Inside

Advocacy, Quality and Regulatory in 2012
Three senior staff from NHPCO’s Office of Health Policy answer more than a dozen specific questions to help address many of the issues on members’ minds.

Highlights From 2011
Despite the increasing demands and challenges, 2011 represented an impressive body of work that reflects collaboration and a strong and purposeful focus on care at the bedside. We look back—with convenient links to many resources.

Hospice in the Continuum
Hospice at Home introduced a Palliative Care Service in 2006 and a Transitions program in 2009—and both are having a very positive impact on hospice referrals and lengths of stay. Melinda Graham, the director of development and strategic initiatives, explains.

The Voice of NCHPP
Terri Maxwell and Sue Zimmerman from the NCHPP QAPI Section provide guidance on the new quality reporting requirements.

By J. Donald Schumacher, PsyD
As we start a new year, let me thank you for the profound difference you make in the lives of the people you care for and in the communities you live. You ensure that people nearing the end of life do so with support, dignity and compassion; that families are able to step out of the shadow that death so often leaves.

Nowhere in the world are there professionals or volunteers more proficient at providing high quality, patient and family-centered care at the end of life. There is no question that we—the unified hospice and palliative care community—are the leading experts in caring for people facing serious, advanced and life-limiting illnesses.

However, in order to maintain our standing as the experts, we must respond to the challenges and be willing to adapt to the changing world around us.

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We must learn how to thrive in an environment that is different from that of even a decade ago. We can do this, no question in my mind—but it will require dedication and commitment.

Threats to reimbursement, regulatory scrutiny, more complex compliance issues, quality mandates, growing competition…the stressors we face are many. Not to mention the necessity of creating a more seamless continuum of care that is responsive to the needs of our aging society. This is what we are facing and it is daunting.

For some, there is a fear that organizational or industry-wide changes—whether initiated within our field or from external forces—seem to go against the values held dear by many of us. It is important to remember that many of us got into this work in the early years because we insisted that the care of the dying be delivered more compassionately. We must tap into the strength and creativity that was once a mainstay in this community as we embrace the challenges of today.

In the face of change, what matters the most and what we can never take for granted is our commitment to providing quality care to patients and families. Ultimately, it all comes down to care at the bedside.

I am fortunate in my job to visit with providers of all types—large and small, urban and rural, nonprofit, for-profit, system-owned, faith-based, multi-state and single-site—an amazing range of providers which share a common mission.

Just as no two communities are exactly alike, no two hospice providers are exactly alike. As hospices evolve to meet the needs of the communities they serve, that’s exactly how it should be. Yet one thing that must remain consistent among all hospices is the commitment to quality, compliance and ethical practice. It must be the top priority shared by every one of us. No exceptions.

As I look toward the year ahead, I would like to offer some specific thoughts about what will be required from all of us:

- **We**, as a unified community, must be able to skillfully engage in respectful discourse that recognizes divergent opinions and points of view, but is always guided by the best interests of the entire hospice and palliative care community.
- **The skills** that brought many of us to this point in our history may not be enough to lead successfully in our changing environment. It is critical that we develop new strategies that will allow us to guide our organizations through the changing environment. We must proactively prepare the next generation of leaders in our field.
- **It** is critical that we identify innovative approaches that expand the reach of hospice and palliative care as we actively engage in the creation of a seamless continuum of care. As the recognized experts on palliative care in this country, hospice providers must lead the development of the care continuum. We must not stand passively by while others craft models that exclude us in the work we do. Hospice and palliative care are inextricably linked and must connect if the care continuum is to be successful and beneficial to patients and families.
- **Strategies** that allow every one of us at local and national levels to engage, influence and promote hospice and palliative care are critical. This means proactively reaching out within our communities to referral sources, regulators and legislators. And let us not forget our colleagues, staff members, volunteers, boards, donors and other supporters.

Nowhere is this engagement more important than as it relates to rate protection. This has been the major public policy issue at NHPCO and our affiliate, the Hospice Action Network, for a number of years and will only increase in the year ahead. For us to soften
inevitable rate cuts as much as possible, we must speak as a unified provider community. Successful rate protection is something that every single provider in the field should take seriously.

NHPCO’s Hospice Action Network is the most powerful tool we have to carry the unified voice of the hospice community to Capitol Hill. Through NHPCO and HAN, we have the most experienced, knowledgeable and well-respected group of professional advocates on Capitol Hill that this field has ever seen.

Much of what I have described here requires more than perseverance and passion. It requires trust. Trust among our colleagues and staff at the organizational level as well as trust among the broader national provider community.

I want to see hospices working together to build that trust, so we know we are safe in working on challenging issues without fear of them being taken out beyond our community and used in a distorted way.

If we allow our fears to keep us from exploring and embracing necessary change, or to become inert as an industry, we are not only hurting ourselves, but we are also hurting the many patients and families that desperately need the care and services that we are the best in the world at providing.

NHPCO and our affiliates are working collaboratively to help and support you. So, while we are facing challenges, we should recognize how far we, as a provider community, have come. We are an integral component of care in this country and we enjoy a level of public trust unequaled by other sectors.

As our secondary feature this month, we list some of NHPCO’s key accomplishments during 2011. I hope you will take a moment to look over what we’ve accomplished together. Many of these are tangible examples of our membership working collaboratively and reflect our shared vision of the highest quality care at the end of life.

I am honored to be working with you and I thank you for your involvement and support. NHPCO is your organization and you make our work possible.

J. Donald Schumacher serves as the president/CEO of NHPCO, the National Hospice Foundation and FHSSA, as well as president of the Hospice Action Network’s board of directors. In addition to his service at the national level, Dr. Schumacher was the president/CEO of The Center for Hospice and Palliative Care (Buffalo, NY) from 1989 to 2002, and president/CEO of Hospice West (Waltham, MA) from 1978 to 1989. He was also the founder and president of one of the country’s first HIV/AIDS hospices, The Hospice of Mission Hill (Boston, MA).
The last year has been punctuated by uncertainty, increasing regulatory demands, and continued threats to hospice reimbursement. Despite the fears and challenges, 2011 also represents an impressive body of work that reflects collaboration and a strong and purposeful focus on advancing care at the bedside.

Please take a moment to review some of this good work in the pages that follow. It is not only a valuable reminder of what we have accomplished together, but it is also a good opportunity to access some of the tools and resources you may have missed during the year.

Above: Some winning images from NHPCO’s 2011 Creative Arts Contest.
Leadership

External Engagement
• Engaged with other national associations, organizational stakeholders and federal agencies, including AAHPM, AARP, ABA, ACA, AHCA, Aetna, AHA, Alzheimer’s Association, AMDA, APCA, APC, ASA, ASCP, ASPE, CAPC, CHAP, CHI, CMS, DC Pediatric Palliative Care Collaboration, DEA, Department of Veterans Affairs, EAPC, EPA, FDA, Federal Bureau of Prisons, HFA, HHS, HPCASA, HPM Pediatric Collaboration, HPNA, International AIDS Society, JCAHO, Leading Age, MedPAC, NAAG, NAC, NAHC, NASW, National Cancer Coalition, NCCS, NFDA, NHC, NHDD, NQF, NRHA, OPM, Pain Care Forum, and WPCA.

• Collaborated with the Council of States to strengthen the state-national partnership and bring state resources to NHPCO members.

• Promoted the ongoing efforts of NHPCO’s National Council of Hospice and Palliative Professionals to promote the benefits of interdisciplinary teams and discipline-specific professionals.

• Served as a national partner for the National Day of Listening, including special programming at the 2011 Clinical Team Conference (e.g., Listening Lounge; concurrent session).

Advocacy
• Led the successful effort to introduce the bipartisan, bicameral legislation, the Wyden-Roberts HELP Hospice Act.

• Sponsored two Congressional briefings on timely issues important to the hospice community and on hospice’s work in meeting the needs of Veterans.

• Ran the three-part print ad series, “I am hospice,” in Congressional publications to tell a compelling hospice story on Capitol Hill.
• Brought 500 hospice advocates to the halls of Congress—along with 8,000 virtual participants—to make the voice of hospice heard during 2011 Capitol Hill Day.

• Launched the Hospice Advocacy Local Leaders program to help advocates engage at a higher level with Congress.

• Created In-District Action Kits for summer advocacy efforts.

• Created a new series of Video Advocacy testimonials, featuring hospice patients and providers.

