

HOSPICE Management ADVISOR™

Integration • Outcomes • Managed Care • Medicare Compliance • Risk Management • QI • End-of-Life Care



AHC Media LLC

IN THIS ISSUE

■ Hospice CEO explains how Q&A project worked 51

■ Hopefulness, experience, and education are key to successful nurses with end-of-life patients 53

■ Nurse survey chart: Questions asked about care of dying children 54

■ Deactivating implanted cardiac devices: Inform patient, weigh benefits and risks . . . 55

■ Music and end of life: Harp provides therapy at end of life for patients, families 57

■ Wanted: Focused, motivated person to sell 58

MAY 2007

VOL. 12, NO. 5 • (pages 49-60)

Enhance employee satisfaction to improve family care and quality

Massages, celebrations, education are among strategies

Hospice employees and managers have probably felt at times that when staff morale is low, that's when more patient/family problems pop up.

Now, there's a little more evidence showing that employee satisfaction is closely linked to hospice family satisfaction, and that if a hospice improves the former, the latter will follow.

A Nashville, TN, hospice found that when its employee satisfaction was high, so was family satisfaction, which in turn, led to more referrals by families, a greater revenue growth.

"We noticed that as our employee satisfaction improved statistically, our family evaluation of hospice care improved also," says **Janet L. Jones**, RN, BSN, chief executive officer of Alive Hospice Inc. of Nashville, TN.

Alive Hospice began surveying employees five years ago, contracting with the Center for Nonprofit Management of Nashville. For the patient/family satisfaction measurement, the hospice uses the National Hospice and Palliative Care Organization's (NHPCO's) survey tool, Jones says.

"We looked at roughly three different years, 900 patients, and 300 employees," says **Stan York**, EdD, an assistant professor of strategic management of Belmont University in Nashville, TN.

"These employees are very loyal to the company, and the turnover is low," York says. "The more satisfied they are, the more loyal they are, and these loyal employees also are more productive."

With York's help, the hospice was able to take individual results from the employee survey and use these to predict outcomes on the family evaluation survey, Jones notes.

"Most people know intrinsically that happy employees make for happier hospice families," Jones says. "Now we know that the quality of patient care is better when employees are happy with their work environment."

NOW AVAILABLE ON-LINE: www.ahcmedia.com/online.html
Call (800) 688-2421 for details.

The employee satisfaction survey contains about 30 questions, with scaled answers, in a variety of dimensions, including task significance, competency, support, integration, structure, execution, and strategy.

It is distributed to staff through their payroll envelopes, and it contains a self-addressed, self-stamped envelope they can return to the survey contractor. The response rate has ranged from 49% to 75%, and the hospice now has more than 300 employees, Jones says.

Among the questions asked were these:

- Do you have time to do your job?
- Are you comfortable, or not comfortable,

with our growth and the direction we're headed in?

"We feel that if there's burnout, we expect it will be reflected in the overall satisfaction of employees, and this will lead to more turnover," York notes.

Researchers reviewed the literature about family satisfaction in hospice care and found that the volume of studies on this topic was small, he says.

They also compared hospice employee satis-

faction and patient satisfaction with the relationship between employee satisfaction and patient satisfaction in hospitals and Veterans Administration hospitals, he says.

"We found that the correlation between employee satisfaction and quality of the family was higher in the hospice industry than it was in the hospital or VA system," York says.

This is probably because the hospice industry is the most relationship-oriented of all health care industries, York says.

"We related these attributes of employee satisfaction back to the domains of care that were described in the family evaluation of hospice care, and we found a strong relationship between employee satisfaction and overall family satisfaction," York says. "We found that certain attributes of family satisfaction were more highly significant than others."

For instance, task orientation was highly related to quality of work, York says.

"We took some statistics we had about dimensions of satisfaction, like task significance, and the fact they're in hospice and it's very meaningful to them," York explains.

"We followed this linkage through the entire process, looking at various attributes of satisfaction and comparing these to coordination of care and symptom information," he adds.

So the quality improvement aspect of the survey was to address this question: "What do satisfied families do, and how does that help us as a company?" York says. "We know there are two outcomes: one is you have repeat business, and the other is they will refer us to other people."

Survey results showed that highly satisfied families were more likely to refer the hospice services to other people, he notes.

"What we did then is we compared that referral rating to improvement in the bottom line in terms — we compared it, for example, to their total revenue and to their total return on the equity and return on investment," York says. "And we found a very high positive correlation to the fact that these families will refer us to the organizational performance."

Here is how higher staff satisfaction might result in bottom-line business improvements:

- There would be an increase in revenue and days of care, York says.
- There was an improvement in the hospice's margin because its costs decreased, he adds.

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. 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@ahcmmedia.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 \$9.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. 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.ahcmmedia.com>.

