The Journey Begins…

The Hospice Team on the New CoPs
Is your pharmacy able to identify your patients’ Medication Related Problems?

- In the United States (US), adverse drug reactions affect nearly 2 million patients, resulting in about 100,000 deaths each year
- Pharmacists working as part of the multidisciplinary hospice or palliative care team identify an average of 2 to 4 MRPs per patient
- 20-50% of MRPs identified by pharmacists in the hospice or palliative care settings involved one or more potentially inappropriate drugs
- 84% of interventions made by pharmacists were accepted by the prescriber

Speak with an HP team member today to see how HP can become part of your team!
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The Journey Begins
December 2, 2008 is the deadline for compliance with the new Medicare Hospice Conditions of Participation (Hospice CoPs), the federal guidelines that hospice programs must follow when serving the needs of Medicare beneficiaries.

Since the final regulations were published on June 5, 2008, NHPCO members throughout the country have been hard at work preparing for this important day. In fact, since the launch of NHPCO’s Quality Partners program in the fall of 2006, NHPCO leadership and staff have been working closely with members and state hospice leaders to help organizations prepare for the new requirements. Still, this month marks a beginning as much as it represents the conclusion of many months of hard work. As NHPCO’s president/CEO, Don Schumacher, has said, “The new regulations are the foundation—or point of departure—for the hospice community. They set the standard for higher quality care while also giving hospices flexibility in what to do in order to get there.”

The new guidelines focus on providing patient-centered care and putting the needs of the patient and family first, with emphasis on demonstrating that commitment through a formal quality assessment and performance improvement program. To realize these goals, providers must draw upon the knowledge and skills of the entire hospice interdisciplinary group—from the hospice medical director, nurse and social worker to the spiritual caregiver, bereavement counselor, and other key members of the hospice team.

Fittingly, in this issue, you will find contributions from more than a dozen members of the National Council of Hospice and Palliative Professionals that provide each discipline’s perspective on the new regulations. You will also learn how two members are using some of NHPCO’s complimentary tools to help meet the new requirements—plus much more.
Unity, camaraderie, teamwork—do these words describe your hospice team? While the hospice team—or interdisciplinary group (IDG)—has great capacity to improve the lives of terminal patients, it can sometimes be a challenge to meld the recommendations of the team’s representative disciplines into a viable plan of care that also meets the patient’s and family’s needs. We know that each professional’s level of training and field experience, along with personality traits and working style, can often hinder a team’s best efforts to function as a cohesive group. Yet, when we are able to work as a team, our patients and families truly benefit.

Under the new Hospice CoPs, bringing the team together—and working as a team—is essential if we are to meet the requirements of CoP §418.54 (Initial and Comprehensive Assessment of the Patient). The hospice IDG must now complete an initial and a comprehensive assessment that identify the patient’s need for medical, nursing, psychosocial, emotional and spiritual care. The initial assessment will determine the patient’s and family’s immediate needs and the comprehensive assessment forms the basis for the plan of care. Perhaps more importantly, the IDG is required to directly involve the patient, family and caregivers in the patient’s plan of care.

How can we help to ensure the IDG works as a team—and keeps the goals of the patient and family first?

While the senior leadership of every hospice organization must encourage, promote and develop a culture that fosters teamwork, that alone is not enough. The team members themselves must accept accountability for good communication. Even though each discipline comes to the table with certain strengths, knowledge and ability, it is imperative that the disciplines share information with each other on a situation-by-situation basis. It is well worth everyone’s time to ensure that fellow team members are always kept up to date on the patient and family’s case—whether it is a matter of leaving a note, picking up the phone, or supplying technical information or resources that can shed better light on the issues at hand.

The new Hospice CoPs also requires that the IDG involve—and respect—the desires and wishes of the patient and family. Having this ‘patient and family centered’ focus can also help unite the team. I think we all recognize that there are times in our IDG meetings—and even in casual conversations in the hallway—that it can sometimes become more about what “we want and think is best for the patient” rather than what the patient and family want. For example, when I hear that “Mrs. R. is non-compliant with her pain medication,” the first question...
The new CoPs requires that the IDG respect the desires and wishes of the patient and family. Having this ‘patient and family centered’ focus can also help unite the team.

Gregory Wood is president of the Oklahoma Hospice & Palliative Care Association and executive director of the Hospice of North Central Oklahoma. He also serves as NCHPP’s CEO/executive director/president section leader.

Nurse Section

By Pat Gibbons, BSN, CHPN

In 1983 when the first Hospice CoPs was published, I was a novice, having been in hospice for less than five years. For me, the regulations just represented ‘what we had to do to get paid.’ Now, as a long-time hospice nurse, I am pleased to say the new Hospice CoPs is a welcome recognition of the value of hospice and the importance of quality practice. I do believe that this recognition is due, in part, to the fact that the development of these new guidelines was a collaborative process. The Centers for Medicare and Medicaid Services and NHPCO have worked together to provide a framework that will help improve—and standardize—the quality of care among the nation’s providers.

As a hospice nurse, I feel that the regulations which address the Initial and Comprehensive Assessment of the Patient (CoP §418.54) and Interdisciplinary Group and Coordination of Services (CoP §418.56) will impact our discipline the most. These CoPs are the essence of hospice care. The initial assessment, to be completed by a nurse within 48 hours of election to hospice, requires an overall assessment of the patient’s and family’s needs. This initial assessment will acknowledge the immediate needs of the patient and family as they identify them. The initial assessment will create the foundation for the comprehensive assessment which is to be completed by the IDG within five days of election to hospice. The information obtained in the initial assessment—and expanded upon in the comprehensive assessment—will then be used to formulate the plan of care—one of the most important documents in hospice care!

Hospice nurses, who are charged with initiating the assessment process, are also responsible for coordinating the plan of care. All services revolve around the plan of care which is now

continued on next page
 driven by the needs and wishes of the patient and family. The comprehensive assessment will be updated as frequently as the patient’s condition requires, but at a minimum of every 15 days. This is a dynamic, ongoing process directed toward meeting the patient and family’s defined goals throughout the course of the illness.

As hospice nurses, we are all proud of the work that we do and the care we provide to patients and families. These new Hospice CoPs will help us to define our role within the IDG and foster the value of interdisciplinary care. I am pleased that the focus of care is so clearly placed with the patient and family. We have always said that hospice is centered around the patient and family and now we must demonstrate this through data collection during the initial and comprehensive assessments and in our documentation processes—and then be sure this information is used to address the provision of care, as mandated by the Quality Assessment and Performance Improvement (QAPI) component (CoP §418.58). Things that we have known to be true, we will now be able to prove through our work in meeting the QAPI requirements. We will be able to define evidence based practice and show improved outcomes for patients and families—a goal of all who provide hospice care.

Pat Gibbons is director of Beacon Place, the 14-bed hospice facility operated by Hospice and Palliative Care of Greensboro (Greensboro, NC), and NCHPP’s nurse section leader.
services. Collected data should include adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, operations, clinical outcomes and consumer perception.

For hospices just getting started with data collection, the key is to start with data that is already being collected for internal and external reporting and benchmarking, such as patient statistics, and survey and staff productivity data. The adoption of tools, such as assessment and risk management forms, will offer additional opportunities for data collection. In fact, the need to identify “hospice-wide” data to meet the new requirements may reveal gaps in your data collection processes. A comprehensive QAPI program will have measurable quality indicators not only for patient care, but also for all aspects of the hospice organization’s performance, such as stewardship, staffing, and business operations. (To help in this work, explore industry-endorsed measures such as NHPCO’s Family Surveys, National Data Set and End Result Outcome Measures (www.nhpco.org/research), and the PEACE Project measures.)

The QAPI Program

Data by itself is of no value to an organization unless it is used to improve processes or services. Hospices need to have a defined performance improvement process in place that will guide improvement efforts when suboptimal results are identified through benchmarking comparisons or undesirable trends. Processes, such as the Institute of Healthcare Improvement (IHI) methodology of “plan, do, study, act” can assist a team in creating an action plan designed to improve specific measurable results. Continued measurement is vital for monitoring that improvements are sustained. (NHPCO’s Performance Improvement Collaboratives provide training that uses the IHI model: visit www.nhpco.org/quality and select “Discover the PIP Intensives. In addition, NHPCO’s Self-Assessment System is a free online tool for members; see the sidebar at right.)

Program Structure

Review of the structure and scope of the QAPI program is a critical part of implementation. Hospices need to ensure that the governing body has accepted formal responsibility for the management and evaluation of the QAPI program, and has designated one or more individuals to be responsible for operating the program. Program policies and structure may also need to

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**CoP §418.58**

The Quality Assessment and Performance Improvement (QAPI) component is new to the regulations, but is similar to CMS’s requirements for hospitals and other healthcare providers certified by Medicare. It requires that hospices:

1. conduct a 360-degree surveillance of their operation and assess the impact of the medical, psychosocial, and spiritual care provided to the patient/family;
2. initiate performance improvement projects, where needed, to demonstrate measurable improvements; and
3. evaluate performance and continue to make improvements as needed.

Since CMS recognizes that it will take time for programs to assess their operations, collect data, and develop plans for improvement, the agency is giving hospices until February 2, 2009 to comply with this specific CoP.

**Self-Assessment System Free to Members**

NHPCO’s Quality Partners program offers a self-assessment system to help members conduct a 360-degree surveillance of their operation and identify priorities for their QAPI initiatives. The self-assessments are an online tool that provide results ‘in real-time’ for immediate use. Visit www.nhpco.org/quality.

See page 24 to learn how one program is using the self assessments!
be revised to include the frequency and detail of data collection, program focus, committee structure and responsibilities, and the performance improvement process. Hospices will need to have a process in place to document QAPI efforts and demonstrate effectiveness.

Organizational Support

The foundation of any successful QAPI program is the support of organizational leadership. The new Hospice CoPs explains clearly the technical responsibility of the governing body for defining, implementing, maintaining and evaluating the QAPI program; however, the amount of buy-in and support from the governing body and organizational leadership is what really makes the difference between a flourishing QAPI program and one that is in name only. Management and frontline staff need to hear and see that people in the leadership positions are taking QAPI seriously. There needs to be clear communication with staff about the importance of their role in the QAPI program. QAPI program activities and responsibilities need to be incorporated into the job descriptions and performance reviews of each and every employee. Adequate resources—finances, tools and personnel—must be allocated in order to support an active program.

Rhonda Fisher-Brown LCSW, Hospice by the Bay; Martha Tecca, M&M Strategies; Patricia Vigilante RNC, CHPN, MPA, Visiting Nurse Service of New York Hospice Care; and Susan Zimmerman, Delaware Hospice and NCHPP’s QA/PI section leader.

Public Relations/Development/Marketing Section

By Pam Brown, CFRE

Under the new CoPs, “comprehensive assessment” means a thorough evaluation of the patient’s physical, psychosocial, emotional and spiritual needs due to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver’s and family’s willingness and capability to care for the patient. From our Section’s perspective, this new requirement will ensure more patients, especially those with shorter lengths of stay, will benefit from the IDG’s services. It will also require a more thorough initial physical assessment which, in turn, will allow for better symptom and pain management from the onset of service delivery. The timely evaluation of the caregiver’s and family’s needs will also assist programs in anticipating if placement in a long term care facility or inpatient unit will be necessary.

