Later this month, NHPCO will be releasing the eagerly awaited update to its staffing ratio recommendations—but it is far more than just an 'update.' The new document, “Staffing Guidelines for Hospice Home Care Teams,” will help each hospice determine its unique staffing requirements, based on its model of delivery, patient characteristics and environmental considerations.

In this article, Tara Brodbeck, the president/CEO of Hospice of the Miami Valley and the co-chair of the Task Force charged with developing the new Guidelines, talks about the tool, including why a new approach was taken, the member feedback from field testing, and suggestions on using it.

By Tara Brodbeck, MS, RN, CHPN

In 2008, as the NHPCO Quality and Standards Committee began revising the Standards of Practice for Hospice Care to incorporate the new Hospice CoPs, we knew it was also time to take on the challenging task of revising the staffing ratio recommendations in NHPCO’s “Hospice Services Guidelines and Definitions” (which had been produced back in 1994!).

As soon as the project was added to our committee agenda, questions and comments began pouring in from members across the country. It seemed that many had strong ideas about the topic and what the revision should address. Here’s a sampling of the initial feedback we received:

continued on next page
“The current staffing ratios are outdated and not useful—staff are complaining if we ask them to take more patients.”

“What is the correct number of patients per discipline?”

“My CFO/director wants to know how many positions per census to budget.”

“How will we find the “correct” number that all programs could use [when] our hospice is different from other hospices?”

Some Background About Development
As a committee, we had to approach this important project in a thoughtful, organized and very thorough manner. So first, we held an all-day, onsite appreciative inquiry in January 2009 to elicit the entire committee’s feedback concerning the ratios. It was a very exciting and lively meeting, with an open, free-form discussion so all ideas and comments could be heard.

By the end of the day, committee members felt the task was critical enough to require more input from the entire group as well as further in-depth discussions, so we made the decision not to delegate the project to a smaller work group at that time. Throughout the year, the committee developed structure for the project’s discussions and a framework for the new guidelines. In January 2010, a smaller Staffing Guidelines Task Force (see sidebar) was then formed, with the goal of completing the project by the end of the year.

In response to the concerns of hospice providers, the Task Force made a concerted effort to be as inclusive as possible. This included the presentation of revised drafts at the Ohio Hospice and Palliative Care 2009 annual conference and NHPCO’s 2010 Management and Leadership Conference. In total, we were pleased that more than 200 hospice managers and staff provided input over the course of its two-year development.

Why a New Approach
While information concerning staffing ratios was only one small section of the 1994 “Hospice Services Guidelines,” it had become one of the most controversial topics among providers as the hospice industry matured.

Given the sparse data available, the ratios had been developed from a small sample of hospice programs at that time, and consensus could only be based on...
As we go to press with this issue, I am finalizing details for a new series of executive conference calls that will be open to the senior leaders among our membership. These calls, aptly named “NHPCO Executive Conversations,” will be held every other month, beginning on March 9.

I will serve as host of these one-hour sessions that will focus on a specific, timely topic and feature guests who can bring both perspective and insight to the issue.

The topic of our March 9 Conversation—“One Voice: Standing Together in the Face of an Inflammatory Press”—concerns the controversial article that recently appeared in JAMA (“Association of Hospice Agency Profit Status With Patient Diagnosis, Location of Care and Length of Stay”). I think our choice for this first session tells you why it is so important to have these conversations.

In that article, the authors presented some unsubstantiated suppositions based on less-than-representative patient demographics. As the study authors clearly wrote, quality measures were not a factor in their research. Nor did they look at costs, or variations in visit types or the needs of the patients served. Despite this, many in the media turned the findings into a sensationalized story and, more disturbing still, so did many of my colleagues in the hospice and palliative care community.

With today’s technology, which allows us to disseminate our opinions as facts in real time, it is very easy to do great harm. In fact, when I spoke with the article’s lead author, she said that some of the messaging had overstepped the study’s findings and the message that she and her fellow researchers intended to convey.

These events speak to the crucial need for an outlet through which we can regularly discuss the key issues that affect us—thoroughly, thoughtfully, and based on actual facts. And this is our intent in holding these Conversations.

While the JAMA article seemed a most appropriate topic for March, future sessions will address a range of issues. For example, I think a discussion of MedPAC findings would be helpful once the Commission releases its next report.

We also welcome your feedback on topics of interest or concern—for these Conversations or in other ways that NHPCO may help you. If you’ll be attending MLC in April, speak to me or any member of our staff. We will also be conducting a membership survey this year that will allow you to share feedback. Or, send us an email. We want to hear from you in the way you find most comfortable.

J. Donald Schumacher  
President/CEO
what was “thought to be” good practice. In the mid-90s, hospice service models were also more basic and uniform, and the patient populations were vastly different from those of today. For example, 57 percent of patients admitted to hospice in 1994 had a primary diagnosis of cancer (National Center for Health Statistics) compared to only the 40 percent who were admitted in 2009 (NHPCO Facts and Figures).

**Key Considerations Addressed**

The Task Force began the process by asking five key questions:

- What was the purpose of providing the staff ratio recommendations?
- What would be the expected outcome from the revision?
- Do ratios and caseloads directly relate to quality of care? If so, how?
- How do different hospice models of care fit into these guidelines?
- What characteristics of a hospice program affect ratios and caseloads?

Exploring these questions evolved into discussion of hospice best practices. We explored different processes of care, such as admission, specialty teams, on-call processes, and how different hospice programs structured their teams. We then compared these processes to best practices known to date, and looked at current outcomes, tools and industry benchmarks (such as NHPCO’s Family Evaluation of Hospice Care and Family Evaluation of Bereavement Services).

While engaging in these discussions was both helpful and useful, Task Force members realized that we must bring more clarity to the discussion by focusing specifically on the staffing ratios and caseloads. That said, during these best-practices discussions, we heard about the many interesting ways in which hospices were structuring their resources and utilizing their staff, which led us to the final path of developing new guidelines that would help each hospice arrive at numbers that took its situation into account.
The Many Factors Affecting Ratios and Caseloads

As hospices have evolved, they have created diverse models and processes of care to serve their patients and families. These models and processes have been driven by a variety of factors in each particular hospice program.

The Task Force started to list the different models and processes of care, including admission teams, care specialty teams (e.g., disease-specific teams, nursing home teams), primary care models of care, on-call teams, RN-LPN partner teams and, of course, many others. We also had a rich discussion concerning “caseloads” versus case mix/intensity of care and decided it was best to integrate acuity/intensity of care into the factors we thought could be reason to support a lower or higher caseload. We wound up with 90 different factors to consider when determining staffing ratios and caseloads! Recognizing that this number was unworkable, we reviewed each factor and, if it didn’t directly influence a caseload, we discarded it.

During these discussions, the term “staffing ratios” evolved into “caseloads.” We also made the decision to not be prescriptive by using a definitive number for a particular discipline’s caseload for two reasons:

1. It was seen as too restrictive and didn’t allow for creative staffing approaches in our hospice industry, and
2. There was a lack of research data on staffing caseloads.

As a result of our discussions, the 90 initial factors were ultimately reduced to 11 factors under three categories. These factors are listed and discussed on page 6 of this article.

Feedback from the Field

As the Task Force co-chair, I was very pleased the Quality and Standards Committee gave me permission to present the initial draft of the new guidelines at the Ohio Hospice and Palliative Care Organization annual conference in 2009. Because Task Force members had worked so closely on the project for such a long time, we were very anxious to get feedback from our fellow providers in the field—especially since the new guidelines had taken this new approach. The timing of the Ohio conference was quite fortuitous.

