Preserving Hospice Values in a Difficult Economy

Meeting the Challenge Through Teamwork...
2009 National Hospice Foundation Gala

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Introduction:

Meeting the Challenge Through Teamwork
The economic downturn is affecting all of us, in both our personal and professional lives. Some people are losing their jobs, others are taking on more responsibilities for the same or less pay, and many businesses are struggling to remain open. For hospice providers, the challenge may feel even greater as new regulatory requirements call for changes in the way we practice as well as demonstrable improvements in the quality of our services. So what are the answers? Where are the solutions?

Many of the answers and solutions may be right down the hall, at your next team meeting, and even in the staff lunchroom. In the face of crises like these, an organization’s senior leaders may feel like they must shoulder the burden alone, have all the answers, and make all of the tough choices. In reality, one of the most important steps you can take to preserve the hospice mission and your margin is asking staff and volunteers for input.

This issue is proof of that. In the pages that follow, you may not find that one big idea or solution, but you will find many small ones. More than a dozen members of the hospice interdisciplinary team, representing large and small programs from around the country, share their thoughts on what we need to remember in times of financial crisis and how each of us can help. As Robert Arnold and Roxanne Griffin note in their article on page 13, we are challenged each day to have the most intimate of conversations with our patients and families. In these challenging times, we must speak to one another as well.
It is 2:30 a.m. on a cold, windy and snowy morning. Jackie Davis, a registered nurse with Prairie Haven Hospice (PHH) in Scottsbluff, Nebraska, has been with a patient for the past three hours to manage his pain and support his family. Just as she arrives home, she receives a call from the wife of another patient who states her husband has been very restless for the past two hours and she is worried about him. After giving the wife some basic instructions, Jackie heads out the door again at 3:00 a.m.

This is not an unusual night for a hospice nurse on-call. However, this is Jackie’s third night on call and, on this night alone, she will travel over 259 miles on isolated country roads—and sometimes dirt paths—to provide PHH patients with care, comfort and support. In rural western Nebraska, there is no hospice on-call team and patients live in very remote areas. While the needs of patients are growing more complex, the cost of providing them with quality care is becoming more and more of a challenge. With limited human resources, limited and dwindling dollars to spend, higher costs for medications and supplies, and long distances to travel between patients, PHH has had to become even more resourceful than ever before to maintain its mission of comprehensive, compassionate and high-quality care and, at the same time, support and retain its incredibly hard working, skilled and dedicated staff.

Meeting the Challenge

We have had the hard conversations about reducing the area we serve, but in accordance with the PHH mission to ensure access to all patients and families in need, we don’t want to stop servicing an area unless hospice care can be provided by another program. Thus, we have explored collaboration and partnerships in those areas where we can. For example, we are now working on a collaborative effort with a nursing facility
and critical access hospital to ensure access in one particular area that's been impacted by staffing changes.

We have also looked at limiting services that are not reimbursable, such as massage therapy. We have also reviewed how much time we can actually spend together as a team with travel being costly and time intensive. We have opted to do more video-conferencing, which works well when the technology works in western Nebraska's terrain. Our team also wears many hats and utilizes skilled members of our community where their volunteer service can help fill important gaps. For example, PHH has formed a QAPI Committee and Hospice Awareness Committee to assist us in furthering our mission to provide quality care.

A huge challenge for us is the long distances between patients' homes. We "staff geographically," but even that has been difficult since many patients live 30-plus miles apart. We strive to work as efficiently and effectively as possible—by planning our visits, making sure patients have ample medications and supplies, and providing comprehensive education and support to their caregivers.

We have always operated on a very low profit margin—so low in fact that our figures often glow red. We are accustomed to doing more with less and rely on and are most appreciative of the donations we receive that truly allow us to fulfill our mission. We also recognize that future donations may not be as plentiful as we all struggle with an unstable economy. We must consistently look for ways to raise the extra dollars that are critical to our program and, unfortunately, must also re-evaluate the support we lend to other agencies and find new and different ways to assist them.

PHH has always made an effort to work in concert and collaboration with other organizations and providers to enhance services and increase access to care. In an area where resources are limited, everyone works together and assists each other to provide high-quality care. One particular partnership is with our local community college whereby PHH staff can take classes in exchange for teaching other students about end-of-life care issues.

While every hospice provider is facing its own specific challenges, our rewards are the same. Feedback PHH recently received from the wife of a former patient brings this point home. She and her husband were married for 57 years, but she wanted us to know that her grief has been manageable since his death because of our help—because he was able to remain at home throughout his illness and because of the bereavement support she has received. A heartfelt reminder to us all in these particularly difficult times.

Linda Rock has over 25 years of experience in the hospice field and is currently executive director of Prairie Haven Hospice (Scottsbluff, NE), where she has worked since 1997. In addition, she is a member of the NHPCO Board of Directors and chair of the NHPCO Professional Education Committee.
Did you ever take a cold call from someone selling newspaper advertising and get the feeling you were actually talking to someone reading a carefully prepared script from the middle of a huge call center?

Did you ever look at an urgent notice to review and correct, if necessary, your hospice’s valuable Yellow Pages listing and wonder why the phone company didn’t have the correct information already?

Did you ever get solicited to buy an ad campaign in which the advertising representative focused on a heavily discounted price to the exclusion of every other factor necessary to evaluate an advertising buy?

In good economic times and not-so-good times, all hospice providers—whether private or public, nonprofit or for-profit—have a fiduciary responsibility to be careful stewards of the financial resources entrusted to them by governmental and private payors. That includes the valuable funds spent on advertising. That’s exactly why questions like these—and many more—should be top of mind for anyone responsible for a hospice’s marketing and advertising dollars.

**Healthcare Advertising**

Healthcare advertising is still a relatively young phenomenon. The first, courageous health systems cautiously began testing the waters in the 1970s. Physician advertising, like hospice advertising, came much later.

But even well into the 1990s, the occasional private nonprofit or public hospital came under fire from some critics who
questioned the propriety of a donor-supported or taxpayer-supported institution spending those dollars on something so crassly unrelated to patient care as advertising. Even today, the occasional controversy will erupt when a self-appointed arbiter of what’s right decides to condemn a nonprofit for daring to spend scarce resources to advertise its services—advertising that would help inform consumers and healthcare professionals about the benefits of a timely and appropriate referral for hospice care and, yes, maintain or even build its fiscal health in an increasingly competitive environment.

Although hospices today are well-run entities with experienced professionals responsible for every aspect of the business side of the organization, the scammers who make their living selling fake, fraudulent and worthless advertising still tend to think of hospices as small, unsophisticated organizations just ripe for ripping off.

So when you get that call from what sounds like a boiler room, during which a pleasant-sounding woman informs you that your local newspaper is running a special “Business Review” or “Community Focus” section just for local companies like yours and that, in fact, they’ve already written a special ad for you and would you like to hear it…guess what? It’s not your local newspaper calling. It IS a boiler room and it’s based in Hampton Roads, Virginia. And that hospice ad they’ve written just for you? It’s the same ad they’ve run in nearly every paper in which they’ve placed their cluttered local ad section. And, other than the fact that the ads they’re selling are over-priced, poorly designed, poorly written and appear in a newspaper section that looks and feels like advertorial junk, it’s a great buy!

The Strategy Behind Many Ad Scams

Many—but not all—of the most successful ad scams as well as legitimate ads of questionable value, are low-dollar items. The fraudulent Yellow Pages come-ons generally carry a cost between $200 and $300. The worthless business-to-business directories (print and web-based) usually cost $400 to $600 if you are unlucky enough to get tricked into okaying a listing and order one. The strategy behind that low-pricing point is compelling. These firms don’t want their invoices scrutinized by a CEO, COO or CFO with signing authority for large purchases. Their business proposition is built on the assumption that someone like an accounts/payable clerk or a business manager will have signing authority for such small sums and that invoices can sail through without question by a higher authority.

Still, you might wonder what’s the harm if a multimillion-dollar hospice organization falls for one or a few of these over the course of a year? While an annoyance, it certainly wouldn’t be financially fatal, right?

The answer is that none of these scams happen in a vacuum. Firms that fall for scams like these are placed on a vendor’s “sucker list.” When that vendor no longer can squeeze anything more out of a sucker, instead of writing off the victim, most firms will sell their “sucker list” to other unscrupulous companies. So, falling for just one of these frauds can make you and your organization a target for a constant barrage of fraudulent solicitations for years to come.

continued on next page
It’s About More Than Money

Not all bad advertising deals are perpetrated by outright frauds and scammers. Some advertisers, while legitimate, will put together advertising deals of questionable value and pitch them to businesses on their prospect list that do not regularly advertise in their publication or on their station.

Many of the representatives who sell advertising for a living assume that ALL hospices are small, unsophisticated, community-based programs. They assume there is little or no knowledge or sophistication about buying advertising within the organization. As a result, when they cold-call a hospice to pitch an ad campaign, they invariably center their pitch on what they perceive is the highest price they can quote that will still sound like a deal just too good to pass up.

Advertising, of course, is not about the sheer dollars you spend. It’s about the size of the audience you reach, the demographics of the audience you reach, and the frequency with which you reach that audience. Buying a 10-spots-a-week package on one radio or TV station in a mid-size market because you never thought you could afford to buy a broadcast “campaign” for such an artificially low dollar amount, for example, is not the way to buy advertising. When will the spots air? What are the demographics of that audience? What is the size of that audience? In a busy market, two spots a day on radio or TV, unless they are ideally placed in prime radio or TV time, will have little-to-no impact. And a broadcast campaign like that, without coordinated support in other media, such as newspapers, will be even less likely to be successful. But the price WILL be compellingly low.

As a final point, keep in mind that every time you place a legitimate ad in a medium, every other advertising representative in town will see or hear that ad. If you are not buying advertising from them too, they will put you on their prospect lists. Buying a modest ad campaign with just one or two advertisers easily can net you another dozen cold calls from ad reps—whether they’re selling real advertising or a scam.

Mark Cohen has more than 25 years of experience in communications, marketing, public relations and related fields, including eight years in hospice and nine years in the hospital field. He currently serves as senior vice president of communications and public relations for VITAS Innovative Hospice Care.®
Bank bailouts. Automaker bailouts. A depressed real estate market. Stock market uncertainty. National transition of power. Low consumer confidence. A stagnate economy. What a time to be in the business of asking others to share their wealth with your hospice! But for many of us, that’s exactly what we are paid to do. So what have we seen so far? What can we expect? What can we do?

As is typically the case, the answers are far more complex than the questions. But in short, we must be on our guard. We don’t know exactly how philanthropy will be affected by the current economic conditions, but I am certain that it will be. In fact, the effects will likely range from programs doing better than ever in their fundraising initiatives to programs wondering just what they’re going to do to replace the donated income that is conspicuously absent from their budgets.

At my hospice, Valley Hospice in Rayland, Ohio, the last year has been a good one in terms of fundraising. But like any hospice, there are certain characteristics that make us unique. Our region, a former steel-producing and coal-mining powerhouse, has been rusting away in economic decline for decades. So, while we hear about the impact of the nation’s economic crisis loud and clear on the news, in reality, we just don’t have as much to lose as some other areas of the country.

