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## Want to enhance minority enrollment? Study suggests opportunities exist

Hospices are responding to the challenge of improving patient enrollment among minorities, and recent research shows that hospice's quality of care is perceived as high among African Americans. But experts say challenges and opportunities remain.<sup>1</sup>

"We know from previous research that African Americans perceive their quality of end-of-life care is poor," says **Stephen Connor**, PhD, vice president for research and international development at the National Hospice & Palliative Care Organization (NHPCO) in Alexandria, VA. However, a new study found that once African American patients are enrolled in hospice care, their perceived quality of end-of-life care improves.<sup>1</sup>

Using data from a family evaluation of hospice care survey, investigators reviewed information regarding more than 4,000 African Americans and 97,000 whites, Connor says. "We found that basically African Americans evaluate their experience once they get into hospice about the same as whites," Connor says. "So this disparity in end-of-life care seems to improve dramatically after they get into hospice care."

There remain issues about palliative care and a resistance to receiving it, but once African Americans are referred to hospice care, those are resolved, and they appear to be happy with the care they're receiving, Connor adds.

### *Disparities in noncancer diagnosis*

Another recent study has found that hospice enrollment of African American patients with a noncancer diagnosis has increased, but disparities between African Americans and whites remain.<sup>2</sup> "In 1999, 42% of African Americans had a noncancer diagnosis, and by 2003, this was up to 49.7%," says **Kimberly S. Johnson**, MD, an assistant professor of medicine at Duke University School of Medicine in Durham, NC. Among Caucasians, it was 57.9% who had noncancer diagnoses in 1999, and 64.3% in 2003, Johnson says.

"Many studies discuss health care disparities, but we focused on

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noncancer diagnoses because noncancer diagnoses have grown so much in hospice, and many people see these as less traditional [patients] than cancer patients," she says.

A possible reason for disparities in enrollment is a lack of knowledge about how hospices can serve noncancer patients, Johnson says.

"Some data from studies say African Americans know less about hospice," Johnson says. "Another thing that might be important is the idea that's supported by a number of studies that African Americans are more likely to want life-sustaining therapies at the end of life."

Several hospice CEOs say their hospices have worked hard in recent years to improve access to hospice among African Americans and other minorities and to improve perceptions of care among those enrolled. "In the African American community, we've been using the faith-based community as an entry point," says **Malene Smith Davis**, MBA, MSN, RN, CHPN, president

and CEO of Capital Hospice in Falls Church, VA.

There are five megachurches serving African American communities in one county of the hospice's service area, so Davis has targeted those as places to market hospice services. This idea came from an African American U.S. congressman whom she'd invited to speak with the hospice staff about public policy issues. "While he was there learning about the hospice benefit, we were able to share with him that we were not able to serve the African American population as much as we'd like to," Davis recalls.

The congressman suggested Davis write letters to the large churches. He signed them as a way of introducing the hospice to African American congregations. The hospice has received some speaking engagement requests since the letters were sent out in the fall of 2007, Davis says. "We're recruiting volunteers from them," she says.

Also, the hospice has had inquiries from African Americans who would like to serve on the hospice's board, she adds. "We're looking for some new board members," Davis says. "We want to reach out to people who can teach us and help us progress and move down this path of sharing this good work that hospice does," Davis says.

### ***Increasing bilingual workers helps***

Capital Hospice also has worked hard to increase the number of hospice workers who speak Spanish and are Latino, says **Emily J. Pezzulich**, creative advisor for Capital Hospice. (See story on Capital Hospice's Latino outreach program, p. 16.)

"Our human resources department is actively recruiting bilingual and Latino staff in the local Spanish-language newspapers," she says. "In 2008, we will have a presence in various Latino job fairs, and we often cover costs for certain types of training as an incentive for Latino job-seekers."

It's Capital Hospice's goal to increase the ranks of people receiving hospice care from all races, creeds, and religions, Davis notes.

Other hospice CEOs also express concern about the challenges they've faced in diversifying their staffs and patient populations. Hospice of the Bluegrass in Lexington, KY, has focused on recruiting and retaining African American staff, says **Gretchen M. Brown**, MSW, president and CEO. "We have had limited success with that, particularly with clinicians," Brown says. "We have excellent African American employees, but

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#### **Editorial Questions**

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we don't have as many as we'd like to see in the professional, clinical positions."

If the hospice had the same proportion of African Americans in clinical positions as there are African Americans in the community, then it would make a big difference in improving perceptions of hospice care among African Americans, she says.

