By Melanie P. Merriman, PhD, MBA, Martha Tecca, MBA, and Heather P. Wilson, PhD

While Medicare surveys differ significantly state to state, many a hospice provider can tell the story of a survey that felt like an episode of Law and Order. So the overall shift in emphasis within Subpart C (Patient Care) of the proposed Conditions of Participation (CoPs) should be welcome.

Where the existing CoPs, in force since 1983, focus on prescribed patient care practices, the proposed CoPs, due to be final by May 2008, take an outcome-oriented approach that allows hospices more flexibility in the processes used to achieve quality care. With increased flexibility, however, comes increased responsibility for improving performance. It is as if CMS is saying ‘We’ll back off a little in telling you what to do, but you will have to show us that what you choose to do leads to quality care and better patient outcomes.’ To be sure, the proposed CoPs still include many requirements, but these are focused more on processes known to improve outcomes, and they address the primary deficiencies identified via surveys in recent years.

Subpart C (Patient Care) of the CoPs is anchored by three core conditions—Patient Rights, Comprehensive Assessment of the Patient, and Interdisciplinary Group Care Planning and Coordination of Services. It is continued on page 5

Inside:

Excerpts from Don’s MLC Presentation
At this April’s Management and Leadership Conference, president/CEO, Don Schumacher, addressed the realities of today, and the trends and changes in healthcare, federal spending and public policy that will impact our future.

See page 10.
Your Membership

Dues at Work:

A number of improvements to NHPCO’s member database and the online interface between the database and nhpco.org have been completed. We hope members have noticed improvements to online conference registration and Marketplace shopping. NHPCO wants to share another major upgrade with you.

**Now It’s Easy to Manage Your Organization’s Roster**

The person in your organization who you’ve designated as the “primary contact,” can access NHPCO’s roster of your organization’s staff. The primary contact can verify the names of those individuals listed and make any necessary adjustments. This makes it easy to remove individuals who are no longer employees, and to add new staff and volunteers to the roster.*

How is this done? The primary contact for your organization—or for your location if you have multiple sites—would log on to nhpco.org, using their individual ID and password. Once logged in, a “Manage Company” link will appear on the left-hand navigation bar (below the “View Profile” link). The “Manage Company” link directs primary contacts to the “Manage Organization Information” page where your organization’s roster can be edited.

Keep your eyes on our e-newsletter, NewsBriefs, for news of additional upgrades!

* As provider members, all staff and volunteers are eligible for free NCHPP membership. When you add staff to your organization’s roster, they are automatically enrolled as an NCHPP member and will receive an individual ID and password to access the members-only section of the NHPCO Web site. For details about NCHPP, contact Member Services at 800/646-6460.
Our Responsibility Is to Serve All Eligible Patients

Over the course of the year, we have continued to bring relevant topics to you through the pages of NewsLine, many written by some very notable experts in our field. In this issue, our cover story looks at the proposed Hospice CoPs, due to be final in May of 2008. For those of you unable to attend this past April’s Management and Leadership Conference, you’ll also find key messages from my opening address.

In NewsLine and throughout all of our publications, we have consistently mentioned the fact that hospice will be facing more scrutiny in the future to include the public, our regulators, and Congress as well as other healthcare sectors. This is a certainty.

Increased oversight can be a good thing as it ensures we are meeting our obligations as care providers that serve all eligible patients. There is a key word in that last sentence that I do not use lightly—eligible. One of our responsibilities as providers is to reach all eligible patients in need while also taking into account regulatory guidelines and compliance. As professionals in the field, it is our responsibility to know these regulations.

We must keep the integrity and purpose of hospice as our key focus. The Medicare Hospice Benefit is a benefit for those at the end of life. It is not a chronic care benefit.

This message is not intended to keep you from reaching out and increasing access. In fact, one of the greatest tragedies we could suffer would be to overreact and not admit patients who need us as they face the difficult journey at the end of life. However, we must not admit patients who don’t qualify for hospice by using the often-misunderstood term “open access.”

Without doubt, more people at the end of life can benefit from our services, so we must look beyond the Medicare Hospice Benefit to serve their needs. But, we must also recognize factors of eligibility in admitting patients.

The Quality Partners program has been constructed with our hospice standards as a core component. NHPCO’s regulatory pages (nhpco.org/regulatory) are being constantly updated.

We’ve also set up a new online resource (nhpco.org/access) with helpful materials.

NHPCO is working hard to support you in your mission to reach eligible patients in need. Please keep up the good work!

