Palliative Sedation in Hospice Care:

NHPCO Ethics Committee Offers Guidance

By Timothy W. Kirk, PhD

A front page article in a leading national newspaper implies that palliative sedation is equivalent to “slow euthanasia” and draws connections between the practice and the death of Michael Jackson.... A veteran hospice nurse on an inpatient unit refuses to participate in palliative sedation, believing that if she participates, she would be “killing” her patient.... A patient suffers uncontrollably in the last hours of life, while her family and the dedicated hospice team look on helplessly, unaware that palliative sedation can be a safe and effective intervention for patients who do not respond to other treatments.

continued on next page

Also Featured This Month:

Your Regulatory Questions Answered.... As scrutiny of the hospice industry increases, so do the regulatory requirements. To assist members with compliance, this article recaps some of the recent issues and clarifications from CMS—see page 8.

FHSSA Quarterly Report—see page 29
All three of these events occurred in the past 12 months, and they reflect the pervasive misunderstanding and lack of knowledge about the practice of palliative sedation at the end of life. Last month, NHPCO took a major step forward to redress this misunderstanding with the release of a position statement and commentary on the “Use of Palliative Sedation in Imminently Dying Terminally Ill Patients” (which is posted on the NHPCO website at www.nhpco.org/communications).

The position statement and commentary were issued in response to two primary phenomena: (1) increasing requests from NHPCO members for guidance in addressing the ethical issues surrounding palliative sedation, and (2) a growing interest in the hospice and palliative care literature regarding the ethical questions raised by the practice of palliative sedation. The document’s timely release not only provides members with needed guidance, but also helps ensure that the voice of NHPCO is thoughtfully present in the discussion of this topic.

This article provides background about the position statement’s development, followed by an explanation of some of its key aspects and suggestions on how hospice organizations can utilize it fully.

About Its Development
The NHPCO Ethics Committee convened a task force in the fall of 2008 to explore ways to best provide a resource on palliative sedation to the entire palliative care community. The task force, in concert with the Ethics Committee as a whole, identified the following four goals:

- Separate fact from fiction, given the heated rhetoric and ungrounded assumptions that can creep into discussions of palliative sedation;
- Identify and analyze the most robust evidence and arguments about palliative sedation;
- Summarize that material in a way that is helpful to the NHPCO membership;
- Put forth a publication that supports and promotes the core values of NHPCO and the most widely agreed upon components of the hospice philosophy of care.

Members of the task force represented broad disciplinary diversity—two physicians, two nurses, a chaplain, two

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Task Force Members
Kathleen Bliss, MSN, RN, CHA
Pamela Dalinis, MA, BSN, RN
Timothy Kirk, PhD (Chair)
Mimi Mahon, PhD, RN, FAAN
Martha McCusker, MD, FACP
W. Brian Guthrie, MD
Marian Silverman, PhD, RN, CHPN
Joseph Wadas, STL

Special thanks is also extended to Mark Murray, a member of the NHPCO board of directors and former-chair of the Ethics Committee, under whose leadership this project began.
The data collection phase of this project is now under way... and we need more providers to step up and submit.

The Moran Data Project: Our Path to Positive Payment Reform

The many components that comprise our new health care reform law will be implemented gradually—over the next months and years. For the hospice and palliative care community, however, it will be the appointment of a CMS administrator that will drive implementation of the components that affect us—from the promising concurrent care demonstration project which NHPCO has long supported to hospice payment reform.

Right now, the confirmation of a CMS administrator is still under way. Regardless of who is appointed, Health and Human Services Secretary Kathleen Sebelius, in concert with the CMS administrator, will be required to collect, analyze, and revise the Medicare payment methodologies which determine hospice reimbursement rates. Fortunately, any changes to be made cannot occur before FY 2013—allowing time to gather and assess the data.

I am proud to say that NHPCO leadership has been way ahead of the curve. Last July, we retained the Washington, DC-based healthcare research firm, The Moran Company, to conduct our own data collection and assessment project on behalf of the hospice and palliative care field—one that we fondly refer to as the “Moran Data Project.”

Utilizing this highly regarded, third-party research firm, our plan is to develop and present to CMS—and the Medicare Payment Advisory Commission—alternative Medicare payment models that all of us can live with, rather than leaving this task solely to federal regulators. However, in order for our models to be sound, we must have comprehensive, patient-level data—and for that, we need your assistance.

The data collection phase of this project is now under way. As we have publicized in NewsBriefs and NewsLine, it began in February and will conclude in late summer. There are now about 200 providers which are submitting data—but we need 800 more to step up and submit.

Software Vendors are Helping to Make Submission Easy

I want to personally acknowledge and thank the software vendors which, as we go to press with this issue, have come forward and agreed to assist their hospice clients with data submission: Allscripts; Cerner BeyondNow; Consolo Services Group; Delta Health Technologies; Homecare Homebase; McKesson Corporation; mumms® Software; and Suncoast Solutions. In the coming weeks, I am also hopeful that others will come forward.

I know that members are juggling many more demands these days, so the assistance of these vendors in simplifying and supporting the data submission process is a tremendous benefit. Providers can also be assured that their data will remain completely confidential. In fact, NHPCO will not see any of the hospice-specific data nor will the data be released to any government agency. Only aggregated results will be included in the reports produced by The Moran Company. To learn how you can help, please visit www.nhpco.org/moran.

While payment reform is inevitable, I am confident that we will see positive change if we continue to work together, just as we are now doing in the early stages of this important project.

J. Donald Schumacher
President/CEO
administrators, and a philosopher. After reviewing current NHPCO materials on palliative sedation and conducting an exhaustive literature search and review, the task force recommended the creation of a position statement. Given the complexity of the practice and the highly nuanced nature of claims and arguments surrounding palliative sedation, task force members also recommended an accompanying commentary to supplement the position statement. The Ethics Committee concurred, and secured permission from the NHPCO board of directors to proceed with the project.

Over the course of 15 months, the task force deliberated heavily, with each member composing sections of the statement that were subsequently critiqued and revised by other members. Several drafts were presented to the entire Ethics Committee for feedback and suggestions, which resulted in additional revisions and additions. Once the task force felt it had a strong enough document and had secured permission from the Ethics Committee and the NHPCO board, it circulated it for peer review to international experts in ethics and palliative sedation outside of NHPCO. The task force identified 20 candidates who were research and practice leaders in ethics and palliative sedation, and proceeded through a three-month peer-review process and two additional drafts. The final draft was approved by the Ethics Committee in October 2009 and approved by the NHPCO board of directors in December. It was then submitted to the Journal of Pain and Symptom Management and, following a second round of peer review, was accepted for publication in the May 2010 issue.

Palliative Sedation Defined
One source of confusion in discussions about palliative sedation is the definition itself. Based on a review of the literature, task force members selected the following definition:

“Palliative sedation is the controlled administration of sedative medications to reduce patient consciousness to the minimum extent necessary to render intolerable and refractory suffering tolerable.”