Covenant Hospice in Pensacola, FL, which serves 35 counties in Alabama and Florida, tracks referrals according to demographics to make certain all members of the community are well served, says **Dale O. Knee**, MHCA, president and CEO. "We want to develop a better understanding within a cultural group and learn why there might be variances within the referrals," Knee says.

Covenant Hospice recruits minority staff at minority job fairs within the community and encourages staff to refer minority job applicants, he says. "If a registered nurse who is a minority recruits minority nurses to fill in open positions, then that's celebrated," Knee says. "We don't pay them a bonus, but we have other ways of recognizing them by making the person an employee of the month or year."

One of the hospice organization's most successful ways of improving hospice access among minority communities is its use of community advisory groups. **(See story on tips for improving hospice's reach into ethnic communities, p. 17.)**

"We have advisory groups at each of the 13 branch operations, and these are made up of minority populations within those communities and minority members of our staff," Knee says. "Those advisory groups talk about real and perceived barriers to access to care at Covenant Hospice, and we develop strategies on how to reduce those barriers."

Most of the advisory groups meet quarterly. Members are recruited from within the hospice organization's volunteers, and minority staff members are asked to suggest people they know in the community, Knee says. "In some cases, we've more proactively gone out to minority leaders in the community and sought their advice and assistance in recruiting group members," he says.

The branch office directors and community educators also attend these meetings and discuss with the group how the hospice can improve minority access, he adds. Hospice professionals facilitate and encourage a group leader to emerge

from the community members, Knee says.

Each group reviews the referral demographic data and looks for opportunities to better serve its community. They come up with suggestions for how to increase awareness of what hospice offers among ethnic groups, Knee adds. "We've had groups that are the most effective in terms of having an open exchange of information and guidance to us," he says. "We've had a measurable increase in referrals from minority populations."

### ***Group's suggestions quickly implemented***

Because the hospice's community educators participate in the advisory group meetings, they quickly can implement suggestions made by members, he notes.

For example, one interesting comment some advisory group members made is that the way hospice professionals describe hospice services might need to be changed with different populations, Knee says. "For one cultural group, it might feel like an insult when a hospice worker says that hospice is there regardless of your ability to

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pay," he explains. "Some people have a high level of pride and don't want to be characterized as indigent."

Also, some cultures are sensitive to being characterized as less affluent than others, and hospice workers need to be sensitive to those feelings, Knee says. "Even with well-intentioned language that all of us use every day, we might not be using the appropriate language for a certain culture we're serving," he adds.

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1. Rhodes RL, Teno JM, Connor SR. African American bereaved family members' perceptions of the quality of hospice care: Lessened disparities, but opportunities to improve remain. *J Pain Symptom Manag* 2007; 34:472-479.

2. Johnson KS, Kuchibhatla M, Tanis D, et al. Racial differences in the growth of noncancer diagnoses among hospice enrollees. *J Pain Symptom Manag* 2007; 34:286-293. ■

## Program targeting Latinos addresses mix-ups

*Key is to build trust, cultural understanding*

When Capital Hospice of Falls Church, VA, started an outreach program for the region's Latino community, one area that received a great deal of attention was in choosing the program's name of *Caminando Juntos*.

"*Caminando Juntos* means 'walking together,'" says **Emily J. Pezzulich**, creative advisor for Capital Hospice.

The outreach program's name is intended to emphasize how hospice care is not intended to take the place of the family, but it is intended to serve with the family in caring for a person at the end of life. "In the Latino/Hispanic culture, families take care of their own," she notes. "Multiple generations of families often live in the same home, and births, deaths, and everything in between typically occur at home."

This multigenerational experience underscores the important and deeply entrenched belief that no one can take better care of a family member than the family, Pezzulich says. Because of this, hospitals often are viewed with distaste and suspicion, particularly if they are overcrowded and understaffed, and this distaste is transferred to the word "hospice," Pezzulich explains. "To the extent Latinos have heard about hospice care, it is

perceived as a facility with all of the attendant negative associations," she says. "In our experience, very few Latinos understand that hospice is care that can be provided at the patient's home or wherever he or she lives."

## Program provides valuable support

Capital Hospice's goal with *Caminando Juntos* is to teach the Latino community that hospice provides valuable support to families who are caring for a loved one who is seriously ill and that it does not take place of the family, Pezzulich says.

"It helps the family provide even better care for their loved one," she says.