In light of the new requirements, managers should devote adequate time and resources to provide staff with thorough training on their program’s healthcare software. Also, be open to flexible shifts so that initial and comprehensive assessments can take place across a broader spectrum of hours.

Pam Brown is executive vice president of community development at Alive Hospice (Nashville, TN) and NCHPP’s public relations/development/marketing section leader.

Physician Section

By Joan Harrold, MD, MPH, FAAHPM

The new Hospice CoPs underscores the importance of the hospice physician to programs, staff, and patients. Hospice physicians should be prepared to participate in a variety of activities, including timely communication with staff, development of assessment tools and processes, and design of systems to measure meaningful outcomes.

Certification of terminal prognosis remains the purview of the hospice physician and is based on the physician’s clinical judgment. Physicians should help develop processes by which they can consistently and reliably access clinical information about new patients and return verbal or written certifications within 48 hours. Physicians should also be fluent in current, evidence-based prognostic factors and not rely solely on static guidelines.

To comply with the new requirements, programs must develop and maintain a variety of assessment tools and processes. Hospice physicians can add their knowledge and expertise in pain and symptom management, symptom assessment, and evaluation of treatment efficacy to these tasks.

For example, the new CoPs requires hospices to conduct and document “a patient-specific comprehensive assessment that identifies the patient’s need for hospice care and services, and the patient’s needs for physical, psychosocial, emotional, and spiritual care” (CoP §418.54). Physicians can contribute to the development of assessment tools that focus on clinically relevant information. This could include:

- the selection of validated symptom assessment scales;
- development of processes for reviewing medication effectiveness, side effects, and drug interactions; and
- consistent identification of patients in need of referral for evaluation by other health professionals.

A hospice physician who is named as the hospice medical director is responsible for providing medical direction (see sidebar at right) and will be required to evaluate the services offered for the palliation and management of the terminal illness and related conditions. This hospice physician should...
be knowledgeable about available interventions and medications, the expected palliative benefits in the hospice population, and the likely ability to meet the needs of an individual patient. Physicians should also help the team define and measure meaningful outcomes to assess effectiveness of these interventions and medications in individual patients. In this way the hospice physician serves as both a resource to the IDG and an advocate for patients.

The new COPs emphasizes that hospice physicians also have responsibility for the plan of care beyond offering medical advice to hospice staff during IDG meetings. To meet this responsibility, physicians should collaborate with the patient’s attending physician as needed to maintain an effective plan of care. This collaboration should occur whether the patient resides in a family home or a facility.

Finally, the new COPs requires hospices to “develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement (QAPI) program.” Hospice physicians should help programs define indicators related to “improved palliative outcomes” and the “effectiveness and safety of service.” These indicators should be demonstrably valid, consistently measurable, and clinically meaningful.

Joan Harrold is the medical director and vice president of medical services for Hospice of Lancaster County (Lancaster, PA) and NCHPP’s physician section leader.

Research/Academics/Education Section

By Joy Berger, DMA, BCC, MT-BC

Quite simply, the new Hospice CoPs is about changing our thinking from ‘nouns to active verbs’—or moving from somewhat static documents to highly coordinated, interdisciplinary processes that involve action. For example, the “informed consent” document now calls for informing the patient of rights, and protecting and promoting the exercise of those rights (CoP §418.52). Similarly and significantly, the previous “plan of care” is now defined repeatedly as actions of planning and coordinating services.

These shifts easily encourage hospice educators to incorporate more adult education methods into their teachings, such as differentiated learning, case studies, interdisciplinary problem-solving, self-reflections, synthesis, and role plays (or other communication methods). No single hospice educator can “know all.” Instead, educators should strive to be expert
education facilitators, as in planning and coordinating educational programs with those they serve. Such education service extends to patients and families, employees (and contract staff), volunteers, and care partners (SNF/NF or ICF/NR, and vendors).

**Sharpening Educational Content**

For hospice educators, researchers and academic professionals, the new Hospice CoPs more clearly defines previous requirements, and increases consistency of educational objectives and measured outcomes to reach. Examples include:

- licensure requirements for social workers (CoP §418.114 (3)) and grief and loss education for bereavement professionals (CoP §418.64 (1));
- extensive skills training lists for hospice aides (CoP §418.76);
- shared interdisciplinary responsibilities for educating the patient and family; and
- orientation for care partners (i.e., SNF/NF or ICF/NR) and contract employees, with the ongoing coordination of services (CoP §418.122f).

**Measuring Outcomes**

Expected outcomes take into account the basic tools available today, versus those available when the initial CoPs was written in 1983. Today’s real-time communications, such as data storage/compilation/retrieval, have significantly raised improved best practices. The new CoPs provides researchers with a wealth of hospice care processes and outcomes to explore. Academics are charged with using these new regulations to design education content and processes that prepare our future generations of hospice professionals and partners.

**Putting the New Regulations into Practice**

The new Hospice CoPs more clearly defines how the rules should be applied in our roles as hospice educators, researchers and academic professionals.

Educators will apply the new CoPs when...

- Orienting, assessing, and precepting new hires;
- Providing ongoing continuing education and in-services;
- Developing discipline-specific and team competencies; and
- Evaluating outcome measures and planning future educational programs.

Researchers will apply the new CoPs when...

- Examining extensive criteria for IRB approval;
- Identifying projects for the Quality Assessment/Performance Improvement process;
- Ensuring professional accountability of all research personnel; and
- Coordinating hospice care research with hospice care services.

Academics will apply the new CoPs when...

- Defining topics, objectives, and outcomes for end-of-life education (i.e., a single lecture, a course syllabus, a curriculum program, and interdisciplinary professional systems);
- Instilling core values of patient centered care, supported through the interdisciplinary processes of communicating, planning, and coordinating; and
- Normalizing expectations and skills for improved, timely, coordinated documentation.

In closing, what then are the three key points for our profession in terms of these new regulations? First, the broader accountability of education when working with the patient and family, the hospice workforce, and SNF/NF care partners. Secondly, the detailed expectations related to the new training requirements (e.g., skills training for hospice aides). And, finally, the comprehensive, active nature of interdisciplinary processes and outcomes.

Joy Berger is director of education and volunteers for Hosparus (Louisville, KY) and NCHPP’s research/academics/education section leader.
Social Work Section

By Sherri Weisenfluh, MSW, LCSW

The most significant change for social workers under the new regulations is CoP §418.114b that pertains to the social worker’s personnel qualifications (see sidebar at right).

Per this CoP:

- social workers may now hold a bachelor’s degree in psychology, sociology, or another field related to social work; and
- social workers on the team holding a bachelor’s degree must now be supervised by an MSW.

While some members still have concerns regarding these changes, the intent of this new standard is to better ensure that quality psychosocial services are provided to patients and families.

Programs adequately staffed may not need to make any changes. For others, here are some tips for implementing these new requirements:

- Other than psychology and sociology, CMS has not specified other fields “related to social work” that would be acceptable in meeting the new requirement for baccalaureate candidates. Thus, programs should determine the parameters of a “related field” by developing or refining their policy and procedures for hiring candidates.

- In an effort to protect the public from individuals who misrepresent their qualifications, some states have passed laws which prevent individuals from using the title of social worker unless they have a social work degree. Thus, programs must be aware of their state laws—because those state laws prevail over the federal regulations if they are the more stringent. The Web site of the Association of Social Work Boards is a good resource to learn more about individual state laws and regulations relating to the profession: www.aswb.org.

- For programs that must hire someone from a “related field,” (1) compare curriculums from various degrees to assure essential training, (2) determine if the degree offers any practicum opportunities, and (3) ask if the field has regulatory safeguards in place for protecting the public.

- Collaboration with your state hospice organization to build relationships with local Schools of Social Work may facilitate hiring.

- Rural or small programs that have had difficulty recruiting may need to contract with a MSW for a specific number of hours per week to provide supervision.

continued on next page
Some licensed social workers have also expressed concern about providing clinical oversight to individuals from related fields since they assume a level of legal responsibility for the patient care provided by individuals they supervise. Programs should determine the level of supervision needed to assure high quality patient care, including both clinical and administrative supervision, and establish a written policy. NHPCO’s Social Work Guidelines provides information on clinical supervision and may be a helpful resource (www.nhpco.org/marketplace; Item 712653).

Other CoPs Affecting the Discipline

- Under CoP §418.54, the initial assessment is conducted within 48 hours of the date that the patient/representative signs the election of hospice benefits form and serves to determine the patient’s and family’s immediate needs. Many programs are accustomed to involving a registered nurse and a social worker in the admissions visit which, under the new regulations, could be part of the initial assessment. One suggestion is to have the social worker use this time to evaluate the patient’s current psychosocial needs and collect data to contribute to his/her plan of care.

- Under CoP §418.58, programs must conduct performance improvement projects as a part of the quality assessment and performance improvement process—and many of these projects may include issues involving social work. Since social workers may not be familiar with collecting data for the purposes of outcome measures, additional education and collaboration may be called for. Programs located in communities with institutions of higher learning may want to seek training from social work faculty.

Sherri Weisenfluh is associate vice president of counseling for Hospice of the Bluegrass (Lexington, KY) and NCHPP’s social work section leader.

Defining Bereavement Counseling

Nowhere in the new regulations does it say that bereavement counselors must be the ones to provide bereavement support before the patient’s death. For many hospices, it is the role of the social worker or chaplain to provide the ‘pre-death’ assessment and counseling while the bereavement staff provides support after the patient’s death. Bereavement counselors play an important role on the IDG in making sure clinical staff is well-versed in current grief and loss theory and normal-versus-complicated grief reactions. They also can provide training on how to best support grieving patients and family members. Bereavement staff may also occasionally supplement the pre-death support provided by the social worker and chaplain, but this is usually only done on a case-by-case basis.

Bereavement Professional Section

By Patti Homan, PhD, LPC, FT

Compared with changes impacting other disciplines, the changes in the new Hospice CoPs should have little effect on hospice bereavement programs. However, these new regulations do provide the opportunity to review, refresh and re-clarify all aspects of the delivery of hospice bereavement services—if your program doesn’t already conduct this process as a matter of good practice. Here is some guidance as you take a closer look at the services your program provides.

CoP §418.64

Per the new requirements, the hospice must:

- Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.

- Make bereavement services available to the family and other individuals in the bereavement plan of care up to one year following the death of the patient. (Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care.)

- Ensure that bereavement services reflect the needs of the bereaved.

- Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery.

Bereavement Assessments

Patients and families must receive an initial bereavement assessment that informs the plan of care and is included in the bereavement plan of care to ensure continuity and attention to the identified needs. Strong lines of communication and collaboration between the IDG and the bereavement staff is the best way to ensure grief and loss needs are continually monitored and addressed.

Bereavement Counseling Services

Some hospices do not have a qualified professional with experience or education in grief and loss counseling to oversee the bereavement program. These programs may need to hire
The new CoPs includes a number of new standards related to drug therapy oversight and management.

Patti Homan is director for the PATHways Center for Grief & Loss at Hospice of Lancaster County (Lancaster, PA) and NCHPP’s bereavement professional section leader.

Pharmacist Section

By Phyllis Grauer, RPh, PharmD

Since the publication of the new Hospice CoPs, programs have been challenged to develop policies and implement processes to meet the new criteria. The focus of the new guidelines is to assure quality care and optimal patient outcomes, with emphasis on quality assessment and process improvement activities.

