

# HOSPICE Management Advisor™

Reimbursement • Palliative Care • Risk Management • Best Practices

December 2010: Vol. 15, No. 12  
Pages 133-144

## IN THIS ISSUE

- Retain employees by addressing concerns . . . . cover
- Satisfaction surveys identify improvement opportunities . . . . . 135
- Case managers and end-of-life care for patients who are hospitalized . . . . . 136
- End-of-life care for heart failure, prostate cancer . . . . 138
- Most men dying of prostate cancer wait too long to use hospice . . . . . 140
- Withholding palliative sedation v. euthanasia . . . . 141
- The role of the peds oncology nurse at the end of life . . . . 141
- Communication and outcomes for whites, blacks. . . . . 142
- Cancer patient's costs rise. . . . . 142
- **News briefs:** More patients choose hospice; Program recognizes needs of veterans . . . . . 143
- **Enclosed in this issue:**  
2010 Index

## In this economy, you can't afford to lose good hospice employees

*Happy workers won't leave when job markets open up*

*[Editor's note: This is the first of a two-part series that examines strategies for employee retention. This month we look at the importance of patient satisfaction surveys and exit interviews. Next month, we'll look at specific programs that enhance retention.]*

The 161 employees at Rainbow Hospice and Palliative Care in Park Ridge, IL are accustomed to annual employee satisfaction surveys, but the 2010 survey was a little different than those from previous years. Results of the nationally benchmarked survey resulted in their agency's selection as one of Modern Healthcare's Best Places to Work 2010.

"We are committed to doing an employee satisfaction survey every year but this year, like all other hospices, we've been on a fiscal diet," says **Pat Ahern**, chief executive officer of the hospice. "Although the hospice's retention rate of 83% is higher than the national average of 80%, we want to continue looking for ways to keep employees satisfied and

### EXECUTIVE SUMMARY

Finding and keeping good employees is a challenge for all hospice managers. The uncertain economy in the past few years has resulted in fewer employees willing to leave current employers and give up seniority, but this is the time to pay attention to employee satisfaction to ensure your good employees stay when the economic tide turns.

- Employee satisfaction surveys help you identify areas of concern or dissatisfaction.
- Respond to all suggestions and ideas, even if your response is that you are unable to implement the idea.
- Use exit interviews and focus groups to identify potential problems in addition to satisfaction surveys.

surveys enable us to identify needs. We chose to participate in the Modern Healthcare employee survey because it gave us an opportunity to benchmark our results against healthcare organizations throughout the country.”

There is no participation fee required, and full reports that include employee feedback and comments can be purchased to give hospice agency managers an opportunity to address concerns, Ahern points out. (See resource box on p. 135 for information about the survey.) “We were able to conduct a survey without spending a lot of money,” Ahern adds.

Although Ahern and her management team were only expecting results that they could use to identify areas to improve employees’ perception of the agency as a work environment, the surprise

result was being named as one of the top 100 Best Places to Work. “We don’t have a specific strategy that identifies employee satisfaction or employee retention as an organizational goal, but we have set a goal of enhancing internal resources,” says Ahern. The most valuable internal resource is the staff, so several new programs reflect the agency’s efforts to give staff members tools to help them perform their job or recognize their value to the organization, she adds. Electronic medical records, tuition reimbursement and a leadership development program are three programs implemented in recent years as a result of feedback from employee surveys, she points out.

Retention is an important issue for hospice managers but it may not be at the top of everyone’s mind, admits Moses Altsech, PhD, founder of Marketing Hospice, a Madison, WI-based marketing consulting service specific to the hospice community. Managers understand that continuously hiring and training new staff is more costly than retaining existing quality staff members, but many “talk the talk, but don’t walk the walk,” he points out. “Right now, the slow economy has meant that employees are less likely to change jobs because of the uncertain job market, the loss of seniority, and the risk that the new job may be eliminated due to budget cuts,” he explains.

This situation won’t last forever, so now is the time for hospice managers to make sure their employees are happy so they won’t leave when other hospices start hiring, he recommends. “If you wait for the economy to improve to work on retaining your employees, you’ll be too late,” he warns.

## Use surveys to measure morale

Employee satisfaction surveys are essential for any organization that wants to improve retention, says Altsech.

“It’s important to pay your employees well, because pay is an expression of their value to the organization, and it’s important to offer recognition programs that thank them for doing a good job, but satisfaction surveys give you an opportunity to identify significant issues that affect job satisfaction,” he explains.

How you conduct the survey, evaluate the data, and communicate the results is another way you let employees know how seriously you take their opinions, Altsech says. “It is best to use a third party to develop and conduct the survey to maintain confidentiality and credibility,” he suggests.

Another way to identify issues that affect reten-

---

**Hospice Management Advisor™** (ISSN# 1087-0288) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

**POSTMASTER:** Send address changes to Hospice Management Advisor™, P.O. Box 740059, Atlanta, GA 30374.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

### SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: One year (12 issues), \$399. Add \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are \$67 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcmedia.com>.

Editor: **Sheryl Jackson** (sheryljackson@bellsouth.net).  
Executive Editor: **Coles McKagen** (404) 262-5420 (coles.mckagen@ahcmedia.com).  
Senior Managing Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).  
Production Editor: **Neill L. Kimball**.

Copyright © 2010 by AHC Media LLC. Hospice Management Advisor™ is a trademark of AHC Media LLC. The trademark Hospice Management Advisor™ is used herein under license. All rights reserved.



**Editorial Questions**  
For questions or comments,  
call Joy Daughtery Dickinson  
at (229) 551-9195.

tion are exit interviews, suggests Julia Houck, vice president of human resources for Madison, WI-based HospiceCare Inc., which has been named “No. 1 Best Place to Work” by Madison Magazine in 2010 and 2008. “We’ve set an organizational goal for 92% to 94% retention of employees, and we are currently at 93.5%,” she says. “We’ve been in a growth mode for several years and have increased our staff from 55 employees to 550 employees in 10 years.”

Because the hospice already is hiring many new employees as it expands, it is critical to retain existing employees, she says. “When an employee does leave, we conduct an exit interview to identify the reasons for leaving,” says Houck. “We track the information gathered in the exit interviews and look for trends.”