Since the program began in September 2007, hospice referrals have increased significantly, Pezzulich says. For example, there was one terminally ill Cuban man who wanted to go home from the hospital to be with his wife, although he was afraid to be home alone when she was working, Pezzulich says. "Additionally, the wife belonged to a church, members of whom were constantly telling her that hospice would 'kill' her husband," Pezzulich adds. "The hospital had indicated that the only way he could go home was with hospice care."

A *Caminando Juntos* social worker spoke with the man and his wife to explain what hospice was and how it could help them. The man then decided to enter the hospice program, and he received continuous care for several days until he and his wife were comfortable with the situation, she adds. "He then had our standard home care program with Spanish-speaking CNAs and nurses visiting regularly," Pezzulich says. "He died in our care after 21 days."

Through *Caminando Juntos*, the hospice trains volunteers to speak to various leaders in the Latino community and to Latino groups.

Volunteers and staff outreach workers need to be trained to understand Latino traditions and cultural nuances, including the traditions, foods, and customs of different Latin American countries, Pezzulich says. Also, Spanish-speaking people need to be on staff to take phone calls and admit and care for patients, she adds. "We spread the word via informational booths and tables at Latino health fairs and festivals, faith communities, city and county agencies, and Latino-owned businesses, Pezzulich says.

Outreach workers distribute Spanish language literature about the program, and they have

begun to hang posters in store windows and on community bulletin boards. "A Spanish-language web site and educational radio programs to be aired on local Latino radio stations are currently in development," she says.

The Caminando Juntos program is building trust and a referral base among Latinos, often one family at a time. For example, one woman who recently was a hospice patient had been very cautious about entering the program because her family and friends had told her that hospice people would kill her if she went into the inpatient center for care, Pezzulich recalls. "Fortunately, the family chose to speak to our Caminando Juntos liaison, who explained the real purpose of the inpatient center — to provide short-term care to get difficult pain and symptoms under control," Pezzulich says. "The woman was admitted to the inpatient center and received excellent care, with her family members at her side."

The woman died while in the inpatient center, but her family was so pleased with her care that they've made it a family mission to educate others about hospice care, Pezzulich adds.

Hospice is a win-win situation for the Latino community, and it's up to hospices to get that message out, Pezzulich says. "Latino families will get much-needed medical, emotional, spiritual, and practical support in their homes, from compassionate and trained caregivers," she says. "And we have the privilege of teaching about and providing a highly beneficial service to a grossly underserved and rapidly growing community right in our own neighborhood." ■

## Tips for increasing minority staff, access to care

*Outreach in key communities is crucial*

Hospice leaders and other experts say that hospices can improve their ratio of minority staff and increase referrals among minority patients by making this a goal and implementing creative outreach programs.

Here are some of their suggestions:

- **Attend ethnic festivals and market in ethnic media.**

The Hospice of the Bluegrass in Lexington, KY, makes a point of having a presence at the area's annual Roots Heritage Festival, says **Gretchen**

**M. Brown, MSW, president and CEO.**

"We have Hispanic and African American radio stations and newspapers in our communities, and we attempt to get stories in them," Brown says.

- **Employ more minorities.**

"At the end of life, people tend to cling to more familiar institutions, customs, and networks, so hospices that have African American nurses, nursing assistants, chaplains, and social workers might be more attractive to African American patients," says **Kimberly S. Johnson, MD**, an assistant professor of medicine at Duke University School of Medicine in Durham, NC.

- **Recruit ethnic and bilingual volunteers.**

"We are seeing an increasing number of Hispanic patients, many of whom are taking care of family members who don't speak English," Brown says. "We have some Spanish staff and bilingual employees, but we're also recruiting volunteers who speak Spanish, and we offer Spanish lessons here."

Hospice of the Bluegrass offers staff a six-week, basic Spanish course that is provided in collaboration with the adult education office of the local school district when needed, Brown says. Other hospices might contact their local school district office to inquire about the availability of bilingual teachers and the costs of having them teach on-site, she suggests.

- **Train staff to listen to patient's needs and be open to cultural differences.**

"When people do end-of-life care well, they offer culturally appropriate communication," Johnson says. "They listen to patients and families when they discuss their own beliefs about care and show that they'll respond to their needs and concerns."

- **Provide education to minority staff to improve their careers.**

Sometimes the problem is that there aren't enough minority professionals on staff.

This is an opportunity for hospices to recruit minority professionals through providing training and education that will help nonprofessional staff move into a professional position.