In recognition of the importance of medication management in hospice care, the new CoPs has included a number of new standards related to drug therapy oversight and management. In order to meet these new requirements as they are intended, programs would be wise to employ the services of a clinical pharmacist who is knowledgeable in hospice care and the regulations that govern it.

someone or contract with other community resources to ensure compliance with this requirement. Most programs already make services available to the bereaved for at least one year after the patient’s death. However some may not be as vigilant about providing support to residents of a SNF/NF or ICF/MR— as the new regulations require.

The new Hospice CoPs also emphasizes the importance of providing services that reflect the needs identified in the bereavement plan of care and specifying how frequently the services should be provided. Thus, some programs may need to take a closer look at their documentation to ensure it is tailored to the individual clients they are serving. In reviewing bereavement records, the documentation should ‘paint a picture’ to convey the impact the death has had on that particular individual. Peer chart reviews are a great way to ensure compliance as well as consistency among staff documentation of client assessments, interventions, and the plan of care.

Patti Homan is director for the PATHways Center for Grief & Loss at Hospice of Lancaster County (Lancaster, PA) and NCHPP’s bereavement professional section leader.

Pharmacist Section

By Phyllis Grauer, RPh, PharmD

Since the publication of the new Hospice CoPs, programs have been challenged to develop policies and implement processes to meet the new criteria. The focus of the new guidelines is to assure quality care and optimal patient outcomes, with emphasis on quality assessment and process improvement activities.

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Drug Profile Reviews

A major component of the regulations is the importance of the initial and comprehensive assessments, including thorough, ongoing patient drug profile reviews (CoP §418.54c). Prescription, over-the-counter and herbal or alternative drug therapies must be identified. Hospices are required to document the relationship of the medication to the terminal illness or related conditions. The medication reviews must identify ineffective therapies, actual and potential drug interactions, therapeutic duplications, and therapies that require laboratory monitoring.

Drugs and Biological Oversight

CoP §418.106a mandates that the IDG must confer with an “individual with education and training in drug management” to ensure that drugs and biological meet the patient’s particular needs. Although it does not specify that a pharmacist perform this function, the breadth of knowledge needed to appropriately address drug therapy—as outlined in the new CoPs—is not generally within the scope of other clinical team members. The interpretive guidelines may clarify who, other than a pharmacist, is qualified to perform this function. However, it is unrealistic to expect other disciplines to have the same working knowledge of drug therapy and related issues as that of a pharmacist. This same standard does specify that “pharmacy services must be under the direction of a licensed pharmacist” in the inpatient setting.

Disposal of Controlled Substances

Along with the standards for drug ordering, labeling, dispensing, administering and storing of medication, the new CoPs requires a written policy for the disposal of controlled substances that are no longer needed by the patient (CoP §418.106b-e). Documentation must reflect that the disposal policy has been discussed with the patient and family at the time a controlled substance is first ordered and dispensed.

Drug Restraint

The regulation addressing restraint and seclusion includes the term “drug restraint” and defines the term as “drugs or medications that are used to manage the patient’s behavior or restrict the patient’s freedom of movement that is not standard therapy.” Although this language is similar to the long-term care regulations related to medications used to restrain movement, CMS acknowledges that symptoms commonly experienced by hospice patients may warrant medication use to restrict movement to prevent harm to themselves or others. The standard clearly outlines the protocol guidelines for continuation of these therapies (§418.110m).

NHPCO expects that CMS will publish the interpretive guidelines for the new CoPs in the near future—possibly during mid-2009. While the guidelines should provide clarification on various aspects of the new rule, programs should continue to evaluate resources internally and externally to determine the expertise and services they need for purposes of compliance.

Phyllis Grauer is vice president of clinical development for Palliative Care Consulting Group (Dublin, OH) and NCHPP’s pharmacist section leader.

Finance/Information Systems Section

By Anne Hochsprung, CPA

There are no specific changes outlined in the new Hospice CoPs that will directly impact the finance and information technology disciplines. However, many of the new standards will impact the cost of the delivery of care while the requirement for additional data to support the provision of care (i.e. QAPI) will place greater demands on an organization’s finance and information technology departments.

The hospice industry has grown tremendously over the past five years, with hospice Medicare expenditures now exceeding $10 billion annually. The Medicare Hospice Benefit (MHB) was initially designed, in part, to provide an alternative to traditional end-of-life care in a hospital setting by enabling patients to receive care in a less intensive, home-based setting at a lower cost to Medicare. We must continue to be able to demonstrate this cost benefit to CMS. We must also continue to be transparent as we provide services to our patients, families and the communities we serve. Today, more than ever, hospices will be challenged to balance the caring sanctuary with a sound business.
More emphasis must be placed on effective electronic processes.

With the significant growth in Medicare spending, CMS has requested additional information to assess the care being provided to patients and families. This has come in the form of additional billing burdens to the business offices as hospices have begun to provide such information as location of care, level of care and certain discipline-specific visit data. In my opinion, the information that CMS has requested to date will not be enough to accurately assess the current reimbursement structure. The burden of additional information requests on the delivery of care will continue to be modified and updated as CMS begins to analyze this initial data.

As CMS places the MHB under a microscope, as it begins to phase out the Wage Index budget neutrality adjustment factor, and as programs are mandated to provide more data on a regular basis, it will become imperative that we become more efficient in our back-office processes, such as finance and information technology. The increase in the cost of care continues to outpace the increase in reimbursement and, therefore, in order to continue to provide patients and families with a high-quality level of care, we must be more efficient. More emphasis must be placed on effective electronic processes, rather than costly manual processes.

Although the new Hospice CoPs does not identify any specific changes that will occur in the finance and information technology departments, more focus is being given to the transparency of operations and the need to statistically describe the services provided to patients and families.

Anne Hochsprung is vice president of finance for The Hospice of the Florida Suncoast (Clearwater, FL) and NCHPP’s finance/information technology section leader.

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The new Hospice CoPs poses an interesting challenge for spiritual care in end-of-life practice. On the one hand, CMS has been clear to state that the presence and tracking of spiritual issues are part of the core work that needs to be done for hospice programs to be compliant. On the other hand, the agency is somewhat vague as to how that should look and who should be performing the work. This leaves hospice programs and spiritual care practitioners with a somewhat unknown path to follow that is full of opportunities—as well as dangers. For example, we have the opportunity to be flexible and creative in our practice of spiritual care. However, there is danger in not having a definition or guidelines on what the capabilities of spiritual care practitioners should be. Therefore, as we move into the next phase of implementation, we must focus on defining best practices and the spiritual caregiver’s role.

Perhaps a place to start is in defining the best title for this role. Throughout the new CoPs, spiritual counselor, clergy, and pastoral counselor seem to be used interchangeably, which begs the question, “Are they?” This is hard to say, as the definitions for these titles vary from organization to organization. What can be said is that these titles represent a broad spectrum of practice methods and abilities within the skill set of end-of-life care. So which is the most appropriate? The argument could be made that “spiritual,” whether it refers to counseling or to needs, is perhaps the most inclusive and best able to express the work done by the discipline. This is not to say that other titles, such as chaplain, aren’t acceptable; it just seems important to acknowledge the language used by CMS and, in doing so, work within the bounds of the new guidelines.

With a title defined, it is then essential to look at the framework for how spiritual care should be practiced and who exactly should be doing the work. Clearly, hospice programs throughout the country will make their own choices regarding this, based on location, size and resources at hand as well as how the program defines the role within its interdisciplinary team. However, given the flexibility which the new guidelines provide, we must also decide how high we are willing to place the bar. In my opinion, we should set the bar high, for ultimately it will only serve our patients, families, staff and organizations that much better. This would seem to be at the heart of the work we are committed to do, and the new regulations are here to support us—not stifle us.

Rarely does striving past the bare minimum hurt us, and so it should be here. If it is resources that limit your organization, then remember that there are palliative care programs in the world that provide incredibly dynamic care with but a portion of what is available to us. We are limited only by what we cannot imagine. Our hope, then, is for your imagination to be boundless.

Carlyle Coash is a hospice chaplain with Kaiser Permanente (Martinez, CA) and NCHPP’s spiritual caregiver section leader.
Volunteer/Volunteer Management Section

By the Section Steering Committee

There are several key changes in the new Hospice CoPs that will affect volunteer programs. While some of the new regulations are already being met by hospice organizations, many will need to invest time and resources to become compliant.

In CoP §418.78 (Volunteers), there are very few changes. The phrase “day to day,” which is used when describing the role of volunteers, clarifies that programs must incorporate volunteer services into their daily patient care and operations in order to retain the volunteer-based essence of hospice. This language is used to ensure that hospice programs fully integrate volunteers into work of the organization rather than use them only for special events in order to meet the “five percent” volunteer requirement.

Another change relates to the statement by CMS that hospice volunteer programs may count travel time toward the five percent requirement, provided the same is done for paid staff. In the Federal Register CMS writes, “We (CMS) understand that traveling, providing care or services, documenting information, and calling patients all consume volunteer time, and we (CMS) agree that the time may be used in calculating the level of volunteer activity in a hospice. If a hospice chooses to include any of these areas that are directly related to providing direct patient care or administrative services in its percentage of calculation of volunteer hours, it must ensure that the time spent by its paid employees and contractors for the same activity is also included in the calculation. What that means is that if your staff is paid for the time it takes them to drive to a patient’s home, then you can count the time it takes for a volunteer to drive to a patient’s home. However, if you do not pay an administrative staff for the time it takes to drive to the office, then you cannot count the travel time of the volunteer who drives to an office location to volunteer.”

There are additional regulations in the new CoPs which also affect aspects of volunteer programs:

Training
Volunteers are considered employees and therefore volunteer orientation and training should be closely aligned with that which is offered to paid staff. A hospice must:

- provide orientation about the hospice philosophy to all employees (including volunteers) as well as contracted staff members who have patient and family contact;
- provide an initial orientation for each employee (and volunteer) that addresses the employee's (and volunteer’s) specific job duties;
- assess the skills and competence of all individuals furnishing care, including volunteers, and provide in-service training and education where required; and
- establish written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.

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The new regulations, however, do not mandate that, to become a volunteer, a person must attend training. Only if the volunteer furnishes patient care does he/she require orientation in the hospice philosophy. For example, volunteers who donate their sewing skills can be considered volunteers and their hours can be counted toward the five percent requirement. Each organization should develop its own criteria for volunteer service and provide orientation and training in accordance with the established criteria.

**Criminal Background Checks**

Because volunteers are considered employees, criminal background checks must be obtained in accordance with state requirements. In the absence of state requirements, criminal background checks must be obtained within three months of the date of employment in all states that the individual has lived or worked during the past three years. Although the scope of the background checks is not defined, volunteer services programs should follow the same guidelines that their human resources departments follow.

**Coordination of Services**

The new CoPs places increased emphasis on the coordination of services—and this impacts both paid staff and volunteers.

CoP §418.56c (IDG Planning and Coordination of Services) specifically requires "a detailed statement of the scope and frequency of services to meet the patient’s and family’s needs.” It also specifies that the plan of care must be reviewed as frequently as the patient’s condition requires, but no less frequently than every 15 days.