J. Donald Schumacher
President/CEO
Lehigh Valley, PA

Named again as one of “America’s Best Hospitals” by U.S. News & World Report, Lehigh Valley Hospital and Health Network (www.LVH.org) is seeking a visionary Medical Director to lead our Medicare-certified Hospice Program. Lead interdisciplinary team approach to patient care and care planning, provide comprehensive oversight for the medical management of patients, interface with PCPs and facilitate outreach opportunities. Growing program includes 10-bed hospice unit and averages 100+ home and community-based visits. Take advantage of strong institutional support and donor-based funding along with opportunity to work with network’s new palliative care program.

Ideal physician will have experience in hospice care and be fellowship-trained or possess certification from the American Academy of Hospice and Palliative Medicine.

The Lehigh Valley is an attractive, growing area of 750,000 with a moderate cost of living, excellent suburban schools, ten colleges and universities and an array of recreational and cultural offerings. Philadelphia is 60 minutes south and NYC is 90 minutes east. LVH offers an excellent compensation package including fully paid medical insurance for self and family. Please email CV to Frank.Gallagher@LVH.com or call 610.969.0275/76 for more information.

Advocacy

As a pioneer in the hospice movement, as an advocate for the rights of the terminally ill, VITAS has been a leader in expanding hospice access to population groups historically underserved by healthcare providers.

- VITAS cares for all hospice-appropriate patients referred to us, regardless of their ability to pay. In 2006, VITAS provided approximately $8.5 million in charity care services to patients and families.
- VITAS often admits patients whose treatment plan may require expensive palliative chemotherapy or radiation; patients with complicated diagnoses; patients without a primary caregiver in their home; patients who are not willing to sign a DNR order.
- VITAS and the Rainbow/PUSH Coalition have formed a national partnership to improve the accessibility to and quality of end-of-life care available to African Americans across the nation.

Wouldn’t you choose America’s hospice leader?
Please call 305.350.6957
www.VITAS.com
also anchored by one overarching condition—Quality Assessment and Performance Improvement (or QAPI).

The Patient Rights condition will replace and broaden the current informed-consent CoP to require that hospices inform patients about factors affecting palliation and comfort, as well as basic patients’ rights. This article focuses on the remaining two Patient Care CoPs, and describes ways in which comprehensive assessment, care planning, and QAPI (i.e., the “big three” conditions) are designed to work together to improve quality of care.

The Comprehensive Assessment CoP
The comprehensive assessment CoP is new and represents the first time this function is addressed in specific detail.

This proposed condition distinguishes the comprehensive assessment from the initial assessment that is required to begin care on admission. This initial assessment will replace the current requirement for an initial plan of care. The proposed CoP outlines the content of the comprehensive assessment and the timeframes in which it must be completed and updated. As would be expected, the proposed content of the comprehensive assessment (shown below) reflects the interdisciplinary model of care and includes the data needed to develop a plan of care for the patient and the family. The assessment must also include data elements that can be used to measure effectiveness of interventions and outcomes of care. The proposed condition calls for completion of the comprehensive assessment within the first four days of care, and an update every 14 days at a minimum. If the content is gathered via assessment forms used by different disciplines, as may be the case in many organizations, all of these forms would have to be completed within the prescribed timeframes.

The Interdisciplinary Group Care Planning CoP
The proposed IDG care planning CoP is explicitly linked to the comprehensive assessment CoP. The hospice interdisciplinary team must use the information from the comprehensive assessment to identify the “problems” to be addressed in the plan of care. In addition, the plan of care must include “data-driven” interventions, meaning those that are supported by data showing they typically work to relieve or at least abate specified symptoms.

This proposed CoP makes it clear that both patient and family needs, along with planned interventions for addressing them, are part of the plan of care. Just as the assessment must include data to be used in measuring patient outcomes, the plan of care must include information on patient/family goals and expected outcomes, as well as on progress toward achieving them.

**Proposed Content of the Comprehensive Assessment**

- Physical, psychosocial, spiritual needs related to terminal illness;
- Condition causing admission (objective & subjective data);
- Complications and risk factors for delivering care;
- Drug therapy — current, effectiveness, interactions, side effects;
- Bereavement assessment.
The proposed CoP requires, for the first time, an explicit timeframe for review and update; the plan of care must be periodically reviewed and updated “as designated in the plan, but no less than every 14 days.” In addition, this proposed condition includes a new standard that addresses coordination of care.

This new standard is an example of the outcome focus of the proposed CoPs, described at the beginning of this article. Hospices must achieve coordination of all disciplines and services involved in the plan of care, but they have flexibility in determining the specific systems of communication and integration.

