Caring for Ourselves
Holistic nurse, Lucia Thornton, discusses the key principles of holistic nursing and how these principles can be used by hospice nurses—and all hospice staff—as a way to care for themselves. Be sure to also read the companion piece on how one nurse uses restorative yoga to help bedbound hospice patients find deep relaxation.

Advanced Certification for Hospice Social Workers
In collaboration with NHPCO, NASW created two specialty certificates for hospice social workers. While among the fastest growing credentials of the 17 offered by NASW, barriers do exist. Sherri Weisenfluh and Brandon Wollerson from the NCHPP Social Worker Section explain.

QAPI for Volunteer Programs
“Traditionally hospice volunteer programs have reported soft outcomes, such as volunteer and patient stories,” says NCHPP Volunteer/Volunteer Management Section leader, Sandra Huster. “But while these are vitally important, we must begin documenting quality outcomes.” As this month’s Voice of NCHPP feature, she provides guidance, with specific examples of quality measures for volunteer programs.

A Message From Don

Member News and Notes

Regulatory Tip of the Month

Videos Worth Watching

For decades, I have been told during medical physicals that “my mother just died of old age” or that “my father just gave up.” From a medical perspective, however, people don’t die of old age or from “giving up.” They can, however, die from geriatric frailty—as I explain in this article.

Geriatric Frailty Defined
The medical definition of geriatric frailty (or frailty) was first published in 2001 and, since that time, we have come to understand the emerging concept far better (Fried 2001).

The American Geriatric Society now defines frailty as a physiologic syndrome, characterized by decreased reserve and diminished resistance to stressors, resulting from cumulative decline across
multiple physiologic systems and causing vulnerability to adverse outcomes (Boockyar 2006).
Note that this is a decline in *multiple* systems, differentiating it from end-organ disease. The severity of decline is therefore less in each system, perhaps not enough to call it end-stage, but in combination with other declines, puts the patient on a terminal trajectory.

Frailty is also independent of other medical conditions. It can therefore exist alone (i.e., primary frailty), or in conjunction with other conditions (i.e., secondary frailty). Although both primary and secondary frailty increase risks to patients, secondary frailty imparts a much worse prognosis.

It is also important to note that frailty is progressive, and with any progressive disease we can engage in chronic disease management. We cannot stop the process from moving forward but, as with CHF, COPD or renal disease, we can slow the process, improve quality of life, and delay inevitable outcomes.

From the end-of-life care perspective, this understanding of frailty offers us opportunities to better define the dying process and deliver better care.

**Identifying Geriatric Frailty**

Medical evidence shows that across multiple systems, about two thirds of physiological function is redundant (Bortzil 2002). Examples include arterial cross sectional area, hemoglobin-oxygen dissociation, or hepatic and renal function. We must lose about two thirds of physiologic function before subjective symptoms occur. How fast a patient uses their reserve is determined by many factors, including genetics, life events and lifestyle. One of the banes of physicians is dealing with patients who live by the motto, “I feel fine so I must be fine.” When reserve exists, subjectively the patient feels normal. However, once the reserve is lost, the patient develops overt disease, or primary frailty if he or she lacks an obvious dominant disease.

So it’s not surprising that geriatric frailty often goes unrecognized. It does not fit the classic end-organ disease model—it is a gradual decline in strength, function and nutrition. As such, it is also not surprising that healthcare providers, patients and families simply attribute the changes to “old age,” not appreciating that a clinical response is relevant and warranted. So how is geriatric frailty identified?

**OF NOTE:**

Geriatric frailty should not be confused with disability. Frail patients lack physiologic reserve; disabled patients may not. In fact, disabled patients may still have tremendous reserve.

For example, a young person in a persistent vegetative state after hypoxic brain injury may survive for a prolonged period, whereas an elderly frail patient could not.

Medical treatment and ethics mandate different treatment approaches on many levels.

Geriatric frailty has a phenotype. To make this diagnosis, three of the five general criteria listed below must be present. The more criteria that are present, the more advanced the patient’s condition.

1. Loss of muscle strength
2. Unintended weight loss
3. Increased sleep or low activity level
4. Poor endurance or easy fatigability
5. Unsteady gait or slowed performance

Secondary criteria include decreased cognition, balance,
As many of you have, I began my career as a hospice volunteer. So like you, I find National Volunteer Week an important time to recognize the individuals who donate their time and talents to hospice.

Since I know you already extend your appreciation in a variety of creative ways, let me take a moment to highlight some upcoming opportunities that NHPCO is coordinating to support you in this important work.

**Virtual Conference in July**
On July 30 through August 3, NHPCO is hosting its first-ever virtual conference that will focus on volunteer leadership, but will also include one full day of programming specifically for volunteers. All staff and volunteers with Internet access can attend right from their office or home—and also access the various offerings for three months afterwards. I’m also pleased that pricing for this event is based on hospice census, so smaller programs with limited dollars for professional development should be able to extend this opportunity to many of their volunteers. To learn more, visit the NHPCO website or see the story in December NewsLine.

**2012 Volunteer Awards**
NHPCO, together with the National Hospice Foundation, sponsors three annual awards to recognize volunteers in the areas of Patient/Family Service, Organizational Support, and Service by a Teen. The awards are presented at the Clinical Team Conference which, this year, is being held on November 5-7. The nomination process, which was streamlined last year, will open in late summer. Please bookmark the webpage now and begin thinking about the volunteers in your organization that deserve this national recognition.

I’d like to close with a special acknowledgement to Jamey Boudreaux, the executive director of the Louisiana-Mississippi Hospice and Palliative Care Organization. Jamey, in partnership with Warden Burl Cain and the Louisiana Department of Corrections, has accomplished a great thing. Through their efforts and coordination, the first conference for hospice volunteer inmates took place on March 13-16 at the Louisiana State Penitentiary at Angola. There are now six inmate hospice volunteer programs in Louisiana and the inmates who serve as volunteers are doing tremendous work. It is wonderful to see that they are being recognized and supported in a very meaningful way.

Make some time to enjoy the spring season!

J. Donald Schumacher
President/CEO
and motor processing. Change in emotional status (e.g. “just gave up”), poor self-rated health status and deficient social support are also secondary features.

System associations include decreased muscle, neurologic and energy metabolism. As well, immune senescence and altered endocrine and hematopoietic function are noted. It makes sense then that these patients are at increased risk of falls, acute illness, new or worse functional impairment, institutionalization, lengthy hospitalizations, and eventually death. Frailty in general is associated with a 300-to-500 percent increased risk of mortality. Secondary frailty has a 600-percent increased risk of mortality at four years, and a 1000-percent increased risk of morbidity.