This CoP will have the greatest impact on programs which don’t already document the plan of care. It requires that volunteers who take part in the patient’s plan of care also take part in the care planning process— from documenting the initial plan of care to reviewing, revising and documenting that plan as frequently as the patient’s condition requires, but no less frequently than every 15 calendar days. In general, this new language emphasizes the increased importance of volunteers and enables a volunteer program to document and, therefore, provide proof of the value of the volunteer workforce within a hospice organization.

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**Clinical and Operations Management Section**

*By Sharon Stewart-Brown, LMSW*

The plan of care, as required under CoP §418.56, may require changes to a program’s practices, policies, and procedures. With the focus of the IDG being linked to the needs of the individual patient, it is essential that a plan of care be developed for each patient.

*The First Step—the Initial Assessment*

The hospice registered nurse must complete an initial assessment within 48 hours of the date that the patient/representative signs the election of hospice benefits form. The initial assessment must address the patient’s immediate physical, psychosocial and emotional needs. This regulation helps to ensure that all hospice care and services will follow a written plan of care established by the IDG in collaboration with the patient’s attending physician. The hospice registered nurse is responsible for the coordination of care and helps foster communication between the patient and other members of the IDG. The patient, family and primary caregiver must be involved in the plan of care which is very much at the heart of the hospice philosophy to treat ‘the patient and family unit.”

*Ongoing Comprehensive Assessment*

A comprehensive assessment of the patient’s and caregiver’s needs must then be completed by the IDG in consultation with the individual’s attending physician and the hospice medical director within five days of the date that the patient/representative signs the election of hospice benefits form. The care must include the palliation and management of the terminal illness and related medical conditions, and must promote the hospice patient’s well-being, comfort, and dignity throughout the dying process.

The information collected from the initial and comprehensive assessments is the driving force for developing the patient’s plan of care. The plan of care must be a “living and breathing” document that the patient has participated in, understands, and agrees with. Continuous review of the patient assessments must occur every 15 days as to ensure discussion and documentation toward patient outcomes.

*Other Changes of Note*

Hospice Aide and Homemaker Service (CoP §418.76): In this CoP, “home health aide” has been renamed “hospice aide” and stipulates that all services provided by the aide be ordered by the IDG based on the patient’s assessed needs. This condition

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*Deborah A. Braun, CVA, Hospice of Northwest Ohio; Lisa Gallagher, RN, Hospice of the Western Reserve; Tia Hovatter Stevens, BA, Mountain Hospice; Sandra Huster, BA, Covenant Hospice; Catherine C. Kobacker; Beth Logan, BA, Hospice Savannah; Bobbi Wexler, BA, Home & Hospice Care of Rhode Island; and Kathy Roble, MS, The Hospice of the Florida Suncoast, and NCHPP’s vice chair and volunteer/volunteer management section leader.*
also requires specific training and demonstration of the aide’s competency that is similar to the requirements for home health aides in the Home Healthcare regulations:

- No less than every 14 days, a registered nurse must make an on-site visit to the patient’s home to assess the quality and services of the hospice aide, but the aide need not be present during these visits. If an area of concern is noted, however, the hospice must make an on-site visit while the aide is performing the care.

- A registered nurse must also make an annual on-site visit to a location where a patient is receiving care in order to observe and assess each aide as he/she is performing care. In addition, the aid must complete a minimum of 12 hours of in-service training each year.

It is very important for the hospice aide to establish a good rapport with nursing home facilities. Many times, the aides are the eyes and ears of the hospice staff and a very crucial member of the IDG. Review your program’s current policies and practices for ensuring the competency of home health aides.

**Short Term Inpatient Care (CoP §418.108):** Under this CoP, a registered nurse will no longer be required to be on site and provide direct patient care 24 hours per day. Each hospice must determine the changes needed in its written agreements and update them accordingly.

**Criminal Background Check (CoP §418.114):** Under this CoP, all employees with direct patient contact or contact with patient records and billing should undergo a criminal background check. This COP includes volunteers, since they are considered employees for the purposes of these regulations. This could be a change from existing practice in your hospice. The CoP also requires criminal background checks for contracted agencies; however, there is ongoing discussion with CMS about how to implement this provision. For current compliance with this CoP, concentrate on those over whom you have direct control.

_Sharon Stewart-Brown is the southeast Kansas regional director for Harry Hynes Memorial Hospice (Parsons, KS) and NCHPP’s clinical and operations management section leader._
Like many hospice programs, Providence Hospice of Seattle has always attempted to obtain feedback from the bereaved we serve through a program evaluation that was developed “in house.” This survey had been in place for years and the results we received each month were dutifully tabulated and stored in a database. However, while some of the information informed program direction and development, most of the time the data gained from this instrument simply languished in the database or in storage boxes where the returned forms came to rest. Yes, we had data, but what did it reflect? How specific was the feedback and was it helpful? Lastly, how did our findings compare to the responses received by other programs which offer similar bereavement services? Because we had created the survey ourselves, the answers to these questions left us wishing for something more substantive.

When I learned that NHPCO had developed an evaluation tool for bereavement programs, I was intrigued and excited. For years I had followed the results of the Family Evaluation of Hospice Care (FEHC) survey, knowing that a family’s perceptions about hospice services shortly after a patient’s death would, in all likelihood, inform their initial perception of bereavement services. However, because the focus of FEHC is on patient care, it doesn’t provide feedback to help us evaluate our post-death bereavement services. Fortunately, with the launch of NHPCO’s Family Evaluation of Bereavement Services (FEBS) survey, we now have a way to gain data for program evaluation and, at the same time, be able to measure our progress against national averages.

As noted in the introductory PDF, FEBS Guidelines (www.nhpco.org/febs), the survey was designed by specialists from the University of Massachusetts in association with NHPCO and a team of hospice bereavement professionals. It received extensive cognitive and field testing that involved multiple revisions before becoming available to the NHPCO membership in January of 2007.
FEBS’ Advantages
Upon receiving a copy of the final survey (which members can download from www.nhpco.org/febs), I noticed some similarities and differences when compared with our program’s “in-house” survey.

While at seven pages, the FEBS appears to be lengthy, it is not that much longer than our program’s in-house survey; on closer review, one will see that it is designed to allow respondents to skip over sections that do not apply to them. “Because there is wide variation in the number and nature of bereavement services offered by hospice programs,” says Carol Spence, NHPCO’s director of research, “the survey was designed to be comprehensive and, at the same time, to consider the dissimilarity of the configuration of bereavement services among hospices. Thus, the survey’s developers decided to include questions on a wide range of services and simply ask respondents to skip those questions that do not apply to their experience.”

FEBS is organized into sections that allow easy evaluation of specific services. The primary sections seek feedback on Services, Mailings, Telephone Calls, In-Person Visits, and Other Contacts, and are followed by a section on Overall Evaluation. Respondents also have the opportunity to provide comments and to offer a brief glimpse of their lives 13 months after the death of their loved one (i.e., where they found (and are finding) support and how it has been (or is) helpful to them). The survey concludes with questions about the types and amount of support they received, whether they have experienced other losses, the types of losses, and demographic information.

Our Experience So Far
We began using FEBS in early 2007 and have seen a marked increase in the number of responses we have received. Our “in-house” survey would typically generate a 16 to 18 percent rate of return. Since our program began using FEBS, our rate of return has jumped to 22 percent. What’s more, the amount of comments we receive has substantially increased since moving to the new survey.

Another benefit of FEBS is the opportunity for respondents to identify themselves and request follow up from our program. The number of respondents who have completed this section—asking that we contact them—has been significant. In addition to helping us evaluate what we do within the context of a specific case, this also gives us the opportunity to offer referral resources to those individuals in need.

Throughout the course of each six-month period, we submit the data we receive to NHPCO and NHPCO, in turn, provides us with a summary report twice a year (see sidebar above). This report not only includes our program’s data, but also includes national responses and percentages. With each summary, we are able to identify areas for growth as well as areas that merit celebration for work well done.
FEBS’ Role in Our QAPI Program

To my mind, the Quality Assessment and Performance Improvement (QAPI) component of the new Hospice CoPs seems to be its “heart and soul.” Early on, during development of our program’s quality plan, we developed several strategic objectives, one of which is “Excellent Clinical Services.” Indicators for this objective came from a variety of sources—including FEBS.

The county our agency serves is highly diverse, with a heavy concentration of Pacific Islanders, Asians, African Americans, Native Americans, Russians and Latinos. To help us capture data that would help us determine how well our bereavement services are being perceived by these cultures, we turned to Question 21 of the FEBS survey: “How good a job did hospice do at delivering bereavement services in ways that were sensitive to your cultural and spiritual background?”

We also recognized that FEBS provided us with an opportunity to take this question to a new, informative level. While NHPCO’s semiannual reports summarize the demographic data for us, it does not break out the answer to Question 21 by race/culture. Thus, we decided that each time a survey was returned, we would cross reference the answer to Question 21 with the demographic information that was given at the end of the survey. By maintaining this simple database, we have begun to identify culturally specific performance improvement bereavement projects that will help our program to better serve the cultures within our community. It is one small step, but a much-needed one.

As we do this work on a day-to-day basis, it is often easy to overlook the value of being able to compare our findings with other programs in order to offer the highest quality of service. The NHPCO FEBS is an example of one important way we can tap into that information and quantify it. It also offers us—as bereavement professionals—the chance to be highly visible and active participants in our program’s QAPI initiatives. What an opportunity for visibility, program growth, and the chance to raise our service standards to a new level.

Rex Allen has worked in the field of loss and grief as a professional and volunteer for over 18 years. He is currently the grief support services supervisor for Providence Hospice of Seattle in Washington, and is a member of the NCHPP Bereavement Steering Committee.

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ike many other hospice programs around the country, Bristol Hospice recognizes the importance of demonstrating our commitment to quality services through implementation of a Quality Assessment and Performance Improvement (QAPI) program. However, in light of the new Hospice CoPs—and the increased importance now placed on the management of quality—Bristol Hospice was in need of a framework for our QAPI program—one that would dovetail with our mission and purpose.

We chose NHPCO’s Quality Partners program to provide the needed framework. The program was designed to assist hospice providers in completing a 360-degree review of all aspects of their organizational delivery of hospice care by providing tools and resources to help hospices assess, monitor, and sustain the quality of their care and services.

We embraced the Quality Partners program in early 2007, finding that it provided the data-driven framework, operational systems, and processes that we needed. In laying the groundwork for our QAPI program, we took into account the Institute of Medicine’s Six Aims for Improving the Healthcare System as well as Quality Partners’ 10 Components of Quality in Hospice Care. (Both the Six Aims and 10 Components are posted on the NHPCO Web site—www.nhpco.org/quality.)

Our strategy for rolling out, monitoring, and sustaining our QAPI program was developed in a collaborative effort with leadership from our four program locations and our QAPI Committees, and was then presented to Bristol Hospice’s governing body for review and approval. The strategy included the following NHPCO tools as mechanisms for monitoring quality:

- Quality Partners’ Self-Assessment System
- Family Evaluation of Hospice Care
- Family Evaluation of Bereavement Services
- End Result Outcome Measures

Our next step was to provide an organization-wide educational program to help staff understand and appreciate the connection between the Quality Partners program and its relationship to our organization’s delivery of high quality care. This educational program was presented during weekly conference calls and an organization-wide review of the Quality Partners program on the NHPCO Web site (www.nhpco.org/quality).
We embraced the Quality Partners program in early 2007, finding it provided the data-driven framework, operational systems and processes that we needed.