For example, an employee might be dissatisfied with the way paid time off is handled or might not think that he or she was supervised well, she explains. “We’ll use a focus group of employees to explore the issue and get more details,” she says. “If an employee who is leaving has a complaint, you can be sure that other employees who are staying are aware of the issue, and a focus group is a good way to get specific information that can help us address the problem.”

Career Pathing is one program implemented at HospiceCare to address employees’ desire for

## SOURCES/RESOURCE

For more information about employee retention, contact:

- **Pat Ahern**, Chief Executive Officer, Rainbow Hospice, 444 N. Northwest Highway, Suite 145, Park Ridge, IL 60068. Telephone: (847) 685-9900. Fax: (847) 685-6390. E-mail: pahern@rainbowhospice.org.
- **Moses Altsech**, PhD, Marketing Hospice, Madison, WI. Telephone: (608) 213-4110. E-mail: moses@marketinghospice.com.
- **Julia Houck**, Vice President of Human Resources, HospiceCare Inc., 5395 E. Cheryl Parkway, Madison, WI 53711. Telephone: (608) 276-4660. E-mail: Julia.Houck@hospicecareinc.com.

For information about Modern Healthcare’s Best Places to Work in Healthcare program and survey, go to [www.bestplacestoworkhc.com](http://www.bestplacestoworkhc.com). The web site has information on the program, past winners, application, deadlines, and reports. There is no participation fee for online surveys or the summary report. Reports for individual organizations can be purchased for a fee that ranges from \$650 to \$995, based upon the number of employees in the organization.

advancement, says Houck. In addition to the typical annual performance evaluation, all employees also meet during the year with their supervisors for an interim session that includes discussion of career aspirations, she says. “Our job descriptions are linked to competencies so if we have a nurse who wants to eventually be a team leader, the supervisor can compare the two job descriptions and conduct a gap analysis with the employee,” she says. By comparing the nurse’s current role responsibilities with the future role responsibilities, the supervisor and nurse can develop a plan to help the nurse gain the experience or education she needs to be a candidate for team leader, she adds.

Although employee surveys and development of programs to enhance career advancement take time and money, hospice managers cannot afford to ignore them, says Ahern. “A hospice’s most valuable resource is its employees,” she points out. “When our treasured assets go home at night, we want them to want to come back the next day.” ■

## Anonymous surveys bring out the truth

*Communicate results, actions based on input*

Asking employees what they think of their employer can be tricky. To obtain truthful answers, you want the survey to be anonymous, and one way to ensure anonymity is to use an outside source to conduct the survey, says **Moses Altsech**, PhD, founder of Marketing Hospice, a Madison, WI-based marketing consulting service.

“Employees are more open if they know that a human resource person or their own supervisors are not going to be seeing the survey forms,” Altsech says.

An outside consultant also can provide additional help evaluating the information, he points out. “A third party has no preconceived ideas about the hospice and also has the opportunity to share information from work with other clients,” Altsech explains. “This perspective can provide options that a hospice manager might not consider.”

Another way to conduct a survey anonymously is to use an online tool, says **Julia Houck**, vice president of human resources for Madison, WI-based HospiceCare Inc. “We use Survey Monkey, which is a cost-effective way to survey employees,” she says. “We can build our own survey and the reports include comments as well as data.” [Edi-

tor's note: Survey Monkey offers free and paid online survey tools. Go to [www.surveymonkey.com](http://www.surveymonkey.com).]

However you conduct your employee satisfaction survey, the most important part of the survey is sharing information with employees, says Altsech. "You can't just ask employees what they think of their employer. You have to show employees that you listened to and considered their ideas and concerns," he says. "Sometimes the issue can be easily addressed."

For example, one of Altsech's clients learned that a simple cost-cutting measure greatly affected employee morale. "The hospice stopped paying for a subscription for a newspaper that was placed in the break room," he says. "Employees commented that the only time they got a chance to read the paper was in the break room and they missed having the paper." The client reinstated the subscription, and employees saw that their concerns were heard, he adds.

Sometimes ideas or complaints are not as easy to address, admits Altsech. "Even if the idea is not feasible, tell employees that the idea was received and explain why you can't implement it," he says. Whether the reason is based on financial or regulatory reasons, or even the fact that the idea doesn't fit the hospice's goals and strategies, be honest, he says.

**Pat Ahern**, chief executive officer of Rainbow Hospice and Palliative Care in Park Ridge, IL, says, "We always identify the top three concerns to address from each year's employee satisfaction survey."

A team composed of management and non-management employees is put together to work on solutions that can be implemented, Ahern says. "Sometimes we can address the concern easily. Other ideas take longer to implement," she adds.

One year employees complained about the use of separate vacation and sick leave hours as compared to a general pool of paid time off, Ahern says. "Employees said they didn't like lying about being sick when they really just wanted a mental health day," she says. Following the survey, Ahern told employees that the agency would work toward a paid time off system, but it would take time. During the five years it took to convert to the new system, Ahern and supervisors kept employees up to date about progress, she adds.

"I'm always truthful with employees, says Ahern. "If they know we're trying to do the right thing, they understand why something will take longer to implement or why something can't be implemented." ■

## Palliative care team, case managers help

*Approach can cut LOS, patient throughput*

When Integris Baptist Medical Center in Oklahoma City began looking at implementing palliative care and end-of-life services, the case management department was the appropriate place to start, says **Anita Bell**, RN, MEd CHPN, palliative care coordinator at the 508-bed facility.

"There are so many similarities between palliative care and case management. Hospital case managers are constantly challenged to decrease the utilization of hospital resources and length of stay while maintaining quality care. Studies have shown that palliative care can decrease the cost of hospitalization and improve a patient's quality of life by advocating for care in the most appropriate setting," Bell says.

In addition to Bell, the palliative care team includes a chaplain, the medical director, a social worker, a pharmacist, and a nurse who does healing touch. "We've done some research, and healing touch has been able to show a decrease in pain and anxiety," Bell says.

The team is assisted by volunteers who handle data entry and make comfort care shawls that the palliative care team or nurse give to patients or family members, depending on the situation.

Case managers can see the big picture within the hospital and often are the first clinicians who identify patients who might benefit from palliative care services, Bell says. "Because of the case managers' focus on setting goals with the family, educating them, and looking at their discharge needs, they are instrumental in making sure we meet with patients and families who need palliative care services," she adds.

