On Tuesday morning, I found myself sitting at our large conference table, colleagues on either side, ready to hear a presentation about innovation and potential partnership. A cadre of consultants sitting across the table begin to present their colorful PowerPoint slides full of aligned boxes and knowing arrows. As I listened to the pitch, it became clear—while no one has ever done it before, they know exactly how to make my company part of an Accountable Care Organization (ACO). I sat in curious amazement as I listened to discussions about certifications, cornerstones and “solution accelerators,” and finally it dawned on me that this scene was playing out across the country as providers try to figure out what an “ACO” really means. There are people sitting in countless conference rooms right now listening to the unproven and self-proclaimed “answer” about how to create an ACO—and that scares me.

I should declare my bias right away. I have spent a significant amount of time struggling to bring several ACOs to life in the last few years. Along with a team from Dartmouth and Brookings,1 I worked on getting five ACO pilots with commercial payers continued on next page

Accountable Care Organizations:
What You Should Know and the Role You Can Play

By Julie Lewis

Inside

A Message From Don
NHPCO President/CEO, Don Schumacher, shares some additional thoughts on ACOs and the role of hospice in this new model.

Keeping Our Promise: Assessing Pain and Suffering
Demonstrating our exceptionalism in addressing both pain and suffering is especially important now. Gary Gardia discusses why, but also explores the many aspects of suffering and provides specific questions you can ask patients and families to help with an assessment.

Hospice in the Continuum
Over the past 15 years, Samaritan Healthcare and Hospice has introduced a Transitions program, community-based grief counseling, geriatric care management, and palliative care for children and adults. President/CEO Mary Ann Boccolini answers key questions about its expansion.

The Voice of NCHPP
How do you get to know—and engage—a 24-year old developmentally disabled patient when the usual methods don’t work? Sally Cobb discusses a recent case at HPCG’s Beacon Place.

Plus...

• NHPCO’s Executive Scholarship Program
• Circle of Life Award: Call for Nominations
• “Seasons of Caring” Ads Win the Gold
• Member News and Notes
• Regulatory Tip of the Month
• NHPCO Educational Offerings
off the ground (with varying degrees of success), aided in the development of an initial set of performance measures for ACOs, and worked on some of the early dissemination around the ACO idea.

You might think that the ACO model is all roses and rainbows in my mind, and I have to admit that you would be partially right. However, working with potential ACOs also has the opposite effect: the challenges become clearer and more pronounced. When I started working on ACOs several years ago, the idea was mostly unknown. The persistent momentum of healthcare reform moved the concept of ACOs into the limelight in a hurry. Groups like the National Committee for Quality Assurance jumped to develop a certification program, Premier developed an Accountable Care Collaborative, and consultants and lawyers nationwide tried to figure out how to operationalize this new model. Before we had a defined model, we had groups trying to certify and sell it.

The release of the proposed rule by the Centers for Medicare and Medicaid Services (CMS) only made the situation worse. I had no less than 26 emails during the week the rule was released that advertised calls, Webinars, and meetings that would tell me “everything I needed to know” about complying with the CMS rule. We all got pulled down into the weeds, trying to understand the minutiae, before we understood the vision.

In our early efforts to define a “how to” plan for executing an idea called ACOs, I had the great privilege to travel around the country meeting with healthcare systems. I met with providers and payers, including hospitals, physician groups, independent physician associations, integrated systems, provider associations, state governments, and commercial insurers to talk about ACOs. I think it’s safe to say that I have seen nearly every possible reaction to the ACO model (food was thrown at one point), but mostly I saw unease, confusion, and fear (sometimes healthy, sometimes irrational). The reactions weren’t surprising. Whenever we run across something new and so complex, it is natural for us to want the formula, to want the roadmap to success. With the ACO model, we just aren’t there yet.

**Take a Step Back**

It is time to take a broader view and address some key questions. Who should be an ACO? Who shouldn’t? What’s the shared savings threshold ACOs talk about? What are the quality measures? Do I need new IT systems? Should I get certified as an ACO?

Before any of these questions should be discussed, we need to talk about the reason and the vision behind ACOs. If you don’t have a vision, you aren’t going to be successful as an ACO, regardless how attractive the rules are. Building a successful ACO means transformational change for you and for your partners. But, how about the bad news first? It won’t be pretty, it won’t be easy, and you will want to give up. You will constantly be wrestling against the comfort of the
ACOs: Some Additional Thoughts

There has been quite a buzz about Accountable Care Organizations since they were included in healthcare reform legislation. ACOs are a new and innovative model for care delivery that is being applied for the first time to Medicare.

This month’s cover article will help you understand a bit more about ACOs. We are honored to have Julie Lewis—one of the nation’s leading experts on the subject—share some insight with us. In April, Julie presented on this topic at an NHPCO board meeting, and also joined me on an executive leadership call about ACOs on May 11. So it seems a perfect time to share more expansive information about ACOs with the field. In addition to this NewsLine article which includes some suggested resources, I want to offer a couple of thoughts:

• Hospice and palliative care providers have an attractive range of services that ACOs would want to have available to their participants.

• Working with an ACO affords hospice and palliative care providers an excellent platform to help broaden their reach.

• Due to the many restrictions and the complexity of the proposed regulations, it is unlikely that many hospice providers will be able to serve as an organizing partner of an ACO; however, the opportunity to contract with an ACO in their service area is well worth exploring.

One frequent question I’ve gotten from members is whether participating in an ACO will change reimbursement. Unlike bundled payment models, the ACO model envisions continued use of the current Medicare reimbursement structure.

In early June, NHPCO submitted comments to the Centers for Medicare and Medicaid Services on the ACO proposed rule. That comment letter is available as a PDF on the NHPCO website.

I am interested in your thoughts about ACOs and what activity you might see in your area, so please feel free to share any developments with me—dschumacher@nhpco.org.

J. Donald Schumacher
President/CEO
status quo, misaligned financial incentives, and the realization that one person’s waste is another person’s income. In the middle of the transformation, it will be your belief in your vision that will pull you through.

**Consider the Backdrop**
We have an unsustainable healthcare system. How many times have you heard that? Now the real question—do you really believe it? It is difficult for us to truly understand the magnitude of the situation. Whether you hear $2.5 trillion in spending, 20 percent of our gross domestic product, or $1 trillion in waste every year, most of us are at a loss when it comes to understanding the magnitude of those numbers or what it means for the fiscal health of our country. And those numbers don’t even scratch the surface on topics like quality and patient safety.

Our current payment model has created an almost unmitigated propensity to “pass the buck” on the problems within our healthcare system. Whose problem is it? If you are a patient, it’s your crumby insurance company with co-payments and deductibles or pre-authorizations. And after all that, they still raise your premiums each year, and you watch a larger portion of your income go out the window. You might also blame the providers, who are never available when you are (e.g., nights and weekends) and who certainly never talk to each other to coordinate your care. If you are a physician, it’s the fee-for-service (FFS) payment system forcing you to cram more patients in each day, it’s the malpractice environment forcing you to practice defensive medicine, or it’s the insurance companies constantly denying claims and requiring dozens of unnecessary forms to be completed. If you’re a business trying to provide healthcare, the problem is the insurance companies which really aren’t managing any risk at all, because every year your premiums keep going up. And finally, if you are the insurer, it’s the providers who are “gaming” the payment system to ramp up volume and intensity to pad their wallets, and it’s patients who can’t put the Big Mac and Marlboro Lights down. That doesn’t even touch on how you feel about health reform. So, who’s right? Everyone. Who’s problem is it? Everyone’s.

We also shouldn’t forget that we have many wonderful accomplishments to pay for as well. Our elderly population is expanding, and our average life expectancy is increasing. We have also made extraordinary, if expensive, breakthroughs in medicine. Whether it is care of premature infants or our fight against cancer, new breakthroughs are allowing us to save and extend lives. Too often we assume that these are the interventions that must be cut. On the contrary, we need to cut out every ounce of waste and efficiency so we can provide these treatments to patients in need.

**ACOs—An Opportunity**
We don’t like to think about our healthcare system as a “single payer system,” but I assure you, it is. You and I are the only payers. Whether it’s our tax dollars for Medicare, Medicaid or uncompensated care or our foregone income that allows our company to buy health insurance, we are the only payers. Where does the ACO fit into all of this?

The ACO is an opportunity. It’s not perfect, it’s not the silver bullet, it’s not the answer (yet)— but it is an opportunity. The challenges and unsustainability of our healthcare system aren’t going away. The ACO (or an ACO-like model) is our opportunity to try and “get it right.” For the innumerable critics of the ACO,
I say, give me something better. Is the ACO model going to look the same in a year? In five years? I certainly hope not. If we are successful, it will be much better than it is today.

The ACO Model
While many healthcare stakeholders would call the ACO model “disruptive,” is it truly a disruptive innovation? The ACO model is very much built on ideas (and lessons) from the past. We have learned that fee-for-service payments to providers incent increased services and that silo-based payments (e.g., one payment to the hospital, one payment to the physician, etc.) lead to uncoordinated care. We have also learned from reform attempts that have gone before us. Whether it’s moving to diagnosis-related group (DRG) payments for hospitals or the rise of managed care, there have been many reform attempts to better align incentives and integrate care. The ACO model aims to take another step toward a sustainable healthcare system.

