POLST: An Evidence-based Tool for Advance Care Planning

By Michael Nisco, MD, MBA; James Mittelberger, MD, MPH; and Judy Citko, JD

The “Physician Orders for Life Sustaining Treatment” form, known as POLST, is designed to give seriously ill patients more control over their end-of-life care and is rapidly being adopted across the United States. In this article, we provide an overview of POLST, and then share our experience in developing and implementing POLST in California, with the hope that all NHPCO members will consider taking similar action in their own communities.

POLST Basics

POLST is a physician order that specifies the types of medical treatment that a patient wishes to receive toward the end of life. Produced on a distinctive brightly colored form and signed by both the doctor and patient (in some states), POLST travels with the patient when he or she is moved from one residential or medical setting to another. It ensures that the expressed wishes of patients always travel with them. As a result, POLST can prevent unwanted or medically ineffective treatment, reduce patient and family suffering, and help ensure that a patient’s wishes are honored.

The POLST form captures important and specific procedural decisions to guide care at the end of life, including wishes about attempting cardiopulmonary resuscitation, administration of antibiotics and IV fluids, use of intubation and mechanical ventilation, and provision of artificial nutrition. POLST also outlines patients’ wishes regarding whether they would want to receive comfort care versus limited or full intensive care, and whether they would want to be transferred out of their residence for treatment.
The goal of POLST is to provide a framework for healthcare professionals to execute physician orders that ensure that patients receive the treatments they DO want and avoid those treatments they DO NOT want. (By way of example, see the 2011 California POLST form.)

**History and Development**

POLST was first developed in Oregon in 1990 in response to concerns that traditional Do Not Resuscitate (DNR) orders and advance directives do not assure that a patient’s wishes for life sustaining treatments are honored.

Because advance directives are often not available or require medical interpretation before being followed, and because traditional DNR orders are vague and incomplete, many patients receive medical treatments that are not consistent with their wishes. Studies in Oregon and in other settings across the nation have demonstrated that POLST is significantly more effective in ensuring that patients receive the treatments they desire and avoid the treatments they do not desire.

**The POLST Paradigm**

A state or community wanting to implement POLST must meet certain requirements to qualify as an “endorsed” POLST Paradigm program. The requirements are established by the National POLST Paradigm Initiative Task Force, which is comprised of individuals who have experience and expertise in POLST Paradigm development. (See the Task Force’s website for an interactive map with helpful information by state.)

**Who Needs a POLST**

One of the advantages of POLST is also a limitation: POLST is not designed for all individuals. While anyone can have a POLST, it is designed for people who have a chronic progressive illness, serious health condition, or are medically frail. There are no age specifications, and POLST can be used with both adult and pediatric patients. To help determine who may benefit most from POLST, ask yourself this question: “Would you be surprised if this person were to die within a year?”

**POLST vs Advance Health Care Directives**

POLST does not replace an advance health care directive—POLST complements it:

- An advance directive should be completed by all adults, regardless of their health status. It allows individuals to appoint the person they want to speak on their behalf and provides a broad outline of the individual’s wishes relating to future end-of-life care. What’s more, an advance directive does not carry the immediate clarity of a physician order, and it is often unavailable when needed.

- In contrast, POLST is designed for the seriously ill. It identifies a patient’s specific wishes on key medical decisions based on their current medical condition. In addition, POLST is a physician order, and is designed to travel with a patient from one setting to another.

**POLST vs the Advance Health Care Directive**

<table>
<thead>
<tr>
<th>POLST:</th>
<th>AHCD:</th>
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<tbody>
<tr>
<td>For the seriously ill/frail, at any age</td>
<td>For anyone 18 and older</td>
</tr>
<tr>
<td>Specific orders for current treatment</td>
<td>General instructions for future treatment</td>
</tr>
<tr>
<td>Can be signed by decision maker</td>
<td>Appoints decision maker</td>
</tr>
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Remember, It Takes a Team

The nation’s budget deficit and the ongoing political debates about the health reform law, together with a 2012 election mentality, means that protecting Medicare reimbursement rates will continue to be challenging. I also know this weighs on your mind as you work especially hard to provide care at the bedside—under increasingly stringent regulatory requirements. So let me use this month’s column to reinforce one important thing: None of us should feel like we’re going it alone. That’s a key benefit of being part of a national organization.

Here at the National Center, NHPCO and the Hospice Action Network are continuing to build on some important relationships at the federal level. NHPCO senior staff joined me for a very constructive meeting with CMS Administrator Don Berwick on March 28, where we discussed the BNAF rate cuts, the concurrent care demonstration, FEHC and FEBS survey results and, of course, the physician ‘face to face’ encounter. This was a valuable exchange that complements the ongoing dialog we have with officials at both CMS and MedPAC.

On April 4, we were also successful in facilitating the introduction of the Wyden-Roberts HELP Hospice Act (S. 722) in the Senate. This bipartisan bill calls for establishing a payment-reform demonstration program to test and evaluate any prospective payment revisions to hospice; increasing the frequency of hospice surveys; and amending the face-to-face requirement to reflect operational realities. Regardless of the outcome, it will help reinforce our concerns among all members of Congress. In fact, let me thank our many supporters of last month’s Capitol Hill Day events—the strategy sessions, the Pep Rally on the grounds of the Capitol, and meetings on the Hill.

For me, last month’s entire Management and Leadership Conference reminded me of our power as a committed and unified group—yet every one of us has unique gifts to share and we each contribute to our mission of caring in an important way.

As she often does, my dear friend and colleague, Mary Labyak, the president/CEO of Suncoast Hospice, seemed to sum it up best. I was privileged to present her with the NHF Healthcare Architect Award at this year’s Gala and in a personal note that followed, she wrote “I am just one person… we all have different talents and are at different points in our careers and our lives. We all have different messages that others are starved to hear.” It does indeed take a team, and I am proud that each of you has chosen to be part of NHPCO and to work toward our mission of helping patients and families live their best.

J. Donald Schumacher
President/CEO
An advantage of POLST over an advance directive is that the decisions embodied in POLST require physician involvement and signature.

For example, POLST legislation that was enacted in California states that when the form is signed by a physician and the patient or the patient’s decision maker, it is a valid order anywhere in any setting, and must be followed by healthcare providers. The law also provides immunity for any medical action taken to implement the orders on the POLST.

A recent multi-state study published in *The Journal of the American Geriatric Society* demonstrated that POLST may be more effective than traditional advance directives alone in ensuring that patients’ preferences for life-sustaining treatments are recorded and honored.

