On the surface, maintaining professional boundaries may seem like something that isn’t all that important. After all, aren’t we in one of the “caring professions”? Doesn’t it always help to extend ourselves and go the extra mile to help patients and their loved ones? The answers are actually yes and no.

We need professional boundaries to guide and direct the relationships we have with patients and families for three very clear reasons—to protect the clinician, to protect the patient and family, and to protect the organization.

Staff who work in acute care benefit from having the physical boundaries of a facility to help remind them of their professional boundaries. As home care providers, however, it’s more difficult for staff to adhere to these boundaries because, as much as we might like to, we can’t really control...

continued on next page

Real Stories of Boundary Violations and What We Can Learn From Them

By April Perry, APN, MEd

Inside

New 2011-12 Outreach Materials
Each year NHPCO produces a collection of display ads, along with a range of other materials, for members to use during National Hospice and Palliative Care Month—and throughout the new year. Take a look at these beautiful new materials!

Hospice in the Continuum
Carolina East Home Care & Hospice began providing case management and adult day services for residents of eastern North Carolina over 10 years ago. Executive Director Lynn Hardy discusses both services, including the benefits and challenges in today’s fiscal climate.

The Voice of NCHPP
Hospice educators may sometimes feel they can’t dance fast enough to meet today’s many demands. NCHPP Research/Academics/Education Section leader, Mary Lou Proch, shares information to help managers stabilize the change process and plan for the future.

Plus...

- A Message From Don
- Bereavement Counseling Benefit for Veterans’ Survivors
- WHPCD: Plan Ahead to Show the World We Care
- Member News and Notes
- Regulatory Tip of the Month
- NHPCO Educational Offerings
what happens in the patient’s home. Relationships often play out much differently than those which develop in a more public arena.

There are, of course, serious boundary violations that can lead to criminal prosecution and legal liability. While these violations will be addressed in this article, they are the easy ones to spot and, in reality, are the most straightforward to deal with. So this article will focus more on the less-obvious boundary violations. The ones that are apt to elicit responses like “I don’t really see anything wrong with that” or preferably, “Ah… I never thought about it that way.” They are also based on real situations that I have learned about as different hospices have sought help in dealing with this difficult and prevalent problem (with names and other identifiers changed to ensure confidentiality).

**The 3 Reason We Need Professional Boundaries**

**To Protect the Clinician**

While many clinicians will view boundaries as restrictive, confining, and just more rules to follow, professional boundaries are necessary to help protect them. I have found that clinicians are more likely to pay attention to them when they come to understand this. Let’s take Paul for example:

Paul is a hospice clinical social worker. For some reason that is not clear, Paul’s elderly patient wants to give Paul an extra computer printer that he has. When Paul comes to visit, the patient has the printer packaged in a box and ready for him. Paul accepts the gift without reservation. He doesn’t really need a printer, but if he doesn’t find a use for it, he will just give it to his neighbor who has three school-aged children. It seems innocent enough—after all, it is just a computer printer. However, several days later, the patient’s son calls the executive director of the hospice for which Paul works and is nothing short of irate. He tells the executive director that he just found out his father has given one of the staff the computer printer and in the box, along with it, was $100 in cash. The son wants the money and the printer returned immediately.

Put yourself in the executive director’s shoes. Paul stated there was no money in the computer box and, from all of your dealings with Paul, you have no reason not to believe him. However, he didn’t report the gift to his supervisor, so she had no idea that this situation had even occurred. He did not open the box in front of her or anyone else, so there is no verification that the box only held the printer. Consequently, there is no way for hospice leadership to defend the staff member. Had Paul been better able to maintain professional boundaries, his actions may have been easier to defend and he would have been better protected.

**To Protect the Patient**

All patients are vulnerable on many different levels. Keeping the relationship professional will protect patients and their families from being exploited during their time of vulnerability.

**To Protect the Agency**

Protecting the agency from professional liability issues is important, but it is equally important to protect the agency’s reputation. If a staff member violates professional boundaries and there is a misunderstanding or hard feelings, the agency’s reputation can suffer. The family Paul was caring for was very upset and financial restitution had to be made. However, the damage to the agency’s reputation was far greater than the $100 that had to be repaid.

...continued on page 4...
This month, FHSSA is launching a special campaign to recruit 20 additional U.S. partners for 20 African hospices in need. To learn more, contact Erinn Nanney.

This month, as we celebrate World Hospice & Palliative Care Day, I’d like to acknowledge those members who are extending a caring hand a continent away.

Through NHPCO affiliate, FHSSA, and the FHSSA Partnership Program, there are 93 NHPCO member-providers who are partnering with 93 other hospices in 15 countries of sub-Saharan Africa.

As the president/CEO of both FHSSA and NHPCO, seeing connections, like these, being built and sustained is one more reminder of why I love this field and the dedicated professionals who serve it.

Last month FHSSA shared results from its annual Partnership Report. These yearly reports, which are completed by U.S. and African partners, help FHSSA identify the current challenges and needs among African providers—and how we can help. Like U.S. hospices, the needs vary, based on location (rural, urban or urban/rural) and primary diagnosis. While HIV remains the predominant diagnosis (60%), our African partners are also serving cancer patients (30%), and those with chronic diseases such as diabetes, tuberculosis and heart disease (10%).

FHSSA’s 93 U.S. hospices lend support in several ways—from simple camaraderie and the exchange of ideas and resources to technical and fundraising assistance. Through their contributions in 2010, $450,000 was sent directly to FHSSA partner programs, with an additional $122,000 in in-kind donations. FHSSA estimates that this support helped improve care for 60,000 African patients and 300,000 family members.

As you read this message, NHPCO’s 12th Clinical Conference is about to begin in San Diego. Its theme is “Leading and Innovating Quality Throughout the Care Continuum” and reflects the role we must each play, in every corner of this country, to make sure hospice remains relevant and valued as our nation’s healthcare system continues to evolve. But it also reflects some of the fine work we are already doing, here at home and a continent away.

J. Donald Schumacher
President/CEO
Data has shown that for every bad experience a person encounters with a business, they will tell at least 12 people. Imagine if each of those 12 people tell even one other person? It doesn’t take much to see how an agency’s reputation could be damaged through this process and how referral patterns could suffer. All of this can happen before a lawyer is ever contacted.

