

Application of the VALUE Communication Principles in ACTIVE Hospice Team Meetings

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Abstract

Background: The ACTIVE (Assessing Caregivers for Team Intervention through Video Encounters) intervention uses technology to enable family caregivers to participate in hospice interdisciplinary team (IDT) meetings from geographically remote locations. Previous research has suggested that effective communication is critical to the success of these meetings. The purpose of this study was to explore communication in ACTIVE IDT meetings involving family caregivers and to assess the degree to which hospice teams use specific communication principles (summarized in the mnemonic VALUE: value, acknowledge, listen, understand, and elicit), which have been supported in previous research in intensive care settings.

Methods: Researchers analyzed team-family communication during 84 video- and/or audio-recorded care plan discussions that took place during ACTIVE team meetings, using a template approach to text analysis to determine the extent and quality of VALUE principles. The total content analyzed was 9 hours, 28 minutes in length.

Results: Hospice clinicians routinely employed the VALUE communication principles in communication during ACTIVE IDT meetings with family caregivers, but the quality of this communication was frequently rated moderate or poor. The majority of such communication was task-focused. Less often, communication centered on emotional concerns and efforts to gain a more holistic understanding of patients and families.

Conclusions: This analysis suggests an opportunity for improving support for family members during ACTIVE IDT meetings. Members of hospice IDTs should remain aware of the opportunity for additional attention to the emotional realities of the hospice experience for family caregivers and could improve support for family caregivers during IDT meetings by ensuring that messages used to exemplify VALUE principles during team-family communication are of a high quality.

Introduction

THE HOSPICE PLAN OF CARE GUIDES the interdisciplinary team's (IDT) efforts to help patients and families achieve physical, psychosocial, and spiritual goals as patients enter their final months, weeks, and days.¹ Hospice agencies implementing the intervention known as ACTIVE (Assessing Caregivers for Team Intervention through Video Encounters) use technologies such as telephones, videophones, and Internet-based videoconferencing tools to facilitate family caregivers' participation in IDT meetings during which care plans are established and reviewed.^{2,3} Research has shown

that, in the absence of options such as the ACTIVE intervention, family caregivers are typically unable to attend IDT meetings due to patients' care needs and other logistics, limiting their ability to provide input and address questions or concerns with the full interdisciplinary team.^{4,5}

Early pilot testing of the ACTIVE intervention revealed its potential to enhance hospice team functioning,⁶ improve pain management,³ and provide additional support to family caregivers in the community.⁶ Data further indicated that a vital component of the ACTIVE intervention, and the mechanism by which many of the aforementioned outcomes may be achieved, is effective clinician-family communication.⁷

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This is consistent with findings of numerous other studies that cite communication as one of the most important aspects of end-of-life care.⁸⁻¹⁰

Research emphasizing the vital role of communication in palliative and end-of-life care has paved the way for the identification of best practices in the area of clinician-family communication. Of particular relevance to the ACTIVE intervention is the work of Curtis and colleagues,¹¹⁻¹³ who have investigated strategies to improve communication with family members about end-of-life issues. Specifically, they have identified principles of clinician-family communication associated with decreased psychological distress among family members, increased satisfaction with communication, and improved overall quality of care.¹³ To establish practical tools for effective communication with families, Curtis' team synthesized these findings and summarized them in a mnemonic for five evidence-based principles to enhance clinician-family communication: VALUE (value, acknowledge, listen, understand, and elicit). In short, the VALUE principles remind members of the health care team to engage in communication that values family statements, acknowledges family emotions, emphasizes listening to the family, enhances understanding of the patient as a person, and facilitates elicitation of questions from family members.

Although developed in an intensive care setting, the principles undergirding the VALUE approach are congruent with communication recommendations for use in other settings,^{14,15} supporting their potential applicability beyond the intensive care unit. The goal of this study was to explore communication in ACTIVE IDT meetings involving family caregivers and to gain a better understanding of the hospice teams' use of the VALUE principles. The following research questions guided the study: 1) To what extent did the hospice teams' communication reflect specific VALUE principles during ACTIVE IDT meetings with family caregivers? 2) What was the quality of the messages used to enact the VALUE principles during ACTIVE IDT meetings?