Making a Tangible Commitment to Quality

An important step in joining NHPCO’s Quality Partners program is making a tangible commitment to quality—by signing the program’s pledges (there is an organizational pledge and an individual pledge).

Senior leadership of Bristol Hospice—as well as leadership at each office location—reviewed and signed the organizational pledge while all staff and volunteers reviewed and signed the individual pledge. The act of reading and signing these pledges solidified our commitment to delivering and maintaining a quality program for our community.

Keeping that Commitment in Full View

In order to hardwire Bristol Hospice’s commitment to quality, copies of the pledges, as well as NHPCO’s Code of Ethics poster, were posted at each of our office locations. To further entrench Bristol Hospice’s commitment to an ongoing performance improvement culture, the individual pledge has been incorporated into our hospice orientation program and is reviewed annually during the evaluation of staff members. Our governing body, corporate leadership and committee staff also complete an annual review of the pledge. Patients and families are also made aware of Bristol Hospice’s commitment to quality during the admissions process, as a brief summary of our organization’s commitment to quality is included in our Patient/Family Guidebook.

Appointing a Task Force to Lead and Sustain the Program

In order to create an environment of excitement and enthusiasm for our QAPI program, our governing body established a Quality Task Force—with a designated leader—for each of our organization’s four locations. Their job is to initiate, drive, monitor, and sustain our QAPI program.

We encouraged the Task Force to be creative and to share ideas, experiences, and pictures about how staff was ‘raising the bar’ within each location’s service area. Staff at one location, for example, created the tagline, “Put your thinking caps on for quality,” and reached out to members of the interdisciplinary team to learn how they felt we could promote quality. This simple gesture, and others like it, created amazing energy and an environment that is more open and better able to foster positive change.

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Each Task Force assumed part ownership in the program, including responsibility for completing the Quality Partners self-assessments at their location.

**About the Self Assessments**

The Quality Partners self-assessment system is a set of 10 online self-assessment forms. The self-assessments 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

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. By completing the self-assessments, your program can spot the problem areas in operations and processes, and begin to prioritize when and how improvement efforts should occur.

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 to help you gauge your performance against colleagues.

Each Task Force at Bristol Hospice was charged with bringing the self-assessments full circle—that is, not only identifying where the service gaps were, but also utilizing the necessary tools to achieve designated outcomes. The roll out consisted of conference calls in which the participating staff selected one of the 10 self-assessments on which to focus and committed to timelines for completion. However, a primary goal in implementation was to make sure we took a “collaborative approach”—involving both corporate leadership and each location’s leadership in the process too.

**Using What We Learned**

Following the completion of the self assessments, education was provided on how to utilize the NHPCO DART system to capture and store each office location’s self-assessment data. Once the data entry was completed, the Task Force presented their findings to Bristol Hospice’s governing body and each location’s QAPI Committee so the members could analyze and select quality indicators for their respective locations. The governing body also reviewed the actual self assessments and remained involved in leading Bristol Hospice’s quality effort. The goal is to include the key stakeholders from beginning to end and, in doing so, create an environment that is steadfastly focused on quality and ongoing performance improvement.

In his book, *Economics for Healthcare Managers*, Robert Lee writes that “Reengineering and quality management are strategies for improving the performance of organizations from the perspective of their customers.” Focusing on our patients and families as the center of the care delivery system, an organization’s governing body ensures that quality improvement and patient safety are maintained and evaluated. The organization’s QAPI Committee, in turn, owns and directs the quality improvement process within the organization. The committee is charged with determining the performance improvement projects to initiate, based upon findings from completion of the self assessments. The committee also ensures that analysis, trending, and monitoring of the identified quality indicators and the organization’s QAPI process are consistent—and sustained. The emphasis is on assessing outcomes to determine whether the desired results are being achieved. The continuation of this process throughout our organization has infused a new confidence in our team’s ability to drive their own improvements.

We believe that our collaborative implementation of Quality Partners’ self assessments, in addition to Quality Partners’ other tools, is helping us instill a higher level of accountability for external as well as internal quality improvement. We look forward to the future as we continue our quality journey.

**Christie Franklin** is president/CEO of Bristol Hospice (based in Salt Lake City, UT), with over 20 years of experience as a registered nurse and hospice/homecare leader. She currently serves on NHPCO’s Quality and Standards Committee and previously served on its Governance Committee.

**Jeanette Dove** is vice president of clinical quality management for Bristol Hospice, with over 18 years of experience in nursing and hospice management.

To learn more about NHPCO’s Evaluation of Care survey tools, visit [www.nhpco.org/research](http://www.nhpco.org/research).

To learn more about Quality Partners, go to [www.nhpco.org/quality](http://www.nhpco.org/quality).
Winners of this year’s Photography, Film and Writing Contest were announced during NHPCO’s 9th Clinical Team Conference in October 2008. In the following pages, we are proud to showcase the winning entries—a wonderful testament to the talent and creativity of so many members around the country.
Photography Contest – Adult Category

First Place:
“Family and Friends”
Jeff Sikorovsky
Hospice Care
Dunbar, WV

Second Place:
“Everlasting Love”
Ashley Faison
Hospice and Community Care
Rock Hill, SC

Third Place:
“Gift of Music”
Sue Brookins
Senior Independence Hospice
Columbus, OH

Honorable Mention:
“Memory and Harmony”
Melody Farrin
VITAS Innovative Hospice Care
Pittsburgh, PA
**Photography Contest – Young People Category**

**First Place:**

“Letting them be Children”  
Ben Fournier  
Delaware Hospice, Wilmington, DE

**Second Place:**

“Querida”  
JH Photography  
Hospice of Northeast Georgia Medical Center, Gainesville, GA

**Third Place:**

“Sleeping Fairy”  
Tammy Benner  
Serenity Hospice, Lafayette, IN

**Honorable Mention:**

“A Brother’s Love”  
JH Photography  
Hospice of Northeast Georgia Medical Center, Gainesville, GA
**Photography Contest – Nature/Abstract Category**

First Place:

“Rays of Hope”

Joanne Jones
Aseracare Hospice of Atlanta
Atlanta, GA

Second Place:

“Balance”

Gary Goatcher
Heart of Hospice, Hood River, OR

Third Place:

“Letting Go”

Carole Clem
Montgomery Hospice, Rockville, MD

Honorable Mention:

“Hands and Heart”

Gary Goatcher
Heart of Hospice
Hood River, OR
This year’s film contest focused on public service announcements used to help educate the public and build awareness of hospice and palliative care. What stood out the most among the winning entries was the use of patients, families and professional staff who shared their personal experiences to help viewers understand what hospice and palliative care offers. The winning submissions were designed to carry accurate and relevant information to a diverse population.

**First Place:**

*Treasuring Life — PSA Collection*

Treasure Coast Hospice
Stuart, FL
Filmmakers: Jeff Jones Productions and RP Marketing

**Second Place:**

*VITAS Television Spots*

VITAS Innovative Hospice Care®
Miami, FL
Filmmaker: VITAS Innovative Hospice Care®

**Honorable Mention:**

*Peaceful & Proud: Personalized Care for Veterans*

Hospice of the Western Reserve
Cleveland, OH
Filmmaker: Anne Bruder

*Sharing the Journey: Willamette Valley Hospice*

Willamette Valley Hospice
Salem, OR
Filmmaker: Allied Video Productions
“People die the way they live,” the nurses here at my hospice often say. That sounds like we are all destined to be plagued by our bad habits (or better, rewarded by our hard-earned virtues) right up to our very last moments. Or maybe, as I prefer to think, it means that the unavoidable end of life can be as varied, unique and fascinating as any adventure possible.

Each patient I have had the privilege of knowing at our hospice house has shown me the distinct individuality of the experience. Kathleen was a terminal cancer patient who resolutely pushed her walker outside every day to sit in state on the veranda, chain smoking and drinking cups of black coffee. She took great joy in the birds fluttering at the feeder and in holding court with the various aides and nurses who shared her love of tobacco. Once a month she dressed up in her party clothes to go to the Foxwoods casino with her daughter, returning jubilantly to report her losses. She adored the fresh-baked fruit pies and chocolate cakes the hospice cook made, growing rosier and plumper with each passing month. She thrived despite her terminal illness, living for two years beyond all predictions.

Max, on the other hand, was furious at his diagnosis. His eyes blazed at each staffer as they came in to help. “What are you doing here?” he would snap. His loving wife would sit helplessly by, trying to calm him down with a pat on the arm or an embarrassed apology. Max would have none of it. He especially fumed at the presence of the chaplain. “There’s no blessing in any of this,” he parried as she offered to engage in a spiritual dialogue. “I don’t believe in God and never will. It’s a load of hogwash.” But as time went on and Max weakened, his fire damped down. He let his wife take his hand and began to ask questions of the chaplain. “What happens to me when I die? Is there life after death? Will I be able to send a sign to my wife after I’m gone?” The hard angles in his face softened. He began to accept that he didn’t have answers to the questions, but it was enough to let them be heard.

Sherry was unable to walk or talk at all. Almost completely paralyzed from a rare form of ALS in her early fifties, she had rapidly transformed from athletic sprinter and decathlon champion to wheel chair bound and mute. Yet she was exquisitely expressive in her silence. She communicated with an alphabet chart over which she could slowly pass her hand, stopping at each letter to spell out words. When I figured out a word, she would beam up at me with the most intensely beautiful smile I have ever seen. She somehow managed to communicate, with surprising tact and grace, her gratitude at having her every physical need tended to. One afternoon I thanked her for her good humor despite being stuck in this strange prison her body had become, and I acknowledged how hard it must be. Her eyes filled with tears, and she nodded with as much emphasis as she could muster. I will never forget the unshielded honesty of those eyes, the way I could hear her speak to me despite the fact she had no voice, like a deer wounded or a fox trapped.

Laureen was on oxygen, fading fast, too weak to sit up. Her son came to visit her for the first time from out of the country, bringing his South American fiancé. When they saw Laureen so weak, they knew the wedding scheduled several months hence would be too late for her participation. So the couple asked our hospice doctor if they could get married that afternoon at Laureen’s bedside. In a matter of hours, local merchants donated a wedding dress, bouquet, champagne, and two gorgeous wedding cakes. The room was transformed with a nuptial altar of candles and flowers. The bride appeared, trembling and beautiful in her white gown, and the ceremony was performed by the chaplain in his vestments. The oxygen tank whirred softly as vows were repeated in both English and Spanish. Rings were exchanged and champagne glasses lifted high. Beaming from her propped pillows, Laureen mouthed the words “Thank you” to the hospice doctor, squeezing her hand tight.

Stan was a devout Christian who continuously read his worn Bible, clutching it to his chest whenever he slept. His sister was a nun who would come to visit frequently. I sat with them one morning while they told childhood stories of falling out of trees and chasing sheep. Then they described how Stan had arrived at the hospice house just last month comatose from overmedication. “When I came here, I started to live again,” he said, smiling. With new medications, he discovered a new lease on life and, as they told me, he often said, “I think I could have died without regret.”

