Quality Partners: After One Year
Quality Partners Turns One Year Old

Since NHPCO launched Quality Partners in September 2006, nearly 3,000 organizations and individuals have signed the initiative’s pledge in support of improving the quality of end-of-life care across the country. In fact, on the front cover—and throughout this issue—you will see the names of many members who have signed the Quality Partners Pledge.

For this special issue, NCHPP members have also written a range of articles that address various aspects of Quality Partners’ 10 Components of Quality in Hospice Care, the framework around which the initiative was developed. You will also find mention of several resources to help you participate in Quality Partners—just look for the Quality Partners lapel pin shown here at right.

We have much to celebrate together after just one year. On behalf of all of us at NHPCO, thank you!
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Incredible as it may seem, a year has now passed since Quality Partners was unveiled at the Management and Leadership Conference in New York City.

Since then, I trust all of you have become more familiar with the program through one means or another, be that from our conferences, our Reach Every State presentations, the Quality pages of NHPCO’s Web site, or from NewsLine and NewsBriefs. We are delighted that all of the nation’s state hospice and palliative care organizations have signed the Quality Partners Pledge and are committed to working with us.

As I’ve said on many occasions, this is a pivotal time for end-of-life care. There are dramatic changes occurring in federal spending and public policy as well as in the demographic mix of the very patients we serve—changes that make the need for what Quality Partners offers that much more important.

These changes, in and of themselves, are not necessarily great cause for concern. But how we handle them could be. While there is much exceptional work being done by our members and partners in the field, from our unique vantage point here at NHPCO, we are also seeing some practices that do concern us and could ultimately jeopardize our future success. I’d like to take this time, as we celebrate the first anniversary of Quality Partners, to talk about some of these concerns.

Managing Change

This year, more than 1.2 million people will receive care from our nation’s hospices. According to the latest NHPCO research, over 50 percent of these patients have non-cancer diagnoses, a percentage that will more than likely increase in the coming years. As the patient mix we serve becomes more complex, the current parameters of the Hospice Medicare Benefit might not easily fit the population of those who need our services. We must be willing to expand our understanding of quality care and look at ways to reach all eligible people within current regulatory guidelines. In essence, that’s what “access and inclusion” are all about.

Our past provides the skills and understanding we need to tackle this challenge as well as others. But we must be open to making the necessary adaptations to meet such challenges. One of my deepest concerns is that, as an industry, we are becoming too rigid in our thinking while the world around us is changing. If we allow this to continue, we will stagnate, and those who could benefit from what we offer will find those services elsewhere.

Us vs. Them Mentality

Another concern I have—which is shared by many others—is the growing chasm that is developing between nonprofit and for-profit providers. We hear ongoing conversations among our members about “the roles of for-profit versus nonprofit providers.” In fact, this was reflected in the member survey we just conducted earlier this year. Let me share a few representative comments that point to this:

From Our Nonprofit Members…

- “You need to listen to all your constituents.”
- “I am concerned that the for-profit hospices have such a loud voice at NHPCO.”
- “I think that the large chains dominate NHPCO.”
From Our For-Profit Members...

- “I think you still look at hospice from a nonprofit mentality and are not sensitive to those of us who are for-profit.”
- “NHPCO doesn’t take our concerns as seriously as those of nonprofits.”

I share these comments only to say that NHPCO works very hard to stay attuned to the needs of all providers. We know that the changes we are seeing in the hospice industry are affecting all programs and that competition is increasing. But I also feel that as an industry, we must put our energy into responding and adapting to these changes rather than pointing fingers at one another. No one wins when we pit the nonprofits against the for-profits, the old against the new, or the small against the large. We must stand together to demonstrate the hospice philosophy in all we do and speak with one, unified voice.

The Spirit of Sharing
While I’ve been president/CEO of NHPCO for nearly five years, I was also privileged to work in the field for over 25 years, including 13 years as CEO of The Center for Hospice and Palliative Care in Buffalo. So I remember when hospices shared policies, practices, and programs more freely with one another. In today’s competitive environment, organizations are becoming more territorial and insular about their successes for fear of losing market share. This is so destructive to the field. We not only hurt each other through such behavior, but also the very patients and families who need our help.

While There are Concerns, There is Much to Applaud
We wouldn’t be doing our job if we weren’t mindful of attitudes and behaviors, like these, which could potentially impede our progress, so understand this is my intent in addressing them now. While these concerns weigh on my mind, I am continually heartened by the outstanding work being done by many providers. And this very issue of NewsLine/Insights is testament to that work.

While this issue spotlights some of the resources available through Quality Partners, it also features some very valuable articles; articles written by your colleagues who have taken time to share what they have learned with each of us. So read these articles for their information and guidance. But let them also serve as a reminder of the benefits that come from working together.
Take a minute to think about what it was like to be a participant in team meeting as a team member. What was your experience? What were your greatest frustrations and greatest joys? What were your expectations? Were they met or unmet?

Now spend a minute thinking about your role as the team manager and how you might answer those questions differently.

The Medicare Hospice Conditions of Participation (CoPs) outline the mission and purpose of team meeting in the standard on the Interdisciplinary Group (Sec. 418.68). The standard states that the role of the group includes: (1) participation in the establishment of the care plan; (2) the provision of supervision of hospice care and services; and (3) periodic review and updating of the care plan for each individual receiving care.

The CoP for the care plan (Sec. 418.58) states that a written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan. The plan must be established by the attending physician, the medical director, and interdisciplinary group prior to providing care. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director, and interdisciplinary group. These reviews must be documented. The plan must include an assessment of the individual’s needs and identification of the services, including the management of discomfort and symptom relief. And, it must state in detail the scope and frequency of services needed to meet the patient’s and family’s needs.

How do we ensure that your team meeting is a place where care planning takes place effectively? It starts with team leadership and the team manager role. One of the most significant roles of a team manager in team meeting is that of facilitator.

Facilitation is an art, one which involves a set of skills which is not necessarily taught in clinical discipline schools. Three components of effective facilitation include communicating well, creating commitment and synergy, and keeping the energy flowing. Before we look at each of these in more depth, however, let’s start with a common problem.

Are Team Members Really Listening or Just Waiting to Talk?

Are your team meetings filled with folks who are desperate for interaction with one another after having been autonomous in the field? Are there times when the most competent clinician seems to be going on and on when the question has been answered? Is team meeting more like a party? If so, you are not alone. One of my favorite quotes from a hospice peer is “Ask yourself, are you really listening or are you just waiting to talk?”

Comparing and sharing are valid and very real human needs for connection. So how and when do you meet these needs without interfering with the team meeting? You could have folks come into the office for lunch before the start of team meeting or set up a quarterly team “fun” activity. Ongoing staff support activities sponsored by your program will allow for social connection between your staff and keep the focus of team meeting on care planning!

The Components of Becoming a Skilled Facilitator

A team manager helps to model, and by modeling, teaches effective communication skills. He or she needs to listen, observe, and question...
throughout the group process. Some helpful questions which focus on moving the process of the meeting along, rather than becoming caught in the content, include:

- Can you give me an example?
- Help me understand how that relates to the issue we’re discussing?
- Do we need to look at this from another perspective?
- Does your conclusion match the patient’s and/or family’s?

Remember, it is your role and responsibility to engage your team. You are not just there to make announcements!

The next step is to create commitment. One way to do this successfully is to be aware of group dynamics. Focus on problem-prone areas of group interaction, such as listening, courtesy, tone, and presentation style. Model how to engage in each of these areas productively. Remind team members of the importance of how they interact with one another. Ask them, “How could we have communicated that better or more effectively, or in a kinder, gentler way?”

Once there is a foundation of commitment, it is time to create synergy. One key to creating synergy is your preparation. It is imperative that you understand that team meeting starts BEFORE the team meeting’s designated time. First, list the materials you need on hand for team meeting: an agenda, medication lists, and any useful reports. Next, prepare psychologically for team meeting. Set aside five minutes to finish what you are doing, take a few deep breaths, take a trip to the bathroom, and get yourself a drink prior to the start of the meeting. Allow yourself to stop what you are doing and to prepare for what you will be doing next.

In order to have an effective meeting, team or otherwise, an agenda outlining what will occur during the meeting time is essential. A sample team meeting agenda might include:

- Opening
- Bereavement
- Patient review
- Recertifications
- Patients receiving continuous care
- Inpatients in contract beds
- Discharged patients
- Patients at risk
- Break
- Announcements
- Routine patient review
- Scheduling

One way to prepare your group for team meeting psychologically is to open with a centering activity. One used successfully in our hospices, which also meets the need for establishing commitment, is our Commitment to Team Meeting. Have your team create a set of ground rules which they promise to follow during team meeting. Each member can recite a rule at the
beginning of the meeting. They are most likely to follow rules they have established as a group.

Finally, find ways to keep the energy flowing. It is often beneficial to ask for suggestions to address specific concerns. What should be the order of activities discussed? When should we take breaks and what about including reenergizing activities? What is our policy on food and beverages?

Let’s turn our attention back to the primary focus of team meeting, the care plan. During patient review, everything revolves around the care plan! When things get off track, it is up to you to gently but directly bring the team back around. Ask yourself, who is the head of the hospice team? There is only one answer—the patient and family. While they are the only people who are NOT in team meeting, one way to symbolically represent them is to put an empty chair at the table—acknowledging that the empty chair is there to represent them.

Let’s talk about the care planning process. In your team meeting, is the care plan a living document? Remember that the care plan is the sole source of documented communication both internally and externally. It is THE story of the care provided to the patient and their family.

A key question used by the folks at Hospice of the Bluegrass is “How will this patient die?” By asking this you are able to prepare the patient and family for what their hospice journey may bring. Continuing to ask that question keeps the care planning process on course while ensuring that it is unique to the patient and family. Keep everyone on the team on the same page by asking:

- What do the patient and family want?
- Have you listened well enough to know what they want?
- Are there patient and family goals?
- When are these goals met and how?
- How often are they reviewed?
- What is important to the patient and family NOW?
- How is bereavement care being addressed?
- Does the family feel prepared for the actual death event?

Evaluating your team meeting is essential to ensuring successful outcomes for the patient and family and, therefore, the team. Successful outcomes may include:

- reviewing each patient’s medication list for polypharmacy and efficacy;
- ensuring that the frequency of visits match the care plan and schedule, and are adequate to meet the needs of the patient and family;
- documenting the scope of services being provided and making sure they’re meeting the needs of the patient and family (including bereavement); and
- ensuring that high-risk patient needs are being evaluated.

Successful outcomes for team members may include: (1) making sure the meetings start and stop on time; (2) encouraging each team member to contribute to the care plan discussion; (3) offering team members help with patient care; and (4) making team members feel supported.

Begin now! Ask yourself what’s working for you, and what steps you need to take to get team meeting where you want it to be. Running an effective team meeting is hard work; however, the team and your patients and families will thank you for it.

