Southern Tier Hospice and Palliative Care (STHPC) has been serving residents of the upstate New York counties of Chemung, Schuyler and Steuben since 1981—with a staff of 90 and an average daily census of 110 to 120 patients. By the fall of 2008, the organization was at a crossroads. We had been a small part of our local healthcare landscape for decades—beloved by many, disliked by a few and largely irrelevant to the majority of patients and providers we sought to serve. In the rapidly changing world of healthcare, we needed to find a place at the table (or wind up on the menu).
Our strategy of relying on the ebb and flow of referrals from a few reliable sources was not sufficient for financial stability, let alone meaningful growth. So we had two choices: Continue what we have always done and run the risk of becoming marginalized or look beyond our current market and truly live our mission statement. We also quickly realized that opting for the latter choice would require a significant shift in philosophy, not only for our patients and referring physicians, but also for STHPC staff.

Hospice Patients are Changing

We resolutely believe in the mission of hospice to affirm life and provide comfort and care to those families coping with serious illness. However, we believe that the framework of traditional hospice is not the only way to meet that mission, especially given the changes we are seeing in the patients coming onto hospice.

The hospice industry grew, of course, from an oncology model. This model worked very well when 95 percent of the people hospice served were cancer patients. But hospice patients have changed. According to NHPCO's latest Facts and Figures, 64.4 percent of hospice patients have non-cancer diagnoses, such as heart disease, debility unspecified, dementia and lung disease. The best care practices for these patients are very different from those for cancer patients. It is no longer a one-size-fits-all model. Symptom response needs to be replaced by symptom management and, when possible, prevention.

As an example, cancer patients are treated for dyspnea with morphine—with excellent results. For patients who have suffered heart failure, however, morphine may hinder respiratory functioning. Better results may come from aggressively addressing edema or using medications to make the heart beat more effectively. As another example, encouraging cancer patients to eat whatever
Cutting Through the Noise

Bobbe Donsbach, a patient care coordinator, attended—making the long trip from Lewistown, Montana. Amanda Dunnem, a hospice aide from Buchanan, Michigan, also attended, as did David Isom, a hospice director from St. George, Utah, and Carrie Landau, an RN case manager from Tucson, Arizona. There were 180 attendees in all, and 75 percent of them were hospice staff and caregivers who provide care at the bedside.

The event was the Advocacy Intensive held here in Washington on June 18 and 19. It was a strategic effort, organized by NHPCO and HAN, to cut through the noise and get our message heard on Capitol Hill during this particularly vocal election year.

Our goal was to convene a small but diverse group who could share the stories of hospice care that would resonate beyond the usual rhetoric. And as I shared in last month’s NewsLine, we could not have asked for better representation.

The attendees met with 250 Congressional offices, including influential members of the Senate Finance Committee and the House Ways and Means Committee. Both the hospice staff and many members of Congress came away from these meetings knowing more—and eager to do more.

Among the most significant was the meeting between Bobbe Donsbach and Senator Max Baucus (D-MT), chair of the Senate Finance Committee. It was the first time that Senator Baucus met directly with a member of the hospice IDG in his Capitol Hill office, and quite telling that he spent a half hour with just one constituent.

While this event was a success, the month of August is an opportune time for all members of the hospice community to build on that success. Members of Congress will be in their home states and many will be quite willing to visit hospices in their area. This is vitally important because seeing is believing.

If you are intimidated or hesitant about reaching out, please don’t be! Just as HAN staff supported the attendees of the Intensive, they are also here to support you. As a start, please see the resources they’ve developed—Free Basic Advocacy Training, Tip Sheets, an In-district Advocacy Toolkit, and more. You can then email them with specific questions.

Please join us in this advocacy work—and keep us posted on your success.

J. Donald Schumacher, PsyD
President/CEO
appeals to them is appropriate; for patients who have suffered heart failure, eating whatever appeals to them may give rise to fluid retention and a crisis event.

In cancer patients, we respond to what the patient presents us with and little we do affects the steady and somewhat predictable course of the disease. But with many other patients with end-stage illnesses, waiting until the symptom presents itself is not effective care. Predicting and preventing crises is called for and requires a more “aggressive” care plan.

**Health Care is Also Changing**

At the same time, the health care system is becoming much more focused on efficiency, effectiveness and results. By indentifying how we can best meet the shortfalls in the continuum of care, we can make ourselves almost invaluable to our professional peers—and our referral sources. And once we do this, it will be in the providers’ best interest to utilize us in as many ways as possible. So how do hospices do this?

Based on our experience at STHPC, there needs to be a true culture shift within the industry whereby hospices become more flexible, challenge old ideas and embrace new models, seek out new markets, and find new partners. This change must be planned and purposeful, driven by data and precise research to identify gaps within each hospice’s service area. It must also be supported by business planning, with the strategy specifically formulated for each health care system. This is not a one-size-fits-all model.

**Our New Approach**

One important way that STHPC broke new ground was in our diagnosis-specific programming. By this we mean the
specialization of hospice care to best meet the needs of individual disease processes.

First we conducted research. We examined STHPC’s market penetration, conducted longitudinal studies of our service provision, talked with key consumers and providers in our health care system, and looked at models being used by other hospices and health care providers. Through this work, we discovered that STHPC was underserving the heart-failure population. For example, at times in 2009, only 5 to 7 percent of our patients had chronic heart failure (CHF). With this information, we developed a business plan to meet this specific gap—and our cardiac-specific hospice program, “LifeBeat,” was born.

Our first step in developing the business plan was meeting with stakeholders in the field—cardiologists, nurse practitioners, disease-management clinicians and hospital administrators. We asked them what “we” could do to meet these patients’ needs. We asked them what changes they would like to see and then incorporated many of their suggestions into our business plan. We also asked them if they would be willing to invest themselves in this change process.

Next we looked within ourselves. We understood that if we wanted people with CHF to commit their care to our hands, we had to offer something they could not obtain elsewhere. With this in mind, we looked at the challenges facing CHF patients: edema, dyspnea, fatigue, medication management and diet compliance. We decided to target these five areas and see if aggressive symptom management could improve outcomes.

Our clinical protocol for the CHF patients in our LifeBeat program was fairly simple. We asked them to weigh themselves daily and to record the results, reporting to their nurse any gain of more than 2 pounds in 24 hours or 3 pounds in 48 hours; to use a medication pre-fill box for better compliance; and to follow the sodium-restricted diet ordered by their doctor. Our care plans reflected these priorities. The nurse would visit weekly to review...
the weights, assist with the med box, perform a physical assessment, and provide education. If the patient called to report problems, additional visits would be made. We also provided social work, spiritual care, personal care and volunteer support, using the same criteria used for STHPC’s other patients.

