The IDT: Staying the Course, Staying True
In the midst of many changes and challenges, it is easy to focus only on your work, your worries, your goals. But where does that leave your colleagues? And why does it matter?

The articles in this issue—written by members of NHPCO’s National Council of Hospice and Palliative Professionals—explore these questions and provide guidance that can help each of us manage the changes in our work life while upholding the interdisciplinary team* model and honoring the goals of those we serve...

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* While the current Medicare Hospice Conditions of Participation (Hospice CoPs) refers to the interdisciplinary team (IDT) as the “interdisciplinary group” (IDG), NHPCO continues to use the term “interdisciplinary team” in its communications (except in those concerning the specific regulations). We believe that using IDT helps reinforce and remain ever-mindful of the importance of team collaboration in interdisciplinary practice.
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by Shareefah Sabur, MA, MNO, CDP
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The Art of NCHPP
This special section features photographs taken by NCHPP members around the country. Appreciating the creativity of these staff, who bring new voice and fresh perspective to the work we do every day—is a wonderful way to conclude this issue and begin the new year.

NHPCO’s Educational Offerings
Upcoming conferences, Webinars, webcasts and E-OL courses

My.NHPCO—Care, Share, Connect
This website is an easy way to share and exchange ideas, concerns and solutions with fellow members and colleagues around the country. Learn more about this free membership benefit.
NHPCO’s National Council of Hospice and Palliative Professionals (NCHPP) is comprised of 40,000 staff and volunteers who work for NHPCO provider-members. It is organized into 15 discipline-specific sections that represent the interdisciplinary team, and is led by the NCHPP chair, vice chair and 15 Section leaders.

In mid-December, NCHPP chair, Shareefah Sabur, passed the baton to Gregory Wood, who will serve as NCHPP chair from 2011 to 2013. Rex Allen, who has served as the NCHPP Bereavement Professional Section leader, will continue as Section leader, but will also assume the role of NCHPP vice chair.

These individuals, together with NCHPP’s 15 Section leaders and their steering committees, volunteer tremendous time and expertise to a variety of NHPCO projects, both within and across disciplines. Their contributions are significant and the volunteer time they devote to that work is truly inspiring. On behalf of the NHPCO board and staff, a heartfelt thanks to Shareefah, Greg and Rex for their service and dedication.
This Swahili proverb provides a strong visual image and metaphor for teams and teamwork. Can’t you just picture a boat where each rower is doing his/her own thing? The boat might go in circles, it might stand still, or I suppose it might even capsize. To propel the boat forward, it is crucial that all rowers work in collaboration with each other.

This proverb also provides a strong metaphor for the hospice interdisciplinary team. Isn’t it just as important that team members work in collaboration with the patient and family and with each other to ensure the patient’s goals are met? While we may understand the value of the interdisciplinary team as a practice that distinguishes hospice from the rest of healthcare, we also know that teams often fall short of this ideal. Nevertheless, it is important to uphold such a standard; it gives organizations and teams something to strive toward.

Okay, you acknowledge that a team of rowers makes sense when striving to propel a boat forward, but why is a team so essential to hospice care? At the time the modern-day hospice movement began, medical care focused exclusively on physical care (and still does in most venues), with no attention to a person’s emotional, social and spiritual “selves.” Yet the founding leaders of the hospice movement believed, as we...
continue to, that a person is more than a physical being, that a patient and family in the care of hospice is more than a diagnosis or number in a chart; each is a complicated being with feelings, beliefs, values and perceptions, and often surrounded by a circle of family or other social support, who has created and is living a life of some meaning, value and purpose.

This holistic “lens” through which we understand patients and families also recognizes that what happens physically affects a person emotionally, spiritually and socially. It’s all quite a complicated network of systems, each of which affects the other, both within the individual and throughout his/her family and social network.

Given this intricate, intimate and integrated network, hospice pioneers recognized that it would require a team or “crew” with unique yet complementary skills to truly preserve the dignity of an ill person and to teach, support and encourage their families. Hence, the birth of the interdisciplinary team.

Still, wouldn’t it be simpler if just one person rowed the boat and was “in control” of its direction and momentum? For starters, rowing alone is tiring. It also takes much longer to get where you’re going and, frankly, it’s just not as satisfying once you get there. There’s a powerful esprit de corps that develops in the best and highest functioning teams which are working toward a common purpose—regardless of whether it is to reach the finish line first or assist a patient and family in reaching their goals with determination and confidence.

It does make sense to have someone “in charge,” someone who determines where the boat is headed. That person (or persons) is, of course, the patient and his/her family. And they are the most important part of the team—the very reason the team exists. The patient and family should always be the ones to determine the destination, the goals toward which all should “row” while also deciding when the boat has arrived, when it needs to change direction or when it needs to stay on course. Hospice professionals and volunteers should not be charged with any of these things; they are there to facilitate the journey—to support the patient and family on their chosen route, and identify and help remove potential obstacles along with the way.
Why Some Teams Succeed and Some Don’t

It is amazing to observe a team of divergent yet complementary people who are committed to a common goal, are passionate about working together to attain it, and are willing to forego individual recognition and achievement in service to its mission. We feel a remarkable sense of pride and admiration for such teams. There’s a palpable energy within them; we can see it, we can feel it, and we often vicariously experience it. It’s electrifying, exhilarating—and motivating! We may even long to be part of such a team. But let’s be honest, when is the last time you felt this way about the interdisciplinary team that you’re part of?

If your response is “this week” or even “last month,” many of your colleagues across the country would be envious. Why is it that our hospice interdisciplinary teams often fall short of achieving such synergy?

Having worked in the hospice field for more than 25 years, I think teams fall short of such synergy because they fail to keep “first things first”; they forget that the patient and family are in charge of the direction of the boat and that their purpose, their sole purpose, is to help the patient and family reach their goals as best they can. When teams put “first things first,” common barriers to successful team function—disciplinarian-ism, martyr-ism, lone ranger-ism—fade into the background. Of course there are other reasons that interdisciplinary teams fail, but this is a key one.

Sometimes, the organization’s culture does not support interdisciplinary teamwork. The organization may use the right “language” and have policies and procedures that speak to the importance of the team, but the organization does not “practice what it preaches.” This is understandable. Few professionals working in hospice environments were trained to work within the interdisciplinary model. Most learned to practice in relative isolation of other disciplines. When they enter the hospice environment, they may learn that an interdisciplinary model is expected, but they do not receive specific training about what that means. They then cobble together a practice approach. An interdisciplinary culture must be a culture by design; not by default. It requires the commitment of everyone in the organization to ensure that the design facilitates interdisciplinary team practice.

In a perfect world, the perspective of each interdisciplinary team member is considered and honored, and contributes to the team’s understanding of the patient and family’s plan of care and goals. With any given patient and family, any member of the team might be able to contribute information that changes the approach, clarifies a goal, or points the team in a
Helpful Definitions

The following definitions have been developed by the Competency Subcommittee of NHPCO’s Professional Education Committee. They are included in an Interdisciplinary Team Competency that is available to members on the NHPCO website.

**Discipline-ism**
- Identification with one’s own specialty in a way that presumes one’s own discipline has more value than the others or that diminishes the contributions of other disciplines
- Lack of collaboration or failure to recognize the value of perspectives from other disciplines and a team approach
- Domination or control due to the influence or approach of members in particular disciplines
- Limiting opportunities for input from other disciplines
- Failure to convey value of other disciplines to patients and families

**Lone-Ranger-ism**
- Acting independently, without collaboration or input from the interdisciplinary team
- Behavior that results in isolation or lack of fellowship, responsibility, and accountability of all team members toward each other
- Demonstrates lack of ability to participate as a team member/work with team; possibly a result of discomfort sharing attention or success with others
- Acting and believing that “I can do it alone”

**Martyr-ism**
- Acting and believing that “I have to carry the burden because no one else can do what I do,” resulting in perceived sacrifice of self
- Behavior indicates need for attention, need for recognition or inability to practice within appropriate professional boundaries
- Behavior reflects an exaggerated sense of self-importance and skill
- Inability (or lack of willingness) to identify and utilize appropriate resources
specific direction. I still recall one team meeting I attended where a new, shy volunteer contributed the most relevant information about the patient and family’s values and needs in a quiet, unassuming manner. His contribution helped the team determine how to be most useful and supportive and I remember thinking that we would have truly “missed the boat” without his input! How many times have we assumed that clinical professionals, with their finely honed assessment skills, are the ones who are best able to drill down to what is most important? The volunteer, through his simple, gentle wisdom, learned what the other team members could not, and it was his contribution—on behalf of the patient to whom he was assigned—that helped chart the course for the support and care that followed.

In a true interdisciplinary team, each person’s perspective is valued and considered. How does your team measure up? Regardless of the challenges, there’s high value in the interdisciplinary model of care. It does take practice—lots of practice—to develop a team that can work in collaboration and harmony with each other and with patients and families. It also requires a willingness to evaluate each time the team ends up off course and to celebrate each time a patient and family reach their goals. It may also require a shift in focus to ensure that first things always come first, that the organizational culture supports and values interdisciplinary teamwork, and that each person on the team is respected and valued—but it’s worth it. To you, your colleagues and, ultimately, to the patients and families who count on us.

Barbara Bouton has more than 25 years of experience in the hospice field, including 23 years with Hospice of Louisville (now Hosparus) in Louisville, Kentucky, where she worked in the areas of bereavement education and volunteer management. Under her leadership as director of Bridges Center, the hospice developed a full spectrum of innovative bereavement programs and services that received local, state and national recognition. She currently serves as NHPCO’s director of professional development, a position she has held since 2005.
Is it a perception or reality that hospice employees don’t like change? It certainly feels like a reality because change—or the angst about change—is an ongoing topic of discussion within many hospice organizations today.

So, when Hospice of Northwest Ohio successfully managed a sudden, unplanned change in 2009 (albeit with a few bumps and bruises along the way), I had to ask myself: “Why did it ultimately go so smoothly?” As the executive director of the organization, and also a graduate student in Organizational Leadership, I wondered what we had done right and, more important, how can we do it again when change occurs in the future?
These questions ultimately became the topic I explored in the graduate paper, *A Situational Case Study on Change*, the highlights of which are included here.

**First, a Little Background**

Founded in 1981, Hospice of Northwest Ohio is a community-based program caring for patients living in northwest Ohio and southeast Michigan. It is one of the largest nonprofit hospice programs in Ohio with almost 500 employees caring for about 3,000 patients each year. The organization currently has five home care teams serving the region, plus two freestanding inpatient centers with a total of 49 beds.

Throughout our history, we have experienced much change—as well as the resistance that sometimes comes with it. Two upheavals involved the opening of our hospice centers—the first one in 1995 and the second in 2004. From an organizational perspective, these changes were positive and occurred as a result of growth in the number of patients served. Unfortunately, they also caused some internal turmoil and negativity as staff struggled to adjust to new care environments, offices, processes, employees, and an increasingly complex and multi-layered organization. Some of the staff expressed negative attitudes, longed for the past and pointed out numerous reasons why the changes would not work; some even left the organization.

We have all since adjusted and the two centers are functioning beautifully. However, in 2009, our ability to manage change was again put to the test when we were faced with opening an office in Michigan—quickly.

