The Interpretive Guidelines for the new Medicare Hospice Conditions of Participation (CoPs) are the guidelines which surveyors use when performing inspections of hospice programs. These Guidelines, which are prepared by the Survey and Certification Group of the Centers for Medicare and Medicaid Services (CMS), provide surveyors with probe questions and direction when assessing a hospice program’s compliance with the CoPs.

CMS issued Draft Interim Guidelines on November 18, 2008 as the first surveyors were being trained on the new CoPs, and on January 2, 2009 released Interim Final Guidelines (Version 1.1). While the Guidelines and NHPCO’s analysis are posted online (www.nhpco.org/regulatory), this article takes a closer look at some of the areas of special import to help members become that much better prepared when survey day arrives.

Also Featured This Month:
NHPCO’s New Pediatric Standards... In partnership with ChiPPS, NHPCO has developed the first national “Standards of Practice for Pediatric Hospice and Palliative Care Programs” to help providers develop safe, effective and high-quality programming for children and their families. See page 9.

FHSSA’s Quarterly Report—following page 22.
Areas of Focus

Patient Rights (§418.52)

The new Hospice CoPs place significant emphasis on patient rights. Surveyors will be looking for signed evidence that patients or their representatives have received the Notice of Patient Rights and will be asking patients and families to:

- explain, in their own words, how the rights apply to the care being provided and if they have any concerns about the financial implications of the services they are receiving; and
- confirm that they have received information on developing advance directives; the hospice’s complaint process; reporting violations of their rights; and how to reach the hospice staff.

Since patients have a right to effective pain management and symptom control, surveyors will be looking closely at (1) the initial and ongoing pain and symptom acuity assessments, (2) patients’ involvement in forming their pain and symptom management plan, and (3) the hospice’s response to patient needs.

Patient Assessments (§418.54)

The Guidelines reinforce that hospice programs do have flexibility with regard to the forms, process, and format they use in meeting the requirements for initial and comprehensive assessments of the patient’s and family’s needs.

Initial Assessment

In terms of the initial assessment, there are a few key points to keep in mind. First, the initial assessment must be completed by the hospice RN within 48 hours of the election of hospice services (i.e., the effective date on the Election of Hospice Benefit form) and must address the patient’s and family’s immediate needs. In other words, the initial assessment is not a “meet and greet” visit whereby the hospice introduces itself and begins to evaluate the patient’s interest in and appropriateness for hospice care. Secondly, the initial assessment should take place in the location where the hospice services are being delivered.

Comprehensive Assessment

The comprehensive assessment can be viewed as the “holistic” assessment and must be completed within five calendar days of the date on which the patient elects hospice services.

While the CoPs direct the hospice RN to coordinate the initial assessment process and development of the patient’s plan of care, other members of the hospice interdisciplinary group (IDG) are required to participate in the comprehensive assessment. As such, this holistic evaluation must encompass the physical, psychosocial, emotional, and spiritual needs related to the terminal illness. Guidelines leave it up to the hospice to determine which IDG members are involved in the comprehensive assessment, but selection should be consistent with the hospice program’s policies and procedures as well as its scope of practice.

As part of the comprehensive assessment, the hospice must conduct a review of all of the patient’s prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This mandate is tied to CoP §418.106 (a) that requires the hospice IDG to confer with an individual with education and training in drug management (see page 6). The Guidelines direct the hospice to evaluate drug effectiveness, side effects, interactions of drugs, duplicate drugs...

Of Note:

- On November 18, 2008, CMS issued Draft Interim Guidelines on the new Hospice CoPs and, in an unprecedented gesture, shared the document with NHPCO to review and share with members.
- On January 2, 2009, the Interim Final Guidelines (Version 1.1) were released and, by January 5, NHPCO’s Regulatory team provided members with an analysis and crosswalk of the changes.
- NHPCO expects the final Interpretive Guidelines to be published early this year.
- For updates and access to pertinent materials, visit NHPCO’s Regulatory & Compliance Center, or go directly to www.nhpco.org/cops.
As I write this, it has been only a few hours since our nation’s first African American President took the oath of office here in Washington, DC and delivered what I felt to be one of the most poignant inaugural speeches in my lifetime. One of the messages in that speech that still resonates with me was his call to all Americans to do their part as involved citizens.

“Our challenges may be new. The instruments with which we meet them may be new. But those values upon which our success depends...these things are old...” he said. “What is required of us now is a new era of responsibility—a recognition, on the part of every American, that we have duties to ourselves, our nation, and the world, duties that we do not grudgingly accept but rather seize gladly, firm in the knowledge that there is nothing so satisfying to the spirit, so defining of our character, than giving our all to a difficult task.”

