

# Nebraska End of Life Survey Report

*Thoughts of Nebraskans about living at the end of life  
—and implications for those working to improve care  
and conditions for chronically and terminally ill Nebraskans*

January 2007

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## About the Nebraska Hospice and Palliative Care Partnership

**The Nebraska Hospice and Palliative Care Partnership** (NHPCP) is a statewide partnership of more than 60 organizations collaborating to improve the quality of life for Nebraskans with chronic or terminal conditions and support those who care for them. NHPCP was incorporated as the Nebraska Hospice Association on June 6, 1983, and added “Palliative Care” to its name in 2003. In April of 2006, Nebraska’s 34 hospice programs, two hospice residential facilities, and 14 community end-of-life coalitions broadened the 501(c)3 non-profit into a partnership that includes over a dozen other leading Nebraska organizations and agencies who have an interest in improving end-of-life care for Nebraskans.

**Vision:** No Nebraskan lives in pain or dies badly. Nebraskans with chronic or end-of-life conditions, regardless of age, live their last months to their fullest, with their wishes expressed and respected, their pain and suffering alleviated, their fears and questions heard and addressed, their relational, spiritual, cultural, and financial needs met, and their loved ones around them and supported up to and following their death.

**NHPCP pursues initiatives in five broad areas:** professional education, community engagement, advocacy, research, and quality improvement. NHPCP is a leader within the Nebraska Hospice-Veteran Partnership, the Nebraska Pain Initiative, the Nebraska Caregiver Coalition, and the Nebraska Comprehensive Cancer Control Partnership. For information about NHPCP initiatives and how you can get involved, please visit [www.nehospice.org](http://www.nehospice.org).

## Acknowledgements

In 2003, three organizations—the Nebraska Coalition for Compassionate Care, NHPCP, and the Robert Wood Johnson Foundation (RWJF), through the end-of-life coalition Last Acts—collaborated to conduct in Nebraska a first-in-the-nation statewide survey of perceptions of end-of-life issues. Now, three years later, the survey has been repeated. Results of both surveys are at [www.nehospice.org](http://www.nehospice.org).

This survey draws on the work of the Life’s End Institute: *Missoula Demonstration Project* and of AARP-North Carolina and the Carolinas Center for Hospice and End of Life Care, who generously provided their 2003 survey and report of North Carolina AARP members as a model.

The principal researcher for both Nebraska surveys was Kaye Norris, PhD, a national leader in end-of-life research and innovative end-of-life programming, formerly with the Life’s End Institute. Charles Asp, PhD, provided statistical analysis support. NHPCP Education and Outreach Coordinator Jennifer Eurek has chaired the Nebraska Survey Task Force since 2003. Task Force members for the 2006 survey include Lynn Borstelmann (Nebraska Medical Center), Bill Brennan (Saint Francis Medical Center Foundation), Marjorie Jones (Saint Francis Medical Center Home Care Services), Julie Masters (University of Nebraska, Omaha, Gerontology Department), Aloha Schmid (Hospice of Tabitha), Paula Sitzman (CIMRO of Nebraska), Teresa Stitche Fritz (Alzheimer’s Association, Great Plains Chapter), and Jonathan Krutz (NHPCP), co-author with Dr. Norris of this report. Additional input came from the NHPCP Research/Quality Improvement Committee, chaired by Greg Schieke (CIMRO). State Senator Joel Johnson graciously hosted the release of this report on Jan. 30, 2007, at the Nebraska State Capitol.

Principal funding came from the Nebraska Comprehensive Cancer Control Partnership; Grand Island’s Coalition for End of Life Care and St. Francis Medical Center Foundation; Alegent Health Systems; HPC Foundation for Hospice; and Pender Community Hospital, with capacity support also from RWJF through the National Hospice and Palliative Care Organization’s Caring Connections program.

NHPCP thanks each of these individuals and organizations for their contributions to this pioneering research: a first-in-the-nation follow-up survey of a state’s perceptions of end-of-life issues.

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## Definitions

**Hospice** provides an interdisciplinary team of a doctor, nurse, social worker, chaplain (if desired), various therapists (as needed), and volunteers. Hospice is 100% paid by Medicare, Medicaid, the VA System, and many private insurance carriers for individuals diagnosed by a physician as having six months or less to live who choose to forego further curative treatment. Hospice helps families and the health care system know and respect the wishes of the terminally ill. Available wherever a dying person calls home—including assisted living and nursing facilities, hospitals, and prisons—hospice assesses and addresses physical, social, spiritual and psychological issues to alleviate pain, symptoms, and suffering and improve the quality of life of those in their last months of life.

Hospice does not provide room and board services or serve as the on-site caregiver for a terminally ill person, but hospice provides regular visits and is available on call 24/7 to address and assist with needs and issues whenever they arise. Hospice supports both the dying person and his/her family or other caregivers with practical expertise and education on pain and symptom management, living arrangements, identifying and meeting end-of-life wishes, the dying process and issues to expect, end-of-life financial considerations, relationship and spiritual issues, and access to respite care and other resources. Hospice also provides bereavement support up to and beyond the first anniversary of a loved one's death, a service many hospice programs extend to any community member, not just those whose loved one received hospice care.

Hospice listens. Hospice addresses pain, symptoms, questions, and fears. Hospice educates. Hospice provides support and comfort. Hospice consistently earns the highest satisfaction ratings in health care.

**Palliative Care** means comfort care (vs. curative care). It makes the hospice philosophy accessible to those with non-terminal conditions. Like hospice, palliative care is holistic. It includes and goes beyond palliative medicine—which focuses on pain and symptom management—to identify and address social, psychological, and spiritual issues that can impact both an individual's physical condition and the effectiveness of medical interventions. Except in a few situations, neither federal, state, nor private health plans pay for palliative care. However, more than 1,000 hospitals nationwide and over a dozen in Nebraska have now established palliative care programs, finding that palliative care increases patient satisfaction and decreases the need for medical interventions, thus lowering costs.

**Advance Directives** allow you “in advance” to “direct” the health care system and loved ones on what medical decisions you would want made if you are physically or mentally unable to communicate for yourself, either temporarily or permanently. This might occur, for instance, if you were in a coma or persistent vegetative state, if you had Alzheimer's disease or other dementia, if you were under sedation, or if you suffered a brain injury. There are several kinds of advance directives:

- **Health Care Power of Attorney (HCPA)** allows you to legally name another person to make health care decisions on your behalf if you are incompetent or unable to make them for yourself.
- **Living Will** allows you to identify treatments you would or would not want if you were dying: for instance, whether, under what conditions, or for how long you would want a feeding tube.
- **Organ Donor** provides your permission for your organs to be given to others when you die.
- **Do Not Resuscitate (DNR) or Allow Natural Death (AND)** gives your permission to health care workers to forego emergency interventions if you stop breathing or your heart stops.
- **POLST (Physician Order for Life-Sustaining Treatment)** is a one-page form used in several states (and Columbus, Nebraska) that accompanies a patient's medical chart to make HCPA, DNR/AND, and Living Will information immediately useable in health care settings.

## I. Analysis and Overview

Everybody dies. Not everybody dies well.

This survey provides a look at what Nebraskans say “dying well” looks like. Not surprisingly, more than 95% say it includes honest answers from doctors, an understanding of treatment options, having things settled with family, being free from pain, not being a burden to loved ones, being at peace spiritually, having family and friends visit, and having finances in order. More than 90% say being able to stay in their own home is important—a challenge in a state where less than one in five die at home, the lowest rate in the nation.

The results of this survey provide direction for those working to improve end-of-life care and conditions across Nebraska: a mission of the Nebraska Hospice and Palliative Care Partnership that is shared by our many partner organizations.

Dying well is far from guaranteed. Too often the end of life involves pain, an erosion of personal dignity, family in-fighting over care decisions made in crisis situations, wishes disregarded, difficult adjustments to deteriorating physical and mental abilities, family members carrying a heavy load, family tensions over assets and debts, relationships and spiritual issues unaddressed, loneliness in unfamiliar surroundings, and loved ones being angry, bitter, confused, overwhelmed, lost, alone, and unsupported after the death of their beloved.

Our health care system, so effective at healing and curing, is not designed to address many of these critical issues for dying Nebraskans. Yet the dying end up in the health care system by default as they pass beyond healing and beyond cure. And by default they are at risk of the health care crisis of abundance: additional medical interventions to keep the dying alive as long as possible, something three out of four Nebraskans say they would not want.

Ninety-three percent of Nebraskans in our survey say they are comfortable talking about death, 81% say they are likely to speak freely to loved ones about death and dying, and more than three out of four Nebraskans say they have talked with someone about their end-of-life wishes. Encouragingly, due to NHPCP efforts and the publicity of Terry Schiavo’s death, the completion rate of advance directives is up nearly 25% from our first survey three years ago: now 36% of Nebraskans have completed a health care power of attorney and 38% have completed a living will. Still, that means more than six in ten Nebraskans have not yet put their wishes in writing. NHPCP is working to move medical decision-making out of crisis situations by encouraging Nebraskans to complete advance directives and by working to make advance directives easier to access by the health care system, for instance by advocating for an advance directive designation on Nebraska drivers’ licenses.

NHPCP promotes hospice because over the past 25 years, hospice has emerged as the most effective service to meet the unique physical, emotional, spiritual, and social needs of individuals living near the end of life, and their loved ones. Nationally and in Nebraska, roughly one in three of those who die now receive hospice care for at least some of their last days, a number that has been growing rapidly. In Nebraska, 50% more people received hospice care in 2006 than in 2001. This reflects a national trend that is expected to continue as the Baby Boom generation

heads into retirement. “Medicare’s spending on hospice services is projected to increase at an average annual rate of 9% per year from 2004 to 2015,” MedPac reported to Congress last June.

Hospice is an important and expanding part of how we can assure that Nebraskans die well. But hospice requires a physician’s judgment that a person has six months or less to live. This may be easy to predict for some conditions but nearly impossible for others until the very end. As a result, one third of those receiving hospice care do not get it until their last week of life, far too late for many of the benefits of hospice to be realized. Also, for hospice to be received as a covered benefit, an individual must forego curative treatment. As a result, those who choose to fight their medical conditions, regardless of their chances for success, cannot get hospice support despite living under a very immediate threat of death.

NHPCP promotes palliative care because palliative care offers support for Nebraskans living under the threat of death who do not meet hospice requirements. More than a dozen Nebraska hospitals have now launched palliative care programs. A small but growing number of Nebraska physicians, nurses, and other health care professionals have become certified for palliative care. Nebraska’s medical and nursing schools are considering the addition of palliative care courses. NHPCP offers palliative care certification review courses and is collaborating with the Nebraska Health Care Association to prepare a palliative care course for Nebraska nursing facility professionals.

While hospice and palliative care can offer much support for Nebraskans living under the threat of death, the impact of death and dying in our state goes beyond the reach of these services. To address that impact, NHPCP works in five broad areas: professional education, community engagement, advocacy, quality improvement, and research. We encourage you to learn more about the initiatives of NHPCP and to consider joining our important work as an individual or organizational member. Details can be found at [www.nehospice.org](http://www.nehospice.org).

The responses of Nebraskans through this survey will guide our efforts to reduce the impact of death on the dying and their caregivers, to improve the end-of-life experience for all Nebraskans, and to help Nebraskans avoid dying badly. We share these survey results with you so they may guide your efforts, as well.

## **SURVEY OVERVIEW**

In August of 2003, the Nebraska Coalition for Compassionate Care and NHPCP conducted the first randomly sampled statewide end-of-life survey in the United States. Our purpose was to find out Nebraskan’s views on end-of-life issues, to identify baseline measures for efforts to improve end-of-life care and conditions in Nebraska, and to help those involved in such efforts to focus their activities and set appropriate priorities. Three hundred (300) Nebraskans completed the survey in 2003, with the results released as the Nebraska End-of-Life Survey Report in January of 2004, available online at [www.nehospice.org](http://www.nehospice.org).

The 2004 Survey Report identified five areas for action which remain supported by the most recent survey results and continue to direct the efforts of NHPCP today:

1. Encourage end-of-life conversations and decision-making in advance
2. Improve education on pain issues
3. Improve awareness and access to hospice and other resources
4. Improve awareness of end-of-life issues among clergy and faith communities

5. Improve awareness and training in end-of-life issues among health professionals and within health care systems

In August of 2006, we repeated the survey with another random sample of Nebraskans. From this random sample, 324 Nebraskans completed the survey. Unless otherwise identified, this report provides the views of these 324 Nebraskans, and, at some points, compares them with the views of the 300 respondents from 2003 to highlight changes over time. In addition, in 2006, we mailed the survey to the 300 respondents from 2003. One hundred responded again, giving us a second window on changes over time, reported in the last section of Key Findings.