POLST and advance directives each have their place in a continuum of advance care planning, as illustrated in the diagram on page 5.

**POLST vs Prehospital DNR**

<table>
<thead>
<tr>
<th>POLST:</th>
<th>Prehospital DNR:</th>
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<tbody>
<tr>
<td>Allows for choosing resuscitation</td>
<td>Can only use if choosing DNR</td>
</tr>
<tr>
<td>Allows for other medical treatments</td>
<td>Only applies to resuscitation</td>
</tr>
<tr>
<td>Honored across all healthcare settings</td>
<td>Only honored outside the hospital</td>
</tr>
</tbody>
</table>

...and distinguishes between cardiopulmonary resuscitation for someone pulseless and not breathing from interventions such as intubation and mechanical intervention. The former has extremely poor effectiveness in patients facing advanced illness, while the latter is often effective (though burdensome) in many debilitated patients.

The **POLST Conversation**

One of the ways that POLST helps patients control their end-of-life treatment is to facilitate communications about the topic between a patient, their family, and their healthcare providers. POLST provides a framework for guiding the conversation which makes it easier to have the discussion and more likely that patients will express their wishes and have those wishes honored.

One of the issues that makes these conversations difficult is that healthcare providers have long used the term “DNR” without a clear definition of exactly what the term means. Even providers in the same institution, working together for many years, will often have different interpretations of the meaning of a DNR order. With a long list of possible life-sustaining treatments available, it is essential that the term DNR have a well-defined meaning so it will be interpreted consistently.

The POLST paradigm defines DNR as efforts to resuscitate a patient in cardiopulmonary arrest. By using this definition, we separate the conversation about goals of care and treatment options into two parts: (1) what should be done if the patient is in cardiopulmonary arrest, and (2) what should be done prior to cardiopulmonary arrest. When the patient is in cardiopulmonary arrest, is the goal to attempt resuscitation (perform CPR and ACLS per protocol), or to allow a natural death (DNR)? We must also make a point to specifically discuss if the patient has any preferences for...
withholding treatment prior to cardiopulmonary arrest.

For many primary or palliative care providers, the POLST form supports an effective conversation about goals and intensity of care. After the provider reviews the patient’s goals, the choices on the POLST form allow for a patient to document specific decisions. This process allows the patient to (1) choose either the less or more invasive treatment approach without bias, and (2) begin to consider each treatment individually in terms of its benefits and burdens. From its very inception, and built into the definition of the POLST paradigm, the POLST order is grounded in a careful conversation with a provider.

Completing the POLST Form
The completion of a POLST form requires more discussion than just abstract advance care planning because it results in specific orders related to specific treatment options and a medical situation.

Having a conversation with a patient about end-of-life issues is an important and necessary part of good medical care. Like the transdisciplinary nature of hospice and palliative care, the POLST form and conversation may be completed by members of a patient’s care team, including physicians, nurses, social workers or chaplains. However, physicians (and in some states, nurse practitioners or physician assistants) are responsible for signing the POLST form and ensuring that the orders accurately reflect the patient’s wishes.

About the Implementation in California
California enacted legislation making POLST effective on January 1, 2009. Its rapid implementation in California continued on next page
was facilitated by grant support from the California HealthCare Foundation and broad engagement and support from a large array of stakeholders.

The grant support began in 2007, with nine small grants to community POLST coalitions. By 2009, when legislation was passed to enact POLST into law, the California POLST Task Force included more than 25 healthcare organizations, from palliative care and hospice providers to emergency physicians and multiple governmental agencies. Also involved were numerous consumer organizations.

This legislation has established a standardized POLST form in California. The California POLST Task Force Documentation Committee continues to monitor the form and revisions are implemented by the California State Emergency Medical Services Authority approximately every two years. A 2011 California POLST form became effective on April 1 of this year.

However, as those who are working to improve palliative care well understand, the final goal of ensuring patient rights will not be achieved with legislation or actions at the state level alone. A broad-based effort addressing the multiple barriers to advance care planning is required. Thus, the California POLST Task Force is also supporting work at the local level—more than 25 community coalitions have been established to engage individuals at hospitals, nursing homes, and physician offices. Medical societies and many large medical groups have also been instrumental in implementing POLST with a broad array of patients.

**Your Role as an Essential Proponent of POLST**

POLST is an important evidence-based tool to help ensure that patient wishes are honored and that unnecessary pain and suffering are avoided. Thus, it’s not surprising that hospice and palliative care providers have been leaders in the POLST initiative at every step. We encourage all of our fellow NHPCO members to implement and use POLST in their communities.

With this in mind, listed here are some of the key challenges we encountered in California’s implementation of POLST, followed by suggestions to help ensure your success.

**Some of the Challenges:**

- Difficulty getting the attention of key stakeholders
- A lack of end-of-life education among healthcare providers
- An attitude among healthcare providers that they already knew what they needed to know about POLST
- Poorly defined and disconnected systems for documentation of life-sustaining orders
- A lack of physician engagement in the POLST process
- A lack of meaningful conversation about the decisions documented on the POLST form
- The quality of the completed POLST forms
- Issues related to transferring POLST forms and records retention
- Moving from interest in POLST to active implementation
- Issues and misunderstanding about decision-making capacity and use of surrogates
- Translation of POLST into inpatient orders in the acute care hospital
• Regulations in residential care facilities that conflict with patient wishes on the POLST form regarding not being transferred to the hospital.

**Keys to Success:**

• Collaboration—it takes more than one organization or provider in a community to make POLST work
• Identification of physician champion(s) to ensure high physician engagement
• Building a POLST team and champion in each setting
• Building POLST coalitions of key stakeholders
• Recognizing the need for ongoing education.

The Coalition for Compassionate Care of California is the lead organization for POLST in California. It convenes the POLST Task Force and our POLST “physician champions” who provide vital support to California’s POLST initiative. We have developed train-the-trainer programs for physicians and non-physicians which are interdisciplinary in approach and based on the concept that full informed decision-making by patients may be enhanced by several conversations, not all of which require physician expertise.

**Resource to Help**

Forms, videos, PowerPoints and other POLST tools—for both providers and patients—are available on the national POLST coalition website (www.polst.org) and the California POLST website (www.capolst.org).

