

HOSPICE Management ADVISOR

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Volunteer hospice programs offer a solution to access problem

30 years later, volunteer programs are still around and succeeding

Carolyn Nystrom, RN, takes offense at the notion that volunteer hospices do not match up to their Medicare-supported counterparts. She realizes how easy it is to think that way, due to the small annual budgets, the challenge of finding volunteer nurses, chaplains, and social workers, and the absence of reimbursement. But don't tell her that the Medicare Hospice Benefit is the only way to bring hospice care to those who need it — and certainly don't tell her that it is better than her way.

"I would put our clinical competence up against the best Medicare hospice," says Nystrom, executive director of the Hospice of the Wood River Valley in Ketchum, ID. Nystrom should know; she used to run a Medicare hospice herself.

In fact, upon closer inspection, most hospices would like to be in the same position as Nystrom. Wood River Valley, with an average daily census of 20 patients, raises roughly \$240,000 with about 60 hours of fundraising a year, with no special events needed. Volunteers provide the lion's share of the care through 5,048 hours of services per year.

The hospice provides the complete range of care — including 24-hour nursing care, spiritual care, social worker services, and bereavement care — that would qualify for Medicare certification. Its average length of service is 85 days and median length of service is 45 days.

But the most impressive statistic reflects how well entrenched the hospice is in the expansive rural community it serves. Wood River Valley cares for 95% of those who die in the 2,400-square-mile rural area it covers. And yes, that figure includes traumatic deaths that occur from automobile accidents, heart attacks, and suicides. The hospice has been able to reach the vast majority of dying patients and their families as a result of widespread loyalty among physicians, hospitals, nursing homes, home health, and emergency personnel.

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“We get calls from 911 operators to tell us when a traumatic death occurs so that we can respond and provide care to families,” says Nystrom.

Nystrom acknowledges that Wood River Valley is on the extreme of the volunteer hospice spectrum, perhaps even the extreme for hospices in general, but says volunteer hospices deserve greater respect than they currently get in the industry. In fact, the hospice industry should look at the volunteer hospice model as a way to address the access problems that plague Medicare hospices.

“The volunteer model is a model for complete access to end-of-life care,” Nystrom says. “I think [the hospice industry] needs to be innovative if it wants to reach people early.”

Still a mystery to some

Volunteer hospices come in a variety of shapes and sizes. Depending on individual state regulations, volunteer hospices may provide typical clinical services as well as nonclinical services such as spiritual and bereavement care, says **Rhoda Eagan**, president of the Volunteer Hospice Network in Fredericksburg, VA, an affinity group of 150 volunteer hospices around the country.

“The magical part of volunteer hospices is that they are community-owned, meaning that they are a beloved function in most communities,” Eagan says.

Their daily caseloads range from five patients per day to 100 patients per day, with budgets ranging from \$10,000 to \$2 million per year. Few, if any, charge their patients for the care provided.

Because of the predominance of Medicare hospices, the volunteer hospice is a mystery even to those in the hospice industry, says Eagan. The result has been a relegation to second-class status. Eagan, however, is quick to point out that the hospice movement started three decades ago when all hospices were volunteer programs. The advent of Medicare reimbursement, many experts say, has been both the best and the worst thing that has happened to the hospice industry.

“Our hospice looked at becoming a Medicare-reimbursed hospice when it first became available,” says **Mary Ellen Walsh**, president of Fox Valley Hospice, a large volunteer hospice in Geneva, IL. “Our volunteers and board looked at it and felt that a number of people would not be served. And we have looked at it every year since.”

On one hand, Medicare has provided a steady stream of reimbursement and helped bring the discipline of end-of-life care out of the shadows. On the other hand, Medicare is fraught with regulations and paperwork, both of which stifle a hospice’s ability to accept patients early in the disease process and provide optimal benefit.

Unencumbered by Medicare rules and regulations, volunteer hospices can provide care at any point in the disease process, whether or not there is a terminal diagnosis. For that reason, the day of the volunteer hospice has emerged, says Eagan.

“Medicare hospices should think about starting volunteer hospices and creating an entity that can help them care for more patients,” says Walsh.

One example of a hospice forming a volunteer program can be found at the Hospice of Martin and St. Lucie in Stuart, FL. In 1999, the Hospice of Martin and St. Lucie created Transitions Pre-Hospice, a mostly volunteer-staffed program that provides free services designed to bridge the gap between the diagnoses of a potentially life-limiting illness and Medicare hospice eligibility.

