Stepping Up, Reaching Out

Providing Higher Quality Care...
Thank You…

For nearly 18 months, the hospice community has been fighting to halt the elimination of the budget neutrality adjustment factor (BNAF) that is to take effect on October 1, 2009. As NHPCO and its affiliate, The Alliance for Care at the End of Life, has previously reported, if no action was taken, elimination of the BNAF would cost the hospice community $2.9 billion in lost revenue during federal fiscal years 2010-2014—a loss that would have devastating impact on many programs nationwide.

Throughout these many months, Hospice Advocates from all corners of the country have rallied together and lent tremendous support to NHPCO and The Alliance as part of an integrated grassroots campaign—and our collective efforts have indeed paid off.

While elimination of the BNAF was not halted, the cut will now be phased in over seven years (FY 2010 – FY 2016), enabling the hospice community to plan for and absorb the loss over a longer term.

Given the current fiscal climate, this is no small feat—and one that would not have been accomplished without the help of these dedicated individuals:

- More than 600 Hospice Advocates met with Members of Congress and staff during NHPCO’s 2009 Hill Day;
- 3,524 hospice programs— representing small and large providers, urban and rural providers, and for profit and nonprofit providers—lent their names to a letter NHPCO drafted to President Obama on behalf of the hospice and palliative care community, urging him to intervene and halt the BNAF reduction; and
- Throughout the course of the campaign, over 100,000 calls, emails, and letters were sent to Congress and the White House from hospice staff and volunteers, community members, and patients and families that conveyed the essence of hospice in very real and poignant terms.

These efforts and others demonstrate the impact we can make when we work—together—as a unified community. This important work will continue as we move forward throughout this year and into the next. Our accomplishments to date give me great confidence that by working together, so much is possible.

On behalf of NHPCO, The Alliance, and the patients and families we serve, our heartfelt thanks to each and every Hospice Advocate for your assistance and ongoing support.

J. Donald Schumacher  
President/CEO  
NHPCO

As reported by NHPCO in the News Alert, “CMS Announces Final Wage Index Changes” (7/30/09), the final FY 2010 Wage Index reflects the adjusted BNAF reductions. NHPCO has posted a Wage Index Calculator that will automatically compute your program’s rates and revenue based on the county and state in which you provide care: Visit www.nhpco.org/wageindex.
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Introduction:

Making Great Strides with Many Small Steps
Quality has been the focal point of NHPCO’s strategic plan over the last five years, with the development of its “Blueprint for Quality and Access” in 2004 and the launch of Quality Partners in 2006.

These efforts, together with the publication of the new Hospice Conditions of Participation in June 2008, have prompted hospice organizations from all around the country to take a discerning look at every aspect of their organizations and invest their time, talent and resources to make improvements in both care and delivery. In fact, to date, nearly 6,000 individual staff and organizations have signed NHPCO’s Quality Partners Pledge as testament to their commitment. So how are programs doing? What are some of the innovations and best practices being implemented in the field?

In this issue, members of the interdisciplinary team report on a range of valuable work.... You’ll learn about an initiative being funded by the Archstone Foundation that is bringing together important research to support—and advance—the role of spiritual care in end-of-life care. You’ll discover how technologies, such as point-of-care documentation, are making a world of difference in care at the bedside while also providing family caregivers with added peace of mind. You’ll receive practical—but often overlooked—guidance on keeping the patient’s attending physician involved in the care plan—and much more.

In our NewsLine feature, which appears on page 39, members also provide their initial feedback on NHPCO’s new online social networking community, “My.NHPCO.org.” Launched in late July, this new communications tool gives members the power to share their experiences and knowledge with peers, participate in end-of-life care discussions through blogging, exchange helpful documents, rank resources—and benefit from an upgraded listserv system.

Turn the page for a closer look at the many small ways that are helping members provide higher quality care in their day-to-day practice....
Archstone Foundation Grant: Exploring the Role of Spiritual Care in Palliative Care

By Carlyle Coash, MA, BCC
Innovation can be a tricky thing. This is because it does not work well in a vacuum. It needs a context and a form in which to be heard and placed into practice. It needs encouragement while it takes shape and persistence through moments of uncertainty. It needs someone to recognize the possibilities and have faith that they can become manifest.

I think of my great grandfather who started Underwood Typewriters. He held the patent for the open-roller typewriter, which was quite an innovation at the time. Before that, typewriters were designed so that you could not actually see what you were typing. His idea was to change all of that. He tried and tried to find funding to start his company and was unable to do so. Here he had this innovative idea, but no environment to help it find wings. Finally he was going to give up and sell the patent rights to another company. When that company postponed the meeting in which he was to sell the patent, he went to lunch with an old friend while he waited. When his friend heard the story, he offered to fund the start-up costs right then and there. Not long after Underwood Typewriters became a household name.

My great grandfather needed someone to see the possibilities and take a chance. Luckily his friend was there just in time and his innovation was able to flourish. Although our work in hospice and palliative care has little to do with the typewriter industry, the same principles apply to our ability to be creative and innovate new solutions within the ever-changing landscape of the work we do. We need support from our programs to try out a new idea about how to handle a patient-care issue or a barrier to access. If we are not encouraged and challenged in this way, then our work can become routine and uninventive. Innovation takes risk—and there is always the possibility that it may not work. It may also need time to take flight.

The Archstone Foundation Grant

In October 2008, the Archstone Foundation gave a $500,000 grant to City of Hope Hospice and George Washington Institute of Spirituality and Health to explore the role of spiritual care as a dimension of palliative care. The foundation did this not really knowing what the result might be, or even if a result was possible. How do you explore spiritual care in this way so that it has a practical application? What would you be tracking and how could you show that there was an issue to advocate for? One might say the foundation had a sense that there was something there—a possibility—and that was the reason to take the chance. A $500,000 chance.

The proposed agenda was to create an initial consensus document that would be reviewed by a handful of selected professionals from a variety of perspectives within the palliative care field. Next was to convene a slightly larger group, of about 40 professionals, for a two-day symposium to explore the document in depth. I was fortunate to be one of the 40 invited.

The assembled group was quite diverse, resulting in a vigorous and lively conversation over the course of two days. There were lots of strong opinions, yet lots of innovation as well. Our goal was to strengthen the consensus document and see what was missing and

“The future belongs to people who see possibilities before they become obvious.”

Ted Levitt
needed improvement, but we also celebrated what was strong already. Toward the end of the gathering, the president of the Archstone Foundation, Joseph Prevratil, said that it was clear that something could be created and that the final document would likely be a great resource for the practice of palliative care and hospice around the country. It felt good to know, that as a group, we were able to demonstrate that not only was this an important subject, but also something that could have a demonstrated use and outcome.

After the two-day symposium, the main team went back and created another draft of the document. This was then reviewed by the symposium group and sent to a larger group of reviewers, many of whom volunteered simply upon hearing of the grant announcement last year. In addition to the comments, all participants were asked to send in all of the books, articles, assessment models and other resources that they found essential to the practice of spiritual care and its role at the end of life. An end goal of the project is to create a database through George Washington University that will be home to as much data, research, articles and other resources as possible regarding the role of spiritual care in end-of-life issues. There is a great deal of innovation that is held locally in various programs throughout the country and this database will create a home for those innovations to be utilized. We are at a time when we need to share and collaborate so that the work as a whole can benefit.

This October, a summary report will be published in the Journal of Palliative Medicine and the entire work will be published by the Templeton Press. What is perhaps most striking about the document is that it has managed to bring together much of the research done on the essential role of spiritual care within the field of medical care across the continuum. I do not think anyone has taken the time to compile all of these peer-reviewed articles into one central location and the data collected is very telling. Despite a deep need and want for people to have their spiritual care met during times of illness and end of life, the healthcare system consistently fails to support those needs. Empirical data is one of the best ways for us to demonstrate that spiritual care is integral to the best-quality care.

Studies that Support the Importance of Spiritual Care

In one study, published in the Archives of Internal Medicine, Monroe et al surveyed physicians regarding their attitudes and preferences about religion and spirituality in medical encounters. Although 84.5 percent of physicians thought they should be aware of a patient’s spirituality, most would not ask about it unless the patient was dying. Fewer than one-third of the physicians would pray with patients, even if they were dying, yet this increased to 77.1 percent if the patient requested it. In a 1997 George Gallup survey, people overwhelmingly wanted to reclaim the spiritual aspects of their dying. The respondents in the survey talked about the role of prayer in their healing, how they worried about forgiveness from God and others, and how they wanted relationships with their healthcare providers that would allow for these conversations to occur. While 65 to 70 percent of those polled said they wanted their physicians to address their spiritual issues, only 10 percent said they had such conversations with their physicians.

Another study worth mentioning was conducted in 2007 by Balboni and his colleagues, and focused on patients with terminal cancer. Approximately 88 percent of the patients with terminal cancer found that religious and spiritual beliefs...
played an important role in coping with their illnesses and facing death; yet, only 26 percent of these patients felt those needs were met by the medical community, and only 51 percent felt those needs were met by their religious community. This reflects a subtle change that has occurred in our modern health system, which finds the medical component to be paramount when treating a life-limiting illness. This imposed filter removes essential layers needed for meaning-making to occur in a deeper way. In my work as a palliative care team member, I spend much of my time supporting patients and families as they attempt to decipher the illness at hand and their prognosis. Supporting this aspect of care should not be an afterthought; it should be present from the very beginning. These research studies seem to be saying the same thing.

Since the Archstone Foundation’s summary report won’t be published until next month, I am somewhat limited about what I can share regarding the details. What I can say is that the document, and all of its supporting resources, are a strong step forward in the advocacy of spiritual care—providing evidence, rather than opinion, of the important role of spiritual care in supporting a patient and family. It will create a foundation that we can truly build upon, inspiring further innovation and opening doors to greater possibilities.

Updated Spiritual Care Guidelines

This past spring, NHPCO released an updated version of the Guidelines for Spiritual Care in Hospice that was first published in 2002.

The Guidelines are based on the NHPCO Standards of Practice for Hospice Programs and the new Hospice CoPs—and provide valuable direction as today’s spiritual care providers navigate the recent changes.

To purchase the Guidelines, visit www.nhpco.org/marketplace (Item 820015; Member: $17.99).

References:


2. Gallup Poll 1997 and 2003. This also referenced Ehman, J.W., Ott, B.B., Short, T.H., Ciampa, R.C., and Hansen-Flaschen, J. (1999) Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? Archives of Internal Medicine, 159 (15), 1803-1806.

The Denver Hospice's Environmental Stewardship Program began with a caregiver’s comment: “Please find a safer way to dispose of medications without poisoning our water supplies.”

Out of that plea written on a comment card, Team Green was born in 2003—a pioneer program to safely dispose of medications without poisoning landfills and water systems.

Once a common practice, the disposal of unused medications down sinks and toilets is no longer advised since pharmaceuticals are being found in lakes, rivers and drinking water resources.