Methods

Participant recruitment

In partnership with two hospice agencies serving geographically distinct regions of one Midwestern state, family caregivers were recruited to participate in a randomized controlled trial of the ACTIVE intervention funded by the National Institute of Nursing Research (R01NR011472; Parker Oliver, Principal Investigator). Family caregivers of hospice patients were eligible to participate in the study if they were providing unpaid care to a patient receiving home hospice services, were age 18 or older, had completed at least a sixth-grade education, had no or only mild cognitive impairment, were able to speak and read English, and were without functional hearing loss or had a hearing aid. Participation in the study was not limited to biological and/or legal family members. Rather, potential participants included individuals who were part of the patient's informal system of care and who were defined by the patient as family. Likewise, researchers did not narrowly restrict participation in the study to individuals providing care to a patient in a private residence. For the purposes of this study, home hospice services were defined as those delivered on an outpatient basis (in contrast to an inpatient hospice unit or hospital) and included private residences,

assisted living facilities, skilled nursing facilities, and other outpatient locations. Because the residence of the patient and caregiver could reasonably impact the study findings, this information was collected and recorded for all participants for consideration during data analysis.

At the time of hospice admission, each family caregiver was informed of the research opportunity by a hospice staff member. Admissions personnel forwarded contact information for all interested caregivers to a member of the research team who then scheduled an informational visit in the caregiver's home. During the informational visit, a member of the research team reviewed the informed consent documents and enrolled all consenting subjects who met the eligibility criteria. Because participating caregivers would be granted access to private health information regarding the patient, the consent of the patient (or more commonly the individual legally designated to make health care decisions on behalf of the patient) was required. Following enrollment in the study, participants were randomly assigned to one of two groups: the control group or the ACTIVE intervention group.

The ACTIVE intervention

Participants in the ACTIVE intervention used one of two technology options to join the biweekly hospice IDT meetings during which their loved one's care plan was reviewed: a standard telephone or a computer connected to high-speed Internet service with accompanying webcam and headphones. The hospice site was equipped with comparable technology that, for virtual visits conducted via webcam, projected an enlarged image of the family caregiver onto a screen for the hospice team to see. On the caregiver's end, an image of the IDT was visible. A conference telephone was used to provide an audio-only connection for caregivers without Internet access. Caregivers' participation was limited to the portion of the IDT meeting during which their loved one's care was discussed. After that segment, they were disconnected, and discussion of the next patient took place. Prior to taking part in ACTIVE team meetings and on an annual basis thereafter, members of the hospice IDT received approximately one hour of basic training on the ACTIVE intervention and involving family caregivers in care planning; however, the VALUE principles were not specifically taught as part of the training. At least one member of the research team was present for each ACTIVE team meeting, allowing for video- and/or audio-recording of communication between the hospice team and family caregivers. Additional methodological details and emerging findings¹⁶⁻¹⁸ related to the ongoing randomized controlled trial of the ACTIVE intervention have been made available elsewhere.

Sample

Content from 88 ACTIVE team meetings, conducted as part of the intervention arm of the randomized controlled trial and recorded at random intervals, was included in the initial dataset on which the present analysis is based. Participants in the control arm of the trial did not take part in the ACTIVE intervention; therefore, no control group data are included in the present analysis. Team meetings involved the discussion of one patient's plan of care with the family caregiver. Content from four team meetings was determined to be unusable due to poor audio quality, resulting in a final sample of 84