Our average memorial contribution is $50.26. If someone gives you $50.00, they can generally continue to do so whether the economy is up, down or sideways. That type of gift is coming out of the family checking account, not a trust account. One of our board members suggests that the area we need to watch is the $1,000 to $2,500 donor range, as these individuals are more likely to hold on to cash in an economic downturn. We have had a few of our major donors, with large multi-year capital pledges, ask to extend their payment periods for an additional year because they took a hit in the market. Of course, we graciously agreed. Being flexible and saving your donor any possible shame in his or her circles of friends will pay off tenfold in the future. In another instance, one of our major donors said to me, “You know when you get so much money and you have it invested right, it really doesn’t matter what happens to the economy.” My colleagues in other areas would beg to differ, as they tell me that they have seen major foundation funding reduce to a trickle.

Keep in mind that because we are fundraising for hospice, we are all lucky. Hospice is a good cause—a humanitarian cause and a service that people value in the truest sense. After experiencing the comfort of hospice care, people feel compelled to support the service in order to help others. Therefore, the best action that any hospice can take to solidify its philanthropic financial future is to take exceptional care of patients.... People give to hospice because of their experience.

Fundraising Tips

By R.J. Konkoleski, BA, CLF

The best action that any hospice can take to solidify its philanthropic financial future is to take exceptional care of patients.... People give to hospice because of their experience.
neighbor, sister, or best friend had hospice care. I'm sure those of you who are involved in marketing will concur: It is difficult to explain “what hospice does” to a person unfamiliar with the concept, but once someone experiences hospice care in their family or among friends, it is very easy to see.

What You Can Do Right Now

Here are a few suggestions that are simple, inexpensive, and could prove to be very helpful in the coming months:

- Talk to staff members about how their care at the bedside drives your donor base. Tell them exactly what you want them to say and do if a patient or family starts to ask questions about donating. Let them know how important they are to your success. Share your successes with them.
- Know your donors. Make files on them, electronic or otherwise. Since we have started keeping track of our donors, I have been amazed at how many people are making small gifts every month. They move through the system, get their thank you cards, but until recently, we didn’t see the big picture. Develop a way to honor cumulative giving.
- Develop a special donor recognition program for patients and families who list your hospice as the donor of choice in the obituary.

So here we stand. It’s the era of change. Things are going to be different, and we all need to be prepared to change with the times, adapt to the needs of our major donors, and increase our donor base. Do not presume that the slow economy is the ruin of your fundraising program. It may be just the opposite. Don’t presume that your program is untouchable. Be prepared for anything and be flexible. This, too, will pass.

R.J. Konkoleski has more than 11 years of experience in nonprofit fundraising and is currently the executive director of the Valley Hospice Foundation (Rayland, OH). He also serves on the NCHPP Development/Public Relations/Marketing Steering Committee.
The typical stressors and challenges that staff and volunteers face are very likely compounded in today’s economy. Costs for food, fuel and the essentials of everyday living are rising. Retirement funds are disappearing and many Americans, including our staff, volunteers and their loved ones, are at risk of losing their homes and, in some situations, their jobs. These stressors impact the quality of life for staff and volunteers and may adversely affect their capacity to provide care to the communities we serve.

Hospice educators, in collaboration with the human resources team, can play a vital role in supporting staff by creating an environment of honesty, developing reliable resources, targeting economic topics, and facilitating community partnerships to provide, support and sensitively address financial stress. This article focuses on some strategies that can help reduce the generalized anxiety brought on by uncertain economic times and can promote stress reduction and skill development for staff and volunteers.

Creating an Environment of Honesty

For a very long time, talking about personal financial matters has been taboo—especially in the workplace. The discussion of salary, debt, and other financial details has been considered “a private matter” not to be discussed in public and often not discussed with family or friends. Today’s economic challenges require the acknowledgment, validation, and normalization of financial hardship faced by many in order to support the mental health and self esteem of the individual. Hospice educators can assist in creating an “environment of honesty.” This begins with creating opportunities to openly dialog and discuss financial topics one-on-one, in small groups, or as an organization.

Starting the Conversation

One approach toward starting the conversation about financial issues may be to invite staff and volunteers to remember that “we are who we serve.” As human beings, we may experience the same physical, emotional, social, spiritual, and financial challenges faced by the patients and families we care for. The acknowledgement of our own humanity is a great first step in helping people access support and find solutions.

It is also important to remind staff and volunteers that it is normal to feel stressed and anxious when faced with significant economic pressure and the perception of a loss of control. Hospice educators can encourage staff and volunteers to be open to emotional support available from friends, family, counselors or members of their faith community.
In addition, many of us have the privilege of working with volunteers who experienced the Great Depression. Inviting them to share their stories of how ordinary people have faced extraordinary financial hardships may create additional opportunities for conversation, provide a reality check, and instill hope for the future. As hospice professionals and volunteers, we are challenged each day to have the most intimate of conversations with our patients and families; in these challenging times, we must speak to one another as well.

**Resource Development**

The development of a list of resources (we call it a “Street Sheet”) is a great first step in promoting awareness and providing community based options for financial services and support. Resources may include credit counseling services, healthcare services, local food banks, utility assistance, discount products and services, print and online coupons, and other ways to manage and save money. Be sure the list of resources is thoroughly researched before dissemination to staff in order to reduce the creation of additional stress and/or embarrassment. The information can then be distributed to staff via email, in newsletters, or as a standalone document. The key is to distribute the information to everyone. Remember, this economic crisis is impacting Americans across all socioeconomic groups.

**Developing Targeted Class Content**

Addressing financial issues in the classroom setting is another opportunity for hospice educators to distribute information and support economic empowerment through skill development. This may require the creation of targeted class content. An example may be a class about “How to Spend Less and Save More.” Another approach is to add content to existing classes. During this past holiday season, our staff requested that we add content on smart consumer strategies to our annual “Coping with the Holidays” presentation. Staff members left this session with a better understanding of their own spending habits, strategies to save money, tools to create a budget, and methods to reduce the use of credit.

**Community Partnerships and Content Experts**

It is important to work in collaboration with your human resources team to invite credit counseling, debt management, consumer spending, and financial planning professionals to hold events and trainings for your staff and volunteers. This is also a great way to strengthen community partnerships while educating your teams. These professionals may be willing to provide education and guidance for free or for a nominal fee. Remember, however, that it is important to interview any outside presenter, check references, and establish goals and learning objectives for such events. These steps will assure that staff and volunteers get what they need and help avoid potential conflicts of interest.

**Providing Perspective**

Times like these call upon us to learn new skills, adapt to a new normal, and perhaps view our world in a brand new way. The “Serenity Prayer” reminds us to honor both our power and powerlessness to influence the world. By creating an environment of honesty, developing reliable resources, targeting economic topics, and facilitating community partnerships, hospice educators can play a vital role in supporting staff and volunteers as we all ride this wave of economic uncertainty.

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Robert Arnold has worked in the hospice field for 15 years and is currently a professional development coordinator in the Center for Learning at The Hospice of the Florida Suncoast (Clearwater, FL). Bob also serves on NCHPP’s Research/Academics/Education Steering Committee.

Roxanne Griffin has served as a licensed mental health counselor with The Hospice of the Florida Suncoast (Clearwater, FL) since 2001, initially as a member of a care team and currently as a professional development coordinator in the Center for Learning.
John Lennon once said, “Life is what happens when we’re busy making other plans.” This certainly fits our world today. Every relationship we have and everything we do is tested by adversity—that is part of life. In today’s world, each of us is also impacted by the volatility of the economic environment which creates stress at home and at work.

During difficult economic times, stress might arise from anticipated events, such as the loss of a job or home, or from feeling overwhelmed by heavier personal and professional responsibilities. Symptoms secondary to stress range from trouble sleeping, digestive ailments, unexplained weight gain or loss, and lack of joy in daily events to severe anxiety or even panic attacks. Other symptoms might include the inability to “let go” of money problems, and avoidance behaviors or self-destructive denial. Couples may discover that they are arguing more often about money or the financial habits of one another or the need to tighten the household budget. All members of the family, including children, may be affected by changes in the budget and this could result in greater household distress.
Strategies to Help

Here are some basic strategies to help reduce economic stress on individuals and families:

• **Prioritize and plan.** Create long- and short-term financial goals supported by a planned budget. Seek out the assistance of a financial advisor.

• **Communicate—with all members of the family.** Couples need to work together to identify priorities, but should also include children in the budget planning in age-appropriate ways. Frequent communication can encourage a safe and secure environment for all.

• **Make what changes you are able to and let go of the rest.** Remember that we cannot control everything! Constant worrying about finances, especially after one has made reasonable choices, will only increase one’s stress. Limit your worry time and force yourself to let go and move on.

• **Change the focus.** Spend time doing things you enjoy that are inexpensive or free. Be creative. Discover new interests or hobbies. Reconnect with old friends and develop new ones.

• **Think positive!** Positive thoughts and outcomes can decrease your stress level and improve your outlook on life. Focus on your strengths and possibilities. Affirm yourself.

Stress in the workplace also affects each of us, but can be reduced by adopting some of these suggestions:

• Walk daily. Ask a colleague or a new friend to join you.

• Find an exercise that you enjoy doing and do it daily or at least three to four times a week.

• Sort clothes and other “stuff” that you are not using and donate them to a local charity, give them away, or take them to a consignment store and earn some money.

• Smile at everyone you meet (even when you look at yourself in the mirror).

* Create a humor board and post cartoons or funny stories—real or not.

* Make an effort to bring more balance into your life—revamp your work and home schedules to provide time for you.

Stress is a necessary and integral part of human life. Minimal amounts of stress help us to challenge ourselves and accomplish our goals, but too much can be unhealthy and even cause long-term health consequences. By understanding what creates the stress in your life and adopting some or all of these suggestions, stress can be reduced and life can become more manageable, even during tough economic times.

Joanne Sheldon has over 25 years of experience in the hospice field. She is currently education coordinator for the Hospice of the Western Reserve (Cleveland, OH) and serves on NCHPP’s Research/Academics/Education Steering Committee.

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Now more than ever before, healthcare organizations, including hospice programs, are facing the immediate reality of providing quality care while, at the same time, having to adjust to rising costs, regulatory requirements and lower reimbursement. In order to succeed in this rapidly changing environment, organizations must make strategic decisions that are driven by reliable data.

When responding to these challenges, and in planning ways in which to do more with less, successful organizations should re-examine all aspects of their quality programs, including data management. This article provides organizations with example tools, guidance and resources to assist them in this process.

The Data Collection Plan
The first step to take when re-examining data collection processes is to develop a comprehensive data collection plan. Consider these tips from the National Association for Healthcare Quality as you develop your plan:

- Identify the who, what, when, where, how and why
- Establish a framework for data collection and analysis
- Select and continue to develop a data collection method
- Identify and provide necessary training and education
- Delegate responsibilities to incorporate all staff
- Facilitate the budget requirements
- Conduct pilot procedures for the forms and data collection process

By Lori Anne Williams, RN, MPA/H, CHCE, CPHQ, CHE, and Susan Zimmerman

Cost Efficient Ways to Capture Data
Note too that data collection activities—unless fully automated—can be an expensive process that often requires the time of a skilled clinician or employee fully trained in the process.