We educated STHPC staff on best practices for cardiac care, including both nursing and non-nursing clinical staff. Wherever possible, we asked the new partners among our stakeholders to provide this education to help reinforce that we were truly part of “their care team.” Not only did this increase their investment in the program, but it also increased their trust in the skills of our staff. They knew what we could do because they taught us to do it.

As a small hospice whose patients consisted mostly of those with cancer, our clinical team was already well-versed in pain management and disease progression for that diagnosis. Now we were asking them to rethink their perception of hospice, to expand their practice, and to run counter to the rules ingrained so deeply in them. Our staff had always understood that the hospice philosophy was to do nothing that prolonged life or hastened death—and to focus on quality of life. Now we were asking them to enforce daily self-assessment and diet compliance for patients near the end of life. Why were we asking terminally ill people to eat a healthy diet? Why were we rigidly focusing on their weight when a two-pound weight gain might just indicate a need for a bowel movement? And why were we suddenly telling patients that it was okay to go to the hospital to seek treatment that would sustain their lives?

We worked hard to reassure staff that LifeBeat was hospice care. The goals were, and would always remain, symptom management and comfort. We began to look
at the “why” behind the treatment that was being suggested, not the “what.” If the treatment would produce a significant palliative benefit without an undue burden on the patient, we would support it. For instance, we agreed that low-level cardiac rehabilitation could definitely produce palliative gain and, thus, could be part of a hospice plan of care. Once staff members understood these goals, they bought into the new approach and were eager to move forward.

We also looked at our internal processes and predicted how they might have to change. We expected that we would be doing more general inpatient admissions due to the need for intervention that, while palliative in scope, would be more intensive than the interventions traditionally used in hospice. This included things like intravenous antibiotics or diuretics. We benchmarked STHPC’s use of inpatient care compared to state and national standards, and found that we were underutilizing the inpatient benefit and had room to grow.

One immediate challenge was how to respond to crisis situations when serving patients whose normal response was to go to the emergency room. We worked with the doctors, patients and ER staff to determine what interventions were usually done in the ER, and to what extent these could be duplicated at home. This provided the patients with the security of knowing that their needs would be met, and that hospice was truly built around “their” needs and desires rather than a preset protocol that limited their choices.

While developing the clinical aspects of LifeBeat, we also developed marketing strategies. Hospices are constantly struggling with misconceptions and biases, and the “H” word itself shuts many doors. What’s more, for many cardiac patients and their physicians, hospice is just for cancer and only needed at the very end of life. We knew we needed a different approach.
So Much is in a Name

The power of a name is amazing. By naming the program LifeBeat, we created a new identity—one that is separate from traditional hospice. While we don’t hide the fact that LifeBeat is a program of STHPC, by using this name, people are able to focus on the services we provide rather than the “H” word and all it represents to them. It raises interest and makes people—both patients and providers—willing to learn more. It also gives those who are introducing the idea of hospice to a family (such as a doctor or a discharge planner) an option for care that doesn’t focus on hospice.

Having a “new program” to roll out also reenergized our marketing program. We proudly focus on the symptom management power of LifeBeat. Hospice care for cardiac patients, especially when the referral is made at the appropriate time, lengthens survival time; decreases symptom burden, depression, anxiety, hospital use and cost; and increases patient and family satisfaction. We have also found that this, along with a greater focus on the Medicare Hospice CoPs, allows providers and the public to re-examine how they look at hospice as a whole.

Our Biggest Challenge

One of our biggest challenges was—and continues to be—the internal culture of both our hospice and the industry as a whole. Many of STHPC staff felt the organization was trying to deceive patients and providers. We were often asked “is this patient on LifeBeat or hospice?” It took a long time for people to recognize that high-quality symptom management for advanced and end-stage illness is not a radical concept. It is still hospice! These patients still meet the admission criteria in every way. The plan of care is still palliative. And the patients and their families are fully informed. We are, however, focusing on a larger picture. We are not just looking at the end of life—we are
also looking at how to best manage a patient medically until he or she reaches that point.

Physicians often tell us that they never really thought of hospice as providing medical care. Aren’t we doing our patients a huge disservice if we—of all industries—are not doing the best possible job of trying to prevent symptoms from occurring?

Hospice and palliative care providers have tremendous power. In LifeBeat, we are constantly working with patients who have been trapped in an endless cycle of hospitalizations, with little stability or comfort to show for it. Under the care of LifeBeat, they are able to stay out of the hospital and in their own homes with a sustainable level of comfort. In other words, we, with the power of palliative care, are able to achieve what the most aggressive of treatment plans often do not. Our patients not only feel better, they are better.

**Results Speak Volumes**

Since the launch of LifeBeat in May of 2009, STHPC’s percentage of cardiac patients increased from 5 percent to 25 percent, and our overall patient census has almost doubled. Average length of stay has also increased by more than one-third and our referral base has markedly increased. We were invited into many new partnerships with peers, such as local clinics and hospitals. We saw a shift in how the public perceived us. And we have created a cultural change within our organization and hired many new staff. In a time when many hospices are looking to survive and maintain the status quo, we are looking at growth and new markets.

**Is Your Program Ready for Change?**

Each health care system is different. Only through research and comprehensive, data-driven business planning will you be able to identify the right solution for your market. The processes that STHPC engaged in, as described here, are what’s replicable; not the specific LifeBeat program. Only after you determine what your market demands, can you develop a planned approach to meet your specific business needs.

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Since starting down this path, STHPC has identified other market gaps which have resulted in additional program development. We have since launched two additional hospice programs—Living with Dementia and Breath—that provide specialized care for patients with dementia and respiratory disease. Outside of diagnosis-specific programming, STHPC has also created community and inpatient palliative care programs in partnership with a major hospital system—which came about as a result of our work in the LifeBeat program. For these palliative care programs, we have entered into a contractual arrangement wherein the hospital pays us to have our staff on its floors daily, consulting on palliative care issues. We are also growing our pediatric hospice, palliative care and bereavement services.

If hospice is to truly serve its mission and embrace the unique strength of palliative care, hospice professionals must face (and embrace) change—and we believe that diagnosis-specific hospice programming is a powerful step in that direction.

Suzanne Scheib has spent most of the last 20 years in home health. In 2007, she began working in hospice care, first as a primary nurse, and currently as admissions coordinator for Southern Tier Hospice and Palliative Care. She co-developed the organization’s diagnosis-specific programs and has spoken extensively on the subject at the state and national level. She can be reached at ScheibS@STHospice.org.