Media Relations
• Provided outreach and support to national and local media, including ABC News; Associated Press; CNN; USA Today; Kaiser Health News; Readers Digest; Associated Press; Reuters; US News & World Report; USA Today; and the Wall Street Journal.

• Served as a resource to industry press, including AARP Physician Bulletin; AMA News; Decision Health; Eli’s; Home Health Line; Hospice Letter; Kaiser Health News; McKnight’s LTC; Medical Ethics Advisor; Modern Healthcare; and Oncology Today.

• Distributed audio and multimedia news releases about the We Honor Veterans initiative that were carried by radio stations nationwide, reaching an estimated audience of 51,826,000.

Quality

Regulatory and Compliance
• Negotiated with CMS for a three-month delay in the enforcement of the hospice face-to-face encounter requirement and developed tools for provider compliance.

• Participated in the Technical Advisory Panel discussions concerning hospice payment reform.

• Offered a 12-Webinar track on timely regulatory topics, including Preparing for Hospice Audits, Physician Contracting and Billing, and Hospice Care in the Nursing Home.

• Developed the annual Wage Index Calculator which NHPCO was the first to develop, plus other rate index tools just for members.

Research
• Completed an analysis of hospice provider information in preparation for further discussions on hospice payment reform with CMS, MedPAC and other federal policymakers. (More than 500 hospice provider numbers—with 500,000 patients and 13 million visits—were part of the analysis.)

• Published the new benchmarking and planning tool, NHPCO Peer Reports, offering NDS data broken out by hospice size and type. (To purchase the reports, email NDS@nhpco.org.)

• Released the 2010 edition of NHPCO Facts and Figures: Hospice Care in America. (The 2011 edition is scheduled for release in early 2012.)

Hospice Admissions Pocket Guide Just Updated

NHPCO has released a new edition of this laminated pocket guide to hospice admissions, with the latest information from CMS on the certification and recertification process, and face-to-face encounter requirement.
• Made State Hospice Profile™ reports available to the field. The state reports, developed specifically for NHPCO, provide county-level information for strategic planning and feasibility studies.

• Released online and print editions of the new Staffing Guidelines for Hospice Home Care Teams.

• Revised and enriched the content of the Quality Resource Center on the NHPCO website to include information and resources on the CMS quality reporting requirements.

• Revised the quarterly reports for the Family Evaluation of Hospice Care (FEHC) to make the results as informative and useful a performance improvement tool as possible.

• Continued to provide national-level comparative reporting results for four NPHCO-sponsored performance measures (EROM, FEHC, FEBS and NDS).

• Successfully submitted two NHPCO quality measures for continued endorsement from the National Quality Forum.

• Released a Veterans Module for the Family Evaluation of Hospice Care (FEHC-V) for evaluation of care delivered to Veterans.

**Access**

**Reaching Populations**

• In partnership with the Department of Veterans Affairs (VA), enhanced the pioneering We Honor Veterans campaign through the provision of new resources, free Webinars, networking calls, an awards process, and much more. There are now over 1,250 hospice and palliative care providers which participate in the campaign, with 375 providers having achieved status as a Partner. (Visit the We Honor Veterans website to learn more—including how to enroll as a Recruit or Partner.)

• Awarded funding to five providers, through a contract with the VA, to support their innovative programming geared toward increasing access to rural and homeless Veterans. (See the “Reaching Out Final Report 2011” available online.)

• Received funding to develop a comprehensive pain awareness campaign to launch in the spring of 2012.

• Developed resources to advance pediatric palliative care:
  - Quarterly e-newsletter of best practices from NHPCO’s Children’s Project on Palliative/Hospice Services (ChiPPS);

**FEHC Data Featured in AHRQ Report**

NHPCO provided both data and guidance on three of the six Supportive and Palliative Care Measures discussed in the National Healthcare Quality Report.

Produced by the Agency for Healthcare Research and Quality, the report sheds important light on the nation’s progress toward improving healthcare quality.

(To learn more, see June NewsLine.)
An Implementation Toolkit for the Concurrent Care for Children Requirement, with grant support from the DC Pediatric Palliative Care Collaboration;

Three modules for the E-OL 10-module series: the Pediatric Palliative Care Online Training Program; and

Expanded offerings for the NHPCO Pediatric Intensive at the 2011 Clinical Team Conference.

Consumer Engagement
- Distributed the award-winning hospice PSA, “My Father,” to television and cable channels nationwide—which aired in 21 states and was seen by an estimated 154,000 viewers.
- Broadcast a 15-second Veterans Day message, every 72 minutes, on the NYC Times Square Jumbotron and the Las Vegas Strip: “We Honor Veterans: Hospices on a mission to serve those who served us.”
- Helped raise the profile of National Healthcare Decisions Day by providing funding support for the website redesign, and by disseminating communications (blogs and other social media content and press releases).
- Through NHPCO’s program, Caring Connections, distributed 473,317 brochures, advance directives and information directly to consumers, free of charge.
- Produced Choosing a Quality Hospice, a free worksheet for patients and families that contains a series of questions to assist them in choosing the best hospice for their unique needs.
- Referred more than 10,000 people to NHPCO member hospices via the Caring Connections Helpline and the NHPCO website’s Find a Provider tool.

Innovation
- Produced the 36-page report, “Private Conversations and Public Discourse,” that summarizes the progress made in raising public understanding about end-of-life care while also outlining where more work is needed, with specific recommendations to assist stakeholders in gaining donor interest and funding support.
- Hosted NHPCO’s first virtual web event, Hospice MDP Summer School, where 156 hospice staff from all corners of the country completed Levels I and II of the NHPCO Hospice Manager Development Program right from their office or home in just three months.
- Added more than 20 new courses to NHPCO’s web-based education portal, End-of-Life Online (E-OL).
- Launched the Executive Leadership Conversation, a series of one-hour conference calls for senior leaders in which NHPCO president/CEO, Don Schumacher, and an expert guest discuss topical issues.
- Published the position statement and commentary, “Hospice and Palliative Care: Ethical Marketing Practices.” (Visit the NHPCO website for all NHPCO position statements.)
• Released the comprehensive Hospice Care: A Physician’s Guide that explores the current regulatory landscape and provides practical advice and resources to help physicians in their new, more broader roles.

• Introduced the “Hospice in the Continuum” monthly feature in NewsLine where, in a Q&A format, members hear firsthand from providers on what they are doing to expand beyond the Medicare Hospice Benefit. (See December NewsLine for a recap of featured programs, with links to each article.)

• Developed a Continuum of Care Assessment tool—an Excel Workbook that guides member-providers through an eight-step process to help determine unmet community needs and their ability to fill them. (See December NewsLine.)

• Redesigned the interface of My.NHPCO, the professional networking site exclusively for NHPCO members.

• Launched Print On-Demand Marketplace, allowing providers to easily and economically custom brand community outreach and patient/family education resources.

Seasons of Caring Ads Win the Gold

The series of three display ads from NHPCO’s 2010-2011 Outreach Materials won the 2011 Aster Award in the category of newspaper advertising.

The Aster Awards honor the nation’s most talented healthcare marketing professionals for excellence in advertising. (See July NewsLine for details.)

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The Office of Philanthropy

NHPCO formed the Office of Philanthropy in the fall of 2010. This new office guides fund development for NHPCO and affiliate, FHSSA, through the National Hospice Foundation (NHF). In 2011, the Office:

- Launched a Capital Campaign to purchase the National Center for Care at the End of Life and has already raised $2.7 million.

- Hosted the most well-attended and financially successful Gala in NHPCO’s history. (The 2012 Gala, on March 30, will celebrate the “Women of Hospice.”)

- Established a Philanthropy Committee to advance the goals of the Office of Philanthropy.

To learn more, see the NHF newsletter on page 41.
The Value of Membership

Despite these leaner economic times, 99 percent of NHPCO provider-members renewed their membership in 2011—a very strong statement about the value of membership.

Today, NHPCO represents 3,864 hospice and palliative care providers and their 48,000 staff; 46 state organizations; and 178 healthcare vendors and consulting firms.

In addition to the work already shared in these pages, it is also worth noting that:

- More than 18,000 callers were assisted by the NHPCO Member Services Center
- There were over 400,000 unique visits to the NHPCO website
- NHPCO Regulatory Assistance responded to 4,800 inquiries.

