

NewsLine

The Monthly Membership Publication of the National Hospice and Palliative Care Organization

March 2012

NHPCO Facts and Figures on Hospice Care in America



At the top of the new year, NHPCO released the 2011 edition of *NHPCO Facts and Figures: Hospice Care in America* (Facts and Figures). Through an easy-to-read narrative written for the non-hospice reader—along with over 20 supporting figures and tables—this annual report offers a national-level snapshot of hospice utilization, patient and provider demographics, and payer sources.

Many members use the report's findings in both their community and advocacy outreach, but the information is also valued by the media, hospice advocates and government agencies, such as CMS. In 2011, Facts and Figures was downloaded from the NHPCO website nearly 23,000 times.

The 2011 edition, which reports on data from 2010, is posted on the NHPCO website. In this article, NewsLine reviews some of Facts and Figures' findings from the past five years for an interesting look at the continuing evolution of hospice—which now serves 1.58 million Americans a year.

Inside

In Tribute to Mary Labyak

NHPCO president/CEO, Don Schumacher, pays tribute to Mary Labyak, one of the icons in our community as well as a dear friend and mentor to many.

Fall Prevention and Assessment

Studies have shown that medications, decreasing functional ability and multiple chronic conditions can increase an individual's risk of falls, making hospice patients a particularly vulnerable population. Catherine Emmett shares the hospice-specific assessment and intervention plan that is helping to reduce falls at Chapters Health System.

Hospice in the Continuum

Hope HealthCare Services opened its first PACE site in 2008 and, today, serves 300 clients each day at four centers on southern Florida's Gulf Coast. President/CEO Samira Beckwith discusses the experience and the role of PACE within the future healthcare continuum.

The Voice of NCHPP

In memory of Mary Labyak, NewsLine shares her landmark article, "The Experience Model." While written more than a decade ago, providers still embrace this model and continue to request copies of the article—testament to her enduring legacy.

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Plus...

Short Takes:

- MSN Change: Over a Year of Advocacy Pays Off
- Why Partner With a Hospice in Africa? Watch This Video
- NHDD is April 16: Let's Keep Up the Pace
- New Volunteer Outreach Materials Now Online
- Our New Hospice T-Shirt is Here!

Member News and Notes

Regulatory Tip of the Month

Hospice Utilization

More People Being Served Annually

The number of patients served by hospice continues to rise, albeit at a smaller rate. As noted in Table 1, 1.58 million patients were served in 2010—up just 20,000 from 2009. Included in this number are patients who died; patients who remained on the hospice census since admission in the year before (i.e., carryovers); and patients who were discharged alive.

Some Decline in Lengths of Service

As shown in Table 2, both average and median lengths of service (LOS) increased between 2006 and 2009. However, in 2010, average LOS decreased by 1.6 days and median length of service decreased 1.4 days.

Median length of service is considered to be the more meaningful measure for understanding the experience of the typical patient since it is not influenced by outliers (or extreme values). In looking at median LOS in 2010, half of hospice patients received care for less than 20 days. While “late referrals” are certainly a factor, disease course and access to care are also contributing factors.

Table 1: Total Hospice Patients by Year (in millions)

	2006	2007	2008	2009	2010
	1.3	1.4	1.45	1.56	1.58

Table 2: Lengths of Service in Days

	2006	2007	2008	2009	2010
Median	20.6	20.0	21.3	21.1	19.7
Average	59.8	67.4	69.5	69.0	67.4

Table 3: Location of Patients at Death

	2006	2007	2008	2009	2010
Patient's Place of Residence	74.1%	70.3%	68.8%	68.6%	66.7%
Private Residence	47.1%	42.0%	40.7%	40.1%	41.1%
Nursing Home	22.5%	22.8%	22.0%	18.9%	18.0%
Residential Facility	4.6%	5.5%	6.1%	9.6%	7.3%
Hospice Inpatient Facility	17.0%	19.2%	21.0%	21.2%	21.9%
Acute Care Hospital	8.8%	10.5%	10.1%	10.1%	11.4%

More Patients Served Outside the “Home Setting”

While nearly 67 percent of patients died at home in 2010, there has been a steady increase in the proportion of patients who have died in hospice inpatient and acute-care hospital settings (Table 3). In part, this may be due to hospice’s changing population—a predominantly older population with co-morbid and more medically complex conditions (see page 4).

The Faces Behind the Numbers

Tables 4 through 7 (on page 4) provide a snapshot of the patients being served by hospice.

Of particular note are the ages and primary diagnoses of today’s hospice patients:

- 82.7 percent of patients served in 2010 were age 65 or older (and more than one third were age 85 or older).
- 64.4 percent of admissions were due to non-cancer diagnoses compared with 55.9 percent just five years ago.

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IN TRIBUTE TO MARY

The hospice and palliative care community is mourning the loss of one of the icons in our community, Mary Labyak. Mary died peacefully at her home in Florida on February 4, under the care of her team at Suncoast Hospice, the program she helped build and where she served as president and CEO. Mary was chair of the National Hospice Foundation, served on the NHPCO board of directors (was a past chair of NHO), was co-chair of the Capital Campaign for the National Center for Care at the End of Life, and an active NHPCO member at the time of her death. She was the recipient of awards and honors too numerous to list here.

Mary was also a friend and a mentor, to me and to numerous others throughout the field. Through her dedication and enduring leadership, Mary's work has touched the lives of the people who knew her, those who did not, and many who will never have the pleasure of knowing her.

This very special woman made significant accomplishments within her program, her community, in the state, and nationally. She was involved in the creation of the Medicare Hospice Benefit, and the program she led was one of the original HCFA demonstration sites. Her work with NHPCO, the National Hospice Foundation (NHF), FHSSA and HAN goes back to these organizations' earliest days.

One of the most valuable gifts that she gave to us was her unwavering commitment to patients and families. Throughout her work she always emphasized the importance of putting the patient and family at the center of care. They are—and will continue to be—the most important part of the work we share and her commitment was an inspiration to us all.

NHPCO and NHF issued a statement following her death that is available on our websites. We also put together a very special video of remarks Mary made when she was awarded the NHF Healthcare Architect Award in 2011. I encourage you to watch this [video tribute](#) and reflect on Mary's words of wisdom.

Additionally, Mary contributed an article to NewsLine that was originally published in 2001. As one of the most frequently requested articles from members, it was reprinted last year. We have chosen to share it with you again in this issue [page 16] as a tribute to Mary's enduring legacy of leadership.



J. Donald Schumacher
President/CEO



Table 4: Percentage of Patients by Gender

	2006	2007	2008	2009	2010
Female	55.6%	53.9%	56.6%	53.8%	56.1%
Male	44.4%	46.1%	43.4%	46.2%	43.9%

Table 5: Percentage of Patients by Age

	2006	2007	2008	2009	2010
34 and Younger	.9%	.9%	.9%	.8%	.13%
35 to 64	17.3%	16.5%	15.9%	16.3%	16.1%
65 to 74	17.1%	16.2%	16.2%	16.3%	15.9%
75 to 84	31.4%	30.0%	29.2%	28.7%	27.9%
85 and Older	33.2%	36.6%	37.8%	38.0%	38.9%

Table 6: Percentage of Patients by Race

	2006	2007	2008	2009	2010
White/Caucasian	80.9%	81.3%	81.9%	80.5%	77.3%
Multiracial or Other Race	8.8%	7.8%	9.5%	8.7%	11.0%
Black/African American	8.2%	9.0%	7.2%	8.7%	8.9%
Asian, Hawaiian, Other Pacific Islander	1.8%	1.6%	1.1%	1.9%	2.5%
American Indian or Alaskan Native	.3%	.3%	.3%	.2%	.3%

Table 7: Percentage of Admissions by Primary Diagnosis

	2006	2007	2008	2009	2010
Cancer	44.1%	41.3%	38.3%	40.1%	35.6%
Non-cancer	55.9%	58.7%	61.7%	59.9%	64.4%
Heart	12.2%	11.8%	11.7%	11.5%	14.3%
Debility Unspecified	11.8%	11.2%	15.3%	13.1%	13.0%
Dementia	10.0%	10.1%	11.1%	11.2%	13.0%
Lung	7.7%	7.9%	7.9%	8.2%	8.3%
Other	3.7%	6.5%	4.4%	4.5%	5.4%
Stroke or Coma	3.4%	3.8%	4.0%	4.0%	4.2%
Kidney (ESRD)	2.9%	2.6%	2.8%	3.8%	2.4%
Liver	1.8%	2.0%	1.5%	1.8%	1.9%
Non-ALS Motor Neuron	-	1.9%	2.1%	1.9%	1.2%
HIV/AIDS	.5%	1.0%	.5%	.4%	.3%
ALS	-	.4%	.4%	.4%	.4%

A Look at Hospice Programs and Staff

Most Care Still Provided by Freestanding Hospices

While there has been some decline in hospice care that's provided by hospital and home-health agency based hospices, the proportion of freestanding hospices increased by 1.8 percent between 2006 and 2010 (Table 8).

Some Decline in Small Programs

The proportion of programs with a 1-to-49 patient census has steadily declined over the last five years—from 17.9 percent in 2006 to 15.9 percent in 2010 (Table 9).

The proportion of midsize programs (50 to 500 patients) have remained roughly the same, while some growth has occurred in larger programs with a patient census of 501 or more.