Palliative care and case management have mutual goals: decreasing length of stay and ensuring that patients receive the care they need at the right place in the continuum, Bell says. "Many times when patients have problems with pain or symptom management, they have a longer length of stay as the hospital staff try to get the problem under control. Palliative care helps with pain and symptom management, which can improve patient throughput and length of stay in the hospital," Bell says.

Case managers often call in the palliative care team for help in working with patients and family members to understand their options and to set goals of care for the patient, she adds. “The case managers will say to me that the physicians have talked to the patient and family, but they need more help understanding how ill the patient is and options for care. The palliative care team can go in with the doctor’s permission and help educate the family and support them as they make choices,” she says.

Patients who could benefit from a palliative care consultation often are identified during discharge planning rounds, says **Suzanne Creekmore, RN, CCM**, case manager for the med/surg intensive care unit and the intermediate care unit.

The discharge planning rounds in the ICU are attended by the case manager, the social worker, the nurse taking care of the patient, the chaplain, the ICU clinical director, the palliative care coordinator, and representatives from dietary, pharmacy, and other disciplines and departments if needed.

The team goes through each patient, one by one, starting with the diagnosis, the family support, and the goals for the day, along with individual details such as use of pain medication, ventilator length of stay, and psychosocial or family issues. The team discusses the plan of care and the discharge plan and looks at options if the patient isn’t able to go home. For instance, if a patient has a stroke, is not responding, and isn’t likely to recover, the team may call in Bell to help the family through the grieving process. Bell also may be called in if patients have a lot of pain that isn’t being controlled with IV pain medication.

“We want to help the patients have better control of their pain for whatever time they have left, whether it’s a matter of months or years. Some patients aren’t ready for hospice and want to keep treatment going, but their quality of life will be better if their pain is under control,” Creekmore says.

The case managers often call for a palliative care consultation for people who have chronic diseases, such as chronic obstructive pulmonary disorder, who are not necessarily at the end of the life but are getting worse. In those cases, Bell helps them get advance directives in place before they get really sick, Creekmore says. “We want to bring the palliative care team in as early as possible to help educate the patient and family members of their options for palliative care and com-

fort care. Our goal is to get the process started sooner so we can help the patient and family make the appropriate choices at the appropriate time,” Creekmore says.

Bell gives the unit an extra set of eyes to help determine the best discharge plan for the patient, Creekmore says. “Her expertise can help us determine if it would be appropriate for us to discharge the patient to hospice or if he should stay in the hospital and receive hospice care here. She helps us determine how best to approach the family and comfort them,” Creekmore says.

When a physician orders a palliative care consult, the case manager and the social worker on the unit accompany Bell as she visits with the patient and family members. But once Bell gets involved, Creekmore limits her visits with the family. “If too many people are involved in an emotional situation, it gets to be too much for the family. Once Anita takes over, I back off and go in and talk to the family every day,” she says.

When she is called in on a consultation, Bell works with the chaplain, the social worker, the case manager, and physicians to look at pain and symptom management, develop goals of care, help the family do advance care planning, and to support the patient and family if they decide to withdraw lifesaving treatment, move to hospice care, or continue aggressive treatment. The team can call on a palliative care-certified physician who can meet with patients and help them understand their options.

“When people are in the ICU, so many things are being done for them. The case managers often hear that the patient never wanted that. They call the palliative care team in to talk with the family and clarify the goal of care and what the person wanted,” Bell says.

In addition to Bell and the palliative care team, the hospital established the position of palliative care resource nurse on most of the units. The nurses have other nursing duties but have participated in training on palliative care, keep up with current literature on the subject, and know what resources are available. The palliative care resource nurses are an added level of expertise on the unit level and are able to identify patients who have more complex needs than what the regular staff can provide and who could benefit from a palliative care consultation, Bell says.

“When families are struggling with trying to make decisions, the palliative care resource nurse

knows where to find the information they need. They have a higher training and competency than the rest of the staff. If the family needs more help, they may ask the doctor to ask for a palliative care consultation,” she says.

Before establishing the palliative care program, the administration at Integris Baptist researched how the services are provided at other hospitals. The palliative care process was developed by a committee that included Bell, the case manager director at the time, the director of hospice, and the palliative care medical director, all of whom attended a conference to get ideas for the structures and processes that would work best at Integris Baptist. “We decided on an approach that embeds palliative care into our culture. We have palliative care resource nurses on most of the units who work along with the palliative care team,” Bell says.

The team held in-service education sessions for the hospital’s clinical staff and developed written material to educate the staff about palliative care. In the beginning of the program, Bell worked with the case management team to help them understand how palliative care could be helpful to their patients, so they could help inform other members of the treatment team about palliative care. She also taught them how to identify patients and family members who could benefit from a consultation.

The hospital established a palliative care steering committee to keep the process moving forward. The committee includes the palliative care coordinator, representatives from cardiovascular medicine service, the emergency department, the critical care and neurosciences services, chaplaincy services, pharmacy, social services, hospital medicine services, the ethics committee, and the cancer committee.

Before there was a formal process, most of the family consultations on palliative care and end-of-life issues were done by the social worker or the hospice team was called in, Creekmore says. “The palliative care team is a wonderful resource that can supplement communication and education provided by the treatment team and help the patients and family members understand their options,” she says. “Health care is so fragmented and patients and families are often overwhelmed with the disease process. All of us want to relieve suffering and improve the quality of life for our patients and family members.” (*For more information, contact Bell at BellAM@Integris-Health.com.*) ■

## EOL care patterns shift for heart failure patients

*Use of hospice for prostate cancer grows*

Health care in the last six months of life has become progressively more expensive for patients with heart failure among Medicare beneficiaries in the United States and older adults in Canada, with a high rate of hospitalizations in the final six months of life in both countries, according to two reports posted online. The reports will be published in the Feb. 14, 2011, print issue of *Archives of Internal Medicine*.<sup>1</sup>

A third report finds that more men dying of prostate cancer are receiving hospice care, but that the timing of hospice referral remains poor.

Heart failure is a common cause of death in the United States and Canada, according to background information in the articles. The condition is listed on one in eight death certificates in the United States, and the five-year death rate among those hospitalized with heart failure is about 70%.