Robin Stawasz joined Southern Tier Hospice and Palliative Care as a social worker in 1990. She is currently the director of provider relations and family services and coordinates much of the organization’s program development work, including the diagnosis-specific programming. She has also joined Suzanne in presenting on the topic at state and national conferences. She can be reached at StawaszR@STHospice.org.
Those hospice providers which have the capacity and interest to expand services to meet unmet needs in their communities have a tool at their disposal—NHPCO’s Continuum of Care Assessment.

Designed as an Excel Workbook, the Assessment guides you through an eight-step process to help you determine unmet needs and your ability to fill them, either alone or in collaboration with other providers. The eight steps, which are presented as separate tabs in the Excel Workbook, include:

1. Internal Hospice Assessment
2. Hospice Competitor Assessment
3. Community Services Assessment
4. Organizational Strength Assessment
5. Prioritizing and Mapping Gaps and Strengths
6. Community Data and Trends
7. Determining Return on Investment
8. Implementation

Keep in mind that the Assessment may take several weeks or months to complete. To facilitate interdisciplinary perspectives and input, NHPCO recommends that you form a workgroup to complete the Assessment in collaboration with your organization’s leadership team and other stakeholders.

At the conclusion of the process, you will have detailed information about the types of services offered in your community, as well as the assets of your organization that can be leveraged to develop new services or enhance those you already have.
Hospice clinicians invest many years of study to earn their degrees so they may better serve patients and families facing challenging life issues. Through their work, they will serve the patients and families being cared for by their organization and, when given the opportunity through outreach, assist other members of the local community. In rare instances, a newspaper or TV station may call upon them for an interview, increasing their brief fleeting reach to tens of thousands. However, if we really want to make a difference to the population as a whole, we must look at new ways of communicating the knowledge we have gathered.

Web-based publishing has grown in scope and variety in the past decades and health care professionals are making efforts to use this new tool as a way to shape public health. In the online world, multiple options allow for the creative use of media formats, from podcasts and blogs to embedded videos, slide shows, games, apps and more.

One of the more versatile online platforms is the blog, derived from the term web log. It consists of journal entries published in reverse chronological order, thereby keeping the newest post at the top of the list. Blogging is versatile because, beyond simple text, it can include the variety of embeddable media mentioned above, such as videos and slide shows. For example, if a blogger finds a YouTube video that is very relevant to a key point of his or her post, the video can be embedded so it will play directly on the blog’s site without having the reader click away.
Blogging Basics

A single blog post may take between one and three hours to write and publish, with most blogs posting two to three times per week. Posts can be anywhere from quick updates with links to other sites or longer-form editorials and discussions on complex topics. This flexibility makes blogging very useful to health care professionals.

When I first started blogging on Pallimed with Dr. Drew Rosielle in 2005, we would post quick updates on important news occasionally, but more often focused on a detailed, yet conversational, analysis of an important research article. Research-focused blogs can be found in a variety of scientific areas, but medical professionals should be at the vanguard of communicating research findings to each other as professionals in addition to our efforts to educate the public. Institutions have already begun examining why it takes so long to introduce research breakthroughs into clinical practice, and blogging may play a lead role in disseminating research from professional to professional.

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When Citing Patient Stories

In hospice, we know there is more to share beyond the data. We experience amazing stories every day through our work with patients and families and our colleagues. But with privacy rules such as HIPAA, we must be cautious about using a blog to share these stories with the world.

There are three approaches that you can take when considering whether or not to publish online content relating to a particular patient, family member or caregiver: Open Consent; Generalizing; and De-identification.

Open Consent

Open consent provides the largest built-in safeguard because the patient and family have signed disclosure forms demonstrating understanding of the use of their story, words, pictures, and video. Most organizations have forms for media use—and blogging could be considered a form of media. Just make certain it is explicit in the form if not currently present.

Open consent may seem intimidating to families, but most are very open to sharing their story with the world; they just have not been asked yet. Their stories are probably best shared on an organizational website, rather than an independent professional blog.

Generalizing

Another way to share stories and experiences you have witnessed is to “generalize” about the information. While this may not be quite as rich of a storytelling mechanism, it does allow for publishing on topics that do not need specifics. For example, if you recently saw a patient with a Left Ventricular Assist Device (LVAD) and wanted to write about the experience, you will not want to write about any detail which could identify that patient. Even something as simple as “Today I saw a patient with a LVAD...” could be trouble. Instead, write a post about a LVAD research article while referencing “things one might consider when seeing a patient with an LVAD.”
You are still able to share your experience, but it does not violate any one person’s privacy.

**De-identification**

The most tricky form of sharing personal stories is de-identification. While sharing a personal story is one of the foundations of powerful communication, when protected health information is posted, one clearly is at risk for a HIPAA violation. Thus, whenever sharing a de-identified story, be sure to state very clearly at the beginning of the post that many identifying features have been changed to protect the individual’s identity.

Granted, some of the situations we encounter in medicine are unique enough to make de-identification very challenging without losing some key part of the story. If that is the case, then I would strongly suggest you look at open consent. In some situations, it may even be helpful to secure consent and, at the same time, de-identify the case if that is the patient and family’s desire.

**The Problem with Anonymous Posts**

Some clinicians might be tempted to post online anonymously. However, even with anonymous posts, people have the ability to track down the poster. That clear danger aside, anonymous posting misses a critical benefit of having your smartest clinicians posting online as themselves—and that’s sharing their offline clout with the online world. A physician blogger has near-instant credibility online, so leveraging this allows for pretty quick dividends to your site. If you trust them to speak to a local community group, they might be really good at speaking to the world.

**In Summary**

You may be wondering if blogging is something you or your clinicians should do at all? If that’s the case, understand you will miss 100 percent of the swings you never take. There are ways to mitigate risk from online publishing no matter the platform. Online publishing is a critical tool for a hospice organization to understand...
and utilize effectively, including getting professionals closely involved in creating the content. We now have a way to tell our stories and share advances in the field with a much wider audience, without relying solely on the media. The choice is ours.

**Christian Sinclair** is a national hospice medical director for Gentiva Health Services and the editor of “Pallimed, a Hospice and Palliative Medicine Blog.” Prior to joining Gentiva, he served for eight years as associate hospice medical director for Kansas City Hospice and Palliative Care. He was also the first chair and co-founder of the professionals-in-training special interest group of the American Academy of Hospice & Palliative Medicine (AAHPM). He was elected to the AAHPM board of directors in 2009 and was recently elected to a second term. You can follow him on Twitter @ctsinclair or @pallimed.

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**Some Favorite Blogs**

NewsLine asked members of the NCHPP Physician Section Steering Committee if they enjoy reading blogs— and the ones they read most.

“I prefer the ones that have links to more information, such as an original article which is being discussed or referenced,” says Bernice Burkarth, MD, chief medical officer and vice president of medical services for Treasure Coast Hospice in Fort Pierce, FL. “My favorites are Pallimed and KevinMD.com.”

