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Want to boost revenue by $300,000? Open a hospice consignment shop

Good management creates cash and goodwill for agencies

Not only has the recession resulted in a 3.6% drop in charitable giving[1] but 62% of Americans say they also have cut back on their spending since the recession began.[2]

Although the drop in charitable giving is not good news for hospice managers, the change in spending habits has provided a boost in income for hospice programs that offer resale or consignment shops. According to the National Association of Resale Professionals, resellers report a net growth in sales of 12.7%.[3]

Advanced care planning conversations dropped from wellness exam

One of the more controversial components of the health care reform law has been the inclusion of advanced care planning as part of a Medicare annual checkup or wellness visit. The specter of "death panels" initially resulted in the elimination of the payment for physicians to talk with patients about advanced care planning, but the payment reappeared in a Medicare regulation that described the items covered in an annual or wellness visit.

The decision to once again drop compensation for advanced care planning conversations came just one week before a Republican-led effort in the House of Representatives to repeal President Obama's health care overhaul.

"We are surprised that the administration has decided to reverse the decision to include voluntary advance care planning consultations as part of a Medicare beneficiary's annual wellness exam," says **J. Donald Schumacher**, president and chief executive officer of the National Hospice and Palliative Care Organization. "Frankly, we are somewhat disappointed that the regulatory guideline making this part of the annual Medicare exam and compensating the physician for taking time to talk about personal preferences has become such a political issue." Schumacher points out that the advanced care planning consultation is to educate patients about decisions they might need to make in the future and supporting their choices.

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"We have a 23 to 24% profit margin for our stores, which means we've been able to give about $300,000 annually to the hospice," says **Cathy Olsen**, director of resale shops at Hospice of Palm Beach County in West Palm Beach, FL. The hospice has two resale shops, one at the north end of the county, and one centrally located in the county served by the hospice, she says. "Our north shop has been open for 17 years, and our central shop opened 12 years ago," she says. "The central shop recently moved to a new location and expanded to 7,000 square feet of space." The previous location had 4,000 square feet and almost no parking, so it was important to move, she says.

Although a hospice might not need 7,000 square feet when first opening, your needs might grow quickly, Olsen says. "We started with a couple of 1,200-square-feet spaces and grew as we needed," she says.

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EXECUTIVE SUMMARY

Although the recession has negatively affected charitable giving, hospices with resale shops are enjoying the benefits of donations of goods and new customers. People are looking for ways to give other than cash and also looking for good prices on items they need. Some resale shops report raising as much as $300,000 annually for their hospice.

- Volunteer labor supplements employee labor and keeps overhead costs down.
- The right location ensures visibility and customer traffic.
- Marketing efforts can generate donations as well as customers.
- Quality standards for items offered for sale ensures repeat customers.
- Consignment programs can attract some donations and business that resale alone might not attract.

The two shops accept donations of household items, clothing, furniture, appliances, and vehicles, says Olsen. "We've had donations of a recreational vehicle, a plane, boats, and even a Rolls Royce," she says. "We also had a condominium donated as part of an estate left to the hospice by the donor." The vehicles and condominium are not typical donations, but all donations are evaluated before they are accepted, she says. "They cannot be damaged or soiled and must fit our motto of 'resale at its finest,'" she adds. Even when you tell donors that you are looking for gently used and clean items, you may receive donations that are not appropriate for your shop, she says. Consider giving them to other local thrift shops that take a wider range of items, she suggests. "If we end up with something we can't sell, we pass it on or use our dumpster."

Although she's seen an increase in the number of people coming into the stores to purchase items, Olsen admits that the donations of furniture and household items has dropped some due to the slow housing market. "Most people clean out their homes as they pack to move and they get rid of furnishings and larger items they intend to replace in the new home," she says. With fewer people buying new homes, there is less "cleaning out" these days. "We are still seeing donations of clothing and smaller items, especially from families of former patients," Olsen says.

The hospice resale shop at Hospice of the Western Reserve in Cleveland, OH, has not seen a drop off in donations in their area, says **Debbie Ludvik**, manager. "Families of hospice patients and other people see donations to the resale shop as a way to get a tax write-off for a charitable contribution when they don't have the money to make a cash donation," she says. "We are also seeing an

increase in our shopping traffic because women can buy a $35 shirt for $15 or $20."

Her shop also has strict guidelines about the quality of item accepted for donation, says Ludvik. "Clothing must be in good shape and be clean with no pills," she says. "We want repeat customers, and the way to ensure that is to offer good merchandise at good prices in an attractive setting."