Types of Data
When prioritizing data collection processes, one of the first priorities is to “drill down” and define “what.” Programs should avoid the common mistake of grouping data into one general category when exploring options to reduce data collection, as not all data are created equal when various sampling methodologies are considered.

The definition of “sample” as it pertains to data collection is the “selection of cases from the accessible population” to (1) provide a logical way of making statements about a larger group that is based on a smaller group and (2) permit generalizations from the sample to the population.

The most useful sampling methodology used in healthcare is “probability sampling.” Probability sampling requires every element in the population to have an equal or random chance of being selected for inclusion in the sample. Through the use of varied sampling methodologies, programs can maximize their opportunity to reduce data collection efforts and, at the same time, continue to ensure the integrity and reliability of the process and data.

Probability Sampling Methodologies
• *Simple Random Sampling:* Each individual in the sampling frame (all subjects in the population) has an equal chance of being chosen.
• *Systematic Sampling:* After randomly selecting the first case, this method involves drawing every nth element from a population.
• *Stratified Random Sampling:* After the population has been divided into strata, each member has an equal probability of being selected. (Examples of strata include gender, age or primary diagnosis.)
• *Cluster Sampling:* This method requires that the population be divided into groups or clusters.

Block Sampling
This methodology is designed to select units in a block or predetermined size that is time- or sequence-driven. Block sampling is useful for capturing the detailed behavior of the process. When using this method, a very small sample size can yield useful results.

Choosing Sampling Methods
The table (at right) identifies recommended sampling methodology by data types most often collected and utilized in hospice.

One common way of determining a reliable sample is by a proportion of the total population. When planning for a reliable sample size, organizations need to collect just enough to demonstrate reliability and avoid over measurement. Generally speaking, the larger the sample, the more valid and accurate the study because a larger sample size is more likely to be more representative of the population.

Many healthcare organizations have adopted sampling policies based on these recommendations by The Joint Commission:
• For a population size of less than 30 cases, sample 100 percent
• For a population size of up to 100 cases, sample 30 percent
• For a population size of 101 to 500 cases, sample 50 percent
• For a population size of 500 or more cases, sample 70 percent

Also:
• Reduce those monthly measures with acceptable performance to quarterly measures;
• Reduce those quarterly measures with acceptable performance to semi-annual measures;
• Eliminate ongoing measures with acceptable performance and do a random check throughout the year.

Using Technology to Capture Data
Incorporating technology to help automate data collection ensures consistency and efficiency. Consistently defined and collected data provide accurately comparable results—both within your own system as well as across the industry.

Investing in a cost-effective method is critical as hospices look to maximize their data collection and analysis efforts with minimal financial impact. It is, however, important to look at the big picture when assessing financial impact. While there may be an initial investment when committing to the use of technology, the return on that investment can be significant. To determine the full impact—positive and negative—it is important to consider all of the “hidden” factors that may add to your return. Important benefits include the ability to capture data at one time for multiple uses; link—and access—information across the system; designate “required” elements to ensure compliance; and analyze patient-specific data.
The process of utilizing technology should not be a blind leap of faith. It can be practical to start slowly with what is currently accessible and understandable—and build from there. For example, maximize use of basic software, optimize networking between computers, maximize use of integrated IT systems, “Band-aid” older versions of IT systems, and modify any internally-designed systems.

**Making the Most of Your Investment**

Initial training on new technology often focuses on the function rather than the capabilities of the system. IT vendors—whether providing software or services to assist your data collection and analysis processes—should be willing and eager to share their expertise and go beyond the basics. For all types of technology, the system is only as good as the individual using it. Make sure to take advantage of everything your vendor has to offer: strategic educational programs; ongoing training opportunities; cutting-edge data analysis; and custom reporting.

<table>
<thead>
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<th>Type of Measure</th>
<th>Data Type</th>
<th>Recommended Methodology</th>
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<tr>
<td>Outcome</td>
<td>Patient fall rate</td>
<td>Simple, Systematic, Stratified or Cluster</td>
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<td></td>
<td>Turnover rate</td>
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<tr>
<td>Satisfaction</td>
<td>Timely medication delivery</td>
<td>Simple, Systematic, Stratified or Cluster</td>
</tr>
<tr>
<td>Performance</td>
<td>Visit frequency per patient per week per location</td>
<td>Stratified</td>
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<tr>
<td>Process</td>
<td>Visit frequency per location</td>
<td>Block Sampling or any Probability Sampling</td>
</tr>
<tr>
<td>Structure</td>
<td>Number of staff in compliance with annual safety training</td>
<td>Simple, Systematic, Stratified or Cluster</td>
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</table>

The process of utilizing technology should not be a blind leap of faith. It can be practical to start slowly with what is currently accessible and understandable—and build from there. For example, maximize use of basic software, optimize networking between computers, maximize use of integrated IT systems, “Band-aid” older versions of IT systems, and modify any internally-designed systems.

**Lori Anne Williams** is a healthcare quality and compliance expert with over 20 years of senior level experience in hospice, home care and acute care environments, and is founder of Healthcare Foundations.

**Susan Zimmerman** is the performance improvement coordinator at Delaware Hospice (Wilmington, DE), where she has worked since 2001. She also serves as NCHPP’s Quality Assessment/Performance Improvement section leader.
Technology, next to salaries and benefits, is one of the most expensive line items in a program’s budget. As we face reimbursement cuts and the fear that comes with economic uncertainty, it is important to reconsider all aspects of our business. We must understand how each expenditure impacts our work, so we can preserve those tools that best enable us to serve patients and families.

Because of the cost, there is a reflexive tendency to cut technology during an economic downturn. However, the right technology can actually help organizations remain financially viable. Here are several tools to consider.

EHR and Laptops at the Point of Care
The use of the electronic health record (EHR) at the point-of-care can make a significant contribution to the quality of end-of-life care. EHR is not about documentation—it’s about communication.

The computer laptop or other point-of-care device with an EHR places information about the patients and families we serve at the fingertips of care staff. This avenue for timely communication is the key to successful, efficient delivery of hospice and other home care services. Such communication ensures that patients and families do not serve as conduits of information between multiple care providers that enter their home. All staff members, regardless of when they work, have the information they need to assist the patient and family immediately and effectively. Staff can better determine whether a visit is needed or a phone call will suffice. What’s more, the time and costs associated with traveling to the office, printing documents, listening to reports and poring over paper files can be greatly reduced or eliminated.

When wireless technology is added to point-of-care devices, the EHR becomes “real time” (i.e., up-to-date information about the patient is available as the updates occur). This transforms EHR from a “communication device” to a “care tool,” not unlike the stethoscope or a Morphine PCA Pump.

EHR can also strengthen relationships with community partners, such as nursing homes and hospitals. The technology gives staff members greater ability to communicate during patient visits and provide relevant data for their charts or to share with physicians. In general, continuity of care becomes more manageable.

Using laptops at the point of care also provides the ability to collect electronic data for the purpose of analysis, benchmarking, and quality measurement—and creates an excellent opportunity for business intelligence. We can mine the data to understand the basics (such as census and length of stay) and guide our strategic planning. In addition, we can begin to identify effective interventions, such as the way to manage pain in 50-year-old male patients with pancreatic cancer, how suffering relates to pain management, and what 90-year-old female patients living alone are most worried about.

Within this data also lies the knowledge needed to teach staff about best practices, improving outcomes and decreasing the trial-and-error methods of care planning. Data can make us more focused, more efficient in meeting the basic needs of our patients, and more available for providing our most important intervention, “presence.”

Voice Communication
Cell phones, blackberries, text pages, instant messaging—these tools are essential to our ability to respond quickly and effectively to the needs of patients and families. For example, as baby boomers become part of the population we care for, we are finding that their children don’t communicate by phone, but through emails sent at midnight, instant messaging in times of crisis, and voicemail. Once again, these tools are necessary if we want care staff to be operationally efficient and responsive to patients and families.
Establishing Communication Practices
Critical to the success of all communication tools is the development of a process or guidelines to instruct staff on which tool to use when—in other words, “communication practices.” When staff members know which tool to use for which reason and the organization is expert at closing loops and creating effective communication, efficiency goes up, cost goes down, reiteration decreases and customer satisfaction is improved.

Aligning Technology With Your Strategy
Technology not aligned with strategy is truly money ill spent. It is important that your organization perform strategic planning and align its technology initiatives with those strategies (e.g., access, quality of care, regulatory compliance, service excellence, competitive advantage). As author Jim Collins notes in Good to Great: “None of the good-to-great companies began their transformations with pioneering technology, yet they all became pioneers in the application of technology once they grasped how it fits with their strategy. Technology is not what drives a company from good to great, it is an enabler.”

Lastly, it’s important to embrace change management theory. Doing what we have always done and adding technology to the mix will add costs, but will not change outcomes or behaviors. Embracing change allows technology to replace costly operational habits. Organizations need to adopt a theory of change, integrate change management into all project plans, and use change resistance as an opportunity to move people from where they are to where they need to be in order to move hospice into the next millennium.

As you review the suggestions noted here, it is evident that the synergy created by employing all of them together is the real value proposition. Any one of these contributions alone will not benefit the organization enough to create financial stability, but when we implement them together, we can increase efficiency and thereby reduce the cost of doing business. Technology is a component of our future.

Gay Madden is vice president of management information systems for The Hospice of the Florida Suncoast (Clearwater, FL).
Monica Roman is a dementia patient who is no longer able to speak, but Charmaine, her only daughter and primary caregiver, is able to be her voice.

The Romans are originally from Jamaica. Charmaine came to the United States in the 1980s and is a clinical therapist for a social service agency in the Cleveland, Ohio area. She is also in nursing school.

When Charmaine's father died several years ago, she promised her mother that she would return to Jamaica once a year to celebrate Christmas with her. During her visit home in December 2003, Charmaine could tell something was wrong—her mother wasn’t her usual self. To make matters worse, her mother’s retail shop was in jeopardy: “The Jamaican government wanted to relocate her business and that seemed to knock the wind right out of her,” Charmaine recalled. “The business was the center of my mother’s life and her tie to valued friendships.”

In 2006, Charmaine brought her mother to live with her here in the United States. At that time, her diagnosis of dementia was inconclusive and she seemed to be managing okay—doing some cooking and light chores. However, Charmaine said her mother had felt lonely and increasingly isolated. In order to assure her mother of proper care, Charmaine made some adjustments in her schedule and in her life. She also recruited some friends, who would stay weeks at a time to help. They were a godsend, providing support to Charmaine and needed companionship to her mother.

But over time, Charmaine had to start hiring caregivers to stay with her mother during the day. “The Alzheimer’s Association was a great resource,” she said. “They were encouraging and helped prepare me for the difficult times ahead.” While Charmaine thought she would always be able to manage, as time progressed, it became more challenging to provide the care her mother needed. When Monica started to have skin breakdown, edema, and needed stronger pain medications, Charmaine knew she needed more help. “I had no more money and could no longer afford a caregiver,” Charmaine said.

But Charmaine’s prayers were answered. On faith, she called Hospice of the Western Reserve (HWR) while thinking that her mother might not qualify. She was familiar with hospice because of a previous visit to HWR’s Hospice House and connections through a friend who had a positive hospice experience. “I called hospice and they came promptly, providing care in our home for about a week, but then suggested my mother be moved to Hospice House.”
In this closing article of Section 1, a family caregiver provides perspective on how the economic downturn is affecting her life and the valuable role of hospice amidst continued uncertainty.