The Data-Driven Cycle of Care
CMS suggests that the proposed assessment and care planning conditions, along with care management processes, can be envisioned as a “cycle of care” (shown below). Patient and family assessment data are used to identify “problems” and goals which drive the selection of interventions for the plan of care.

Throughout the implementation of the plan of care, reassessments identify any new problems as well as measure progress toward outcomes. The plan of care is modified as necessary to address new issues or to improve expected and actual outcomes of care.

The bridge between this “cycle of care” and the proposed QAPI CoP is the patient outcomes measure. As noted earlier, the comprehensive assessment of each patient must include data elements that can be used to measure outcomes of care. Aggregation and analysis of these patient-level data elements allow for a quantitative assessment and improvement of clinical quality across the organization.

The proposed CoPs explicitly tie the components of the data-driven cycle of care with organization-wide management processes.

THE QAPI CoP
The proposed quality assessment and performance improvement (QAPI) CoP defines the data-driven, hospice-wide management approach that measures quality of all hospice services, tracks indicators of improved palliative outcomes, monitors quality (and safety) data, identifies opportunities for improvement, and demonstrates improvement in performance.

QAPI is comprised of two different but related functions: assessing quality and improving performance. Just as patient assessment data are used to identify problems and develop an individual’s plan of care, data about hospice operations are used to (1) identify operational problems or hospice-wide care issues, and (2) develop a performance improvement plan for the organization.

In this proposed condition and its standards, CMS makes the biggest shift toward increased flexibility in the requirements and increased responsibility for the hospice to improve quality. The QAPI CoP requires a comprehensive organizational assessment, analogous to the comprehensive patient and family assessment required in the cycle of care just described. However, there are no specific required quality measures identified in the condition or the standards. Hospices are free to measure the things that matter most to them, as they implement “360-degree” surveillance of their organizations. The idea is that hospices know where they have the greatest need and/or potential to improve both clinical and non-clinical operations. Compliance with the QAPI CoP requires that they measure and improve performance in those areas while monitoring performance across all aspects of hospice
care, services and management. For ideas about what to measure in a QAPI program, visit the Quality Partners’ Performance Measurement section of the NHCP0 Web site (nhpco.org/qualitypartners).

**Linking the “Big Three” CoPs with Data**

You may have noticed several themes that connect the “big three” CoPs.

One theme is the use of data to guide decision-making. Hospices will need to show how data on individual patients, as well as outcomes for all patients, drive decisions about interventions, and how data on hospice operations drive performance improvement activities.

Another theme is the documentation of data elements. Data elements are the basic units of identifiable and definable information, recorded in specific blocks on a form and/or “fields” in an electronic record. Examples are birthdate, admission date, a pain severity score, or a “yes/no” response to a question like, “Are you satisfied with current control of symptoms?” When captured and recorded consistently, data elements can be aggregated to summarize experience or combined to create performance measures.

Data consistency and standardization form another theme. The proposed comprehensive assessment CoP requires that data elements be captured and retrievable in systematic ways. This means that the hospice must make sure that every clinician knows the right way to gather each data element. Further, data elements to be used for outcome measurement and/or quality assessment must be recorded so they can be easily used in the necessary calculations.

In the preamble to introduce the proposed Conditions of Participation, CMS describes a “QAPI Loop” to explain the process of using data to identify problems and take action to improve performance (shown below).

The fact is that nearly all hospices collect many data elements that could help drive care planning and decision-making for individual patients as well as support overall performance improvement at the organizational level. Data are gathered into patient charts, incident reports, after-hours call logs, satisfaction surveys, billing records, and HR files among other places.

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**QAPI is comprised of two different but related functions:**

- Assessing quality
- Improving performance

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**QAPI Loop**

1. **Collect Data**
2. **Measure, analyze & track data**
3. **Identify strengths & weaknesses**
4. **Act towards performance improvement**
5. **Track and measure success**

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continued on next page
Preparing to Meet the Proposed CoPs
Most hospices will find that they already collect much of the data they want and need to meet the new CoP requirements, but they will need to look at how they currently use the data. Questions for hospice managers include:

- How can data we capture now be used regularly to assess and improve care at the individual patient level, and performance across the organization?
- Do we explicitly connect the data elements captured on assessment forms with the problems and interventions identified in our care plans?
- Are we recording quantitative patient and family goals, and identifying measurable targeted outcomes for patients and families?
- Do team meetings include a review of data on how well each patient is responding to specific interventions, and progressing toward meeting desired outcomes?
- Are we aggregating data on individual patients to see how the hospice performs overall in terms of patient outcomes and are we using this information to improve performance?
- Are nonclinical operations data such as staff competence, training and turnover being used to monitor and improve workforce excellence?
- Are data tracked (consistently) over time to see how performance is changing?