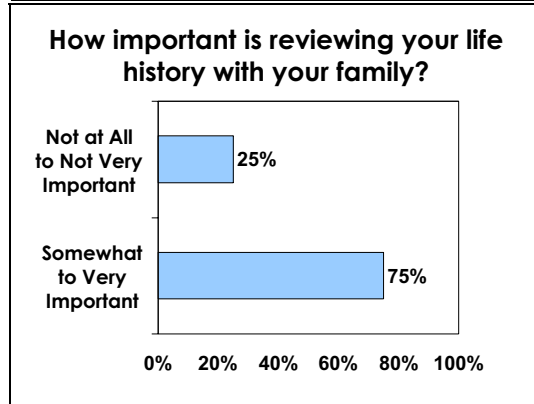
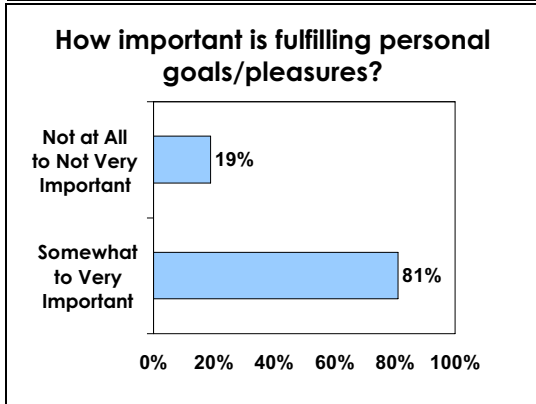
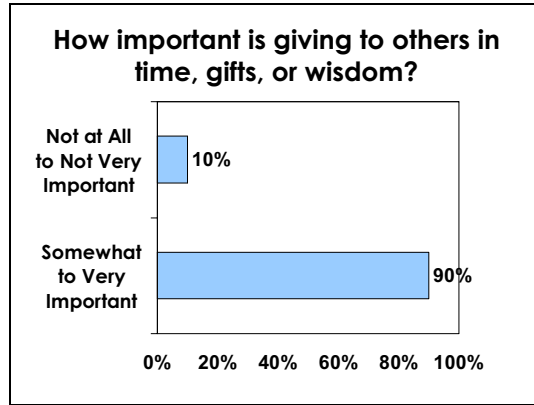
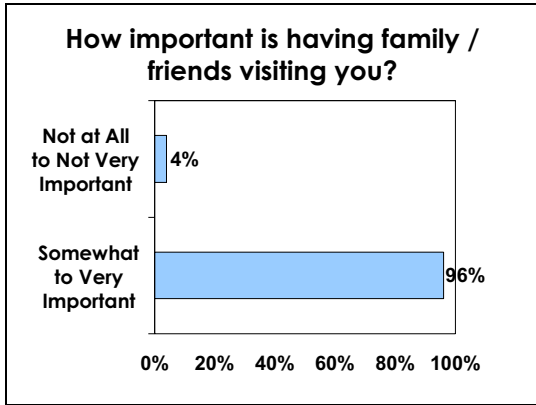
In the coming months, we will further analyze and report on the responses of the following subgroups from the most recent survey: those who identify themselves as caregivers, veterans, those living alone, those age 65 and older, and those who say they have someone with a chronic condition living in their household. The sub-group reports will be posted online at [www.nehospice.org](http://www.nehospice.org) as they are released. Also on the website you will find the survey questionnaire, a complete set of responses to each survey question, slides comparing 2003 and 2006 responses, and the full set of responses for each of the sub-groups identified above.

Demographics of the 2006 random sample are included in the Methods section of this report. Key findings are reported in the next section in the following areas: wishes, planning in advance, pain issues, fear issues, and resources and support.

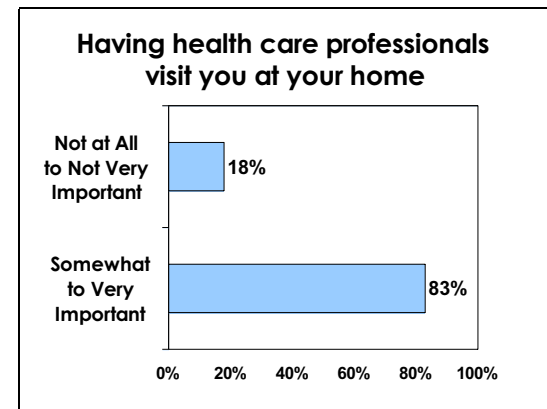
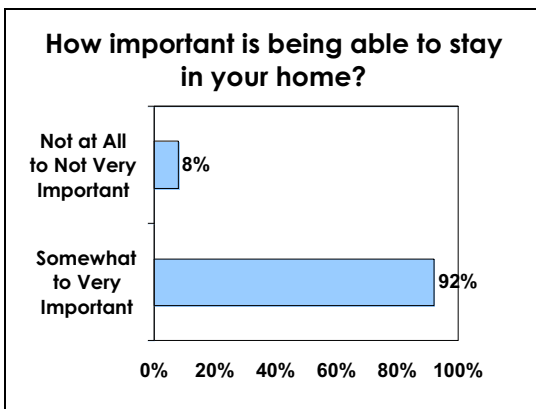
In these same categories we then compare the 2003 responses with those from 2006, first comparing the two random samples, then comparing the responses of the 100 households who completed a survey in both years. Differences are reported for responses that were "statistically significant," which means that if we drew two random samples of Nebraskans and asked them this item, there would be less than 1 chance in 20 that we would see the same magnitude of difference as we see here. When we refer to "statistically significant" results, we mean that the difference we see is unlikely to be the result of chance. Since there is less than 1 chance in 20 that the "statistically significant" results are due to chance, we assume the difference is because of group membership and not random error.

## II. Key Findings

### 1. WISHES

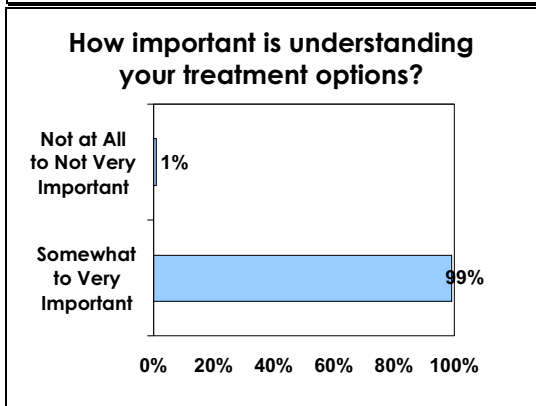
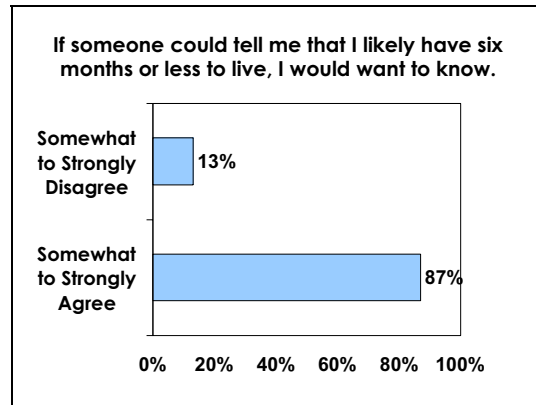
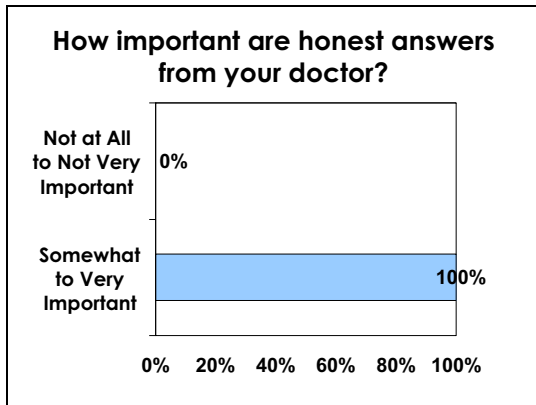


When asked what would be important during their dying experience, respondents indicated a strong desire to have family and friends visit, to give to others, to fulfill personal goals and to review their life history with family.

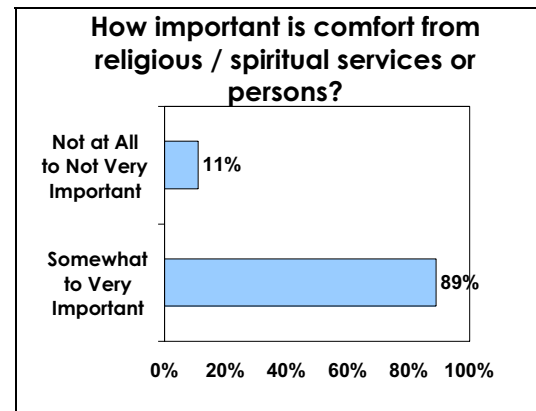
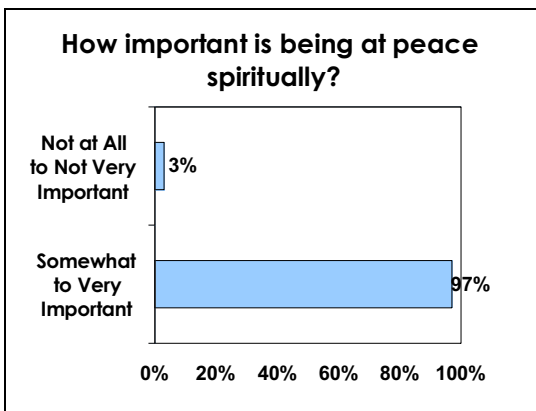


According to the 2002 Means to a Better End report<sup>1</sup>, 80% of Nebraskans do not die in their own homes. Yet our data indicates that nearly 100% of Nebraskans feel dying at home would be important to them. And, having health care professionals come to the home is also important.

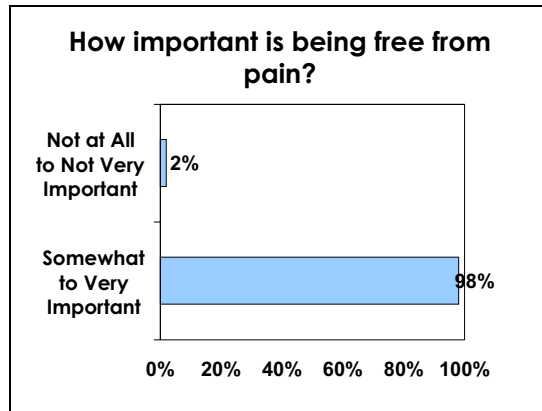
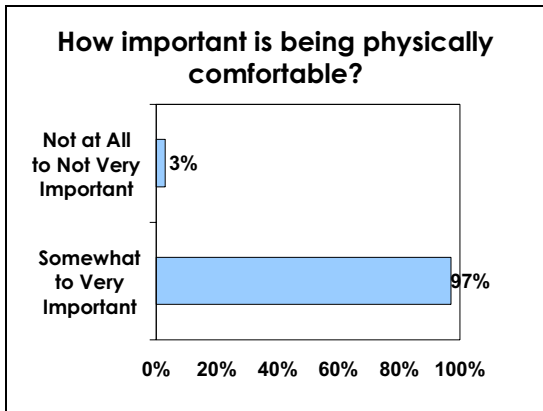
<sup>1</sup> <http://www.rwjf.org/files/publications/other/meansbetterend.pdf>



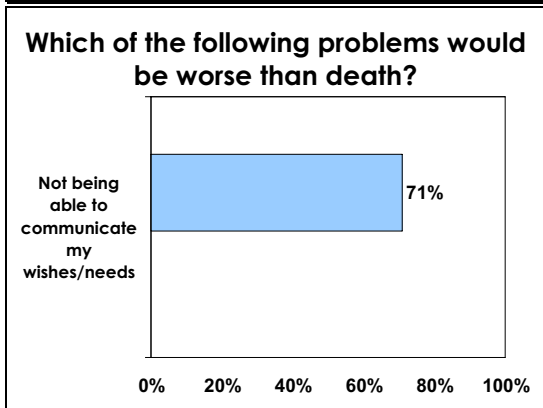
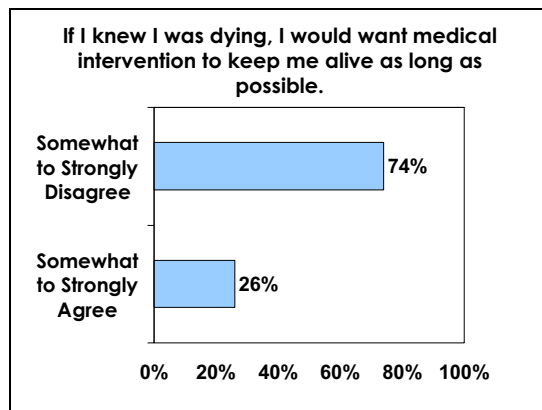
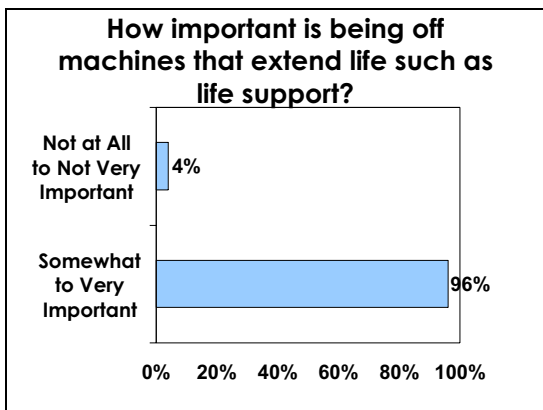
Our respondents feel an overwhelming desire for honest answers from their doctors. One hundred percent indicated this would be important. They also want to know if they only have six months to live. Yet, that type of prognosis is difficult to determine and there are still strong social mores and medical reluctance to acknowledge pending death. Understanding treatment options is also important for almost all of our participants.



Feeling at peace spiritually and receiving comfort from religious/spiritual services or persons is also important to nearly all of the respondents.