Capital Hospice in Falls Church, VA, had a young Latina worker who cleaned the building, says **Malene Smith Davis, MBA, MSN, RN, CHPN**, president and CEO. "I was talking to her one day and learned she wanted to become a certified nursing assistant [CNA]," she recalls. "I said, 'Why don't you look into schooling?'"

The woman said it costs \$1,400 to take the classes she'd need, and she couldn't afford it. At

the time, Capital Hospice didn't have education funds to cover that cost, so Davis paid for her coursework out of her own personal funds. The woman earned her CNA certificate and now is a dedicated employee, she reports.

Inspired by this experience, Davis had the hospice start a scholarship fund that pays for staff to improve their professional education. "We need to be looking for employees like her because you never know who is in your midst," she says.

- **Market hospice on a broader scale.**

The National Hospice & Palliative Care Organization (NHPCO) of Alexandria, VA, started a program, which now is a separate organization Foundation for Hospices in sub-Saharan Africa (FHSSA), in which hospices can partner with hospices in sub-Saharan Africa, Brown says.

"So we have a partner hospice in South Africa, and we hold fundraisers for it," Brown says. "Our plan is to use this partnership to [garner] some interest in the greater community." (See resource box below for information on how to contact FHSSA.)

- **Educate staff to change attitudes about different cultures.**

Sometimes an obstacle to improving hospice access to minorities is a misperception among hospice staff. For example, Brown has sometimes heard hospice staff say that a particular culture doesn't need hospice care because they're more family-oriented and take care of their own. "Generalities about ethnic groups are always dangerous," she says.

One way to overcome this barrier is to provide hospice staff with education and teaching sheets about diversity and dealing with different cultures, Brown says. NHPCO provides some diversity and cultural information, she says. (See resource box, below left, for NHPCO's contact information.) Some hospitals also have such material available.

- **Provide a community bereavement program.**

Bereavement programs are an excellent way to provide outreach to the entire community, including minority groups, Brown suggests.

Hospice of the Bluegrass started a bereavement program that has blossomed into a partnership with various groups in the community, and it's provides a good example of the kind of help hospice offers, she says. "In many cities, you have young men dying of violence and drug abuse problems," she says. "We wanted a community bereavement program for people impacted by these issues." (For more information on bereavement groups, see story, below.) ■

## Need More Information?

For more information on minority staff and referrals among minority patients, contact:

- ▣ **Foundation for Hospices in sub-Saharan Africa**, 1700 Diagonal Road, Suite 630, Alexandria, Virginia 22314. Telephone: (703) 647-5176. E-mail: info@fhssa.org.
- ▣ **National Hospice and Palliative Care Organization (NHPCO)**, 1700 Diagonal Road, Suite 625, Alexandria, VA 22314. Telephone: (703) 837-1500. Web: www.nhpco.org. Also, specific and free information about different cultures and diversity can be found at NHPCO's Caring Connections web site: www.caringinfo.org/Community/Diversity\_Outreach.htm.
- ▣ **NHPCO's "Inclusion and Access Toolbox"** is a collection of suggestions and successes based on the thoughts and experiences of hospice providers in many settings throughout the United States. It highlights populations with diverse economic, education, sexual preference, and physical and other abilities. It's available for sale on the NHPCO web site (www.nhpco.org under "Catalogs") for \$24.99 for NHPCO members and \$39.99 for nonmembers.

## Outreach includes bereavement support

*Providers share tips for successful groups*

A California hospice has found that its bereavement center and support groups have been successful in promoting hospice care and helping members of the public with grief after a loss.

In 2000, TrinityCare Hospice of Redondo Beach, CA, founded the Gathering Place in partnership with the Beach City Health District as a way to help everyone in the community who has experienced a loss, says **Claire Towle, LCSW**, director of the Gathering Place.

The drop-in center is open from 10 a.m. to 4 p.m. weekdays, although it's available for longer hours when needed. It has a welcoming room for people to gather and read bereavement information, and it has a room that is used by support

groups, she says. "We have music and soft lights," Towle says. "There also is a child's playroom with art therapy activity, games, and toys."

The center is for loss and life transitions, but it's also marketed as a preventive care program, Towle notes. "It's our belief that if people receive the bereavement support they need, then we can reduce the number of long-term mental health problems related to long-term grief, anxiety, depression, substance use, social isolation, and anger," she explains.

The program has many anecdotal examples of its success, particularly among people who participate in the bereavement groups, Towle says. "We have a very positive image in the community, and people feel that hospice is doing a wonderful service for the community because of the bereavement center," she says. "We've received referrals from hospitals, churches, and word-of-mouth from people who were happy with our services."