The NHPCO staff—all 54 of us—thank you for your support!
Just before Thanksgiving, the Congressional Joint Select Committee on Deficit Reduction (aka the “Super Committee”) announced an impasse in its efforts to reduce the federal deficit by $1.2 trillion over the next 10 years. What’s next for the deficit reduction effort and what could it mean for hospice?

AT: Based on The Budget Control Act signed into law in early August, the next step is the automatic across-the-board cuts for Medicare providers and defense spending through a process called sequestration. According to the law, the cuts can be no more than 2 percent off of overall spending on hospice and would last for 10 years. This would be in addition to the reductions we are already absorbing due to the phase out of the BNAF and the anticipated productivity cuts dealt to hospice in the Affordable Care Act [health reform].

What are the next steps in this process? That is, when will the recommendations be implemented?

AT: The cuts would not go into effect until January of 2013, so while sequestration was technically “triggered” by the failure of the Super Committee, Congress still has a good deal of time and a great deal of political pressure to come up with alternative ways to get to the savings. In this budget environment, there’s a chance that hospice could be hit under any scenario Congress might pursue, so the community will have to be vigilant in its advocacy engagement in 2012.
Is there anything that can be done to appeal or minimize these cuts?

AT: For sequestration, the cuts are technically triggered and already written into law. NHPCO will be making the case that, given the other cuts facing the community, an additional 2 percent would be devastating to patient access. At the same time, we’ll need to work a separate track to engage on any and all alternatives that Congress will be pursuing to avoid sequestration. We expect there to be many moving targets. Again, vigilance will be key in 2012.

In this presidential election year, are their opportunities for additional advocacy engagement?

AT: Absolutely. And, it’s not just a presidential election year, but also the full House of Representatives and one third of the Senate who will be campaigning for their jobs this year. Because of that, you’ll see a lot more attention paid to deficit reduction and attempts to reign in entitlement spending. That puts hospice on the table, and in danger of additional cuts. We’ll be rolling out new ways to engage with Congress from home, but we’ll also be offering, for the first time, two opportunities for NHPCO members to go to the Hill as part of a organized lobby day for a united hospice community. Our vigilance, Hill presence and a unified message on the Hill has never been more important. [Information about these opportunities will be featured in the February issue of NewsLine.]

What is the status of the Medicare Hospice “Concurrent Care Demonstration” project?

JLP: The Concurrent Care Demonstration project is still awaiting funding in the CMS Office of Innovations. At the moment, there is no timetable on when funding might be available for the project.
Where do reimbursement rates stand for hospice care in the nursing home?

AT: There’s a good deal of interest by our regulators and Congress on this issue. There was a series of reports on this topic from the Office of the Inspector General. In addition, last fall MedPAC made some hasty recommendations for reductions in reimbursement to hospice providers for services in the nursing home. Fortunately, Congress didn’t act on them in 2011 and wasn’t convinced that MedPAC’s recommendations were the best way to move forward at that time. We’ve done a great deal of Congressional education on this topic and plan to do much more in 2012, but it is still an area where we are vulnerable.

In your travels and discussions with providers, what are the early adapters doing in anticipation of further reimbursement cuts?

JLP: Early adapters are looking at ways to streamline operations, taking a hard look at staffing and staff caseloads, looking at service area reductions to cut down on mileage and staff time costs, and taking a hard look at services that could be reduced without affecting patient care. Some programs are also looking for ways to increase charitable giving as a way to cover some costs.

Was NHPCO satisfied with changes to the CAP Calculation Methodology outlined in the FY2012 Hospice Wage Index final rule?

JLP: The changes in the cap calculation methodology were supported by NHPCO as a way to address patients whose hospice stay spreads over two years. The FY2012 Hospice Wage Index final rule has made the switch in cap calculation methodology very complex, so there is still a great deal of confusion about exactly how the new methodology works, when it becomes effective and what impact it has on the aggregate cap for a provider. NHPCO has been working with CMS to sort out some of the questions that providers have about the new cap methodologies and will publish tips for providers as soon as there is written guidance available about the transition.

How are hospices, especially those serving rural communities, addressing compliance with the newly implemented hospice face-to-face encounter requirement?

JLP: NHPCO has formed a Rural Task Force chaired by Linda Rock, the executive director of Prairie Haven Hospice in Scottsbluff, Nebraska. Members of the task force have shared strategies they have used to address the face-to-face requirement, including multiple contracts with physicians in different parts of the service area to conduct the face-to-face encounter for patients living specifically in that part of the widely dispersed service area, and occasional contracts with nurse practitioners. Rural providers continue to share the challenges of finding available physicians and nurse practitioners to do this work and have strongly supported the expansion of the list of professionals available to do the encounter to include physician assistants and clinical nurse specialists, as outlined in the HELP Hospice Legislation, S722 and HR 3506. [Feedback from the Task Force’s work will be shared in an upcoming issue of NewsLine.]
As fraud-prevention efforts continue to increase, are there certain steps or precautions that hospices should take?

JLP: Every hospice should be increasingly vigilant about their compliance activities, including compliance with the Medicare Hospice Conditions of Participation, claims submission requirements, eligibility requirements, and requirements for continued eligibility. Every hospice should already have a compliance plan, with specific timeframes for internal audits of agency practices and a protocol for reviewing processes that may be out of compliance with current laws and regulations.

There are four areas of risk for hospice today:

1. Eligibility—Does the patient meet the eligibility requirements for admission to the hospice program?
2. Site of Care—Do the patients in nursing facilities meet the eligibility requirements for hospice? Is the length of stay appropriate, or were those patients admitted “too early” for hospice care?
3. Level of Care—Does the level of care match the patient’s symptom management concerns or family need for respite? Is General Inpatient care appropriate and documented in the medical record?
4. Claims Submissions—Are the dates of service, Q-codes for location of care, and levels of care accurate?

While the NHPCO Regulatory Alert on August 1 spelled out the new quality reporting requirements, can you recap the key points and deadlines?

CS: There are two quality measures that will be required for quality reporting.

One is a structural measure that consists of two parts: (a) confirmation of participation in a QAPI program that includes at least three patient care related performance measures, and (b) descriptions of all of the patient care measures in use during the data collection period.

The second is the outcome measure, NQF#0209, that addresses pain brought to a comfortable level within 48 hours of the initial assessment. Hospices will report on “the percentage of patients who were uncomfortable because of pain on admission

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to hospice whose pain was brought to a comfortable level within 48 hours.” This measure, also known as the Comfortable Dying measure, was developed by NHPCO. Information on implementation and comparative reporting are provided on the NHPCO website [www.nhpc.org/outcomemeasures].

Reporting takes place in two phases. The initial phase is Voluntary Reporting for the QAPI structural measure. To participate in Voluntary Reporting, hospices identify the quality indicators [i.e., measures] related to patient care utilized in their QAPI program during the data collection period of October 1, 2011 to December 31, 2011, and submit the data by January 31, 2012. The second phase is Mandatory Reporting for both the QAPI Structural Measure and the Comfortable Dying measure (NQF #0209). Hospices submit data collected from October 1, 2012 to December 31, 2012. The data for the QAPI Structural measure must be submitted by January 31, 2013 and the data for the Comfortable Dying measure (NQF #0209) must be submitted by April 1, 2013. [For more about these quality reporting requirements, see the article on page 26.]

Do you know what other measures are under consideration?

CS: Measures selected by CMS for quality reporting must have been endorsed by the consensus-based entity under contract to CMS, which is currently the National Quality Forum (NQF). There are fourteen measures related to palliative care and end of life that are now undergoing review for NQF endorsement. Two indicators of overall performance from the Family Evaluation of Hospice Care (FEHC) survey are among the measures being considered—the Composite Score and the Overall Rating question.

Based on your past work with providers on NHPCO’s various performance measure and data collection tools, do you feel the average provider is equipped to meet the quality reporting requirements?

Do you have any specific concerns?

CS: Hospices that have comprehensive QAPI programs and are already using the Comfortable Dying measure should have no difficulty meeting the quality reporting requirements. However, hospices that are not yet using the Comfortable Dying measure need to start now.

Quality reporting may seem to be far in the future, but hospices cannot afford to wait to implement the Comfortable Dying measure or to ensure that they have at least 3 patient care related measures in their QAPI programs. In addition to training staff to implement the Comfortable Dying measure, hospices must be sure that documentation is congruent with the data needed for reporting and that they are able to extract the data from records. This is a multi-step process that cannot be put in place overnight.

Is there special guidance you can provide on how providers can best train their staff?