Pricing items is a challenge, Ludvik says. "We want items priced competitively, but we can't discount items so much that we don't raise funds for our hospice," she says. Donations such as designer clothing with price tags still attached, Longaberger lamps, Burberry coats, and antique jewelry contribute to profits that enabled the resale shop to raise $40,000 for the hospice last year, she says. "High-end items as well as antiques require special research by one of my employees to make sure we don't underprice the item," she says. By using a computer in the office and surfing the Internet, her employee is able to see what other sellers are charging for the items, she says. "Once we set our prices, we don't negotiate a different price."

Although customers in previous years have complained that prices in the shop were too high for a "thrift shop," Ludvik has noticed fewer complaints now that people understand the difference between "resale" and "thrift." There are several not-for-profit organizations in the area that accept lower quality items in the area and price the items at thrift shop levels, she says. "When we have customers looking for lower prices or offering to donate items that are not appropriate for our store, we refer them to the other shops," she says.

Consider contracts for pickups

Ludvik's shop does accept some furniture for the shop after she's had a chance to visit the home and evaluate the pieces if there are several, she says.

"I make sure it is the right quality for our shop and that the size is something we can handle," she says. "We contract with a local moving company to pick up large items, so I want to make sure the items will be appropriate before we pay for the pickup."

Transporting large items is one issue that can be tricky, says Ludvik. "We used to have a couple of our people handle pickups with a truck that we would rent by the day, but it became too costly for us to continue," she says. "Now, we contract with a local moving company, and it is more efficient when you don't routinely have large items to pick up." *(See p. 16 for more tips.)*

The resale shops at Hospice of Palm Beach County employ two truck drivers and own a van for pickup of larger items, says Olsen. As one way to combat the drop in furniture and appliance donations due to the slow housing market, only one of the shops has a consignment section, which includes furniture. There is a pickup charge of $65 per hour for items that are in the consignment program, but the shop picks up donated items for free, she says. "Usually, we only pick up a piece or two of furniture from donors, but consigners often have a truckload of furniture they place with us," she adds. The seller sets the price for consignment items, she points out. "Our consignment program lasts 90 days, and we split the proceeds with the seller, so the seller gets one-half of the price. If the item has not sold in 90 days, the seller can pick up their items or they can donate it to the shop for us to sell at our own price."

One reason Olsen's shops have a high profit margin as compared to the typical retail shop's 4% margin is the availability of volunteer labor to supplement a small paid staff to keep the shops open six days each week. "I have two truck drivers and three employees in each of the shops in addition to myself as paid staff, but we have over 100 volunteers who work in the two shops," she explains.

Recruiting volunteers is easy because the shops are a fun place to work, Olsen says. The volunteers get to see the items as they come in, so they have the opportunity to purchase items before customers see them, she says. "Volunteers attend the hospice orientation and select the areas in which they want to work. If they choose the resale shops, they attend the hospice volunteer orientation, then come to us for orientation to the shop," she says. "We schedule volunteers according to their availability and their specific job."

Volunteers specialize in areas such as receiving, checkout, sales, and setting up displays, Olsen explains. "We have one lady who dresses the mannequins as her job because that is what interests her and because she's very good at it," she adds.

Olsen had retail experience in her background when she started working at the hospice eight years ago, because she had managed a sales staff and three retail stores for a telephone provider. Ludvik, however, remembers telling hospice management that she "liked to shop" when talking with them four years ago about accepting the shop manager position. "I had been with the agency as a consultant and volunteer for 16 years, so I knew the agency philosophy, and I had served as a fundraiser and community development coordinator," she says.

Although retail experience might not be

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required for the shop manager position, it is important to run the shop as a retail business, Olsen says. "Bottom line is important so when sales decline, you have to understand how to manage expenses," she says. Cutting back on promotion activities, controlling overhead expenses such as repairs, or delaying the installation of new displays are all ways that a shop manager can manage expenses, she adds.

Marketing efforts such as newspaper ads, flyers, and social media publicity are all ways to improve donations and sales, Olsen says. "Our main focus is raising money for patient care, so we are always looking for opportunities to increase donations and sales so we can keep contributing money to the hospice," she says.

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Resale shops require creative approaches

Location, marketing, inventory top list of tips

"Location, location, location" is often cited as the key to success in the real estate market, and it is not that different in the retail business, says **Debbie Ludvik**, manager of the hospice resale shop at Hospice of the Western Reserve in Cleveland, OH.