A recent survey evaluation, developed at the center, was sent to support group participants. It elicited very positive comments about how rewarding the program was, Towle says.

The bereavement center and support groups also have helped TrinityCare Hospice recruit more volunteers among the people who first received grief counseling and support and then decided to volunteer to help others receiving hospice care, Towle says.

During 2006 and 2007, the nonprofit center served 757 clients with funding from the TrinityCare Hospice foundation, and public grants and donations, she says. Referrals come from the hospice, as well as from the community. "The hospice bereavement coordinator tells families about our program and gives them a packet of information," Towle says.

### **Maintain support groups**

One of the reasons for the bereavement center's success is that the support groups are carefully maintained. Bereavement experts follow a curriculum, developed at the center, for the support groups and provide additional information and handouts, also developed at the center, to members.

"At the same time, we go with the flow of the needs of the group," Towle says. "We find a balance between having an agenda and providing information that's supportive."

Here are the center's strategies for maintaining

successful support groups:

#### **1. Provide a basic structure.**

Support groups are offered in nine-week sessions instead of the drop-in type of support groups that continue indefinitely. "We also charge a small amount for adult support groups of \$75 for a nine-week program and \$10 for each drop-in group," Towle adds. "We started charging the fee two years ago as a donation that can be waived if someone cannot pay it." No one has complained or asked to have the fee waived, she adds.

The fee covers some of the nonprofit organization's costs, including materials costs, the salaries of two facilitators who run the support group, an average of one hour per participant in preparation time, and the time spent calling support group members in follow-up, Towle says. "A person's grief process is so important that it seems like an important investment for them that they want to pay for it," Towle says.

There is a skeletal curriculum that's individualized based on the support group members' needs and what kind of loss they've experienced, Towle says. At the first sessions, participants get to know one another. Everyone tells his or her story of who they are, she says. Typically, there are two group facilitators, who also will introduce themselves and tell their stories as a way to develop rapport. "They let members know this is a safe place," Towle says.

Facilitators hand out educational material and review the guidelines for participation, including confidentiality. Each meeting ends with an inspirational poem, meditation, some kind of relaxation, or candle lighting ceremony of some sort," Towle says. "By about the third meeting of each series, people ask if they can bring in their own inspirational saying, so they become invested in the process," she adds.

#### **2. Discuss common responses to grief.**

"The second meeting usually has a discussion about the common responses to grief," Towle says. "We talk about what people experience mentally, spiritually, behaviorally."

This meeting is very helpful to attendees because people can identify with these responses and realize that what they've experienced is normal, she says. "This facilitates interaction between members of the group, and they find common bonds," Towle adds.

#### **3. Follow the model of tasks of grief.**

The support groups do not follow the well-known Elisabeth Kubler Ross model of grief.

Instead, they use the J. William Worden's Four Tasks of Grief Model, Towle says. Worden's theory has been published in several books:

- *Grief Counseling and Grief Therapy: A Handbook for the Mental Health Professional* (3rd ed.), Springer Publishing; 2001.
- *Children and Grief: When a Parent Dies* (paperback), Guilford Press; 2001.

"People go through certain tasks in their grief process," Towle says. "One task is to accept the reality of the loss, that this really happened, because there's a terrible disbelief when it happened." Subsequently, people will mourn and exhibit outward expressions of pain, she says.

Another task is to remember the person who died and begin to think of the person in terms other than the illness and facts of the death, Towle explains. "They begin to remember the good times and incorporate that loss into their lives, because their lives are different than they were," Towle says.

Moving forward is a task of grief, but it includes the understanding that throughout one's life there will be periods when the grief reappears with acute painfulness, she notes. "We provide some education on what they might experience, and we emphasize that grief is unique and each person will experience it in their own way and at their own time," Towle says.

#### **4. Certain types of loss follow slightly different patterns.**

One of the more successful support groups has been one for parents who've lost a baby shortly after birth or through a miscarriage. "We address some things that are unique to that experience," Towle says. "One thing that comes up is this is a grief that people don't understand; it's a disenfranchised grief."

People who've lost a baby before or right after the baby's birth feel they can't publicly mourn because people don't understand their loss, she adds. "They need a safe place where they can talk about this loss and what it means to them and to vent about the lack of understanding that people have for their experience," Towle says.

The support group teaches people that it's OK to mourn and provides a safe place for them to do that, she says. "We talk about their baby, and sometimes they'll bring in their photographs of the baby at birth and talk about their dreams and hopes and plans for this child," Towle says.