**Put to the Test**

As a provider on the borderline of Ohio and Michigan, Hospice of Northwest Ohio has been committed to caring for Michigan residents since our inception. Though we have a substantial patient base there, it was not in our strategic plan to open an office across the state line. In 2009, however, with changes in regulations and the lack of a reciprocal agreement between the two states, it became apparent that we would have to. Our board of trustees unanimously approved a Michigan location and set an aggressive timeline for it to become operational.

The team leader whose territory included Michigan agreed immediately to relocate and assist in setting up the office. Her entire team—comprised of 16 nurses, counselors and chaplains—followed her. After much work by many people across the organization, the new site opened for operation just six weeks later and, one month after that, the team successfully completed a state licensure survey. It took 12 more months to become accredited and certified through The Joint Commission deemed status survey process. Though there were many challenges along the way, the Michigan office now hums along—and is fully integrated into our system—as if it has always been there.

**Recent Research on Change Theory**

According to literature on the theory of change, a healthy organization is never without change, but should challenge itself to find a balance between change and constancy. The variables which may positively or negatively influence the outcome of change are the amount, type and rate of change. The leadership, culture and quality of communication within an organization can also have an enormous influence on the outcome of change.

**Leading Through Change**

“Leader behavior is crucial during organizational change, as leaders provide a vision of the change, give direct support to employees and model appropriate behavior. These actions help to build stability during change and enhance employees’ commitment to it.”

One reason for resistance to change occurs because managers and employees perceive change differently. Managers, when in their role as leaders, are charged to...
see the bigger picture and can visualize the change as an opportunity. Leaders should also consider if the changes affect the whole organization or just a few employees. Are there a lot of minor changes or a few major changes? Conversely, employees view change on an individual level and are concerned with how any change will affect them personally.

Employees may resist change because of fear. Dent and Goldberg reported employees’ fears are related to the unknown, of being dictated to or being made to do something that doesn’t work. Employees want to implement change and follow the vision of the leader, but need help when unforeseen barriers get in the way. It is the leader’s job to communicate and remove any barriers identified before or during the change process.

_Cuing into Your Culture_

The right culture can act as a positive force to help staff adapt to change. Conversely, the reason some organizations can’t change is because the culture does not allow for change. We have all heard employees express to new staff “that is just the way we do things around here.” This expression is often used to define culture in an organization and may be a barrier to change. Another variable for effective change is related to whether employees experience a “just” workplace. In a just organization, the team is seen as effective and has high morale and good cooperation; employees are also treated fairly and, consequently, are more likely to have positive attitudes toward change.

_Communication is Key_

Communication in an organization is always important and during times of change becomes critical. Jian cites that communication which includes dialogue and negotiation is key to producing positive change. Without good communication the system will break down, rumors will flourish and negative unintended consequences will occur.

Communication must also be enhanced with clear and consistent messages regarding what needs to change and why, and must give the explicit reasons as to why employees should support the change. Staff will need to be encouraged to strive for higher performance and leaders will need to be on guard to decrease the amount of...
misinformation or falsehoods that may circulate. During change, leaders will also need to continuously realign the employees’ work with the organization’s performance improvement goals.7

Methodology and Findings from the Study

Through the research conducted for my graduate paper, I attempted to identify what variables within Hospice of Northwest Ohio influenced the employees’ response to change, how they felt about it and how they adapted to it. Employees who were directly involved in the relocation to the new office were interviewed. Participation was voluntary and of the 17 possible staff, eight consented to be interviewed by a paid interviewer. In order to protect the anonymity of the staff members who participated (i.e., the study “subjects”), I did not have any contact with them and all comments shared are attributed to females. The interview questions were written by me and covered the topics of change, culture, leadership and a just workplace.

How Employees Felt

Five of the eight subjects selected the adjective “excited” when describing their move to the office in Michigan and said they viewed the change as an opportunity. They were enthusiastic about the potential for the organization’s growth and described the change as “new territory”—an adventure which would bring the team even closer because they would be detached from the rest of the organization.

The other three subjects used the words “suspicious,” “uncertain” and “saddened.” These words indicated that they viewed the change as negative or as a threat. One said that she was skeptical because of all of the past changes at the organization and that this was just another big change. She was concerned with how smoothly things would run, how communication would flow and if she would have access to people, supplies and patient records. She stated that the first few months after the move were rough because the phones and computer systems did not work well and staff had to use temporary furniture and live out of boxes. This finding was not surprising as employees often view change as threatening because of the disruption and intrusion in their daily work flow.3

What They Feared Most

The subjects also stated that they feared an inferior work space, missing co-workers, isolation, and glitches in the processes or systems which would affect workload. One feared that the organization was growing too big and might lose its reputation as a provider of high-quality care. Another feared the team would be separated. These responses mirrored research by DiTullio and MacDonald, who studied growth and change within the hospice industry.8 The most significant changes noted by hospice employees in their study were related to a more complicated and formal organizational structure; loss of intimacy with colleagues; more teams; less team unity; growth in the numbers of staff and patients; and increased workloads. Stress specifically related to change was caused from the perceived loss of relationships, with the key to coping for most hospice workers being the restoration of quality relationships.

Positive Views on Leadership

According to Elrod and Tippet, an effective leader is one who helps guide employees through change and creates a culture which helps them cope and adapt to inevitable changes.9 When asked about the Hospice of Northwest Ohio leadership, the subjects viewed the leadership as being very influential in the success of the change. They described the leaders as confident, respected, trustworthy, supportive and representative of the values and philosophy of Hospice. Subjects also described the leaders as personally caring toward employees, willing to listen, and allowing autonomy while being available for back-up when needed.

It is important to note that the subjects were not necessarily talking about the same leader within the organization when providing this feedback.
example, one subject described her supervisor as having a huge influence on her attitude and felt she was positive about the change specifically because of her supervisor. This staff member saw her supervisor as a great leader who would be followed by many staff—even if she wanted them to go to Timbuktu!

Another subject stated that her sense of independence and the trust from her leader had been her motivation. According to Parish, Cadwallader and Busch, having a high-quality relationship between the supervisor and employee enhances the influence of the leader and decreases resistance to change. Managers with good relationships use that relationship to create commitment, trust and satisfaction and, ultimately, buy-in to change.

**A Consistent Culture**

Sadri and Lees report successful organizations identify the positive aspects of their culture and use those to facilitate change.

The subjects interviewed in the Hospice of Northwest Ohio study described the culture as being true to the mission, team-focused, respectful, motivational, encouraging of healthy lifestyles, open to new opportunities to learn, and consistently focused on what is good for the patient, family and the team.

The culture at the team level was described as harmonious and positive, with much laughter and tasteful joking. Subjects said it was fun to be with each other and after-work fellowship was a positive outcome of the personal relationships amongst the team.

Another positive aspect of the culture is the years of steady leadership within the organization, as multiple changes in leadership can dramatically shift the culture of an organization over time.

**A Just Workplace**

One subject described the Hospice of Northwest Ohio leadership as very honest, very fair, respectful and supportive. Others said they are treated fairly, work in effective teams and have strong relationships with co-workers and their leader. This highly functioning team becomes even more important during a change process. Subjects also reported that the mission of the organization is articulated well and demonstrated daily in the work of the employees...
and leaders as they care for patients and families.

**Keep on Communicating**

Subjects were also asked how they heard of the change. Four said they heard about the change directly from their team leader. One of them related the importance of obtaining the information in person, which helped her understand the situation and decrease the number of unknowns. Another subject said that she generally feels the leaders have open lines of communication and doesn’t feel blindsided by things. Another stated that communication at the hospice was not good for a while, but that it has gotten a lot better. She sees the organization and its leaders as trying to maintain good communication.

Two of the subjects said they received the information about the change through informal processes of rumors or by word-of-mouth. One was upset due to the misinformation which leaked out and by inconsistent and unclear messages.

Organizations should consider communication as a strategic initiative and a tool which can inform, educate and motivate employees. Since 2005, I have been much more intentional and thoughtful regarding communication throughout our organization and, in fact, our 2004-2007 strategic plan included “improved internal communication” as a goal. In addition to creating an internal communications position, we totally reorganized our process for sharing accurate, timely information with supervisors, staff and volunteers.

**Looking Ahead**

There is no doubt the hospice industry will continue to face rapid change as we strive to respond to the economy, health care reform, and changes in regulations and patient and family expectations. Instead of focusing on ways to decrease resistance to change, a leader needs to focus time and energy “upstream in the organization,” creating a culture which helps people cope and adapt to the inevitable changes. Through their research, DiTullio and MacDonald confirmed that hospice employees are committed to an organization, its mission and each other. Their research found that relationships and connectedness are key elements that enhance the culture and make hospice professionals work differently than those in other occupations and, thus, are a vital source of strength in a hospice organization. This bond makes the hospice culture cohesive and helps hospice employees cope with changes.

Conversely, fragmented relationships among team members in a hospice can exaggerate the negative effects of change and increase problems. Hospices must use the positive aspects of their culture, the authentic relationships and the deep connectedness to drive change and meet future challenges.

Employees’ resistance to change mirrors that of grief and loss and includes the behaviors of shock, denial, anger, bargaining, grief, acceptance, exploration, opportunity, accomplishment and creativity. Because we see these behaviors exhibited in patients and families every day, we should be better equipped to deal with them in our employees as well. It is important for leaders to understand how and why employees are responding to change and then find a way to help them navigate through the changes. In simple terms, the art of leadership is the art of guiding others through change.

Since this paper was completed, we have had more change at Hospice of Northwest Ohio, not the least of which has been implementing a new electronic medical record. I have learned that, while I can’t take away the change, I can try to manage the pain while staff adapts. Building strong communication into the change process and relying on our leaders at every level to support their teams and reiterate important messages has made it that much easier. Leadership, culture and communication are the keys to successful change in any organization and, as hospice organizations, we must take advantage of these strong
assets to navigate the countless challenges that lie ahead.

**Judy L. Seibenick joined Hospice of Northwest Ohio in 1984 as a registered nurse. During her 26-year career with the organization, she has risen through the ranks, having served as a patient care coordinator and as associate director before assuming the position of executive director in 2002.**

**References**


The role of the physician in hospice has changed dramatically. Even prior to the changes in the 2008 Medicare Hospice Conditions of Participation (Hospice CoPs), hospices nationwide had begun to increase the role of physicians in the care of their patients.

When I started in 1998 as a hospice medical director, my role was to show up for meetings when asked, provide a small amount of over-the-phone consultation, issue medical orders as needed, and do the occasional patient visit. This “show up and sign” model was extremely common and the norm for the vast majority of hospices in the United States. Over the intervening years, however, more and more hospices began employing physicians to do much more.

The expanding role of hospice physicians most likely occurred for a number of reasons, but key among them was the ability to have more hospice patients seen by a physician.

While not, by any means, a substitute for the excellent work already being done by hospices, bringing additional physician resources to the table helped hospices improve care at the bedside and, at the same time, strengthen their relationships with community physicians. For example, in speaking to many community physicians, most say they would love to be able to see their patients, but simply do not have the

By Daniel Maison, MD, FAAHPM
time. Having more physician time available allowed for more hospice patients to receive home visits by physicians and allowed hospices to reach out to the referring physicians they served and deliver “physician to physician” messages. Likewise, hospices were able to gauge potential projects or programs from a physician perspective and more fully understand the perceived needs and wants of the medical community in their area.