As I listened to this stirring call to action, I could not help but reflect on the journey we have taken together. New regulations and compliance issues, legislation and litigation, rate protection—these are just some of the significant challenges our field has clearly faced during the past year. And throughout this time, I’ve been proud of the way the hospice community has stood together to tackle these challenges head on. Through our work together, we have taken the collective voice of the hospice community to Capitol Hill and to regulators focused on the field. The thoughtful feedback to CMS regarding regulatory issues, the overwhelming number of emails and calls that went to our elected officials and the White House, the support of NHPCO’s litigation efforts to protect hospice rates, all this and so much more demonstrates the shared commitment we have for providing quality care to patients and family caregivers.

As we go to press with this issue, we are in fact heartened by legislation in the House of Representatives that would halt the elimination of the Budget Neutrality Adjustment Factor for one year. While I can’t predict the final outcome as I write this, I trust this achievement provides a measure of hope in these challenging times. If, ultimately, this legislative action succeeds, we can celebrate. But regardless of outcome, let this be a reminder that our involvement as hospice advocates never really stops. As President Obama calls for all Americans to become involved, I ask that each of you continue your activity to make the voice of the hospice community heard.

As we embrace the New Year and recommit ourselves to our work together, please consider joining NHPCO and The Alliance for Care at the End of Life for our Capitol Hill Day event (see page 14). This event precedes MLC and the National Hospice Foundation Gala—and all are wonderful opportunities to meet with colleagues, old and new, and celebrate our work together.

Let me also pass along my sincere appreciation to those providers who have mailed in their NHPCO dues payment. NHPCO could not do the work we do without your commitment and support. So thank you for the critically important role you play through your membership.

I hope to see you in Washington in April!

J. Donald Schumacher
President/CEO
and drugs associated with laboratory testing which could affect the patient. The surveyor will be looking for documented evidence in the clinical record that common side effects of medications are anticipated and preventive measures are being implemented. The hospice should review each patient’s medications and monitor the patient for medication effectiveness, actual or potential medication-related effects, duplicate drug therapy, and as new medications are added or changed, or the patient’s condition changes.

**Updating the Comprehensive Assessment**

The comprehensive assessment must be updated as frequently as the condition of the patient requires or at a minimum of every 15 days. When a change is needed to the plan of care, there must be documentation that the patient and family are receiving the services required by the change. If there are no changes to the patient’s status, that must be identified and documented too. Hospices are free to establish the process and documentation forms used to update the assessment, but both should be described in the program’s written policies and procedures as a matter of record.

Updating the comprehensive assessment has been a challenge for hospice providers, so it is helpful to be mindful of CMS’s intent behind the requirement: “The purpose of updating the assessment is to ensure that the hospice IDG has the most recent accurate information about the patient and family in order to make accurate care planning decisions. Assessment updates should be easily identified in the clinical record.”

Lastly, hospices should ensure that there are “data elements” incorporated into the comprehensive assessments to help measure their success in addressing patients’ needs and symptoms (i.e., data elements to measure treatment of pain, dyspnea, nausea, vomiting, constipation, emotional distress, and spiritual needs).

**IDG, Care Planning, and Coordination of Services (§418.56)**

CMS believes the patient’s plan of care is the most important document in hospice care. To assess compliance, surveyors will be asking providers what steps they are taking to ensure that a written plan of care is developed for each patient, with full participation of the interdisciplinary group (IDG) and in consultation with the patient’s attending physician, if any. In response, programs will need to present documentation that demonstrates that (1) all members of the IDG contributed to each patient-specific written plan of care and (2) the plan of care was a collaborative effort that also involved the attending physician. While the IDG members and attending physician do not have to sign off on the written plan of care, there must be documentation of their involvement (e.g., documented phone conversations, electronic communications, and received orders).

There should be a direct link between the needs identified in the comprehensive assessments and the plan of care. When there are needs identified which are not directly related to the terminal illness, the hospice should still document these needs in the plan of care, and note who will be responsible for addressing them.

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**Coordination of Care**

The hospice RN is designated to coordinate the patient’s plan of care and, therefore, must be ready to describe to the surveyor the program’s system for:

- developing and revising patient care goals and objectives;
- facilitating the exchange of information among staff, the patient, and the caregiver; and
- developing a mechanism whereby a continual flow of information regarding the patient’s and family’s needs is made available to members of the IDG.

In addition, the surveyor may interview the program administrator, observe staff, and/or complete clinical record reviews in order to validate the information provided by the hospice RN.

**Specifying Visit Frequency**

The Guidelines confirm that it is acceptable to specify ranges for the number of visits needed to meet the plan of care, provided the following parameters are followed:

- The specified range must meet the patient’s and family’s needs and must represent small intervals (i.e., 1-3 visits per week; 2-4 visits per week). “0” is not allowed as part of a range.
- The specified range may be exceeded in order to address the patient’s and family’s needs; however, the patient’s records should be documented to describe why the extra visit(s) are warranted. If exceeding the specified number of visits persists, the plan of care should be updated to include the need for additional visits.
Standing and routine orders must be individualized to address the patient’s specific needs and must be signed by the patient’s physician.

