northern California Chinese Unit. It was a tremendous success with 99 attendees, almost double the anticipated number, demonstrating the significant interest in and need for end-of-life care in this community.

In 2006, CACCC was awarded a competitive one-year grant from the Lance Armstrong Foundation to conduct outreach to Chinese-speaking cancer survivors and their loved ones in the greater San Francisco Bay Area. In the future, CACCC would like to develop trainings for healthcare providers who work with Chinese patients and their loved ones at the end of life, and establish key words and common messages in Chinese.

HomeReach Hospice
HomeReach Hospice of OhioHealth (ohiohealth.com/homereach) received a 32-month grant in 2005 from the Aetna Foundation to improve access and educate the Chinese community and other underserved immigrant populations about end-of-life care. Its Chinese community is largely middle-class, educated immigrants from Taiwan, and many elders live with children and grandchildren.

The Link, Learn and Support End of Life Project, under the guidance of project coordinator Betty Tom-Denzer, partnered with a local service provider, Asian-American Community Services. The main AACS liaison is originally from Taiwan and has strong ties to the local Buddhist community. In early 2006, she surveyed community members and discovered a growing awareness of end-of-life issues among younger Chinese people and a need for more education. Through partnering with the Buddhist community and others, HomeReach has recognized the importance of educating about end-of-life care in general rather than emphasizing its services. Community members have not yet been ready to totally embrace the hospice concept, but are interested in learning more about advance directives and improving their loved ones’ quality-of-life.

In addition to community outreach, HomeReach continues to review internal policies to understand how members of immigrant communities are referred, and to prepare staff to become better able to serve immigrant populations.

-Ashley Hammarth
Wish You Could Go To A Hospice Regulatory Boot Camp?

Well now you can! Weatherbee Resources, Inc. and several state hospice organizations are co-sponsoring intensive 2 ½ day workshops which are being held in various locations throughout 2007. The Hospice Regulatory Boot Camp is an innovative educational program that provides hospice executives with state of the art knowledge, understanding, and resources related to hospice regulations. It was created to respond to a need in the hospice industry for an in-depth program that covers all aspects of the Federal regulations that govern hospices. The program is designed for new and seasoned senior level hospice executives including State hospice association directors and hospice CEOs, clinical directors, and compliance officers. A previous participant said:

“This training is essential for state and program hospice leaders, and the resources provided are incredible!” Cordt Kassner, Ph.D., Executive Director, Colorado Hospice Organization.

For additional information, please view the Boot Camp Calendar and registration information on our website: http://www.weatherbeersources.com or give us a call at 508-375-0098

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What Leadership Brings to the Quality Initiative

In this issue, we focus on component nine in Quality Partners’ 10-component framework.

S	ewardship and accountability ultimately relate to the quality of the organization’s leadership. Have the hospice’s senior leaders aligned the organization’s budget development and financial priorities with its articulated values and quality improvement goals? In other words, “Does the hospice do what it says it is going to do?”

Statements of values, codes of ethics, policies on conflicts of interest, and similar governance structures, policies and procedures can be put in place to help strengthen its foundation, but ultimately the organization will rise no further than its leader can carry it, says John Horan, board chair of The Denver Hospice. “It’s extremely important to have a principled leader who is both effective and visionary—who walks the talk. It’s also important for the board to challenge that senior leader, support her and give her the tools she needs to succeed.”

The Denver Hospice’s CEO, Bev Sloan, adds that leadership for an organization like hers is built on respect, trust and integrity. “Fundamentally, if you’re going to lead the organization, you have to model your values for everyone to see,” she says. “We believe everyone here is equally valuable, and equally capable of solving problems, and that’s part of what I try to model. I have an open door policy and I try to be very approachable, to listen to staff and ask for input.”

Fine-Tuning the Message

In its competitive market, The Denver Hospice recently made a major commitment to gather fresh evaluations of its services from referral sources, and patients and families—as well as asking what they wanted and needed from the organization. “We needed to take stock of how their needs have changed—rather than assume that we have all the answers,” Sloan says.

Some of those needs have changed over time, while in other cases the hospice’s assumptions about what was important to its customers weren’t necessarily correct. NHPCO’s Family Evaluation of Hospice Care survey, benchmarking comparisons with other large hospices belonging to the National Hospice Work Group, and staff opinion surveys provided additional input.