A resale shop, by itself, does not attract new customers who come into the shop on a whim, Ludvik points out. "One key source of our new customers is those who come into our shopping center to visit a nearby store," she says. "We have a wonderful deli and a popular shoe store near us, so those two stores generate traffic in our area."

Although customers of the other two retailers do not come into the shopping center specifically to visit the resale shop, they often come in to the shop because something in the window caught their eye or because they are curious, Ludvik says.

Marketing a resale shop also requires thinking like a retail store but emphasizing your differences, she says. An early sign for the shop used the words "resale store" but a new sign says "Hospice Resale Shop" to let people know they are supporting a community organization, Ludvik says. "It is large enough to see from the street and is easy to read," she adds. "The new sign resulted in quite a few people telling us that they heard about our store because they were driving by."

Unfortunately, one issue that resale shops and traditional retail stores do have in common is shoplifting, says Ludvik. "We've lost a clock valued at $300 and a set of casserole dishes valued at $200, along with designer shoes, jewelry, and CDs," she says. After a series of thefts, Ludvik began placing items such as CDs, jewelry, and expensive china or clocks in locked display cases that employees or volunteers can open for customers to examine. After finding someone's old shoes placed in a box that contained a pair of designer shoes on display one day, the method of displaying designer shoes changed, she says. "Our designer shoe display has only one shoe on display and an employee or volunteer can go into our back room to get the other shoe for a customer," she says.

Because some of these items were taken out of the store during busy sales days in which all volunteers and employees were at the cash registers or with other customers, a new position was created, says Ludvik. "Now we have a volunteer who 'patrols' the shop to talk to customers and keep an eye anyone who might be suspicious," she says. "We've found that talking with people and letting them know that not everyone is busy with other customers can discourage shoplifting."

Ludvik and **Cathy Olsen**, director of resale shops at Hospice of Palm Beach County in West Palm Beach, FL, set quality standards for the items they accept for their shops. This policy enables them to set competitive but profitable prices for

their items and attract customers on an ongoing basis. However, it also presents a problem most retailers don't face, says Olsen. "Inventory control is a real challenge for resale shops because you have no control over what items are donated and when they are donated," she explains.

Even though a resale shop manager can't place orders for specific items like most retail store managers, there is a way to let people know what you need, Olsen says. "We don't get specific, such as asking for winter coats, but we do remind people each quarter to donate gently used items to our shop," she says. The reminders are a combination of newspaper articles or advertisements, postings on the resale shops' web site or Facebook page, and agency intranet for employees, Olsen says. "We tie the reminders to specific seasons such as spring cleaning, end-of-year tax deductions, or making room for holiday gifts," she adds.

In addition to encouraging visitors to the shops' facebook page to donate items, coupons and photos of items in the shops encourage people to visit as customers, says Olsen. "We often have donors become customers, but photos and announcements of new items in the shops generate even more new customers," she adds. *(For more information about the use of social media, see "Want a marketing bonanza? Hospices use social media,"* Hospice Management Advisor*, October 2009, p. 109.)*

Ludvik says, "One of our most effective marketing strategies is a bag stuffer for every customer." Her small marketing budget doesn't allow much advertising, so flyers promoting upcoming sales are put in the bags for every purchase. "I've found that special sales, such as a clothing sale or a home accessory sale, generate more traffic than a generic sale," Ludvik says.

Of course, one of the most obvious places to promote a resale shop is the admission packet for all new patients, she says. "Families and friends of hospice patients often make donations to us and let us know that the hospice cared for their loved one," Ludvik says. "They like the opportunity to give to the hospice that provided care, even when they are not able to make a cash donation," she adds.

In addition to raising money for the hospice, the resale shop serves another purpose, says Ludvik. "We are a good public relations tool for the hospice because we are in the community, and we give people who have never had a chance to learn about hospice to learn about us through literature in our store or by talking with our employees and volunteers, and we give everyone a way to support us," she says. ■

Oklahoma hospital addresses EOL in facility

Palliative care, case managers handle

When Integris Baptist Medical Center in Oklahoma City began looking at implementing palliative care and end-of-life services, the case management department was the appropriate place to start, says **Anita Bell**, RN, MEd CHPN, palliative care coordinator at the 508-bed facility.

"There are so many similarities between palliative care and case management," Bell says. "Hospital case managers are constantly challenged to decrease the utilization of hospital resources and length of stay while maintaining quality care. Studies have shown that palliative care can decrease the cost of hospitalization and improve a patient's quality of life by advocating for care in the most appropriate setting."