Having this type of support group is very helpful for parents who've experienced this loss because they're in a room with people who

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understand the loss, and it helps them feel less alone, Towle says.

"We talk about ways to memorialize the baby's birth, which often is the same day as the baby's death," she says. "In this group, people talk about their fears of a future pregnancy, fears that it could happen again."

Also, husbands and wives learn that they might be grieving differently, and it's OK if the wife is openly sad but the husband doesn't express his grief outwardly, Towle says. "They need to know that they can do it differently, and it's OK," she explains. "Sometimes that can pull people apart because the wife thinks her husband doesn't care or understand how sad she is."

#### **5. Encourage group members to return.**

"We call members midweek during the first four weeks and then every other week after that," Towle says. "We ask if they had anything to talk about that they were uncomfortable bringing up at the meeting. We give them personal attention and ask how the group session was for them."

These calls encourage members to return and show them that the bereavement center is there to support them even between their support group meetings, she says. "Many times I see someone on this first session in the support group, and their pain is so difficult," Towle says. "You can absorb the pain and sadness in the air."

By the ninth group session, there is a bond among the support group members and the atmosphere is lightened, she says. "The people in the group connect," Towle says. "Many people become best friends and continue to be friends for years and years."

Also, support group members will continue to meet after the nine weeks are over, getting together several times a year, she adds. "Their connection becomes more than their loss," Towle explains. "It started with the loss, but they become bonded and friends." ■

# Don't use rigid approach for spiritual assessment

*Search for clues, elicit what inspires patients*

A 2004 study published in the *Annals of Family Medicine* analyzed when patients want a discussion about spirituality and what they want done with the information.<sup>1</sup> The authors found that of the 800 people who answered the survey, 83% wanted some sort of discourse about their spiritual selves.

Whether the patient feels his or her spirituality or religious beliefs are crucial to health and recovery, or simply has certain things that bring feelings of hope and comfort, that information is important

for the hospice provider to know. Eliciting that information, or taking a spiritual assessment or spiritual "history," takes a deft hand, and not a rigid question-and-answer session.

"It's not like taking a [medical] history, with a checklist," says **J. Vincent Guss Jr.**, MDiv, a pastoral care and bioethics consultant in Alexandria, VA, and advocacy commissioner for the Association of Professional Chaplains. "It needs to be done in a sensitive and caring way as one looks for clues about what is spiritually significant."

Guss says sometimes a patient will respond to questions of spirituality less than enthusiastically, particularly if the patient does not consider him or herself to be "religious" and perceives the conversation to be about religion. The person attempting the spiritual assessment should make clear that the purpose of the inquiry is to determine what is

## Mnemonic Tools for Use in Making a Spiritual Assessment

### The FICA tool:

**F:** Faith — Does the patient consider himself or herself spiritual? What gives his or her life meaning?

**I:** Importance — What importance does faith or belief have in the patient's life?

**C:** Community — Does the patient belong to a spiritual or religious community that is meaningful to him or her?

**A:** Address in care — How does the patient want his or her spirituality to be addressed by the health care team?

*Source:* Puchalski CM, Romer AL. Taking a spiritual history allows clinicians to understand patients more fully. *J Pall Med* 2000; 3:129-37.

### The HOPE mnemonic:

**H:** Hope — Sources of meaning, comfort, strength, peace, love, and connection.

**O:** Organized religion.

**P:** Personal spirituality and practices.

**E:** Effects on medical care and end-of-life decisions.

*Source:* Anandarajah G, Hight E. Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. *Am Fam Physician* 2001; 63:81-88.

### The FAITH tool:

**F:** Faith — Do you have a faith or religion that is important to you?

**A:** Apply — Do your beliefs apply to your health?

**I:** Involved — Are you involved in a church or faith community?

**T:** Treatment — How do your spiritual views affect your views about treatment?

**H:** Help — How can I help you with any spiritual concerns?

*Source:* King DE. "Spirituality and Medicine." In: *Fundamentals of Clinical Practice*. Mengel MB, Holleman WA, Fields SL, eds. New York City: Plenum; 2002, pp. 651-669.

### The SPIRIT mnemonic:

**S** — Spiritual belief system.

**P** — Personal spirituality.

**I** — Integration and Involvement in a spiritual community.

**R** — Ritualized practices and restrictions.

**I** — Implications for medical care.

**T** — Terminal events planning (advance directives).

*Source:* Murgans TA. The SPIRITual history. *Arch Fam Med* 1996; 5:11-16.