When a hospice captures data on clinical and nonclinical outcomes effectively, it strengthens its own resources to support data-based decision-making and ongoing performance improvement. Often, this internal information allows the hospice to “discover” best practices on one team or by one individual and then spread this “excellence” throughout the organization.

Performance Improvement Projects
The proposed QAPI requirement includes a standard describing performance improvement projects (PIPs). When the hospice identifies an area where better performance is necessary and/or desired, a performance improvement team is identified to determine the best way to change systems or processes to improve quality. Perhaps the most often overlooked part of the PIP process is the initial study of current processes. Aggregated data can and should be used to identify the points at which specific processes are not working so that the PIP can focus on these “broken” points in the system. This is also the time when “pockets of excellence”—where some variation on the standard processes may be working especially well—can be found and used to improve performance across the organization.

To help demonstrate how the “big 3” CoPs—assessment, care planning, and QAPI—work together, let’s look at the following fictional case study on hospice use of “unwanted hospitalization” (which is one of the NHPCO outcome measures for self-determined life closure).

Case Study—Unwanted Hospitalization
At Hospice QE, the comprehensive assessment includes a question about whether the patient and family wish to avoid hospitalization if the patient’s condition worsens. The answer is recorded on the assessment form and on the cover sheet for the patient’s medical record in a specific shaded box provided for this information.

If hospitalization is to be avoided, there are specific interventions added to the plan of care, such as (1) a sticker on the phones at the patient’s home directing everyone to call the hospice’s 24 hour number rather than 911 if the patient’s condition worsens, (2) a note in the patient’s electronic and paper record for on-call staff that indicates the preference to avoid hospitalization, and (3) other procedures to assure that calls from this patient and family receive priority response from a team member.

At each reassessment, the patient and family preference regarding hospitalization is reviewed and updated. The information is also updated on the face sheet, and any unwanted and/or unexpected hospitalizations since the last review are also noted on the care plan and on the cover sheet (in the area provided for this information); then the team determines whether any interventions need to be changed.

During the monthly review of all discharged pa-
tient charts, the medical records reviewer adds the information on unwanted hospitalization for each individual patient to the Excel spreadsheet created for aggregating the data.

Quarterly, the QAPI manager runs a pre-programmed report from the Excel spreadsheet that tallies the number of patients who had data on this indicator, the number who at any time wanted to avoid hospitalization, and the number of those wanting to avoid hospitalization, but were still hospitalized. The percentage [i.e., those who wanted to avoid AND who were not hospitalized divided by the number who wanted to avoid X 100] is tracked for every month and reported quarterly as shown in the graph. If the percentage drops below 95 percent more than once in a quarter, the hospice will conduct a performance improvement study to understand why patients are receiving unwanted hospitalization and to determine whether and how the hospice can improve.

The proposed CoPs are meant to better reflect how hospices currently do business and to acknowledge that mature hospices in 2007 are very different from the emerging hospices of 1983 when the first CoPs were written. Our challenge as an industry is to accept the added responsibility to prove that our processes lead to quality care and outcomes for patients and families.


Melanie P. Merriman is founder of Touchstone Consulting in North Bay Village, FL. She can be reached at 305/762-7966 or by email (touchst@ix.netcom.com). Martha Tecca is senior director of Hospice and PeerForum at Outcome Concept Systems, Inc. in Lyme, NH. She can reached at 603/795-4802 or by email (martec@ocsys.com). Heather P. Wilson is president of Weatherbee Resources, Inc. in Yarmouth Port, MA. Contact Heather at 508/375-0098 or hwilson@weatherbeeresources.com.

These authors have also written the manual, The QAPI Requirement: Resources for Hospice Programs, available through NHPCO’s Marketplace (see page 23), or from www.weatherbeeresources.com.

See page 13 for a listing of materials and resources to help you prepare for the proposed CoPs.
NHPCO’s president/CEO, Don Schumacher, welcomed close to 2,000 members, advocates and supporters during his opening presentation at the 22nd Management and Leadership Conference in Washington, DC this past April.

While there was much to celebrate in this 25th year commemorating the enactment of the Medicare Hospice Benefit, Dr. Schumacher took time to touch on where the industry is today, and the trends and changes in healthcare, federal spending and public policy that will impact our future.