Are any of these typical? No more so than the ways in which each of us shares our common biology. We are so distinctly unique that resemblances pale before our sublime variety. Yet, like squares in an elaborate quilt, our pieces match, despite contrasting patterns. No one knows when our time will come, though we all know it is inevitable. If we are lucky enough to be in a circumstance where our needs are fully met, we might step across the threshold in a way that illuminates the blessings of transformation.
On May 8, 2006, my husband Lee and I received a call from Harvey, a close friend of ours in Missouri. He reported to us that his beloved wife, Eileen passed away due to complications from breast cancer. She suffered for 10 years and fought the battle to the end. Eileen was with the local hospice program for just weeks before her death.

Eileen and I became friends while our husbands were attending Kent State University in the seventies...yes, during the notorious shooting incident. Harvey was a law student and Lee a chemistry major. As Eileen and I attended a meeting of the wives club on campus, I noticed her beautiful auburn hair. She also spoke with an accent that was familiar to me and I immediately identified it as “Philadelphian.” I was right! Lee and I were born in the same city as Eileen and Harvey. We soon became fast friends and went through many stages in our life—finishing college, the birth of children, moves, job changes as well as illness and serious accidents of our spouses.

Eileen and I not only shared the same name, we shared the same basic philosophy of life. We respected each other’s differences. She and Harvey were Jewish; Lee and I, Catholic. We saw “Jesus Christ, Super Star” and “Fiddler on the Roof” together and marveled at both of these shows.

During Eileen’s fight with breast cancer and subsequent decline, I introduced her to a book for children about the explanation of death. It was recommended to me by one of the chaplains at the hospice organization where I worked. When I told Eileen about the dragonfly theme of the book, she agreed for me to send it to her.

In the story, a water bug is found climbing up a stalk in a pond. When it reaches the water level, it becomes a beautiful dragonfly. However, it is not able to return to the water to tell the other water bugs what happens when they reach the top. The dragonfly is blissfully happy flying around in the beautiful world above the pond. This story is a comparison to our souls leaving the drudgery of this world to become a new form in a beautiful place.

I sent the story to Eileen but never did hear from her as to her reaction. I knew she was still going through treatment for her cancer so I did not mention it to her again.

As we prepared to go to Missouri for the funeral, I talked with Lee about the dragonfly story and he listened with skepticism. He believes in an afterlife and is a Christian, but some of my hospice stories were hard for him to comprehend, even symbolic ones.

Harvey chose my husband as a pallbearer. When Lee came back from the ceremony of bringing Eileen’s casket to her resting place, he sat down and looked very pale. I asked him if he felt alright. He said in a somber tone, “I’ll tell you later in the car.” As we headed to Harvey’s home after the service, Lee spoke about what startled him at the cemetery. “As I stood on the hill with the other pallbearers, I noticed a dragonfly flutter by along our path. It circled over the hearse then disappeared. What amazed me is that it stopped in front of me just long enough to notice its color. The dragonfly had auburn wings. My husband, to lighten the moment, said to himself “you can’t fool me, I know who you are.” It gave me comfort to know that perhaps Eileen was consoling us by portraying our little analogy of heaven and afterlife.

I love you, Eileen, and I hope that you are enjoying your eternal reward and displaying your beautiful colors for all to see.
I’ve always believed that the essence of our work in hospice is to be present with the dying, to “hold space” for the grief unfolding. To be a compassionate witness, walking alongside, sharing the enormity of the moment, as not only to provide a sanctuary, but to truly know in your soul, the essence of suffering. As if, together, you might reach beyond the devastation of illness to uncover this thread of discovery, of grace, within.

My most heartfelt and personal understanding of this included the care of two babies, fraternal twins, who shared the diagnosis of spinal muscular atrophy. This disease, like muscular dystrophy in older children, causes weakening of all muscle groups, precludes lung function, and almost exclusively, results in death within the first year of life. The infants were five months old. Ben was by far the sickest, and was already on continual oxygen when our hospice first met with them. Anna, on the other hand, was chubby and flourishing. Except for floppiness in her extremities, you would not know that she shared her brother’s disease.

The house overflowed with toys and baby books and pictures of these precious charges. Two of everything filled the front room, from highchairs to car seats to playpens, but only the double stroller had gotten any use. There were daily walks when Ben could tolerate them, and Ben and Anna would be filled with the wonder of trees, flowers, and the ducks that waddled at a pond nearby. It was an extravaganza that could last up to two hours, and this outing was the time when both children seemed most captivated, most relaxed. The small oxygen cylinder tethered to Ben was hidden under blankets along with bottles and tube feeding supplies, and a bulb syringe for suctioning, if needed.

Ben, from profound fatigue, could no longer nipple feed. Any swallowed liquid became an increased threat for aspiration, where the fluid could silently enter his airway, resulting in pneumonia. His parents, Debbie and Robert, had agreed with, and allowed the doctor to place a small tube in his stomach, through which the formula would be given. His breathing improved somewhat after the gastric tube was inserted, but the stress of the procedure weakened him further. The anxiety in his face and his air hunger were briefly relieved by his mother’s touch. He watched her face, and listened intently to the sound of her words. Soothed, he would sleep for short snippets of time, to awaken and strain for his mother’s voice, as he hadn’t the strength to cry. And still, with his body perpetually in high fowler’s, small trickles of formula would sometimes find their way into his already compromised lungs. Meanwhile, Anna joyfully watched a video of Teletubbies, and although unable to move her limbs, gleefully babbled to anyone who would listen.

Minuscule amounts of morphine allowed Ben to breathe more easily, and the anxiety on his face softened. Many treatments were tried to aid the frail lungs, without response. The physician had already spoken to the parents about a tracheotomy tube inserted through the neck, and the eventual use of a ventilator to keep their son alive. Watching the struggle of their only son, and knowing that death would soon steal his life regardless, they declined the tube. In the second month of hospice, in dawn’s deepest hour, Ben died peacefully and quietly in his mother’s arms, both held by the grieving father, both feeling a part of themselves dying, alongside their son.

The funeral was a celebration of Ben’s brief and brilliant life, with Debbie and Robert each reading a letter that they had written to their son, describing what they had learned from him, and thanking him for the treasured time he had graced their lives. Leaning into each other for support, the three remaining huddled out of the church as one body, one spirit. It was a matter of time before Anna needed hospice, even though she still looked so healthy. I silently prayed that they would have many more healthy months with their daughter. But it would only be two.

Debbie called me one morning at work. She and Robert had elected to have a gastric tube placed in Anna’s stomach, so that when she could no longer nipple feed, the tube could be used. They saw how compromised their son had been to have the procedure after he was already so sick, and they concluded that this prophylactic treatment should be helpful. After careful consideration, they decided against a fundoplication, which would place a purse string suture around the esophagus close to the stomach, so that food couldn’t seep into the lungs. It was more invasive and sometimes didn’t work, so Anna was not put through the surgery. Debbie reported that Anna had not done as well as expected, and in the last few weeks, she seemed to have a harder time with feeding and digestion.

She asked about hospice coming out “just to evaluate” Anna, even though she was sure things would get better. The doctor agreed with the plan, and the social worker and I again met with Mom and Dad and Anna in their home. One highchair,
playpen, and car seat were stashed neatly in the corner as if they might, at some time, be of use. Like Ben, Anna now required a car bed, especially made for babies that could not hold up their heads. Anna was in mild distress, and mom shared that she had already had a short bout of apnea, prompting Debbie to puff into her mouth and “bring her back.” She feared that her daughter could already be aspirating. It was decided that Anna would start hospice, for Mom and Dad appreciated the support of the hospice team, the nurse, social worker, chaplain, and volunteer who helped out with Ben. She felt safer knowing that there was a nurse available 24 hours by phone, and if needed, to make a home visit. Like Ben, Anna had a DNR, Do Not Resuscitate order, as they believed that putting her on life support would prolong their daughter’s suffering. Debbie and Robert declined the oxygen and the “stand by” morphine, “to maintain a household of normalcy for as long as possible,” Mom hoped. It was Friday.

The weekend had been largely uneventful, except for Anna having some short bouts of apnea. Debbie had requested an afternoon visit but called frantically around 9 a.m. on Monday morning to say that Anna was having increased trouble breathing and increased periods of apnea. On my way out to the home, Debbie called again, sobbing that Anna wasn’t breathing. As I entered, Mom and Dad were huddled as one unit, holding Anna, and each other. She was again breathing, weak and shallow. In tears, Mom told how she needed to puff into Anna’s mouth, over and over, to get her back. “Why is this happening,” she pleaded, “Why does she stop breathing?” Mom and Dad were overwhelmed with grief, and I slowly sat beside them, and quietly reviewed the options. Did they understand that Anna was dying? I didn’t even want to believe that, although I knew it to be true. Hadn’t they gone through enough for this to happen so soon? They could go back to the hospital, but it wouldn’t change the outcome. This Debbie and Robert knew. They did not want to put their daughter through any more trauma. “No, if it was to happen, we want Anna, here, with us.” The doctor was notified, and oxygen and morphine were ordered.

The next two hours seemed like twenty, with Anna struggling to breathe, and Mom feeling the need to puff precious air into her daughter’s failing lungs, with anguished cries of “How could this be happening!” and, “Oh, Anna, please don’t leave us!” I spoke to them in quite, low tones, trying to guide them and support them. I watched hearts breaking into pieces, shattered by this impending death, and could do nothing but stand there, to be present, to hold space, to be a compassionate witness to their despair and desperation. At that moment I understood fully what those words meant, for I felt them in every fiber of my being. As Anna lay dying, I cried quietly but openly for this life, this grief, these bereft parents who would lose their only children within two months of each other, the agony of which I could hardly imagine, unfolding before me.

The social worker waited at the pharmacy for the morphine to be filled and brought it with her. The oxygen still hadn’t arrived, and even in an emergent situation, the lag time could be four hours. Anna was struggling and Debbie knew that she could not continue to breathe into her baby’s withering lungs, in order to keep her here. They did not want to go back to the hospital. I told them that we could give the morphine, knowing that in Anna’s fatigue, she would probably relax enough to let go, and take her last breath. Or we could continue this vigil, and wait for the oxygen, which could help offset some of Anna’s air hunger. It was Debbie who finally asked for the morphine. “This isn’t fair. I’m keeping her here for my needs, not hers.” Dad agreed that Anna had suffered enough, and that she needed to be comfortable. In the corner of Anna’s mouth, I dripped in a few drops of morphine, half of the dose ordered. Within ten minutes, Anna no longer struggled; her breathing was shallow, but quiet and regular. She looked around and captured, then held, the devastated faces of her parents, just as they held one another, and spoke something to them with her eyes. As their tears fell, there was a quiet serenity in the room, as if these moments, or hours, were suspended in time. After several minutes, Anna closed her eyes, then gently and quietly, died.

The great dichotomy of our existence is that amid suffering, one can also discover profound beauty; grace that is not separate, but as threads woven into the same cloth.
Bones glisten beneath
   a thin suit of flesh,
A woman. My age.
Only months ago
she laughed
and told stories
and complained to her children.
Now, on the cusp of a mystery,
I can’t begin to understand,
her breath is a dry wind
against a cracked windowpane.
Music is my only offering. The softest I have ever played.
In a slow dance,
holding each other without touching—the way some families do—
husband and children encircle the bed.
Leaning close,
attentive to the smallest change,
they breathe
in and out with her.
Little by little, their rhythm slows,
until, with an exhale,
it ceases altogether.