The list goes on and on, but suffice it to say, physicians became a more fully integrated part of hospice teams across the country over the last 10 years. Flash-forward to 2010, and physicians are not only now a larger part of every hospice, but their role is much more clearly defined by the Hospice CoPs.

As with all change, there are challenges and opportunities. Whenever a new facet is added to a team, adjustments are necessary. We all respond to change differently, and hospices have been no exception. Speaking from my own experience, as we changed how we provided hospice care and more fully integrated a physician into the day-to-day operation, we had to check in regularly with everyone to make sure we were on the same page. Making sure that roles are clearly defined and that chain of command is maintained can be a challenge when introducing a new professional into facets of an organization that has been functioning for some time. There are no shortcuts to these endeavors; however, the hard work pays off and the result is a well-functioning team and organization that benefits greatly from having additional expertise and perspective.

For those of us who devote our full-time practice to hospice care, the one entity that defines who we are and the work that we do is the interdisciplinary team. Personally, it was the interdisciplinary team model that drew me to the hospice field when I completed my medical training. The idea that every patient’s total needs were addressed by an entire team—composed of multiple disciplines each with incredibly valuable insight and expertise—was simply irresistible to me as a physician. Here was a place where patients received ALL of the care they needed, including the often undertreated or unrecognized non-physical aspects of their care. Even more amazing, every patient’s family was included in the care planning and the care provided to each and every patient. While these concepts...
are second nature to hospice professionals, as a young physician, they were mind blowing to me.

Everything we do for hospice patients starts with the collaboration of the interdisciplinary team. And today, whether it is the “certification/recertification patient narratives” or the very new “hospice face-to-face encounter requirement,” the physician is a truly integral part of the hospice team.

As with any mandated change, there are many different ways to view the new regulations. I have found the best way to approach required change is to consider the positives as well as the opportunities that such changes present.

For example, the patient narratives are indeed time consuming and can be quite cumbersome to complete. However, completing the narratives allows us to summarize why someone needs hospice and qualifies for hospice services in a way not done before. Additionally, by having a physician summarize all of the reasons why someone qualifies for services, we now have the opportunity for another set of eyes to review the needs of the patient. When we catalog all of the factors that define someone’s prognosis, we are not only making a list to meet admission criteria, we are defining the patient’s total needs. Which activities of daily living does the patient need the most help with? Which symptoms are giving the patient the most trouble? These are not merely regulatory minimums. The items cataloged in the physician’s narrative help define what the patient needs from a symptom management and care-provision perspective. Seen in this light, the new requirements are another way to ensure that we take care of every patient the best way possible every time.

Make sure that every member of the interdisciplinary team contributes as fully as possible to the care of each and every hospice patient. Physicians, as part of the team, have much to contribute. Use these new regulatory changes as the opportunity they present—a chance to make sure that we are all utilizing the entire interdisciplinary team to their full capacity to take the best possible care of patients and families.

Daniel Maison has worked in the hospice field for over 12 years, and is currently a palliative care physician for Spectrum Health Medical Group, based in Grand Rapids, Michigan. Prior to joining Spectrum in August 2010, Dr. Maison served as chief medical officer and medical director for Treasure Coast Hospice in Stuart, Florida. He is board certified in internal medicine and hospice and palliative medicine, and is a Fellow of the American Academy of Hospice and Palliative Medicine (AAHPM). He also serves as the Physician Section leader for NHPCO’s National Council of Hospice and Palliative Professionals.

The U.S. Department of Health and Human Services has developed a helpful guide for new physicians—“Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse.” Available online, free of charge, the Roadmap summarizes the five main Federal fraud and abuse laws and provides compliance guidance when working with Medicare and Medicaid programs, vendors (such as drug, biologic, and medical device companies) and fellow providers (such as hospitals, nursing homes and physician offices). Visit the OIG website to preview or download a copy.
Most people assume that volunteer Linda Feld is a full-time employee. Linda manages over 100 volunteers for Hospice of the Comforter’s inpatient unit (IPU) volunteer services program and is an essential member of the IPU clinical management team. She is respected by paid staff for her ability to “make happen” whatever is needed from our volunteers. Linda knows how to maximize the contributions of the volunteers she leads because she created the IPU volunteer services program.

continued on next page...
Rethinking Volunteer Roles

In 2005, after she learned that Hospice of the Comforter was preparing to build an inpatient facility, Linda approached the organization’s executive leadership with a proposal that volunteers design, implement and manage an IPU volunteer program. While it was a new concept for the agency to give program development and management responsibilities to volunteers, Hospice of the Comforter decided to broaden its thinking to support volunteers in taking on leadership roles—and gladly accepted Linda’s offer to donate her professional skills in the development of the program.

Volunteer Leaders Bring Innovation

Once she received approval to proceed, Linda recruited four other volunteers to co-lead the program’s planning and implementation. These five volunteer leaders then joined forces with paid staff to determine what was needed from volunteers to best meet the needs of patients and families.

The volunteer leaders were not able to find an existing IPU volunteer services model that attended to all ascertained needs, so they got to work on creating one. They put countless hours into devising innovative processes to provide a steady flow of wraparound volunteer services. They constructed a unique program that would enlist over 100 volunteers to work on a continually rotating back-to-back shift basis from 9 a.m. to 9 p.m., 356 days a year. They included novel program activities that would link a large number of volunteers into a cohesive team, facilitate strong staff/volunteer collaboration, and respond to changes in service needs.

After the IPU Planning Committee gave them the green light on their program model, Linda and her team did the work of recruiting and training the needed volunteers, including some fresh approaches to recruit and train 140 highly committed volunteers in a very short time.

When the inpatient unit opened in January 2008, the IPU volunteer services program was also up and running. Paid staff was impressed by a volunteer shift schedule that ran like clockwork and generated continuous volunteer support. Staff was also impressed with the volunteers’ abilities to “fill in” all the places where help was needed and to provide any service that was asked of them. These “Volunteer Comforters” quickly became indispensable members of the IPU interdisciplinary team.
Volunteer Managers Get Results

By 2009, the positive impact of Hospice of the Comforter’s decision to utilize the management talent of volunteers was clear. During that year:

• Services provided by Volunteer Comforters were consistently noted as a contributing factor to outstanding family satisfaction ratings for the IPU;
• A high degree of family satisfaction with IPU services generated increased high-end donations;
• Feedback from clinical staff indicated that their capacity to meet patient needs was increased by the wraparound services provided by the volunteers;
• IPU volunteers gave 18,272 service hours and realized a cost savings of $370,008;
• Volunteer retention rates for IPU volunteers and volunteer leaders was close to 100 percent;
• Volunteer recruitment outcomes were enhanced by the availability of IPU Volunteer Comforter and Leader service opportunities;
• Linda Feld and her four colleagues who originated and managed the program received the National Hospice Foundation’s 2010 M. Catherine Ray Award, bringing national attention to Hospice of the Comforter.

Engaging the New Volunteer Workforce

The wisdom of placing volunteers in management positions is supported by current research on volunteer management best practices. Research indicates that 74 percent of volunteers performing professional or management activities develop strong organizational connections that motivate them to make monetary donations and continue volunteering.

The Winter 2009 edition of the Stanford Social Innovation Review advises organizations who depend on volunteers to “expand their vision of volunteering…and reinvent the way [they] support and manage volunteer talent.” The Stanford Review states that one of the most promising places to recruit new volunteers is among baby boomers, and refers to this group as “the new volunteer workforce.”

To attract and retain “the new volunteer workforce,”
organizations need to create compelling opportunities for these volunteers to perform important roles and make the most of their skills, talents and experience.

A Corporation for National and Community Service research brief on baby boomer volunteer retention and turnover echoes the recommendations in the Stanford Review. According to key findings in this 2007 brief:

- Harnessing baby boomer’s skills and accommodating their expectations will be critical to volunteer recruiting in the years ahead.
- To attract baby boomers to volunteering, organizations must re-imagine roles that cater to boomers’ skills and the desire to make their own mark in their own way.
- The retention rate for boomer volunteers who engage in management or other highly skilled functions will be the highest.
- Boomers who perform general tasks that require little specialized skill will be the least likely to continue volunteering.
- The more hours boomers devote to volunteering in challenging assignments, the more likely they will be to volunteer from year-to-year and become donors.

Augmenting Organizational Capacity

The value of utilizing highly skilled volunteers in management roles goes beyond increasing retention rates and donations. The results achieved by volunteers at Hospice of the Comforter’s IPU demonstrate other benefits validated by research. Tapping into the assets baby boomer volunteers have to offer builds organizational capacity. And enhanced organizational capacity improves patient and family care outcomes.

In these times of reduced budgets and increased demands, boomer volunteers are an available and abundant resource for professional skills and experience much needed in the hospice industry. Organizations seeking to build their capacity by leveraging this talent pool may need to “re-imagine” volunteer roles. It can be well worth it to get past any discomfort in giving leadership responsibilities to volunteers. Modernizing our understanding of the value of unpaid work and using volunteer talent in new ways can help us fulfill our mission.

Rose van der Berg has worked in the fields of organizational development, leadership development, and volunteer management for 22 years and is currently director of volunteer services and a member of the Leadership Team at Hospice of the Comforter in Altamonte Springs, Florida. She has been recognized by the State of Florida for her leadership development work with volunteer citizen leaders, and has presented at NHPCO national conferences in 2009 and 2010.

References


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Current Offerings at Montgomery Hospice

**Touch Therapy**
Lavender-oil hand massages by hospice volunteers.
Comfort Touch®/palliative massages by volunteer licensed massage therapists.

**Music by the Bedside**
Reverie Harp as well as music for relaxation and recreation by trained staff and volunteers.

**Aromatherapy**
Staff- and volunteer-administered essential oils deemed safe for hospice patients, including three custom aromatherapy blends, with guidelines for use.

**Pet Therapy**
Offered in partnership with a local Pets-on-Wheels program.

**Art Therapy**
Expressive arts to complement bereavement services—enhanced with the recent hire of a bereavement counselor with a degree in art therapy.

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Complementary Therapy Innovators

*By Valerie Hartman RN, CHPN, CTRN*

There are many ways to use complementary therapies to bring comfort and relaxation to hospice patients and families, but starting a complementary therapy program will move this work into the therapeutic realm. In this article, you will learn about three hospice organizations which have done just that, and some of the amazing benefits that have come from offering a range of modalities. Then, beginning on page 28, you’ll find guidance about starting a Complementary Therapies Program, including why you should start one, who to hire, and some safety considerations.

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At Montgomery Hospice

Sandra Lavengood, MHSA, LMT, is the touch therapies manager at Montgomery Hospice in Rockville, Maryland. A licensed massage therapist and energy practitioner, Sandra started out as one of three volunteer services managers at this suburban Maryland hospice. However, rapid growth in the last year (from a census of 200 to now nearly 300), together with grant funding as part of a major dementia initiative, enabled the hospice to expand and formalize its Complementary Therapies Program.

For several years, lavender-oil hand massage had been included in basic training for all 230 volunteers. Today, under the new Complementary Therapies Program, touch and music therapy as well as aromatherapy are offered and Sandra has been able to transition into a newly created position as “touch therapies manager”—with the responsibility for developing and supervising a Volunteer Massage Therapy Program and coordinating complementary therapies more broadly.

