The cuts and ongoing threat to hospice reimbursement rates are reason enough for any hospice to review its costs and look for ways to increase efficiencies. But there are other important reasons too. A profitable and efficiently managed hospice is far more able to provide high-quality patient care, attract and retain sophisticated donors, and enhance employee morale. It’s also better able to position itself for long-term viability.

Hospice By The Bay (HBTB), founded in 1975, is the second oldest hospice in the country. Today it remains a freestanding, not-for-profit organization that serves about 400 patients per day—an ethnically diverse population from both rural and urban areas of Marin, Sonoma and San Francisco counties.

In FY 2008-09, HBTB had a per-patient-day cost of $213 and posted a 10 percent operating loss. Over the next several years, the Finance Department and agency leadership addressed cost structures and were able to reduce the per-patient-day cost to just $189. We are now on track to deliver a 12 percent operating surplus in FY 2012. This article discusses the approach we followed, but also shares the specific cost containment projects that were implemented.

How to Lose a Million Dollars

A Case Study in Cost Containment

By Denis Viscek, MBA, Michelle H. Martinez, MBA, and Michael Christman

The July 2012 VLVC: A Glowing Example of Things to Come
The New Outreach Ads are Here!

Inside

11 Strategies to Help Sustain a PC Program
Four Seasons in western North Carolina launched a palliative care program in 2003 to serve patients in both inpatient and outpatient settings. Over the first eight years, it grew rapidly, expanding to encompass three hospital systems, multiple nursing homes and assisted living facilities, and hundreds of home patients. But with rapid growth also came increased losses. In this article, chief medical officer and medical director, Janet Bull, MD, shares 11 strategies that helped Four Seasons make notable improvements in the financials as well as staff productivity and the quality of care.

Teaching Tips to Improve Retention
“We often think that if we give employees knowledge, they will automatically change their behavior, but changing behavior is a complicated process that requires more than knowledge to achieve,” says NCHPP Research/Academics/Education Section leader, Mary Lou Proch. In this article, she shares tips to improve the outcome of your educational programming.

Short Takes:
• 2012 Circle of Life Honorees
• How “the Fiscal Cliff” Will Affect Hospice
• World Day: Plan Ahead and Show the World We Care

A Message From Don
Member News and Notes
Compliance Tip of the Month
Videos Worth Watching
News From NHF
First, Some General Advice

When embarking on a cost containment project, the first question to ask is “Where do I begin?”

When we began our cost containment program, our first step was to compare overhead structure to what it was three years earlier. This historical comparison highlighted areas where expenses increased and, therefore, showed us areas of focus for improvement. Equally important was a clear understanding of where we were headed as an industry and an organization.

Everyone is keenly aware of the state of hospice reimbursement rates, but what does this really mean to the individual hospice? Our projections at HBTB mirror the results produced by the independent consultant retained by NHPCO in 2011, who examined the effect of reimbursement cuts on the industry. If we changed nothing, we would easily see a $5 to $7 million negative impact on our bottom line within five years. (We have also used the analysis in projections for other hospices, both larger and smaller than ours, with similar results.) The obvious question is then, “Can an organization’s bottom line..."
Innovation News!

Innovation within the hospice community is not a new concept—especially to those of us who have been working on behalf of end-of-life care since the early days of the hospice movement.

For many hospice pioneers, innovation was born out of necessity, and it has continued to be something of a guiding star for our field. Fittingly, it has also been the inspiration behind a new initiative that NHPCO officially announced late last month: the Mary J. Labyak Institute for Innovation.

The Institute is designed to continue the work of hospice pioneer, Mary Labyak, whom many of you know passed away last February. It will carry out her legacy of listening, learning and innovating while also informing and enriching the field within the broader context of a very different and still-evolving health care continuum.

The Institute will focus on developing and promoting new strategies to ensure the best possible care for patients and families—while always keeping the needs of patients and families at the center of those strategies. I invite you to learn more at www.nhpco.org/innovation.

That said, the Institute is not the only setting in which creative work is taking place. This past summer, NHPCO hosted a five-day virtual conference on volunteer leadership. As we note in the feature on page 22, the response to this new format was overwhelmingly positive and we will certainly use virtual conferencing for other offerings in 2013, both large and small. Additionally, NHPCO’s website is being completely redesigned and should be launched by the end of this year. Significant upgrades to the member database are also under way and will help us serve you better.

Finally, let me share news about an exciting collaboration that’s in the works—an app for mobile devices called “eHospice.” UK-based Help the Hospices is developing an international version that is being released this fall and NHPCO will launch a U.S. version for health care professionals for release in early 2013. More details will follow in next month’s NewsLine.

Many of you are also leading or supporting innovative work in your own communities. Please let us know what you are doing by sending a simple note or more formal communication to newsline@nhpco.org.

J. Donald Schumacher, PsyD
President/CEO
take this kind of hit and remain financially viable?”

Therefore, another—critical—early step is to examine the future. We prepare five-year rolling projections on what rates will be, based on the best information available. We use realistic census projections and estimates of cost increases, such as staff raises and potential inflationary increases of non-payroll costs coupled with studies of certain individual expense line items, such as health care benefits and worker’s compensation insurance. We then prepare pro-forma income statements for five years into the future, and we update our projections every year.

It is important to note that being able to project financials into the future assumes you have already built the framework to produce accurate, timely and detailed monthly financial reports. By this we mean reports that compare your organization to benchmark peers, trend costs over a period of time, and drill down to specifics on expense categories, such as patient-related expenses. Over the past several years, we have literally tripled the number of standard reports that are produced and reviewed every month.

Without good reporting, benchmarking and detailed projections, it is difficult to determine where to start, how much must be cut, and during what time period it must be accomplished. Without this information, it is also difficult to effectively demonstrate to others in your agency why it is important to reduce expenses at all. And if you can’t explain why, it will be extremely difficult to get the organizational buy-in that is necessary to make a cost containment project successful.

Besides completing a historical cost-review comparison and preparing five-year rolling projections, participating in a benchmarking program can identify areas that may warrant cost reductions. By benchmarking your financial data against other hospices, you can identify specific areas and even line items that should be addressed. We relied heavily on benchmark comparisons during our cost containment project.

Senior management buy-in is also critical to success. Initially, don’t try to engage the entire organization or even the whole
management team. Countless organizational behavior studies suggest that if you want to effect change—which is at the heart of a cost containment project—start with a few select individuals. In our case, we chose the CEO, COO and key members of the Finance Department. It’s important to remember that you do not all have to agree on every individual point, but you do have to agree on an overall approach.

As you design and implement your program, also be prepared for the “well buts” (well but…I need my own printer; well but…I really like buying from this vendor; well but…we have always done it this way”). This is why it’s essential to use brainstorming sessions effectively. Members of the cost-containment team must operate openly and honestly with regard to potential areas for cuts. This is the time to put egos and personal agendas aside and only consider what is best for the organization. You will probably discard four out of every five ideas, or maybe more. Some of our best ideas—such as the Fleet Car Program and the shared services model that we discuss later—were generated from brainstorming sessions.

Where We Found and Lost That Million Dollars

Let’s look at some of the areas where we made cuts, saving HBTB more than $1 million annually.

Salary and Staffing Considerations

First and foremost, we addressed salaries—not the elimination of positions.

Prior to the changes in reimbursement, HBTB generally gave automatic increases tied back to the annual Medicare reimbursement rate. During our budget process, it was the norm to budget 4-to-6 percent salary increases for the entire staff. Annual increases totaled $840,000 since salary expenses were more than 50 percent of the total budget.

There were also no limitations or caps for any position in the organization. With no caps and little employee turnover, the organization had the potential to pay more than a position was worth or to exceed the position’s market value. For example, historically a nurse could be hired at a rate negotiated specific to him or her and be offered a 6 percent annual increase. Over a five-year period that would exceed...
a 30 percent increase. A nurse with a starting salary of $85,000 would be making $113,000 in five years—34 percent more than the original salary. There was also no uniformity between starting salaries for like positions.

To address the salary issues, we implemented a tiered system where every position in the organization was evaluated.

We set a minimum and maximum salary range for each job based on duties, education and experience. We then created four quadrants or ranges, with the first quadrant being the minimum hourly rate a position would pay, and the forth quadrant indicating the maximum the position could earn. Having four ranges of pay gives the employee room to grow and develop, in addition to gaining on-the-job experience.

When an employee reaches the cap, we offer them a 1 percent bonus, similar to what General Motors recently announced in its efforts to control costs. We plan to review salary ranges every two years to ensure they remain competitive within the market.

The process to implement this tiered system took well over nine months:

- First we updated the job descriptions and created a salary range for every position, using several industry salary guides.
- We presented the new structure to the board of directors for approval, and then rolled out the program to senior management.
- Management then met with each staff member one-on-one to explain the new system.

During this process, we also discovered some employees were being paid below the minimum pay range, so these individuals received an increase in pay to bring them up to the minimum.

The total savings from this initiative was $399,155.

**Mileage and the Fleet Leasing Program**

The employee reimbursement rate for using a personal vehicle for company business can be a touchy subject. Two common complaints are that “the reimbursement rate is too low” and “no advances are made to cover the employee’s costs.”

