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Innovative programs help stressed-out caregivers cope with problems

Alert systems, community nursing fill gaps

(Editor's note: This is the second of a two-part series that examines family caregiver issues such as education, stress, burnout, and support. Last month, experts talked about the educational needs of family caregivers and how a home health nurse can recognize caregiver burnout. In this month's article, programs to support caregivers and different ways to offer care to home health patients are discussed.)

The spouse used to be so calm with the patient. The caregiver isn't purchasing the patient's medications on a regular basis. The wife doesn't help the patient out of bed to use the toilet. Does any of this sound familiar?

Caregivers experience burnout for a number of reasons, such as emotional, financial, and physical stresses, say experts.

One of the first steps a home health nurse should take when there are signs of caregiver burnout is to find community resources that can provide needed support, says **Nancy Stallings**, MAM, program manager for caregiver support for Salt Lake County Aging Services in Salt Lake City.

One of the best resources is your local area agency on aging, says Stallings. "We offer federally funded caregiver support by providing classes on coping with stress and dealing with issues related to caregiving, and we offer short-term respite for family caregivers," she explains. Area agencies on aging also will fund some home modifications that are needed for older adults with mobility or stability problems, she adds.

Because the costs of caring for a homebound person can mount quickly, it's also important to offer counseling and advice about bills, claims, and financial resources, says Stallings. "There are programs that either offer discounts or underwrite the cost of certain medications," she notes. **(For information on finding drug assistance programs, see resource box, p. 75.)** Even if a home health nurse or aide brings in a

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social worker to offer referrals to community resources, the nurse or aide should know about the resources so the caregiver can be reassured that there is help, she explains.

Other good resources for caregivers are local churches, says Stallings. "Many churches have programs that may provide someone to sit with the patient for a short time while the caregiver goes shopping, to a hair appointment, or to his or her own doctor's appointment. Even a brief period of time for themselves gives caregivers a much-needed break," she says.

Another service that provides peace of mind to family members who are concerned about elderly homebound patients and elderly spouses who are caregivers are alert systems that enable patients and caregivers to quickly summon help.

"We've been using a personal alert system for many of our patients since the late 1980s," says **Carol Ortiz**, intake coordinator for Fishkill Home Care in Beacon, NY. "Most of our patients are

elderly with elderly spouses as caregivers, or they live alone," she says. "Because we are in a rural area, it's important that the patients be able to easily and quickly call for help," she adds.

Personal alert systems are designed to automatically call a monitoring center that will send an ambulance when the patient pushes a button that is either on the unit, on a necklace, or on a wristband. Telephone service is necessary for the unit's operation, and all units come with battery backup in the case of a power outage.

Although Medicaid patients' personal alert systems are covered, Medicare patients and private-pay patients must pay for their own systems, Ortiz says. Usually, other family members who don't live with the patient and caregiver will choose to pay for the system for the peace of mind it offers, she adds. **(For information on costs of medical alert systems, see resource box, p. 75.)**

If you are considering offering personal alert systems as an added service, Ortiz has the following suggestions:

- **Plan to keep four to 10 units in your agency to send out on the admission visit.**

"It's best to have the units available on the first visit so the nurse or another staff member doesn't have to make a second trip," she says. "It also gives the patient a sense of more security because they do have a way to call for help if needed," she explains.

- **Prepare your nurses to handle installation.**

"The installation is simple, but be sure the company that provides your personal alert systems is available to educate your staff initially and be available if a nurse encounters a difficult installation," says Ortiz.

- **Insist on 24-hour, seven-day-a-week monitoring.**

"In addition to full-time monitoring, make sure the company updates information about emergency assistance in the patient's area on a regular basis," Ortiz suggests.

- **Choose a unit with which your patients are comfortable.**

"A couple of years ago, we tried a really neat unit that talked to patients to remind them to take medications, check blood sugar, or other actions," says Ortiz. "All of our staff thought it was a great idea, but our patients said it drove them crazy," she says. "We learned that sometimes more sophisticated technology makes our older patients uncomfortable," she adds.

Another way to support caregivers and patients is to provide a service that continues

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Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

Resources for Caregivers

- For information about services for older adults, visit: www.aoa.gov/directory/default.htm. This directory was compiled by the Administration on Aging and the National Institute on Aging and contains a comprehensive list of all community-based programs and organizations that offer services to older Americans. Contact information, locations, and links to individual web sites are included.

- For information about prescription drug assistance programs, visit www.needymeds.com. The web site offers a description of all assistance programs offered by drug manufacturers and other groups. The listings are available by manufacturer and by specific drug.