TABLE 1. VALUE PRINCIPLES CODING HIERARCHY AND EXAMPLES

Principle	Level and examples (high quality to low quality)	%
<u>Value</u>	<p>Team member(s)...</p> <ul style="list-style-type: none"> • Solicit input from the caregiver about the subjective experience of an occurrence or of information presented. • 16% <i>Example:</i> <ul style="list-style-type: none"> ➢ "How would that [medication change] work with your schedule?" • Solicit factual, specific information needed for assessment and/or documentation without addressing the subjective experience of the information or occurrence. • 80% <i>Examples:</i> <ul style="list-style-type: none"> ➢ "How would you rate [the patient's] pain on a scale of 0–10?" ➢ "Which knee is [hurting the patient]?" • Communicate value for the caregiver's input in a perfunctory or routine manner. • 4% <i>Examples:</i> <ul style="list-style-type: none"> ➢ Quickly thank caregiver for participating in the team meeting. ➢ Greet caregiver using a question such as, "How are you doing today?" 	
<u>Acknowledge</u>	<p>Team members(s)...</p> <ul style="list-style-type: none"> • Explore the patient and/or family's emotional experience(s). • 68% <i>Examples:</i> <ul style="list-style-type: none"> ➢ "How is your dad coping?" ➢ "How are you doing with [your mother's cognitive decline]?" • Provide an empathic statement and/or offer of support in response to the caregiver's expression of emotion; the intensity of the response matches that of the caregiver's initial expression. • 24% <i>Example:</i> <ul style="list-style-type: none"> ➢ In response to a caregiver's expression of considerable distress, a team member states, "You know you can call any time...if you need any extra support from both [team member's name] and myself. We are here for you." • Provide an empathic statement and/or offer of support in response to the caregiver's expression of emotion; the intensity of the response does not match that of the caregiver's initial expression. • 8% <ul style="list-style-type: none"> ➢ In response to a report of serious pain, a member of the team casually states, "That doesn't sound good." 	
<u>Listen^a</u>	<p>Team member(s)...</p> <ul style="list-style-type: none"> • Provide two or more indicators of listening (i.e., maintaining eye contact with camera, nodding, saying <i>uh-huh</i> or <i>yes</i>), while appearing to give the caregiver undivided attention. • 14% • Provide one indicator of listening, while appearing to give the caregiver undivided attention. • 59% • Provide at least one indicator of listening; however, the team member providing the listening indicator is visibly engaged in other tasks while doing so (e.g., shuffling papers, looking around the room). • 27% 	
<u>Understand</u>	<p>Team member(s)...</p> <ul style="list-style-type: none"> • Discuss and/or ask an open-ended question about patient or family members' personalities, life experiences, values, and/or preferences; while discussion may include content relevant to the plan of care, some discussion of individuals beyond their role(s) as patient or caregiver is also included. • 55% <i>Examples:</i> <ul style="list-style-type: none"> ➢ "When did you say your brothers and sisters were coming back? And you are going to need a lot of... support while they are here?" ➢ Team member engages caregiver in a discussion about the caregiver's stress related to housekeeping demands. • Discuss and/or ask an open-ended question about patient or family members' personalities, life experiences, values, and/or preferences that are directly related and limited to the hospice plan of care. • 45% <i>Example:</i> <ul style="list-style-type: none"> ➢ Team member engages caregiver in a discussion about the patient's pain tolerance prior to the patient becoming ill. • Ask a closed-ended (yes/no) question about patient or family members' personalities, life experiences, values, and/or preferences and provide no additional discussion. • 0% <p><i>Note:</i> Low quality messages coded for <i>understand</i> (U) were not present in the data.</p>	

(continued)

TABLE 1. (CONTINUED)

Principle	Level and examples (high quality to low quality)	%
Elicit	<p>Team member(s) ...</p> <ul style="list-style-type: none"> • Elicit questions or concerns from the caregiver about a specific issue; sufficient time is allowed for a response. <i>Note:</i> High quality messages coded for <i>elicit</i> (E) were not present in the data. • Ask a general question to ascertain whether the caregiver has any questions or concerns; sufficient time is allowed for a response, and there is no indication that the question is being used to conclude the meeting. <i>Example:</i> <ul style="list-style-type: none"> ➢ "Is there anything else that you can think of that we need to be doing for [the patient] or any other concerns you have?" • Ask a general question to ascertain whether the caregiver has questions or concerns; however, communication is perfunctory or routine and/or the question appears to be asked as a way to conclude the meeting. <i>Example:</i> <ul style="list-style-type: none"> ➢ Team member quickly asks, "Any questions?" just before ending the meeting. 	<ul style="list-style-type: none"> • 0% • 86% • 14%