Importantly, this definition refers to the implementation of an evidence-based sedation regimen with the primary effect of sedation, and not titrating levels of other medications (like opioids) which are already being administered for pain, but which are not recommended for sedation in evidence-based protocols.

The Position Statement and Its Structure
The position statement consists of the following six core tenets. It then provides an extended commentary which defines key terms, addresses areas of complexity, and suggests ways for hospices to create policies and guidelines to articulate and govern the practice of palliative sedation in their organizations.

1. Availability
Palliative sedation is an important tool among the spectrum of therapies available in hospice and palliative care. For the small number of imminently dying patients whose suffering is intolerable and refractory, NHPCO supports making the option of palliative sedation, delivered by highly trained healthcare professionals, available to patients.

2. Proportionality
The goal of palliative sedation is to provide relief from symptoms that are otherwise intolerable and intractable. Since the goal is symptom relief (and not unconsciousness per se), sedation should be titrated to the minimum level of consciousness reduction necessary to render symptoms tolerable. For some patients, this may be total unconsciousness. For most, however, it will be less than total unconsciousness, allowing the patient to rest comfortably, but to be aroused.

3. Interdisciplinary Evaluation
Palliative sedation is a medical treatment. As such, there must be a physician with expertise in palliative care leading the intervention. Suffering at the end of life, however, is a phenomenon that may respond best to the efforts of a highly skilled interdisciplinary team. As such, NHPCO recommends the practice of convening an interdisciplinary conference specifically about the use of palliative sedation for each patient with whom it is being considered. Such conferences should include practitioners from many disciplines who can speak to the modalities available in their disciplines and discuss the degree to which they have been tried and exhausted. Expertise is required in pharmacology; management of pain and other symptoms; and interventions targeted at the aspects of suffering that are psychological, interpersonal, spiritual, and other domains as relevant to each individual patient. In all cases, care must be patient- and family-centered.

4. Education
In addition to expertise in palliative care, those involved in palliative sedation must have training and competence in this particular intervention. As with all healthcare providers, those involved in the process of providing palliative sedation should be engaged in ongoing education. This education should address symptom assessment and management, as well as the
ethical considerations related to use of palliative sedation. Education must also address family-centered care.

5. Concerning Existential Suffering
Increasing discussion in the hospice and palliative care literature about the use of palliative sedation for existential suffering reflects the recognition that suffering can occur in all aspects of the person—even when physical symptoms are well controlled. As with any other type of suffering, NHPCO believes that hospice and palliative care professionals have an ethical obligation to respond to existential suffering using the knowledge, tools, and expertise of the interdisciplinary team. Whether or not palliative sedation should be a part of that response is an important, growing and unresolved question. Having carefully reviewed the data and arguments for and against using palliative sedation for existential suffering, the Ethics Committee is unable to reach agreement on a recommendation regarding this practice. NHPCO strongly urges providers to carefully consider this question, and supports further ethical discussion. NHPCO also encourages research within and across disciplines to build an evidence base supporting multiple interventions for existential suffering.

6. Relationship to Euthanasia and Assisted Suicide
Properly administered, palliative sedation of patients who are imminently dying is not the proximate cause of patient death, nor is death a means to achieve symptom relief in palliative sedation. As such, palliative sedation is categorically distinct from euthanasia and assisted suicide.
Putting the Statement into Practice
The commentary which accompanies the position statement discusses the indications for the use of palliative sedation, and provides an overview of ethical issues related to its use and the processes that could be implemented to address those issues.

The task force recommends that hospices create clear, comprehensive clinical policies concerning palliative sedation and educate appropriate staff regularly on (1) the availability, criteria, and procedure for palliative sedation; (2) the checks and balances in place to ensure the safety of sedation administration; and (3) the ongoing case review and quality improvement efforts to account for the rapidly changing evidence and practice recommendations.

The position statement and commentary were written to help guide hospices in this policy-creation process. Additionally, as a product of the NHPCO Ethics Committee, the statement and commentary provide rigorous overview of the ethical arguments for and against the use of sedation in different kinds of care environments and with different kinds of patients. Including this material should help hospices reflect on, discuss, and educate their teams, patients, families, and communities about the moral questions raised by palliative sedation and the strong arguments which, for example, distinguish the practice of palliative sedation from euthanasia.

Although intended as a guidance document, the position statement and commentary—like all NHPCO publications—are not intended to replace the thoughtful, well-informed, and lively interdisciplinary discussion and debate within each hospice that should be a significant part of the development of any organizational policies and practice standards.

The Specific Issues Addressed in the Commentary:
- Continuation of Concurrent Life-Sustaining Therapies
- Artificial Nutrition and Hydration
- Proximity to Death
- Level of Sedation
- Education and Clinician Support
- Palliative Sedation Distinguished from Euthanasia and Physician Assisted Death
- Frequency of Use
- Palliative Sedation and Existential Suffering
- Case Review and Utilization Review

To access the position statement and commentary, visit www.nhpco.org/communications

Timothy Kirk is an assistant professor of philosophy at City University of New York/York College and has served on the NHPCO Ethics Committee since 2007. In addition to serving as chair of the Palliative Sedation Task Force, he also chaired the task force that created the NHPCO position statement, “The Care of Hospice Patients with Automatic Implantable Cardioverter-Defibrillators,” released in 2008. Dr. Kirk chairs the hospice and palliative care affinity group of the American Society for Bioethics and Humanities, serves on the executive board of the International Philosophy of Nursing Society, and is ethics consultant to the Visiting Nurse Service of New York Hospice Care program.
About the NHPCO Ethics Committee

The Ethics Committee is one of nine standing committees of the NHPCO board of directors. It is comprised of one board member (who serves as the committee chair) and 15 to 25 volunteer members who are selected by the board from applicants who respond to NHPCO’s annual call for volunteers. Members of the Ethics Committee serve one three-year term, with the option to serve one additional term.

The committee’s primary goal is to identify, clarify, and address clinical and organizational ethical issues which arise in hospice and/or palliative care. In addition to this new position statement on palliative sedation, the committee has also developed the following documents:

- Position Statement and Call to Action on Access to Palliative Care in Critical Care Settings
- The Care of Hospice Patients with Automatic Implantable Cardioverter-Defibrillators
- Physician Assisted Suicide Narrative and Resolution
- Artificial Nutrition and Hydration Narrative and Statement
- NHPCO Code of Ethics

A PDF of each document can be downloaded from the NHPCO website (www.nhpco.org/communications). To learn more about the committee, including the roster of members, visit nhpco.org > About NHPCO > Committees & Task Forces.
As scrutiny of the hospice industry increases, so do the regulatory requirements. The Centers for Medicare and Medicaid Services (CMS) issued more than six change requests between November 2009 and April 2010 that directly impact hospice providers, and NHPCO has already issued 17 Regulatory Alerts in 2010. With this rapid-fire posting of change requests and other regulatory guidance from CMS, many hospice providers are confused and overwhelmed—and asking “is this the new normal?”