Approximately 50 hospice staff attended the presentation in Ohio, and were asked to complete a survey. Overall, feedback was very positive, with 86 percent of the attendees indicating that the guidelines’ instructions were clear and the tables were easy to understand. The majority also

continued on next page
believed their agencies would use the new tool.

We reviewed every suggestion and comment the attendees had shared and incorporated many of them into a second draft, which was then presented to 100 attendees at the NHPCO Management and Leadership Conference in April 2010. These attendees, who were asked to complete a longer, three-page survey, were even more positive about the tool than the Ohio conference attendees.

In addition to field testing at both conferences, a number of Task Force members conducted similar surveys at their own hospice programs.

Using the Guidelines

The new Staffing Guidelines is organized into four sections:

**Section I** contains background about the original guidelines as well as a key table (“Hospice Homecare Staffing Guidelines Analysis”) that delineates the factors you should use to compare your hospice’s characteristics (e.g., length of stay) with median hospice characteristics from NHPCO’s National Data Set.

**Section II** contains the actual “Staffing Guidelines Analysis Worksheet” that you fill out as you conduct the analysis to determine the staffing caseload needs for your hospice, based on 11 specific factors. Step-by-step instructions are also provided to help you complete both the Analysis and the Worksheet.

**Section III** provides three different hospice-program “case scenarios” for illustrative purposes.

**Section IV** provides a glossary of the terms used in the document.

As a first step, you should undertake a thoughtful planning process that includes:

- Analysis of your care delivery models, or other models needed
- Characteristics of your patient population
- Environmental considerations
- Unique circumstances of your hospice program

As part of this planning process, take time to review the “National Summary of Hospice Care,” the 25-page report which NHPCO produces annually. The National Summary contains comprehensive national estimates for agency demographics, patient demographics, staffing management and delivery, payer mix, revenue and expenses—estimates that will help as you move on to completion of the guidelines’ Table and Worksheet.

**The Guidelines Analysis Table and List of Factors to Consider**

Reviewing this one-page, three-column table will help you identify the information about your hospice related to the multiple factors that must be considered to determine the optimal staffing caseloads for your particular situation.

The first column lists three major hospice characteristics and multiple sub-factors that should be taken into consideration:

1. Length of Stay Characteristics
   - Short Length of Stay
2. Staffing Model Characteristics
   - Admission Model
   - On-call Model
   - RN/LPN Model
Shared Team Model
Bereavement Model
Staff Turnover Rate

3. Organizational Characteristics
   Percent of Routine Level of Care Access
   Aide/Homemaker Delivery Model
   Use of Ancillary Services (e.g., art, music, massage, PT/OT)

For each factor, caseloads are adjusted in the direction indicated in columns two and three of the table (i.e., increase or decrease).

Other factors which may impact staffing caseloads, but which do not have comparison data available, are listed and explained in the narrative section that follows this Table. These factors include pattern of utilization of continuous care and general inpatient care; multiple roles for the IDT; psychosocial issues; travel time issues; and several others.

A Note About Acuity: While it would be ideal to compare caseloads based on level of patient acuity, currently there is no validated instrument in common use by hospices which would allow for comparison. Thus, some of the measures in the Table were chosen as surrogates of acuity, such as short length of stay. (The Guidelines elaborate on this issue.)

The Guidelines Analysis Worksheet
This two-part Worksheet walks you through each statistic and factor, and helps you to determine whether you should consider staffing caseloads that are smaller or larger than national norms, based on how your hospice’s organizational characteristics compare to national norms and the presence of other organizational and environmental factors. For example:

- In Part I of the Worksheet, for each organizational characteristic listed, you first write in your hospice’s information and compare it to the national norm. Then, write in a plus (+), minus (-), or equal (=) symbol according to the guideline for each characteristic as a directional indicator for lower or higher staffing caseloads.

- In Part II, review each of the additional factors listed, write in the qualities of these factors for your hospice, and determine the direction of influence of these factors on your staffing caseloads (i.e., plus, minus or equal) as outlined in the factor explanations.

Once you have completed the Worksheet, review the pluses,
minuses, and equal signs. This will provide an indication of whether you should consider utilizing caseloads above or below the national norms.

This analysis allows you to individualize your staffing caseloads according to the organizational and environmental characteristics that are specific to your hospice, much in the same way your staff individualize care plans for the patients they serve.

**An Ongoing Process**

Keep in mind that this analysis only provides a starting point for determining estimated optimal staffing caseloads for your hospice. Ongoing evaluation must also be part of the process.

Be sure to repeat your analysis at an appropriate interval after instituting caseload changes, and continuously monitor your hospice’s comparative performance using performance measurement tools (such as the Family Evaluation of Hospice Care (FEHC), the Survey of Team Attitudes and Relationships (STAR), and your other program-quality measures). This will help assure continued high-quality patient care as well as high levels of staff performance and well-being.

The development of these new guidelines is only one step in the NHPCO Quality and Standards Committee’s mission to help providers respond to industry changes in an efficient and effective manner while forever keeping at the forefront of our mind “excellence in patient care service.”

Tara Brodbeck is president/CEO of Hospice of the Miami Valley (Xenia, OH) and currently serves as a national director on the NHPCO board of directors. She has also served as a member of the NHPCO Executive and Governance Committees and as chair of the Quality and Standards Committee (2007-2009). In addition, she served as co-chair of the Staffing Guidelines Task Force. She can be reached at brodbeckt@homv.org.
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In this new feature, NewsLine will shine the light on a hospice provider which has introduced or expanded services outside the Medicare Hospice box—and, in so doing, is generating supplemental revenue while forging earlier relationships with patients and families.

“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.”
“PACE is like hospice on steroids,” says Karren Weichert, the president/CEO of Midland Care in Topeka, Kansas. It stands for ‘Program of All-Inclusive Care for the Elderly,’ and essentially is a community based long-term care alternative to nursing home placement. The program serves individuals who meet state functional assessment scoring for nursing home eligibility, but wraps services around them to care for and support them in the community.

While PACE is not a suitable option for all hospices, Midland Care decided to become a PACE site in 2002, and launched its program in February 2007. Here, Karren shares some of Midland’s experience for those members who may be contemplating PACE as a possible revenue stream.

Why did Midland decide to become a PACE site?
In addition to offering hospice care, Midland Care had been offering adult day care in the community since the early 90s. Originally, we served only hospice patients, but over time began to get more community requests for adult day for frail elders unable to stay at home alone during the day. This led to the addition of a six-bed respite center (not for hospice but for the community at large) as we encountered exhausted caregivers needing temporary reprieve from caregiving responsibilities.

We were also seeing changes nationally, regionally and locally that we began to evaluate in our strategic planning process—hospice regulations and compliance were becoming more costly to manage; reimbursement was threatened and predicted to decrease; length of stays were declining; and the number of competitors for the same hospice market was increasing. We knew we needed to consider diversifying our services.

So becoming a PACE site had a lot of appeal. In addition to drawing on our core competencies, it helped us address a real need we’d been observing for some time: those persons in adult day care who were slipping through the cracks in terms of their healthcare needs, those hospice patients and families who said “we wish we had called hospice sooner,” and those palliative care patients who think hospice means giving up hope and waiting to die no matter how many times we say it doesn’t.
Can you tell us a little about PACE—who’s eligible and what it provides?
The criteria to qualify is actually pretty simple. One must be 55 or older; eligible for nursing home care as defined by the state functional assessment tool; and able to live safely in the community at the time of enrollment. One must also live within the PACE site’s geographic service area. Because this is a Medicare and Medicaid program, one must also be eligible for Medicare or Medicaid, or be financially able to pay what those payors would have paid for PACE services.