For an eternity nothing in the world breathes.

Then, with a clap of thunder, the sky opens and the rain begins.
Mary stares
Mary’s face is blank
Mary looks like
no one is home
behind hollow cheeks
and pale withered skin
Mary lies against the
blue pillow slip
her mouth collapsed open
her thin grey hair
flattened by the pillow
her blue lids conceal
vacant eyes

What is her level of
consciousness
does she know what
day it is
where she is
who she is

Mary weakens
I drip cold water
into her mouth
through a straw
rub her back
pad her with pillows

Mary doesn’t understand
what’s happening
this slow withering
and fading away
this effort of breath
after breath after breath…
Sometimes crying out
for her mother
who has been dead for decades

Mary grows weaker
she is going to die
We sit at her bedside
soothing her
stroking her clenched
hands open
moistening her mouth
with a wet cotton swab
placing cool cloths
on her forehead
telling her
“it’s alright”

Mary struggles
with each breath
her eyes never open now
she does not answer
Mary is leaving now
slipping away

Light in the room
is warm softness
peacefulness robs words
from my mouth
our heart is a golden
sun warmed meadow
Mary is letting go
Poetry

Honorable Mention:

Reflections

By Mary Jo Krueer
Hosparus – Hospice of Central Kentucky
Elizabethtown, KY

When I look back, I remember…
sleepless nights—wondering if there was more we
could have done…
should have done…
would have done.

I remember…
calling Hospice in the middle of the night…
calling Hospice at 8:05…
hanging up the phone feeling relieved.

I remember…
crying when you could not see…
laughing out loud with you…
holding your hand and looking into loving eyes.

I remember…
changing the bed…
changing you…
changing me.

I remember…
watching you sleep…
watching the clock…
watching you die.

There is so much I remember…
some I want to forget…
but, mostly, I know there was no place
I would rather have been
than by your side.

When I look back, it was a gift.
The Expanded Role of the Hospice Physician

By Cheryl Arenella, MD, MPH

The new Hospice CoPs delineates a greatly expanded role for the hospice medical director and hospice team physician, and emphasizes the importance of close collaboration with the patient’s attending physician. This article highlights some of the specific changes in the new regulations that pertain to what is now expected from these medical professionals.

One Medical Director

Each hospice must name one medical director to assume responsibility for the medical component of the hospice’s patient care program. Per CMS, if a hospice corporate office has multiple certification numbers, a medical director must be named for each certification number. Other physicians working in the hospice can hold the title of associate or assistant medical director, and must report to the hospice medical director (see page 11 for more about this provision).

continued on next page
The Physician’s Contract

The required elements in the contract between a hospice and a physician are outlined in CoP §418.102a, including the clarification that the contract may be with a professional entity or a physician group, so long as a specific individual physician is named in the contract.

Initial Certification

The initial certification of terminal illness must include a review of defined elements by the hospice medical director in determining eligibility (CoP §418.102b). These defined elements include:

- Primary diagnosis
- Related diagnoses
- Subjective and objective medical findings
- Current medications and treatments
- Medical management for unrelated conditions

Initial certification by the hospice medical director or team physician and the attending physician (if any) must be completed within 48 hours of the patient’s admission to hospice. Although nurse practitioners may serve as the patient’s attending physician, they may not certify the presence of a terminal illness. The hospice medical director must review pertinent clinical information before recertifying that the patient is terminally ill (CoP §418.102c). Finally, the hospice medical director is clearly identified as being responsible for the medical component of the hospice’s patient care program (CoP §418.102d).

Additional Responsibilities

Other responsibilities now under the purview of the hospice medical director are noted in various other sections of the regulations. For example:

- The medical director is responsible for (1) supervising all hospice physicians (CoP §418.64a1); (2) ensuring compliance with state laws for health and safety (CoP §418.116); and (3) meeting the general medical needs of the patient—beyond those related to the terminal illness—if the patient’s attending physician is unavailable (CoP §418.64a3).

- The medical director should have “knowledge and skills” necessary to meet the needs of the hospice patient. The physician, as a contracted or employed member of the hospice, must meet the personnel qualifications, as specified in CoP §418.114, including criminal background checks and licensure requirements.

- Physician services must be available 24 hours a day, 7 days a week (CoP §418.106 and CoP §418.100g).

Patient Assessment

The new CoPs also includes a greatly expanded section on Patient Assessment (CoP §418.54). In addition to retaining responsibility for certification and recertification, the medical director and team physician are integral members of the interdisciplinary group (IDG) and perform an important function in the assessment of the hospice patient—particularly during the ongoing comprehensive assessments.

While the initial assessment of the patient and family is to be completed by the hospice team’s registered nurse, other members of the IDG—including the medical director and team physician—may be involved as appropriate. In addition, the comprehensive assessment must be completed by the IDG in consultation with the patient’s attending physician, within five calendar days of the patient’s election of hospice care (CoP §418.45b).
The required elements of the comprehensive assessment (CoP §418.54c) include:

- Physical, psychosocial, emotional, and spiritual needs related to the terminal illness and related conditions
- Nature and condition-causing admission
- Complications and risk factors
- Functional status
- Imminence of death
- Symptom severity
- Drug profile (including effectiveness, SEs, interactions, duplications, lab monitoring)
- Bereavement
- Referrals

The comprehensive assessment should be updated as frequently as the patient’s condition requires, but at a minimum of every 15 days (CoP §418.45d). It must include retrievable, patient-level data elements that should be collected in a systematic way and used in patient care planning and evaluation as well as in the hospice’s quality assurance and performance improvement (QAPI) program (CoP §418.54e).

Care Planning and Coordination of Services

As active members of the IDG engaged in care planning and coordination of services both within hospice and with other healthcare providers, this regulation (CoP §418.56) should be of intense interest to the hospice medical director and team physician.

The plan of care is viewed as one of the most important documents in hospice care, and it flows from the continually updated comprehensive assessment. The registered nurse in the IDG is charged with coordinating the care planning process to ensure continued implementation and revision of the plan of care. However, the IDG must consult with the patient’s attending physician (if any), the patient or representative, and the primary caregiver in establishing the plan of care. All services provided to the patient must follow a written plan of care (see the sidebar at right).

Revisions to the plan of care should include information from the updated comprehensive assessment and progress toward achieving specified outcomes and goals. It should be reviewed as frequently as the patient’s condition warrants (but no less than every 15 calendar days), and must be completed by the IDG in collaboration with the patient’s attending physician (if any).

The IDG maintains responsibility for direction, coordination, and supervision of the plan of care. There must be evidence of coordination of services between hospice disciplines in
all settings and with other non-hospice healthcare providers which furnish services unrelated to the terminal illness and related conditions (CoP §418.56e). The hospice must also designate a specific IDG (not necessarily the patient’s IDG) to establish day-to-day policies and procedures of the hospice (CoP §418.56a).

Quality Assessment and Performance Improvement

QAPI is clearly another high priority in the new Hospice CoPs [CoP §418.58]. While medical directors just narrowly escaped from being responsible for their hospice’s QAPI program (the proposed CoPs had stipulated the medical director as responsible, but in the final regulations the governing body is charged with that role), CMS expects the medical director and team physicians to be integrally involved in the hospice QAPI activities.

The medical director retains responsibility for the medical component of the patient care program (CoP §418.102d) and, thus, should note the requirement that the hospice QAPI program show measurable improvement in indicators that will improve palliative outcomes and end-of-life support services for patients and families (CoP §418.58a). Following logically from the assessment and plan of care sections, CoP §418.58b reiterates that QAPI must utilize quality indicator data—including patient care data—to monitor the effectiveness and safety of services and the quality of care. The focus should be on high risk, high volume, and problem-prone areas (CoP §418.58c). Performance improvement projects should begin by February 2, 2009, and measurable progress is expected over time (CoP §418.58).

Patient Rights

In this important addition to the new regulations (CoP §418.52), hospice personnel—whether employed or contracted—have the responsibility to report violations of patient rights to the hospice administrator. The right of the patient to be free of restraints or seclusion imposed as a punishment, or for the convenience of staff, is expanded upon in CoP §418.110m, with prescriptive requirements for the use and monitoring of physical restraints or seclusion. Death reporting requirements related to the use of restraints or seclusion will likely rely on physician determination of causality.

These new patient-centered regulations—with its emphasis on collaboration, continuity of care, patient outcomes and quality improvement—have the potential to catalyze greatly enhanced quality of service while decreasing between-program variability in service provision.

AWS on the Expanded Role of Physicians

The expanded roles of the hospice medical director and team physician were addressed by Dr. Harrold and other physician leaders in a recent NHPCO audio web seminar. For a CD of the session, visit www.nhpco.org/marketplace (Item 821297; Member: $75.00).

Cheryl Arenella is board certified in family medicine, geriatrics and hospice and palliative medicine, and serves as a consulting medical director for NHPCO. She retired from Capital Hospice (based in Falls Church, VA) in 2005, after 25 years of service as medical director.
A brand-new report explores the changing needs of families who give home-based care to their older loved ones and the clinicians who must educate and support family caregivers.

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CONSULTING SERVICES • EXECUTIVE SEARCH • EDUCATION PRODUCTS & TRAINING
The National Hospice Foundation (NHF) and NHPCO’s Caring Connections are working with a relatively new organization whose founder is as inspiring as his mission.

David Fajgenbaum, a medical student at the University of Pennsylvania, founded the National Students of Ailing Mothers and Fathers (AMF) Support Network in 2004, following the death of his mother, Anne Marie, who was diagnosed with brain cancer in 2003 and found comfort and compassion in hospice care.

The organization’s mission is to support all college students with an ailing or deceased loved one, empower them to get involved in public service, and raise awareness about the needs of grieving college students. The National Students of AMF accomplishes this mission in several ways. It helps other students to develop campus chapters nationwide, provides grief support online, hosts an annual national conference on college student grief, and sponsors fundraising events, including an annual Boot Camp 2 Beat Cancer.

“I began National Students of AMF because I knew just how difficult it was to have my mom (and best friend) sick while I was at college. Without the help of my incredible friends, teachers, teammates, and roommates, I never could have made it through my first three semesters of college. I have tried to emulate this same kind of support through this organization.”

—David Fajgenbaum

Support for the Entire End-of-Life Community

In April 2008, the entire end-of-life community also benefited from this group’s work. NHF received a $100,000 grant from the Reader's Digest Foundation (RDF) in honor of founder, David Fajgenbaum.

This unrestricted grant was the second of ten $100,000 grants awarded through the RDF’s initiative, “Make It Matter.” The gift to NHF is supporting a range of NHPCO programs, including: fundamental research and program development in hospice access, quality of care, and pain management; professional education of hospice leadership and staff; promotion of inter-organization and interdisciplinary cooperation; and related public policy issues.

Collaborative Work

All three organizations—National Students of AMF, NHF and NHPCO—have committed to providing more awareness, education and resources to help students who are dealing with...
Better Benefits and Pricing in Store for 2009

For many years, NHPCO has offered an MSDS Program to members at group-discounted rates. Through this program, subscribers have easy access to already-prepared Material Safety Data Sheets that comply with hazardous material requirements—plus a host of other benefits to increase productivity and reduce risk.