In addition to Bell, the palliative care team includes a chaplain, the medical director, a social worker, a pharmacist, and a nurse who does healing touch. "We've done some research, and healing touch has been able to show a decrease in pain and anxiety," Bell says.

The team is assisted by volunteers who handle data entry and make comfort care shawls that the palliative care team or nurse give to patients or family members, depending on the situation.

Case managers can see the big picture within the hospital and often are the first clinicians who identify patients who might benefit from palliative care services, Bell says. "Because of the case managers' focus on setting goals with the family, educating them, and looking at their discharge needs, they are instrumental in making sure we meet with patients and families who need palliative care services," she adds.

Palliative care and case management have mutual goals: decreasing length of stay and ensuring that patients receive the care they need at the right place in the continuum, Bell says. "Many times when patients have problems with pain or symptom management, they have a longer length of stay as the hospital staff try to get the problem under control," she says. "Palliative care helps with pain and symptom management, which can improve patient throughput and length of stay in the hospital."

Case managers often call in the palliative care team for help in working with patients and family

members to understand their options and to set goals of care for the patient, Bell adds. "The case managers will say to me that the physicians have talked to the patient and family, but they need more help understanding how ill the patient is and options for care," she says. "The palliative care team can go in with the doctor's permission and help educate the family and support them as they make choices."

Patients who could benefit from a palliative care consultation often are identified during discharge planning rounds, says **Suzanne Creekmore**, RN, CCM, case manager for the med/surg intensive care unit and the intermediate care unit. The discharge planning rounds in the ICU are attended by the case manager; the social worker; the nurse taking care of the patient; the chaplain; the ICU clinical director; the palliative care coordinator; and representatives from dietary, pharmacy, and other disciplines and departments if needed.

The team goes through each patient, one by one, starting with the diagnosis, the family support, and the goals for the day, along with individual details such as use of pain medication, ventilator length of stay, psychosocial or family issues. The team discusses the plan of care and the discharge plan and looks at options if the patient isn't able to go home. For example, if a patient has a stroke, is not responding, and isn't likely to recover, the team might call in Bell to help the family through the grieving process.

She also might be called in if patients have a lot of pain that isn't being controlled with IV pain medication. Creekmore says, "We want to help the patients have better control of their pain for whatever time they have left, whether it's a matter of months or years. Some patients aren't ready for hospice and want to keep treatment going, but their quality of life will be better if their pain is under control."

The case managers often call for a palliative care consultation for people who have chronic diseases, such as chronic obstructive pulmonary disorder, who are not necessarily at the end of the life but are getting worse. In those cases, Bell helps them get advance directives in place before they get really sick, Creekmore says. "We want to bring the palliative care team in as early as possible to help educate the patient and family members of their options for palliative care and comfort care," she says. "Our goal is to get the process started sooner so we can help the patient and family make the appropriate choices at the appropriate time."

Bell gives the unit an extra set of eyes to help determine the best discharge plan for the patient, Creekmore says. "Her expertise can help us determine if it would be appropriate for us to discharge the patient to hospice or if he should stay in the hospital and receive hospice care here," she says. "She helps us determine how best to approach the family and comfort them."

When a physician orders a palliative care consult, the case manager and the social worker on the unit accompany Bell as she visits with the patient and family members. But once Bell gets involved, Creekmore limits her visits with the family. "If too many people are involved in an emotional situation, it gets to be too much for the family," Creekmore says. "Once Anita takes over, I back off and go in and talk to the family every day."

When she is called in on a consultation, Bell works with the chaplain, the social worker, the case manager, and physicians to look at pain and symptom management, develop goals of care, help the family do advance care planning, and to support the patient and family if they decide to withdraw lifesaving treatment, move to hospice care, or continue aggressive treatment. The team can call on a palliative care-certified physician who can meet with patients and help them understand their options. "When people are in the ICU, so many things are being done for them. The case managers often hear that the patient never wanted that," Bell says. "They call the palliative care team in to talk with the family and clarify the goal of care and what the person wanted."

In addition to Bell and the palliative care team, the hospital established the position of palliative care resource nurse on most of the units. The nurses have other nursing duties but have participated in training on palliative care, keep up with current literature on the subject, and know what resources are available. The palliative care resource nurses are an added level of expertise on the unit level and are able to identify patients who have more complex needs than what the regular staff can provide and who could benefit from a palliative care consultation, Bell says.

"When families are struggling with trying to make decisions, the palliative care resource nurse knows where to find the information they need," she says. "They have a higher training and competency than the rest of the staff. If the family needs more help, they may ask the doctor to ask for a palliative care consultation."