Monica Roman seemed to settle in after her move to Hospice House, and is eating and sitting up in bed. Charmaine visits her mother daily and said that she feels sad each time she leaves. Monica had always been right there next to her as she studied. Now, Charmaine returns to an empty house and must face the reality of her mother’s impending death. It’s bearable, she says, because she has the support of friends, church members and colleagues from work.

I asked Charmaine more about the particular struggles she is facing now. “Staying in nursing school is difficult, but giving up is not an option,” she said. “Loans have been reduced by half and with the banking situation, it is more difficult to qualify for new loans. At some point in the future I may be homeless. Everything is crunched and tighter. I barely qualify for a private student loan this year. Still, I will do whatever I have to do to finish school. I may not be able to stay in my home and it’s difficult to sell right now, but I’m continuing to look at all the options.”

So often with dementia patients in hospice, we do not have the opportunity to know them as they once were. So I also asked Charmaine to tell me what her mother was like. A slow smile swept across her face… She described her mother as a Jamaican that became modernized. She traveled a lot to buy supplies for her retail business. She was a dutiful wife and paid attention to her husband and family. When her husband died, she seemed to blossom even more. She formed new friendships in her community and started a weekly potluck club. Networking was also integral to her being. She loved people and loved having them around her. She was a positive force in the life of those around her and encouraged her daughter to get a good education and to never give up. I could see that Charmaine was taking joy in describing her mother. As she spoke, I could almost see her mother in the vibrant, colorful life she had once lived.

We in hospice understand that the patient and family form the unit of care. I am grateful that Charmaine took the time to help me know her mother and to understand her own personal challenges. She ended our conversation by asking, “What’s in the water here? Everyone is so nice. Thank you. I am overwhelmed with kindness.”

**Shareefah Sabur is chief strategy officer for Hospice of the Western Reserve (Cleveland, OH), where she has worked since 1993. She also serves as the chair of NCHPP, as a member of the board of directors for NHPCO affiliate, the Foundation for Hospices in Sub-Saharan Africa, and as a faculty member for NHPCO’s Manager Development Program.**
In these tough economic times, there are several ways that hospice educators and leadership can reduce educational expenses and still provide quality education programs for staff and volunteers. Here are several tips on curriculum design, teaching strategies and scheduling that can help.

**Curriculum Design**

**Consider the Level of Importance**

High-risk and high-impact content requires intensive education methods. The curriculum should include clearly defined risks to the organization, desired behavior changes and accountability. Present the information in clear points and steps to promote retention of the information. Keep in mind that education relating to changes in the organization that will produce an emotional reaction calls for curriculum that contains clearly stated facts and defined roles as well as time in class for staff to react to the changes. The preferred method of instruction in these situations is live presentations.

In our organization, we changed major processes within our IDG to implement the new Hospice CoPs. Staff members needed time to react to these changes before they were able to process the information about expected behavioral changes.

**Develop the Content for the Target Audience**

In the curriculum design process, identify your primary target audience. Your target audience includes staff members who will need to implement the changes identified in the program. Plan the education to include only the information they will utilize (i.e., only what they need to know). You may need to modify the program for each target audience. For example, content for staff working in the nursing home setting may differ significantly with the content for staff working in the home or inpatient setting. The “one size fits all” approach is not effective.

You will also need to develop an educational program for your secondary target group. The secondary target group is comprised of staff members who need to know about the changes, but are not directly affected by them or won’t need to directly implement them. Members of the secondary target group only need an overview of the material and, therefore, will not need the detailed information which the primary target group requires. Combining the two groups into one class is not effective; it creates confusion, frustration and boredom—and ultimately results in a waste of time and other resources.

If the program’s content is for information purposes only or is a review of previously learned material, an online or written packet is an appropriate method of instruction. Be sure to include in the online or written module who to contact if the staff member has questions or needs information clarified.
Teaching Strategies

Determine Staff’s Learning Styles

The majority of adults prefer to learn through interactive and multisensory (hear, print, sight, touch) methods. Providing all education in an online or self-study format may not match the preferred learning styles of your employees. Resistance to learning can develop when learning styles and learning preferences are mismatched. Providing education solely through online programs or self-study packets can be a death sentence for the educator. In our organization, employees distinctly prefer interaction and live classes to online and self-study learning options.

Provide Information in Multiple Ways, with Planned Repetition

It can be a nightmare to try to provide enough classes to meet all the schedule challenges of hospice staff. When designing a live class, prepare the content so it can be delivered in other ways too—such as online or in a study packet that can be used to support classroom learning. Providing staff with one exposure to new information is not enough to produce a change in behavior, as adults learn through repetition. In developing teaching strategies, planned repetition should be included. This can include repeating the major points of the class in a newsletter, at a team meeting, in a flier, or as an alert on the computer.

Scheduling Classes

Schedule classes at times and locations that are convenient for staff. Although this sounds easy and makes sense, it is difficult to implement. A hospice staff’s main mission is to meet the needs of patients and families. With this in mind, class schedules need to be created so that staff members spend as little time out of the field as possible. While this will create more work and travel for the educator, it will produce better outcomes in both the quality of education and staff attendance. If the organization has multiple locations, it is preferable to schedule the program at the different sites—rather than at one location—so that staff travel time and expenses are minimized.

In our organization, we found that education programs offered after IDG meetings seemed like a convenient time. After implementing this practice, however, we discovered that while convenient from a time perspective, the staff’s attention was not on education. Staff members were focused on completing IDG paperwork and anxious to see patients. Because this timing did not meet their needs, they were not learning and their retention of information was nil. Needless to say, we stopped this process. Our staff also suggested that education programs not
be scheduled during the week in which a holiday falls, since they are focused on seeing their patients during the shortened work week.

The reality is “there is no one perfect time for education” that will meet everyone’s needs. The goal is to try to schedule classes to meet the needs of the majority of staff members. In our organization, we survey our staff annually to determine the best time and best day for education. Experiment with different forums to determine a successful method. This could include a monthly nurses meeting, breakfast sessions or monthly site education.

Mary Lou Proch has over 30 years of experience in clinical education and is currently director of education for HPC Healthcare, Inc, the corporate office of LifePath Hospice and Palliative Care (Tampa, FL).

**Improving Staff Productivity**

*Tips from the NCHPP Clinical and Operations Management Section*

- When scheduling patient visits, map out the route in advance and plan the visits in the best possible sequence to minimize travel time (and save on fuel costs), while also being cognizant of each patient’s needs.

- Have the hospice nurse respond to the initial referral call on his/her own—and involve the social worker and chaplain only if their expertise is needed. The social worker and chaplain should still be assigned to each patient, but unless needs are identified, they need not make contact.

- Consider having the triage or on-call nurse make all referral visits after 3:00 p.m. to minimize overtime by the primary nurse.

- Utilize social workers for informational visits when the referral nurse is not available.

- While monetary incentives can bolster staff efficiency, they are not the only option. A simple “thank you,” along with public acknowledgement for work well done, can be a powerful motivator.

- Some patients do not want a volunteer in their home. One organization has begun the program, Phone Tag, that provides support by phone to honor patients’ preferences.

- When changes are required, remember to explain to staff why the changes are needed. Also invite their input when possible and appropriate. This fosters buy-in and cooperation—and may also generate creative suggestions that improve upon the change.

- Do not expect staff to automatically know what they don’t know. Be mindful of your staff’s need for education and training. Supporting their work through job training promotes job satisfaction and high-quality care for patients and families.
Volunteers: Preserving the Mission and the Margin

By Sandra Huster

Many hospice volunteers may already understand the impact of tough economic times on their program’s operating budget. Our job, however, is to make sure they all do.

Each member of the “hospice family” needs to do his and her part to increase revenue and cut expenses. That family includes board members, senior leaders, managers, IDG members, support staff and volunteers. Toward this end, hospice programs need to be transparent in sharing financial concerns with volunteers and need to trust that volunteers can be part of the solution. Here’s a good example. After explaining to a group of volunteers “why” my organization was making some difficult financial decisions, every volunteer in the meeting asked how he or she could help. They offered to volunteer more often, to assume multiple volunteer roles, to be trained to do new things, and to raise more money. It is up to us to share the information with our volunteers and provide them with opportunities to lend more assistance.

Changing Our View of Their Role

If we are going to use volunteers to fill service gaps and thereby decrease expenses, we have to be willing to utilize their skills in new and different ways—not limit their work to areas that are “comfortable and safe” to our organizations. Additionally, leaders must provide lots of reassurance to employees that their jobs are not going to be replaced by volunteers that assume these new roles (an obvious concern for staff in this unstable economic climate). Here is a good example.

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In 2008, Covenant Hospice initiated the Tuck-in Volunteer Program. Volunteers are trained to call patients at home prior to the weekend to make sure they have everything they need. The purpose of the calls is to increase family satisfaction of weekend care and to be proactive in meeting needs. (One of the volunteers who provided leadership in writing a call script and designing a tracking log is a retired nursing administrator.)

Soon after the program’s implementation, clinical team members began to question the use of volunteers in this role. There were concerns that this job was not appropriate for volunteers and that volunteers should not be asking about pain levels, medications and supply needs. There was also concern that the volunteers were being used to “check up” on employees. In response to these concerns, the Tuck-in volunteers attended a team meeting and shared some of the stories and outcomes from the calls they were making. By the end of the year, the program was a success in all 11 branches of Covenant Hospice: On-call weekend nurses were reporting fewer non-emergency calls; hospice physicians were reporting fewer weekend calls for pain issues and medication needs; and patients and families were expressing their appreciation of the volunteer support. Were there cost savings? Yes! Were we keeping our promise to provide excellent end-of-life care? Absolutely!

Many Ways to Lend Support
Just as volunteers are credited with founding and expanding the hospice movement, I believe that in many organizations, they will be credited with preserving the hospice mission while protecting a healthy operating margin. In this period of economic uncertainty, there are many things that hospice volunteers are already doing:

- Volunteer board members are helping hospices make sound financial decisions;
- Patient and family care volunteers are expanding the scope and the frequency in which care is provided;
- Volunteers are delivering supplies and medications, and helping with transportation needs;
- Professional volunteers are providing marketing expertise and lending a hand with development, outreach, training, and other services (e.g., Covenant Hospice’s Ambassador volunteers support outreach and education initiatives—enhancing the work of community educators; Donor Diplomat volunteers make personal calls to donors, thanking them for their gifts and cultivating future giving);
- Administrative volunteers are filling service gaps and increasing productivity; and
- Volunteer advocates are calling legislators and sharing their stories about the important role of hospice care in the lives of all Americans.

It really is a “catch 22” as hospice organizations attempt to utilize volunteers in new ways. It is the right thing to do, but it is a difficult time to do it. We are asking volunteers to work alongside IDG members and support staff at the very time that these employees are feeling the most vulnerable and the least secure in their jobs. Hospice organizations must be sure that managers and team members understand the “intent” of these efforts—to continue to provide excellent care and services, not replace current staff.