CS: Performance improvement is the responsibility of the entire team. All hospices must review their QAPI programs to be sure they have a minimum of three measures related to patient care and that they can describe each
of those measures in terms of a numerator and a denominator.

Implementation of the Comfortable Dying measure involves not only nursing staff who do the initial assessment, but all staff responsible for patient care as well as documentation and patient records. As with provisions of patient care in hospice, preparation for quality reporting will require getting everyone involved.

NHPCO will be offering a range of tools and educational programming to assist members. For example, we have a new Quality and Regulatory track as part of the 2012 Webinar series. For the January 24 Webinar, I will be co-presenting on the new mandatory quality measures with NHPCO board member, John Thoma, who serves on the Quality and Standards Committee. And on April 24, another Webinar will be presented on preparing for required quality reporting on the Comfortable Dying measure. I will also be presenting an MLC preconference session, “Countdown to Quality Reporting: Don’t Panic. Act!” on March 27 and on March 28. I’d also suggest that members bookmark the new page on the NHPCO website that will include a growing list of tools and information.

Upcoming Webinars to Help Staff Prepare

NHPCO has introduced a new Quality and Regulatory track as part of the 2012 Webinar Series. Coming up:

January 24:
The New Mandatory Quality Measures: Is Your Organization Ready?

February 28:
Tools and Models for Building an Effective Compliance Program

March 20:
HIPAA and HITECH – Ensuring Compliance

April 24:
Preparing for Required Quality Reporting on the Comfortable Dying Measure

Visit the NHPCO website to learn more or to register.
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 at Home, based in St. Joseph, Michigan, introduced a Palliative Care Service in 2006 and a pre-hospice Transitions program in 2009.

“Jointly, these programs provide our community with high-quality care, while also increasing referrals to our hospice program,” says Melinda Graham, MBA, CFRE, the director of development and strategic initiatives. “In general, our hospice admits an average of 10 people from these programs each month. The patients also tend to stay on hospice longer—the current average being 100 days.”

In the following interview, Graham talks about the agency’s experience since launching the services—both of which have also helped to increase donor engagement.

Tell us about your Palliative Care Service—how is it structured and staffed?
Hospice at Home offers a physician-led, home-based Palliative Care Service as part of its spectrum of care for seriously ill individuals. Our palliative care physician and an administrative scheduler are at the core of the service. Working in coordination with our Transitions Program and Referral Center, both symptom management and psychosocial support are offered through a variety of means. Our physician visits patients, families and caregivers in their homes, assisted living facilities, adult foster care homes and skilled nursing facilities.

Does it have a defined mission and focus?
In order to serve the growing number of patients with chronic illnesses, the physician visits focus on three things: relief from symptoms associated with the illness; assistance with understanding difficult treatment choices—from what to expect of the disease process to help with determining priorities and navigating the healthcare system; and collaboration with providers and physicians to provide consistent health care and give patients a better understanding of their options.
How many patients are you serving?
In 2011, we served approximately 275 palliative care patients, and averaged eight new patients and 60 physician visits per month. This past October, our palliative care physician became full-time and our census almost immediately jumped to an average of 10 patients and 90 visits per month.

How do you get referrals?
Our palliative care referrals come from primary care physicians, oncologists, other specialty physicians, long term care facilities, and patients and families. We also receive referrals from our Transitions program and Hospice at Home’s Referral Center when the patients are not medically eligible for hospice.

How much time is spent with patients?
After receiving a referral from a physician or a call to our Referral Center, our palliative care physician works closely with the patient’s referring and/or primary care physician as well as the patient and family. The care begins with an initial 60 to 90-minute consultation, and follow-up visits of roughly 30 to 45 minutes. During a palliative care visit, our physician meets in the home with the patient and family to address symptoms, discuss goals, assist them with understanding the course of the disease, and help them establish realistic expectations.

How is the service funded?
We have a Medicare part B provider number that allows us to bill Medicare, Medicaid, and most major insurance providers for the palliative care physician visits. Co-pays are billed to a secondary insurance and/or to the patient. We use a sliding-fee scale, so that patients who cannot afford the co-pay will not feel financial hardship and can still be cared for by our physician.

Tell us about your Transitions program?
In 2009, Hospice at Home purchased the Transitions program of Transitions PreHospice, Inc. It is a family support program where non-clinical staff and volunteers serve people who are coping with an advanced progressive illness.

A full-time Transitions coordinator and a part-time Transitions spiritual care coordinator work with volunteers to support the Transitions clients. The staff identifies their needs and helps connect them with community resources. But the staff also discusses such aspects of care as the emotional impact of living with an advanced progressive illness, and helps them set clear goals so care decisions reflect what is most important to them. The volunteers are also available to provide companionship and respite.

What works especially well are the Transitions/Palliative Care team meetings that are held weekly to discuss the individuals being served by both programs. It helps encourage valuable collaboration between the two programs.

Who are your referral sources for the Transitions program?
Some are hospice referrals who are not yet medically eligible for hospice, some are live hospice discharges, and others come to us from our Palliative Care Service when it is determined that they could benefit from Transitions. We also receive referrals from the
medical community and from individuals who recognize a person may need Transitions support. In 2011, we served 375 people.

**It sounds like there is real continuity of care between the services?**
Yes, these programs have become our model for seamless care for seriously ill individuals. The beauty of these programs is that they are able to address patient needs from multiple directions, yet work in concert. With Palliative Care, patients receive a physician partner for the pain and symptom management that they need to live comfortably. With Transitions, people who need assistance planning and coordinating care and resources have the help that they need to connect with local agencies and programs.

**What have been some of the quantitative benefits?**
Jointly, these two programs provide the community with high-quality care while also increasing referrals to our hospice program. In general, our hospice admits an average of 10 people from these programs each month. The patients also tend to stay on hospice longer—the current average being 100 days. Both the Palliative Care and Transitions programs also provide us with a formalized system to build a relationship with people who are not yet eligible for hospice care, yet could benefit from our expertise. It also allows us, as an organization, to continue our relationship with those patients who are discharged from hospice because they no longer meet the criteria of the Medicare hospice benefit.

**What have been some of the qualitative benefits?**
Our Palliative Care and Transitions programs have really helped us ‘widen our reach’ with many different constituencies—patients, physicians, volunteers and donors.

We have been able to have conversations with patients and their families earlier because they don’t have to give up treatment or other curative measures while receiving the services. It helps them to have someone come to their home to answer questions and discuss options. Whichever program they start with, they have people checking in on them frequently and making sure they have the appropriate level of care. It is especially helpful for those people who have several different doctors for various conditions to have someone looking at the big picture and helping to ensure their plan of care is in line with their priorities.

For our community physicians, it makes their work a little easier. They appreciate the extra time our Palliative Care physician can spend with the patient and family to discuss options and end-of-life care wishes. We have also found it helpful with volunteer recruitment, since some volunteers find it easier to work with Palliative Care or Transitions clients. It allows them
to build longer-term relationships and to continue to volunteer for the patient if he or she transitions to hospice care.

And finally, the programs have given us reason to seek additional support from donors and grantors and, in so doing, has helped us cultivate more program ambassadors and a strong sense of ownership within the community.

What have been some of the challenges?
Our Palliative Care and Transitions programs have definitely evolved over time. We developed a palliative care business plan in 2004 and had a joint task force with our local hospital. The joint task force sent a team from both organizations to attend palliative care intensive training sponsored by the Center to Advance Palliative Care (CAPC). Unfortunately, the joint task force ceased meeting in 2006 without a joint Palliative Care program. So Hospice at Home began using a nurse practitioner to make palliative care patient visits and develop the program. We discovered that a physician-led program would be more effective and hired a palliative care physician in 2009. The challenge then became how to best utilize his time. We found that Palliative Care patients frequently needed assistance with connecting with community resources and finding ways to meet their daily living goals, and that led to our purchase of the Transitions program. This past year, we re-initiated working with the hospital to create a joint Palliative Care program—and we will formally begin a combined program this month.

What advice can you offer other hospice providers who want to expand into palliative care?
Evidence-based models now exist and more research is being published to help hospice providers establish and expand into palliative care. Our advice is to use this information and resources, such as those available through CAPC, to create a quality program that you can be proud of. We have learned that, in many cases, palliative care is the first contact that someone has with your organization. If that person is impressed with your care, he or she will trust you when it is time for hospice care. If your palliative care service is not meeting his or her needs, that person will likely go elsewhere.