As with any new innovation, it is nearly impossible to credit one person or one group with its inception. Instead, it took many people, both in policy circles and on the ground, to continually refine and improve the ACO concept.2-5

What Makes an ACO an ACO?
While a discrete definition of an ACO still remains undefined, there are a few core elements that characterize an ACO.6

Local Providers
An ACO is comprised of local providers who organize in an effort to be accountable for total spending and quality for a defined patient population. That is a “100,000 foot” view of an ACO. But, what exactly do those words mean?

At its core, the ACO model is about care delivery. An ACO has to leverage the best components the care delivery system has to offer, be mindful of resources, and generate accountability. Therefore, providers (e.g., physicians, hospitals, home care, hospice) are the organizers. This is not to say that challenges like patient engagement and insurance reform shouldn’t be addressed—or even that they won’t eventually

The Motivation for ACO Development:
Healthcare costs are rising at an unsustainable rate.
Fragmentation in our system is leading to increased costs.
Primary care providers are not incented to coordinate care of complex patients.
The current FFS payment model does not align incentives among healthcare stakeholders.
Medicare beneficiaries in the FFS program must be able to maintain choice (at least for now).
Most providers are not equipped to manage insurance risk.
The majority of physician providers work in small practices.
Providers cannot be incented with efficiency without simultaneous quality measurement.
Healthcare is local.

continued on next page
be addressed in an ACO—but, by design, the ACO model is aimed at reforming our care delivery system.

The CMS proposed regulations have specific criteria for ACO providers and suppliers. In most models, physicians are the required component of an ACO. In other words, a hospital cannot be an ACO unless the hospital has employed or contracted physicians. Similarly, an insurance company cannot be an ACO alone; it has to have employed physicians.

Should an ACO include providers other than physicians? Absolutely. There is no need to re-learn the lesson that a “gatekeeper model”—a model by which primary care physicians serve as a gatekeeper to the rest of the healthcare system—does not work. Volume-driven incentives outside of the ACO are too strong for any one group to offset. The ACO must adopt an “everyone wins together or everybody loses together” strategy. Individual provider incentives must be aligned with the goals of the ACO.

There is no such thing as the “right” group of providers for an ACO. Participation will be driven by local relationships, shared vision, and local challenges. One question that often arises from providers is, “do I have to choose one ACO to partner with (to the detriment of other relationships)?” Putting aside local market factors, the answer is generally “no.” While there might be other reasons for a provider to participate in a single ACO, there is only one technical reason: Physicians who are used to assigning patients to an ACO can only be part of one ACO, and this will mostly apply to primary care physicians. Some ACOs will include physician specialists, and post-acute, home care, and hospice providers who participate in multiple ACOs. An ACO might also contract with multiple hospitals. Given the diversity of health care delivery in our country, it’s likely that many different models will prosper.

What will these provider organizations look like? There are a few common elements found in most ACO models. The ACO likely has to become a legal entity. Each individual provider may still receive customary FFS payments, but the ACO entity would receive any payments (and bear risk) for the ACO. In rural areas, the ACO might be a “virtual” collaboration of providers over hundreds of miles. In other areas, the ACO might be a “bricks and mortar” structure with all providers under one roof. There are dozens of variations, and no right answer.

**Accountability for Total Spending and Quality**

In the current FFS payment environment, incentives to providers are not aligned with the goal of payers to manage costs or with the goals of patients to receive high-quality, patient-centered care. Our silo-based payment system encourages inefficiency and waste, as providers are not encouraged to share information and coordinate care.

Accountability in the ACO model is based on aligned incentives across silos while still maintaining a FFS payment structure (at least in the short term). There are a few mechanisms that can be used to increase accountability, including shared savings arrangements, in which providers get to keep a portion of savings; shared savings plus risk, which generally refers to providers who not only have the opportunity to share in the savings but are also at risk for some portion of overspending; and, partial capitation, which allows providers to receive upfront
payments for a portion of care for which they bear the financial risk.

The type of financial arrangement should be based on the ACO’s experience with managing risk, as well as its infrastructure and ability to prospectively manage patient populations. The idea of partial capitation (or the word “capitation,” in general) resurrects painful memories for most providers. While there are a number of potential ACOs accustomed to managing risk, most groups are not. Therefore, multiple types of financial arrangements should be available to potential ACOs.

Much attention has been paid to Medicare’s participation in an ACO model. Clearly, Medicare is an important component, but many commercial insurers are also exploring innovative models. A successful ACO will likely include multiple payers, because it will be easier for the ACO to make changes in infrastructure and personnel if all (or the majority of) care is delivered under an ACO-like payment model.

A lot of air-time is devoted to the payment mechanisms for an ACO, but the quality measurement component is equally important. An ACO’s accountability lies in both cost and quality, and ACOs will be continuously (and increasingly) measured on their performance. A decrease in quality means reduced shared savings payments to the ACO.

Measuring quality in the ACO has the same tradeoffs as measuring provider quality today. A balance between comprehensive measurement and the burden of collection is always difficult. Our country’s current lack of an electronic, interoperable healthcare infrastructure makes clinical data collection difficult. Today, quality measures that rely on claims data are frequently preferred—though often clinically weaker—because they do not require chart abstraction, an expensive, laborious task.

Limitations in measuring ACO performance remain, but the increasing push toward health information technology and increasing emphasis on performance measure development and testing will help this progression.

**Defined Patient Population** Getting patients “into” an ACO is one of the most sensitive issues in ACO policy development. Questions include a few general themes:

- Will the patients choose to be in an ACO?
- Will patient incentives be aligned?

There is no such thing as the “right” group of providers for an ACO. Participation will be driven by local relationships, shared vision, and local challenges.
For which patients will providers be accountable?

How to communicate with patients is an unanswered question. The CMS proposed rule leans toward an “opt-out” strategy for patients who are potentially aligned with an ACO, but there are many options for patient engagement. Hopefully, through pilots, we will gain a better understanding of how and when patients should be informed and educated about “their” ACO.

It is likely that Medicare ACO programs will not provide incentives for beneficiaries to participate. In the private sector and in future Medicare programs, we could see patient incentives such as tiered co-pays and deductibles based on lifestyle choices or on which providers the patient chooses. The lack of reliable data on provider cost and quality make this a difficult task today, but the concept is well established, including the use of reduced co-pays for generic versus brand-name drugs.

In many models, claims data is used to assign (or, per CMS, “align”) patients to an ACO. Generally, primary care physician visits are used as a proxy for where the patient’s care coordination is currently taking place. The ACO with the most primary care visits is then assigned the patient and becomes accountable for that patient’s overall costs and the quality of his/her care. Another option is to simply ask patients which physician or network they consider their primary provider. This approach has the benefit of patient “buy-in,” but it does not necessarily reflect the patient’s utilization pattern.

### Potential Areas for ACO Savings:

- Reduction/conversion of unnecessary capacity (e.g., excess hospital beds, imaging machines).
- Restructuring of primary care practices.
- Comprehensive, continuous care for high-utilizers, including coordination and health coaching.
- Management and coordination of end-of-life care.
- IT investment that supports care coordination, waste reduction, and standardized care.
- Emergency room diversion to outpatient and home providers.

### Making an ACO Work

While the description above addressed the components of an ACO model, it does not explain how an ACO achieves savings. Again, this is where the vision and mission come in. Each ACO will have to examine its current infrastructure, processes, and personnel to develop a strategy for savings. Getting the ACO established will be hard work, but it is only the beginning of the process. Lack of resources will force a new, fledgling ACO to analyze opportunities for the largest impact based on the characteristics of the organization. The ACO will have to focus its resources and effort.

### ACO vs. Medical Home vs. Bundled Payments

Health care reform included many potential reform programs, including ACOs, bundled payments, and medical homes. The question is, are we going to throw all of these reforms at the wall and see what sticks? Or, are we going to design a well-coordinated approach to paying for healthcare? Though far from decided, let’s assume the latter for our purposes.

ACOs, bundled payments and medical homes are not mutually
exclusive. In fact, they function better together than apart. The medical home has evolved in the last few years, but it was originally designed as a state-of-the-art primary care practice to coordinate care and receive an additional payment for doing so. While there is no doubt that primary care financing needs a major overhaul, additional payments without accountability for costs and quality is concerning. However, if your medical home resides in an ACO, now you have both.9

Bundled payments are more of a conceptual model than a reality at this stage of development, and many challenges to implementation exist.10 That being said, bundled payments hold great promise because of their ability to align incentives toward efficiency and coordination across providers. They may also serve as a building block for groups of providers interested in moving toward an ACO model. A procedure-specific bundle typically has very discrete aspects of care and definable time elements that allow for appropriate attribution of measures, resource use and accountability. The challenge with this type of bundle is that incentives are only aligned inside of the bundle. Care outside of the bundle is still potentially uncoordinated, and the incentive still exists to increase the number of bundles you provide.