Editor: **Melinda Young**, (864) 241-4449.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmmedia.com).

Managing Editor: **Leslie Hamlin**, (404) 262-5416, (leslie.hamlin@ahcmmedia.com).

Copyright © 2007 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 **Leslie Hamlin** at (404) 262-5416.

"This makes sense because if employees stay around and are loyal to us, then we don't have a large turnover problem and we get better at what we do," York says.

Investigators found that the correlation between family referral and revenue growth was 0.96 statistically, very close to a perfect correlation of 1.00, York says.

The relationship between employee satisfaction and overall family satisfaction was 0.95, and the relationship between family satisfaction and family referral was 0.83 — still very high, York adds.

"So that tells you satisfied families are likely to refer hospice services to others," he says.

The survey results also were used for the purpose of identifying quality-of-care deficits and correcting them.

The first survey's scores were not bad, but they showed some room for improvement, Jones recalls.

"We take the results from the staff survey and go over them with a statistician to see if there are areas that are red flags for us," Jones explains. "Then we engage an employee committee to look at those areas."

In some cases, the committee needed to investigate to find the root cause of a problem and what this means to the staff and the agency, she adds.

Employees' answers suggested that the hospice focus on several key areas for improvement, including the following:

- enhancing education and training program;
- coping with growth; and
- handling stress.

Based on these answers, the hospice made various improvements in these three areas, Jones says. **(See the following story on how a hospice improved quality and staff satisfaction.)**

Another use for the data will be to develop a tool to help hospices design their service delivery systems to improve quality-of-life care for patients, York says.

"We have developed a cross-walk that looks at the dimensions of employee satisfaction and then correlates this to dimensions of patient satisfaction," York explains. "So if you want to improve in one area of patient or family satisfaction, you can use this cross-walk to say, 'These are the dimensions of employee satisfaction I need to work on.'"

Need More Information?

☞ **Janet L. Jones**, RN, BSN, Chief Executive Officer, Alive Hospice, Inc., 1718 Patterson Street, Nashville, TN 37203. Telephone: (615) 963-4740. Email: janjones@alivhospice.org. Web site: www.alivhospice.org.

☞ **Stan York**, EdD, Assistant Professor of Strategic Management, Belmont University, College of Business Administration, 1900 Belmont Blvd., Nashville, TN 37212.

Although the pilot study with Alive Hospice suggested the cross-walk could work, it can't be generalized to the hospice industry just yet, York says.

"Our next step is to do something on a national level so we can do a more generalized pool," York says. "We know some hospices have employee satisfaction surveys, and some do not, and NHPCO is trying to develop a standard employee satisfaction survey." ■

How Alive Hospice improved care and staff satisfaction

Training, stress levels were addressed

A Nashville, TN, hospice used well-analyzed results from staff satisfaction surveys and family satisfaction surveys to improve the quality of care, as well as staff satisfaction.

Here's how Alive Hospice Inc. of Nashville made improvements based on the problems identified in the surveys:

1. Concern: The education and training program was inadequate.

One area that needed improvement, according to the initial survey's results, involved staff education and training, says **Janet L. Jones**, RN, BSN, chief executive officer of Alive Hospice.

"So we focused some energy on how we conducted our internal education program for staff, and beefed up that department," Jones says.

“Over the course of three years, we saw a statistical difference in how staff saw the support they received in education and training, and there was concomitant increases in parts of the family satisfaction with hospice care.”

The first step the hospice took was to restructure the education program and form a department called Organizational Excellence and Mission, which has a vice president in charge of this department, she says.

“We’ve focused more intensely on education, and not just on internal education,” Jones says. “We’ve also budgeted more dollars to send staff to different workshops outside the organization.”

For example, staff is sent to NHPCO seminars and local Tennessee hospice organization educational sessions, she says.

“We’ve also used the family evaluation of hospice care as a kind of guideline to what to focus on in our educational offerings,” Jones says.

Also, the hospice began to invest in an ongoing management and leadership training program.

“When we looked at the employee evaluation survey, we found there was a high level of stress in all employees, but it was higher for those in management than in those who were in direct caregiving,” Jones said. “So we invested some dollars in a robust management training program that we’ll continue to invest in.”

The improved staff training and education program has resulted in the hospice moving all of the required educational areas, such as infection control, to an on-line program so employees can complete these courses at their convenience in order to meet all of the requirements, Jones says.

Another educational offering is the hospice’s Ethics Grand Rounds, which are held every six months.

“It involves taking a particular case, usually a difficult hospice case, and we have a panel of ethicists and staff who present the case and talk about what the ethical implications are for the case,” Jones says.

“We talk about what the hospice has in place to support the staff in their ethical decision-making,” Jones says. “Sometimes we come up with things to address, such as developing a new policy.”

There also is an ethics roundtable discussion that is held on a quarterly basis.