Some of the results from the customer surveys were surprising, says board chair Horan, owner of a local mortuary group. “We thought we were better than we actually were in some areas, and I don’t think our referral sources could distinguish us from our competitors as well as we might have hoped.” The results also pointed toward ways to fine tune operations in response to what patients and families really need and want.

Based on this consumer input, a commitment was made to increasing home health aide contacts and hours with patients, which are appreciated by referral sources and families, and make a measurable contribution to quality. By contrast, bereavement services, while an essential component of hospice care, were not as well understood or highly sought by the organization’s customers, so they may not be increased beyond present levels. To take another example, the agency’s palliative care services are not always well understood by patients and families, but they are highly valued by referral sources, and most of the organization’s business comes from those referrers.

Building on this input, the organization developed new branding concepts, changed its name (from Hospice of Metro Denver), and tried to simplify its strategic messages as much as possible in order to be better understood by its staff and customer base. Even internal department names and structures have been streamlined.

The organization redefined its mission statement and identified five core values—which were then prioritized in a Values Ladder, because values can conflict. “If you have to choose between respect for patients’ wishes and patient safety, we would choose the former,” Sloan relates. “If a gentleman really wants to waltz—this is a real-life
example from two days ago—then we need to facilitate that wish, even though he is physically frail.”

The new concepts and messages were rolled out to staff in a series of mandatory, two-hour, all-staff meetings for every shift and department. Hospice marketing consultant Peter Benjamin was brought in to give a hard-hitting portrayal of the competitive environment hospices face. Benjamin explained to staff that clear and careful branding of the hospice’s product is important not just to marketing goals but to help patients and families make choices and get the services they really need. “It’s not just about the care we provide, but how we communicate about it,” Sloan explains.

The degree to which staff understood and bought into these changes was surprising, she adds. “People were thrilled to see that we were building on the mission we’ve had here for the past 28 years.” Staff has also been able to embrace the need for efficiency and the belief that margin is as important as mission to the organization’s long-term viability.

Philanthropy remains an essential underpinning for the hospice’s operations, but it is important to understand the net costs of various programs and services and then make conscious decisions about what gets supported and why, Horan says. “When we know how much things cost, we can go back and say, ‘We’re going to do this anyway, because it’s important.’”

“Operationalizing” this kind of strategic positioning in order to lead the hospice where it needs to go requires good information, Sloan says. “Any hospice can ask people in its community how well it is doing, how they perceive its messages, and what is most important to them.” There are expensive ways to gather more rigorous customer input, but that may not be necessary. “It’s really just taking the time to ask questions. But you have to do honest self-assessment by some method. Then you need to make a commitment to addressing the clearest areas of need that emerge—and be accountable to staff and the board for meeting those needs.”

**The Board’s Essential Role**

The board chair’s role in all of this, Horan says, is “to make sure we define well, measure well, report well and reward well.” Another important responsibility is to manage the diversity of the board itself and its balance between business leaders, representatives of diverse communities, major donors and people who make other, non-financial contributions of value. “It has been a challenge for Bev and me to identify the right people, but now it’s fun to go to the board meetings and hear the perspectives expressed,” he observes.

“We also practice environmental stewardship,” Sloan says. “And we are very involved with hospice care in Africa and with the Foundation for Hospices in Sub-Saharan Africa. That’s a different kind of stewardship—promoting access to palliative care for people who are less fortunate. But these things reinforce our commitment to our values at home.”

An intentional approach to leadership and stewardship is an essential foundation for high-quality hospice services. Visit nhpc.org/quality for resources and checklists to help you in this all-important process.

— Larry Beresford
A New Tool to Help Open Access

Opening access to your entire community requires a commitment to inclusion. Your program, services, policies, and procedures—along with all the staff and volunteers who operationalize them—must foster a culture of inclusion.

NHPCO has developed a new resource, the Inclusion and Access Toolbox, to help in your efforts to create an inclusive organization. Consistent use of this manual will guide your hospice organization to:

- Expand board, leadership, staff, and volunteer understanding of inclusion and access in end-of-life care;
- Employ new paths toward inclusion through community, staff, board, and volunteer engagement;
- Develop an organization-wide plan to increase inclusion in all areas of hospice care;
- Demonstrate individual and collective best practices for inclusion which are cornerstones of culturally relevant and sensitive care.