With a professional and holistic vision, she researched a variety of trainings and decided to establish a massage program on the use of Comfort Touch®, a trademarked acupressure protocol that is deemed safe and effective for patients receiving hospice services. Sandra received training in Comfort

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Touch® and permission from its developer to train and establish competency for the volunteer massage therapists who donate their time to the program.

Grant funds have also been used to develop volunteer-based music and aromatherapy programs with the help of contracted certified therapists. In addition to creating a large music library, the hospice has purchased four Reverie Harps. These delightful, soothing stringed instruments—specifically designed to be played with patients—have proven to be very popular. Three custom aromatherapy blends have also been created to be used by staff and volunteers. Training will be provided to volunteers and staff in all of these areas.

As the touch therapies manager, Sandra reports to Montgomery Hospice’s vice president of nursing. In her role as the complementary therapies coordinator, she also works closely with the organization’s director of volunteers, and serves as a hospice-wide resource and champion for the ongoing integration of complementary therapies.

At Cranberry Hospice
Karen Foster is the volunteer coordinator for Cranberry Hospice and Fragile Footprints Pediatric Palliative Care in Plymouth, Massachusetts, a small hospice with a census of 80. Typical of small programs, the provision of complementary therapies is considered too costly to even consider without the gracious support of volunteers. Fortunately, with passion, creativity and access to some mature and professional certified therapists in the Plymouth community, Karen has helped establish a one-of-a-kind program: The Cranberry Hospice Holistic Helpers. With the assistance of 10 volunteers (nine women and one man), patients and caregivers have access to eight modalities: aroma, art, Healing Touch, massage, music, pet, Reiki, and reflexology.

The Cranberry Hospice interdisciplinary team members are educated on the benefits provided by these volunteer therapists and are able to assess and recommend modalities for both patients and family caregivers. The team’s referrals go directly to Karen who then coordinates the needed services with the volunteer therapists, and provides them with supervision and support (including finding opportunities in education to further develop and validate each volunteer therapists skills). The volunteer therapist’s meet on a monthly basis, and follow a structured agenda to discuss current cases and program development. With only two years under their belt, much has been accomplished by this “branch” of the interdisciplinary team. They have been involved in pediatric palliative care cases as well as hospice cases; in-service development for patients in the skilled nursing and assisted living settings; the development of promotional materials about Cranberry Hospice’s complementary therapies; and the facilitation of monthly Healing Circles for the general public.

Feedback on the Many Benefits
“Imagine sitting at your weekly IDT meeting and having your medical director ask, ‘Have we thought about using Healing Touch with this patient to help ease some of her anxiety?’” Karen says. “And then being able to say ‘Yes, one of our volunteer therapists is providing that weekly.’ It’s been such an honor to work with these gifted individuals who volunteer their time to make a profound difference in the lives of our patients.”

Karen also recalls the first time one of the program’s Healing Touch volunteers made a home visit. She was greeted by the patient’s wife who informed her that her husband had been a man ‘in control’ all of his life and had not been open or expressive about his feelings. Still, the wife said, he was “willing to give this therapy a try.” During the session, her husband “opened up” completely, verbalizing his final wishes for his family and his awareness of his terminal condition. He was finally able to let his guard down and cry.
As another moving example, Karen shared one of their reflexologist’s recent experiences. The reflexologist was seeing the young mother of a pediatric palliative care patient who was struggling with foot pain while trying to provide her child with comfort and support. After one visit, in which the reflexologist also used an aromatherapy blend to start the session, their relationship was transformed. The volunteer found herself listening and held in the stories of this mother’s concerns, worries and fears. “Essential oils have the most direct link to emotional memory in the limbic system of the brain,” Karen explains. “Reflexology is a face-to-face therapy applied distally (to hands or feet) and often elicits meaningful dialogue.”

At Holy Redeemer Home Health and Hospice

I am a certified hospice palliative nurse at Holy Redeemer Home Care and Hospice Services in Philadelphia, Pennsylvania, with certification in massage and reflexology. I had the good fortune to help develop the organization’s complementary therapy program in 2002 from the ground up, based on the innovative role of the complementary therapy registered nurse (CTRN), and am now a complementary therapy coordinator who oversees a regional program with a patient census of approximately 500.

The CTRN is a registered hospice nurse with dual certification in advanced bodywork therapy. CTRNs co-share and collaborate with the registered nurse case managers in all hospice settings, providing nursing assessment and regular therapeutic bodywork for high-stress cases. Patients and caregivers are seen on a regular basis (usually weekly, but sometimes twice a week or once every other week, depending on need). The CTRN is able to handle any medical changes that could potentially come up as well as provide the advanced...
bodywork therapy. Today, Holy Redeemer employs four CTRNs while other hospice team members are encouraged to seek out certification to use in their own professional roles—using access to guidance that’s built into the structure of the complementary therapy program.

**Dual-Certified Staff at Holy Redeemer**

The strength and “reach” of the complementary therapy program at Holy Redeemer is the direct result of having many members of the interdisciplinary team “dual certified” in a range of complementary therapies that enhance their work:

- A pastoral care member is certified in bedside harp
- A bereavement coordinator is certified in reflexology
- A nurse case manager is certified in massage therapy (and manual lymphatic drainage)
- Three social workers (in the home-hospice, SNF and IPU settings) are certified in basic reflexology and/or Healing Touch
- Two CNAs (in the home-hospice and IPU settings) are certified in Healing Touch

In addition:

- 10 IDT members are students of Healing Touch
- 7 nurses and nurse practitioners are working toward clinical aromatherapy certification
- ‘Last bath’ competency is under way for CNAs
- Vertical reflex therapy competency (for the hands) and Health Touch (Level 1-Scudder Technique) competency is under way for all IDT members

Once a complementary therapy program is established, it can serve as a strong foundation for the expansion of therapies throughout a hospice organization. Really, there is hardly an aspect of hospice care that cannot benefit from the offering of these services. Whether reflexology is used to ease the breathing of a patient with end-stage COPD, or Healing Touch is used to help a coworker manage a high-stress caseload, these therapies can provide tremendous benefits with many ripple effects.

**A Complementary Therapies Primer**

Complementary therapy is the use of alternative modalities alongside traditional healthcare practices for the purpose of healing, coping with, or preventing illness. There are thousands of holistic therapies practiced worldwide; however, the common modalities now used in end-of-life care include those just discussed as well as horticulture therapy, comfort massage and other light-pressure bodywork (e.g., reflexology, acupressure, biofield energy-based therapies), and mind-body practices such as meditation, progressive relaxation exercises, and guided imagery. These modalities can calm the nervous-system response to fear and worry, and can foster or serve as a form of communication between staff and patients or between patients and their families.

Emotional and heart-centered dialogue are often evoked during a complementary therapy session. Trust develops quickly in this climate of “non-judgment and quiet attentive presence,” a skill developed in holistic training. The symptoms of stress are relieved when sensory therapies are added to the plan of care. Patients can transition from being “stuck in fear” to a sense of peace in the dying process. Families are invited to get closer when a therapist models familiar approaches that allow them to ‘be with’ instead of ‘do for.’ The bereaved have new ways to self-empower their grieving process, using therapies that help them pace their ‘feeling levels.’

So, this is specialized work. Not only are the complementary therapy modalities adapted to the stages and changes in the dying process, but 50 percent of the skill set required of the hospice complementary therapist is knowing how to work as an interdisciplinary team member. A therapist learns to work within the boundaries of the team, with specific goals in mind. Hospice
therapists are “developed” by either seeking out resources to learn how to work effectively in end-of-life care or relying on the hospice program to help them learn skills. Hospice practices are not taught in traditional certification programs, and every modality is adapted to address emotional and physical changes unique to the dying process. Whether utilizing volunteer therapists or hired therapists, the development of complementary therapy policies is critical, along with education and mentoring support to help establish a strong and committed staff who are recognized as a viable part of interdisciplinary team practice.

**Why Start a CT Program?**

Adding complementary therapy into the plan of care is often much more than providing what some team members may perceive as ‘something nice to do,’ or as pampering or relaxation. There are many ways to bring comforting touch, music, and aroma to someone for the purpose of relaxation, but starting a complementary therapy program will move this work into the therapeutic realm.

Massage and bodywork therapy, music therapy, aromatherapy, guided imagery and meditation—these are modalities that target the “fight or flight” response and break the effects of fear through work involving the senses. Stress symptoms worsen shortness of breath, contribute to gastrointestinal symptoms, and are responsible for the literal feeling of anxiety and panic (which is often perceived as suffering). The level of sustained tension that patients and family members experience in hospice also contribute to poor sleep, appetite changes, behavioral changes, depression, withdrawal, and lost hope.

One primary reason that we use complementary therapy is to shift the nervous system into a parasympathetic state of relaxation, easing stress-related symptoms. The goal is to break this tension state regularly and, in so doing, contribute to effective coping and ease the symptoms of stress (e.g., dyspnea, intractable nausea, muscle tension).

Since the nervous system uses the senses to survey the ‘territory’ for the feeling of safety versus perceived threat, and the mind makes sense of the sensory data that comes in, it should make sense that a patient can be calmed, therapeutically, to feel secure, by the use of complementary therapy modalities.

*continued on next page...*
Staffing a CT Program

Over the past decade, hospice and palliative programs have increasingly recognized the value of bringing complementary therapies into the plan of care. Typically a hospice starts with a volunteer complementary therapist. IDT members observe the effects of the therapy and hear about the results from patients and stressed caregivers. Interest grows and the IDT brings more referrals for complementary therapy support. Decisions then have to be made about who is a priority referral on census and if it’s possible to increase access by finding more therapists to work.

Below are some of the titles and functions of staff now serving in complementary therapy programs around the country:

**Volunteer Coordinator**
Develops a specific complementary therapy program track and actively recruits, trains, schedules, and oversees volunteer complementary therapists (as Karen does at Cranberry Hospice).

**CT Coordinator/Manager**
Oversees a volunteer-based complementary therapy program. (A volunteer coordinator could make a move into this focused role or a complementary therapist may have a strong interest in developing this program (as Sandra had at Montgomery Hospice).

Grant funding may also be an option to help cover the cost of a CT coordinator or manager. Grant funding allows for a range of options and choices that can ‘jump start’ a self-sustaining program, or could rely on future donations or fundraising for sustainability. An energetic visionary is a good candidate for this position who can hire therapists, oversee volunteer therapists and train IDT members in comfort techniques, pioneer education and resource development, and promote the services in the community.

**CT Program Coordinator**
Establishes the organization’s formal complementary therapy program, and hires therapists skilled in end-of-life practices. The goal is to create a sustainable, integrative model that can slowly build on itself. The program works well when complementary therapists specializing in hospice practices can be hired who are accustomed and skilled in working closely with the IDT, or by certifying hospice IDT members in complementary therapy modalities to provide non-pharmacological adjunctive services. The program coordinator works collaboratively with a volunteer coordinator who might also oversee volunteer complementary therapists, and would be responsible for integration throughout the entire IDT to find creative ways to access vital therapies.

Lisa Browder of Nathan Adelson Hospice (Las Vegas, NV) has graciously shared the job description her program developed for her position as complementary therapies manager. The document is posted in the eLibrary of My.NHPCO.