We found it was both difficult and time-consuming to validate the actual number of business miles that were driven. We also found a
high rate of turnover among lower-paid clinical staff and a high rate of absenteeism that were clearly linked to vehicle issues.

One day our CEO dropped off a flyer from a vehicle leasing program that she had received at a trade show, so we gave the company a call. After discussions with various types of service providers, researching the miles driven by our employees, and checking vendor references, we submitted a proposal to HBTB management and the board of directors for a Fleet Leasing Program.

This past August marks the Fleet Leasing Program’s second anniversary—and the following accomplishments:

- **Business miles are captured at the pump:** Employees are given a fuel card and required to enter a passcode along with the odometer reading at the pump.

- **Increased employee safety:** Our highest-mileage drivers are now in brand new Ford Focus sedans. For many employees, this program gives them the opportunity to drive their first new vehicle.

- **Increased employee retention and recruitment:** Since we started the Fleet Program, not one employee with a company vehicle has left the organization.

- **We have saved $0.07 in per-patient-day costs:** We were able to negotiate savings directly with Ford Motor Company based on the number of vehicles we ordered. We now have more than 40 vehicles in the program, and the cost to maintain them is cheaper than the cost of reimbursing employees at the IRS mileage rate to use their personal vehicles.

**Copier Leases and Printer/Paper Usage**

In looking at our leases and usage, we discovered some interesting things: the amount of paper used by HBTB annually would stack up 11 stories high; our technology was seven years behind the times, with no “green” technology employed; each office had different equipment, making it difficult for float employees to use the equipment; costly desktop printers were the norm (this is one of the “well buts” noted earlier); and our copiers couldn’t print on both sides of a sheet while the defaults were set to print in color.

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So what did we do? We requested quotes from several vendors and selected one that uses green technology. We addressed the well buts and eliminated virtually all desktop printers and standardized equipment throughout the organization. All fax transmissions are now delivered to each department electronically and double-sided printing is now the default on our copiers. We also set up a password for color copies and, by default, printing is black and white. We now use 27 percent less paper.

**Group Purchasing Organizations**
Prior to taking a hard look at ordering habits, each office would research vendors and place orders after obtaining a manager’s verbal approval. Because each location ordered office supplies independently, we were not leveraging our purchasing power.

To rectify this, we joined a $7-billion group purchasing organization (GPO) and instituted new ordering processes. We now enjoy the GPO’s total purchasing power when looking for supplies and services—and have also been able to pass on the cost-savings from some vendors to our employees. There are several GPOs to choose from that specialize in health care.

**Mortgage Paydown and Real Estate Considerations**
With today’s low stock market and CD returns, it probably makes sense for many organizations to use the extra cash generated by operations or unrestricted fundraising to pay down any debts. This strategy saved HBTB about $248,000 per year in interest payments, and increased cash flow by more than $300,000, making our balance sheet look dramatically better.

If you rent space, now is also the time to renegotiate your leases. While home sales appear to be improving, this is the softest real estate market in years and the prudent hospice will take advantage of it. We renegotiated one of our leases and, even with the yearly escalators, it will not be until 2017 that we will pay rent equal to what we paid in 2009.

This is also the time to consider consolidating space and leasing excess space. We leased out one small group of offices in our headquarters for $24,000 per year.

Also, engage your local utility company to perform an energy audit—most do this for free. After our audit, it was recommended we add energy-saving film to west- and south-facing windows. We hoped for a two and one-half
to three-year payoff, but paid off our investment in just 18 months. We now enjoy a $6,000 per-year savings. We also replaced the lights in our parking lot with LEDs. This investment was paid off in just over a year, and we now see $200 per-month savings.

**Outsourcing Phone Services**

By moving our phone system to The Cloud, we did not need to replace a highly compensated IT staff person who had left HBTB. Now, instead of relying on one person to troubleshoot phone issues, we have a whole team available 24/7. Perhaps more importantly, our new vendor assumed responsibility for the replacement and upgrade of the phone system. Over the life of our contract, we will save over $190,000 per year. (You can learn more about The Cloud online.)

**Accounts Receivable**

Excellent management of accounts receivable (AR) processes is simply a matter of taking full advantage of free money. When it takes an inordinate amount of time to collect for services that you have already delivered, at best, you are negatively impacting cash flow and, at worst, you are borrowing money and paying interest just to cover timing issues that you have created!

Over the past five years, we went from having an AR turnover of 100 days (at times) to a stable run-rate of 35 days. The AR staff works closely with our Intake Department from the minute a new referral comes in. This leads to much fewer collection issues down the road. In 2006, we wrote off 2.5 percent of our earned revenue. Given that the average hospice has about a 4 percent profit margin, we were writing off 50 percent of our return! Since 2008, we now write off less than 1 percent.

**Patient-related Expenses**

We focused our energies on lowering costs for the big four—DME, Medical Supplies, Pharmacy and Oxygen—without impacting the quality of patient care. We accomplished this by clearly defining which team was responsible for what—and holding them accountable for the results.

Our Contracting Department researches vendors and negotiates contracts; our clinical folks manage ordering habits and use formulary items whenever possible; and our accounts payable team ensures that we receive the contracted rates. When shown as a percent-of-net patient revenue, our direct per-patient-day expenses are now 4.8 percent lower than our benchmark peers, which adds an
additional $790,000 annually to our bottom line.

**Self-insured Unemployment**

We discovered The Nonprofit Trust when we decided to take a closer look at some “junk” mail we received. It is a member-owned, cost-effective alternative to paying State Unemployment Insurance (SUI) Taxes—and is only available to 501(c)(3) nonprofit organizations. By joining The Nonprofit Trust, we have saved our Human Resources Department significant time, since it coordinates all services related to claims, including communications between members and the various state unemployment departments; auditing every claim for correct charges and apportionment; contesting claims on behalf of members preparing for and attending unemployment hearings; and answering unemployment-related questions. It has also resulted in significant cost savings—$87,500 in the first year alone.

**Shared Service Opportunities**

We believe what we call our “Shared Services Model” will be the next great frontier for cost-savings and efficiencies. Simply stated, it is the practice of sharing personnel and associated costs with other organizations for administrative functions, such as finance, HR, IT and other backroom activities. Each individual organization still maintains its own clinical identity, as well as its own identity in the community with its distinct donor base.

We firmly believe that this will be the path which stand-alone hospices, particularly nonprofits, must take in order to survive into the future. Further, given the reach of today’s technology, it is a model that has no geographic boundaries.

This is not really a radical concept. It is what multi-branch hospices or, for that matter, any multi-branch company does. We currently partner with another small nonprofit in the Bay Area to provide these services. The combined savings for both entities is in excess of $200,000 per year.

**In Summary**

Through brainstorming sessions, research and a dedicated effort, HBTB has saved more than $1 million each year since instituting these changes (see next page).

Of course cost containment is an ongoing process—and one idea always leads to another. You want
your cost containment project to become woven into the fabric of your organization. Even if no new ideas come forth, if cost containment becomes “the way you do things,” you can prevent overhead creep from eroding the gains you have achieved. It is our sincere hope that other hospices replicate some of the strategies discussed in this article and improve their fiscal stability too.

Denis Viscek is chief operating officer for Hospice By the Bay, based in Larkspur, California, Michelle H. Martinez is controller, and Michael Christman is assistant controller.

The authors presented on this project at the NHPCO 2012 Management and Leadership Conference and the session is now available on CD or as an MP3 file for just $10.

To purchase it, visit www.dcpроvidersonline.com/nhpcо, select 2012 MLC, and enter “2E” in the Keyword Search. Then scroll to the session listing, “How to Lose a Million Dollars.”
11 Strategies
Four Seasons, a nonprofit hospice and palliative care organization in western North Carolina, launched a palliative care program in 2003 to serve patients in both inpatient and outpatient settings. Over the first eight years, the palliative care program grew rapidly, expanding to encompass three hospital systems, multiple nursing homes and assisted living facilities, and hundreds of home patients. But with rapid growth also came increased losses.

By 2008, our palliative care providers—11 physicians, nurse practitioners and physician assistants—were serving over 2,600 new patients and making 12,000-plus palliative care visits annually, with losses from the program exceeding $400,000. We needed to put a tourniquet on the hemorrhage!

Four Seasons is not alone in this predicament. Palliative care organizations around the country struggle to stay afloat. Many run at consistent loss, and depend upon philanthropy to sustain them. Others simply close their doors.

Despite the Losses, a Critical Need

Palliative care has grown dramatically over recent years. However, the majority of expansion has occurred not in community settings, but in acute care. From 2005 to 2008, the number of palliative care programs among hospitals with 50 or more beds increased 126 percent (from 658 to 1,486). Larger hospitals account for the bulk of growth—81 percent of hospitals with more than 300 beds offer a palliative care program.¹

Few outpatient palliative care programs exist in the United States today. Even rarer are palliative care bridge programs that follow patients as they transition from one setting to another (e.g., from hospital to community clinic, assisted living facility, nursing home, or private home). So discontinuities in care often result. For example, in the Palliative Care Quality Network in California, only 20 percent of providers report that patients are followed by outpatient palliative care services.² All too often,
palliative care inpatients, once discharged, fall into a gap in which no one coordinates or manages their continued care.