The Toolbox is available as both a manual and CD through NHPCO’s Marketplace (nhpco.org/marketplace). More details about the new tool can be found at nhpco.org/access.

May Launch of Diana Legacy Fund Draws National Attention

The Diana Legacy Fund celebrated its national launch last month in San Diego, California. Special guest Archbishop Desmond Tutu welcomed attendees and officially announced the Fund which is dedicated to supporting programs that encourage and sustain hospice and palliative care in sub-Saharan Africa.

The event garnered both media attention and new supporters for this important cause.

The late Diana, Princess of Wales, reached out to people on the very margins of society, lighting up their lives with her compassion, grace and humor. One of her strongest beliefs was that there is a basic right to pain-free, end-of-life care and support for families of the dying. The National Hospice Foundation established the Fund, named in memory of the late princess, to perpetuate this cause close to her heart.

In sub-Saharan Africa, 6,500 people die of HIV/AIDS each day, many of whom are children. Only a small fraction of the dying has access to appropriate services, including adequate pain medication. Through the Diana Legacy Fund, attention is being drawn to the dire need for hospice and palliative care in this region, and the ways in which all Americans—specifically the hospice community—can lend their support.

Currently, through FHSSA’s innovative partnering initiative, hospice and palliative care programs in 12 African countries are receiving support from hospices in the U.S. The Diana Legacy Fund will build on this successful program as well as fund additional efforts to advance needed care.

Donations in support of the Diana Legacy Fund can be made online at dianalegacyfund.org, or by calling 877/470-6472.
New AHLA Guide for People With Life-Limiting Conditions

A Guide to Legal Issues in Life-Limiting Conditions is one of several new resources that can be found on the Caring Connections’ Web site.

Written and produced by the American Health Lawyers Association (AHLA), the Guide provides an overview of the principle legal and practical issues that arise in the care of individuals who face a life-limiting condition or those who are providing care to someone with the condition.

These individuals often find themselves facing a host of complex decisions, often at a time when they are in crisis. Making an important decision under these circumstances is invariably difficult. In evaluating long-term care options, for example, many seniors and their families fall prey to the “chandelier effect” under which they incorrectly conclude that a beautiful facility with attractive surroundings ensures that they will receive high-quality services. The questions in this Guide are designed to assist individuals in accurately assessing the type, frequency, and quality of services offered by healthcare providers as well as the related costs.

As an aid to the planning process, the Guide is organized around the continuum of care, beginning with healthy individuals who are able to live at home and following the continuum to independent retirement communities, assisted living, long term care, and eventually to hospice care.

Along with this Guide, Caring Connections has developed the following flyers in partnership with AHLA:

- We All Need to Plan for the Future
- Long Term Care Options
- Choosing a Long Term Care Facility
- Choosing an Independent Living Arrangement
- Settling into a Long Term Care Facility

To access the Guide and the flyers, visit caringinfo.org (and select Resources” from the top menu bar, then “Free Brochures”).

...Many seniors fall prey to the “chandelier effect” under which they incorrectly conclude that a beautiful facility...ensures... high-quality services.
People and Places

Hospice Produces Songs of Healing CD
Hospice of the Chesapeake, based in Annapolis, MD, has produced a CD of inspirational music as a tangible means of comfort and relaxation for patients, caregivers and the community. Created especially for the hospice, Songs of Healing consists of 16 original works by renowned Anne Arundel County musician Rob Levit.

Levit ensured the CD would live up to its title by spending time with patients at the John & Arloine Mandrin Chesapeake Hospice House before entering the studio to record the music. “This project has been the most meaningful I have ever engaged in,” he said.

Songs of Healing is available for purchase from Hospice of the Chesapeake. For details, email stramella@hospicechesapeake.org.

Johnson Named General Manager of VITAS of Greater Washington
Timothy Johnson has been named general manager of VITAS Innovative Hospice Care® of Greater Washington, serving patients living in Washington, DC. In this role, Johnson will oversee all aspects of VITAS in the District of Columbia.

Johnson has more than 15 years of experience in patient care and senior management, most recently as executive director at the Shoreline HealthCare/Grant Park Care Center in Washington, DC.