In this ever-changing environment, hospice providers need to be both knowledgeable and vigilant about these compliance issues. To assist members, this article recaps some of the recent issues and clarifications from CMS—grouped together by topic area.

Physician Narrative in Certification and Recertification of Terminal Illness

**Background:**
The 2010 Medicare Hospice Wage Index, effective October 1, 2009, requires physicians who certify or recertify hospice patients as terminally ill to include a brief narrative explanation of the clinical findings that support the life expectancy of six months or less. CMS added this requirement in an effort to increase physician accountability in the certification and recertification process. NHPCO was pleased that CMS clarified that only one physician must provide a “brief narrative” to accompany the initial certification, rather than both the hospice medical director and the patient’s attending physician.

**Member Inquiries:**
In response to member inquiries, NHPCO asked CMS if a physician must provide an oral narrative as part of an oral certification/recertification, if the written certification/recertification cannot be completed within two calendar days. CMS published the following response (CMS, Q&A ID 9969, 01/10):

“The oral certification/recertification should state that the patient is terminally ill with a life expectancy of six months or less, if the illness runs its normal course. Currently, we [CMS] do not require the narrative to be provided orally at the same time as the oral certification/recertification. However, we would remind certifying/recertifying physicians and hospices, that while the narrative (verbal or otherwise) is not required as part of the oral certification/recertification, the essence of what the written narrative will ultimately entail in its explanation of...
the clinical findings that support a life expectancy of six months or less, is expected to be the basis for the oral certification/recertification. While a verbal narrative is not required as part of the oral certification/recertification, the written narrative is required prior to filing a claim.”

For further information, read the NHPCO Regulatory Alert (01/22/10).

**Physician-related Billing Changes**

**Attending Physician’s NPI for Validating Hospice Part B Payments**

CMS issued Change Request (CR) 6540 on November 27, 2009. It requires hospice providers to report the National Provider Identifier (NPI) of the attending physician or nurse practitioner in the attending physician field on notice of election and hospice claim forms with effective dates and dates of service on or after April 1, 2010. (The original implementation date was to be January 2, 2010, but as a result of NHPCO dialog with CMS, the federal agency extended the implementation deadline to April 1.)

**Midstream Changes in Attending and Certifying Physicians**

On January 7, 2010, CMS provided clarification on CR 6540 concerning the process for identifying midstream physician changes on hospice claim forms:

- For midstream changes in the “attending” physician, hospices should report the attending physician that exists at the end of the billing period of that particular claim. At this time, CMS is not requiring changes to the “attending physician” on the notice of election.

- For midstream changes in the “certifying” physician, hospices should report the physician who actually certified the beneficiary for the hospice benefit period reflected by the services on the claim. If the billing period spans more than one hospice benefit period, the hospice should report the physician who certified the beneficiary for the latest, most recent hospice benefit period reflected on the claim. At this time, CMS is not requiring changes to the “certifying physician” on the notice of election.

**Elimination of Physician Consultation Codes for Medicare Payments**

Per CR 6740, physician consultation codes are no longer recognized for Medicare Part B payments as of January 1, 2010. Physicians must code patient evaluation and management visits with E/M codes that represent where the visit occurs and identify the complexity of the visit performed.

In response to NHPCO’s request for clarification on this change request, CMS issued additional guidance: (1) hospice services provided by physicians must use the most appropriate E/M codes to bill for E/M services, and (2) CPT consultation codes are no longer valid for hospices, even when physician services are provided under Medicare Part A.

For further information, read the NHPCO Regulatory Alert (02/26/10).
Other Billing Changes

Additional Visit Details on Hospice Claims

Background:
The requirement to provide additional visit details on hospice claim forms was issued by CMS as CR 6440 in April 2009. It requires hospice providers to report additional details as follows:

- For all routine home care, continuous home care and respite care billing, Medicare hospice claims should report each visit performed by nurses, aides, and social workers employed by the hospice.
- In addition to the actual number of visits, the time spent during each visit must be reported in 15-minute increments, on a separate line.

Member Inquiries:
Several aspects of CR 6440 generated questions and concerns among members. NHPCO requested clarification from CMS both prior to and following its January 1, 2010 implementation date. Here is clarification concerning documentation time, phone calls by social workers, and the format for reporting charges.

Documentation Time
Some providers ask staff to spend time on documentation during the course of a patient visit. For example, those using electronic medical records may record patient data in the medical record as the patient is being assessed. In these cases, members wanted to know if the documentation time must be backed out of (or excluded from) the visit time reported.

Per CMS, when documentation time occurs during, and as part of, an otherwise covered and billable visit to a patient, it can be included in the time reported for the visit. Documentation time which occurs outside the context of such a visit is not reportable.

For further information, read the NHPCO Regulatory Alert (12/01/09).

Phone Calls By Social Workers
On February 2, 2010, CMS acknowledged that phone calls by social workers make regarding care coordination can be reportable on the hospice claim form—in addition to the time spent counseling family members.

This issuance is a change from the CMS response on January 27, 2010 which stated that only calls to the patient and family should be recorded on the claim form. NHPCO had earlier discussions with CMS about the scope of the social worker’s role in hospice—and all of the possible calls a social worker might make on a patient and family’s behalf—and asked CMS to consider a broader interpretation. NHPCO was pleased that CMS took the recommendation into account and published this latest issuance.

For further information, read the NHPCO Regulatory Alert (2/19/10).

Format for Reporting Charges
In response to inquiries from members and software vendors, NHPCO asked CMS for clarification on the format to be used for reporting charges on hospice claim forms. Here, CMS provides some latitude: Charges can be listed as either (1) a total charge only or (2) in 15-minute increments.

While each hospice may select either format and follow that format on all of its claim submissions, NHPCO strongly encourages hospices to report charges in 15-minute increments and to be vigilant about reporting the charges accurately. Hospice payment reform is on the agenda for federal policymakers and the information on claim forms—including charges—could be used to evaluate different payment options in the future.

For further information concerning these issues, read the NHPCO Regulatory Alerts: 01/27/10 and 04/07/10.