PACE must manage—and is financially responsible—for every aspect of a person’s healthcare once he or she enrolls. It must provide all of the preventive, acute, and tertiary care needed, and that can be a very long list. It includes adult day care; home support/home health services; primary physician and medical specialty services; medications and medical equipment; physical, occupational and speech therapies; dental care; inpatient and outpatient services; transportation; nutrition counseling and end-of-life care when needed. Essentially everything that would be covered under Medicare and/or Medicaid must be covered by PACE, with the care being managed through an interdisciplinary team, case-management approach.

Who pays for the PACE services?
PACE is reimbursed on a per member, per-month basis, and is a blended payment stream from Medicare, Medicaid and Medicare Part D.

Medicare payment is based on the medical frailty of the individual served. Medicaid is a negotiated amount with each PACE provider and its state administering agency. Medicare D payments are based on an annual bidding process by the PACE site to CMS.

The services not provided directly by the PACE interdisciplinary team, including all ancillary services and medical specialties, are made available through contractual agreements and are the financial obligation of the PACE provider which is at full risk for all medical services. In fact, some programs purchase a reinsurance product to cap risk at certain levels.

What is the typical length of stay?
Nationally, the average length of stay is about 28 months (from the time of enrollment to the time of discharge). Based on our experience so far, lengths of stay average 18 months from the time of enrollment to time of death. Most of our discharges have been due to death or because the individual could not manage the cost of the program, including their participant obligation under Medicaid. It continues to strike me as unethical that a program designed for the Medicaid population is not affordable for them. In the state of Kansas, the participant can only retain $741 dollars of their monthly income if they enroll in this program. Participant obligations range anywhere from $0 to $1,500 per month (this is one of the elements that potential providers should investigate because it can significantly impact the rate of enrollment in the program).

Was making the transition difficult?
There are clearly many similarities between hospice and PACE, so it’s not a giant leap. Both are patient centered, managed care and holistic in nature; both encompass the family unit; both require multiple contractual arrangements; and both require out-of-the-box thinking to meet needs.
PACE is, for the most part, palliative care—but with a much longer care trajectory than we usually see in hospice. So, the difference in the length of stay for staff who are used to caring for patients for only a few months—and the requirement to fully care for all the chronic and disease elements of the person’s health—does require a very different intellectual and emotional skill set. We have been able to adapt our EMR to serve both programs and that has made the transition for staff members easier as they have not had to learn a new or different system.

In terms of the paperwork, the application process is quite cumbersome. However, we found most of the required components were elements we already had in place, including most of the necessary infrastructure. Interestingly, CMS regulations require a Quality Assurance Performance Improvement Plan for PACE which is almost identical to the new hospice CoPs. There is more emphasis on the PACE side for taking QAPI deep into the organization and identifying and capturing improvement opportunities throughout the breadth of the program. We have been able to develop our annual QAPI plan utilizing quality indicators applicable across the continuum of our services.

What are the start-up costs?
Since the heart of a PACE program is an adult day center, there will most likely be some capital costs for any hospice program moving to establish a PACE site. Midland already had a campus of buildings, including the one we had utilized for our adult day care services. However, we embarked on a renovation of that building for PACE in order to provide a clinic, therapy area, and more bathrooms to accommodate increased census and programming. The total cost of the renovation was $1.2 million. There was also the investment for clinic medical equipment, rehabilitation equipment, and transportation vehicles for the program. Depending on the resources already available to an organization, initial capital investment in building and equipment could range from $1 to $3 million.

At initial start-up, most of our PACE staff came from our hospice

While Midland already had a campus of buildings to serve as the PACE site, it underwent significant renovation to be better able to meet programming needs. Shown here are views of the PACE Center.
ranks. The social workers, nurses and home health aides were all hospice staff with an interest in the new program. This resulted in significant cost savings at the beginning, but also as the program has grown. Currently, we employ 27 full and part-time staff for 96 PACE participants. Two positions, a physical therapist and a dietician, are employed by Midland Care and shared across programs. Some of the 14 staff in the adult day program serve both PACE and community clients, but the majority are PACE participants. These PACE participants reside in seven of the counties within our 16-county hospice service area.

What were some of the challenges?
One of the most difficult obstacles was working with our state legislature to approve the program. That process took four years. Our board had the foresight to include PACE as an initiative in all three years of our strategic plan. A less persistent organization might have given up, but we were determined to bring the PACE option to our community. While not all states may require that same level of perseverance, the process will most likely take a minimum of 18 months to two years.

What have been some of the benefits?
PACE has helped us provide care to a new constituency and diversify our funding streams. It also placed us ahead of the curve for health reform. PACE meets many of the elements of an accountable care organization, chronic care management, and medical home. Over the course of the past four years, we have seen our organizational revenue mix transition from 90 percent hospice to 58 percent hospice/38 percent PACE/4 percent other programming (as projected for 2011). That said, some of the funding for PACE comes from Medicare, so there is always the possibility that it too will experience reimbursement decreases.

Any final thoughts?
I would certainly not encourage every hospice to consider PACE as part of a diversification strategy. It is a risk, so you first must determine if your organization could fiscally manage this type of undertaking. Programs should also examine their mission, vision and organizational culture. There is a tremendous amount of work to be done internally to determine if PACE will be a good fit. The longer your hospice has been in existence, the more difficult it may be to evolve into a new dimension of care.

There is also a great deal of research required on the external drivers of PACE. Does your state have PACE as a Medicaid state plan option? How supportive of PACE is the state legislature and state administering agency? What’s the criteria for financial eligibility for Medicaid and would there be participant obligation? What is the size of the potential pool of participants in your service area who would meet the age and the functional and financial eligibility requirements? Is there a single point of entry for elder services in the community? Who would refer?

Even though our state included PACE as an option under the Medicaid state plan, there was a lack of knowledge and understanding about PACE among our legislative representatives and the state administering agency. As a result, we also put forth a
dedicated effort to educate them on the basics of PACE and the benefits to participants, providers and payors. We also had to get legislative approval on the number of participants we would be permitted to enroll prior to submitting our final application to CMS—and that legislative approval took three years.

If you decide that PACE is not the right fit, I would encourage you to assess what’s going on in your community and, where possible, find ways to collaborate with PACE and other new models of care.

To Learn More:

Several sessions about PACE were presented at NHPCO’s August 2010 conference on “Developing the Care Continuum—and are now available on CD for just $10 each (or as MP3 files).

To review or purchase the sessions: (1) click on the hyperlink, (2) enter the session number shown in the Keyword Search, and (3) scroll to the session name.

**Hospice Pioneers in PACE?**  
*Karren Weichert, Samira Beckwith and Linda Todd*  
Click here and enter 9F in the Keyword Search.

**PACE and Other Delivery Care Models**  
*Karren Weichert*  
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**PACE: An In-Depth Look at Market and Financial Feasibility**  
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**PACE: Pathway to Operations**  
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**Opportunities and Transitions within a Continuum**  
*Karren Weichert and Candace Young*  
Click here and enter 3E in the Keyword Search.