Clinicians need to be attuned to this diagnosis. Geriatric frailty is frequently not diagnosed until late in the disease process and, at this point, there may be nothing that can be done to prevent or delay inevitable outcomes. As an example, studies have shown that providing supplemental nutrition as a late-stage frail patient begins to lose weight does not decrease mortality, stop the weight loss or improve function (this is discussed in more detail on page 6).

**The Science Behind It**

Geriatric frailty can be understood. “From a cellular perspective, organisms are born with a finite capacity for stem-cell mediated repair after chronic exposure to tissue injury. Once the capacity is exhausted, a cycle of pathologic inflammation ensues and leads to overt disease manifestations” (Goldschmidt-Clement 2003). In other words, the faster we burn through our stem-cell cycles, the more quickly we approach the end of life. It is estimated that each person has about 40 to 60 stem-cell cycles. Recent research also suggests that if we can develop a way to replace stem cells, the human life span may increase to over 200 years. Needless to say, that would create tremendous medical, social and ethical challenges.

The pathophysiology of geriatric frailty entails sarcopenia (loss of skeletal muscle mass), neuroendocrine dysfunction and chronic low-grade inflammation. Muscle loss is normal as a person ages; however, after the age of about 40, 8 to 12 percent of muscle mass is lost per decade, with further acceleration of muscle loss after the age of 75. Geriatric frailty, in its later stages, appears to also include the loss of visceral proteins such as albumin.

Why are these issues important? Because adipose tissue and skeletal muscle are acting as endocrine organs in this process. To date, at least eight hormones have been found to be secreted from adipose tissue (called adipokines) (Mayo 2011). As with other life changes, geriatric frailty appears to occur when certain hormonal equilibriums occur.

Neuroendocrine dysfunction also plays a role in geriatric frailty. Stable macromolecules may be the surrogate manifestations of cytokines. Hormones associated with geriatric frailty include low levels of estrogen, testosterone, DHEA, cortisol, growth hormone, and insulin growth factor. However, supplementing these hormones has not been shown to improve outcomes, at least at this time.

Chronic inflammation is a third pathophysiologic process of geriatric frailty. Increased levels of pro-inflammatory cytokines such as IL6 or Cachexin (tumor necrosis factor) occur when physiologic systems strain to function as they lose their physiologic reserve. Adipose tissue also has been found to secret IL6. Obesity may express
its harm not only by end-organ disease, but also by prolonged exposure to elevated levels of pro-inflammatory cytokines. It is estimated that patients control about 25 percent of their cytokine levels by lifestyle, diet and exercise.

From a chemical level, geriatric frailty is the expression of the balance between pro- and anti-inflammatory cytokines. Normal physiology increases adipose tissue as we age, and adipose tissue secretes pro-inflammatory cytokines, particularly visceral fat. Muscle decreases as we age, and muscle secretes anti-inflammatory cytokines. Thus, over time, the balance of pro- and anti-inflammatory cytokines may assist in determining which diseases are expressed and when the body starts to shut down. Pro-inflammatory cytokines, for example, effect osteoclast activity, inhibit erythropoietin, stimulate plasma cells, increase inflammatory proteins, cause endothelial injury and increase catabolic processes. These processes are associated with conditions such as atherosclerosis, Alzheimer’s, increased gamma globulins, anemia, osteoporosis and cachexia (Ershler 2003).

Cytokine dysregulation may also explain the cognitive impairment so often seen in late-stage disease and end-of-life patients. It is speculated that risk factors such as age, infections, genetic predisposition, trauma or vascular endothelial insults induce this dysregulation. Cytokine dysregulation causes
neurodegeneration by various means which results in cognitive impairment (Wilson 2002). Cognitive impairment induced by these insults is not always reversible.

**Recognition Can Improve Patient Outcomes**

Falls are an excellent example of why identifying geriatric frailty can be important. While the elderly are at increased risk of falls, some of the treatments suggested to prevent falls may not be ideal for those who are frail. As one example, I can recall one female patient in her late-80s who was advised by her ophthalmologist to have her cataract removed. Due to the benign nature of such surgery, her surgeon felt the risk to her was minimal while I felt there should be a higher level of concern because of her frailty. Soon after her surgery, she showed progressive decline in her mental status and died six months later. Obviously, I cannot say for certain that the surgery induced the mental status change or the decline in this patient, but the sudden change after cataract removal raises concerns.

In addition to falls, weakness, balance, fatigue (i.e., energy management) and sarcopenia can be addressed more effectively if geriatric frailty is recognized.

Weight loss is particularly concerning. Efforts to delay weight loss and maintain visceral protein are rewarded when geriatric frailty is recognized early enough. However, in the late stages, medical evidence does not support improved outcomes with supplemental nutrition.

In two review articles, weight gain, strength, function or mortality were not significantly affected by supplemental nutrition. (Boockyar 2006) (Cochrane 2009). Furthermore, in another research article, institutionalized patients on prolonged tube feeding eventually lost weight and developed bedsores despite receiving the same care and nutrition as in the years prior to these changes. The conclusions to this research were that the lack of significant benefit from supplemental nutrition was due to neuroendocrine dysregulation and chronic low-grade inflammation. These patients were not starving or receiving inadequate nutrition.

As end-of-life care providers, it is important to proactively manage the medical and emotional needs of frail patients. Ironically, if a patient lives to be frail, their end-of-life experience will likely include bed sores, infections, delirium and cachexia.

As with other medical conditions, geriatric frailty permits both event and time prognostication. Proactively advising patients and their families of the coarse and inevitable consequences of their disease helps them prepare emotionally, and helps us gain credibility while setting appropriate treatment goals.

The American College of Surgeons has now published research acknowledging the dramatically increased risk of death and institutionalization when surgery is performed on these patients (Makary 2010). The American Heart Association has similarly published advice stating that, as an industry, we need to re-evaluate treatment guidelines for this demographic (Alexander 2007).

As with all prognostication, combining biometric models, functional decline patterns and biologic data can guide the healthcare provider in
Falls are an excellent example of why identifying geriatric frailty can be important.

giving accurate and professional advice. When frail patients are approaching the end of life, biologic data is especially valuable. When a trigger event occurs (e.g., unplanned hospitalization, planned surgery, infection), any patient may experience an acute phase reaction. However, in frail patients, this occurs in addition to their baseline chronic low-level inflammation. The cumulative acute on chronic inflammation creates an irreversible energy balance. Frail patients subsequently either die from the event or enter into a cycle of decline which ultimately takes their life. This, in fact, may explain the high six-month mortality rate (53 percent) for late-stage demented patients after an acute event, such as a hip fracture or pneumonia; many may have secondary frailty. Similarly, patients with cardiac cachexia may be better diagnosed as cardiac patients with secondary frailty; these patients also have a very poor prognosis.