The hospice team should also make every effort to be proactive when developing the plan of care—by anticipating changes and considering the preferences of the patient and family at all times rather than only when crises arise.

**QAPI (§418.58)**

The quality assessment and performance improvement (QAPI) condition is a new and evolving component of the CoPs. Its primary purpose, says CMS, is to set a clear expectation that hospices must take a proactive approach to improve performance, with special focus on improving care and the activities that impact a patient’s health and safety.

Per this condition, the hospice must develop, implement, and maintain an ongoing, hospice-wide data-driven QAPI program. The hospice’s governing body must ensure that the program:

- reflects the complexity of its organization and services;
- involves all hospice services (including those services furnished under contract or arrangement);
- focuses on indicators related to improved palliative outcomes; and
- take actions to demonstrate improvement in hospice performance.

The hospice must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. In order to help assess compliance, surveyors will want to see:

- the hospice’s aggregated data and its analysis of that data;
- a copy or description of the QAPI program;
- minutes or notes from meetings about the development and implementation of the QAPI program; and
- the individual(s) responsible for the QAPI program.

In addition, surveyors will want to know how the hospice uses the data analysis to select performance improvement projects, how it implements such projects, and how it uses the data to evaluate the effectiveness of those projects.

As one way to help educate staff about QAPI—and put the abstract notion of quality to work in day-to-day practice—NHPCO’s Quality Partners program developed an 80-page fictional story about one program’s journey toward compliance. The story chronicles “The Adventures of Mary Maven and Hospice of the Good Intentions,” a medium-sized hospice which learns to embrace QAPI and the value of performance improvement while building an organizational culture of quality. To learn more about this training tool, visit www.nhpco.org/quality.
A QAPI Program Begins With Self-Assessment

Conducting self-assessments on a routine basis is key to a successful QAPI program. The exercise helps determine what areas require improvement and allows staff to track and build upon the actual performance improvements. Per CMS, the following elements should be included in a QAPI program:

- Program objectives;
- All patient care disciplines;
- Description of how the initiative will be administered and coordinated;
- Methodology for monitoring and evaluating the quality of care;
- Priorities for resolution of problems;
- Monitoring to determine effectiveness of action;
- Oversight responsibility reports to governing body; and
- Documentation supporting review of the QAPI program.

February 2, 2009 was the deadline to comply with the QAPI component of the new CoPs. CMS now expects hospices to have their QAPI programs in place, and data collection and analysis under way. There is no requirement for hospices to conduct a specific number of performance improvement projects per year. Rather, hospices should be selecting performance improvement projects based on the results of their hospice-wide self-assessments, state and/or accreditation surveys, and other quality assessment tools. Note also that actual performance improvement projects must be documented in written form and must include the elements outlined in the standard.

Naming One Medical Director (§418.102)

It is clear from the Guidelines that a hospice program must name one medical director to assume responsibility for the medical component of its patient care program, per each Hospice Medicare Provider Number. If a hospice has multiple locations, but those locations share the same provider number, only one medical director should be named.

The medical director may work as an employee, contractor, or volunteer and may work either full time or part time, but must assume oversight responsibility for the physician, nursing, social work, therapy, and counseling areas within the hospice to ensure these areas consistently meet patient and family needs. A “physician designee” must also be pre-selected to serve as medical director in the named medical director’s absence.

Drug Management (§418.106)

The Guidelines provide clarification on the requirement that the IDG confer with an individual with “education and training in drug management” to ensure that drugs and biologicals meet each patient’s needs (under “Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment”). Per CMS, qualifying individuals include: licensed pharmacists; physicians who are board certified in hospice and palliative medicine; RNs who are certified in hospice and palliative care; physicians, RNs and nurse practitioners who complete a specific hospice or palliative care drug management course; and other individuals as allowed by applicable state law. The hospice must also provide evidence or documentation that the qualifying individual has the required education and training.

Hospice Care in the SNF/NF and ICF/MR (§418.112)

The Guidelines also emphasize that hospices retain responsibility for the quality of care provided to the patient and family when they enter into contractual agreements with skilled nursing facilities (SNF), nursing facilities (NF), and intermediate care facilities for the mentally retarded (ICR/MR); however, both organizations must comply with their applicable conditions and requirements for participation in Medicare/Medicaid. Here are some key points to keep in mind:

- The facility’s services must be consistent with the plan of care developed in coordination with the hospice (the hospice patient residing in a facility should not experience any lack of services or personal care because of his/her status as a hospice patient);
- The facility must offer the same services to its residents who have elected the Medicare Hospice Benefit as it furnishes to residents who have not elected the Benefit;
- The professional services provided by the hospice to the patient in his/her home should continue to be provided to the patient while in a facility or other care setting;
- Hospice core services must be routinely provided by the hospice, and cannot be delegated to the facility; and
There should be evidence that the hospice and the facility have reached an agreement on how to communicate concerns and responses 24 hours a day in order to work together to meet the needs of the patient as identified in the plan of care. The hospice must document that this communication has occurred.