**Adult Day Care: Opportunity for Diversification and Collaboration**  
*Karren Weichert*  
Click here and enter 4D in the Keyword Search.
April 5-6, 2011

Flash forward to March 2011. HAN staff has found that Brian’s story is far from an anomaly as other first-time attendees have shared similar stories. Many have recounted their excitement about realizing the profound impact they could have on the way the hospice story is shared with our nation’s lawmakers.

Now, with Capitol Hill Day 2011 next month—on April 5 and 6—you will not want to miss the opportunity and satisfaction of taking Hospice Advocacy to the Hill, whether you’ve experienced it before or you’re a Hill Day novice. After all, 2011 may prove to be the most critical year yet for Hospice Advocates. As a result of health care reform, the Medicare Hospice Benefit is
facing significant changes—from reimbursement cuts...to new quality measures...to payment reform. Additionally, the elections of 2010 brought us more than 100 new members of Congress to educate and cultivate as Hospice Champions, a necessary step in the short- and long-term battles ahead for the hospice community.

**What’s On the Agenda**

This year’s event is even bigger and better than any we’ve hosted before. Being held in tandem with NHPCO’s Management and Leadership Conference (MLC), Capitol Hill Day 2011 will offer an expanded opportunity for you to sharpen your skills and tell the hospice story—along with more time to cover critical ground on Capitol Hill.

**On April 5:**
A half day of comprehensive strategy sessions will be held, expanded to include two sessions:
- “Hill Meeting Fundamentals” will be an introductory session (or brush-up course) for anyone who was unable to attend last year.
- “Messaging & State Coordination” will focus on making sure everyone is in tune with our unified strategy and messaging.

The session attendees will receive materials for their Hill Day meetings and will work with outside experts to finetune their advocacy skills.

**On April 6:**
The entire day will be devoted exclusively to meeting with members of Congress. The day will begin with an early morning Pep Rally in the shadow of the nation’s Capitol on the National Mall. Hospice Advocates will hear directly from Congressional Hospice Champions and then head to their prescheduled meetings, with up-to-the-minute legislative updates from these federal representatives. NHPCO staff will be there to guide attendees through the process every step of the way—handling everything from the meeting scheduling and coordination to making respite provisions for free time in between meetings.

Last year, hundreds of Hill Day participants left Washington, DC with both a sense of great accomplishment and the tools to better advocate for hospice on all levels. We anticipate hundreds more at this year’s event. Be a part of the movement to ensure continued access to quality end-of-life care for years to come. Your voice will make all the difference.

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**Don’t Delay:**
Registration for Hill Day
Ends March 18:
www.nhpco.org/hillday2011

**Questions?**
Email HAN at hillday@nhpco.org
In the fall of 2010, NHPCO’s Department of Professional Development, in collaboration with NHPCO’s Research team, invited hospice and palliative care professionals across the country to complete its bi-annual Education Needs Assessment surveys.

As a leader in end-of-life care education, NHPCO provides continuing education/continuing medical education credit for nurses, physicians, social workers and counselors. Findings from these surveys will provide valuable insight into the specific educational needs of each discipline and will support NHPCO’s Professional Education Committee and its subcommittees in the development of future educational activities and products.

**About the Surveys**

To prepare for such an undertaking, NHPCO relied on the expertise and guidance of the Education Needs Assessment Subcommittee of NHPCO’s Professional Education Committee (see sidebar).

After months of development, NHPCO launched two surveys—a General Survey and an Executive Survey.

The General Survey was designed for all members not working in a senior executive capacity while the Executive Survey was geared toward presidents, chief executive and chief operating officers, and executive directors.

Both surveys sought information on education format preferences, educational needs related to specific topics, and the identification of professional practice gaps.

Additionally, the Executive Survey provided leaders with the opportunity to assess the overall education and training needs of their staffs in order to increase competencies and improve professional performance.

**Feedback from Over 2,500 Professionals**

The surveys were completed over the course of one month and, within that time, more than 2,500 professionals participated. Here’s a brief recap of the feedback received.
### General Survey

**Format Preferences:**
1. 59% are likely to attend National Conferences
2. 72% are likely to participate in Webinars
3. 72% are likely to participate in Distance Learning On-demand

**Top 5 Areas of Educational Need (Related to Physical Care):**
1. Terminal Restlessness
2. Advanced Pain Management
3. Complementary Therapies
4. End-Stage Alzheimer’s/Dementia Management
5. Advanced Non-pain Symptom Management

### Executive Survey

**Highest Priorities for Staff Education/Training:**
1. Physical Care
2. Regulatory and Compliance
3. Quality and Performance Measurement

**Top 5 Areas of Educational Need (Related to Leadership):**
1. Strategic Marketing
2. Integrating Business and Clinical Practices
3. Managing Growth and Expansion
4. Restructuring for Efficiency
5. Integrating Business Expertise, Management Processes and Leadership Skills

“NHPCO was enormously happy to receive input from so many professionals across all disciplines” said Barbara Bouton, MA, FT, NHPCO’s director of professional development. “Our thanks to all the members who took time to participate.”

### 2010 Education Needs Assessment Subcommittee

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tr>
<td>Suzanne Abercrombie</td>
<td>Hospice of Baton Rouge</td>
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<tr>
<td>Andrea Allen</td>
<td>Hospice &amp; Palliative Care of Cabarrus County</td>
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<td>Joy Berger</td>
<td>Hosparus Inc</td>
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<td>Marcia Cederdahl</td>
<td>AseraCare Hospice</td>
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<td>Mauna Cowan</td>
<td>Parkview Home Health &amp; Hospice</td>
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<td>Christina Foley</td>
<td>AseraCare Hospice</td>
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<td>Virginia Graves</td>
<td>Seasons Hospice and Palliative Care of Massachusetts, LLC</td>
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<td>Edgar Guedry</td>
<td>Hospice Associates of New Orleans, LLC</td>
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<td>Barbara Ivanko</td>
<td>Hospice of Palm Beach County, Inc.</td>
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<td>Jason Kimbrel</td>
<td>HospiScript Services, LLC</td>
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<td>Bonnie Meyer</td>
<td>Hospice of the Bluegrass</td>
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<td>Teresa Wheatley</td>
<td>Hospice of Lancaster County</td>
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<td>Gloria Ramsey</td>
<td>Uniformed Services University of the Health Sciences Graduate School of Nursing</td>
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<tr>
<td>Diane Spain</td>
<td>Harry Hynes Memorial Hospice</td>
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<td>Cathy Stauffer</td>
<td>Hospice of Lancaster County</td>
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2011 “Reaching Out” Grant Recipients

Five hospice organizations have been chosen as third-year grant recipients in NHPCO’s Reaching Out grants program:
- Guardian Hospice
  Franklin, TN
- Hope Hospice & Palliative Care
  Medford, WI
- Hospice of Central Iowa
  West Des Moines, IA
- Mercy Hospice
  Roseburg, OR
- Mountain Hospice
  Belington, WV

Funded through a contract with the Department of Veterans Affairs, the Reaching Out grants were created to support innovative programs committed to increasing access to hospice and palliative care for rural and homeless Veterans.

“These grants serve a two-fold purpose,” said NHPCO president/CEO, Don Schumacher. “They support specific, community-based programs and the lessons learned will help the VA in discovering new ways to reach Veterans who are homeless or living in rural areas and in need of quality care as they near the end of life.”

Throughout 2011, grantees will be implementing outreach models in their communities that are designed to expand and increase the quality of care and services provided to rural and homeless Veterans with life-limiting illnesses. Their work will be shared with members through NHPCO’s various communications, with periodic updates on NHPCO’s new We Honor Veterans website, which was developed in partnership with the VA.