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Members Pledge Their Commitment...

Since Quality Partners was unveiled, 2,907 individuals and organizations have pledged their commitment to improving the quality and delivery of care. If you haven’t yet signed the pledge, visit: nhpco.org/quality > Get Started.
Waves 1, 2, and 3 in the ‘Sea’ of Quality

By Pat Gibbons, BSN, CHPN

The Quality Partners Improvement Collaborative was launched in September 2006 as part of NHPCO’s Quality Partners program. The collaborative is not one single initiative, but a series of six-to nine-month programs—or waves—which offer participating members the training, resources, and support to make improvements within their respective organizations. Here, Pat Gibbons, NCHPP’s Nurse Section Leader, updates us on her experience as a faculty coach in this initiative.

The Quality Partners program has certainly gained momentum since its launch a year ago. While there are many aspects of this initiative that have the potential to positively impact all hospice and palliative care programs, I have found the Quality Partners Improvement Collaborative to be particularly valuable. As I reflect on my experience as a faculty coach, I am reminded of the lyrics to a song, “and the times they are a changing.” And, in this case, the changes will benefit all those who receive hospice and palliative care.

I must admit that I don’t know where the idea of referring to the collaborative groups as “waves” came from, but it definitely fits! Wave 1 began in September 2006 during NHPCO’s Management and Leadership Conference and concluded nine months later. Each team would periodically get together for “face-to-face” meetings to process and troubleshoot their projects, and then return home to implement ideas—trying them out, changing them if they did not work the first time, and reporting back via conference call and written reports. The experience clearly ebbed and flowed—ever-changing, but always moving forward under the guidance of the Institute for Healthcare Improvement (IHI) model.

Wave 1 participants “graduated” at the Management and Leadership Conference this past April, after successfully completing their projects and reporting back to the entire group. At the same time that Wave 1 participants were graduating, Wave 2 was under way, having begun in February, while Wave 3 was ready to begin in May—like overlapping ocean waves. The work of these teams is amazing, with each team fully committed and eager to improve in the specific areas they identified.

We all realize that there are new regulatory challenges related to quality in hospice organizations, and there has been concern about variation in the quality of care and services being provided. As a faculty coach for Wave 1, I saw firsthand a commitment to quality by the participating teams— but not because of concerns about regulatory scrutiny or variation in care. While these concerns are justified, the teams’ reasons for improving quality were much closer to their hearts: They were driven by the desire to provide better care.

As part of the collaborative process, each team clearly identified (1) exactly what they wanted to improve, (2) by how much, (3) the changes they would make to realize their goal, and (4) how they planned to measure and/or determine whether the change really resulted in an improvement. Wave 1 teams were our “guinea pigs” for everything from logistics to processes.

Within the IHI model, the method of “plan, do, study, act” fosters planning small changes, testing the changes, evaluating the effects, and then acting on the results. This approach is effective because it does not overwhelm an organization, and can result in achievable goals within a short time that can then be expanded within the organization in a planned and organized fashion.

Once an organization learns the IHI model, it can become the standard for all changes within the organization. By utilizing this process within
a collaborative model like this Quality Partners’ initiative, the individual teams have the benefit of coming together and learning from each other in an “all teach all learn” environment. The teams also have the benefit of having faculty coaches who offer support and guidance on a monthly basis, via reports and coaching calls, so everyone stays on track. Interestingly enough, many of the teams may choose a similar project and a different way of approaching it, yet still have the same outcome. Again, within the IHI model, the support of team members is invaluable—no one is expected to work in a vacuum.

The work of the Wave 1 teams was exceptional, and I will freely admit that many achieved far more than I expected:

- A group from the VA system was able to get a change made to the computer documentation on end-of-life decisions;
- A small hospice program from Staten Island was able to identify improvement in caregiver confidence through their project;
- A program in the Midwest was able to show improvement in offering the right amount of emotional support to caregivers;
- A large program has redesigned its referral process to more clearly define that patients are being admitted in a timely fashion.

These are just a few examples of some of the projects from the first wave. Similar projects are also being completed in Waves 2 and 3, along with other teams which are looking at opportunities to improve symptom management. Information about these projects is available on NHPCO’s Web site (nhpc.org/quality > Discover the QP Improvement Collaborative). We also anticipate the publication of many of these projects so the industry-at-large can learn from them too.

As I said earlier—the times are changing. As hospice workers, we are no longer “favored” for the good work we do. We are held accountable for the quality of care and services we provide. NHPCO has identified quality as a focus, and the organization offers a range of resources—like the quality collaborative—to help us meet our goals. We should feel very proud that our goal to improve quality within our organizations is driven by our desire to meet the needs of patients and families.

**Pat Gibbons is director of Beacon Place, the 14-bed hospice facility operated by Hospice and Palliative Care of Greensboro in North Carolina. She currently serves as NCHPP’s Nurse Section Leader.**
Nursing assistants can play an important role in assuring the safety of both patients and their caregivers. According to the Hospice and Palliative Nurses Association, because of our intense, consistent interactions with patients and families, we may be the first members of the team to observe the physical, psychosocial and spiritual symptoms that are common as patients experience the profound, multiple losses and grief that accompany the dying process.

For this reason, the nursing assistant often serves as a bellwether for possible patient and caregiver safety issues. Through effective communication techniques, we can alert the primary nurse, social worker, or chaplain to safety concerns that require attention. In many situations, however, we can also address safety issues on our own. The home setting, in particular, offers the most challenging, yet most manageable, environment in which to teach and apply safety measures.

The initial meetings with a patient’s family, for example, is a perfect opportunity to teach caregivers the proper procedures for performing personal care in a safe environment. Here are a few suggestions.

- Proper hand washing should be one of the first safety measures taught to caregivers. (The hand-washing techniques recommended by the CDC are the healthcare standard.)
- Falls account for about half of all accidental deaths in the home. The following simple suggestions will go far in preventing falls:
  - If a patient uses a cane or walker, remove obstacles that are directly in the patient’s pathway;
  - Wipe up spills immediately after they occur;
  - Don’t stretch electrical cords across rooms, and never run extension cords underneath a rug or carpet (they are not only an obstacle, but could also become a fire hazard);
  - Keep stairs and steps well lit and free of objects, and make sure that light switches are accessible from the top and bottom of the stairway;
  - Do not use stairways to store boxes, equipment or other items—even temporarily;
  - Advise patients and caregivers to use extra care when going up or down stairs, especially when wearing house slippers or robes;
  - Never place small rugs at the top or bottom of stairways;
  - If a patient is mobile and the home has hardwood floors, non-skid wax should be used on the floors to help prevent slips.

- Bed rails should always be raised, even during momentary absences. If a patient requires a hospital bed, but has refused one, the patient’s bed can be placed against a wall and a mattress placed on the floor beside the bed for protection should the patient roll out of the bed.
- Ask the caregiver to assist you with bathing the patient for the first time, so he/she can see what is involved and has the chance to ask questions and express concerns.
- Teach the caregiver how to roll the patient to one side, placing the patient’s hand on the rail to offer him/her a sense of control.
- Safety devices such as smoke detectors and carbon monoxide detectors should be located near all bedrooms in the patient’s home, and the batteries checked regularly.
- Baby monitors are often an effective tool to alert the caregiver that the patient is moving around or needs help. Bed alarms or chair alarms may also be used for confused yet mobile patients.
If the patient can get into the shower by him/herself, but is weak, a shower chair should be used. Always use a rubber mat (or towel) in the bathtub or on the shower floor if the patient is standing on his/her own.

The safety of the patient is critical, but nursing assistants can help assure a caregiver’s safety too by offering helpful guidance. For example:
- When caring for a bed-bound patient, remind caregivers to raise the bed to a higher position to avoid back strain and injury.
- The use of assistive devices when moving patients is also an important part of self-care—and patient safety. When lifting, moving or assisting a patient with ambulation, it is a good idea to use a draw sheet, mechanical lift, trapeze bar, or transfer board and gait belt. It is very important that patients, families and caregivers be educated on the proper use of the devices.
- Offer instruction and hands-on demonstrations that will allow the caregiver to safely transfer a patient from bed to shower or bed to chair with minimal effort and the least risk of injury.

Ensuring patient and caregiver safety is every team member’s responsibility, but nursing assistants can play a key role to support this critical aspect of quality care.

The nursing assistant often serves as a bellwether for possible patient and caregiver safety issues.

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The Inclusion and Access component in Quality Partners’ 10-component framework speaks to our collective responsibility to ensure that all people have access to hospice and palliative care. As we celebrate the one-year anniversary of the Quality Partners program, I’m writing to share our experience as a new PACE provider—a role that is clearly helping us meet this important goal.

PACE (Program of All-Inclusive Care for the Elderly) is like adult day care on steroids. Essentially, it’s a program serving nursing-home eligible individuals (based on physical, cognitive frailty scores) which wraps services around them to keep them in their own residence. It’s a nursing home “without walls.”

Midland Hospice Care has always prided itself on being a “needs-responsive” organization. In fact, we will soon be celebrating 30 years as a hospice provider and, through the years, have developed our program in response to identified community needs.

Our mission reads: “Midland enhances life’s journey by providing care and education with respect, dignity and hope.” This mission is broad enough to allow for the provision of a variety of services that all focus on taking care of people.

In addition to providing hospice care (both at home and in our inpatient facility), our program began offering adult day care in the community 14 years ago. We also have a small respite center (six-bed unit) for the community at large, an extensive community-wide bereavement service, and an education center that offers at least one professional education opportunity every month for community health providers.

During our strategic planning process several years ago, we developed our current mission statement and six key initiatives to move us into the future. The initiatives related to staff development/retention, utilizing technology, developing collaborative relationships and advocacy networks, and diversifying programs and services with an emphasis on growth in continuum of care and diversification of funding streams.

We are well aware that our field will most likely experience some significant cuts to the Hospice Medicare Benefit over the next several years. At the very least, the increases to the benefit will be markedly less and will not keep up with the cost of providing care. For these reasons, Midland began exploring other opportunities in care that would build on our core competencies as an organization. One of the options we investigated was becoming a PACE site.

Since the early 90s, we had provided adult day care to frail adults. Originally, the program was designed to serve hospice patients, but due to the short lengths of stay for most of our hospice patients, it evolved into a community-wide program. And, because of our work in adult day care, the opportunity to become a PACE site had a lot of appeal. We often saw adult day participants who were slipping through the gaps in terms of their healthcare needs. We were one small component and were powerless to help much beyond the adult day care services we provided.

About PACE
To qualify for PACE, you must (1) be 55 years of age or older, (2) live in the PACE service area, (3) be eligible for nursing home care in terms of frailty scores, and (4) be able to live safely in the community with supports.