## Need More Information?

▣ **J. Vincent Guss Jr.**, MDiv, Pastoral Care and Bioethics Consultant, Alexandria, VA; advocacy commissioner, Association of Professional Chaplains. Phone: (703) 404-5215.

important to that patient in particular. “The spiritual dimensions of a person are those values he holds dearest, his ultimate concerns, whether he has a God or gods, the source of meaning in his life,” Guss explains. “What is their sense of grace and providence? What do they consider holy? What is their sense of hope or despair, their sense of vocation or calling in life? These relate very much to our emotional, mental, and physical well-being.”

The ethics literature urges clinicians to bear in mind that their own sense of spirituality or religion can affect the provider-patient relationship, and providers who hold strong feelings of being very religious or very nonreligious should exercise care with patients whose feelings are the opposite.

A spiritual assessment is a search for clues about a patient’s spiritual needs and preferences. It might involve direct questions and answers, or be more conversational in nature. It might be done in one sitting or in bits and pieces. Information might be gleaned by more than one person. Family members or clergy might provide insight.

“However it is conducted, the patient should be made to feel that the person talking with him or her is interested in the patient and is comfortable having the conversation,” Guss adds. “It can be weird if the patient feels the [provider] is uncomfortable having the conversation.”

### **Mnemonics can help**

One of the pioneering advocates of spiritual assessments, **Christine M. Puchalski**, MD, director of the George Washington Institute for Spirituality and Health (GWISH) at The George Washington University Medical Center, developed the FICA mnemonic to help guide the taking of a spiritual history or assessment, and it’s the one Guss says he most often relies on.

There are others that can work as well, Guss says. The important thing is that the person taking an assessment uses a mnemonic as a reminder of points to cover, not as a checklist that causes the assessment interviews to sound rote.

(See table, p. 21, for descriptions of mnemonics relating to patient spiritual assessment.)

“When a checklist is used to take a spiritual history in an interrogatory manner, the pastoral care that the assessment is geared to help enhance in the first place is interrupted,” Guss notes. “The assessment can unfold gradually, and it’s important to establish a rapport.”

A 2007 study by Harvard medical researchers showed nearly three-quarters of advanced cancer patients surveyed felt their spiritual needs were not met by the medical system.<sup>2</sup> People who had spiritual support tended to have better quality of life, and people who described themselves as religious were twice as likely to want more aggressive treatment to extend their lives, the authors report.

### **References**

1. McCord G. Discussing spirituality with patients: A rational and ethical approach. *Ann Fam Med* 2004; 2:356-361.
2. Balboni TA, Vanderwerker LC, Block SD, et al. Religiosity and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *J Clin Oncol* 2007; 25:555-560. ■

## Initiative sparked by close call with DNR wristband

A “near-miss” in which a nurse at a Pennsylvania hospital incorrectly placed a “do not resuscitate” (DNR) wristband on a patient has prompted an Ohio initiative aimed at implementing statewide standardization of colored wristbands. Fortunately, she notes, another nurse at the Pennsylvania facility caught the mistake just in time to resuscitate the patient.

Based on the Pennsylvania incident, which occurred because the nurse worked at multiple hospitals that used different-colored bands to designate a DNR order, an Ohio task force looked at how the process was handled by that state’s providers, says **Rosalie Weakland**, director of quality improvement for the Ohio Hospital Association (OHA). The task force includes representatives from hospice organizations, hospitals, home health agencies, and ambulatory facilities.

In surveying Ohio providers, Weakland says, “we found 19 different colors [for wristbands], with 28 different meanings. Sometimes the same color was used for two things. For example, emergency department patients had yellow

wristbands, and then when they became inpatients, a yellow wristband was for a person who was at high risk for a fall."

The task force, convened by the Ohio Patient Safety Institute (OPSI), set an ultimate goal of eliminating all wristbands except those used for patient identification, in favor of electronic tracking systems, Weakland says. But because many providers are not ready for that step, she adds, an interim goal of standardizing and reducing the colors used for wristbands to four was established.

The OPSI now recommends that all Ohio providers adopt the following standard wristbands:

- white/clear for patient identification;
- red for a known allergy;
- yellow for a high fall risk;
- green for blood products (if a patient is supposed to get platelets or a unit of blood).

Weakland's ultimate mission is a national standard. "Health care professionals go across the nation and, depending on locations, hospitals transfer patients across state borders," she says. Different colors between states can lead to problems, "so we're trying to get our bordering states to have consistent colors."