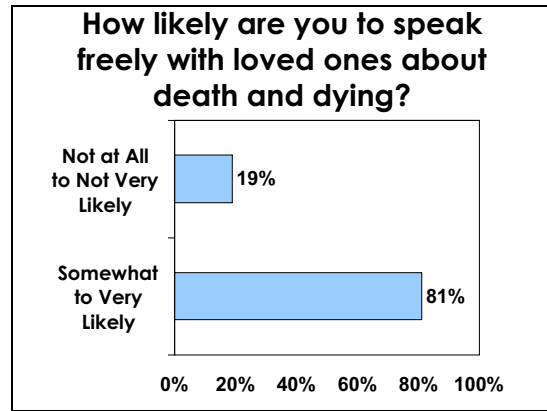
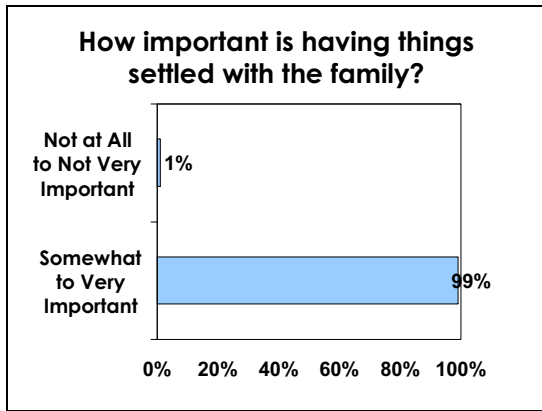


Not only is spiritual comfort important, but being free from pain and being physically comfortable is also important to nearly 100% of participants.

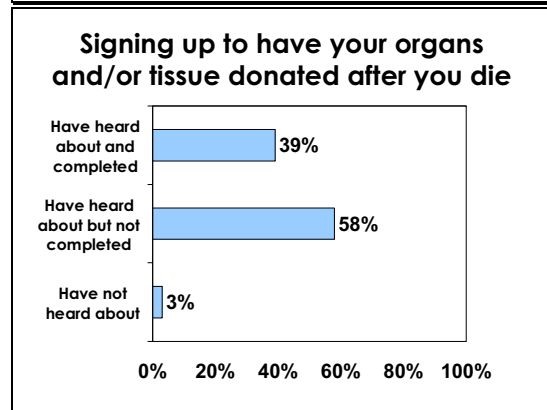
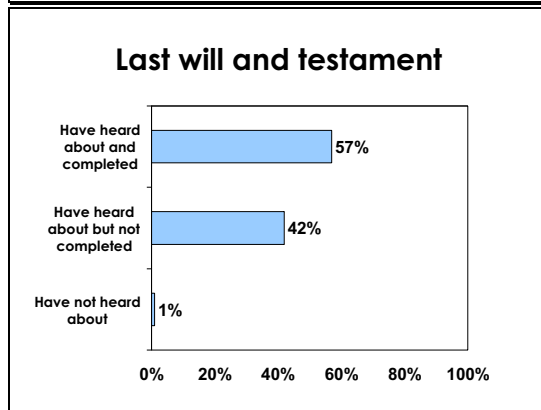
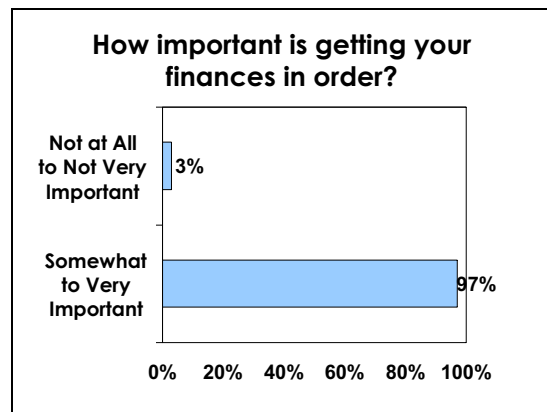
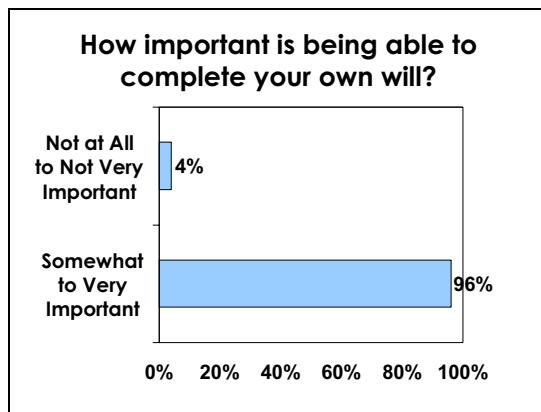


Even though our medical system has a natural bias toward continued treatment, nearly 100% of our participants indicated that they do not want their lives extended with artificial life support, and only one-fourth said they would want medical interventions to keep them alive as long as possible. In fact, seven in ten believe that not being able to communicate their wishes would be worse than death.

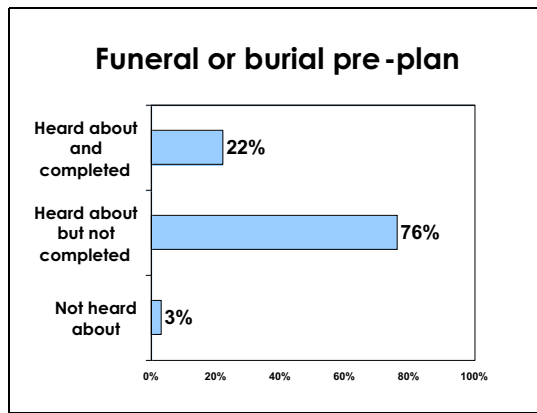
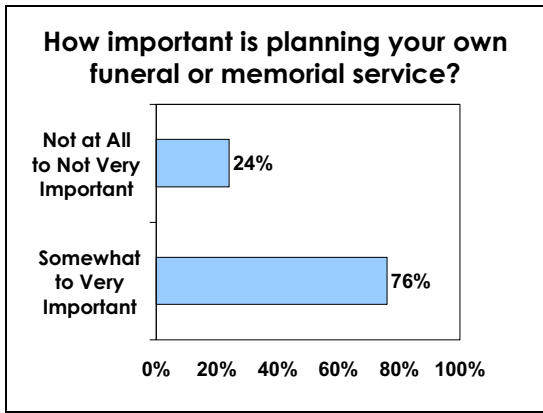
## 2. PLANNING IN ADVANCE



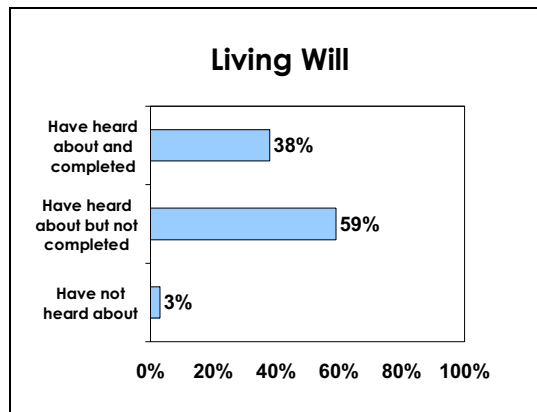
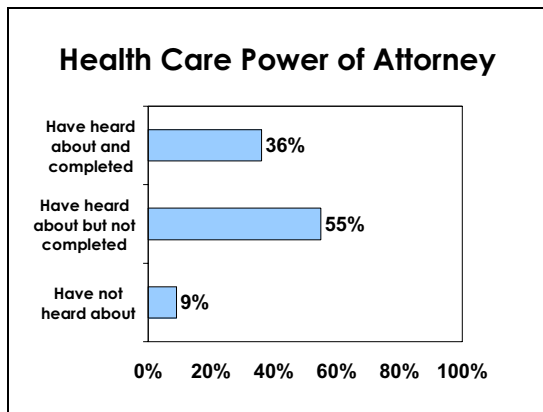
As previously indicated, a high percentage of our respondents know what they would wish to have happen if they were dying. Above we see that having things settled with their family is important and that most are likely to speak freely with loved ones about death and dying.



Likewise, being able to complete their will and having their finances in order is important. However, just over one-half have actually completed their will, and only approximately two in five had signed up for organ donation.



Additionally, even though three-fourths of respondents indicated that planning their own funeral or memorial would be important, less than one-fourth have pre-planned funeral or burial services.

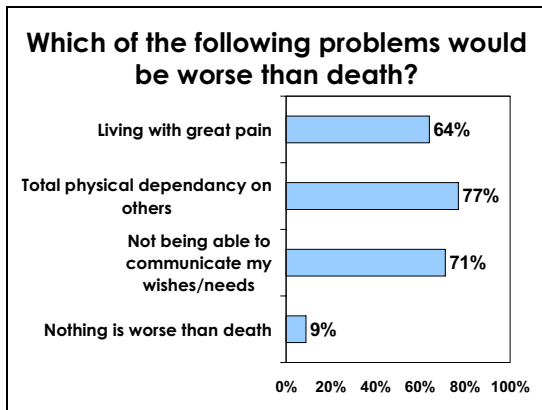
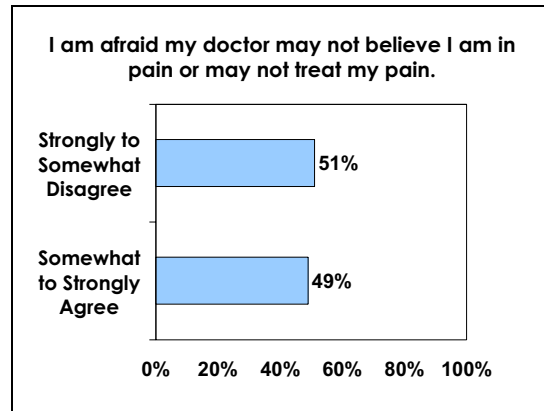
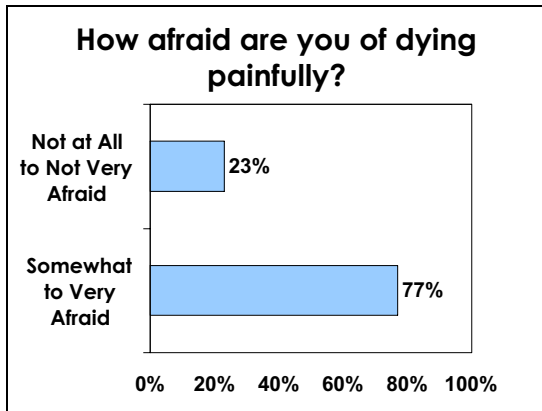


Finally, only slightly over one-third of the respondents have completed a health care power of attorney (HCPA) and a living will. And, although this is an increase from 2003, where only 30% had an HCPA (6% less than in 2006), and only 30% had a living will (8% less than 2006), rates of advance planning are still low.

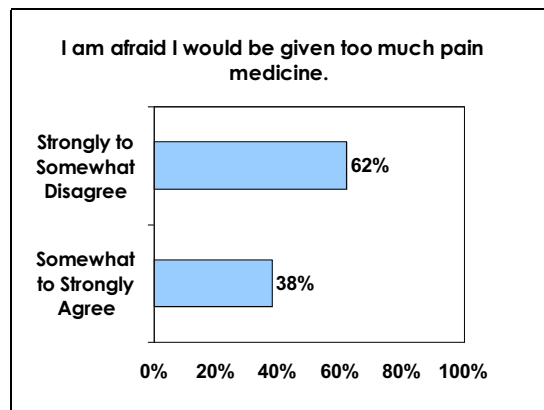
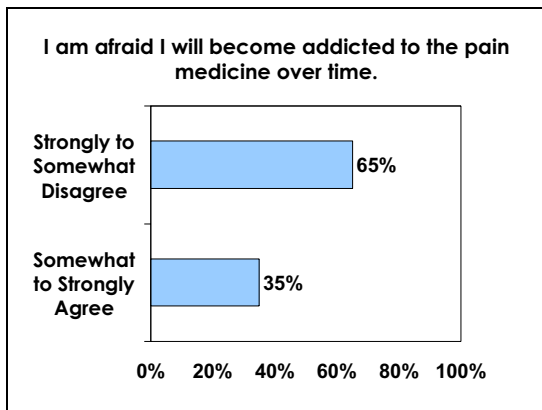
Within our data, one-half of the respondents who have someone in their household with a chronic condition indicated that they have an HCPA and a Living Will. Similarly, approximately one-half of those who live alone have these two documents. And, of those 65 years or older, 55% have completed HCPAs and living wills. These results suggest that people who are more vulnerable, or might not have someone to speak for them, are more likely to have documented their wishes in writing.

### 3. PAIN ISSUES

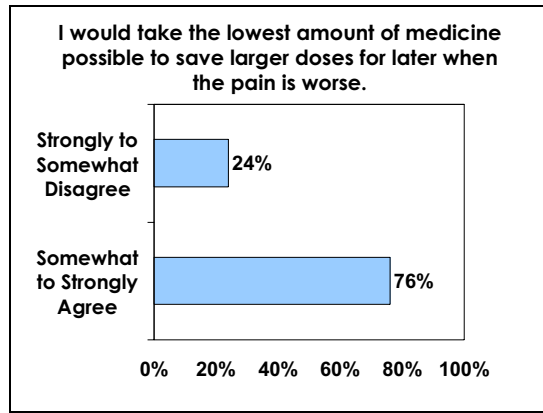
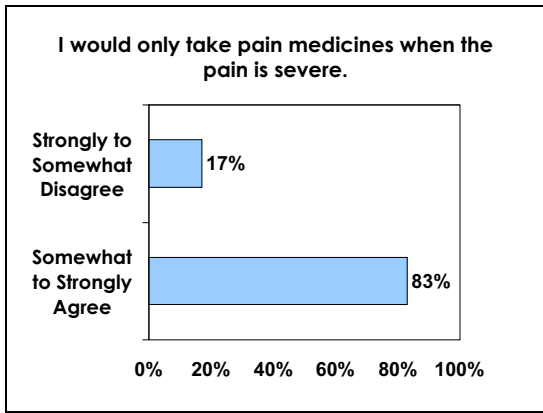
Because pain is commonly experienced during the dying process, we asked respondents about their concerns and their understanding of pain treatment.