“It doesn’t have an agenda, but we encourage a

discussion of ethical dilemmas for any employee who wants to come,” Jones explains.

2. Concern: Hospice was growing too fast.

“Surveys suggested that employees are concerned that we’re growing too fast,” Jones says. “In any organization when you experience a lot of growth, it’s difficult to find the time to take a breath and adjust to the growth you had before you step forward to grow some more.”

From staff satisfaction surveys, hospice administrators have learned that it’s important to communicate intently and clearly about the organization’s growth plans and strategy, Jones notes.

The key is to avoid surprises, she says.

“So we are very purposeful in all staff meetings held quarterly to share what’s ready to be shared,” Jones says. “Some things are in an early discussion phase and are not ready for primetime, but we’ll share everything we can about what our growth strategies are.”

Hospice leaders also listen to employees to hear what their concerns are in regard to the growth plans and strategies, she adds.

“We hold what we call ‘coffee talks,’ where I meet with groups of employees on a periodic basis to share what we’re doing and to hear individually about concerns regarding our growth strategies,” Jones says. “So it kind of keeps us in touch with what we’re doing.”

Any organization’s leaders need to keep in mind that growth is fearful to staff who worry whether they can deliver the intimacy and quality of care the organization is known for, while growing larger, Jones notes.

“I think those are valid concerns, and we need to stay in touch with what precisely are the areas we need to address because you don’t want things to slip between the cracks during the growth,” she says.

“So it’s important to stay in touch with staff and find out what they’re seeing and feeling,” Jones says.

3. Concern: Staff experienced high levels of stress.

“We found there’s a high level of stress involved in the hospice work here, and I don’t think that surprises anybody,” Jones says. “So this employee committee looks at what we need to do to address the high level of stress in the workplace.”

For example, the committee addresses these questions:

- How do we design things to provide support for staff?
- How can we apply the organization's cultural mission of providing radical loving care to better address employee stress?

The cultural program, called, "Infusion of Radical Loving Care Culture," involves the idea of getting people back in touch with why they came to work in the first place, and why their work is meaningful to them, Jones explains.

Other strategies for alleviating stress include having a masseuse visit the hospice office each payday to offer 15-minute massages to anyone in need, Jones says.

"We offer a lot of educational sessions about what employees can do personally to address their stress and remain healthy," Jones says.

Also, the hospice has a full-time employee health nurse, and there is a Weight Watchers meeting held on site, she says.

"There are discounts to workout facilities that are available to staff, and we encourage them to take care of themselves so they are able to take better care of others," Jones says.

The hospice also encourages the staff to have fun, and celebrations are held regularly.

"We honor employees at quarterly staff meetings, recognizing the wonderful things they do and the wonderful things they accomplish," Jones says. "Any excuse for a party around here is just great."

The all-staff meetings provide recognition pins to employees who have been at the hospice for three, five, 10, 15, and 20 years.

"We discuss the state of our organization at each of these meetings, so if people have questions about anything regarding quality performance, we can give a report on what the quality measures have shown, and answer questions," Jones says.

"We also sing 'Happy Birthday' to everyone who has a birthday in the quarter, and we serve the staff cake," she adds.

At Halloween, the staff dress in costumes and do reverse trick-or-treating, taking treats to patients and families in the 30-bed hospice residence on campus, she says.

"We have barbecues, jewelry sales, a book club, and we do all kinds of things to engage the staff and celebrate what they do, while having fun at the same time," Jones says. "Every time we come together we celebrate our work." ■

Hopefulness is a positive quality for end-of-life nurses

More education and experience also are benefits

Researchers at a large children's hospital found that nurses who were comfortable working with dying children and their families were also nurses who reported high levels of hopefulness.¹

"The study was prompted by our desire to see why it appeared that some nurses were more comfortable with end-of-life care and, in particular, talking to the families and having difficult conversations with them," says **Gina Santucci**, MSN, RN, nursing coordinator, Pediatric Advanced Care Team (PACT) of the Children's Hospital of Philadelphia, PA.

Investigators analyzed nurses' work experience, education levels, and hopefulness, and compared these to their self-assessment of competence in palliative care.¹

The study found that nurses with more nursing experience tended to express higher levels of comfort working with dying children and their families, and the same was true with nurses who had more years of education and higher levels of hopefulness, according to the Adult Dispositional Hope Scale.¹

Santucci wanted to include "hopefulness" in the study due to her own personal experiences as a nurse.

"I've worked on the floor and taken care of patients, and when I look back at my experiences, I can remember situations where I didn't feel hopeful about what I was doing," Santucci says. "Then there were other experiences that were equally difficult, but I felt everything was working well, and I felt hope had something to do with it."