As volunteer leaders, it is our responsibility to help ensure the financial stability and future of our hospice organizations by fully utilizing the skills of our dedicated volunteer staff. This is an opportunity for our discipline. As we begin using volunteers in new and different ways to meet financial challenges, they will become increasingly visible and valuable within our organizations.

Sandra Huster has worked in the field of volunteer management for 13 years and is currently director of volunteer services for Covenant Hospice (Pensacola, FL). She also serves on NCHPP’s Volunteer/Volunteer Management Steering Committee and has been a frequent presenter at NHPCO’s national conferences.
Bereavement coordinators have had to learn how to be creative, mindful and some might say frugal in their methods and options for supporting family members since Medicare reimbursement stops just as the need for bereavement support increases. As purse strings tighten further, becoming more creative is even more crucial. Thankfully, there are a host of possible options to consider.

Fully Utilize Volunteers
If your program does not utilize volunteers in its bereavement program, this might be the time to explore doing so. If your program does, consider using the volunteers more fully. Volunteers can provide administrative assistance (e.g., copying and collating materials); assist with data entry (a great way to use teen volunteers); and manage library materials (our organization recruited a former librarian to help us).

With additional specialized training, volunteers can also offer direct service support, such as visiting with bereaved family members, making follow-up phone calls, co-facilitating support groups, assisting at camps and retreats, helping with registration at community education events, and representing the bereavement program at fairs or as part of a speaker’s bureau.

Seek Donations
Beyond what may already be an organization’s fundraising efforts, it is possible to solicit funds specifically for bereavement services. Part of this might include making donation envelopes available or displayed during support group sessions or other bereavement programs. Wording on the envelopes or on other materials can simply and tastefully remind readers that “donations are always appreciated.” Also, consider posting a “wish list” on your Web site and include it in newsletters or other publications to generate dollars or needed materials and supplies.

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Another idea is to expand upon or seek donations of “in kind” services from skilled professionals: massage therapists, yoga instructors, Reiki practitioners, and even licensed bereavement counselors; gardeners or nurseries; and musical talent for groups or memorial services. Obtaining supplies as donations is also always helpful—from arts/crafts materials and snacks/meals for a family support group to office supplies.

**Write Grants**

Many aspects of bereavement services have an appeal to potential funding sources. While there is work involved in researching and writing grants, the financial rewards can make it worthwhile. The cost/benefit factor for this does, of course, need to be considered. If development department resources are too limited to take this on, perhaps a staff member is interested in learning how to write grants. Also, some schools and student intern programs encourage, if not expect, grant writing as part of their programs and might be willing to lend assistance. Programs can craft grants that address specific projects, such as children’s services, outreach to schools, camps, adult retreats, special workshops, or projects such as quilt making and music therapy.

**Host Special Events**

Funds are often easier to raise when they are for a specific purpose such as a special event. This can be appealing to the funding source as well as to the community members who might participate. Sometimes groups will be interested in running the event and donating the proceeds to a particular designated aspect of the bereavement program. For example, local retailers or restaurants might consider a day-long store promotion in which a portion of the day’s revenue or sales is donated to the bereavement program. Organizations running raffles, golf tournaments or auctions might also be willing to donate proceeds from their events.

**Explore Collaborations and Partnerships**

Sharing resources is just one of the many good reasons to partner with other organizations. Collaboration can also provide your program with greater exposure to populations previously unaware of your work and resources as well as introduce or expand upon skills, resources and expertise your agency may not have. Here are a few suggestions:

- Partner with a cancer center to offer a support group for children who have an ill family member (use their space, share the costs for refreshments and art supplies, have both of you provide a co-facilitator);
- Partner with a senior center to offer a bereavement support group or an educational series at its site;
- Partner with Compassionate Friends, Samaritans, Survivors of Suicide, Alzheimer’s Association or the American Cancer Society to offer educational programs or support groups to populations they serve.

While all disciplines within a hospice organization are taking a closer look at ways to carefully utilize their resources, it is worth considering the fact that bereavement is the last discipline involved with hospice families. The psychological, emotional and community “revenue” generated by providing this service should not be underestimated.

**Nancy Sherman** is director of bereavement services for the Center for Grief and Healing at Hospice of the North Shore (Danvers, MA). She is a member of NCHPP’s Bereavement Section Steering Committee and a member of the Massachusetts Hospice and Palliative Care Federation’s Education Committee.

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Get Better Acquainted With E-OL

End-of-Life Online (E-OL) is NHPCO’s online learning gateway. Staff and volunteers can:

- Select from a range of offerings categorized by topic area (e.g., Office/Business, Management/Leadership, Clinical, Quality);
- Enroll online, and
- Take the sessions when convenient.

As an example of the offerings, here are two under the Management/Leadership category:

**Managing with an Eye to Finances**

In this session, hospice managers learn the basics of financial management and performance, including budgeting, reporting and monitoring of financial operations.

**Coaching to Drive Performance**

The best leaders help others build the knowledge, skills, and attitudes they need to thrive and thereby move an organization forward. In this session, hospice managers learn to identify ongoing coaching opportunities and how to implement collaborative coaching while also learning how behavioral styles can affect the interaction.

E-OL is an affordable and convenient way for NHPCO members to supplement the education and training of staff and volunteers.

To learn more, visit www.nhpco.org/conferences and select “End-of-Life Online.”
Historically, the role of the pharmacist as a member of the hospice interdisciplinary group (IDG) has been somewhat nebulous. The new Medicare Hospice Conditions of Participation (Hospice CoPs), in effect, has afforded us the opportunity to re-evaluate and redefine this valuable resource.

A pharmacist’s training and experience are entirely focused on the pharmacodynamics of drug therapy and provide in-depth knowledge about all aspects of medication therapy management. While nurses and physicians have training and understanding in pharmacology, medication use and administration, their drug knowledge, in comparison to that of a pharmacist’s, is relatively limited. Although the physician may be an active participant in a patient’s care and is the prescriber of his/her medication, hospice nurses are regularly put in a position to recommend and evaluate the patient’s drug therapy. The nurse, as well as the rest of the team, can benefit from the support and expertise of a palliative care trained clinical pharmacist to assist with this aspect of care.

Using the Pharmacist’s Skills:

A Mandate and a Benefit

By Pat Gibbons, BSN, CHPN, and Phyllis Grauer, PharmD, CGP

As drug expenditures are second only to personnel costs...it is critical to have the knowledge that the pharmacist brings to the table.
The Pharmacist’s Role in the New Regulations

In the new Hospice CoPs, the nurse is designated as the IDG member who is responsible for (1) completing the initial assessment of the patient’s immediate needs within 48 hours of electing hospice services and (2) coordinating the completion of the comprehensive assessment that must include input from all applicable team members. Likewise, the nurse is also designated as the coordinator of the plan of care.

Included in these assessments and the plan of care is medication management for the patient. CoP 418.54 (b) (6) states that the comprehensive assessment must include “a review of all of the patient’s prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: effectiveness of drug therapy; drug side effects; actual or potential drug interactions; duplicate drug therapy; and drug therapy currently associated with laboratory monitoring.”

Also, per CoP 418.106 (a)(1): “The hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures and state law, who is an employee of or under contract with the hospice to ensure that drugs and biologicals meet each patient’s needs.”

In addition, the Interim Final Guidelines (Version 1.1)—the guidelines which surveyors use when performing inspections of hospice programs—states that “individuals with education and training in drug management may include: licensed pharmacists; physicians who are board certified in palliative medicine; RNs who are certified in palliative care; and physicians, RNs and nurse practitioners who complete a specific hospice or palliative care drug management course, and other individuals as allowed by state law. The hospice must be able to demonstrate that the individual has specific education and training in drug management.”

While nurses or physicians who demonstrate this knowledge and training can, from a regulatory standpoint, fulfill this regulation, input and support from a pharmacist is invaluable in helping the team ensure that the extent as well as the intent of the regulations are met.

The pharmacist’s role in the inpatient care setting is another matter. Per CoP 418.106 (a) (1): “A hospice that provides inpatient care directly in its own facility must provide pharmacy services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice. The provided pharmacist services must include evaluation of a patient’s response to medication therapy, identification of potential adverse drug reactions, and recommended appropriate corrective action.” In other words, no other discipline can provide this oversight in the inpatient setting.

More than a Mandate—a Benefit

In this time of increased expectations and unstable reimbursement, it is critical that the hospice demonstrates sound financial stewardship in order to maintain the highest quality care and support for patients and their caregivers. As drug expenditures are second only to personnel costs in the operating budgets of most hospice programs, it is critical to have the knowledge of cost-effective drug therapy alternatives that the pharmacist brings to the table. Aside from reducing costs, a pharmacist can also provide supportive information on when to eliminate unnecessary or futile drug therapy that can minimize unwanted side effects and drug interactions as well as decrease a patient’s overall “pill burden.”

Frequently, the nurse is said to be “the eyes and ears” for the physician in terms of reporting on the clinical status of a patient. The pharmacist might best be described as “the guide through the medication maze” for the patient, the nurse and the physician. This valuable team member is able to view the patient through a different lens and can identify both the positive and adverse factors that may be impacting a patient’s care. By utilizing the expertise of the nurse, physician and pharmacist, everyone benefits. Hospice programs are encouraged to explore creative and affordable ways for incorporating the knowledge and expertise of a palliative care clinical pharmacist as an active member of the IDG.

Pat Gibbons is director of Beacon Place, the 14-bed hospice facility operated by Hospice and Palliative Care of Greensboro (Greensboro, NC), and NCHPP’s Nurse section leader.

Phyllis Grauer is vice president of clinical development for Palliative Care Consulting Group (Dublin, OH) and NCHPP’s Pharmacist section leader.
It’s impossible to read a newspaper or watch the evening news without feeling grim about the economy. ComPsyc, a global provider of employee assistance programs found that 90 percent of polled workers were losing sleep over the sad state of the economy. In the same article, mental health professionals in Tucson, Arizona reported seeing increases in calls for help as well as a shift in the reasons people were seeking assistance (Gargulinski, R., 2008). The Health and Retirement Survey conducted in 2000 found a causal relationship between job loss and morbidity among older workers (Gallo, W., Bradley E. Siegel M. and Kasl, S., 2000). Looking ahead, hospice providers need to be prepared for assisting patients and families impacted by the economic downturn. Savings accounts have suffered, unemployment will no doubt strike some of our caregivers and the numbers of uninsured are likely to grow.

Unfortunately the economic downturn affects us all. Just as families are impacted, hospice programs, too, are looking for ways to economize. Fear of rate reductions and other changes to the Medicare Hospice Benefit may lead hospices to re-evaluate their options, weighing essential services and potential cost savings.

During this re-evaluation process, providers should consider research conducted in 2001 by Mary Raymer, a past NCHPP social work section leader, and Dona Reese, then assistant professor of social work at the University of Arkansas. The study found that providing adequate social work services in conjunction with physical care significantly reduces overall hospice costs. Additional benefits included fewer hospitalizations for the patient, decreased nursing costs, and higher client satisfaction (Raymer, M. and Reese, D. 2001).

Raymer noted that the study provided encouraging data that affirms the role of social work on the hospice team. “While reducing social work services may initially produce cost savings,” she said, “our study strongly suggests that it is much more cost effective in the long run to preserve the role of social work, which can enhance team functioning as well as impact client and financial outcomes.”