The Final Reports from 2009 and 2010, and materials developed by the Reaching Out grant recipients during 2010, are available now on the We Honor Veterans website.

National Healthcare Decisions Day: New Website to Increase Awareness

Since National Healthcare Decisions Day was established in 2008, it has helped raise public awareness about the importance of advance care planning. Now, a redesigned website will help raise its national profile and improve upon that good work.

The site also includes a range of helpful information that has been re-organized for quick and easy access…. The FAQs page includes links to some excellent resources for consumers and professionals alike. The Facts page has handy information to include in your outreach materials. And you will also find some fresh ideas on how to promote advance care planning in your community.

NHPCO is among NHDD’s proud supporters. Be sure to visit the site—and bookmark it for future reference. This year’s NHDD falls on April 16!
JPSM Call for Papers on Quality Improvement:
Submission Deadline is April 15!

The Journal of Pain and Symptom Management (JPSM) is seeking papers that report the results of quality improvement initiatives in palliative care.

Submissions should describe:

- The specific quality improvement projects, such as efforts to increase pain screening, encourage goals discussions, promote palliative care consults, encourage earlier hospice referrals, or support staff well-being; and
- The impact of the intervention, either in terms of change over time or relative to a comparator.

Submissions should include:

- A structured abstract with five headings (Background, Measures, Intervention, Outcomes, Conclusions/Lessons Learned), not to exceed 150 words.
- Five sections (Background, Measures, Intervention, Outcomes, and Conclusions/Lessons learned), not to exceed 1,250 words.
- No more than 10 references and two graphs or tables. (References/tables/graphs are not included in the word count.)
- A cover letter specifying that the paper (i.e. Brief Report) is being submitted in response to this Call for Papers.

Email submissions to JPSM by April 15, 2011.

About Evaluation and Acceptance:
Papers that fulfill the length and formatting requirements will undergo preliminary review by the editors, and some will undergo external peer review. Acceptance for publication will depend on evaluation of the problem addressed, innovation, quality of the description, and clinical relevance of the intervention and outcomes.

Questions:
Questions about the format or content of potential manuscripts should be directed to Dr. David Casarett (Casarett@mail.med.upenn.edu).

continued on next page
Through NHPCO’s Webinars, you can bring nationally known speakers to your organization twice a month to keep staff current on the many changes affecting the field, while also helping them earn necessary CE/CME.

**Upcoming Webinars:**

**April 14:**
Whose Needs Are You Meeting?
Providing Truly Patient/Family-Centered Care  
**CE/CME Offered:** Counselor, Nurse, Physician, and Social Work

**April 26:**
Concurrent Care Models – Current Status and Future Predictions  
**CE/CME Offered:** Nurse, Physician, Counselor and Social Work

**May 12:**
Assessing Patient/Family Needs: Initial, Comprehensive, Bereavement  
**CE/CME Offered:** Counselor, Nurse, Physician, and Social Work

**May 24:**
Are You at Risk? Top Compliance Risk Areas  
**CE/CME Offered:** Nurse, Physician, Counselor and Social Work

**June 9:**
Challenging Patients/Families: Approaches, Strategies and Interventions  
**CE/CME Offered:** Nurse, Physician, Counselor, and Social Work

**June 28:**
Surveyor Says…” Top Ten Hospice Survey Deficiencies and the Top Ten Solutions  
**CE/CME Offered:** Counselor, Nurse, Physician, and Social Work

**July 14:**
You “Lost” Them? Tackling Drug Diversion  
**CE/CME Offered:** Counselor, Nurse, Physician, and Social Work

**July 26:**
Write it Right: Documenting with Accuracy for Increased Scrutiny  
**CE/CME Offered:** Counselor, Nurse, Physician, and Social Work

**August 11:**
Reaching, Influencing and Collaborating with Community Physicians to Increase Access  
**CE/CME Offered:** Nurse, Physician, and Social Work

**August 23:**
Physician Contracting and Billing: Dotting “I”s, Crossing “T”s  
**CE/CME Offered:** Nurse, Physician, and Social Work

For the full schedule and registration details, visit the NHPCO website: [www.nhpco.org/webinar](http://www.nhpco.org/webinar).

**Member Rates**

- **1 Webinar:** $85  
  (or $95 with MP3 download)
- **6-Webinar Package:** $450  
  (or $510 with MP3 download)
- **12-Webinar Package:** $899  
  (or $1,019 with MP3 download)

All Webinars are held from 2:00-3:30 p.m. (ET).
March is National Social Work Month: Give the Gift of Knowledge

In recognition of National Social Work Month, NewsLine asked Sherri Weisenfluh, LCSW, ACHP-SW, the Social Work Section leader for NHPCO’s National Council of Hospice and Palliative Professionals, to share some of her favorite social work resources—as a possible gift idea for the social workers serving your program. While it was no small feat to winnow them down to a select few, here are several that Sherri recommends:

**The Journal of Social Work in End of Life and Palliative Care**
Published by Taylor & Francis Group and edited by Ellen Csikai, this is a peer-reviewed journal that publishes psychosocial research and invited articles. It is an excellent source of current information.

**Dying, Death and Bereavement in Social Work Practice**
Written by Terry Wolfer and Vicki Runnion, this book offers a set of detailed case studies and companion teaching notes that can be utilized for orientation, clinical supervision or to facilitate discussion of common ethical dilemmas. It is published by Columbia University Press.

**Living with Dying**
Published in 2004 and edited by Joan Berzoff and Phyllis Silverman, this is another excellent resource for social workers seeking a deeper understanding of social work practice. Berzoff and Silverman cover theoretical aspects of death and clinical practice issues, and offer chapters on leadership and self care.

**Just Released—Oxford Textbook of Palliative Social Work**
Shirley Otis-Green, Lisa Kilburn and Terry Altillio worked with social worker authors (both national and international) to create this inaugural textbook, reflecting a vision of palliative care that is integrated across settings, populations and disease states. It is a companion volume to the Oxford Textbook of Palliative Medicine and Oxford Textbook of Palliative Nursing. (See the display ad on page 25.)

March was officially established as National Social Work Month in 1984 by President Ronald Reagan. Under the leadership of the National Association of Social Workers (NASW), the month of March serves to promote social issues and the profession. As this year’s theme, NASW has chosen “Social Workers Change Futures” to promote the role of the social worker as a positive change agent. Learn more by visiting the NASW website.

NHPCO salutes all social workers, especially those who have dedicated their practice to end-of-life care.

Your expertise helps patients and families find peace and dignity during the most challenging stage of life.

Thank you.
New Volunteer Outreach Materials
Now Online

Every year, NHPCO provides members with a range of outreach materials to help them recognize the volunteers in their programs and communities during National Volunteer Week—as well as throughout the year.

A snapshot of the materials you'll find on the NHPCO website is shown below. Members can use these materials in any way they see fit—the copy or the graphics can be used in other program materials or “as is.” NHPCO’s goal is to make it easy and affordable for members to honor these special individuals.

Display Ad/Poster
The display ad/poster is available as a PDF, with the Volunteer Week date (as shown on left), or without the date.