**Biomarkers as Indicators**

Multiple biomarkers assist us in prognostication. While all cannot be addressed here,
c-reactive protein, sedimentation rate, hemoglobin, albumin and total cholesterol are some of the more important ones. However, these are all surrogate markers for cytokine activity. A cardiovascular health study published in the *Archives of Internal Medicine* showed that, for hemoglobin, the adjusted risk ratio for mortality was 1.57, regardless or cause. This was for both low or excess hemoglobin (Zakai 2005).

Albumin has long been known to define risk in patients. An albumin of less than 3.5 mg/dl on hospital admission is associated with a 350-percent increase in hospital mortality. As well, low albumin on admission is a stronger predictor of hospital death, length of stay and readmission than age (Hermann 1992). For example, nursing home men with an albumin of less than 3.5gm/dl have a 50-percent mortality rate at one year (Rudman 1987).

Total cholesterol is also useful for prognostic purposes. Unfortunately, the benefits of this marker have been lost in the context of traditional earlier-life trajectory treatment strategies. Low cholesterol levels (less than 155mg/dl) in nursing home women are associated with a 520-percent increase in mortality compared to a nadir of 270mg/dl (Forette 1989). Nursing home men with cholesterol levels of less than 150mg/dl were associated with a 64-percent mortality rate at 14 months (Rudman 1988). This compares to a 9-percent mortality rate if their cholesterol was over 150mg/dl. There was a 1000-percent increase in mortality in another study (Verdery 1991) when cholesterol reached very low levels (e.g., 89mg/dl). This study also found a 400-percent increased risk of mortality for low albumin, low hemoglobin or low BMI. When low cholesterol was combined with low albumin and low hemoglobin, there was an 84-percent one-year rate of mortality. This compares to a 7-percent rate of mortality if no metabolic risk factors appeared.

**In Summary**

Healthcare knowledge is constantly evolving. There is no variation from this norm in end-of-life care. To some, it may seem that we are dehumanizing “old age.” However, understanding geriatric frailty can help us define the process and provide state-of-the-art interventions for this population; to provide comfort
and moral absolution; and direct our care towards appropriate and cost-effective treatments. As society ages, the prevalence of frailty will rise. It will behoove us to recognize this diagnosis early; to treat frailty as an independent and progressive but treatable diagnosis; and to develop the compassionate professional skills to advise patients and families of proactive strategies to prepare them for the inevitable consequences of the life process.

Daniel Hoefer is the associate medical director for hospice and chief medical officer for outpatient palliative care at Sharp HospiceCare, based in San Diego, CA. Dr. Hoefer’s experience includes 12 years in hospice and 25 years in family medicine.

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Hermann, Francois, R, MD, Serum Albumin Level on Admission as a Predictor of Death, Length of Stay and Readmission, 1992 Archives of Internal Medicine 152, 125-29.
The emotional and psychological challenges which hospice nurses face each day may, at times, feel overwhelming and may contribute to a high percentage of nurse burnout and nurse turnover. However, integrating practices and concepts of self-care and self-healing that are central to holistic nursing can help hospice nurses create healthier ways of being and decrease burnout and turnover. This article discusses these key concepts—and how to integrate them into your daily life.

“Holistic nursing and hospice nursing have a lot in common,” says author and holistic nurse, Lucia Thornton. “As a matter of fact, if you compare the scope and standards of practice for both specialties, the vast majority of the content is the same or very similar.”

Through a collaboration with the American Holistic Nurses Association, NewsLine is pleased to share this article by Lucia, who discusses the key principles of holistic nursing and how these principles can be used by hospice nurses as a way to care for themselves and, in so doing, improve the care provided to patients. The end of the article also includes information on holistic nursing certification, for clinicians interested in learning about dual certification.

Caring for Ourselves:
A Holistic Nurse Provides Guidance

By Lucia Thornton, RN, MSN, AHN-BC

The emotional and psychological challenges which hospice nurses face each day may, at times, feel overwhelming and may contribute to a high percentage of nurse burnout and nurse turnover. However, integrating practices and concepts of self-care and self-healing that are central to holistic nursing can help hospice nurses create healthier ways of being and decrease burnout and turnover. This article discusses these key concepts—and how to integrate them into your daily life.

Being a Caring and Healing Presence

A primary focus of holistic nursing is to bring caring and healing back into our healthcare system. The first step in
this process is for nurses to learn to love and care for themselves. While this may seem a selfish pursuit, it is not. Learning to care deeply for yourself by taking the time to nurture yourself physically, emotionally, mentally and spiritually is absolutely essential. When you do, you begin to realize your wholeness and you actually become a healing presence for your patients.

Who you are, how you feel inside, and the attitude that you convey have a profound effect on the patient. When you walk into a patient’s home feeling depleted and exhausted, you are creating an unhealthy environment by your presence. If, on the other hand, you are well rested and feel content and peaceful, you create a healthy and wholesome environment by your very presence.

Taking good care of yourself is a prerequisite to providing quality care for your hospice patients. Learning to listen deeply to your own heart and your own truth allows you to connect in a deeply caring way. As the distinguished professor of nursing, Jean Watson, says, “We must learn to treat ourselves with love and respect before we are able to treat others that way.” Love and caring are essential in the healing process, both for you and your patients!

**Role Models for Healthy Living**

Holistic nurses strive to be models of healthy behavior by creating optimal health in every aspect of their lives. Achieving optimal health is, however, a continual and lifelong endeavor that involves deep inner inquiry, exploration, commitment and perseverance.

Resistance to change, self-doubt, and low self-esteem can block your journey to optimal nurturance. Examining these blocks is crucial for understanding and identifying sources of resistance. Many of these attitudes and beliefs are caused by social conditioning and early life experiences that simply no longer apply to adult life. Being willing to explore what lies beneath the surface is important if we are to create healthy patterns of living.

**Commitment to Self-care, Self-exploration and Awareness**

Taking time to examine the various aspects of your life is crucial to living in a conscious way. The first step in this process is gaining an awareness of your patterns and habits and bringing into consciousness that

When you walk into a patient’s room feeling depleted and exhausted, you are creating an unhealthy environment.
which has been unconscious. Some of the practices utilized by holistic nurses for self-exploration and awareness include meditation, creating time for reflection and introspection, dream work, mindfulness practice, and journaling. (See opposite page.)