“We started our program as a way for us to reach patients whose physicians have been unable to prognosticate their patients’ illnesses and to establish links to cancer centers,” says **Patricia Murphy**, RN, MA, chief executive officer of the Hospice of Martin and St. Lucie. “It’s been very successful. Our reputation in the community has improved, and we’ve forged strong relationships with cancer centers.”

Anti-kickback laws may not apply

But wait. Giving away services to potential patients — isn’t that bending federal anti-kickback laws? According to the federal Office of the Inspector General, the Hospice of Martin & St. Lucie model is within the law because it clearly delineates between the free, non-clinical services it provides and its reimbursed core services.

In 2000, the OIG granted a qualified approval of the program. The OIG said that while the hospice could allow volunteers to visit patients and not seek remuneration for the service, there was still the potential to generate prohibited remuneration under federal anti-kickback laws. While it could be construed that the hospice is offering the services in exchange for future referrals, the OIG said the hospice’s program did not subject it to

How a volunteer hospice can avoid legal problems

Avoid duplicate services

Transitions Pre-Hospice, a mostly volunteer-staffed program of Hospice of Martin and St. Lucie in Stuart, FL, provides free services designed to bridge the gap between the diagnoses of a potentially life-limiting illness and Medicare hospice eligibility. The hospice avoids questionable practices by ensuring the free services it provides do not duplicate services provided by nursing homes.

In an advisory opinion on the program's operation, the federal Office of Inspector General (OIG) found that, "Under the program, the hospice does not offer any services to nursing home patients that duplicate the services nursing homes are obligated to provide, such as food preparation and respite care or that are covered by the Florida Medicaid nursing facility per diem," the advisory said.

According to the OIG, the Transitions program raises three principal issues:

- whether the hospice knows or should know that its provision of free services to potential hospice patients will likely influence the patients' choice of hospice provider;
- whether one purpose of the program is to induce patients to use the hospice;
- whether the provision of services to the

sanctions because it clearly separated volunteer services from its core services. That included placing the volunteer program under the auspices of its hospice foundation, which is a separate nonprofit organization. **(For details of the OIG advisory, see story, above.)**

The following services, which make up the program, do not overlap with the hospice's core services:

- friendship and visitation;
- transportation;
- assistance with writing and reading correspondence;
- running errands;
- food preparation;
- respite care for the family or caregiver.

The program is designed to provide services to both home health patients and nursing home

patients who live in nursing homes may be remuneration to the nursing homes for permitting the hospice access to their patients.

While the OIG said that at least some of the services being provided may have value and constitute remuneration, it would not subject the program to sanctions under the anti-kick-back statute for several reasons. First, the services are provided by unpaid volunteers. Second, the benefits of the program are primarily intangible in that they are designed to help the patients adjust to their illnesses by helping them cope with the day-to-day burdens of life. Third, the program provides a substantial benefit to a vulnerable patient group. Finally, the OIG said there are "substantial barriers" to a beneficiary's election of hospice care, including the requirement that the beneficiary renounce coverage for curative medical treatment for the terminal condition.

The OIG noted that it has additional concerns with the provision of these services to patients in nursing homes. "In particular, we are concerned that the services provided by the hospice could substitute for services the nursing home would otherwise have to provide, thereby resulting in the hospice providing free services to the nursing home," said the OIG.

While the OIG was clear in its advisory that its opinion should not be taken as permission for or protection of similar nursing home and hospice arrangements, it does provide a road map from which guidance can be gleaned. ■

patients. A home service volunteer can provide all of the six services, while a nursing home volunteer is limited to providing only friendship and visitation, transportation, and assistance with writing and reading correspondence.

While there several similar "bridge" programs around the country, Hospice of Martin and St. Lucie's Transitions program is believed to be the nation's first and only program to have earned the OIG's "favorable" approval.

The mission of the pre-hospice program is to provide volunteer and case management services to people with a terminal illness who have a prognosis of one year or less to live. Unlike the parent hospice, the volunteer program is allowed to provide care to patients regardless of whether they are currently undergoing treatment that might cure their diseases.

Affinity group can aid your volunteer effort

Free support available

Thinking about starting a volunteer hospice program or volunteer bridge program? The Volunteer Hospice Network of Fredericksburg, VA, can help. VHN is an affinity group of more than 150 volunteer organizations across the United States that provide a wide variety of free services to the terminally ill, their families, and those who are grieving.