“Provision of high-quality health care at the end of life poses challenges for both health care providers and policy makers,” the authors write. “End-of-life care has many dimensions, including patient preferences and values, health care provider practices, and concerns about the appropriate use of resources. Although most patients prefer to die at home, many die in hospitals or nursing homes. The cost of health care at the end of life is also substantial. More than one-quarter of Medicare spending occurs in the last year of life, a figure that has remained stable for several decades.”

In one article, **Kathleen T. Unroe, MD**, MHA, of Duke Clinical Research Institute, Durham, NC, and colleagues studied 229,543 Medicare beneficiaries with heart failure who died between 2000 and 2007. They examined resource use in the last six months of life and calculated costs to Medicare.

Over the entire study period, about 80% of patients were hospitalized in the last six months of life. Between 2000 and 2007, days in the intensive care unit increased from 3.5 to 4.6, hospice use increased from 19% to nearly 40% of patients, and unadjusted average costs to Medicare per patient increased 26% from \$28,766 to \$36,216. After adjusting for age, sex, race, co-occurring medical conditions and region, costs increased by 11%. Older patients tended to have lower costs,

while those with kidney disease, lung disease, or who were black were more likely to have higher costs.

The trend of increasing hospice use marks a substantial change in end-of-life care, the authors note. "Some studies have found hospice care to be more cost-effective than nonhospice care, but we did not observe lower use of other services as the use of hospice increased," they write. "Rates of inpatient hospitalization remained high, suggesting that the potential for hospice to prevent costly hospitalizations has yet to be fully realized."

### Higher costs for hospitalized heart failures

In another article, **Padma Kaul**, PhD, of the University of Alberta, Edmonton, Alberta, Canada, and colleagues evaluated data from 33,144 patients in Canada who died of heart failure between 2000 and 2006. They also assessed resource use in the last six months of life along with costs to the national health care system, as Canada has a single-payer system with universal access.

The percentage of patients who were hospitalized during the last six months of life decreased over the study period, from 84% to 76%, as did the percentage of patients dying in the hospital (from 60% to 54%). However, patients who died in later years were substantially more likely to receive outpatient care in the last six months of life (52.8% in 2000 vs. 69.8% in 2006), and the average number of visits among those receiving such care increased from 6.4 to 7.7.

In 2006, the average end-of-life cost was \$27,983 in Canadian dollars. "Costs in the last six months of life among patients who died in hospital were more than double those for patients who did not," \$38,279 vs. \$15,905, the authors write. "The substantial impact of location of death on costs can be illustrated as follows: reducing the number of hospital deaths by 10% in 2006 would have saved the health care system approximately \$11 million (486 patients multiplied by mean cost savings of \$22,374 per patient)."

"Increasing the availability of alternative venues of care, such as long-term care and home care, may be effective in further reducing hospitalizations and containing costs," they conclude.

### Hospice encouraged for prostate cancer

In a third article, **Jonathan Bergman**, MD, of the University of California, Los Angeles, and colleagues linked data from the Surveillance, Epide-

miology, and End Results (SEER) Program cancer registries to Medicare data to identify 14,521 men dying of prostate cancer in the United States between 1992 and 2005.

Overall, 7,646 of the men (53%) had used hospice, for a median (midpoint) of 24 days. African Americans and those with more co-occurring illnesses were less likely to use hospice, whereas having a partner and dying more recently were associated with greater use. Men who enrolled in hospice were less likely to receive high-intensity care, including admission to the intensive care unit, inpatient stays, and multiple emergency department visits.

Although hospice use increased over time, almost one-third of patients enrolled in hospice within seven days of death or more than 180 days before dying. "Hospice stays shorter than seven days are too brief to maximize the benefit of enrollment, and individuals making shorter stays receive fewer services and benefit less from the input of the full interdisciplinary team," the authors write. "At the other end of the spectrum, the Medicare hospice benefit requires that a primary care physician and a hospice medical director certify that an individual's expected prognosis does not exceed 180 days when he or she is enrolled in hospice."

"Increasing appropriate hospice use may improve the quality of death for men at the end of life while rationalizing health care expenditures during this high-cost period," they conclude. (*For information on an editorial commenting on these studies, see story below.*)

### REFERENCE

1. *Arch Intern Med*. Published online Oct. 11, 2010. Doi:10.1001/archinternmed.2010.371, 10.1001/archinternmed.2010.365, 10.1001/archinternmed.2010.366. ■

## Palliative care essential for patients at end of life

"Countries around the world expend substantial resources to relieve the suffering caused by the burden of disease," writes **Rosemary Gibson**, MSc, in an editorial accompanying three articles examining health care at the end of life posted online that will be published in the Feb. 14, 2011, print issue of *Archives of Internal Medicine*.<sup>1</sup>

"Conversations that allow the patient to describe what is important as he or she lives life

with serious illness or near life's end should be paramount in guiding the course of treatment," Gibson writes. "High-quality palliative care — provided in hospitals, nursing homes, at home or in hospice — can help patients understand their illness and make informed decisions about their care, together with their families. It must be integrated into the care of patients in all settings."

"Only with the explicit goal of relieving the burden of illness, and relieving the burden of treatment, will health care systems fulfill their intended purpose of caring for the patient."

Gibson led the Robert Wood Johnson Foundation's strategy to improve end-of-life care for more than a decade and is the author of two books.

## REFERENCE

1. *Arch Intern Med*. Published online Oct. 11, 2010. Doi:10.1001/archinternmed.2010.360. ■

# Men dying of prostate cancer referred too late

More than half of men dying of prostate cancer use hospice care, which is a significant increase over the last two decades; however, most wait too long to enroll so they can't take full advantage of the palliative care that could make their deaths easier, a study by researchers at UCLA's Jonsson Comprehensive Cancer Center found.

The study also found that men with spouses or partners were more likely to take advantage of hospice care, while African American men were 20% less likely to enroll.

For hospice care to be most effective, patients should be enrolled for several weeks prior to their deaths. However, the study found most men enrolled just one to two weeks before they died, said **Mark Litwin**, MD, a professor of urology and public health, a Jonsson Cancer Center researcher, and senior author of the study.

"It's important that we maximize quality of life when quantity of life cannot be changed," Litwin said. "Most men are being referred to hospice too late, and that timing hasn't changed in the last 20 years, which is unfortunate. As cancer specialists, we should offer these patients the best quality of life that we can, and that often means offering them the best quality of death that we can give them."