Three-fourths of the respondents indicated a fear of dying painfully, and one-half are concerned that their doctor may not believe they are in pain or treat it. A strong statement regarding fear of pain is that 64% indicated that living with great pain would be worse than death. Even more people with chronic illness (71%) hold this belief.



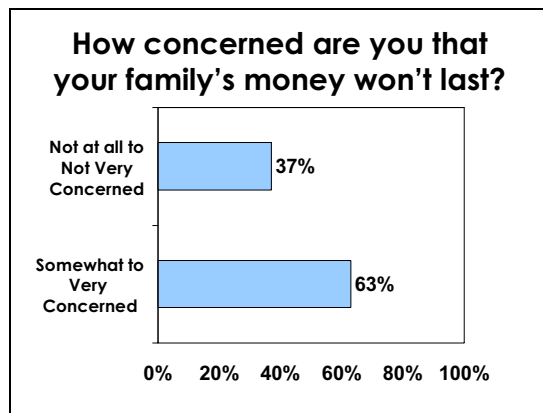
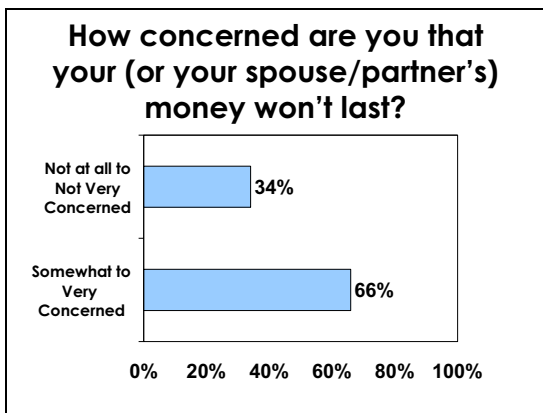
Although in recent years, there has been much education and media coverage regarding appropriate treatment for pain, one-third of our participants have some worry that they would become addicted to pain medicine and that they would be given too much medication.



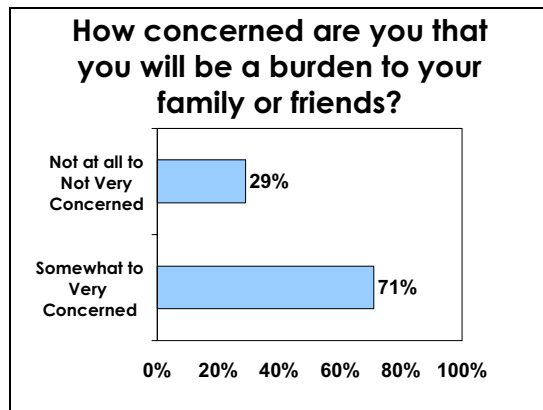
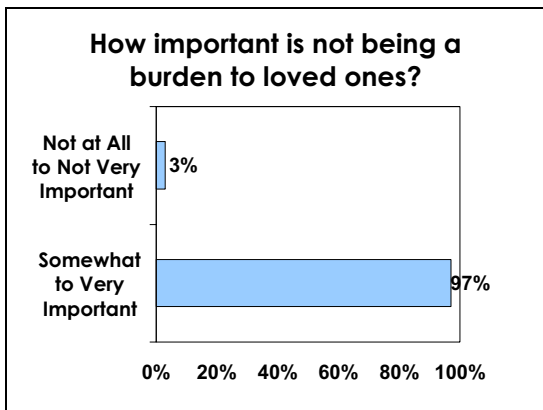
Even though current understanding of effective pain treatment indicates that medication should be taken in large enough doses and as soon as the pain begins to keep it from escalating, respondents are reluctant to use medication until the pain is severe and would wait until the pain was worse before taking a larger dose.

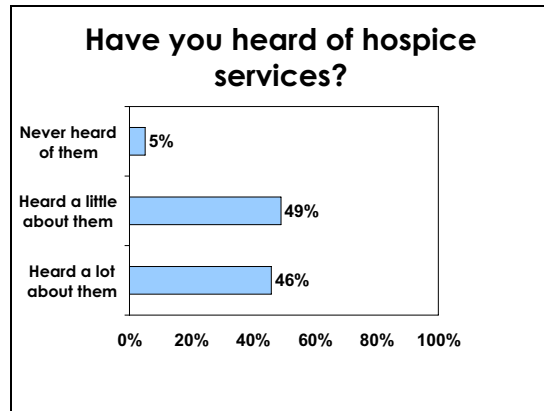
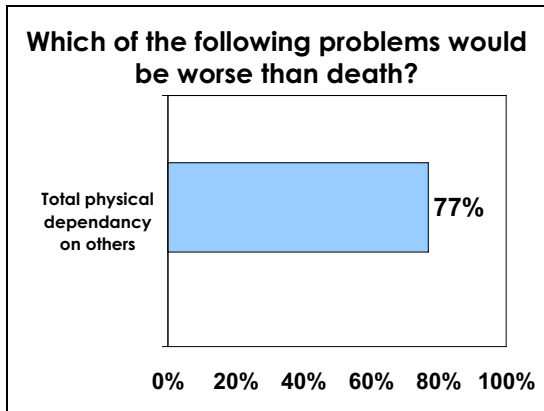
#### 4. FEAR ISSUES

Many Nebraskans express fear regarding specific aspects of dying.

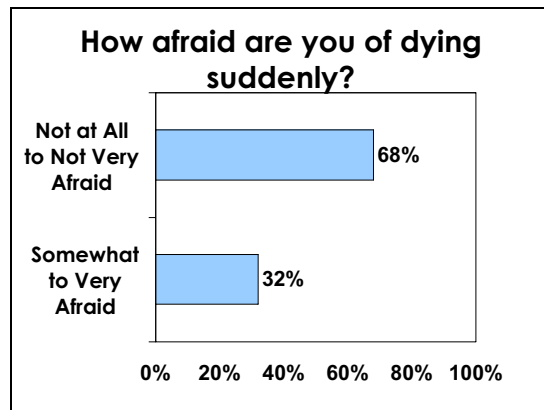
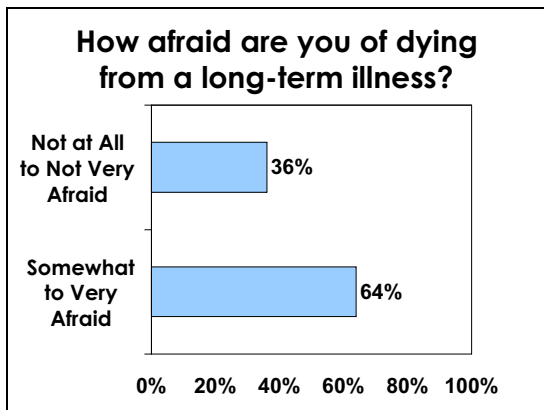


Financial concerns regarding both the respondent's money, as well as the family's money are shared by over 60%.

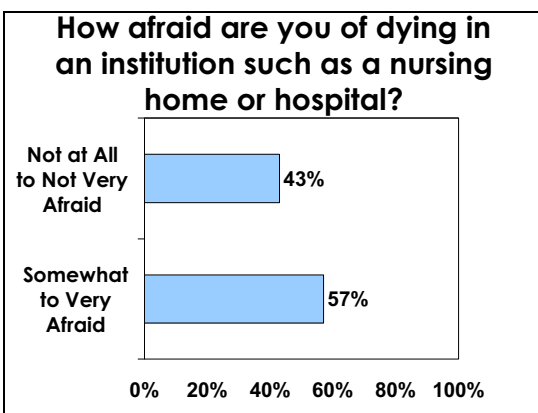
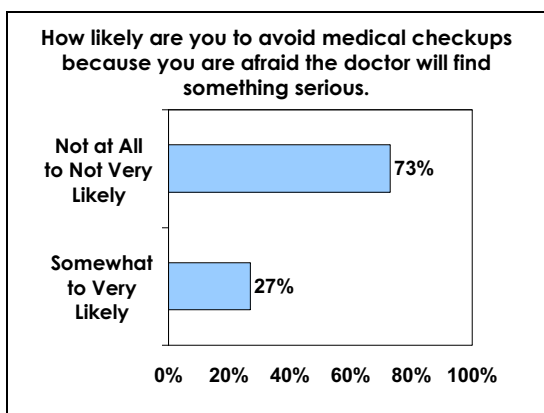


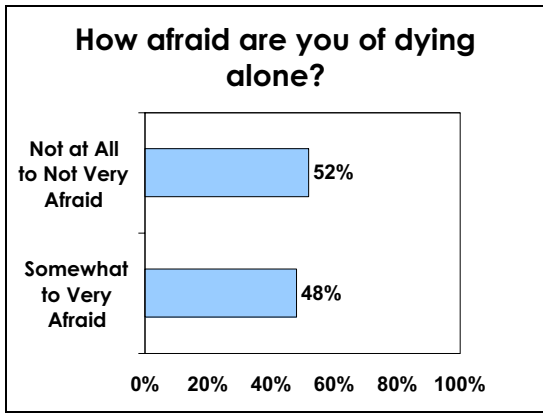


Not being a burden to loved ones is important to nearly 100% of respondents, and three-fourths are concerned that they will be a burden. Additionally, being totally physically dependent on others is seen as worse than death to 77% of participants. And, although hospice services can greatly reduce the burden that families experience while caring for a dying loved one, and in fact hospice use in Nebraska has grown 42% between 2001 and 2005, nearly 54% of survey respondents had heard little or nothing about hospice, and 71% did not know that Medicare pays for hospice services.



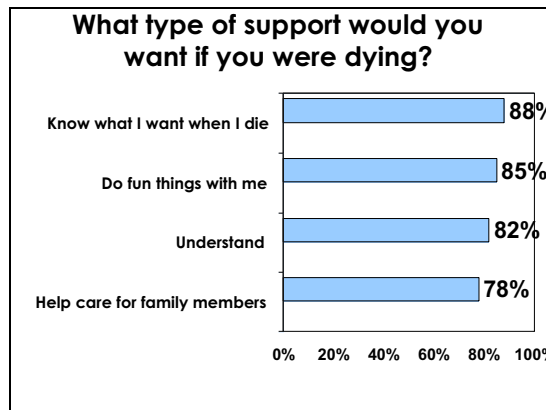
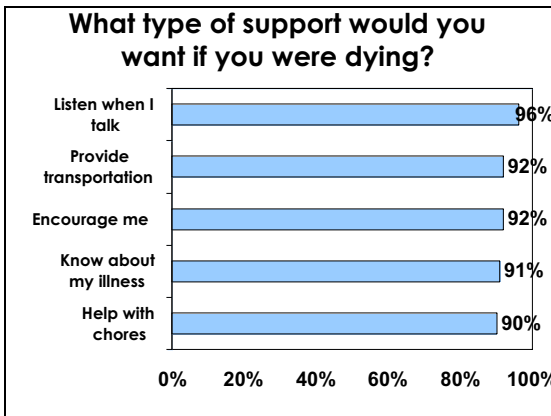
Respondents indicated that they have some fear of dying from a long-term illness (64%), while only one-third are afraid of dying suddenly.



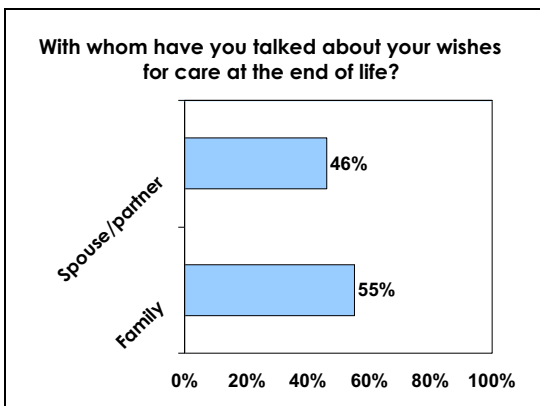


One-third of respondents would be likely to avoid medical checkups for fear that they might have a serious medical condition. Nearly 50% of participants are afraid of dying in an institution, and also of dying alone. As our medical technology continues to improve, we increasingly are dying from long-term illness and according to the 2002 Means to a Better End report<sup>2</sup> over 80% of Nebraskans die in institutions.

## 5. RESOURCES AND SUPPORT



We know from the survey that a high percentage of respondents indicated they know what they would want if they were dying, and share common fears. The results above indicate that most participants also want similar types of support during the dying process.



<sup>2</sup> <http://www.rwjf.org/files/publications/other/meansbetterend.pdf>

Although respondents have this awareness, only one-half have talked to their family, and slightly less to their spouse or partner, about their end-of-life wishes.

Even so, we turn to family first. Less than 20% had talked with friends (19%), their lawyer (15%), primary physician (8%) or clergy (5%).

And when asked whom they would want to provide them with types of support, the highest percentages of respondents reported family as indicated by the total average for the rows in the table below.