Bridge programs and outpatient palliative care programs can help close this gap, but several daunting obstacles impede their expansion. Some of these include fragmentation of care resulting from sub-specialization; insufficient reimbursement for palliative care services; and scarcity of palliative care providers. Concerns about sustainability, arguably, stand as the most significant and modifiable obstacle currently inhibiting the growth of such programs. Can we make community-based palliative care sustainable?

**What, No Assembly Instructions? No Manual?**

Introduction or expansion of a service typically requires a business case to justify the change. Inpatient palliative care programs can build this case using data that demonstrate cost savings for hospitals and improvements in clinical outcomes. But the business case for community-based, outpatient palliative care and bridge programs is not so clear, and various business models have been suggested.³

One approach is to create a referral stream between palliative care and affiliated hospices to justify some of the costs of palliative care. The nurse practitioner (NPs) models which have followed this approach have shown only limited success.⁴ In one study, for example, less than half of NP costs for palliative care were covered with revenue from fee-for-service billing. Many organizations have started palliative care programs only to find that they are unable to navigate the financial challenges.⁵ Sorely needed is a business model that is not narrowly defined but, instead, describes how a health care organization can initiate and sustain a palliative care program by drawing from proven strategies that can be flexibly adapted to its local details.

For four years, Four Seasons has been systematically developing such a model. Because, under current health care policy and reimbursement schemes, palliative care programs can be expected to operate at a loss, Four Seasons has defined sustainability as continued delivery of high-quality care, with high levels of patient/family and provider satisfaction, while minimizing loss. Described here are the process and action strategies that we honed to increase the program’s sustainability.
The 11 Strategies
The process of developing and testing a set of strategies for sustainability unfolded over 18 months, under the guidance of a task force of Four Seasons providers and stakeholders.

The task force first analyzed organizational issues holistically, considering a constellation of relevant factors rather than just financial ones. This process resulted in agreement on five focus areas: Quality; People; Compliance; Growth, and Finance. Within each focus area, the task force identified specific issues that compromised the program’s sustainability, and then articulated an actionable strategy to respond to each:

Strategy 1: Standardize the Palliative Care Visit
Substantial variability in clinical encounters, such as differing lengths of visits, raised concerns. To ensure quality as well as increase efficiency and productivity, Four Seasons designed a standardized palliative care visit based on the National Quality Forum’s 38 preferred practices.6 Templates were created for key aspects of the visit (e.g., assessment). The standardized visit also incorporated screening of new patients for research trial eligibility. This helps advance the science and promotes organizational and provider learning, while also providing an additional method of generating revenue (through enrolling patients in clinical trials).

Strategy 2: Standardize, Aggregate and Analyze the Data
Four Seasons palliative care providers differed in how they documented clinical encounters. Moreover, a provider’s data collection could differ from one visit to another. This variability impeded our ability to evaluate and report on quality. To standardize the data collection, we and our colleagues at Duke University Medical Center developed the QDACT (Quality Data Assessment Tool).7 The QDACT allows us to monitor reasons for consults, symptoms, advance care planning, functional scores, and three PQRI (Physician Quality Reporting Index) measures: advance care planning; falls; and fall prevention. PQRI reporting is expected to become mandatory in 2012-13. Data we now collect enable Four Seasons to meet Medicare’s quality reporting guidelines, and even generate returns. (In 2011, we received additional Medicare reimbursement for complying with PQRI requirements.)

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We also began tracking provider data and compliance metrics rigorously. Monthly provider reports show the number of visits, total amount billed, amount billed per visit, time per visit, transition to hospice, and research referrals. Performance tracking allows us to identify and work with providers who need coaching and, thus, increases both efficiency and quality.

**Strategy 3: Increase Referrals From Palliative Care to Hospice**
Hospice is the gold standard for end-of-life care, so we defined hospice referrals as a quality measure for the palliative care program. Also raised was a legitimate concern that patients might die in palliative care before being transferred to hospice. To address this challenge, we developed a way to track the impact on the organization of palliative care referrals to hospice. We also educated providers about prognostication and mentored them in end-of-life discussions.

**Strategy 4: Increase Referrals to Palliative Care**
To improve our palliative care program’s financial status, an obvious strategy was to increase the number of patients served. In order to expand into new markets in surrounding areas, we educated the community and providers at local nursing homes and assisted living facilities about the advantages of palliative care, what it can offer to patients and families, and how it interfaces with traditional and ongoing medical care. Consultations increased, as did the number of palliative care visits.

**Strategy 5: Develop Provider Competence**
A sustainable palliative care program needs a sufficient number of well-trained and competent providers. Clinicians, especially at the NP and physician assistant (PA) level, possess diverse backgrounds when entering hospice and palliative medicine. All need core competencies, including knowledge of disease pathology and presentation, and skills related to diagnosis, symptom management, and communication.

At Four Seasons, we agreed that all new providers should have palliative care-specific orientation. Additionally, our physicians now mentor our NPs and PAs which has led to higher provider satisfaction and will likely aid in retention. The team also chose three measures to track provider competence: improvement in pain and dyspnea scores, transition to
hospice, and family satisfaction. All newly hired providers are also required to attend the 40-hour Palliative Care Immersion Course offered through the Four Seasons Center of Excellence.

**Strategy 6: Create a Culture of Accountability**
Typically, hospice and palliative care data are collected and stored on paper, which is bulky, static, and location-specific (e.g., charts kept in binders at a facility). New electronic methods make data available in real time, facilitating better communication and coordination among care providers, minimal duplication, more frequent and timely reporting, and greater efficiency. However, many palliative care organizations will need to educate their staff and providers and change their internal culture before they can successfully update their methods of data collection and management. Four Seasons has worked to change its culture so the clinicians are motivated to transition to electronic methods. We have educated providers and staff, provided feedback based on data collected in the new way, and held regular one-on-one meetings to discuss each individual’s data and performance.

**Strategy 7: Expand the Workforce**
The availability of physicians, and the high cost of their time relative to other providers, limited the growth of our palliative care program. Advanced practice nurses are also in short supply. PAs, a new addition to the palliative care team, can help meet clinical needs with competent, discipline-specific care. In seeking to maximize both quality and efficiency across care settings, we determined provider ratios specific to our outpatient services (4 NP/PA: 1 MD/DO), and inpatient services (1 NP/PA:1 MD/DO), with the former relying less heavily on physicians. To meet projected needs for 2,400 new palliative care referrals and 14,000-plus visits per year, we expanded our palliative care staff to 6 PAs, 6 NPs, and 5 FTE MDs/DOs.

**Strategy 8: Increase Accuracy in Coding and Billing**
An external consultant’s analysis revealed that our providers were significantly under-coding visits, with most billing based on time rather than complexity. The team developed an education plan to teach providers when and how to bill by complexity, using prolonged service codes.

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We developed reference templates, set up a peer-review process, and initiated quarterly internal and external audits. As a result, our providers now code approximately 70 percent on complexity and revenues have increased accordingly. For example, the average amount generated per visit rose from $92 in 2009 to $137 in 2011.

A consultant also performs annual audits and educational webinars, with continued focus on proper billing. At the same time, we are developing a process to more efficiently collect copayments (a 50 percent increase here would boost clinical income by $150,000 per year).

**Strategy 9: Use Leadership Time Efficiently**

In examining how palliative care personnel allocated their time, we found that much of leadership time (0.8 FTE of the medical director and 0.4 FTE of NP time) was spent on administrative tasks. We therefore hired an administrator for these tasks and increased the medical director’s clinical time from 0.2 to 0.8 FTE. This resulted in a net fiscal gain despite the added personnel cost.

**Strategy 10: Increase Productivity**

Our strategy to increase productivity focused on performance expectations and logistical support.

First, we defined visit expectations for Four Seasons providers. With input from the palliative care team, we rewrote job descriptions to include expectations for the average hourly work week and visit volume. Next, we reassigned non-billable administrative tasks (e.g., scheduling, obtaining medical records) and marketing activities to administrative and other non-clinical staff, as appropriate. Visit times were also reapportioned from two hours to 90 minutes for a new patient and from one hour to 45 minutes for an established patient, with daily visit volume expectations defined for each care setting. From 2008 to 2010, average visits per provider per day increased from 4 to 6.5 visits.

We now track each provider’s billings per month and coach outliers to help them improve productivity. To increase efficiency—based on the observation that providers were spending non-productive time coming to the office each day—we also instituted a virtual workday. We invested in technologies (e.g., smart phones, laptop computers, and enhanced technical support) that allow clinicians to work remotely. Providers now
start their workday from home and come into the office only one day per week for team meetings. For scheduling staff, we purchased mapping software to reduce the mileage expense and the providers’ travel time.

**Strategy 11: Identify Creative Funding Solutions**

Until reimbursement policies become more favorable for palliative care, sustainability in this field will require creative approaches to financial challenges.

At Four Seasons, philanthropy provided early support for the palliative care program’s development. Since then, we have employed several strategies to enhance the program’s fiscal viability.