The primary reason for the delay in referrals to

hospice is that oncologists often are loathe to give up the fight, and they aren't good at predicting how long patients have left to live. Additionally, medical students aren't taught that preservation of life may not be the sole goal in caring for patients.

"As doctors, we often don't want to give up. We've sworn to help our patients, and a death is a failure to us," Litwin said. "But the optimization of life should be our goal. Sometimes survival is of such poor quality that it should not be our primary goal."

Programs have been launched at the David Geffen School of Medicine at UCLA to address the importance of quality of life and palliative care, Litwin said. However, it can take a time to make a significant change in the institutional mentality.

Patients are not referred to hospice care early enough, agrees **David Wallenstein**, MD, a clinical assistant professor of family medicine who works with the UCLA Palliative Care Service and serves as medical director for the Skirball Hospice at the Jewish Home of Los Angeles. He has seen patients referred to hospice who die the same day they arrive.

"What would be ideal when a patient is referred for hospice care is that we have enough time to control their pain and symptoms and enhance their quality of life," Wallenstein said. "It's difficult to pinpoint exactly how much time is enough, but Wallenstein said "it would be nice to have at least a couple of weeks."

"If you have more time, you can fine tune the medications, try a variety of medications, and work to minimize side effects," he said. "You can control pain pretty easily, but is the patient going to be awake and alert? Most patients prefer to be interactive with their loved ones when the end is near."

Litwin's study also found that utilizing hospice care could decrease healthcare costs, as those patients were not prescribed costly, but ultimately futile, therapies. "In an era when increased attention is being focused on what to do to reign in runaway healthcare costs, there should be a clear focus on limiting therapies that ultimately will fail for these patients: costly chemotherapy treatments, more imaging studies, emergency room visits, lengthy ICU stays," Litwin said. "We need to eliminate costs that don't provide benefit and try to give our patients the most dignified deaths that we can."

For most prostate cancer patients, the arc from diagnosis to death is a long and often slow one, and men most often die from other causes before their prostate cancer can kill them. But there are about 30,000 men every year who will die from

their disease, and providing appropriate palliative care to this population is vital, Litwin said.

“Studies have shown that the quality of the death experience is much greater when everyone has the opportunity to face the issues and say the things they need to say,” he said. “Looking back, family members who use hospice rate the quality of the death experience much higher than those who did not use hospice.”

For the study, Litwin and his team identified 14,521 men aged 66 and older who died of prostate cancer between 1992 and 2005. Searching in-patient and physician claims, the team was able to identify those patients that enrolled in hospice care. Of the 14,521 studied, 7,646 or 53% used hospice care for a median of 24 days. About 22% of patients in the study enrolled within seven days of their death.

“Hospice stays shorter than seven days are too brief to maximize the benefit of enrollment, and individuals making shorter stays receive fewer services and benefit less from the input of the full interdisciplinary team,” the study states. “Increasing appropriate hospice use may improve the quality of death for men at the end of life while rationalizing health care expenditures during this high-cost period.”

The study was funded by the Urologic Diseases in America Project, which is sponsored by a grant from the National Institute of Diabetes and Digestive and Kidney Diseases, a part of the National Institutes of Health.

The study appeared Oct. 11, 2010, in the early, online edition of *Archives of Internal Medicine*. ■

## Ethical decision making reviewed with EOL care

In a review article published in the October issue of *Mayo Clinic Proceedings*, Mayo Clinic physicians differentiate the ethical and legal permissibility of withholding or withdrawing life-sustaining treatments and accepted comfort measures, specifically palliative sedation, from that of physician-assisted suicide or euthanasia.

Physician reviewers find that palliative sedation has an important place on the continuum of appropriate palliative care. “At the end of life, patient goals often shift to comfort, and removal of burdens and relief of suffering become paramount,” says lead author, **Paul Mueller, MD**, General Internal Medicine, Mayo Clinic. “Many

physicians are uncomfortable removing life-sustaining therapy or providing comfort-directed medication because of confusion about the ethical soundness of such treatments. In contrast to physician-assisted suicide or euthanasia, withdrawal of or withholding life-sustaining treatment and administering palliative sedation are ethically sound options.”

Palliative sedation is appropriate therapy for refractory and unacceptably severe suffering. “As with any other therapy, the patient or surrogate should be informed of potential adverse effects, including loss of social interaction and potential for life-threatening aspiration or respiratory depression,” Mueller says. “Palliative medicine teams should be involved, if possible, in any case in which palliative sedation is considered. We hope that by increasing familiarity with the ethical basis for these practices we will encourage their appropriate application.” ■

## Peds palliative care nurses have role at end of life

Despite great advances in cure rates, some children with cancer die each year. While pediatric oncology nurses have expertise in caring for children receiving treatment for cancer, during difficult times, including at end of life, many nurses are more comfortable “doing for” the child and their family than “being with” them.

This point was made at a session on “The Art of Pediatric Palliative Care Nursing” at the Association of Pediatric Hematology/Oncology Nurses (APHON) 34th Annual Convention, Oct. 14-16, 2010, in Minneapolis, MN. The speakers were **Kathy Perko, MS, PNP, CPON**, of Doernbecher Children’s Hospital in Portland, OR, and **Cynthia A. Stutzer, RN, MS**, of British Columbia Children’s Hospital in Vancouver, British Columbia, Canada.

Perko and Stutzer discussed ways to emotionally support a family at the time of a child’s death and strategies to improve communication with children and families at end of life. They noted that nurses often ask, “What do I do? What do I say?” as they struggle to provide high quality pediatric oncology palliative care. Perko and Stutzer addressed grief, companionship, getting to know each other, listening, reflecting, responding, and attending to the individuals physically, mentally, and verbally. They presented practical ideas to assist nurses in

developing their own “toolkits” as they learn and remember the art of being with a child and their family at the end of life.

We need both the science and art of nursing to care for children and their families at the end of life, the speakers said. They encouraged participants to not be afraid to “think outside the box” in providing pediatric palliative care. They said communication is the cornerstone in planning and providing care for children and their families. They said the presence of the nurse is a gift that only they can provide for families at the end of life. ■

## Outcomes of EOL talks seem to differ by race

While both black patients and white patients appear to benefit from end of life discussions with their physician, black patients are less likely to experience end-of-life care that accurately reflects their preferences, according to a report in the Sept. 27 issue of *Archives of Internal Medicine*.