- For information about personal alert systems, contact:

- **LifeFone Personal Response Services**, 16 Yellowstone Ave., White Plains, NY 10607. Telephone: (800) 882-2280. Web site: www.lifefone.com. Costs for LifeFone are \$75 for the initial programming fee and \$26 to \$29 per month.

- **Lifeline Services**, 111 Lawrence St., Framingham, MA 01702. Telephone: (800) 543-3546. Web site: www.lifelinesys.com. Initial programming fees range from \$50 to \$100, and monthly fees range from \$35 to \$45.

after the Medicare episode is over, says **Lisa M. Zerull**, RN, MS, program director at Valley Health System in Winchester, VA. "Our community nursing program grew out of a need by our acute care hospital to find a way to help patients manage chronic conditions after they no longer qualify for Medicare home health coverage," she says. A community nursing program that enables RNs to continue visiting patients who are no longer homebound to ensure that they comply with medication schedules, blood sugar monitoring, or other recommendations for managing their disease was the answer, she says. **(See full description of program in story at right.)**

By offering patients an option for follow-up beyond a Medicare home health admission, Valley Health System has cut hospital admissions, emergency department visits, and critical care days, she says. "We looked at the hospital use of patients in our program and saw that pre-community nursing had 499 hospital admissions, 70 emergency department visits, and 67 critical care days," she explains. "After they

were enrolled in the community nursing program, the number of hospital admissions dropped to 219, emergency visits dropped to 48, and critical care days dropped to 20," she says.

At this time, Valley Health does not charge patients for community nursing care, but a fee structure is being evaluated, says Zerull. "The health system determined that the cost avoidance that results from a longer period of follow-up to ensure compliance with things like medication schedules was worth the expense of creating a community nursing program," she says. The department has three full-time RNs and one part-time director. Salary and other costs amount to \$65,000 per nurse, but each nurse has a caseload of approximately 35 patients, says Zerull. "When we took a look at what our patients typically cost the hospital in terms of admissions or emergency department visits, we found that potential cost avoidance to the hospital ranged from \$350,000 to \$1 million per year as a result of community nursing," she adds.

No matter how a home health agency chooses to help caregivers find the support they need or bridge the gap in coverage by Medicare or insurance, Ortiz points out that it is important to find a way to reassure patients and caregivers that they are not alone. She says, "We have to find nonclinical ways to make sure our patients are getting the assistance they need, even when the nurse is not with them." ■

System unites community nursing and home health

Coordinate intake and resources for success

Although Valley Health System in Winchester, VA, originally set up its community nurse case management program as a separate department that operated independently of home health, staff soon realized that the two areas needed to coordinate their activities, says **Lisa M. Zerull**, RN, MS, program director of the community nurse case management program.

"Physicians were confused with two departments offering care in the homes, and we would accept patients who would have qualified for home health and vice versa," says Zerull.

"We also found that physicians would refer

their patients to community nurse management because there are fewer requirements in terms of written orders, signatures, and oversight," says **Patricia Klinefelter**, RNC, BSN, home health director for Valley Health.

To address these problems, home health's intake department now screens all patients referred for home care and determines which level of care is best for the patient, says Klinefelter. Basically, a home health admission is a patient who has experienced an acute episode, is coming out of a hospital admission, and needs skilled nursing services such as wound care, Foley catheter care, or intravenous medications, she says. Community nurse management patients are chronic patients, often with congestive heart failure, diabetes, chronic obstructive pulmonary disease, behavioral health, or other heart conditions, she adds.

Community nursing doesn't require MD order

Other ways in which home health is different from community nursing are that home health requires a physician order, provides medical care, and can provide visits multiple times during a day, week, or month, says Zerull. "Community nursing does not require a physician order, unless we are asked to fill medication boxes or take pulse oximetry readings. We focus on nursing care, patient education, and assessment of the patients' understanding of their condition and their responsibilities," she says. "We also visit the patients only once per week."

Because there only are three nurses in the community nursing program, Zerull has chosen to hire only RNs. "We want to make sure the nurse is able to assess the physical and medical condition of the patients to make sure they are stable and not in need of other medical care," she explains.

Although physician orders are not necessary for community nursing, Zerull says they do contact the patient's physician with a letter that lets the physician know a nurse is seeing the patient, and periodic reports are faxed to the physician.

With the nursing shortage making it difficult for home health agencies to find qualified nurses, Zerull was careful not to "raid" the home health agency. "My three nurses were all employed in the hospital in the rehabilitation, pulmonary, and emergency departments," she says. "They required some training and attended inservices with the home health staff, but they made the

transition to community nursing very easily," she explains.