First, we partnered with two hospitals in our county, which enabled us to generate yearly financial support, share social work and chaplaincy staff, and integrate our services with those of our hospital partners.

Second, we started a research program which, in addition to supporting our mission of providing high-quality, evidence-based, compassionate care, created a revenue stream to cross-subsidize our palliative care program. The relationship is symbiotic: palliative care generates referrals for clinical trials; income from clinical trials subsidizes palliative care.

Third, we created a palliative care endowment fund, with the goal of covering future losses with endowment interest.

And, lastly, we created a Center of Excellence which offers consulting services and a 40-hour Palliative Care Immersion Course. The immersion course, which is offered three times per year, is an intense learning experience for new or inexperienced palliative care providers. We reinvest the tuition income in the palliative care program.

**The Proof is in the Pudding**

Notable improvements in finances, productivity, and quality have resulted from implementing these 11 strategies:

- Our palliative care program grew by 100 percent from 6,898 visits in 2009 to 13,764 in 2011.
- Program losses were reduced to less than $250,000 per year.
- Average visits per provider per day (across all providers) rose by more than 60 percent.

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• Average revenue per visit increased by almost 50 percent, and the average amount billed per provider increased by approximately 35 percent.

• Referrals to hospice also increased: QDACT analyses demonstrated improvement in symptoms while discussions of goals of care occurred with 99 percent of patients.8

Optimism Through the Lens of Realism

While we have succeeded in reducing the financial burden of our palliative care program by following the approach and implementing the 11 strategies described here, the program still and expectedly operates at a loss. For the foreseeable future, it will require a variety of fiscal sustainability measures, including support from our hospice and the community as well as the transfer of funds from Four Seasons’ Research Department and Center of Excellence. Still, these strategies have been successful in minimizing our losses and may help your organization in building a sustainable business model for your palliative care program.

Please also keep in mind that, while not every organization will identify a need in each area of the five domains we identified (i.e., Quality; People; Compliance; Growth, and Finance), it is important to evaluate potential needs across a reasonably comprehensive spectrum of areas in order to understand which aspects of the organization function well and which ones warrant attention and improvement.

On a final note, Four Seasons is not done yet! Ongoing evaluation will likely result in new action plans, which in turn will continue to strengthen our model, allowing us to minimize losses further, develop new strategies for funding, and maintain high levels of provider competence and satisfaction. Together, given the current health care environment, these achievements amount to sustainability for our community-based palliative care program.
Janet Bull is the medical director and chief medical officer for Four Seasons, based in Flat Rock, NC, where she has worked since 2000. She was instrumental in starting the organization’s Palliative Care Program as well as founding its Clinical Research Department in an effort to bring meaningful studies to help lessen patient suffering. She is a Fellow of the American Academy of Hospice and Palliative Medicine and a member of its Research Committee as well as an associate editor of PC-FACS. Dr. Bull is also a recipient of the 2012 Hastings Center Cunniff Dixon Award.

The author also addressed this topic in the *Journal of Pain and Symptom Management*. Visit the JPSM website for the abstract and further details.

References:
July 30th was the start of a weeklong, skills-building event for volunteer leaders and volunteers—and a first for NHPCO.

The event was NHPCO’s first virtual conference—the Volunteer Leadership Virtual Conference (VLVC)—which drew attendance from 500 programs in all 50 states.

Each day as many as 2,000 hospice staff tuned in to the daily offerings right from their desktop or as part of a group—except on Thursday. That day, which featured programming designed specifically for volunteers, drew more than 5,000 hospice volunteers.

The VLVC offerings mirrored the rich content of NHPCO’s national conferences, with keynote plenaries, concurrent sessions and helpful handouts.

But it also featured innovative Ignite sessions, real-time networking and even a virtual exhibit hall. (A virtual exhibit hall? See page 25 to take a peek.) As an added benefit, attendees had access to the entire week’s content for a full 90 days after the conference, allowing them to re-watch any or all past sessions.

One of NHPCO’s strategic goals is to fully utilize today’s technology to share innovations and best practices with hospice programs of all sizes in all corners of the country. Through live-streaming, this event combined the interactive benefits of onsite learning with the convenience and affordability of distance learning—and it worked seamlessly. Look for more virtual learning opportunities from NHPCO in 2013—both one-hour sessions and multi-day events like this.

**Feedback From Attendees:**

“Great speakers. Many used unique strategies to help empower leadership with volunteerism.”

“Excellent handouts and speakers. I really felt connected.”

**Snapshots From a Few Virtual Attendees**

The VLVC gave hospice staff and volunteers the chance to gather and connect as a group—a luxury for many who, on most days, are dispersed in the field.
NHPCO’s Judi Lund Person presented on “Regulatory Matters for Volunteer Leaders” at the VLVC. Below is an excerpt from the helpful resource booklet she distributed to attendees.

FAQs From Volunteer Leaders

What activities can be included in the 5 percent cost savings calculation?
CMS allows hospice providers to count direct patient care activities and administrative activities towards the 5 percent cost savings calculation.

- Examples of direct patient care activities include helping patients and families with household chores (e.g., mowing a patient’s lawn or walking his/her dog), shopping, transportation, and companionship. The key is that the volunteer has direct contact with the patient and the family.
- Volunteers may assist in ancillary and office activities that support direct patient care activities. These duties may include answering telephones, filing, assisting with patient and family mailings, and data entry.

What activities don’t count towards the 5 percent cost savings calculation?
Hospices may use volunteers in non-administrative and non-direct patient care activities, but CMS has stated that they are not eligible for inclusion in the “5 percent” calculation. Some of these activities include craft projects; quilting/sewing/knitting; cooking and baking; orientation and in-service education; attendance at interdisciplinary team meetings; board participation and attendance at board meetings; and community events (e.g. health fairs).

How many hours should a volunteer orientation program include?
The federal regulations do not specify a required length of volunteer training, but providers should review state hospice licensure regulations for any related requirements. NHPCO’s, Hospice Volunteer Program Resource Manual suggests a 16-hour training program.

continued on next page

Left to right: Summa Palliative Care and Hospice Services in Akron, OH; Sangre de Cristo Hospice and Palliative Care in Canon City, CO; and Hospice of Cleveland County in Shelby, NC.
**What content must be included in a volunteer training program?**

Regardless of the specific duties a volunteer will perform, orientation training should include:

- Hospice goals, services and philosophy;
- Confidentiality and protection of the patient’s and family’s rights;
- Family dynamics, and coping mechanisms and psychological issues surrounding terminal illness, death and bereavement;
- Guidance related specifically to individual responsibilities.

Surveyors will also be looking for documented evidence that volunteers (1) are aware of their duties and responsibilities and (2) know to whom they should report before being assigned to a patient and family or given administrative duties.

**Do all volunteers need to have a criminal background check?**

Since volunteers are considered employees, they are included in the criminal background check requirement per the Medicare Hospice Conditions of Participation (418.114).

**Can a hospice treat student interns as volunteers and then use their hours towards the 5 percent cost savings calculation?**

After reviewing the CoP regulatory text and the interpretive guideline language, there is lack of detail related to the use of interns as volunteers. Using interns as volunteers and counting their hours towards the 5 percent would be at your organization’s discretion.

**Can a hospice list a volunteer’s visit frequency as PRN?**

CMS requires that all disciplines that are listed on the patient’s plan of care (including volunteers) have distinct visit frequencies. Visit ranges are acceptable, but should not have an excessive gap (e.g., 2 to 3 visits/week versus 2 to 6 visits/week). PRN is not allowable as a standalone visit frequency. PRN can accompany a distinct visit frequency such as 1 to 2/month and 2 PRNs. If there is no specified visit frequency for the volunteer, the provider could use a phrase such as “per patient request” as the frequency on the patient’s plan of care.

**Can a hospice treat student interns as volunteers and then use their hours towards the 5 percent cost savings calculation?**

After reviewing the CoP regulatory text and the interpretive guideline language, there is lack of detail related to the use of interns as volunteers. Using interns as volunteers and counting their hours towards the 5 percent would be at your organization’s discretion.

**What staff hours can a hospice use when calculating the required 5 percent cost savings?**

To determine how many hours will be required to meet your program’s 5 percent requirement, divide the number of hours that hospice volunteers spent providing administrative and/or direct patient care services by the total number of patient care hours of all paid hospice employees and contract staff.

**Where can a hospice find a volunteer value rate to use in its 5 percent cost savings calculation?**

NHPCO’s Hospice Volunteer Program Resource Manual recommends referring to the Points of Light Institute or Independent Sector website to determine volunteer hourly rates.
An Inside Look at the Virtual Exhibit Hall

Like any NHPCO conference, the VLVC gave vendors the opportunity to promote their skills and services to hospice organizations—but in a virtual exhibit hall!

From the exhibit hall landing page (below), attendees could visit a webpage about each exhibitor. The webpage not only featured information and links about the product or service, but also an online chat option for dialog in real-time.

Take a look now. The exhibit hall will remain open until November 5.
Each year, NHPCO produces a collection of professionally designed display ads which feature a new theme and tagline. The goal is to make outreach easier and more affordable for all members, large and small, during National Hospice and Palliative Care Month and beyond.