A recent national study conducted by Dona Reese (2008)—now assistant professor with the School of Social Work at Southern Illinois University—finds that hospice directors view social workers as most qualified to address the following issues with patients and families:

- Financial counseling
- Referrals
- Counseling about suicide, denial and anticipatory grief
- Facilitating social support
- Promoting cultural competence
- Providing community outreach
- Providing crisis intervention

As patients and families struggle with a deepening recession, the need for psychosocial services increases.
While none of us knows how long this economic downturn will last, investing in the role of social work assures that patients and families have access to trained staff that are knowledgeable about ever-changing Medicaid eligibility, VA benefits, Social Security, disability guidelines and a myriad of other resources.

Providing financial counseling may only be the “tip of the iceberg.” Loss of employment is reflected in both poorer physical functioning and mental health. In our culture, we are defined by what we do. When we lose that identity we suffer. Anger, anxiety, depression and feelings of hopelessness are common reactions to the pressure of meeting financial obligations in the event of job loss. Social workers will need to assess and intervene to mitigate this sense of hopelessness.

Programs aiming to reduce costs may also want to consider caseload size. As patients and families struggle with a deepening recession, the need for psychosocial services increases and the ability to help the disadvantaged find resources becomes increasingly important. If caseloads become too large however, social workers are more likely to react to a family in crisis rather than proactively work to prevent a crisis. Prevention of crises, such as unwanted hospitalization, can usually reduce overall cost to the hospice and increase patient and family satisfaction. Anticipating and preventing problems should account for a high percentage of a social worker’s time.

The stress of coping with a terminal illness, combined with the grim economic realities facing many we serve, create challenges for all healthcare providers. Hospice programs will need to assure increased access to psychosocial services to counter economic pressures on families. Fortunately research shows that doing so should reduce costs and increase patient satisfaction.

Reflected in both poorer physical functioning and mental health is the stress of coping with a terminal illness, combined with the grim economic realities facing many we serve, creating challenges for all healthcare providers. Hospice programs will need to assure increased access to psychosocial services to counter economic pressures on families. Fortunately research shows that doing so should reduce costs and increase patient satisfaction.

References:
Reese, D., personal communication Dec. 27, 2008.

Among their many contributions to society, professional social workers help us discover our potential as human beings and help us improve our lives and those of our loved ones. There is no better example of this than the dedicated professionals who work in the hospice and palliative care field. Each and every day, they help patients and their families live fully—and find peace and dignity—during the most challenging stage of life.

Join NHPCO and the National Council of Hospice and Palliative Professionals in recognizing these dedicated colleagues during National Professional Social Work Month.

NHPCO encourages members to visit the Web site of the National Association of Social Workers for information and resources about this national observance: www.socialworkers.org.
Change is inevitable. It is, for better or worse, part of our daily experience. If you still have any doubts, just look at our current situation. There is so much change lately that there is hardly any space to adjust before another shift takes place. As we all know, it makes the future look a little unsteady.

Now one might say that if any group of people is familiar with change and transition it is those working in end-of-life care. Yet these current changes are such that we run a great risk of compromising many of the values we hold dear in our work with those who are seriously ill. When there is greater oversight and challenged finances, it is natural to streamline services and even cut back elements of care. It can be in these moments that what is truly important gets lost in the sea of worries of the future. The challenge is to ensure that the hard choices we make are rooted in what we know is the best quality of care possible.

The theme of this issue is very much about making choices and moving through difficult times. Certainly an ongoing concern for those practicing spiritual care is that we potentially stand to lose something as organizations look to reduce spending. I have already seen this happening. Hiring for spiritual care is being put on hold or cancelled indefinitely. Additional demands are also being placed on spiritual care staff, many of whom are already overwhelmed. Most importantly, a continued attitude persists that spiritual care is an “additional” service rather than intrinsic to end-of-life care. I mean this not only in the sense of valuing best practice in spiritual care, but also in acknowledging that training for all staff in the core spiritual elements of end-of-life care is part of the basic skill set needed, regardless of discipline. We have only to look to the late Dame Cicely Saunders to confirm this, as she frequently addressed spiritual care in her work.

Surveys over the last several years repeatedly show that a large percentage of patients... want to be asked about and supported in the spiritual dimensions of their experience.

Spiritual Care: Intrinsic to End-of-Life Care

By Carlyle Coash, MA, BCC

Surveys over the last several years repeatedly show that a large percentage of patients... want to be asked about and supported in the spiritual dimensions of their experience.
Studies Supporting the Need for Quality Spiritual Care

A couple of months ago, City of Hope, an NCI-designated comprehensive cancer center, and George Washington University received a $500,000 grant from the Archstone Foundation to create a project to improve the Quality of Spiritual Care as a Dimension of Palliative Care. The intent of the project is to look at the core values of what we do, and then examine what we need to build and grow so that our care can be at a deeper level. In a sense, we need to move past the constrictions of the modern medical approach to something akin to how medicine is practiced—and has been practiced for thousands of years—in various parts of the world. It is about addressing the whole person, not just the physical aspect.

There is now consistent research in the field of medicine that demonstrates that spiritual care is one of the fundamental aspects of care that is consistently overlooked. Surveys over the last several years repeatedly show that a large percentage of patients being treated during a serious illness or at the end of life want to be asked about and supported in the spiritual dimensions of their experience. Further studies have shown that when these spiritual elements were supported and given the space to be expressed, those patients and families demonstrated higher resilience in coping with difficulties.

Clearly it is not by accident that, in these challenging times, such resources would go to exploring this subject. What I find compelling is the fact that this project is supporting the work of the National Consensus Project for Quality Palliative Care and the National Quality Forum. It is building on what has already been established as one of the best models for quality practice in the country—a model that clearly shows the spiritual component as a core value to end-of-life care. It seems that it is time for us to truly integrate it more fully into the work we do.

This requires two basic steps: (1) committing to the development of quality spiritual care in our programs and (2) taking the time to deepen the skills of all IDG members as well as other staff.

The first step requires us to heed the wealth of knowledge already available regarding the skill set and training for spiritual care practitioners. It means striving for clinical and professional competencies that reach beyond the bare minimum. The Joint Commission has also noted the importance of using clinically trained spiritual care professionals as members of the team who can act as a “cultural broker” for the diverse spiritual and cultural nuances of the care of patients and families: “Organizations should actively involve professional healthcare pastoral care providers who are clinically trained and nationally board certified.” (Joint Commission Publications, 2006, pg 76). The message seems clear.

The second step requires time for teams to develop a deeper working knowledge of themselves and the compassion that drives their work. This means cultivating an understanding of all aspects of their person that is affected by the ongoing interaction with people in crisis. To say that we are not affected is to over-professionalize, which ultimately creates a veneer of compassionate connection. Our presence with others must hold a bolder standard for itself, even in a time of adversity. Otherwise we simply go through the motions.

Are we busy? Yes. Are we being asked for greater accountability? Yes. Are we being financially challenged? Yes. Should this be an excuse to compromise our core values? Never! People with far less have done far more and kept the heart of end-of-life care beating strong. Now is the time to step forward, rather than back. As Abraham Heschel once said, “To heal a person, you must first be a person.” It requires us to bring our whole person and to commit to that fully. So commit to it. Fearlessly. You will not regret it.

Carlyle Coash is a hospice chaplain with the Zen Hospice Project in San Francisco, CA, and NCHPP’s Spiritual Caregiver section leader.
Is your pharmacy able to identify your patients’ Medication Related Problems (MRPs)?

- In the United States, adverse drug reactions affect nearly 2 million patients, resulting in about 100,000 deaths each year.
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Speak with an HP team member today and see how we can become part of your team!
Shareefah Sabur has been at Hospice of the Western Reserve since 1993 and serves as chief strategy officer. In addition to her role as NCHPP chair, she is a member of the board of directors for NHPCO affiliate, the Foundation for Hospices in Sub-Saharan Africa, and serves on the faculty of the NHPCO Manager Development Program. She previously served for six years as the Quality Assessment/Performance Improvement section leader.

Kathy Roble has been director of volunteer services for The Hospice of the Florida Suncoast since 1994 and has been a frequent presenter at local, state and national conferences. In addition to her role as NCHPP vice chair, she has served as the Volunteer/Volunteer Management section leader since 2004.

Valerie Hartman has 22 years of holistic hospice nursing experience and, for the past 11 years, has included the integration of massage and bodywork therapy into her practice. Since 2002, she has coordinated Holy Redeemer’s complementary therapies program, overseeing and developing an innovative model of professional complementary care.

Rex Allen has worked in the field of loss and grief as a professional and volunteer for over 18 years. He is currently the grief support services supervisor for Providence Hospice of Seattle.

Greg Wood has been the executive director for Hospice of North Central Oklahoma since 2002 and is also serving his third year as president of the Oklahoma Hospice & Palliative Care Association. In addition to his service as NCHPP section leader, he is a member of the NHPCO Regulatory Committee, Governance Committee, and Council of States Steering Committee.

Tandra Chandler has been a certified nursing assistant for 30 years. For the past 16 years she has worked for the Hospice and Palliative CareCenter, where she is currently a CNA team leader. In addition to several promotions and continued studies leading to her CNAII designation, Tandra has earned certifications in phlebotomy, EKG, and hospice and palliative care.
Clinical and Operations Management Section Leader
Sharon Stewart-Brown, LMSW
Harry Hynes Memorial Hospice
Parsons, KS
Sharon Stewart-Brown joined Harry Hynes Memorial Hospice in 2004 and has served as its southeast Kansas regional director for the past three years. Prior to joining the program, Sharon was an adjunct instructor at the University of Kansas where she taught graduate-level courses in spirituality and cultural diversity. She also served as the director of disability determination services for the state of Kansas, receiving both state and national recognition for her work.

Development/Public Relations/Marketing Section Leader
Tom J. Simms, RN, CHPN
Lighthouse Hospice
Cherry Hill, NJ
Tom Simms has been involved with hospice since the early 1990s, serving clients in the greater Philadelphia-South Jersey area. As a certified hospice and palliative care registered nurse, he has extensive experience in providing and directing care to patients with terminal illnesses. He is currently director of education and quality and a member of the leadership team for Lighthouse Hospice.

Finance/Information Systems Section Leader
Anne Hochsprung, CPA
The Hospice of the Florida Suncoast
Clearwater, FL
Anne Hochsprung is vice president of finance for The Hospice of the Florida Suncoast, where she has worked since 1999. Prior to joining the program, she spent 20 years working in the healthcare industry. In addition to her role as section leader, Anne serves on the faculty of the NHPCO Manager Development Program and is a member of the NHPCO Audit Committee.

Nurse Section Leader
Pat Gibbons, BSN, CHPN
Beacon Place
Greensboro, NC
Pat Gibbons is director of Beacon Place, the 14-bed hospice facility operated by Hospice and Palliative Care of Greensboro. Under Pat’s leadership, the facility has been a nursing student placement site for RN to BSN students and baccalaureate nursing students.

Quality Assessment/Performance Improvement Section Leader
Susan Zimmerman
Delaware Hospice, Inc.
Wilmington, DE
Susan Zimmerman is the performance improvement coordinator for Delaware Hospice, where she has worked since 2001. She has presented both nationally and locally on topics related to quality assessment and performance improvement.