Recognition Ideas & Outreach Suggestions
• Ideas and Examples from Providers (PDF)

Document Templates
• Press Release (Word)
• Media Alert for an Event (Word)
• Letter to the Editor (Word)
• Public Service Announcements (Word)
• Proclamation (Word)

Volunteer Facts & Statistics
• Volunteering and Hospice: Facts from NHPCO (PDF)
• US Department of Labor: Volunteering in the US in 2010
• Points of Light Institute: Facts on Volunteering (PDF)

Also posted on the NHPCO website are copies of popular volunteer recognition logos that you can download and use in your materials, plus links to other helpful resources. Visit www.nhpc.org/communications and select “2011 National Volunteer Week Outreach Materials.”

Also, see page 26 for a range of gift items available from NHPCO’s Marketplace.
“...The breadth and depth of content in this *Textbook* are monumental. They have defined the field and in doing so, there is no turning back.”

—From the Foreword by Betty Ferrell, PhD, MA, FAAN, FPCN, Research Scientist, City of Hope Medical Center

2011 • 848 pp
9780199739110 • Hardback • $99.95/$79.95

Oxford University Press
www.oup.com/us
Never worry about volunteer recognition again! These exciting new milestone lapel pins can solve it all! Each yearly design comes in a beautiful and distinct color, featuring an elegant symbol of excellence and achievement in the center of the pin.

The Olympic torch incorporated into a “V” for volunteer and surrounded by laurel leaves is raised in 14K gold layered surface.

Hospice Volunteer Milestone Recognition Lapel Pin
Select the specific year, from one year to ten, fifteen or twenty! Each pin has “Hospice” text distinctly featured under the centerpiece design to specifically recognize your volunteer’s hard work and dedication.

Hospice & Palliative Care Volunteer Milestone Recognition Lapel Pin
Select the specific year, from one year to ten, fifteen or twenty! Each pin has “Hospice & Palliative Care” text distinctly featured under the centerpiece design to specifically recognize your volunteer’s hard work and dedication.

For more information
CALL 800/646-6460 GO TO WWW.NHPCO.ORG/MARKETPLACE
National Volunteer Week is in April! Acknowledge your hard working volunteers with this wonderfully coordinated collection of handy items specifically designed for them!

A. Hospice Volunteer Tote Bag
The beige with orange trim Hospice Volunteer tote bag is an eye catching tote that keeps you organized while on the go. The front features a pen loop (pen not included) for easy access, a large main compartment with zippered closure, an interior organizer for pens, MP3 player and business cards. It is made of 400 denier polyester and is 17.5” x 14” x 3”.

Item #: 821477
Member: $13.00
Non-Member: $17.00

B. Hospice Volunteer Note Pad
The Hospice Volunteer purple or white 4” x 5 ¼” spiral notebook with an attached folding mini pen is perfect to keep your notes or to give as a gift.

Item #: 821478
Member: $5.95
Non-Member: $8.95

C. Hospice Volunteer Lunch Bag
Enjoy your lunch in style with a Hospice Volunteer silver lunch bag made of 600 denier polycanvas. Features include a dual zippered insulated main compartment, an additional outside pocket, mesh side catch pockets, and an adjustable black comfort shoulder strap. The size is 8” x 7” x 5” and will hold a lot.

Item #: 821479
Member: $10.95
Non-Member: $13.00

D. Hospice Volunteer Photo Frame
Brighten up your day with your favorite photograph. The Hospice Volunteer white photo frame has a digital display desk clock, calendar and alarm functions. It also includes wall pegs or a stand. The AA batteries are included but not inserted.

Item #: 821480
Member: $12.95
Non-Member: $15.95

E. Hospice Volunteer Bookmark
Celebrate this special week with a Hospice Volunteer bookmark. The white 2” x 7” laminated 10 point coated paper bookmarks have a white tassel.

Item #: 821481
Member: $1.00
Non-Member: $1.50

F. Hospice Volunteer Keylight
Light up Volunteer Week with a silver oval key light with a white LED light. The button cell batteries are included.

Item #: 821482
Member: $5.00
Non-Member: $7.00

G. Hospice Volunteer Travel Mug
This 16 ounce silver stainless steel travel tumbler is a great way to display the Hospice Volunteer logo while quenching your thirst. The tumbler has an insulated steel outer wall and plastic liner. The lid screws and has a slide opening. Keep it for yourself or get one to give to others.

Item #: 821482
Member: $12.95
Non-Member: $15.00

For more information
CALL 800/646-6460 GO TO WWW.NHPCO.ORG/MARKETPLACE
NHPCO’s National Council of Hospice and Palliative Professionals (NCHPP) is comprised of 40,000 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 Quality Assessment/Performance Improvement Section, and an article by Ellen Martin.....
Miranda Fontaine is the lead chaplain at Hospice Austin. As a frontline manager at the largest nonprofit hospice in central Texas, Miranda has responsibility for all aspects of spiritual care services, including chaplain assignments and coverage, hiring, training, meeting organizational and regulatory requirements, maintaining community relationships, and working with the chaplain team to improve care. Spending time with Miranda gave me a new appreciation for the complexity of her role, helped me understand the unique skills and educational background of chaplains, and made me think about my role differently—I am a nurse with responsibility for the quality program in our organization.

We met on a Friday morning promptly at 8 a.m. Right away I could tell it was going to be a busy day. Miranda’s first step each day is to review incoming communications that are relevant to the spiritual care team. She started with the admission-list email and then listened to voicemail to get updates on staffing and patient transfers to hospitals or to home, deaths, and discharges. As on most days, several new patients were admitted. Miranda looks up where each patient lives, current chaplain caseloads, and whether a readmitted patient has a previous relationship with a chaplain. She makes the assignment and posts it to a folder on the network so the chaplains can access it, and leaves a chaplain team voicemail so the assignments are also accessible by phone.

One patient was transferred from home to the hospital and Miranda coordinated with the social worker who knew the patient and family needs and when a spiritual care visit would provide the most benefit. Hospitalizations are often the result of a sudden or unexpected change in the patient’s physical condition and a change in prognosis or shifting goals of care can intensify feelings of grief and loss in the patient and family. While I knew that hospice care is a service that responds to the ever-changing needs of patients and families, I was surprised by just how many changes there are to keep track...
of on any given day. According to NHPCO Facts and Figures, 34.4 percent of hospice patients are on service for 7 days or less1, so chaplains try to develop a trusting relationship quickly. It requires more communication and coordination than I realized to make sure spiritual needs are addressed, sometimes urgently. The morning flew by. A new chaplain arrived for orientation at 10 a.m. Miranda went over the spiritual care reference guide that outlines work expectations, forms and procedures, and Medicare timeframes for the comprehensive assessment and care plan updates. The entire chaplain team reviews the guide each month for a refresher and to generate discussion about issues and barriers to care. The monthly chaplain meeting is also a time to support each other. With time and experience, chaplains become more comfortable with serious illness, dying and death, but initially, that support is so critical. “We don’t get used to it, or numb, but comfortable in the sense that it is an important part of life and a transition we all go through,” Miranda explained. Later, she told me that the biggest challenge for most chaplains is learning to use the electronic medical record. It is not very user-friendly or intuitive and even people with good computer skills struggle. Generally speaking, chaplains are less documentation-oriented than other disciplines, but Miranda and the chaplain team consistently have excellent ratings on documentation audits.

When interviewing chaplain candidates, the most important characteristic Miranda looks for is “great compassion.” She uses behavioral interviewing techniques to elicit specific examples of past performance, such as “tell me about a time you recently participated on a team.” Miranda listens for tolerance and collegiality. If the response is centered on the self, the person may have issues working with others. She also listens for humility. No one has all the answers and if a person comes across as if he or she has nothing more to learn, then the person may have difficulty coping with organizational change or assimilating new knowledge that doesn’t fit with his or her existing worldview. I didn’t realize that many chaplains have advanced degrees with extensive training in communications, ethics, and counseling.