As we think about defining condition-specific bundles, new challenges arise, including increased complexity (e.g., a patient with heart failure, diabetes and behavioral health conditions) and lack of a well-defined episode. As we try to create episodes for patients with multiple chronic conditions, we might find ourselves right back in an ACO-like financial structure as it becomes more difficult to assign a bundle to a specific provider and the costs for each condition become more difficult to untangle.

Your Role in an ACO

ACOs are going to be developed differently depending on the local environment, which means that your role in an ACO is also dependent on the environment. There will be highly-motivated, innovative ACOs that are immediately interested in tackling end-of-life challenges with you as a partner. In these ACOs, you need to be at the table as a full partner and offer innovative, “out-of-the-box” solutions.

However, many ACOs are still trying to find their way. Predominately led by physician and hospital organizations, these groups are trying to figure out how to “clean up” their house...
before they turn externally for partnership opportunities. Or worse, they are trying to achieve vertical integration by integrating low-cost providers into the highest-cost settings.

For the ACOs that are not as forward-thinking, focus on being an ACO supplier. The more data you collect on your performance and quality, the better story you have to tell. Data on the local market, including end-of-life costs in the region, as well as current use of the hospice benefit, could be useful information to the ACO and increase your value as a partner. If your task is to show the benefit of your hospice specifically, you need data on areas of interest to the ACO—specifically on cost (or a proxy such as hospital admissions), quality and patient satisfaction.

Final Thoughts
The challenges to successful implementation of an ACO model are innumerable, and naysayers are more than willing to elaborate on the problems. So why do it? Why try to become part of an ACO model?

I have four reasons for you to think about.

The Challenges:

1. **Control Over Your Reimbursement Destiny:**
   If you believe the argument that our current system is unsustainable, then you likely believe that change is coming. ACOs are our opportunity to move toward a system based on value and efficiency. If it fails and the government needs to act, history tells us that “change” will look a lot more like deep, across-the-board cuts to our current fee-for-service system.

2. **First-mover Advantage:**
   Businesses and government programs will begin to push patient volume toward high-quality, efficient providers. The providers starting down the path now are more likely to be able to take advantage of opportunities when the tipping point is reached. In addition, those organizations that participate while ACO programs are nascent and voluntary will have the opportunity to shape the final programs.

3. **Sustainable Healthcare:**
   Whether you are thinking about your future great-grandchildren or the health of your business, there are millions of good reasons to keep the U.S. healthcare system healthy. A system based on efficiency and quality will allow more care to be delivered for the same amount of healthcare dollars and will slow the growth of future expenditures.

4. **It’s Right for Patients:**
   A focus on care coordination, patient experience, and efficiency leads to better patient care. Expensive care is often dangerous care. Care coordination could result
in fewer duplicative tests, medical errors, dangerous medication interactions, and general confusion on the part of patients and caregivers. In short, we should be creating a system that we would want to experience as a patient.

**Resources and Reading**

The citations below provide valuable reading on the concept and policy surrounding the ACO model. In addition, Atul Gwande has two *New Yorker* articles that can help you understand the current challenges we are facing.

The articles are much easier to read than a MedPAC report and produce a similar effect: *The Cost Conundrum: What a Texas Town can Teach Us About Health Care* (June 1, 2009); and *The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?* (January 24, 2011).

*Julie Lewis is currently the vice president for health policy at Amedisys, Inc.*

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**References:**

1. The Dartmouth Institute for Health Policy & Clinical Practice and the Engelberg Center for Healthcare Reform at the Brookings Institution.
8. The Patient Protection and Affordable Care Act of 2010.
11. [www.dartmouthatlas.org](http://www.dartmouthatlas.org) provides information on the average cost of care for the last two years of life by hospital.
I recently received an email from the National Association of Social Workers. The subject line read: “Budget Cuts Potential to be Large for Human Needs Programs.” Is that a surprise to you? Our national deficit is now somewhere over $14 trillion and we all know cuts have to be made somewhere—but should hospice care be cut? Personally, I believe the answer is yes “if” end-of-life care can be provided just as well somewhere else. Or, to say it another way, “if the care we provide has become redundant.” But, let me explain.....
Imagine that it’s possible to remain totally objective for a moment. Wouldn’t we all agree that if cutting hospice reimbursement rates—or even eliminating hospice altogether—would be in the best interest of this country, then that is what we should do? The truth, however, is that we do not believe this to be true. Instead, we hold tight to our passion for this work because we have all experienced the profound difference that it can make. We have witnessed firsthand the outcome of the vision we all share for quality end-of-life care.

So what then about budget cuts? Would you not agree that we could be facing our own 11th hour if something isn’t done soon? Time is truly of the essence. We can sit back and wait for our government leaders to do something about it or we can take action into our own hands. How do we do that? We do that by making certain it is clear that hospice care is not redundant, and by consistently demonstrating exceptionalism in all areas of end-of-life care. We are not just another version of care focused on the medical needs of the person who is ill. We distinguish ourselves by focusing on seven goals:

- Providing holistic care that utilizes the biopsychosocial and spiritual model;
- Addressing the needs of the patient and her/his family;
- Assisting patients and families in designing—and achieving—their best possible end-of-life experience;
- Guiding, supporting and empowering patients and families through the process of understanding their experience;
- Utilizing highly skilled and well-coordinated interdisciplinary teams;
- Ensuring that teams are guided by the patient and family’s goals; and
- Aggressively addressing both pain AND suffering.

Eric Cassell, MD, MACP, describes suffering as distress brought about by the actual or perceived impending threat to the integrity or continued existence of the whole person. Suffering can include physical pain, but it
is by no means limited to it. For the sake of this discussion, I will use the word “pain” to describe the experience associated with the state of the physical body and the word “suffering” to describe the experience associated with psychological, emotional, social and spiritual distress.

**Demonstrating Our Exceptionalism**

Our commitment to address both pain and suffering through the expertise of an interdisciplinary team may hold the key to demonstrating our exceptionalism. Read over the following statements and see where you stand:

- I/we are effective at guiding patients and families through a process that enables them to articulate their own goals and design their best possible end-of-life experience.
- Our plans of care are used as a guide for team members in order to assist patients and families to achieve their goals. Team members use the plan as their guide.
- Our team meetings are interdisciplinary and effective. At the end of each meeting, all team members are aware of their specific role in addressing both pain and suffering.
- We understand that for some patients and families, addressing suffering is their primary concern/need and we flex our care in order to meet that need.
- We are as aggressive (from time of admission or first contact) at addressing suffering as we are at addressing the medical needs that are present.

In the first century BC, the author Publilius Syrus said, “The pain of the mind is worse than the pain of the body.” I believe we have all witnessed situations either personally and/or professionally where this is the case. Imagine a child who is being seriously abused but never beaten. We now know that, in many cases, emotional abuse (i.e., suffering) can be much more excruciating than physical abuse—for many reasons. One explanation is that emotional scars are not readily evident. When we see people who are suffering, there is a tendency to call them dramatic, difficult or even crazy. Isn’t it true that when someone is in obvious physical pain, we tend to be more tolerant and understanding even when their anger is directed at us?

### The Many Aspects of Suffering

As pain comes in many forms and has many different causes, so does suffering. There is the suffering we observe, such as the outward expression of grief, and there is suffering that is suppressed or hidden. Many of us have become very skilled at hiding away our suffering. Sharing our emotional distress with others is not always met with compassion and, in some cases, is perceived as weakness. It stands to reason then that assessing suffering followed by effective intervention requires a skilled and well-coordinated team, just as it takes a skilled and well-coordinated team to successfully address pain.

Let us take a look at some of the complexities of suffering. It is common to hear hospice folks say things like “hospice is not about giving up hope.” Try doing a search on the Internet using these words and see what you find. It appears a lot of energy is given to convincing folks that hospice is not about giving up hope, but is this really true? If you are the person who is told that a cure is no longer an option, how might you feel about the word “hope”? Would “hope for quality times with your family for your
remaining days” really be enough to replace a lifetime of experiences with them? If we are going to address the suffering that accompanies the loss of hope for a cure, we need to be certain that we have highly skilled teams available.

Consider for a moment the following questions: (1) How much time do you and/or your teams actually spend assisting people with redefining hope? (2) How successful are you? (3) How do you do it? For example, can you describe and demonstrate the skills necessary to assist people in addressing one of the great sources of suffering at the end of life—the loss of hope for more life?

Other causes of suffering are feelings of helplessness and the inability to find meaning or purpose. How many of us define ourselves, even if partially, by the work that we do? When we are no longer capable of going to work, but instead find ourselves incapacitated to some degree, we may feel quite helpless. For example, a person once said to me, “I was once a nurse, but now I am bedbound and unable to participate with family and friends in any kind of meaningful way. I am useless.” Feeling helpless at any point in our lives can certainly lead to intense sadness. In addition, we know that people who are able to find meaning in life’s events are more likely to achieve a higher level of “quality of life.” Isn’t that what we are all about? How effective are you in helping patients address their feelings of helplessness and find meaning or purpose in their lives? How often are you not effective and why?
According to NHPCO Facts and Figures: Hospice Care in America, the median length of service in 2009 was 21.1 days. This means that half of hospice patients received care for less than three weeks and half received care for more than three weeks. It is also reported that in 2009, 34.4 percent of hospice patients died or were discharged within seven days of admission. Just seven days! This means that for many people, we need to accomplish all of this in a very short amount of time.