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*The authors wish to thank Susan Tolle, MD, director of the Center for Ethics in Health Care at Oregon Health & Science University, for her assistance with this article.*

*Special thanks is also extended to the Coalition for Compassionate Care of California for permission to reproduce the diagram and tables featured in this article.*
ICD-10: It’s Time to Begin Preparing

By Jean Acevedo, LHRM, CPC, CHC, CENTC
ICD–10–CM is the updated version of the ICD–9–CM code set that is currently used for (1) coding diagnoses on all healthcare standard administrative transactions and (2) coding procedures on standard inpatient hospital transactions.

The ICD–9 code set was developed by the World Health Organization and modified in 1977 for use in the United States. It has been in widespread use since 1988 and has been required for use under HIPAA since 2002.

The ICD-10 Final Rule (CMS-0013-F) was published on January 16, 2009. As CMS shared during a May 2009 presentation, the move to ICD-10 is fueled primarily by the following four factors:

- ICD-9-CM is not sufficiently robust to serve future healthcare needs
- Most developed countries have already made the change
- The number of codes is limited and the structure is restrictive
- Better data is needed to drive the changes necessary for healthcare.

Per CMS, October 1, 2013 is a “firm date” for implementation of the new ICD-10 coding system—and everything I’ve been reading on this topic tells me that there will be no delays.

When the U.S. healthcare system starts using ICD-10 to assign diagnostic codes to conditions, signs and symptoms, it will mean going from the approximately 14,500 diagnostic codes in use today to about 69,000.

Why Do This?
According to the American Health Information Management Association, “Today’s data needs are dramatically different than they were 30 years ago. Implementation of ICD-10-CM/PCS will advance healthcare in many ways, with benefits accruing across five major categories: quality measurement, public health, research, organizational monitoring and performance, and reimbursement.”

What Do the Changes Involve?
The primary changes in ICD-10 are in its organization and structure, code composition, and level of detail:

What ICD-10 Stands For
ICD-10 is the easier way to refer to the “International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)” and the “International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS).”
• ICD-10 codes have three to seven digits; ICD-9 codes have three to five;
• ICD-10 codes always start with an alpha character; ICD-9 codes have either a letter or a number as their first character;
• ICD-10 codes have increased descriptive granularity such as laterality (left, right, bilateral). For example: 50.511/Malignant neoplasm of lower-outer quadrant of right female breast; L89.012/Pressure ulcer of right elbow, stage II.

Suffice it to say, there will be a paradigm shift in medical record documentation. As the Medical Group Management Association’s Dr. William Jesse noted in 2008, “Moving to these new code sets has the potential to be the most complex change for the U.S. healthcare system in decades.”

While it is difficult to determine the amount of change involved in documentation, it is certain that additional time will be spent documenting care. The American Medical Association put it this way in 2008:

“...physicians who bill electronically would need to have electronic transaction software that can handle the upgrade. All physicians who take Medicare or private insurance would need to learn a new set of diagnostic codes that is often much more complex than the current system.... For example, a wrist injury with one ICD-9 code might have several ICD-10 codes that allow a physician to specify which wrist was injured, how severe the injury is and how the injury occurred. Also, some current codes have been condensed in ICD-10 or do not have an exact equivalent code in the new system.”

The documentation of physicians and other healthcare providers will require specificity not typically documented today. I doubt it is coincidental that electronic medical records (EMRs) are exceedingly more conducive to capturing this needed granularity than paper charts could ever be. It is interesting how, at the same time the medical community is being offered incentives to move toward EMRs, the industry will be transitioning to a coding system that almost demands documentation be done electronically. Without the requisite documentation detail, one will not be able to assign the appropriate codes.

In preparation for this article, NHPCO provided me with the “top 100” primary diagnoses codes used on hospice claims. Of the first 10 listed, three (428/CHF NOS; 290/senile dementia uncomplicated; and 331/Alzheimer’s disease) do not have a one-to-one correlation to any ICD-10 code and would require more detailed information to enable a coder to assign the diagnosis code. The table (on opposite page) shows three of the other common hospice diagnoses crosswalked from ICD-9 to ICD-10.

The hospice community will have to wait and see when CMS and other payers announce how specific payment and coverage policies will be converted to ICD-10 codes. At least CMS will undergo formal rulemaking to announce its final decisions for specific payment policies.

To complicate matters, while ICD-10 codes will be accepted for services provided on or after October 1, 2013, ICD-9-CM will continue to flow through
systems for a period of time for services provided prior to the implementation date.

For example, when a hospice claim goes in the first week of October 2013, it will be for services rendered in September and coded with ICD-9. However, two months later, when an adjustment is due (perhaps as a result of missing physician charges which must now be submitted), the revised September claim must also be submitted with the ICD-9 diagnosis codes—even though all current claims are now being submitted with ICD-10 codes. Clearly, you must be assured by your financial software vendor that this will be possible.

**Training Staff**

Organizations that are thinking about training physicians and other staff members in using the new codes should, at a minimum, plan to start their training from six to nine months before the 2013 implementation date. Staff responsible for billing and coding should already have a basic understanding of ICD-10—not necessarily a working knowledge, but if asked, should be able to provide management with answers about what is written here.

Clinical and administrative staff will require significant time to simply learn about the new codes. Since ICD-10 is not a simple substitution of one code set for another, the learning curve is expected to be quite steep for both clinicians and administrative staff, particularly for small- and medium-sized organizations that do not employ professional coders.

Detailed training will be required across the board for clinical and administrative staff involved in documenting patient activities, coding of medical

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**Sample ICD-9 to ICD-10 Codes For Common Hospice Diagnoses**

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>162.9</td>
<td>Mal Neo Bronch/Lung NOS</td>
<td>C34.90</td>
<td>Malignant neoplasm of unspecified part of unspecified bronchus or lung</td>
</tr>
<tr>
<td>496</td>
<td>Chr. Airway Obstruction, NEC</td>
<td>J44.9</td>
<td>Chronic obstructive pulmonary disease, unspecified</td>
</tr>
<tr>
<td>436</td>
<td>CVA</td>
<td>I67.8</td>
<td>Other specified cerebrovascular diseases</td>
</tr>
</tbody>
</table>

Training should, at a minimum, begin six to nine months before the 2013 implementation date.
and administrative records, information technology, health plan relations, and contracts. In addition, learned patterns and relationships among codes would have to be relearned because of the changed structure and organization of the code set.²

It is estimated that to understand the coding differences, approximately eight hours of training will be needed for coding and clinical staff.³ Hospices will need to determine the number of people to send to these training sessions. Both in-person and web-based training are available through CMS, the American Academy of Professional Coders, and other organizations.