Ensuring Safe Practice

Complementary therapy can do harm:

- Ask the music therapist who was playing harp in the common area waiting-room of a cardiac surgical floor as a patient was wheeled into surgery, only to learn the surgery was cancelled because the patient thought the harp music was a bad omen.

- Many massage therapists have to “relearn” lighter-pressure or no-pressure techniques in hospice massage training. There are physical, emotional, psychological and spiritual considerations when applying massage and bodywork therapy in the hospice and palliative care setting that are unique to each patient.

- Quality aromatherapy companies should provide Manufacturer Safety
Without proper training, the therapist could feel overwhelmed or overstep another discipline’s boundaries.

Creating room for a professional program with oversight will allow the time to bring policies and guidelines, education and orientation into a structure that minimizes fear, misconceptions, and allows for professional growth. It all starts with one small step that leads to the next, and the next, and the next.

Valerie Hartman has 23 years of holistic hospice nursing experience and, for the past 12 years, has included the integration of massage and bodywork therapy into her practice. Since 2002, she has coordinated the complementary therapies program of Holy Redeemer Home Care and Hospice Services (Philadelphia, PA). She also serves as the Allied Therapist Section leader for NHPCO’s National Council of Hospice and Palliative Professionals.

Valerie welcomes your questions. Contact her by phone (267-974-1815) or email (vhartman@holyredeemer.com). Or, post your question in the Allied Therapy eGroup on My.NHPCO.

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Spending a Day in Your Team Member’s Shoes

Many of the articles in this issue speak to the importance of respecting and honoring the work of your colleagues as an instrumental component of a well-functioning team. While we can show respect and honor their work in many ways, the first important step is learning what they really do—getting past the broad brushstrokes of a job description and into their day-to-day practice.

In the following four articles, NCHPP members share their observations and insights from doing just that…
At any given meeting of a hospice interdisciplinary team, the faces of the staff members who gather to review and discuss the needs of patients and families are reflective of the multifaceted work that is hospice care. As bereavement professionals, we can probably provide a ‘sketch’ of the various responsibilities attached to any particular discipline. However, in all likelihood, that ‘sketch’ in no way truly reflects the extraordinary ways these team members hold those with whom they are privileged to serve, and in so doing, help prepare them for their own unique bereavement journey.

In an effort to better understand the work our colleagues perform and the foundation they create for bereavement services, several members of the Bereavement Professional Steering Committee took to the field to shadow our teammates and observe them ‘in action.’ Our hope was to find a place of learning at the feet of our colleagues, and become better prepared to provide bereavement services that are based in the foundational work of the entire team.

Lessons from a Home Hospice Nurse

Coleen Savoca, RN, is a hospice nurse at VITAS Innovative Hospice Care®. One of the first things you will notice about Coleen is the passion she brings to her work. To her, the work is more than a job—she feels she is getting “the gift” rather than giving it. As she speaks of her work, she settles into a place of self-assurance and kindness. “I don’t just take their blood pressure, I look them in the eyes and look to see if there is fear even if they cannot articulate it. I address what I see.” In that statement I
am reminded of the question that Dame Cicely Saunders always asked of her patients, “How are you within?”

By offering patients and their families the opportunity to consider their world within, Coleen helps provide a foundation for bereavement care. In all likelihood, the questions that arise during end-of-life care are related on some level to loss and grief. By enabling patients and families to explore these questions prior to the death of their loved one, the stage is set for bereavement professionals who can enter into conversations that may have begun even before the death of their family member.

—Robin Fiorelli

Jeannette MacDowell, RN, is a hospice nurse at Kaplan Family Hospice House, a program of Hospice of the North Shore in Danvers, MA. She has provided care at this 20 bed, free standing inpatient facility since it opened in 2005. What you notice initially about Jeannette is that she is constantly in motion. And yet that motion never seems to interrupt her gentle and calming demeanor.

As I watched her work, I was amazed by Jeannette’s capability to draw each member of the IDG into the care of the particular patient she was serving. She and the hospice aide worked as a seamless in-sync team providing gentle, efficient and loving personal care. Jeannette was in and out of rooms, up and down hallways, compassionately providing care and efficiently documenting it.

My time with Jeannette reminded me that, while there are foundations being laid for the provision of bereavement support to families, it is also important to recognize the bereavement needs of staff. Frequent patient turnover and the intensity of the setting can make it difficult for staff to find the time and/or give themselves permission to take care of their grief-related needs. It behooves us to creatively find ways in which to support and allow for grief in small but frequent ways: encouraging a moment of silence and/or a few moments of reflection during each shift change; creating room transition rituals; or offering staff a reflection or few words of comfort in a written form on a weekly basis.

—Nancy Sherman

Lessons from a Social Worker

Anne Downing is a social worker at Odyssey Hospice in Gahanna, OH. She began her career as a social worker in 1987 and came to hospice work four years ago. ‘Walking with Anne’ reminded me of how often social workers serve as a bridge between disciplines and help make sure that the needs of the family are served in the best possible way. Their advocacy promotes a setting where clients are given the opportunity to truly have self determination in their care.

Foundational to Anne’s work is an expertise in the area of loss and grief. As she walks with patients and their families through the challenges of end-of-life care, she provides them the opportunity to engage in conversations and discourse that might not otherwise occur. It is in those conversations that the bereavement needs of the family may first take shape. And in the capable hands of social workers like Anne, the transition for families into bereavement can be healthy, smooth and effective for all involved.

—Rev. Brian K. Shaffer

Lessons from a Spiritual Care Counselor

Learning to broaden the vision of the spiritual response in the hospice setting is a lesson that I was privileged to witness in the work of Spiritual Care Counselor Maggie Finley. Maggie is a beautiful African American woman whose tender heart is reflected in the warm smile of her eyes and the joy she brings into a room. As I sat with Maggie, I watched her quickly intuit the needs of a patient who had found that her diagnosis and illness had brought with it a disruption to the rhythms of day-to-day living that had changed...
the music of her life. Finding herself in a constant stream of interaction, she was no longer able to return to a place of solace and solitude that was an essential component of her life. Just as music needs its pauses or ‘rests’ for it to be understood, so too this patient was in dire need of the ‘rest’ of solitude to better find meaning in the experiences that her life was bringing her.

Drawing upon her experience as an accomplished jazz singer, Maggie gently began to change the rhythm of the room. First in her phrasing and questions, and finally in her singing of a tender version of the Lord’s Prayer, Maggie was able to create a space that allowed this patient a few moments of ‘rest’ in the blaring rhythms that were causing her distress. Her subtle work was a privilege to witness and helped me to better understand how rhythm, time and grief are all part of the spiritual process of being human and essential to the work we do.

—Rex Allen

Lessons from a Home Hospice Aide

Irene Downar is a hospice aide at the Palliative Care & Home Hospice Program of Northwestern Memorial Hospital. Over the six years that she has served as an aide, she has seen subtle but important shifts in her role as part of the IDT. She believes that her perspectives and professional input have become more highly valued and appreciated. And that appreciation has made her more comfortable in discussing issues that arise with a patient and family. She is the eyes and ears for other disciplines.

Irena’s work sets the foundation for bereavement follow-up by creating an environment of rapport and trust that allows both the patient and family members to truly verbalize their specific needs. Her caring presence provides a safe setting where stories can be told and she can model a healthy exchange of information between family members. The gifts she provides families continue on in the days of bereavement support.

—Pamela R. Palmentera

Lessons from an Art Therapist

Barbara Trauger-Querry, ATR-BC, is an art therapist at the Hospice of the Western Reserve. One of the first things you will notice as you walk with Barbara, is the calm centeredness that is core
to who she is. It seems to penetrate the environment in which she works and sets the stage for the magic that she is about to perform.

Barbara has been working with hospice for over 25 years, including 17 years as an art therapist. Today she is here to work with Bea, an elderly patient with chronic airway obstruction who has been experiencing anxiety and depression. As she sits with Bea, she listens carefully, and it is clear that her calming presence allows for Bea to feel that she is heard.

Prior to meeting Barbara, Bea had never painted before. And yet, in Barbara’s loving presence, Bea’s artistic expression came to life. Hands that shook as the session began lay peacefully in her lap at its conclusion. It was visibly apparent that she was relaxed and less anxious and very proud of her work.

Bea’s work is being gathered into a scrapbook that she loves to share with visitors. As our session concludes, I am deeply aware of how important a role that scrapbook will play in the bereavement process. Bea’s art collection will become a treasure for both her husband and her children. Each page is a gift that has the potential to serve as a catalyst for storytelling—stories for healing and stories for making meaning.

—Diane Snyder Cowan

Lessons from a Vigil Volunteer

Pat Crowley is a vigil volunteer at Niagara Hospice in Lockport, NY. When first meeting Pat, it is her warm compassionate smile that first engages you. As a member of the hospice vigil team, she provides support to family members in the last hours prior to their loved one’s death. During the nine years that Pat has provided service, she has watched the community more openly embrace the hospice philosophy even though many don’t always understand how or why she would do the work she does. With her smile fully engaged, she goes on to relate that, without the help of a hospice volunteer when her husband was ill, she would never have been able to leave the house.

As she reflects on the service she provides, Pat says that developing trust is the key to being effective in her work. In a time when much is uncertain and vulnerability is running high, Pat’s trusting and embracing presence lays yet another stone in the foundational work of the IDT in preparing families for bereavement. As I sit a moment in the presence of Pat’s engaging smile, reflecting on her work and its impact on the bereavement process, I am profoundly aware of how important and powerful that stone is.

— Lorie Ann Hildreth

Lorie Ann Hildreth is a bereavement volunteer for Niagara Hospice in Lockport, NY. • Robin Fiorelli is senior director of bereavement and volunteers for VITAS Innovative Hospice Care® in San Diego, CA. • Nancy Sherman is director of the Bertolon Center for Grief & Healing in Danvers, MA. • Rev. Brian K. Shaffer is the bereavement coordinator for Odyssey Hospice in Gahanna, OH. • Rex Allen is the grief support services supervisor for Providence Hospice of Seattle in Seattle, WA, and also serves as the Bereavement Professional Section leader for NHPCO’s National Council of Hospice and Palliative Professionals. Beginning this month, he also assumes the role of vice chair of NCHPP. • Pamela R. Palmentera is the bereavement coordinator for Palliative Care & Home Hospice Program of Northwestern Memorial Hospital in Chicago, IL. • Diane Snyder Cowan is director of the Elisabeth Severance Prentiss Bereavement Center of Hospice of the Western Reserve in Cleveland, OH.

These members of the NCHPP Bereavement Professional Steering Committee extend special thanks “to all of their teachers from the IDT, both named and unnamed, who help prepare families for the journey of grief of which they are privileged to bear witness.”

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Pharmacists and Nurses Connect

The interdisciplinary model employed by hospice helps to ensure that the complex needs of patients at the end of life are holistically addressed. The success of the interdisciplinary team depends on a mutual understanding of each team member’s role, responsibilities, strengths and weaknesses. Pharmacists have an increasingly important role as members of the hospice IDT; however, education about palliative care lags behind that offered in nursing and medical schools and pharmacists rarely have an opportunity to directly observe nurse-hospice patient interactions.