The Interdisciplinary Mix

Table 11 provides a snapshot of paid full-time equivalent employees (FTEs) working in hospice over the past five years.

Table 8: Agency Type	2006	2007	2008	2009	2010
Freestanding/Independent Hospice	56.2%	58.3%	57.5%	57.7%	58.0%
Part of a Hospital System	22.6%	20.8%	21.8%	21.4%	21.3%
Part of a Home Health Agency	20.1%	19.7%	19.4%	19.5%	19.2%
Part of a Nursing Home	1.2%	1.3%	1.4%	1.4%	1.4%

Table 9: Agency Size by Patient Admissions	2006	2007	2008	2009	2010
1 to 49	17.9%	18.5%	18.1%	17.1%	15.9%
50 to 150	29.0%	28.0%	29.5%	29.4%	30.1%
151 to 500	34.1%	32.9%	32.1%	32.9%	33.0%
501 to 1,500	14.5%	16.1%	16.1%	16.1%	16.3%
More than 1,500	4.5%	4.6%	4.2%	4.5%	4.6%

Table 10: Percentage of Patients Served by Payer	2006	2007	2008	2009	2010
Medicare Hospice Benefit	83.7%	83.6%	84.3%	83.4%	83.8%
Managed Care or Private Insurance	-	8.5%	7.8%	8.6%	7.9%
Medicaid Hospice Benefit	5.3%	5.0%	5.1%	4.9%	4.9%
Uncompensated or Charity Care	-	1.3%	1.3%	1.6%	1.5%
Self Pay	-	.9%	.7%	.7%	1.1%
Other Payment Sources	3.0%	.7%	.8%	.8%	.8%

Table 11: Distribution of Paid FTEs	2006	2007	2008	2009	2010
Clinical (direct patient care)	71.9%	71.6%	72.0%	65.5%	66.9%
Nursing	30.7%	33.8%	34.8%	30.7%	30.1%
Nurse Practitioners	-	-	-	-	.4%
Home Health Aides	23.9%	19.8%	18.6%	18.1%	19.4%
Social Services	8.5%	8.2%	9.1%	9.0%	8.5%
Physicians (excludes volunteers)	2.6%	3.4%	3.4%	2.2%	2.7%
Chaplains	-	4.2%	4.1%	3.9%	4.3%
Other Clinical	6.9%	4.8%	3.8%	2.1%	2.0%
Nursing (indirect clinical)	-	-	-	8.1%	7.5%
Non-clinical (administrative/general)	23.5%	23.7%	23.4%	22.4%	21.9%
Bereavement	4.6%	4.7%	4.6%	4.2%	3.8%

The proportion of
midsize programs has
remained roughly the
same since 2006.

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More Providers are Using FEHC to Measure the Quality of Care

The Family Evaluation of Hospice Care (FEHC) is one of several survey tools that NHPCO makes available to members, free of charge, to measure the quality of their hospice care from the perspective of family caregivers.

FEHC is a post-death survey designed to yield actionable information. Hospices that submit FEHC data to NHPCO receive quarterly reports that include individual hospice results plus state and national results for comparison.

As shown in Table 12 (on opposite page), the use of this valuable survey tool has increased in recent years—evidence that NHPCO provider-members are tracking their performance more closely.

If your organization does not yet utilize this tool, the time is right to learn more—the next data submission period begins May 1. For details, visit www.nhpco.org/fehc.

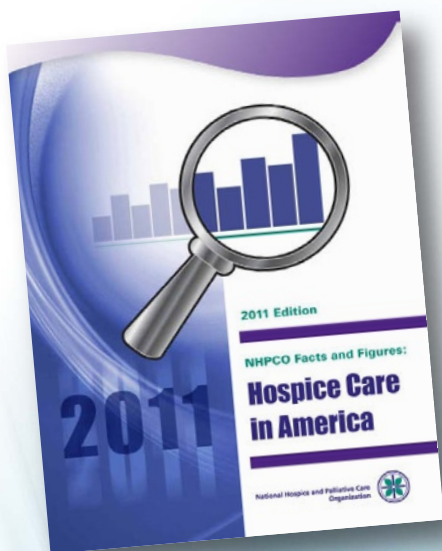


Continued Drop in Volunteer Service

Facts and Figures also reports on volunteer service. During 2008, there were 550,000 volunteers working in hospice compared with 468,000 in 2009 and 458,000 in 2010—representing an overall decline of 17 percent. However, this decline may be due to economic stressors. In NHPCO's 2009 Economic Impact Study, for example, hospices reported that many of their volunteers were being forced to seek paid employment because other family members had lost jobs. Next year's numbers should provide a better understanding of whether the decline in volunteer service is the result of the national economy or a trend that warrants concern.

Table 12: Provider Locations Using FEHC

	2007	2008	2009	2010	2011
	1,007	1,192	1,297	1,317	1,498



The 2011 edition of Facts and Figures is an 18-page PDF that members can download free of charge from the NHPCO website.

This new edition includes information on “Hospice Use by Medicare Decedents” (page 4) and “Hospice Care in the Nursing Home” (page 6). Also included is an Appendix that details the methodology NHPCO used to arrive at the estimates cited in the report.

Increasing use of
FEHC is evidence that
providers are tracking
their performance more
closely.





Fall Prevention and at Chapters Health System

It probably comes as no surprise that, as people age, their risk of falls and injuries also increases. In fact, one out of every three adults, age 65 or older, falls each year. However, consider these additional facts:

- Falls are a leading cause of injury *and death* for community dwelling older adults.
- Studies have shown that medications, decreasing functional ability and the number of chronic conditions can increase an individual's risk of falls.

If your organization's patient population is at all similar to ours at Chapters Health System (and I expect that it is), these statistics point to the important need to have an effective fall prevention and assessment plan in place as part of your practice.

Assessment

By Catherine Parsons Emmett, BSN, MSN, ARNP, CHPN

This article shares the steps that Chapters Health System took to adopt such a plan—a hospice-specific assessment and intervention plan that meets The Joint Commission accreditation requirements and is helping to reduce the occurrence of falls among our elderly-patient population.

First, Some Background

Chapters Health System operates two hospice programs that cover a four-county area in West Central Florida, a palliative care program, and a PACE site (i.e., a Program of All Inclusive Care for the Elderly). So the very individuals who are at higher risk of falls represent the majority of patients under our care.

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As a requirement for The Joint Commission accreditation of our two hospices, we had developed a fall assessment and prevention program several years ago. With time, however, we realized that the assessment tool we were utilizing (which had been developed and validated in a *hospital* setting) was not specific enough for the home- and community-based patients we were serving, nor was it sufficient in helping to meet the Patient Safety Goal (No. 9) issued by The Joint Commission in 2011:

- Assess the patient's risk for falls;
- Implement interventions to reduce falls based on the patient's assessed risk factors;
- Educate staff on the fall reduction program in time frames determined by the organization;
- Educate the patient and, as needed the family, on any individualized fall reduction strategies;
- Evaluate the effectiveness of all fall reduction activities including assessment, interventions and education.

Factors Affecting the Risk of Falls

Researchers have paid increasing attention to falls in the home and community, and have noted that risk factors for falls include both intrinsic and extrinsic factors.

Intrinsic risk factors are related to the patient's personal functioning, and include age, disease, vision, mental status, incontinence and hypertension. Extrinsic risk factors are related to the patient's external environment, and include medications, bathrooms, ground surfaces, lighting, footwear, and improper or inadequate use of devices.

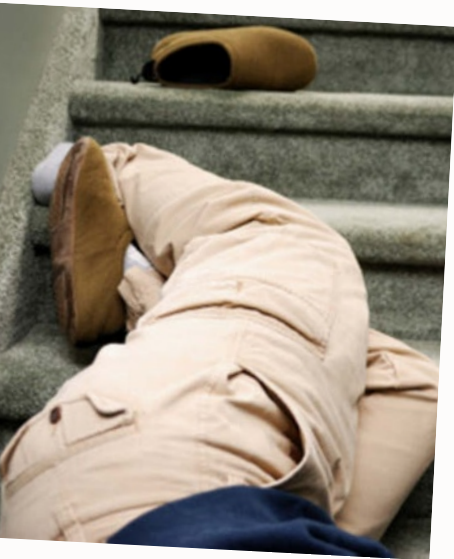
Additionally, psychological factors also play a role in fall risk. Individuals may fear falling as they age and may become more socially isolated and depressed. Once older adults have suffered a fall, they can experience Post-fall Syndrome which is exhibited by hesitancy in ambulation as well as loss of confidence. This can then lead to decreased mobility and independence.



Revising Our Program

With this information, our organization set out to develop a more comprehensive fall assessment and prevention program that would be better at identifying home and community dwelling patients who were at risk, but would also tie evidenced-based interventions to prevent falls and injury to specific risk factors.

We began by convening a Falls Workgroup, which included participants from each of our subsidiary organizations and all levels and clinical departments within the organizations. This Workgroup reviewed home care fall assessment tools and evidenced-based interventions from the literature over the past decade. The group then identified four possible fall assessment forms and set about to determine which form would meet our



needs. Among the questions considered were: Had the form been used and validated in home and community settings? Was the form user friendly—that is, was it easy to administer and score, with good inter-rater reliability? And was it cost effective to implement?