Software Revisions: The Version 5010 Protocol

Effective January 1, 2012

Healthcare providers also need to start planning for another change: Implementation of the new 5010 protocol for submitting electronic claims that will become effective on January 1, 2012.

During a June 2010 conference call, Christine Stahlecker, director of the Medicare billing procedures division of CMS, said that electronic claims submitted to Medicare on or after that date must use the new protocol or they will not be accepted.⁷ Thus, providers, claims clearinghouses, and anyone else who will be using the new protocol should begin internal testing immediately if they have not done so already, followed by external testing as soon as possible.

Stahlecker also noted that the new protocol is needed because the current one, known as 4010, is outdated. She said that almost 500 change requests were received and addressed in the new version. If you think about it, your current billing software for submitting UB04s does not contain the fields necessary for using ICD-10 for claims submission while version 5010 does. There are other technical changes as well that may require the revision of intake forms to capture primary language spoken, etc. Electronic remittance advices and all other electronic protocols must be updated to the 5010 protocol as well.

What It Means for the Healthcare Industry

- Staff will need to be trained.
- Physicians will need to be trained.
- Software, and possibly hardware, will need to be updated or purchased.
- Revisions to forms will be required.
- Mapping of old and new codes must be completed.
- Your clearinghouse for claims transmission must be ready.
- Increased denials during the learning curve and some glitches are to be expected.
- There will be a need for both ICD-9 and ICD-10 for at least two years.
- There will be process and policy changes for both providers and payers.
- LCDs with diagnosis codes will need to be revised.

If you haven’t spoken to your software vendor about these changes, you must do so immediately. Within the next six months (depending on when you’re reading this article), your present software performing billing and collecting functions will be obsolete. Be certain to ask your vendor four key questions: When will your system be upgraded? When will testing begin? Will you require a hardware upgrade too? How much will all of this cost?
Concluding Thoughts

The differences between ICD-9 and ICD-10 are significant and physicians and practice management staff need to start educating themselves now about this major change so they will be able to meet the October 1, 2013 compliance deadline.

Any ICD-9 codes used in claims submission for services on or after the compliance date of October 1, 2013, will be rejected as non-compliant and the claims will not be processed. Consequently, it may be prudent to obtain a line of credit now, as a proactive measure, to avoid the possibility of cash flow disruptions.

The implementation of ICD-10 will pose a significant burden on all sectors of the healthcare industry—providers and payers alike. There may be benefits gained as a result of the more-detailed information reported by ICD-10 codes; however, it is clear that implementation will (1) require comprehensive training for clinicians and other staff and (2) involve significant changes in administrative systems that capture and report these codes.

While you may be unable to budget for software and hardware changes to the 5010 protocol in 2011, you will have to write those checks. However, it is not too late to budget for the conversion to ICD-10. Also keep in mind that how well you plan for this transition will have a direct impact on cash flow at the end of 2013. Think about who must be on the transition team to make this happen as seamlessly as possible. Make sure you provide them with the resources and time needed to help ensure success. And start now if you haven’t already!

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References:
1 Retrieved from the American Academy of Professional Coders ICD-10 Code Translator.
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In this new monthly feature, just launched in March, 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.”
is the first of several diagnostic-specific programs which Southern Tier Hospice and Palliative Care (STHPC) offers within its three-county service area in Upstate New York. Launched in 2009, it is a cardiac-specific hospice program that is meeting the specialized needs of patients who have suffered heart failure, but do not yet ‘believe’ that they are candidates for hospice.

“Cardiac patients usually fall through the cracks of home care services, leaving them with few options other than going to the ER or facing further hospitalizations,” says STHPC’s Provider Relations and Family Services Director Robin Stawasz, BS, LMSW. “And this is where LifeBeat is helping to fill an important gap. Our specially trained hospice team offers 24-hour coverage, self-care education, and day-to-day monitoring that enables these individuals to remain at home longer.”

Since its inception, LifeBeat has helped to reduce acute in-patient hospital days by 34 percent while increasing the program’s cardiac patient census by 284 percent. STHPC’s average daily census has also grown 34 percent. Here, Stawasz and STHPC’s Home Care Nurse Case Manager, Suzanne Scheib, RN, BSN, CHPN, answer some important questions for those members who may be interested in providing a similar service in their community.

**What prompted STHPC to launch LifeBeat?**

We realized that we—STHPC specifically and hospice generally—were underserving people with non-cancer diagnoses. Hospice has grown out of an oncology model and that does not meet the needs of all patients. It is not a “one size fits all” kind of business. We saw that people with cardiac heart failure (CHF) required a different approach to symptom management and care than our traditional population. In addition, these patients and their healthcare providers were not inclined to consider hospice as an option for care. Nonetheless, these people were clearly in need of exactly what hospice does best—palliative care and symptom management. We needed to find a way to bridge that gap.
Can you tell us more about it—what it provides and how it differs from “hospice”?

LifeBeat is hospice. While it’s specialized to meet the needs of cardiac patients, it is still hospice. All of our LifeBeat patients are expected to meet the Medicare guidelines for disease progression and prognosis, just like all hospice patients. Our goal, however, is to admit patients earlier on in the disease progression, when they can still receive considerable positive impact from quality symptom management. We therefore strongly stress the Medicare clinical guidelines for hospice admission with healthcare providers, moving as far away as possible from the “six months or less” that trips up so many, especially with a disease as hard to predict as CHF.

We also re-examined how we define palliative treatment. When deciding what is included in a care plan, we look less at “what are we doing” and more at “why are we doing it.” If the goal of a treatment is symptom control and the provision of the treatment is not causing undue burden for the patient and is being administrated in the most efficient manner available, some treatments that are normally not considered part of “hospice” become appropriate. This includes things such as hospitalization for IV diuretics if a patient has lost their oral route, and low-impact cardiac rehabilitation.

Our LifeBeat patients get all the benefits of hospice care with an added, aggressive program to monitor and respond to changes in cardiac status. People on LifeBeat are expected to check and record daily weights and vital signs. They are encouraged to follow a sodium-restricted diet as prescribed by their doctor and are expected to be medication compliant. These are the tools that best keep their edema, dyspnea and pain under control. We work closely with the patients and their families to educate, to support and to respond very quickly to any changes which may lead to decline. We call the doctor with any changes in weight that is greater than 2 pounds in 24 hours so that edema can be aggressively managed, leading to decreased dyspnea, increased comfort, and improved functioning. We try very hard to help the patient help themselves and have found that teaching cause and effect in the disease process leads to greater compliance and greater success on the part of the patient. When patients and families understand ‘why’ something is happening, they feel empowered to take the necessary actions to maximize and maintain their level of function. When patients begin a final decline, we are there to help support them, and transition them to end-of-life care.