Members include volunteer hospices, grief support programs, and many other volunteer groups that care for the dying, whether or not they are called "hospice." Although a few volunteer hospices provide medical care, most focus exclusively on practical, respite, emotional, and bereavement support. The core values of volunteer hospice include respect for

diversity, love of community, and protection of local solutions, says **Rhoda Eagan**, president of VHN.

VHN provides free technical and professional support on issues such as management, fundraising, board of directors, volunteer recruitment, and volunteer training. Member volunteer hospices share their expertise on how to:

- start a volunteer hospice;
- establish a residence project for patients without primary caregivers;
- structure volunteer home care teams;
- create a bereavement center;
- form a children's grief camp;
- form partnerships with Medicare hospices and palliative care centers;
- transition from a Medicare hospice program to a volunteer hospice.

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The Transitions program does not provide the core services its hospice partner provides. One paid nurse handles initial patient contact and assessment. The remainder of care is handled by a team of 75 people, each of whom donates about four hours per week.

Evaluate your hospice's size, financial status

Whether a hospice should form a volunteer arm to reach patients who are currently ineligible for the hospice benefit depends largely on its size and financial situation, says Murphy. For example, some hospices are forging relationships with hospitals to create inpatient palliative care units as a way to reach pre-hospice patients. In fact, The hospice of Martin and St. Lucie is doing just that in addition to its volunteer program.

"It doesn't have to be an either-or proposition," says Murphy. "The reality is that some hospices may not be able to afford doing both, or a palliative care program. If a hospice doesn't have the resources to develop a palliative care program, the Transitions program is a good first step."

Yet, Murphy does not go so far as to say that volunteer bridge programs will be the saving grace for hospices struggling to reach patients earlier in the disease process. While volunteer programs can be cost-effective, they do require

significant time and money to get started and maintain. Costs will be primarily centered on fundraising, volunteer recruitment and training, and salaries of administrative staff needed to run the organization.

"There are limitations to the volunteer model," says Murphy. "The patient often needs more than the volunteer model can handle. If there is one thing I'd like to say, it's that our transition program is one solution to the problem."

Collaborate with other hospices

Yet another option exists for hospices interested in volunteer programs aimed at reaching hospice-ineligible patients. Walsh says Medicare hospices should collaborate with other hospices in their market to create a volunteer program that could serve them all by treating patients not yet ready to invoke their hospice benefit. While Eagan, Murphy, Nystrom, and Walsh see this as an innovative way for hospice to address one of the most perplexing problems facing Medicare hospices today, they also recall a time when volunteer hospices were innovative enough to prompt the federal government to create the Medicare Hospice benefit.

"The volunteer hospice is how we all got started," Walsh says. "Let's not forget that." ■

Reimbursement hopes raised, then dashed

Alzheimer's coverage stands pat

It seemed almost too good to be true. In a March 31 article, *The New York Times* reported that Medicare had quietly made changes that would prevent denials in coverage for patients battling Alzheimer's Disease, including hospice services. In the days that followed, hospice leaders scrambled to figure out exactly what these changes meant. Would patients in the advanced stages gain easier access to hospice services? Would physicians be empowered to certify a terminal diagnosis sooner, allowing patients to be referred to hospice sooner?

As it turns out, hospice eligibility remains unchanged despite Medicare's recent policy announcement. The change reported in the *Times* is not a change at all. Rather, it's a clarification of existing Medicare policy and an attempt to direct Medicare carriers in reimbursement for care related to the disease.

"This week, a *New York Times* article suggested that Alzheimer's patients were newly eligible for hospice care and a number of other Medicare benefits," the National Hospice and Palliative Care Organization (NHPCO) of Alexandria, VA, said in a written statement a few days after the story. "The news has prompted questions about what has changed for Alzheimer's patients and their hospice eligibility. After reviewing the issue, however, NHPCO has determined that the policies governing Alzheimer's patients' eligibility for hospice care remain unchanged."

No more edits

The change the *Times* refers to is a Sept. 25, 2001, Centers for Medicare and Medicaid Services (CMS) Program Memorandum (#AB-01-135), which states that contractors may not install edits that result in the automatic denial of services based solely on the ICD-9 codes for dementia. The clarification of existing regulations, CMS administrator **Tom Scully** says, is in "response to advocate concerns that Medicare contractors were increasingly denying services to Medicare beneficiaries based solely because they had been diagnosed with Alzheimer's disease."