^aExamples are not provided for data coded for the VALUE principle *listening* (L); the majority of these data were brief verbal or nonverbal listening indicators.

recorded meetings. The total video- and/or audio-recorded content was 9 hours, 28 minutes in length. The average meeting lasted 6 minutes, 41 seconds; meetings ranged in length from 1 minute, 45 seconds to 19 minutes, 52 seconds.

Data analysis

Data were analyzed using a template approach to text analysis as explicated by Crabtree and Miller.¹⁹ First, the research team met to establish an initial codebook based on the VALUE communication principles. Then, two members of the research team independently coded 10% of the initial dataset with a goal of achieving inter-coder reliability. Once the inter-coder reliability of 0.92 was reached, the remaining data were divided equally between two coders who independently analyzed their assigned data by applying codes to segments of data that exemplified specific VALUE communication principles. During this process, recorded interactions were transcribed and described. To fully capture assessment of listening, non-verbal and verbal indicators that reflected engaged and active listening were documented. This included verbal utterances such as "uh-huh" and "yes" in addition to non-verbal communication behaviors such as nodding or looking at the camera when the caregiver was speaking.

Once data were coded into a specific principle, a second round of coding was conducted to ascertain the quality of the messages within each coding principle. Two members of the research team met together to discuss and rate each coded principle according to the extent to which the principle was evident. Together, the researchers determined whether the principles were minimally evident (low quality), moderately evident (moderate quality), or fully evident (high quality) according to criteria established by three members of the research team (two clinicians and one communications scholar), who arrived at consensus on the criteria through an iterative process of viewing and discussing recorded content. Data coded for the VALUE principle *listening* (L) were excluded from the quality assessment, given the researchers' inability to assess the quality of nonverbal communication during team meetings in which family caregivers participated by phone.

Results

Overall, hospice team members' communication included 395 instances that reflected use of the VALUE principles. Of those, 42% involved team members valuing input provided by caregivers and actively involving them in care planning efforts (V); 9% were acknowledgements of family members' or patients' emotions (A); 22% were examples of team members communicating that they were listening to caregivers (L); 3% of the instances involved communication designed to better understand patients' and family members' individual personalities, life experiences, values, and/or preferences (U); and 24% included elicitation of caregivers' questions (E). Differences existed in the quality of the messages reflecting VALUE principles and are described below and summarized in Table 1, along with a complete listing of coding definitions, quality criteria, and specific examples.

Value

Of the 164 interactions coded with the label *value* (V), 16% were of high quality, indicating that team members solicited factual information and followed-up with questions about the subjective experience for the patient and family. For example, after discussing the practical issues associated with a patient's move to her daughter's home, a team member asked, "How is the adjustment going?" Moderate quality messages accounted for 80% of *value* (V) interactions. In these interactions, factual information was solicited or incorporated into the plan of care with no corresponding inquiry regarding the impact of the facts or events on the patient or family. Finally, 4% of the messages were low quality and considered to be perfunctory or automatic (e.g., team member quickly asking, "Anything else?").

Acknowledge

Sixty-eight percent of the interactions coded with the label *acknowledge* (A) were of high quality and illustrated team members' exploration of the emotional aspects of the hospice experience with ACTIVE participants. For example, in the

following exchange, team members addressed the caregiver's feelings about her dying mother's behavior:

Chaplain: *[Your mother] seems pretty content with [experiencing the presence of deceased individuals]. It doesn't seem scary to her.*