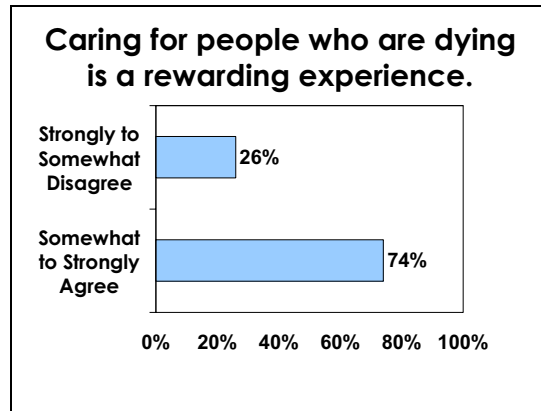
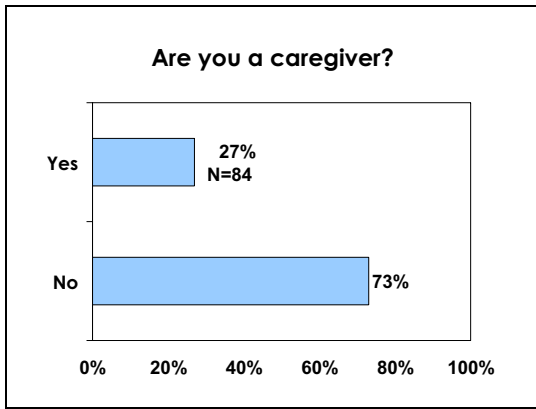
Table 1: Types of Support Expected and by Whom

	Listen	Transport	Encourage	Know illness	Chores	Know desires	Fun things	Understand	Care for family	Total Average
Children	84%	72%	81%	81%	75%	84%	85%	71%	69%	78%
Spouse/ Partner	64%	61%	65%	65%	59%	65%	64%	63%	58%	63%
Other Family	51%	47%	61%	57%	48%	46%	64%	47%	60%	53%
Friends/ Neighbors	40%	39%	56%	44%	37%	24%	61%	42%	36%	42%
Faith Community	45%	20%	48%	33%	18%	26%	25%	34%	31%	31%
Health Providers	53%	19%	35%	51%	17%	26%	09%	47%	20%	31%
Community Organization	04%	13%	08%	05%	11%	01%	07%	10%	08%	7%
Work Associates	08%	03%	11%	07%	03%	03%	06%	09%	04%	6%

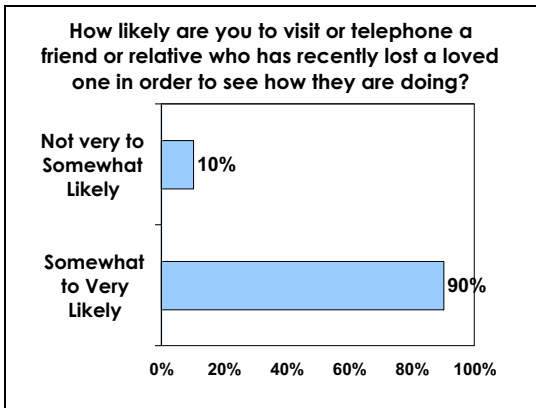
Taking the average across all the types of support shows us that the respondents have the highest expectation of their children, then spouse/partner, then other family members. However, what also can be seen is that one-third to almost one-half would turn to friends, neighbors and faith communities to provide them with support.

Those respondents that indicated they were single, divorced, widowed, or living alone were statistically more likely than those who were married to talk with friends about their wishes and to want support from the following people:

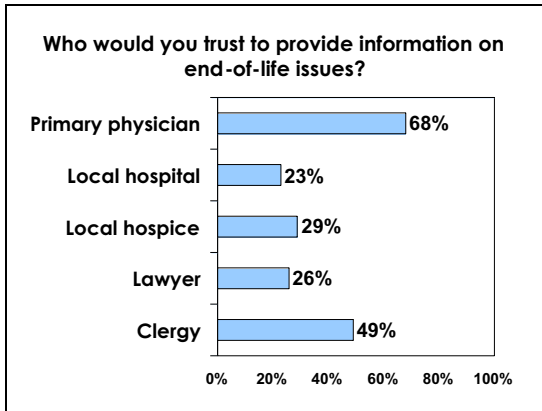
- friends/neighbors to provide transportation
- health providers to help with chores
- friends/neighbors and community organizations to do fun things with them
- other family and friends/neighbors to know what they want when they die
- friends/neighbors and health providers to care for other family members
- friends and neighbors to encourage them when they are down
- friends/neighbors to understand what they are going through
- friends/neighbors know about my illness



As can be seen above, slightly more than one-fourth of respondents identified themselves as caregivers and three-fourths agree that caring for people who are dying is a rewarding experience. Below, we see that 90% would visit or telephone a friend who had recently lost a loved one.



All of these results, taken together, suggest that people in Nebraska would tend to rely on their families for the help and support needed during their dying process. However, they are equally ready to provide support to others going through the dying process, either in an emotional way or by serving as a caregiver for their loved ones. This is an interesting finding because, as the results showed, most respondents were afraid of being a burden to their loved ones. Yet, they would not hesitate to provide support to a loved one during this difficult time. It is important to get out the message that families do not consider assistance given at the end-of-life a burden. Instead, they are willing to provide the type of support that *they* would want if in the same situation.

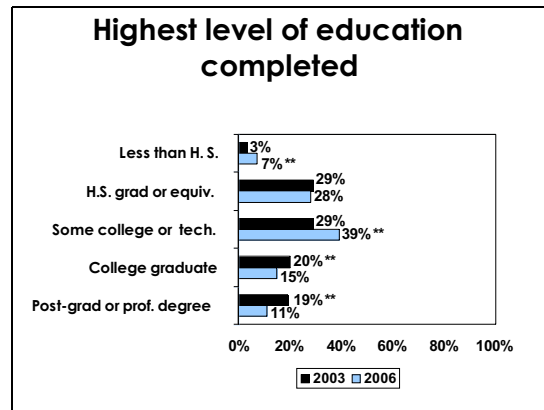
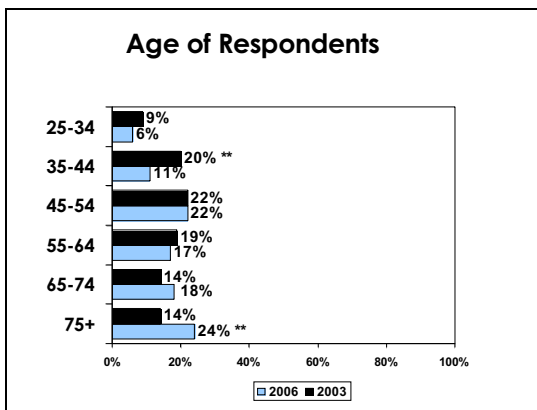


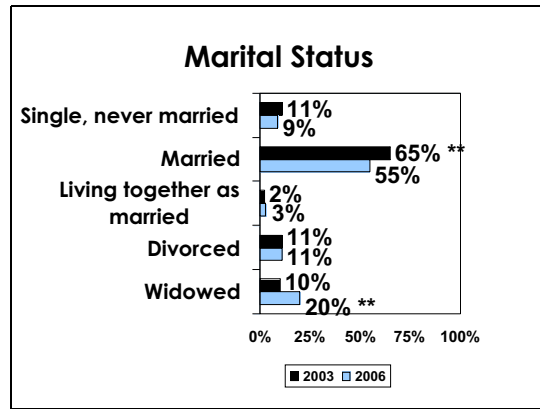
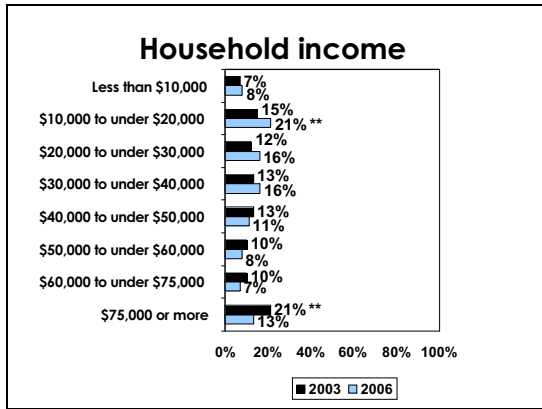
Finally, respondents indicated that they would particularly trust physicians (68%) and clergy (49%) to provide end-of-life information. This finding encourages the growing efforts to include training on end-of-life issues in the educational programs of physicians and faith leaders, most of whom have had no formal training on death and dying.

## II. Changes Over Time: 2003 to 2006

### 1. COMPARING THE RANDOM SAMPLES

We were interested in examining whether the 300 survey participants in 2003 differed in their responses to those of the 324 participants in 2006. Thus, we ran statistical tests on all of the items. We report here only those items that were found to be different in a statistically significant way. When multiple answers are possible, we use asterisks to denote the statistically significant differences. We present the 2006 results with light bars, while the 2003 are dark.



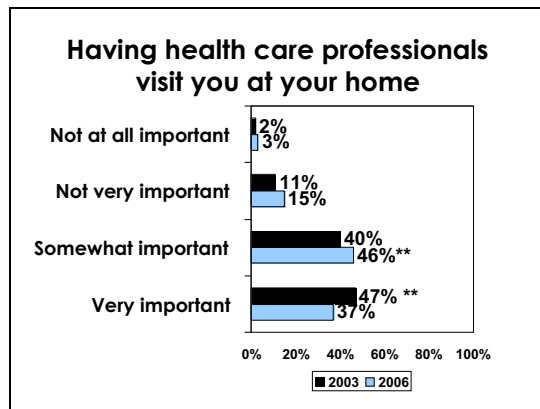
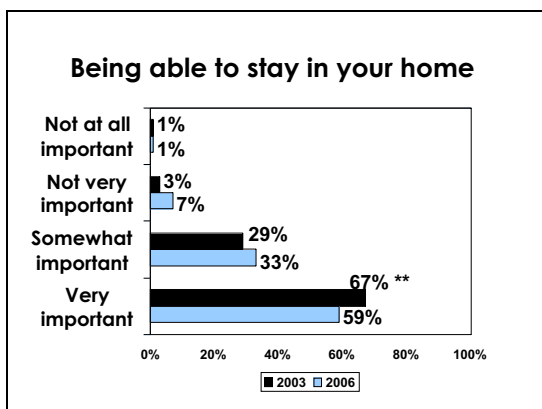


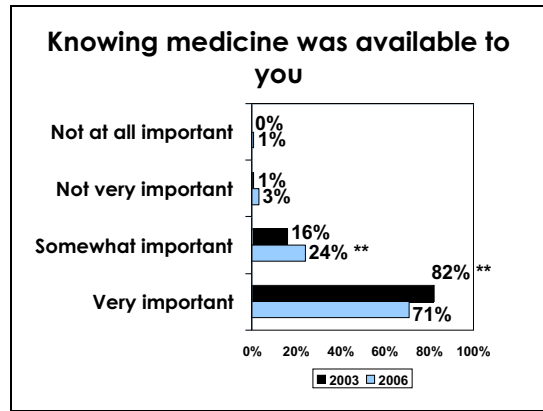
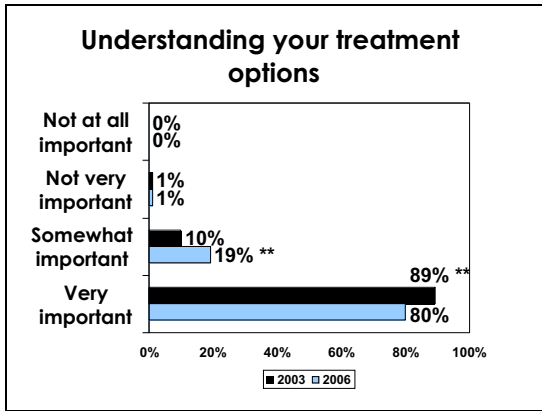
First, we looked at demographics and found that our 2006 respondents are older, less educated, have lower income, are less likely to be married and more likely to be widowed and retired. As can be seen in 2006 we had more seventy-five years and older respondents and less thirty-five to forty-four year olds; more participants who did not have a high school degree, more that had some college or technical training, but fewer college and post graduate degrees; more respondents in the \$20,000 to under \$30,000 bracket and fewer in the \$75,000 plus bracket; 36% of the 2006 participants were retired compared to 27% in 2003.

Because of the extent of the demographic differences between the participants in 2003 and 2006, we cannot rule out that these characteristics are influencing the following results. Since the older age of the 2006 participants is likely the reason they have lower income, less education, fewer are married and more are widowed, we ran statistical analysis on the results that controlled for the variable of age. Even with age controlled, time also appears to have at least some influence on participants' responses. (See Methodology section of this report.)

## WISHES

There were only four items in our "Wishes" category that 2006 participants responded differently than those in 2003.

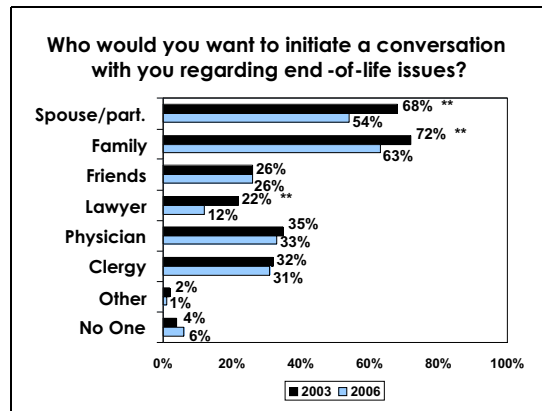
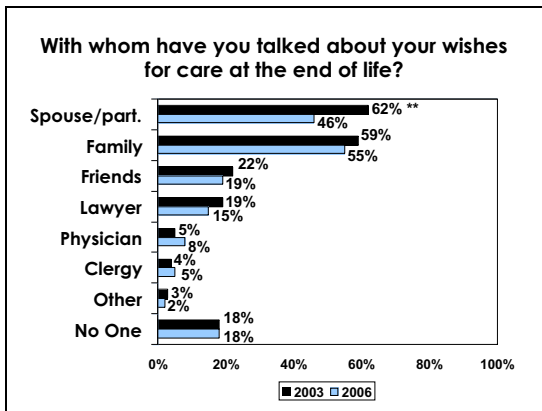




The 2006 participants were less likely to say that staying at home was “very important” (67% 2003; 59% 2006); less likely to indicate that having health care professionals visit them was very important (47% 2003; 37% 2006); more likely to report that “understanding their treatment options” was very important (89% 2006; 80% 2003); and less likely to feel that knowing medicine available to them was very important (82% 2003; 71% 2006).