CMS issued the memorandum to clarify existing

reimbursement policies. The September 2001 instructions direct Medicare contractors not to install system edits that would automatically deny Medicare-covered services based solely on claims for dementia.

Specifically, the memo stated: "Contractors may not use ICD-9 codes for dementia alone as a basis for determining whether a Medicare-covered benefit was reasonable and necessary, because these codes do not define the extent of a beneficiary's cognitive impairment."

CMS provided the following example: A claim submitted with only a diagnosis of Alzheimer's disease (ICD-9 code 331.0) may entitle a beneficiary to evaluation and management visits and therapies if the contractor determines that these therapies are reasonable and necessary when reviewed in the context of a beneficiary's overall medical condition. Because dementia is a diagnostic term with broad clinical implications, it may not support the medical necessity of a Medicare-covered benefit when used alone. For this reason, contractors should continue performing routine data analysis to identify aberrant billing patterns on claims for Medicare-covered services provided to beneficiaries with dementia. They also should instruct providers to enter the primary diagnosis or condition as well as secondary diagnoses or conditions that most closely reflect the medical necessity of the billed service on line 21 of Form HCFA-1500.

For instance, a provider using physical therapy to treat a patient with an unsteady gait due to Alzheimer's dementia may enter either ICD-9 code 331.0 (Alzheimer's disease) or ICD-9 code 781.2 (Abnormality of gait) as the primary diagnosis.

If the provider enters ICD-9 code 331.0 as the primary diagnosis, then he or she should include ICD-9 code 781.2 as the secondary diagnosis to support the medical necessity of the physical therapy service. When a beneficiary with dementia experiences an illness or injury unrelated to his or her dementia, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's disease, a physical therapy provider should submit a claim using ICD-9 code V43.64 (Hip joint replacement by artificial or mechanical device or prosthesis) as the primary diagnosis, not ICD-9 code 331.0 (Alzheimer's disease). ■

How one hospice reaches Alzheimer's patients

Survey data help identify needs

Despite the absence of any monumental policy change in Medicare reimbursement for Alzheimer's patients, programs affiliated with hospice organizations offer a solution to organizations trying to provide better access to care for those patients. One example is the Alzheimer's Respite program affiliated with Visiting Nurse Health System in Atlanta, the parent of Hospice Atlanta.

"We are totally dependent on benefactor money to run the program," says **Talya Bloom**, RNC, director of the Alzheimer's Care Program at Hospice Atlanta. "As it stands, we can only handle 20 to 25 families at a time."

Hospice Atlanta's Alzheimer's respite program works to meet these goals:

- Identify the needs of the caregiver.
- Identify volunteers within a close proximity to visit with the patient and caregiver.
- Keep caregivers connected to the community.

Discovering the types of respite care needed

Although families waiting to have their loved ones placed in the Alzheimer's program had indicated that respite care was needed, the types of relief care they needed weren't known. For instance, some caregivers simply wanted time to themselves when they could sit in another room and read a book or sleep, while others needed volunteers to care for a family member while the caregiver ran essential errands.

In order to discover the specific needs of each patient, caregivers are asked to fill out a needs survey. The survey asks about transportation the caregiver needs to places such as church, shopping, and social activities. The caregiver is asked to list the normal dates and times these trips occur during the week.

The survey also asks caregivers about common errands, such as trips to the grocery store or post office, and whether they need a volunteer to prepare meals or perform household chores. The survey asks whether patient companionship is needed to give the caregiver a two- to four-hour break. There is a section that asks whether the caregiver needs telephone assistance in the form

of assurance or in trying to secure community services and programs.

The survey allows the hospice to match the needs of the family with the best-suited volunteer. Hospice Atlanta's Alzheimer's respite program has about 40 volunteers, all with a variety of skills, availabilities, and restrictions. For instance, some volunteers only want to work with certain types of patients, while others have work and family obligations that limit their availability.

Intense training program prepares volunteers

Volunteers are subjected to an intense training program that covers everything from a quick education about the disease to observation techniques to their role as a volunteer in the patient's home.

Volunteer training consists of four distinct parts:

- **Program overview.**

Volunteers are introduced to the Alzheimer's Care Program and given its history. The first part of the training outlines other venues in which patients are cared for, such as day care and home health. Informing volunteers of alternative care sites such as day care centers arms them with additional knowledge they can pass along to families looking for additional respite care.

- **Patient and family information.**

Volunteers are trained in assessing caregiver needs and getting to know the patient. This helps the volunteer establish a relationship with the patient and captures information that will help clinical staff when the patient is admitted into hospice.