PACE provides for all the preventive, acute, and tertiary care that its participants might need:
- home health services
- primary physician services
- medical specialist services
- medications
- medical equipment
The PACE services that are not provided directly by our staff—including all ancillary services and medical specialties—are made available through contractual agreements. Care is managed through an interdisciplinary team, case management approach. PACE is reimbursed on a per-member, per-month basis, and is a blended payment stream from Medicare, Medicaid and Medicare Part D.

**PACE is Palliative Care**

In many respects, the PACE program provides palliative care. The goal is to keep these very frail participants as comfortable and healthy as possible for as long as possible. The average length of stay in a PACE program is twenty-eight months from time of admission to time of discharge. Our PACE program has only been operational for four months and already we have experienced the death of two participants. Our hospice team was serving neither at the time of death; both deaths were sudden and unexpected, but speak to the frailty of the individuals served.

**For Some, the Transition Can Be Easy**

There are so many similarities between hospice and PACE that making the leap to become a PACE site is very much a possibility for many hospices, especially if they have already added a palliative care program to their continuum of services.

Both hospice and PACE are managed care; both utilize an interdisciplinary team approach; both are patient centered and holistic in nature; both encompass the family unit; both require multiple contractual arrangements; and both often require out-of-the-box thinking to meet needs. Hospice is reimbursed on a per-diem basis and PACE is reimbursed on a per-member, per-month basis.

In terms of the paperwork, the application process to become a PACE provider is cumbersome. However, we found most of the required components were elements we already had in place, including most of the necessary infrastructure. (Interestingly, CMS regulations require a Quality Assurance Performance Improvement Plan for PACE that’s almost identical to that proposed in the new Hospice CoPs.) Also, utilizing existing hospice staff to get the program started has afforded us some cost savings in the initial start-up. Yet, as the program grows, it will definitely require its own dedicated staff.

Since the heart of a PACE program is an adult day center, there will most likely be some capital costs for any hospice program moving to establish a PACE program. Midland already has a campus of buildings, including the one...
we had utilized for adult day care services. We embarked on a renovation of that building for PACE in order to provide a clinic, therapy area, and more bathrooms to accommodate increased census and programming.

**Some of the Challenges**
One of the most difficult obstacles has been working with our state legislature to approve the program. That process has taken four years. Our board had the foresight to include PACE as an initiative in all three years of our strategic plan. A less-persistent organization might have given up, but we were determined to bring the PACE option to our community. While not all states will require that same level of perseverance, the process will most likely take a minimum of 18 months to two years.

For Midland, the inclusion of PACE into our continuum has been very beneficial. It has helped us provide care to a new constituency and has diversified funding streams to help stabilize our organization from future cuts in hospice. PACE is also funded in part by Medicare, so there is always the possibility that it too will experience reimbursement decreases.

I would not encourage every hospice to consider becoming a PACE provider as part of a diversification strategy. It is a risk, so you must determine if your organization could manage this type of undertaking. I would, however, encourage all hospices to be aware of what’s going on in their communities and, where possible, find ways to collaborate. If a PACE program or new Medicare/Medicaid waiver programs are introduced into your area, they will be a competitor or a partner— the choice is, in part, up to you.

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**Is Your Organization Inclusive?**

Are you serving all populations in your community? Is that your goal, but you’re not quite sure the steps you should take or how to begin?

NHPCO’s Inclusion and Access Toolbox offers a host of resources to help support your program’s efforts to create an inclusive organization.

The Toolbox is a 116-page manual that is organized into eight chapters, covering such topics as Vision, Mission and Values; Community Presence; Marketing/Public Relations; Board Development; and Workforce Development. However, what makes this manual particularly helpful is the wealth of suggestions and successes that have been compiled from hospice programs around the country. You’ll learn firsthand what worked for organizations just like yours.

To preview the manual, visit nhpc.org/access. To order your copy, visit nhpc.org/marketplace (Item 821026, Member Price: $24.99).
HPCO developed the **10 Components of Quality in Hospice Care** as a helpful guide to organizing, assessing and monitoring all aspects of your organization. To review these components, download the brochure, **Quality Partners: An Introduction** from nhpco.org/quality.
“So, tell me, how will you live out your hospice mission in your role?” We ask each new employee this question during the first afternoon of orientation.

Zach, a college student who would assist maintenance during the summer responded: “Well, I’ll be sure hallways are clean and doors are working so that care providers can get in and out of the office to visit patients as fast and easy as possible.” We applauded. Zach enthusiastically added: “And if I’m outside mowing the lawn, I need to keep an eye out for anyone who looks like they’re not sure where to go. They might want to get information about hospice, make a donation, volunteer, or attend an education session. I need to stop and ask if I can help. We want people to feel welcome.” More applause. Zach’s insights and passion for excellence were contagious.

Educating our workforce toward excellence begins and ends with our hospice mission. Whatever one’s role, the goals and outcomes of one’s work will reflect one’s understandings (or not) of our hospice care. Grasping one’s roles and goals within the larger organization can ignite one’s purpose with passion. It can fuel problem-solving with steadfast perseverance.

Such education begins with the interview of any potential employee, student, or volunteer. Crucial questions should be explored:

- What do you understand hospice is and does?
- How do you see this job contributing to that?
- Do this person’s behaviors, skills, and experience match up with our expectations of this specific role, and its place within our larger mission?

One employee might be highly skilled on paper, but miss the mission. Other employees might not have much initial information about hospice, but their in-the-moment behaviors inform you that they are already learning and getting it. The interview is a two-way street, for we communicate our hospice values and standards of excellence (or not) in our interview process. The interviewer and process should accurately mirror the organization’s standards of excellence.

Ongoing opportunities to link one’s role to the hospice mission abound. A natural continuum of education starts with the interview and hiring process, and moves through orientation and precepting. Assessments help the supervisor and person set personalized learning goals, with resources and timeframes identified. The employee translates concepts of the mission into on-the-job tasks, behaviors, and relating, with feedback from one’s supervisor and colleagues. The employee’s implementation of the mission is nurtured with inservices, demonstrated through competencies, and fleshed out in annual performance appraisals. One’s personal standards of excellence are examined. New goals for one’s role are envisioned and defined.

Quality Partners’ 10 Components of Quality in Hospice Care define measures of workforce excellence for any individual and for all departments within an organization. Workforce excellence requires individual accountability and moves outward to one’s team, and further to embrace and affirm all parts of the whole organization.

The word “organization” is similar to the words “organism” or “organ,” which denote a living, breathing entity; not a dead, on-paper-only chart. A physical body requires well-functioning organs, living and breathing together as a whole. Most hospice employees can articulate how we provide holistic care to the person and family’s physical, psychosocial, and spiritual needs. Further, can our hospice employees de-
Workforce excellence requires both self-awareness and other-awareness. It calls us to value and respect the contributions each of us makes to our hospice mission. Workforce excellence confronts us to discard those attitudes or activities which clutter our daily paths.

As the director for two separate departments moving into shared workspace, I had each department write on sticky notes all of the responsibilities they knew the other department did, and post these on a wall. Next, each group wrote what they actually do on different colored sticky notes and posted these alongside the first. Readers can guess what happened. Lively interaction, learning, and appreciation took over as members got to talk with each other about their daily roles and goals. Next, I had both departments write sticky notes for (1) hospice values that drive their work, (2) frustrations in accomplishing work, and (3) hopes for outcomes from their work. Readers can guess again. This time, values, frustrations, and hopes were incredibly aligned. Those became our starting place for creating our new shared spaces and encounters ahead.

The 10 Components of Quality in Hospice Care, themselves, teach the importance of each person, of each discipline, and of working together with inclusiveness, integrity, and excellence. A CEO/director or other leader can readily affirm and educate all persons and disciplines by simply walking through the 10 components during an organizational-wide staff meeting. Divisive ‘we-they’ mentalities can be confronted and perceptions can be stretched. Mission-driven understandings for self and others can be instilled.

Other educational opportunities for linking everyone’s role to the mission might include:

- team competencies (measuring/demonstrating how well the team functions);
- cross-disciplinary shadowing;
- reward and recognition programs;
- mentoring leaders and teachers;
- examining new programs or initiatives against one’s mission statement; and
- having a contest for ideas from staff/volunteers for ways to learn about each other’s roles.
“So, tell us, how do you and your colleagues live out your hospice mission?”
We’re eager to hear.

Joy Berger is director of the Hospice Institute in Louisville, Kentucky as well as an adjunct music therapy faculty member at the University of Louisville. She is board certified as both a music therapist and chaplain, and currently serves as NCHPP’s Research/Academics/Education Section Leader.

Healers Grieve Too:
Healing the Healer

By Donna Burgess, LISW, ACSW, BCD, CT

Being involved with end-of-life care does not make us immune to the effects of death. Hospice employees experience the same kinds of loss that our patients and families experience. We have husbands, wives, brothers, sisters, children and grandchildren who die. Some will die with the care we give and others will go unexpectedly. We become attached to particular patients and grieve them when they die. At times, we even have to cope with the death of our co-workers.

Professional Grief
Our professional death experiences are different from deaths we experience in our personal lives. Both should be addressed, but they may be mourned differently.

According to the National Association of Social Workers, we mourn professional losses as distant losses. These are the people we provided care for, but they had not been part of our everyday lives until we began providing services. The effects of this grief may be subtle, evident in emotions such as anger, anxiety, helplessness or guilt. If not addressed, professional grief can be cumulative. It can lead to compassion fatigue, ineffective job function, and eventually burnout.

It is important to continually address one’s professional losses when working in end-of-life care. Staff should be aware of the variety of ways they can grieve and mourn these losses. If the staff choose to, attending the memorial visitation enables them to say “good-bye” to the patient while honoring that person and his/her family. All staff should be given an opportunity to process the death with peers or supervisor(s).

Besides the rituals surrounding death, we need to give ourselves permission to take care of ourselves (in keeping with the saying that ‘you can’t give what you don’t have’). A balance between work and the rest of our life helps facilitate our emotional and physical well-being. Taking breaks, going on vacation, and turning off the cell phone when not on-call are just a few ways of getting away from the stress of work.

Death of a Co-Worker
According to LifeLines Online, the most common workplace fatality is highway crashes. With nurses, social workers, home health aides, chaplains and bereavement staff logging many hours and miles each week on the road, the likelihood of an accident increases—especially since hospice staff is notorious for driving while

continued on page 22
Yes,

you can maintain relationships with your community pharmacy!

Hospice Pharmacia utilizes a pharmacy network of more than 60,000 pharmacies nationwide for medication access. So, YES, you can partner with HP for comprehensive medication management services and still maintain relationships with your preferred community pharmacies!
eating, talking on the cell phone, or writing a note. All of these activities increase the odds of becoming a tragic statistic.