The community nurse's main responsibility is to enhance patient education and help patients comply with the activities they need to perform in order to stay stable or improve their condition, explains Zerull. "The nurses develop a close, long-term relationship that is more like a friendship with the patients because they see them for almost three months in most cases," she says. "We've had many patients who want to please their nurse, so they make sure they check and log their blood sugar levels or whatever task the nurse will check," she adds.

Patients are discharged from community nursing when they:

- meet intake criteria for home health, hospice, or other community agency;
- are able to manage self-care with little or no support;
- move out of the region or receive health care from another hospital or health system;
- choose not to work toward improved self-care;
- are not at home three times for scheduled visits;
- engage in drinking, drug abuse, or other activity that makes the environment unsafe for the nurse.

Coordination makes accreditation easier

The key to a successful community-nursing program is to coordinate care between home health and community nursing, Klinefelter points out.

"We want to make sure that no nurse is asked to perform a duty outside the scope of his or her service," she says. "We also wanted to streamline the process so referral sources or patients could make one phone call and be admitted to the best service for their needs."

Another reason to have the two programs work closely together is accreditation, Zerull adds. "Community nursing is surveyed under the same standards as home health, so we did borrow the home health policies and procedures to set up our own.

"We recently underwent an accreditation survey by the Joint Commission on Accreditation of Healthcare Organizations and received a score of 99 for home health and community nursing," she says. "Surveyors commented on how the coordination of the programs reduced duplication of services and assured good patient care." ■

Should hospices scale back AIDS programs?

Case management offers model approach

Nearly a decade ago, 50,000 people died of AIDS in one year alone. At the height of AIDS mortality, hospices built inpatient facilities and assembled the expertise to deal with an epidemic that seemed to have no end in sight. Since then, however, improved drugs and prevention education have lowered the number of annual deaths to fewer than 9,000 per year.

Hospices that once dedicated much of their resources to handling the growing number of patients dying from AIDS or AIDS-related illnesses have seen the number of AIDS patients steadily decline. AIDS is now characterized as a chronic illness marked by frequent and sometimes life-threatening exacerbations that can include infections, malignancies, and neurologic consequences.

As with Alzheimer's disease, it is difficult to estimate how long an AIDS patient has to live. Further, drugs, including protease inhibitors, have helped patients improve their health even when death seemed imminent. This often leads to hospice admission when the patient is in the end stages of disease and is thus too weak — and perhaps too ravaged by dementia — to truly benefit from hospice care.

"Some of our clients live for long periods of time; others fail miserably on the medications and die very quickly," says **Jeffrey L. Reynolds**, MPA, vice president for public affairs for the Long Island Association for AIDS Care in New York. "In any event, hospice utilization is down considerably."

It seems hospices are at a crossroads in AIDS care. With fewer patients, it's hard to justify spending money on AIDS programs or acquiring and maintaining expertise when there are more cost-effective ways to spend money. Still, there are compelling reasons for hospices to not only maintain their current AIDS programs, but also to plan for the near future so they will not be caught off guard. Those reasons include:

- **Public health officials have been stepping up HIV/AIDS awareness in recent months.** This is because there are signs that HIV infections will increase in the next few years, reversing the trend of decreased HIV diagnoses since 1994.

- **The population of people living with HIV/AIDS is growing older.** According to the Centers for Disease Control and Prevention (CDC) in Atlanta, more than 500,000 adults are living with either HIV infection or AIDS. While drugs have helped prevent the progression of the disease, many will fall ill with other diseases, such as chronic heart failure. "This creates a very complex medical condition," says **Betsy Gornett**, FACHE, chief executive officer of Hospice of Marin in Corte Madera, CA. "A nurse that is unfamiliar with AIDS will be lost."

- **The majority of new HIV infections and AIDS cases are among African-Americans.** This population has been difficult for hospices to reach.

The all-disease approach

Hospice referral for AIDS usually occurs when patients have reached the end stages of the disease, but referral often is delayed until the patient is in late-stage AIDS. Late-stage AIDS is defined as CD4+ counts below 200, and end-stage AIDS is when CD4+ counts are below 50. Both stages of the disease are characterized by frequently occurring opportunistic infections, often with more than one pathogen. Symptoms of these advanced stages include pain, diarrhea, nausea and vomiting, fever, dyspnea, cough, congestive heart failure, anemia, skin disorders, dementia and delirium, wasting, depression, anxiety, fatigue, and fear. These patients' need for palliative care is unquestionable. The challenge, however, is meeting the needs of AIDS patients without sacrificing the resources needed for the larger population of patients with more common illnesses.