They also are introduced to the program's Participant Highlight Sheet, which prompts volunteers to ask a list of questions about the patient, including the patient's birthplace, hobbies, and favorite foods, to name a few.

Volunteers are trained to use a prevention checklist to help them look out for items that could lead to falls or injuries. The checklist requires volunteers to investigate the bathroom for things like non-slip surfaces and safety rails.

Volunteers also perform nutrition screening, using a form that asks the volunteer to assess functional status. For example, the form asks a volunteer to circle whether the patient is able to cook and feed self; requires some assistance; relies on the caregiver to prepare food; or relies on caregiver to both prepare and feed.

- **Role of the volunteer.**

This section of training deals with procedures volunteers must follow. At Hospice Atlanta, the role of the volunteer is described in these terms:

— **Purpose:** To ensure that Alzheimer's caregivers on waiting list have access to volunteer support in conjunction with interdisciplinary team and the plan of care.

— **Policy:** Volunteer coordinator will assess each patient/family for needs that could be met by a trained volunteer. The volunteer, once assigned to a patient, becomes part of the interdisciplinary team, communicating observations made during each visit.

The volunteer respite provider is trained in establishing an initial relationship with the client, establishing trust, and learning about the impact they can have on the family. They are taught that trust is gained through positive body language, a warm approach, assuring the family of their support, and letting them know that they enjoy the client's company.

- **Overview of Alzheimer's disease.**

One of the ways to establish a trusting relationship with the client, volunteer trainees are told, is to show knowledge of the disease. So part of the training includes a comprehensive education on the disease's symptoms, diagnosis, and treatment. Volunteers are schooled in the progression of the disease, problem behavior, and bereavement.

Learning about Alzheimer's disease

Disease education begins with a brief description of the disease, along with statistics, including the cost of caring for an Alzheimer's patient. Volunteers learn that Alzheimer's is a long process that can last a dozen years, with three distinct stages of dementia. As volunteers learn more about the disease, they will come to understand basic principles involved in caring for patients with the disease, such as the importance of creativity in the caregiver's approach. They also will learn how to treat each patient with respect and dignity.

The creation of a volunteer program to complement Hospice Atlanta's Alzheimer's care program has been critical to the hospice's efforts to serve patients and their families, even if they have not been admitted into the program.

"It's a way to keep in touch with them and provide them with the resources they need," said Bloom. ■



Branding your hospice refines your identity

Put your donors in the right frame of mind

By **Dee Vandeventer**

Partner, Mathis, Ernest & Vandeventer
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Imagine this: You've dialed the phone and your prospect answers. You introduce yourself and say you are from hospice. The voice on the other end says, "I'm sorry, but I'm not familiar with your group."

If you or your volunteers have ever experienced this, you know how frustrating it can be. But other hospice organizations around the country aren't having these kind of problems — what do they know that you don't? Many nonprofit organizations are beginning to realize that a visible and recognizable "personality" isn't just for businesses anymore and are taking steps to build their own identities.

In the for-profit sector, building identity is known as "branding." You may not be familiar with the word, but you understand the concept:

"A product is made in a factory but a brand is made in your head and heart. Products might leave your factory by the thousands a day, but brands are sold one at a time, and they are sold by F-E-E-L-I-N-G-S."¹ In other words, a brand is how it makes you feel.

Businesses use branding to pre-sell products or services by developing an idea or concept in consumers' minds through a variety of marketing approaches.

But most hospice organizations don't have the funds to spend on marketing. Thus, it becomes even more important to understand how branding can "sell" your organization to potential donors. And when people know you and know what you stand for, they are more likely to give to you.

Take that charity event you lost money on. Imagine you can turn back the clock and do it all over again. What can you do to brand your organization to increase visibility, attendance, and fundraising dollars? Advertise more in the newspaper and on the radio? Enlist more volunteers?

Not necessarily. Getting people interested in your charitable event has to begin long before the entertainment is booked and the menu determined.

Let's look at what one hospice organization did to increase its visibility, familiarity, and ultimately, its contributions.

Joliet Area Community Hospice (JACH) dreamed of building a hospice home — the first of its kind in Illinois. To do so, it needed to raise \$3 million. A feasibility study revealed that, while the hospice had a stellar image among those who knew of it, most people knew little about the hospice, its programs, or its services. JACH needed to create a visible image to expand its patient base and attract donors so its campaign goal could be reached.