The study was a Web-based questionnaire, and 932 nurses at the hospital were invited to participate, via email, in the questionnaire. Nurses also were reminded of the survey at staff meetings.¹

In all, 410 nurses completed the questionnaire, which is a 44% response rate, Santucci says. (See **Palliative care nursing survey sample questions, p. 54.**)

"We were happy that the response rate was over 20%," she adds.

"Our most substantial finding was with education," Santucci says. "Specifically in palliative care, that was the highest."

Nurses who had more hours of palliative care

education were the most comfortable in providing palliative care and talking about death and dying with their patients and families, Santucci says.

The Web-based survey included these kinds of questions, asking for a rating from four, which means extremely competent, to zero, meaning not competent, to assess a nurse's opinion of her/his own competency in each of these areas:

- proving nursing interventions to improve the child's quality of life;
- managing pain;

Survey asks nurses about problems that might occur

Survey can be found on-line

The following questions were included in a Web-based survey created by researchers at the Pediatric Advanced Care Team of the Children's Hospital of Philadelphia, PA. The survey's purpose was to determine whether a nurse's experience level, education level, and hopefulness were correlated with feelings of competence when dealing with palliative care patients and families.

The entire survey can be found on-line at http://www.pediatric-generalists.org/files/feudtner/RN_Survey.pdf.

Here are some of the sample questions:

Please rate your level of agreement from STRONGLY AGREE (4) to STRONGLY DISAGREE (0). "In caring for dying children, I frequently encounter the following problems:"

- Poor communication between the healthcare team and the family;
- Inadequate pain management;
- Inadequate symptom management;
- Uncertainty about the goals of care;
- Inadequate psychosocial support;
- Inadequate bereavement care;
- Inadequate spiritual support;
- Lack of cultural understanding;
- Lack of agreement between the healthcare team and the family about what treatment the child should receive;
- The healthcare team's reluctance to initiate conversation about hospice with the family;
- Lack of opportunity to discuss a child's death afterwards with the medical or surgical team;
- Difficulty in eliciting information from the family about a child's DNR/DNI status. ■

- managing other symptoms;
- talking with children and families about dying;
- emphasizing goals, not limitations;
- understanding the role of hospice;
- recognizing impending death;
- understanding advance directives;
- being sensitive to spiritual needs;
- being sensitive to cultural values and issues;
- understanding ethical issues surrounding end-of-life care; and
- knowing where to find help within the hospital when faced with an ethical dilemma.

Also, nurses with the most education reported feeling more competent, she adds.

The second highest correlation was between experience and feelings of comfort and competence in dealing with dying patients.

Researchers found that nurses with more experience expressed being comfortable with talking to dying patients and their families, Santucci says.

"But once nurses had five to six years of experience, their comfort level hit a plateau," she adds. "Also, their difficulty in talking with families was higher if they were new nurses, and would gradually decrease with years of practice, reaching a plateau at about 10 years of practice."

The study found that there also was a slight increase in comfort with higher levels of hope, Santucci says.

"With increased hopefulness, there was a significant decrease in difficulty in talking to families about end-of-life challenges, and there was a slight increase in confidence," she says.

The Adult Dispositional Hope Scale includes these eight questions, which a person will rate from definitely false to mostly false to mostly true to definitely true:^{1,2}

- I can think of many ways to get out of a jam;
- My past experiences have prepared me well for my future;
- I meet the goals I set for myself;
- I energetically pursue my goals;
- There are lots of ways around any problem;
- I can think of many ways to get things in life that are most important to me;
- Even when others get discouraged, I know I can find a way to solve the problem; and
- I've been pretty successful in life.

While the solution is fairly obvious with education and experience, enhancing hopefulness among nurses is more of a challenge, Santucci says.

"The question is, 'How do you engender

Need More Information?

☛ **Gina Santucci, MSN, RN, Nursing Coordinator,** Pediatric Advanced Care Team, Children's Hospital of Philadelphia, 34th Street and Civic Center Boulevard, Philadelphia, PA 19104. Email: santucci@email.chop.edu.

hope and how do you change things to make nurses more hopeful?" Santucci says. "How do you eliminate those things we do to take away hope."

There likely will be another study that looks at this issue, she adds.

"My ideas are that when people are dying at home, sometimes they get less and less visitors because people are not comfortable around death," Santucci says.

Although nurses in a children's hospital are wonderful, it's difficult sometimes for them to sit and be with a family, not saying much, but just being present, she explains.

"It's having an understanding of what the family may want, and that can only be done when you sit and listen for a long time," Santucci says. "It's hard to express, but when a child is dying, knowing what you need to do and being in tune with the child and family takes a lot of time, and it's difficult for everybody." ■

References

1. Feudtner C, et al. Hopeful thinking and level of comfort regarding providing pediatric palliative care: A survey of hospital nurses. *Pediatrics*. 2007;119:e186-e192.
2. Snyder CR, et al. The will and the ways: Development and validation of an individual-differences measure of hope. *J Pers Soc Psychol*. 1991;60:570-585.