“Our staff, including our pharmacist, went to work years ago— ahead of federal guidelines—to come up with an environmentally friendly drug disposal method,” said Bev Sloan, CEO of The Denver Hospice. “Our hospice nurses had a passion for finding a solution and after extensive research and a pilot project in our Inpatient Care Center, our team developed a kit for nurses and guidelines for safe disposal of meds.” (See page 11 for the kit’s contents and guidelines.)

“People from across the country wanted to know about our medication disposal program and other agencies were turning to us for help,” said Sloan. “Our hope is that we can help people throughout the U.S. avoid ever flushing medications again.”

A Nationwide Model

The Denver Hospice program has since become a model for others—from the Florida Department of Environmental Protection and the Hospice and Palliative Nurses Association to the Colorado Hospice Organization and NHPCO.

“At the time of a love one’s death, the task of disposing medications can be daunting, so we wanted to come up with a simple solution,” said Sloan. “Our families have thanked us for not only giving them some guidelines, but helping them feel they are doing their part to protect the environment.”

Interest in Team Green grew even stronger last spring when Environmental Protection Agency (EPA) findings turned up residues of pharmaceuticals in fish caught near wastewater treatment plants serving five major U.S. cities. Findings from the first nationwide study of human drugs in fish tissue also prompted the EPA to significantly expand similar ongoing research to more than 150 different locations.

“It’s a great feeling to know that we proactively did something unique and novel, and created something that didn’t exist before,” said Sloan. “And we recognize there is more to do.”

The Denver Hospice has also created an internship program with Colorado State University to research and develop “greener” methods throughout the organization and to partner with other businesses on medication disposal issues, legislation, and possible development of a drug take-back program.

Lynn Bronikowski is communications director of The Denver Hospice (Denver, CO), which she joined in January 2007 after operating her own freelance writing and public relations business. Prior to that, she was a journalist at newspapers in Ohio and Florida, and spent 13 years as a reporter and editor at the Rocky Mountain News.
The following information for the disposal of unused medication is provided in the kit’s flier:

1. To safeguard private health information, cross out the personal information on the medication containers using a black, permanent marker.

2. Keep medications in the original containers when feasible. If not, a plastic container, such as a beverage container with a screw-top cap, may be used. Multiple medications may be placed together in a single, large container.

3. Render the drugs unusable and prevent the unintended ingestion of discarded medication. Here’s how:
   - **Liquids and IV Medications**: Add kitty litter or flour to the container and recap. A funnel may be helpful.
   - **Tablets and Capsules**: Add rubbing alcohol or water to the container followed by kitty litter or flour, and recap.
   - **Suppositories**: Add kitty litter or flour to the container, and recap.

4. Place all medication containers in a plain paper bag to protect identification and discourage tampering. Dispose in a trash bin.
Technology, next to salaries and benefits, is probably one of the most expensive line items in an organization’s operating budget. However, the right technology can be a cost-effective tool that goes a long way in improving care at the bedside. In the articles that follow, members of the interdisciplinary team discuss some of the technologies that are helping their programs meet the needs of patients and families—from the electronic medical record to point-of-care documentation and encryption software. The final article in this section (on page 19), draws our attention to HIPAA standards concerning technology and steps we should take to protect patient information.

**Transforming Care at the Bedside**

*By Bridget J. Montana, MSN, APRN, MBA, FPCN*

Hospice is well known for compassionate, holistic care that is based on the patient and family’s goals and is delivered through a team model that uses the “art and science” of practice to achieve quality outcomes. Originally, the hospice industry may have valued a “low tech, high touch” approach to achieve patient outcomes. In the early years, it was a mindset that was effective in meeting the needs of the patients, caregivers, and referral sources.

As the world turns and time passes, hospices are increasingly challenged with caring for patients with acute symptoms and a prognosis of less than two weeks. The high intensity of care is becoming the norm. Emphasis on information throughout the 24-hour period is essential. Communication within an organization and across care settings is occurring at the speed of thought. Many healthcare centers now mandate sending referrals, patient information and communications to hospices electronically, and expect hospices to comply. It seems like yesterday, but this intensity began to gain momentum in 2001 and continues today.

The purpose of this article is to discuss the steps that administrators need to consider as they move their organizations into the age of technology—beginning with the transformation of care at the bedside.

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**Developing the Vision—Your North Star**

Before making decisions, it is important to create a vision that is based on core values that are espoused by the organization from the board to the point of service. Communication of that vision is important because staff will see that as a north star, a point to focus on as they move through the uncertainty and struggles of change. The core values of the organization may include values such as best practices, safe patient care, continuity of care across settings, and leadership in end-of-life care.

As one considers the vision and the arrival of that dream, it is imperative to consider the ripple effects of implementing technology. It is rare that any change is done in isolation of other systems or processes. Organizations begin to transform as processes become electronic. This ultimately impacts the work of the end user.

For example, prior to the implementation of the electronic medical record (EMR), the following areas need to be explored:

1. Describe how technology will support the organization’s vision and strategic objectives, including how the EMR will enable staff to better meet the needs of patients, caregivers and referrals sources;
2. Identify current systems and processes which use paper records that are labor-intensive and inefficient;
3. Define the initial costs of hardware and software, licensing and maintenance fees, and costs for replacement of hardware and upgrades to software;
4. Explore software/hardware options that are cost-efficient and user-friendly for staff;
5. Define new opportunities to be gained by using EMR; and
6. Define the savings by using EMR.

As administrators are analyzing the information to decide what their electronic future will look like, it is important to note that implementation of a new electronic medical record involves processes that interweave education and training throughout the organization. For example, submission of bills to Medicare requires a financial-service team that is knowledgeable in the accounts payable module of the EMR and is able to access patient information.

**Some of the Positive Outcomes**

Initially, with implementation of an EMR, our organization kept minimal information (such as consents and living wills) in a hard-copy chart. Several years after implementation, however, we have the ability to scan these documents and have become paperless. This example reflects how quickly technology is changing and how the needs that are not met today will quickly be met with evolving technology.

*continued on page 14*
Implementation of EMR involves processes that interweave education and training throughout the organization.
While transformation of care at the bedside becomes the ultimate outcome, other notable outcomes include:

- Decrease in the amount of time spent in voicemail as a result of real-time access to data;
- Decrease in faxing reports;
- Point-of-care documentation which involves the patient in his/her care plan;
- Access to resource manuals and references at the bedside; and
- Decrease in driving time and mileage as staff do not need to be in the office every morning.

Information that is input correctly provides accurate patient information that is available instantly. The quality of the communication between teams such as on-call, admissions and continuous care also increases and, thus, improves care. Training takes time to obtain proficiency and, as an administrator, you will need to dedicate resources to initial and ongoing education. Once proficiency is obtained, teams are usually quite committed to excellence in documentation.

Other innovations, such as wireless technology, allow staff to transform work patterns and become “virtual employees.” They can work from anywhere and bedside charting is the standard. The ripple effect is the challenge for leaders to manage the virtual employee, stay true to the core value of the team, and maintain a strong cohesive team. Skill building for managers, including new ways to communicate, is necessary.

A fiscal outcome to virtual work is a cost savings in office space as employees require more “drop in” space and less permanent space.

The retrieval of data becomes easier for all, provided the system you select has the capability for staff to quickly query data. As staff becomes comfortable with technology, sophistication of skills improves. Sharing of systems with pharmacy, DME and suppliers is a natural evolution. Improved access to data also assists a manager in monitoring costs, outcomes, and improvement measures.

### Allocating Sufficient Budget Dollars

As a leader in the organization, you will allocate monies for technology that may be a significant percentage of the budget. This is a required cost to remain competitive in the market and in clinical care. Measuring return on investment will be crucial. According to the *Journal of Managed Care Pharmacy*, health information exchanges involve the sharing of clinical, financial and demographic data among healthcare stakeholders in support of care delivery, financing, public health surveillance, research and other health systems activities.

According to a September 2008 survey by the eHealth Initiative, most fully operational information exchange systems reported a 69 percent reduction in costs. These reductions were realized through improvements in quality of care, lower costs of care, minimizing errors, a decrease in over-ordering supplies and therapies, and a reduction in administrative time.

In the next five years, it is forecasted that technology will continue to evolve and provide opportunities for clinicians and organizations to raise care to a higher standard. This is an exciting time in the history of the hospice industry. Though improvements and changes in technology may include a fiscal component, an equal challenge will be to stay true to the core values of hospice and palliative care; this will keep us grounded in the human, spiritual experience of care delivery. The future is bright for those who can fully utilize technology to deliver holistic, high-quality care.

Bridget Montana is the chief operating officer at Hospice of the Western Reserve (based in Cleveland, OH), and serves on NHPCO’s Governance and Regulatory Committees.

### References

Point-of-Care Documentation: Perception Versus Reality

By Jill Cornwell, RN

The perception of staff regarding their transition to point-of-care (POC) documentation has proven to be one of the greatest challenges to adopting this new model in hospice and palliative care. Many staff, including nurses, social workers and chaplains, have voiced their concerns that taking a laptop or tablet to the bedside of a dying patient will create a barrier to care.

This perception may be based on the fact that they do not feel comfortable with their own ability to use the technology and are perfectly comfortable with the old process about which they have knowledge and understanding. When we don’t understand something, we inherently reach back to what makes us feel comfortable.

The role of hospice and palliative care leadership is to provide staff with the knowledge and understanding of how POC documentation can improve the delivery of care. The most important thing to stress is that such documentation is only as good as the staff members who complete it in a timely fashion so as to make it available to everyone else. Traditionally, nurses and other members of the interdisciplinary team have visited patients in their homes and have done minimal documentation at the bedside. They then go back to an office, the car, or home to complete their paperwork. Because staff members have become so comfortable with this, they have forgotten that when they worked in the acute care environment, such as a hospital, they were required to complete documentation by the end of each shift. Stress to your staff that the sooner the documentation is recorded, the more accurate it will be.

When I was a child, I remember a game we played where someone showed us several different items in a box. We were allowed to look at the items for a few minutes and then the box was closed. The object of the game was to see how many items you could remember after several minutes. Usually you would remember some items quickly but after a short time, fewer would come to mind. This is also true in your observation of patients. The color of the skin, the respiratory pattern, facial grimacing and wound appearance are examples of things that are more accurately recorded as soon as they are observed.

Excellent Tool for Monitoring the Plan of Care

POC documentation can be an excellent tool for tracking the history of a patient’s symptoms and improvement or decline in condition. Software programs should offer the ability to easily refer back to previous notes or assessments. An example would be the ability to look back at the last few pain assessments to see how the plan of care is working to improve symptoms. Another would be the ability for an on-call nurse to see when a catheter was changed, or what type of wound care is being used for a particular site. The availability of this information saves time and phone calls as well as trips to the office to look at a paper chart. The ultimate advantage becomes improved continuity of care and care delivery.

POC documentation also assists nurses with updating medication profiles and reconciliation of medications at the bedside. Electronic documentation programs can
help to avoid medication errors created by incorrect spelling and use of improper abbreviations, in addition to eliminating the need to interpret handwriting.