To help address this education gap, Hospice Pharmacia, a national hospice pharmacy, developed a Hospice Visit Program for pharmacists, in collaboration with four hospices: Holy Redeemer Home Care and Hospice Services (Philadelphia, PA); Jefferson Hospice and Home Care (Radnor, PA); Lighthouse Hospice (Cherry Hill, NJ); and Methodist Alliance Hospice (Memphis, TN).

The Hospice Visit Program was launched in March 2010 and continues today. It is aimed at improving the pharmacists’ understanding of the patient and family experience in hospice and to expose them to the role and responsibilities of hospice nurses. When implementing the program, it was agreed that the experience should provide a realistic view of a “typical day” for a hospice nurse.

The Program’s Structure

The program consists of three parts: pre-visit preparation; one-day hospice visit; and a post-visit reflection and evaluation.

To prepare pharmacists for their visits, they are provided a field guide containing several recommended readings and

By Terri L. Maxwell, PhD, APRN; Laura Scarpaci, PharmD, BCPS; and Terre Mirsch, RN, BSN, CHPN, CHPCA

continued on next page...
videos, information about the hospice organization, and practical considerations. They are also asked to identify three learning objectives that they want to achieve during their visit and to complete a survey on their general knowledge and attitudes about hospice.

Each pharmacist then shadows a hospice nurse for a day while he or she visits hospice patients. After the visit, the pharmacist completes a post-visit survey to evaluate the experience and provides suggestions to improve the program.

The pharmacists must also write a brief reflection paper at the completion of the visit, describing what they learned about themselves, the nurses, and the patients. The goal of this paper is to encourage self-reflection and promote self-directed learning and behavior change.

**Pharmacist Perspectives**

All pharmacists have rated the program highly and recommend it to their peers. Post-visit survey responses indicate that the program results in improved knowledge, skills and increased empathy towards nurses, patients and families.

Reflections from the pharmacist’s essays illustrate a number of interesting outcomes from the program. Themes centered on the following:

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**Appreciation of the Hospice Nurse**

Pharmacists are consistently impressed with the nurses they accompany on visits. They are surprised at the numerous roles that nurses play, the varied and often challenging conditions in which they work, and how understanding and thoughtful they are with patients and caregivers. The pharmacists are also astonished at how organized patients and families are and how well they manage the daily demands of care. Here are several comments taken from the pharmacists’ essays that speak to this:

“I was expecting the nurses’ interaction with the family to consist mainly of clinical assessments and care planning. Instead, I saw a healthcare professional with a multitude of roles: nurse, clergy, psychiatrist, social worker, policeman, and oftentimes, the most anticipated relative to visit that day.”

“I was able to see how the patient’s home and lifestyle provide significant challenges to the nurse.”

“Observing the care, sympathy, empathy and attentiveness of the nurse truly moved me. After our first visit, it became abundantly clear to me exactly what impact these nurses have on a patient.”

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**Increased Empathy**

One of the goals of the project is to deepen the pharmacists’ empathy towards patients, caregivers and nurses by providing them with firsthand experience. Increased empathy can improve communication and enhances the pharmacists’ sense of mission in providing hospice care. Many of the pharmacists say that, as a result of the experience, they have an altered view of nurses, patients and caregivers that will positively affect their interactions with nurses and other members of the IDT in the future:

“I feel that after the visit, I am more empathetic to the nurses that may seem rushed or busy and to the concerns of family members.”

“I soon realized that each patient was not a number or a subject during a call. They are a person in need, with family members, caregivers, and loved ones doing their best trying to cope and deal with what is happening.”

“I am hopeful that I will be able to repeat this experience and that I will be able to bring a piece of this experience with me to work each day and that my work will reflect it.”

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**Changing Preconceptions**

Many of the essays begin with the pharmacist describing a sense of apprehension about the visit. Although they look forward to the experience, some are anxious about what they might encounter. A number of pharmacists have views about hospice that are shaped by their own personal experience. Expecting to encounter patients and caregivers who are depressed and hopeless, instead they frequently observe patients and family members who are happy and enjoying life. Many of the pharmacists also expect to see bedbound, debilitated patients. They are surprised when they visit patients who are oriented, ambulatory, and able to participate in activities of daily living. This has given pharmacists an opportunity to appreciate the wide spectrum of illness in hospice and discuss different disease trajectories with nurses, thereby promoting a better understanding of the patient and family experience. Some pharmacists also become more comfortable with the concept of death and have described ways in which the visit encouraged their own spiritual reflection.

“*I had a preconception that hospice patients were debilitated people with little to no life left.*”

“*Hospice is not a limitation, but an empowering option.*”

“*This made me realize even more how important hospice is and how much a difference it can make for the patient and the family.*”

**The Pharmacist’s Role on the Team**

Pharmacists end the visit with an improved sense of their role in hospice and deeper appreciation for ways in which they have the potential to impact patient care.

“*In every home that I entered, I had a dynamic interaction with the patient and/or caregiver. I provided medication advice and recommendations and I could actually feel the impact that I had.*”

“*The nurses said that it would be great to have a pharmacist with them every day. This made me feel appreciated and is a great testament for all of the hard work and dedication that each of us put forth on a daily basis.*”

**Nurse Perspectives**

The nurses who participate in the project also find it to be

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tremendously beneficial on all levels—for the pharmacist, for the nurse, and for the patient and family. All of the nurses believe that the time with the pharmacist in the field is educational and helps the pharmacist to gain a better understanding and appreciation of a hospice nurse’s daily experience. Examples include a better understanding of the environmental challenges within the neighborhoods and homes, the nurse’s involvement in family dynamics or conflict within the home, the holistic nature of hospice nursing, and the overall complexities that can exist when providing care in the home setting. The nurses also noted that the pharmacists were surprised at some of the difficulties the nurses experienced in contacting and communicating with community physicians when attempting to recommend changes to the plan of care.

Patients, families, and nurses appreciate the opportunity to interact with a pharmacist during the home visits, all of whom took the time to review the patient medication regimen, provide education, and make recommendations. One nurse said, “I wish that we could have a pharmacist travel with us every day!” Family members were tremendously grateful and felt privileged to receive this specialized time and attention.

Nurses also report that the project has given them a greater understanding and appreciation of the role and some of the daily challenges that a pharmacist experiences. Having the opportunity to spend time with the pharmacist added a human quality and connection that they feel will make future communications more personal. The nurses are now more likely to utilize the pharmacist for consultation and recommendations for all symptom and medication changes, including the use of over-the-counter products. Nurses also have a better appreciation of the pharmacists’ limitations, such as the challenges posed by their inability to physically see the patient, and how painting a clearer picture of the patient and the home setting would be helpful during consultations.

The pharmacist’s role in hospice is evolving and growing. Making it possible for pharmacists to accompany hospice nurses into patient homes exposes the pharmacist to the “real world” of hospice care. Furthermore, visiting patients offers pharmacists an important perspective on the impact that hospice care has on patients and their families. In turn, nurses gain a greater appreciation of pharmacists’ skills and knowledge. This shared experience enhances opportunities for pharmacists and nurse to collaborate, which has great potential to improve patient care.

Terri Maxwell is vice president of clinical initiatives and Laura Scarpaci is manager of clinical performance improvement for Hospice Pharmacia, a division of excelleRx Inc. Terre Mirsch is vice president of Holy Redeemer Home Care and Hospice Services in Philadelphia, PA.

The authors extend special thanks to the nurses from participating hospices who are helping to make the Hospice Visit Program a success.

References


Watch our video to learn more about My.NHPCO!
“Hello, Hospice of the Bluegrass, Pikeville Office, how can I help you?” My current role is overseeing the counseling programs for Hospice of the Bluegrass, but today I am answering the phones and working as the office manager. Normally, Belinda McKinney is sitting in this chair, making the job look easy. Today, however, Belinda is sick.

The phone continues to ring frequently. Family members call wanting to talk to their nurse or another team member. A hospital discharge planner calls in with a referral. Staff members in the field call to follow up on patients. There are three phone lines and at times all of them are ringing. The local hospital is calling to provide additional information regarding a referral. I track down the referral form and discover that the patient was admitted last night, but the referral is not entered into the computer. I need to talk with staff from Medical Records for assistance. The Pikeville office is our smallest office. I wonder what it would be like to work as the office manager in one of our larger offices?

In addition to answering phone calls, the office managers at Hospice of the Bluegrass enter referrals into the computer, process the mail, assist with filing for medical records, fax information to other healthcare providers and do that portion of a job description commonly known as “other duties as assigned.” I feel certain I am overlooking other job duties.

I have traveled to Pikeville to serve as an acting director, sent to help fill in while our agency continues to search for a new director. The phones are ringing the minute I walk in the door and it doesn’t take long for me to figure out that the
most important job for today
is answering the phones and
filling in for Belinda. Pikeville
is one of our newest sites
and has a different phone
system than our other offices.
I don’t know how to transfer
a call, I don’t know the phone
extensions of staff members—
and I need to learn both fast.

My lack of knowledge about
the patients in the area
becomes obvious from the first
phone call. Is patient X ready
to move from the hospital to
home? Mrs. X’s son wants
to know when the certified
nursing assistant is due to
arrive while Mr. X is wondering
if his prescription should be
arriving today.... Somehow I
manage to page nurses, talk to
various team members and call
patients back.

By noon I realize I need to ask
for help in covering the phone
lines to be able to eat lunch
and follow up on several earlier
phone calls. I take a deep
breath and realize how easy
it is to make judgments about
another persons workload.
Today I didn’t walk in another
person’s shoes, I ran in another
person’s shoes.

What are the Take-home
Messages?

• A favorite Japanese
  proverb of mine says,
  “None of us is as smart as
  all of us,” which is another
  way of saying it truly does
take a team—and the
team encompasses more
than the interdisciplinary
team. This experience has
encouraged me to take
the time to appreciate the
multiple roles required to
run an efficient patient-
centered organization.

• Office staff plays a
  key role in facilitating
  communication. Remember
to include office personnel
in quality initiatives,
communication analysis
and in soliciting solutions.

• How callers are
greeted plays a role in
the reputation of the
organization. Friendly, calm
and organized responses
are important. Realize that
the individual who answers
the phone is the voice and,
at times, the face of your
organization.

• Moving out of your comfort
zone is stressful, but there
are benefits. Consider
walking (or running) in
someone else’s shoes to
broaden your appreciation
of the various roles needed
to make an organization
successful.

The next time I was in the
Pikeville office, I took the time
to watch Belinda. Once again
she made the job look easy. I
thanked her for being the office
manager and was secretly
grateful that for now I got to go
back to my comfort zone.

Sherri Weisenfluh is associate vice
president of counseling for Hospice
of the Bluegrass (Lexington, KY) and
serves as Social Work Section leader
for the National Council of Hospice
and Palliative Professionals.
Clinical and Marketing Teams Shadow Each Other

In the spring of 2009, Hospice of Lancaster County decided to develop a marketing department and I was asked to participate in its development. “Marketing hospice” was a new concept to me. Sure, as a registered nurse I educate the community about end-of-life issues and the benefits of hospice and palliative care, but marketing? My first thought was, “How do you sell what we do?” This appeared to be the beginning of a large culture change within our organization. My role on this team was to help educate our non-clinical staff about end-of-life care.