Associating Hospice Visits With the Level of Care on Hospice Claim Forms

Background: CMS issued CR 6791 on January 29, 2010 requiring that hospice providers report separate line items for the level of care being provided each time the level of care changes. The requirement applies to all claims submitted on or after April 29, 2010 and includes revenue codes 0651 (Routine Home Care), 0655 (Inpatient Respite Care) and 0656 (General Inpatient Care). Per this requirement, hospice providers are required to report visits, as well as social work phone calls and their intensity, for nearly all hospice days billed, for each line item date of service.
What prompted this change request? When a hospice patient had different levels of care within a given month, it was sometimes not clear on the claim form which visits or calls were associated with each level of care being reported—and obtaining this information is vitally important to CMS. Per the federal agency, having this visit data will better reflect the services provided to Medicare hospice beneficiaries, and may be used in research conducted for possible future payment reform. Thus, for the data to fully serve its purposes, the visit or call must always be associated with the level of care being billed. For example:

If a patient begins the month receiving routine home care, followed by a period of general inpatient care, and then later returns to routine home care all in the same month, in addition to the one line reporting the general inpatient care days, there should be two separate line items for routine home care. Each routine home care line should report a line item date of service to indicate the first date that level of care began for that consecutive period.

For further information, read the NHPCO Regulatory Alert (02/03/10).

**Ambulance Transport**

In CR 6778, CMS clarified when hospice providers are responsible for the payment of ambulance transports:

- The hospice is responsible when ambulance transports of a hospice patient are related to the terminal diagnosis and occur after the effective date of election.
- The hospice is not responsible when ambulance transports occur on the effective date of the hospice election (i.e., the date of admission), but prior to the initial assessment and prior to the plan of care's development. (Per the S&C 09-19, Advance Copy-Hospice Program Interpretive Guidance Version 1.1, the initial assessment must be conducted in the location where hospice services will be provided, and the plan of care must be developed from that initial assessment and the comprehensive assessment.)

CR 6778 applies to all claims submitted on or after July 6, 2010.

CMS has updated the Medicare Benefit Policy Manual (CMS Pub. 100-02) to reflect this clarification. For further information, including the relevant excerpt from the manual, read the NHPCO Regulatory Alert (02/26/10).

**Medicare Advantage and Hospice Claims**

Per CR 6778, effective July 6, 2010, the Medicare Common Working File (CWF) will allow claims to be processed for both the Medicare Advantage Plans and Medicare hospice services that occur on the date of the hospice election. This will prevent Medicare hospice services provided on the date of the election from being rejected as Medicare Advantage Plan responsibility. Providers that have claims being disputed may resubmit their claims on or after July 6 to the appropriate FFS Medicare contractor for payment consideration; however, contractors will not be required to provide automated adjustments.

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Continuous Care Hours
CR 6778 also provided a technical correction regarding the calculation of continuous care hours, stating that “nursing care must be provided for more than half of the period of care.” “More than half” is best understood by example:

Continuous care must be provided for at least eight hours in a 24-hour period, beginning and ending at midnight. Care is calculated and billed in 15-minute increments. If the care is provided for eight hours, that would be 32 15-minute increments. Thus, nursing must be provided for at least 17 15-minute increments.

This change is effective July 6, 2010, and the Medicare Benefit Policy Manual (CMS Pub 100-04, Section 30.1) has been updated to reflect it.

Site of Service
Revisions to the level of care and sites of service have also been made—and will become effective July 6, 2010. These changes will help ensure that levels of care are allowed at a specific site of service.

The chart shown below lists the Q-codes for hospice care that is provided in various care settings.

<table>
<thead>
<tr>
<th>Site Where Hospice Care is Provided</th>
<th>HCPCS Site of Service Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Home/Residence</td>
<td>Q5001</td>
</tr>
<tr>
<td>Assisted Living Facility</td>
<td>Q5002</td>
</tr>
<tr>
<td>Nursing Facility¹</td>
<td>Q5003 (should be reported when a hospice patient receives unskilled care from the nursing facility staff in a nursing facility. Q5004 (should be reported when a hospice patient receives skilled care from the nursing facility staff of a skilled nursing facility.</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Q5005</td>
</tr>
<tr>
<td>Inpatient Hospice Facility</td>
<td>Q5006</td>
</tr>
<tr>
<td>Long-term Care Hospital (LTACH)</td>
<td>Q5007</td>
</tr>
<tr>
<td>Inpatient Psychiatric Facility</td>
<td>Q5008</td>
</tr>
<tr>
<td>Other Site (i.e., not otherwise specified [NOS])</td>
<td>Q5009</td>
</tr>
</tbody>
</table>

¹ Patients receiving GIP care require a skilled level of care from the staff of a “skilled nursing facility” and, as such, CMS regulations do not permit hospice patients to receive GIP care in a nursing facility.

Service Code for Hospice Patients Receiving Routine and Continuous Home Care
As noted in the chart below:
- Site of Service Code Q5006 should be used when a hospice patient is receiving routine home care while residing in an inpatient hospice facility.
- Site of Service Code Q5009 should be used when a hospice patient is receiving routine home care or continuous home care while residing in a residential hospice facility.

CMS issued this clarification on April 9, 2010—and also noted that this instruction may change as it considers adding a new site of service code for hospice home care provided in hospice facilities.

Service Code for Hospice Patients in Nursing Homes and Skilled Nursing Facilities
On April 9, 2010, CMS also advised that:
- Site of Service Code Q5003 should be used when a hospice patient receives unskilled care from the nursing facility staff of a nursing facility.
- Site of Service Code Q5004 should be used when a hospice patient receives skilled care from the nursing facility staff of a skilled nursing facility.

This, too, is reflected in the chart below.
HITECH Requirements

The HITECH requirements became effective on February 17, 2010. HITECH stands for “Health Information Technology for Economic and Clinical Health” and calls for providers to update business associate contracts, breach notification, and other policies.

The HITECH provisions—which are part of the American Recovery and Reinvestment Act of 2009—codify and expand on many of the requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that protects the privacy and security of protected health information. HITECH changed the privacy and security landscape by imposing a direct legal obligation on the business associates of entities which are covered by HIPAA requirements (known as covered entities or CEs). Now, business associates of CEs must also comply with many new and existing requirements under the HIPAA privacy and security regulations. Further, HITECH imposes new data breach notification obligations on both CEs and their business associates, and enhances enforcement authority with respect to HIPAA violations.

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HITECH raises the stakes for complying with HIPAA, as potential civil monetary penalties have been increased and criminal penalties may now be levied against individuals. Previously, HIPAA violations were investigated and enforced through the U.S. Department of Health and Human Services (HHS) and the Department of Justice, but now each state attorney general also has authority to bring a HIPAA enforcement action. Note also that HITECH requires HHS to conduct mandatory periodic audits to ensure compliance.

Due to these new privacy and security requirements, current agreements should be updated to incorporate them. To assist members, NHPCO's legal counsel, Hogan and Hartson, LLP, has prepared a tip sheet that summarizes the requirements, offers compliance tips, and provides information about enforcement. To download the tip sheet, visit http://www.nhpco.org/files/public/regulatory/HITECH_tip_sheet.pdf.

2. **Hospice Related Services and Medicare Parts A/B:** Health Data Insights will be reviewing Medicare Part A and B claims paid on or after October 1, 2007 to ensure that no payments were made to any provider for services that were related to the patient’s terminal illness and, therefore, included in the hospice per diem rate.