Members are also encouraged to use the theme and tagline in other aspects of their outreach. Doing so saves time and development costs, but also helps promote unified messaging in communities all across the country.

This year’s tagline—comfort. love. respect.—was created by actor Torrey DeVitto, who has been a hospice volunteer for nearly five years and now serves as NHPCO’s first hospice ambassador. She created the tagline for a t-shirt she designed for NHPCO to raise awareness and funds for hospice—and it worked beautifully as the message for this year’s display ads.

The displays ads are available online as full-page vertical and half-page horizontal, high-resolution PDFs. Each ad is also provided with and without reference to National Hospice and Palliative Care Month, so they can be used in November and thereafter.

To learn more about Torrey and a special display ad highlighting her role as a volunteer, see page 29.
Additional Resources Now Online

Basic Outreach
• An Introduction to Outreach
• Event Planning Guide
• Media Relations Tips

Media Outreach
• Press Release for National H/PC Month
• Letter to the Editor (National H/PC Month)
• Letter to the Editor (from a family member who is now a volunteer)
• PSA Radio Scripts
• National H/PC Month Proclamation

Article Collection
(Evergreen content for use all year)
• Hospice and Palliative Care: Making a Difference
• Don’t Wait to Talk About the Care You Would Want
• Facts About Hospice Care Everyone Should Know
• How Can Palliative Care Help?
• Paying for End-of-Life Care
• and More

Background Documents
(Evergreen content for use all year)
• NHPCO Facts & Figures on Hospice Care in U.S.
• NHPCO Facts & Figures: Pediatric Palliative and Hospice Care in U.S.
• Common Misconceptions About Hospice
• and More

PowerPoint presentations and a range of outreach guides for various underserved populations are also available as part of this year’s outreach collection.

Visit www.nhpco.org/outreach
Answers to Common Questions

Will there be a hospice quilt and quilt poster this year?
No, there will not be a hospice quilt or quilt poster. That was a special campaign that was launched in 2000 and concluded with the 2011 hospice quilt. However, NHPCO has created a poster-size version of the third display ad in this new collection that you can download and quick-print—even incorporating your organization logo if you so choose. The poster-size ad is available online, along with the other display ads in this collection.

Do I need permission to personalize the ads—or use the photos or copy in other materials?
No, NHPCO members (with current, paid membership) do not need permission to utilize these ads in any way that helps them promote their organization and services. In fact, NHPCO encourages members to maximize the use of these materials to advance the hospice and palliative care message!

How do I personalize the ads and insert my organization logo?
The ads are provided as high-resolution PDFs that can be opened and easily manipulated in Adobe Acrobat Professional (7.0) or Adobe Illustrator. For written instructions, see How to Insert My Logo.

Where can I find the “Member of NHPCO” logo if I also want to insert that?
Various versions of the “Member of NHPCO” logo are available online (on the same page as the ad collection). Members can use the logo in these display ads, on other materials, or even on their website to visually communicate their commitment to quality.
Honoring Hospice Volunteers

This new collection features an ad with actor Torrey DeVitto, a hospice volunteer and NHPCO’s first hospice ambassador.

Attendees of NHPCO’s 2011 Clinical Team Conference (CTC) and 2012 Management and Leadership Conference (MLC) had the chance to meet Torrey. While her work as an accomplished actor keeps her running, she made time to be an active part of each event, and had the special privilege of presenting the 2011 Volunteers are the Foundation of Hospice awards with NCHPP vice chair, Rex Allen. She will also be a part of the 2012 CTC next month.

To learn more about Torrey, see the interview that appeared in the February 2012 issue of NewsLine.

To order the t-shirt she designed and is wearing in the ad, visit the NHPCO Marketplace.
The Voice of NCHPP:
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.

This month we spotlight the Research/Academics/Education Section, and an article by Mary Lou Proch....

continued on next page
n a recent class on Wound Care, 50 nurses were crowded into a classroom designed for 30 people. The instructor flipped through 75 Power Point slides in 45 minutes. While the staff was happy to get through this required class so quickly, the issues with wound care that prompted the class were not resolved. Clearly this class was very efficient, but not terribly effective.

Our hospice profession is rapidly changing. Hospice educators are responsible for implementing education programs to communicate these changes to staff. Effective education is the goal of every education event, and this goal is achieved when participants change their behavior to meet the desired outcome of the program. Often, however, programs are designed to be efficient, and consideration for the program's effectiveness is not included in program planning. We often think that if we give staff the knowledge, they will automatically change their behavior. Changing behavior is a
complicated process and takes more than knowledge to achieve. This article will present a process to use in program planning to improve the outcomes of education events.

**Identify Changes in Behavior**

“Beginning with the end in mind” is one of the habits identified by Stephen Covey in “The 7 Habits of Highly Effective People.” This habit serves us well in program planning. We need to identify what changes in staff behavior are desired before designing an education program. Behavioral changes can occur in the domains of practice, process, attitudes or skills. Identifying the domain(s) for change requires educators to work with those requesting the education program so we are clear on the desired results. Additionally, it is equally important to determine why the changes are needed and the consequences of non-adherence to the required changes.

**Course Curriculum**

Once desired behavioral changes have been identified, course information is developed to support these changes. The delivery of this information is important to support true learning. Ned Herrmann, the author of The Creative Brain, researched the information processing functions of the brain. His research demonstrated that information presented in whole brain method dramatically improved retention.

Whole brain techniques include presenting the information in a logical and sequential manner, being sure to include data, research, references or other key documents. Use of graphs or other pictorial representation of data assists in memory and recall of information, as the brain stores information presented in pictures more easily than information presented in words. Critical information must be presented clearly, concisely and kept to three or four key points. Exceeding this number decreases the likelihood of information retention. In planning the curriculum, remember to repeat key points six to eight times, as repetition is essential to retention.

It is essential to incorporate into the educational presentation activities that apply the information in simulations. These activities can include games, puzzles, role-play exercises, case studies and/or critique of scenarios. Incorporating activities into the curriculum provides learners with additional repetition of key points, the opportunity for social exchange and a way to involve multiple senses into the learning process.

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**NCHPP RAE Steering Committee**

Section Leader:
Mary Lou Proch
Chapters Health System
Temple Terrace, FL
prochm@chaptershealth.org

Committee Members:
Susan Balfour
Hospice Fundamentals
Cary, NC
Paul Longenecker
Lourdes College
Sylvania, OH
Susan Rogers
DCPPCC
Washington, DC

Learn about serving on the RAE Steering Committee.
Visit the NCHPP page of the NHPCO website.
Remember to also be aware of the group’s experience with learning activities. For those new to them, start small and increase the level of activity in additional classes. Although they may seem like fun, these activities are a serious part of every learning event. It is also imperative that the leader give feedback during or after each activity to enhance its impact on learning.

Selecting a theme or metaphor for educational programs also supports retention of information and changes in behaviors. The theme can be a TV show, movie, slogan, song, or current buzz word. As an example, when teaching nurses in documentation classes about the importance of incorporating a patient’s functional status of mobility, activity, and communication into their assessments, the theme of the Big Mac attack was used. The use of symbolism and stories paints a picture for staff that aids the brain in storing and retaining the information for later use.

In hospice, we know the power of stories to convey emotions, meaning and purpose. Stories are an effective way to reinforce underlying principles of learning programs and can be a particularly effective way to demonstrate the impact behavioral changes can have.

**Opening and Closing Segments**

It is important to plan both the opening and closing segments of the class. The opening segment includes the “why” and “what” of the class—why the changes are important and what will be discussed.

Drawing a road map of the class activities helps participants understand class activities. To promote clarity, be sure to use words and terms that are familiar to the staff and explain any new terms. Additionally, the opening segment sets the stage for mutual respect. Making introductions, setting class ground rules and including a short ice-breaker activity help to set expectations. We learn from those we respect and trust, so be sure to establish to staff that you are a knowledgeable and trusted resource. Review your professional and personal credibility to assure staff that you are confident and well-versed in the course content.

The closing segment should start with a summary of class content. This repetition aids in retention of information and also serves as an opportunity to reinforce key concepts and the value of what was learned. Make sure directions for application of the material is very clear to all staff, and give examples of when and where to apply the information. The closing segment should also incorporate how the changes will be measured and monitored, including the steps to ensure accountability. Also plan an activity that
celebrates the accomplishments of the class and staff—and thank them for their attendance and participation. Finally, let participants know about additional classes and topics of future classes that relate to this learning program.

**Classroom Setting**

The environment plays a large role in the effectiveness of education. Temperature, lighting and seating arrangements should be set to both promote comfort and provide stimulation for the brain. Playing Baroque music while staff are entering the classroom and getting settled helps calm the brain. Other ways to calm the brain include using popular scents such as peppermint and citrus. Providing toys on the tables and encouraging their use helps staff to be in a creative and caring mode.

For example, during a long series of documentation classes at our organization, staff began the session by painting a picture of their favorite hospice story. Every hour, one of the pictures was shown to the group while the staff member who created it shared the inspiring story. This activity helped staff members realize why they were there and, perhaps more importantly, that the heart of hospice remains even though processes often change.