Training Resources

NHPCO offers members a range of training resources on the new Hospice CoPs, including the following tapes from recent Audio Web Seminars:

- **New**—The Interpretive Guidelines and the IDG (Item 821370)
- **New**—The Interpretive Guidelines for Hospice Managers & Leaders (Item 821384)
- Conditions of Participation for Managers and Leaders (Item 821209)
- Conditions of Participation for Clinical Staff (Item 821197)
- Conditions of Participation for Hospice Medical Directors, Physician Members of the IDG and Attending Physicians (Item 821297)
- Hospice in Long-Term Care Facilities: Doing It the Right Way (Item 821198)

To purchase the AWS tapes, visit [www.nhpco.org/marketplace](http://www.nhpco.org/marketplace). For other resources, visit NHPCO’s Regulatory & Compliance Center—or go directly to [www.nhpco.org/cops](http://www.nhpco.org/cops) and scroll to “Provider Tools and Resources.”

*Jennifer Kennedy is NHPCO’s regulatory and compliance specialist. She has authored several articles on the Hospice CoPs and is a frequent presenter on regulatory and compliance issues.*
Despite amazing progress in medicine and technology, the unfortunate reality remains that children die. Approximately 53,000 children die each year in the United States and at least 400,000 more live every day with chronic, life-threatening conditions. While these numbers pale in comparison to the number of dying adults, the impact on families and on society is immeasurable.

As noted in “A Call for Change,” the 2001 white paper by the Children’s Project on Palliative/Hospice Services (ChiPPS): “Chronic illness and death can result in devastating consequences for affected children and the people who know and love them, but these consequences are not a foregone conclusion—the harm associated with the death of a child can be lessened by the provision of high-quality palliative and bereavement care.”

Currently, only 10 to 20 percent of dying children receive hospice services (generally for a brief duration), and a similar minority of children with life-threatening conditions receive palliative care support and interventions. Barriers to the provision of this necessary care are numerous and daunting. However, the exponential growth in expertise, programs, resources and educational materials—together with the increasing mandate from patients and families, providers, supporters and healthcare monitoring organizations—means that the time is now for the field of hospice and palliative care to ensure access to its youngest and most vulnerable members.

The Pediatric Services Survey which NHPCO conducted in 2007 reveals that a majority of responding agencies serve pediatric patients, but only a minority has formal pediatric hospice and palliative care programs with specially-trained staff. Many providers indicate willingness to start or expand pediatric services but lack education, tools, resources and performance improvement methods to create and sustain high-quality programming. In response to this need, NHPCO has developed the first national Pediatric Standards—the “Standards of Practice for Pediatric Hospice and Palliative Care Programs.”

These new standards will be available online and free to NHPCO members later this month (www.nhpco.org/pediatrics or www.nhpco.org/quality). This article takes a closer look at their development and how they can help advance the quality and availability of care to children.

continued on next page
Developing the Pediatric Standards

In 2006, NHPCO reorganized the Standards of Practice for Hospice Programs (i.e., the “NHPCO Standards”) around the “10 Components of Quality in Hospice Care,” which serve as the framework for the NHPCO quality initiative, Quality Partners:

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

Quality Partners has an overall goal of offering user-friendly tools and resources to help NHPCO members demonstrate clear, measurable outcomes for clinical and non-clinical operations and develop a robust quality assessment/performance improvement (QAPI) program. Organizational attention to these 10 domains will not only improve care for patients and families, but will also enable providers to meet the QAPI requirements outlined in the Hospice Conditions of Participation (Hospice CoPs).

The Pediatric Presence

Recognizing the emergence of pediatric palliative care as a burgeoning discipline and the important differences between adult and pediatric palliative/hospice care, NHPCO asked ChiPPS (see sidebar at right) to develop Pediatric Standards. The ChiPPS Quality work group, with members from the U.S. and Canada, took on the task.

While the Pediatric Standards will be available as a stand-alone document, they were developed as an appendix or “supplement” to the NHPCO Standards (which is now under development to
reflect the new Hospice CoPs). So, the first step was to broaden the language in the NHPCO Standards to include “palliative care,” as more children are cared for through palliative care programs than through hospice. The group then spent the next two years developing the new pediatric-specific standards.