Caregiver #29: *No. It's not scary to her. She's more than ready to [die].*

Social Worker: *How are you doing with that?*

Moderate and low quality messages included empathic statements by team member(s) in response to caregiver-initiated disclosure of emotions. Moderate quality messages (24%) occurred when clinicians matched the emotional intensity of the caregiver. Low quality messages (8%) involved the team's failure to mirror the caregiver's feelings. For example, during one interaction, a caregiver reported distress associated with significant pain. In response, a team member casually stated, *"That doesn't sound good."*

Listen

High quality *listening* (L) messages (14%) included interactions in which team members focused solely on the caregiver and provided two or more listening indicators (i.e., verbal utterances, nods, eye contact). When delivering moderate quality messages (59%), team members appeared to give the caregiver their undivided attention but used only one listening indicator. Low quality messages comprised 27% of all interactions coded for *listening* (L) and depicted team members communicating that they were listening to the caregiver by issuing verbal utterances, nodding, or making eye contact with the camera; however, they were doing so while engaging in other tasks (e.g., shuffling papers, looking around the room).

Understand

Communication in which messages were used to obtain information to understand patients' and caregivers' personal backgrounds, preferences, life events, and other information not directly related to the hospice experience made up high quality messages. These comprised 55% of interactions coded for *understanding* (U). For example, in the following interaction a team member explored the reasoning behind a patient's distress by inquiring about her family. Prior to the exchange, the family caregiver described how upset her mother, a nursing home resident, had become when viewing news coverage of a natural disaster that had occurred elsewhere in the state.

Nurse: *Does she have family in [the town that experienced the natural disaster]? Or is it just in general that she gets distressed over the news?*

Caregiver #48: *No, we don't have family there. She just gets distressed when there are major disasters... And we tell her that it's okay to pray, but there's not anything that she can do, so she needs to not watch [news coverage of the disaster]... but sometimes she does, and then we'll get another call at 11 o'clock at night and she's still sitting there watching it and crying.*

Almost equally present were moderate quality messages (45%) characterized by team members' discussion of patients and family members as individuals, limited to the confines of their roles as patients and caregivers, such as preferences regarding medication administration, sleep patterns, and relationships with staff members. Low quality messages were not present.

Elicit

No interactions coded for *elicit* (E) were of high quality, indicating that team members did not invite caregivers to ask questions or voice concerns about specific issues (e.g., changes to the plan of care, what to expect in the future with regard to a specific symptom). Moderate quality messages (86%) included team members inviting caregivers to ask questions, but were not focused on a particular topic or area of concern (e.g., *"Do you have any questions for us?"*). These messages differed from low quality messages in that they were followed by a sufficient period of time for the caregiver to respond. They were commonly posed early in the meeting and served as an opportunity for caregivers to shape the team discussion. Low quality messages (14%) were perfunctory or routine and primarily included instances in which team members quickly asked if anyone had final questions before ending the meeting.

Discussion

As the above analysis illustrates, hospice clinicians routinely employed the VALUE principles in communication during ACTIVE IDT meetings with family caregivers. The majority of such communication was task-focused and included efforts to gather information and/or to invite caregivers to share questions or concerns related to the hospice plan of care. Decidedly less often, communication centered on emotional concerns and efforts to gain a deeper, more holistic understanding of patients and families. Also noteworthy were the differences in the quality of the messages exemplifying the VALUE principles, regardless of the specific principle being demonstrated.

Study findings highlighting the relative lack of emotion-based communication in ACTIVE IDT meetings are consistent with previous research.⁷ It should be noted that this is not inherently problematic. Interdisciplinary teams are first and foremost work groups.²⁰ IDT meetings are, therefore, by their nature task-focused. Concomitantly, it is important to keep in mind the hospice philosophy of care, which maintains that attending to the emotional, social, and spiritual needs of patients and families is very much the responsibility of the hospice IDT.²¹ This conceptualization of care suggests that provision of support for the holistic person is not only a legitimate task of the IDT, it is a requisite one. This is not to suggest that IDT meetings involving family caregivers be converted into therapeutic groups (which would be inconsistent with the meetings' purpose and an impossibility given existing time constraints), but to highlight the potential opportunity for additional awareness of and attention to the emotional realities of the hospice experience for patients and families.