“Although black patients are also more likely than white patients to desire life-prolonging measures, receipt of life-prolonging care at the end of life is associated with greater distress and with poorer quality of life,” the authors write as background to the study. “These findings raise the concern that black patients receive inferior end-of-life care, a possibility underscored by disparities between black patients and white patients in certain objective care measures, such as pain management.”

Jennifer W. Mack, MD, MPH, of the Dana-Farber Cancer Institute, Boston, and colleagues studied 332 patients who were recruited between October 2002 and September 2007, were self-identified as non-Hispanic white or black, had cancer with distant metastases with failure of first-line chemotherapy, were 20 years of age or older, and died during the course of the study.

The authors found that black patients reported similar rates of end-of-life discussions to white patients but were less aware that their illness was terminal. Compared with white patients who had not had end-of-life discussions with their health-care clinician, those that had end-of-life discussions tended to have a shorter survival time from baseline assessment. Additionally, the authors found that compared with black patients with fewer years of education, black patients with more education were marginally more likely to report having end-of-life discussions with their physician.

“Despite similar rates of end-of-life discussions, white patients were more likely than black patients to prefer symptom-directed care over life-prolonging end-of-life care and to have DNR [do not resuscitate] orders in place. White patients were also less likely to receive life-prolonging care in their last week of life.” The authors also found that, “although end-of-life discussions and communication goals assist white patients in receiving less burdensome life-prolonging care at the end-of-life, black patients tend to receive more aggressive care regardless of their preferences.” Additionally, black patients without DNR orders are just as likely to receive life-prolonging treatment as black patients with a DNR.

Based on the findings, the authors conclude that, “although the reasons for our findings are not fully understood, white patients appear to have undefined advantages when it comes to receiving end-of-life care that reflects their values.”

This study was supported by a grant from the National Institute of Mental Health, a grant from the National Cancer Institute, by a Fetzer Religion at the End-of-Life Grant, and by the Center for Psycho-oncology and Palliative Care Research, Dana-Farber Cancer Institute. ■

## Healthcare costs rise for cancer patients

### *Stopping hospice increases expenses*

Cancer patients who stop hospice care are far more likely to use expensive medical services, such as emergency care and hospitalization. Use of these services leads to healthcare costs that are nearly five times higher for patients who disenroll from hospice care compared to patients who remain in hospice, according to a study published in *Journal of Clinical Oncology*.<sup>1</sup>

Authors also found a higher than expected rate of disenrollment. More than 1 in 10 patients with terminal cancer (nearly 11%) who enrolled in hospice care ended up leaving. Reasons for disenrollment were not evaluated in the study.

Cancer patients who disenrolled from hospice care were more likely to be hospitalized (39.8% vs 1.6%), more likely to seek emergency care (33.9% vs 3.1%), more likely to be admitted to the intensive care unit (5.7% vs 0.1%), and more likely to die in the hospital (9.6% vs 0.2%).

Cancer patients represent the largest diagnostic group of hospice users. In the United States,

560,000 cancer patients were referred for hospice care in 2008. Previous research indicates that 11% to 15% of hospice patients disenroll from hospice care, the authors say. Factors such as being younger, not being white, being male, and having a diagnosis other than cancer are associated with hospice withdrawal, they note.

Researchers analyzed data from 90,826 patients who died with a primary diagnosis of cancer between 1998 and 2002 at 66 years of age or older. All patients used hospice services at some point in the six months before their death.

A total of 9,936 patients (10.9%) disenrolled from hospice care before they died, with a median of 28 days from hospice enrollment to disenrollment. More than half (57%) of patients who disenrolled died within 30 days. The authors also noted a pattern of enrollment, disenrollment, and re-enrollment in more than one-third (38%) of patients. Those who re-enrolled died a median of 24 days after re-enrollment.

#### REFERENCE:

1. Carlson MDA, Herrin J, Du Q, et al. Impact of hospice disenrollment on health care use and Medicare expenditures for patients with cancer. *J Clin Onc* 2010;4371-4375. ■



## Record number of patients receive hospice care

*Latest study reports 1.56 million served*

An estimated 41.6% of all people who died in the United States last year were under the care of a hospice program, according to the latest “Facts and Figures: Hospice Care in America” report produced by the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA. This statistic represents an increase over previous years: 38.8% in 2008 and 35% in 2007.

Statistics in the report are based on data from NHPCO’s annual survey, the National Data Set, and NHPCO membership data. Secondary sources include Medicare Provider of Services certification data, Medicare hospice cost report data, state-

mandated data submissions, and state association membership surveys.

Other findings include:

- The average length of service remained steady at 69 days. Median length of service also was steady at 21.1 days, which means half of hospice patients received care for less than three weeks and half received care for more than three weeks.

- Routine home care accounted for 95.9% of patient care days.

- At 68.8%, most hospice care was provided in the home, whether the patient’s home is a private residence, nursing home, or residential facility.

Facts and Figures: Hospice Care in America is available at NHPCO’s web site, [www.nhpco.org/newsroom](http://www.nhpco.org/newsroom). Look under the “News and Information on Hospice and Palliative Care” section of the page. ■

## Hospice program focuses on veterans

*Resources, tools address special needs*

More than 680,000 or 25% of all deaths in the United States each year are veterans. A new program provided by the National Hospice and Palliative Care Organization and the Department of Veterans Affairs offers hospices resources and tools to honor patients’ service and address the special needs of military veterans.

The resources of the program, We Honor Veterans, focus on respectful inquiry, compassionate listening, and grateful acknowledgment, coupled with veteran-centric education of staff caring for veterans.

Checklists and resources provide hospice staff with information that helps them understand the psychosocial, medical, and emotional needs that

### COMING IN FUTURE MONTHS

■ The benefit of therapy animals

■ Tips for hospices to meet cost report requirements

■ Hospice employee retention strategies that work

■ HIPAA update on new requirements

veterans may have that differ from patients with no military background. Information on ways to honor patients for their military service is also available.

Another part of the We Honor Veterans campaign provides recognition to organizations that demonstrate a systematic commitment to improving care for veterans. These “partners” will assess their ability to serve veterans and, using resources provided as part of the campaign, integrate best practices for providing end-of-life care to veterans into their organization.