Dan Maison, MD, FAAHPM, the medical director for Spectrum Health Palliative Care and the NCHPP Physician Section leader, is a proponent of blogs too. “I think they are very valuable and enjoy them immensely, especially PalliMed and GeriPal” he says. “I read them for the content and the updates, but also for the musings of people engaged in the same kind of work that I’m doing. They can be an excellent way to learn about innovative solutions to common problems.”

Take a look: Pallimed; KevinMD.com; GeriPal.
New NHPCO Service Allows Programs to Personalize Outreach and Education Resources

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

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

As a first time user, please take a few minutes to familiarize yourself with this outstanding service by clicking on “Ordering Guide.”

Please visit www.nhpco.org/marketplace to access your Custom-Print Marketplace!
Hospice in the Continuum:

In this monthly feature, NewsLine shines the light on a hospice organization which has expanded services or has partnered with other community organizations to reach patients earlier in the illness trajectory—before they may need hospice care. In a Q&A format, members hear firsthand from the organization’s senior leaders who speak directly to the challenges, the benefits, and the lessons learned.
Hospice of Michigan introduced @HOMe Support™ in 2000, a program that helps patients with advanced illness manage their symptoms at home. Unlike some transitions and palliative care programs, it provides comprehensive, interdisciplinary-focused care by a team of physicians, nurse practitioners, registered nurses, social workers, spiritual caregivers, patient-family assistants, and volunteers. It also places emphasis on education and support for the patient’s caregiver.

Launching the program had its risks. “There were many times when we questioned the viability of a program that was not fully reimbursed,” says Hospice of Michigan’s president/CEO, Dottie Deremo, RN, MSN, MHSA, FACHE. “But we put our best people on the project to innovate the new service, and invested significant resources.”

Today, the organization is seeing the rewards of taking that risk. Two recent studies have demonstrated improved outcomes as well as cost savings from @HOMe Support™, and a new partnership with the Detroit Medical Center (DMC) has just been finalized to provide care to DMC patients as part of the Michigan Pioneer ACO.

In the following interview, Deremo discusses the program, including some of the rewards and challenges.

**What sparked the idea for the @HOMe Support™ program?**

Hospice of Michigan and the University of Michigan conducted a study in 1999 that was funded by the Robert Wood Johnson (RWJ) Foundation called The Palliative Care Project. It demonstrated that no matter how informed people were about hospice care, when

**Quick Facts About Hospice of Michigan**

- Founded in 1980.
- Serves 56 counties in Michigan.
- Employs 498 FTEs and 1,100 volunteers.
- Established a Pediatric Program in 1994, with care provided in 18 counties.
- Offers perinatal hospice as a free community service for families anticipating life-threatening or terminal conditions for their unborn children.
- Average Daily Census: 1,000 (for hospice, pediatric and perinatal).
- Opened the Maggie Allesee Center for Innovation in 2001 to lead research, education and community outreach initiatives to improve quality of life through the end of life.

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faced with terminal illness, about 60 to 70 percent of them did not want hospice—the majority didn’t want to forego treatment and a possible cure.

In 2000, with the results in hand, we realized that many people who would benefit from hospice care were not likely to receive it. And, yet, there was no alternative to hospice, leaving the burdens of the illness and care to the patient and his or her primary caregiver. So we began to pose some ‘what ifs.’ First casually; then with focus.

What if we did not make people with terminal illnesses choose between treatment and hospice care? What if information and education are provided to caregivers and family members to make caregiving easier? What if we support the family with a team that helps alleviate fear, is accessible 24/7 to discuss arising issues and concerns, and helps the family cope with stresses related to the illness? What if support includes help with household chores to ease the caregiver’s burden? These discussions were the starting point for our design of the @HOMe Support™ model.

**How long did it take to launch?**
We first piloted the program for five years. Then in 2005, we began meeting with administrators at major HMOs in Michigan to show them how implementing the model could have a positive impact on the cost of services. They were interested and, in 2006, we signed our first contracts. Then in 2007, we accepted our first patient. Since then, we have steadily increased the number of patients we serve every month.

**Can you elaborate on the services provided?**
It fills a gap in care that exists for the majority of individuals diagnosed with advanced illnesses by providing comprehensive care to support both the patient and the caregiver—telephonic and in-home care, with access to both 24/7.

The program is staffed by a team trained in advanced illness strategies, and includes physicians, nurse practitioners, registered nurses, social workers, spiritual caregivers, patient-family assistants, and volunteers. And, as in hospice, comprehensive assessments are completed, but with a plan of care developed for both the patient and caregiver.

But it also does more. It’s a proactive service, helping patients identify their wishes, assisting with preparation of advanced directives and the
Medical Durable Power of Attorney. It also places emphasis on educating and empowering caregivers to advocate for the patient’s treatment goals and wishes. In fact, to ensure treatment goals are communicated and understood, at the family’s request, @HOMe Support™ staff will accompany patients and families to health care settings.

I’d like to also reinforce that, while we have learned from our experience in hospice, @HOMe Support™ is not hospice or ‘hospice lite.’ It is not traditional home care or chronic disease management either. It is a unique blend of the best strategies from all of these models, using 10 years of evidence-based outcomes research. We believe it produces the best quality and cost outcomes.

When did interest in the program begin to increase?
The year 2011 stands out in two important ways. That year, our Maggie Allesee Center secured a grant from the Blue Cross Blue Shield of Michigan Foundation to study the cost outcomes of the patients served by @HOMe Support™ in two separate HMOs since 2007. The results of the study demonstrated the model’s impressive health care cost savings, and gave us proven outcomes to share with interested parties. In light of the Affordable Care Act, we knew that major health care systems were very eager to cut costs and improve quality outcomes—and we were ready. We had a viable model and data to support its use.

In addition, we had developed two invaluable tools—a proprietary software that sifts medical claims data to identify patients with advanced illnesses most likely to benefit from @HOMe Support™, and we had a proprietary electronic medical record that tracks specific quality and effectiveness outcomes for each patient.

Another study this year also showed cost savings, correct?
Yes. In April of this year we announced the results of a study with Wayne State University that analyzed medical costs of patients enrolled on @HOMe Support™ and those who were not enrolled. The medical costs of those on @HOMe Support™ were more than 30 percent lower.

Please tell us about your new partnership and work with the Michigan ACO?
After undergoing a rigorous review, our program was selected to be part of the Michigan Pioneer Accountable Care Organization. We are continued on next page
partnering with the Detroit Medical Center (DMC) to enhance care and reduce costs for patients in its largely urban, multi-hospital health system. The Michigan ACO cited several reasons for selecting the program, including our 10 years of experience in advanced illness management and Hospice of Michigan’s reputation. But, most importantly, we had data on the program’s proven outcomes.