**Tips on Implementation**

Be creative in designing how staff will use the software. It is unrealistic to expect that staff members will make the switch in a matter of days. I found that suggesting a gradual transition has been helpful. I encourage nurses to try opening the software to enter vital signs and a pain evaluation on their first visit and adding a little more documentation to each visit as they become more familiar with the tool.

Reevaluate your processes from time to time and seek input from staff regarding what works well and what needs improvement. We have tried to describe to staff members how to incorporate the laptop into their visits, but have found it best to have someone accompany them to help them get started. Identifying “super users” or a buddy system will help to support staff. Having a cheerleader behind them will help to build confidence and reduce stress.

Recognize that end-users are at many levels of comfort with technology, so be sure that all staff have the basic knowledge to work with computers. Many of our staff members are seasoned hospice employees, but call themselves “technologically challenged” and need some basic training on the front end.

So I go back to the perception that POC documentation is a barrier to quality care. In truth, not having the most up-to-date information on our patients at the bedside is the real barrier.

**POC Documentation: A ‘Technophobe’ Signs On**

By Pat Gibbons, BSN, CHPN

In a recent issue of *TIME* magazine that featured a cover story about Twitter, the magazine’s managing editor observed that “new forms of communication are changing the way we relate to one another” and cited how the telephone, television, and Internet have done that in ways we are still processing. However, he also noted that technology itself is neutral. It is a tool, neither good nor evil. It all comes down to how we use it.

One might ask how this relates to hospice and palliative care? Do we not pride ourselves on being “low tech, high touch”? How does each of us view technology—as a benefit or a burden, as good or evil?

Most staff will agree that some forms of technology have been extremely valuable in helping us provide quality care in difficult circumstances. One example is the analgesic infusion pump. This small pump enhances a patient’s quality of life by providing a sense of freedom while still maintaining high-quality pain control. This can easily be seen as a good technology. Many programs have also utilized electronic billing for years; some may consider this a benefit while others may consider it a burden.

More and more programs are also transitioning to point-of-care (POC) documentation for hospice clinical staff. For many the transition has been rocky. Many clinical staff perceive computers in the home as barriers to relationship-building and even to care. While Jill Cornwell’s article offers helpful guidance on the best ways to introduce resistant staff to this new tool, let me provide perspective as a true “technophobe.”

**Focus on the Benefit to Patients and Families**

For many, the resistance may be related to change and the need to learn new skills. However, for patients and families, the change may be of little notice. It is important to keep in mind that end-of-life care is not the only area of healthcare that is using an electronic system to document care. In fact, I would hazard a guess that we are one of the last areas to introduce this system. Families are used to computers in other areas, so why not in hospice and palliative care? Families have told me that it gives them a sense of security to know that “things get put down so you don’t have to go over the story again and again.” Families have also said that the computer is like having “instant recall”—there is a record of the last visit in which the staff person was present. Patients and families

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Jill Cornwell was a home care nurse for Alive Hospice (based in Nashville, TN) for 14 years. She assumed the role of health information educator in 2007 due to her strong interest in adopting EMR and, in May of this year, was promoted to director of health information management.
see computers at the bedside as a means to assure continuity of care—and a definite benefit!

Many staff members who were initially resistant to computers and POC documentation have moved away from initial fears and angst to acceptance and appreciation, recognizing its value to patients and families as well as the interdisciplinary team. A social worker colleague told me that she loves it, and described it as an efficient, clean, reliable and convenient professional communication tool. Many have also come to feel that computers allow for improved care coordination and teamwork. Staff members feel much more organized, consistent, accountable and clear in care planning and clinical work as a result of POC documentation. Quality care is also enhanced with this form of communication. For example, the ability to capture information for QAPI projects and benchmarking is improved while new requirements, such as CMS Change Request 6440, are easier to implement.

According to Teresa McCreary, my colleague on NCHPP’s Nurse Steering Committee, patients and their caregivers appreciate when POC documentation is used. She says that caregivers actually sit down next to staff members as they enter the basic demographics on admission. Caregivers have said that when they call in and ask for assistance with medications, they feel safer giving the medications because they know staff members are looking right at the patient’s electronic record and have the most up-to-date information. Teresa also points out that when out-of-town family members call in during the evening, wanting an update on their loved one, the information is available with a touch of a button. “This helps them feel more connected from a distance” she says.

**The Turning Point for Me**

As someone resistant to technology, I had an “attitude readjustment” while helping a dear friend care for her terminally ill husband. The sense of relief expressed by my friend when the hospice staff visited was palpable. All of the staff utilized laptop computers and the fact that so much information was readily available for review helped my friend feel “less responsible” for all of the clinical details. She was a very capable caregiver but, by not having to keep track of ‘everything,” her stress level was significantly reduced. She also felt “included” in the plan of care as each staff person reviewed the plan on each visit, strengthening the collaborative approach to care planning and caregiving. I was sold on laptops from that point on!

Yes there are burdens to POC documentation as I am sure any IT department will admit—frequent required updates, a missing stylus, the need for staff education. However, ultimately, I do believe that the general consensus among those using the new technology is very positive—the benefits to patients and families far outweigh the burdens to the staff or to the organization.

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.
Utilizing Volunteers More Fully—With the Help of Technology

By Kathy Roble, MS

Have you ever wondered how many potential volunteers you have in your community who want to volunteer from home? Is your hospice organization limited to daytime office hours and can’t tap into the skills and interests of those who work full-time? The availability of encryption computer software provides limitless opportunities to tap into the human resources waiting to assist us, but in the past were constricted by our need to ensure security of patient information as defined by good practice and by HIPAA requirements.

Individuals who volunteer for hospice programs with secure networks can email the friends and family of a patient with updates on his/her condition, with the patient’s prior approval. What a gift for a daughter who lives in California to receive an email from her mother’s volunteer in Florida, letting her know that her mother received a visit from the hospice team that morning and was resting comfortably. The volunteer can let the daughter know that her mother is looking forward to seeing her and can pass on her request to “please bring some family pictures too.” Encryption software provides the opportunity for communication that may not have existed before.

Through secure email, volunteers can also advise the interdisciplinary team that they will be out of town and can’t visit their patients, without fear that confidential information will be shared or the patients will be identified. There are no limits to the possibilities for better communication between volunteers, patients and families, and the hospice team.

Required Processes Become Easier Too

Volunteer visit notes must be provided for each visit made with a patient or family member, and most volunteer managers struggle to find ways to retrieve those visit notes. Preparing the notes is a particular challenge for working volunteers who not only have to document each visit by hand, but also sign and mail the note back to the hospice after working a long day in their regular paid job. With the freedom and flexibility that encryption software provides, volunteers can utilize e-note technology that many hospice IT departments make available to staff. This level of efficiency is what working volunteers demand more and more.

Encryption software can also be a helpful tool for volunteers who provide bereavement support. Counselors can email the lists of patients’ survivors to these specially trained volunteers who can then make a reassuring phone call or visit to the person who is grieving, document the call or visit on a bereavement volunteer e-note, and email it back to the counselor. The bereaved receive the care and support they need and the volunteers are able to do the work without ever leaving home. (Of course, volunteers should be instructed to notify the counselor immediately about any urgent issues.)

As technology increases, there will be even more opportunities to maximize the potential use of our valuable volunteer workforce. How many times have we heard from recent volunteer-training graduates, “I wish I had known earlier about the programs and services of hospice when my family member was ill?” Providing those in our community who want to assist with the tools that will make volunteering more manageable empowers them, helps our patients and families, and supports our organizations. Utilize technology and open up the possibilities.

Kathy Roble has been director of volunteer services for Suncoast Hospice (formerly The Hospice of the Florida Suncoast) since 1994. She has served as NCHPP’s Volunteer/Volunteer Management Section leader since 2004, and assumed the additional role of NCHPP vice-chair in 2008.
HIPAA and Technology: Some Considerations

By Gay Madden, RN

We begin with a brief overview of HIPAA (Health Insurance Portability and Accountability Act) and move on to discuss some of the issues you may not have considered when your organization first implemented procedures to meet its requirements. However, let us not forget that HIPAA began as a transaction standardization effort; it was not until the breaches that occurred in healthcare during the initial HIV crisis of the early 1980s—that cost many individuals their healthcare benefits and jobs—that it became a federal rule. The information patients and families share with us is a sacred trust and one that deserves our time and attention to safeguard.

HIPAA took effect on April 14, 2006 and must be followed by all healthcare providers. It helps ensure that all medical records, medical billing, and patient accounts meet certain consistent standards with regard to documentation, handling, and privacy. In addition, it grants patients access to their own medical records as well as the ability to correct errors or omissions and to be informed of how their information is shared.

HIPAA is actually a set of three rules:

- **HIPAA Privacy Rule** mandates the protection and privacy of all health information, specifically the authorized uses and disclosures of individually identifiable health information. This rule provides broad protection for all forms of health information which is transferred through verbal, print and electronic communications.

- **HIPAA Transactions and Code Set Rule** addresses the use of predefined transaction standards for communications and billing.

- **HIPAA Security Rule** mandates the security of electronic medical records. This rule addresses the technical aspects of protecting electronic health information, and specifically targets:
  - **Administrative Security**: The assignment of security responsibility to an individual.
  - **Physical Security**: The protection of electronic systems, equipment and data.
  - **Technical Security**: The authentication and encryption to control access.

Most of us have gone through the hard part—the initial risk assessment, the development of policy and procedures, and the education of our staff, care partners, and patients and families. We have survived the initial implementation and have seen some enforcement by the Office of Civil Rights. Most of us have gone beyond finding the log-on and passwords of our staff on post-it notes affixed to their computers. We have heard the stories of stolen or lost computers, faxes sent to incorrect fax machines, and...
car break-ins where the notebook holding confidential referral information was taken. At this point in our journey, it is time to think about those aspects of the HIPAA rule that may not be as obvious. The table below outlines aspects of the HIPAA Security Rule and poses probe questions and recommendations to help you make sure your patient records have adequate safeguards.

HIPAA is much more than the traditional interventions to protect health information. The challenge is to look beyond the obvious and to be diligent about the protection of the sacred information that patients and families share with us.

Gay Madden is vice president of management information systems for Suncoast Hospice (Clearwater, FL).