Reprinted here are some of the key points from his address. A summary of his remarks can also be found on NHPCO’s Web site (nhpco.org > About NHPCO > Mission & Vision).

As an Industry, We Have Matured
It was 25 years ago that a number of visionary congressional advocates and passionate hospice pioneers worked to create a benefit under Medicare that would make hospice services available to more people and their family caregivers.

This year, over 1.2 million people have been served by hospice while hospice expenditures exceed $10 billion annually. In the course of three decades, we have gone from healthcare pioneers and a grassroots movement to an industry that is globally recognized. Today, hospice is an integral part of healthcare in America.

With this maturation and growth, however, comes a new degree of exposure that we never had to contend with before. Exposure that is legislative, regulatory, public and professional. Thinking that hospice is “untouchable” because of the good work we do would be naïve.

What This Means for Providers and for NHPCO
We are at a critical juncture in our existence. You’ve heard me say this before: Hospice providers have about 97 percent of their claims processed by the fiscal intermediaries without question. There is no other sector of healthcare that has anything close to this. Yet, things may not always stay this way. We must be responsive to the current means of oversight and be prepared for even greater scrutiny.

Every single provider must be prepared for the time when the focus turns to their program. We must be prepared to demonstrate excellence and the value of hospice care, and document our performance. We can do this through compliance, through a commitment to quality, by participating in data collection like NHPCO’s National Data Set, through dedication to those we serve, and through the development and growth of our colleagues.

Scrutiny isn’t necessarily a bad thing. This is one of the reasons that I feel mandatory, annual provider surveys are critically important to us as an industry. By not giving us the oversight we are entitled to, we are being set up for compliance
problems. Rather than waiting for your state survey team, I want each of you, as program leaders, to conduct your own rigorous survey, tougher than what the state could throw at you, and see how you can improve your care.

We must also continue to expand our understanding of quality care and examine how we reach the people who need our care... because the next 25 years may look very different from these past 25 years.

How NHPCO is Adapting—a New Affiliate Focused on Advocacy

Healthcare, federal spending, and public policy advocacy are influenced by a broad range of issues that have evolved significantly in the 25 years since the Medicare Hospice Benefit was enacted. For example:

- Medicare spending on hospice care has risen to almost $10 billion annually;
- Hospice is caring for a patient population that reflects more complex diagnoses with potentially longer lengths of stay;
- Healthcare systems are more competitive than ever;
- In recent federal budget proposals, the President has consistently recommended cuts in the Medicare Hospice Benefit—which, so far, the collective hospice community, through NHPCO, has prevented;
- There has been a change in leadership in both the House and the Senate, including a re-energized Energy and Commerce committee responsible for oversight of Medicare spending;
- Rapid and sustained growth in the number of hospice providers has been noted by representatives in Congress, especially in the past two years;
- Both the House of Representatives and Senate have indicated they intend to review practices and providers in search of possible fraud within the hospice community.

This also means that advocacy on Capitol Hill has become an increasingly specialized endeavor. “Flying under the radar” is no longer advisable or acceptable: It is time for a new approach. For this reason, NHPCO has formed an affiliate organization—the Alliance for Care at the End of Life—to lobby on behalf of hospice and palliative care as a 501(c)4 organization.

About the Alliance

As a 501(c)3, NHPCO faces limits on the time and resources that may be used for advocacy on Capitol Hill and at the grassroots level. A new 501(c)4 affiliate organization without those constraints will help us meet growing challenges.
The Alliance for Care at the End of Life will provide a more aggressive and comprehensive voice that will serve the entire field. The main goals for the Alliance are:

- Protecting the Medicare Benefit;
- Examining issues and policies involving the Medicare CAP;
- Exploring new models of care that will increase access and quality;
- Proposing needed changes and adjustments to the Benefit, such as modifiers for assessment and the difficult “6 month” prognosis guideline;
- Ensuring that we reach all the patients in need of our care.

NHPCO and the Alliance will work in concert with one another. For example, NHPCO’s work on regulatory issues and compliance will continue as it does now. NHPCO’s public policy committee and legislative subcommittee will continue to look at legislative issues and provide analysis. Dialog at the NHPCO board table involving public policy issues will go on. And, NHPCO will continue to develop a public policy agenda, just as it does now. What will be different will be our ability to take this agenda and make it heard more clearly on the Hill—through this affiliate lobbying organization. This is the right thing to do for the right reasons.