The shorter the length of stay, the more difficult it will be to develop a patient/family centered plan and assist the family in achieving their definition of “a good death.” Shorter lengths of stay also mean it is more likely that the majority of care will focus on the medical needs of the patient and that our interventions will lean towards the medical model of care (i.e., to diagnose and treat). It also means we will be less likely to address suffering adequately.

But “less likely” does not mean impossible, and it does not necessarily mean we have to spend more money.

**Some Ways to Help Address Suffering**

Consider some of the following options:

- Take a look at your employee orientation and consider adding training on addressing suffering;
- Assess the effectiveness of teams and team communications;
- Make sure discussions in team meetings are truly interdisciplinary;
- Examine policies that may inhibit your ability to address suffering closer to the time of admission;
- Consider staffing models that include evening and weekend (and not just on-call) coverage;
- Get the most out of volunteers by providing quality orientation and ongoing education;
- Consider recruiting professional volunteers to assist with staff and volunteer skill development; and
- Never underestimate the critical nature and importance of nursing assistants!

Finally, let’s take a look at one method to quickly assess suffering.

Questions for the person who is ill:

1. Do you ever wish this were all over?
2. What do you hope for? (If the person says “a cure,” acknowledge this response and continue to explore it by saying “are there other things you hope for?”)
3. Besides the physical symptoms of your illness, what causes you the most concern? (Consider using other words, such as anxiety, discomfort, or distress.)
4. On a scale of 0 to 10, how would you rate this feeling? (0 being the absence of concern; 1 to 4 being mild concern; 5 to 8 being moderate concern; and 9 to 10 being intense concern.)
5. Compared to your physical pain and symptoms, which would you consider to be worse at this moment?
Questions for family members:
1. Do you ever think that life is not worth living now or after your loved one dies?
2. What do you hope for? (Again, if the person says “a cure,” acknowledge this response and explore “what else.”)
3. Besides your loved one’s physical symptoms, what part of all this is most distressful for you now?
4. On a scale of 0 to 10, how would you rate these feelings—or this distress? (0 being the absence of distress; 1 to 4 being mild distress; 5 to 8 being moderate distress; and 9 to 10 being intense distress.)
5. Which is worse for you right now, your loved one’s illness or these feelings you have just described?

The American socialist, Charles Horton Cooley, taught us that a person who shows signs of “mental aberration” is often shut off and isolated. According to Cooley, this person is frequently met with “curiosity, indifference, aversion, or pity…and he suffers pain and loss of a kind and degree which others can only faintly imagine, and for the most part ignore.” In end-of-life care, we have pain and symptom management down to a fine art. We also understand that the human experience encompasses more than our physical bodies. It is this understanding that makes hospice care, by definition, unique. It is up to us to make it exceptional.

Gary Gardia entered the hospice field more than 25 years ago as a volunteer, and has served in a variety of leadership capacities in the areas of social work, bereavement, education, and volunteer management. An active member of NHPCO, Gary is a frequent presenter at NHPCO conferences and serves on the faculty of the Hospice Manager Development Program.
Our hospice consultants have gained their understanding from years of hands on experience. We can assist whether you are investigating the feasibility of entry into the hospice market or in maximizing your organization’s performance.

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NHPCO’s National Council of Hospice and Palliative Professionals (NCHPP) is comprised of 48,000 staff and volunteers who work for NHPCO provider-members. Organized into 15 discipline-specific sections that are led by the NCHPP chair, vice chair and 15 section leaders, NCHPP represents the perspectives of the interdisciplinary team—the very essence of hospice care.

These individuals—together with each Section’s Steering Committee—volunteer their time and expertise to a variety of NHPCO projects to help preserve and develop the “interdisciplinary model” within the evolving world of hospice and palliative care.

In this NewsLine feature, we shine the light on a different NCHPP Section each month, so all members can benefit from each discipline’s perspective on important topics. It will also help members learn more about the work of NCHPP and how to get more involved—whether it’s taking better advantage of some of the Section’s free activities or joining a Section’s Steering Committee.

This month we spotlight the Allied Therapist Section, and an article by Sally Cobb....

continued on next page
When walking into one of the 14 rooms at Beacon Place, the adult residential facility of Hospice and Palliative Care of Greensboro (HPCG), the staff doesn’t usually find a patient watching an animated television show or thumbing through a notebook of trading cards. However, this was the case a few months ago if you were to walk into Wynton’s room.

Only 24-years old, diagnosed with an aggressive soft tissue tumor and developmentally disabled, Wynton was confined to his bed. His devoted grandmother rarely left his side, spending each night in his room and providing most of his care. Staff members were challenged to find ways to get to know him, as the usual ways of patient engagement were not available.

Soon after Wynton’s arrival, Pat Gibbons, the director and nurse manager for Beacon Place, invited Ernie Schiller, MD, a physician from HPCG’s pediatric program, Kids Path, to attend the weekly interdisciplinary meeting. The collaboration between teams provided expertise and insight into the mind and habits of this atypical Beacon Place patient, whose thoughts and behavior seemed to be more in line with a young adolescent’s.

Dr. Schiller shared that he had visited Wynton, toting a plant, soil and a container, and had invited him to “pot up” the plant to give to his grandmother. Wynton not only agreed, but successfully completed each step. Allowing the nonambulatory patient the opportunity to create something—and change his focus from being care receiver to gardener—opened the door for both the patient and staff.

As a horticultural therapist, I felt challenged to find other positive outlets for Wynton as I listened to Dr. Schiller share his experience and talk about the importance of a therapeutic alliance. “The prime step in forming a successful alliance is connecting with the patients and allowing them to reconnect or better connect with themselves,” he said. “Healing consists of bringing together those things within the patient that allow the
reintegration of the mind, body, and spirit.”

Would it be possible for nature to be one of the tools used to help Wynton reintegrate his mind, body and spirit? Upon hearing at our team meeting that he had been having nightmares, I imagined that nature might be the soothing stimulus that may allow peacefulness to crowd out some of the darkness in his life.

Later that week, after finding out that Wynton’s favorite color was blue, I entered his room with a cart. It was full of freshly cut flowers and leaves from our grounds; pictures of those same flowers and leaves; two notebooks that were blue, but of different hues; sheet protectors; vases; and a small watering can.

I explained that the flowers and leaves had been collected from our grounds and that there were pictures of each one on the cart. We held, touched, and smelled these gifts of nature, and created an arrangement for his room. Then we looked at the pictures of the flowers and leaves we had used.

I explained that each of these plants has a name, just like all of the people who work here and come into his room. I also noted how hard it is to remember the names of all the plants, in the same way it is hard to remember the people’s names. Finally, I asked him if he might like to make a notebook with the pictures of the plants, and invite staff who enter his room to pick their favorite plant and write their name, along with a little something about themselves, on the sheet beside it. He nodded yes and then chose the deeper blue notebook, along with his favorite picture, to slide into the plastic sleeve as the cover of his new “plant/people book.” Through the use of nature, this patient found a creative outlet and a new way to communicate with staff.

Next, Wynton and I talked about the possibilities of other creative activities, and I introduced him to two HPCG volunteers who I thought could help enhance his situation. Both volunteers, Gayle and Jean, readily agreed to be a part of the team. Gayle brought her drum and other musical instruments. Jean came equipped with her clay.

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In the days that followed, the Beacon Place staff cared for and supported both Wynton and his grandmother. Gayle, Jean and I spent time with them as well, allowing their worlds to expand into the creative realm. While Wynton napped, his grandmother helped me plant pansies for an outside plant shelf, created a clay piece of her own with help from Jean, and shared her love for her grandson with Gayle and other staff.

Wynton also taught us a few lessons. He helped us ‘think outside the box’ in terms of what else can be done to enrich a patient’s experience at the end of life. For example, under Pat Gibbons’ guidance, picture boards were posted at Beacon Place as visual reminders of simple, yet gratifying practices available to all of us—music, pets, flowers, bird-watching, a hand massage! One staff member graciously donated a Reverie harp, small enough for a patient to hold while in bed. A workshop was also held for volunteers to help them tap into their creative gifts as well as provide new ideas on how they can help patients find creative stimulation, whether that be at Beacon Place, in homecare, or at long term care facilities.

Wynton died earlier this year. However, his grandmother now has Wynton’s creative pieces, along with one that she had made during the last weeks of his short life, as a treasured remembrance of her grandson and their time together. These are gifts to look back on as reminders of what all of us in hospice embrace—that each life matters. As Cicely Saunders so beautifully said, “You matter because you are you…you matter until the end of your life.”