<table>
<thead>
<tr>
<th>HIPAA Standard</th>
<th>Definition</th>
<th>Questions</th>
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<tr>
<td><strong>Administrative Security: Workforce Security</strong></td>
<td>An organization must implement policies and procedures to ensure that its employees have appropriate access to electronic protected health information (ePHI).</td>
<td>When is the last time you reviewed employees’ security access to ePHI? If it was in 2006, what is the likelihood that it has evolved beyond your awareness?</td>
<td>Set up a process to do annual security access audits of your applications containing ePHI. Establish personal user directories on your network drives to house files containing ePHI.</td>
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<td><strong>Physical Safeguards: Facility Access</strong></td>
<td>An organization must implement policies and procedures that limit physical access to electronic information systems and their locations to authorized individuals only.</td>
<td>During IDT meetings, who has access to the team areas where computers are located? Do housekeeping staff members have access to buildings where computers are left on and accessible? Do you have whiteboards for scheduling and can you read them from the windows of your facility?</td>
<td>Do a walk-through of your facilities with a focus on HIPAA and look at what kind of access exists for those who have no rights to ePHI! Be sure you have implemented the auto-locking features on your desktops and laptops that engage after a given time of inactivity.</td>
</tr>
<tr>
<td><strong>Physical Safeguards: Device and Media Control</strong></td>
<td>An organization must implement policies and procedures governing the transport of hardware and electronic media that contain ePHI into, out of, and within the organization.</td>
<td>Transport of data includes the use of CD drives, DVD drives, flash drives, iPods, PDA devices, and USB devices. How does your organization manage these risks to ePHI?</td>
<td>Perform monthly audits of all systems and peripherals attached to the network infrastructure. On a daily basis, (1) inspect all internal networks to identify unauthorized hardware attached to your network, and (2) look for routes between the organization’s network and external networks. Establish a policy for the use of all peripheral devices that can create avenues for transporting ePHI. (Third Party “End Node Security Suites” now exist to provide mechanisms to manage removable storage.) Avoid granting local administrative rights to end-users to limit staff’s ability to install software and drivers.</td>
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<td>HIPAA Standard</td>
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<td><strong>Technical Safeguards: Transmission Security</strong></td>
<td>An organization must implement security measures to prevent unauthorized access to ePHI that is being transmitted over an electronic communications network.</td>
<td>Are you using cell phones to send text messages to staff? Did you know that text messages go across the Internet which is unencrypted and creates a breach of ePHI? Do you have wireless cards for your mobile laptops? Is there a secure access to your network from these devices?</td>
<td>Text messages should be cryptic to protect ePHI. Create abbreviations and codes that support text messaging without breaching ePHI. Establish a VPN that creates a secure tunnel for wireless-card access to your network. Consider Zixcorp Email Encryption which ‘lives’ in your network’s outbound mail stream and reviews your email and encrypts for ePHI as well as financial data.</td>
</tr>
<tr>
<td><strong>Technical Safeguards: Integrity</strong></td>
<td>An organization must implement policies and procedures to protect ePHI from being improperly changed or destroyed.</td>
<td>Do staff members create errors as they document the electronic health record? Do you have a single point of correction or multiple access? Do you audit records for data integrity, such as documentation in the wrong record, misspellings, and record duplication?</td>
<td>Create a comprehensive data correction process and policy, with limited points of access for correction. Ensure feedback and measurement to create accountability and process improvement. Create an audit tool and audit methodology both by humans and systems to ensure the integrity of EHR data.</td>
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An apple a day may keep the doctor away, but as hospice professionals we should be asking, “How do we keep the doctor closer?” And not just any doctor—the patient’s attending physician.

Per the Hospice Medicare Conditions of Participation, we know that the attending physician “is identified by the individual, at the time he/she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual’s medical care.” Unfortunately, keeping the attending physician in that “significant role” is often quite challenging.

Several factors increase this challenge. Many hospice patients are no longer able to travel to physicians’ offices as they had been, making the relationship more difficult to maintain. The attending physician may rely increasingly on the hospice team to utilize its expertise and protocols to assess and manage symptoms. Even helpful observations and recommendations from the hospice medical director may overshadow the attending physician’s input regarding the “determination and delivery” of a patient’s medical care.

Despite these challenges, it is important to be mindful of the role of the attending physician. Patients often want to maintain enduring relationships with their physicians despite decreasing ability to visit the office. Patients and families trust that the attending physician knows them—knows the history of their medical conditions and the treatments most likely to help them. And the attending physician may have insight into the unique history and needs of patients and families that will affect them throughout the course of hospice care.

One of the most important factors in working closely with the patient’s choice of attending physician is to be certain that you have established how the physician wants to receive information. Some doctors favor telephone calls. That may mean direct conversation or conversation with a member of the physician’s staff with a return call to the hospice nurse if needed. Others prefer faxed information that can be easily filed in a patient’s chart. While urgent communication may dictate immediate and direct conversation, it would be helpful to know how the physician prefers to collaborate about more routine matters.

In one practice, the physician became so annoyed with routine faxes from all sources that he had the office fax machine turned off unless he or his staff needed to send a fax. The hospice did not know this and became frustrated with the lack of returned...
orders. It was only after visiting the practice and learning that faxed communications were no longer accepted that the hospice and the physician’s staff devised a way to send and receive orders in a timely way.

Another important factor is to know how often the physician would like routine updates on the patient’s condition. Changes in status should certainly prompt immediate communication, but a patient may experience a period of time with well-managed symptoms when there are no abrupt changes or urgent needs. Nevertheless, the hospice patient is quite compromised compared to many other patients in the physician’s practice. Many physicians count on hospice to keep them informed not only of changes, but of ongoing status in these patients.

One issue that can hamper or improve communication is the frequency with which the hospice is sending information about all of the hospice patients in a practice. Sending faxes or calling about one or two patients may not be burdensome; however, large oncology, cardiology, or geriatric practices may have many patients receiving hospice care and, even if that care is from one hospice, there may be different nurses and teams involved. So communications may be numerous and feel haphazard.

After counting the faxes and phone calls from a single hospice in one week, it became clear why the office staff of one large oncology practice was feeling overwhelmed. All of the calls and documents were necessary, but they came from different hospice staff for a variety of patients. Some were calls with reports of changes and urgent requests for medications. Some were calls or faxes for requests for routine refills. Others were faxed reminders to return orders and certifications that had been mailed.

While urgent communication may dictate immediate and direct conversation, it’s helpful to establish how the physician prefers to collaborate about more routine matters.
The staff met with the hospice and instituted several changes. First, everyone agreed that sudden changes and urgent requests were to be called in and the physician would respond immediately. Second, routine requests and updates were to be faxed to the practice. Third, a folder was created for all signed certifications and orders; twice weekly, a hospice nurse would visit the practice to leave certifications, plans of care, and verbal orders in need of signature while retrieving the signed documents from the previous visit. These new procedures markedly reduced the chaos in the office and gave the hospice nurse a chance to assess how the system was working each week. It also gave her the opportunity to answer other questions and intervene when the practice had other concerns.

Communication may also vary based on where the patient lives. When patients reside in nursing homes, the physician may not want to get faxes and calls from both the hospice staff and the nursing-home staff. Or the nursing-home staff may prefer to relay information and requests from the hospice nurse so that returned orders can be initiated and filed according to facility protocols. It is imperative to consider such preferences when communicating with a patient’s attending physician.

One hospice routinely mailed all plans of care and orders to physicians’ private offices for signature, regardless of where the patients lived. After talking with several physicians, however, the hospice staff learned that the physicians only saw the nursing-home residents in the nursing homes. What’s more, their active charts were kept in the nursing homes, not the office, and all visit documentation and orders were in nursing-home charts. It created extra work for the physicians’ office staff to send copies of the hospice documentation to the nursing homes. The hospice began to mail information for nursing-home residents to the physicians’ offices in the nursing homes, and the process was much more efficient for everyone.

Maintaining close involvement from the attending physician is essential. It is comforting to patients and families to have their doctor participate in the plan of care. It is respectful of the relationship that the patient and physician have created, often over many years. It also enhances the ability of the hospice and the physician to work together effectively and efficiently in the care of all patients that they share.

*Joan Harrold is medical director and vice president of medical services for Hospice of Lancaster County (Lancaster, PA). In addition to her service as NCHPP’s Physician Section leader, she serves on the American Academy of Hospice and Palliative Medicine board of directors and on the American Board of Internal Medicine Hospice and Palliative Medicine Examination Committee.*
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- Boston, MA area, Sept. 18, 2009
- At the Kaplan Family Hospice House
- Cincinnati, OH, date to be determined
- At the Hospice of Cincinnati
- Denver, CO, Sept. 22-24, 2009
- NHPCO’s 10th Clinical Team Conference
- Hyatt Regency Denver
- Orlando, FL, Dec. 4-6, 2009
- NHPCO’s 6th National Conference on Volunteerism and Family Caregiving,
- Walt Disney World Swan, Lake Buena Vista, FL

Contact Susan Messina,
Director of Development Communications, at
smessina@nationalhospicefoundation.org
or 571-275-4324.
www.runtoremember.org
Preview RTR merchandise on pp. 46-47.
Do you ever wonder what happens after the admitting staff leaves a patient’s home? Are the caregivers confused as to what will happen next? When there is delivery of DME, do they know how to use it? Do caregivers understand how to use new medications that are delivered?

While we may do our best to instruct and prepare caregivers for their new responsibilities, they are more times than not overwhelmed by the situation. Yes, they have been given the “24-hour number” to call should they have questions, but do patients and their caregivers really feel comfortable calling this number? As professionals in hospice and palliative care, it’s all a “breeze” to us. However, imagine an electric hospital bed taking over the bed you have slept in for years. Imagine the delivery of opioids for pain control or a new Foley catheter to care for when you have no medical training. How can we help assure caregivers that they’re not alone on this new journey?
The Hospice of Lancaster Supper Club

Two years ago, Hospice of Lancaster County started a care program to enhance quality patient service. The program, which is called the Supper Club, is staffed by volunteers who come into our program around 5 p.m. each day and call patients and families to see how they’re doing:

- The volunteers call all patients who were admitted that day, asking if their first day has gone smoothly and if they have any questions for the program’s evening staff: “Did today’s initial visit answer your questions and concerns? Is there anything that you thought about and wanted to ask after our staff left?”

- They also contact patients and caregivers who have received new equipment or new prescriptions and ask these basic questions:
  
  “Did you receive the medications that you were supposed to? Do you understand how to use them?”
  “Did you receive and understand the use of the equipment?”
  “Do you know how to reach hospice if you need to? Please do not hesitate to call if you have any questions or concerns.”

If the patients or caregivers need assistance, there are nurses available to help them quickly.

The Supper Club volunteers also make calls to patients and their caregivers when pain was present on admission. As hospice and palliative care professionals, it’s an important part of our job to ensure that patients are relieved of pain within 48 hours of admission, and this extra level of customer service has proven to be very helpful.

Results So Far

The Supper Club has been very successful in helping our patients and caregivers feel more confident and supported during a very difficult time. We have seen a 90 percent reduction in “after-9 p.m.” calls to our DME company and to our pharmacy while the number of evening calls we receive has dropped by 30 percent or more.

In our ongoing effort to provide excellent care at the end of life, we need to continually look at new and innovative ways, like the Supper Club, to help us reach this important goal.

Teresa McCreary is the access services manager for Hospice of Lancaster County (Lancaster, PA), where she has worked for 24 years.
HONORING COMMUNITY CHAMPIONS:

The Angel of Light Award Program

By Max Hahnen

While one of our local nursing homes was conducting some general hospice education for nursing home staff, a member of the group wanted to know more about the specific benefits of hospice care. A nurse in the group came forward and relayed her personal experience with two residents and their families who had greatly benefited from hospice services.