When should you deactivate implanted cardiac devices?

Look to patient autonomy standards

Are internal defibrillators and pacemakers biofixtures, like artificial hearts, that should not be deactivated when a patient is dying? Or are they like any other external device — for example, supplemental oxygen —

that are protective of life but employed at the discretion of the user?

A survey of hospices in the Denver area shows that the issue of deactivating defibrillators and pacemakers arises often, and physicians vary widely in how comfortable they are with deactivating the devices. Doctors perceive a lack of adequate information, the survey reports.

James Kirkpatrick, MD, an echocardiologist at the Hospital of the University of Pennsylvania and an associate of the Center for Bioethics at Penn, says there is a lack of national guidelines that would help physicians — and patients — make decisions about implanted devices when the end of life approaches.

"On a national level, there hasn't been enough discussion about this," says Kirkpatrick. "The traditional agencies [American College of Cardiology, American Heart Association, Heart Rhythm Society, etc.] haven't come forward and addressed this issue. But many practitioners are very uncomfortable with turning them off."

But many patients themselves are anxious for their doctors to agree to turn off the devices when they are actively dying, so as not to artificially prolong their lives. This creates a dilemma for their physicians.

And more and more physicians are going to find themselves facing this question, as the number of patients with implantable devices skyrockets. Kirkpatrick says current data indicate that 3 million patients qualify for implantable devices, and 400,000 more come into qualification each year.

"So we're talking about a huge population, and before, there hadn't been much discussion about what to do with them at death," he points out. "Now we have all these patients [with devices] who get sick from cardiac disease or who are just getting older and getting other diseases that are going to be terminal, so we need more discussion on what to do with them."

Discuss devices early with patients

The survey of hospices in Denver, published in 2005¹, indicates that while the question of whether to deactivate internal cardiac devices arises often and there is clinical and ethical support for deactivating them, the decision to do so is accompanied by "high feelings and inadequate

information.”

The author of the study, **Jennifer Ballantine**, MA, writes that if a competent patient perceives that the device is interfering with a peaceful death and prolonging suffering, keeping the device going may constitute an “intolerable burden.” Relieving that burden, she adds, could be ample justification to deactivate the device.

Ballantine asserts that while the literature is “scant” on the subject of withdrawing or deactivating low-burden support technologies, such as defibrillators and pacemakers, there is no suggestion in the published papers that deactivating the devices might legally or ethically constitute physician-assisted suicide or euthanasia, even in patients completely dependent on the devices.

What needs to happen, Ballantine proposes, is that physicians and patients need to talk about implanted devices upon admission to hospice, or in other discussions about any end-of-life issues, particularly when the topic of extraordinary measures arises.

“Decisions made in advance can provide clear guidance for family and care team members,” writes Ballantine.

Nathan Goldstein, MD, an assistant professor at Brookdale Department of Geriatrics and Adult Development, Mount Sinai Medical Center, NY, asked about physician-patient discussions regarding deactivating defibrillators at Yale-New Haven (CT) Hospital in 2004, and found that the issue came up in only 27 out of 100 terminally ill patients (all of whom had defibrillators) at the hospital — sometimes, not until after the devices had delivered shocks that were painful to the patients, distressing to family members who witnessed them, or both. Among patients who had DNRs, the discussion still only took place 45% of the time.²

Part of the problem, Kirkpatrick says, is that electrophysiologists “are not trained to think about end-of-life care and hospice, and hospice physicians are not trained to think about the intricacies of defibrillator management.”

“Cardiologists are somewhere in the middle,” he adds.

One way to get clinicians thinking along the same lines, he says, would be to establish end-of-life and ethics education initiatives for electrophysiologists and cardiologists, and for primary care and hospice physicians on defibrillator management at the end of life.

Talking with patients about the benefits and drawbacks of disabling internal devices at the end of life not only allows the physician to fully inform the patient, but also may shed light on the patient’s reasons for wanting the device disabled.

“You have to look at why someone would be interested in turning it off,” says Kirkpatrick. “In the traditional sense, most people who make that decision have a terminal illness and don’t want to continue life unnecessarily. So [for them] it makes sense to turn it off, because they’re thinking that if they die from an abnormal heart rhythm, that is not such a bad way to die.”

Avoid unnecessary suffering

While most patients who undergo CPR or a shock from an implanted defibrillator are unconscious when it happens, sometimes patients are awake and aware of the shock, which they describe as being like a kick in the chest by a horse.

“Undergoing CPR and defibrillation is traumatic, and getting shocked multiple times while in hospice [as the heart rhythm falters] can be extremely distressing and painful,” Kirkpatrick says. “So there is an ethical issue involved — to relieve suffering. And when people have multiple conditions, they can be predisposed to unnecessary suffering.”