Before there was a formal process, most of the

family consultations on palliative care and end-of-life issues were done by the social worker or the hospice team was called in, Creekmore says.

"The palliative care team is a wonderful resource that can supplement communication and education provided by the treatment team and help the patients and family members understand their options," she says. "Heath care is so fragmented, and patients and families are often overwhelmed with the disease process. All of us want to relieve suffering and improve the quality of life for our patients and family members." ■

Know end-of-life issues in the Jewish religion

Judaism is practiced in many diverse ways in the United States, yet sometimes even non-practicing Jews still observe Jewish laws at the end of life, suggests **Barry Kinzbrunner**, MD, chief medical officer for VITAS Innovative Hospice Care in Miami.

Kinzbrunner, who is also a rabbi, was trained as an oncologist; however, he says that in the last decade he has become more interested in spiritual care and diversity "as most people have, and have [chosen] my interest in Jewish medical ethics based on my own faith, in trying to understand, especially, how the people in my faith who are traditional really approach end-of-life care."

"We have traditional, Orthodox Jews who are people who basically believe that God revealed himself to Moses . . . who gave the 10 Commandments, and in fact, gave the entire Five Books of Moses, which are the basis for Jewish law. And everything that religious Jews do is based on that Jewish law that has since been interpreted over the generations," Kinzbrunner told an audience at a conference sponsored by the National Hospice and Palliative Care Organization.

According to Judaism, Moses also provided additional information, which the religion calls the "oral law." That law then was thought to have been passed down from Moses to Joshua and from Joshua to the prophets, and it has gone through several iterations since, resulting in the "Mishnah, which became the Talmud, as well as a table of law called Shuchan Aruch," he explains.

"So, that's where we get the Jewish legal system in a sense, and for Orthodox Jews, they follow that law, and therefore, they do everything that God wants them to do based on that law," he says. "Now, if you move toward Conservative and Reform Judaism, they have modified and reinterpreted what they believe Jewish law means in the context of a more modern world," Kinzbrunner notes. "When we talk about Jewish medical ethics, in very many ways they tend to be more in keeping with the secular points of view when there are differences between how they view things and how traditional orthodoxy views Jewish law."

Secular values defined by Jewish law

In secular medical ethics, the "primary core values" are those of autonomy, beneficence, nonmaleficence, and justice, "with justice divided into social and distributive justice," Kinzbrunner says.

"In Judaism, what the rabbis have done -- and in the modern context of medical ethics -- is people have interpreted these ethical values according to their understanding of Jewish law and given them Jewish definitions based on Jewish law," he says.

A Jewish person who is traditional therefore makes decisions on whatever they do, which includes healthcare decisions, that are "consistent with God's law, with whatever God wants him or her to do," Kinzbrunner says.

Many people, however, do not understand what it is that God would have them do or the decisions they should make, particularly at the end of life, he says. As a consequence, Kinzbrunner maintains that patients and their families in such instances "need the advice of a rabbi who is an expert in God's law to guide them." This place is where the core secular values as defined by Jewish law come into play in patients and physicians making healthcare decisions. One of the core secular values, nonmaleficence, essentially means avoidance of harm. The Hippocratic writings for physicians states that physicians must "do no harm."

"The secular ethicists question how much of a role it plays, because most treatments have risks," he says. "There's always risk, so therefore, are we really following the "first, do no harm" [obligation]? And the answer is really no."

As with all hospice care, in Jewish law, decisions are made on a case-by-case basis, he says. "So, where there are rules or the [cases where] we say, 'This is what the rule is,' there is always the ability to make exceptions to that rule," Kinzbrunner notes.

But end-of-life care and end-of-life decision-making "only applies to patients who are terminally ill," which has been determined as those with a year or less to live.

Another end-of-life definition in Jewish law is called the goses. "A goses is somebody who is actively dying; the hallmark in physical findings is . . . the death rattle, the upper airway secretions." In the Talmud, it was defined as "the last three days of life," Kinzbrunner says. "The important thing about a goses is that you're not allowed to do any interventions other than basic needs," such as to those necessary to keep a patient clean and dignified. Also, in the Talmud, Jewish law says that if someone touches a goses and the goses dies, "you're responsible for the death," Kinzbrunner explains.

"Withdrawal of life support and other interventions [are] generally not permissible, according to Jewish law, unless the intervention is clearly viewed as an impediment to death," he says. "... Food and fluid, in traditional Judaism, are considered basic needs by most rabbis, even when it's delivered artificially."