Why do you use the name “LifeBeat”?

For so many cardiac providers and patients, “hospice” means dying and it means cancer. So, for those with heart disease, the word itself automatically shuts the door. For this reason, we elected to market the program under a separate name that captures exactly what is special and unique about our services to this group of people, while keeping the lines of communication open. It allows people to take another look at hospice and challenges some of their assumptions. We do not hide the fact that this is hospice, but we don’t have to hit them over the head with it either. We liked the idea of a positive, life-affirming name for the program as well!

Which hospice team members provide the care and what special training do they receive?

The whole team is part of LifeBeat. Our clinical staff receives training in cardiac disease
process, progression, medications, diet, and symptom management. Through this process, we combine all that is best about hospice with an added layer of cardiac specialty. Our social workers and spiritual care counselors are trained in the unique needs of the CHF population, and our LPNs are taught to evaluate cardiac symptoms and management.

**How is LifeBeat funded?**
Since these are hospice patients, we work with the standard hospice benefit systems. While we thought that some of these patients might be somewhat expensive to carry due to expanded care plans, long medication lists and such, this turned out not to be the case. Due to our ability to act proactively, effective symptom management and long lengths of stay, serving these patients has turned out to be extremely cost effective.

**When you first launched LifeBeat, how did you get referrals?**
We are fortunate to work closely with the nurse practitioner who manages Heart Failure Disease Management at the local medical center. She was an early champion of our program and helped us to connect with the cardiologists in our area. We provided direct education to the local cardiologists and primary care doctors as well. We went to these providers with the simple question, “how can we help you manage these patients?” By doing this, we included the providers as an integral part of the design of the program and it has proven mutually beneficial. We have also drastically improved our partnership with local hospitals as this is the only program they have seen so far that significantly reduces their readmission rate. Once we showed them what we could do for them, the hospitals themselves were looking for ways to promote the program.

**What have been some of the quantitative benefits?**
The benefits of LifeBeat far exceeded our expectations. The number of cardiac patients we were serving tripled and now they make up more than a quarter of our hospice census. Our average length of stay for all patients has almost doubled to just under 60 days. We were predicting that our acute inpatient days would increase, given the frequency that CHF patients seek hospitalization. However, due to effectiveness of proactive aggressive disease management, our days actually decreased by a third, even with our increase in census.

**What have been some of the qualitative benefits?**
We have seen a significant improvement in the quality of life of our patients with CHF. They
are staying where they want to be and avoiding the hospital as much as possible. They feel increased confidence in their care plan and their ability to manage the disease. Their symptoms are under better control. Both the patients and the families are less stressed and better prepared. Isn’t this what hospice is all about? In addition, our relationships with healthcare providers in the area have strengthened and our public profile has expanded.

**Do you recall some of the early challenges?**

It was difficult, initially, to help our staff look beyond their traditional view of hospice to a broader mindset, one that focused on symptom management to maximize quality of life regardless of disease process. We found that, with CHF patients, effective symptom management led to improved function, which left many of our staff feeling that the patients no longer needed us. It has taken some time for us as an agency to recognize that good symptom management IS good hospice care and should not be taken to mean that the patient is no longer hospice appropriate. We also needed to educate our providers that hospice can do more than care for people at the very end of life. For the patients, they needed help coming to grips with the fact that their diseases are life-limiting and that hospice is NOT there to displace their current medical management.

**What are your plans to serve other diagnoses?**

Later in 2009, we launched Living with Dementia, a hospice program specialized to the needs of dementia patients. That has been very successful in growing our partnerships with skilled nursing facilities. Recently, we launched our Breath program to provide care to people with respiratory disease. This is modeled closely on LifeBeat and we hope it will help us meet the needs of an even more severely underserved population—COPD patients.

**Any final thoughts or suggestions for fellow members?**

Change is hard and many people need time to acclimate. Make sure you provide frequent opportunities for enhanced education for your staff, and monitor closely to ensure that the protocols for treatment are being followed consistently. Our healthcare environment is changing. If hospice does not adapt and find how we best fit, we will be at risk. Diagnostic-specific programming is a powerful tool to keep hospice relevant and growing, while serving those who need our expert services.
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The Voice of NCHPP
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 Physician Section, and an article by Barry Kinzbrunner, MD....

continued on next page
t is well established that quality end-of-life care requires an interdisciplinary model of care that addresses not only the physical, but the psychosocial and spiritual needs of patients and families. For physicians who are, for the most part, scientists by nature and training, the spiritual component of comprehensive end-of-life care is probably the most challenging to fully grasp. This is due, at least in part, to difficulties in defining exactly what spiritual care truly means, the lack of objectivity that is inherent in the nature of spiritual care, and a significant disconnect between how patients and families view the importance of spiritual care and how it is viewed by the physicians who care for them.

What is Spiritual Care?
The word spiritual is derived from the Latin *spiritus*, which means “breath.” However, spirituality, which means matters of the spirit, is the term most often used to describe one’s association with the “spiritual.” But what exactly is spirituality? Herein lies the challenge. For in a comprehensive literature review performed in 2002, at least 92 different definitions of spirituality were found, which, fortunately, could be coned down into seven common themes: relationship to a higher power or reality greater than self; not of the self; transcendence or connectedness unrelated to a higher being; not of the material world; meaning and purpose of life; life force for the person; and summative definitions that combined two or more of the six themes already delineated.¹

Of these themes, there are two that would seem to oppose one another: “relationship to a higher power” and “transcendence or connectedness unrelated to a higher being.” In other words, what is the role, if any, of God or religion in spirituality and, therefore, in spiritual care?

Kearny and Mount² define religion and spirituality separately, with the former being “a dimension of personhood...a part of our being” while the latter is “a construct of human making that...enables conceptualization and expression of spirituality.” What is interesting is that, in essence, they define religion as a way of expressing, and hence, a subset of spirituality. The idea that religion may be one of a number of ways of expressing spirituality is further demonstrated by the final two statements in the definition of spirituality in the *Scottish National Health Service*...
Guidelines on Chaplaincy and Spiritual Care (2002): “Spiritual care is not necessarily religious. Religious care, at its best, should always be spiritual.”