**Centering and Intention Setting**
Centering and creating an intention for healing are processes the holistic nurse engages in prior to any patient interaction. Centering involves focusing your attention on your heart, setting aside concerns and thoughts, and connecting with feelings of love and compassion. A compassionate attitude is foundational in hospice care. Every decision we make, and every interaction we have with our patients and families, must be informed first and foremost by compassion.3

Creating an intention is a powerful way for the nurse to create an optimal environment for a caring-healing and compassionate interaction. Examine the following intention: “I am here for the greater good of this person. I set aside my own concerns and worries and am fully present to the person here and now.” With this intention the nurse is consciously setting aside her own concerns and focusing on the patient. She has set into motion the dynamic that this interaction will be “for the greater good of this person” and she is making a conscious decision to be fully present. The nurse, through this intention, creates an environment that promotes and sustains a caring, healing and compassionate interaction. This type of interaction creates a healing environment that nurtures both the nurse and the patient. (See opposite page.)

**Integrating Holistic Nursing into Hospice Practice**
Many holistic nurses utilize a variety of complementary and alternative therapies as part of providing holistic care. These include subtle energy healing (e.g. Healing Touch, Therapeutic Touch, Reiki), reflexology, guided imagery, aromatherapy, massage, music and sound therapy, and acupressure. Holistic nurses, through their knowledge and understanding...
Questions for Self-exploration

Take some time each day to reflect on an aspect of your life. Here are some questions to help you get started:

- **Physical**: Is my diet optimal? Does my intake consist mainly of whole and natural foods? Are my elimination patterns frequent and regular? Do I receive optimal sleep and rest daily? Do I engage in beneficial movement and exercise daily? Do my breathing patterns promote well being?

- **Mental**: Do I have a problem-solving orientation toward life rather than a victim mentality? Do I usually have a positive attitude and positive thoughts toward work? Do I have a sense of humor? Do I possess self-awareness—am I objective about my strengths, limitations and possibilities? Am I able to perceive reality with clarity?

- **Emotional**: Do I love and accept myself and others? Am I able to give and receive love? Am I able to express my own truth? Am I able to have deep feelings of identification, sympathy, and affection for others?

- **Social/Relational**: Do I engage in relationships that are loving? Do I engage in relationships that promote growth in myself and others? Am I able to set healthy boundaries with others? Do I engage in work that is meaningful?

- **Spiritual/Energetic**: Am I able to connect with God/higher self/universe/spirit? Do I engage in meditation/prayer/introspective practices regularly? Do I know and understand love as the essence of self? Do I have a deep respect for all?

Take your time in addressing each question. Remember this is a lifelong process of deep inner inquiry and growth. As you go through these questions, note when you respond with a powerful no. These are the areas that need your attention. Focus on one area at a time. Create some short and long-term goals for each of the areas that you want to improve. Remember to treat yourself with compassion, love and kindness!

Centering and Intention-setting Technique

- Pause for a moment before entering the patient’s room.
- Set aside any concerns regarding the past or the future. These can be picked up when leaving the room.
- Gently close your eyes.
- Breathe deeply and slowly.
- Repeat to yourself, I am here for the greater good of this patient. I give my full attention to the here and now.
- Direct awareness to the area around your heart, bringing to mind something or someone that evokes your love and compassion.
- When connected with that feeling, repeat again, I am present to the moment.
- This entire process takes between 5 to 10 seconds.
of complementary and alternative practices, guide their patients in safely integrating these therapies into their lives. (See the article on page 15 about how one holistic nurse uses restorative yoga to help meet hospice patients’ needs.)

Holistic nursing is a way of being, living and practice that can enhance your effectiveness as a hospice nurse. Holistic nursing encourages the nurse to nurture and care for her own self and adopt a healthier and more wholesome lifestyle. In so doing, the hospice nurse becomes a healing presence for patients and co-workers and helps create a healing environment and a vital and healthy workplace.

**Board Certification in Holistic Nursing**
There are currently 12 undergraduate programs in the U.S. which are endorsed by the American Holistic Nurses Certification Corporation and prepare undergraduate students in holistic nursing. For more information about holistic nursing, visit the website of the American Holistic Nurses Association.

Lucia Thornton is a past president of the American Holistic Nurses Association. She has been involved in nursing, holistic healing, and healthcare for more than 35 years and developed The Model of Whole-Person Caring™, a holistic interdisciplinary model with demonstrated success in improving patient satisfaction, increasing nurse retention and creating a healthy workplace. She was also instrumental in creating one of the first residential hospice homes in the country. Email Lucia at lucia@luciathornton.com or visit her website at www.luciathornton.com.

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**About AHNA**
The American Holistic Nurses Association is a non-profit membership association for nurses and other holistic healthcare professionals. Founded in 1981, AHNA is the definitive voice for holistic nursing, and promotes the education of nurses, other healthcare professionals, and the public in all aspects of holistic caring and healing, serving as a bridge between conventional medicine and complementary and alternative healing practices. To learn more, visit **www.ahna.org**
Adapting Restorative Yoga for the Hospice Patient

By Liz George, RN, BSN, PHN, HNB-BC

The inspiration to offer restorative yoga to my hospice patients came from a young hospice resident who had lived with cancer for many years, maintaining his health with a vegan diet and a regular yoga practice. When he arrived at the hospice residence, he was no longer able to practice yoga and greatly lamented the loss.

I have practiced yoga for over eight years and it occurred to me that restorative yoga might offer this young man the opportunity to enjoy yoga postures even while bedbound. I made a list of several restorative postures I thought might be appropriately done in bed and offered to assist him into those postures, with the help of two volunteers, and he was quite eager to try them.

We began with a legs up a chair pose by placing a chair on the bed and using a draw sheet to hold his feet together onto the chair. His arms and head were well supported with pillows and his eyes were covered with a small pillow filled with rice and lavender. After a cleansing breath, in through his nose and out through his mouth, he was instructed to breathe deeply in and out through his nose, consciously letting go of his stress and tension with every outgoing

continued on next page
breath. He remained in this posture for approximately 10 minutes, after which I called the patient’s name, let him know we would be changing position, and slowly moved him out of the position.

Next, we helped the patient into a *Butterfly* posture. Once the chair was removed from the bed and the patient was flat on his back again, a volunteer helped me to log-roll him onto his side. I placed a small rolled blanket in the center of the bed and the patient rolled onto it so that it was along his spine from the base of his neck to his sacrum. Again his head and arms were well supported with pillows. We drew his feet together so that the soles touched, placing blankets under his knees to support them and using a draw sheet to gently hold his feet together. I repeated the instructions to take a cleansing breath and then to use each outgoing breath to let go of tension and stress.

After 10 minutes, we assisted the patient to lie on his stomach with a small rolled towel in a v shape supporting his head, his arms palms down at his sides and his feet supported by pillows. After 5 minutes, we raised his arms over his head for another 5 minutes, then gently returned him to his back.

Finally, we assisted the patient onto his back, legs and arms outstretched to the edges of the bed, head well supported with pillows, a rolled blanket under his ankles, arms supported by pillows, the rice and lavender eye pillow in place and an extra blanket covering him. He fell asleep in this position, waking after 30 minutes to express an increased sense of calm and then returning to sleep for a nap of several hours duration.