**In Summary**

Being prepared to make change happen is a critical skill for all hospice staff. Education of staff is a key component in the chain of events to implement change. Using a process to develop a curriculum that is effective is essential. Efficient and effective education is needed to promote the changes in behavior that are necessary to implement change.

*Mary Lou Proch is the director of education for Chapters Heath System, based in Temple Terrace, Florida. She presents frequently at NHPCO’s national conferences and currently serves as the NCHPP Research/Academics/Education Section leader.*

References:


Free Section Activities

Bimonthly Chats

The NCHPP Research/Academics/Education (RAE) Section holds bimonthly chats—or conference calls—which are open to all NCHPP members. Each call focuses on a specific topic and is a great way to “connect” as a diverse group of professionals working in all corners of the country.

Coming Up:

November 13:
1:00 to 2:00 p.m. (ET)
“Where Do We Go From Here?”
Follow-up discussion from the 2012 Clinical Team Conference

January 15:
1:00 to 2:00 p.m. (ET)
“Learner-based Teaching Program”
Presented Paul Longenecker

Joining the Chats:

Call 530-881-1000, and enter the Participant Access Code when prompted: 239095#. (Please do not dial in earlier than 12:55 p.m. (ET) on the day of the call.)

Connect at CTC Too

The RAE Section is holding a Section Meeting at 2012 CTC, on November 6 from Noon to 1 p.m.

If you’re attending CTC, be sure to join this luncheon discussion with your peers.
Section eGroup on My.NHPCO

One of the best ways to exchange ideas and tips with your colleagues is through the NCHPP Research/Academics/Education 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 (Monday through Friday, 8:30 a.m. to 5:30 p.m., ET).
Since 2000, the American Hospital Association (AHA) has presented the prestigious Circle of Life Award® to honor innovation in palliative and end-of-life care. This year, six programs were honored during the AHA annual summit in July—five of which are NHPCO members.

**Award Winners:**

- Haslinger Family Pediatric Palliative Care Center  
  Akron Children’s Hospital  
  Akron, OH
- Calvary Hospital  
  The Bronx, NY
- Sharp HealthCare  
  San Diego, CA

**Citation Winners:**

- Community PedsCare  
  Community Hospice of Northeast Florida  
  Jacksonville, FL.
- St. Joseph Palliative Care Program  
  Orange, CA
- Unity  
  De Pere, WI
The work of these honorees reflect an overriding theme of compassion, dedication and collaboration. NHPCO and the National Hospice Foundation are proud co-sponsors of this award and, on behalf of all the sponsors, extend congratulations to these organizations.

Left to right: AHA chair-elect, Benjamin Chu, with Amanda Sommerfeldt of Unity; Suzi Johnson of Sharp HospiceCare (representing Sharp Healthcare); Rosemary Le of St. Joseph Palliative Care Program; Robert Brescia of Calvary Hospital; Sarah Friebert of Haslinger Family Pediatric Palliative Care Center; and John Mastrojohn, senior vice president of NHPCO. [Not pictured: Terri Eason of Community PedsCare.]

To learn about their innovative work, visit Circle of Life Award on the AHA website or watch an AHA video, featuring interviews with the winners.
How Will “The Fiscal Cliff” Affect Hospice?
NHPCO Paper Offers Insight

While Congress returned to Capitol Hill for a few short weeks in September, the majority of legislative activity will occur after the November elections. Despite this delay, political posturing and public debate on “the fiscal cliff” have already begun.

NHPCO and affiliate, the Hospice Action Network (HAN), have prepared a five-page briefing paper to help members understand this complex issue and “be in the know” as the dialogue and debates continue: Policy Analysis: The Fiscal Cliff.

Whatever the turnout of the elections or the Administration’s implementation plan, NHPCO and HAN have been working for months to educate key policy makers on how the proposed economic packages could impact access to high-quality end-of-life care. You’ll be hearing more from HAN in the coming days and weeks about how you can get involved. In the meantime, this briefing paper gives you just enough information to be prepared for the future—in your program and as a Hospice Advocate.

Please do not hesitate to contact HAN if you have questions.

World Day: Plan Ahead—and Show the World We Care

Each year, on the second Saturday of October, groups and organizations in countries around the globe help celebrate and support World Hospice and Palliative Care Day (World Day). Some sponsor public awareness campaigns, others engage in advocacy, while others hold fundraising events.

Many NHPCO members already lend support, but greater participation will make the event that much more effective in 2013 and beyond. If you’re not yet familiar with World Day, here’s some information to help you plan ahead.

Every Year Has a Theme
The theme for 2012 World Day—on October 13—is “Living to the end: palliative care for an aging population.” Check the World Day website later this year to find out next year’s theme.

Voices for Hospices
Every two years, World Day features Voices for Hospices, a wave of simultaneous concerts which take place around the globe and complement the educational events and activities. World Day 2013 will feature Voices for Hospices.

What You Can Do
Your organization can plan any event or activity to educate your community about end-of-life care and the dire needs around the globe. As one example, NHPCO member, Lifetime Care in Rochester, NY, hosted a concert to celebrate World Day while also raising funds for South African FHSSA partner, Zululand Hospice.

Do your part! Visit the World Day website to learn more.
The Benefits of Offering a Charitable Gift Annuity (CGA) to Your Donor

- No matter what happens to interest rates or the stock market, they or their beneficiary receive fixed payments for life.
- Donors make a gift with a minimum gift of $10,000 cash or other property.
- In most cases, CGAs provide significant tax savings.

Partner with the National Hospice Foundation

Your Program Receives a Portion of the Remainder

- Avoid administrative and management costs, as well as financial risk.
- Eliminate the need to train staff and purchase expensive software.

To learn more about partnering with NHF, please contact Heather Slack-Ratiu, 703-837-3155, or hslackratiu@nationalhospicefoundation.org

Solving your hospice challenges

At your service is a team of experts with extensive industry experience. Whether your hospice is for profit, nonprofit, freestanding or hospital-based, take advantage of practical insight and tools that reduce costs, mitigate risk, and improve efficiencies to make your hospice programs clinically, operationally and financially viable.

Get more insight at 800.949.0388
info@simione.com or simione.com
Remembering Hospice Activist Jean Bergaust

Jean C. Bergaust, an activist in the hospice movement who also worked on behalf of the elderly in Republican presidential campaigns, died of congestive heart failure on August 30 at the age of 82.

From 1993 to 1996, Mrs. Bergaust was executive director of what is now the International Association for Hospice and Palliative Care, a group that works to establish hospice care in developing countries. In the 1980 Reagan-Bush presidential run, Mrs. Bergaust oversaw the office to recruit seniors to the campaign and answer questions affecting seniors. She was special assistant to the director of the 1981 White House Conference on Aging. Later in the Reagan presidency, she was a Paris-based U.S. political adviser to UNESCO and special assistant to the director of the Office of Community Services at the White House. She also served as an advisor on issues affecting the elderly in the McCain-Palin presidential campaign of 2008.

Hospice Care of South Carolina Named 2012 Employer of the Year

Hospice Care of South Carolina is the first organization in its state to receive the Employer of the Year Award from the National Board for Certification of Hospice and Palliative Nurses (NBCHPN).

The NBCHPN award recognizes dedication from an employer which has provided outstanding support to the certification programs for hospice and palliative providers. Each year, one exemplary organization from thousands across the nation is selected, based on certification levels, support for certification and continuing education.

Hospice Southeastern Connecticut Hosts Lieutenant Governor

Lieutenant Governor Nancy Wyman visited Hospice Southeastern Connecticut (Hospice SC) in September to learn about the options for patients and families provided by the revised state hospice residence regulations.

Wyman heard firsthand how the new regulations will expand the choices that patients and families are given when hospice care in the home is not possible. The visit also included a presentation about all of Hospice SC’s services, as well as its plans to build a hospice residence in Norwich. The presentation was followed by a tour of the organization’s administrative office and bereavement center.
When life gets serious
you’ll want our serious experience on your side.

It can easily happen.

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.

Lawsuits are expensive to defend, and some result in very high-dollar losses. That’s why liability insurance coverage is so important. Glatfelter Healthcare Practice is administered by Glatfelter Insurance Group, a national agency. We work closely with your insurance agent to provide competitive proposals and friendly service for special businesses like yours.

Remember, before you can take care of others, you have to take care of yourself.

Insurance for Hospices and Home Health Care Agencies

- Professional Liability
- General Liability
- Directors & Officers Liability
- Property Insurance
- Non-owned Auto Liability


Glatfelter Healthcare Practice
A Division of Glatfelter Insurance Group

NHPCO'S AFFINITY PROGRAM

NHPCO's Affinity Program is an exclusive NHPCO member benefit designed to:

- Enhance your NHPCO membership investment
- Offer unique benefits on price, products, and services
- Increase value in your organization

The following selected Affinity Program Partner programs and services are available to NHPCO members, their employees and volunteers:

Visit www.nhpco.org/affinity to more info. For membership information, contact NHPCO Solutions Center at 800/646-6460 and ask for the Membership Department.
NHPCO Regulatory Assistance receives many questions from providers about the proper use of the ABN—the Advance Beneficiary Notice for hospice patients.