We also have co-workers who die from illnesses, possibly even in our hospice program. These are people we worked with side by side, providing care, and now they are the ones receiving it. There is a friendship component along with the professional relationship and the response to the death reflects both. The loss becomes personalized as the co-worker is no longer there but the business must continue, as though the death were of a usual nature.

Staff often does not take enough time to grieve a death of a co-worker. When it is an immediate family member, staff usually takes bereavement leave and, at times, a few more days off. They may also take a day off when a friend dies. But, when a co-worker dies, the business at hand often continues. It is rare to have an office that can close down even for as long as a funeral. Acknowledging the death of the co-worker is important. Gathering together the entire staff following the death or attending the visitation/funeral often helps. While it will take time out of the workday, doing so will honor the deceased and allow the grief and mourning process to begin for surviving staff members.

**Personal Loss**

Personal loss also has a profound effect on the employee whose loved one has died. Sometimes we mistakenly believe that somehow, because we work in the field, we are protected from experiencing the same emotions as our families. The emotional side of us does not change just because we have the knowledge to understand what is happening and possibly the foresight to know how the grief journey may unfold. Sometimes knowing is harder and we might have a tendency to want to hurry the process along faster than it would normally progress.

The personal losses of family members and friends can interfere with our ability as staff to be present and effective with hospice patients and families. It is important not to turn the focus of the conversation toward our story when theirs is what needs to be heard. Knowing people who we can talk to about our personal losses can be an enormous help in this process.

Having staff members recognize the death is significant to the healing process for those who have had personal losses. Taking the time to recognize the grief of co-workers allows them to tell their story and normalize their own grief. As well as validating the loss, consider other services or options to support the employee. Some hospices provide staff with written material on grief education. Others invite the staff person to grief support groups. Still others recommend books or poetry that may be helpful to grieving staff. Regardless of the modality, reaching out to the person and being supportive in the grief journey is of utmost importance. If staff feel heard and supported, and can identify ways to express and cope with their losses, they will be better able to provide as well as receive care.

**Closing Thoughts**

No matter what type of loss, it is important not to overlook our feelings. This helps address

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**Resources to Help You Support Staff**

Caring Connections has developed a special initiative, It’s About How You LIVE — at Work, to help businesses evaluate and enhance their current “work-life” programs and policies to better support staff during times of personal loss and serious illness. See the display ad on page 41.

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If staff feel heard and supported, and can identify ways to express...their losses, they will be better able to provide care.

Donna Burgess is the grief and volunteer services director at Hospice of Central Iowa in West Des Moines. She is serving her first term as a Bereavement Professional Steering Committee member.

References:


Palliative Care and Hospice Positions—Pennsylvania

MEDICAL DIRECTOR, HOSPICE – Seeking physician with experience in hospice care to provide comprehensive oversight for the medical management of patients in the Medicare–certified hospice program of 800–bed Lehigh Valley Hospital (LVH). Embrace a patient centered care philosophy and lead an interdisciplinary team approach to patient care. Facilitate medical education opportunities, with reference to end of life hospice care, consult with patients’ attending physicians, make hospice rounds and home visits and provide medical leadership and advocacy for program growth. Oversee 10–bed hospice unit and 100+ in–home patients. Please e–mail cover letter and CV to: carol.voorhees@LVH.com Phone 610–969–0212.

PALLIATIVE CARE PHYSICIAN and NURSE PRACTITIONERS– Compassionate clinicians with experience caring for seriously ill patients needed for growing practice at Lehigh Valley Hospital and Health Network. OACIS (Optimizing Advanced Complex Illness Support) is a newly–formed practice which takes a comprehensive approach to caring for patients, in hospital and at home, who need palliative care across the illness continuum. Join a practice with tremendous growth potential. Clinicians should be BC/BE in Hospice and Palliative Care. Please e–mail CV to: debra.perna@LVH.com Phone 610–969–0216.

LVH offers competitive salaries and superb benefits including family health care with no employee contribution. Lehigh Valley is located 60 miles north of Philadelphia and 90 miles west of Manhattan.
While it is essential that the rehabilitation staff who see our patients provide the most sensitive, appropriate and timely care, it remains a challenge for many agencies to find these therapists and integrate them into the interdisciplinary team.

It may be that our organizations have internal barriers to therapy utilization, which have been developed over time and from the experiences of past practice. Having gotten along with little utilization of physical, occupational and speech therapy since the ‘early days’ of hospice, it might seem that other staff would be adequate to provide general instruction to a patient or family caregiver. Negative experiences also may have occurred when a therapist’s intervention was not aligned with the interdisciplinary team’s goals. Difficulty in finding and keeping therapists have also been frequently reported.

External barriers also exist and might be identified by therapists whom you hope would join your staff. As in every profession, many therapists have limited experience and comfort with dying people and their families. Those feelings may come from a lack of education, or perhaps a negative personal experience. Many therapists may not be aware of how much there is to offer people to enhance comfort and quality of life as they live in their time of dying. The therapist may also miss the window of opportunity to provide meaningful intervention, if other patients are seen as a priority over hospice patients. The lower frequency of hospice therapy visits—and often-changing activity level—is a challenge for therapists who are more comfortable with other, more predictable practice areas and patterns.

The Proposed Medicare Conditions of Participation, which are expected out in May 2008, identify the availability and provision of physical, occupational and speech therapy consistent with the accepted standards of practice. This language has evolved from ‘as needed’ in the original CoPs from 25 years ago and is still in use. New therapy practice patterns have developed as the hospice and palliative care field has grown that mesh perfectly with the end-of-life care our organizations provide. Physical therapy has much to offer towards maximizing functional mobility, increasing patient and caregiver safety, and improving comfort and quality of life. Occupational therapy likewise eases the struggles of self care and activities of daily living, provides adaptive equipment with modifications, and supports work, family and leisure roles. Speech therapy assesses language and cognition to promote communication at this important time of transition, and can instruct on safe swallowing and even ‘recreational eating.’

Help Wanted: Hospice Therapist

By Richard Briggs MA, PT

The first step to hiring therapists is to identify reasons that they would be attracted to joining your organization. If the therapists are coming from a home health environment, the paperwork is apt to be dramatically reduced, as they would not do case admissions, any OASIS data collection, or discharge summaries. The autonomy that hospice professionals enjoy as part of the IDT is shared by therapists who, in many states, are allowed such practice; in fact, many rehabilitation centers have similar IDTs.

Working within the team can be extremely rewarding as together we solve the many complex and unique situations of end-of-life care in the home. Flexible scheduling may also be attractive, recognizing that in the majority of smaller hospices, patient census may not support a full-time position. Therapists can also share the curiosity, learning and growth experienced in providing care to the terminally ill.

Opportunities for recruitment are many. As a number of speakers at NHPCO’s recent Management and Leadership Conference identified,
personal contacts through your staff may be an excellent way to identify rehabilitation professionals who might fit in well with your organization. Physical, occupational, and speech therapy programs exist at universities in nearly every state across the country. Providing outreach and end-of-life education to these programs would certainly build awareness and contacts for potential candidates. Local and regional media, as well as professional journals and periodicals, will carry Help Wanted ads. The professional organizations for each discipline also have Web sites with connections to locate therapists in your community with expertise in areas such as oncology, geriatrics, or home health, if not hospice or palliative care (see the sidebar on page 26).

**Tips on Training and Retaining Staff**

So now you have found and hired a therapist. What is the next step? I pose this question: How would you train or orient any other clinician new to a hospice or palliative care environment?

A comprehensive orientation program would be the first step to welcoming the new therapist to the interdisciplinary team. Not only are the session’s organizational components important, but the session itself can help nurture understanding and comfort with the complex issues and questions that arise around the dying process.

A therapist’s attendance at IDT meetings is also essential and serves several purposes. It promotes communication and team building as well as significant learning about transdisciplinary care issues and the practice of language around end-of-life issues. Ongoing staff development should include the rehabilitation providers as well. Full integration of therapists into the team is the best investment we can make to assure appropriate care and healthy staff.

Use of professional resources from NHPCO’s Marketplace such as the Complementary Therapies in End-of-Life Care handbook (nhpc.org/marketplace; item 700290), NCHPP’s Allied Therapist Section (nhpc.org/nchpp), or the APTA’s Hospice and Palliative Care Special Interest Group (oncologypt.org/sigs/hospice.cfm) can support the new hospice therapy professional.

While none of these actions will happen by themselves, many of the pieces are in place in most hospice programs, or the national organizations which provide support to professional development.

The benefits of having rehabilitation professionals readily available to your agency and community are significant. Using this integrated care, it is often possible to exchange nursing visits with therapy visits and reduce CNA needs as caregivers are more independent and satisfied in caring for their loved one. Patient safety is improved with reduced falls, as well as fewer call-out visits. Improving quality of life and receiving earlier referrals from successful integration of rehabilitation therapies may also increase length of stay. These cost-neutral strategies allow for improved quality and satisfaction in a fiscally responsible manner.
Make an action plan. What three things can you do to help build your rehabilitation therapy services component this year?

Richard Briggs has 20 years of experience as a physical therapist with Enloe Homecare and Hospice in Chico, California and serves as NCHPP’s Allied Therapist Section Leader. He also writes, lectures, and consults with agencies to integrate physical therapy into hospice care through his practice, Hospice Physical Therapy Associates.

Some Helpful Ways to Find Therapists

- American Physical Therapy Association: apta.org > Find a PT
- American Occupational Therapy Association: aota.org > OT JobLink
- American Speech-Language-Hearing Association: asha.org > Find a Professional
- American Music Therapy Association: musictherapy.org/find.html
- American Massage Therapy Association: amtamassage.org/findamassage/locator.htm
- American Art Therapy Association: arttherapy.org

Top 10 Reasons Hospice Avoids Therapy Services*

- Nurses can do those things well enough
- We have gotten along without them for years
- They cost too much
- They never see my patients soon enough
- The last one hurt my patient
- They will only raise patient’s and family’s hopes
- I cannot find or keep a therapist very long
- These people are dying
- Their goals are never realistic
- What could they do?

Top 10 Reasons Therapists Avoid Hospice*

- It’s like the plague
- Every patient dies
- Public ambivalence: valuable work... let’s change the subject
- I don’t have anything to offer
- Low and variable visit frequency
- Negative personal experience with dying
- Other patients are more important and urgent
- Limited return clientele
- Continued need for patient-family-team education
- Low referral frequency

Top 10 Reasons For Therapists To Enjoy Hospice Practice*

- No OASIS
- No Case Admissions
- No Discharge Summaries
- Hospice Benefit—local team fiscal oversight
- Unique problem-solving opportunities
- Flexible scheduling
- Satisfaction with provision of valuable care
- Supportive IDT
- Morbid sense of humor
- Interest in end-of-life care, experiences, and issues

Resources Revised to Help Meet Your Quality Improvement Goals...

You will find that many of NHPCO’s educational resources have been reorganized to reflect the 10 Components of Quality—from the items presented in Marketplace...to NHPCO’s Standards of Practice.