Pat Soenksen Named HPCG’s President/CEO
Patricia A. Soenksen has been appointed president/CEO of Hospice and Palliative Care of Greensboro (based in Greensboro, NC). Soenksen is the second executive leader for HPCG, filling the vacancy created by the resignation of Pam Barrett in December 2006. Soenksen comes to Greensboro directly from Oncology Resource Consultants in Washington, DC where she was a vice president.

Medical Director of CareSource Home Health and Hospice Awarded Board Certification
Dr. Crystal Owens, medical director of CareSource Home Health and Hospice (based in Salt Lake City, UT) was awarded board certification in hospice and palliative medicine from the American Board of Hospice and Palliative Medicine. Dr. Owens joins more than 2,800 fellow physicians who have achieved this distinction.

Hope President Receives Designation from Leading Society of Healthcare Professionals
Samira K. Beckwith, president/CEO of Hope Hospice and Community Services (Fort Myers, FL), has been designated as a Fellow of the American College of Healthcare Executives, a society of the world’s leading healthcare professionals. The FACHE Fellowship credential recognizes achievement of the highest standards of professional development.
Burden Buddies to the Rescue

For many years, Parkview Home Health & Hospice (Fort Wayne, IN) has given teddy bears—aptly named “Burden Buddies”—to hospice patients and families as a gesture of support and comfort. According to Mauna Cowan, the program’s volunteer coordinator, the bears help grieving families deal with their losses, help kids cope with emotions that can be frightening, and help hospice patients with dementia remember important times in their lives. When its supply recently ran low, hospice staff asked Fort Wayne’s Girl Scout Troop 547 if they’d consider making more bears as a group project.

Sure enough, they agreed. The troop of eight girls, ages 12 and 13, sewed, stuffed and accessorized 40 bears—and kept going until they had produced 95 bears in honor of the 95th birthday of the Girl Scouts. The troop’s generosity and commitment to this project helped them earn the Girl Scout’s Silver Award—the highest award given to cadet scouts.
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**NHPCO’s Audio Web Seminars**

**Interdisciplinary Topics** – Second Thursday of the Month, 2:00 – 3:30 pm EDT.

- 07/12/07—From Continuous Care to Hospitalization and Respite Care – Continuity and Communication
- 08/09/07—Calming the Storm: Addressing Terminal Restlessness

**Leadership Topics** – Fourth Tuesday of the Month, 2:00 – 3:30 pm EDT.

- 07/24/07—How Do You Measure Up? Using Performance Measurement Data to Promote Excellence
- 08/28/07—RORI: Return on Marketing Investment – Make Sure You Are Getting It!

**NHPCO Conferences**

- July 30 – August 1, 2007—Caring For the Mind, Body and Spirit: Psychosocial, Bereavement, and Spiritual Needs, Albuquerque, NM
- November 29 – December 1, 2007—8th Clinical Team Conference, New Orleans, LA
- April 10-12, 2008—23rd Management and Leadership Conference, Washington, DC

**Hospice MDP Two-Day Foundational Course**

- July 28-29, 2007—Albuquerque, NM
- August 22-24, 2007—Durham, NC
- October 1-2, 2007—Bloomington, MN

Additional MDP Level I and II modules are available in online formats! Visit nhpco.org/mdp for more information.

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**Marketplace**

**This month’s picks are germane to this issue’s theme — Caring for Mind, Body and Spirit.**

- Psychosocial Aspects of Death and Dying
  By John D. Canine
  Item: 810040, Member: $43.19

- Spirituality, Health, and Healing
  By Caroline Young
  Item: 820883, Member: $32.95

- Parting: A Handbook for Spiritual Care Near the End of Life
  By Jennifer Sutton Holder and Jann Aldredge-Clanton
  Item: 820489, Member: $7.61

- Voices of Bereavement: A Casebook for Grief Counselors
  By Joan Beder
  Item: 820786, Member: $21.21

- Caregiving: Hospice-Proven Techniques for Healing
  By Douglas C. Smith
  Item: 820209, Member: $9.91

- Dying, Death, and Bereavement: A Challenge for Living
  Edited by Inge Corless, Barbara B. Germino and Mary A. Pittman
  Item: 820920, Member: $17.00

To order, visit nhpco.org/marketplace or call 800/646-6460. Mention Code: NL06
In this photo, a patient at Beacon Place finds welcome distraction while helping with garden work. To learn about the benefits of horticultural therapy in hospice, turn to page 10.