The Assessment Form Selected

Once these questions were answered, the Workgroup selected the [Missouri Alliance for Home Care Fall Risk Assessment Form](#). This form has been

in use by home health agencies across the country for many years and has been approved for use by CMS for the OASIS-C Fall Risk when used in conjunction with the TUGS (Timed Up and Go Test). It is currently undergoing a validation study by the University of Kansas. The form is simple and easy to use, and assesses the presence of 10 risk factors:

- Age 65+
- Three or more medical diagnoses
- Prior history of falls within 3 months
- Incontinence
- Visual impairment
- Impaired functional mobility
- Environmental hazards
- Poly Pharmacy (4 or more prescriptions)
- Pain affecting level of function
- Cognitive impairment

If four or more risk factors are present, the patient is considered to be at risk of a fall, and interventions should be initiated to decrease the risk of injury.

The Interventions

In identifying interventions to initiate, the Falls Workgroup reviewed evidenced-based interventions from a number of sources, including the



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American Geriatric Society, the Veterans Health Administration Falls Toolkit, the Centers for Disease Control, and the National Council on Aging. Additionally, our chief medical officer led a retrospective study that looked at predictors of falls in our hospice population.

The Workgroup then created a Fall Prevention Plan of Care, which tied interventions to specific risk factors. Discipline specific modules and post tests were designed to provide education on the new form and process for fall assessments as well as the new Fall Prevention Plan of Care.

The Entire Team Should Be Responsible for Fall Prevention

All staff should:

- Know who is at risk
- Remind patients and families of the individualized interventions
- Report any falls to the RN/Manager.

Frequently, responsibility for fall assessment and prevention is designated to the nursing staff. In our education, we stressed that fall prevention is the responsibility of the entire interdisciplinary team. Once a patient is identified as being at risk of falls, each member of the team has individual responsibilities for interventions and reinforcement of the interventions. We assess fall risk at the time of admission and then with each recertification, change in level of care, and change in residence as well as should a fall occur. If a patient is identified as at risk of falling, interventions specific to that risk factor are initiated and discussed with the patient and caregivers. We utilize a Patient Resource Guide to reinforce and educate the patient and caregivers on the specific fall-prevention interventions that have been identified.

Should a Fall Occur

If a patient suffers a fall, the Fall Risk Assessment is completed to determine if additional risk factors are now present and/or if additional interventions for existing risk factors need to be added or changed. Attending

Helpful Training Tool:

The author presented on this topic at NHPCO's 2011 Clinical Team Conference. To purchase a CD or download an MP3 file of the session (for just \$10):

Visit the NHPCO
Conference Media Center:
www.dcpvidersonline.com/nhpco

Enter "3C" in the
Keyword Search

Then scroll to the session
listing (Fall Prevention
and Assessment).

physicians are notified of the fall, and we enter information regarding the specifics of the fall into our occurrence data base (which was revised to allow for reporting of falls to match the 10 risk factors identified in the Missouri Home Care Alliance tool). This allows for QAPI analysis and trending to identify the success of our program.

Falls can cause serious harm to our patient population and emotional distress to both patients and caregivers. Together, we believe we can make a difference in our patient population by identifying those

at risk for falls and linking the appropriate evidenced-based interventions to those risk factors.

Catherine Parsons Emmett has over 25 years of experience as a gerontological nurse practitioner in hospitals, nursing homes, not-for-profit senior service organizations, and hospice. She is currently the clinical manager and home care coordinator of Chapters Health PACE, based in Tampa, FL, and is a doctoral candidate with the School for Aging Studies at the University of South Florida.



If a patient is identified as at risk of falling, interventions specific to that risk factor are initiated.

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The Voice of NCHPP:



NHPCO's National Council of Hospice and Palliative Professionals (NCHPP) is comprised of 48,000 staff and volunteers who work for NHPCO provider-members. Organized into 15 discipline-specific sections that are led by the NCHPP chair, vice chair and 15 section leaders, NCHPP represents the perspectives of the interdisciplinary team—the very essence of hospice care.

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

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

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Featured This Month: **NCHPP CEO Section**

The Experience Model

By Mary J. Labyak, MSSW, LCSW

As this month's feature, NewsLine is republishing the landmark article, "The Experience Model," written by Suncoast Hospice President/CEO, Mary Labyak, who died on February 4, 2012. While written in 2001, providers still embrace this model and continue to request copies of the article—testament to Mary's lifelong impact as a hospice leader.

No one would argue that each patient, family and community member who seeks services from a hospice or palliative care provider deserves the best we can offer them. People who need our support are often in the midst of a heart-wrenching journey for which they have received no preparation or guidance. As end-of-life providers we usually have only one opportunity to ensure that the experiences of these patients and families meet their unique needs.

Palliative care providers are also challenged to meet the growing expectations of people familiar with our services. Twenty years ago patients and families were happy simply to have someone to call, and to receive basic pain and symptom management, and acknowledgement of their grief. Today's consumers know the incredible support and services that palliative care teams provide and frequently express a desire for "that medicine my neighbor had."

Successful current and future models of hospice and palliative care will honor what we have learned from those we have served. When staff and volunteers at all levels of the organization focus on the experiences of patients, families and community members, we foster an organizational culture in which our services are based on the unique values, end-of-life goals and wishes of each person we serve.

As reflected in *The Quest to Die with Dignity: An Analysis of Americans' Values, Opinions and Attitudes Concerning End-of-life Care*, people tend to see the last phase of life as one of awaiting death, with the hope for some measure of comfort while not being a burden to others. These perceptions about the end of life can be transformed into a more meaningful journey through quality palliative care that honors each individual's values and goals.

Hospice and palliative care providers create a transformative experience for patients and families that differs significantly from the experience of receiving care through a disease-focused model. A disease-focused approach involves curing the disease or restoring to a previous health state. In the hospice and palliative care model, the experience for the patient becomes that of a journey toward comfort, resolution, and life closure (rather than a forced march toward physical wellness).

In reflecting on what patients and families have taught us, the experiences of advanced illness, dying and bereavement are much more than medical experiences. By helping to reduce all dimensions of suffering and reframe the end-of-life experience, quality palliative care facilitates personal growth and meaning toward a more peaceful life closure.

A Model for End-of-Life Care

The Experience Model, which transforms end-of-life care, works best when the concept transcends all areas of an organization.

Figure 1 depicts the relationships of all staff and volunteers to patients, families and community members. In the center of the



Figure 1

circle are the patients, families and community members who direct our care and services. The next circle represents the direct service staff and volunteers who provide the care and services. The outer-most circle represents all other staff and volunteers who serve and support the direct service staff and volunteers in providing optimal care.

How do we help to transform experiences for patients, families, and community members; for the staff and volunteers who provide direct service; and for those who create and maintain systems and resources that support the other two groups?

Transforming the Experiences of Patients and Families

As the family member of one patient shared: “What I appreciate about hospice is that you cared for

**The Model works best
when the concept
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an organization.**

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her as the person she had always been, not the patient she had become.”

Hospice and palliative care are uniquely different from the care provided by other providers of health and human services. In contrast to the more traditional disease-focused model that addresses the physical dimensions of illness, the Experience Model is directed by the patient’s and family’s individual goals and wishes as they adapt to the effects of advancing illness, dying and bereavement.

We have learned from patients and families that this experience involves not only a physical dimension but also psychological, social, emotional, and spiritual dimensions. As an example, we know pain is not only a physical problem. The physical dimensions of pain simultaneously affect other dimensions as well, including the ability to care for oneself, the quality of interactions with others, the sense of well-being or disease, and the sense of spirituality. Like an infant’s mobile, this experience is dynamic. When one dimension is affected, all other dimensions are involved. The experience is not only “multidimensional,” it is “inter-dimensional.”

Therefore, quality hospice and palliative models of care must be able to support and address all four dimensions—the physical, interpersonal, spiritual and emotional.

Transforming the Experiences of Staff and Volunteers

Patient-and-family values and life-closure goals should drive care and services. They define what is important at this time in the patient’s and family’s life and become the focus and foundation for a patient/family Experience Model. However, it is oftentimes a challenge to transform a professional’s approach to care since the drivers of a traditional disease-focused model differ from the drivers of the Experience Model.

When we start by understanding the inter-dimensional experience described above, our relationship with the patient and family is directed by their defined end-of-life goals and values instead of a more traditional disease-focused model directed by healthcare goals alone.

Table 1 illustrates the differences between the Experience Model and disease-focused model.

In the more traditional disease-focused model, the process

begins with identifying disease and symptoms. Then, based on the discipline’s area of expertise (e.g., nurse, physician, social worker), goals are developed to help reverse or minimize the disease process. Care is usually directed by what the professionals believe is important and needed. Outcomes are based on meeting the professional’s goals of care.

The Experience Model begins with a dialog with the patient and family during which they begin to tell their life stories. Through ongoing discussions, we discern what is important to them at this time in their lives, based on their unique values and life experiences. We take their lead and our interdisciplinary collaboration and service are directed by what the patient and family wish this experience to be and on what they define as their end-of-life goals.