In our diverse society, the acceptance of the notion that religiosity is just one of the ways to express spirituality can then allow for the development of a “neutral” definition of spirituality in palliative care, such as the one proposed by Cassidy and Davies: “[Spirituality]...has come to describe the depth of human life, with individuals seeking significance in their experiences and in the relationships they share with family and friends, with others who experience illness, and with those engaged in their treatment and support.”

**Spiritual Care: Physicians vs Patients**

While the vast majority of Americans believe in the existence of God (90 percent) or identify with a major religion (84 percent), the same cannot be said of the physicians who care for them. In fact, a 2005 study showed that physicians, when compared with the population at large, were less likely to carry their religious beliefs into other dealings in life (58 percent versus 73 percent); more likely to consider themselves spiritual but not religious (20 percent versus 9 percent); and more likely to cope with major problems without relying on God (61 percent versus 29 percent).

This discordance between the spiritual and religious attitudes of physicians and those of the general population...
The population is also reflected in several comparative studies. The first evaluated the importance of specific spiritual and/or religious needs near the end of life to patients and families, and to the physicians who cared for them. The study found that significantly more patients than physicians thought that “being at peace with God” (89 percent versus 66 percent), “prayer” (85 percent versus 56 percent), and “feeling one’s life was complete” (80 percent versus 68 percent) were very important.6

A second study, comparing how cancer patients and their physicians viewed the importance of various factors in decision making, demonstrated that while the patients and families ranked “faith in God” as the second most important of seven factors, (only exceeded by input from the medical oncologist), the physicians themselves ranked “faith in God” last.7

Finally, in a study evaluating the attitudes of the public and physicians toward potentially fatal traumatic injury, 57.4 percent of the public believed that divine intervention could save a person when the treating physician believed further treatment was futile. In contrast, this belief was shared by slightly less than 20 percent of trauma professionals.8

The practical consequences of this gap in attitude between patients and physicians regarding spirituality and healthcare is demonstrated by a study assessing how well patients believed their spiritual needs were being met. While only 45 percent of the patients questioned believed that spiritual or religious beliefs would influence their medical decisions if they became gravely ill, two thirds of the patients (irrespective of their answer to the first question) believed that this information should be elicited as part of the medical history. Only 15 percent of the patients, however, recalled having been asked.9

Health Outcomes Related to Spiritual Care

How can this gap between physicians and patients in regards to spirituality and spiritual care be closed? One way is to provide physicians with an evidence base which shows that the health of their patients is improved by the addition of spiritual care services to their treatment armamentarium.

Studies evaluating the efficacy of religious and spiritual care on health and illness have shown that spiritual care may have a protective effect against despair and depression in patients near the end of life. On the other hand, studies evaluating the effects of religious and spiritual care on morbidity and mortality in the overall patient population are much more controversial, with both positive and negative studies reported in the literature.10 Of note is a recent study that evaluated the effects of religiosity and spirituality on cognitive decline in patients meeting criteria for probable Alzheimer’s disease; it showed that higher levels of spirituality (as determined by a standardized scale) and participation in private religious practices were significantly
associated with slower rates of cognitive decline.\textsuperscript{11} Additionally, a meta-analysis of several studies that evaluated over 125,000 participants suggested a beneficial relationship between spirituality or religiosity and health status, although the considerable amount of heterogeneity among the studies greatly limits any conclusions that one can draw.\textsuperscript{12}

Finally, an interesting study on healthy volunteers demonstrated that modulation of the perception of pain may be influenced by viewing religious images prior to and during a painful stimulus and, based on functional MRI scanning, this modulation can be associated with a specific area of the brain, the right ventrolateral prefrontal cortex.\textsuperscript{13}

In order to evaluate the effects of religious and spiritual support on end-of-life treatment preferences and quality of life in advanced cancer patients, a number of studies have been generated from data collected as part of the federally funded “Coping with Cancer” study.

Most of the study population (88 percent) considered religion to be at least somewhat important in their lives. However, 47 percent felt that their spiritual needs were only minimally met or not met at all by their religious community, while 72 percent felt the same lack of support from the medical community—despite the fact that, for these patients, there was a significant association between quality of life and having their spiritual needs met.

A significant direct correlation was also found between the level of patient religiousness and the desire for life-extending therapies near the end of life,\textsuperscript{14} with a follow-up study showing that patients who use religion in a positive way to cope with their terminal cancer were almost three times as likely to actually receive intensive life-prolonging medical care in the last few days of life.\textsuperscript{15} Most recently, it was reported that when the spiritual needs of these patients were met by the medical team and/or by the pastoral care service, the patients had higher quality of life, were more likely to utilize hospice prior to death, and the sub-group who had high religious coping were less likely to receive less aggressive care at the end of life.\textsuperscript{16}

### The Physician’s Role in Spiritual Care

With evidence that patients and families believe that spiritual care is important, and that there may be some positive health-related outcomes associated with the provision of spiritual care, physicians have an obligation to ensure that patients and families

When the spiritual needs of these patients were met... the patients had higher quality of life...
receive spiritual care based on their specific needs.

To help accomplish this, the Working Group on Religious and Spiritual Issues at the End of Life published a series of recommendations in 2002, as noted below:

- When encountering patients, it is of most importance that physicians “elicit and identify any spiritual and/or religious concerns” that are present and may be affecting patient well-being. There are various available tools that physicians may utilize to ensure that the necessary questions are asked, although a more detailed discussion is beyond the scope of this article.

- The physician should attempt to “collaborate and connect with patients” by making sure that questions are open-ended, allowing patients to elaborate on any spiritual issues or concerns that are raised.

- The physician should be sure to “respect patients’ views and follow their lead,” realizing that these views may influence the therapeutic plan going forward. At the same time, the physician has a right to “maintain his or her own spiritual and/or religious integrity.” This can be rather challenging when patients, for example, ask physicians to pray with them. Recognizing the importance of prayer to patients and families, a physician might respond to such a request in a number of different ways that both validates the importance of the activity to the patient while, at the same time, not compromising the physician’s own belief system or professional role.

- Having learned from patients about any spiritual or religious issues that are important to their care, the interdisciplinary team should “develop a spiritual treatment plan that reflects appropriate goals of care.” Physicians should also be comfortable “utilizing appropriate resources,” such as the chaplain member of the interdisciplinary team.