However, he also notes that if food or fluid would be provided without benefit or it is actually harmful, "then you might be able to avoid artificial nutritional support after consultation with the rabbi. And one may not forcibly feed a goses, because the putting in of the line or tube is a medical act, and you can't do that to a goses." ■

Home health workforce, sharps injuries grow

As the nation's population ages, a growing number of registered nurses, certified nursing assistants, and nurses' aides will be working in patients' homes rather than in hospitals. But many of them will be working without the basic safety devices that most nurses now take for granted, safety experts say.

"Home health is the fastest growing sector in health care, yet they're not having the benefit of the changing landscape in safety needles. That's not fair," says **Robyn Gershon**, DrPH, professor of socio-medical sciences and associate dean for research resources at the Mailman School of Public Health at Columbia University in New York City.

A study of occupational hazards among home health nurses in New York state found that safety equipment was lacking. Only 14% were provided with sharps containers, 9% had safety needles and syringes, and only about one in four had safety butterfly needles (23%) or safety lancets (26%).[1]

The primary reason, says Gershon, is economic. "It's really about the finances," she says. In some cases, the home health agency is not providing the proper safety devices because they are more expensive, she says. In other cases, the home health nurse uses the devices that patients have in their home, and those do not have to have safety features. In fact, the safety versions might not be fully reimbursed by insurers, Gershon notes.

Not surprisingly, fewer safety devices mean more sharps injuries. A study of home health nurses in North Carolina found that almost one in 10 (8.9%) had a blood exposure in the past year. The exposure rates were highest among nurses who had worked in home health for less than five years and for contract nurses or those who worked part-time.[2]

Researchers also found that nurses often didn't use personal protective equipment (PPE) that would prevent blood exposures, and the primary reason was because the equipment wasn't provided by employers. **Jack K. Leiss**, PhD, head of the Epidemiology Research Program at the Cedar Grove Institute for Sustainable Communities, a nonprofit research organization in Mebane, NC, says, "There's a national policy to protect health care workers. The policy is to provide them with safety medical devices and PPE. It's not working."

Granted, it's more difficult to enforce the bloodborne pathogen standard in a home care environment. "OSHA [the U.S. Occupational Safety and Health Administration] doesn't regulate the home environment," says Gershon. "Yet there are workers in that home environment, and they're unprotected in multiple ways."

In fiscal year 2009, for example, OSHA conducted just three inspections of home health agencies that included bloodborne pathogens concerns and issued 12 citations. **Dionne Williams**, MPH, a senior industrial hygienist with OSHA, says, "Home health is very unique. It's very distinct from the hospital setting. It's a lot more challenging."

Employers still are responsible for providing safety equipment and training, she says. But they do not have control over the work environment, the patient's home, so they aren't responsible for making sure employees use the equipment, she says. In some cases, the employer isn't even responsible for the devices. "Employees may have to administer the meds but use the devices that the patients supply," Williams says. In that instance, employers still would be responsible for providing sharps containers.

Sharps safety in home health care mighty be a growing issue as the nation ages and the nature of

health care delivery changes. According to the U.S. Bureau of Labor Statistics, the employment of registered nurses will rise twice as fast in home health as in hospitals through 2018.

An increased emphasis on worker safety in health care overall would benefit home health nurses, says Gershon.

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Advance directives give patients a voice

Completing advance directives should not be seen as a legal task. While there is a legal component to the document, it is primarily a communication task, says **Charlie Sabatino**, JD, director of the American Bar Association (ABA) Commission on Law and Aging in Washington, DC.

When a patient is incapacitated, the person he or she has designated as the health care proxy becomes the voice of the patient. At a time when The Joint Commission is putting standards in place that emphasize effective communication, ensuring patients have a clear understanding of advance directives makes sense.

Since 1990, when Congress passed the Patient Self-Determination Act, hospitals have been required not only to ask patients if they have advance directives when admitted, but also to provide education about them to consumers and staff, says Sabatino.

Yet surveys indicate that only about one-third of the adult population has some form of advance directive, he says. For people over the age of 65, survey data indicates that more than 50% have advance directives, he adds. "But that doesn't tell us how effective they are or how well thought-out they are," says Sabatino.

What information do consumers need to create advance directives that are well thought-out, effective communication tools?

Advance directives do not need to provide detailed instructions about the type of care consumers would like to receive based on medical scenarios. "My advice is that specific instructions are useful to the extent they are based on a person's actual medical history and not imagined ideas or stories about what you might encounter in the face of life-threatening conditions," says Sabatino.