While communities will differ in their response to this question, Hospice of Marin has adopted a case management approach that may serve as a model. The hospice's approach is strikingly similar to case manager models advocated by hospice industry experts trying to introduce hospice and palliative care earlier in the process. Demonstrations of case management in hospice have been used to coordinate care among patients that have been recently diagnosed with cancer.

Hospice of Marin's approach calls for a case manager who coordinates an AIDS patient's care, including palliative care and medical care. Marin also involves community organizations to ensure patients have access to services provided by the hospice or other providers.

The program works like most case management models. Patients with AIDS meet with a

case manager for an assessment of need. The patient is told what services are available currently and in the future as the illness progresses. Recognizing that AIDS patients have a unique set of medical and psychosocial needs, such as poverty, drug addiction, and housing, community groups — such as food banks, housing programs, and churches — are included in the care discussion, creating an expanded interdisciplinary team.

Case managers remain in touch with patients, both in times of frequent medical care and in periods when a patient's health has improved. Without this consistent contact, medical workers lose touch with patients during periods of improved health, only to be reunited when the illness flares up and sends the patient to the emergency room.

"By staying in touch, we can decrease the intensity of these cycles," says Gornett.

Case management cuts across diseases

The beauty of Marin's case management approach is that it is adaptable to other diseases, says **David Martin**, MDiv, executive director of Marin AIDS Interfaith Network. "It's important not to get pigeonholed by disease," he adds. "It's critical that we see care across diseases.

Whatever the disease or setting, comprehensive case management includes at least five components:

1. intake;
2. assessment;
3. crisis intervention and counseling;
4. initial service plan;
5. monitoring, follow-up, and reassessment.

In 2002, Promoting Excellence, a National Program Office of The Robert Wood Johnson Foundation that has provided \$15 million in grants and technical support to innovative programs that promote improved care for the dying, conducted a study at three sites to measure the financial implications of combining palliative care with medical intervention. Following are the study's findings:

• Hospice of Michigan and the University of Michigan Comprehensive Cancer Center.

This program, which provides hospice care to patients who receive cancer treatment, recorded fewer emergency room visits and lower hospitalization costs. Compared with patients receiving only cancer treatments, patients receiving both palliative care and cancer therapy had fewer

emergency room visits per patient (0.8 vs. 1.07), fewer hospital admissions per patient (1.65 vs. 1.83), and shorter hospital stays per patient (7.7 vs. 9.9 days).

Average hospitalization costs for patients receiving only cancer care were \$13,126 per patient, compared with \$8,974 for those receiving both cancer care and hospice care. Average total costs for patients receiving only cancer treatments were \$19,790 per patient, compared with \$12,682 for those receiving both forms of care.

Program has higher satisfaction, lower cost

• Kaiser Hospice and Home Health.

The Downey, CA, hospice program provides hospice care along with curative and restorative care to patients with congestive heart failure, respiratory disease, and cancer. Most patients have as long as a year to live. A team of physicians, social workers, nurses, and aides make home visits to patients, develop treatment goals, and provide care. In addition, the team provides respite care and emotional and social support to the family. The goal of the program is to prevent unnecessary hospitalizations and to allow patients to die at home, if possible.

Based on a two-year comparative study involving 300 patients who died, patients who were in the program reported higher satisfaction with the care they received. More than 87% of the program patients died at home, compared with less than 57% of the control group patients. The average daily cost for a patient in the palliative care program was \$62, compared with \$133 for a patient receiving usual care. Total per-patient costs for those in the program were 45% lower than for those receiving usual care (\$7,990 vs. \$14,570).

• Lillian and Benjamin Hertzberg Palliative Care Institute at Mt. Sinai Medical Center.

By allowing palliative care nurses and physicians to consult hospital providers, this program netted more \$750,000 in hospital length of stay costs.

The New York City-based program provides a team of nurses and physicians to advise hospital providers on pain management and to consult with family members regarding decisions over life-sustaining care. Aside from showing symptom improvement among patients experiencing severe, moderate, or mild levels of pain, nausea, and breathing problems, cost savings from palliative care were \$757,555 for those patients who stayed in the hospital for longer than 14 days and

\$455,936 for those who stayed for longer than 28 days.

Another reason not to scale back on hospice AIDS programs is that, inevitably, people living with HIV infection or with AIDS are going to die. Many will die from AIDS or AIDS-related illness; others may come to hospice with a terminal illness unrelated to AIDS, but complicated by it. For example, many HIV/AIDS patients develop high blood pressure from the use of protease inhibitors. In addition, hepatitis C is expected to be a common co-infection among HIV/AIDS patients, says Martin.