Our assessment focuses on what is happening in all of the dimensions that are helping or hindering the patient and family from attending to what is important to them at this time. Services are chosen by the patient and family and evaluation is based on *their perception* of how well they have reached their end-of-life goals. This process can

Table 1

Disease-Focused Model	Experience (Palliative) Model
Patient Presents with Symptoms of Disease.	Patient and Family are Affected by a Life-limited Condition that Cannot be Reversed.
	<i>Facilitate a dialog to help the patient and family define their end-of-life values, goals, and life-closure wishes. These become the overriding goals of the patient and family care plan to direct our services.</i>
Focus on Curing or Fixing the Problems.	Determine What is Helping or Hindering the Patient and Family from Reaching their End-of-Life Goals and Wishes.
<i>Assess from the perspective of how symptoms and disease process should be different.</i>	<i>Assess from the perspective of what is helping the patient and family from reaching their goals with regard to pain, family dynamics, spiritual issues, and caregiving support.</i>
<i>Plan and define goals of medical care for patient based on what care providers feel is best.</i>	<i>Plan how the interdisciplinary team can support the patient and family in reaching their goals and, in so doing, reduce suffering and maximize potential toward a self-determined life closure.</i>
<i>Provide interventions as outlined on the plan of care to restore or reverse medical condition.</i>	<i>Help patient and family to minimize or eliminate those things that are hindering them from reaching their goals. Create opportunity for transformational experiences of growth.</i>
<i>Evaluate the effectiveness of disciplines' care plan based on medical goals.</i>	<i>Evaluate effectiveness based on the patient and family's experience of what is important to them at this time. To what degree have we helped them reach their goals?</i>

continued on next page

Like an infant's mobile,
this experience is
dynamic. When one
dimension is affected,
all other dimensions are
involved.

happen whether the patient has nine hours, nine days or nine months to live—always focusing on what is most important to the patient and family at any given moment.

Assessment by any discipline goes beyond identifying a problem in the dimension they are most comfortable assessing, such as the physical dimension assessed by a nurse. All disciplines approach assessment from the perspective of identifying how any issue or problem is affecting all dimensions. For instance, all disciplines approach patient and family-identified problems of pain with a broader vision of how it is simultaneously affecting the patient's and family's other dimensions, including their functional abilities, interpersonal relationships, sense of well-being and sense of spirituality. In palliative care, the disciplines don't own problems or care plans—they are not ours to own. It is not our experience, it is the patient's and family's experience. All disciplines must be competent at some level to respond to all of these dimensions and adept at collaboration with an interdisciplinary team to optimally transform this end-of-life experience.

Comparing how a patient and family are discussed in an interdisciplinary care plan meeting will illustrate these differences. In a disease-focused model, the following might be used to introduce a patient and family, usually "reported" by the nurse:

Mr. Jones is a 78-year old patient with COPD. He was on O2 prn. With his increased dyspnea at rest and bilateral congestion, he is using his oxygen on a continual basis. He is anxious at night, has trouble walking from his bed to his living room and is demanding. The doctor changed his inhaler this week because he was not compliant with taking his other medications since he didn't like the aftertaste. The HHA visits four times a week to assist with his personal care. They are not asking for any other help at this time.

The discussion becomes problem-focused, often identifying the patient as a disease first, then perhaps mentioning how this is affecting the rest of the patient's life (although this part is often not a focus). In contrast, team dialog in the Experience Model focuses

on the patient and family's values, goals and wishes as the starting point:

Mr. and Mrs. Jones have shared 58 years together since they met and married in college. They have stated that what is most important to them at this time is for Mr. Jones' symptoms to be controlled enough to allow him to spend quality time with his children and grandchildren who live close by. Mr. Jones wants to be able to communicate his thoughts and wishes to each of his grandchildren before he dies. He is also concerned about how his wife will be cared for after he is gone. Mrs. Jones is hoping that she has enough strength and endurance to stay by his side and care for him until the end. They define themselves as practicing Catholics and state that their faith has given them strength. Their usual activities, before Mr. Jones could no longer participate, included golf and travel. They now enjoy reading, movies, writing letters, and listening to old-time music.

Once the interdisciplinary team has been introduced to patients



and families through the story of their lives and what is important to them, the team can consider the following question: What is happening with this patient and family that is helping or hindering the patient and family from getting to what is important to them at this time?

Each team member approaches his or her assessment from this perspective by supporting those aspects that are helping the patient and family reach their goals, reframe their hope and experiences, or by helping them meet the challenges of those aspects that are hindering them from reaching their goals. Symptoms that take away the patient's ability to focus on what is important are minimized or controlled so his energies can be used to reach his goal of spending quality time with his family. Additional activities that help the patient create and

communicate his legacy, such as life review with his children, are critical aspects of service. The team can provide additional caregiving support to his wife so she can endure the 24-hour care required and still have energy to do the activities they enjoy together. Each member of the interdisciplinary team brings expertise on one or more of the dimensions of the patient and family experience, which makes all of their input and suggestions equally valuable in the Experience Model. The care plan problems are not 'nursing problems' or 'social work problems,' but the patient's and family's experience—and their care plan is directed by their values and end-of-life goals.

The Benefits to Those Who Serve

Organizational culture plays a large role in affecting the delivery of the Experience

continued on next page

**The disciplines don't
own problems or care
plans—they are not
ours to own.**

Model. Systems and resources that allow for individualized care while maintaining high-quality standards encourage and motivate everyone toward service excellence. It is this culture of service excellence that transforms all interactions and experiences.

Transformative end-of-life experiences for patients and families happen when staff and volunteers understand the value of their roles in creating these experiences, even when they do not provide direct care. For instance, the finance department understands the value in processing medical bills so patients and families don't have the burden of that additional task and can spend more time doing what is important to them. Education staff understands that many of the resource materials they develop will help caregivers feel confident about the care they are providing and perhaps bring meaning to the caregiving experience. And administrative teams create systems that allow for decision making and flexibility at the bedside, without lengthy bureaucratic approvals. Leaders motivate staff and volunteers by helping them to see the connections

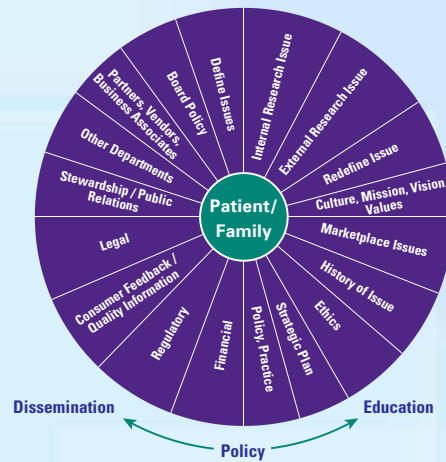


Figure 2

between their job functions and transforming the patient's and family's experiences. When we share stories about how their efforts transform end-of-life experiences, we create a passion for their roles and enhance their desire to provide service excellence in everything they do.

Policies and procedures, systems, and the organizational culture must reinforce the concept that all hospice staff work to enhance the end-of-life experiences for those they serve. Figure 2 depicts a framework for mission-based policy decisions that take into account the patient and family's values, goals and wishes.

The following questions will help hospice staff members assess their organization's ability

to transform the end-of-life care experiences of their patients and families:

What are your organization's systemic barriers to transforming patient and family experiences?

Are care delivery models flexible enough to meet the unique needs of each patient and family?

How does the voice of the patient and family drive interdisciplinary discussions?

Do IDT collaborative discussions begin with the story of the patient and family, including what is most important to them at this time?

Is the care planning process truly directed by the goals, values, and wishes of patients and families?

Are all disciplines encouraged to participate in team care discussions?

Is every member of the IDT competent in recognizing all dimensions of patient and family experiences?

Is staff empowered to take risks that support patient and family goals?

Are community members asked on a regular basis what end-of-life services they want and need?

Are programs and services provided, based on current reimbursement mechanisms or the needs of all members of our communities?

What drives organizational decisions—the needs and experiences of patients and families, or regulations, reimbursement, and liability issues?

The future of end-of-life service delivery is being written every day by hospice and palliative care providers. All end-of-life care models must honor the patient's and family's unique experiences and be ready to simultaneously address all dimensions. We must respond by developing new, evolving models that not only address the disease but also address *all dimensions* to truly create transforming experiences.

We only have one chance to support patients through a transforming experience at the end-of-life. The price of failure is not acceptable.

Mary Labyak served as the president/CEO of Suncoast Hospice (formerly The Hospice of the Florida Suncoast) from 1983 until her death on February 4, 2012. Under her leadership, the organization evolved from a small volunteer-based program to the largest nonprofit community based hospice in the nation. A nationally recognized expert in hospice and palliative care, she was the recipient of numerous accolades, including the National Hospice Foundation's prestigious Heart of Hospice Award. She was also an active member and supporter of NHPCO, serving as chair of the NHPCO board (1994), and as a member of the National Hospice Foundation's board of trustees, where she served as chair (2011-12).

continued on next page

All end-of-life care models must honor the patient's and family's unique experiences....



Print This Article

Get Involved in My.NHPCO

One of the easiest ways to get involved in the NCHPP CEO/ Executive Director/President Section (or any NCHPP Section) is to utilize NHPCO's professional networking site, My.NHPCO.

Each NCHPP Section has an eGroup (much like NHPCO's old listserves, but better). Just visit the [My.NHPCO website](http://www.nhpc.org) to watch the introductory tutorial, then go to the tab, "Getting Started," for details:

Information about NCHPP is also available on the NHPCO website: www.nhpc.org/nchpphome.