The action of a pacemaker, however, is less disturbing to the end-of-life scenario in most cases, Kirkpatrick adds.

“If you continue pacing, in most cases that won’t forestall death, because by the time a patient gets to the end of life, there’s a metabolic milieu that will probably prevent the pacemaker from capturing [the rhythm],” he explains. “So I wouldn’t necessarily turn [a pacemaker] off in most cases, and that seems to be the consensus.”

Until national guidelines evolve, Ballantine suggests using accepted ethics guidelines for discontinuing life-sustaining treatment when discussing deactivation of devices in competent patients. These guiding points include:

- The patient’s request is rational and consistent;
- The physician understands the patient’s condition, and the patient understands his or her options;
- Any conditions that might distort the

patient's judgment should be identified and addressed;

- A clear plan should be set up;
- A second opinion and/or ethics consult should be sought.

Should devices be recycled?

Reuse of internal defibrillators and pacemakers in humans is currently illegal in the United States (though pacemaker reuse in animals, usually dogs and horses, is common). But Kirkpatrick is among physician-ethicists who think the subject is ripe for discussion.

"After death, we found in surveying morticians in the Chicago area, most devices get thrown away if they are removed," he relates. "If they are still in the body, they get buried." (Implanted devices are removed before cremation.)

"We found that morticians really don't know what they are supposed to do with them. The device companies want them back, and the reason for that is they can do bench testing on the pulse generation to determine the error rate."

The official position of the Heart Rhythm Society is that the devices should be returned, but Kirkpatrick says pacemakers are finding new use via transplants in other countries.

"A missionary doctor can take them overseas and transplant them into patients who otherwise wouldn't get them," he explains. "Defibrillators probably are less useful, but pacemakers can be very important [to such patients]. When you consider someone in South America with Chagas disease [parasitic disease that can lead to cardiomyopathy, altered heart rhythm, and cardiac arrest], who is a laborer who can't work and support his family, a pacemaker would not only be lifesaving for the patient, but for the family as well."

There are still questions, though, about how to sterilize used devices adequately, as well as the reliability of recycled pacemakers and how to follow up with patients who don't have ready access to care.

References

1. Ballentine JM. Pacemaker and defibrillator deactivation in competent hospice patients: An ethical consideration. *Am J Hosp Palliat Care* 2005; 22;14.
2. Goldstein NE, Lampert R, Bradley E, et al. Management of implantable cardioverter defibrillators in end-of-life care. *Ann Intern Med* 2004; 141:835-838. ■

Harp provides therapy at end of life for patients,

Music calms agitation, regulates breathing

At the end of life, there often comes a point when there's nothing more, clinically, that can be done. That's when the music starts for some patients.

"There is therapeutic value in music when someone is actively dying," according to **Donalyn Gross**, PhD, LCSW, CMP, a Longmeadow, MA, social worker and thanatologist who provides therapeutic harp music to dying patients.

Gross has been a counselor to the dying and their families for three decades, but a few years ago she heard a therapeutic harpist playing at the bedside of a patient.

"I knew that's what I wanted to do," she says. A lifelong musician, Gross became a certified music practitioner through the Music for Healing and Transition Program in Hillsdale, NY (www.mhtp.org). As the acceptance of music therapy in health care gains acceptance, industry-wide protocols are being developed for training and certification of music therapists.

Jewish Geriatric Services, a Springfield, MA, nursing facility, received a grant in late 2006 to provide music to the terminally ill in their last hours of life. When a patient is actively dying, Gross is paged and family members are offered her services.

Often, they are the primary recipients of Gross's therapy. She plays for about 45 minutes on a portable harp designed to be easily moved and used in confined spaces.

"I would say a majority of patients aren't aware I'm there," says Gross. But as she plays — usually unrecognizable melodies in low tones — the patient's breathing regulates and slows, and agitation wanes.

"A big part of it is for the families. Sometimes they just need a break and they know someone is there to calm [the patient]," she says. "Sometimes they stay, and the music soothes them. It just makes the atmosphere very peaceful and comfortable."

The results of a study conducted by researchers at the University of Utah Center on Aging, published in 2006 in the *American Journal of Hospice and*

Palliative Medicine,¹ indicate that harp vigils at the bedside of dying patients could have a positive influence on both the agitation and wakefulness of the patients. The reasons for this, researchers speculate, could be that hearing is the sensory ability that usually functions until the end of life, and that music “can influence the heart and brain on a physiological and psychological level simultaneously.”

Harp music seems particularly effective, the Utah researchers found, a point agreed to by Gross and associations that promote music for end of life. Maybe because harp music is associated subconsciously with angels and death, Gross suggests; however, while harps are the most common, music therapists have reported similarly positive effects with other instruments.