To learn more about We Honor Veterans and to access the free resources, go to [www.wehonorveterans.org](http://www.wehonorveterans.org). ■

---

**To reproduce any part of this newsletter for promotional purposes, please contact:**

*Stephen Vance*

**Phone:** (800) 688-2421, ext. 5511

**Fax:** (800) 284-3291

**Email:** [stephen.vance@ahcmedia.com](mailto:stephen.vance@ahcmedia.com)

**To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:**

*Tria Kreutzer*

**Phone:** (800) 688-2421, ext. 5482

**Fax:** (800) 284-3291

**Email:** [tria.kreutzer@ahcmedia.com](mailto:tria.kreutzer@ahcmedia.com)

**Address:** AHC Media LLC  
3525 Piedmont Road, Bldg. 6, Ste. 400  
Atlanta, GA 30305 USA

**To reproduce any part of AHC newsletters for educational purposes, please contact:**

*The Copyright Clearance Center* for permission

**Email:** [info@copyright.com](mailto:info@copyright.com)

**Website:** [www.copyright.com](http://www.copyright.com)

**Phone:** (978) 750-8400

**Fax:** (978) 646-8600

**Address:** Copyright Clearance Center  
222 Rosewood Drive  
Danvers, MA 01923 USA

## EDITORIAL ADVISORY BOARD

Consulting Editor:

The Rev. **Jeanne Brenneis**,  
MDiv, STM  
Chaplain, Hospice of Northern Virginia  
Falls Church, VA

**Gretchen M. Brown**, MSW  
President and CEO  
Hospice of the Bluegrass  
Lexington, KY

**Earl Ash Evens**,  
MSW, MBA  
President and CEO  
AdvaCare Inc.  
Pittsburgh

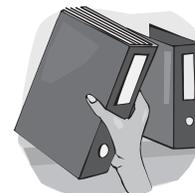
**Peggy Pettit**  
Executive Vice President and Chief Operating Officer  
Vitas Innovative Hospice Care  
Miami

**Claire B. Tehan**, MA  
Vice President, Hospice  
Hospital Home Health Care Agency of California  
Torrance, CA

## BINDERS AVAILABLE

**HOSPICE MANAGEMENT ADVISOR** has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **binders@**

**ahcmedia.com**. Please be sure to include the name of the newsletter, the subscriber number and your full address.



If you need copies of past issues or prefer online, searchable access to past issues, you may get that at **<http://www.ahcmedia.com/online.html>**.

If you have questions or a problem, please call a customer service representative at **(800) 688-2421**.

## 2010 Index

### Accreditation

Internet conferences target accreditation, FEB:24

Joint Commission changes survey agenda process, MAR:33

### Advanced directives

Advanced directives have evolved, AUG:93

Critically ill's wishes should be doctor's orders, AUG:92

Many elderly can't make decisions at death, MAY:56

Oregon POLST registry secures 18,000 forms, JUL:81

POLST helps avoid unwanted hospital stay, AUG:94

### Bereavement counseling

For caregiver, death at home is less trauma, NOV:131

Greater need for bereavement counseling, JUL:82

Peds palliative care nurses have role at end of life, DEC:141

Working through grief differs for every person, MAR:34

### Centers for Medicare & Medicaid

CMS proposes rules that will impact you, SEP:107

NHPCO objects to MedPAC projections, MAR:35

Payment fact sheet available from CMS, MAR:35

Physician narrative must be carefully evaluated, JUN:65

### Cultural competence

Guidance for Muslim patient care, JUL:82

Minorities with heart failure less likely to use hospice, APR:45

Outreach efforts pay off for award-winning hospice, NOV:121

Outreach program to Latino community, MAR:28

Reaching varied cultural groups requires education of staff, community, MAR:25

### Clinical issues

Are you talking to patients about deactivation of their ICDs? JUN:61

Best practices bring reduction of ulcers, JAN:6

Emergency medications produce good results, SEP:106

End-of-life care falls short for kidney disease patients, MAR:32

When looking for information on a specific topic, back issues of Hospice Management Advisor may be useful. If you haven't already activated your online subscription so that you can access the newsletter archives through the company web site, go to [www.ahcmedia.com](http://www.ahcmedia.com) and click on "Activate Your Subscription" in the left navigation area. Or contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Phone: (800) 688-2421 or (404) 262-5476. Fax: (800) 284-3291 or (404) 262-5560. E-mail: [customerservice@ahcmedia.com](mailto:customerservice@ahcmedia.com).

EOL care patterns shift for heart failure patients — Use of hospice for prostate cancer grows, DEC:138