Do you have plans for future expansion?
Yes, we are one of three partners creating an independent PACE organization [Program of All-inclusive Care for the Elderly] since the integrated “PACE approach” to health and social services matches our strengths as a hospice and palliative provider. In partnership with our local Area Agency on Aging and our regional health system, the Area Agency on Aging building is being remodeled and increased in size to create a PACE day services center. This center will be the hub of PACE activities, including meal service and a health clinic to support the frail elderly and enable them to live at home for as long as possible. Our hope is to have the site open by July, 2012.

We are also affiliating with our local health system to create an advance healthcare planning program and expand our bereavement services throughout the continuum.

Are you offering a non-hospice service too?
And would you like your work spotlighted in NewsLine?
Complete our brief questionnaire.
NHPCO has revised and improved the popular resource about hospice care for the community attending physician. This “Physician Guide to Hospice Care” provides basic information for the attending physician about:

- hospice care and the provision of services
- referring a patient for hospice care
- reimbursement for attending physicians of hospice patients
- hospice provider support for the attending physician
- local coverage determinations for hospice diagnoses

**Item #:** 714384  
**Member:** $10.99  
**Non-Member:** $21.99

The Physician Guide to Hospice Care is also available with the option of being customized with your logo and four lines of text on the back cover at no additional charge. There is a quantity minimum of 100 copies to customize. Visit [www.nhpco.org/marketplace](http://www.nhpco.org/marketplace) and click on custom-print marketplace to place your order. Please allow 2-3 weeks for productions.

The Corridor Group’s “Hospice Quickflips©” is the perfect companion to the physicians guide. Hospice Quickflips© are a pocket-sized resource designed to help clinicians document care that reflects professional skill, while also demonstrating compliance and eligibility under the regulations and guidelines published by Medicare. Also included are information and tips to enhance and improve interdisciplinary teamwork, the structure of the IDT meeting and regulatory knowledge.
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 NCHPP Quality Assessment Performance Improvement Section, and an article by Terri L. Maxwell, PhD, APRN, and Susan Zimmerman…

continued on next page
Last August, the Centers for Medicare and Medicaid Services (CMS) announced important new reporting requirements that NHPCO shared in a Regulatory Alert to the NHPCO membership. To briefly recap the key points:

• The Patient Protection and Affordable Care Act (Section 3004) requires hospices and other post-acute settings to submit quality data to CMS—which must be collected during 2012 and submitted to CMS in 2013.

• CMS is required to reduce the 2014 market basket update by 2 percent for those hospices that do not comply with the quality reporting requirements.

• CMS intends to make hospice quality data available to the public, although no timeline has yet been given.

In order to meet the new quality reporting requirements, hospices must track and report on patient-specific indicators selected by CMS and endorsed by a consensus body such as the National Quality Forum (NQF). However, CMS may also require hospices to track and report on some quality indicators which have undergone less rigorous review (and are discussed later in this article).

The Two Accepted Measures to Date

CMS has announced the first measures that will be required for quality reporting:

1. A Structural Measure that consists of two parts: Confirmation of participation in a QAPI program that includes at least three patient-care related performance measures; and descriptions of all patient-care measures in use during the data collection period.

2. NQF #0209 Measure (i.e., NHPCO's Comfortable Dying Measure) that addresses pain brought to a comfortable level within 48 hours of initial assessment.

The following table provides a snapshot of the requirements and timeline for compliance. (NHPCO has also developed a more detailed timeline which members can download from the NHPCO website.)
To meet the NQF #0209 pain management measure requirement, providers should utilize the NHPCO Comfortable Dying Measure that was introduced in 2001 to help hospices assess the quality of their patient care. This NHPCO Measure has received NQF endorsement and was selected by CMS for use in meeting the new requirement.

When collecting data for this measure, it is very important to adhere to the exact wording in the two patient-answered questions:

- “Are you uncomfortable because of pain?”
- For those who report yes, “Was your pain brought to a comfortable level within 48 hours of the start of hospice services?” (This question should be asked within 48 to 72 hours of asking the initial question.)

### NQF #0209 Measure

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<tr>
<th>Structural Measure (Use 3 or More Clinical QAPI Indicators)</th>
<th>Deadline for Data Submission</th>
<th>Timeframe for Data Collection</th>
<th>What You Can Do Now</th>
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<tr>
<td><strong>Voluntary:</strong> January 31, 2012</td>
<td>October 1 to December 31, 2011</td>
<td>Confirm current measures and descriptions.</td>
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<tr>
<td><strong>Mandatory:</strong> January 31, 2013</td>
<td>October 1 to December 2012</td>
<td>Review measures in QAPI program; add more patient-centered measures if needed. Review CMS online submission form.</td>
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| NQF #0209 Measure (NHPCO Comfortable Dying Measure) | Mandatory: April 1, 2013 | October 1 to December 31, 2012 | Review specifications and protocol. Ensure system for accurate data generation and capture. Calculate measure—improve! |

### NCHPP QAPI Section Steering Committee

**Section Leader:**
Susan Zimmerman
Deyta, LLC
Louisville, KY
szimmerman@Deyta.com

**Committee Members:**
Rhonda Fisher-Brown
Hospice by the Bay
Larkspur, CA

Ellen Martin
Hospice Austin
Austin, TX

Terri Maxwell
Hospice Pharmacia
Philadelphia, PA

Laurie West
Suncoast Hospice
Clearwater, FL

Katie Weyandt
Infinity Hospice Care
Las Vegas, NV

Patricia Vigilante
VNSNY Hospice Care
New York, NY
This measure does not require interpretation of a pain scale and should be asked prior to asking the patient to rate his or her pain and performing a comprehensive pain assessment. It is also important to note that patients included in the sample must be age 18 or older and surrogate responses are not permitted, including the interpretation of a patient’s nonverbal response based upon observation.

More information about the NHPCO Comfortable Dying Measure can be found online.

**Structural Measure**

The Structural Measure requirement is based on the Medicare Hospice Conditions of Participation (Hospice CoPs) which state that providers must “monitor the effectiveness and safety of services and quality of care... [and] focus on high risk areas.” The Hospice CoPs also require providers to “track adverse events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.”

There are a number of indicators that you can use in your QAPI program in order to meet this Structural Measure requirement. Examples include questions from the Family Evaluation of Hospice Care (FEHC) survey, documentation of advance directives, and patient safety indicators such as medication errors and falls.

The indicators that you select must relate to patient care and fall under a patient care domain, such as:
- Providing care in accordance with documented patient and family goals
- Effective and timely symptom management
- Care coordination
- Patient safety

So how do you choose which indicators to use? There are many sources for well-designed and valid indicators, including the Family Evaluation of Hospice Care and the CMS-funded AIM and PEACE projects (see Helpful Resources on page 30). When reviewing those to use, look for indicators that will demonstrate the quality care your program provides as well as measureable improvement in patient outcomes. Both patient- and agency-level indicators should be included.

**Some Indicators Being Used by Your Colleagues**

At NHPCO’s 12th Clinical Team Conference in September 2011, members of the NCHPP QAPI Steering Committee presented on some of the quality measures now being used at their programs—and two of the examples that were shared are described below.

**At Hospice by the Bay**

The presentation by Rhonda Fisher, LCSW, director of quality management at Hospice By The Bay (HBTB) based in Larkspur, CA, included a discussion of her organization’s use of medication errors as a quality indicator.

In being a key patient safety issue and a requirement in the Hospice CoPs, medication errors are an excellent choice for a quality indicator. There are also many types of medication errors that hospices can track, including problems related to delivery, wrong or misread labels, transcription errors, and errors related to route, dose, patient, or drug. In addition to documenting the type of error, it is important to record if the error resulted in an injury or adverse event and where the error originated (e.g., patient, hired caregiver, facility or hospice staff or pharmacy), so that performance efforts can be targeted to the root cause.

Through the process of collecting and evaluating data on medication errors, HBTB identified issues with its pharmacy providers and took steps to notify them of the errors related to their service. This information was presented in a
positive manner that enhanced collaboration between the organizations and, in turn, helped to reduce future errors.

**At Infinity Hospice Care**
Falls are another significant patient safety concern and an important indicator of hospice quality and safety, per the Hospice CoPs. Patients in hospice are at high risk of falling based upon their frailty, age, medications, environmental hazards, and changes in mental status.