Since that initial experience, I have had the opportunity to help patients into postures several times. The *legs up a chair* posture is very effective for patients with lower extremity edema and relieves discomfort for patients with pressure ulcers. The postures offer patients the ability to achieve deeper relaxation when combined with deep breathing or guided imagery. Even patients who have never practiced yoga have been open to trying these gentle supported postures. I am grateful to that young man for inspiring the addition of restorative yoga to my CAM repertoire.

For more information, read the article, *Restorative Yoga*, from the Yoga Journal.

*Liz George is a board certified holistic nurse with the Zen Hospice Project in San Francisco, CA.*
Nurse Product Line
National Nurse's Week is in May! Acknowledge your hard working Nursing staff with this wonderfully coordinated collection of handy items specifically designed just for them!

A. Hospice Nurse Tote Bag
The beige with orange trim Hospice Nurse tote bag is an eye catching tote that keeps you organized while on the go. The front features a pen loop (pen not included) for easy access, a large main compartment with zippered closure, an interior organizer for pens, MP3 player and business cards. It is made of 400 denier polyester and is 17.5” x 14” x 3”.
Item #: 821463
Member: $13.00
Non-Member: $17.00

B. Hospice Nurse Note Pad
The Hospice Nurse purple or white 4” x 5 ¼” spiral notebook with an attached folding mini pen is perfect to keep your notes or to give as a gift.
Item #: 821464
Member: $5.95
Non-Member: $8.95

C. Hospice Nurse Lunch Bag
Enjoy your lunch in style with a Hospice Nurse silver lunch bag made of 600 denier polycanvas. Features include a dual zippered insulated main compartment, an additional outside pocket, mesh side catch pockets, and an adjustable black comfort shoulder strap. The size is 8” x 7” x 5” and will hold a lot.
Item #: 821465
Member: $10.95
Non-Member: $13.00

D. Hospice Nurse Photo Frame
Brighten up your day with your favorite photograph. The Hospice Nurse white photo frame has a digital display desk clock, calendar and alarm functions. It also includes wall pegs or a stand. The AA batteries are included but not inserted.
Item #: 821466
Member: $12.95
Non-Member: $15.95

E. Hospice Nurse Travel Mug
This 16 ounce silver stainless steel travel tumbler is a great way to display the Hospice Nurse logo while quenching your thirst. The tumbler has an insulated steel outer wall and plastic liner. The lid screws and has a slide opening. Keep it for yourself or get one to give to others.
Item #: 821469
Member: $12.95
Non-Member: $15.95

F. Hospice Nurse Bookmark
Celebrate this special week with a Hospice Nurse bookmark. The white 2” x 7” laminated 10 point coated paper bookmarks have a white tassel.
Item #: 821467
Member: $1.00
Non-Member: $1.50

G. Hospice Nurse Keylight
Light up Nurse Week with a silver oval key light with a white LED light. The button cell batteries are included.
Item #: 821468
Member: $5.00
Non-Member: $7.00

For more information
CALL 800/646-6460 GO TO WWW.NHPCO.ORG/MARKETPLACE
Since its inception, the hospice movement has relied heavily on the psychosocial knowledge and interpersonal skills which social workers bring to the interdisciplinary team. Historically, social workers practicing in hospice, and later as part of palliative care teams, have long sought recognition for the specialized knowledge and skills needed to work in end-of-life care.

Over the past 20 years, several national social work organizations were approached in the hope of creating a credential similar to the Hospice and Palliative Nursing Association; however, no single social work organization had the financial resources or the structure needed to create and administer a national social work end-of-life care exam. Discussions in 2008 ultimately led to a partnership between the National Association of Social Work (NASW) and NHPCO to create a specialty certificate—which came to fruition that same year.

In November 2008, NASW introduced the specialty certificate, the Advanced Certified Hospice and Palliative Social Worker (ACHP-SW), making it available to qualifying masters degreed social workers. Then in the following year, NASW introduced a specialty certificate for BSW-level social workers—Certified Hospice and Palliative Care Social Worker (CHP-SW). Requirements, fees and application forms can be found on the NASW website.
Some of the Benefits

As the NASW notes on its website, credentialed social workers are recognized as having in-depth knowledge, proven work experience, leadership capacity, competence, and dedication to the social work profession. As part of the credentialing process, these individuals undergo a fairly intense review that strives to measure adherence to the NASW Code of Ethics, NASW Standards for Continuing Education and National Practice Standards, consistent with their area of specialized social work practice. For these very reasons, credentialed social workers often have a competitive edge in the labor market. But there are other benefits too.

Carly Bassett, LMSW ACHP-SW, who has worked for Hospice Austin for three years, received her ACHP-SW certification in October 2010. Carly reports that her employer has encouraged social work staff to obtain the certification—along with financial assistance. Social workers at Hospice Austin who pursue certification receive a salary increase and are reimbursed for the application fee. When asked how receiving the certification has impacted her job performance, she says it has given her a greater sense of pride to say she’s certified as a hospice social worker. “Having the designation has helped to validate what I already felt about this work—that it truly is a great honor and privilege to be a part of hospice care.”

In addition to a greater sense of confidence and satisfaction in her career choice, Carly has also witnessed a direct impact on patients and families. “It gives me an opportunity to educate others about social work, hospice and the certification,” she says. “A lot of people do not know what it takes to become a social worker, so when I am asked about it, I can educate people about the profession in general and then by explaining the certification, it elevates the trust and faith that families have in my role on the interdisciplinary team.”

Some of the Barriers

While many social workers who practice in the field have pursued certification, some have noted barriers.

For those employed by organizations that don’t provide any financial support, it’s often a matter of cost. In fact, 11 percent of respondents to a national social work survey conducted by NHPCO in 2010 saw cost as a barrier.
For example, because this certification is a joint partnership between NASW and NHPCO, membership is an issue:

- Social workers must maintain membership in NASW—or be willing to pay an NASW non-membership fee to obtain the specialty certification (which can run about $450).
- Membership in NHPCO (as an NCHPP member) is also required; however, since membership is a free benefit to all staff and volunteers who work for NHPCO provider-members, that cost is generally not a factor.

Obtaining the necessary continuing education was also cited as a barrier. For example, social workers must earn 20 CEUs in hospice and palliative care every two years in order to renew their ACHP-SW certification, and some organizations don’t have the budget and/or interest to provide that level of financial support. On the plus side, both NASW and NHPCO now offer numerous Webinars as a lower-cost alternative for obtaining CEUs versus attending conferences. Webinars hosted by other organizations, online courses, and local workshops are also available. Social workers are also encouraged to present on hospice and palliative care at local and regional conferences to help increase learning opportunities and educate other professionals.