*Sally Cobb has been employed as the horticultural therapist at Hospice and Palliative Care of Greensboro in North Carolina since 2003. She currently serves on the Allied Therapist Steering Committee of NHPCO’s National Council of Hospice and Palliative Professionals.*

**NCHPP Allied Therapist Steering Committee**

**Section Leader**  
Valerie Hartman  
Holy Redeemer Home Health and Hospice Services  
Philadelphia, PA  
vhartman@holyredeemer.com

Richard Briggs  
Enloe Hospice  
Chico, CA

Lisa Browder  
Nathan Adelson Hospice  
Las Vegas, NV

Sally Cobb  
Hospice and Palliative Care of Greensboro  
Greensboro, NC

Russell E. Hilliard  
Seasons Hospice and Palliative Care, Inc.  
Des Plaines, IL

Karen Mueller  
Northland Hospice & Palliative Care  
Flagstaff, AZ

Laura Thomae  
Keystone Hospice  
Wyndmoor, PA

Barbara Trauger-Querry  
Hospice of the Western Reserve, Inc.  
Cleveland, OH

*as of June 1, 2011*
Get Involved

One of the easiest ways to get involved in the NCHPP Allied Therapist Section (or any NCHPP Section) is to utilize NHPCO’s professional networking site, My.NHPCO.

Each NCHPP Section has an eGroup (much like NHPCO’s old listserves, but better). Just visit the My.NHPCO website and see “Getting Started” in the top right corner of the homepage.

Information about NCHPP is also available on the NHPCO website: www.nhpco.org/nchpphome.

Horticultural Therapy: Learn More

The website of the American Horticultural Therapy Association provides information on how professionals can obtain training in this area, including details on the AHTA-Accredited Certificate Programs. Visit www.ahta.org.
In this monthly feature, NewsLine shines the light on a hospice provider which has introduced or expanded services and, in so doing, is forging earlier relationships with patients and families while also improving its bottom line.

“There is nothing more valuable than forming these early relationships,” says NHPCO President/CEO Don Schumacher. “My hope is that every provider will find both inspiration and guidance from the information shared.”
this past May, Samaritan Hospice, based in Marlton, NJ, changed its name to Samaritan Healthcare & Hospice. “Our new name is a better reflection of who we are today,” says president/CEO, Mary Ann Boccolini. “It reflects our expanded mission to offer a range of care options for patients and families before they may need hospice.”

Samaritan has certainly taken that mission seriously. Over the past 15 years, the organization has introduced several care options to complement its traditional hospice services, including a Transitions program; grief counseling through a community-grief center; a geriatric care management program; and palliative care services for both children and adults.

In the following interview, Boccolini answers some key questions about Samaritan’s experience to help those programs considering similar expansion.

**Your organization is clearly one of the frontrunners in thinking outside the ‘Medicare Hospice box.’ What was the first service you offered and what prompted the decision to take that step?**

Our first non-hospice service was our Center for Grief and Loss which opened in 1999. We had already been offering the required 13 months of grief counseling and support to families of our hospice patients, but realized that people who had not used our hospice services could benefit from our staff’s expertise. So, we opened up our services to anyone in the community who was coping with a loss.

Now called The Center for Grief Support, it offers individual and family counseling on a sliding fee scale, a range of free grief support groups geared to different losses, what we believe is the area’s only therapeutic play/grief support group for three-to-five year olds, and even pet loss. We also do much work within our local school systems. This includes grief education, and onsite support groups and debriefings for traumatic losses such as teen suicides, prom-related car crashes, and the death of beloved teachers. We also provide PTSD counseling for active-duty military as well as veterans and their families.

**Quick Facts About Samaritan Healthcare & Hospice**

- Founded in 1980.
- Serves five counties in southern New Jersey, covering more than 2,000 square miles.
- Employs 290 FTEs and 450 volunteers.
- Average daily hospice census in 2010: 358.
- Opened Center for Grief and Loss and launched the Transitions program in 1999.
- Opened the Institute for Education and Research in 2002.
- Introduced SeniorWise Care Management and Samaritan Palliative Partners in 2009.
- Expanded Palliative Partners into a physician practice in 2011 and renamed it Palliative Medical Partners.

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After taking that initial step, what other ‘non-hospice’ services followed?
In 1999, we also introduced a Transitions program to provide options, resources and support for those patients in our community who have a progressive illness, but do not yet meet the criteria for hospice care. It’s a volunteer support system that is offered at no charge both during and after curative treatments, and helps patients connect with community resources and services. Each Transitions client is also offered the companionship and support of a trained volunteer.

Then, in 2004, we added a program with palliative and hospice services for those living with end-stage heart failure. Many people in the community still believe that hospice care is solely for cancer patients, so this program helps dispel that myth. It also takes into account, with specially trained staff and cardiac-specific protocols, that the trajectory of heart failure—with its ups and downs and frequent hospitalizations—is not necessarily the same as a cancer patient’s journey. That same year, working with the renowned Children’s Hospital of Philadelphia, we also introduced a pediatric palliative program, serving newborns and children through age 18.

In 2009, we expanded our services again with the introduction of SeniorWise Care Management, a non-hospice, fee-for-service geriatric care management program. Headed by a certified geriatric care manager, this program offers comprehensive in-home assessments and follow-up care coordination for frail elderly seeking to remain safely and independently in their homes for as long as possible.

That year, we also introduced the first model of our adult palliative care program, Samaritan Palliative Partners. While we’ve just made some significant enhancements, this early program was limited to home-based services. Samaritan contracted with a company for nurse practitioner services to provide pain and symptom management for patients who were not eligible for hospice care. These patients also received the benefits of our Transitions’ volunteer support and referrals to community services.

What enhancements have been made to Samaritan Palliative Partners? And what prompted them?
This year we renamed the program “Samaritan Palliative Medical Partners,” and made some significant changes. It is now a palliative physician practice which is staffed by our own dedicated team, comprised of a physician, nurse practitioner, social worker and program coordinator.

We believe that the physician-practice model engenders the highest level of respect from patients, families and other physicians, which provides the greatest opportunity to support each patient’s personal treatment goals. As a patient with heart disease would be referred to a cardiologist, a patient with pain and other distressing symptoms would benefit from referral to a palliative medical specialist. Consultations are now available in the hospital and long-term care facility as well as at home.

The decision to make these changes was really prompted by several factors—the growing need we are seeing for non-hospice, hospital-based palliative medicine as well as healthcare reform’s
focus on coordinated community efforts to reduce unnecessary hospitalizations and improve the quality of care.

**What level of investment was required to transition to the fully staffed Palliative Medical Partners? And how is the program funded?**

The development of these programs was an outcome of Samaritan’s extensive strategic planning process. Once the many expansion opportunities were evaluated, Samaritan’s investment began with a thorough analysis of the external and internal factors required for success. Samaritan realigned its physician team and dedicated the services of Chief Medical Officer Stephen Goldfine to the Palliative Medical Partners service. We added nurse practitioner and social worker positions. Administrative, financial and marketing systems were developed to support the program through existing departmental staff and resources. Program expenses are covered by budget allocations and public support; physician and nurse practitioner consultations are reimbursed by Medicare and many commercial insurers.

**Would you recommend that providers today take a similar first step before taking on this greater investment?**

I recommend strategic evaluation and analysis of any expansion investment to determine what is the best path for each organization. Feasibility studies are required to confirm the need for new or expanded services, and the organization must develop strong operational and growth plans to support and sustain the expansion efforts.

**Can you also share the level of investment required in offering the SeniorWise geriatric program? For example, is it a stand-alone program? Do you reap cost savings by utilizing your hospice staff?**

After confirming the need and analyzing growth potential, Samaritan was prepared to invest in the SeniorWise program by recruiting a certified geriatric care manager and aligning existing resources to support program development, administration, and financial and marketing investments. As per the program model, expansion efforts at significant milestones have been carefully planned to support continuous growth and eventual self-sustainability.

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What are some of the primary funding sources for these initiatives?
Much support comes from memorial and tribute gifts from grateful families and friends, the creation of Loving Tribute Funds, and bequests. In addition, we receive grants from United Way, the Department of Military and Veterans Affairs, and various foundations. We also run three major fundraisers each year: a Celebration of Life gala in late February, a golf tournament in late June, and five Tree of Life celebrations during the first week of December. These fundraisers attract widespread corporate sponsorship. Over the last few years, we have also seen the growth of what we call “community fundraisers”—events run totally by community members or groups with the proceeds going to Samaritan. For example, this summer Samaritan will receive funds from a car show to benefit our outreach and service to veterans.

You noted that last year you received $1.25 million of community support to help fund essential services not covered by Medicare, Medicaid and private insurance. Do you think your expansion into non-hospice services has helped you gain financial support from the community?
As a locally based hospice, Samaritan works hard to build and maintain strong community roots. Over the last 31 years, we estimate that our programs have embraced more than 50,000 families coping with illness and grief. So, first and foremost, we believe that the quality of our programs and the compassion of our care contributes to grateful families and friends wanting to give back to help others who will need the same services they just received. For example, this has resulted in specific support for our Center for Grief and our Transitions program. And, while the full scope of our broadened continuum has only been in place since January 2011, early indicators are that it is being well received by our community, which we feel will help continue and extend this support. With increased access to more services by more people, we definitely feel that Samaritan has broadened its base of support.