Miranda doesn’t worry about each chaplain’s style or approach because everyone is different and has unique strengths. She does talk with each chaplain about basic presentation and shares her expectations about being constantly aware of tone of voice and body language. She coaches new chaplains on how to make a first-contact phone call in a way.
that sounds inviting without being “too peppy.” She also coaches them on ways to frame conversations to make sure the patient and family understand the services being offered so they can make an informed choice to accept or decline hospice. Small changes in the way chaplain services are offered influence the acceptance of spiritual care services. According to one study on hospice service utilization, about 60 percent of patients report receiving spiritual care, but at Hospice Austin it is closer to 80 percent. A common misconception is that spiritual care is only about religious traditions and prayer, but as Miranda explained, “chaplains respond to whatever the patient finds important.”

**More than Anointing the Sick**

One of the most important aspects of a leadership role is the ability to effectively communicate the unique contribution each discipline makes towards healthcare outcomes. Miranda is frequently asked to participate in guest lectures and panel presentations to educate students on spirituality at the end of life. When you say the word chaplain, many healthcare providers immediately think about religion or rituals, such as anointing of the sick. This limited view of spiritual care is akin to describing nursing as “giving pills and shots.”

Effective spiritual interventions involve establishing trusting relationships and creating a safe space for patients and families to talk about issues of meaning, hope, and transcendence. In the past, data to measure the effectiveness of spiritual care has been limited to bereaved caregiver evaluations of hospice care. Miranda has led her team in an effort to develop a new spiritual care documentation system that integrates ongoing assessment with the plan of care. This system not only facilitates chaplain documentation, but allows measurement of spiritual care outcomes individually and in aggregate for quality improvement.

Nurses have the opportunity to recognize early signs of spiritual distress and encourage patients and families to meet with their chaplain. Although nurses may have spiritual beliefs and practices in the same way a chaplain might have health beliefs and practices, chaplains are the most qualified to do a spiritual assessment and work with the patient and family to develop a spiritual plan of care. Patients and families benefit most when the team works together to ensure needs are met by the appropriate discipline. Job shadowing allows the participants to share perspectives. It is not so much about specific activities (what they do and how they do it), but more to gain insight about what it means to the overall patient and family experience of hospice care.

**Ellen Martin** has worked in healthcare quality improvement for over 15 years, and is currently the director of performance improvement at Hospice Austin in Austin, Texas. She is a Certified Professional in Healthcare Quality, a senior member of the American Society for Quality, and a member of NHPCO’s National Council of Hospice and Palliative Professionals Quality Assessment/Performance Improvement Steering Committee. Ellen is also a third-year doctoral student at the University of Texas at Austin and hopes to teach some day.

**References**

Section Activities: Monthly Chats

The NCHPP Quality Assessment/Performance Improvement (QAPI) Section holds monthly chats—or conference calls. These chats, which are open to all members who join the QAPI Section, are one of the easiest ways to communicate as a diverse group of professionals working in all corners of the country.

While the format of each chat is informal, the topics for discussion are developed in advance so members can join the calls that interest them most.

Upcoming Chats

All chats are held the second Thursday of each month, from 3:00 to 4:00 p.m. (ET).

**March 10:** HIPAA & Compliance
Facilitator: Rhonda Fisher-Brown

**April 14:** Face to Face Physician Visits—Best Practice
Facilitator: Katie Weyandt

**May 12:** Using Checklists for Quality Improvement
Facilitator: Ellen Martin

How do I join the chat?

Once you enroll in the QAPI Section, you need only dial in, toll-free, to join the call: (866) 355-8646. However, please do NOT dial in earlier than 2:55 p.m. on the day of the call and please make sure you’re enrolled in the QAPI Section first.

What are the remaining topics for 2011?

As future topics are determined, the schedule is updated and posted in the QAPI Section Library of My.NHPCO.*

Are there other ways to connect with QAPI Section members?

Absolutely. By joining NHPCO’s professional networking site, My.NHPCO (which is also free to all members), you can join the QAPI eGroup and benefit from online discussions. Turn the page to learn more.

*You will need your NHPCO log-in ID and password to access My.NHPCO. If you need assistance, or have other questions, contact NHPCO Member Services at 800-646-6460.

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How do I join the QAPI Section?

Joining NCHPP and enrolling in the QAPI Section is free to all staff and volunteers of NHPCO provider-members. Visit the NHPCO website to complete the brief application.
Get Involved

One of the easiest ways to get involved in the NCHPP Quality Assessment/Performance Improvement 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 to watch the introductory tutorial, then go to the tab, “Getting Started,” for details:

Information about NCHPP is also available on the NHPCO website: www.nhpco.org/nchpphome.
Two Great Speakers • Four Convenient Locations

THE GOOD DEATH, GOOD GRIEF, GOOD FUNERALS
Finding Our Place on the Continuum of Care

Featuring Dr. Thomas G. Long and Thomas Lynch

Dr. Thomas G. Long is the Bandy Professor of Preaching at Candler School of Theology at Emory University in Atlanta, GA. He is the author of many books including, The Witness of Preaching and Accompany Them with Singing: The Christian Funeral.

Thomas Lynch is a writer and funeral director from Milford, Michigan. He has taught with the Graduate Program in Creative Writing at University of Michigan. His books include The Undertaking, which became an Emmy Award-winning PBS documentary by the same name.

A seminar for clergy, hospice and health care professionals, educators and funeral directors focusing on strategies for better serving the dying, the dead and the bereaved.

Dates/Locations/Time/Fee: 1-4 p.m. $50 per person, per seminar
April 5, 2011 Northampton Community College, Bethlehem, PA
April 6, 2011 Mt. Ida College, Newton Centre, MA
April 12, 2011 Emory University, Atlanta, GA
April 18, 2011 University of Notre Dame, South Bend, IN

Up to 3 hours of continuing education may be available for licensed funeral directors, based on state requirements, and members of the clergy. NOTE: Should unforeseen circumstances occur, dates and locations may be subject to change.

Presented by the National Funeral Directors Association in cooperation with the funeral director associations of AL, CT, IL, IN, GA, MA, ME, MI, OH, NC, NH, NY, NJ, PA, RI, SC, TN, VT

For additional information or to register visit www.nfda.org/outreachseminars
One-of-a-Kind Hospice Unit Opens for Ohio Veterans

Through a public-private partnership, the Ohio Department of Veterans Services and Stein Hospice have opened a new 22-bed hospice unit at the Ohio Veterans Home in Georgetown, OH. The Georgetown home is the first Veterans Home in the country to offer hospice services in a designated, in-house unit.

The Ohio Department of Veterans Services selected Stein Hospice as its partner based on the hospice’s well-established service to Veterans at the state’s other Veterans Home in Sandusky. Rather than a designated area, Sandusky hospice patients are located throughout the home and are cared for by the on-site Stein staff, who are available around the clock.

Stein is one of a dozen hospices nationwide to reach the first level of “We Honor Veterans,” a national campaign unveiled in September by NHPCO and the VA that focuses on quality care for our nation’s Veterans. To learn more, visit the We Honor Veterans website. Be sure to also see the NewsLine feature about the new site.