The decision to audit this issue should prompt hospice providers to ensure that they are indeed assuming financial responsibility for all covered services related to the terminal illness and related conditions, including treatments, medications, equipment, supplies and other services. Medicare Part A or Part B providers whose claims are pulled for this audit may also be contacting hospice providers for guidance on determining who was financially responsible for the services rendered.

NHPCO expects that other RACs will be conducting the same or similar audits very soon. For further information, read the NHPCO Regulatory Alert (01/27/10).

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**Last But Not Least—RAC Scrutiny Begins**

The Recovery Audit Contractor (RAC) program is a cost-containment initiative mandated by Congress to detect and correct previous improper payments within Medicare programs while also identifying process improvements to reduce or eliminate future improper payments.

As May NewsLine goes to press, there are no RAC audits specifically targeting hospice providers; however, in January, Health Data Insights, the RAC for Region D, announced that it will be conducting two audits of the following hospice-related issues:

1. **DME While in Hospice:** DME services related to a hospice terminal diagnosis that are provided during a hospice period are included in the hospice payment and are not paid separately. Health Data Insights will review DME provider claims, paid on or after October 1, 2007, to determine whether payment was made to the DME provider for services provided to hospice patients that were related to the patient’s terminal diagnosis and, therefore, paid for in the hospice’s per diem rate.

2. **Hospice Related Services and Medicare Parts A/B:** Health Data Insights will be reviewing Medicare Part A and B claims paid on or after October 1, 2007 to ensure that no payments were made to any provider for services that were related to the patient’s terminal illness and, therefore, included in the hospice per diem rate.

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_Judi Lund Person is NHPCO’s vice president of compliance and regulatory, and serves as the key contact and liaison with CMS. She began her career as a volunteer coordinator and has nearly 30 years of experience in the end-of-life care field._

_Jennifer Kennedy is NHPCO’s director of compliance and regulatory, and has worked in the hospice field for over 15 years, including 10 years as a hospice nurse and five years as director of education, quality and compliance._
Keep Current on the Changes

Be sure to follow the NHPCO Regulatory Alerts that are emailed to members as compliance issues change.

The alerts are also posted on the NHPCO website: www.nhpc.org/regulatory.
More than 50,000 American veterans die each month. Many may have received hospice care without the benefit of having their service—and its impact on their lives—known. Others may have had no idea what hospice was or how it could help.

Fortunately, some hospice providers are taking steps to identify who among their patients are veterans, so they can tailor plans of care to better meet their needs. Others are improving access through outreach in their communities. In this article, Ray Weglarz, a longtime hospice nurse and advocate for veterans, shares his experience on ways we can help bridge the gaps.

8 Ways to Improve Access and Care for Veterans

By Ray Weglarz, RN, CHPN
My decision to attend nursing school 34 years ago was largely due to the influence of a Vietnam veteran named Mike.... I had completed my high school work a semester early and had just turned 17 when I enrolled in the local community college. Fortunately, I was befriended by Mike and four of his friends who were all Vietnam veterans and took me under their wing. Mike soon became one of the most positive male role models in my young life. He had just completed a tour of duty as an Army field medic in Vietnam and, while he admitted that it was “tough work,” he often reflected on how meaningful and rewarding it was. Now, back home, he had enrolled in the college’s nursing program—and after two years of general studies, I decided to do the same.

I have now practiced nursing for over 30 years in a variety of care settings, including hospitals, home care and hospice. Yet, until four years ago, I had not given much thought to whether the patients I served were veterans—or how their experiences in the military might impact their healthcare needs.

That changed in 2004, when I received a call from Jeff Towns, president/CEO of the Michigan Hospice and Palliative Care Organization. Jeff, in his upbeat and gracious manner, asked if I would serve as the hospice provider representative for the Upper Peninsula of Michigan—on the newly formed Michigan Hospice Veterans Partnership (HVP). At the time, I was the hospice program manager for the Keweenaw Home Health and Hospice in Calumet, Michigan and, with the encouragement of the hospice administrator, I joined the Michigan HVP (see sidebar at right).

The experience of working collaboratively with the Department of Veterans Affairs (VA) and both VA and hospice providers opened my eyes to the special end-of-life care needs of our nation’s veterans. It also reinforced the importance of identifying if patients are

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_About HVPs_

Hospice Veteran Partnerships are coalitions of VA facilities, community hospices, and others working together to ensure that excellent care at the end of life is available for our nation’s veterans and their families.

These coalitions can be community-based or statewide, and may function independently or within an existing structure.

Information about HVPs, including a helpful HP/VA 101 Toolkit, is available on the NHPCO website: [www.nhpco.org/veterans](http://www.nhpco.org/veterans)
veterans, so that knowledge can help inform their plan of care.

Based on my experience, here are eight steps that may help your organization improve access for the veterans living in your community:

1. Routinely track referrals and admissions—and identify which patients are veterans. Use the one-page Military History Checklist (available at www.nhpco.org/veterans) to identify basic but valuable information, such as branch of service, in which era or period the patient served, and whether he/she is enrolled in the VA and receives VA benefits. Enter the information into your program’s database and make certain the information is shared with interdisciplinary team members. A two-page Military Checklist Guide, also available on the NHPCO website, explains why asking each of these questions is important to case coordination and the plan of care.

2. Educate management and clinical staff on veteran end-of-life care resources. In addition to information on the NHPCO website (www.nhpco.org/veterans) and VA website (www.va.gov), contact your state hospice organization to see if your state has formed a Hospice Veterans Partnership. It can be an excellent source of information.

3. Appoint a key member of your hospice interdisciplinary team to serve as the point person for questions and information on veterans’ issues. The individual can also serve as an ambassador and “care link” between your organization and VA organizations and resources. For example, many veterans may be eligible for VA benefits even if they are enrolled in hospice through a non-VA payor source. I can recall one veteran who was eligible to receive VA-funded private duty aide assistance for 24 hours each week while enrolled in our hospice program—which complemented our services and provided respite for his family caregiver.

4. Visit—and develop a relationship—with your local VA community based outpatient clinic and the physicians, nurses and other staff who are responsible for hospice and palliative care referrals. Inform them of your program’s services and service area; this will help you and them.

5. Visit—and develop a relationship—with your county veterans service officer (VSO). While I was the hospice program manager for Keweenaw Home Health and Hospice, outreach to our local VSO led to a lunch-and-learn session for our entire hospice team, with the VSO coming out and presenting very useful information on veterans’ issues. For example, until that session, we had no idea that our local VSO made home visits to assess and support veterans who were not able to travel due to illness.

6. Visit your local VA Medical Center (VAMC) and make a point of meeting with members of the palliative care team to learn about their referral process and preferences, while also updating them about your program’s services.