JACH used a “you-centered” message; an intense public relations campaign, including video, radio, TV, and newspaper; an experienced team of volunteers; and a fundraising plan to identify itself to possible donors.

The hospice home campaign began in April 2001. Since that time, donors have contributed more than \$2.5 million. The dream is within reach.

This kind of effectiveness didn't just magically happen. JACH plugged into the power of branding, and got electrifying results. Whether you're part of a large hospice organization or a small one, branding has to become an essential part of your operation.

There are now more than 850,000 501(c)(3) organizations in the United States, compared with just over 600,000 in 1995.² With all those organizations competing for charitable dollars, many nonprofits realize they cannot conduct business as usual. Branding can help you meet the needs of those you serve amid rising competition for charitable dollars in a slowing economy.

Branding is about saying the right thing to the right person at the right time. It's listening to and understanding what's in donors' hearts and minds.

Your organization has to find a way to be first in donors' minds above all others. And to be first, you have to tell your story in a way that reaches people's minds and hearts.

Tailor your message to the needs of your donors, not your organization. Also realize that no one message will appeal to or motivate everyone it reaches.

Know your audience. Put yourself in their place. They have to know exactly what your hospice's mission is before they commit to you.

While you want to focus your time on raising

funds, investing in target audience research will pay off in the long run. Use focus groups, e-mails, phone surveys, or direct-mail questionnaires to gather information. Some nonprofit organizations also collect information via their web sites.

Speaking of web sites, they're a good way to establish brand credibility. **Barbara Mulville**, CFRE, past chair of the Association of Fundraising Professionals, says nonprofit organizations with web sites gain instant credibility, particularly if they use the site to communicate with donors or constituents regularly.³ Just be sure the information is consistent with the other messages you are sending via traditional channels.

A brand name should evoke both the brand's promise and its emotional value.¹ If you work for a hospice with a name that does both, don't mess with a good thing. Nothing confuses people more than changing names of organizations to suit the times.

If you've already got a powerful logo, great. If your logo doesn't fit the hospice's name or purpose, perhaps it's time to revamp it. Either way, put that logo to use. Every piece of marketing that goes out the door should have your organization's logo on it. It's like your calling card; it gets you in the door of current and potential donors.

Integrating the message

Integrating your logo, tagline, colors, and typeface into all print materials, videos, and web information reinforces the message you send your audience. Every time donors see your logo or tagline, it reinforces in their minds who you are.

Don't forget about media outlets. Ask those people you have the strongest relationships with to donate space or time to support your organization. This will reinforce your brand.

Branding goes beyond creating a name, a logo, and a look. It's about creating loyalty, which begins with being trustworthy, honest, simple, and relevant. Some final tips to help you open the door for future opportunities with your donors and constituents:

- Give your donors a positive experience every time they interact with your organization. This includes thoroughly training your volunteers about your organization and mission.
- Be straightforward with your donors about where their dollars are going. But don't overload them with too much information.

- Always thank your donors — seven times. Keep in touch with donors. Send e-mails, newsletters, newspaper articles, birthday cards, and other communications. Don't assume just because they've given once, they'll give again. Nurture those relationships.

- Listen to what donors say about your organization. Set up avenues for them to respond, through surveys, direct mail, or e-mail. Then, whenever possible, act on their suggestions and comments.

When you get right down to it, it's all about relationships. People give to people. But first they have to know you. Successful branding can create and enhance those relationships, aiding you in the donor courtship phase. And once they know you, they'll get involved. They'll develop an ownership with your hospice that then leads them to giving. Before you know it, you'll be on the way to turning donors into lifelong contributors.

[Editor's note: For more information, contact Dee Vandeventer via e-mail at dee@MEandV.com, or by telephone at (319) 268-9151.]

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News From the End of Life

Medicare program touts hospice benefits

The Centers for Medicare and Medicaid Services (CMS) is reminding physicians and long-term care providers of the substantial benefits provided by Medicare to patients and families facing the end of life.

In a two-page article intended to reach the nation's doctors, home health care agencies, and nursing homes, the Medicare program explains how the Medicare Hospice Benefit works, the services it provides for patients, and why it is

important for physicians to refer terminally ill patients to hospice care. CMS recently published "End-of-Life Care Enhances Dignity and Peace As Life Nears Its End" in *The Physician Executive*, *Caring Magazine*, and McKnight's *Long-Term Care News*.