Effective January 1, 2009, NHPCO has contracted with a new vendor, MSDSonline, to provide this service. The MSDSonline program offers a range of attractive features, including a complete online system for easier, more convenient access to data sheets. Here's a glimpse of the many benefits:

- Complete online system—75% more efficient than paper-based systems;
- OSHA-compliant electronic MSDS management;
- Around-the-clock access to the online database;
- On-demand access to MSDS management tools;
- Easy access for all staff and departments;
- Built-in comprehensive regulatory reports;
- Multi-site administrative capabilities;
- Extensive incident case management and record-keeping tools.

The best part of moving to this new program is the pricing. Details will be provided in your 2009 Membership Renewal Package that will be mailed out in early January. Stay tuned!
Community Hospice Appoints New Medical Director

Community Hospice of Northeast Florida (based in Jacksonville) has promoted Frank Santamaria, MD to medical director and chief medical officer.

In his new role, Dr. Santamaria oversees the program’s Medical Services Department, which consists of eight full-time associate medical directors and four advanced registered nurse practitioners, as well as part-time and PRN staff. Dr. Santamaria also has been charged with helping to coordinate organizational changes required by the new Hospice Conditions of Participation.

Bob Sweeney’s Camp HOPE Offers Unique Services to Children and Families

Good Shepherd Hospice (Port Jefferson, NY), a member of Catholic Health Services of Long Island, established a free bereavement camp six years ago for children, ages 5 to 17, who live on Long Island and have experienced the death of an immediate family member. Funded by the Robert L. Sweeney Foundation, Camp HOPE has become the largest bereavement camp on Long Island and bears the unique distinction of allowing adult caregivers to participate in the experience alongside their children.

Among the special services offered is its “Healing Circles.” Led by social workers, Healing Circles gives the children the chance to share stories about their loved ones. Trained adult volunteers known as “Big Buddies” help their “Little Buddies” navigate through their feelings and emotions.

Campers who have “graduated” from Camp HOPE walk across the bridge in the closing ceremony of the weekend to meet their “Big Buddies.”

Alive Hospice CEO Honored for Healthcare Leadership

Janet L. Jones, president/CEO of Alive Hospice (Nashville, TN), has been recognized for her leadership in healthcare by the American Academy of Medical Administrators. Jones was selected as the 2008 recipient of its highest-level award: the Healthcare Executive of the Year Award. In addition, Nashville Business Journal has named Jones one of its 2008 Healthcare Heroes in the Community Leader category. Jones is a member of the NHPCO board of directors, chair of its Finance and Membership Committee, and former chair of its Ethics Committee.

Covenant Hospice Appoints New COO

Susan Lovelady was recently appointed senior vice president of operations and chief operating officer for Covenant Hospice (Pensacola, FL). Prior to the new position, Lovelady had served as chief financial officer since 2003. In her new role, she will be responsible for the leadership and management of multiple divisions and functions within the organization, including regional operations and clinical services, funds development, supply management, and human resources.

Correction:

In the article by Howard Tuch, “A Medical Director’s Inside Look at Health Policy in Washington” (September 2008 NewsLine/Insights), we incorrectly stated that Mr. Tuch left his position as “medical director for The Hospice of the Florida Suncoast” to serve a three-year term as a Robert Wood Johnson Foundation Health Policy Fellow. In fact, Mr. Tuch left his position as “medical director of Tidewell Hospice and Palliative Care” to serve as Health Policy Fellow. Our apologies for the error.
NHPCO presented awards to leaders in the hospice and palliative care field during its 9th Clinical Team Conference in October 2008. The awards were presented on behalf of NHPCO and the National Council of Hospice and Palliative Professionals (NCHPP)—the segment of the NHPCO membership that represents members of the interdisciplinary team. *NewsLine* is proud to spotlight these honorees and their work.

**Heart of Hospice Award**  
**Clinical/Caregiver Category**  
Alexander R. Nesbitt, MD, Susquehanna Hospice, Williamsport, PA

Dr. Nesbitt is the medical director for Susquehanna Hospice. Among many achievements, he spearheaded an advance care planning project involving three hospitals, eight nursing homes, and various community groups in a cooperative change initiative. He has been very involved in advancing professional education of end-of-life issues and improving community awareness.

**Excellence in Teamwork Award**  
**The Palliative Care Program Team**  
Hospice & Palliative Care Charlotte Region, Charlotte, NC

The Palliative Care Program Team has developed a successful model that demonstrates effective and sustained integration of hospice and palliative medicine across the healthcare continuum. The Team partners with the third largest public healthcare system in the United States, Carolinas HealthCare System, as well as care facilities throughout its eight-county service area. In its first year, the Team consulted on 65 patients. In 2007, the number grew to 2,500, with services extending to multiple sites and settings, including an outpatient clinic.

**Volunteers are the Foundation of Hospice Award**  
Co-sponsored By NCHPP and the National Hospice Foundation

**Patient/Family Service Category:**  
John Camara, Old Colony Hospice, Randolph, MA

For 18 years, John has been an active volunteer known for his willingness to seek out new challenges and responsibilities. A veteran of the U.S. Air Force, John is sensitive to the issues that veterans face at the end of life and has contributed significantly to the hospice’s Veterans Volunteer Program.

**Teen Service Category:**  
Amy-Joy Thompson, The Hospice of the Florida Suncoast Clearwater, FL

Amy-Joy discovered hospice in her sophomore year of high school. Now an Honors Medical Scholar at Florida State University, she hopes to become a physician and be a part of hospice throughout her life.

**NHPCO Distinguished Research Award**  
Betty Kramer, PhD, MSSW

Dr. Kramer is a professor in the School of Social Work and a member of the Comprehensive Cancer Center at the University of Wisconsin-Madison. A primary aim of Dr. Kramer’s research has been to understand the experience and variation found among family members caring for older adults with chronic and terminal illnesses in order to enhance service provision.

NHPCO and NCHPP depend on members in the field to nominate their colleagues for these special honors. Calls for nomination are announced in NHPCO’s e-newsletter, *NewsBriefs*, as well as on the Breaking News Section of the NHPCO Web site ([www.nhpco.org](http://www.nhpco.org)). You can also visit [www.nhpco.org/awards](http://www.nhpco.org/awards).
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It can easily happen. The days are long, and patients are frail and often heavy. With just a little miscommunication or dizziness or movement in the wrong direction, the patient can end up on the floor instead of on his feet. Patient transfers are a cause of many lawsuits against hospices and home health care agencies.

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Hospice on Call
The Best in After-Hours Triage

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Hospice on Call with respond and assist patients and families who’s care has been entrusted to us by our valued hospice clients with a compassionate heart and a dedication to clinical excellence.

Who We Are
Hospice On Call is a growing, national company that partners with your agency to provide after-hours RN phone triage to your patients and their care givers. Our nurses are experienced in hospice care as managers or as phone triage providers. The quality of work we do will increase the satisfaction in the after-hours service given to your patients, their families, your staff and your referral sources.

What We Can Do For You
- Our licensed RN’s answer your after-hours call “live”. No more answering service or pager delays.
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AAHPM, HPNA, and NHPCO congratulate
Diane E. Meier, MD,
Recipient of a 2008 MacArthur Foundation Fellowship Award

Home for the holidays?

This holiday season, many will brave the weather and crowds... some to be with loved ones, some to do their duty.

We thank our VITAS teams—and hospice caregivers everywhere—for their efforts to make this remaining time for those at the end of life and their families truly meaningful and memorable.

Wherever the road leads, VITAS will be there to help.

Happy holidays from America’s hospice leader
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NHPCO’s
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Audio Web Seminars

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Interdisciplinary Topics:
12/11/08: Providing Comfort to Seriously Ill Children: Pediatric Pain Management
01/08/09: Review of the Interpretive Guidelines for the New Hospice CoPs
02/12/09: Working With Challenging Families

Leadership Topics:
12/16/08: Where Have We Been? Where Are We Going? Understanding Industry Trends and Implications

01/27/09: Review of the Interpretive Guidelines for the New Hospice CoPs
02/24/09: Expanding Your Reach: PACE and Other Programs

Timely Sessions Now on Tape:
CoPs for Hospice Medical Directors and Physicians
Item: 821297, Member: $75.
Visit nhpco.org/marketplace.

National Conferences

24th Management and Leadership Conference:
4/23 – 4/25/09 in Washington, DC with the National Hospice Foundation Gala on Friday, April 24

Conference Sessions Now on Tape:
2nd National Conference on Access (8/18 – 8/20/08)
Visit www.nhpco.org/conferences and select “Conference Audio Recording & Web Cast Library.”

Hospice MDP Two-Day Foundational Courses

2/12 – 2/13/09 in Vancouver, WA in collaboration with the Washington State Hospice and Palliative Care Organization

Plus—Hospice MDP Level 1 and Level 2 modules are offered online to continue the learning and development of hospice managers. Visit www.nhpco.org/mdp.

End-of-Life OnLine (E-OL)

This is NHPCO’s distance learning gateway. Staff and volunteers can enroll online, select from a catalog of sessions organized by topic area, and take the sessions at their convenience. Timely sessions of note include:

Leading High Performance Teams—This course presents practical techniques to help learners build and lead teams that achieve greater results (under Interdisciplinary Team).

Dealing With Difficult People—Learners will gain insight into analyzing situations, determining the best course of action, and resolving problems (under Office/Business Skills).

For details on these offerings and others, visit nhpco.org/conferences.
In Memoriam:

Florence Schorske Wald, RN, MSN, FAAN

Florence Wald, a pioneer in the field of hospice care, died peacefully at her home in Connecticut on Saturday, November 8, 2008. She was 91.

Ms. Wald was an internationally recognized expert in end-of-life care and was, perhaps, best known as the Dean of Nursing at Yale University (1959-1968) who brought modern hospice care to the United States.

The modern concept of hospice was a new model being developed by Cicely Saunders at St. Christopher’s Hospice outside of London in the 1960s. Wald was so inspired by the work being done at St. Christopher’s that she invited Saunders to serve as a visiting faculty member at Yale in 1965. The professional collaboration—and indeed the friendship of these two pioneers—took a deep hold. In 1968, Wald left her position at Yale to spend a year at St. Christopher’s to learn as much as possible about caring for the dying. On her return to the United States, she was instrumental in organizing an effort that led to the opening of Connecticut Hospice, which is credited as the first hospice program in this country.

“Florence Wald was a true American pioneer and her work led to fundamental changes in the care that dying people in this country receive. Her leadership, dedication and visionary understanding of caring for people at the end of life have been instrumental to the work being done every day in hospice and palliative care programs across the country,” said J. Donald Schumacher, president/CEO of NHPCO.

NHPCO and its three affiliate organizations—the National Hospice Foundation, the Foundation for Hospices in Sub Saharan Africa, and The Alliance for Care at the End of Life—extend deepest sympathies to Ms. Wald’s family, friends, and colleagues the world over and honor her for her special gifts and contributions that improved the way we live and die.
Please visit our Web site at nhpco.org.

NHPCO is proud to share the winning entries from this year’s Photography, Film and Writing Contest. The winning entries from the Special Section on page 27 will also be featured in NewsLine and Insights throughout the new year.

Please visit our Web site at nhpco.org.