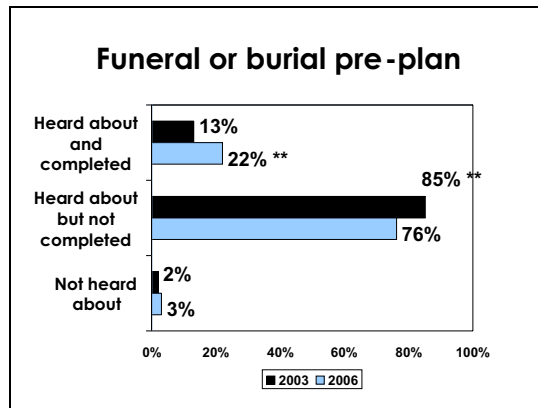
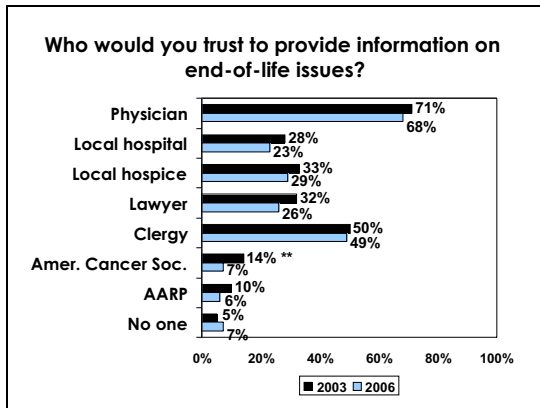
When examining these results, we can surmise that because there are a higher percentage of widowed people in 2006, they might not feel as strongly about being able to stay in their home if they were dying. It is more difficult to interpret why having health care professionals and knowing medicine was available to them was less important. When looking at the percentages of people who feel that understanding treatment options is at least somewhat important (adding somewhat and very together), we see that each group adds to 99%. Thus, though the strength of importance is different, the same very small percentage of people (1%) indicated a low level of importance.

## PLANNING IN ADVANCE



Regarding who they had talked to about end-of-life wishes, the only statistical difference between the two groups was that the 2003 participants had spoken with their spouse/partner more than those in 2006. This result is likely due to the higher percentage of 2003 respondents that were married. However, it is interesting to note that, although not statistically different, a lower percentage of the 2006 participants had talked with all categories of people except physicians (and this was only 3% more in 2006) and clergy (only 1% more in 2006). This same pattern holds true for who they would like to initiate end-of-life conversations and who they would trust

to do so. Again, we see that a lower percentage of 2006 participants want their spouse/partner (also likely because fewer are married) to initiate the conversation, but additionally a statistically lower percentage want their children to initiate conversations. Finally, there are no categories of people or organizations that the 2006 participants would trust equally, or more than, the 2003 respondents. The one statistical difference is that a higher percentage of 2003 participants would trust the American Cancer Society to provide end-of-life information.



Although the 2006 participants seem to be more private about their end-of-life wishes, a higher percentage of them had completed funeral or burial pre-plans. Additionally, even though the differences were not significant, there was an increase of 6% in the 2006 participants who had completed a Health Care Power of Attorney, and 8% more had completed a Living Will. Since we did find a statistical difference in completion of these documents between those 65 years and older compared to those 64 years and younger, we can surmise that age is influencing this result.

## PAIN ISSUES

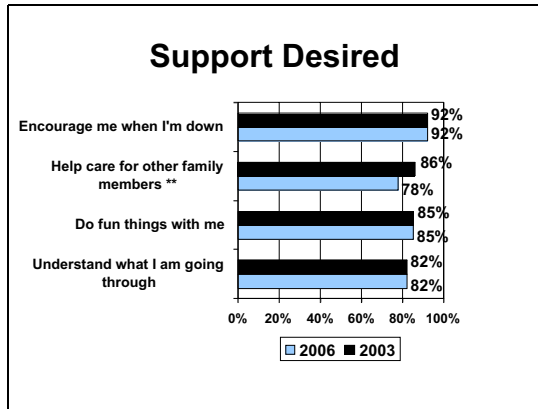
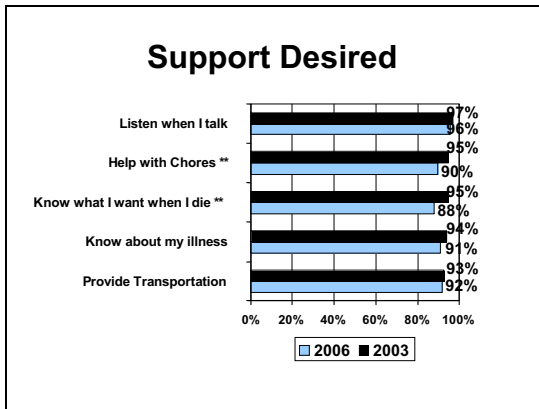
There were no statistically different responses between the two groups on any of the items that related to the experience of dying painfully or related to the treatment of pain.

## FEAR ISSUES

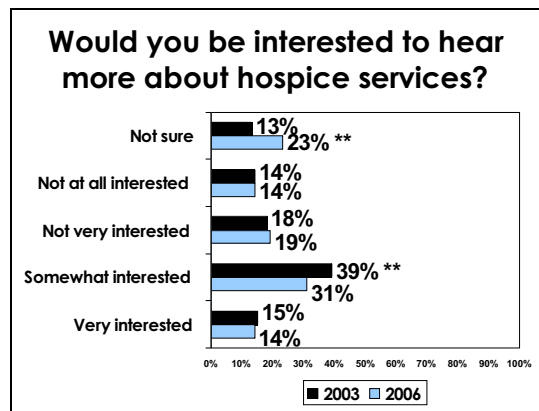
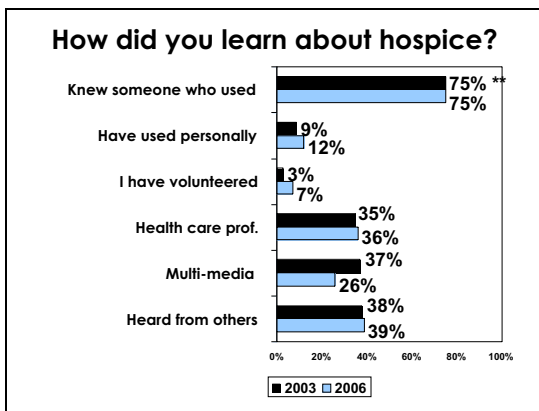
There were no statistically different responses between the two groups on any of the items that addressed concerns or situations that participants agreed they would be afraid of happening if they were dying.

## RESOURCES AND SUPPORT

The responses of the two groups were very similar when asked what types of support they would expect to need near the end of their life. However, regarding help with chores, knowing what they want when they die, and help in caring for other family members, a lower percentage of the 2006 participants expected these types of help.



When asked who they would expect to provide this type of support out of the following list: spouse/partner, children, other family, friends/neighbors, health providers, work associates, faith community, or community organizations, the only statistical difference between the two groups was that spouse/partner was chosen more frequently by the 2003 participants than the 2006. Again, this is likely because a higher percentage of the 2003 respondents were married.



Regarding hospice support, we compared those who indicated they had heard a lot about hospice in 2003 and in 2006. Only two items were found to be statistically different. A lower percentage of the 2006 participants had heard about hospice through multi-media resources such as radio, television, and literature. Additionally, the 2006 participants were less sure they wanted to hear more about hospice services.

## CONCLUSION

Because of the demographic differences between the 2003 and 2006 participants, it is difficult to determine which of the above results are due to these characteristics or to time. In the three years between the two surveys, the Terri Schiavo case gained much attention in the media and in the political arena. In addition, in the summer of 2006 a ballot petition was circulated across Nebraska that proposed inhibiting the removal of feeding tubes. These events may have influenced our results. However, what we find notable is that there are so few differences, even though the 2006 sample is older, less educated, lower income, more likely to be retired and less likely to be married. And, although there are initiatives ongoing in Nebraska to improve the quality of life's end, we know that changing long-standing cultural and medical norms takes time. Thus, we will continue our efforts in the area of community outreach to educate people

about hospice services, and encourage them to plan in advance. We will work with professional groups to assist them in identifying how they can contribute to helping people fulfill their wishes at the end of their life.

## **2. COMPARING THOSE WHO RESPONDED IN BOTH YEARS**

We were interested in examining whether the responses of the 100 households that completed the survey in 2003, and again in 2006, might have changed over time. Thus, we ran statistical tests on all of the items for this group of 100 participants. Keep in mind while reading this section that both sets of results relate to the same people: The 100 participants who completed the survey in 2003 and completed it again in 2006. We report here only those items that were found to be different in a statistically significant way.

### **DEMOGRAPHICS**

First we looked at demographics, and found that the only statistical difference is with age. Over the three-year period, we had more 2006 participants in the 75 years and older group and fewer in the 35 to 44 year group. This is not surprising since our 2006 respondents are three years older than in they were in 2003. This was the only demographic characteristic that was statistically different between 2003 and 2006. Again, this suggests that age, as well as time, may be influencing how participants responded.

### **WISHES**

Examination of the items we categorized as wishes found only one that was statistically different: Having family/friends visit them during their dying experience was more important to the respondents in 2006 than it had been to them in 2003 (86% very important in 2006; 78% very important in 2003). This single difference suggests that what we wish for at the end of life changes very little over time or with age.

### **PLANNING IN ADVANCE**

Three items that we categorized as planning in advance were found to be statistically different. Writing their own wills had become more comfortable (78% very comfortable in 2006; 68% in 2003); having things settled with their families had become more important (87% very important in 2006; 83% in 2003); and the desire to have lawyers initiate end-of-life conversations had grown less (11% in 2006; 25% in 2003). Thus, some planning becomes easier and having things settled with family becomes more important.

### **PAIN ISSUES**

There were no statistical differences in any of the items related to dying painfully or related to the treatment of pain within respondents who completed the survey in 2003 and again in 2006. Thus, neither time nor age seems to have influenced participants to respond differently on issues related to pain.

## **FEAR ISSUES**

Examination of items we categorized as fear issues found three that were statistically different. By 2006 participants were less likely to avoid medical check-ups for fear the doctor would find something wrong (55% not at all likely in 2006; 47% in 2003), but were more worried about being a burden to family or friends while dying (41% very concerned in 2006; 38% in 2003); and, thinking that being totally physically dependent on others, such as being in a coma, would be worse than death was a greater concern in 2006 than it had been in 2003 (94% in 2006; 81% in 2003). Here we see that time and age may be moving participants to focus on how their health issues impact family.

## **RESOURCES AND SUPPORT**

Regarding resources and support, by 2006 respondents were more likely to visit or telephone a friend who had recently lost a loved one (52% very likely in 2006; 38% in 2003); had a stronger desire for support in understanding what they were going through (91% in 2006; 82% in 2003); were more likely to expect health providers to listen when they needed to talk (65% in 2006; 48% in 2003) and to provide transportation (31% in 2006; 19% in 2003); and were less likely to expect friends/neighbors to help with chores (32% in 2006; 44% in 2003) and expect their faith community to encourage them when they were down (41% in 2006; 54% in 2003).

When asked about hospice, by 2006, a higher percentage of respondents who had heard a lot about hospice indicated that they would want hospice services if they were dying (95% in 2006; 77% in 2003).

## **CONCLUSION**

These results suggest that, over time, our wishes for the end of life remain relatively stable. However, our planning in advance does not really improve, even though we become more worried about being a burden and being totally physically dependent on others. Regarding pain, it seems that neither time, nor age, changes our concerns regarding dying painfully, nor do these variables improve our knowledge of appropriate pain treatment. However, time and age do seem to influence our understanding of how others might need our support if they have lost a loved one, and that the health care provider system may be more able to provide certain supports. Finally, it is quite clear that over the last three years, these participants have determined that hospice services would be very important during their dying experience.

As the end-of-life movement continues to attempt to improve the quality of life for dying people and their families, community outreach needs to be guided by research. Thus, further research focusing on the general community and how they view end-of-life issues over time seems warranted.

## Appendix A: Methodology

### METHODOLOGY

In July 2006, the Nebraska Hospice and Palliative Care Partnership conducted a random-sample mailed survey to Nebraska residents age 18 and older. The sample was purchased from Accudata American, the largest independent list broker in the nation. Accudata lists are compiled from a variety of sources including telephone directories, public records, U.S. Census Bureau, U.S. Postal Service information, surveys, birth records, door-to-door canvassing, warranty cards, mortgage data and more. The specifications were for a sample containing half rural and half urban individuals. Although more Nebraskans live in urban than rural settings, we requested half the sample be individuals from rural locations, over-sampling these people ensured we had a large enough sample to compare rural and urban responses. We also over-sampled individuals living in Hall County because an end-of-life coalition had been actively pursuing community engagement. Additional demographic information was collected for this sample including: gender, area code, length of residence, education, ethnicity, income, marital status, and county. The computer randomly chose across the entire list to provide an even distribution of the selected demographics. In addition to the random sample, surveys were sent to all individuals who completed the survey in 2003. This was done to examine changes over time in the 2003 respondents' attitudes and beliefs.