Working on the project was an exciting and groundbreaking opportunity for members of the ChiPPS workgroup. As many providers know, the needs of children and their families do not fit into the typical adult hospice model on many levels. Traditionally, hospice programs have cared for small numbers of children, whose needs easily get lost among the large numbers of adults being served in the community. Organizational implementation of the Pediatric Standards will enable the development of safe, effective, high-quality pediatric programming.

Safety is the first and primary goal when delivering care to children and families. Along with safe care, providers must also strive to improve quality by enhancing effectiveness of team expertise in pediatric care. Applying standards and defining best practice allows pediatric hospice and palliative care teams to achieve two major goals: (1) to identify and support specific medical, psychosocial, spiritual, educational, developmental and emotional needs of children of all ages and their families; and (2) to recognize that improvement of knowledge, skills and increased support is necessary for all caregivers. A third benefit of the Pediatric Standards is to allow unmet needs in care delivery to be identified, thus enabling providers to expand services and develop further partnerships with community providers.

Throughout September 2008, the Pediatric Standards were posted on the NHPCO Web site for public comment. The intent of the field review was to give NHPCO members and pediatric hospice/palliative care practitioners the opportunity to review the proposed standards and language, to discuss the document with peers and colleagues, and to provide feedback. After the public comment period, the ChiPPS Quality work group reconvened to incorporate public feedback to strengthen the document. As a result of this process, the Pediatric Standards have evolved to represent a truly democratic and informed pediatric-specific addendum to the adult NHPCO Standards. Hospice and palliative care programs can now use the Pediatric Standards to develop best practices, with the knowledge that the guidelines have been developed, reviewed, and revised by experts in the field of pediatric palliative and hospice care.

**Implementing the Standards**

The Pediatric Standards do not stand alone, but are designed to supplement the NHPCO Standards and set clinical and organizational precedence for hospice and palliative care programs providing care to infants, children, adolescents, and their families in the home, hospital, and long-term care and respite facilities.

*continued on next page*
As with the NHPCO Standards, successful implementation of the Pediatric Standards involves systematic, intentional application of each of the 10 domains outlined, from Patient and Family-Centered Care to Performance Measurement. The first step is to use the standards as an organizational self-assessment tool. This year, the Pediatric Standards will be incorporated into the Quality Partners Self-Assessment System. The system is currently available for use with the existing NHPCO Standards and provides members with a user-friendly means of assessing their organizations and identifying strengths and opportunities for improvement. Programs will have the ability to use the same system and principles for the Pediatric Standards when they are added. (To learn more about the self-assessments, visit www.nhpco.org/quality).

Setting the Bar and Moving Forward

All children with life-threatening conditions deserve excellent pediatric palliative care, either as the primary plan of care or concurrently with life-prolonging therapies. In fact, the sole criterion for entry into a pediatric palliative care or hospice program should be that a child is not expected to survive to adulthood. Delays in the inclusion of palliative care strategies and services are associated with increased physical, emotional and spiritual suffering of children and their families. Families in every area of the country should have access to high-quality pediatric hospice and/or palliative care services, and should have a choice to bring their children home to die when that is the likely outcome. Hospices and palliative care programs are in the best position to provide this crucial care, as they are available in the communities that children call home, and are staffed by interdisciplinary teams capable of alleviating all sources of suffering encountered by children and families facing life-threatening illness.

Creation of excellent, sustainable, robust pediatric services requires each organization to develop a system-wide infrastructure for pediatrics, whether the organization cares for many children or for the occasional child in their service area. Individual organizations will vary in availability of resources to provide safe and effective pediatric palliative care, and may need to partner with programs in the community, regionally or nationally through distance mentoring. Whatever the model, the Pediatric Standards can be used to create a template to prescribe organizational best practice in safe, effective, high-quality care for children and their families facing life-threatening illness.

Sarah Friebert is board certified in pediatrics, pediatric hematology/oncology and hospice/palliative medicine. Currently, she directs the Haslinger Family Pediatric Palliative Care Division at Akron Children’s Hospital in Akron, Ohio and serves as a consulting medical director to NHPCO.

Susan Huff has worked as a practitioner, researcher and educator in pediatric hospice and palliative care for over 25 years. Currently, she is the director of Pediatrics at Home, a Program of Johns Hopkins Medicine in Baltimore Maryland, and also serves as co-chair of ChiPPS, NHPCO’s Children’s Advisory Council on Palliative/Hospice Services.
Resources

More information on pediatric hospice and palliative care can be found on the ChiPPS web page of the NHPCO Web site (www.nhpco.org/pediatrics). In addition, the following resources are available for purchase from NHPCO’s Marketplace (www.nhpco.org/marketplace) at member-discounted rates:

- Education and Training Curriculum for Pediatric Palliative Care (Item 820285)
- Compendium of Pediatric Palliative Care (Item 810030)
- Caring for Kids: How to Develop a Home-Based Support Program (Item 820577)
- Family Education Brochures (available in English and Spanish):
  - When Your Child is in Pain (Item 821104)
  - Talking with Your Child about His/Her Illness (Item 821106)
  - Talking to Your Child’s Doctor (Item 821108)
  - When a Child Dies: A Guide for Family and Friends (Item 821110)
  - Helping Children Cope with the Death of a Loved One (Item 820974)
Preview This Year’s Agenda and Sign Up Soon!