The CMS article emphasizes that "the Medicare program recognizes that terminal illnesses do not have entirely predictable courses, therefore the benefit is available for extended periods of time beyond six months. . . . There is no reason for a physician to be concerned about certifying an individual for hospice care who he or she believes is terminally ill," the article says.

Hospice provides 'generous benefits'

Jonathan Keyserling, public policy vice president of the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, called the article's publication good news for an aging nation. "For Americans to receive the care they need, it's imperative that the medical community, patients, and families are well informed of all their options at the end of life," Keyserling said. "The nation's hospices and palliative care programs applaud and welcome the efforts of CMS to raise awareness of hospice's generous benefits and essential services.

"Over the past 20 years, the Medicare Hospice Benefit has dramatically improved the way people die in America," Keyserling said. "But for every one patient served by hospice, NHPCO estimates that two more could benefit. That means that too many people are dying without the aggressive pain control, symptom management, emotional support, and bereavement counseling that hospice provides. With more than 3,100 hospice programs in the United States and the broad eligibility for the Medicare Hospice Benefit, everyone who needs it should be able to access hospice."

Under the Part A reimbursement system, the Medicare Hospice Benefit provides a wide range of services at little or no cost to patients and families, including: physician services, nursing care, medical appliances and supplies, prescriptions for symptom management and pain relief, short-term inpatient and respite care, homemaker and home health aide services, counseling, social work services, spiritual care, volunteer participation, bereavement services, physical therapy, occupational therapy, and speech/language pathology services. ▼

Hospices, VA join to enhance end-of-life care

Launching a program to expand end-of-life care options for United States veterans, the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, the Department of Veterans of Affairs (VA) in Washington, DC, and the Center for Advanced Illness Coordinated Care in Albany, NY, are seeking to increase veterans' access to hospice and palliative services while providing educational opportunities for the clinicians who provide end-of-life care to veterans.

"Because VA is the largest integrated health care system in the country, we are positioned to be a national leader in end-of-life care," said Secretary of Veterans Affairs **Anthony J. Principi**. "But we can't provide all the services our aging veterans need. This initiative is exciting not only because it is aimed at improving care for veterans, but also because it will affect how end-of-life care is provided for all Americans."

The VA Hospice and Palliative Care (VAHPC) Initiative will expand and strengthen the relationships between hospice and palliative care programs across the country and VA health programs and facilities. The VAHPC Initiative is a two-year program designed to accelerate access to compassionate and coordinated hospice and palliative care services for United States veterans by addressing two critical concerns. These include the imperatives to: 1) substantively increase veterans' access to the continuum of hospice and palliative services, and 2) contribute significantly to palliative care education and training of VA staff and trainees.

The VAHPC Initiative aims to:

- Improve access to hospice and palliative care services across all levels and sites of care.
- Expand and strengthen relationships between VA and non-VA health care organizations to enhance the delivery of hospice and palliative care services.
- Advance opportunities for excellent palliative

care education of VA employees and trainees through the enhancement of staff development activities, academic programs, and multimedia products.

- Establish an enduring network of administrators, clinicians, and educators interested in advancing exemplary hospice and palliative care services and education.

"Like the VA, NHPCO and the nation's hospices want veterans to have more choices about where and how they spend the final phase of their lives," said **Chris Cody**, NHPCO vice president of education and innovation. "Access and education are the keys. By increasing veterans' access to quality hospice and palliative care services across all settings and expanding the knowledge and skills of the clinicians providing care, the nation's veterans will benefit from an enhanced range of end-of-life care options. This means the medical, emotional, social, and spiritual care provided by hospice and palliative care programs will be available to veterans whether they are at home, at VA, or in a community hospice setting." ▼

Social workers discuss how to improve care

During a three-day summit, experts in social work and end-of-life care designed a social work agenda to improve care for the dying and their families. The agenda calls for organized professional leadership, standards of practice, and increased preparation at all levels of social work education.

"Our goal is to form a coalition of national organizations, institutions, and experts that can enhance and elevate end-of-life care training, education, practice, research, and policy within our profession and beyond," said summit co-coordinator **Susan Blacker**, LCSW-C, of The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins University in Baltimore.

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The Social Work Summit on End-of-Life and Palliative Care, held March 20-22 at Duke University in Durham, NC, addressed the need for a formalized collaborative effort within the social work profession that focuses on end-of-life care and highlighted the importance of grief work to end-of-life care.