The screenshot displays the My.NHPCO website interface. At the top, there is a navigation bar with links: HOME, MY PROFILE, DIRECTORY, LIBRARIES, EGROUPS, BLOGS, and EVENTS. A search bar is located on the right. Below the navigation bar, the page is divided into several sections:

- What's Hot:** Includes QUICK LINKS (Communities, Members, eGroups) and UPCOMING EVENTS (Tools and Models for Building an Effective Compliance Program, Complex Symptom Management in End-Stage Liver Disease, HIPAA and HITECH - Ensuring Compliance).
- In the Know:** Features a FEATURED VIDEO and LATEST eGROUP DISCUSSIONS (RE:V66.7, Request for Massage Therapy Competencies for Allied...).
- Our Community:** Includes GETTING STARTED (1. Customize your profile and preferences, 2. Adjust your subscription settings, 3. Start a conversation - post a message in one of the eGroups, 4. Start networking - go to the Directory and Find a Member to connect with), Care, Share, Connect (Learn From Others), and MOST ACTIVE MEMBERS FOR THE PAST WEEK (Natalasha Beauchamp, Valerie Hartman, Brianna DeLaRosa, Brandi Townley, Julia Francis).
- ANNOUNCEMENTS:** 2012 Webinar Packages (Stay connected and on the pulse of change in the hospice and palliative care industry...), Include Professional Development in your Budget!
- MARKETPLACE ITEM OF THE WEEK:** Download the 2012 Educational Catalog.
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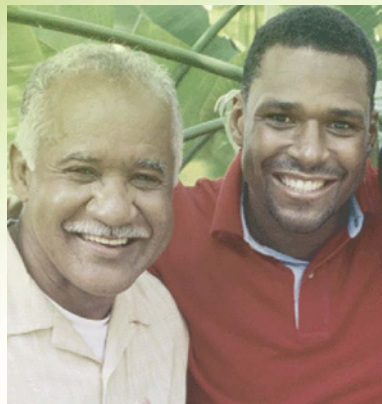
Cocktails and Silent Auction

7:30pm

Dinner, Awards and Live Auction
Dancing and Dessert to follow

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Hospice in the Continuum:



In this monthly feature, *NewsLine* shines the light on a hospice organization which has expanded services or has partnered with other community organizations to reach patients earlier in the illness trajectory—before they may need hospice care. In a Q&A format, members hear firsthand from the organization's senior leaders who speak directly to the challenges, the benefits, and the lessons learned.



Hope PACE

Hope HealthCare Services, based in Fort Myers, Florida, was one of the first providers in the state to launch PACE (Program for All-inclusive Care for the Elderly). Today, its program, Hope PACE, serves 300 clients each day at four centers on South Florida's Gulf Coast and is considered one of the country's model programs.

At one time, PACE was not considered a viable expansion option for many hospices, namely due to the start-up costs associated with building a "center" to serve as the hub for most PACE services. But has this changed, especially in light of healthcare reform's focus on coordinated care?

In this interview, Hope HealthCare Services president/CEO, Samira Beckwith, who serves as treasurer and national director on the NHPKO board of directors, talks about her experience and PACE's place within the evolving healthcare continuum.

Can you briefly recap Hope's expansion into PACE?

We began to explore the feasibility of offering PACE in the early 90s after a community needs assessment, and worked with the State of Florida to open the state's second PACE program in Fort Myers in 2008. The site was immediately embraced by the community. According to our quality surveys, 100 percent of the participants responding said they would recommend PACE to others.

Following the introduction of PACE in Fort Myers, we opened a new Hope Hospice House in Lehigh Acres in 2010 that includes our second PACE center. There were economic, logistical and other advantages in building a dual-purpose facility. Later in 2010, we opened our third PACE center in Port Charlotte. And this year, we will expand our services with a fourth center.

The increased visibility of the multiple centers has helped to build the knowledge about PACE services as well as our other Hope programs.

Quick Facts About PACE

What is PACE?

It is a coordinated-care program for people, age 55 or older, with health conditions that make them eligible for nursing home care, but otherwise able to live safely at home with support.

What services are provided?

Services, which are usually provided in PACE centers, include primary and specialty medical care; in-home support; prescriptions; therapies; meals; social programs; dental care; and hospital and ED services.

Who pays for PACE?

PACE is a blended payment stream from Medicare, Medicaid and Medicare Part D, which is reimbursed on a per client, per-month basis.

How many PACE sites are there?

According to the latest data from the [*National PACE Association*](#)[™], there are 75 PACE programs in 29 states.

Your organization has been a frontrunner in offering an array of “pre-hospice” services. Did your involvement in other services make your entry into PACE easier?

Hope has provided hospice care in Florida for more than 30 years. Over time, we found that many other people with unmet needs would benefit from our core competencies and in fact wanted our care. However they did not meet the prognosis criteria, so we began to search for other programs. We knew we could do more, particularly in light of the oncoming surge in the population of aging baby boomers, who will live longer and require more care.

Hope HealthCare Services was designated as our umbrella name as we introduced additional, person-centered, coordinated care programs that focus on the quality of life for the frail elderly and the seriously ill of all ages. Before PACE, we had implemented four other programs. *Hope Choices* is a long-term, at-home care program provided by Medicaid and the Florida Department of Elder Affairs for people 65 and older who want to continue living at home. *Hope Comfort Care* is

a community based palliative care program offering in-home symptom management and counseling for people of all ages with serious and advanced illness. Hope Connections provides home-based independent living alternatives for people 60 and older. And *Partners in Care: Together for Kids* provides pain control, symptom management, in-home care, counseling; expressive therapies and respite care for children.

So we had experience with “pre-hospice” care before the introduction of PACE. However, all of our care programs are based on utilizing our experience and skills which focus on quality of life and comfort for the person with advanced illness and their family. These programs are a natural extension of the circle of care.

While there are a lot of considerations that go into expanding into PACE, what are the first questions a hospice provider should be ask?

Hospices are ideally positioned to provide PACE care because the framework and skill needs are very similar. A community

Quick Facts About Hope HealthCare Services

- Licensed by the State of Florida since 1984.
- Serves 9 counties in southwest and mid-Florida.
- Employs 860 FTEs and 1,200 volunteers.
- Average Daily Hospice Census in 2011: 1,800
- Operates 4 Hope Hospice Houses, accommodating 100 patients.
- Provides an array of pre-hospice, and hospice and palliative care services, including:
 - 4 Comfort at Home Programs for people over 60 and the frail elderly;
 - Parkinson Program;
 - Kids Care; and
 - Support Programs, including grief support in the workplace and for families of Veterans.



assessment of gaps in care and a desire to expand access are good first steps. Hope also serves as a technical assistance center for agencies that are interested in exploring the feasibility and community needs [see end of article for details].

What would you say are the key factors that impact a provider's success as a PACE provider?

Primarily, the same factors that impact success as a hospice provider. A successful PACE program will be built on the same level of skills, experience and commitment to quality care. Like hospice, PACE interdisciplinary teams must ensure that all areas of the individual's care are monitored and addressed so that the individual will live comfortably, with dignity. As in hospice, care management is always focused on the needs, preferences and goals of the individual. Both programs are paid in a capitated manner and require the provider to be able to manage risk.

Based on your experience, what would you say are the ballpark startup costs for becoming a PACE provider? Does being a provider of interdisciplinary care provide any cost efficiencies?

PACE startup costs will depend on how the program is to be structured. The plan for the center itself is a primary consideration: A facility must be constructed, leased, or developed as part of an existing property.

Efficiencies may be found in building capacity if the PACE center is co-located with a hospice house, as with our second PACE center. A number of our hospice staff members transferred to Hope PACE, which resulted in HR and training-related efficiencies. Hospice administrative functions such as HR, IT, Finance and Marketing can support PACE with minimal additions to staff. Hospice and PACE marketing and outreach focus on very similar population segments.

Can you tell us about the demographics of the PACE clients you serve?

PACE clients must be 55 or older and eligible for nursing home care. Our current clients range in age from 55 to 95 and most are dually eligible for Medicare and Medicaid, with a variety of health issues. One common denominator for many participants is transportation needs, which are met as part of the program.

continued on next page

Efficiencies may be found in building capacity if the PACE site is co-located with a hospice house.

What is the collaborative relationship between Hope PACE and hospice?

Hope PACE contracts with hospice, so PACE participants are also able to receive the benefits of hospice care while in the PACE program. PACE clients can transition seamlessly into hospice care at the appropriate time.

From a purely business standpoint, what have been some of the tangible benefits in becoming a PACE provider?

The PACE program has proven to be a much-needed service, further establishing Hope as ‘part of the local healthcare safety net’ and ‘weaving us’ into the fabric of the community. It has enhanced the respect, trust and confidence from people living in the community and that translates into more referrals for PACE, hospice and other care programs. As we all know, hospice may not be readily accepted by those who have never experienced our specialized kind of care. Our PACE participants understand Hope focuses on exceptional care and quality of life, opening the door to other services as needed.

Can you recall some of the early challenges? And did you encounter different challenges when launching the newest site in Naples?

Among the original challenges was creating awareness of this unique set of benefits. One of our clients told us that her friends were skeptical about the program, because it sounded ‘too good to be true’! Early on, we found that one of the best ways to promote the program was by reaching out to adult children, often family caregivers, to let them know we can alleviate their concerns about the safety and well being of their parents.

The extension of PACE services in Naples has been well accepted since we have been providing a nursing home alternative program there for nearly 10 years. In general, since many people in our community are familiar with Hope Hospice, it gives them confidence in PACE as well as our other programs. We also have established the trust of other healthcare professionals who refer to us, as they have become more aware of our work.