You also opened an Education Institute in 2002 to “advance understanding and practice.” Has the Institute had a positive ripple effect on improving the community’s perceptions about your services?
We believe it has. The impact of our educational outreach is evident in Samaritan’s growth, both in the number of people served and the services we offer. We’re proud to be in the top five percent of hospices nationwide which admit more than 1,500 patients per year. The Institute offers evidence-based training for our own staff to keep their skills cutting edge, but we also offer a full array of continuing education programs, internships and field placements for our community’s healthcare professionals. This helps to build awareness for palliative and hospice care among current practitioners as well as the next generation of clinicians and therapists, including physicians. We also provide presentations for churches and community groups, veterans groups, and student groups to help create awareness, dispel myths and build timely access to services for all who can benefit from our care.

In general, have your expansion efforts improved access and lengths of stay within your hospice? Has any one service had the greatest impact?
Our Transitions program has been a way to increase earlier
access to services for those who needed help but were not yet ready for hospice. This program, however, does not include hands-on palliative care. Because our expanded Palliative Medical Partners program just began services in January, it is still too early to gauge its full impact. However, the early results from this physician practice show increased hospice admissions, length of stay and census—very promising trends toward a more comprehensive hospice experience for our patients and families. Similarly, we have seen some hospice admissions develop from services for some of our ongoing SeniorWise Care Management clients.

**Can you share any quantitative benefits from your expansion efforts?**

Samaritan has always been very proactive about quantifying quality. With our hospice program, for example, we voluntarily have been accredited by the Joint Commission since 1998 and were among the early participants in NHPCO’s Quality Partners. We use NHPCO’s FEHC and FEBS surveys and also submit our data to NHPCO’s National Data Set so we can benchmark our programs, services and outcomes against state and national data. We constantly measure data from all our efforts to assess the impact of individual programs, but also how they mesh together as a whole. With our expanded programs, we have internally established quality protocols and routinely reassess their cost versus their impact on meeting our community’s needs. So far, the strategic plan we have adopted appears to be on the right track.

**What have been some of the qualitative benefits?**

Our mission is always to increase access to care and our expanded services are providing more entry doors, so to speak. The early feedback from physicians, case managers and other referral sources has been positive. They tell us they find it easier to recommend palliative medicine as compared to hospice care because it is less stressful for patients and families to hear a recommendation for palliative medicine which can begin much earlier. With some cardiac patients, for example, the referral to Palliative Medical Partners can begin at time of diagnosis, when there is less stress and anxiety than at end stages of care. Also, the referral to our SeniorWise Care Management program provides physicians, case managers, elder law attorneys and financial planners with another community resource to assist families who may have specific

*continued on next page*
caregiving concerns that are not appropriate for palliative or hospice care.

**While the challenges of expansion differ depending on the service, were there any that stand out?**

Since 1999, as we added each additional service, the challenges were just to develop a program structure that met a need and then monitor that program for ongoing relevance and quality. With each new addition, we weighed service expansion opportunities, balancing available resources with potential benefits, mission, operational and cultural fit, community needs, and so on. We tested each new program for its fit within our core values as an organization. Over the last two years, however, as the depth and breadth of those programs grew, the challenge became whether or not to actually change our identity to reflect the whole continuum.

There is always a risk in changing a name, logo, and corporate color that is well known and respected in a community. There are also costs involved in creating new materials, signs, etc. So there was much thought, research and soul-searching in evaluating this milestone move. But in the end, the need to let our community know that we are more than hospice, that we have more ways to serve them, made the risks and challenges worthwhile.

**Any final thoughts or tips for providers who are now beginning to think outside the Medicare Hospice box?**

Let your community’s needs dictate your path and then focus on extending the same commitment to quality into those non-hospice services as Medicare demands for our hospice care.

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**Expanding Hospice Services Too**

In addition to expanding into non-hospice services, Samaritan Healthcare and Hospice has also engaged in some creative partnerships to improve access to hospice care.

In collaboration with the Jewish Family and Children’s Service of Southern New Jersey, the organization introduced the Jewish Hospice Program, Sukkat Shalom (Shelter of Peace), in 2002. “Though Samaritan is non-sectarian, our name sometimes connotes a Christian focus,” says Boccolini, “so, through this partnership, we’re able to honor the richness of Jewish traditions and rituals.” In addition to required hospice services, a Rabbi on staff provides spiritual support.

In 2006, Samaritan also launched Via Lucis (Way of Light), a Hospice Ministry for Catholic patients and families. “Roman Catholics comprise from 38 to 41 percent of our hospice patients each year,” says Boccolini. “This program helps to sensitively address the sacramental needs and moral teachings of our single largest demographic. It is supported by an advisory committee made up of staff, volunteers and representatives from local parishes and the two Dioceses serving Samaritan’s five-county service area.”

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**Are you offering a non-hospice service too?**

And would you like your work spotlighted in NewsLine?

Just complete our brief questionnaire.
New NHPCO Service Allows Programs to Personalize Outreach and Education Resources

Did you ever wish you could purchase NHPCO’s “What is Hospice,” “Phases of Hospice Care,” or bereavement cards with your organization’s name, contact information and logo printed on them? Well now you can! NHPCO’s Custom-Print Marketplace allows you to add your brand identification to these and many other patient/family education and physician outreach resources. Order today and you’ll receive your custom-printed resources in 2-3 weeks.

Visit NHPCO’s Custom-Print Marketplace today and begin customizing your education and outreach resources. www.nhpco.org/marketplace click “Custom-Print Marketplace” under Quick links to popular materials.

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Please visit www.nhpco.org/marketplace to access your Custom-Print Marketplace!
In today’s leaner economic times, many providers are not always able to send staff (or as many staff as they’d like) to NHPCO conferences. There are certainly ways to help bring that training home, through the plenary Webcasts and session videos made available after the event. However, nothing really beats attending a conference. There is energy and a spirit of collaboration and comraderie that help each of us preserve “the passion” that drives service excellence.

Through generous support from Glatfelter Insurance Group, administrators of Hospice and CommunityCare Insurance Services, 14 staff from hospice programs around the country were able to attend the 26th Management and Leadership Conference in Washington, DC last April—who would have otherwise been unable to attend. In fact, this is the second year that the insurance agency has supported this worthwhile program.

“In the 10 years I’ve been attending NHPCO conferences, I’ve seen how the events resonate with attendees and know they are taking those ideas home and will put them into practice,” noted Glatfelter executive vice president, Bruce D. Williams. “We have been very proud to lend support.”

NHPCO plans to extend the same scholarship opportunity for the 12th Clinical Team Conference in San Diego, CA, on October 6-8, 2011. For details and an application to apply, visit www.nhpco.org/CTC2011.

**Circle of Life Award: Call for Nominations**

Sponsored annually, the prestigious Circle of Life Award celebrates innovation in palliative and end-of-life care. In 2012, up to three organizations will win the award while others may be recognized with citations of honor.

All organizations or groups in the U.S. that provide palliative or end-of-life care are eligible for the award. To nominate an organization or program (either your own or another), visit the website of the American Hospital Association.

Winners will be honored at the American Hospital Association Health Forum Summit, July 19-21, 2012, in San Francisco. For a look at previous winners, visit www.aha.org/circleoflife.
NHPCO’s “Seasons of Caring” Ads Win the Gold

The series of three display ads (shown at right) which NHPCO developed, in collaboration with Transcend Hospice Marketing Group, has earned the 2011 Aster Award in the category of newspaper advertising. The ads were part of the 2010/2011 Outreach Materials that NHPCO put together to assist members in their outreach during National Hospice/Palliative Care Month and throughout 2011.

The Aster Awards is an annual medical marketing awards contest for healthcare organizations and advertising agencies. This elite competition honors the nation’s most talented healthcare marketing professionals for excellence in advertising, with awards at three levels: Gold, Silver and Bronze. A panel of design and healthcare marketing professionals judges entries based on a set of criteria, including creativity, layout and design, typography, production, quality, and overall effectiveness. All materials are judged on their own merit for effectively communicating marketing messages without additional supporting materials or documentation.

“It’s obviously a great honor to receive this recognition,” noted NHPCO vice president of communications, Jon Radulovic, “but what’s really special is that it points to the effectiveness of the ads in delivering our message—that hospice care is more than just medical care.”

During development, NHPCO asked for feedback and direction from the NCHPP Development/Public Relations/Marketing Steering Committee, headed by Section Leader Tom Simms of Lighthouse Hospice in Cherry Hill, NJ. “It was so helpful to receive the input from this group of professionals,” said Radulovic. “They not only know marketing, but they provided valuable perspective from the provider’s viewpoint on what would resonate best with the public.”

To learn more about the Aster Awards, visit www.asterawards.com.

Seasons of Wishes reminds us that advance care planning can mean greater peace of mind.

Seasons of Comfort reminds us that palliative care provides relief when it’s needed most.

Seasons of Caring reminds us that hospice care helps patients and families focus on living.

Use these ads in your current outreach—their messages are timeless. To learn more, see November 2010 NewsLine. To download copies, visit the NHPCO website.
Community PedsCare Physicians Earn HPM Certification

Kelly Komatz, MD, MPH, and Susan Krieger, MD, who serve as associate medical directors of Community PedsCare®, recently became board certified in hospice and palliative medicine.