This “Angel of Light” talked about how the hospice assisted in obtaining pain and symptom management medication orders from a rather difficult attending physician. She also talked about the hospice social worker who provided support to the patient’s son who was having difficulty envisioning life without his mother. She went on to say that one of her patients was being treated for end-stage dementia and she witnessed the ability of the hospice team to engage the spouse in taking better care of himself by taking a break and having a volunteer sit at the bedside with his wife.

In essence, this nurse, or Angel of Light, was taking it upon herself to refer patients to hospice care when they were declining and exhibiting what she knew to be end-stage clinical symptoms. She also helped her peers recognize the support and education that hospice provides to families and facility staff as well as patients themselves. She was recognized by her peers as a patient advocate for palliative approaches to care when curative plans of care were no longer the patient and family’s choice.

By recognizing the contributions of this nurse, I realized that I could also identify an “Angel of Light” in other care settings—someone who could directly share the benefits of hospice and carry the “torch” to help ensure that many more eligible patients would be offered the choice of hospice.

It was after this discovery that the Angel of Light Award Program became an annual event for our hospice. The Angel of Light Award is given to a clinician who champions end-of-life care within the care setting he/she serves. This award recipient could be a skilled nursing facility nurse or social worker, assisted living director, hospital case manager, or even physician office staff. The recipient is someone who is recognized by their peers as playing an active role in assuring that each person is given the choice to receive hospice care.

The Angel of Light Award Program is very easy to implement:

- Identify a few champions within your care community in different healthcare markets (e.g., hospitals, nursing homes, assisted living communities, physician practices). An easy way to do this is to ask members of your hospice staff to nominate their “partners in care” or, in the case of the nursing home, have the director of nursing services recommend a staff member. Once you have identified the recipient, gather some testimonials that can be read at a presentation event.
- Coordinate an event at the award recipient’s organization, being sure to involve the executive director and the administrator or manager at the location. We present a plaque that acknowledges the Angel of Light and is given directly to the recipient, but also post a plaque at the location that lists all of the award recipients. We have also asked family members to attend the presentation and directly share their experience and appreciation of the award recipient’s contributions.

The award program is a great opportunity to advance knowledge and interest in hospice services as well as involve the media and leaders in your community. Typically, I have chosen to honor recipients during National Hospice/Palliative Care Month; this provides the opportunity for additional media coverage since local newspapers are usually interested in hospice human interest stories during the month of November.

Max Hahnen is the national director of business development for Interim HealthCare Hospice (based in Sunrise, FL) with leadership experience in nursing homes and assisted living settings as well as hospice. She supports a quality driven program for the Interim Hospice Division by offering patients care, comfort and choice.
As hospices increase access to historically underserved communities, hospice bereavement professionals need to develop cultural competence in understanding the unique grief needs of these communities. This article will start by examining the role that culture has on an individual’s grief process and will then review basic concepts and specific interventions in providing culturally competent bereavement care.

Culture defines our learned behaviors, our values, beliefs and customs. It provides a sense of membership in a group as well as a structure for life experiences. In a sense, the family acts as a lens through which we view the larger culture, and it influences our specific cultural responses to any of life’s events.

An individual’s experience of grief, though, tends to be similar across cultures. However, according to Cook and Jenkins (1982), patterns of behavior surrounding death and bereavement, especially in mourning rituals and behavioral expressions of grief, are among the most enduring of any cultural traditions. Mourning rituals serve a functional purpose—that is, the recognition of the loss followed by reorganization and reintegration of the loss. Mourning practices also serve to promote the integrity of the cultural group. An example of this would be the Jewish tradition of Shivah. During Shivah, mourners receive guests at their home to provide support and community. This ritual, in addition to providing a means of bereavement support, serves to promote a Jewish cultural tradition.
Categorizing grief responses of various cultural groups allows us a \textit{starting point} in our understanding of the grief experience of an individual within that group. We do, however, need to remain vigilant with regard to the range of possibilities in grief within each cultural group. Given the multicultural nature of our society today, there are large variations even among homogeneous cultures. These variations need to be acknowledged so stereotypes do not occur. A culture also evolves and changes over time as members learn new information and have new experiences.

While a racial and cultural match between the mourner and the bereavement professional is ideal, if not possible, there are characteristics of the clinician that are important in providing culturally competent care.

The first is the clinician’s awareness of his/her own multi-cultural heritage and his/her values related to grief and loss. Next is awareness of how these values might play a part in the relationship with the mourner. We look at life through our own cultural lens and this lens has the potential of distorting what we observe. In clinical practice and even in social science research, one often sees a Western bias in that which is “normal,” healthy, and appropriate grieving. Shapiro (1994) notes, “In the dominant North American culture, which emphasizes the centrality of the isolated individual; minimizes the importance of spiritual, as compared to scientific, explanations; and stresses the value of ‘letting go’ and ‘moving on,’ social sanctions are likely to pressure the bereaved into reentering the flow of ordinary life long before they feel psychologically ready.”

Culturally competent clinicians are aware of and respect the mourner’s culture, social class and spirituality. They are sensitive to institutional barriers that prevent minorities from accessing and utilizing bereavement services. They have the ability to establish rapport, exhibit genuineness, warmth, acceptance and empathy. Lastly, they are willing to refer mourners to other professionals when they feel they cannot serve them effectively.

In working with mourners from a different culture, McGoldrick (1991) suggests that hospice professionals first determine what an individual’s beliefs are about what happens after death and then determine what is considered an appropriate emotional expression and integration of the loss in that culture. Additionally, she suggests asking what the gender rules are for handling the death, and whether certain types of death carry a stigma. It is also important for the bereavement professional to understand in a broader sense how the culture interprets stress, stress management and level of functioning. It is then important to understand what role social and kin networks as well as religion play in providing support during the mourning process.

When providing bereavement support to individuals from a different culture than your own, it can be helpful to remember the following guidelines:

\begin{itemize}
  \item Think of yourself as a guest in their world.
  \item Ask about their customs and traditions.
  \item Identify the degree of acculturation and assimilation the individual appears to have toward the dominant culture.
  \item Assess the degree of involvement with both the culture of origin and the host culture.
  \item You may need to give them permission to experience some things that we may define as normal, but they may define as unacceptable, or vice versa. Even people whose faith or cultural tradition is familiar to you, may vary regarding their understanding of what it is acceptable for them to do and experience.
  \item Be careful not to evaluate culturally relevant mourning behaviors as abnormal.
\end{itemize}
We look at life through our own cultural lens and this lens has the potential of distorting what we observe.

• Listen to what they have to say. Observe their reactions.
• Ask leading questions. Ask them what they want—they will tell you. Don’t assume you know what people may want to do or may want from you.
• Do not talk or lecture them on what they need until you hear what they are experiencing.
• Pass on what you have learned to others who may be encountering this family.
• Lastly, remember, there is great power in just being present with a mourner. Visiting, calling, showing concern, and offering help and suggestions based on your assessment of their needs goes a long way. Often, all people need is to know that someone cares.

According to NHPCO’s Guidelines for Bereavement Care in Hospice, bereavement professionals should identify and collaborate with community agencies devoted to addressing the needs of diverse cultures. This may include sensitive translations of bereavement materials and hiring staff and volunteers from different cultures. It is also important to serve as a resource for these community agencies.

Robin Fiorelli is senior director for bereavement and volunteer services for VITAS Healthcare Corporation and is a member of NCHPP’s Bereavement Section Steering Committee.

Wanda Jenkins is the bereavement services manager for VITAS Healthcare in Chicago, Illinois.

References:
Last fall, NHPCO invited members to submit applications for a series of “Reaching Out” grants that were being funded by the Department of Veterans Affairs to improve access to quality hospice and palliative care among our nation’s homeless veterans and those living in rural areas. In February 2009, 18 programs were awarded grants to support and advance initiatives that each had in place, with the ultimate goal of helping the VA discover new and better ways of reaching this underserved population.

A report summarizing the work of the 18 grant recipients is available on the NHPCO Web site (www.nhpco.org/veterans). Here, two recipients share with us the good work they are doing to help meet the special needs of these very special individuals.

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**Hospice & Palliative Care Center’s Hospice Veterans Project**

*By Wendi J. Uselton, MSN, RN*

Visit Winston Salem, North Carolina sometime and you will be impressed with the city’s diversity. The area is known for its two major medical centers that provide excellent care to the entire region as well as several major banking centers, institutions of higher learning, and a thriving arts district. In Winston Salem, one can also step back in time with a visit to Old Salem or enjoy the modern amenities of downtown.

Winston Salem is also home to North Carolina’s original hospice, Hospice & Palliative Care Center (HPCC). HPCC is celebrating 30 years of providing comfort, compassion and care to the residents of Winston Salem and the surrounding 13 counties. It prides itself on delivering unmatched quality end-of-life care through an array of programs and services that result from identifying community needs.

“I am so proud to work with an organization that shares my own passion and respect for serving veterans appropriately at the end-of-life,” says Ken Bradstock, an HPCC chaplain and U.S. Marine Corps veteran. Ken has been working over the last year with an interdisciplinary team to establish The Hospice Veterans Project, a specialized program to meet the needs of veterans at the end-of-life. “About 14 percent of our patients are veterans and we know that they face special issues related to post-traumatic stress disorder, stoicism, flashbacks and other spiritual challenges,” says Ken.

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The Hospice Veterans Project has a special place among HPCC’s programs and services. HPCC knows that hospice employees and volunteers who are knowledgeable and trained concerning veterans issues provide informed and enhanced quality care to veterans. Ken expresses the sentiment of his co-workers when he says, “With all of the sacrifices that these men and women have made in the name of freedom, it is my duty and honor to learn as much as I can in order to serve and support them to the fullest extent possible in their time of need.”

The Hospice Veterans Project honors veteran patients, volunteers, board members and staff on Veterans Day and Memorial Day. Gene Atkinson, a two-year hospice volunteer and 30-year Veteran says, “In all of my working life, I have never been associated with a place that values my service to this country so much. HPCC honoring me on these holidays has been so meaningful.” HPCC also collects veteran stories that can be given to family and friends as a treasured keepsake. In addition to being a meaningful gift for relatives and friends, the stories can also be submitted to the United States Library of Congress’ Veteran History Project.

While all of these elements are important, there is one challenge facing Winston Salem’s veterans that cannot be ignored. Just beyond the bright lights and glimmer of Winston Salem’s downtown, there is a quiet area where many of the homeless population reside. There are as many as 590 homeless veterans living throughout the area, many of whom may need hospice and palliative services. Sam Parker, an HPCC social worker and Navy veteran says, “The homeless consist of a disproportionate number of veterans, and there isn’t a population who deserves to be served and protected more.”

HPCC’s Work Under the Reaching Out Grant

This is why HPCC was immediately committed to applying for one of the Reaching Out grants that was funded by the Department of Veterans Affairs (VA) and offered through NHPCO earlier this year. The grants were established to support hospice and palliative care organizations in the development of programs that improve access to services for homeless and/or rural veterans. As one of the lucky recipients, HPCC is using the financial support to meet a two-fold goal: to provide a place for homeless veterans to receive hospice and palliative services and to train homeless shelter staff to identify those who may be appropriate for hospice care.