Do you see PACE, as a coordinated care plan, as a necessary part of our future? Should more hospices be considering how to do it, versus why they can’t?

As we began introducing new programs of care, some hospice providers asked if we shouldn’t just stick with our specialty—hospice—rather than trying to branch out. Our answer was that “we do specialize.” All of our programs are focused on quality of life, comfort, dignity, safety and peace of mind. Each program utilizes essentially the same skills, expertise and experience, benefiting everyone in much the same way. Rather than branching out into something completely different, we are simply expanding our circle of care—our community safety net—to reach more people in need.

America’s demographics are changing. More people need more care for a much longer period of time than ever before. The family dynamic has also changed. For example, in many instances, family caregivers are no longer available. So many people come to us because they want to continue living in their private home rather than moving to a facility. Through

PACE, we bring the services to them, as they can't always access them on their own. Hospice and PACE share the same values and culture. For all of these reasons, PACE is indeed a necessary part of our future and should be given serious consideration by hospice providers.

What do you think of partnering to provide PACE? Have you heard of other innovative ways to bring the service to the community if the hospice is reluctant to take it on alone?

There are many great advantages and benefits in partnering as well as collaborating to provide PACE. Working with other healthcare organizations can create a value-based partnership that will enable a group of providers to work together in order to add needed services. Really, all options should be explored and each community should adopt a structure and approach that works best for that community.

In our service area, there were no other providers that wanted to participate in beginning PACE—though they were supportive of our efforts. However, we have taken advantage of a number of long-term collaborative relationships, which have

maximized the effectiveness of the program. We collaborate with other healthcare organizations; non-profit agencies such as the United Way and a local elder abuse coalition; senior services; and civic partnerships such as the faith community and veterans organizations. Each organization has brought new opportunities and synergies. For example, Meals on Wheels agreed to distribute our PACE brochures along with their home-delivered meals, enabling Hope to reach a very large portion of our target demographic.

You recently formed the Florida PACE Association, where you're now serving as president.

What's the goal of this group?

The Florida PACE Association is a collaborative organization of PACE providers dedicated to providing healthcare to frail, older adults in Florida. We are working together to assure the success of PACE efforts so frail elderly Floridians have access to the program. We can also support the State of Florida by predicting healthcare costs.

Are there similar associations in other states?

The number of state associations is beginning to increase because of the need to work together

Rather than branching out into something completely different, we are extending our circle of care.

continued on next page

to address social, legislative, regulatory and education issues.

Do you have some general guidelines for the provider who hasn't engaged in any real expansion today, but is interested in PACE?

I would encourage everyone who is interested to visit a PACE center. You are welcome to visit our centers in Florida! Suncoast Neighborly and Chapters Health System also have excellent programs. Our Hope/HMA technical assistance center is delighted to share our experiences and consult

with other hospices. [This fee-based service is a cooperative effort with Health Management Associates (HMA). To learn more, contact Samira Beckwith (239-489-9157) or Susan Tucker at HMA (850-222-0310).]

I'd also suggest that you assess your community's needs to determine if there is an adequate demand for services. As you begin the PACE application process, you will gain access to start-up funding and other tools you will need. [See page 33 for NHPCO's free community assessment tool.]

Do you have plans for future expansion or diversification?

As Will Rogers used to say, "Even if you are on the right track, you'll get run over if you just sit there." That is a great reminder that healthcare needs will continue to grow and change and, as providers, we must always be mindful of future needs. I am confident that Hope will continue to expand with PACE, as we explore other innovations—new and better ways to serve the community.

**Are you offering a non-hospice service too?
And would you like your work spotlighted in *NewsLine*?
Complete our brief questionnaire.**

A Free Tool to Help Assess Your Community's Needs

Those hospice providers which have the capacity and interest to expand their services to meet unmet needs in their communities now have a new tool at their disposal—NHPCO's [Continuum of Care Assessment](#).

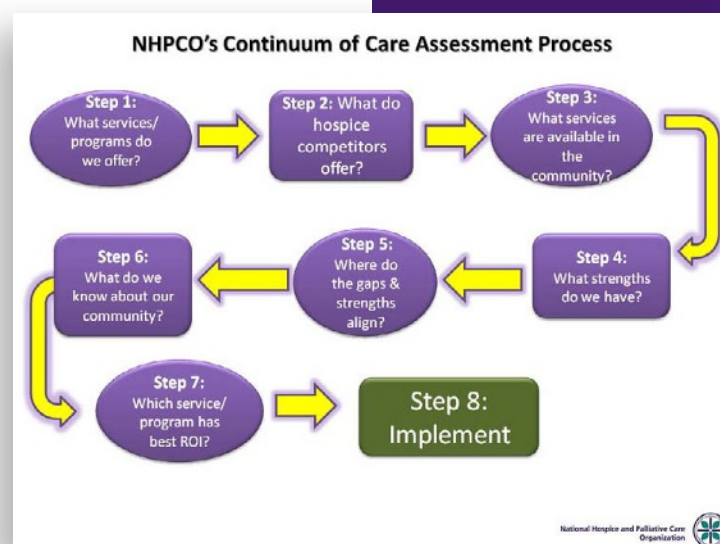
Designed as an Excel Workbook, the Assessment guides you through an eight-step process to help you determine unmet needs and your ability to fill them, either alone or in collaboration with other providers. The eight steps, which are presented as separate tabs in the Excel Workbook, include:

1. Internal Hospice Assessment
2. Hospice Competitor Assessment
3. Community Services Assessment
4. Organizational Strength Assessment
5. Prioritizing and Mapping Gaps and Strengths
6. Community Data and Trends
7. Determining Return on Investment
8. Implementation

Keep in mind that the Assessment may take several weeks or months to complete. To facilitate interdisciplinary perspectives and input, NHPCO recommends that you form a workgroup to complete the Assessment in collaboration with your organization's leadership team and other stakeholders.

At the conclusion of the process, you will have detailed information about the types of services offered in your community, as well as the assets of your organization that can be leveraged to develop new services or enhance those you already have.

Designed as an Excel Workbook, the Assessment guides you through an 8-step process



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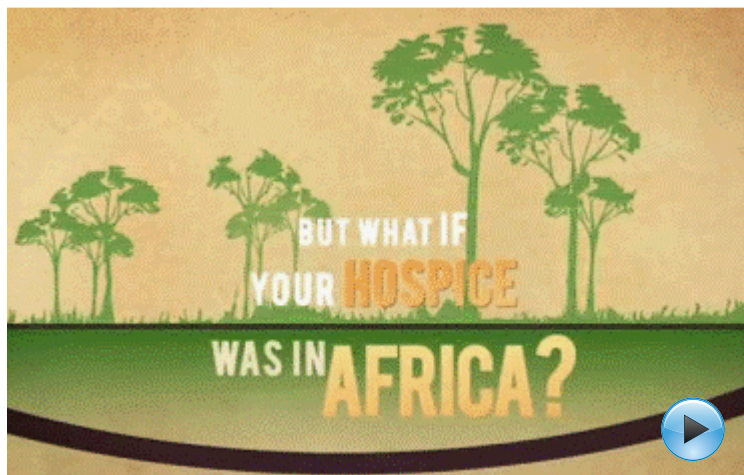
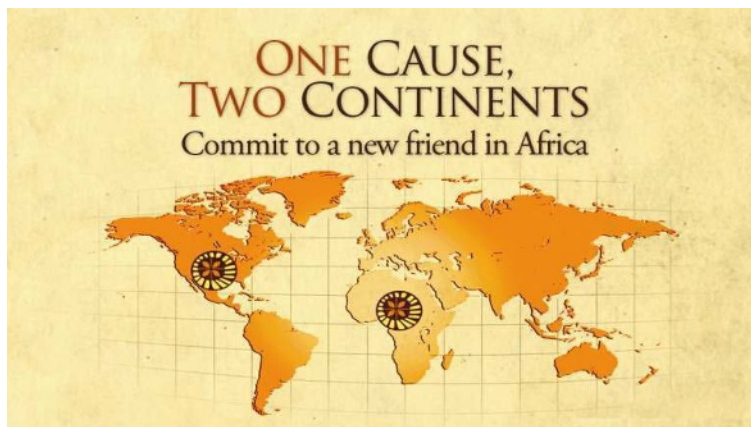
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Why Partner with a Program in Africa? A New Video Speaks to the Reasons in a Very Creative Way

Last October, NHPCO affiliate, FHSSA, launched the campaign, “One Cause Two Continents: Commit to a New Friend in Africa.” The goal is to recruit more U.S. hospices to partner with African hospices in need as part of FHSSA’s Partnership Program.

While the successful program now has 95 U.S. hospices which partner with African programs (including new partners Kaiser Permanente Oakland Hospice and Susquehanna Hospice), there are still 18 African hospices in need of a partner. These hospices are located in 11 countries across Africa and are as diversely structured as those in the U.S.— from hospital-based palliative care programs and freestanding in-patient hospices to home-based palliative care programs.



So why consider partnering? And what do you have to do?

A new video answers these questions in just about 3 minutes. Created by the digital animation and visual design firm, Pixeldust Studios, in partnership with FHSSA, the video uses 2D animation and graphics to bring home the very real needs—and the many benefits of partnering—in a creative way.