Established in 2000, Community PedsCare® is a program of Community Hospice of Northeast Florida (Jacksonville, FL), in collaboration with Wolfson Children’s Hospital, Nemours Children’s Clinic, and the University of Florida-Jacksonville.

Hospice of the Comforter Appoints Jeff White

Hospice of the Comforter (Altamonte Springs, FL) has appointed Jeff White as chief compliance officer, responsible for planning, implementation and monitoring of the compliance, quality assurance, safety and infection control, and risk programs.

White has over 20 years of experience in healthcare and hospital administration. Most recently, he was director of corporate compliance for CCS Medical.

Joseph McNett Receives Hospice Storybook Award for Memorializing a Patient “Without a Name”

A story about a man with no name and no family, who touched the hearts of those caring for him at Hospice of Palm Beach County (West Palm Beach, FL), won the Hospice Storybook Award from Florida Hospices and Palliative Care (FHPC).

The Hospice Storybook Award recognizes original, non-published works by individuals about their meaningful hospice experiences.

The winning story, which was written by hospice chaplain, Joseph McNett, remembers a patient whom staff named “Pedro.” Pedro had a tracheotomy, permitting him to communicate only through gestures and facial expressions. “Despite his slow decline and physical difficulties...the one thing we could always count on was a smile or salute from him,” wrote McNett. “Unfortunately, despite our best efforts, we were never really able to find out who he was. Pedro’s memory was ravaged and he could only recall bits and pieces. Pedro had no one….We cared for him and loved him…. Although there was no one to claim him then...we do now.”
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When was the last time you really self assessed the security of patient health information (PHI) in your system? Is your information safe at all times?

The HITECH Act requires that covered entities notify patients of any unauthorized access, use, or disclosure of their unsecured PHI. The HITECH Act defines unsecured PHI as any patient health information which is not secured by technology that makes it unusable, unreadable, or indecipherable to unauthorized individuals. The technology must also be developed or endorsed by a standards-developing organization that is accredited by the American National Standards Institute.

Here are some tips for HITECH compliance:

**Complete a Risk Assessment**
Per the HITECH rule: “All e-PHI created, received, maintained or transmitted by an organization is subject to the Security Rule.” The Security Rule requires entities to evaluate risks and vulnerabilities in their environments and to implement reasonable and appropriate security measures to protect against reasonably anticipated threats or hazards to the security or integrity of e-PHI.

The HHS Office for Civil Rights (OCR) has issued draft guidance on risk assessments and plans to revise the guidance, based on public comments, as the first in a series of educational materials mandated by the HITECH Act. OCR calls risk analysis the “first step” to identify and implement safeguards that comply with and carry out the standards and implementation specifications in the Security Rule.

**Follow the Path of Your Patient’s PHI**
Your employees need access to patient information every day to do their job. To ensure security of patient information, you need to know:

- Who has access to PHI and how much information can they obtain with their access?
- Is the access appropriate for their position? For instance, a volunteer does not need the same access to PHI that a clinical director would.
- How is PHI communicated in your organization and do the modes of communication keep information secure?
- Do you have a policy and a plan in place to deal with a PHI breach?

**Keep Your Staff in the Loop**
The greatest success factor for HITECH compliance are your employees:

- Educate them about the new HITECH requirements and re-educate them about the HIPAA Privacy and Security Rules.
- Interview staff members as part of your compliance assessment to assess their knowledge about keeping PHI safe and their compliance with your privacy policies.
- Complete joint visits with your field staff to assess how they secure PHI offsite.

For more information about the HITECH rule, visit the U.S. Department of Health & Human Services website.
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 well-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/education.
2011 Creative Arts Contest Now Under Way

This year, NHPCO’s annual photography/writing contest has a new name and a new focus! It is now the Creative Arts Contest and, in addition to photographs, it will recognize examples of effective social media from our members.

Contest categories are:

- **Photographs** showing adults, young people, or nature/abstract images.
- **Facebook pages** of member organizations.
- **Individual videos** from members which are posted on social media or other websites.

Entries should reinforce the spirit of collaboration and inclusion within the hospice and palliative care community. Hurry—deadline for submissions is July 15. For details, visit Awards & Contests on the NHPCO website.

One of the winning entries from 2010: “Kid’s Night” by Diana Wayne Haven Hospice, Gainesville FL
650 Guests Celebrated Hospice “From Sea to Shining Sea”, at NHF’s Seventh Annual Gala

The Sparkling New Venue at National Harbor, MD was a Hit

Emmy-Award winning actor/comedian Brad Garrett was the perfect Master of Ceremonies. NHF honored him with the Buchwald Spirit Award for Public Awareness, in recognition of the work he has done through the Maximum Hope Foundation, an organization he founded to help families cope with the financial hurdles that accompany caring for a terminally ill child.

The mother and sister of the late Dr. Carlos Gomez were on stage to receive the Humanitarian Leadership Award on his behalf. NHF bestowed this award posthumously upon Dr. Gomez, in recognition of the dedication and passion he brought to caring for critically ill children and advocating on their behalf.

One of America’s most revered hospice executives, Mary Labyak, received the Healthcare Architect Award. This award recognizes individuals who have made a significant impact in the delivery and understanding of hospice and palliative care. Hear her moving speech at www.nationalhospicefoundation.org/Gala2011.

William Shoenhard, Deputy Under Secretary for Health Operations and Management for the Veterans Health Administration, accepted the Global Vision Award in recognition of the VA’s groundbreaking efforts to ensure Veterans have access to high-quality hospice and palliative care. To learn more about the initiative with NHPCO, visit www.WeHonorVeterans.org.

Among the honored guests were June Ebensteiner (center), her daughter Teresa Kassan (left), and Mary Taverna (right). Mrs. Ebensteiner has been a long-time supporter of NHF.

After dinner and the award ceremony, many people took the dance floor, including Ken Zeri of Hospice Hawaii and NHPCO board member Kate Cummings of Fairview Home Care in Minneapolis.

Save the Date!
Next year’s Gala will be held on Friday, March 30 at the same fantastic location: the Gaylord National Resort & Convention Center National Harbor, MD. It will be part of NHPCO’s 27th Management and Leadership Conference. Hope to see you there!
With a big birthday ending in zero coming up in 2011, NHF Trustee Eleanor Blayney started thinking last year about how to mark this occasion. She decided on a really big challenge. This fall, she will run the Marine Corps Marathon, for the first time since 1994.

But she’s not just training for 26.2 miles. She’s also committed to raising $60,000 for NHF’s Campaign for the National Center for Care at the End of Life. She has already achieved more than 25% of her goal and the race isn’t until October 30.

Eleanor explained, “It may take me a bit longer to train and to finish the race than it did 17 years ago, but I have so much more to run for. Hospice gives us all the hope and assurance that all our days can be lived in comfort and dignity, with everyone and everything around us that we love. Hospice is about living, for every day and minute we are alive. I need your help to get across that finish line so that more people can receive the gift of hospice.”

“We at NHF are just in awe of Eleanor. She’s been a valuable member of our board since 2006. She helped us start our Charitable Gift Annuity program and made the first CGA gift in NHF history. And now, she’s participating in Run to Remember with incredible zeal. We thank her deeply,” said John Mastrojohn, NHF’s executive director, “and are inspired by her commitment.”

To donate to Eleanor’s race, visit [http://www.active.com/donate/runtoremember2010/EBlayne1](http://www.active.com/donate/runtoremember2010/EBlayne1)
Donors Participate in Naming Spaces at the National Center for Care at the End of Life

Already, 21 Areas of the Building Have Been Named

The five-year $10 million Campaign for the National Center for Care at the End of Life is off to a strong start, with $2.4 million raised in gifts and pledges by May 31, 2011.

“In a spiritual sense, this building doesn’t belong to NHPCO. It belongs to the donors who believe so completely in the value of hospice and palliative care that they have made significant financial contributions to ensure a permanent home in the Washington DC area,” said J. Donald Schumacher, President and CEO of NHPCO and its affiliates, including NHF.

One key way of demonstrating that the building is a place for everyone is by creating naming opportunities. Already, 21 areas of the building have been reserved. We will showcase some of those named areas—and the donors behind them—in each issue of this newsletter.

Mail Room
The mail room has been named by Home Healthcare Solutions. This company serves the medical supply management needs of hospice and home care organizations across the country.

Their Mobile Supply Closet™ Program provides staff with on-hand supplies for immediate need and eliminates on-site inventory. Rob Goodsell, Vice President, Business Development said, “After learning about the National Center last summer, it was clear to our team this was a great opportunity to partner with the national organization and give back. We were also thrilled to learn we could select an office space to have our name. Since our core business is medical supply delivery and management to hospice and home health care organizations across the country, we selected the mail room.”

Run to Remember Office
The office of the Director of Communications and Special Projects has been named by Jeannee and Mike Martin. Jeannee is a long-time board member of NHF and has been a champion of Run to Remember. She’s raised tens of thousands of dollars for NHF by her own participation in several marathons. “We chose this office,” explained Jeannee, “because the primary staff person in charge of Run to Remember is the Director of Communications and Special Projects. We feel such enthusiasm for Run to Remember that it was a natural choice for us.”