A two-page document providing some basic information about the Alliance for Care at the End of Life is available to members on NHPCO’s Web site (nhpc.org > About NHPCO > Mission & Vision). This document will answer some of the questions you may have. More information will be coming in the near future.

**Stronger Together**

Twenty-five years ago, when the visionaries and pioneers were making history by changing the care people receive at the end of life, they might never have imagined the amazing success and accomplishments we’ve all seen and been a part of. We must work together as the collective body and voice of hospice and palliative care to find a future as bright as the past 25 years have been.

We must stand together to demonstrate the hospice philosophy in all that we do—and speak with one, unified voice.

Please Note: Since Dr. Schumacher’s announcement of NHPCO’s new affiliate, the Alliance for Care at the End of Life, a number of hospice programs and state organizations have been contacted by a group calling itself the “National Alliance for Hospice Access” (NAHA). NAHA is not in any way affiliated with NHPCO and should not be confused with the Alliance for Care at the End of Life.
Helpful CoP Resources

The NHPCO Web site has a host of resources to help you understand—and prepare for—the proposed CoPs. Here’s a snapshot of what you’ll find:

**Proposed CoP Resources**
- NHPCO Final Comment Letter to CMS
- Quality Assessment and Performance Improvement Feedback Loop
- Crosswalk of CoPs from Old to New
- Request for Comments from “Train the Trainer” Session
- Hospice NPRM Slideshow
- Organizational Structure of Subparts C and D
- NHPCO’s initial Public Policy Alert and Press Release

**Other Internet Links Provided to Members**
- CoPs Proposed Rule from May 27, 2005, available in PDF from the Federal Register
- CMS original Press Release announcing the proposed CoPs
Visit nhpco.org/regulatory.

**Performance Measurement Resources**
- National Data Set
- Family Evaluation of Hospice Care
- End Result Outcome Measures
Visit nhpco.org/research.

And the newest NHPCO resource is Quality Partners. Many members are already using the Quality Partners online self-assessments to begin improvement efforts within various areas of their organizations. If you are not familiar with all that Quality Partners has to offer, visit www.nhpco.org/quality. You can also email quality@nhpco.org for information.
Leaders in Hospice and Palliative Care Recognized at MLC

During NHPCO’s 22nd annual Management and Leadership Conference in Washington, DC this past April, five individuals were honored for their contributions to the field.

Founders Award

True Ryndes
Founding President/CEO
National Hospice Work Group

and

Diane Meier
Director, Center to Advance Palliative Care

The prestigious Founders Award was given to True Ryndes and Diane Meier in recognition of their achievements in the advancement of hospice and palliative care.

Heart of Hospice Award

Senior Executive Category:
Sally A. Adelus,
Executive Director
Hospice of the Valley, San Jose, CA

Management Category:
Sandra J. Petersen
Chief Nursing Officer
Trinity Hospice, Dallas, TX

The Heart of Hospice Award was created on behalf of NHPCO’s professional member division, the National Council of Hospice and Palliative Professionals. This year, the award was given to Sally Adelus and Sandra Petersen in recognition of their repeated outstanding achievements within the hospice field.

Person of the Year Award

Art Buchwald
Pulitzer Prize winning journalist, Art Buchwald, was honored for helping to dispel many misperceptions about hospice care by openly sharing his personal experience in hospice during the last year of his life. The award was accepted by Art’s son, Joel Buchwald.
Leaders in Hospice and Palliative Care Recognized at MLC

Hyatt Regency, Albuquerque
Albuquerque, New Mexico
July 30 through August 1, 2007

REGISTER EARLY AND SAVE!
Join NHPCO in beautiful and rustic Albuquerque, New Mexico for this important conference.

Who should attend:
Bereavement Professionals,
Spiritual Caregivers, Chaplains,
Social Workers, Counselors,
Therapists, Nurses, and other end-of-life care professionals.

NHPCO’s
Caring for Mind, Body and Spirit:
Psychosocial,
Bereavement and Spiritual Needs at the End of Life

FOR MORE INFORMATION
AND TO REGISTER, VISIT
WWW.NHPCO.ORG/PBS2007.
Help Celebrate WHPCD on October 6

The first Saturday in October 2007 is set for World Hospice and Palliative Care Day.

The concept behind WHPCD is simple: Get everyone concerned about access to end-of-life care to hold an event or activity within their community on the same day, and you help create global recognition of the need for expanded services worldwide. It’s a unified day of action to celebrate and support hospice and palliative care around the globe.