**How many patients are you serving?**
Since signing the contract with the Michigan ACO last March, we are serving more than 200 patients, of which half are ACO patients. We expect to be serving more than 400 patients by the end of the year, and to steadily increase the number served in 2013. Our contracts with health plans, independent of the ACO, also continue to expand and we will have additional patient volume growth with these contracts as well.

**What prompted your emphasis on caregiver support?**
One of the most important findings from the RWJ Palliative Care Project was the significant decrease in caregiver burden when support was provided to both the patient and the primary caregiver. These early findings have been corroborated in subsequent studies, showing that caregivers are likely to become patients themselves because the burden of care, over time, is substantial. The @HOMe Support™ program intentionally set out to support the caregiver and reduce their burden. This support makes a big difference in the lives of the patient and the caregiver.

**What’s the next step?**
Now that we have a contract with the Detroit Medical Center, we are being approached by other organizations to manage the dual-eligible populations in their networks.

We will also continue to seek partnerships with healthcare providers that strategically are working to improve outcomes on quality measures related to patient care while working to reduce costs. We expect to conduct studies on the impact of the @HOMe Support™ model on the quality of life of caregivers and the costs associated with caregiver medical care.
Do you envision this as a model that other hospices can replicate? Even those not as large as Hospice of Michigan?
This model has significant benefits to patients, families and, potentially, the health care system, and we certainly hope it will be evaluated for broader use.

We are exploring partnership opportunities with other hospice organizations to expand the model nationally. One of the biggest obstacles that other hospices face in adapting this model is that there is no defined benefit for this service. Another hurdle is that, without research results to back up their proposal, it is hard to convince the payers that the model works. We at Hospice of Michigan and @HOMe Support™ will talk with hospices that would like to know more about getting past the hurdles. [Members interested in doing so, may contact Executive Vice President Robert Cahill at 313-578-5017 or Vice President of Marketing Michael Jasperson at 313-578-5023.]

Any final thoughts?
As a patient, I would want this kind of care. As a provider, I think everyone in health care should be saying, “Let’s care more about the impact our care has on our patients, about the voids in care after they leave the doctor’s office, about the way patients and families flounder because they have no day-to-day support. If we care about the patients, we need better questions and better answers about what can be provided to improve their lives.

We must provide cost-effective solutions to the looming health care crisis—and for the ‘silver tsunami’ of baby boomers starting to crash onto our shores. We must find ways to serve more patients and caregivers with higher quality outcomes and do this with fewer professional and financial resources. I think @HOMe Support™ is one answer.

@HOMe Support™ started as an idea to fill a gap that real people were falling into, and it looks like doing the right thing for the right reason may have far-reaching benefits. It is going to help a lot of people and we are proud to innovate this new model of care in America.
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 CNA Section, and an article by Tandra Chandler....

continued on next page
Members of the hospice interdisciplinary team must manage case after case, month after month. As more patients enroll in hospice care with increasingly complex conditions, that work can become more challenging and stressful, particularly for the hospice aide.

Managing stress is a critical part of our work because it not only impacts our life and well-being, but also the lives of the patients and families under our care. “Who you are, how you feel, and the attitude that you convey have a profound effect on patients,” says holistic nurse and author, Lucia Thornton, RN, MSN, AHN-BC. “When you walk into a patient’s home feeling depleted
and exhausted, you are creating an unhealthy environment by your presence. If, on the other hand, you are well rested and feel content and peaceful, you create a healthy and wholesome environment by your very presence.” So recognizing how stress manifests itself in each of us and how we can help ourselves to ‘de-stress’ are very important.

Stress is, of course, our body’s way of responding to any kind of demand—whether it’s good or bad. When people feel stressed by something going on around them, their bodies react by releasing stress hormones into the blood steam. This provides them with the energy and strength they need to respond to the demand. Stress becomes a problem when it happens too often—when it finds its way into our daily lives. It is also something we should not ignore: Long-term stress has been linked to heart disease, ulcers and cancers.

Most of us recognize the typical symptoms of stress—at least on our body. There’s the nagging headache that just won’t go away, an upset stomach, trouble sleeping, and fatigue. But stress also impacts our mood and behavior. According to the Mayo Clinic, anxiety, restlessness, irritability, and a lack of motivation or focus can also be signs of stress.

A Few Simple Strategies
When I’m feeling stressed, I have found the following tips to be personally helpful:

- Remember to breathe deeply and slowly (Breathe in peace...breathe out anxiety; breathe in hope...breathe out despair; breathe in love...breathe out pain; breathe in laughter...breathe out sorrow.)
- Find a way to lighten the mood by sharing an appropriate joke or funny story. My favorite saying is “don’t sweat the small stuff.”
- Keep a journal. My friend and colleague, Cassandra Cotton, CHPNA, said that journaling helped her cope with the loss of her mother from breast cancer. “I felt powerless, fearful and overwhelmed,”
she said. “Journaling was a safe mode of expression that brought me peace and understanding.”

- Make time for exercise—even if it is only a 10-minute walk during lunch or a 15-minute walk after dinner. Short breaks throughout the day can have enormous therapeutic value, much more than previously realized.

- Don’t be afraid to ask for help when you need it; your team members need to know.

**Improving Mood and Morale**

Fellow NCHPP member, Laura Thomae, MT-BC, who is the creative arts and complementary therapy program director for Keystone Hospice in Wynmoor, Pennsylvania, shared some wonderful suggestions to help improve staff mood and morale:

- The right music can instantly enhance the environment. Live music is best as this can be modified to meet the needs of listeners “in the moment.” Suggest to your supervisor that live music be played in a hallway or near a central stairwell, making it accessible to everyone—patients and families as well as staff.

- Make lavender lotion with pure essential oil. The essential oil has a calming effect on the nervous system, and the intensity of the natural aroma can promote a sense of well-being. (If your hospice employs an aromatherapist or another complementary therapist, enlist his or her expertise.)

- To help inpatient and residential staff cope with the loss of patients in their care, ask your supervisor about offering a memory-sharing exercise, such as the following Memory Share-Zen Board:

  **Supplies/Setup:**
  Take two large pieces of black construction paper and tape them, side-by-side, onto a wall. Make available a large watercolor brush and cup of water.

  **The Exercise:**
  1. Ask staff to read the names of patients who have died and reserve a few moments of silence for individual reflection;
  2. Ask each staff member to write a word or two about a patient or an aspect of hospice work on the construction paper, using the watercolor brush dipped into the water;
  3. As the writing fades quickly within this ritual space, the seconds seem suspended in time as a reminder of the ephemeral nature of life and our work.