The hospice community has never had more reason to ramp up its presence on Capitol Hill. With the continued threats to the Medicare Hospice Benefit and the inevitable healthcare reform coming in the near future, it is critical that NHPCO members build and strengthen their relationships with members of Congress.

To help make this happen, NHPCO is hosting Capitol Hill Day on April 22—and this year’s event will be bigger and better than ever. We will be using the latest advocacy techniques, with proven results, to ensure that the voice of the hospice community resonates on the Hill long after the 22nd.

Sponsored in partnership with lobbying affiliate, The Alliance for Care at the End of Life, Capitol Hill Day will be held from 9:30 a.m. to 7:30 p.m. on April 22, in conjunction with NHPCO’s Management and Leadership Conference (MLC) at the Omni Shoreham Hotel in Washington, DC.

Attending the event is free to all MLC registrants and just $149 for NHPCO members who are unable to attend the conference.

Take a moment to review what’s in store this year—particularly the new “Strategy Session” in the morning and NHPCO’s new approach to congressional meeting coordination.

Agenda at a Glance

April 22, 2009

9:30 a.m. to 12:30 p.m.
Capitol Hill Strategy Sessions

During these small-group sessions, which will be customized to your level of advocacy expertise, you will have the chance to work with colleagues, industry experts, key policy makers and issue advocates to fine-tune your advocacy skills in preparation for your afternoon meetings on the Hill. You will also receive up-to-the-minute developments on legislative activity impacting the hospice community, plus materials to take with you to the meetings. (A Metro card will also be provided.)

12:30 p.m. to 5:30 p.m.
Meetings on Capitol Hill

This is your time to meet with members of Congress to educate them on the benefits and challenges of providing hospice and palliative care and to position your program as a valuable community resource. To help you take this all-important step, NHPCO will:

• Schedule and coordinate congressional meetings for you, with the option to meet with other federal officials in your program’s service area;
• Provide a Respite Room on the Hill to grab a quick snack and ask questions;
• Provide a personalized schedule of the meetings, with maps and materials customized for each meeting; and
• Provide a customized questionnaire to make it easy to document and report back on your meetings.
5:30 p.m. to 7:30 p.m.

Celebrate Your Success at the Capitol Hill Reception

You can celebrate the conclusion of this productive day at this evening reception on the Hill—right in the heart of the action! Last year’s reception was held at the historic Longworth House Office Building and was attended by more than 300 NHPCO members as well as members of Congress and their staff.

Register By April 1, 2009

- Registration for Capitol Hill Day (“Capitol Hill Strategy Session & Visit”) is handled as part of the registration for MLC (even if you are not attending MLC).
- Visit www.nhpc.org/MLC2009, select “Registration” and go to “Online Registration.”
- This event is free to MLC registrants and just $149 for non-registrants.

Please Note: 2009 Capitol Hill Day is a comprehensive, all-day event that begins promptly at 9:30 a.m. on April 22. Attendees should make sure their travel arrangements allow for the full day of activities.

Sponsored By:

National Hospice and Palliative Care Organization
Plan Ahead: National Healthcare Decisions Day is April 16, 2009!

Last year, NHPCO, along with other national, state and community organizations, led a massive effort to highlight the importance of advance healthcare decision-making. That joint effort culminated in the formal designation of April 16 as National Healthcare Decisions Day.

2009 National Healthcare Decisions Day (NHDD) will fall on Thursday, April 16. Here are some of the ways you can help raise awareness on this important day:

- Make sure everyone in your organization is informed about NHDD (including staff, board of directors, volunteers and others) and ask for their involvement to promote NHDD in your community. For example, have staff wear a button that says “Ask Me About Advance Directives!”

The Report allows hospices which have used the survey to compare their individual results with the national-level results for benchmarking. It also includes hospice staff salaries and descriptive demographic information that can be used for budget preparations and strategic planning by all providers.

To purchase the Report, visit www.nhpco.org/Marketplace (Item 821340; Member: $200). To learn more about STAR, refer to the cover story in the November 2008 issue of NewsLine (www.nhpco.org/newsLine) or visit www.nhpco.org/star.