What You Can Do
Each year, WHPCD carries a specific theme. This year, it’s “Across the Ages: from Children to Older People,” to reinforce that people of all ages need access to hospice and palliative care, either as patients, loved ones, or caregivers of people facing terminal illness.

While all types of events and activities are encouraged, this year WHPCD organizers are urging organizations to host a Voices for Hospices concert.

About Voices for Hospices
Voices for Hospices is a UK-registered charity which coordinates a ‘Mexican Wave’ of simultaneous concerts around the globe, on the same day, once every two years. This year, the Voices for Hospices concert will take place on October 6 — and will serve as WHPCD’s official fundraising event.

A global musical marathon, this ‘Mexican wave’ will consist of concerts at 7:30 p.m. local time in more than 70 countries—all on October 6!

NHPCO encourages all members to consider hosting a concert in their community. To learn more, including how to register your event, visit worldday.org as well as the Voices for Hospices Web site (voicesforhospices.org). These sites provide further information, planning tips, outreach materials, and more.

Bookmark InfoCenter as a Quality Partners Resource

NHPCO’s InfoCenter is an online database with over 400 records of resources related to Quality Partners’ 10 components.

On the “Quality Partners @ Infocenter” Web page, you’ll find a list of the 10 components, with links for specific resources:

- Cornerstone Documents
- Background Materials
- NHPCO Resources
- NewsLine/Insights Articles
- Conference Sessions
- Technical Materials

Make use of this important benefit of membership. Visit nhpc.org/qualitypartners, and select “Explore Quality Partners @ Infocenter” on the bottom right corner of your screen.

Note: You will need your user ID and password to access InfoCenter. All staff of NHPCO member-organizations can receive a user ID and password free of charge. If you don’t yet have one, contact NHPCO’s Member Services Center at 800/646-6460.
How to Support Someone Caring for Another

Many of us know someone who is a caregiver. Do you know someone who spends time providing physical, emotional or practical support to a family member or friend? Many caregivers feel alone, helpless, confused, unprepared, tired and unable to provide for the needs of their family member or friend. Often, people caring for another need help and do not know how to ask for it.

There are many ways to help support a caregiver...

Caring Connections
a program of the National Hospice and Palliative Care Organization

For more information about caregiving, please call Caring Connections at 1-800-658-8898, email us at consumers@nhpco.org or visit us at www.caringinfo.org
People and Places

Community Hospice Names New President/CEO
Ronald F. Watson has been named the president/CEO of The Community Hospice (based in Albany, NY). Watson comes to the program from Arizona-based VistaCare, where he served as executive vice president.

Hospice of Chattanooga Physician Dies
Peter S. Soteres, MD, a team physician at Hospice of Chattanooga in Tennessee, died on April 13, 2007. Dr. Soteres had practiced medicine in Chattanooga for more than 30 years and joined the program five years ago, following a brief retirement. He was not only known for his medical expertise, but also for his warm bedside manner, his attentiveness to those under his care, and for the support he provided to the program’s staff, patients and families.

Co-Founder of Hospice Buffalo Dies
Charlotte N. Shedd, RN, MN, one of the pioneers of the country’s hospice movement and the co-founder of Hospice Buffalo (Cheektowaga, NY), died on April 28, 2007 at age 84. Shedd had been receiving care in the Mary and Ralph Wilson, Jr. Hospice Buffalo Inpatient Unit, the unit she helped establish with the founding of Hospice Buffalo 29 years ago.

Shedd’s passion for hospice was nurtured at Yale, where she had the opportunity to hear Dame Cicely Saunders speak during two visits to the university. Her work with Hospice Buffalo helped bring hospice into the mainstream and change public and political response to the needs of the terminally ill. She retired in 1989, after 11 years as executive director. Shedd was also a co-founder of the New York State Hospice & Palliative Care Association, and an early member of NHPCO’s governing board of directors.

Kerr Appointed Medical Director for The Center for Hospice and Palliative Care
The Center for Hospice and Palliative Care (based in Cheektowaga, NY) has appointed Christopher Kerr, MD, PhD, as medical director for its affiliate agencies, including Hospice Buffalo. Dr. Kerr will oversee all direction of medical care and treatment provided to patients and families, replacing Robert Milch, MD, who retired in June.

Agnew to Lead VITAS of St. Louis
Katrina Agnew has been named general manager of VITAS Innovative Hospice Care® of St. Louis, serving patients living in St. Louis and the surrounding communities. In addition to leading the program’s daily operations, Agnew will focus on increasing access to hospice care for underserved and underprivileged populations in the Greater St. Louis area.