All the residents in the sample, 2,409 new individuals and 304 individuals who previously responded in 2003, received two pieces of mail: the survey with a cover letter that explained its purpose and a reminder postcard mailed to them only if they had not returned the survey within one week. A total of 424 completed surveys were returned by the cutoff date. Of these, 420 contained usable data. A participation incentive was offered. Everyone who returned a survey was eligible for one of ten \$50 awards. The respondents were directed to check a box if they wanted to be entered in the drawing. No names or addresses were placed on the survey. Each survey was coded so reminder postcards could be mailed to those who had not completed it within one week, and so those who entered the drawing could receive their award.

The survey has a sampling error of plus or minus 5.6%. This means that out of 100 samples of this size, the results obtained in the sample would fall in a range of plus or minus 5.6 percentage points of what would have been obtained if every Nebraskan resident age 20 and older had been surveyed.

The database was written using SPSS Data Entry Builder and the data analyzed using SPSS statistical software. Frequencies were run on all variables of interest. Also, tests of significance were conducted, when appropriate, to examine differences between various groups of interest.

The percentages presented for each question in this report are the "valid percentages," meaning they were computed using the valid sample size for each question. To compute the valid sample size for each question, respondents with missing or non-responsive answers were subtracted from the total number of respondents. The valid percentages for a given question should add to approximately 100% (slightly more or less than 100% because of rounding error). The percentages for the missing/non-responsive answers are separate from the valid percentages and are not included in this sum.

A Respondent/Non-Respondent analysis was conducted from the initial random sample database for the two groups to determine demographic differences between those who chose to respond to the survey and those that did not. This analysis indicated that the respondents were more likely to be women, married, older, come from rural areas, and have lower incomes. Because of these differences between the responders and non-responders, we compared the demographics of our sample to those of Nebraska's 2005 U.S. Census Bureau Population Estimates. The participants in our survey were significantly different from Nebraska's overall population in both gender and age. Women and older people are more represented than men or younger people. It is not uncommon for more women to complete surveys than men. And, although, younger people do experience death and dying, older people are more likely to be facing issues related to the end of life and women are more likely to be caregivers. To determine age biases, we examined how participants who were 65 years and older responded differently than those who were 64 years and younger. (See report at [www.nehospice.org](http://www.nehospice.org).)

One of the goals of the current survey was to compare the current respondents with those from 2003. As stated above, the 2006 respondents were different from the overall Nebraska population, tending to be older and female. This was also true in comparison to the 2003 sample. Initially, we were uncertain of the effects these differences would have on the comparison results between the 2003 sample and the current 2006 sample. Significant differences emerged between these samples on various items. To determine the degree to which age influenced these results, we re-analyzed them while statistically controlling for these factors. The results showed that the effect of age, although substantial, did not remove the importance of the year variable. In other words, even when we controlled for age, the differences we found between the 2003 and 2006 samples remained, suggesting that time also influenced how the participants responded.

## **SURVEY HISTORY**

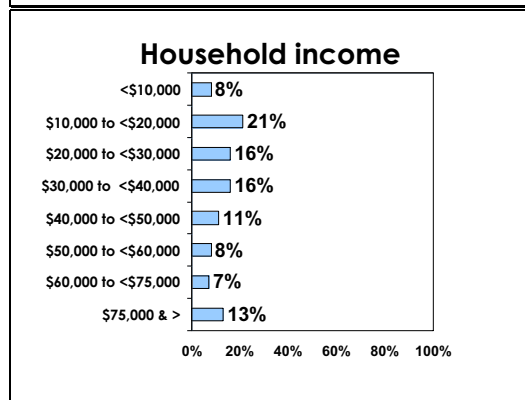
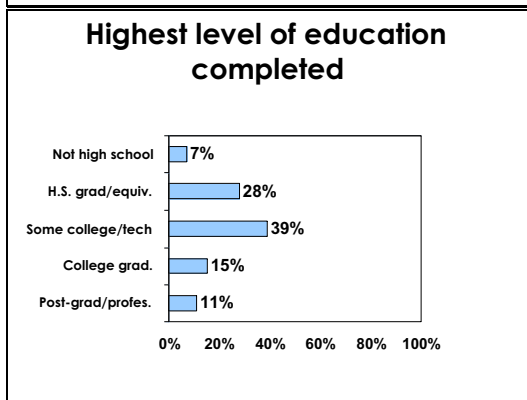
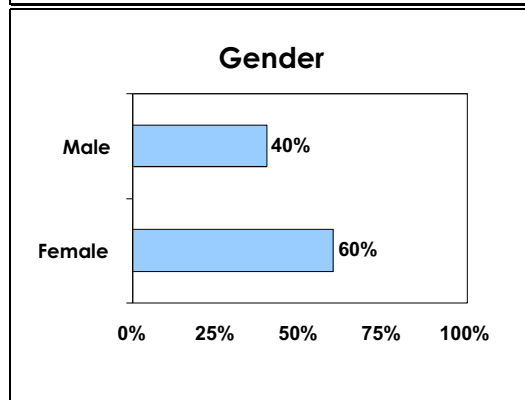
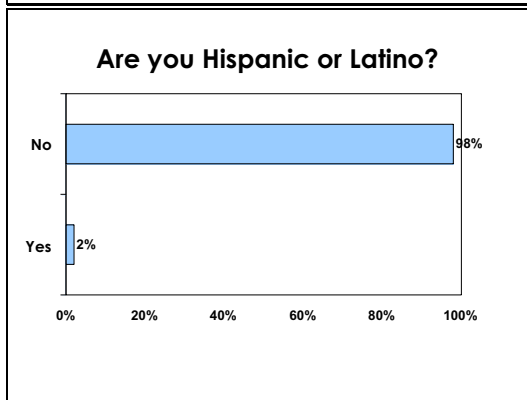
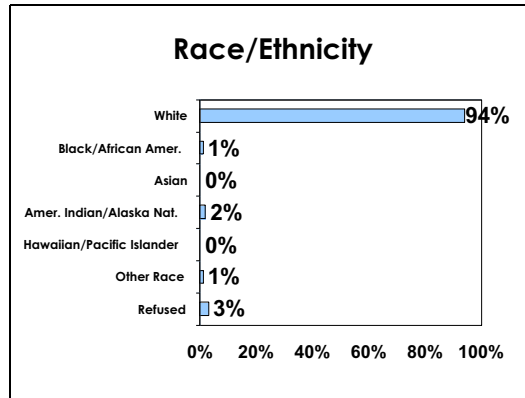
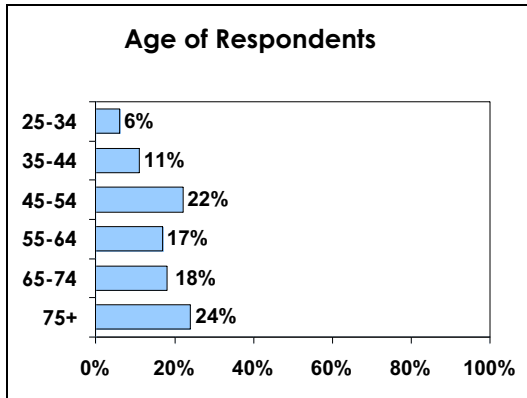
The survey is adapted from the original Life's End Institute: *Missoula Demonstration Project's* Community Survey. In 1997, Life's End Institute completed a seventy-three item comprehensive survey in Missoula County, Montana to determine prevailing attitudes, expectations, and experiences with the dying process. Two comparison communities were also surveyed: Bannock County, Idaho and Albany County, Wyoming.

Using modified questions and a modified response scale from the Corriveau-Kelly Death Anxiety Scale (which itself was built upon Templer's Death Anxiety Scale), the survey tool gathers basic demographic information as well as data related to advance care planning, knowledge of hospice services, spiritual beliefs and customs related to death and dying, preferred medical practices, financial concerns, pain management and social support systems.

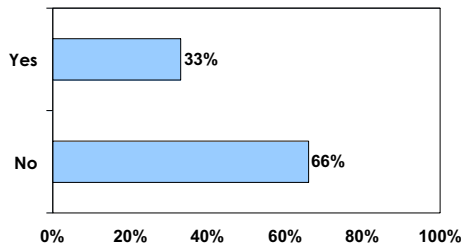
The data from the survey have proven to be useful, serving as the basis for several community engagement initiatives in Missoula County. Since its inception, the Missoula Community Survey has been adapted for statewide use and has been successfully used in several communities and states nationwide. In 2001, North Carolina was the first state to implement the survey to a random sample of AARP members. Because the original Missoula survey was developed in 1997, an advisory group was created to review and revise the survey so that it would be more current. The core of the survey is the same. New items were added regarding advance planning and hospice. Nebraska was the next state to use the survey. We refined the advance planning questions. This survey was then used as the core survey in Massachusetts,

Idaho, and South Dakota. Each state has included some unique items relevant to initiatives in their state, but the core survey remains the same.

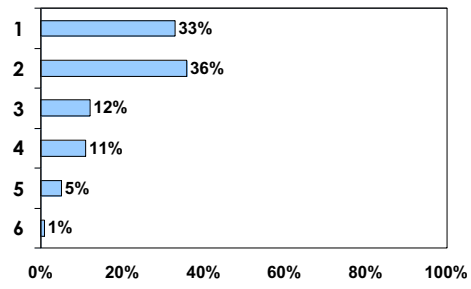
## DEMOGRAPHICS



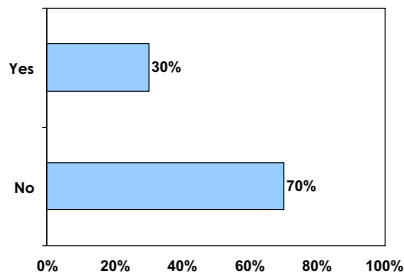
### Do you live alone?



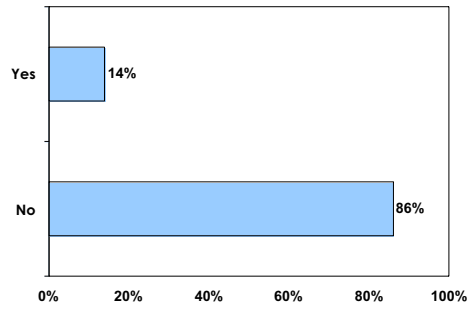
### Number of persons living in household



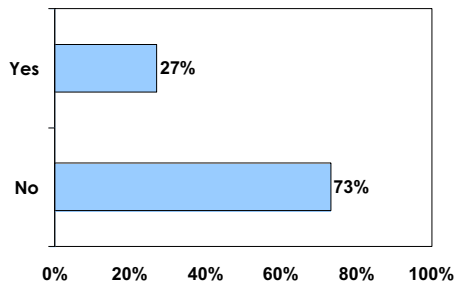
### Are you a member of AARP?



### Are you a United States Veteran?



### Are you a caregiver?



## Appendix B: NHPCP Partners and Leadership



### **Nebraska Hospice and Palliative Care Partnership**

*Improving Care and Conditions for Chronically and Terminally Ill Nebraskans*

4720 Randolph St., Bethel Bldg.  
Lincoln, NE 68510  
Phone/Fax: 402/477-0204  
www.nehospice.org

**NHPCP Organizational Partners:** Great Plains chapter of the national Alzheimer's Association  
Nebraska C.A.R.E.S. (Cancer Awareness, Research, Education, and Services) CIMRO of Nebraska  
Hospice Pharmacia HospiScript Center for Health Policy & Ethics at Creighton University Medical  
Center Madonna Rehabilitation Hospital Nebraska Coalition for Compassionate Care Nebraska Funeral  
Directors Association Nebraska Health Care Association Nebraska Hospital Association Nebraska  
Medical Association Nebraska Medical Center UNMC College of Nursing

**NHPCP Hospice Partners (100% of Nebraska hospices):** Alegent Health Hospice AseraCare  
Hospice (Lincoln, Omaha, & Norfolk) Beatrice Community Hospice Burt-Washington Hospice Central  
Plains Hospice Chadron Community Hospice Community Healthcare & Hospice Compassionate Care  
Hospice Custer County Hospice Faith Regional Hospice Care Fremont Area Medical Center Hospice  
Good Samaritan Hospice Great Plains Hospice HoriSun Hospice Hospice & Home Healthcare of  
Saunders County Hospice House Hospice of Columbus Community Hospital Hospice of Siouxland  
Hospice of Tabitha In Home Health Care Mary Lanning Hospice Memorial Health Center Hospice  
Methodist Home Health Hospice Odyssey Health Care of Omaha Prairie Haven Hospice Providence  
Hospice Saint Francis Medical Center Hospice St. Elizabeth Hospice St. Francis Hospice St. Joseph  
Villa Hospice The Monarch Tri-County Hospital Hospice Visiting Nurse Association of the Midlands  
Hospice

**NHPCP Community End-of-Life Coalitions:** Ainsworth, Cass County, Columbus, Custer County,  
West Point, Grand Island, Lincoln, Norfolk, Northeast Nebraska, North Platte, Greater Omaha, Scotts Bluff  
County, Seward, York