Leaders from national social work organizations, schools of social work, hospices, hospitals, government agencies, and end-of-life care advocacy groups attended the meeting on behalf of more than 30 organizations. The groups in attendance represented over 160,000 practicing social workers.

“The summit was an opportunity for the many prominent leaders in this field to sit down and design a comprehensive agenda for the future,” said summit co-coordinator **Grace Christ**, DSW, of Columbia University School of Social Work in New York City. “One of our goals is to advocate for greater attention to grief work and the psychosocial dimensions of palliative care.”

Grief work for sudden catastrophe

Often, limited attention is given to strengthening these areas in multidisciplinary education, practice, research, and policy development. Participants agreed that in order to more adequately reflect the breadth and depth of social work practice and patients’ and families’ needs, social work should encompass palliative care, end-of-life care, and grief work. Since the Sept. 11 tragedies, social workers have become more aware of the importance of standards of practice that include grief work for cases of sudden, traumatic or catastrophic deaths, Christ added.

Social workers often take the lead in providing essential emotional and social services to the dying and the bereaved, including counsel on advance directives, emotional support for the terminally ill, and assistance in locating health care and financial resources. Yet, social workers report gaps in end-of-life care education at the undergraduate, graduate, and post-graduate levels and lack of access to leadership in practice, teaching, research, and advocacy.

“By encouraging collaborative efforts between schools of social work, practice sites, and professional disciplines, we will reduce the professional isolation experienced by many social workers and strengthen professional practice of palliative and end-of-life care,” said Blacker.

Additional priorities established at the summit included:

- promoting advocacy, education, research, networking, and sharing of information between individual social workers and national organizations;
- increasing social work research in palliative, end-of-life care, and grief work;
- incorporating cultural sensitivity, life span variations, and interdisciplinary context throughout the end-of-life care educational curriculum;
- increasing public awareness through an educational campaign regarding psychosocial dimensions of palliative care, end-of-life care, and grief work and the role of social work in this care.

“Social workers touch a broad array of areas within end-of-life care,” said Christ. “Through practice, education, research, and policy development, we have the power to influence the culture of death in America.” ▼

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Editorial Questions

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OIG warns of expanded administrative sanctions

Senior counsel cites need for regulatory fixes

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) plans to increase the use of administrative sanctions — including the civil monetary penalty and exclusion authorities — “where the evidence warrants,” said **Mac Thornton**, the OIG’s senior counselor.

For the first time, a practicing health care lawyer is Inspector General, and that has brought a new perspective to the OIG, Thornton told attendees at the American Health Lawyers’ conference in Baltimore on April 3. On one hand, that means cooperation with health care providers. “But make no mistake, the OIG is still expanding in staff and in geographical reach,” he warns. According to Thornton, the OIG’s Office of Investigations will have established resident offices in all 50 states by the end of this year.

Thornton discounts contentions that the OIG is criminalizing honest mistakes and innocent errors. He pointed out that over the last three years, fewer than 50 physicians a year have received a criminal conviction or civil sanction as a result of OIG action.

According to Thornton, the OIG believes certain important infrastructure components require attention. One is the system for assessing overpayment collections and the Medicare appeals process. Contractor claims-processing procedures for overpayment collections could be more standardized nationally, and methods for determining overpayments also should be standardized, he argues.

The same holds for differences among contractors regarding coverage and payment policies, which could be made more consistent, Thornton says. Medical reviews also should be more standardized and predictable, he adds.

“All of these steps are important in view of the fact that many health care enterprises now provide services in more than one jurisdiction of carriers or intermediaries,” says Thornton.

The current framework for conducting Medicare appeals is “ineffective, untimely, and confusing for everybody,” Thornton concedes. He adds that while fundamental reform is pending in Congress, many improvements could be made immediately through regulatory action.

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Among the OIG’s suggestions for improvement are the establishment of an administrative appeals process dedicated to Medicare, ensuring adequate resources for each level of appeal, and providing for Centers for Medicare and Medicaid Services representation at the higher levels of appeal.

Another problem, he says, is that reviewers at different levels use different standards. “A lot of improvements could be made,” he argues.

“The IG can make a difference at the margins, but with respect to grand shifts in policy, that’s up to Congress,” argues former HHS principal deputy general counsel **Robert Charrow**. “The IG can steer a ship a few degrees to the right or left, but only Congress can turn the ship around.”

Correcting the outdated enforcement that now governs health care fraud enforcement must be a top priority, says Charrow, of the law firm Crowell Moring in Washington, DC. ■

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