To learn more about naming opportunities, visit http://www.nationalhospicefoundation.org/files/public/Campaign/NAMINGRIGHTS.pdf
NHF Establishes the Zachary Morfogen Art of Caring Award

For Many, the Arts Open Doors of Understanding

The arts have long provided avenues for individuals—and communities—to engage with challenging topics. In recognition of the role that the arts can play in helping people learn more about end-of-life issues, NHF established the Zachary Morfogen Art of Caring Award. This award will acknowledge the individuals or organizations who have used the arts as a means to inspire and increase awareness of end-of-life care and whose central focus of their art is related to end-of-life issues. The creation of the award was formally announced at an NHF reception held at HBO in New York City on June 23, 2011.

The award is named for Zachary P. Morfogen, founding chair of both NHPCO and NHF. Author, playwright, artist, publishing executive and champion of the arts, he became one of the nation’s earliest advocates for hospice care during his tenure as a trustee of Riverside Hospital in New Jersey. Zachary persuaded Riverside Hospital to establish one of the nation’s first free-standing hospices and convinced Time magazine to do a story about the hospice movement. He remains involved with the National Hospice Foundation, serving as an Honorary Trustee and holding the title Founding Chair Emeritus.

Morfogen Gallery of the Arts

Awardees will be presented with a specially selected art prize that has been displayed at the Morfogen Gallery of the Arts, located within the National Center for Care at the End of Life. The names of all awardees will also be displayed in the Morfogen Gallery. The Gallery of the Arts recognizes Zachary’s work on behalf of hospice care and his life-long dedication to improving care for those at the end of life.

The Importance of the Arts

“We are so pleased that NHF will be able to now formally recognize the importance of the arts in educating people about end-of-life issues. For many, it’s easier to understand information—and access feelings—about this period through artistic expression than other means,” said J. Donald Schumacher, president and CEO of NHF and NHPCO.

The first Morfogen Art of Caring Award will be given at the eighth annual NHF Gala, to be held on March 30, 2012 in National Harbor, Maryland, in conjunction with NHPCO’s Management and Leadership Conference.

Your generosity is inspiring

Donors Respond to Call for Disaster Relief Donations After Tomatoes and Floods of this Spring

Using Disaster Relief Funds, NHF awarded grants of $18,000 to the Alabama Hospice Organization and $10,000 to the Missouri Hospice and Palliative Care Association, in the wake of natural disasters this spring. It is the custom of NHF to lend a helping hand to state organizations in times of need. We have also sent donations to other countries, such as Haiti, following the earthquake.

Of course, it is imperative that we replenish the coffers so that we are ready for the next disaster. We sent out two e-appeals, one in May and one in June, resulting in gifts totaling $3,695 to date.

We were moved by the generosity that ranged from individuals making $25 or $50 donations all the way to the Louisiana-Mississippi Hospice and Palliative Care Organization making a $1,000 contribution. “LMHPCO’s gift was particularly poignant,” noted NHF Executive Director John Mastrojohn, “since the Fund helped Louisiana and Mississippi in the wake of Hurricane Katrina.”

This Spring’s disasters have made a big dent in the Fund. Please donate today.

Donate online at: www.nationalhospicefoundation.org/disasterrelief
Grateful Patient Leaves Money to Hospice in Her Will

Mary Patricia Schubert
April, 1963 – September, 2010

It is not unusual for the National Hospice Foundation to receive bequests. Many people feel grateful to the role hospice has played in the lives of their loved ones.

It is somewhat unusual, however, for the bequest to come directly from a grateful patient—someone who was receiving services, facing their own mortality, and yet actively made the decision to thank their hospice with a legacy gift.

But that’s exactly what Mary Patricia Schubert—known as Tricia—did.

She left $5,000 to Evercare Hospice, in gratitude for the care she received during the last year of her 8-year battle with LAM, a rare and often fatal lung disease that affects almost exclusively women. Evercare Hospice & Palliative Care is a for-profit company, they have a special partnership with NHF to sign over charitable donations to us, so that donors can still receive a charitable tax donation.

Tricia’s Story
Her twin sister Paula explains, “She was diagnosed right after our 40th birthday. For six years, the disease progressed slowly. She had the chance to travel, work, and become very involved in some important charitable efforts. Going into her seventh year, her health started to decline and she got used to enduring a lot of pain. About a year before she died, she made the call to hospice.”

Tricia’s brother Walter picks up the story: “As an oncology nurse, Tricia knew everything that was going on and what she needed.” Paula adds, “Tricia and her hospice nurse, Mary Griffith, became fast friends and that bond grew into a very special relationship. Mary went above and beyond her duties and our family will forever be grateful to her for her compassion and heartfelt generosity.”

Paula thinks it was that bond between Tricia and her nurse that propelled Tricia to include Evercare Hospice in her will, along with other organizations that meant a lot to her.

Tricia’s Impact
Another organization to benefit from Tricia’s generosity was the Jatukik Providence Foundation. As the first president of this organization, Tricia had a tremendous impact on its mission to serve poor communities in the Congo, Haiti and the U.S. Today, posters of Tricia hang in Washington, DC and throughout buildings in the Congo, several of which she financed. Although Tricia was never able to travel to Africa or the Caribbean, her spirit continues to live on with all of the people whose lives were changed by her works.

She also had a big effect in her community of Alexandria, Virginia. She was deeply involved in trying to make the lower-income parts of the city safer. Tricia was President of the Inner City Civic Association from 2005 through 2007 and was honored for her leadership, commitment, and unwavering loyalty to the Alexandria Police Department and the ICCA with an award.

Paula says, “Tricia never boasted about what she had done. She was very humble. Very spiritual.” Walter notes, “She derived a great deal of fulfillment in helping people. The joy she got was all she needed. She didn’t want headlines or stories; that didn’t matter to her.”

It matters to us at NHF that we were touched by so special a soul as Mary Patricia Schubert. We are proud to be able to share some of her life story with our supporters. We are immensely grateful for her bequest.

Tricia is survived by her brothers Walter and Joe (Debbie), and her sisters, Paula Schubert, Maria Saltonstall, and Margaret (Paul) Sullivan. She also left behind her nephews, Jack, Matthew, Andrew, Ryan, and Tim, over 100 aunts, uncles, and cousins, and her “second mother,” Dessa Ingram. She was predeceased by her parents, Winifred and Walter Schubert.

Leaves a Legacy to Advance Care and Compassion.

We are honored to receive bequests of any size. You can build your legacy of caring by naming NHF in your will and becoming part of our Legacy Society.

To become a member, simply notify us of your intentions by emailing planning@nationalhospicefoundation.org or phoning us at 703-516-4928.

Check out other information about planned giving at www.nationalhospicefoundation.org/planning.
The 4th of July is a time for American patriotism. It is also a good time to publicly show our respect for those who have lost their lives in defense of our country and to offer support to grieving loved ones.

As we mark the 4th of July this year, we are a country involved in conflicts abroad. The ongoing fighting in Iraq and Afghanistan continues to take a toll on our nation. Serious injuries and the untimely deaths of our brave service men and women remind us that life is precious.

Hospice and palliative care professionals – who help families cope with loss on a daily basis – share ideas on how to honor this sacrifice:

1. **Acknowledge the day with a phone call or card to the family**; tell a story you remember about the service member who has died and/or ask the family to share a story. Keeping their loved one’s memory alive is an important part of healthy grief and coping.

2. **Offer to accompany or take the grieving person to the cemetery or other place of remembrance**; people are sometimes reluctant to take advantage of such opportunities alone and will appreciate your thoughtfulness.

3. **Make a donation in memory of the person who has died to a charity that was important to the service member or the family**; this can be a powerful reminder to them that you remember and that you care.

4. **Listen**. Sometimes the greatest gift we can give is to listen to what others think and feel. Supporting those who are grieving can be as simple as lending an ear or holding a hand.

5. **Acknowledge your own feelings**; share the range of thoughts and emotions you experience with someone you trust, but not necessarily with the grieving family. Whether it is pride or shame, grief or hope, sharing these feelings is important.

Your community hospice can be a source of information on grief and bereavement. Caring Connections, a program of NHPCO, also offers information on grief at caringinfo.org or by calling the HelpLine at 1-800-658-8898.

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**Five Tips to Support Those Who’ve Lost a Loved One in Service to our Country**

In collaboration with the Department of Veterans Affairs, NHPCO launched We Honor Veterans in September 2010. This pioneering campaign is aimed at improving the care Veterans receive from hospice and palliative care providers. See [www.WeHonorVeterans.org](http://www.WeHonorVeterans.org)

NHF is dedicated to raising significant financial resources to support this important campaign. You can learn more or donate, visit [www.nationalhospicefoundation.org/veterans](http://www.nationalhospicefoundation.org/veterans).

To join the Hospice for Veterans Cause on Facebook, visit [www.causes.com/causes/590046](http://www.causes.com/causes/590046).