In Memoriam...

Hospice of Chattanooga Physician Dies
Peter S. Soteres, MD, a team physician at Hospice of Chattanooga in Tennessee, died on April 13, 2007. Dr. Soteres had practiced medicine in Chattanooga for more than 30 years and joined the program five years ago, following a brief retirement. He was not only known for his medical expertise, but also for his warm bedside manner, his attentiveness to those under his care, and for the support he provided to the program’s staff, patients and families.

Community Hospice Names New President/CEO
Ronald F. Watson has been named the president/CEO of The Community Hospice (based in Albany, NY). Watson comes to the program from Arizona-based VistaCare, where he served as executive vice president.
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Wish You Could Go To A Hospice Regulatory Boot Camp?

Well now you can! Weatherbee Resources, Inc. and several state hospice organizations are co-sponsoring intensive 2 1/2 day workshops which are being held in various locations throughout 2007. The Hospice Regulatory Boot Camp is an innovative educational program that provides hospice executives with state of the art knowledge, understanding, and resources related to hospice regulations. It was created to respond to a need in the hospice industry for an in-depth program that covers all aspects of the Federal regulations that govern hospices. The program is designed for new and seasoned senior-level hospice executives including State hospice association directors and hospice CEOs, clinical directors, and compliance officers. A previous participant said:

“This training is essential for state and program hospice leaders, and the resources provided are incredible!” Cordt Kassner, Ph.D., Executive Director, Colorado Hospice Organization.

For additional information, please view the Boot Camp Calendar and registration information on our website: http://www.weatherbeersources.com or give us a call at 508-375-0098

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**Marketplace Picks**

This month, Marketplace spotlights top picks relating to compliance with laws and regulations.

**The QAPI Requirement: Resources for Hospice Programs**  
By Heather P. Wilson, PhD, Melanie P. Merriman, PhD, MBA, and Martha Tecca, MBA  
Item: 820921, Member: $395.00

**The Compliance Program Toolkit**  
Developed by NHPCO  
Item: 810003, Member: $119.00

**Revised: CoPs in a Binder: The Interim Edition**  
By Weatherbee Resources  
Item: 820922, Member: $375.00

**Revised: Hospice Policies and Procedures: Administration, Human Resources, and Patient Care**  
By Weatherbee Resources  
Item: 820923, Member: $1,100.00

**The Hospice Regulatory Reference Binder**  
By Weatherbee Resources  
Item: 820987, Member: $495.00

**QAPI: What You Need to Know (AWS)**  
Presented by Heather P. Wilson, PhD, Melanie P. Merriman, PhD, MBA, and Martha Tecca, MBA  
Item: 820838, Member: $29.99

**To order, visit nhpc.org/marketplace or call 800/646-6460. Mention Code: NL01**

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**Dates to Remember**

**NHPCO’s Audio Web Seminars**

**Interdisciplinary Topics** – second Thursday of the Month, 2:00 – 3:30 pm EDT.

- **08/09/07** — Calming the Storm: Addressing Terminal Restlessness  
- **09/20/07** — Saying Goodbye and Meaning It! Effective Closure with Clear Boundaries for Hospice Team Members

**Leadership Topics** – fourth Tuesday of the Month, 2:00 – 3:30 pm EDT.

- **08/28/07** — ROMI: Return on Marketing Investment—Make Sure You Are Getting It!  
- **09/25/07** — Pioneering Practices in Palliative Care: Get Ahead of the Curve!

**NHPCO Conferences**

- **July 30 – August 1, 2007** — Caring For the Mind, Body and Spirit: Psychosocial, Bereavement, and Spiritual Needs, Albuquerque, NM
- **November 29 – December 1, 2007** — 8th Clinical Team Conference, New Orleans, LA

**Hospice MDP Two-Day Foundational Course**

- **July 28-29, 2007** — Albuquerque, NM  
- **August 22 - 24, 2007** — Durham, NC  
- **October 1 - 2, 2007** — Bloomington, MN  
- **November 27 - 28, 2007** — New Orleans, LA

Visit nhpc.org/mdp for details.
Each summer, Hospice of the Valley in San Jose, CA holds an annual memorial event at the world-famous Hakone Gardens to celebrate the lives of those patients they have served in the last year. This picture, which was a submission to NHPCO’s 2004 Photography Contest, captures the portion of the program where guests and families gather for the chaplain’s “Circle of Blessing.” For details on our 2007 contest, visit nhpco.org > About NHPCO > Awards & Contests.