CMS recently updated the Medicare Claims Processing Manual (Chapter 30/Financial Liability Protections) to reflect new guidance concerning both the ABN and the Notice of Medicare Noncoverage (NOMNC).

Per this new guidance, the ABN should only be issued when:

- The patient is determined to be no longer “terminally ill” by the hospice physician.
- Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary.
- The level of hospice care is determined to be not reasonable or medically necessary, specifically for the management of the terminal illness and/or related conditions (i.e., the patient no longer qualifies for a GIP stay and refuses to leave the inpatient unit).

When it is determined that the patient is no longer terminally ill and the patient is discharged from hospice, the hospice must issue the NOMNC (CMS 10123). If the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the non-covered care to the beneficiary. If no further hospice services are provided after discharge, ABN issuance would not be required.

NHPCO developed the following chart to assist providers in deciding which notice should be issued to their patient at the time of discharge.

<table>
<thead>
<tr>
<th>Discharge Reason</th>
<th>ABN or NONMC Issuance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient moves out of service area or enters a non-contracted facility</td>
<td>No CMS form is issued</td>
</tr>
<tr>
<td>Patient is no longer terminally ill</td>
<td>Two-day notice, with issuance of NONMC if no further services are to be provided</td>
</tr>
<tr>
<td></td>
<td>Two-day notice, with issuance of ABN and NONMC if services are expected to continue</td>
</tr>
<tr>
<td>Discharge for cause</td>
<td>No CMS form is issued</td>
</tr>
<tr>
<td>Patient revokes the hospice benefit</td>
<td>Patient signs revocation form; No CMS form is issued</td>
</tr>
</tbody>
</table>

Visit the NHPCO Regulatory & Compliance Center for more information about the ABN and NONMC, with convenient links to the CMS forms.
COLLABORATE
ASSESS
RELIEVE
EVALUATE
It's About How We CARE
The 13th Clinical Team Conference and Pediatric Intensive

Preconference Seminars: November 3–4, 2012
Main Conference and Pediatric Intensive: November 5–7, 2012

The 13th CTC and Pediatric Intensive provides you with information to keep pace with evidence-based practice, adapt and respond to impending changes, work in partnership across the care continuum and ensure that the CARE you provide is of exceptional quality.

Opening Plenary
Identifying and Treating Traumatic Stress at the End-of-Life
with Therese A. Rando, PhD, BCETS, BCBT

General Plenary II
Hospice and Palliative Care — Simply the Best
with Ira Byock, MD and J. Donald Schumacher, PsyD

Closing Plenary
Shed or You’re Dead: How to Stay Alive and Thrive in the Midst of Turbulent Healthcare Change
with Kathy B. Dempsey

Learn more and register at www.nhpco.org/CTC2012
Stanford ICU nurse Laura Heldebrant credits palliative care specialists with helping her mother live out her remaining days the way she wanted to, “creating an environment” where she felt comfortable expressing herself. Heldebrant shares her experience in a video produced by Stanford’s director of palliative care education and training. It’s part of the series, “Can We Talk,” that he hopes encourages people to engage their loved ones in conversations about their end-of-life wishes. Watch the five-minute video now.
A Very Personal Experience with Hospice
Kate Cummings Shares the Story Behind Her National Center Room Dedication to Her Mother

As director of hospice and palliative care with Fairview Home Care and Hospice in Minneapolis, Kate Cummings is confident in the skills of her staff. As a nurse working in hospice for 30 years, the last 13 of which with Fairview, she has experienced all facets of what it means to bring compassionate care to those facing the end of life. But last year, she learned on a much more personal level what hospice brings to patients and families and confirmed her faith in her staff. Kate’s mother passed away in January of this year with the help, skill, and kindness of Fairview Hospice. She shared her story with GivingMatters.

Frances “Babe” Cummings was the mother of seven girls. She was a loving wife, mother, and grandmother who exuded warmth, humor, and enthusiasm for every aspect of her life, including listening to and sharing stories with friends and loved ones. She was an instant friend to anyone she met.

After a difficult summer of dealing with complications from multiple myeloma that led to hospital stays and rounds of chemo, Frances decided on Labor Day of last year, with the help of her family, that it was time to stop aggressive care and to elect hospice care. The family decided that the best option was for Frances to live with Kate and her husband, John, with the help of Kate’s sisters and Fairview Hospice.

When friends asked Kate if it was awkward or uncomfortable having her own staff in her home caring for her mother, Kate’s response was, “Why wouldn’t I want my own staff there caring for her? I knew she would get the best possible care.” Showing the sense of humor she must have inherited from her mother, Kate adds, “Those first few mornings I would jump out of bed, worried about who would see the dirty dishes in my sink, but after a while, I thought, ‘oh, they don’t care about my dishes!’”

Christmas was a special time for Kate’s family as they all gathered for what they knew would be their last with Frances. Kate describes it as a wonderful holiday with lots of singing and laughing. Shortly after the holiday, Kate knew that her mother’s condition was changing rapidly. In early January she called her sisters and said that it was time to come to be by their mother’s...
side. The night before Frances died, she was surrounded by all seven of her daughters, her husband, and Kate’s husband, John. They knew she could hear them even though she could no longer speak.

Two of Kate’s sisters noticed in the pre-dawn hours of the morning that Frances died, the most remarkably beautiful full moon they had ever seen. Knowing their mother’s life-long love of gazing at the moon, the sisters opened the blinds of the window near their mother’s bed. Though she hadn’t opened her eyes in days, Frances’ eyes flickered as her daughters described the moon and encouraged her to look out to see it. Kate and her sisters told their mother, “Go with the moon, Mom. Go with the moon.” And Frances Cummings took her last breath as the moon disappeared into the horizon.

This spring, Kate made a contribution to the National Center for Care at the End of Life and chose to name the Terrace Seating area of the building in honor of her mother. “I had originally selected a different spot in the building, but as soon as I saw the Terrace, just outside the staff lunchroom, I knew it had to be that. Mom would love to be sitting out there with the staff every day, listening to their stories, cracking jokes, and busing dishes or cleaning up. That’s who she was.”

National Hospice and Palliative Care Organization Collaborates with Dignity Memorial® to Expand Reach to Veterans

Today, one in four dying Americans is a Veteran. These men and women often carry experiences from their military service that present unique challenges at the end of life. Across America, hospice professionals are enhancing their skills to meet these needs through We Honor Veterans (WHV), a program of the National Hospice and Palliative Care Organization (NHPCO). Dignity Memorial (a network of funeral homes) recently collaborated with NHPCO to bring that same education and training to funeral home professionals across the country.

As the founding WHV Community Partner, Dignity Memorial is the first corporate collaborator to join NHPCO to build on the success of the We Honor Veterans program. This partnership is designated solely for non-hospice organizations that understand the importance of serving Veterans based on their preferences for care and services.

“Dignity Memorial providers have always been focused on serving our veterans with respect, integrity and dignity. Through the We Honor Veterans program, we hope to assure that every veteran receives such care no matter the service provider they choose. We are honored to be a part of such an incredible and...
innovative program,” said Diana Vazquez, director of hospice and community relations for the Dignity Memorial network.

In collaboration with NHPCO, Dignity Memorial will develop four levels of distinction based on the facilities’ involvement with Veteran education and interaction with Veterans and their family members. These levels will ensure that the very best care is being provided to those who have served our country.

“In developing We Honor Veterans, we have learned so much about what makes the end of life so unique for each veteran. Reaching out to those outside of the hospice community means that we can share all that we have learned about how to meet those needs in a supportive, meaningful and respectful way. We’re so pleased that Dignity Memorial has joined us in that pursuit,” said J. Donald Schumacher, president and CEO of NHPCO.

To learn more about the We Honor Veterans program or to become a Community Partner, visit: www.WeHonorVeterans.org.

One way you can support the work of the We Honor Veterans program is to donate through the Combined Federal Campaign (CFC).

Combined Federal Campaign

If you are a federal employee, you can participate in the annual CFC, which runs from September 1 through December 15. Support through the CFC will help such great programs as We Honor Veterans continue to provide programs and services focused on improving the quality of hospice care for Veterans and their families. The CFC number to use: NHPCO #11241. To support FHSSA’s work #11018.

Does your employer offer matching gifts?
Many employers have matching gift programs that can double or even triple your contribution. Make the most of your donation by requesting a matching gift form from your employer. If you send a completed and signed form with your gift, we will take care of the rest! Not sure? Want to learn more? Contact Sarah Meltzer at smeltzer@nationalhospicefoundation.org or 703-837-3149.

Make a Decision Today, to Make a Gift Tomorrow

NHF Connects with a Unique and Inspiring Couple

When Duane and Shelly Ryder of New Hill, North Carolina began planning for the future of their finances, they made the important decision to include charitable gifts in their plan and included the National Hospice Foundation in their estate plan along with a number of other charities. In their early 40s, the couple should serve as an inspiration to us all.

“We were moved by the level of compassion provided by the caregiver for Duane’s father in his final weeks battling esophageal cancer,” said Shelly. “I’m also impressed by the variety of educational initiatives and family resources provided by NHF. There are many ways our gift can benefit those who support us in our last days,” she added.