Remind staff that getting referrals from families and professionals is what keeps their salaries coming in. When referral patterns are damaged, fewer referrals are made, less income is generated, and fewer staff is needed. It is important to everyone that the agency’s reputation remain strong within the community.

**Some Guidelines for Staying Within the Lines**

As you reflect on your interactions with patients and families, the first and most important thing to remember is that everything you do must be *for the benefit of the patient*. That is the foundation of a therapeutic relationship. Hopefully in doing that, you will receive the self satisfaction you need to carry on in this difficult and, at times, emotionally draining work.

However, many staff members will say that most of the situations they deal with are not so black and white. As you work with patients and families, ask yourself the following questions to help evaluate if the interaction is therapeutic for the patient while also professionally appropriate:

- Can I discuss the patient interaction with all members of the interdisciplinary team?
- If this patient interaction made headline news in the local newspaper, would that be okay with me—and my supervisor and agency leadership?
- Am I doing this because it is the best thing for the patient or because it will bring me satisfaction?
- Is it more important that “I” do this for the patient, or can it be done by others in my organization?
- Can I document this interaction in the medical...
Laura is a new nurse going through orientation. She and her preceptor nurse are doing a later afternoon/early evening admission. At the end of the admission, as the case manager is giving the family information on how to contact someone from the hospice in the evening should they need to, Laura interrupts and says, “Oh, if you need something, let me just give you my personal cell number. I live a mile down the road. I can come help if you need anything.”

We would all applaud Laura’s enthusiasm and desire to help the patient and the family, and to provide the care they need. That is good customer service. However, as innocent and well-meaning as this offer may seem, it has a multitude of ramifications. Laura has now given the family her own personal information, which they could ultimately use for reasons unrelated to their care. She has also undermined the processes that are in place for meeting patient’s needs outside of regular work hours. Without intending to, she may have given the patient and family the impression that on-call staff may not be able to respond as well as she could. Finally, what if the patient calls Laura’s number at a time when she is not available or unable to respond in a timely manner? The agency would pay the price for her very innocent and well-intended action. Whether any of these consequences actually happen is irrelevant. It is simply prudent business practice to prepare for the eventualities.

Risky Behaviors

Several behaviors that are common to many staff can lead to boundary crossings or violations. Remind staff to avoid the following:

1. Interacting with patients outside of regular work hours.
   - The patient and the family ask for information or an aspect of their patient interactions. Remind staff to avoid giving personal information.

2. Withholding information (or an aspect of their patient interactions) with other members of the team. The patient and/or family ask for something they need, but it is not within their job description.

3. “Helping” the patient and/or family in areas outside their job description.
   - The third behavior is the one I have found to be the most common and most problematic—without illustrating the following example (which, again, is based on a real incident):

   1. Laura has now given the family her own personal information, which they could ultimately use for reasons unrelated to their care. She has also undermined the processes that are in place for meeting patient’s needs outside of regular work hours. Without intending to, she may have given the patient and family the impression that on-call staff may not be able to respond as well as she could. Finally, what if the patient calls Laura’s number at a time when she is not available or unable to respond in a timely manner? The agency would pay the price for her very innocent and well-intended action. Whether any of these consequences actually happen is irrelevant. It is simply prudent business practice to prepare for the eventualities.

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   - Interacting with patients outside of regular work hours.
   - Withholding information (or an aspect of their patient interactions) with other members of the team. The patient and/or family ask for something they need, but it is not within their job description.
   - “Helping” the patient and/or family in areas outside their job description.

How to Deal with Staff Who Cross the Line

1. If the act was well-intended and just misguided, acknowledge that the employee’s action was the reason that he or she makes a good employee—that it exhibits compassion and the desire to help people in need.
2. Help the employee broaden his or her perspective to imagine the worst-case scenario and see things from the agency’s perspective.
3. Assist the employee in defining the real need of the patient and how the need can be met within the policies and the bounds of professional conduct.
Marilyn is a hospice social worker. She has an elderly low-income patient who lives in a mobile home in a rural part of the county. It is mid-summer and Marilyn has determined that the patient could benefit from a window air conditioner. Her church has a benevolence fund, so she notifies the fund coordinator of the patient’s need. They agree to provide the funds for the air conditioner. At lunch time on Monday, she goes to the local home store, purchases a window unit that is small enough to fit in her car, goes home and changes her clothes, and proceeds to the patient’s mobile home to install it. Since it is a small unit, she decides she can get the job done during her regularly planned visit—and even plugs it in for the patient.

We all can see that Marilyn has identified a need and has gone out of her way to see that it’s been met. However, using the worst-case scenario question noted earlier, there are several problems in this real-life situation that bear closer review:

- Potential for a fire, electrical overload or other mechanical problem if the unit wasn’t installed correctly—and the resulting liability risks to the agency;
- Risk of injury to Marilyn during the installation (and, were an injury to occur, would she be eligible for worker’s compensation benefits?);
- Possible HIPAA violation, if the patient had not given Marilyn the permission to share his name with the church’s fund coordinator.

On the surface, this situation has that “feel good” overtone—which is often the case with many boundary violations. In fact, we can even see how this caring gesture could be extolled in the agency’s newsletter as an example of someone who goes “above and beyond” the call of duty. In doing so, however, it sends very mixed messages to staff as to what constitutes appropriate behavior and what crosses the line.

**The Problem With Dual Roles**

When staff become personally involved with patients and families, it can impact their therapeutic relationship—a situation known as dual roles. Here is one example:

*Nancy, the hospice nurse, has a young hospice patient who is dying of pancreatic cancer. His wife, Debra, does house cleaning, but is currently out of work. They have three children and their financial situation concerns Nancy. Since she has often contemplated having a professional housekeeper clean her house, she decides to ask Debra if she’d like to clean her house for pay—which Debra happily agrees to. The first two weekly cleanings go well and Nancy pays Debra her standard fee by check. However, after the third and fourth cleanings, Nancy notices that Debra is not doing as thorough a job and she is no longer satisfied with her work.*

No one could fault Nancy for her feelings of compassion towards this family and her desire to help them. Indeed, it is these very qualities which make her the kind of employee this agency wants on its team. But in her misguided desire to help, Nancy has now entered into a dual role in her relationship with this patient and family.