[Watch the video now](#)—and share it with your colleagues and staff.

Then, to learn more about partnering, see the [feature article in November NewsLine](#) or visit the [FHSSA website](#). Or email Erinn Nanney on the FHSSA team (enanne@fhssa.org).

NHDD is April 16: Let's Keep Up the Pace!

April 16, 2012 will be the five-year anniversary of National Healthcare Decisions Day (NHDD), a national day of observance that was established to inspire, educate and empower the public and providers about the importance of advance care planning.

So What Can You Do?

Anything and everything to help raise awareness of this important day and what it stands for. For example....

- **Link to the New NHDD Video:** NHDD organizers have created a wonderful three-minute video about the importance of advance care planning that is posted on the [NHDD homepage](#). NHPCO members are encouraged to post a link to the video on their own websites or in their social media. The video is also available on disk, free of charge, for use at public programs, on closed-circuit TV, or elsewhere (simply complete a [brief consent form](#)).
- **Host an Event:** Ask your local bar association to provide a volunteer speaker and host an educational event for the public at a nearby library, school or church.
- **Distribute Information:** Ask your volunteers to hand out advance directive forms and other information at the movie theater as people leave a film.

NHDD organizers have more suggestions on the [NHDD website](#), along with logos, templates and tools to make outreach easy.

Do Your Efforts Make a Difference?

Absolutely! Public awareness has improved steadily each year since NHDD was established:

- At least 1 million members of the general public participated in NHDD events and/or were known to have received advance directive information.
- Over 2 million people were exposed to NHDD via various social media outlets.
- Over 17,500 advance directives were completed on the four NHDDs alone.

See the NHDD [“Report Card”](#) for more about its positive impact—and join NHPCO and other NHDD participants in promoting April 16 and the importance of advance care planning.



MSN Change: Over a Year of Advocacy Pays Off!

For more than a year, NHPCO has been advocating for changes to the Hospice Medicare Summary Notice (MSN) with the Centers for Medicare and Medicaid Services (CMS).

NHPCO's discussions with CMS began as provider members described in detail the confusion these notices were causing among some patients and families. For example, the notices list charges incurred per discipline, even though hospice services are billed on a per diem basis and the hospice does not bill Medicare for the individual services. Such confusion was even causing some patients and families to revoke hospice services.

On January 26, 2012, NHPCO's advocacy efforts paid off. In CR 7675, CMS announced a series of helpful changes that will make the notices more reader-friendly and less confusing to patients and

families, as illustrated in the example below. (Note: No changes will be made to how hospice physician services are displayed.)

These changes will take effect on July 1, 2012 and will be implemented on July 2nd. For details, see the [NHPCO Regulatory Alert](#) (January 31, 2012).

		Description of payment as a part of the hospice daily rate – no visit charges in this column. See the footnote.	
Number of nursing visits	20 Routine Home Care	\$2000.00	
	5 Skilled Nursing Visit		b
	6 Medical Social Visit		b
Number of social work visits	1 Continuous Home Care	\$600.00	
	1 Skilled Nursing Visit		b
	1 Medical Social Visit		b
Claim Total		\$2600.00	
b Payment for this hospice service is included in the payment for the hospice daily level of care. You shouldn't be billed for this service.			

New Volunteer Outreach Materials Now Online

Every year, NHPCO provides members with a range of outreach materials to help them recognize the volunteers in their programs during National Volunteer Week—and throughout the year.

This year's theme, "We Care, We Listen," mirrors the theme of NHPCO's [2011-2012 Outreach Materials](#) for consistent messaging.

Here's a snapshot of the materials you'll find online—all free to use as you see fit (as a benefit of NHPCO membership!):

- Volunteer Week Ad – 1 (featuring Hospice Quilt)
- Volunteer Week Ad – 2

- Recognition & Outreach Ideas From Providers
- Press Release Template
- Proclamation Template
- Facts on Volunteering and Hospice
- Volunteer Recognition Logos

See [Outreach Materials for Volunteer Week](#) for these materials and more.

Also, see page 40 for gift items available from *Marketplace*.



Actor and Hospice Advocate Torrey DeVitto Designs T-shirt to Raise Awareness

As part of her role as NHPCO's first Hospice Ambassador, actor and hospice volunteer, Torrey DeVitto, designed a special t-shirt to help raise awareness of hospice—especially among her young fans and their parents.

The front of the t-shirt (as modeled by Torrey at right) features the hospice message, "Comfort – Love – Respect." On the back is a reminder that "hospice is about how you live" and reflects Torrey's passion for the work we do.

Torrey is an accomplished actor currently appearing in the CW hit-series, *The Vampire Diaries*, and on the ABC Family TV series, *Pretty Little Liars*. She has co-starred in *One Tree Hill*, the series *Beautiful People*, and has been seen on shows such as *Castle* and *CSI-Miami*.

To learn more about Torrey, including why she became a hospice volunteer four years ago, see [February NewsLine](#).

To order the t-shirt, see the NHPCO Marketplace [Order Form](#).



Torrey will be attending **2012 MLC**, and the **NHF Gala on March 30**. If you will be attending, be sure to say hello and thank her for her support.

NHPCO's Hospice and Palliative Care Professional Scholarship Program

Supported by an educational grant from Glatfelter Healthcare Practice

**ARE BUDGET
CONSTRAINTS
RESTRICTING YOU
FROM ATTENDING
THE MLC?**

**Applications are now being accepted
for the Hospice and Palliative Care
Professional Scholarship Program.**

Scholarship recipients will receive one complimentary full conference registration to the **27th Management and Leadership Conference**. For eligibility criteria and to apply, visit www.nhpco.org/mlc2012. Space is limited, so submit your application today.

National Hospice and Palliative Care
Organization



Glatfelter
Healthcare
PracticeSM
A Division of Centimark Insurance Group

www.nhpco.org/mlc2012

Volunteer Recognition Week

Milestone Lapel Pins

Never worry about volunteer recognition again! These exciting new milestone lapel pins can solve it all! Each yearly design comes in a beautiful and distinct color, featuring an elegant symbol of excellence and achievement in the center of the pin.

The Olympic torch incorporated into a "V" for volunteer and surrounded by laurel leaves is raised in 14K gold layered surface.

HOSPICE



Enlarged to show detail
Actual size 1" high

821080	821081	821082	821083	821084	821085
821086	821087	821088	821089	821090	821091

Hospice Volunteer Milestone Recognition Lapel Pin

Select the specific year, from one year to ten, fifteen or twenty! Each pin has "Hospice" text distinctly featured under the centerpiece design to specifically recognize your volunteer's hard work and dedication.

Buy More and Save!

HOSPICE AND PALLIATIVE CARE



Enlarged to show detail
Actual size 1" high

821092	821093	821094	821095	821096	821097
821098	821099	821100	821101	821102	821103

Hospice & Palliative Care Volunteer Milestone Recognition Lapel Pin

Select the specific year, from one year to ten, fifteen or twenty! Each pin has "Hospice & Palliative Care" text distinctly featured under the centerpiece design to specifically recognize your volunteer's hard work and dedication.

QUANTITY	MEMBER	NONMEMBER
149	\$3.25 EACH	\$5.25 EACH
50+	\$2.95 EACH	\$4.95 EACH

For more information

CALL 800/646-6460 GO TO WWW.NHPCO.ORG/MARKETPLACE

April 15th – 21st

National Hospice and Palliative Care
Organization



National Volunteer Week is in April! Acknowledge your hard working volunteers with this wonderfully coordinated collection of handy items specifically designed for them!

A. Hospice Volunteer Tote Bag

The beige with orange trim Hospice Volunteer tote bag is an eye catching tote that keeps you organized while on the go. The front features a pen loop (pen not included) for easy access, a large main compartment with zippered closure, an interior organizer for pens, MP3 player and business cards. It is made of 400 denier polyester and is 17.5" x 14" x 3".

Item #: 821477

Member: \$13.00

Non-Member: \$17.00

B. Hospice Volunteer Note Pad

The Hospice Volunteer purple or white 4" x 5 1/4" spiral notebook with an attached folding mini pen is perfect to keep your notes or to give as a gift.

Item #: 821478

Member: \$5.95

Non-Member: \$8.95

C. Hospice Volunteer Lunch Bag

Enjoy your lunch in style with a Hospice Volunteer silver lunch bag made of 600 denier polycanvas. Features include a dual zippered insulated main compartment, an additional outside pocket, mesh side catch pockets, and an adjustable black comfort shoulder strap. The size is 8" x 7" x 5" and will hold a lot.

Item #: 821479

Member: \$10.95

Non-Member: \$13.00

D. Hospice Volunteer Photo Frame

Brighten up your day with your favorite photograph. The Hospice Volunteer white photo frame has a digital display desk clock, calendar and alarm functions. It also includes wall pegs or a stand. The AA batteries are included but not inserted.

Item #: 821480

Member: \$12.95

Non-Member: \$15.95

E. Hospice Volunteer Bookmark

Celebrate this special week with a Hospice Volunteer bookmark. The white 2" x 7" laminated 10 point coated paper bookmarks have a white tassel.

Item #: 821481

Member: \$1.00

Non-Member: \$1.50

F. Hospice Volunteer Keylight

Light up Volunteer Week with a silver oval key light with a white LED light. The button cell batteries are included.