These are but a few ways to help manage the stress in our demanding lives. If you have discovered ways that you have found particularly helpful, please share them with your fellow hospice aides on My.NHPCO.org. See the opposite page to learn more about this free benefit of NHPCO membership.

*Tandra Chandler has been a certified nursing assistant for over 30 years. For the past 19 years she has worked for the Hospice and Palliative CareCenter, where she served as a CNA team leader for 17 years and currently serves as the clinical continuous care scheduler. Tandra also serves as NCHPP’s CNA Section leader.*
One of the best ways to exchange ideas and tips with your colleagues is through the NCHPP CNA eGroup on NHPCO’s professional networking site, My.NHPCO. (It’s free for staff and volunteers of NHPCO provider-members.)

Each NCHPP Section has an eGroup on My.NHPCO (much like the former listserves, but better), plus an eLibrary where members post helpful information and resources to help one another.

If you’re not already a My.NHPCO user, visit the homepage and see “Getting Started” in the top right corner. For specific questions, contact the NHPCO Solutions Center at 800-646-6460 (Monday through Friday, 8:30 a.m. to 5:30 p.m., ET).
In August 2011, CMS announced the requirements for the first year of quality reporting with which all Medicare-certified hospices must comply (per the nation’s new health care law). Now, a year later, the deadlines for data collection and submission are drawing near.

As illustrated in the timeline below:

- By October 1, 2012, hospices must be prepared for data collection on two separate measures: NQF #0209 (aka the NHPCO Comfortable Dying measure) and a QAPI Structural measure.
• This means that:
  • Hospices should now be collecting data on NQF #0209, using the information and resources on the NHPCO Comfortable Dying webpage.
  • Hospices should make certain their QAPI program includes at least three patient-care related performance measures (in order to meet the Structural measure requirement). Examples of patient-care related measures include questions from the NHPCO Family Evaluation of Hospice Care (FEHC) survey; documentation of advance directives; and patient safety measures such as medication errors and falls.

• Updates on data submission for both measures will be posted online as CMS makes the information available—so bookmark and check these websites regularly: CMS Quality Reporting and NHPCO Countdown to Quality Reporting.

• Note also that hospices which do not comply with the quality reporting requirements will be penalized with a 2 percent market basket reduction, effective October 1, 2013.

**Submitting the Data**

Hospices will submit data to CMS through the CMS.gov website—visit the CMS Data Submission webpage for further information.

**Training and Support**

**CMS Training Videos:**
CMS has created quality reporting training videos on both the Comfortable Dying and Structural measures, based on Webinars conducted in April 2012. The videos can be downloaded from the CMS website (as zip files) and viewed using either MP4 or Windows Media Video. There is also a Q&A document that may be helpful.

For details, visit the Spotlights and Announcements webpage of the CMS site, and scroll to “6/22/2012.” Links to the videos are found at the bottom of this webpage.

**NHPCO Website:**
Information relating to the quality reporting requirements can also be found on the NHPCO website—on the Countdown to Quality Reporting webpage. You will find links to CMS resources and updates, along with information about NHPCO’s Comfortable Dying Measure (NQF #0209) and more.
There is a great similarity in the dying process, regardless of place or time of death. For five years I have been finding this parallel in the homes of families living in well-appointed mansions and in old cluttered campers. What is the same is the way people lovingly touch each other with such profound tenderness. Love is what survives any prognosis to the last breath; love is all that is left in the end. This is what I strive to photograph.

I primarily serve folks with end-stage dementia or Alzheimer’s disease, and many of these lovely people die alone. For two years I photographed the hands of these hospice patients as I held their hands, and shared the photographs with their families who lived out of state. It brought them comfort to see that their loved ones were not alone. Then about 10 months ago, I started offering families hand portraits and, if desired, photographs of faces. I usually offer this service while I am at a scheduled nursing visit. The nurses and social workers with whom I work also offer my photography service to patients and families. (I always carry my camera with me, along with my stethoscope!) I don’t advertise this service in any other way... I’m busy enough! While it takes me less than three minutes to take the photos,
I spend an average of two hours per week processing and framing the photographs. I have photographed well over 200 families—I have quite a collection. I charge nothing for this service, but do receive enough in donations to cover the printing and framing costs.

Most family members love the idea. Without exception, all are profoundly moved and pleased when I present them with a framed print and CD. The meaning magnifies after their loved one has passed away. The testimonies I have received validate this work. When a patient’s wife tearfully told me that her hand portrait with her husband (on the last day of his life) was her most cherished object, I knew I had to keep doing this.

I obtain verbal and written consents for these portraits, but even with these permissions, I don’t use any patient identifiers for posts on my Facebook page or website. Sometimes I use first names in the brief stories I post about them, but always with their permission.”

To see more of Mary’s photographs, visit her new website:

www.HospicePortraits.com
“Essential health benefits” (EHB) are one of the requirements of the Affordable Care Act. They refer to a set of services that insurance companies must cover in the health insurance plans sold to individuals and small businesses, both within and outside the new state-based exchanges.¹

These essential health benefits are a minimum set of services that fall into 10 broad categories, ranging from hospitalization, maternity and newborn care to ambulatory care and prescription drugs. When the ACA was signed into law, it was thought that the federal government would create a standard set of essential health benefits that private insurance plans in all states would be required to cover. In December of 2011, however, the U.S. Department of Health and Human Services (HHS) issued a Bulletin stating that it would defer to the states to develop their own benchmark plans, with their own set of essential health benefits.

While managed care and private insurance represent just 7.9 percent of hospice revenue (per NHPCO’s latest Facts and Figures), NHPCO and the Hospice Action Network (HAN) have been monitoring this issue since the ACA took effect in March of 2010—and have taken action when appropriate.

Here’s a brief recap of the key events to date, along with the recommended next steps for hospice advocates and supporters.

NHPCO Engages COS: Spring 2010
Upon passage of the ACA, NHPCO and HAN were immediately concerned that hospice care could be overlooked in what everyone thought would be a standard set of essential health benefits, especially since there wasn’t a clear place for hospice within the 10 specified categories.

During meetings and discussions with NHPCO’s Council of States (COS), NHPCO presented on the topic to engage all state hospice organizations on this issue. The object was to lay the groundwork for multiple national groups to educate and advocate for inclusion of the strongest state hospice benefit in this standard set of essential health benefits. Several state organizations were proactive, assisting NHPCO in identifying Maine and California as the states with the best hospice coverage and the ones that should be promoted through HAN’s outreach to national stakeholders.

Making the Case for Hospice
During the remainder of 2010 and throughout 2011, NHPCO and HAN held a series of meetings with CMS, the HHS Office of Health Care Reform and the Office of the Assistant Secretary for Planning and Evaluation to make their case for inclusion of hospice coverage in the essential health benefits package.