Canned instructions included in living wills don't really address the real circumstances, which are usually quite complicated and unique, he says. Generalized instructions about nutritional hydration or respirators don't really turn out to be very applicable or helpful, he says.

However, patients in their 80s who have lived with chronic obstructive pulmonary disease for years and have had experience with ventilators might have specific instructions based on personal knowledge, not abstract scenarios, says Sabatino.

Advance directives should be seen as a developmental process, he says, and that is why he prefers the term "advance care planning." People in their 20s might simply choose a person they wish to have power of attorney. Yet at age 50 and beyond, people might have come to some decisions based on experience they would like to express. "Depending on what stage of life and health you are at, you are going to approach this somewhat differently," says Sabatino.

Many of the growing number of resources present a workbook approach to the process that provides guidance on how to have the discussions, he says. For example, the ABA has a "Consumer's Toolkit for Healthcare Advance Planning" (http://www.abanet.org/aging/toolkit/home.html) on its web site. The National Hospice and Palliative Care Organization in Alexandria, VA, has guidelines on its site (www.caringinfo.org), as does Aging with Dignity (www.agingwithdignity.org), to name a few. Sabatino suggests hospitals provide educational materials to their primary care physician network. ■

Meds reconciliation becomes simpler

NPSG revised to focus on key risks

Revisions to The Joint Commission's National Patient Safety Goal (NPSG) on reconciling medication information will provide some relief for hospice and home health providers when the changes become effective on July 1, 2011.

"We streamlined the goal's requirements and reduced the number of elements of performance

from 17 to 5," explains **Maureen Carr,** MBA, project director in the Department of Standards and Surveys for The Joint Commission. This move did not weaken the patient safety goal, Carr points out. "We focused on the key risk points for hospice and home care and made the requirements less prescriptive," she says. This change enables the hospice to implement processes that are most appropriate for the agency and its patients, Carr adds.

The only new requirement included in the elements of performance (EPs) for the medication reconciliation goal is the hospice's responsibility to explain the importance of managing medication information to the patient, she says. Because many hospices already include this information in their teaching, it is not an onerous addition to the requirement, Carr adds.

The revisions were made as a result of input from providers and surveyors that the NPSG's requirements were too prescriptive and required too much documentation for non-24 hour care settings, she says. "We did use input from home health and hospice focus groups to finalize the revisions," Carr says.

There are no new NPSGs for 2011, but there are some goals in development for 2012, adds Carr.

To see a copy of the EPs for the medication reconciliation NPSG, go to www.jointcommission.org. Select "standards" from top navigational bar, then choose "National Patient Safety Goals." Under "2011 NPSG Program Links," select "Home Care." Choose "Revised National Patient Safety Goal on Reconciling Medication Information" and select "Home Care Accreditation Program." ■

Enforcement delayed for face-to-face requirement

CMS to enforce rule on April 1, 2011

In a welcome move, the Centers for Medicare and Medicaid Services (CMS) has announced a three-month suspension in enforcement of the hospice and home health face-to-face recertification requirements that were in effect on Jan. 1, 2011. The suspension followed a meeting between National Hospice and Palliative Care Organization's (NHPCO) leadership and CMS officials.

The delay in enforcement did not eliminate the requirement that hospice providers implement procedures to meet the face-to-face requirement on Jan. 1, but Medicare Administrative Contractors (MACs) were alerted in late December that enforcement of the requirement is suspended until April 1, 2011.

During the first quarter, NHPCO and CMS will work together to answer additional questions and resolve ongoing interpretations and implementation processes. NHPCO has posted a list of frequently asked questions to assist providers. To see a copy of the FAQ document, go to www.nhpco.org/files/public/regulatory/FAQs_Face-to-Face_v2.pdf. ■

JOURNAL REVIEWS

Nursing home residents with dementia use hospice

Increased use improves patient care

A study of nursing home records shows more residents with dementia are seeking hospice care and use the benefit for a longer period of time.[1] The study, published in *American Journal of Alzheimer's Disease and Other Dementias*, used records of more than 3.8 million deceased nursing home residents.

The report shows that the proportion of nursing home residents who benefited from Medicare hospice care nearly tripled between 1999 and 2006 and that the duration of care more than doubled. The authors note that hospice care provides important medical benefits to patients with dementia, including more attentive assistance with feeding and medication, that can improve quality of life.