When she arrives at their door for her next visit—who is she? Is she the patient’s hospice nurse or his wife’s employer? Obviously entering into this dual role dramatically affects the way in which both parties feel toward each other. Nancy may now feel trapped in this employer relationship. After all,
how does she tactfully fire her patient’s wife from the house cleaning job? On the other hand, the patient’s wife may now feel a strong sense of obligation to Nancy because she has given her a job, making it hard for her to tell Nancy, as their hospice nurse, her real needs as the primary caregiver. Finally, from the agency standpoint, management will now have checks written by a hospice staff member to the family of a patient. Regardless of the actual reason, there is the appearance of impropriety. Neither person in this situation will emerge unscathed. And the worst part may be that the patient/family unit in this situation may not receive the care that was needed.

Had Nancy just taken a few minutes to reflect on the situation in light of the questions noted earlier, she would have probably seen that entering into a employer/employee relationship with this patient’s wife—regardless of her good intentions—could easily lead to serious consequences. She could have also discussed the situation with other members of the team who may have been able to assist her in finding appropriate resources for the family without compromising professional boundaries.

The Problem With Gifts

Hospice workers often find themselves in the position of having a gift offered to them by patients and families who are grateful for their services during a difficult time. Is it appropriate to accept gifts? And, if so, under what circumstances?

One can make a case for accepting gifts in order to acknowledge this expression of gratitude. On the other hand, we all get paid for what we do and accepting gifts can easily become problematic. For this reason, the agency for whom I work has formulated a gift policy, with clear guidelines: Staff members are allowed to accept only one gift while the patient is on our service (including bereavement time); the value of the gift cannot exceed $20, and cannot be in the form of cash or gift cards; and, should a gift card be received in the mail following a patient’s termination of service, the gift card must be donated to the agency.

When formulating a gift policy for your organization, consider the following:

• Should employees report all gifts to their supervisors?
• Is there a monetary limit on the value of the gift that may be accepted?

continued on next page
• Is accepting gift cards or cash acceptable?

• How many times in the relationship with the patient/family can the staff member accept gifts?

• Are there other ways in which the patient and family can express their gratitude, such as making a donation to the hospice or a related business (such as a hospice-run thrift store)?

Having a gift policy makes declining a gift or accepting only one gift easier to relay without offending the patient or family. Consider this example:

Carol has taken care of her hospice patient for over seven months, an elderly woman dying of heart failure. On her regularly scheduled visit at Christmas time, Carol’s patient presents her with a lovely gift—a holiday ornament that she has made herself. Carol thanks the patient for the gift, but also explains to the patient her agency’s policy on accepting gifts: “Mrs. Simons, thank you so much for this beautiful ornament. It is very special to me and I am grateful for it. I just want you to know that our hospice has a policy that I can only accept one gift from a patient, so I’m accepting this lovely ornament as that gift.”

Stating up front that the organization has a policy and noting what the expectations are in accepting the gift gives staff members the opportunity to “fall back on that” should the patient or family offer another gift. If they persist, staff members can explain that they could lose their job or get in trouble if they accept another gift; this will often diffuse the situation. Staff should also be encouraged to talk to their supervisors about any problems with patients or families related to gift-giving.

There are many other issues and events that provide opportunities for boundary violations: attending a patient’s funeral; being offered food or produce gifts; hiring the relatives of families for services such as car repairs or legal work (especially in small communities); giving patients birthday gifts or other gifts; and purchasing items from patients or families.

Using the guidelines described in this article can help us continue to provide compassionate care while also honoring the professional boundaries designed to protect us, our agency, and our patients and families.

April Perry has over 30 years of experience as an advanced practice nurse and educator, with special expertise in oncology and in adult and pediatric cardiology. For the past four years, she has served as a clinical educator for Duke Home Care and Hospice in Durham, NC, and also serves on the faculty of the Duke School of Nursing. She is a frequent presenter at state and national conferences, including those hosted by NHPCO.
Just Imagine...

Take a moment to imagine the worst-case scenario in each of the following situations:

• A hospice volunteer wants to bring in homemade cookies each week for the lobby waiting room.
• A patient gives $20 to a CNA and asks him to run down to the drug store to pick up his medications.
• A social worker’s husband, who is a professional carpenter, comes out to a patient’s house on the weekend to fix a loose handrail.
• A hospice nurse volunteers to babysit for a patient’s children to give the patient and his spouse a much-needed night out.
• A patient who is a professional singer offers for sale some CDs of his music; several team members purchase copies.
• A nurse makes a patient visit at noontime and is asked by the patient’s wife to join them for lunch.
• A nurse decides that having the patient’s bathroom door removed will make it safer for him. She removes the hinges herself, allowing the door to be removed one day during her regular visit.
• Knowing that a patient’s favorite food is beef stew, a hospice chaplain purchases two quarts of beef stew from a church sale and brings it to him on her next visit.

Do these actions and situations cross the line? Are they worth the risk?
Each year NHPCO produces a collection of display ads that highlights key aspects of hospice and palliative care. These ads, along with a range of other materials, are now available for use during National Hospice and Palliative Care Month in November—and over the next 12 months. By providing this collection of “Outreach Materials,” NHPCO hopes to make community education and engagement easier and more affordable for all members, especially those with tight budgets and limited resources.

This year’s theme, “We Care, We Listen” was selected to complement the “National Day of Listening” that also falls in November (see page 13). This theme is also carried out in five full-color display ads, three of which are shown here:
What You’ll Find Online

In addition to the five display ads, you can access these and other materials on the NHPCO website:

Introduction to Outreach Collection
This PDF is a guide to the resources in this 2011-12 collection.

Outreach Strategies
This section includes basic outreach strategies, along with an Event Planning Guide (Word); Media Relations Tips (PDF), and consumer outreach resources from NHPCO’s Caring Connections.