Pharmacist Section Leader
Phyllis Grauer, RPh, PharmD
Palliative Care Consulting Group
Dublin, OH
Phyllis Grauer has been a palliative care consultant pharmacist for over 20 years and is founder of the Palliative Care Consulting Group. Following PCCG’s merger with Hospiscript Services, Phyllis assumed the role of vice president of clinical services. She is also an assistant clinical professor at the Ohio State University College of Pharmacy.

continued on next page
Physician Section Leader
Joan K. Harrold, MD, MPH, FAAHPM
Hospice of Lancaster County
Lancaster, PA
Joan Harrold is medical director and vice president of medical services for Hospice of Lancaster County. In addition to her service as section leader, she is past-president of the Pennsylvania Hospice Network Board of Directors. Joan also serves on the American Academy of Hospice and Palliative Medicine Board of Directors and on the American Board of Internal Medicine Hospice and Palliative Medicine Examination Committee.

Research/Academics/Education Section Leader
Joy Berger, DMA, BCC, MT-BC
Hosparus
Louisville, KY
Joy Berger is director of the Hosparus Education and Volunteer Center and an adjunct instructor of music therapy at the University of Louisville. She is board certified as both a music therapist and chaplain.

Social Work Section Leader
Sherri Weisenfluh, MSW, LCSW
Hospice of the Bluegrass
Lexington, KY
Sherri Weisenfluh has over 25 years of experience as a licensed clinical social worker. She is currently an associate vice president of counseling for Hospice of the Bluegrass, a position she has held for 17 years. In addition to her service as section leader, she teaches part-time at the University of Kentucky.

Spiritual Caregiver Section Leader
Carlyle Coash, MA, BCC
Zen Hospice Project
San Francisco, CA
Carlyle Coash has been a hospice chaplain since 2000 in both Colorado and California and is board certified with the Association of Professional Chaplains. He has a deep passion for the work of palliative care and hospice as it is practiced throughout the world and is an advocate for innovation and positive change. He also strives to support the continued vision of holistic care and its benefits for patients, families and staff.
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For more details on the Audio Web Seminars (including updated dates & times), please visit www.nhpco.org/conferences
**2009 Audio Web Seminar Registration Form – Monthly Topics**

- **Interdisciplinary Topics** – the 2nd Thursday of every month*
- **Leadership and Management Topics** – the 4th Tuesday of every month*

*PLEASE NOTE: Some dates will change to avoid holiday and event conflicts. Topics and titles are also subject to change.

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### Interdisciplinary Topics
- January 8 – Interpretive Guidelines – IDG
- February 12 – Working with Challenging Families
- March 12 – Medication Safety
- April 9 – IDG Care Plans: Maximum Quality, Minimum Deficiency
- May 14 – Palliative Sedation: Clinical and Ethical Considerations
- June 11 – Increasing Family Satisfaction: Preparation for the Time of Death
- July 9 – “But They Might Steal the Drugs:” Caring for Families with Addiction Issues
- August 13 – End-Stage Dementia Management
- September 10 – Complicated Bereavement: Current Understandings and Hospice’s Responsibilities
- October 8 – The Comprehensive Assessment: Best Practices
- November 12 – Why Interdisciplinary? How Interdisciplinary?
- December 10 – Boundaries and Self-Care Strategies

### Leadership and Management Topics
- January 27 – Interpretive Guidelines - Org
- February 24 – Expanding Your Reach: PACE and Other Programs
- March 24 – QAPI in Action
- April 30 – Fast and Friendly: Retooling the Hospice Admissions Process
- May 26 – The Evolving Role of the Hospice Physician
- June 23 – Increasing Family Satisfaction: On Call and After Hours Care
- July 28 – Regulatory Conundrums
- August 25 – Raising Money: Strategies that Work!
- September 22 – The Top 10 Skills for New Hospice Leaders
- October 27 – “Hot” Regulatory Topics
- November 24 – Long Term Care and Hospice
- December 18 – Creating an Organizational Culture that Embraces Hospice Values and Practices Excellence

### Both Monthly Topics (check appropriate month)
- JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC

*Highlighted dates are dates changed from our normal schedule to avoid conflicts with holidays/NHPCO events

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**ONLINE:** www.nhpc.org/aws2009

**MAIL:** Complete registration form to: NHPCO AWS Registration P.O. Box 34929 Alexandria, VA 22339-0929 Rush deliveries should call: 800/646-6460

NewsLine 43
History

For 30 years, VITAS has been a leader in the American hospice movement, helping to define the standards of care for hospice and working to ensure that terminally ill patients and their families have ready access to compassionate and effective end-of-life care through Medicare and Medicaid.

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As NHPCO members look at ways to ensure quality care within their organizations during this economic downturn, a national initiative is also under way to address the broader issues of improving care and cutting waste throughout the entire healthcare system. The initiative, which is called the National Priorities Partnership, was convened in November 2008 by the Washington, DC-based not-for-profit organization, the National Quality Forum.

As a member of the National Quality Forum, NHPCO attended the November press event announcing the Partnership’s formation and will continue to monitor its progress and update NHPCO members as information becomes available. In this article, we provide a brief overview as a helpful introduction.

About the Partnership

The National Priorities Partnership is comprised of a diverse group of 28 national organizations representing those who receive, pay for, deliver, and evaluate healthcare (the member roster is available at www.nationalprioritiespartnership.org). With each member of the Partnership wielding influence over major portions of healthcare delivery, the coalition has the power to set in motion a national movement to deliver transformative improvements to America’s health and healthcare system.

Its Goals

The Partnership has a vision for world class, affordable healthcare and aims to transform healthcare from the inside out. Toward this end, it has identified six “National Priorities”...
that target reform in ways that will eliminate waste, harm and disparities and, in so doing, create and expand world-class, patient-centered, affordable healthcare. These priorities are:

1. Patient and Family Engagement, to provide patient-centered, effective care;
2. Population Health, to bring greater focus on wellness and prevention starting in our communities;
3. Safety, to improve reliability and eliminate errors wherever and whenever possible;
4. Care Coordination, to provide patient-centered, high-value care;
5. Palliative and End-of-Life Care, to guarantee appropriate and compassionate care for patients with advanced illnesses; and
6. Overuse, to remove waste, encourage appropriate use, and achieve effective, affordable care.

**Why Now**
The nation’s economic crisis makes addressing healthcare even more urgent. With healthcare spending continuing to rise and states in severe budgetary straits, cutting waste to achieve savings and better care is an imperative. Here are just a few of the statistics* that support this:

- The United States spends more per capita on healthcare than any other industrialized country. Yet our results on many important indicators of quality, such as preventable deaths and timely access to primary care, fall significantly below those of similar nations.
- Healthcare spending accounts for 16 percent of the Gross Domestic Product and is increasing at an average annual rate of approximately 7 percent.
- One in seven Americans lacks health insurance, and an estimated 57 million American families are struggling to pay their medical bills (43 million of whom have insurance).
- Racial and ethnic minorities, and those in low-income groups, face disproportionately higher rates of disease, disability, and mortality. African Americans have higher death rates from heart disease, diabetes, AIDS, and cancer, and American Indians and Alaskan Natives have lower life expectancies and higher rates of infant mortality.
- Studies have shown that shared decision-making can reduce the number of patients opting for more invasive surgical procedures by 21 to 44 percent without adversely impacting health outcomes.
- An estimated 30 to 40 cents of every dollar we spend on healthcare (estimated $600-$700 billion) is spent on unnecessary and even unsafe care.

“The need to improve this nation’s healthcare system is one that all providers recognize and this new partnership is a significant step forward in making a difference,” said NHPCO’s president/CEO, Don Schumacher. “Every organization and individual has a role to play and I’m grateful that end-of-life care has been identified as one of the six key focus areas.”

**Learn More**
In this new year—with a new Administration and new Congress, the Partnership will enlist other powerful organizations to help accomplish its goals. To learn more and keep tabs on its progress, visit [www.nationalprioritiespartnership.org](http://www.nationalprioritiespartnership.org).

* For more facts and source information for these statistics, visit [www.nationalprioritiespartnership.org > About NPP > Just the Facts.](http://www.nationalprioritiespartnership.org)
Is Your Census Decreasing?

Free Tools That Can Help

NHPCO’s Caring Connections offers resources that can help NHPCO members retool or create a comprehensive marketing plan—on a shoestring budget.

Here’s a glimpse of the cost- and time-saving materials you can download—free of charge—from the Caring Connections Web site:

- The Golden Rules of Outreach [PDF]
- The Naturally Occurring Communities Toolkit [PDF]
- Strategic Outreach Using Printed Materials [PDF]
- Strategic Communications Workbook [Word document]
- Event Planning Toolkit [Word document]
- Making a Big Splash: Checklist for Hosting Successful Community Events [PDF]
- If You Promote It, They Will Come: Coalition Marketing Workbook [PDF]
- Convening Town Hall Meetings [PDF]
- Marketing Hospice: A Core Competency in Competitive Markets [PPT]

Visit www.caringinfo.org/community/outreachstrategiesandtools.

NHPCO Position Statements Available Online

The NHPCO Ethics Committee is comprised of 28 members from around the country who volunteer their time and attention to identifying, clarifying, and addressing ethical issues which arise in the hospice or palliative care setting. Among the Committee’s responsibilities is the development of NHPCO Position Statements to help guide the work of providers.

The following Position Statements, along with NHPCO’s Code of Ethics, are posted on the NHPCO Web site (www.nhpco.org/communications) as a convenience to members:

- **Nearest Addition**—Position Statement and Call to Action on Access to Palliative Care in Critical Care Settings
- The Care of Hospice Patients with Automatic Implantable Cardioverter-Defibrillators
- Physician Assisted Suicide Narrative and Resolution
- Artificial Nutrition and Hydration Narrative and Statement
- NHPCO Code of Ethics

The Committee, which is chaired by Mark Murray, president/CEO of The Center for Hospice and Palliative Care, is currently at work on a palliative sedation therapy statement. To learn more about the Ethics Committee, including its roster of members, visit nhpco.org > About NHPCO > Committees & Task Forces.
Since the new Medicare Hospice Conditions of Participation (Hospice CoPs) were published in June 2008, NHPCO has continued to develop new tools and resources to help providers become familiar with the requirements and make necessary changes in their operations and processes.

Here are some of the more popular resources—including the newest additions. Members can download these resources and others, free of charge, from the NHPCO Web site. Visit the Regulatory and Compliance Center (www.nhpco.org/regulatory)—or go directly to www.nhpco.org/cops.

**New—Interpretive Guidelines Quick List:** The Interpretive Guidelines is the reference document which surveyors use when performing inspections of hospice programs. Based on the final draft guidelines released on January 2, 2009, NHPCO has developed a cheat sheet that lists the criteria (i.e. L-Tags) for compliance with each CoP, along with the applicable regulatory text and interpretive guidelines. By running down this Quick List, hospice managers can ascertain which aspects of their operations and processes require closer review and possible modification.

**New—Admission Care Map:** NHPCO has developed a Hospice Admission Care Map which outlines the entire admission process in accordance with the new regulations. Print out copies of this two-page schematic and share it with staff.

For easy access to this resource, go to www.nhpco.org/cops, select “Provider Tools and Resources,” and scroll to “418.54.” The map is listed under this condition.