According to Tom Edes, MD, the chief of home and community based care at the VA, providing hospice and palliative care to homeless veterans is a special challenge. The VA is depending on programs like the one at HPCC to set an example and provide best-practice information about how to provide care to the homeless veteran population.

In the four months since the grant was awarded, HPCC has made great strides. Staff hit the ground running by making contact with local homeless shelters and the VA’s homeless outreach coordinator for the Winston-Salem area.

Homeless shelter staff members have been so welcoming and thankful for HPCC’s help with this deserving population because of the experiences they frequently face. To help us understand, they ask us to imagine a homeless Vietnam veteran who arrives at the shelter for the night....

The veteran is suffering from the effects of HIV/AIDS. The homeless shelter rules state that a client can be admitted for the night, but must be turned back onto the street the next day. This particular man, because of his illness, should not be returned to the street in the morning. To make the situation even more challenging, he does not want to go to the hospital nor is he sick enough to require hospitalization. How in the world will this man find a restroom, a drink of water, a warm blanket, or the rest his body needs?

Most of us do not want to come to work—in a temperature-controlled office—when we are suffering the effects of a stomach virus. Clearly, an HIV/AIDS victim and a U.S. veteran who has valiantly and honorably served this country is deserving of the best possible care. The VA Reaching Out grant is helping HPCC serve their needs.

During the next phase of our project, HPCC will provide training for homeless shelter staff, including general “Hospice 101” education to familiarize them with programs and services, and more specialized training to help them identify veterans who would benefit from hospice care.

Based on our experience, I encourage you to visit homeless shelters in your community if you haven’t already, and acquaint the staff with your program and services. The information you provide will be helpful to veterans as well as all of the homeless individuals in your area. Everyone deserves the best possible end-of-life care, especially our homeless veterans.

Wendi J. Uselton is director of community outreach for Hospice & Palliative CareCenter (based in Winston Salem, NC). Wendi has worked at HPCC for the past three and a half years and is a registered nurse with 20 years of experience in home and hospice care.
Hospice of the Bluegrass: Partnering to Improve Access

By Sherri Weisenfluh, LCSW, ACHP-SW and Candice Combs

Even though the topic is serious, Bill’s laughter fills the room. He is one of a small group of veterans who has decided to attend our outreach event. This Tuesday night he has come to the VFW club to eat a meal and be with other veterans as they listen to the speaker, Kay Mueggenburg of Hospice of the Bluegrass. Bill is slowly smoking his cigarette as he leans in to listen to Kay explain healthcare decisions we may face at the end of life. His face is weathered and his hair is loosely tied back in a ponytail. After the presentation, Bill talks about his frustration with trying to access VA services, but he is hesitant to admit he is homeless. Bill talks about using a community food bank and admits he often ignores his own healthcare needs. He jokes that the local library is known as a place to “hang” because it has free Internet access. Bill says he knows of other veterans who need the information being presented. The others in attendance nod in agreement.
Reaching Out to Homeless Veterans

According to a 2009 press release from the National Coalition for Homeless Veterans, the latest estimate on the number of homeless veterans on any given night is 131,000. While we envision most of the homeless primarily located in larger metropolitan areas, some homeless veterans, such as Bill, have gravitated to smaller rural areas. In response, NHPCO released a request for proposals earlier this year for the VA-funded “Reaching Out” grants.

Hospice of the Bluegrass (HOB) is one of the 18 hospice and palliative care programs to receive funding from the Reaching Out initiative. Bill exemplifies the type of veterans which HOB hopes to assist through its collaboration with a coalition of six community partners:

- Department of Veterans Affairs, represented by a veteran-benefits field staff member who serves as an advocate for the population’s special needs.
- Corner Haven Crisis Center, which provides emergency shelter for men and women; financial assistance for people facing eviction, utility disconnection or foreclosure; and additional support, such as food, clothing and household goods.
- Hazard Perry County Community Ministries, which offers transitional housing and support services to help families and individuals get back on their feet.
- Eastern Kentucky Veterans Center, a 120-bed facility that provides long-term skilled nursing care and a range of other services for the convenience, comfort and well-being of veterans.
- Kentucky Mountain Health Alliance, which operates a free clinic with medical care and mental health services for the uninsured.
- VA Community Based Outpatient Clinic, which provides clinical services to veterans through long-term care facilities, community mental-health programs, homeless shelters, medical clinics and others.

Insight from each of the coalition members and an analysis of issues that emerged from the VFW dinner event show a magnitude of problems facing America’s homeless veteran population. Despite the existing services offered by coalition members, veterans such as Bill, when given the opportunity, identify a host of psychosocial issues that need our attention:

- Estrangement from family members and the accompanying social isolation;
- Suspicion towards the military and other bureaucracies;
- Lack of transportation;
- Lack of affordable housing;
- Substandard housing;
- Lack of knowledge about existing resources;
- Frustration with trying to obtain VA services;
- Pride that prevents them from accepting services viewed as charity;
- Unresolved grief issues from their war experiences; and
- Inability or unwillingness to access mental health services.

HOB and its coalition partners plan to hold more events like the VFW dinner, which provided a welcoming and informal venue for the sharing of information on advance care planning and other end-of-life issues. In addition, two other Eastern Kentucky communities have been targeted for coalition building. HOB also plans to continue to identify key VA personnel on the state and local levels and provide additional educational outreach. Strengthening and finding ways to keep the newly formed community coalition thriving is a long-range goal. Ultimately, work funded by the Reaching Out grant will help lay the foundation for a community-wide commitment to veterans such as Bill.

Sherri Weisenfluh is associate vice president of counseling for Hospice of the Bluegrass (Lexington, KY) and NCHPP’s Social Work Section leader.

Candice Combs has worked for Hospice of the Bluegrass for three years, and serves as the professional liaison for the HOB Mountain Community and as one of the project managers for the VA Reaching Out grant.
Free Resources to Support Your Work with Veterans

Many NHPCO members may not realize that more than 50,000 veterans die each month—that’s roughly 28 percent of all deaths in the United States. In fact, many programs are probably serving veterans, but don’t realize it. Yet determining if a patient is a veteran can often guide the plan of care, since many veterans have specific psychosocial needs as a result of their war experiences.

Here are some of the free resources posted on the NHPCO Web site that can help you in your work:

**Military History Checklist for Hospice Patients**
This checklist (PDF) helps community hospices identify their veteran patients, evaluate the impact of the experience, and determine if there are benefits to which the veteran and surviving dependents may be entitled.

**Hospice Veterans Partnership/VA 101 Toolkit**
This toolkit is a collection of documents and PowerPoint slides that provide background information and resources for starting up and maintaining a Hospice Veterans Partnership (HVP) program.

**Resources for Working with Veterans**
A range of materials developed by the VA are also posted on the NHPCO site, including the VA’s Military Facts for Non-military Social Workers; a Guide to Understanding the National Guard and Reserves; and the VA Benefit Program Fact Sheet.

Visit the NHPCO Web site to access this information—and more: www.nhpco.org/veterans.
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Facebook, Twitter, MySpace, YouTube, Flickr, LinkedIn, Blogspot—Internet sites that where unfamiliar to most people only a couple of years ago are now part of daily life for many Americans. Tweeting, texting, posting, linking, and surfing have new meaning in our contemporary vocabulary.

What many refer to as social networking tools were created to facilitate communication between two individuals, however, the professional world has been quick to adopt these communications tools and see how they might benefit life in the workplace.

Some would observe that these social networking tools are perhaps a greater part of the lives of those on the younger side of Generation X, but demographics show that people of all ages are using these tools in varying degrees to communicate.

While the full impact of social networking as a professional tool in the workplace is unknown, the power of this medium cannot be questioned. More and more organizations are integrating these tools as part of their communications strategy and are only now beginning to assess the effectiveness of these changes.

In the hospice and palliative care community, there has been any number of early adopters. For example, San Diego Hospice and its Palliative Care Center has been active on Twitter for some time, Alive Hospice in Nashville launched its successful online blog last year, and the blog, Pallimed.org, has established itself as a valuable source of news and information. Now, NHPCO has launched its own social networking community

continued on next page
online—My.NHPCO. These all reflect significant changes in the way professionals communicate.

In thinking about this issue, NHPCO President and CEO J. Donald Schumacher noted that “Times change. That’s one thing that living in the Twenty-first Century has made clear, change will occur whether we are looking for it or not.”

“And the end-of-life community is no stranger to change,” he said. “CoPs and regulatory compliance, expanding populations and the needs of those we serve, healthcare reform and legislation, competition in the market—we have a successful history of effectively adapting to change. By embracing advances in technology, such as My.NHPCO, that allow us to work smarter, we will all benefit.”

About My.NHPCO
This new, online networking community connects member hospice and palliative care professionals and volunteers from across the country. Similar to other popular networking sites, My.NHPCO gives members the power to share their experiences and knowledge with their peers. It allows users to participate in end-of-life care discussions through blogging, document sharing, resource ranking, eGroups—our improved listserves, and much, much more!

My.NHPCO Users Can:
• Create a secure personal profile that is pre-filled with information from NHPCO’s membership database and may be expanded (as the user wishes) by completing additional fields of information;
• Define who may view their profile and what information site visitors can see;
• Participate in pre-established eGroups, and eGroups based on topics of interest—basically an enhanced version of the previous listserves;
• Search past eGroup discussions for specific topics of interest—a feature unavailable with the previous listserves;
• Share documents via online libraries and browse other documents posted by members—our previous system did not allow for the safe and secure sharing of documents;
• Search the NHPCO directory to find colleagues and friends—and categorize contacts into personally defined groups such as co-workers and fellow committee members;
• Explore the contact lists of fellow contacts to identify mutual friends; and
• Create their own blog, follow other users’ blogs—and much more.

Responses from members have been as varied as the membership itself. For example, Rhonda Kurvink, executive director of Oklahoma’s Hospice of McAlester, quickly felt at ease telling NHPCO, “I don’t like change, especially when I don’t have time to figure it out or make the transition! This said, I took time on Friday evening, after work, to review and set up my profile and was surprised that it really wasn’t so difficult or time-consuming! Like the little engine that could, ‘I THINK I CAN, I THINK I CAN’ became, ‘WOW, I DID IT!’”

And members are quickly realizing that My.NHPCO can help them be more efficient. NHPCO board member, Charlene Bunts, shared her thoughts in the week following the July 22 launch: “My work email receives so many messages each day, that I appreciate the opportunity to check My.NHPCO information on its own site. Additionally, I set up a separate email on one of my personal accounts to receive notification of posts to My.NHPCO. It has reduced the number of messages to only those that I am interested in reading.”
Other members have commented on not feeling computer-savvy enough to learn a new system or of being wary about putting information into a profile. And some have said they are not interested in all of the features on My.NHPCO.

Flexibility is what makes My.NHPCO such a useful tool. Users may take advantage of as many or as few of the features that they choose. Users need not fill out all the fields on a profile and can be selective about what other users can see on their profile. The system is secure and will actually prevent some of the threats that accompany traditional email communication.