IOM Report: October 2011
The Institute of Medicine released an HHS-commissioned report on October 6, 2011, providing its recommendations on the approach and process the agency should follow concerning essential health benefits. It is also worth noting that hospice coverage was favorably presented in the report.
HHS Bulletin: December 2011
Two months after the IOM Report, HHS issued a Bulletin outlining the approach it would use to determine essential health benefits. To the surprise of many observers and pundits, HHS did not follow the direction recommended in the IOM Report. Instead, HHS said that it would allow each state to select its own benchmark plan with its own set of essential health benefits. States would make their selection by choosing from one of the three largest health plans currently sold in their state. They were also given the option to choose the same plan for their Medicare beneficiaries or a different one. HHS also said that this overall approach could change in 2016, depending on evaluation and feedback.1

NHPCO Provides Comment: January 2012
At the end of 2011, HHS offered the first opportunity to publicly comment on the Bulletin, providing a 30-day window. NHPCO took advantage of this opportunity in two ways: by providing comment individually, in a January 10, 2012 letter from NHPCO President/CEO Don Schumacher; and again on January 31, as part of the National Coalition for Hospice and Palliative Care (a consortium that includes AAHPM, CAPC, HPNA, NASW and NPCRC).

Where We Go From Here
In light of the Supreme Court’s recent decision to uphold the ACA, states must begin the work of selecting their benchmark plans and their set of essential health benefits. Thus, the issue of hospice care as an essential health benefit becomes an issue for each state—and both an opportunity and challenge for grassroots advocates.

NHPCO and HAN will continue to work with its state hospice organization partners to support their work at the local level—and encourages individual providers to do the same. To assist, download a copy of HAN’s talking points: The Case for Including Coverage for Hospice.

References
This past June, CMS’s Center for Medicare and Medicaid Innovation announced that 81 additional organizations are receiving Health Care Innovation Awards, made possible through the Affordable Care Act.

The goal of these awards is to support innovative projects nationwide that are designed to deliver high-quality medical care, enhance the health care workforce, and save money. Combined with the first batch of awards announced in May, 107 projects are receiving awards that expect to save the health care system an estimated $1.9 billion over the next three years.

Four of the awardees are NHPCO members:

**Palliative Care Consultants of Santa Barbara:**
Awarded $4,254,615 for its work in providing health care services to the frail elderly in times of crisis.

**Suttercare Corporation:**
Awarded $13,000,000 for expansion of its Advanced Illness Management program that serves patients with severe chronic illness who are not ready for hospice; are in clinical, functional, or nutritional decline; and are high-level consumers of health care.

**The Trustees of the University of Pennsylvania:**
Awarded $4,361,539 to test a comprehensive set of home care services for Medicare and/or Medicaid beneficiaries with advanced cancer who are receiving skilled home care and have substantial palliative care needs, but are not yet eligible for hospice. [The organization is also receiving a second award for a program to improve medication adherence for coronary artery disease patients.]

**University of Alabama at Birmingham:**
Awarded $15,007,263 for extending a regional network of lay health workers to expand comprehensive cancer care support services throughout a five-state region.

To learn more about the awards and all awardees, visit the Innovations Center website.
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Hospice providers run the risk of pharmacy audits from any number of governmental and commercial insurance entities.

To reinforce this point, consider the June 2012 report by the Office of the Inspector General (OIG): Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice. According to this report, 198,543 beneficiaries received 677,022 prescription drugs through Medicare Part D that potentially should have been covered under the per diem payments made to hospice organizations. No matter who the auditor may be, however, the focus is the same: Were there medications charged to another payer that should have been covered by the hospice?

To ensure optimal compliance, hospice providers should initiate the following actions:

1. Complete a comprehensive assessment of the patient’s medications and clearly document in the clinical record which medications will be covered under hospice.

2. Discuss with the patient and family which medications will not be covered by the hospice—and why.

3. Complete an assessment of patients residing in a nursing facility to ensure that pharmacies are not billing hospice-related medications to another payer once a patient has elected the hospice benefit.
The National Hospice and Palliative Care Organization presents:

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Learn more and register at
www.nhpco.org/CTC2012
Since 2009, the Hospice Action Network has supplied hospice staff, patients and families, and other supporters around the country with video cameras so they can share their stories firsthand. More than 50 videos have now been recorded and posted on the HAN YouTube channel—like the one of clinical coordinator, Teri Humphries, who recorded her video in the car in between patient visits.
Grant Will Be Used to Build Capacity in Palliative Care in Africa

Efforts to improve the quality and availability of palliative care services in Africa recently received a major funding boost. The Diana, Princess of Wales Memorial Fund awarded FHSSA a grant to further its work in improving palliative care in Africa.

The grant will allow FHSSA to make significant advancements in palliative care education and training in Africa. The focus of the funding will be to: establish a network of mentors, develop centers of excellence for clinical placement, finalize standard clinical guidelines, establish sound training practices and a network of trainers for palliative care.

The countries of focus for the grant are: Kenya, Malawi, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe. FHSSA will work in close collaboration with the African Palliative Care Association (APCA), and other programs contributing to palliative care in Africa to meet the goals of the grant.

“This grant will make a significant difference in our ability to strengthen the knowledge base of palliative care in Africa,” said John Mastrojohn III, executive director of FHSSA. “The effects of a sound mentoring and training program will improve care in these countries for decades to come.”

The Diana, Princess of Wales Memorial Fund has been a leading donor and advocate for palliative care in sub-Saharan Africa since 2001,
committing more than £13 million towards integrating palliative care into national health systems and ensuring it is available to all those with HIV/AIDS, cancer and other life-limiting illnesses who need it. The Fund selected FHSSA to further its mission because of FHSSA’s experience and success in improving the quality and access to palliative care services in the region and for its network of partners across the continent.

“Education and training is vital to the development and sustainability of palliative care and has been central to our work,” said Olivia Dix, Head of the Fund’s Palliative Care Initiative. “In the Fund’s final year of operation, I am delighted that we are supporting an organization with FHSSA’s skills, commitment and networks to develop the education programme further.”

FHSSA has already begun work on the grant (see “Clinical Placement Guidelines Workshop” article). For more information about FHSSA, or its work on this grant, contact Shelley Smith at (703) 647-6695 or ssmith@fhssa.org.

**Clinical Placement Guidelines Workshop – Kampala, Uganda**

The Diana, Princess of Wales Memorial Fund Project Gets Underway

One of the first activities with The Diana, Princess of Wales Memorial Fund resources was to organize a workshop in Kampala, Uganda with the African Palliative Care Association (APCA) and leadership and staff of The Diana, Princess of Wales Memorial Fund.