Because the prognosis of someone with dementia is hard to determine so precisely, some patients with dementia have remained in hospice care for much longer than six months, which is a concern for Medicare officials, the authors say. While the national average hospice length of stay for nursing home patients with advanced dementia increased from 46 days in 1999 to 118 days in 2006 — still

within the six-month time frame — in eight states more than 25% of such patients retained hospice care for more than six months. Oklahoma had the largest proportion of long-staying patients with 46.6%, followed by Alabama, New Mexico, Wyoming, South Carolina, Mississippi, Arizona, and North Dakota.

The variations revealed in the state-by-state data suggest that very long stays are not just a product of a general uncertainty about prognosis but also a reflection of different practices such as physicians supporting early admission to hospice, in different parts of the country. *(For more information about hospice in nursing homes, see "Are you taking advantage of nursing home opportunities?"* Hospice Management Advisor, *February 2010, p. 13.)*

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Will doctor shortage continue for hospices?

More funds needed to support specialty

A report by a task force appointed by the American Academy of Hospice and Palliative Medicine (AAHPM) to assess the current and future need and availability of hospice and palliative medicine (HPM) physicians shows that an acute shortage exists and current programs do not have the capacity to fill projected needs.[1]

About 4,400 physicians are HPM physicians, as defined by board certification or membership in the AAHPM. Most practice HPM part time, leading to an estimated physician workforce level from 1,700 full-time equivalents (FTEs) to 3,300 FTEs. An estimated 4,487 hospice and 10,810 palliative care physician FTEs are needed to staff the current number of hospice- and hospital-based palliative care programs at appropriate levels. The estimated gap between the current supply and the hypothetical demand to reach mature physician staffing levels is thus 2,787 FTEs to 7,510 FTEs, which is equivalent to 6,000 to 18,000 individual physicians, depending on what proportion of time each physician devotes to HPM practice.

The authors conclude that changes in graduate medical education funding and structures are needed to foster the capacity to train sufficient numbers of HPM physicians.

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Bioactive peptides found to promote wound healing

Newly created bioactive peptides promote wound healing through the growth of new blood vessels and epithelial tissue, such as skin. These wound-healing peptides, synthesized by researchers at the Tufts Center for Innovations in Wound Healing Research, increased angiogenesis in vitro by 200%. The discovery, reported online in advance of print in Wound Repair and Regeneration, provides a better understanding of the mechanisms regulating wound healing and might lead to new therapies for acute and chronic wound healing.

"We identified specific bioactive peptides that are produced from collagenase treatment of extracellular matrix, which stimulate the healing process within a wound. By creating combinations of several key peptide fragments, we were able to synthesize an entirely novel class of wound-healing peptides that promote the fundamental response to injury: blood vessel formation and epithelialization," said senior author Ira Herman, PhD, a professor of molecular physiology and pharmacology at Tufts University School of Medicine; member of the cell, molecular & developmental biology, and cellular & molecular physiology program faculties at the Sackler School of Graduate Biomedical Sciences; and director, Tufts Center for Innovations

COMING IN FUTURE MONTHS

- Providing art therapy at your hospice
- Providing support for employees at work
- Tool for evaluating dementia patients
- Developing a hospice sales team

in Wound Healing Research, all in Boston.

"This is the first time these peptides have been identified and synthesized, and we hope that these discoveries and new technologies will have broad implications for acute, chronic, burn, and scarless wound healing," Herman said.

The team from Tufts used a three-dimensional wound model to examine the effect of the bioactive peptides on wound healing. After three days, wounds treated with the peptides showed signs of robust repair, while controls did not.

First author Tatiana Demidova-Rice, BS, a PhD candidate in the cell, molecular and developmental biology program at the Sackler School of Graduate Biomedical Sciences at Tufts, said, "We found that collagenase enzyme derived from Clostridium histolyticum bacteria releases biologically active fragments — peptides — from extracellular mammalian proteins. These peptides stimulate proliferation of capillary endothelial cells, enhance microvascular remodeling in the 2-D model, and induce endothelial sprouting in a 3-D model of injury repair, and therefore are likely to have potential to stimulate blood vessel formation and promote healing in response to injury in animals and humans."

Angiogenesis, the formation of new blood vessels from existing vessels, is a key step in all types of wound healing from knee scrapes to venous stasis ulcers, pressure sores and diabetic foot ulcers. In order for tissues to be repaired, there must be an adequate blood supply bringing nutrients, oxygen, and signaling molecules to the site of the injury. Collageneses are enzymes that remodel extracellular matrix by cleaving one of its key components, collagen. ■