



## *Colleague to Colleague*



**Jim Monahan**

Jim Monahan, MEd, ACHE, is Vice President of Marketing and Communications for Community Hospice & Palliative Care, Jacksonville, Florida. Jim Monahan provides leadership for the marketing, communications, referral call center, admissions and health care relations functions at the Jacksonville, Florida-based nonprofit, which serves nearly 1,300 patients each day in northeast and north-central Florida. Monahan has more than 25 years of hospice experience, including patient care, bereavement support, census development and executive leadership. He has led the referral and admission activities for hospice providers in Florida, Texas and Indiana. For the past six years, the business development and admission teams he has led have admitted up to 35 patients a day and more than 7,150 patients per year. A worldwide authority on hospice and grief, Monahan has been named a “Consultant” by the Chinese Association for Life Care in Beijing and was named Director of the Year by the Texas & New Mexico Hospice Organization. He has lectured about grief and hospice care in England, Australia, New Zealand, China and Portugal. He has also authored numerous publications, including a co-authoring a chapter with J. Worden, Ph.D. on parental grief in the book, “Hospice Care for Children” published by Oxford University Press.

### ***What led you to work in hospice and palliative care?***

Unlike some people in the field, I was not drawn to the work because of a personal experience with a loved one's death or hospice care. In college, I took a course on death and dying, and a guest speaker came in to talk about starting a new hospice in the community. Although I can't say why, I found myself very certain that somehow, I would end up working in that field, but didn't actively pursue hospice work for a long time. I did some volunteer work through my church with young widows and widowers and found that work to be very compelling. Later in my career, I was working in an administrative position on a college campus, and a client asked me for information about grief support. I contacted a hospice about their grief programs, and found myself asking about volunteer opportunities; I took the training and was hooked.

I went on to get my MEd in psychology and ultimately started working in hospice, in what would be primarily a social worker's role. While doing that work, I had heard J. William Worden speak and became very interested in bereavement. I ended up moving into bereavement work, and lectured and co-authored a book chapter with Dr. Worden. Perhaps because of my psychology background, I also continued to be interested in marketing—how were we communicating to people about the work we were doing in hospice? Even though we offered wonderful grief support, people didn't want to come in for counseling—how could I change that? So, for the last 25 years my work has been providing hospice services. This is either direct service provision or opening the door to hospice by showing how we can help. During the last 6 years, I have led hospice promotion and admission efforts that led to the admission of over 30,000 patients. I have been working at Community Hospice & Palliative Care since March of this year.

### ***How do you help make those connections?***

A consistent response from families whose loved one has been cared for by hospice is, "We wish we had known about hospice sooner." The challenge, of course, is that most people don't "want" hospice—in a sense, we are promoting a service that no one wants until they have to have it, because of difficult circumstances.

The conversation is also a challenging one with referral sources. As we know from research, many medical professionals have not received training in talking with patients about end-of-life options. I also find that many clinicians feel like they are asked to be "salespeople" about hospice care. And I even have concerns around what I see as issues of "customer service." Think about how people access services these days. I rarely write a check anymore; I just use auto-pay. I can order shoes at 2 o'clock in the morning and know they will arrive two days later. So why should referral sources and even patients not have those same expectations around hospice care? Yet of course that adds a layer of challenges around how we deliver care, especially to people who are potentially hearing news they don't want to hear.

### ***Do you find resistance to this change in attitude even within hospice as well?***

It is always important to find a balance between the "business" of hospice and ensuring that clinicians have the time they need to do the work they need to. There can be an inherent tension between service providers and administrators; talking "numbers" with hospice clinicians is challenging. But at the end of the day, the goals are the same—to provide the best care we can to patients and families

***What changes have you seen in the field in terms of improving these lines of communication?***

One positive change for hospices has been the focus on reducing readmissions for hospitalizations. Hospital professionals recognize that hospice care can help with lowering these rates, so may be more open to earlier referrals and collaboration. I see it somewhat like the fable of the Androcles and the Lion; if you pull enough thorns out of paws, people realize you are the one to call to help with thorns! This reality may add pressure to a hospice staff, however, because it requires the need to respond to referrals quickly and at any time (for instance, even in an ER visit at 2am.)

***Your upcoming webinar will focus on the changing nature of the hospice landscape, especially around more complex medical situations. Can you talk more about what you are seeing?***

If a hospice program is a good one, then they will be receiving more complex referrals; that is the reality. Complex medical issues and treatments may cost a lot of money, and handling these in patients may be a real challenge for smaller hospices. Working with families who are making the move into palliative or hospice care in these situations is another challenge. If families have been pursuing complex and extensive treatments, there has probably been a mindset that they are going to “do everything,” so hospice professionals may need to do a lot of communication around why hospice does not mean giving up, or why this change in care does not mean failure.

***How do you work with hospice professionals to talk about the need for marketing and communication?***

Each hospice program has its own culture, so these conversations will differ for each organization. We talked earlier about issues of customer service, but there may be concern from some hospice professionals about thinking of patients as “customers.” But what do customers need? Responsiveness to concerns, good communication about services—and these are definitely areas that hospices can excel. And it’s critical to think about how people communicate now. Social media is a critical component, both in marketing but also in being responsive to people’s concerns (or complaints).

***With the changing landscape of hospice and an increased focus on communication and referrals, have you seen any noticeable changes in the knowledge that families bring to hospice?***

That is a great question! Certainly, coping with more complex medical situations can lead to challenges in bereavement for families. And the reality is that hospice is still not something that families want to discuss or learn about, especially if there is no need to do so. We always will have to be thinking about how our message comes across. Hospices always need to understand what the expectations are.