Population-specific Guides
This section includes links to several guides to help providers reach diverse populations: Caregiver Outreach; Diversity Outreach; Faith Outreach; Pediatric Outreach; Hospice Sabbath resources; and more.

Templates and Tools
This section includes a range of materials to reproduce “as is” or excerpt and/or adapt for use in other materials:

Articles:
- 10 Important Facts About Hospice Care You May Not Know
- Hospice Leaves a Legacy of Compassion
- Are You Traveling Without a Map? A Layperson’s Guide to Advance Care Planning
- How to Help a Grieving Loved One During the Holidays

PowerPoint Presentations:
- Hospice, Palliative Care and End-of-Life Issues
- Planning Ahead: Communicating End-of-Life Issues
- Advance Directives and End-of-Life Decisions

Media Outreach Documents:
- Hospice/Palliative Care Month Press Release
- Public Service Announcement Radio Scripts
- Feature Press Pitch Sample
- Letter to the Editor
- Hospice/Palliative Care Month Proclamation

Statistics and Backgrounders:
- NHPCO Facts and Figures: (2010 edition)
- NHPCO Facts and Figures: Pediatric Palliative and Hospice Care
- Common Misconceptions About Hospice
- The Medicare Hospice Benefit

You will need your NHPCO log-in ID and password to access these materials. For assistance, contact NHPCO’s Member Services at 800-646-6460.
No-Text Versions Available Too

Two of the display ads in the collection are available without text for members who want to craft their own copy.

Add your own promotional copy to these ‘no-text’ versions, along with your organization’s logo and contact information.

You can also use these ads to promote National Hospice and Palliative Care Month. Just add an appropriate subhead (e.g., “Join XYZ Hospice in Celebrating National Hospice and Palliative Care Month”) below the photo, followed by information about your services.

To download these ads, visit the NHPCO website.

If you have any questions, contact NHPCO’s Members Services Department at 800-646-6460 (8:30 am to 5:30 pm ET).
About the National Day of Listening

The National Day of Listening is a relatively new tradition that was started in November 2008 by the organization, StoryCorps.

On What Day Does It Fall?
It falls on the Friday after Thanksgiving Day—which, this year, is November 25.

What’s the Purpose?
To invite all Americans to conduct an interview with a friend, family member, or someone special in their community and, in so doing, enrich and preserve the relationships that bring meaning to their lives—something which hospice professionals have always encouraged and supported as part of patient- and family-centered care.

What Role Can Hospices Play?
On November 25—and throughout Hospice and Palliative Care Month—encourage patients, families, and all members of your community to share their stories. To help you, StoryCorps has developed several resources that it’s sharing with NHPCO members, including a do-it-yourself instruction guide for conducting interviews. These materials are posted on the NHPCO website: www.nhpco.org/outreach.

What is StoryCorps?
Many members may be familiar with StoryCorps from its weekly broadcasts on NPR’s Morning Edition. It is a nonprofit organization that was founded in 2003 to provide Americans of all backgrounds and beliefs with the opportunity to record, share, and preserve the stories of their lives. In addition to the NPR broadcasts, StoryCorps has published two best-selling books.

What’s Its Connection with NHPCO?
StoryCorps partners with organizations around the country to make sure it captures stories that reflect the widest diversity possible. Over the past year, NHPCO has worked with StoryCorps on its Legacy Project. This new project, which will be unveiled next month, will provide tools and support to help hospice and palliative care providers preserve patient and family stories. In addition to this work, NHPCO is also serving as a national partner for The National Day of Listening.
For National Hospice/Palliative Care Month or Veterans Day, Marketplace is pleased to offer you outstanding gift ideas for the occasion.

**National Hospice/Palliative Care Month Poster**
This commemorative poster featuring the 2011 hospice/palliative care quilt highlights this year's outreach theme, "We Listen, We Care." Available with or without "National Hospice and Palliative Care Month 2011" printed at the top.

Dated poster:
Item #: 821824 Member: $7.95 Non-member: $9.95
Non-dated poster also available.
Item #: 821825 Member: $7.95 Non-member: $9.95

**Bookmark**
This 2” by 8” bookmark, printed on both sides, features the 2011 quilt. Adorned with a tassel it’s suitable for any occasion. An affordable way to share a caring message.

Item #: 821827 Member: 1-500: $1.00 each 501+: $0.80 each Non-member: 1-500: $1.50 each 501+: $0.95 each

**10 "Must Ask" Questions Choosing Quality Hospice**
Raise awareness of choosing a quality hospice with this laminated FAQ card that's folded for convenience and features the 2011 quilt.

Item #: 821829 Member: 1-500: $0.75 each 501+: $0.65 each Non-member: 1-500: $1.05 each 501+: $0.95 each

**Key Holder**
A key ring (1 1/2 by 1 1/2”) with the 2011 quilt on both sides, enclosed in acrylic with a nickel-plated steel ring attached. A useful item that can be carried with pride.

Item #: 821826 Member: 1-500: $1.50 each 501+: $0.95 each Non-member: 1-500: $1.95 each 501+: $1.45 each

**Pen on a Rope**
This medium point pen on a rope has black ink and an attached 16” white breakaway safety clasp. Always have a pen handy when you need one. The imprint of the 2011 quilt image lets others know you listen and care all year around.

Item #: 821828 Member: $2.95 Non-Member: $3.95

**Thank You Cards w/Envelopes**
This 6x9” note card with the 2011 quilt on the front is a great way to say "We Listen, We Care" and THANK YOU! The card is blank inside, ready for your message, or you may have the cards customized with your logo and four lines of text at no additional charge.

NOTE: There is a quantity minimum of 150 cards to customize. Visit www.nhpco.org/marketplace and click on custom-print marketplace to place your order. Please allow 2-3 weeks for productions.