With HIV-positive people living longer, a growing number of deaths from AIDS are occurring among older people. In 1994, one in four deaths from AIDS occurred among people ages 45 years and older, according to the Health Resources and Services Administration (HRSA), a branch of the federal Department of Health and Human Services. By 1998, that proportion had risen to one in three, underscoring the need for systems of care and support that respond to the needs of an aging HIV-positive population.

Treating HIV disease in concert with conditions often associated with the aging process is complex. According to HRSA, doctors may have difficulty distinguishing HIV-related illnesses from those related to aging. For example, pneumocystis pneumonia may be mistaken for congestive heart failure in individuals with chronic heart disease, and HIV-related dementia may look like Alzheimer's disease.

Opportunity to reach African-Americans

AIDS has been particularly devastating to minorities. African-Americans represent about half of the HIV/AIDS cases in the United States, a disproportionate amount considering they represent a much smaller segment of the general population.

According to the CDC, the AIDS rate among African-Americans was nearly ten times the rate reported among whites. From 1996 to 1998, overall AIDS incidence (the number of people with HIV who progress to AIDS each year) declined

rapidly, falling 38% among whites but only 24% among African-Americans.

AIDS deaths during those years showed a similar pattern, declining nearly 60% among whites and only 44% among African-Americans. Since 1998, the falling rates of AIDS cases and deaths have stalled among all races. In addition to historically higher rates of infection, a recent CDC study of 9,113 patients in 11 U.S. cities found that HIV-infected African-Americans were less likely than infected whites to receive the powerful new combination treatments for HIV.

"The 'end of life' stage tends to go faster these days, and the populations most heavily impacted by HIV — racial/ethnic minorities and those who are poor — have never used hospice services to the extent that other groups have," says

Reynolds. "In some instances, our clients who are chronic substance users — a population heavily represented among current HIV cases — have been actively turned away from hospice placements."

Reynolds observes that African-Americans with HIV/AIDS typically have the same misunderstanding of what hospice does that exists among the larger

African-American population.

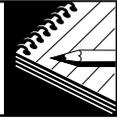
"Hospices still struggle with the popular misconception that they are merely focused on death," says Reynolds. "While hospices have changed that perception among some populations and folks with some illnesses, I think the misconceptions persist among some target groups."

While this article presents compelling reasons for hospices not to scale back their AIDS programs, there are factors that will affect hospices' dedication to treating AIDS patients in era of HIV infection as a chronic illness.

The most significant factor is money. Many AIDS case management programs are supported by government funds. With other pressing problems in health care and diminishing federal and state budgets, funding is harder to come by.

"The challenge, as I see it, is keeping up our response to AIDS when federal and state funding is in rapid decline," says Gornett. "There is just as much money out there for a pure case management approach." ■

With HIV-positive people living longer, a growing number of deaths from AIDS are occurring among older people. In 1994, one in four deaths from AIDS occurred among people ages 45 years and older. By 1998, that proportion had risen to one in three.



How to find and keep good volunteer leaders

Good leaders hold key to fundraising success

By **Dee Vandeventer and Justin Tolan**
Mathis, Earnest & Vandeventer
Cedar Falls, IA

It sounds funny to talk about finding and keeping good volunteer leaders, but as anyone who's been associated with a less-than-stellar fundraising campaign can attest, your campaign is only as successful as its leaders.

Look at this selection process as if you were starting a small company, hiring the necessary "supervisors" and "employees" who have their own responsibilities and tasks to help make the "company" run smoothly. When you look at things this way, it becomes apparent that matching skills to responsibilities is critical to the overall success of the organization. Some companies experience problems when a person who is better-suited to work in the accounting department is placed in the human resources or research and development department. Your hospice's fundraising success depends heavily on matching the right volunteer leader to the right "job."

More important, though, you have to have the right CEO or company president on board before any hiring can begin. You don't want someone experienced only in technology, for example, to run a bank. The process is the same when selecting people to lead your fundraising campaign. You need to find the right fit.

Recruit passion, nurture involvement

Ensuring the right fit is much more than finding a warm body to fill a chair. Superior volunteer leaders must have a passion for what they're doing and a keen belief in the campaign's purpose, goal, organization, and scope. Volunteer leaders who have a passion for what they're doing will unleash their passion and motivate their volunteers to success as well.