Katie Weyandt, RN, the corporate compliance and quality manager for Infinity Hospice Care, based in Phoenix, AZ, noted that her organization chose to monitor falls as a quality indicator, and chose to measure them by looking at the number of falls per 1000 patient days, as that is the format used in the CMS-funded AIM measure (M11).

The falls were defined as “any unintentional change in position resulting in coming to rest on the ground or lower level.” Because falls were measured by the number of falls per 1000 patient days, they could then be compared based on setting (facility versus home), witnessed versus unwitnessed, and injury versus non-injury.

Based on the data, Infinity Hospice Care embarked on a Performance Improvement Project called “Fall Busters.” The project goal was to reduce the number of falls by incorporating fall prevention assessments into all admissions; educating staff on interventions; updating care plans; and providing prevention education to patients and families. The end result was improved communication, education and awareness about the risks of falling.

**Some General Guidance**
These are just two examples of the many ways that hospices are selecting and using quality indicators in their QAPI programs. So what should your organization be doing now to prepare for public reporting?

To meet the Structural Measure, take a good look at your QAPI program and the measures you already have in place. Are they meaningful? Do they demonstrate improvement? Now is the time to:

- Review the definition and protocol for each measure;
- Ensure the measure is consistently implemented; and
- Consider adding measures as you work your way through the review process.

It is also important to be intentional about selecting measures that are specific to your organization and patients—and that focus on ways that you can measurably improve care and services.
Join Fellow QAPI Professionals for Monthly Chats

Each month, the NCHPP QAPI Section holds “chats”—or conference calls—which are open to NHPCO members.* These chats are one of the best ways to connect with colleagues and discuss topical issues.

When Chats are Held:
The second Thursday of each month, from 3:00 to 4:00 p.m. (ET).

To Join the Chat:
Call 805-360-1000, and enter the Participant Access Code when prompted: 1063900# (be sure to include the pound sign). You will be connected as soon as the facilitator has dialed in.

Topics:
As we go to press, specific topics have not yet been finalized. However, in light of the new quality reporting requirements, chats will address public reporting, QAPI program management, and data collection and use.

*In order to join a chat, you must first be enrolled as an NCHPP member (which is free to all staff and volunteers of NHPCO provider-members). If you are not yet enrolled, call the NHPCO Member Services Department at 800-646-6460.

To meet the NQF #0209 Measure, use the NHPCO Comfortable Dying Measure which, as we mentioned earlier, has earned NQF endorsement and is part of the CMS quality reporting requirement.

Voluntary Reporting—an Opportunity
Voluntary reporting of the Structural Measure is another valuable means of preparing for public reporting, but the deadline for submission is approaching fast—January 31, 2012!

For those providers which are able to participate, voluntary reporting will help inform CMS of the measures that are important to the hospice industry. It will also give participating providers more opportunity to review their QAPI program and identify drivers of quality within their organization. It’s also good practice for the mandatory reporting that will be required next year.

Public reporting is upon us and the hospice community is no longer immune to the challenges inherent in collecting and reporting federally required measures. However, this challenge also presents the perfect opportunity for hospices to take a good look at their QAPI programs and continue to develop them broadly, strategically and meaningfully.

Terri Maxwell, PhD, APRN, is the vice president of strategic initiatives for Weatherbee Resources, Inc. and the Hospice Education Network (HEN). She has worked as a practitioner, researcher and educator in hospice and palliative care for over 15 years, and serves on the NCHPP QAPI Section Steering Committee.

Susan Zimmerman is the product manager for Deyta, LLC. Prior to joining Deyta, she served as the associate director of quality and compliance at Delaware Hospice. Susan also serves as section leader for the NCHPP QAPI Section.

Hospice Quality Resources

AIM Project Toolkit (http://www.ipro.org/index/hospice-aim)

American Hospice Foundation (www.americanhospice.org)

CMS Hospice Quality Reporting (www.cms.gov/LTCH-IRF-Hospice-Quality-Reporting)

National Quality Forum (www.qualityforum.org)

PEACE Project (http://www.thecarolinascenter.org/default.aspx?pageid=24)

Post Acute Care Payment Reform Center (www.pacdemo.rti.org)
NHPCO has developed this new webpage as a convenient “go-to” resource for NHPCO members. It includes information to assist hospices in meeting the new CMS quality reporting requirements—information that’s already been reviewed and vetted by the NHPCO Quality Team.

**What You’ll Find Online:**
- NHPCO Quality Reporting Resources
- CMS Quality Reporting Materials and Related Websites
- Quality Reporting Updates

Since these new quality reporting requirements are an ‘evolving process,’ NHPCO will update the information on this webpage regularly. Please bookmark the page (http://www.nhpco.org/i4a/pages/index.cfm?pageid=5841) and check it frequently.
Surgeon, professor and acclaimed author, Atul Gawande, gained particular attention from the American public and media for his stunning article in The New Yorker (August 2, 2010)—“Letting Go: What should medicine do when it can’t save your life?”

“Our medical system is excellent at trying to stave off death with eight-thousand-dollar-a-month chemotherapy, three-thousand-dollar-a-day intensive care, five-thousand-dollar-an-hour surgery. But, ultimately, death comes, and no one is good at knowing when to stop....” he writes. “The hard question we face, then, is not how we can afford this system’s expense. It is how we can build a healthcare system that will actually help dying patients achieve what’s most important to them at the end of their lives.”

Gawande believes that hospice has tried to offer a new ideal for how we die. “Although not everyone has embraced its rituals,” he writes, “those who have are helping to negotiate an ars moriendi for our age.”

As the second plenary on the opening day of NHPCO’s 27th Management and Leadership Conference (MLC 2012), Dr. Gawande will explore this issue further—and share his perspective and insights on how hospice and palliative care organizations can bring this “new ideal for how we die” to the broader healthcare community.
Plenaries

- What Got You Here Won’t Get You There, Marshall Goldsmith, PhD.
- Letting Go: How Hospice and Palliative Care Can Transform the Healthcare System, Atul Gawande, MD.
- Factors Facing Reimbursement, Mark Miller, PhD, Executive Director of MedPAC, with NHPCO President/CEO, Don Schumacher.
- Appreciative Leadership: Building a Thriving Organization, Diana Whitney, PhD.

Venue

Gaylord National Resort and Convention Center
National Harbor, MD
On the waterfront—just eight miles from Washington, DC

For What’s in Store All Year, See NHPCO’s 2012 Education Catalog:

- Continuing Education for CE/CME
- Conferences
- Webinars
- End-of-Life Online
- Hospice MDP
- Hospice Executive Leadership
As I start my second year as board chair, it's only fitting that I begin by thanking you, the membership, for giving me this opportunity to work on your behalf.

I've been a hospice CEO for 14 years and have been involved with NHPCO for 22 years. Like many of you, I've weathered many changes and observed firsthand a myriad of dilemmas confronting our field. I've also been inspired by the passion I see every day and have been energized by the ways hospice and palliative care providers are expanding the continuum of care to ensure all of our communities have access to the finest care at the end of life.

We share a common mission to deliver the highest quality care to patients and families. NHPCO’s commitment to preserving the unity of the hospice and palliative care community is one that I’ve shared with you before and reiterate once again. Our strength as a unified community must not be lost amid the challenges we may be facing.

I sincerely thank you for choosing to be a member of the oldest and largest hospice and palliative care leadership organization in the world. This is your NHPCO.

Mark M Murray
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<tr>
<th>Name</th>
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<td>Michele Fedderly</td>
<td>Minnesota Network of Hospice &amp; Palliative Care</td>
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<td>Council of States Representative</td>
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<td>Dale Knee</td>
<td>Covenant Hospice Inc.</td>
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<td>Mary Labyak</td>
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<td>Susan Lloyd</td>
<td>Delaware Hospice, Inc.</td>
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<td>Terry Melvin</td>
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<td>Michael Nisco</td>
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<td>Joan Teno</td>
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<td>Zachary Morfogen</td>
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<td>Concluding Board Service in 2011</td>
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<td>Gretchen Brown</td>
<td>Hospice of the Bluegrass</td>
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<td>Robert Lefton</td>
<td>Gentiva Health Services</td>
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Highlighted here are some of the feature articles from NewsLine during 2011—with links to each article.

Remember that you can also download a print-friendly copy of each article to read later or share with staff—just go to the end of the article and click the purple “Print This Article” button.