For more information and gift ideas call 800/646-6460 or go to www.nhpco.org/marketplace
### Veteran Acknowledgement Card
For a pinning ceremony, or simple acknowledgment of a Veteran. May be used with an American flag lapel pin, or “We Honor Veterans” lapel pin. Has room for a note on reverse side. (4x6” card)

Item #: 821722  Members: $0.25  Non-Members: $0.75

### Volunteer Acknowledgement Card
For acknowledging volunteers (and staff) for their assistance with Veteran-related programs. May be used with an American flag lapel pin, or “We Honor Veterans” lapel pin. Has room for a note on the reverse side. (4x6 card)

Item #: 821723  Members: $0.25  Non-Members: $0.75

### “We Honor Veterans” Baseball Cap
“We Honor Veterans” khaki embroidered hat has 6 panels, a low profile, and seven eyelets and is made of 100% washed cotton. The visor is pre-curved and the adjustable cloth strap back has a tri-glide buckle. Wear this hat with pride while honoring our Veterans.

Item #: 821721  Members: $14.00  Non-Members: $15.00

### “We Honor Veterans” Pen on a Rope
Keep your pen handy! A white ballpoint pen with removable cap on a 16” white safety breakaway clasp on a rope. The specially designed “We Honor Veterans” color logo is imprinted on the cap and barrel. Whether you buy it for yourself or give as a gift, it will be used with pride.

Item #: 821720  Members: $3.95  Non-Members: $4.50

### “We Honor Veterans” Lanyard
Show your support for Hospice and our Veterans by wearing or giving this royal blue lanyard with the imprint “We Honor Veterans”. The lanyard is 3/8” wide and is made of one-ply cotton, has a swivel clip and a plastic breakaway release. It can easily hold your ID badges or keys.

Item #: 821717  Member: $3.50  Non-Member: $5.00

### American Flag Lapel Pin
Show your patriotism and support for our Veterans by wearing or giving this lapel pin.

Item #: 821719  Members: $1.25  Non-Members: $1.50

### “We Honor Veterans” Lapel Pin
Staff can wear this pin to acknowledge Veterans and their service to our country. May also be used with the Veteran or Volunteer Acknowledgement cards.

Item #: 821718

### “I Care - Hospice Volunteer” Lapel Pin
For acknowledging volunteers (and staff) for their assistance with Veteran-related programs.

Item #: 820079

### Buy More and Save!

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*SHIPPING: $8 for orders up to $100. Multiply “Order Subtotal” x 10% for orders over $100. For rush delivery options call 800/646-6460

### ORDER FORM – NHPCO MARKETPLACE

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- Enclosed is a check for $_______ payable to NHPCO (Payment must be in U.S. dollars and drawn on a U.S. Bank.)
- Please charge $_______ to my
  - VISAX
  - MASTERCARD
  - AMERICAN EXPRESS

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In this monthly feature, NewsLine shines the light on a hospice provider which has introduced or expanded services and, in so doing, is forging earlier relationships with patients and families.

“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.”
Carolina East Home Care & Hospice began providing case management and adult day services for residents of eastern North Carolina over 10 years ago—more to fill an unmet need in a primarily rural community than for any other reason.

In the following interview, Executive Director Lynn Hardy discusses both services, including the benefits and challenges in today’s fiscal climate.

**When did you begin offering Case Management and Adult Day Services—and what prompted it?**

In 1994, North Carolina mandated that each county have a “Lead Agency” to provide a Community Alternative Program for Disabled Adults (CAP/DA). These Lead Agencies are actually county departments such as health departments and departments of social services as well as hospitals. Our local hospital, Duplin General Hospital, agreed to serve as a Lead Agency, but asked our organization to assume the role and provide the services. A couple of years later, we added a Community Alternative Program for Children (CAP/C). Then in 1997, we introduced Adult Day Services, in partnership with the Duplin County Services of the Aged.

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**Quick Facts About Carolina East Home Care & Hospice**

- Founded in 1984 as a home health agency, and introduced hospice care in 1986.
- Serves residents of eastern North Carolina—in the home or at its six-bed residential facility.
- Employs 76 FTEs and 54 volunteers.
- Average Daily Hospice Census: 54.
- In addition to hospice, provides Case Management Services for Disabled Adults and Children, and Adult Day Services.
One of our organization’s goals is to be the preferred home care provider within our community and, in order to help earn that distinction, we wanted to step up and fill the unmet home-care needs of underserved populations. The opportunity to provide the CAP and Adult Day Services were very much in line with that.

**Can you tell us about the demographics of your service area?**

We serve a seven-county area that includes Duplin County and the six contiguous counties of eastern North Carolina. It is a rural and relatively poor area. We have a high percentage of people over 65—higher than our state average. And the poverty level in six of the seven counties also exceeds the state average. There is also a significant military population in two of the counties we serve.

**What do the CAP services provide?**

Both CAP services—for disabled adults and children—provide assessments, care planning, and referral/linkage services, as well as monitoring and follow up. Both are also funded by Medicaid.

To qualify for the adult program, individuals must qualify for Medicaid and need nursing-home level care—but must also have family or friends who are willing to assist with their care.

The program for children is for those under age 18 who qualify for Medicaid and require nursing home and/or hospital level care. Often, these children are vent-dependant, tube fed, non-ambulatory, and non-responsive, and are receiving private duty nursing from eight to 16 hours a day because their parents are employed outside the home.

**How do you staff the services? Does your hospice staff serve dual roles?**

Both the CAP and Adult Day Services are staffed separately from hospice, so no staff members serve dual roles. However, there are times when patients enrolled in hospice are also receiving CAP and Adult Day Services.

**How many people do you serve a year? Who are your referral sources?**

More than 150 adults and children receive CAP services each year. These individuals come to us from a variety of referral sources—physicians, other home health and home care agencies or hospices, nursing homes, pediatric clinics, hospitals, and sometimes from individuals caring for relatives at home.

**In the current fiscal climate, has your Medicare reimbursement changed?**

Due to state budget restraints, there is a limitation on the number of hours that can be billed for case management services. For adult services, for example, we can only bill three hours per month, plus another three for the annual assessment. No additional hours can be billed for crisis management or a sudden decline in health status. The challenge is providing the quality care that’s needed within this very limited timeframe.
Are you taking any proactive steps in anticipation of future cuts?
We have aligned our agency with other agencies in the state which are providing medical home care to Medicaid beneficiaries, such as Community Care of North Carolina, hoping that, through collaboration, we can continue to provide the CAP services. While still early, the dialog has been both positive and promising.