Quality Tracks Added to Conferences and AWS...

NHPCO conferences and audio web seminars feature “Quality” tracks that address Quality Partners’ 10 Components—one more way the message of quality is being integrated into all we do.
You’ve probably heard a lot of buzz about “succession planning” and “talent management.” Both topics are receiving significant attention due to the anticipated retirement of senior hospice managers, the nursing shortage, and increased focus on risk management, quality and “getting the right people on the bus.”

Succession planning (or “leadership continuity planning,” as I prefer to call it) helps an organization prepare for vacancies in key leadership positions. Talent management encompasses a philosophy of dedicated attention to recruiting, training, assessing, rewarding, and retaining high-quality staff and volunteers.

More and more organizations are recognizing the importance of pairing plans for continuity of leadership with talent management as key elements of sustained organizational performance and market leadership. This is a best practice for achieving the goals set forth in Quality Partners’ 10 Components of Quality in Hospice Care, at least in three areas: Organizational Excellence, Stewardship and Accountability, and Workforce Excellence. Together, these plans encompass a number of key attributes of excellent organizations: intentionality, transparency, well-managed risk, constructive board-staff partnerships, and revitalization.

A plan for leadership continuity by itself outlines who might step into vacant positions. However, without a parallel plan for developing leaders, a succession plan may provide for continuity, but not ensure high performance by those who fill the vacancy.

In a study conducted by the Furst Group and NHPCO in 2005, 38 percent of responding hospice executives said they had a succession plan in place, yet only 37 percent of those plans were in writing and only 45 percent had been approved by the board of directors or shared with executive staff. In a more limited study conducted in 2007 by The Corridor Group, 61 percent of respondents reported having a succession plan in place, but of those, 82 percent covered a planned departure, while only 27 percent had a plan in place for emergency succession. Clearly, most hospices have an opportunity to strengthen their plans for ensuring leadership continuity. They can take things to an even higher level by pairing their succession plans with a talent development process.

Together, leadership continuity and leadership development plans provide deliberate and intentional processes to:

- Minimize gaps in leadership;
- Minimize time for new leaders to get up to speed;
- Support those who are stretching in new or interim positions.

**Getting Started with Leadership Continuity Planning**

It makes sense for organizations to prioritize the development of leadership continuity (i.e., succession) plans based primarily upon the potential impact of a vacancy and, secondarily, on the probability of a vacancy in that position. Hence, most organizations begin their continuity planning with the chief executive position and then often expand their plans to cover the senior leadership team and, eventually, the board officers and chairs and/or all management positions.

Continuity plans typically address two types of vacancies: the planned and the unexpected (or emergency). The details of succession plans usu-
ally are based upon whether the incumbent is expected to return and how long it will be before that happens. Each of the two types of vacancies are typically addressed in plans for short-term (three months or less), long-term (more than three months, but incumbent is expected to eventually return), and permanent vacancies. So, a typical plan addresses the six combinations of type (planned and unplanned) and duration (short-term, long-term or permanent).

For each situation, plans typically address the following items:
- Who are the candidates to serve as the interim leader?
- What authority will the interim leader have?
- What compensation change will be made for the interim leader?
- Who will oversee and support the interim leader?
- How will changes be communicated? By and to whom?
- What will define the end of the interim period?
- Will a transition committee be formed? If so, who will serve and what will be the process?
- What systems will be used to ensure that key information held by leaders is documented and retained?

For permanent (and in some cases long-term) vacancies, these additional elements may be added:
- Will a needs assessment be conducted? If so, how?
- What will be the search process? Who will be involved?

And for planned transitions, a final element will be:
- What are the expectations for the departing incumbent?

Many of these elements may be the same across the spectrum of types and lengths of vacancies, but it is a useful exercise to consider what variations, if any, might be appropriate for each situation. All plans should assign responsibilities for oversight and support of those who provide interim leadership.

**Developing High-Performing Leaders**

Developing plans for leadership continuity are comparatively simple compared to developing a culture of leadership development. Such a culture includes deliberate and intentional processes that not only develop high-performing leaders in their current jobs, but also nurture a pool of candidates ready to step into new roles and be high performers in those roles. This effort requires dedicated resources and systems to assess, recruit, train, nurture, and retain high-performing individuals, and the capability to forecast future leadership needs.

Organizations committed to high-performing leadership development are characterized by rigorous screening of candidates, use of behavior and skill assessment tools, in-depth orientation to culture as well as position, and fostering employee/volunteer ownership of their own development. These organizations commit a high level of management focus, and financial and systems support to achieve these goals.
Getting started on creating such a culture can begin with assessing where the organization currently is and where it wants to be in a number of areas. An organization can start with any one of these elements and develop a plan to eventually address all areas as management focus and budget allow:

- Identifying desired behaviors and competencies;
- Incorporating desired attributes into assessments of candidates and current staff;
- Developing a system to track assessments and to document development plans for each staff person;
- Articulating a recruiting “brand” that distinguishes your organization from others;
- Assessing how your orientation process instills organizational values and insures competencies;
- Evaluating the tools that your managers have at their disposal for encouraging and rewarding high performance;
- Integrating leadership development into strategic plans and objectives;
- Matching career paths with formal education, mentoring, and opportunities for “stretch” assignments;
- Monitoring turnover and employee satisfaction.

Checking Progress— Where Do You Stand?

Use the following checklist to assess your progress on ensuring continuity of high-performing leaders:

1. Does a written policy/procedure exist for:  
   a. Unplanned vacancies? ☐ Yes ☐ No  
   b. Planned vacancies? ☐ Yes ☐ No
2. Are systems in place to track leadership development efforts? ☐ Yes ☐ No
3. Are resources and incentives in place to support leadership development (training, mentoring, budget)? ☐ Yes ☐ No
4. Are systems in place to capture key information? ☐ Yes ☐ No
5. Are leadership continuity and development integrated into ongoing processes:  
   a. Strategic planning ☐ Yes ☐ No  
   b. Performance reviews ☐ Yes ☐ No  
   c. Budget development ☐ Yes ☐ No
6. Is a defined process in place to project needed skills, behaviors and competencies for future openings? ☐ Yes ☐ No
7. Are the plans and processes noted above reviewed and updated on a regular basis? ☐ Yes ☐ No
How to Start on a Sure Footing
Here are some suggestions on how to avoid the typical barriers than can derail continuity and leadership development plans:

**Focus on the long-term goal**
Initial discussions between a chief executive and his/her board or between levels of management can often get bogged down by second guessing why each party is bringing up succession planning at this particular point in time (e.g., Is the staff person planning to leave? Is the board or superior unhappy with the staff person?). It is important to establish up front that succession planning is a best practice in and of itself and isn’t necessarily geared to any near-term actions.

**Make sure that all levels of the organization are committed**
A strong level of commitment is key to successfully implementing a combined set of leadership continuity and development practices. Especially for leadership development, an organization must be ready to commit energy and financial resources toward building and maintaining its talent pool. A key part of fostering commitment is including those impacted by the change in defining the change and in re-evaluating the situation on a periodic basis.

**Celebrate progress**
Look for and celebrate any progress in each area. Remember that changes to culture need to be reinforced on a regular basis.

Pairing plans for continuity and leadership development can have a tremendous payback in terms of reduced turn-over, improved morale, and high quality operations. Establishing this linkage takes time and commitment, but can bring rewarding results.

*Bill Musick is the owner and principal consultant of Tower Hill Resources, an affiliate of The Corridor Group. He is an expert in feasibility analysis of hospice care centers and strategic positioning of hospice and end-of-life care services, and has specific interest in working with chief executives and their boards to achieve new levels of effectiveness in the governance of their organizations. He can be reached at BMusick@Tower-Hill.com.*

**Resources:**
- 2005 Hospice and Palliative Care Leadership Survey, National Hospice and Palliative Care Organization and Furst Group, 2005.
- The Annie E. Casey Foundation: Executive Transitions Monograph Series ([www.aecf.org/publications](http://www.aecf.org/publications)):
  - Capturing the Power of Leadership Change
  - Interim Executive Directors—The Power in the Middle
  - Founder Transitions: Creating Good Endings and New Beginnings
  - Up Next—Generation Change and the Leadership of Nonprofit Organizations
  - Staying Engaged, Stepping Up
Quality is upon us, more now than ever. Given the nature of healthcare in this land of ours, it is not surprising that we have held up quality as an attribute of great importance. In the last year, quality has become a last benchmark to divine that heart and value remain in the end-of-life care field for years to come. With an ever-increasing focus on reimbursement levels and regulations, there is little to keep our system of care from becoming lifeless, mired in numbers and documentation. It has felt that this notion of quality possesses something that will allow us to keep the spirit of palliative care and hospice fertile and vibrant. This is because in its nature, quality connotes depth. It connotes ingenuity. It connotes mastery.

It would seem important to remember these aspects of quality as we strive for improvements in ourselves, and the programs we work with. Quality enriches its surroundings because its flavor is complex and embodied. It has a presence that is impeccable. When the caregiving you receive is of high quality, it need not congratulate itself. You know it in how you feel and how you are seen. This is the great gift that quality can bring to our work, to our patients, to our families, and to ourselves. Quality is not simply about improvement. It is a lived state of being. It is an aspiration toward that impeccable state.

We must strive to deepen our work, not just qualify it. The incitation for quality reaches past the refinement of organizational structure and into the meaning of why and for what purpose. For that is the place of growth, the place of learning. In that place, skills become integrated and possess a certain knowing. They truly become a resource. One well-learned skill is worth 10 that are only learned to fulfill a competency. If the motivation is the latter, then quality becomes paper-thin. Quality becomes something concerned with mere compliance, and we are capable of more than that. We are capable of work that is astounding.

For quality to truly be embraced and honored, it must reflect that deeper meaning and goal. After all, it is an initiative. Initiative is a word connected to inventiveness, courage and foresight. Is that how you think of it? Do you feel the quality project your hospice is working on has courage? Or enterprise? What is it striving for? The amazing thing is that aspiring to these levels does not require more energy, time or money. In fact, it’s probably more costly not to aspire to a definition of “quality initiative” that is about embodied excellence.

It has been a year since the start of the Quality Partners program. We have an opportunity to make quality more than a mechanism by which the federal government judges and evaluates us. We can use it to strive for a way of practicing end-of-life care that would make those who came before us proud. They would be proud because they would see commitment to personal and communal growth. For surely they would want us to improve and expand the practice of caregiving to a place of profound artistry, while connecting it back to its roots and innate wisdom. They would want us to be about more than just a diagnosis and a collection of symptoms. Somehow, I feel that they would not have wanted us to relegate quality solely to a series of checkboxes on a form. They would want us to think outside the box, so to speak, and build upon what they taught us.