Still the Fastest Growing Credential

Despite the barriers, there are approximately 570 social workers which have earned the ACHP-SW credential and another 60 who have earned the CHP-SW credential. According to the NASW, these credentials are also the fastest growing certification of the 17 the NASW offers. This tracks with findings from NHPCO’s 2010 survey where 30 percent of respondents felt the certificate would be very useful.

As Carly so aptly said, “Having the designation shows your agency, your peers and your clients that you are dedicated to this work and committed to it on a deeper level.”

Sherri Weisenfluh is the associate chief clinical officer of counseling for Hospice of the Bluegrass (Lexington, KY) and serves as the NCHPP Social Worker Section leader.

Brandon Wollerson is the senior program manager for the CARE Program (Austin, TX), which offers case management, mental health counseling, substance use counseling, and psychiatric services to individuals living with HIV/AIDS. Prior to joining CARE, he was the program coordinator for Doug’s House, the residential AIDS hospice program of Project Transitions. Brandon has served on the NCHPP Social Work Steering Committee for the past two years.
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NHPCO’s National Council of Hospice and Palliative Professionals (NCHPP) is comprised of 48,000 staff and volunteers who work for NHPCO provider-members. Organized into 15 discipline-specific sections that are led by the NCHPP chair, vice chair and 15 section leaders, NCHPP represents the perspectives of the interdisciplinary team—the very essence of hospice care.

These individuals—together with each Section’s Steering Committee—volunteer their time and expertise to a variety of NHPCO projects to help preserve and develop the “interdisciplinary model” within the evolving world of hospice and palliative care.

In this NewsLine feature, we shine the light on a different NCHPP Section each month, so all members can benefit from each discipline’s perspective on important topics. It will also help members learn more about the work of NCHPP and how to get more involved—whether it’s taking better advantage of some of the Section’s free activities or joining a Section’s Steering Committee.

**Featured This Month:**

**NCHPP Volunteer Volunteer Management Section**
QAPI for Hospice Volunteer Programs

By Sandra Huster

When we think of quality assurance and performance improvement (QAPI) initiatives in the hospice setting, our thoughts may not include volunteer programs. The National Council of Hospice and Palliative Professionals (NCHPP) has identified QAPI as a gap in knowledge for leaders of hospice volunteers. This may be due in part to limited data collection in individual hospice volunteer programs and to a lack of understanding of quality measures for this discipline.

Traditionally hospice volunteer programs have reported “soft outcomes,” such as volunteer and patient stories. These are still vitally important for us to remain connected to our purpose and mission. However, today’s hospice leaders and those who provide leadership for volunteer programs must quit assuming and begin documenting quality outcomes. Hospice volunteer programs must identify quality measures, set measurable program goals based on internal and external benchmarks, identify opportunities for improvement, and collaborate with the clinical team on QAPI initiatives. Volunteer programs must prove their value to the organization through “hard data,” documenting and reporting outcomes that improve patient care, increase family satisfaction and save costs.

QAPI initiatives for hospice volunteer programs require collaboration between staff members who lead volunteer programs, the clinical team and volunteers.

Consider your hospice volunteer program:
- Are you assuming that your volunteer program provides quality care and services? Or do you have data that documents quality outcomes?
- What is currently being tracked and reported?
- Who is that data reported to and how is the information being used?
- Does your leader of volunteers have specific measurable goals that are based on internal and external benchmarks? Are results tied to his or her annual performance evaluation and merit increase?
- Does the leader of your volunteer program serve on your QAPI committee?
- Has your volunteer program been involved in a QAPI project?

The volunteer discipline is an integral part of the interdisciplinary team. Volunteers play a crucial role in providing excellent patient care and contribute toward many quality outcomes measured and reported by hospices. The Family Evaluation of Hospice Care (FEHC), the Family Evaluation of Bereavement Services (FEBS), and concurrent patient/family surveys include questions that involve every member of the team, including volunteers. Results can provide good feedback for the volunteer program and provide some “hard data” on the value of volunteers.
Identifying Quality Measures

All hospices must document volunteer service hours that meet the Medicare Hospice Conditions of Participation (Hospice CoPs) for “Volunteers, Level of Activity,” found in 42 CFR 418.78(e).

As defined by Medicare, these activities include direct volunteer patient care hours and administrative volunteer hours that support patient care. The required “Medicare match” is 5 percent.

NHPCO’s 2010 National Summary of Hospice Care (National Summary) reports that the agency mean for volunteer hours as a percent of clinical staff hours (i.e., the Medicare match) is 5.2 percent. Volunteer programs may choose to set a benchmark that is above the required 5 percent match. The National Summary reports that the 75th percentile for all hospices responding to this question is a 7.7 percent Medicare match. The top 25 percent of hospices report that their Medicare match is greater than 7.7 percent. This presents an external benchmark for volunteer programs that want to strive to improve this key quality measure.

Increasing the Medicare match presents opportunities for QAPI initiatives as this goal requires collaboration between the interdisciplinary members who identify patient problems that require volunteer interventions, and the volunteer manager who recruits, trains and places volunteers to meet these needs.

Some Opportunities for Improvement

QAPI initiatives for hospice volunteer programs may set internal or external benchmarks for improvement. The following are examples of opportunities for improvement in hospice volunteer programs, using either internal or external data to set benchmarks. (Specific measurable goals would need to be included in these outcome statements.)

Patient Care Volunteers as a Percent of Total Volunteers

- Increase the percent of direct patient care volunteers to total volunteers. (The National Summary reports 59.3 percent as the agency mean and 81.5 percent as the 75th percentile.)

Volunteer Service Hours and Visits

- Increase Medicare match. (The National Summary reports 5.2 percent as the agency mean and 7.7 percent as the 75th percentile.)
- Increase the percent of patients/families served by volunteers. (No national data available. Hospices must set internal benchmark.)
- Increase the percent of patient/family requests that are met by volunteers. (No

Volunteer programs must prove their value to the organization through hard data.
Hospices must set internal benchmark.)

- Increase the number of patient visits per volunteer. (The National Summary reports 20 visits per volunteer as agency mean and 27.4 visits per volunteer as 75th percentile.)
- Increase volunteer visits as a percent of total IDG visits. (The National Summary reports 5.2 percent as agency mean and 7.3 percent as 75th percentile. These percentages nearly mirror the Medicare match results.)