“The important thing is, when you play music for the dying, you don’t want to play recognizable music, because you don’t want to bring that person back,” Gross explains. “You play in low tones, in certain rhythms, and you try to match the patient’s breathing, to calm them down.”

If Gross receives a page she can’t answer, hospice staff can play a CD she recorded of some of her music; other good substitutes are new age music (no lyrics) or recordings of nature sounds (waterfalls, rainforest, ocean sounds).

“We have had other [nursing home] residents wheel up to the door and listen while I’m playing for someone who is dying,” she recounts. “It is very relaxing and reduces stress. A couple of hospitals, I’ve heard, have harps in the operating room.”

Reference

1. Freeman L, Caserta M, Lund D, et al. Music thanatology: Prescriptive harp music as a palliative care for the dying patient. *Am J Hosp Palliat Care* 2006; 23;100. ■

Wanted: Focused, motivated person to sell

Hire sales person based on passion for selling

Hiring the right person for the job is the key to success for any business but in home health many managers are not sure how to identify the right person for a sales and marketing position.

Home health managers usually come from the clinical side of the agency and may have no sales experience in their background so it is harder for them to evaluate a candidate for a sales position, says **Lucy Andrews**, RN, MN, chief executive officer of At Your Service Home Care in Santa Rosa, CA. “We all love to take one person who is doing well in their job and move them to another position that is important to the agency because we trust them to do a good job,” she says. “Unfortunately, the nurse who is passionate about the use of telemedicine in home care may not be the right person to sell the agency’s telemedicine service to referral sources,” she adds.

“There are many clinical staff members who are enthusiastic about the service they provide and they want to tell others about it, but you have to look for someone who can close the sale,” says Andrews. “You need someone who can talk about the service and then ask the referral source to give your agency a try,” she explains. “This is the area with which many clinicians struggle,” she says.

It is also important to have a person who is dedicated to sales and marketing, points out Andrews. “Sales and marketing is an ongoing effort, not something that can be done between seeing patients,” she says. For this reason, you need to screen your candidates carefully to make sure that nurses who apply for the position understand that they won’t be working with patients, she adds.

It is not necessary to hire sales and marketing staff members who have only clinical or only sales experience, points out Andrews. “You are looking for a person who is excited about selling the agency’s services and getting results,” she says.

Home health managers may think they need someone with a clinical background because the “product” the person is selling is clinical, admits Andrews. “You can teach enough about your business to a non-clinical person but you can’t teach a person who doesn’t love sales how to sell,” she explains.

“A good sales and marketing person can talk about the benefits of using your agency’s services from the perspective of the referral source,” says Andrews. Talking in terms of reduced hospitalization, improved outcomes, and reduction of the cost of providing care, and how that helps the referral source’s business is important, she points out. “The sales person also needs to be able to communicate how the agency can make the refer-

ral source's job easier," she adds.

Because sales and marketing people are motivated by results and by money, you need to be clear about your expectations upfront, recommends Andrews. Develop your sales and marketing program with specific goals related to new admissions, development of new referral sources, or increase in specific programs, she suggests. "Tie these expectations to monetary rewards because sales people are motivated by money," she adds.

The type of pay structure for your sales and marketing staff depends upon your agency, says Andrews. "I've seen commission-only sales staff and salaried staff," she says. To improve motivation, salaried staff members usually have a bonus structure that is tied to goals met for new referrals or other aspects of the business, she adds.

Once you have hired the right person, be sure to provide the tools that he or she needs to do the job, warns Andrews. "If you do hire someone with no home health experience, arrange for her to go on several home visits that represent your core business as well as any special programs you offer," she says.

Even if you hire people with clinical experience, they won't know everything about every type of care, so be sure they have a list of resources within the agency for questions. Also, make sure they have access to data that helps identify potential sources of new admissions, says Andrews. "We have preconceived ideas about who our best referral sources are, but when a sales and marketing person evaluates the data carefully, other sources may prove more valuable," she says.

Have your marketing person look for the referral source, the type of patient typically referred, and any referral trends, Andrews suggests. The "A" list of contacts should include sources who frequently refer patients and represent a great deal of volume, who refer patients who do have insurance or other means to pay, who have the potential to refer more patients, or who see patients that are appropriate for the agency's specialty services. Your "B" list may include sources that have potential but not as great as the sources on the "A" list. "Market to both the A and B lists, with the emphasis on the A list at the beginning," says Andrews.

Make sure your sales and marketing person knows when to drop a source from the marketing list, recommends Andrews. "If you haven't received a referral from a source that you are visiting two times a month over six months, give up," she says. She adds, "You don't want your sales staff wasting their time, not when there are other sources for new referrals." ■

Heart failure patients present challenges

Comorbidities, patient attitudes make care difficult

Patients with heart failure may be among the most challenging for case managers who are coordinating their care. Patients with heart failure must take multiple medications, eat a low-salt diet to keep their condition under control, and monitor their condition constantly. And even if they do everything right, they are likely to find themselves back in the hospital or emergency department several times a year.