7. Speak to your local veteran service organizations. Since joining the Michigan HVP, I have spoken at numerous chapter meetings of the Veterans of Foreign Affairs. This led to an invitation to speak at its annual conference—and the chance to educate hundreds of veterans about hospice care. For a list of these organizations, visit http://www1.va.gov/vso/.

8. Finally, feature articles and stories in your organization’s newsletters that draw attention to the ways in which your organization can serve the needs of veterans. Encourage your organization to support or participate in community veteran-related events and celebrations.

Many veterans are not aware of the wonderful resources available to them through hospice just as many hospice providers are not aware of the special needs of veterans and their families near the end of life. We have the ability to bridge these gaps and honorably serve those who have served our country by implementing these steps.

Ray Weglarz has been a registered nurse for 34 years and has spent the last 17 years in hospice and end-of-life care, most recently as hospice program manager for Keweenaw Home Nursing & Hospice in Calumet, Michigan. He is the author of “On the Way Home: Living with Terminal Illness,” and is a co-founder, volunteer and board member of Omega House, a community based hospice house in Houghton, Michigan. He is currently working as a consultant, in the areas of staff training, program development and community outreach. He can be reached at weglarz@up.net.
Veterans Benefits for Dummies
By Rod Powers
Saving veterans and their families from months of phone calls and internet searches, Veterans Benefits For Dummies outlines the various programs that the VA and other government agencies have in place as well as the procedures for filing applications, claims, and appeals for these benefits which include: health care; ongoing care for wounded and disabled vets; education assistance; vocational rehabilitation; life insurance; home loan guarantees; pensions; survivors’ benefits; and burial benefits.
Softcover: 384 pages
Item #: 821577
Member: $17.99
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War and the Soul: Healing Our Nation’s Veterans from Post-Traumatic Stress Disorder
By Edward Tick
Describes how truly to heal war trauma in veterans, their families, and communities. Drawing on history, mythology, and soldiers’ stories from World War I to Iraq, it affirms the deep damage war does to the psyche and addresses how to reclaim the soul from the effects of war.
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Chicken Soup for the Veteran’s Soul: Stories to Stir the Pride and Honor the Courage of Our Veterans
by Jack Canfield, Mark Victor Hansen, and Sidney R. Shapiro
A collection of true-life experiences of extraordinary men and women who changed the course of history by their acts of valor in World War II, the Korean War, Vietnam and the Persian Gulf War. Their experiences offer a glimpse of timeless history, revealing moments of compassion, bravery, respect and reverence.
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The Complete Idiot’s Guide to Your Military and Veterans Benefits
By Lawrence J. Webber, Kathryn L. Webber
The U.S. Armed Forces exists in a reality all its own. Members are fed, paid, clothed, housed, and protected in a way few other American citizens can claim. This book explains how to reclaim their families with low-cost insurance, and earn a lifetime pension before they turn 40 years old. In fact, military life offers many benefits and perks, it’s hard for the average serviceman or woman to keep track of them. Finally, here is a guide that explains the benefits and how to obtain them. Inside, readers will find:
• Clear and precise explanations of active duty family benefits
• Details on veteran education and medical benefits
• A money-saving guide to discounts for both active duty personnel and Veterans
Softcover: 432 pages

Peace at Last: Stories of Hope and Healing for Veterans and Their Families
by Deborah L. Grassman
This book takes the reader on a journey of understanding and growth. While caring for thousands of veterans in a hospice setting over a 25-year career in a VA hospital, the author gathered the veterans’ stories of pain and redemption, personal awakening, and peace. Designed to help caregivers, family members, and veterans themselves understand the impact of war and military culture on lives and emotions.
Softcover: 272 pages
Item #: 821582
Member: $17.95
Non-Member: $19.95

Once a Warrior: Wired for Life
By Bridget C. Cantrell and Chuck Dear
This book illustrates how to turn negatives into positives and assists our highly-trained military personnel in utilizing their tremendous potential in achieving success and happiness after their released from military service. This book highlights the path along the way to transitioning from warrior to civilian. It is not a book to read just once, but one to study over and over again.
Softcover: 126 pages
Item #: 821583
Member: $14.99
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Forgotten Veterans
by Stephen M. Reay
The poignant story of The Forgotten Veterans is told by the principal character, a Vietnam veteran himself, who has a first-hand understanding of the horrors of combat and the challenges faced by young men and women trying to return to their civilian lives, jobs and families. A chronology of real events, simple by themselves, but put together in context by one who experienced hospitalized veterans problems first hand. This book forms a meaningful and timely testimony for the need to preserve America’s commitment to all of its veterans, particularly those whose lives have been wounded forever.
Softcover: 134 pages
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Ambiguous Loss: Learning to Live with Unresolved Grief
by Pauline Boss
This book defines and explores ambiguous loss, a common and painful condition. Typified by a sense of “frozen grief,” it can occur when a loved one is taken away (through desertion, divorce, or abduction) or can no longer respond (owing to mental or emotional loss or injury). This thorough and compassionate study, written in clear, non-technical language, serves as a guide to those trying to cope and get on with their lives.
Softcover: 176 pages
Item #: 821584
Member: $17.00
Non-Member: $20.00

For more information
CALL 800/646-6460 GO TO WWW.NHPCO.ORG/MARKETPLACE
Pet Peace of Mind

A New Program with Free Start-up Funding for Nonprofit Hospices
For many people, their pets are more than pets—they are members of the family. So, what happens when someone requiring hospice care can no longer care for their pet and has no family member or friend who is able or willing to lend support?

As hospice programs look to more ways to provide patient- and family-centered care, a relatively new program, sponsored by the Banfield Charitable Trust, can be a valuable addition to their services—Pet Peace of Mind.

The Pet Peace of Mind Program was launched in May 2009 with the primary purpose of helping hospice programs keep patients and their pets together while the patient is receiving hospice care. It was designed by a hospice chaplain/veterinarian who recognized the significance of the relationship between hospice patients and their pets—and the positive impact these pets have on a patient’s overall well being.
How the Program Works

The Banfield Charitable Trust, a 501(c)(3) organization, will provide the following funds and program materials to help non-profit hospices get started:

- $5,000 grant to fund pet-care related goods and services for patients’ pets
- The following complimentary materials to assist with implementation:
  - Online training for hospice staff who will serve as the program’s coordinator(s)
  - Training materials for the volunteers and staff who will participate
  - A comprehensive manual that includes a brochure about the program and sample forms, plus marketing and fundraising materials to help fund the program beyond the start-up grant
  - Program support from the Banfield Charitable Trust during the grant-application process as well as before and after the program’s implementation

Currently, there are six hospices which are offering the program, with five more scheduled to launch within the next three months. As Terri Roberts, director of volunteer services for Columbus Hospice (Columbus, GA) notes on page 23, the Pet Peace of Mind Program is a wonderful way to utilize volunteers—and attract more volunteers.