The one day workshop was one in a series of three workshops hosted by the three organizations. The first day, “Developing Guidelines for Clinical Placement in Palliative Care” was led by John Mastrojohn, FHSSA Executive Director. Over 40 palliative care educators and practitioners attended the day representing seven different African countries including Kenya, Uganda, Tanzania, Malawi, Zimbabwe, South Africa and Zambia.

The goal of the workshop was to share current practices for clinical placement for palliative care for various disciplines, discuss definitions and guidelines and develop a way forward to finalize and disseminate the guidelines.

The workshop was extremely successful in sharing information and clearly set the stage for the development of guidelines. “It was an incredible opportunity to have so much experience, talent and energy all together to discuss this important topic,” said John Mastrojohn, FHSSA Executive Director.

The second day focused on e-learning in palliative care and the final two days on palliative care for children in Africa.
Our FHSSA Partners: Results of the 2011 Partner Survey

Organizations that commit to a FHSSA partnership choose to form a one-on-one relationship with an African program. Each Partnership is shaped by the specific talents of each partner and needs of the African program.

The following is a summary of the data from the 2011 yearly survey.*

- African Palliative care providers are caring for a wide variety of diseases. HIV/AIDS and cancer are the two main diagnoses seen in the survey. From 2010 to 2011, listings of primary diagnosis as cancer increased by 12%.

With the combined effort of those in partnership program, from 2010 to 2011 there is an increase of almost 20,000** more patients served by African partners.

- **Primary Diagnosis**

  - **2010**
    - 30% Cancer
    - 70% AIDS
  - **2011**
    - 42% Cancer
    - 58% AIDS

- 77% of the African partners reported collaborating with their African partner on specific projects.
- Most common financially supported collaborations included patient supplies and medications, home based care visits and transportation.

- Supported by US partners African partners are able to achieve greater access to impact in their communities. 77% of African Partners and 81% of US partners described their FHSSA partnership as important to the operation of their organization.

* In total 54% of U.S partners and 49% of African Partners responded.

** Cumulative totals for partner census are derived from the responses of the 2010 and 2011 surveys.
On Saturday, May 19, 2012, FHSSA held its second annual “Lion Chef” Invitational, a fundraising event based on the television culinary cult sensation, “Iron Chef” featuring the legendary kitchen stadium and secret ingredient of lemons. Professional and amateur chefs competed for the “People’s Choice Award” and coveted “Lion Chef” title.

Held in the beautiful atrium of the United States Patent and Trademark Office, more than 40 guests mingled, tasted, and sipped their way through eight creative and delicious dishes, some savory, some sweet and even a refreshing cocktail. Guests cast their ballots for the “People’s Choice Award” which went to Michael Davids and Holly Koechel of Team Marafigi Bora for their dish, “Machungwa kuku na achali,” a grilled chicken with lemon and onion marmalade.

The three official Lion Chef Judges were Sabrina Campbell of Occasionally Cake and Honorary Co-Chairs, Hugh and Barbara Barton. Their deliberations awarded Whole Foods Market Old Town the “Lion Chef” title for “Pastilla Novel.”

Staff of Gilchrist Hospice in Maryland enjoy an evening of food and friends.
In October of 2011, FHSSA launched a campaign to recruit U.S. organizations to partner with one of the over 20 African organizations with applications submitted to FHSSA. The yearlong campaign, “One Cause, Two Continents” continues to raise a great deal of excitement around partnerships from organizations across the U.S. through social media, NHPCO and FHSSA newsletters, and the creation of our new partnership video. Despite the many economic and regulatory changes that U.S. hospices continue to face, the tremendous response to this campaign shows that FHSSA’s mission compels individuals from across the hospice field to connect with and support their colleagues in Africa.

Through the “One Cause, Two Continents” campaign, five new partnerships have formed between organizations in five African countries and five U.S. states. FHSSA is excited for the great relationships and collaborations that these new partnerships will have in the future.

The Center for Hospice Care, based in Indiana, and their FHSSA partner the Palliative Care Association of Uganda, have created a multi-award-winning 30-minute documentary on palliative care in Uganda. They have teamed up with FHSSA to offer a great new way to build awareness and donations around your Partnership through an Event-in-a-Box.

Okuyamba follows the journey of Rose Kiwanuka, Uganda’s first palliative care nurse, as she travels throughout the country, training, supporting and encouraging the nation’s 120 palliative care professionals. This powerful documentary is a great tool to help build awareness of the need in Africa and how work is accomplished.

The free Event-in-a-Box materials you will receive include the DVD of the film, Okuyamba, a How-To guide for hosting a screening, customized posters and self-mailer postcards, and template media requests.

“Okuyamba is such a unique film to use to increase community awareness about all of our partnerships,” says Mike Wargo of Center for Hospice Care. “Our goal is to raise awareness of the critical need for hospice and palliative care services throughout sub-Saharan Africa. Okuyamba is the Lugandan word meaning “to help” and we believe that the Event-in-a-Box is a great tool we can offer to help FHSSA partners engage their local communities in support of the unique needs of their own African partner.”

Want more information on how the Event-in-a-Box can help your FHSSA Partnership? Ready to host your own Screening? Visit http://www.okuyamba.org/

Welcome new FHSSA partners:

- **Kaiser Permanente Oakland Hospice**- Oakland, CA – Partnered with Laikipia Palliative Care Center in Nanyuki, Kenya
- **Susquehanna Home Care and Hospice in Williamsport, PA** – Partnered with Shirati Hospital Palliative Care Center in Shirati, Tanzania
- **Tucson Medical Center Hospice in Tucson, AZ** – Partnered with Rwanda Palliative Care Center
- **Providence Hospice in Portland, OR** – Partnered with Ngora Hospice in Ngora, Uganda
- **Sangre De Cristo Hospice & Palliative Care in Pueblo, CO** – Partnered with Arebaokeng Hospice in Tembisa, South Africa
FHSSA Introduces our new online toolkit for U.S. hospice partners

We invite all partners to share their best practices in partnering

Each FHSSA partnership is unique and focused on the needs and experiences of its programs. Thanks to a new online toolkit offered by FHSSA, the experiences, best practices, lessons learned, and innovations of each partnership can be shared and exchanged with the rest of the more than 95 partnerships.

Partnerships continue to change and evolve and because it is an online resource, FHSSA will modify the toolkit as new information and partner experiences emerge.

The help of all FHSSA partners is needed in order to make the toolkit as dynamic as it is intended. We ask all FHSSA partners to please take the time to share your feedback with us regarding what more you would like to see in the toolkit and to share best practices in your partnership from fundraising to trip planning.

Visit www.fhssa.org/partnertoolkit

The Foundation for Hospices in Sub-Saharan Africa is now doing business as FHSSA.