For many hospice organizations—especially those with a firmly established culture and a strong legacy—moving toward a more aggressive marketing approach can be difficult. While providing the highest level of comfort and care for patients and families is the predominant goal of such a strategy, some staff members can be uncomfortable with a shift toward the more visible promotion of their organization. For them, outward campaigning for patients may appear to detract from a hospice organization’s core values or mission.

In line with adopting strategic marketing initiatives, it was important to make every effort to share the plans with staff at all levels of the organization. It was particularly critical to work toward strengthening the relationships between members of the clinical and marketing teams. The more that individuals within these two groups understood the demands and expectations placed on each, the greater the prospect that they would form a cohesive working partnership.

By Teresa Wheatley, RN, CHPN, with Colleen Steinmetz
The marketing challenge, as it relates to the hospice world, is finding the right balance between sales and communication—a balance that ensures the message is delivered effectively and professionally, with the proper degree of sensitivity. At Hospice of Lancaster County, we paired our provider liaisons from the marketing team with clinical staff so each could get a glimpse of what the other did.

Colleen Steinmetz is one of the provider liaisons. She comes from a background of pharmaceutical sales with little clinical knowledge and no prior hospice experience. I was able to work very closely with Colleen during her orientation. When I asked about her orientation to hospice, she provided a personal perspective on how the experience helped her connect with the clinical team and prepare her for her role:

I learned some valuable lessons from working closely with clinical staff during the orientation process. For example, I learned early on how our clinical staff contributes to our marketing efforts during an admission visit. In my first hospice experience, I was also taken out of my comfort zone as I entered the home of a terminally ill man surrounded by his grieving family. I found myself in the company of a nurse who was comfortable and knowledgeable in her role. I watched her comfort the elderly man and alleviate the fears of his family. She did not speak of death and dying. Rather, she focused on the patient’s goals for end of life and how we could help to achieve them. She dispelled myths and misconceptions that I know so many people still have today.

As my role as a liaison continues to develop, I make visits with our physicians and nurse practitioners to explore what they provide in the community. Each visit represents a new story. Each patient and their caregivers are individuals who are touched by hospice care. Often these patient visits that I experience with our clinical staff become the stories I tell during my educational programs to paint the ‘patient picture.’

I have learned the value of incorporating one of our best assets, our clinical staff, on my calls to physician offices, hospitals and nursing homes. I invite our access services manager so that she can explain the details of when and how to make a hospice referral. Our intake coordinators are the first voice that many referral sources and caregivers hear. I have sat next to them, and have heard how their non-anxious voices and assurances help the callers. I have been amazed at the magic they work as they schedule for “crisis” assessments and admissions. Because of my ongoing interactions with the clinical staff, I feel that I’m better able to understand our customers’ frustrations, fears and barriers to making a hospice referral.

From the Clinical Perspective

As Hospice of Lancaster County’s access services manager, I have visited physician offices and nursing homes with Colleen and have benefitted from seeing the very different approach she takes during this outreach. These appointments are usually proactive, providing us with the opportunity to share information and assess how we can continue to make our referral process as smooth as possible.

The roles of the clinical staff and provider liaisons at Hospice of Lancaster County vary on a daily basis. At the same time, our organization recognizes that, at the end of the day, we share a common goal—to live by our mission of providing care and comfort to help patients and families live better at the end of life. In our continued efforts to remain true to that mission, we are all best served when we work together.
Teresa Wheatley is a registered nurse, and has been certified in hospice and palliative care for 16 years. She is currently the access services manager at Hospice of Lancaster County (Lancaster, PA) and serves as Nurse Section leader for NHPCO’s National Council of Hospice and Palliative Professionals.

The author extends special thanks to Tom Tulli, director of marketing for Hospice of Lancaster, for his assistance and contributions to this article.
Connecting with Your Team:

Helpful Reminders for Executive Leadership

By Gregory A. Wood, MS, LBSW

ave you ever been in a work environment where, no matter what your title or position, you struggled to connect with the boss and leadership? Have you ever been or are you now a leader who has struggled to connect with your team and, as a result, has encountered difficulties with the team’s dynamics?

Making these connections does not come easy. In the hospice community, where there can be 15 or more disciplines represented on a hospice team, with each professional expected to deliver high-quality service, developing and maintaining connections is particularly challenging. It takes effort, conviction, passion and respect among all parties involved—including executive leadership.

Leaders who successfully connect with their teams tend to have highly effective communication skills and the ability to honor everyone on the team and their role within the organization. Below are several simple yet profound techniques that can help all of us foster independence among members of our teams and create an environment for growth and success.

Listen

When reminding myself to listen more and speak less, I often think of a phrase that is several decades old: “We all have two ears and one mouth."
That is for a reason.” Listening is probably the most important part of communicating with others. Through listening, we are able to recognize what is happening around us and gain an understanding of the situation.

Team members also need to be “heard.” They need to know there is someone safe in their professional environment who they can trust to share their ideas, frustrations and desires. I challenge you (and myself) to be that leader who will listen first, understand the situation and gain facts, truth and perspective before voicing opinions and making decisions. Team members are intelligent and intuitive and have the ability to know when their leader is listening. Is that work for the executive? Sometimes. Does it require sacrifice and discernment of the leader? Yes. But is there a pay-off when the executive leader listens to all members of the hospice team? Absolutely. Listening gives the leader perspective and the opportunity to make rational and quality decisions. Listening also lets team members know that their view points are important and honored in the workplace.

Speak When Necessary
When leading such a diverse group of professionals as those who serve the hospice field, it takes much effort on the executive leader’s part to communicate vision, passion and direction. Communication can be exhausting when done to its fullest, but that is where the sacrifice of convenience comes into play if an executive leader is committed to helping the team develop and succeed.

As you know, it is not so much about the position or title as it is the greater good of what the hospice organization offers to patients and their caregivers and family. In other words, an executive who shares little of him/herself, but expects a lot will often feel frustrated, disconnected and ineffective. But when the executive spends time articulating his/her thoughts, ideas, vision and passion for the role of each team member and those in which they serve, a level of respect begins to develop between the leader and the members of the team.

Honor Each Team Member
One of the quickest ways to connect with each member of your team is to honor their role and the value of their discipline

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to the hospice organization. For example, take the role of the hospice aide. As we know, this individual is the one who usually spends the most time with the hospice patient and family, and oftentimes has a strong influence on them. In other words, if you want to know what’s going on with a patient and family, ask the patient, family and the hospice aide. But if the executive wants to connect with the hospice aide and encourage the entire team to connect with the aide, hospice aides should be honored publicly—amidst the entire IDT and the staff of the organization. Highlight the aides’ struggles and their influence with patients and families and, in so doing, you will build a relationship out of mutual respect. Doing this for each hospice professional is vital for the effective executive to connect with those he/she leads.

While honoring each discipline throughout the year and/or on a consistent basis requires time and forethought, the rewards far exceed the effort. Many hospice disciplines have a national day or week that recognizes their work, but for those which don’t, why not create one within your organization? Whether you have a special breakfast or lunch, or offer a small gift or words of praise and appreciation matters less than the act of recognizing them. I also strongly encourage you to honor each discipline in front of all other staff. Don’t simply hold an exclusive lunch for the bereavement professionals, but include everyone on the team and ask them to share how they feel bereavement professionals help support those who are grieving. There is nothing better than to hear the organization’s leader honor and acknowledge individuals in front of their peers and for peers to share in the same activity.

**Be Genuine**

Being genuine with each member of the team is vital. People know when words or actions are not founded on true respect or appreciation. Should the executive ever need to discipline a staff member in a particular matter, then the “new direction” offered by the executive during the discipline process will be better received because it is based on a relationship of mutual respect, trust and appreciation.

When the executive listens first, speaks when support and direction are needed, and honors each staff member based on genuine appreciation of their expertise and contributions, everyone benefits.
The “team” concept is a prominent one in business organizations and the term is used often. However, a group of people working together does not make them a team. In our world of hospice and palliative care, we know that “team”—specifically our interdisciplinary team—is more than a concept; it is at the core of how we bring quality of life to those whose quantity of life is limited. Our teams take pride in representing many disciplines and demonstrating that the whole is greater than the sum of its parts.

Keeping the interdisciplinary spirit alive requires strong individual team members and good leadership as well as...
active participation, mutual trust and respect, and the ability for all team members to manage conflict.

Creating Strong Team Members and Team Leadership

Each member of the team must take responsibility for the team. Although the team leader/supervisor is held accountable for establishing, building, and monitoring team performance, all team members are responsible for their team’s success. You are not just a member of a work group with tasks. Your role as a team member goes far beyond the work itself.

Your team meeting is your meeting and therefore it is your responsibility to do whatever is called for to make it effective. While it may require a slight shift in roles for some team members and for team leaders as well, you must be prepared to take an active role rather than a passive one. You must be a robust participant, actively contributing to what is being discussed and, at the same time, be aware of team dynamics and be willing to intervene when team members are behaving in disruptive ways. It’s not an easy job, but it most definitely is part of your responsibility as a team member. To behave responsibly, you must feel responsible. And your team leader must also be willing to share the responsibility. A lot of work and energy goes into making a team work well and keeping it alive.

There are two things to consider during the team meeting (and all team interactions): content and process. The content and process must be balanced in order to achieve satisfying results and benefit most from the varied experience of individual team members.

Certainly, there may be times during a team meeting when you feel you can’t participate because you are not familiar with the intricacies of the topic being discussed. This doesn’t mean, however, that you can’t contribute by helping the team process work well.

Knowing When You’re Doing it Right

How can you tell whether your team’s process is functional or dysfunctional? In a healthy, functional team, members are able to accomplish tasks and fulfill relationship needs. Members behave in ways that facilitate getting the job done and, at the same time, make other members of the team feel valued, respected, included, and energized. Members leave the meeting saying, “We covered everything thoroughly and I enjoy being a member of this team.”

When there is an imbalance between accomplishing tasks and fulfilling relationship needs, or there is not enough attention paid to either, the team’s process is dysfunctional. If you hear members saying, “We managed to get a lot of things accomplished, but I can’t stand the way we treat each other,” it’s a sure sign that the team hasn’t paid enough attention to its relationship needs. If you hear, “We all get along so well, just like a family, but we sure didn’t get much done,” the team has slipped on the task side. And if you ever hear, “Another waste of two hours—nothing was accomplished. We ended up right where we started after going in circles. Why can’t people at least be civil to each other?” you know there is a lot more work to be done on both the task and relationship sides.

Addressing Problems with the Process

There are many resources available to address content. All disciplines have their particular competencies, expertise, and educational backgrounds which make for rich content in team discussions; therefore, more attention will be paid here to the team process and how each team member can strive for new competencies as a team member and help facilitate the team process.

Dr. R. Meredith Belbin, a leading expert on teams in the U.K., has identified several team facilitation roles that a team member might play,
also known as intervention behaviors. These roles are shown in the table on page 53.

Learning how to observe your team’s process and intervene appropriately takes time and practice. A good way to start is by acquainting yourself with some of the roles which Belbin describes in the table, and then look for the appropriate situations during your team meetings in which to apply them. In other words, first learn what the intervention (or helping) behaviors are, and why and how they help. Then you will more easily see places where you can be helpful. You may notice that you have a natural inclination toward a particular role. View the roles as being available for the filling and also as an opportunity to spread the responsibility of leadership across the whole team.