NHF is grateful to the Ryders and others like them who plan to continue to give to charitable organizations far into the future. To learn more about the opportunities to give and save, meeting your financial goals and maximizing your charitable intentions through gift planning with the National Hospice Foundation, visit: www.nationalhospicefoundation.org/give or contact Heather Slack-Ratiu at hslackratiu@nationalhospicefoundation.org or (703) 837-3155.

Make a decision today…

Learn about the opportunities to give and save—meeting your financial goals and maximizing your charitable intentions through gift planning with the National Hospice Foundation.

www.nationalhospicefoundation.org/give
Mercy at a Time When Life is Most Intense

NHF’s Disaster Relief Fund Helps One Hospice Nurse Make a Difference in Haiti

Your support of the National Hospice Foundation is valuable in so many ways. While we at NHF try to show where your dollars go: supporting important professional education programs, consumer support, and public awareness outreach of the National Hospice and Palliative Care Organization, to name a few examples, it’s not always easy to show a vivid picture of the impact your contributions make.

The story of one hospice nurse’s work in Haiti following the devastating hurricane of 2010, made possible through NHF’s Disaster Relief Fund, is a perfect example of how much of an impact your support makes.

Helen Allums, a registered nurse with Hospice & Palliative Care of Northeastern Illinois, first traveled to Haiti in 2000 with her husband Bob, a minister, as part of a group organized by Northern Illinois Presbytery. Following the hurricane of 2010 that ravished the country, the Allums decided that they needed to return to Haiti.

With the help of a $5,000 grant from NHF to Hospice & Palliative Care of Northeastern Illinois, Helen was able to spend a week in Haiti helping victims of all ages and a myriad of medical conditions. Working with limited supplies in a country with very little infrastructure, Helen treated afflictions including scabies, malnutrition, stomach bugs, and even cholera. She not only helped treat the conditions, but offered valuable education to her patients about how to prevent future illness.

Helen shared an anecdote about a particularly grueling trip to the epicenter of the hurricane damage. Victims had walked for miles in hopes of getting medical treatment at a church where Helen and other volunteers would be working. As she and her fellow volunteers were loading the bus with supplies the brakes went out, causing the bus to careen down a hill, eventually hitting a palm tree.

While no one was injured in the accident, Helen felt terrible about arriving four hours late to the church, knowing how great the need was and how difficult it was for the victims to get there. Yet, when the volunteers finally arrived, the crowd awaiting them began to sing to them and express how grateful they were for the help they would receive.

When asked how her experience as a hospice nurse shaped her work in Haiti, Helen said, “Hospice is about mercy at a time when life is most intense and people are at their most vulnerable. It makes you a better person, and gives you a better appreciation for life.”

Helen plans to return to Haiti early next year to work with a group of volunteers to educate Haitian nurses in hospice and palliative care.

Ride for 3 Reasons

One Man’s Bike Journey around the U.S. to Raise Awareness and Funds for Three Causes Near to His Heart

This September, Illinois resident Bob Lee embarked on his Ride for 3 Reasons: Part III, a solo bike ride from Vancouver, Canada to Tijuana, Mexico for the benefit of three important causes: ALS, cancer, and hospice. All three causes have personal significance for Bob and his family.

Ride for 3 Reasons began in 2001 with a 3,000-plus mile ride across the southern border of the U.S. In 2007, he rode 6,500 miles up the East Coast and across the northern border. Combining those rides with a fundraising campaign, Bob raised nearly $500,000. With this third ride, he will have completed more than 12,000 miles around the perimeter of the country and hopes to raise approximately $1.5 million to be divided among the three organizations.

Bob will ride mostly solo except when local groups and family members join him occasionally. He hopes to visit hospice programs along his journey. To learn more about Ride for 3 Reasons, follow blog posts, and view photos, visit: www.3reasons.org. If you would like Bob to visit your hospice program along the way, contact: Kelly Henry at khenny@hospiceanswers.org or (224) 770-2417.
Show the ones you love that you really care. Each time you make a purchase from one of these vendors, they will donate $10 to the National Hospice Foundation.

Or if gift cards are what you’re looking for, TisBest Charity Gift Cards allow the recipient to make a donation to one of 250 national charities, including NHF! [www.nationalhospicefoundation.org/TisBest](http://www.nationalhospicefoundation.org/TisBest)

Remember also to purchase your greeting cards through Cards for Causes, and 20% of your purchase will go to The National Hospice Foundation! [www.cardsforcauses.com](http://www.cardsforcauses.com). They offer cards for every occasion!

These programs will run through 2012 so include NHF for all holidays to add special meaning to your gift purchases. [www.nationalhospicefoundation.org/Shop](http://www.nationalhospicefoundation.org/Shop)

Turn Your Online Auction Transactions into a Way to Give!

eBay Offers a Way to Designate a Percentage of Sales to NHF and Other Charities

The leading online marketplace, eBay, now offers a way to give a portion of sale proceeds to charitable organizations. eBay Giving Works allows sellers to pledge 10% to 100% of each listing to a non-profit of their choice, such as the National Hospice Foundation.

The process is simple, the site guides sellers interested in donating through the process, and eBay will automatically calculate the donation and send the funds to the selected charity once the item sells. Listings that include a charitable contribution are designated by a blue and orange ribbon and include a special section on the non-profit the seller is supporting. Buyers can search the site for sellers supporting organizations such as NHF.

Thank you to our current community sellers: dfun12011 and xanaduboutique. Be sure to find their eBay stores and purchase items with the blue and orange ribbon as they donate funds to support NHPCO, NHF and FHSSA!
Appropriate disposal of unused and unneeded prescription drugs can be confusing for many, including health professionals. In addition to dangers associated with the medications getting into the hands of someone other than the person for whom they were prescribed, there are also environmental concerns around the common method of putting them down the drain. The National Hospice Foundation is pleased that Home Healthcare Solutions will provide educational grants to support education and guidance on safe and effective ways to dispose of these drugs.

Home Healthcare Solutions is a leader in comprehensive medical supply management and operational solutions for hospice providers.

“We’re happy to support NHF and NHPCO work to ensure the safe disposal of medication in part through contributions from the sale of Disposa-Script www.hh-solutions.com/disposascript,” said Randy Crump, president and CEO of Home Healthcare Solutions. “Through education provided by NHPCO and a movement toward practice improvement, we hope to collectively achieve a new standard in safety, compliance, professionalism, and environmental stewardship with medication disposal in the patient home.”

“Hospice professionals are committed to providing the most comprehensive, highest quality care to their patients and loved ones and are committed to ensuring that the care they provide is safe and effective. Appropriate medication disposal is a key component of that care. We’re so pleased to be able to offer education about these issues to our members,” said J. Donald Schumacher, president and CEO of NHPCO.

For more information on this educational initiative, contact Sarah Meltzer at (703) 837-3149 or smeltzer@nationalhospicefoundation.org.

Did Hospice Help Someone You Love?

Dedicate your Next Race to them.

- Run in Their Memory
- Raise Funds for Hospice, Locally and Nationally

Join the hospice team today

Fernanda Scalera is a wife, a mother, a daughter, a sister, and a runner. This fall she will be running the Chicago Marathon as part of the Run to Remember Team. This will be her sixth marathon and she’ll be running in memory of her father, Alfonso.

Fernanda came to the United States from Columbia by herself as a 16 year old. Slowly she was joined by other family members, but her father and youngest sister stayed behind. Alfonso visited his family in the United States every year to year-and-half for three months at a time. During what turned out to be his last visit, he became very ill and was eventually diagnosed with stage IV colon cancer. After visits to the emergency room and difficulties finding care, Fernanda finally found Tidewell Hospice in Lakewood Ranch, Florida. The hospice team was there within hours, and spent hours locating a nurse who spoke Spanish.

“They treated him like a king,” Fernanda says, “with love, kindness, respect, and dignity. They provided my kids with a grief counselor who visited them at school. For me, I could not have taken care of him for six weeks without their unconditional support.”

“I can’t put into words how thankful I am for such an amazing organization. Hospice makes this world a better place. I want to give back for all they gave to us.” The National Hospice Foundation wishes Fernanda the best of luck in her race, and is so thankful for her words and support.
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national hospice and palliative care month. november 2012

Living life as fully as possible is what hospice and palliative care are all about.

Hospice brings you and your family compassionate care when a cure isn’t possible. Palliative care provides comfort and support earlier in the course of a serious illness. Together hospice and palliative care provide solutions beyond traditional medical care. Most importantly, hospice brings you and your family comfort, love and respect.

Learn more at caringinfo.org, call the Helpline at 800-658-8898, or contact your local hospice.

National Hospice Foundation
comfort. love. respect

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“As a hospice volunteer, I’ve seen firsthand the comfort, love and respect hospice brings to all the people they care for. There is nothing I am more proud or passionate about than being a part of hospice.”

Torrey DeVitto
Actor, Advocate, Hospice Volunteer and NHPCO Hospice Ambassador

It’s never too early to learn how hospice and palliative care can help you or your family.

Giving Matters
A newsletter of the National Hospice Foundation

Learn more at caringinfo.org, call the Helpline at 800-658-8898, or contact your local hospice.