"Heart failure has substantial quality-of-life implications for patients. It has a higher mortality rate than most cancers, and it's difficult to get patients to manage their condition because they think it's an episodic event and not a chronic disease," says **Jill Howie-Esquivel**, PhD, RN, FNP, associate clinical professor at the University of California-San Francisco School of Nursing.

It's also an expensive disease. The American Heart Association estimates that heart failure will cost \$26.9 billion in direct and indirect costs in 2006 for the 5 million people with the condition. The organization estimates that about 500,000 patients are diagnosed with the condition every year. Heart failure deaths have doubled since 1979 and average 250,000 a year.

"Congestive heart failure is one of the largest admitting diagnoses to acute care hospitals. It's a diagnosis with a high mortality rate, and patients with heart failure consume a lot of health care resources, says **Pam Hagley**, RN, BSN, MSHA, ACN, director of clinical resources at New

COMING IN FUTURE MONTHS

■ Encourage more donations to hospice following these strategies

■ Hospice care in nursing homes reduces end-of-life hospitalizations

■ NHPCO discusses palliative care survey results

Hanover Regional Medical Center in Wilmington, NC.

A telephonic case management program for heart failure patients who have been discharged from the hospital has cut readmissions and reduced length of stay, Hagley says.

Many heart failure patients also suffer from depression, a condition that makes it difficult for them to manage their condition, points out **Rick Precord**, MSW, director of clinical care management at Health Alliance Plan (HAP) in Detroit.

HAP's case managers screen all their heart failure patients for depression and refer those who screen positive to the health plan's behavioral health specialists.

When Howie-Esquivel conducted a study of heart failure patients to determine what factors can be used to predict which patients would be readmitted to the hospital, she found that an astonishing 50% of the 72 patients she followed were readmitted within 90 days.

The average age of the patients was 61, and 50% were anemic upon admission and scored 3.25 on the New York Heart Association Classification for Congestive Heart Failure, a four-point scale for classifying heart failure patients.

She looked at clinical factors and activities of daily living, such as how far the patient could walk in six minutes. Her studies showed that women and people who are not white are more likely to be hospitalized. "I was surprised to find that gender and ethnicity were stronger predictors of outcomes than hard clinical data," she says.

One factor may be that the women patients were more frail than the men. They couldn't walk as far, an indicator that they might have problems taking care of themselves at home, Howie-Esquivel says.

Another factor could be that many heart failure patients do not understand their disease. They don't understand that they have a chronic illness that won't ever go away.

"Patients don't understand that when they leave the hospital, they still have heart failure. They think it's like pneumonia. You have it and you're treated and then you're cured," says **Renee Slater**, RN, a case manager with New Hanover Medical Center's telephonic heart failure case management program.

Case managers should work to help heart failure patients understand that they must think about their disease every day, monitoring their sodium intake at every meal, weighing themselves every day, and calling their doctor if they gain weight,

Editorial Advisory Board	
Consulting Editor:	
The Rev. Jeanne Brenneis, MDiv, STM Director, Bioethics Center Chaplain, Hospice of Northern Virginia Falls Church, VA	
Gretchen M. Brown, MSW President and CEO Hospice of the Bluegrass Lexington, KY	Pamela S. Melbourne, RN, MN Director of Clinical Services Hospice Atlanta Atlanta
Earl Ash Evens, MSW, MBA President and CEO AdvaCare Inc. Pittsburgh	Peggy Pettit, RN Vice President Patient/Family Services Vitas Healthcare Corporation Miami
Bonnie Kosman, MSN, RN, CS, CDE Director of Patient Care Lehigh Valley Hospice Allentown, PA	Claire B. Tehan, MA Vice President, Hospice Hospital Home Health Care Agency of California Torrance, CA

Howie-Esquivel says.

"Heart failure patients are notorious for having high rates of readmission around the holidays and in the winter months when they may be eating a lot of canned soups, gravies, and broths. Case managers should caution them to be particularly careful about their diets during the holidays," she says. Case managers should urge patients to write their weight down and to understand that gaining three pounds in a day or five pounds in a week is a signal that they are going to have problems, she adds.

"Case managers should remind patients that if it's harder to sleep at night or they're more short of breath, this could be an indication that they are getting in trouble and may need their diuretic dosage adjusted," she says.

Get a sense of the patient's condition by asking them specific questions about activities of daily living, Howie-Esquivel suggests.

If you feel that a heart failure patient could benefit from exercise, talk to the physician about ordering an exercise program. "We know that exercise benefits patients with heart failure, but it's extraordinarily rare to find a heart failure patient involved in an exercise program. Being involved in an exercise program can't harm the patients, and it can help keep them out of the hospital," she says. ■