Documenting Hospice Physician Services

NHPCO’s New Staffing Guidelines

Hospice Profit Margins in the Next Decade

POLST: An Evidence-based Tool for Advance Care Planning

Managing a Multigenerational Workforce

What You Should Know About ACOs and the Role You Can Play

Ethical Marketing Practices

The Denver Hospice’s Comfortable Dying Measure

Crossing the Line: Boundary Violations and How to Avoid Them

Helping Your Patients Leave a Legacy

Working With Modern Families

Past issues of NewsLine are also available on the NHPCO website—www.nhpco.org/newsline.
NEW Website Boasts Host of Tools for Hospices

www.runstoremember.org/HospiceTools

- Take a free E-Online course about this fundraising program
- Read examples of other hospices’ successes
- Download sample press releases
- Customize recruitment materials with your logo
- And more!

Contact Susan Messina, Director of Development Communications, at smessina@nationalhospicefoundation.org or 571-275-4324. www.runstoremember.org
It is another new year and compliance in your hospice operations is more important than ever! As the Office of the Inspector General continues its focus on hospice in the nursing home, providers should ensure that all aspects of their partnership with nursing facilities are in order. NHPCO suggests assessment of the following components for optimal compliance:

- Ensure that there is a current contract in place that includes the required language from the Medicare Hospice CoPs (§418.112).
- Make sure the contract includes the requirement for the nursing facility to conduct a criminal background check for any individual who has direct patient contact or contact with a hospice patient’s clinical record—and conduct a periodic audit to ensure the nursing facility’s compliance.
- Audit clinical records of patients receiving hospice in the nursing facility to ensure that required documentation (stated in CoPs at §418.112(e)(3)) is included in the hospice clinical record and in the facility clinical record.
- Use NHPCO’s “Hospice in the Facility” audit tool to determine compliance.

**Meg Pekarske on Working with Nursing Facilities**

Meg Pekarske, JD, co-chair of the Hospice & Palliative Care Legal Service group at the law firm of Reinhart Boerner Van Deuren, provided very practical guidance on how hospices can work more effectively with nursing facilities in the NewsLine article, *Putting Yourself in Their Shoes: Fresh Perspective to Improve Your Work with Nursing Homes*. While written in August of 2010, it’s still very relevant today. Read the article now.
The best way to keep informed of the changes occurring in the hospice and palliative care field is to take advantage of NHPCO’s diverse range of educational offerings.

Our goal is to ensure that you and your colleagues are well-informed and better able to deliver quality end-of-life care to all members of your community.

To learn more about our upcoming national conference, our series of timely Webinars, and our E-OL distance-learning courses, just click on the tabs above.

For full details, please visit the NHPCO website: www.nhpco.org/education.

If you are reading a PDF of this issue, please read the digital edition to access the information on the featured tabs. The digital edition is available on www.nhpco.org/newsline.
NHPCO’s We Honor Veterans (WHV) program, created in partnership with the VA, not only supports hospices in meeting Veterans’ needs, but also celebrates and promotes that good work.

WHV recently released several touching videos that share the stories of Veterans and spotlight the WHV hospice partners which serve them. Watch the videos of Ruth Lorraine Chase and Robert Grimsbo now. You can also read some real stories of Veterans online.

To learn more about WHV, visit the We Honor Veterans website.

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The Elizabeth Hospice Honors its Founder by Naming a Space at the National Center for Care at the End of Life

Hospice pioneer, Betty Bulen, has dedicated much of her life to supporting hospice care on the local and national levels.

Another hospice provider has joined the ranks of major donors who have contributed to the five-year $10 million Campaign for the National Center for Care at the End of Life. The Elizabeth Hospice of Escondido, California has named an Education Office in honor of its founder, Elizabeth “Betty” Bulen.

After reading an article in Parade Magazine in the 1970’s about Dame Cicely Saunders, Betty Bulen, a consumate hospice educator and advocate, was inspired to recruit her friends to join her in creating a hospice program in Escondido, CA.

The 50 people who responded to her call to action became the foundation of today’s The Elizabeth Hospice.

Because the program was an all-volunteer organization, Betty wore every conceivable hat. She was chief volunteer coordinator, nurse, executive director, public relations director, and grant writer. But she has always been an educator at heart and spent much of her life teaching the community and health care professionals about the concepts of pain and symptom management.

She also put these skills to use in helping to develop the Medicare Hospice Benefit.

The Education Office named in honor of Betty Bulen is used by the National Center to conduct online and virtual educational activities, including webinars, instructor-led courses, virtual conferences, and online courses.

“Given Betty’s deep commitment to education, we felt this was a perfect space to bear her name,” said Laura Miller, chief executive officer of The Elizabeth Hospice.

To learn more about the Campaign and naming opportunities, visit www.nationalhospicefoundation.org/files/public/Campaign/NAMINGRIGHTS.pdf, or contact Heather Slack-Ratiu at 703-837-3155 or hslackratiu@nationalhospicefoundation.org.
You can find the perfect race this year!

We are thrilled to give you the line-up of special Run to Remember races this year. You can still run “any race at any pace.” However, this set of premier races will have large hospice teams. Most will offer the opportunity for “post-close” entry. Since these are extremely popular events, they can be hard to get into. But, by running for Run to Remember, runners can gain entry.

The National Memorial Race

After careful consideration of the competition, NHF designated the Medtronic Twin Cities Marathon as the 2012 National Memorial Race. The marathon will be held on October 7 in Minneapolis-Saint Paul. The race is called “The Most Beautiful Urban Marathon in America®” and boasts 26.2 miles of parkways, lakes, rivers, and tree-lined boulevards.

Run to Remember will provide outstanding support to any runner planning to participate in the race, including a pre- or post-race event in the Twin Cities and lots of advice and support along the way.

Registration for this race opens February 12. To register, visit www.tcmevents.org/events/medtronic_twin_cities_marathon_weekend/marathon/registration/. And then, register with Run to Remember.

To learn more about how to register for these races, visit: www.runtoremember.org/SpotlightandNMR

Spotlight races

• The ING Miami Marathon and Half Marathon on January 12. Miami’s palm tree lined boulevards and balmy ocean breeze are the perfect backdrop for your winter race.

• The New Jersey Marathon at the Shore on May 6. NHF is an Official Charity Partner of this 1-loop course marathon with beautiful ocean views. It’s flat and so a great race to qualify for Boston.

• The Bourbon Chase Relay on September 27-28. For the third year in a row, the National Hospice Foundation/Run to Remember is an Official Charity of this overnight relay through Kentucky. Each team of 12 runners (plus a support van driver) races to complete the 200-mile course.

• Bank of America Chicago Marathon on October 7. A premier marathon, the Bank of America Chicago Marathon is the second largest marathon in the U.S. Due to its popularity, registration closes very quickly.

• The Nationwide Insurance Columbus Marathon on October 21. According to Running USA, the Nationwide Better Health Columbus is consistently one of the 25 largest marathons in the United States.

• The Marine Corps Marathon on October 28. Take to the streets of Arlington, Virginia and Washington, DC next fall for “the People’s Marathon”—one of the premier marathons this nation offers.

If you run with Run to Remember, NHF will provide you with:

• A high-tech Run to Remember running shirt suitable for race day, printed with the name of your loved one(s) on the back

• Full online training and fundraising support

• An individual fundraising web page you can customize with a photograph and your story, to make fundraising easy

• The opportunity to direct 50% of your fundraising efforts to the local hospice program of YOUR CHOICE—perhaps the organization that touched your life!

• Regular emails packed with fundraising tips, training advice, inspirational support, and encouraging experiences to keep you on the path to marathon success

• A lasting memory of a journey honoring your loved one
Add Special Meaning to Your Gifts

Show the ones you love that you really care. This Valentine’s Day, make your gifts extra special! Each time you make a purchase from one of these vendors, they will donate $10 to the National Hospice Foundation.

ProFlowers

personal creations.com

redEnvelope

CHERRY MOON FARMS

Sharis Berries

Or if gift cards are what you’re looking for, TisBest Charity Gift Cards allow the recipient to make a donation to one of 250 national charities, including NHF! www.nationalhospicefoundation.org/TisBest

Remember also to purchase your greeting cards through Cards for Causes, and 20% of your purchase will go to The National Hospice Foundation! www.cardsforcauses.com. They offer cards for every occasion!