Sharing responsibility, and rotating roles as needed, nurtures participative leadership, and thereby creates interdependence and interdisciplinary behaviors. Shared responsibility makes the team strong by establishing an environment in which all team members feel as responsible as the team leader for the performance of the team.

The What and How of IDT Interaction

The “what” that is needed is strong, consistent participation from each team member. Your job is to do the idea generation, problem solving, and decision-making necessary to arrive at excellent patient/family outcomes.

Apply your individual talents and creativity to contribute ideas and solutions. Not every idea offered will be the one that works, but keep them coming anyway. Listen to the ideas of others. Oftentimes solutions are found by building on to or fattening up the ideas of others. Ask questions and get clarification. You are making decisions about care and it serves everyone much better if you are informed and clear about the topic. Participate fully, your observations and voice are vital. You cannot withhold pieces of the puzzle. Stay focused on the task at hand with the goal of getting results. Stay flexible and open to unanticipated opportunities.

The “how” that is needed is mutual trust and respect. There is a saying, “I may not remember what you said, or what you did, but I will always remember how you made me feel.” It goes without saying that the relationships

You don’t have to be best friends; you just have to be good teammates.

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among and between team members impacts patients and families. You don’t have to be best friends; you just have to be good teammates. Being a good teammate means offering support when needed, valuing the ideas and contributions of others, and recognizing and respecting differences. In short, it means that in whatever you do or say, you are conveying respect. Ways we demonstrate respect for our fellow teammates is by listening to their ideas and opinions without prejudging, being sensitive to personal problems, accepting idiosyncrasies, being present and on time, sharing in their excitement, and offering praise and compliments when something great or difficult has been achieved. Showing respect for teammates creates a climate of trust where open, honest communication can occur.

The glue that really holds the team together and keeps it alive is the ability to manage conflict. Every day will not go smoothly and team members will not always agree. Friction will occur. Communication between the people with conflict is the best starting place. Engaging in that communication as close to the time of the conflict is helpful. Strive for a solution where all parties feel whole because the whole is always greater than the sum of its parts.

—Peter Drucker
## Belbin Team Facilitation Roles*

<table>
<thead>
<tr>
<th>Overall Role</th>
<th>&quot;Belbin&quot; Roles</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doing/Acting</strong></td>
<td>Implementer</td>
<td>Well-organized and predictable. Takes basic ideas and makes them work in practice. Can be slow.</td>
</tr>
<tr>
<td></td>
<td>Shaper</td>
<td>Lots of energy and action, challenging others to move forward. Can be insensitive.</td>
</tr>
<tr>
<td></td>
<td>Completer/Finisher</td>
<td>Reliably sees things through to the end, ironing out the wrinkles and ensuring everything works well. Can worry too much and not trust others.</td>
</tr>
<tr>
<td><strong>Thinking/Problem-solving</strong></td>
<td>Plant</td>
<td>Solves difficult problems with original and creative ideas. Can be poor communicator and may ignore the details.</td>
</tr>
<tr>
<td></td>
<td>Monitor/Evaluator</td>
<td>Sees the big picture. Thinks carefully and accurately about things. May lack energy or ability to inspire others.</td>
</tr>
<tr>
<td></td>
<td>Specialist</td>
<td>Has expert knowledge/skills in key areas and will solve many problems here. Can be disinterested in all other areas.</td>
</tr>
<tr>
<td><strong>People/Feelings</strong></td>
<td>Coordinator</td>
<td>Respected leader who helps everyone focus on their task. Can be seen as excessively controlling.</td>
</tr>
<tr>
<td></td>
<td>Team Worker</td>
<td>Cares for individuals and the team. Good listener and works to resolve social problems. Can have problems making difficult decisions.</td>
</tr>
<tr>
<td></td>
<td>Resource/Investigator</td>
<td>Explores new ideas and possibilities with energy and with others. Good networker. Can be too optimistic and lose energy after the initial flush.</td>
</tr>
</tbody>
</table>

*For more information about Belbin’s Team Role Theory, visit [www.belbin.com](http://www.belbin.com) – or click here.
The Art of NCHPP

In the following four pages, NHPCO is pleased to share some of the photographs taken by NCHPP members and submitted to NHPCO’s 2010 competition. While not among the winning photos, they are nonetheless beautiful expressions of “hospice care in practice” and a very fitting conclusion to this issue. As one nurse so aptly shared, “it brings me great joy to express the richness of our connections with patients, families and colleagues through art.”

Terry Stephenson, an LPN with Hospice of Chautauqua County (Lakewood, NY), was inspired to take this photograph because “it shows how we stand by our families and lend a helping hand.”
Donna Stone, the guest-wing manager at the Talbot Hospice Foundation (Easton, MD), captured this special moment between a granddaughter and her grandmother on the eve of Mother’s Day.

This photograph of Evan and his day nurse, Jalinda, was taken the day before he died. Jalinda was hesitant to have the picture taken, but the family insisted. “Maybe now, as she treasures this photo, she will see she’s always been part of our family,” a family member shared.
Casey Christie snapped this photograph of Darlene Moriarty, a patient at Hoffmann Hospice (Bakersfield, CA), right after her wedding ceremony (to longtime fiancé Scott Slota). Hoffmann volunteers brought the wedding cake and flowers, and decorated the living room of the bride’s home. Hoffmann Hospice chaplain, Wayne Meade, officiated the ceremony.

Marianne Schroeder of CarePartners Hospice and Palliative Care (Ashville, NC) served as a lead volunteer for a United Way Day of Caring brunch. “Many of the volunteers had no experience working with dying patients and families and were afraid of saying the wrong things, but not Mary,” explains Schroeder. In this photo, Schroeder was able to capture the essence of love and compassion in Mary’s heart. “It is all you need to help a hospice patient,” Schroeder said.
“Although she can’t convey much verbally, patient Fariss Howell could not stop smiling after her mini-spa treatment,” noted photographer Shannon Slater, the bereavement services manager for Hospice of the Carolina Foothills (Columbus, NC). Fariss is pictured here with her CNA, Trish.

This photograph of 111-year-old patient Jewell and her volunteer, Deborah, was taken by Debra Thurston, a volunteer coordinator at Safe Harbor Hospice (Fredericktown, MO), right after Jewell tried chocolate-covered strawberries for the very first time—a gift from Deborah that she thoroughly enjoyed!

“Fariss and Trish”

“Jewell and Deborah”

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“Alex Tyree was a much beloved friend and colleague at Delaware Hospice,” explains C. Karen Covey Moore, a bereavement counselor with the program. “He died in February 2010 from gastric cancer but, throughout his life, he encouraged living with mindfulness and finding beauty and joy in life and even in death and bereavement. About a week after his death, four of us from the bereavement department visited his widow. As we were getting out of our cars, we noticed a rainbow over one of them. We all said simultaneously, ‘Alex is smiling at us!’ I quickly grabbed my camera and took this photo.”
About This Free Membership Benefit

My.NHPCO is an online community that helps you “connect” with other members around the country. You can participate in end-of-life care discussions through eGroups (NHPCO’s new listserve) as well as post links to Insights articles that you found helpful, post other resources, and more.

Getting Started:
There are just four simple steps to get started. These steps are posted on My.NHPCO, but are provided here to illustrate just how easy it really is:

- **Login**
  Go to http://my.nhpco.org (do not add “www”) and enter your member ID and password.

  If your organization belongs to NHPCO, but you don’t yet have a member ID and password, simply call the NHPCO Member Services Center to request one: 800-646-6460.

- **Update Your NHPCO Professional Profile**
  When you register with NHPCO and receive a member ID and password, your My.NHPCO profile is automatically populated with basic information. However, you can update the profile and add a photo if you wish—just go to the “Welcome” box in the top right corner of the homepage.

- **Search for Colleagues and Add Them to Your Contact List**
  You can build your own network of contacts from the list of My.NHPCO registered users. You can group your contacts by interest or topic or region—however you wish. It’s also optional and something you can do over time.

- **Join the eGroups that Interest You**
  If you were a fan of NHPCO’s former “listerves,” you’ll love eGroups—they make it easier to exchange information and ideas with your colleagues.

  Each discipline or job function within the hospice and palliative care field is represented by an “NCHPP section”—and has its own eGroup (e.g., Allied Therapists, Bereavement Professionals, Nurses). There are also eGroups based on areas of interest (e.g., Pediatrics, Rural, State Coalitions).

  When you join an eGroup, you can post and receive messages from the group. (You can view the message threads from any eGroup without joining (i.e., subscribing) to it; however, in order to participate in the discussions, you must join the eGroup.)

Using eGroups

1. Go to My.NHPCO—http://my.nhpco.org (do not add “www”)

2. Select the Login tab and enter your member ID and password

3. Select the eGroup tab

4. Select “Add/Change Subscriptions” to join an eGroup. You are eligible to join as many eGroups are you like. You can also choose the way you want to receive posts and how frequently:

   - **Real Time:** You will receive messages via email as soon as an eGroup message is posted

   - **Daily Digest:** You will get an e-mail once a day with all the posts from that eGroup for the previous day

   - **PDA:** When a message is posted to that eGroup, you will receive notification on your PDA

   - **No Email:** You will be a subscriber and will be able to post and reply to messages, but you will not receive notifications of new posts

5. Then click “Save” to save your preferences.

You can make changes to your preferences and settings at any time. Unsubscribing to an eGroup is also easy—just go to “Add/Change Subscriptions” and select the “unsubscribe” button.

If you have specific questions, contact the NHPCO Member Services Center at 800-646-6460. Also be sure to watch our video introduction!
This essential new resource is a “one-stop shop” for managing a hospice whether you are starting a new program or enhancing your current program. This resource is designed to assist providers in understanding basic hospice operations to promote compliance with required regulatory requirements, increase quality care provision, and improve program performance. *The Essential Guide to Hospice Management includes fundamental information about regulatory and compliance of a hospice program, program operations, quality patient care, quality assessment performance improvement, documentation, and ethics and patient rights.*

*Subscription for regulatory updates is for two years from purchase date. Updates will be sent as downloadable/printable files to one e-mail address. Subscriptions may then be renewed on an annual basis.
The best way to keep informed of the changes occurring in the hospice and palliative care field is to take advantage of NHPCO’s diverse range of educational offerings.

Our goal is to ensure that you and your colleagues are well-informed and better able to deliver quality end-of-life care to all members of your community.

To learn more about our upcoming national conference, our series of timely Webinars, and our E-OL distance-learning courses, just click on the tabs above.

For full details, please visit the NHPCO website: www.nhpco.org/education.
Take a Virtual Tour of MLC’s New Venue

The April 2011 26th Management and Leadership Conference will be held at the Gaylord National Resort—a new and beautiful venue that’s conveniently located near Reagan National Airport and Capitol Hill. Take a brief tour and register today!

Navigating the Sea of Change: Excellence in Interdisciplinary Care
April 7-9, 2011
Gaylord National Resort and Convention Center
National Harbor, MD

Plus:
Preconference and Capitol Hill Events: April 5-6
National Hospice Foundation Gala: April 8

For details or to register, visit: www.nhpco.org/mlc2011