Pepsi Grant Funds Covenant Hospice Community Workshops

Covenant Hospice (Pensacola, FL) received a $25,000 grant from Pepsi to sponsor a series of 36 workshops in six coastal communities of Florida. The “Strength and Resilience Community Workshops” focus on refreshing ways to cope with loss, and support each other through times of changes, stress and grief. The grant funding came from the Pepsi Refresh Project, “Do Good for the Gulf,” conducted in August 2010 to support communities affected by the oil spill.

Sylvester and Waller Join Samaritan Care’s Senior Leadership Team

Samaritan Care Hospice of Florida (Orlando, FL) has appointed Eva Sylvester and Robin Waller to its senior leadership team as part of the organization’s ongoing commitment to ensure high-quality service delivery.

Eva Sylvester, who was appointed executive director, has more than 30 years of healthcare leadership experience, including two decades in hospice, homecare, and palliative care.

Robin Waller, RN, CHPN, who assumed the newly created position of director of patient services, has nearly 25 years of healthcare experience, including 10 years in hospice and palliative care.
Sim Named Chief Operating Officer

Hospice & Palliative Care of Cape Cod (Hyannis, MA) has named Carol Sim chief operating officer.

Sim, a registered nurse, became interested in hospice in the 1970s, when she was a rehab nurse at Yale/New Haven Hospital and later the CEO of a VNA in the New Haven area. Most recently, she served as president/CEO of the Rehabilitation Hospital of the Cape and Islands (RHCI). Under her leadership, RHCI offered cutting-edge programs and received numerous awards.

Ferguson Recognized as Unity Guardian Angel

Unity (Green Bay, WI) has selected hospice volunteer, Kay Ferguson, as the recipient of the 2010 Unity Guardian Angel Award.

Ferguson has been a long-time supporter of Unity, serving as a volunteer since 2005. She has donated over 820 hours to the organization, serving as a volunteer companion and vigil volunteer as well as assisting with community outreach and development.

Hospice of the North Shore Acquires Partners Hospice

Hospice of the North Shore (Danvers, MA) has signed an agreement with Partners HealthCare at Home for the acquisition of Partners Hospice.

For 30-plus years, Hospice of the North Shore has provided inpatient and home-based hospice and palliative care services, including state-of-the-art programs in grief support and pediatric care. The acquisition of Partners Hospice will broaden the organization’s service area to include Greater Boston.
**Dorland Recognizes NHPCO Members and Staff**

The Healthcare Media Publisher, Dorland, launched its Annual Dorland Health People Awards in 2010 to recognize healthcare professionals who are making a difference in transitioning the patient through the complicated healthcare landscape. A special emphasis was placed on professionals who spearheaded efforts to increase access to healthcare and ensure that care is safe, quality-driven and cost-effective.

Among the 2010 award recipients were three NHPCO members and a member of the NHPCO leadership team. Julie Burnett, LCSW, a social worker for In-House Hospice and Palliative Care, was the winner in the Hospice/Palliative Care Professional category, and Samira Beckwith, the president/CEO of Hope Healthcare Services, was the winner in the Social Work Leadership category. In addition, Robin Gordon Taft, RN, MS, of RG Taft Consulting (and author of the blog, www.AllowingNaturalDeath.org), and NHPCO senior vice president, Kathy Brandt, MS, were Honorable Mention recipients in the Hospice/Palliative Care Professional category.

**New Documentary Examines Our Struggles With “Having the Talk”**

Motivated by their personal experiences with loss, Mike Bernhagen and Terry Kaldhusdal teamed up in 2009 to begin a creative journey that has resulted in the new documentary film, “Consider the Conversation.”

Bernhagen, the director of Community Engagement & Care Partner Relations at Rainbow Hospice Care (Jefferson, WI) and Kaldhusdal, a teacher and filmmaker from Oconomowoc, WI, donated more than 3,000 hours to the film’s production, which includes over 40 in-depth interviews with patients and families, healthcare professionals and national experts, and 62 “person on the street” interviews.

The film premiered at the Oconomowoc Art Center on February 5 to a sold-out audience. To learn more, visit www.considertheconversation.org.
Hospice of Wake Physicians Earn HPM Certification

Two physicians from Hospice of Wake County (Raleigh, NC) have passed their American Board of Medical Specialties examination in hospice and palliative medicine: Delani Mann-Johnson, MD, a palliative care physician; and Leslie Sutton, MD, a hospice home physician. With this good news, all four physicians with the program are now certified in hospice and palliative medicine.

Hospice Hawaii Receives Funds from Bank of Hawaii Giving Campaign

Hospice Hawaii (based in Honolulu) was one of just 20 local nonprofit charities to receive a donation from Bank of Hawaii, as part of its inaugural “Making a Difference” employee-giving campaign.

Bank employees and retirees raised more than $470,000 during the fund drive, while Bank of Hawaii contributed an additional $530,000. Donations for each beneficiary organization ranged from $5,000 to more than $280,000, based on employee designations.

Andy Duncan Elected to Alexandria Chamber of Commerce Board

Andy Duncan, the director of information services for NHPCO (Alexandria, VA), was recently elected to the Alexandria Chamber of Commerce board of directors. He has been NHPCO’s liaison to the Alexandria community for many years, representing the organization on the Chamber’s Government Relations Committee, serving on the Leadership Alexandria Steering Committee, and volunteering with the Alexandria Medical Reserve Corps. “While a national organization, building strong relationships in the local community has been very important to us,” said NHPCO executive vice president, Galen Miller. “Andy’s involvement has been quite helpful, especially since establishing the National Center for Care at the End of Life in the heart of Alexandria in 2008.”
Hospice and Palliative Care Coalition Reinforces Need to Speak with One Voice

The Hospice and Palliative Care Coalition is comprised of six organizations: the American Academy of Hospice and Palliative Medicine; Center to Advance Palliative Care; Hospice and Palliative Nurses Association; National Association of Social Workers; National Palliative Care Research Center; and NHPCO. Since its founding in 2001, the Coalition has met monthly to discuss regulatory and legislative issues, identify emerging trends and concerns across the field, and share information about the activities of each organization.

At its meeting in December, the Coalition reaffirmed its mission to (1) identify and support a common agenda relating to public policy, education and research; and (2) sustain and enhance access to high-quality services that honor patient and family healthcare decisions.

Coalition members also discussed key priorities for the next three to five years—priorities that are in sync with each organization’s goals and will be refined during the next 90 days. “I think each Coalition member found this last meeting of the year to be very productive,” said NHPCO President/CEO Don Schumacher. “With the many changes the field is undergoing, there was clear consensus on the importance of working together to improve quality of life for patients and families in all settings.”

Are you an emerging hospice leader?
Are budget constraints restricting you from attending the MLC?

Applications are now being accepted for a new initiative to advance the professional development of new hospice leaders. In today’s economic climate, hospice programs must carefully evaluate their budgets, and unfortunately professional education budgets are facing scrutiny and being reduced drastically. Hospice and Community Care Insurance Services is committed to the hospice industry and, in collaboration with NHPCO, has created a scholarship fund to ensure hospice leaders’ education needs are met.

Scholarship recipients will receive complimentary full conference registrations to the 26th Management and Leadership Conference. Space is limited, so submit your application today. For details and to apply, visit www.nhpco.org/mlc2011 today.
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.

If you are reading a PDF of this issue, please read the digital edition to access the information on the featured tabs. The digital edition is available on www.nhpco.org/newsline.
New Volunteer Outreach Materials Now Online

“The Seasons of Caring. The Caring of Volunteers” is the theme for this year’s volunteer outreach materials that NHPCO develops exclusively for members.

For a closer look at what you’ll find online, see page 24 of this issue.