Based on NHPCO’s beta-group testing and the initial member feedback, the ease of use will come with only a little bit of patience and practice.

Lores Vlaminck from Rochester, NY, shared this after her initial experience: “I signed up last night as a user of My.NHPCO and love it…. Much of my profile was already uploaded…and using it was intuitive…. It offers many more options for my online use! Thanks NHPCO for taking the leap!”

The most commonly expressed concern is that the listserves of old would go away. My.NHPCO has not eliminated the listserves, but has updated them to be more robust and accessible to a wider number of members. In fact, the new system will archive past discussions, so users can go back to an eGroup to see what has been said about an issue of importance. The ability to benefit from previous discussions was lost with the old listserv system.

A number of members expressed appreciation for the end of those “out of office” emails and the frequent reply-all emails (saying things like “I’m interested too” or “remove me from this list”) that were inherent with the old listserv system.

Due to increasingly vigilant SPAM filters and virus protection being put into place by organizations, a great number of NHPCO members could not participate in the old listserves. My.NHPCO expands the reach of our members and facilitates virtual communication safely and responsibly.

NCHPP CEO Section leader, Greg Wood shared some helpful thoughts with other section members, “As with all things, we will have adjustments to make, new methods to learn and probably kinks to work out, but from what we can tell, this new method of communicating with each other will enhance our abilities to share documents, questions, blog on professional topics, as well as learn more about each other as we begin to slowly add information about ourselves and our organizations.”

Wood offers wise advice when he stressed, “Please don’t feel the pressure to have all things in order immediately as it may take time (with our busy schedules) to fully learn the details of the system, but that’s okay.”

In terms of filling out the online profile, Bunts reminded followers of the CEO listserve, “If it makes you feel better, you do not have to fill out ALL the information on your profile, especially at first!”

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NHPCO’s Vice President of Membership and Business Development Pam Bouchard quickly found that My.NHPCO isn’t just about virtual interaction. She was pleased to discover that Katie Smith McIntyre, the community relations manager for Hospice of Central Iowa, looked her up on My.NHPCO prior to a site visit in August.

“Staff at the program indicated that they found My.NHPCO to be a great new tool and I was impressed by the way Katie used the system to prepare for our meeting, so it was valuable to them for a face-to-face interaction, not just a Web-based one,” noted Bouchard.

Using the My.NHPCO tools to connect with your peers, participate in discussions, search for relevant information, and communicate with others is not as complicated as it might seem.

Yes, there will be a learning curve and not all members will participate in the early months of the system; however, members are encouraged to keep an open mind, and consider the benefits of embracing this new resource.

A Web-based tutorial is being created for NHPco’s End-of-Life Online and will be available this fall. For those members attending NHPco’s 10th Clinical Team Conference in late-September, be sure to visit the NHPco Pavilion in the exhibit hall where staff will be explaining the features available on My.NHPco.

“I hope members will take time to get to know My.NHPCO,” Schumacher advised. “If I can get accustomed to it, I know just about anyone can.”

To enter My.NHPCO, go to http://my.nhpco.org/ or look for the My.NHPCO link on the NHPCO homepage (www.nhpco.org). Then, getting started on My.NHPCO takes four simple steps:

1. **Login with your NHPCO user ID**
   All current NCHPP and e-NCHPP members have their own user ID and password. All staff and volunteers of provider members are entitled to complimentary e-NCHPP membership. If you don’t know your ID/password, contact NHPCO Member Services at 1-800-646-6460.

2. **Click on “My Network” to update your NHPCO Professional Profile**
   Your profile is populated with the basic information from your current member record. You don’t have to add any more information if you choose not to. Adding a photograph is also optional. However, the additional fields will let you tell other members a bit more about yourself. Share only what you’re comfortable including. You can change your profile at any time.

3. **Search for your colleagues and add them to your contact list**
   Build your own network of contacts from the other members currently using My.NHPCO. Group your contacts by interest, topic, and region—whatever makes the most sense to you. This is also optional and something you can do over time if you choose.

4. **Join eGroups based on interest**
   If you like the current NCHPP listserves, you’ll love eGroups! Each hospice/palliative care discipline or job function has a “section” within NCHPP that promotes networking among peers. Each section has its own eGroup allowing people with common job functions to collaborate and share information with one another. There are also eGroups based on areas of interest and other professional topics such as pediatrics or rural issues. You may join any of the open eGroups to begin reaching out and networking with other members who share a discipline or an interest. Each eGroup has its own discussion thread which is an enhanced version of the former listserves.

Jon Radulovic has served as NHPCO’s vice president of communications since 2002, and is responsible for the internal and external communications of NHPCO and its three affiliate organizations. Prior to joining NHPCO, Jon was director of communications for the Hospice Foundation of America, widely known for its annual “Living with Grief” satellite teleconference.
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For the last 10 years, the American Hospital Association has presented the Circle of Life Award to honor innovation in palliative and end-of-life care.

This year’s five honorees represent a range of service providers—from large academic medical centers to community hospitals and hospice providers in urban, suburban and rural settings. What’s more, each excels in providing a coordinated continuum of care to support the best quality care for patients and families in the “right” care setting. We are particularly proud that two of the honorees, Four Seasons Hospice and Gilchrist Hospice, are NHPCO members:

**Award Winners:**

- Four Seasons Hospice
  Flat Rock, North Carolina
- Oregon Health and Science University
  Palliative Medicine and Comfort Care Program
  Portland, Oregon
- Wishard Health Services
  Palliative Care Program
  Indianapolis, Indiana

**Citations of Honor:**

- St. John’s Regional Medical Center
  and St. John’s Pleasant Valley Hospital
  Palliative Care Services
  Oxnard and Camarillo, California
- Gilchrist Hospice
  and Greater Baltimore Medical Center
  Towson and Baltimore, Maryland

NHPCO and the National Hospice Foundation joined the American Association of Homes and Services for the Aging, the American Hospital Association, and Catholic Health Association as major sponsors of the 2009 awards, in conjunction with the two co-sponsors: the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association. On behalf of all the sponsors, NHPCO extends congratulations to these honorees.

The honorees were recognized during a presentation on July 24, 2009 in San Francisco. To learn more about their work, visit: www.aha.org/aha/news-center/awards/circle-of-life.
These programs serve as models for us all as we move forward in our shared goal of providing high-quality, patient-and-family centered care.”

Don Schumacher
President/CEO,
NHPCO/NHF

Circle of Life Award honorees and sponsors at the awards presentation in San Francisco:
Chris Comeaux, president/CEO, Four Seasons, Flat Rock, NC; Gregory P. Gramelspacher, MD, medical director, Palliative Care Program, Wishard Health Services, Indianapolis, IN; Richard P. de Filippi, trustee, Cambridge Health Alliance, Cambridge, MA and chairman-elect, American Hospital Association; Amy Guthrie, Palliative Care clinical nurse specialist, Oregon Health and Science University Palliative Medicine/Comfort Care Team, Portland, OR; Tina Picchi, director, Palliative Care Services, St. John’s Regional Medical Center, Oxnard, CA and St. John’s Pleasant Valley Hospital, Camarillo, CA; Catherine J. Boyne, president, Gilchrist Hospice Care, Towson, MD; and John Mastrojohn III, vice president of palliative care, quality & research for NHPCO.

The 2009 Circle of Life Awards are supported in part by the California Healthcare Foundation and the Archstone Foundation.
Show your support for hospice

Participate in NHF’s Run to Remember athletic fundraising program dedicated to advancing the cause of hospice care. Run or walk any race at any pace in honor of a loved one.

For more information or to register, please visit www.runtoremember.org

By purchasing RTR items, you support NHF’s national work to improve care at the end of life throughout the United States.
Now is your chance to order items from our “Collectable Collection” with the original Run to Remember logo.

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Drawstring backpack made of 210 denier polyurethane, 14 ½” x 18”. Main compartment has drawstring rope to close. The backpack can be used for many activities. The original Run to Remember logo adorns the backpack.
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- **Non-Member: $9.00**

### Microfiber Cap
A Microfiber cap with the original Run to Remember logo has a low profile and 6 panels with no eyelets, a pre-curved visor and a fabric strap with a matching Velcro closure. Keep your head shaded when you run or out for a fun day.
- **Item #: 821337**
- **Member: $9.00**
- **Non-Member: $11.00**

### Water Bottle
Get the original Run To Remember logo on a 20 oz. water bottle with a sports grip. HDPE and clarified polypropylene. A pull spout allows for drinking ease and helps prevent leaks and spills. Wide mouth design. This product can be recycled under symbol #2, made with 30% recycled material, 100% biodegradable, BPA free!
- **Item #: 821336**
- **Member: $5.00**
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### Hoodie
Show your support with this Run To Remember Hoodie. This stylish sweatshirt comes with a front pouch pocket and hood neck with drawstring. Made from 50% cotton and 50% polyester.
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- **Item #: 821322 – Large**
- **Member: $24.95**
- **Non-Member: $29.95**
- **Item #: 821323 – XL**
- **Member: $26.95**
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- **Member: $28.95**
- **Non-Member: $33.95**

### Long Sleeve T-Shirt
This long sleeve t-shirt is a great way to show support for Run To Remember. This shirt is made from 100% cotton and is extra durable with a double-needled cover-stitched neck and hemmed bottom.
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- **Member: $16.50**
- **Non-Member: $19.50**
- **Item #: 821328 – XL**
- **Member: $18.50**
- **Non-Member: $21.50**

### Short Sleeve T-Shirt
This short sleeve t-shirt is made from 100% cotton and is extra durable with a double-needled cover-stitched neck and hemmed bottom.
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- **Item #: 821331 – Medium**
- **Member: $10.00**
- **Non-Member: $11.50**
- **Item #: 821332 – Large**
- **Member: $11.00**
- **Non-Member: $12.50**
- **Item #: 821333 – XL**
- **Member: $12.00**
- **Non-Member: $13.50**
- **Item #: 821334 – 2XL**
- **Member: $13.00**
- **Non-Member: $14.50**

### Microfiber Cap
- **Item #: 821337**
- **Member: $9.00**
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NHPCO’s Marketplace! ORDER FORM
In late July, AARP hosted President Obama at a Town Hall meeting on healthcare reform. One of the questions from a phone-in participant concerned the Advance Care Planning Consultation provision in the U.S. House of Representatives healthcare reform proposal. The caller said:

“… I have been told there is a clause in there that everyone that’s Medicare age will be visited and told to decide how they wish to die. This bothers me greatly and I’d like for you to promise me that this is not in this bill.”

While President Obama clearly demonstrated his knowledge and support of the provision when addressing the caller’s concern, many Americans are still confused about the provision’s intent. Many, particularly the elderly, mistakenly believe it is “mandatory” end-of-life care advice and counseling due, in large part, to misinformation being publicized by opponents of healthcare reform and the media.

NHPCO has provided information to national and regional print and broadcast media to clarify the provision (including the New York Times, Wall Street Journal, Washington Post, Associated Press, ABC, NBC, CBS, and CNN). To help you assist the members of your community in understanding the provision, here is a brief summary.