"Leadership in itself, let it never be forgotten, is always the key factor in successful fundraising,

whatever the cause, whatever the goal and whatever the scope of the campaign," one expert says.¹

Recruiting volunteer leaders is best done from the top down. For example, the board of directors selects the steering committee members, the steering committee selects the campaign chair, and the campaign chair selects the leadership gift chair, public relations chair, and major gifts chair. The chairs, in turn, select their volunteers.

Although the majority of leaders may already be involved with your hospice, consider looking outside your "family" to those well-known and well-respected community volunteer leaders. Also look to those who are newly rich, newly powerful, and top managers of key corporations. Those who have a passion for the power of philanthropy and volunteerism can be nurtured into directing that passion on behalf of your hospice.

A top volunteer leader must be:

- totally committed to the campaign;
- a successful veteran of other campaigns;
- willing to make a major campaign gift;
- a dynamic and passionate "asker";
- owed more favors than he or she owes because of support for other community projects;
- well-known, admired, and respected in the community;
- able to motivate potential major donors;
- able to surround himself or herself with a team of experienced and loyal volunteers;
- available during the campaign. Absentee management is ineffective in fundraising.

Gather information about volunteers

Find out as much as you can about your volunteers, including organizations they belong to, interests and hobbies, their immediate family's interests and social affiliations, and their all-important link to your hospice. Gathering information about your volunteer leaders can save you time and perhaps embarrassment in the long run.

In addition to tailoring your volunteers' talents to your fundraising goals and objectives, finding out what excites your volunteers also helps you create a relationship with them.

Once you've selected your volunteer leaders, set aside time to talk to them about the campaign and its objectives. Discuss what their responsibilities will be and what you expect of them. Let them ask questions and be honest about the time commitment involved in the fundraising process. Nurture their involvement. Your investment of time with them throughout the campaign will

ensure your volunteer leaders' commitment of their time to your hospice.

"Top leadership should be excited and exciting," another expert says. "If your top leaders aren't excited about your campaign, you can't expect them to get anyone else to be either."²

Here are a few tips to motivate volunteer leaders, increase their productivity, and reduce turnover:

- **Be organized; show appreciation to them and provide a positive experience.**
- **Make their experience meaningful, and don't take their campaign commitment for granted.**
- **Remember they are volunteering their most valuable possession — time.**
- **Provide them with as much training as they need or request.** You've given them a great experience if they can learn and improve their skills while making a difference with the campaign.

Fundraising is all about relationships; people give to people, not to causes. Before they give to

your campaign, they have to know you and trust you. That holds true for recruiting excellent leaders. Volunteers want to know you and your cause before they can trust you and do a good job for you. Committed leaders are the key to success. The more time you spend recruiting leaders and nurturing leadership, the more successful your campaign will be.

(Editor's note: Dee Vandeventer is president and Justin Tolan is chief fundraising advisor of Mathis, Earnest & Vandeventer, a fundraising and marketing company. They can be reached via e-mail at dee@MeandV.com or jtolan@MeandV.com, or by telephone at (319) 268-9151.)

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Hospice Trends

Hospice medical director drives growth, success

Physician employee can provide billable visits

By Larry Beresford

Throughout its history, hospice care in America has suffered from intermittently strained relationships with physicians. Hospices obviously depend on community physicians for referrals and to sign medical orders, while Medicare regulations define essential roles for the hospice medical director as a core member of the team. But inconsistent or insufficient medical leadership of some hospice teams, coupled with occasional conflicts and misunderstandings with referring physicians, have left a lingering perception in some quarters that hospice is "anti-physician."

Such negative perceptions can impede hospice's continued success, but one of the best ways to counteract them is through the active involvement of a competent, collaborative, respected hospice medical director. A full-time

or significantly part-time medical director can help translate, mediate, and facilitate communication between the team and community physicians, as well as elevating the hospice's overall professional practice and adding a complementary set of competencies to the interdisciplinary team. Hospice care and medical practice have both become too complex for hospices to expect to thrive today with a retired, volunteer, or very part-time medical director.

Although the physician's services and time can be expensive to the hospice relative to other professionals on the team, many hospices today are failing to take advantage of the potential to bill Medicare and other payers for the hospice physician's direct patient visits and thereby offset much of the expense of expanding his or her role on the hospice team. Some hospice programs may not even be aware that a physician employee of the hospice can provide billable visits to patients, suggests **Charles von Gunten**, MD, director of the Center for Palliative Studies at San Diego Hospice.