To be impeccable requires us to know the meaning behind the words. To not settle for a surface understanding, but to reach down into our bones and recall the collected heritage of caregiving within us. It is to know ourselves intimately, so that those we are with can feel relaxed in being themselves. It is also about humility. At this point
you might be asking how many crazy pills did this guy have for breakfast this morning? Despite the crazy pills, my question to you is why aspire for less? Why aspire to just get by? Why not encourage and celebrate every member of your team, and ask them what is their meaning of quality? What do they strive for? Trust me, if we can do that, there will be no question as to our presence in the continuum of care. The question is, are we willing to try?

Carlyle Coash has been a hospice chaplain since 2000, in Boulder, Colorado and now California. He is board certified with the Association of Professional Chaplains and currently serves as NCHPP’s Spiritual Caregiving Section Leader.
Guidelines for Better Stewardship and Accountability

By Anne K. Hochsprung, CPA

As a community-based hospice organization, we are accountable to our patients, families, care partners and community to be good stewards of the resources bestowed upon us. We must uphold the highest level of ethical conduct and provide an atmosphere of transparency and accountability.

As such, the Stewardship and Accountability component of the 10 Components of Quality in Hospice Care is an important aspect of the Quality Partners program. While there are many resources that support the premise of these standards, I have found the work provided by the Independent Sector to be especially helpful.

About the Independent Sector

The Independent Sector is a 501c (3) coalition that was established in 1980 to provide leadership to charitable and philanthropic businesses. Since inception, the Independent Sector has been very involved in significant research to help not-for-profits thrive. It has been involved in developing and advancing public policies that support charitable organizations, and has prepared a significant amount of resources to help the staff, governing boards, and volunteers of these organizations better serve their communities.

One goal of this coalition is to promote accountability throughout the nonprofit sector, including foundations, philanthropic organizations, and other non-profit agencies. It has also established the Panel on Nonprofit Sector where significant work has been done in preparing recommendations covering governance, fiduciary responsibilities, regulation, and financial accountability.

Checklist for Accountability

The Independent Sector has created a Checklist for Accountability. It has been added to and modified over time and will continue to be changed as needs arise and further research is completed.

As you review this nine-point checklist (shown below), you can begin to determine your organization’s level of accountability within the community, and identify areas that need improvement. In fact, you should feel free to modify the checklist to meet the specific needs of your own organization, since it’s meant to be a guide when establishing the principles to demonstrate stewardship and accountability.

1. Develop a culture of accountability and transparency

In order to develop a culture of accountability and transparency, an organization should develop standards, rules and practices that are known throughout the organization and the community—through volunteers, employees and all internal/external communications.

2. Adopt a statement of values and code of ethics

An organization should adopt a statement that describes the organization’s ethical principles to be followed by all employees, board members and volunteers. This statement should be adopted by the board annually and discussed with all new staff. It should also be made available for public disclosure, and revisited annually by all.

3. Adopt a conflict of interest policy

An organization should adopt a policy that is consistent with the individual state and federal laws. By complying with this policy, an organization will be able to avoid even the appearance of any improprieties.

4. Ensure that the board of directors understands and can fulfill its financial responsibilities

In order to meet this standard, an organization should ensure that the board regularly reviews and approves the financial statements. In fact, the board should include a financial expert, or be able to rely on an independent financial expert if one does not exist on the board.
5. Conduct independent financial reviews—particularly audits
These reviews/audits should be conducted by an independent third-party financial expert—and be done on an annual basis.

6. Ensure the accuracy of and make public the organization’s Form 990
The Form 990 should be signed by the CEO or CFO and fully reviewed by the board of directors. It should also be filed on a timely basis.

7. Be transparent
In order to be truly transparent, an organization should make information about its finances, operations, and governance available to donors, volunteers, and staff as well as to the public at large. This can be done by posting the IRS Form 990 or its annual report on your Web site.

8. Establish and support a policy on reporting suspected misconduct or malfeasance
Also known as a “Whistleblower Protection Policy,” this policy should be one that encourages employees and volunteers to come forward as soon as possible with any credible information about any illegal practices or violations of the policy. Those who do come forward should also feel safe in reporting this information.

9. Remain current with the law
In order to meet this standard, someone within the organization should be designated as responsible for remaining current with all laws and regulations.

By being able to positively assess an organization’s level of accountability and stewardship through these nine standards, an organization can begin to demonstrate its level of commitment to high ethical standards and integrity.

Anne Hochsprung is vice president of finance for The Hospice of the Florida Suncoast in Clearwater, where she has worked since 1999. Prior to joining the hospice, she spent 20 years working in the healthcare industry. In addition to her role as NCHPP’s Finance Section Leader, Anne is part of the faculty for NHPCO’s Management Development Program.

For more information about the Independent Sector, visit independentsector.org. To review its Checklist of Accountability online, go to: www.independentsector.org/media/20050817_checklist.html.
A Day in the Life of a
Community Relations Professional
By Heather Stulken

This continues our “Day in the Life” series which began in the December 2005 issue. The series was launched to provide readers with a better understanding of the “working life” of hospice professionals around the country. In this issue, Heather Stulken, from Hospice of the Red River Valley, shares one of her “typical days” with us.

Early Morning

I woke early and hit the gym. In addition to the 60-mile commute to work, I had to drive an additional 30 miles to a neighboring community for an on-air radio interview. I had a wonderful drive through the plains of North Dakota and into the Valley.

I arrived at the radio station early—I have been on-air at this radio station before and am getting to know the staff. I had a nice visit with the receptionist until the DJ, Rob, was ready for me. I stood opposite him at a counter with a large microphone suspended from sound equipment. He was busy moving dials and pushing buttons as he controlled pre-recorded sound bites. “Well, here we go,” he said, and we were live.

This particular radio show is entitled, “Let’s Talk About It” and focuses on whatever is going on at the time. I was invited to the show to highlight a few events our organization is sponsoring. Our benefit dance is scheduled for this evening. Community volunteers have been working diligently to put together a great event and have raised substantial support.

Our bereavement specialist is also hosting a few book clubs. She was unable to accompany me to this interview, so I spoke on her behalf. The first book being discussed is authored by a nationally syndicated speaker who recently spoke at our organization’s 25th anniversary celebration.

The 8th Annual Golf Tournament is coming up and is coordinated by another group of dedicated volunteers. This region is inundated with golf tournaments each summer, so it’s important we get the word out early and often.

Midmorning

I head back to Valley City and arrive at my office around 10:30 a.m. to a pile of papers on my desk and voicemail that’s full of messages. As I sort through messages and begin making a ‘to-do’ list, I receive a call from a patient care volunteer who informs me that she’ll be having knee surgery next week and needs to take a leave of absence. This volunteer is one of two assigned to five patients at the long-term care facility in our community. I wonder who I’m going to find to fill her shoes as I enter her phone message into the patient’s charts. I decide to tend to that issue on Monday; I need to organize my thoughts for the benefit tonight.

A last-minute sponsor came in for tonight’s event and I need to add his business to the Sponsorship Poster. Our graphic designer is out of the office for the day and I don’t have access to her software. I make a few phone calls around town, find a print shop that can handle the task, and email the files to them. The printer assured me the posters would be ready by 4 p.m. today.

I receive several phone calls from individuals wanting to attend the spring seminar scheduled for this Tuesday. I jot down names and numbers
while gathering items for the dance. I overhear the office nurse talk about a patient who is actively dying and make a mental note to check on that situation later in the day. That patient may need a specially trained volunteer to sit with her if family isn’t available.

**Afternoon**

Phone calls start coming in from staff out in the field who are wondering what we’re doing for lunch. We have a social worker from another regional office helping us out today and we decide to take her out to lunch. Since our office is located in a small town, we know nearly everyone who eats in the restaurant. This makes it difficult to have a quick lunch, but does offer me good opportunities to make connections with community members and leaders.

I stop at the bank to pick up cash to have on hand for the benefit, make a couple of stops at local businesses to pick up raffle tickets and money, and grab some supplies at the request of a nurse. With about an hour to spare before I need to set things up for tonight’s event, I head back to the office. I’ve got several messages from more individuals wanting to register for spring seminars and another message from our volunteer massage therapist who is wondering if I have scheduled a massage for her for Saturday morning. I reminded her that she had a massage scheduled with a patient’s primary caregiver and call the caregiver to make sure she remembered.

I finish gathering supplies for the benefit, stop by the printer to pick up the poster, and drive to the dance hall. The large facility is completely empty, but unlocked. I arrange our red tablecloth on the large table and assemble a new display board which I had just picked up the evening before. At five foot three, I have to get up on a chair in order to attach the top sections of the board. I use smaller display boards from other events to adorn the lobby area, and arrange several brochures on the table. I stand at the doorway of the lobby to survey the display and am quite happy with what I see.

**Evening**

The office is closed and I’ve got a couple of hours until the benefit begins. Since I live an hour away and it’s a sunny day, I spend the time checking out local flower shops and walking along the river. Valley City is known as the “City of Bridges.” I enjoy the view from the water’s edge.

An hour before the benefit is scheduled to begin, I head to the dance hall. The women who worked on putting the dance together are enjoying a meal together, so I decide to meet the band and visit with them for a bit. I expected the atmosphere to be a bit hectic, but surprisingly all is calm. As dance attendees start arriving, I greet our supporters and capture the festivities with my camera. Our organization is fortunate to be part of a community that offers such great support. We are receiving a fabulous turn out.

The dance ends a little past midnight. I pack up my things and hit the road for my 60-mile drive home.

*Heather Stulken has worked in the healthcare field for the past 12 years. As the community relations representative for Hospice of the Red River Valley in Valley City, ND, she manages the marketing/public relations, development and volunteer needs of her regional office.*
The Newly Revised
Social Work Guidelines

By Sherri Weisenfluh, MSW, LCSW

NCHPP’s Social Work Section has just released its newly revised Guidelines for Social Work in Hospice. These guidelines were designed to provide a framework for the provision of social work services and, with this new edition, can assist programs in strengthening and designing exemplary social work services to benefit patients and families.

What You’ll Find in the Revision
Based on NCHPP Social Work Section meetings, listserv activity, and steering committee discussions, the guidelines subcommittee chose to include the following sections:

- Availability and Scope of Social Work Services
- Education
- Salary
- Workloads
- Supervision
- Social Work Assessment
- Care Plans
- Team Collaboration
- Documentation
- Quality
- Ethics
- Culture and Social Work in End-of-Life Care
- Communication/Language
- Medicare
- Medicaid
- Private Insurance
- Local, State and National Organizations
- Research

There are several new sections in the revised guidelines, with Quality and Communication/Language being key among them. The subcommittee felt strongly that a section on quality was warranted, given NHPCO’s focus on process improvement and quality assurance measures.