The first thing you can do regarding the issue, she suggests, "is try to promote a standardized wristband for patient identification. I personally recommend that all [providers] go with white in all locations . . . not just for inpatients."

Depending on the setting, staff could potentially also look at DNR wristbands, Weakland says, "because a lot of registrars ask [about DNR instructions] as an initial question. If that is the case, be aware of the [type of] wristband that is appropriate for their state."

Some registrars also are in the position of asking about patient allergies, she says, in which case they should be aware of the appropriate wristband for that condition. "Red tends to be the wristband color for [allergies] across the country, DNR is mostly purple, and yellow is consistent for fall risk."

Some states, however, use colors differently, including many that indicate the need for blood products with a red wristband, Weakland says. Ohio is the only state that is required by law to indicate a DNR order with white paper inside of

a clear wristband, she points out.

State activists hope to get that law changed, Weakland adds, and because it is under review, the task force is not making a recommendation regarding DNR wristbands at this time.

The contention of the Ohio task force is that the number of different wristbands used should be limited to four to avoid confusion, she explains. Some hospitals use additional wristbands to indicate things such as which side of the body is scheduled to receive surgery or that a particular limb should not be used to draw blood, Weakland says, but her belief is that having too many increases the chance of error.

"The fewer, the better," she says. The four designated wristbands are high-volume ones, Weakland says. "If we [replace the bands with] technology, the fewer we have to delete, the better."

While leading-edge providers are moving toward bar coding as the alternative to banding, Weakland notes, "technology changes so fast that there may be something additional that will be used."

Another task force recommendation that relates to registration personnel, she adds, is that patients remove community wristbands such as the "Live Strong" band inspired by Lance Armstrong.

"In an emergency, even though those bands are made from different materials, you could have confusion," she says.

*(Editor's note: More information is available at [www.ohiopatientsafety.org](http://www.ohiopatientsafety.org).)* ■

## Report says race plays role in breast cancer

Racial and socioeconomic factors continue to play significant roles in breast cancer, according to the *State of Breast Cancer Report*, recently published by Susan G. Komen for the Cure in Dallas.

Globally, more than 1.1 million people will be diagnosed with the disease and more than 410,000 will die this year.

"There's been a lot of progress in breast cancer,

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but it hasn't reached everybody," says **Cindy Geoghegan**, executive advisor of scientific community relations at Komen.

Once breast cancer is diagnosed, race, poverty, and lack of health insurance lower the chance that treatment will be successful. For example, African American women are less likely to develop breast cancer than Caucasian women, but are more likely to die of the disease. Breast cancer is the leading cause of cancer deaths among Latinos. Only 38% of Hispanic women age 40 and older have regular mammograms. Most members of racial minorities, the elderly, men, those who live in rural communities, women who are lesbian or bisexual, and the poor or disabled have significantly less chances of surviving the disease than their Caucasian female counterparts.

Regarding research, minorities are left out of cancer trials. "Ethnic and racial minorities make up less than 10% of participants in cancer clinical trials," according to the report. "In addition, people 65 or older make up less than one-third of clinical trial enrollees, even though nearly two-thirds of cancer patients are in this age group. Without greater participation of all groups in clinical trials and other types of studies, researchers can't answer basic research questions." Those research questions include:

- Why are some forms of breast cancer more common in some ethnic and racial groups than in the general population?
- Why do African American women tend to have more aggressive forms of breast cancer and die more often from the disease than Caucasian women?

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To eliminate some of the disparities in minority participation in clinical trials, the Department of Health and Human Services introduced two programs: Culturally and Linguistically Appropriate Standards and Clinical Trials (CLAS-ACT) and BackPack are intended to develop national standards for culturally and language-appropriate resources to the clinical trials process. Resources and guidelines will be developed to help scientists and health professionals recruit minority patients into new clinical trials and address attitudes related to mistrust of the health care system.

The projects will be part of a four-year initiative, Eliminating Disparities in Clinical Trials (EDICT), which is being conducted jointly by two Houston-based groups: the Chronic Disease Prevention and Control Research Center at Baylor College of Medicine and the Intercultural Cancer Council, an organization that seeks to eliminate the unequal burden of cancer among racial and ethnic minorities and medically underserved populations. ■

**Correction**

In the December 2007 issue of *Hospice Management Advisor*, there is a quotation on hospice eligibility guidelines. The full term for these guidelines is Local Coverage Determinations for Hospice Eligibility (Determination of a 6 Month Prognosis). These should have been referred to as LCDs. *HMA* apologizes for the error. ■