Staff Satisfaction: How Does Your Organization Measure Up?

In the fall of 2007, NHPCO launched the Survey of Team Attitudes and Relationships (STAR)—the first and only job satisfaction survey designed specifically for the hospice field. Developed by researchers at the University of Pennsylvania in collaboration with NHPCO, STAR can be used by NHPCO provider members—free of charge—to help assess their staff’s job satisfaction and take corrective action in response to the feedback.

First Annual Report Now Available

Based on survey responses from participating providers, NHPCO has produced the first annual National STAR Report. This Report summarizes results at the national level and includes national averages for STAR domains and questions. It also provides results broken out by selected demographics (e.g., clinical/non-clinical, discipline, hours worked) and categorized by size and location.

The Report allows hospices which have used the survey to compare their individual results with the national-level results for benchmarking. It also includes hospice staff salaries and descriptive demographic information that can be used for budget preparations and strategic planning by all providers.

To purchase the Report, visit www.nhpco.org/Marketplace (Item 821340; Member: $200). To learn more about STAR, refer to the cover story in the November 2008 issue of NewsLine (www.nhpco.org/newsLine) or visit www.nhpco.org/star.
NOW AVAILABLE!

THE Credential for Advanced Social Workers in Hospice and Palliative Care

ADVANCED CERTIFIED HOSPICE AND PALLIATIVE – SOCIAL WORKER (ACHP-SW)

• Developed jointly by the National Association of Social Workers and the National Hospice and Palliative Care Organization

• Designed by social work leaders in hospice and palliative care for social workers who meet national standards of excellence

• Recognized as the premier social work credential in hospice and palliative care

• Demonstrates your experience, advanced skill, ongoing professional development, and leadership in hospice and palliative care

• Shows organizations, interdisciplinary team members, colleagues, and clients you have all the qualities essential to specialized practice

State licensure protects consumers. The ACHP-SW credential indicates you have met national standards of specialized care.

Active membership in both the National Association of Social Workers and the National Hospice and Palliative Care Organization is required.

Visit www.socialworkers.org/credentials or call 202.408.8600 ext. 447 for more information.
People & Places

Home Nursing Agency Earns National Recognition as One of the Best Places to Work

Home Nursing Agency (Altoona, PA) was recognized in Modern Healthcare this past fall as one of the “100 Best Places to Work in Healthcare.” The agency garnered 18th place in this nationwide survey which recognized those workplaces that enable employees to perform at their optimum level to provide patients and customers with the best possible care and services. All organizations and companies from all segments of the healthcare industry with a minimum of 25 full-time employees were eligible to participate, with some 238 organizations participating in the 2008 survey.

Bernice Catherine Harper Receives Lifetime Achievement Award

Capital Hospice (Falls Church, VA) honored Bernice Catherine Harper with a Lifetime Achievement Award during the program’s 10th annual Josefina Magno Conference this past fall.

Harper is the former medical care adviser for the Centers for Medicare and Medicaid Services where she was instrumental in formulating healthcare policy that directly affects hospice care today. Drawing on her expertise as a social worker, she contributed insights and ideas that strongly influenced how policy was implemented. Much of her work consisted of raising awareness and advocating successfully for the inclusion of psychosocial components in policy strategy and change. She retired in 2006 after 35 years of service to the federal government and has continued her staunch support of hospice care in America and abroad, including her service as co-founder and chair of NHPCO affiliate, the Foundation for Hospices in Sub Saharan Africa.

Hospice of Piedmont Volunteer Honored for Her Service

Donna Hudson Turner, a longtime volunteer with Hospice of the Piedmont (High Point, NC), was a recipient of the President’s Volunteer Service Award during a ceremony in December. Hudson, who has volunteered for the program since 1979, has contributed nearly 25,000 hours of service—even during a period of rehabilitation that followed a debilitating stroke.

Caris Healthcare Wins Top Quality Award

Caris Healthcare (Knoxville, TN) has won the 2008 Tennessee Excellence Award, the highest award given by the Tennessee Center for Performance Excellence. Caris, which is Tennessee’s only state-wide provider of hospice services, was recognized as an outstanding example of a high-performance organization, exhibiting processes that serve as role models for other businesses.
Bevlock Named Director of Hospice and Palliative Care

Morristown Visiting Nurse Association (Morristown, NJ) has appointed Patty Bevlock as director of hospice and palliative care. Bevlock will oversee clinical and general business services for The Hospice of Morristown VNA, as well as for the Morristown VNA “Living Life” Palliative Care Program. Her background includes work in medical/surgical nursing and case management, and more than 22 years as a hospice/palliative care director and consultant.