How to Use the Guidelines
The guidelines should be used to help you evaluate the provision of social work services. Toward this end, and where applicable, a section will contain reference materials, and how the specific guideline relates to regulatory requirements as well as the corresponding NHPCO standards.

The guidelines can also help you target specific areas for improvement. For example, the Communication/Language section addresses barriers to good communication. It helps educate readers on the Office of Civil Rights’ policies.
and the legal responsibilities of providers which receive federal financial assistance from the U.S. Department of Health and Human Services. Do note, however, that these guidelines are not intended to replace the CMS regulations or NHPCO’s Standards of Practice for Hospice Programs.

A Few Words About the Development
This revision was a two-year undertaking led by a dedicated team. Susan Gerbino, PhD, a member of the NCHPP Social Work Steering Committee, served as chair of the guidelines subcommittee. Dr. Gerbino, a clinical assistant professor with the New York School of Social Work, is the director of a postmaster’s certificate program in palliative and end-of-life care, and serves as a consultant to a number of hospice programs. Other members of the committee were Margie Rodriguez Le Sage, PhD, Amy Thomas, LCSW, Suzanne Bushfield, PhD, Coco Regas, MSW, and myself.

A variety of resources informed these guideline revisions, including helpful publications provided by the Council on Social Work Education and the National Association of Social Workers.

These new guidelines are now available at NHPCO’s Marketplace (nhpco.org/marketplace; item 712653).

Sherri Weisenfluh is the associate vice president of counseling for Hospice of the Bluegrass in Lexington, Kentucky, a position she has held for 15 years. In addition to her service as NCHPP’s Social Work Section Leader, she teaches part-time at the University of Kentucky.

A practical how-to guide for managers that includes information and resources about:
- End-of-life issues that affect employers and employees
- Assessing your organization
- Work-life program models
- Policies and procedures
- And more

Employer's Guide to End-of-Life Programs and Policies
Item #: 821078

It's About How You LIVE — At Work: Educational Brochures

These brochures, which are specifically geared to end-of-life issues in the workplace, include:

- Grief in the Workplace: When a Co-Worker Dies
  Item #: 821007
- Grief in the Workplace: When an Employee Dies
  Item #: 821008
- Supporting Someone Who is Grieving
  Item #: 821009
- A Guide for Working Caregivers
  Item #: 821911
- When a Co-Worker Suffers a Loss
  Item #: 713487
- Helping Employees Cope After a Critical Incident
  Item #: 821910
- A Guide for Managers
  Item #: 713453

It's About How You LIVE — At Work: Community Outreach Guide

A free resource for hospice providers, coalitions and LIVE partners to reach out and educate local employers in their communities about end-of-life issues in the workplace. The Outreach Guide is available to download online at www.caringinfo.org (Click on ‘Community’ then ‘Workplace Outreach.’)

The Outreach Guide includes:

- Strategies to engage employers and employees;
- Specific case examples of workplace outreach program models from hospices and coalitions; and
- Practical resources to help hospices and coalitions develop a successful outreach initiative in workplace settings.

You can also request a copy of the Outreach Guide on CD by contacting the Caring Connections HelpLine.

The Employer's Guide and brochures are available to order via:

PHONE: 800/646-6460

ONLINE: www.nhpc.org/marketplace

For more information about this initiative and these resources, call the Caring Connections HelpLine 800/658-8898 or e-mail liveatwork@nhpc.org.
Quality Partners
Self-Assessments: An Easy-to-Use Online Tool

As NHPCO’s president/CEO, Don Schumacher, has consistently said, hospices will be facing more scrutiny in the very near future from our regulators and Congress as well as from the communities we serve.

One of the key objectives of the Quality Partners program is to get hospice organizations to be the first to scrutinize every aspect of their own programs, identify areas where improvements are needed, and take action toward positive change. The Quality Partners self-assessments, launched in March, are the user-friendly tools to help you do just that. They can help you spot the problem areas in your operations and processes, and help you prioritize your improvement efforts. In fact, you may want to treat them as your organization’s “internal report card.”

About the Self-Assessments
There are 10 separate self-assessment forms that correspond to Quality Partners’ 10 Components of Quality in Hospice Care:
1. Patient and Family Centered Care
2. Ethical Behavior and Consumer Rights
3. Clinical Excellence and Safety
4. Inclusion and Access
5. Organizational Excellence
6. Workforce Excellence
7. Standards
8. Compliance with Laws and Regulations
9. Stewardship and Accountability
10. Performance Measurement

The self-assessments are all available online, accessed from the NHPCO Quality Partners homepage (nhpco.org/quality). Each self-assessment asks key questions that are based on NHPCO’s Standards of Practice for Hospice Programs (2006), and require an answer on a 1-to-5 scale. Each assessment also varies in length; some are quite short while others are much longer.

You can complete each assessment online, or you can print a PDF version and get input from members of your organization (in fact, printing out the assessment for group input is recommended). You can also take the time you like to complete the assessment, working on it in increments or all at once. Editing your work is also easy—it can be done at any point, even months after the initial assessment was completed.

Once you have completed a self-assessment, you can run a report in minutes—showing a summary of results for that particular component (e.g., Clinical Excellence and Safety), or a detailed report with your score for each standard within that component (e.g., CES 1.1). These reports also provide comparative state and national results which, over time as more programs participate, will help you gauge your performance against colleagues.

NHPCO’s quality team has developed the brochure, Understanding the Self-Assessments, with instructions to help you get started. Download the PDF of this brochure from nhpco.org/quality (and select “Assess Your Organization”).
What Users Have Found So Far

Since the self-assessments are based on NHPCO’s Standards, every hospice organization should find them useful, regardless of size, location, or organizational structure.

Anita Dorf is chief quality officer for Harry Hynes Memorial Hospice (based in Wichita, KA), a predominantly rural program which serves about 300 patients a day. She participated in the first and final phases of the field testing that was conducted earlier this year, and is a strong proponent of the self-assessments’ value.

During field testing, Dorf personally completed the self-assessment on Performance Measurement, and involved staff in the completion of the Clinical Excellence and Safety and the Patient and Family Centered Care self-assessments. “Staff were pleased with the exercise because it affirmed their practice in many ways, but also pointed to areas where we have a lot of opportunity to improve,” she said.

The program is planning to complete all 10 self-assessments one at a time, beginning this month, as part of a formal, agency-wide initiative. However, before asking staff to take on more work—even something as important as these self-assessments—the organization decided to look at how it could streamline some internal processes first in order to free up time to complete the assessments in a careful and thoughtful way. This preliminary step has proven very worthwhile, Dorf noted. “It has engaged staff at all levels and has fostered a wonderful energy as we worked toward achieving some common goals.”

As the organization launches its self-assessment initiative, Dorf intends to get input from all staff who want to provide input. “In terms of involving our hands-on patient care staff, our plan is to involve those who want to be involved, the early adapters so to speak,” she said. “Then, once the assessments are completed and action steps for improvement are identified, my hope is that most staff will want to get involved. Staff must buy in to proposed changes if those changes are going to work.”

Fay Ellis, director of performance improvement/compliance for HospiceCare of Boulder and Broomfield Counties in Colorado, has been a long-time advocate of NHPCO’s Standards as a way to evaluate program systems and processes. The program has actually been using NHPCO’s Standards on an annual basis, since they were first published, to assess its operations. With these online self-assessments, it makes the annual review that much easier.

Back in May, Ellis assigned each of the 10 self-assessments to program managers, asking them to complete the forms over a two-month period. Since some of the topics do overlap departments, she admitted that making the assignment was sometimes tricky. She ended up asking the director of clinical services to complete Patient and Family Centered Care and Clinical Excellence and Safety, the director of access to complete Inclusion and Access and Organizational Excellence, the human resources director to complete Work-
force Excellence, and the finance director to complete Stewardship and Accountability, while she took on the remaining four.

Ellis also encouraged managers to get as much input from staff as possible. “It may take more time, but it makes the process far more meaningful,” she said. “In fact, we have found the process is an excellent way for both staff and managers to get familiar with the Standards—it’s especially instructive for our newest employees.”

The program’s Quality and Compliance Committee is now in the process of reviewing the results. “We’re looking at areas where we were rated a 3 or lower, as well as areas where we see gaps, and will prioritize what we want to address,” Ellis said.

**Take the Approach That Works for You**

“Since Quality Partners was unveiled a year ago, NHPCO has developed a host of tools and resources, so it’s understandable that it can sometimes feel overwhelming,” said NHPCO’s director of quality, John Mastrojohn. “But the point behind Quality Partners is to help programs get their arms around issues of quality, and the self-assessments are the perfect tool for doing just that.”

As a first step, Mastrojohn recommends that members visit nhpc.org/quality and review the one-page guide, “Ten Steps to the 10 Components of Quality.” Of course, if you have questions or need assistance, email quality@nhpcio.org or call the Quality team at 703/837-1500.
Sign Up for Benchmarking and Receive the MVI Compensation Tool

Now is the best time to sign up for MVI Benchmarking! It's a new year and perhaps it is also a new chapter in your hospice's success story. But how can you make it a great year without precise monthly data? The Benchmarking System is used by more financially successful hospices than any other! It automates benchmarking and provides the precise monthly information needed to intelligently direct resources and energy. Isn't it time for your hospice to benefit from this revolutionary product that enables you to know how well your hospice is performing as well as how it compares to others...based on query criteria that YOU choose?

Also, if you sign up for Benchmarking services, your hospice will be allowed to participate and use MVI's 2008 Compensation Tool. This filtering tool allows a hospice to see what hospices are paying each position and can be filtered by Region, Average Daily Census, and Service Area Type. What?

We're all about the BUSINESS of Hospice!
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Quality Partners’ Collaboratives Offer “Hands-on” Training...

Since September 2006, programs around the country have participated in quality improvement training that is uniquely designed to help prepare for the 2008 Hospice CoPs. To learn more, see the article on page 10, or visit nhpco.org/quality >Discover the QI Collaborative.
New CMS Requirement

As NHPCO first reported to members in a Regulatory Alert issued on July 26, CMS is requiring additional data on Medicare hospice claims. Starting January 1, 2008, hospice providers will be required to report data which describe the services provided in the course of delivering each hospice level of care billed on their claims for Medicare payment.

For each week, beginning on Sunday and ending on Saturday, hospice providers are to indicate the number of services/visits provided by nurses (i.e., registered, licensed and/or nurse practitioner), home health aides, social workers, physicians, and nurse practitioners serving as the beneficiary’s attending physician. As such, please note:

- A service/visit constitutes direct care to the beneficiary;
- An entry in a medical/clinical record without a visit does not constitute a visit and as such is not counted;
- Only the number of direct patient care visits will be counted;
- Items and services within that visit are not separately counted;
- To be counted, a service/visit must be medically reasonable and necessary.