In addition to identifying the potential opportunity for increased attention to emotional issues, the data analyzed here suggest numerous other opportunities to strengthen application of the VALUE principles in ACTIVE team meetings. First, hospice clinicians can more fully take advantage of family caregivers' expertise by seeking information about patients' and families' subjective experiences in addition to collecting factual information needed for symptom assessment and monitoring. For example, while members of the IDT consistently asked participating caregivers to provide a numeric pain rating for the patient, this was rarely accompanied by inquiries about the experience of witnessing a loved one in

pain, despite a plethora of evidence that such experiences are extremely troubling for family caregivers.^{22,23} An excellent example of soliciting information about caregivers' subjective experiences is provided above in the excerpt from a team meeting with Caregiver #29, whose mother had begun responding to previously deceased family members. The hospice chaplain and social worker discussed the impact of such experiences on the patient (who seemed untroubled) and followed-up by asking the caregiver what these encounters were like for her.

A second area that may benefit from additional attention was identified during coding of the quality of messages communicating the VALUE principles. The research team discovered that when hospice clinicians indicated to caregivers that they were listening, they did so while engaged in other activities (e.g., shuffling papers, writing or typing notes, looking around the room) more than one-fourth of the time. While multi-tasking is, at least anecdotally, a common occurrence in IDT meetings, teams should carefully consider whether this practice best meets the needs of caregivers who might not otherwise have access to the full interdisciplinary group.

Finally, hospice teams should determine the degree to which they support caregivers' meaningful participation in team meetings, rather than involving them in a cursory manner. Maximizing caregiver participation can be accomplished in a variety of ways. Among other strategies, possible approaches include allowing caregivers instead of members of the hospice team to begin the meeting by providing an update about the patient and family; inviting caregivers to introduce topics of concern early in the meeting, ensuring that the concerns of the patient and family drive the activities of the team; and inviting caregivers to ask questions or express concerns about specific issues to ensure their full understanding and involvement in decision making about the plan of care.

Ultimately, the basic premise underlying the ACTIVE intervention is that family caregivers have invaluable expertise and insight into their lives and the lives of their loved ones.² Ideally, caregivers participating in the ACTIVE intervention are regarded as experts and as care partners; they are part of the team.⁶ Maximizing high quality messages of the VALUE principles during ACTIVE team meetings may allow teams to capitalize on this expertise and increase the likelihood that appropriate and effective services will be provided to the patients and families hospices serve.

Study limitations and implications for future research

Numerous limitations of the current study warrant attention. First, researchers did not collect data regarding the outcomes of communication guided by the VALUE principles. Although the VALUE principles have garnered support in research set in intensive care units,¹¹⁻¹³ future studies would be strengthened by systematically measuring the impact of the principles' use during ACTIVE team meetings in the hospice setting. A second limitation, closely related to the first, results from the fact that assessments of the quality of the messages used to enact the VALUE principles were not based on empirically supported criteria. This underscores the importance of future studies including outcome variables; more knowledge about the relationships between outcomes and use of the VALUE principles, particularly the specific mes-

sages used to enact the principles, would further fortify the evidence base related to communication during ACTIVE team meetings and potentially bolster support for the adoption of communication guided by the VALUE principles into routine hospice practice.

In addition, these study findings suggest numerous research questions appropriate for future research. For example, one wonders if certain sociodemographic characteristics (e.g., age, gender, race, education) of family caregivers and/or hospice clinicians influence communication in ACTIVE team meetings. Further, it would be informative to study if and how communication is impacted by the specific technology used to connect family caregivers to the hospice IDT. Are there differences in communication that occurs when ACTIVE team meetings are "audio-only" when compared with meetings that also include a video component? Does the effect of the technology depend on the aforementioned sociodemographic characteristics? Answers to these questions will provide a deeper understanding of interactions during ACTIVE team meetings and may result in the development of additional strategies to promote optimal clinician-family communication.

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