Schmidt and Schoenherr Named MHPCO Physician and Educator of the Year

Patricia Schmidt, medical director for In-House Hospice (Southfield, MI), was named Physician of the Year by the Michigan Hospice and Palliative Care Organization (MHPCO) while Brenda Schoenherr, program director for In-House Hospice, was named Educator of the Year. Both individuals were honored by MHPCO for leadership excellence and service to the community.

Hospice of the Chesapeake Participates in Joint Study with Johns Hopkins and NCI

Hospice of the Chesapeake (Annapolis, MD), in conjunction with two other regional hospice organizations, Coastal Hospice and Hospice of Washington County, is participating in a Small Business Innovation Research project with Johns Hopkins Medicine and the National Cancer Institute.

Phase I of the project will focus on the creation of a software product to address pain and symptom management for hospice patients that is being developed by Medical Decision Logic, Inc., a Baltimore-based research firm. The software development process will center on understanding and meeting the needs of patients and their families as well as supporting hospice staff to be more productive in identifying and defining best practices. Phase II will expand the software product for use by clinicians, patients and hospice administrators, with field testing through a broader network of hospice sites.
CEO/PRESIDENT

We are seeking our next CEO/President to lead our strategic direction of being a world class hospice. Our 130 employees serve an average of 180 patients a day throughout a 3 county region of scenic Upstate New York.

Requirements: Bachelor’s Degree in health care, business administration/related field, three - five years experience in health care management; demonstrated ability to lead and inspire others; develop/maintain Board/community relationships; knowledge of governmental regulations and JCAHO standards; and an intimate knowledge of Medicare Hospice Certification. Masters degree in health care or related field preferred.

Qualified candidates should send a resume and letter of intent to Kelly McGraw, Director of Human Resources, Catskill Area Hospice and Palliative Care, Inc., 1 Birchwood Dr, Oneonta, NY 13820 or email kelly.mcgraw@cahpc.org.

Join us in welcoming the newest Hospice members to the CellTrak Family:

• Caldwell Hospice and Palliative Care
• Horizons Hospice, LLC
• Southwind Hospice, Inc.
2009 National Hospice Foundation Gala

Bricks and Diamonds
Setting a Foundation for the Future

Friday, April 24, 2009

Ambassador and Regency Ballrooms
Omni Shoreham Hotel - Washington, DC

6:30 PM - Cocktails and Silent Auction
Featuring travel experiences, gourmet food and wine, fine art,
and a sparkling showcase of estate, gently used and one-of-a-kind jewelry

7:30 PM - Dinner and Awards
Dessert and Dancing to Follow

Gala Attendee - $350
Gala Attendee with MLC Registration - $250

Emerald Sponsor

For sponsorship opportunities,
please contact NHF at 877/470-6472,
or visit www.nationalhospicefoundation.org
Contracting Toolkits can help you with CoPs Compliance!

The Hospice and Palliative Care Group of Reinhart Boerner Van Deuren is happy to provide NHPCO members with the opportunity to purchase Contracting Toolkits that have been developed to help you with CoPs Compliance. The Toolkits provide templates for easy customization. For more information go to http://reinhartlaw.com/webpages/2/publications.aspx?sec=3

**Medical Director & Physician Contracting Toolkit for Hospice and Palliative Care:**
NHPCO Item Number: 820901

**Hospice and Nursing Home/Assisted Living Contracting Toolkit:**
NHPCO Item Number: 821113

**Hospice Vendor Contracting Toolkit:**
NHPCO Item Number: 821353

**Hospice Medicare Appeals Toolkit:**
NHPCO Item Number: 821354

4 Easy Ways to Order

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PHONE: 800/646 6460
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MAIL: NHPCO Marketplace
PO Box 34929
Alexandria, VA 22334-0929

**Hospice and Palliative Care Practice Group**

Mary Michal  Meg Pekarske  Heather Fields  Matt McManus  Mary McCormack

Our representation of the hospice industry for the past 15 years has resulted in a depth of knowledge of the broad array of hospice issues, particularly during the current climate of decreased reimbursement and increased regulatory scrutiny. We bring to our clients extensive experience in the area of regulatory consultation and representation and consider our role to be that of a trusted advisor who knows and appreciates the hospice industry and supports our clients' missions. Particularly in light of the new Conditions of Participation, we work with hospices all over the country to ensure that compliance efforts and the missions of our clients are aligned.
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:

“But I Don’t Know What to Say”—Provides tools that all staff can use when responding to the needs of children (under Pediatrics).

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

For details on these offerings and others, visit nhpco.org/conferences.
More than 300 NHPCO members—representing all 50 states—participated in last year’s Capitol Hill Day during NHPCO’s Management and Leadership Conference in Washington, DC. This year’s event on April 22 promises to be even bigger and better. To preview the agenda and get registration details, see page 14. To review the agenda and get registration details, see page 14. To preview the agenda and get registration details, see page 14.