Section 1233 (pages 424-434) of the House health reform proposal contains a new Medicare provision to allow coverage for an “Advance Care Planning Consultation.” This provision is intended to offer Medicare beneficiaries an opportunity to engage in an informed and focused conversation with their healthcare practitioner about advance care planning options.

This consultation would be in addition to the current “Welcome to Medicare” physician consultation. And, like other consultations within the Medicare system, the Advance Care Planning Consultation would be voluntary and reimbursable by Medicare when provided no more than once every five years, or whenever a patient undergoes a qualifying event (i.e., a life threatening or terminal diagnosis, chronic disease diagnosis; or admission to a long-term care facility, a skilled nursing facility, or a hospice program).

The Consultation can be conducted by a physician, nurse practitioner or physician’s assistant, and should cover the following topics:

- An explanation of advance care planning, including key questions and considerations, important steps, and the names of other professionals the patient may wish to speak with;
- An explanation of advance directives, living wills and durable powers of attorney, and their uses;
- An explanation of the role and responsibilities of a healthcare proxy;
- The provision of a list of national and state-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, advance care planning clearinghouses, and state legal services organizations; and
- An explanation of the end-of-life services and supports available, including palliative care and hospice.

Again, this proposed Advance Care Planning Consultation provision is not mandatory—and no one is required to undergo the consultation.

Help spread the word in your community about this provision and the importance of advance care planning. Information specifically developed for consumers can be found on the NHPCO Caring Connections Web site (www.caringinfo.org), while NHPCO’s Hospice Advocacy Web pages have a wealth of information about healthcare reform (www.nhpco.org/advocacy).
Caring Connections Partners with Google Health on Advance Care Planning

During the AARP Town Hall Meeting (see story at left), President Obama emphasized the importance of completing an advance directive during his discussion about the House proposal: “...I actually think it’s a good idea to have a living will,” he said. “I’d encourage everybody to get one. I have one. Michelle has one. And we hope we don’t have to use it for a long time, but I think it’s something that is sensible.”

Now, Americans have a new, easy and secure way to complete their advance directives and store them online—with the help of Caring Connections and Google Health. Through their collaboration, all consumers can establish a secure account on Google Health and upload their advance directives to the account so it's easily accessible to loved ones in an emergency.

Here are the four simple steps:

1. Go to www.google.com/health and create an account (which takes minutes to do and is fully secure);
2. Download and print the advance directive form for your state from www.caringinfo.org/googlehealth;
3. Discuss your wishes with loved ones, and complete and sign the form;
4. Scan the signed document and upload it to your Google Health account.

Share this new resource with your staff and volunteers as well as patients and families—or direct them to the Caring Connections Web site (www.caringinfo.org) for these simple instructions and a quick link to Google Health. With healthcare issues on everyone’s mind right now, it’s an opportune time to help all Americans take this important step.
JSSA and its Volunteer Team Receive Marriott’s Spirit to Serve Award

JSSA Hospice (based in Rockville, MD) and its 90 exemplary volunteers who visit the seriously and terminally ill in Montgomery County were recently honored by the Marriott Corporation as recipients of its Spirit to Serve Community Service Award.

The award, which is administered by the Montgomery County Volunteer Center, recognizes extraordinary individuals and groups for their outstanding service to the Montgomery County community. JSSA was selected from a competitive field for one of four such awards.

Burke Hospice’s Commitment to Diversity Finds Expression Through Art

Burke Hospice & Palliative Care (Valdese, NC) participated in the Hospice Foundation of America’s 16th Annual Living with Grief Teleconference last April which explored “Diversity and End-of-Life Care.” In addition to hosting the teleconference for the community, the hospice took the time to create a special banner, based on the HFA teleconference graphic, that incorporated the hand prints of staff members. The banner will be featured at various functions throughout the year to represent the program’s commitment to diversity.

Pathways Hospice Foundation Awarded Grant to Support its Nursing ‘Dream Team’

Pathways Hospice Foundation (Sunnyvale, CA) has received a grant of $34,345 from the Yahoo! Employee Foundation, a corporate advised fund of the Silicon Valley Community Foundation.

The grant will support the 24-hour nursing team of Pathways Home Health & Hospice, which provides “after hours” telephone assistance, and home visits when needed, to patients and families within five Bay Area counties. The “Dream Team” enables a nurse to triage a patient’s symptoms quickly and often helps the patient avoid emergency room visits and hospitalization.

The team covers 104 weekend shifts and nine holidays per year, and is comprised of a full-time director, 12 part-time triage nurses, and five nurses.

The Center for Hospice and Palliative Care Appoints Gregory Gifford as Chief Medical Officer

Gregory C. Gifford, MD, JD, has been appointed chief medical officer of The Center for Hospice and Palliative Care (South Bend, IN). Gifford, who is board certified in both hospice and palliative medicine and in emergency medicine, was most recently employed by Columbus-based Hospice of South Central Indiana.

From left: Linda Morgan, volunteer specialist; Taisha Taylor, executive assistant; and Vince Bartlome, vice president of support services.

Montgomery County Executive Isiah Leggett, with JSSA volunteer coordinator, Amy Goott, during the award reception.

PATHWAYS Home Health, Hospice & Private Duty
The QAPI requirements under the new Hospice CoPs are driving all Medicare-certified programs to make measurable improvements in the quality of their care and services. But how do you accomplish this lofty task? What do you tackle first?

NHPCO developed a self-assessment system as part of the Quality Partners program to help you assess every aspect of your operation and, in doing so, identify and prioritize areas for improvement. Best of all, it’s easy to use and it’s free to all NHPCO members.

The system features 10 online self-assessment forms that correspond with Quality Partners’ 10 Components of Quality in Hospice Care. You can complete one form at a time and generate a report showing your score for each standard and how you compare with other programs in your state and in the nation.

**Take Advantage of This Free Membership Benefit**

A one-page tip sheet and a descriptive brochure are posted on the NHPCO Web site. Visit [www.nhpco.org/quality](http://www.nhpco.org/quality) and select “Self Assessments.”

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**Symeonides Receives CAQ in Hospice and Palliative Medicine**

John Symeonides, MD, Flagler County associate medical director for Florida Hospital HospiceCare (Ormond Beach, FL), has earned a Certificate of Added Qualifications (CAQ) in hospice and palliative medicine from the American Board of Family Medicine. This certificate is designed to recognize excellence among certified family practice physicians in their care of patients with life-limiting illnesses.

**Bradley Becomes First Social Worker to Earn Advanced Social Work Credential**

Judith Bradley of The Hospice of San Angelo (San Angelo, TX) is the nation’s first baccalaureate social worker to attain the new Advanced Certified Hospice and Palliative Social Worker (ACHP-SW) credential.

The National Association of Social Workers (NASW) collaborated with NHPCO to offer this credential for social workers who specialize in hospice and palliative care. “We know that with the aging of the baby boomers and the lengthening of life spans, there is going to be an increased need for professional social workers in hospice and palliative care,” said the NASW’s executive director, Elizabeth Clark. “NASW and NHPCO believe these highly trained professionals should be recognized for their contributions to quality patient care.” (To learn more about the credential, see the display ad on page 54.)
Who is Hospice On Call?
Hospice On Call is an established, national company that partners with your agency to provide after-hours RN phone triage to your patients and their care givers. Hospice On Call provides highly trained professional phone assistance for your patients and their families. When your patients call you for help, a smooth, seamless transition directly to Hospice On Call Triage Services handles needs expertly and efficiently.

Hospice On Call Services Include:
• Experienced staff ensuring that your patients’ calls are answered quickly and professionally.
• Excellent quality service and the care and comfort your patients and their loved ones would expect.
• Individualized triage services tailored to meet your specific needs for patients and their families.
• Compassionate guidance, comfort and education for patients and family members when they need it the most.
• Liaison between families, pharmacies and DME companies
• Assessment based on your own hospice guidelines to determine when a visit to the home is necessary, and the expertise to manage those decisions.

Hospice On Call, the cost-effective and caring solution for after hours phone assistance and triage. For more information please call 1-877-874-2430 or visit our website at www.hospiceoncall.com.

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ADR’S DESTROYING YOUR CASH FLOW?
The only way to restore productivity is to get back to the business of caring for and finding new patients. It’s our job to do your ADR and Denial responses, making it easier for you to restore a healthy cash flow. Give us a call and find out what ADR Pro Prep can do for you.

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• Interfaces with hospice software providers
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...and more!
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.
NHPCO’s Upcoming Educational Offerings

Audio Web Seminars

2:00 – 3:30 p.m. (EDT)

Interdisciplinary Topics:

09/10/09: Complicated Bereavement: Current Understandings and Hospice’s Responsibilities
10/08/09: The Comprehensive Assessment: Best Practices
11/12/09: Why Interdisciplinary? How Interdisciplinary?
12/10/09: Professional Boundaries: Maximizing Care and Minimizing Stress

Leadership Topics:

09/22/09: The Top 10 Skills for New Hospice Leaders
10/27/09: Hot Regulatory Topics
11/24/09: Long Term Care and Hospice
12/18/09: Creating an Organizational Culture that Embraces Hospice Values and Practices Excellence

CE/CME for Counselors, Nurses, Physicians, and Social Workers is offered where appropriate given the topic. For details, visit www.nhpco.org/aws and scroll to “2009 Audio Web Seminars Schedule and Session Descriptions.”

Hospice Manager Development Program

NHPCO’s Hospice Manager Development Program (Hospice MDP) is designed for the ongoing education and development of hospice managers. Comprised of both classroom and online learning, the Hospice MDP helps ensure that managers have the skills they need to provide effective, efficient leadership.

Attending the two-day foundational course is an important first step. Then, managers can take additional modules online to continue the learning process.

Two-Day Foundational Courses:

9/22 – 9/23/09 in Denver, CO
In conjunction with NHPCO’s 10th Clinical Team Conference
10/8 – 10/9/09 in Little Rock, AR
In collaboration with the Arkansas State Hospice and Palliative Care Organization
12/2 – 12/3/09 in Orlando, FL
In conjunction with NHPCO’s 6th National Conference on Volunteerism and Family Caregiving

Visit www.nhpco.org/mdp for details and additional MDP modules.

National Conferences

10th Clinical Team Conference
Soaring to New Heights in Interdisciplinary Care

9/24 – 9/26/09 in Denver, CO


6th National Conference on Volunteerism and Family Caregiving
Honoring the Gift of Caring

12/4 – 12/6/09 in Lake Buena Vista, FL

Plus “Tapping Your Board’s Full Potential” on 12/3 and Disney Institute’s “Disney’s Approach to Leadership Excellence” on 12/4.

For details on these offerings and others, visit nhpco.org/conferences.
More than 50,000 American veterans die each month, many of whom would benefit greatly from the skills and expertise of hospice and palliative professionals. To help improve access—specifically for homeless veterans and those living in rural areas—the Department of Veterans Affairs awarded 18 grants to programs around the country, with assistance from NHPCO. See page 32 to learn more about this initiative and the valuable work being done by two of the grant recipients.