Physician billing requires the hospice to obtain a billing number from Medicare and master its technicalities, using the same fee schedules that community physicians already use. However, there is one key difference: Visits by hospice-employed physicians are billed to Medicare Part A and pay 100% of the allowable fee schedule, in

contrast with attending physicians, who bill Part B and are paid 80% of allowable fees. Direct physician services provided by hospice employees are not included in the hospice's per-diem rate but count against the benefit's aggregate per-patient cap, although that is not likely to be a problem for most hospices.

Upgrading the medical component

A new report issued in June by the National Hospice and Palliative Care Organization (NHPCO) in Alexandria, VA, provides insights into how to enhance the physician's role in hospice — and how to finance that expanded role through billable physician visits to patients. "Providing Direct, Billable Physician Services to Hospice Patients: An Opportunity to Upgrade the Medical Component of Hospice Care" profiles several hospice programs that employ one or more full-time physicians on staff and keep them busy making visits to hospice and palliative care patients at home, in nursing homes and hospitals, or at the hospice's inpatient unit. It demonstrates how hospices can add full-time physician involvement cost-effectively and outlines the regulations and mechanisms under which hospices can bill for their doctors' services.

"We believe there is a strong relationship between a hospice's physician capacity and census growth," says **Stephen Connor**, PhD, NHPCO's director of research. Connor says this correlation is supported by the experiences of a number of hospices that expanded their medical director component and then saw their census rise, "But it's not just about census; it's about increasing access and enhancing quality."

Expanded involvement in the hospice team by a physician who possesses appropriate clinical and interpersonal skills can enhance the quality of the hospice's professional practice, raise its profile in the community, and bring peace of mind to homebound hospice patients who are unable to visit their attending physician's office for a medical examination. To top it off, Connor says, some hospices are now offsetting all or a significant portion of the costs of their full-time physicians' salaries by billing for their visits.

VITAS Healthcare Corp. in Miami has pioneered the practice of hiring full-time physicians and keeping them active as integral members of the hospice interdisciplinary team. Hope Hospice and Palliative Care of Fort Myers, FL, employs nine salaried staff physicians to care for its census

of 650 patients, with plans to hire a tenth. Hope Hospice credits its growth in part to the direct involvement of physicians on the team. San Diego Hospice, which operates significant research, training, and medical school programs through its Center for Palliative Studies, employs ten full-time physicians and four fellows. Pike's Peak Hospice in Colorado Springs, CO, saw its patient census grow from 90 to 225 patients in the 2½ years after the hospice hired a full-time medical director.

The number of physicians working full- or half-time in hospice has grown in recent years, along with the number of physicians certified by the American Board of Hospice and Palliative Medicine. As the NHPCO report makes clear, the benefits of full-time hospice physicians are not limited to the very largest hospices. An agency with a census of 50 could justify investing in an active medical director at half-time or more, because such involvement has been shown to increase both referrals and length of stay. Then the medical director could devote part of his or her time to visiting hospice patients in their homes. It may even be possible for several rural hospices in a region to share the services of a dedicated hospice physician.

However, for some hospices, the first challenge is to recognize the value of expanding the physician's role and overcome lingering, unrealistic fears that greater physician involvement on the team risks turning interdisciplinary hospice care into a medically dominated model. For those inclined to question how they could afford to pay the salary of a full-time or significantly part-time physician, the real question is: How can they afford not to, if they intend to grow and thrive in an increasingly competitive environment?

"I would assert that when there is a physician member of the team who regularly sees patients, it strengthens the entire team, giving access to a broader knowledge base based on the physician's training and an additional perspective that's germane in very important ways," says von Gunten. Physicians intimately understand the culture that is inculcated in all doctors by nature of their arduous training — a culture that has sometimes mystified and frustrated hospice nurses. "If you take it as a given that such acculturation exists, the best way to deal with it is to have someone who speaks both languages and can bridge the two worlds."

It is important to hire the right doctor, one who can be a team player, von Gunten acknowledges.

“The issue of balancing disciplines on the team is a challenge to all hospices, and balancing the physician member of the team is no different. The best way to balance the team is to insist that all members of the team are strong, not to enforce the weakness of some members. Adding the right physician can also be very supportive to other members of the team.”

Roles for hospice physicians

Hospice physicians typically see themselves as consultants to the named attending physician on palliative pain and symptom management issues, reporting back their findings to the attending. They should possess the skills and understand the etiquette of consulting, von Gunten notes. They may visit patients with difficult symptom management needs, newly referred patients just discharged home from the hospital, hospice patients coming up for recertification with questionable prognoses, and palliative care patients who are not yet hospice-appropriate. Hospices with their own inpatient units may have the medical director visit every inpatient on a daily basis. However, the hospices with the most successful physician components strive to have every hospice patient visited by the medical director or other hospice physician at least once, preferably within a few weeks of enrollment.