Item #: 821482

Member: \$5.00

Non-Member: \$7.00

G. Hospice Volunteer Travel Mug

This 16 ounce silver stainless steel travel tumbler is a great way to display the Hospice Volunteer logo while quenching your thirst. The tumbler has an insulated steel outer wall and plastic liner. The lid screws and has a slide opening. Keep it for yourself or get one to give to others.

Item #: 821482

Member: \$12.95

Non-Member: \$15.00



G.



C.



B.



E.



A.



F.



D.



For more information

CALL 800/646-6460 GO TO WWW.NHPCO.ORG/MARKETPLACE



Robert Pittinger Honored for Service to the Community

Robert Pittinger, the facilities manager for Hospice by the Sea, Inc. (HBTS), based in Boca Raton, FL, received the 2011 Senior Achievement

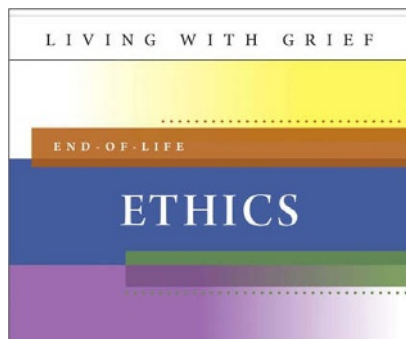
Award presented by the American Health Association. He joins seven other honorees who have displayed exceptional leadership abilities and a genuine commitment to community service.

HFA Program to Focus on Ethics

The Hospice Foundation of America (HFA) 2012 “Living With Grief” program, to be held on April 19, will explore the ethical dilemmas that are likely to arise at the end of life as well as the principles of ethical decision-making and the effects of these decisions on staff and families. The live event, which will be viewed from host sites around the country, will include a panel discussion of several case studies. Timothy Kirk, PhD, a member of the NHPCO Ethics Committee, will appear in a video roll-in.

NHPCO, an in-kind sponsor of the event, will utilize conference space at the National Center to serve as a host site and encourage community

attendance. To learn more, visit the [HFA website](#).



Hospice of Hope Named Among Best Places to Work

Hospice of Hope (Maysville, KY) has been named one of the best places to work in Kentucky by the Kentucky Society for Human Resource Management, in conjunction with the Kentucky Chamber of Commerce.

Winners from across the state were selected in two categories (small/medium-sized employers and large-sized employers with 250-plus staff), and selection was based on an assessment of employee policies and procedures and the results of an internal employee survey.



Hospice of Santa Cruz County Names New Chief Medical Director



Hospice of Santa Cruz County (based in Santa Cruz, CA) has named Vanessa Little, D.O., chief medical director.

Little pursued specialty training in hospice and palliative care at the University of Connecticut and Connecticut Hospice, and was also a participant in the Metta Institute's End-of-Life Care Practitioner Program. Prior to this appointment, she served as a hospice medical director and as a co-medical director of a hospital-based palliative care consult service.

Satu Johal Receives CFO of the Year Award

Satu Johal, CFO at Pathways Home Health & Hospice (based in Sunnyvale, CA), received the *Silicon Valley Business Journal's* 2011 CFO of the Year Award in the category of nonprofit company. Johal was honored for her ability to navigate current economic challenges and for her skill in dealing with a myriad of financial regulations.



Teachey (on right) with the Governor.

Hospice Care of South Carolina Advocates for Better Pediatric Palliative Care

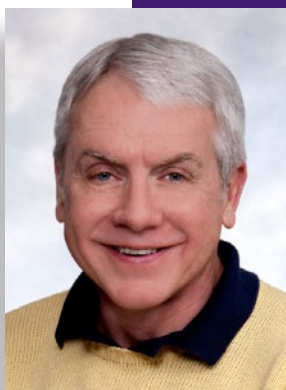
Michele Teachey, CEO of Hospice Care of South Carolina (HCSC), met with South Carolina Governor, Nikki Haley, to discuss concurrent care and pediatric palliative care. The discussions centered on the current landscape and the obstacles that need to be removed in order to streamline quality care for children.

Mark Murray Helps Lead First-ever Hospice and Palliative Care Class at Notre Dame

An interdisciplinary team of physicians, social workers, nurses, and other hospice professionals from Center for Hospice Care (based in South Bend, IN) recently offered the first-ever "Introduction to Hospice and Palliative Care" class at the University of Notre Dame.

The class, which was attended by more than 90 students, covered a variety of topics, including understanding the hospice model; the roles of interdisciplinary team members; and the grieving process.

Mark Murray, the president/CEO of Center for Hospice Care (CHC) and chair of the NHPCO board, teamed up with Dominic Vachon, director of the Ruth M. Hillebrand Center for Compassionate Care in Medicine, and Mike Wargo, the COO of CHC's Hospice Foundation, to organize and present the first class. [Based on their success, the University plans to make the class an annual offering.]



The Regulatory Hat that Every Hospice Physician Must Wear



“It’s rare now to have a day go by without getting a question from a physician, nurse or administrator about an issue that involves the COPs, Face to Face, or some other regulatory topic,” says Ed Martin, MD, MPH, the medical director of Home and Hospice Care of Rhode Island.

Dr. Martin’s experience is not unique. Today, hospice physicians must be knowledgeable about both the medical care of their patients as well as the federal/state regulations and accreditation standards (as applicable) that guide how hospice care is delivered.

While the hospice medical director is responsible for the medical component of the hospice patient’s plan of care (that must be guided by the Medicare Hospice CoPs), all hospice physicians serve as key decision makers in the plans of care and lead the interdisciplinary documentation.

Given their expanding role, it is more important than ever for hospice physicians to stay up to date about the latest regulations, billing, audits, and myriad other issues. A knowledgeable hospice physician and his or her

documentation of the patient’s condition can make the difference in the outcome of a claims appeal, compliance audit, or state/federal survey.

NHPCO offers a variety of resources for hospice physicians. Here are just two to share with the physicians in your program:

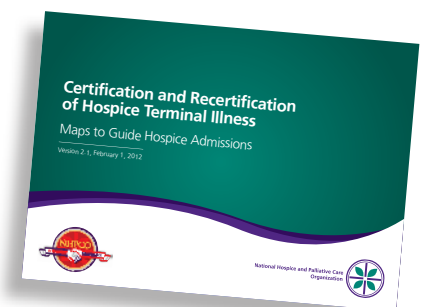
Physician Guide to Hospice Care (Item 714384)

This guide explores the current regulatory landscape and provides hospice physicians with practical advice and resources. It includes appendices on the Hospice CoPs; Criteria and Lab Values for Non-cancer Diagnoses; Evaluative Scales for Determining Functional

Limitations; Patient and Family Resources; and a complete copy of the “Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases.”

Just Updated: Certification & Recertification of Hospice Terminal Illness (Item 821733)

This popular laminated pocket guide, with maps to guide hospice admissions, has just been updated to reflect the most recent regulatory changes.



MLC—Stay Up to Speed and Earn CME

Management and Leadership Conference

March 29-31, 2012

Preconference Seminars: March 27-28

- NHPCO is accredited by the Accreditation Council for Continuing Medical Education.
- More than 100 sessions qualify for CME—an excellent way to earn up to 26 CME credits.

“I have been working in hospice for 25 years and the regulatory environment has never been more challenging. The MLC helps me to keep up with this ever-changing area.”

*Ed Martin, MD, MPH
Medical Director, Home and Hospice Care of Rhode Island*

NHPCO's Upcoming Educational Offerings

Conferences

Webinars

E-OL

Webcasts

The best way to keep informed of the changes occurring in the hospice and palliative care field is to take advantage of NHPCO's diverse range of educational offerings.

Our goal is to ensure that you and your colleagues are well-informed and better able to deliver quality end-of-life care to all members of your community.

To learn more about our upcoming national conference, our series of timely Webinars, and our E-OL distance-learning courses, just click on the tabs above.

For full details, please visit the NHPCO website:
www.nhpc.org/education.

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If you are reading a PDF of this issue, please read the digital edition to access the information on the featured tabs. The digital edition is available on www.nhpc.org/newsline.

Videos Worth Watching



The Office of the Inspector General (OIG) has now posted online a new video and audio podcast presentation on “Tips for Implementing an Effective Compliance Program.” This presentation is part of its HEAT Provider Compliance Training (PCT) series and describes six steps to implement and operate an effective compliance program in a healthcare entity. You can view all seven PCT videos and podcasts, as well as an introductory video by the Inspector General right from the [OIG website](#).

National Hospice and Palliative Care Organization



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Affiliates:



Links to Some Resources on the NHPCO Website

Outreach

[2012 Volunteer Week Materials](#)

[2011-12 Outreach Materials](#)

[Resources to Reach Underserved Populations](#)

Quality and Regulatory

[Quality Reporting Requirements](#)

[QAPI Resources](#)

[Past Regulatory Alerts](#)

[Past Regulatory Roundups](#)

[Hospice Compliance Calendar](#)

[Staffing Guidelines](#)

[Standards of Practice](#)

[Quality Partners Self-Assessment System](#)

Publications

[Past issues of weekly NewsBriefs](#)

[Past issues of monthly NewsLine](#)

[Past issues of ChiPPS Newsletter](#)

Professional Education

[2012 Monthly Webinars—including new Quality and Regulatory track.](#)

[Upcoming Conferences](#)

[End-of-Life Online \(distance learning courses\)](#)

[Webcasts](#)