Hospice volunteers can provide the in-home pet care that is needed, along with handling the pet-food delivery and transportation to and from veterinary and grooming appointments—all with funding support from the program and, thus, at no cost to patients and families.* The Banfield Charitable Trust also encourages hospices to network with both community pet-care organizations and volunteers to provide homes (or foster homes) for the pets upon the patient’s death if there are no family or friends who are able to care for the animal.

Pet Peace of Mind Project Manager, Dr. Delana Taylor McNac, who is a former hospice chaplain and a veterinarian, is passionate about the program and the benefits it brings to hospice patients and their families during a time of crisis. “Anyone who has owned a pet knows their animal is a source of unconditional love,” she notes. “They don’t care how we look, or what we’ve done or fail to do, and they consistently offer affection and approval, often when we need it most. So it’s not difficult to understand the important role pets can play in the lives of the terminally ill.”

To learn more about the Pet Peace of Mind Program, visit the program’s website (www.banfieldcharitabletrust.org/Pet_Peace_Of_Mind) or contact Dr. McNac via email (delana.taylor-mcnac@banfieldcharitabletrust.org) or phone (503-922-5683).

A short, informational video about the program is also available on YouTube: http://www.youtube.com/user/thebctrust#p/a.

* Volunteer hours spent assisting with pet care in the patient’s home (including transportation to and from veterinary and grooming appointments) can be counted toward the 5-percent volunteer service requirement under the Medicare Hospice Conditions of Participation.

continued from previous page
Columbus Hospice was one of the first programs to participate in the Pet Peace of Mind Program. We often have patients who need help taking proper care of their cat or dog—and through this groundbreaking program, we have been able to relieve them of this worry.

In addition to physical impairments that can impact a patient’s ability to care for his or her pet, some also lack the financial resources in light of medical expenses related to their illness. Under the Pet Peace of Mind Program, vaccinations, grooming and flea control, pet supplies such as food and cat litter, spaying and neutering, and pet medications are all covered. Through the program, we have also been able to partner with local rescue groups to help place the pets after their owner dies.

Word about the program has spread quickly throughout our community. An article in our local newspaper about Pet Peace of Mind produced a flurry of phone calls from readers who wanted to help by contributing to the cause. Local veterinarians and groomers have also contacted us, offering their services at a discount. In fact, as a result of the interest, we have not only developed a page on our website about the program, but have also included a link for donations.

A side benefit of the program has been the ability to grow our volunteer base through outreach to animal lovers in our community. At the same time, these volunteers provide a sense of reassurance to our patients and their caregivers—who know these volunteers can understand and appreciate the special bond they have with their pets.

Mr. Koutsky is a Columbus Hospice patient under home care. Because of the program, he and his wife have been able to keep their beloved cat, Buffy, at home—and that has brought them tremendous joy. “He lies on my lap for hours…. I love his company” he said.

Terri Roberts
Director of Volunteer Services
Columbus Hospice
Marie Alvarez Named Executive Director for Samaritan Care Hospice of Florida

Marie Alvarez, MBA, RN, has been named executive director for Samaritan Care Hospice of Florida (Orlando, FL), with responsibility for the organization's strategic vision, day-to-day activities, and its clinical and administrative operations.

Prior to joining the organization, Alvarez was executive vice president for the healthcare consulting firm, CHS Partners. During her 14-plus-year career, she has also served in a number of clinical and executive leadership positions with such organizations as Vitas Healthcare Corporation, Mercy Hospital, and Humana Health Plans.

Visiting Nurse Association of Southeast Michigan Names New Administrative Director

Visiting Nurse Association of Southeast Michigan (Oak Park, MI) has named Margaret Wisniewski the administrative director of hospice, with responsibility for driving business operations, including compliance with state and federal regulations.

Wisniewski’s career encompasses all aspects of hospice care—from direct sales to administration. In her most recent position, she served as an administrator for Heartland Hospice in Southfield, Michigan. Currently, she is also an adjunct faculty member at Madonna University and Cleary University, in the fields of hospice education and healthcare administration.

National Center Hosts Hospice and Palliative Care Coalition

The National Center for Care at the End of Life—home to NHPCO and its three affiliate organizations—served as host site for the March meeting of the Hospice and Palliative Care Coalition.

NHPCO, together with the American Academy of Hospice and Palliative Medicine, the Center to Advance Palliative Care, the Hospice and Palliative Nurses Association, and the National Palliative Care Research Center, formed the coalition to help inform and guide discussions with policymakers and regulators on key issues affecting end-of-life care. While health care reform has been a top agenda item, the group also reviews and monitors other issues with potential impact on providers. As one example, the coalition was instrumental in the FDA's revised decision concerning its “opioid recall” in April 2009.

In addition to occasional face-to-face meetings, such as the March session at the National Center, the coalition holds monthly conference calls to strategize on issues of common concern.
Three Programs Collaborate to Serve Community Needs

Hospice of Martha’s Vineyard (HMV) and Vineyard Nursing Association (VNA) have welcomed Island Hospice to their community as the first Medicare-certified hospice offering residents access to the hospice insurance benefits to which they are entitled. Island Hospice (IH) is a program of Hospice & Palliative Care of Cape Cod, established expressly to bring the Medicare hospice benefit to Martha’s Vineyard residents.

Through a spirit of collaboration and contractual staffing agreements, patients may receive care from HMV from the point of diagnosis. Upon becoming eligible for either skilled homecare or certified hospice services, patients may access those services using their insurance benefits through IH. Due to the cooperative staffing agreements and shared volunteer services, continuity of care relationships are preserved as patients and families are transferred from agency to agency.
Free E-Online Course: The Nuts and Bolts of Run to Remember®

- Learn how to use NHF’s Run to Remember® to raise money for your program.
- Program founder and national director Stuart Lazarus provides step-by-step instructions.
- Register at www.nationalhospicefoundation.org/EOnlineRTR and you are on your way.
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For more information, visit www.runtoremember.org
E-mail Stuart Lazarus, Run to Remember National Program Director at stuart@runtoremember.org

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Experience the ACHC difference
The best way to keep informed of the changes occurring in the hospice and palliative care field is to take advantage of NHPCO’s diverse range of educational offerings.

Our goal is to ensure that you and your colleagues are better informed and better able to deliver quality end-of-life care to all members of your community.

To learn more about our upcoming national conference, our series of timely webinars, and our E-OL distance-learning courses, just click on the tabs above.

For full details, please visit the NHPCO website:

www.nhpco.org/conferences.
This Memorial Day, as we honor the men and women who have died while in uniform, NHPCO extends special thanks to those members who are helping to improve end-of-life care for our nation’s veterans. (For helpful guidance on serving the veterans in your community, see page 16.)
In 1999, FHSSA was established around the central concept of US hospice organizations partnering with African hospice or palliative care programs to form a partnership based on sharing professional expertise, resources, and international relationship building and collaboration. Now in our 10th year of the partnership program, FHSSA has coordinated the formation of more than 80 partnerships between hospices in 30 US states and 13 countries in Africa.