**New—Tip Sheets:** Two tip sheets are now available for those hospice programs which (1) care for patients across state lines and (2) operate multiple locations. The tip sheets address the federal requirements as well as the steps organizations should follow to ensure compliance.

**Tip Sheets By Discipline and By Condition:** Tip Sheets are available for each key hospice discipline and for each condition—and can serve as particularly helpful training tools for staff:

1. **Tip Sheets By Discipline**—Tip sheets are available for physicians, spiritual caregivers, allied therapists, bereavement professionals, hospice aides, nurses, social workers, clinical operations professionals, volunteer managers and performance improvement/quality assessment managers. Each tip sheet provides a summary of the conditions that affect the discipline’s work, a description of each requirement, and a resource checklist to help meet the requirements.

2. **Tip Sheets By Condition**—These tip sheets are a “cheat sheet for each key condition” that is new or has been significantly changed. Along with each tip sheet, members can download a copy of the specific regulation and applicable portions of CMS’s preamble that provides the rationale behind the requirement. In many instances, additional resources related to the condition are also provided.

For easy access to these tip sheets, go to www.nhpco.org/cops and scroll to “Provider Tools and Resources.” Then select either “Tip Sheets by Discipline” or “Subpart C or Subpart D” for Tip Sheets by Condition.

**Plus, These Additional Resources:**
- CoPs and Preamble Text by Topic
- Crosswalk Document (comparing 1983 CoPs and 2008 CoPs)
- Easy-to-read PDF, addressing Subparts A, B, C, D, F, and G
- PowerPoint presentations for in-service education

To access these additional resources, go to www.nhpco.org/cops.

**CoP Resources Also on CD:**
A CD with all CoP-related resources is also available from NHPCO’s Marketplace (Item 821342; Member: $75). Visit www.nhpco.org/marketplace.
The QAPI Requirement: Resources for Hospice Programs
Item: 820921, Member: $395

CoPs in a Book: The Final Edition
Item: 820922, Member: $375

Hospice Policies and Procedures
Administration: Item 821316, Member: $495
Patient Care: Item 821317, Member: $595
Human Resources: Item 821318, Member: $395
Three-Volume Set: Item 821313, Member: $1,100

Hospice Regulatory Policies and Procedures
Item: 821315, Member: $395

To order, visit www.nhpco.org/marketplace or call 800/646-6460.

Webcasts Now Available

The Survey and Certification Group of the Centers for Medicare and Medicaid Services is hosting three 90-minute Webcasts on the new Hospice CoPs. While the Webcasts are designed for surveyors, they provide valuable information for Medicare-certified hospice providers.

- As reported in NHPCO’s e-newsletter, NewsBriefs, the first Webcast focused on Subpart C and took place on January 22. It also included a presentation by Judi Lund Person, NHPCO’s vice president of regulatory and state leadership. To view the archived broadcast, visit the Survey and Certification Group Web site.*

- The second Webcast is scheduled for March. Look for announcements in NewsBriefs or check the Regulatory and Compliance Center on the NHPCO Web site.

The National Data Set (NDS) is one of NHPCO’s most important data collection initiatives. It is an annual initiative, with a two-month window during which hospice organizations from around the country submit data about their programs to NHPCO.

If you are not yet familiar with the NDS and why your participation matters, here’s a quick recap.

**What is the NDS?**
The NDS is a compilation of information that provides a comprehensive picture of hospice operations and care delivery, spotlighting:

- Who provides care (program demographics);
- Who receives care (patient demographics);
- How care is provided (staffing models, bereavement, volunteer use); and
- Financing care (revenue, payer mix, and costs).

**Why Should You Submit Data?**
NDS results strive to provide a comprehensive picture of hospice care that, in many ways, can help advance the field. For example, NDS data are shared and used by hospice advocates, the media, and government entities which monitor and evaluate hospice services. In fact, the annual report, *NHPCO Facts and Figures: Hospice Care in America*, draws heavily from NDS data. Thus, when more members submit data to the NDS, NHPCO is able to provide a more comprehensive and reliable picture of hospice care and services.

**How Do You Submit Data?**
Submission is easier than you might think. Participating programs use the NDS Worksheet posted on the NHPCO Web site to assemble the requested data in preparation for online submission. Since no one person in a hospice program will have all the data, NHPCO recommends that one person in your program coordinate the process. He/she can print off copies of the Worksheet and have the appropriate departments fill in the information. Once the Worksheets are completed and compiled, a staff member can input the data online, through the NHPCO portal, DART.

Instructions for NDS submission (“NDS 101”), along with answers to frequently asked questions (“NDS FAQs”), are posted on the NHPCO Web site.

**Get Started Today**
NDS data submission begins on March 1. To get started, visit the NHPCO Web site and print copies of the NDS Worksheet and other helpful materials noted here: [www.nhpco.org/nds](http://www.nhpco.org/nds).

### How NDS Results Can Help Your Program:

Every fall, NHPCO prepares an NDS Summary Report for participating members to help guide the work of their organizations. Here are some of the ways the data can be used:

- **NDS results can illustrate the effectiveness of care delivery as well as opportunities for improvement;**
- **NDS results can help you measure your organization’s performance against national and state performance in operations and care delivery;**
- **NDS results can help you define your organization’s strategic goals, operating targets, and practice improvement objectives (such as referral source education and staff retention);**
- **NDS results can inform your communications with the media, the healthcare industry, and governmental regulators and policymakers.**
Hospice of the Upstate Physicians Recognized for Expertise in Hospice and Palliative Medicine

Dr. Hunter Woodall, medical director for Hospice of the Upstate (Anderson, SC), has been named a Fellow in the American Academy of Hospice and Palliative Medicine, becoming the second physician in South Carolina to earn this important distinction. Woodall serves the AnMed Health Family Medicine Residency as a professor of family medicine and, since 1998, has also served as the hospice’s medical director.

In addition, Dr. Katie Hanna, Hospice of the Upstate’s home care medical director, has received her hospice and palliative medicine board certification. Hanna, who is also board certified in family medicine, began volunteering with Hospice of the Upstate in April 2005 and assumed the role of home care medical director eight months later.

Iowa Hospice Organization Changes Name

The Iowa Hospice Organization changed its name to Hospice and Palliative Care Association of Iowa, effective January 2009. Since it was established in 1981, the organization has grown to represent 73 agencies which provide hospice and palliative care in 103 locations across the state.

Hospice of Chattanooga Fellowship Earns Accreditation

Hospice of Chattanooga and the University of Tennessee College of Medicine Chattanooga jointly developed a Hospice and Palliative Medicine Fellowship Program that has received accreditation status by the Accreditation Council for Graduate Medical Education. The one-year-old program is among the first hospice fellowships to receive accreditation in the nation and one of two to be accredited in Tennessee. The accreditation will open dialogue for improving how hospices, hospitals and nursing homes care for patients with chronic progressive illnesses as well as end-of-life issues.
VITAS Partners With Local University to Raise Awareness About Death and Dying

VITAS Innovative Hospice Care® of Los Angeles and Ventura County teamed up with California State University Northridge (CSUN) to present VESTA, a one-act play about a dying woman and the choices that she and her family must make as she approaches the end of her life. Written by Bryan Harnetiaux, VESTA introduced the audience to the real-life issues surrounding a terminal diagnosis. The title character is a grandmother in her late 70s who confronts the loss of independence after a stroke, a series of complex medical, economic and personal issues following a fight with cancer and, inevitably, her death. “The point of VESTA is to take the way the elderly are treated during the last few years of their lives out of the shadows,” said David Lackey, VITAS volunteer services manager.

Performances were held on the CSUN campus during this past October and at three senior community centers. The initiative is part of VITAS’ and CSUN’s ongoing effort to use community partnerships to promote conversations about end-of-life care issues. A panel discussion followed the production and was moderated by Jeanne Twohig of the Duke Institute on Care at the End of Life, to which Harnetiaux has donated the copyright to VESTA.

NHPCO Members Receive NCP’s Quality in Palliative Care Leadership Award

Five NHPCO members were awarded the National Consensus Project’s 2008 Quality in Palliative Care Leadership Award:

- Center for Comprehensive Palliative Care (Ocala, FL)
- Community PedsCare (Jacksonville, FL)
- Hope Hospice and Community Services (Fort Myers, FL)
- Hospice of the Western Reserve (Cleveland, OH)
- Our Lady of Lourdes Memorial Hospital (Binghamton, NY)

This award is presented annually to recognize organizations which have enhanced their palliative care services by implementing the palliative care principles espoused by the National Consensus Project for Quality Palliative Care and the National Quality Forum.

These award recipients will be recognized at NHPCO’s 24th Management and Leadership Conference in Washington, DC, April 23-25.
The Model is an approach to operating a hospice as an integrated, coherent and coordinated system that simultaneously balances purpose and financial realities.

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Interested in Reaching Out to Local Employers?

NHPCO’s Caring Connections is currently conducting an 18-month project, “Encouraging Workplace Practices to Help Caregivers Handle Work-Life Responsibilities,” which was funded by the Jacob and Valeria Langeloth Foundation of New York. As part of this project, Caring Connections is actively recruiting 35 hospices to educate employers in their community about end-of-life workplace issues. If your hospice is interested in applying to be a part of this project, please email caringinfo@nhpco.org or call 800/658-8898.

To learn more about the Caring Connections initiative, It’s About How You LIVE—At Work, visit www.caringinfo.org/business.

Audio Web Seminars

2:00 – 3:30 p.m. EDT

Interdisciplinary Topics:

3/12/09: Medication Safety
4/09/09: IDG Care Plans: Maximum Quality, Minimum Deficiency
5/14/09: Palliative Sedation: Clinical and Ethical Considerations

Leadership Topics:

3/24/09: QAPI in Action
4/30/09: Fast and Friendly: Retooling the Hospice Admissions Process
5/26/09: The Evolving Role of the Hospice Physician

6/23/09: Increasing Family Satisfaction: On Call and After Hours Care

Visit www.nhpco.org/conferences—or see page 42.

Timely Sessions on Tape:

Conditions of Participation for Managers and Leaders
(Item 821209)

Conditions of Participation for Clinical Staff
(Item 821197)

Conditions of Participation for Hospice Medical Directors, Physician Members of the IDG and Attending Physicians
(Item 821297)

Hospice in Long-Term Care Facilities: Doing It the Right Way
(Item 821198)

Visit nhpco.org/marketplace.

End-of-Life Online (E-OL)

This is NHPCO's online learning gateway. Staff and volunteers can enroll online, select from a catalog of sessions organized by topic area, and take the sessions at their convenience. Timely sessions of note include:

Leading High Performance Teams—Offers practical techniques to help learners build and lead teams that achieve greater results (under Interdisciplinary Team).


Visit www.nhpco.org/conferences.

It’s About How You LIVE—At Work

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To learn more about the Caring Connections initiative, It’s About How You LIVE—At Work, visit www.caringinfo.org/business.
Please visit our Web site at nhpco.org.

Your NHPCO membership will expire on March 31st. If you have not renewed your membership for 2009, please renew today!

If you have any questions, please contact your Member Service Representative at 800/646-6460.

Provider Members:

Thank you to those of you who have already renewed your membership for 2009!