### **NHPCP Board of Directors**

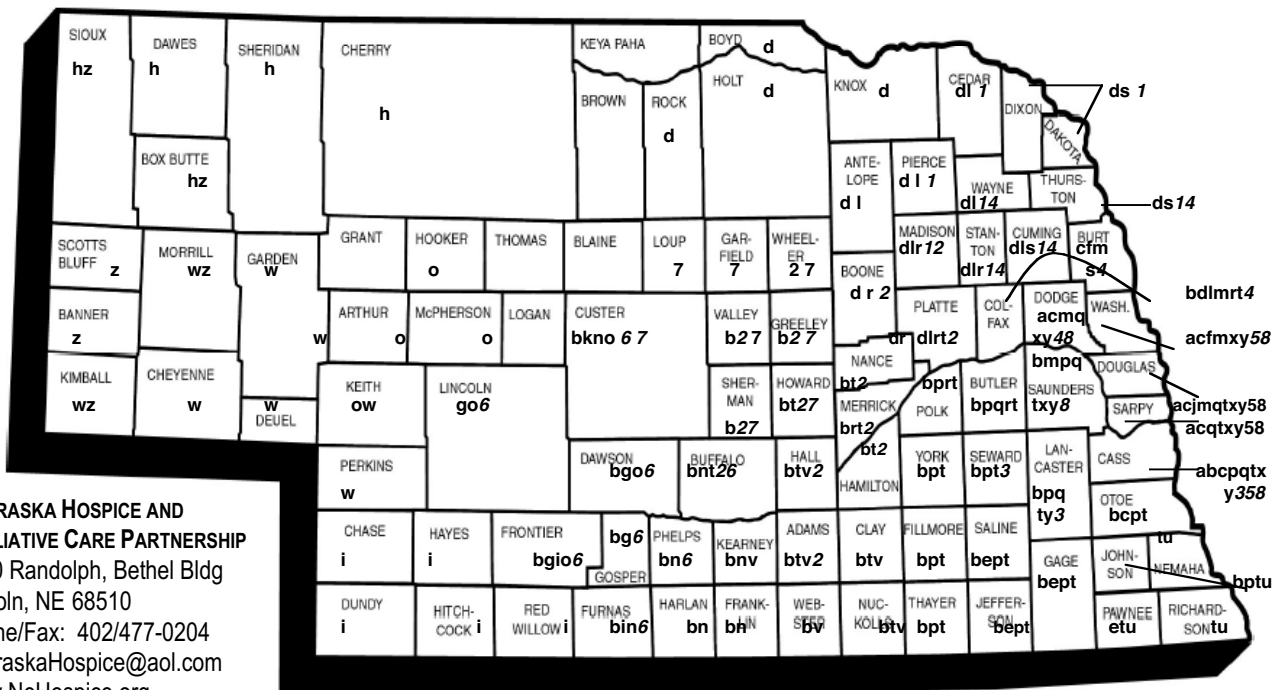
**President – Aloha Schmid, RN, CHPN, Hospice of Tabitha, York**  
**Vice President – Rose Hamilton, RN, BSN, FCN, Good Samaritan Hospice, Kearney**  
**Secretary – Linda Todd, RN, BA, Hospice of Siouxland, Sioux City, Iowa**  
**Treasurer – Alex Willford, NHA, FAMC Home Health Care and Hospice, Fremont**  
**Past President – LaDonna VanEngen, RN, CHPN, St. Elizabeth Hospice, Lincoln**  
**Robert Chitwood, D.Min., Lincoln**  
**Diane Randolph, RN, BSN, Methodist Home Health & Hospice, Omaha**  
**Linda Rock, BA, Prairie Haven Hospice, Scottsbluff**  
**Greg Schieke, MBA, CIMRO of Nebraska, Lincoln**  
**Patricia Snyder, Nebraska Health Care Association, Lincoln**  
**Lisa Weber-Devoll, MSW, Columbus Hospital Hospice, Columbus**

### **NHPCP Staff**

**Jonathan Krutz, MBA, Executive Director, Jon@nehospice.org**  
**Jennifer Eurek, CSW, Education and Outreach Coordinator, Jennifer@nehospice.org**  
**Tracy Rathe, Communications Coordinator, Tracy@nehospice.org**  
**James E. Dube, PharmD, FASHP, Medical Liaison and Clinical Educator, jimdube@cox.net**  
**Sandie Anderson, Executive Assistant, Sandie@nehospice.org**

# Nebraska Hospice Map and Directory

## January 2007



**NEBRASKA HOSPICE AND PALLIATIVE CARE PARTNERSHIP**  
 4720 Randolph, Bethel Bldg  
 Lincoln, NE 68510  
 Phone/Fax: 402/477-0204  
 NebraskaHospice@aol.com  
 www.NeHospice.org

- a. **Alegent Health Hospice**  
 7070 Spring Street  
 Omaha, NE 68106  
 (402) 898-8016  
 Serves Cass, Dodge, Douglas, Sarpy, and Washington Counties
- b. **AseraCare Hospice**  
 1600 South 70<sup>th</sup> St., Ste. 201  
 Lincoln, NE 68506  
 (402) 488-1363  
 Branch Offices:  
**York** --1100 Lincoln Ave., Ste B1  
 York, NE 68467  
 (402) 362-7733  
**Kearney** -- 527 East 25<sup>th</sup> St., Suite 4  
 Kearney, NE 68847  
 (308) 698-0580  
 Serves Adams, Buffalo, Butler, Cass, Clay, Custer, Dawson, Fillmore, Franklin, Frontier, Furnas, Gage, Gosper, Greeley, Hall, Hamilton, Harlan, Howard, Jefferson, Johnson, Kearney, Lancaster, Merrick, Nance, Nuckolls, Otoe, Phelps, Polk, Saline, Saunders, Seward, Sherman, Thayer, Valley, Webster, York Counties
- c. **AseraCare Hospice-Omaha**  
 1104 S 76<sup>th</sup> Avenue  
 Omaha, NE 68124  
 (402) 926-2680
- d. **AseraCare Hospice-Norfolk**  
 1900 Vicki Lane, Ste. 110  
 Norfolk, NE 68701  
 (402) 379-4533  
 Serves Antelope, Boone, Boyd, Cedar, Colfax, Cuming, Dakota, Dixon, Holt, Knox, Madison, Pierce, Platte, Rock, Stanton, Thurston, and Wayne Counties
- e. **Beatrice Community Hospice**  
 1201 South 9<sup>th</sup> St., PO Box 278  
 Beatrice, NE 68310  
 (402) 223-2366  
 Serves Gage, Jefferson, Pawnee, and South Saline Counties
- f. **Burt-Washington Hospice**  
 810 North 22nd St., PO Box 250  
 Blair, NE 68008  
 (402) 426-1292  
 Serves Burt and Washington Counties
- g. **Central Plains Hospice**  
 300 E. 12th Street  
 Cozad, NE 69130  
 (308) 784-4630  
 Serves Dawson, Frontier, Gosper, and Eastern Lincoln Counties
- h. **Chadron Community Hospice**  
 821 Morehead  
 Chadron, NE 69337  
 (308) 432-5521  
 Serves Box Butte, Cherry, Dawes, Sheridan, and Sioux
- i. **Community Healthcare and Hospice**  
 1301 East H, PO Box 1328  
 McCook, NE 69001  
 (308) 345-8356  
 Serves Chase, Dundy, Frontier, Furnas, Hayes, Hitchcock, and Red Willow
- j. **Compassionate Care Hospice**  
 6818 Grover Street, #302  
 Omaha, NE 68106  
 (402) 390-2492  
 Serves Douglas & surrounding area
- k. **Custer County Hospice**  
 145 Memorial Drive  
 PO Box 250  
 Broken Bow, NE 68822  
 (308) 872-2625 ext. 307  
 Serves Custer County
- l. **Faith Regional Hospice Care**  
 1500 Koenigstein  
 Norfolk, NE 68701  
 (402) 644-7455  
 Serves Antelope, Cedar, Colfax, Cuming, Madison, Pierce, Platte, Stanton, and Wayne Counties

- m. **Fremont Area Medical Center Hospice**  
450 E. 23rd Street  
Fremont, NE 68025  
(402) 727-3484  
Serves Burt, Colfax, Dodge, Douglas, Saunders, and Washington Counties
- n. **Good Samaritan Hospice**  
10 E. 31st St.  
Kearney, NE 68848-1990  
(308) 865-7090  
Serves Buffalo, Franklin, Furnas, Harlan, Kearney and Phelps Counties
- o. **Great Plains Hospice**  
c/o: Great Plains Reg. Med Center,  
P.O. Box 1167  
North Platte, NE 69103-1167  
(308) 696-7434  
Serves Custer, Dawson, Frontier, Hooker, Keith, Lincoln, Logan, and McPherson Counties
- p. **HoriSun Hospice, Inc.**  
249 Cherry Hill Blvd., Suite 1  
Lincoln, NE 68510  
(402) 484-6444  
Serves Butler, Cass, Fillmore, Gage, Jefferson, Johnson, Lancaster, Otoe, Polk, Saline, Saunders, Seward, Thayer and York Counties
- q. **Hospice & Home Healthcare of Saunders County**  
754 West 9<sup>th</sup> St., PO Box 367  
Wahoo, NE 68066-0367  
(402) 443-4798  
Serves Saunders, NW Cass, E Butler, N Lancaster, W Sarpy, W Douglas, S Dodge Counties
- r. **Hospice of Columbus Community Hospital, Inc.**  
3005 19th St., PO Box 1800  
Columbus, NE 68602-1800  
(402) 563-3300  
Serves Boone, Butler, Colfax, Madison, Merrick, Nance, Platte, Polk, and Stanton Counties
- s. **Hospice of Siouxland**  
4300 Hamilton Blvd.  
Sioux City, IA 51104  
(712) 233-4144 or (800) 383-4545  
Serves Burt, Cuming, Dakota, Dixon, and Thurston Counties in NE
- t. **Hospice of Tabitha**  
4720 Randolph  
Lincoln, NE 68510  
(402) 486-8575  
Serves Adams, Buffalo, Butler, Cass, Clay, Colfax, Fillmore, Gage, Hall, Hamilton, Howard, Johnson, Lancaster, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Platte, Polk, Richardson, Saline, Sarpy, Seward, Thayer, York, and portions of Douglas, Jefferson, and Saunders Counties
- u. **In Home Health Care, Inc.**  
116 W. 19th Street  
Falls City, NE 68355  
(402) 245-5968  
Serves Johnson, Nemaha, Pawnee, and Richardson Counties
- v. **Mary Lanning Hospice**  
715 N. St. Joseph Ave.  
Hastings, NE 68901  
(402) 460-5868  
Serves Adams, Clay, Kearney, Nuckolls, Webster, portions of Hall County
- w. **Memorial Health Center Hospice**  
645 Osage  
Sidney, NE 69162  
(308) 254-3273  
Serves Arthur, Cheyenne, Deuel, Garden, Keith, Kimball, Morrill, and Perkins Counties
- x. **Methodist Home Health & Hospice**  
8601 W. Dodge St., Suite 138  
Omaha, NE 68114  
(402) 354-3200  
Serves Cass, Dodge, Douglas, Sarpy, Saunders, and Washington Counties
- y. **Odyssey Health Care of Omaha**  
444 Regency Parkway Dr., Ste 200  
Omaha, NE 68114  
(402) 397-0990  
Serves Cass, Dodge, Douglas, Lancaster, Sarpy, Saunders, and Washington Counties
- z. **Prairie Haven Hospice**  
Two West 42nd St., Suite 2300  
Scottsbluff, NE 69361  
(308) 630-1149  
Serves Box Butte, Kimball, Morrill, Scottsbluff, and portions of Banner and Sioux Counties
1. **Providence Hospice**  
1200 Providence Road  
Wayne, NE 68787  
(402) 375-4288  
Serves Cedar, Cuming, Dakota, Dixon, Madison, Pierce, Stanton, Thurston, and Wayne Counties
2. **Saint Francis Med Center Hospice**  
2121 North Webb, Suite 304  
Grand Island, NE 68803  
(308) 398-5470  
Serves Adams, Boone, Buffalo, Greeley, Hall, Howard, Nance, Sherman, and portions of Buffalo, Hamilton, Madison, Merrick, Platte, Valley, and Wheeler Counties
3. **St. Elizabeth Hospice**  
245 S. 84<sup>th</sup> Street, Suite 111  
Lincoln, NE 68510  
(402) 219-7043  
Serves Cass, Lancaster, and Seward Counties
4. **St. Francis Hospice**  
430 N. Monitor  
West Point, NE 68788  
(402) 372-5929  
Serves Burt, Colfax, Cuming, Dodge, Stanton, Thurston, and Wayne Counties
5. **St. Joseph Villa Hospice**  
1000 N 90<sup>th</sup> St., Suite 203  
Omaha, NE 68124  
(402) 926-4444  
Serves Cass, Douglas, Sarpy and Washington Counties
6. **Tri-County Hospital Hospice**  
1600 W 13th St., PO Box 980  
Lexington, NE 68850  
(308) 324-8300  
Serves 45 mile radius of Lexington, including portions of Buffalo, Custer, Dawson, Frontier, Furnas, Gosper Lincoln and Phelps Counties
7. **Valley County Hospital Hospice**  
217 Westridge Drive  
Ord, NE 68862  
1-877-594-8090  
Serves Custer, Garfield, Greeley, Howard, Loup, Sherman, Valley, and Wheeler Counties
8. **Visiting Nurse Association of the Midlands Hospice**  
1941 S. 42nd Street, Suite 225  
Omaha, NE 68106-9855  
(402) 930-4262  
Serves Cass, Douglas, Sarpy, portions of Dodge, Saunders and Washington Counties

Residential Hospice Facilities

**Hospice House**  
7415 Cedar Street  
Omaha, NE 68124  
(402) 343-8600

**The Monarch**  
4201 S. 78<sup>th</sup> St.  
Lincoln, NE 68506  
(402) 489-6591

1/22/07