Please tell us about your Adult Day Services?
The Adult Day Services provide a comfortable and safe haven for people with special needs whose family or caregivers work outside the home. The program provides for group and individual activities, lunch and snacks, and personal care services—all under the supervision of an LPN and CNA.

As I mentioned earlier, this program started out as a collaborative effort with the Duplin County Services for the Aged. In fact, it was really the brainchild of the Services for the Aged director who had wanted to fill this critical need for a very long time.

However, it was also part of our organization’s vision when...
we opened our doors in 1984, though it was 13 years in coming to fruition. And it has most definitely been a struggle since the beginning, primarily due to the challenges of our service area—which spans more than 800 square miles. Without a large town that is centrally located within this service area, access has been a challenge. Our Adult Day Center, where all the services are provided, is located in the largest town in the southern end of Duplin County, making it difficult for people in other areas to attend. There is some public transportation through the county; however, it is often difficult to access at times that would best benefit the individuals in need of the services. Currently, we serve about 15 to 20 people a year, with no more than 10 in attendance on a daily basis.

**What were the start-up costs?**

We kept our costs to a minimum by renovating space in a building we already owned, which ran about $50,000. For meal service, we utilize a nearby Senior Center while the County provides for transportation. Initially, staff salaries were paid for through a contract arrangement with the Duplin County Services for the Aged.

**How are the Adult Day Services now funded?**

Home and Community Block grants, allocated through the Duplin County Services for the Aged, funds the program. However, due to budget restrictions in the last few years, there has been a decrease in the grant funding which, in turn, limits our ability to serve as many people.

**Do you utilize volunteers?**

Volunteers do assist us at the Adult Day Center, mainly with the social activities. However, we also have one volunteer who assists with client care on a regular basis.

**What are some of the benefits of providing Adult Day Services?**

The benefits are in the individual stories. For example, the services enabled one couple caring for the wife's mother to go on vacation for the first time in many years. During their absence, the couple's daughter brought the mother to Day Care and, upon the couple's return, they continued to utilize the services, and went on to utilize the CAP services. Eventually, the mother required hospice and has since died. It also provided respite for man whose wife had dementia, enabling him to participate in church activities, run errands, and get needed rest so he could be there for her, fully, when she was home. There are countless examples like these. The benefits to the participants and the caregivers are immeasurable, but the benefits to the provider is another story. It is clearly not cost efficient.

**Are there any benefits or cost-efficiencies in offering both the CAP and Adult Day Services?**

Being able to serve community needs is the real benefit of offering both services. From an organizational standpoint, offering CAP services is more beneficial and more cost effective. We serve from 120 to 150 individuals a year and our reimbursement covers our direct costs. The individuals utilizing the CAP services are also more likely to remain at home, versus being institutionalized, and will probably eventually use home health and/or hospice services.
**Were you to do it again, would you offer both services? And, if so, would you do anything differently?**

Yes we would do it again. The CAP Services for Disabled Adults and Children continue to get support and recognition because they are non-institutional long-term care, and help reduce hospital admissions and visits to the Emergency Department. Our experience has also come in handy. We just participated in a pilot for CAP/Choice Services that enables the patient and/or caregiver to hire their own staff to provide the care. This program has now been introduced statewide in North Carolina. So, in having been a provider of the services, we have a good grasp of what’s needed, and can empower the patient and caregiver to help themselves by providing practical guidance and direction.

In terms of Adult Day Services, had we been the only provider of the services, without funding restrictions early on, we probably would have opened more than one site, and that would have helped improve access and usage.

**Do you have plans for further expansion or diversification?**

We are looking at PACE, but are looking for partners in urban areas that would like to satellite a PACE site in a rural area. While future cuts to reimbursement are keeping us all up at night, we are facing the future with optimism—community-based care will continue.
The Voice of NCHPP
NHPCO’s National Council of Hospice and Palliative Professionals (NCHPP) is comprised of 48,000 staff and volunteers who work for NHPCO provider-members. Organized into 15 discipline-specific sections that are led by the NCHPP chair, vice chair and 15 section leaders, NCHPP represents the perspectives of the interdisciplinary team—the very essence of hospice care.

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

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

This month we spotlight the Research/Academics/Education Section, and an article by Mary Lou Proch....

continued on next page
Education departments often feel like a revolving door on a variety of issues. Changes in regulations, practices and procedures, QAPI initiatives, and strategic planning all require input and assistance from the education department. Sometimes this makes educators feel like they can’t dance fast enough to meet all the demands. In this article, I share information that will help educators to stabilize the change process and prepare them to assist their organizations in creating the future.

**Develop Education Systems for a Continuum of Learning**

Creating classes and conducting in-services to educate all staff on applicable issues is a short-term solution, but may not bring about long-term changes.

Covering all the information a new staff member will need during his or her first year of work in just two weeks of training violates many adult-learning principles and will not result in retention of information or changes in behavior.

Education departments should transition from a training focus with the purpose of transferring information to an education focus with the purpose of changing behaviors.

For example, every piece of new information needs to find a place in the education system. This education system should provide information *along a continuum* to assist the novice in becoming an expert-level employee. This system is based upon the five rights of education: The information is presented and developed by the *right* person, with the *right* amount of information, by the *right* method, at the *right* time, and with the *right* accountability built into the system.

**Partner With Management and Staff**

Planning, developing, and implementing education systems and programs requires a partnership with leaders and staff.

Leaders at all levels are involved in providing information; setting educational priorities; and assisting in the scheduling of repetition and establishing accountability standards. It is imperative for educators to meet with leaders to conduct a needs assessment and plan education goals for the year. It’s also important to meet with leadership at least quarterly to discuss current educational needs and plan ad hoc classes for the next quarter. Last but not least, partner with staff and seek their input to help ensure that educational programs are accessible, fun, problem-centered, and individualized to the specialties.
Maintaining a strong professional network in which information is shared can provide collective wisdom and new insights or ideas on current issues. The individuals in the network can be other hospice educators, leaders from other levels of healthcare, and staff from community agencies.