Specific instructions regarding this data are included in revisions to the Claims Processing Manual (chapter 11, section 30.3) contained in the original CMS transmittal (Change Request, CR 5567). To read the CMS transmittal in its entirety, visit the CMS Web site (cms.hhs.gov/center/hospice.asp).

The Regulatory Alert issued by NHPCO is also available online (nhpco.org/regulatory). For questions about this CMS directive, contact Jennifer Kennedy at jkennedy@nhpco.org.

Promote Your Work in JPSM

The Journal of Pain and Symptom Management is NHPCO’s official professional journal. It provides the healthcare community with results of important new research as well as clinical information related to pain management, palliative care, and hospice practice.

Practice Reports are one of JPSM’s special sections—a section that allows members to share information about the important work they are doing. The goal of these Practice Reports is to offer an opportunity for providers to present results of quality improvement projects or internal descriptive investigations aimed at care delivery issues or access to care. Through such promotion, members get their work published in a highly respected journal and, at the same time, provide models to inspire and inform others.

Submitting a Practice Report

While the quality improvement project you choose to address does not have to meet the same standards as formal research, it must have quantifiable results based on systematic measurement methods. Submissions should be approximately 1,500 words and include at least one graphic representation of the data discussed, such as a table or bar graph. All Practice Report submissions will undergo editorial review before acceptance for publication. (Please note, however, that NHPCO is happy to work with authors to get their articles ready for submission.)

As a first step, visit the NHPCO Web site (nhpco.org/jpsm) to review some of the recently published Practice Reports. If you have a quality improvement effort you’d like to present, contact NHPCO’s director of research, Carol Spence (cspence@nhpco.org).
Reach Every State Campaign: Creating Success Through Partnering

The Reach Every State Campaign is one of the key ways in which NHPCO is spreading the word about Quality Partners’ many resources—a campaign that wouldn’t be successful without support from our state organization partners.

As state organizations hold their annual conferences or workshops over the course of this year, upon invitation, members of NHPCO’s quality team have been presenting on the Quality Partners program. Depending on the time available, the presentations range from 90 minutes to half-day and full-day sessions. By the end of 2007, the team’s goal is to reach all 50 states or have them scheduled for early 2008. Thus far, feedback from these sessions has been excellent. Better still, the sessions themselves have sparked very creative initiatives by some state organizations.

NHPCP’s Component of the Month Campaign
The work of the Nebraska Hospice and Palliative Care Partnership is one excellent example of how such collaboration can work to everyone’s advantage.

Last April, NHPCO’s director of quality, John Mastrojohn, presented a half-day session during NHPCP’s annual conference. One of the resources of particular interest to NHPCP was Quality Partners’ new self-assessment tools. These tools are, in essence, 10 online forms that correspond to Quality Partners’ 10 Components of Quality in Hospice Care, and can help members evaluate their operations and processes (see the story on page 42).

“After John’s presentation, we came up with the idea for a Component of the Month Campaign,” said Jennifer Eurek, NHPCP’s education and outreach coordinator. “We wanted to encourage as many members as possible to use the self-assessments and to support them through the process.”

The campaign was kicked off in June, with participation from 12 of Nebraska’s 36 programs. While completely voluntary, NHPCP requested that each program do the 10 self-assessments in the same order. Each month since, they have held a conference call to discuss the self-assessment just completed as well as the one that’s up next. “It’s a chance to raise questions, get tips, and compare notes on some best practices that have emerged,” Eurek noted. “While we don’t want to put any pressure on members, knowing there’s a conference call scheduled about the next self-assessment has served as a good motivator. We’re hopeful that, over time and through word of mouth, more programs will participate.”

Since its launch last year, all state hospice organizations have signed or have committed to sign the Quality Partners Pledge in support of the program. Visit the Quality homepage of NHPCO’s Web site for a listing of these organizations (nhpco.org/quality > Get Started).
A CMS Resource You Should Know About

“QIO” is a national network of 53 Quality Improvement Organizations for each U.S. state, territory, and the District of Columbia—which is managed under the direction of the Centers for Medicare and Medicaid Services.

Many members may know these QIOs under their former name of “medical review organizations,” which reflected the mandated regulatory reviews they performed to ensure that Medicare recipients were receiving efficient and appropriate care from healthcare providers. In 2002, however, CMS changed their name to reflect its more intent focus on quality.

Today, under three-year contracts known as “scopes of work,” these QIOs are partnering with hospitals, nursing homes, home health agencies and primary care physicians—on a voluntary basis—to help improve care delivery and, in so doing, help ensure that patients get the right care at the right time. Through the work of multidisciplinary teams (e.g., physicians, nurses, epidemiologists, health educators, communication professionals), QIOs have become an excellent resource to providers regarding best practices and education as well as quality improvement projects in which to participate.

During the next “scopes of work” contract period, which will begin in late 2008 in most states, it is feasible that some aspects of hospice and/or palliative care will be identified as areas for improvement. This will be the first time that the QIOs will have the opportunity to work with hospice organizations in this capacity. Although healthcare organizations in each state have a QIO responsible for them, not every state has its own QIO. Now is a good time to review the QIO Web site and become familiar with their work in your state. Visit cms.hhs.gov/QualityImprovementOrgs.

NHPCO Now Accredited to Provide Continuing Medical Education to Physicians

NHPCO has been awarded accreditation by the Accreditation Council for Continuing Medical Education as a provider of continuing medical education for physicians.

Last year, NHPCO provided more than 20,600 hours of continuing education credits to professionals in the field, through conferences, audio web seminars, and other symposia. With this new accreditation, effective for the next two years, physicians now join these professionals in their ability to earn continuing education credits through NHPCO’s educational offerings.

Advancing Physician Education

This accreditation is an important step in NHPCO’s commitment to taking medical education to a new level.

The ACCME rigorously evaluates the overall continuing medical education programs of institutions according to standards adopted by its seven sponsoring organizations: American Board of Medical Specialties; American Hospital Association; American Medical Association; Association for Hospital Medical Education; Association of the American Medical Colleges; Council of Medical Specialty Societies; and the Federation of State Medical Boards of the U.S., Inc.

This accreditation assures both physicians and the public that continuing medical education activities provided by NHPCO meet the highest educational standards as specified by the ACCME.

For information about NHPCO’s educational programs and opportunities, visit nhpco.org/conferences.
Living life to the fullest, up to the final moment is what hospice and palliative care are all about.

**Palliative care** offers comfort and support, while hospice brings you and your family compassionate care when a cure isn’t possible. Together hospice and palliative care provide solutions beyond traditional medical care.

**Hospice/palliative care... It must be love.**

To learn more about advance care planning, call the HelpLine at 800/658-8898 or visit www.caringinfo.org. Para información en español, llamar 877/658-8896.
People and Places

Hospice of Wake County Honored by Siegel’s Final Address
Joel Siegel, longtime film critic for ABC network’s Good Morning America, died on June 29 due to complications from colon cancer. He battled the disease for 10 years and that experience, together with the death of his second wife, also from cancer, made him an effective spokesperson for preventive care as well as a strong supporter of hospice care.

Hospice of Wake County (Raleigh, NC) was honored to have Siegel as guest speaker for its annual dinner on May 15, which ended up being his last public appearance. During Good Morning America’s special tribute to Siegel on July 9, the broadcast highlighted his support of hospice and his final address at the Wake County program—a fitting conclusion to his work and support of end-of-life care.

Executives Promoted at Hospice of Chattanooga
Hospice of Chattanooga (Chattanooga, TN) announced four executive promotions as part of its recent core management-team reorganization: Terry Melvin, MD, to senior vice president and chief medical officer; David Rawiszer, CPA, to senior vice president and chief financial officer; Theresa Davis to senior vice president and chief marketing officer; and Julie Payne to senior vice president and chief nursing officer.

Community Hospice Physicians Earn ABHPM Certification
Drs. Anna Wright and Paul Borgman, medical directors with Community Hospice of Northeast Florida (Jacksonville), have earned their American Board of Hospice and Palliative Medicine certification, joining just 2,800 other fellow physicians across the country in achieving this important distinction.

Fielding Honored With Leadership Award
Hospice of Palm Beach County’s president/CEO, Dave Fielding, was a recipient of The South Florida Business Journal’s CEO Award for his commitment to excellence, successful leadership, and ongoing support of the community. Fielding was one of nine award recipients and the only executive from a non-profit organization.
Stage Performance Helps Overcome Stigmas About Death and Dying

This summer, the community-based coalition, Citizens for End of Life Care Education (Gibsonville, NC), co-hosted the play, Larger Than Life, in partnership with First Presbyterian Church and Hospice of Alamance-Caswell. The goal was to help the public become more comfortable with conversations about death and dying by staging an interchange between two women—one who is dealing with her imminent death and the other who must assume the role of active listener. This is one of the innovative ways that this coalition—which is both a Caring Connections LIVE partner and an affiliate member of the Carolinas Center for Hospice and End of Life Care—is meeting its mission to spread the word on the value of communicating one’s end-of-life wishes.

Online Self-Assessments—An Automated Way to Evaluate Your Processes...

Quality Partners is all about getting you to be the first to scrutinize every aspect of your own program, assess where improvements are needed, and take positive action. The online self-assessment forms are the newest tools to help you accomplish this. To learn more, see page 42.
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NHPCO’s Audio Web Seminars

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

09/20/07 — Saying Goodbye and Meaning It! Effective Closure with Clear Boundaries for Hospice Team Members
10/11/07 — Assessing and Promoting “Resilience” in Work with Patients and Families at the End of Life

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

09/25/07 — Pioneering Practices in Palliative Care: Get Ahead of the Curve!
10/23/07 — The Nuts and Bolts of Physician Billing

NHPCO Conferences

11/29 – 12/01/07 — 8th Clinical Team Conference, New Orleans, LA
4/10 - 4/12/08 — 23rd Management and Leadership Conference, Washington, DC

Hospice MDP Two-Day Foundational Course

10/1 - 10/2/07 — Bloomington, MN
11/27 - 11/28/07 — New Orleans, LA

Additional MDP Level I and II modules are available in online formats. Visit nhpco.org/mdp for more information.

Marketplace

This month, we spotlight a variety of items relating to the Quality Partners program:

Inspirational Posters
Together...

We Will Explore New Heights
Item: 820983, Member: $5.95

We Will Make a Difference
Item: 820984, Member: $5.95

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Standards of Practice for Hospice Programs
Item: 711077, Member: $59.95

Code of Ethics Poster
Item: 820142, Member: $5.95

To order, visit nhpco.org/marketplace or call 800/646-6460. Mention Code: NL01.
In this submission to NHPCO’s 2004 Photo Contest, a patient from Hospice of Lancaster County in Lancaster, PA, shows us the pendant that was shaped from the wedding band of her late husband, who had also been cared for by hospice. “Whatever my husband needed, hospice provided,” she said. “When the nurse came to see him, it lifted his spirits, and now when she comes, she lifts mine.”