**Number of Volunteers per Patient**

- Increase the total number of volunteers (all types) per patient. (The National Summary reports .29 as the agency mean and .38 as the 75th percentile. This number is calculated using the total number of volunteers (all types) divided by the total number of patients admitted.) This is an important growth measure used to ensure that the overall volunteer program is growing in proportion to growth in the hospice census. It indicates to hospice programs whether they have an adequate number of volunteers to support patients, families and the overall organization in areas such as development and marketing.
- Increase the number of direct care volunteers per patient. (The National Summary reports .15 as the agency mean and .21 as the 75th percentile). This number is calculated using the total number of patient care volunteers divided by the total number of patients admitted. This too is an important growth measure, comparing the growth in patient care volunteers to the growth in patients served, ensuring that patients and families’ volunteer needs are met.

**Family Evaluation of Hospice Care Survey**

- Increase the percent of families responding to this survey who indicate that they have received the right amount of help from volunteers. (This is a new question that was added to the survey in 2011. This measure will be reported in 2012 and will present an external benchmark for hospice volunteer programs.)

**Implementing QAPI Initiatives**

Covenant Hospice’s Volunteer Program has been involved in several QAPI initiatives over the past five years. Some were “owned” by other departments which invited the volunteer program to participate in, while others were initiated by the volunteer program. The following are examples of the QAPI projects initiated by the Volunteer Program.

**No One Dies Alone: Increasing Family Satisfaction of Care at the Time of Death**

Covenant’s final promise to patients and families is that no one under its care should die alone, unless that is the patient’s choice. Our Performance Improvement (PI) Department consistently reviews the charts of patients who have died. One of the key indicators that is noted and reported as a result of this review is whether the patient was alone at the time of death, or if there was someone present—a loved one, facility staff member, Covenant staff member or volunteer.

In 2006, Covenant’s PI Department reported that 95 percent of all patients died with someone present. On one hand...
that might be a number to celebrate; however, our concern was for the 5 percent who died alone.

In collaboration with the PI Department, clinical leaders and interdisciplinary team members, the Volunteer Program focused on the following strategies for improvement of its 11th Hour (Vigil) Volunteer Program:

• Remove barriers for the interdisciplinary team and on-call staff in accessing an 11th hour volunteer;
• Increase the number of trained 11th hour volunteers;
• Hardwire communication between the admissions team, home and facility interdisciplinary members, on-call staff, and patients and families; and
• Improve the process for requesting and utilizing 11th hour volunteers, making sure that no one “falls through the cracks.”

As a result of this initiative, Covenant increased the percentage of patients who died with someone present from 95 percent in 2006 to 97 percent in 2007-2008 and, finally, to 98 percent in 2009-2011. The situations where patients died alone were often not preventable. In most cases, for example, someone had been sitting at the patient’s bedside and left the room right before he or she died. Also, we understand that some patients choose to die alone.

**Tuck-in Volunteers: Increasing Family Satisfaction with Weekend Care**

In 2008, the Volunteer Program collaborated with the clinical team on a QAPI initiative to improve family satisfaction of weekend care. Since that time, volunteers have continued to make weekly “tuck-in calls” to all home patients and families. These trained volunteers utilize a call script that doubles as a tracking log. The purpose of the calls is to identify supply, medication and equipment needs prior to the weekend so that the clinical team can take care of these needs before 5:00 p.m. on Friday. Volunteers are also trained to ask about pain control and to immediately communicate identified pain or symptom control issues to the appropriate nurse.

Covenant reduced weekend calls for non-emergency patient needs by over 50 percent as a result of this program. This represents satisfied families who have the equipment, supplies and medications they need throughout the weekend and a savings in on-call staff time to deliver supplies and medications during the weekend.
**Quality Hospice Volunteer Programs**

The NCHPP Volunteer/Volunteer Management Steering Committee is dedicated to working with NHPCO and hospice volunteer programs to elevate the volunteer discipline within the individual hospice’s interdisciplinary team and with hospices throughout the country. Hospice volunteer managers are professionals whose contributions help to improve patient care, increase family satisfaction and save costs during this challenging time. QAPI initiatives that involve hospice volunteer programs are imperative as we “raise the bar” for this discipline and work together to sustain our organizations.

_Sandra Huster has worked in the field of volunteer management for 15 years and is currently director of volunteer services for Covenant Hospice (Pensacola, FL). She also serves as the NCHPP Volunteer/Volunteer Management Section leader and is a frequent presenter at NHPCO’s national conferences. Sandra can be reached at Sandra.huster@covenanthospice.org._

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**Volunteer/Volunteer Management**

**Monthly Chats**

Each month, the NCHPP Volunteer/Volunteer Management Section holds “chats”—or conference calls—which are open to all NCHPP members. These informal chats are one of the easiest ways to “connect” as a diverse group of professionals working in all corners of the country.

**Upcoming Chats:**

- **April 11:** Open Forum (with updates from NHPCO MLC)
- **May 9:** Inviting and Accommodating Volunteers with Disabilities
- **June 13:** Spiritual Support Volunteers: Creating a Program
- **August 8:** Highlights from NHPCO’s Ignite Volunteer Virtual Conference
- **September 12:** Managing Challenging Volunteers and Creating Positions of Honor for Aging Volunteers
- **October 10:** Care Planning for Volunteer Interventions
- **November 14:** Equipping Volunteers to Effectively Communicate with Alzheimer’s and Dementia Patients
- **December 12:** Open Forum (with discussion of topics for 2013)

**Joining the Chats:**

Call **605-475-4700**, and enter the Participant Access Code when prompted: **777608#**. (Please do not dial in earlier than 2:55 p.m. (ET) on the day of the call.)
One of the best ways to exchange ideas and tips with your colleagues is through the NCHPP Volunteer/Volunteer Management Section eGroup on NHPCO’s professional networking site, My.NHPCO. (It’s free for staff and volunteers of NHPCO provider-members.)

Each NCHPP Section has an eGroup on My.NHPCO (much like the former listserves, but better), plus an eLibrary where members post helpful information and resources to help one another.

If you’re not already a My.NHPCO user, visit the homepage and see “Getting Started” in the top right corner. For specific questions, contact the NHPCO Solutions Center at 800-646-6460 (8:30 a.m. to 5:30 p.m., ET) or email solutions@nhpco.org.
Hospice of the North Shore Honors Ousman Badjie

Hospice of the North Shore & Greater Boston (based in Danvers, MA) recently honored Ousman Badjie, LPN, as the recipient of the Rick Vescovi Memorial Award, established by the program in memory of social worker, Rick Vescovi.

Badjie joined the hospice seven years ago as a hospice aide. He has now received his license in practical nursing, and is currently studying to become a registered nurse. “He epitomizes the qualities that Vescovi was known for,” said president/CEO, Diane Stringer. “He makes sure that our patients have peace and dignity while on our services.”