In recognition of 10 years of the FHSSA partnership program, we set a goal to reach 100 FHSSA partnerships in 2010. With the assistance of the African Palliative Care Association and national hospice and palliative care associations across Africa, we hope to identify and foster the establishment of 15 new partnerships. If your program has thought about forming a partnership but hasn’t made the commitment, now is the time to pair with an organization across the ocean and become part of FHSSA’s campaign for 100 partnerships.

The Partnership Experience: The Denver Hospice and Selian Hospice

Each partnership is unique in their relationship, leveraging resources and expertise from throughout their community. The following report from Lisa Motz-Storey, Chaplain and African Hospice Liaison at The Denver Hospice, highlights some of the successes and experiences that a FHSSA partnership can bring.

“In February 2010, a group from The Denver Hospice visited our partner, Selian Lutheran Hospice in Tanzania. We rode along on visits, helped with a day clinic, and were the guests of honor at a huge Grand Opening celebration and fund-raiser to dedicate the new Selian Hospice Office. The Denver Hospice and our co-partner, Exempla Lutheran Hospice raised the money for the building, so they wanted to dedicate it while we were there. The Denver Hospice has been partnered with Selian since 2001. We have had three visits to Selian, and have hosted seven Selian staff to visit us in Denver.

To share the work of Selian hospice does, included are excerpts from correspondence back home during our most recent visit:

“On Thursday, we started out with the Hospice Team for devotions at the new office, then visited three patients. The first was Tatu, a widow 45 years old with 7 children. All but the youngest are living with other people. The 3-yr-old lives with her. This was a tough one for our group to see, as she lives in a rented room made of dirt and sticks with a tin roof, about 5 feet square. It’s almost pitch dark—no windows, dirt floor. … But the hospice team brings some food staples, and checks on them. Her volunteer visits twice a week. She is grateful . . .

On Friday, we went to the office to prepare for a Day Clinic (they call it Day Care) for patients in a village. The Orphan and Vulnerable Children (OVC) program meets at the same time, so the orphans can support one another. They set up stations for patients to meet with staff to review symptoms and receive medications. The kids went outside, and we played group games and sang songs with them. After the afternoon of games for kids and consultations for adults, everyone received food and clothing to take home. There’s just so much need. Those who are sick are even worse off than others, because they’ve often sold their animals to pay for medical care, and they have no means of generating income. On the positive side, so many of them enjoyed playing, interacting or having their nails painted. A relaxing day with medical, spiritual, social, and nutritional support.”

Continued on next page…
Our partnership is an integral part of our hospice. Staff are involved in many ways. New staff members comment that they can’t believe we are doing such amazing work in Africa, even though we are a non-profit ourselves! Our experience as a FHSSA partner has been so positive, I recommend it to every hospice, and am always happy to share our experience.”

Becoming a FHSSA Program Partner

As a FHSSA partner, the US hospice organization commits to a lasting relationship. In this relationship, each partner must:

- set a fundraising goal of at least $5000 per year
- establish a partnership committee composed of a diverse group of individuals from your organization
- communicate with your partner regularly
- visit your partner or bring them to visit your program in the US within the first two years
- complete a yearly report provided by FHSSA

Each African partner commits to the following:

- communicate with your partner regularly
- visit or host their partner program within the first two years
- provide accounting for all partnership funds sent by FHSSA both in yearly report to FHSSA and confirming receipt of wired funds

In turn for your commitment to a FHSSA partnership, FHSSA provides the following services:

- a partnership toolkit to get your organization started with partnering
- established resources on topics such as communication, trip planning, and fundraising
- personalized assistance and mentoring for any question or concern that may arise
- secure wiring of funds and follow-up services for all partnership funds sent to Africa
- a 10 year history and combined knowledge from our partners in the US and Africa regarding best practices in partnering

Not ready to commit to a partnership? FHSSA has many small project opportunities available for your help. Some examples of these projects include: raising money for a hospice vehicle, supporting caregivers and volunteers by providing home based care kits, special projects, or other support.

For more information on how to become a FHSSA partner or other ways you can become involved contact Erin Nanney, Program Coordinator, at enanney@fhssa.org or call 703-647-5176.
To mark FHSSA’s tenth anniversary, honor our partners, commemorate significant achievements, and celebrate a bright future, the National Hospice Foundation hosted an open house “From Alexandria to Africa…the IMPACT of 10” on Friday, March 26, 2010.

The event featured an evening reception where supporters of FHSSA, old and new, came together to learn and share each other’s experiences. FHSSA and NHF shared our office with approximately 75 guests, raising $7,200 for the FHSSA Impact Fund.

Thank you to the generous sponsors!

First Class Travelers ($510)
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- Trina and Dave Lucas
- Old Town Hilton
- Pork Barrel BBQ/Mango Mike's
Looking to the future, FHSSA is working to update our image. At NHPCO’s Management and Leadership Conference in April, FHSSA launched our new website design. The new website will enable FHSSA supporters and partners, present and future, to easily access information about FHSSA. Features of the new site include a news headline, a section for each type of FHSSA partner (program, global, and supporting), detailed information on our programs in Tanzania and Zimbabwe, and ways that you can get involved with FHSSA.

In conjunction with the website, FHSSA also launched our more active presence on Facebook, Twitter, and YouTube. By becoming a fan of FHSSA’s Facebook page, a follower of FHSSA on Twitter, and watching FHSSA on YouTube, you can stay in touch with FHSSA and remain up to date on what FHSSA is doing and where we are going.

Further working to match our image and message, our mission and vision have been revised to shape FHSSA’s path into the future. Our vision now coincides with that of NHPCO and its other affiliates “A world where individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.” Our new mission is “Building partnerships to enhance compassionate care in Africa.” Along with these new organizational ideals, we are now officially doing business as FHSSA, which we are using in our new logo.

Now in our 10th year of operation, FHSSA has recently released our 10 year report. This document chronicles our last 10 years as an organization, who FHSSA is now, and where we look to go in the future and includes financial reports from 2008 and 2009.

Please take the time to visit FHSSA’s new website, Facebook page, Twitter feed, YouTube page, and to read our 10 year report to find out how you can stay involved with FHSSA.

You Can Leave a Legacy to Support FHSSA

You have proven that you want to make a difference in the world by supporting FHSSA’s work now. Learn how you can extend your commitment and leave a legacy for those who have the greatest need. It might be through your will or it might be through a Charitable Gift Annuity. Please visit the updated section of FHSSA’s website to see how you can make a gift that costs nothing now. Visit FHSSA’s website or call Maureen Lilly to talk about your dreams and wishes for FHSSA 877-470-6472.