There are common issues that we all face and we have a strong opportunity to learn from each other. The book, Better: A Surgeon’s Notes on Performance, is full of innovative examples of solving new and old problems (Gawande, 2007). There are individuals who have already solved the problems we are currently facing and it’s just a matter of looking for them. The NCHPP Research/Academics/Education (RAE) Section has an excellent collection of information that is available on My.NHPCO—in the Section’s e-Library. In 2012, the RAE Section will also be scheduling conference calls to discuss current best practices. [See page 27 to learn more about My.NHPCO and gaining free access to the Section’s eGroup.]

Create the Future
Although no one can predict the future, we can gather information to get a good idea of the direction of change. Begin by improving your understanding of the current legislature in your state to determine the impact on hospice funding or practice. Your hospice’s strategic initiatives and five-year plan will give you additional information about new programs or projected growth. You can translate this information into educational plans.

In the early years of hospice, before Medicare provided funding, programs were established on shoestring budgets by volunteers. Looking back on the history of hospice may also provide insight as we create a future that will most likely have decreased funding.

Understanding the current issues facing hospitals and home health will also provide insight into current trends and hot buttons. For example, the current concern with reimbursement rates for certain readmissions as well as patient care issues have serious implications for hospice care. Understanding these issues and concerns, and what each healthcare setting does best, will help generate new ideas and solutions. Other community agencies, churches and schools have also faced decreased funding, so networking with these individuals can also help us to develop new attitudes and emotional responses to the new reality.

Inspiration regarding future trends and programs comes from a variety of sources. The adult education field is a rich resource for understanding human behavior, and planning and implementing programs that
change behavior to produce positive outcomes. Some classic and some new information to help inform your work can be found on page 27 ("For Further Reading"). In addition, the following resources provide information on evidence-based practices to assist in the development of future protocols and programs: Cochrane Database of Systemic Reviews; Database of Abstracts of Reviews of Effects (DARE); and PubMed.

**The Part You Can Play**

In this difficult financial environment, we need to be creative in finding ways to provide the services our patients need to make the most of life. To improve healthcare, the core concepts of hospice—patient and family choice, interdisciplinary teamwork, serving the patient/family unit, and providing holistic care—must be implemented at all levels. Palliative and hospice care should be part of every discussion concerning chronic disease. Hospice should become the standard of care just as prenatal care is the standard in obstetrics. To succeed in the future, the skills that enabled hospice to develop into a specialty will be critical skills for all employees. These include passion, independent thinking, critical thinking and creativity.

To be a co-creator in the future of hospice, having the right attitude is also essential. A “can do” attitude will remove barriers to creativity while a “can’t do” attitude will create barriers to solutions. Looking to the past may give clues to solutions; holding on to the past stops progress. Ignoring the past will probably only assist us in repeating the same mistakes. Gaining additional skills and knowledge from a variety of sources is ideal preparation. Winging it day after day is careless. Healthy behaviors in all aspects of our lives will fuel effectiveness. Excessive work hours and unhealthy behaviors serve only to increase our activities and decrease positive outcomes.

We must keep one foot in the present and one foot in the future to stabilize the present and create the future.

*Mary Lou Proch is the director of education for Chapters Heath System, based in Temple Terrace, Florida. She is now serving her first term as NCHPP’s Research/Academics/Education Section leader.*
Greg Wood, the president/CEO of Hospice of North Central Oklahoma and the chair of NCHPP, shares his thoughts on the value of NCHPP.

Watch the video now.

Remember, NCHPP membership is free to all staff and volunteers of NHPCO provider members!

For Further Reading


Get Involved!

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

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

Information about NCHPP is also available on the NHPCO website: www.nhpco.org/nchpphome.
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Contact us to learn how we can provide leadership, vision and focus to achieve masterful results.
Every year, on the second Saturday in October, groups and organizations in 70 countries around the globe help celebrate and support World Hospice & Palliative Care Day (WHPCD). Some sponsor public awareness campaigns, others engage in advocacy with policymakers, while others hold fundraising and educational events.

While many providers in this country already lend their support, greater participation from U.S. organizations will make the event that much more effective in 2012 and beyond. If you’re not yet familiar with WHPCD, here’s some information to help you plan ahead.

**Every Year Has a Theme**

The theme for WHPCD 2011 is “Many diseases, many lives, many voices—palliative care for non-communicable conditions.” While not mandatory, many of the planned events and activities will focus on how people living with conditions which are not infectious can benefit from palliative care. The theme for 2012 will be announced early next year on the WHPCD website—bookmark the page for future reference.

**Voices for Hospices: Music to Our Ears!**

Every two years, WHPCD also features Voices for Hospices, a wave of simultaneous concerts which take place around the globe and complement the educational events and activities. WHPCD 2011 will feature Voices for Hospices, as will WHPCD 2013.

**What You Can Do**

Your organization can plan any event or activity that will help educate your community about end-of-life care—and help Americans become more aware of the very dire needs around the globe.

As one example, NHPCO member, Lifetime Care in Rochester, NY, is hosting a Voices for Hospice musical celebration. The organization participates in the Partnership Program of NHPCO affiliate, FHSSA, and is hosting the concert to raise funds for its South African partner, Zululand Hospice.

**Promote Your Plans on the WHPCD Website**

WHPCD has a very user-friendly website—with an online calendar where participants can post their activities. It’s important to post your event on this global calendar. It lets the world know what you (and the United States) is doing to advance hospice and palliative care.

**Free Tools to Help**

A range of materials are available on the WHPCD website, including logos, template press releases, the WHPCD Poster, Web banners, and event ideas. You’ll also find advocacy materials, including several fact-filled reports (see the opposite page).
Free Reports Provide Global Perspective

**Share the Care**
This report highlights how building partnerships and sharing the care can improve the quality of life for even the most vulnerable and marginalized people living with a life-limiting illness.

**Access to Pain Relief**
This report provides a global snapshot of the availability of vital pain relieving drugs, with insights into why so many people do not have access to basic drugs.

**Suffering at the End of Life**
This report details the current global situation, using facts and figures, case studies and photographs to tell the story.
Did You Know...

The immediate family members of Veterans under the care of a VA hospice or similar program are eligible for bereavement counseling through any Veterans Health Administration medical center, as long as the family members had been receiving family support services in connection with the Veteran’s treatment.