Chapters Health Palliative Care to Offer HopeBlue Palliative Care Services

Chapters Health Palliative Care (Tampa, FL), a service of the non-profit Chapters Health System, has entered into a participating provider agreement with Blue Cross and Blue Shield of Florida (BCBSF) to provide palliative care services to BCBSF members in Hillsborough, Polk, Highlands and Hardee counties.

This collaboration is the first of its kind in the state of Florida. Under the agreement, eligible BCBSF members requiring palliative care services will be referred to Chapters Health Palliative Care for an initial evaluation and assessment in the Palliative Care clinic, a nursing facility, assisted living facility, hospital, or the patient’s home. BCBSF member eligibility for HopeBlue palliative care services is subject to the member’s benefit plan coverage.

‘The Vampire Diaries’ Star Torrey DeVitto Raises Awareness for Hospice

NHPCO’s first hospice ambassador, actress Torrey DeVitto, attended the 20th Annual Elton John AIDS Foundation Oscar Viewing Party on February 26—and used the opportunity to help raise awareness for hospice. Among the media attention she garnered was this entry in Examiner.com that helps promote the new t-shirt she designed, in partnership with NHPCO and the National Hospice Foundation, to benefit hospice care.

For more than four years, DeVitto has served as a volunteer at Mission Hospice (Glendale, CA). “I have found such a light in being a part of hospice, one I would have never have thought I’d discover,” she says. “Being a volunteer helps me appreciate things in my own life so much more.” To learn more about her work as hospice ambassador, visit www.caringinfo.org/torrey.
David McGrew to Serve on AAHPM Certification Organizing Board

David McGrew, MD, the medical director for HPH Hospice (Hudson, FL), has been appointed to serve on the organizing board for the AAHPM’s National Board for Hospice Medical Director Certification. Dr. McGrew is a founding member of AAHPCM and a past president of the Florida Chapter. To learn more about the Medical Director Certification, visit the AAHPM website.

Two California Programs Celebrate 35 Years of Service!

Founded in 1977 by several physicians who saw a community need, Pathways Home Health & Hospice (Sunnyvale, CA) was originally known as Mid-Peninsula Health Services, but was renamed Pathways Home Health, Hospice & Private Duty when it began to serve patients beyond the peninsula area. During its first year, this nonprofit cared for 12 patients. In 2011, Pathways cared for over 5,000 home health, hospice and private duty patients in a service area that spans from San Pablo and San Francisco to Gilroy.

From humble beginnings as the first nonprofit hospice provider in the county, San Diego Hospice and The Institute for Palliative Medicine (San Diego, CA) is now one of the largest hospice and palliative care programs in the country, caring for 1,200 patients each day. In addition to patient and family care, The Institute for Palliative Medicine trains 3,400 clinicians (physicians, nurses, social workers, pharmacists and clergy) from around the world in palliative care annually.

Louis Izzo Joins The Center for Hospice & Palliative Care

The Center for Hospice & Palliative Care (based in Buffalo, NY) has named Louis A. Izzo to the position of executive vice president and chief administrative officer. Mr. Izzo joins the organization after many years as an active volunteer and supporter. In this new role, he will oversee operations, including all sites and affiliate companies.
Discussions Under Way to Form a Capitol Region HVP

Hospice-Veteran Partnerships (HVPs) are coalitions of people and organizations that come together to help ensure that Veterans have access to high-quality end-of-life care, including the seamless coordination of care between community hospices and VA medical facilities.

While there are HVPs throughout the country, none exists in our nation’s Capitol Region—but that may be changing.

On February 29, NHPCO hosted an initial day-long meeting at the National Center to explore the formation of a “Washington, DC Metro HVP” that was attended by an enthusiastic and diverse group of organizations—10 area hospices; the DC VA Medical Center; Hospice Foundation of America; the ALS Association; the GW School of Nursing; the National Center for Creative Aging; the Library of Congress; and Veteran-centric organizations, including the VFW and several area Vet Centers.

Look for updates on this initiative in future issues of NewsLine. To learn more about HVPs, visit the We Honor Veterans website.

Thank You for Your Support

The following organizations have provided generous grant support for NHPCO’s 27th Management and Leadership Conference and related events:

- Hospice Pharmacia
- Glatfelter Healthcare Practice
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Faculty: Christine Longaker, author of Facing Death and Finding Hope, Kirsten Deleo, MA; Ann Allegré, MD, Pam Russell, MSW, and Ira Byock, MD.

Among the day’s presenters were Kathleen Bixby, a palliative care educator with the VA Medical Center (on left), and Molly Brooks of Heartland Hospice.
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Your employees and volunteers have more on their minds than their driving. It may be a patient in distress, a grieving family or just the nagging pressure of falling behind a busy schedule. Auto accidents are a major cause of lawsuits against hospices and home health care agencies as well as a cause of serious injuries and lost time.

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Hospice is the only program under Medicare that requires the use of volunteers as part of its day-to-day operations. Therefore, it is important for a hospice program to know the regulations for volunteers under the Medicare Hospice Conditions of Participation (Hospice CoPs) and ensure it remains compliant.

The Role of Volunteers

In addition to serving as companions, homemakers and administrative staff, volunteers often serve as medical directors, nurses, alternative counselors, and spiritual advisors.

Whatever the size or scope of your hospice volunteer program, keep in mind the following:

- It must have a training program;
- It must utilize volunteers for direct patient care or administrative activities; and
- It must document that the volunteer program achieves a 5 percent cost savings through the use of volunteers.

There should also be documentation that the interdisciplinary team assessed the patient and family’s need for a volunteer as well as the time spent and the services provided by the volunteer(s).

Hospices must also document and demonstrate viable and ongoing efforts to recruit and retain volunteers.

NHPCO has comprehensive resources that outline all of the Medicare Hospice regulatory requirements for a volunteer program:

- Medicare Hospice Conditions of Participation 42 CFR 418.78: Volunteers (This six-page PDF includes the regulatory requirements for volunteers; interpretive guidelines which provide more detail; and additional explanatory language from CMS.)
- Tip Sheet on Implementing the Volunteer Regulatory Requirements (1/09 edition)
- The Volunteer Regs Revisited (11/09 NewsLine Article)
The National Hospice and Palliative Care Organization presents:

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Learn more and register at [www.nhpco.org/CTC2012](http://www.nhpco.org/CTC2012)
Hospice volunteers make a difference in a multitude of ways. At San Diego Hospice that includes supporting the wonderful program, Haircuts@Home.

This longstanding program relies on hair stylists in the community who are willing to make house calls—and help patients feel like their ‘old selves again’ with nicely cut and styled hair.

“It’s fulfilling to know that I can make such a big difference by doing something as simple as giving a great haircut,” said Rhys, owner of two salons and a Haircuts@Home volunteer for the past five years. Watch the video to learn more.