Hallucinogen appears safe for some cancer patients, OCT:119

Improve risk assessment for pressure ulcers, JAN:4

Marijuana derivative eyed for pain treatment blocks, AUG:95

Men dying of prostate cancer referred too late to hospice, DEC:140

Meditation helps anxiety, pain relief, MAY:56

Music therapy taken to hospice patients, JAN:7

Oncology case managers guide patient treatment, SEP:105

Packets make assessments easy for nurses to perform, JAN:6

Pain med use varies in hospice care, AUG:94

Palliative care said essential for patients at end of life, DEC:139

Pediatric patients are more than 'little adults', JUL:76

Practices evaluated for pain assessment, JUL:82

Standards for pediatric patients offer support for community hospice, JUL:73

Treatment helps control involuntary outbursts? MAY:55

### Ethics

Academic centers offer resources to colleagues, JUL:78

Discussion of rationing end-of-life care, MAR:32

Ethical decision making reviewed with EOL care, DEC:141

Law and ethics complement each other, JUN:68

Legal developments from bioethics conference, FEB:17

Legality and ethics can create misperceptions, JUN:69

Montana is third state to allow aid in dying, FEB:21

Parents weigh whether to hasten death, APR:46

Relationships explored for patients, caregivers, APR:44

Should providers have right of conscientious refusal? FEB:18

When the patient wants to go home to die, OCT:113

### Financial

Brace for payment revisions under health care reform, MAY:49

Healthcare costs rise for cancer patients, DEC:142

NHPCO members receive fraudulent invoices, MAR:35

Outside experts can help with capital campaign, APR:39

### Health care reform

Brace for payment revisions under health care reform, MAY:49

Health care reform bills: side by side, JAN:11

Hospice-related changes in health care reform law, MAY:51

### Infection control

Hand hygiene woes impact *C. dif* response, JUL:76

Joint Commission hosts H1N1 forum, FEB:23

Mandated flu shots? Some staff say no thanks, OCT:117

Needlesticks increase with stressful environment, MAR:33

New era of transparency on health infection data, JUL:80

### Legal/risk management

Free legal guide available for end-of-life decisions, FEB:22

How to address report of a safety issue, APR:43

Is your web site being used in a fraud scheme? MAR:29

It's 11 o'clock at night — Do you know where your medications are? JAN:1

Needlesticks increase with stressful environment, MAR:33

Pay attention to behavior of family members, friends, JAN:3

Policy should outline steps for deactivation, JUN:64

'Safety comes first' should be more than a slogan, MAR:31

Use checkpoints to ID employee medication theft, JAN:4

Written agreements set clear delineation of duties, FEB:16

### Management

Adult day program adds to hospice service, OCT:113

Adult day services relieve caregiver stress, boost outcomes, SEP:97

Aiding transition from hospital to hospice, SEP:103

CoPs: Just the beginning for most hospices, MAY:52

Don't let language discourage use of hospice, MAR:29

Feasibility, financing, and design are keys to success of inpatient hospice,

APR:37  
Healthcare costs rise for cancer patients  
— Stopping hospice increases expenses, DEC:142  
Hospice program focuses on veterans — Resources, tools address special needs, DEC:143  
How to partner with your faith community, NOV:129  
Keep surveys anonymous for credibility, DEC:135  
Outcomes of EOL talks seem to differ by race, DEC:142  
Outreach efforts pay off for award-winning hospice, NOV:121  
Palliative care programs help challenging groups, JAN:9  
Policy should outline steps for deactivation, JUN:64  
Record number of patients receive hospice care, DEC:143  
Reaching varied cultural groups requires education of staff, community, MAR:25  
'Safety comes first' should be more than a slogan, MAR:31  
Take steps now to keep good employees, DEC:133  
Understand beliefs about death at admission, MAR:27  
Use checkpoints to ID employee medication theft, JAN:4  
Veterans have unique needs at EOL, NOV:126  
Would you like to reduce your weekend calls by 66%? AUG:85

### **Marketing**

Are you taking advantage of nursing home opportunities? FEB:13  
Education paves way for hospice support, FEB:15  
Homelike design appeals to patients and families, APR:40  
Is your web site being used in a fraud scheme? MAR:29  
Maximize social media through integration, OCT:111  
Nursing home patients have hospice potential, JAN:10  
Outreach program to Latino community, MAR:28  
Record number of patients receive hospice care, DEC:143  
Survey sheds light on lack of senior planning, OCT:116  
Want a marketing bonanza? Hospices use social media, OCT:109  
Your guide to social media, OCT:112

### **Palliative care**

Checklist published for in-home palliative care, APR:45  
Chronic pain increases risk of falls in older adults, JAN:10  
Consortium to expand vets' palliative care, AUG:91  
Meditation helps anxiety, pain relief, MAY:56

Most cancer centers have palliative care programs, MAY:58  
NHPCO comments on palliative sedation, JUL:83  
Palliative Care Act is law in New York, NOV:131  
Palliative care program falls short of hopes, OCT:115  
Palliative care programs help challenging groups, JAN:9  
Palliative care essential for patients at end of life, DEC:139  
Palliative care team, case managers help — Approach can cut LOS, patient throughput, DEC:136  
Patients live longer with palliative care, OCT:119  
Peds palliative care nurses have role at end of life, DEC:141

### **Patient education**

Cancer reports may paint overly optimistic view, MAY:57  
EOL video studied with cancer patients, MAY:54  
New book provides tools to assist caregivers, MAY:59  
Peds palliative care nurses have role at end of life, DEC:141

### **Patient safety**

Chronic pain increases risk of falls in older adults, JAN:10  
ECRI launches patient safety blog, JUL:84  
It's 11 o'clock at night — Do you know where your medications are? JAN:1  
Pay attention to behavior of family members, friends, JAN:3  
Psychotropic meds linked to risk of falls in seniors, JAN:12

### **Physicians**

CANCER study: Physicians and end-of-life discussions, APR:41  
Doctors' religious faith and end-of-life care, OCT:120  
How to initiate a difficult conversation, JUN:63  
MDs perspective on EOL spiritual care, NOV:128  
Physicians are trained to treat, APR:42  
Timing of discussion is sensitive to patients, APR:42

### **Quality improvement**

Best practices bring reduction of ulcers, JAN:6  
Improve risk assessment for pressure ulcers, JAN:4  
Packets make assessments easy for nurses to perform, JAN:6  
Technology helps hospices meet QAPI requirements, NOV:124

### **Regulatory**

CoPs: Just the beginning for most hospices, MAY:52

FDA issues requirements for infusion pump recall, SEP:104  
FDA launches initiative to reduce pump risks, JUN:67  
FDA orders Baxter to recall infusion pumps, JUN:66  
HHS asked to address advance directive issue, JUN:72  
Hospice-related changes in health care reform law, MAY:51  
Morphine sulfate solution receives FDA approval, MAR:31  
Should providers have right of conscientious refusal? FEB:18  
Written agreements set clear delineation of duties, FEB:16

### **Staff education**

Choose technology for ease of use, versatility, NOV:125  
Education paves way for hospice support, FEB:15  
Keep education fun for aides, JAN:7  
Program to combat 'compassion fatigue,' SEP:102  
Reaching varied cultural groups requires education of staff, community, MAR:25  
Webinars address grief counseling for children, APR:48

### **Staffing and recruitment**

Anonymous surveys bring out the truth, DEC:135  
Improve retention: Make safety a priority, APR:43  
In this economy, you can't afford to lose good hospice employees, DEC:133  
'Safety comes first' should be more than a slogan, MAR:31

### **Social services**

Develop strategies to improve communication, JUL:75  
How to initiate a difficult conversation, JUN:63  
New book provides tools to assist caregivers, MAY:59  
Peds palliative care nurses have role at end of life, DEC:141  
Spiritual support improves well-being at end of life, FEB:22

### **Volunteers**

Hospice volunteers exhibit specific traits, OCT:118  
New hospice manual for volunteers released, FEB:23  
Recognize volunteers' skills to enhance program, AUG:89  
'Tuck-in' calls prepare patients for weekend, AUG:87  
Vigils and flower visits provide extra support, SEP:100  
Would you like to reduce your weekend calls by 66%? AUG:85