As a final thought, it should be noted that a group of academic spiritual care experts convened in 2009 and, from this meeting, developed and published a set of consensus guidelines for improving the quality of spiritual care delivered to patients receiving hospice and palliative care. While discussion of these recommendations is beyond the scope of this article, it is hoped that these recommendations, together with the increasing evidence that spiritual care is important and necessary to patients and families, will allow physicians to become more comfortable with the idea that these services are as important a part of patient care as physical pain and symptom management.

Barry M. Kinzbrunner is executive vice president and chief medical officer for Vitas Innovative Hospice Care® based in Miami, FL, and has been involved in hospice and palliative medicine for over 26 years.
References:


Get Involved

One of the easiest ways to get involved in the NCHPP Physician 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.

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NHPCO members continue to raise questions about implementation of the Hospice Face-to-Face Encounter. In the March 28, 2011 edition of Regulatory Roundup, NHPCO shared the following clarifications from the Centers for Medicare and Medicaid Services (CMS) concerning several aspects of the rule.

**Using the ‘Same Physician’ for Recertification:**
One physician may be employed or contracted to conduct face-to-face encounters and sign the face-to-face attestation, while a different physician (either an employee of the hospice or under contract to the hospice) may complete the recertification process. If different physicians are involved, the physician conducting the face-to-face encounter and attestation should communicate the clinical findings to the physician who will be completing the recertification. For details, see CR7337.

**Discharges When Face-to-Face Encounter is Not Completed on Time:**
If a hospice does not meet the face-to-face encounter time frames (even for reasons due to exceptional circumstances), the hospice has failed to meet the threshold requirements for recertifying the patient’s terminal illness. Therefore, the patient is no longer deemed eligible for the Medicare Hospice Benefit (MHB).

The hospice may continue to serve the patient under hospice care, but must assume all financial responsibility for the care until the face-to-face encounter is completed. If the face-to-face encounter is completed and if the patient continues to meet the MHB’s eligibility requirements, the patient can be re-admitted to the MHB. For details, see the CMS FAQ.

**Physician Signatures for New Admissions in Second or Later Benefit Periods:**
Should both the attending and the hospice physician sign the recertification form when the patient is new to the hospice, but has received hospice services previously?

Medicare Hospice Regulations [418.22(c)(1)] require both the attending physician and the hospice physician to sign the certification of terminal illness forms only for the initial certification. Therefore, if the patient is in the second or later benefit period, only the signature of the hospice physician is required.

**Using Billing Occurrence Code 77:**
Per CMS, occurrence code 77 may not be used when the face-to-face encounter is not complete. The law requires the encounter to be completed prior to the start of the benefit period for eligibility to continue.
NHPCO Meets With Don Berwick

NHPCO conducts ongoing dialog with CMS to keep our federal officials abreast of questions and concerns from the field and, more importantly, to serve as the representative voice and advocate for NHPCO provider members. On March 28, this included a meeting with CMS Administrator Don Berwick.

During the exchange, NHPCO president/CEO, Don Schumacher and senior staff discussed rolling back the BNAF rate cuts, the concurrent care demonstration project, and results from NHPCO’s FEHC and FEBS survey tools as well as the face-to-face encounter.

Look for updates regarding these discussions in NHPCO’s NewsBriefs and Regulatory Alerts.

New Resource to Help

NHPCO has developed a laminated pocket guide to hospice admissions that describes the certification and recertification process, with special attention given to the face-to-face requirement. It features maps and tables to guide the admission team, hospice physician, or nurse practitioner through the process of certification and recertification, no matter what benefit period the patient is in. For details or to place an order, visit NHPCO’s Marketplace (Item 821733).

For additional tools and resources on the face-to-face encounter, visit nhpco.org/facetoface.
Harvest is a new independent film that is now airing in theatres around the country. Through the eyes of 20-something Josh Winters, we meet three generations of a family who have gathered together at the family home to bear witness to the passing of family patriarch, Siv Monopoli (played by Robert Loggia), while also trying to deal with their own challenges—and each other. Poignant and, at times, tragic, Harvest is also ultimately uplifting, with moments of humor that punctuate a very realistic portrait of a family hanging on.

Harvest’s writer and director, Marc Meyers, brought his film to the attention of NHPCO because he recognized it would resonate with hospice and palliative professionals on many different levels.

“There’s a beauty in how a family honors a loved one at the end of life,” says Meyers. “While this story was inspired by my own experience, many families across America are also saying goodbye to their elders, men and women from our ‘greatest generation,’ and this film is an ode to them too.”

Meyers recently spoke with NHPCO president/CEO, Don Schumacher, about the very personal reasons why he wanted to make this film and the positive feedback and accolades it has received thus far. Here’s an excerpt from their conversation.
Excerpts from Their Conversation

Don: First of all, thank you Marc. I think Harvest does a great job of depicting what can occur in a family’s life when someone is coping with the serious issues of aging. You had a similar experience in your own family’s life, correct?

Marc: I did. It’s based on a little bit of personal experience. So when I look at the movie, I really think it’s a combination of things that I was afraid could happen in a family, mixed with things that I wish would happen in a family. And I always knew that the summer that my own grandfather passed away was a very important, poignant moment in the chapter of a family, so I looked back at some journals I kept during that experience and used that as a loose inspiration that I reinterpreted dramatically to tell the story.

Don: Well, it clearly came through to me that you had experienced and understood what some of these issues were. It is very much the case with just about every hospice family that I have ever worked with—that there are highs and lows for all of it. Some people do very well communicating with each other, and some don’t communicate well at all. I thought the grandson in the film was especially great at bringing the newer generation into the conversation. I’m a baby boomer, and I know that everyone from my generation is dealing with these issues. So I think you will get quite a good response from this film. What kind of feedback have you gotten so far?

Marc: We’ve been showing it for about a year now. It was first viewed at the Cleveland International Film Festival—which is one of the

Many families across America are saying goodbye to their elders…and this film is an ode to them.

continued on next page
largest regional, international film festivals in the country—and we won the best American Independent Film Award there. That was the beginning, when people started to take note and congratulate us for producing a movie that was so full of all the emotions, the humor and sadness and pathos. I think people of all generations seemed to identify with the story, which was really our hope. Then, the film went on to other venues. The most recent responses from the Rehoboth Beach Independent Film Festival really struck a chord with me.

Don: Please tell us more about that.

Marc: Well, there are always a lot of people who are filled with all kinds of emotions after seeing the film. They want to hug each other or share how much it reminded them of their own family, or they just went through this or they are going through this or they could really relate to it. But the Rehoboth Festival was one of the more local, more intimate venues where the film aired. I remember a man came up to us after the screening and said he’s been a psychiatrist for his whole career, and that everything about this movie rang true to him. It felt so good for someone who really is connected to people to have said that.