Other roles for hospice physicians include:

- education and training, including staff insertions, continuing education and grand rounds for community physicians, medical resident and fellow training, and even educational programs for the public;
- development of care protocols and participation in quality improvement and other quality-focused activities;
- reviewing claims denied by fiscal intermediaries to identify possible bases for appeal;
- professional relations, marketing, and outreach to physicians, health systems, and the broader community;
- teaching nurses and other team members to speak the language and understand the culture of physicians, as well as strategizing with them on

how to more effectively interact with referring physicians; and

- administrative duties such as management decision-making and seats on policy-setting committees.

In fact, says von Gunten, with a good hospice physician there's the danger of mission creep — the desire to involve the doctor in all sorts of administrative and promotional activities that will get in the way of income-generating home visits. On the other hand, one of the consequences of the growing professionalism of palliative medicine is that there are now physicians out there looking for hospice positions. They won't be found by advertising for them in the usual places where hospices recruit nurses, such as newspaper want ads, but they can be reached where doctors typically look for jobs, such as in professional journals and through professional associations.

[Editor's note: NHPCO's new report, "Providing Direct, Billable Physician Services to Hospice Patients: An Opportunity to Upgrade the Medical Component of Hospice Care", is now available on the members-only section of its revamped web site (www.nhpco.org) and is offered on CD-ROM for those who are unable to download it. Non-members should contact NHPCO's Marketplace through the web site or at (800) 646-6460 for purchase information. A seminal article on physician billing for palliative services by von Gunten and Frank Ferris, "Procedure/Diagnosis Coding and Reimbursement Mechanisms for Physician Services in Palliative Care" (EPEC Trainer's Guide, 1999) can be found on the web site of the Center to Advance Palliative Care (www.capcmssm.org/content/130/index.html?topic=4), which also offers other helpful resources.

Hospice Management Advisor Columnist Larry Beresford is a freelance journalist based in Oakland, CA, specializing in hospice, palliative, and end-of-life care. A former editor of Hospice Management Advisor, he has produced other hospice newsletters, including Hospice Manager's Monograph and Hospice News Service, and has contributed to health care trade magazines. In 1999 and 2000 he was Senior Writer and Editor for the NHPCO and then was the

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primary researcher and author of *Hospital-Hospice Partnerships in Palliative Care: Creating a Continuum of Services*, a report jointly issued in December 2001 by NHPCO and the Center to Advance Palliative Care. Beresford also is the author of the definitive consumer's guide to hospice care, *The Hospice Handbook* (Boston: Little, Brown & Co., 1993). Contact him at (510) 536-3048 or larryberesford@hotmail.com.] ■

NEWS BRIEF

NHPCO's Schumacher addresses AGs

Don Schumacher, PsyD, president and CEO of the National Hospice and Palliative Care Organization in Alexandria, VA, challenged members of the National Association of Attorneys General (NAAG) to learn more about futile medical care.

"Many patients are unaware of the terminal nature of their illness," Schumacher said during his May 16 address. "And decisions are made to undergo aggressive therapies that ultimately do not benefit the patient. Patients and families must have a full understanding of all available care options in order to give informed consent."

The remarks were made at NAAG's third and final national listening conference on improving end-of-life care. Hosted by NAAG's president, Oklahoma Attorney General Drew Edmondson, the conference provided a panel of attorneys general, key staff people, and an invited audience of more than 125 people with the opportunity to hear noted authorities address a range of care issues involving policy, patient care, pain management, and best practices.

Schumacher emphasized the role that AGs play in influencing public policy and helping educate the public about quality care. Advance directives, living wills, durable powers of attorney, and health care surrogate laws are only some of the ways AGs can work in their home states to improve care for all Americans, he said.

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Schumacher encouraged AGs and their staffs to learn more about the range of services available from hospice and palliative care providers in their communities. Schumacher suggested they visit with local care providers, accompany hospice professionals on a home care visit, talk with families caring for a loved one, or even spend a day as a hospice volunteer.

In responding to questions from the panel of Attorneys General, Schumacher stressed that AGs would indeed make a difference in improving end-of-life care across the nation by focusing on these issues. A summary of Schumacher's remarks is available from NHPCO. The conference was part of NAAG's ongoing presidential initiative to encourage the elimination of legal barriers to quality care, educate the public in planning for their own care needs, and partner with health care professionals to safeguard the rights of patients and families. ■

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