Details about this Bereavement Counseling Benefit—and all other benefits available to Veterans’ survivors—can be obtained from the VA’s Office of Survivor Assistance. OSA was established in October 2008 to help survivors and dependents understand and access all the benefits to which they’re entitled.

Understanding and Navigating the VA System

The We Honor Veterans website includes brief summaries of the following information to help hospice staff serve Veterans and their families. Bookmark these pages for future reference:

- About the VA
- How the VA is Structured
- Healthcare and Working With the VA
- Healthcare Benefits
- Burial Benefits
- Survivor Benefits
We earned our merit badge in Clinical Excellence.

For 15 years, Hospice Pharmacia has been committed to improving the lives of hospice patients through the expert management of medication. In fact, we were the first pharmacy of our kind, and through the years have earned our merit badge in clinical excellence.

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- Cynthia Harris-Panning
VP, Regional CEO, Cornerstone Hospice
Covenant Hospice Named One of Florida’s Best Places to Work

Covenant Hospice (Pensacola, FL) was recently named one of Florida’s “Best Companies to Work For.” One-hundred companies were recognized in small, medium and large-company categories, and Covenant Hospice was ranked 27 in the large-company category.

The “Best Companies To Work For” program was created by Florida Trend and Best Companies Group, and endorsed by the HR Florida State Council. To be considered for participation, companies or government entities had to employ at least 15 workers in Florida and be at least one year old. Companies that chose to participate underwent a two-part survey process: the first part being an evaluation of workplace policies, practices, philosophy, systems and demographics; and the second part being an employee-satisfaction survey.

East Meets West

Sally Adelus, the president/CEO of Hospice of the Valley (San Jose, CA) welcomed Buddhist chaplains, Master Hui Kun and Master Hi Hui, both of Taiwan, during their first trip to Northern California this past summer.

The chaplains joined Adelus, who was NHPCO’s 2007 Heart of Hospice award recipient, and Hospice of the Valley medical director, Monique Kuo, for a candid discussion about palliative and hospice care in their respective countries. Sandy Chen Stokes, founder and executive director of the Chinese American Coalition for Compassionate Care and a member of Hospice of the Valley’s Professional Advisory Board, facilitated the meeting and served as translator.

Unity Volunteers Complete Their 100th Prayer Shawl

Two volunteers from Unity (Green Bay, WI) have each completed their 100th prayer shawl: Mary Lou Schulze has already surpassed making 100 prayer shawls and Irene Pranica recently completed her 100th!

Prayer shawls are created by volunteers who, while knitting or crocheting with a special type of soft yarn, pray for comfort and healing. The handcrafted shawls are provided as gifts to patients, with a poem wishing them peace and comfort.

Both Schulze and Pranica volunteer their talents in several capacities. Since 2000, Schulze has assisted with administrative projects, represented Unity at special events, and provided companionship to patients and families. During the past 14 years, Pranica has supported families dealing with issues of grief and loss through the bereavement program.
In Memoriam:
Marilyn Morfogen
1929 – 2011

Marilyn Morfogen, the wife of NHF and NHPCO board chair-emeritus Zachary Morfogen, died on September 6, 2011. We honor Marilyn for her inspiration and passion to get the Morfogens involved in hospice many years ago, when the hospice movement was just getting started in the United States.

At the family’s request, donations in Marilyn’s memory may be made to the National Hospice Foundation.

Hospice of Palm Beach County Expands into Broward County

Hospice of Palm Beach County (West Palm Beach, FL) has expanded its service area with the launch of Hospice of Broward County in late-August.

Barbara Ivanko, chief operating officer of parent company, Spectrum Health, Inc, will extend her duties, leading both Hospice of Palm Beach County and Hospice of Broward County. Also announced were the appointments of Karen Kennedy, DO, as medical director and Kimberly Horn, MSN, RN, as director of Hospice of Broward County.

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Audit Preparedness and Response

Are you and your staff prepared for an external audit? In today’s hospice environment, there are any number of entities that could audit your clinical records. Some are auditing for reimbursement recovery while others are auditing to ferret out fraud and abuse. No matter the reason, a hospice should have a basic process in place to deal with audit requests.

Your process should include:

1. Identifying a point of contact for internal and external communications. That person should:
   - Ensure that staff members who open mail and answer the phone know which callers or correspondence to forward immediately.
   - Know the players in your geographic area—such as your Medicare Administrative Contractor (MAC); Zone Program Integrity Contractor (ZPIC); Medicaid Integrity Contractor (MIC); and Recovery Audit Contractor (RAC).

2. Establishing an internal team for audit responses (i.e., an interdisciplinary team comprised of legal, finance, clinical, compliance and IT staff).

3. Stamp all correspondence from audit contractors with the date and the time it was received. There are very specific timeframes for responding to these various auditors and the clock may already be ticking when correspondence or a call requesting information is received by the provider.

4. Develop central tracking mechanisms for all incoming and outgoing correspondence.
   - Track auditor requests for patient information, and implement a system and process to track what information was sent to the auditor and the dates it was sent.
   - Coordinate the tracking mechanisms with the communications structure—record reviews and appeal of recoupment deadlines.

5. Copy all information sent to auditors so you can easily identify and access it later should follow-up be necessary.

6. Review all information sent to auditors to determine risk and response, and engage legal services as necessary.

The best strategy for audit preparedness is proactive self assessment to (1) identify potential problems and risk areas and (2) address them in your QAPI plans. For example, review your organization’s previous state and federal survey deficiency reports; the reasons for your MAC/FI claims denials; and MAC/FI ADRs. Doing so will alert you to possible trends and areas for performance improvement.
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.
Learning, Growing and Lending Support—a Continent Away

As we celebrate World Hospice & Palliative Care Day on October 8, NHPCO salutes providers, like Gilchrist Hospice Care, which participate in the FHSSA Partnership Program.

Shown here are staff members during a tour of the palliative care program operated by African partner, Nkoaranga Lutheran Hospital.

See page 3 to learn more about the Partnership Program and the fine work being done by NHPCO members.