Don: That was very nice feedback. I’m a clinical psychologist by training, and I also had a very similar reaction. The level of emotion, the level of conversation, and the interaction with the family members are very much a part of what I’ve observed over the last 30 years... of people trying to come to terms with aging and with loss. It was very realistic, especially the last 40 minutes of the film.

Marc: Thank you. I think that the goal in the first half of the movie is to lighten up the audience and just get them lost in this family. Maybe not always knowing where the family members are headed, but relating to each of them, and then suddenly realizing how invested they are in these characters. Then the film starts to focus in on what has been underneath the surface all summer and really starts to look at it up close.

Don: That’s exactly the response. You are actually very much a casual observer of this family for the first part of the film, and then all of a sudden you realize something big is going on, especially when Robert Loggia’s character talks about his combat experience on his death bed. We have a project here at NHPCO, We Honor Veterans, that recognizes our nation’s veterans and their war experiences, and the impact of those experiences during the last stages of their lives. Not only their own grieving, but grieving for the people who they killed in the course of combat. So I was very especially moved by that scene in the film and I thought it was exceptionally realistic.

Marc: Thanks so much Don. I’m glad that aspect of it came together so well.

Don: If you don’t mind, let me ask a more personal question. How did making this film, and drawing on your own experience, affect you personally? The whole process of watching the family go through what they were going through... of Robert Loggia’s character dying and Barbara Barrie’s character’s subtle way of dealing with dementia?
Marc: Well first off, the realization that you are finally actually making the independent film that you’ve imagined, and you are there with a crew and a cast that you feel blessed to have—that in itself was an extraordinary realization. Then there were certain scenes that I remember filming that felt so real to me they gave me chills because they were so connected to my own personal memories. In fact, I remember that during certain scenes, tears just started streaming down my face.

Don: In many ways I envy your skill and talent, but also your opportunity to have actually made the film. This is a very significant thing to have done.

Marc: Thank you. I was trying to recapture certain moments that were like clothes pins on a story that I created. While I don’t want to reveal too much of the ending here, I too was alone with my grandfather when he passed. And I just happened to have been there for the two days leading up to his passing. And that struck me so strongly. I know that, oftentimes, loved ones want to be present when their family members die and the family members will stay alive for them until they are able to be there. Then, once given the permission to go, or their loved ones leave the room, there is a little bit more freedom for that person to pass. I feel like that circumstance was at play at my grandfather’s death, where my own grandfather’s children, by stepping out of the room, allowed him to just stop. To have been there alone with him, at that very moment he died, has always stuck with me, and probably motivated me to write a screenplay that would lead up to that moment.

Learn more about the film and upcoming venues at [www.raisingharvest.com](http://www.raisingharvest.com).
Hospice and Palliative Care of Greensboro Physicians Earn HPM Certification

Four physicians from Hospice and Palliative Care of Greensboro (Greensboro, NC) have earned their Hospice and Palliative Medicine (HPM) board certification by the American Board of Medical Specialties.

Chief medical officer, Juan-Carlos Monguilod, MD, and staff physician, Rita Layson, MD, were re-certified; and staff physicians, Donald Hertweck, MD, and Nimish Gosrani, MD, became board certified for the first time. All four physicians also hold board certification in Internal Medicine.

Family Hospice & Palliative Care Partners with Faith Community to Improve Access

Family Hospice and Palliative Care (Pittsburgh, PA) has partnered with Bidwell United Presbyterian Church and the North Side Christian Health Center to launch Transitions, a program to help improve understanding and access to hospice care among African Americans living in Pittsburgh’s Greater North Side community.

Since July, the Rev. B. De Neice Welch, pastor of Bidwell United Presbyterian Church, has worked on an interim basis to familiarize the community’s congregations, organizations and businesses with Transitions, and now serves as its coordinator.

The program is made possible through funding from the Buhl and Highmark Foundations and the McKinney Charitable Trust.

Transitions builds on the relationship already formed between Family Hospice and Bidwell Church, which teamed up in 2009 to offer a free, monthly bereavement support group for members of their community.
Physicians with Unity and Hospice of Palm Beach County Earn HPM Specialty Certification

Physicians from Unity (based in Green Bay, WI) and Hospice of Palm Beach County (based in West Palm Beach, FL) have received Certificates of Added Qualifications (CAQ) in Hospice and Palliative Medicine.

Unity’s assistant medical director, Amanda Sommerfeldt, MD, received the HPM CAQ from the American Board of Family Medicine (ABFM)—and joins Unity medical director, Rance Hafner, MD, and Unity physician, James McGovern, MD, in earning this special certification.

Six physicians from Hospice of Palm Beach County also earned their HPM CAQ: Thomas Abraham, MD, and Julie Formoso-Onofrio, MD (from the American Board of Internal Medicine); Gail Austin Cooney, MD (from the American Board of Psychiatry and Neurology); Katherine Brazzale, MD (from the American Board of Family Medicine); Barry Miskin, MD (from the American Board of Surgery); and Karen Kennedy, DO (from the American Board of Anesthesiology).

continued on next page
Described as one of the most famous women of the 20th century, Elizabeth Taylor was an actor, philanthropist and advocate. Long after she had made an indelible impression through her work in film, the two-time Academy Award winner became one of the first public figures in America to speak out on behalf of people living with HIV/AIDS—calling for awareness, care, research and a cure.

During a time when many healthcare professionals were reluctant or unwilling to care for people with AIDS, Ms. Taylor openly embraced them, both physically and figuratively. As the pandemic grew in scope during the 1980s and 1990s, unbeknownst to the media, she made visits to patients with AIDS with the sole intention of brightening their spirits. She was a quiet visitor to many hospices which were caring for those dying from a terrifying illness.

She was also co-founder of the American Foundation for AIDS Research in 1985 and founded the Elizabeth Taylor AIDS Foundation in 1993. Elizabeth Taylor taught the world many important lessons about compassion and dedicated much of her life to ensuring that people facing HIV/AIDS would find dignity and support.

In Memoriam:
Elizabeth Taylor
1932 – 2011
NHPCO’s Upcoming Educational Offerings

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.
NHPCO's Hospice MDP is a unique hospice-specific management training program that helps professionals meet the challenges of managing programs, systems and people. Now, staff can complete Hospice MDP Levels I and II in just three months—without leaving home!

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