These programs will run through 2012 so include NHF for all holidays to add special meaning to your gift purchases.

www.nationalhospicefoundation.org/Shop

A Simple Way to Give Back to Celebrate a Loved One and Express Gratitude for Your Family’s Positive Hospice Experience

Make a decision today to make a gift tomorrow

One of the most popular ways to make a legacy gift is to remember NHF in your will or living trust. This is very simple, can be included at any time, and costs you nothing during your lifetime. Or if you already have a will or living trust, have your attorney add the language in a codicil, or amendment.

How to name us in your will

Sample Language and Tax ID

“I give and bequeath to the National Hospice Foundation, a not-for-profit organization incorporated in the Commonwealth of Virginia, with business address of 1731 King Street, Alexandria, VA 22314, and with a tax identification number of 54-1586967, __________ [describe the asset—i.e. gift amount, percentage, etc.] for the National Hospice Foundation.”

• You can specify an amount. Creating such a bequest is as simple as adding this statement to your will: I bequeath the sum of _______ dollars to the National Hospice Foundation.

• You can specify a particular asset, such as securities, real estate, tangible personal property (valuable works of art, etc.). Including such a statement: I bequeath ______ to the National Hospice Foundation.

• You can designate a percentage of your estate rather than a specific amount and your gift to NHF can grow along with your estate. Such language could read: I bequeath to the National Hospice Foundation, an amount equal to _____ percent of the net value of my estate.

• You can ensure your wishes for family and friends are first met. Simply specify that NHF is to receive or share in the rest and residue of your estate as suggested: I bequeath to the National Hospice Foundation, all the rest, residue, and remainder of my estate; OR _____ portion of the rest, residue and remainder of my estate.

• You can ensure your assets pass to beneficiaries of your choice, should unforeseen circumstances occur, such as an intended beneficiary’s predeceasing you. Sample language for consideration is: If _______ predeceases me, I give such property to the National Hospice Foundation.

To learn more about NHF’s estate planning opportunities, please visit our website www.nationalhospicefoundation.org/i4a/pages/index.cfm?pageID=336

Would you consider becoming a member of The Legacy Society? If you have already included NHF in your estate plans, please let us know so that we can give you the special thanks you deserve. As well, if you prefer to be included as anonymous, we certainly will respect your privacy and oblige.

As always, it is our pleasure to help you and your advisors. For a confidential conversation, without any obligation, please contact, Heather Slack-Ratiu in our Planned Giving Office at 703-837-3155 or hslackratiu@nationalhospicefoundation.org
Picking up on the exact mile marker where he left off in 2009, Colin Skinner is making his way across the United States to raise awareness of hospice.

“It’s not what you know, but who you know. That’s what matters,” according to an excerpt from Colin Skinner’s blog. Skinner is walking across the United States to get people talking about hospice. And he’s doing just that. His journey began in August of 2009 in New York City. During the first leg of his quest, he made it as far as Minot, North Dakota, collecting friends and donations along the way.

This September, Colin put on his backpack, plugged in his iPod (a technological upgrade from 2009!) and hit the pavement again, exactly where he left off: mile marker 283 on Route 2 in Minot, North Dakota. Braving pounding rain, 60-mile-per-hour winds, voracious mosquitoes, and biting cold. Colin is making his way to San Francisco one step at a time.

His journey is enlivened and made possible by the kindness of hospices along the way, and the staff that make sure he has places to stay—sometimes the floor of a church or the sofa of a kind hospice employee or volunteer—and a good meal to eat. In addition to the new friends he collects along the way, Colin continues to cross paths with those he met on his adventure 21 years ago.

Colin’s stops often include a visit with a local newspaper or radio reporter, which gives him a chance to tell his story and spread the word about the benefits of hospice.

Colin expects to reach San Francisco by mid-February. Follow his blog at www.nationalhospicefoundation.org/colin.
Co-Workers’ Discussions Lead to Personal Connection and a Spiritual Journey

Lives are touched in Ethiopia and Ecuador through their generosity

This is the story of two co-workers, Merikokeb Wondafrash and Walter Swenson. Their assignment to a shared office here at the National Center for Care at the End of Life has had remarkable consequence. Their discussions have led to a profound personal connection. They say they would even describe it as a shared spiritual journey.

Merikokeb is NHPCO’s website associate manager. She has been on staff for seven years. Walter serves as a quality and regulatory coordinator in NHPCO’s Office of Health Policy. He has been with NHPCO for three years. In early 2011, they were assigned a roomy office on the first floor. As any “roommates” will do, they would chat on downtime and began to get to know each other.

The First Gift

In August of 2011, Merikokeb was slated to travel home to Addis Ababa, Ethiopia for her younger sister’s wedding. Merikokeb and her husband immigrated to the U.S. 17 years ago. Having heard about her impending trip, and thinking about the human need in Ethiopia, Walter decided he wanted to give Merikokeb $50 to give away.

Fate intervened in two ways. First, Walter, distracted by planning his upcoming wedding, had yet to follow through with what they had discussed. And then, the day before Merikokeb was to leave, an earthquake struck the East Coast of the U.S., literally rocking the National Center for Care at the End of Life and everyone in it. That afternoon, as most of the staff raced to get home, Merikokeb and Walter stayed behind. Merikokeb was working on finishing up some important website work.

Walter was also busy. He was putting $5 bills into envelopes, and handwriting notes of encouragement to the unknown recipients. He gave them to Merikokeb. When she protested, “This is too much,” he simply said, “This is an opportunity to touch someone else’s life. I don’t get this kind of opportunity often. Please take the money.”

In Addis Ababa

At her sister’s wedding, Merikokeb spoke with another guest about Walter’s gift and how she needed to find a good organization to give it to. This man suggested an orphanage run by Mother Teresa’s order.

Merikokeb, her husband, daughter, and another sister, all set about driving through Addis Ababa, trying to find the facility, at no avail. For four hours they drove around, asking for help, but no one seemed to know where it was. Finally, a woman gave them directions to a location in the middle of the city. There were absolutely no markings, no signs. They started knocking on doors. On the third try, they found it. Merikokeb says, “The nuns were at prayer, so we were invited back in two hours. I wanted to see this place for myself, to make sure Walter’s money was getting into the right hands.”

When they returned, Merikokeb and her family were stunned. They had expected to find a small building behind the guarded door, with perhaps 6 to 10 children. What they discovered instead amazed them. “It was a very large place, serving over one thousand people, from newborns to the elderly,” explains Merikokeb. “There were men, women, and children, some in wheelchairs. Most of the residents had been abandoned by their families. It was incredibly clean. I have never seen a place so clean, especially in contrast with the rest of the city which is smelly and dirty.”

After the tour, Merikokeb asked if they did any publicity to get donations. The nun answered simply, “No. We just pray. And people like you knock on the door.” It was then that Merikokeb told Walter’s story. The nuns prayed for Walter all that week, in gratitude for this generous gift from a man they had never met.

Merikokeb returned to the States, and her job, a changed woman. She told Walter, “You changed my life. If you had not given me that money, I would never have found that place. I would never have known what kind of need exists. I knew there were poor people in my home country, but this was a whole different level.”

(continued on page 6)

Merikokeb Wondafrash and Walter Swenson share an office—and a passion for making a difference.
The Second Gift
Walter says, “When she came back and told me the amazing story of her search for the home for the needy, and what the nun said about how they pray for help, that gave me chills. I had written in each note, ‘May you find strength and comfort in Jesus Christ’ because my faith is such an integral part of my life. Hearing what the nun said has strengthened my faith further. It’s clear prayers are being answered.”

Then it was Merikokeb’s turn to give! Walter’s new wife, Daniela, has family living in Ecuador who came to the United States for their wedding. Merikokeb gave Walter money for them to take home with them upon their return and give away however they wanted.

Walter says, “When my wife’s family returned to Ecuador, her grandmother and mother sought out a few individuals they saw regularly on the streets. One man is blind and homeless; he was extremely grateful for the money. Another man makes tables and sells them near the presidential palace. He carries these tables up a big hill every day on his back. Some days he doesn’t sell any and has to carry them all down again. They gave him money as well.”

An Ongoing Endeavor
Moved by their own examples of connection across continents, Merikokeb and Walter are inspired to share their story with others. Walter says, “We want to motivate others to think about how they can give when they travel so we have created a website called ‘The Gift of Travel’ [www.nhpco.org/wm](http://www.nhpco.org/wm). People can go to this site to share their own stories of things they have done or plan to do in the future and to read about other people’s experiences. We hope that this site will serve as inspiration for others to give to those who are less fortunate.”

J. Donald Schumacher, president and CEO of NHPCO and NHF says, “Merikokeb and Walter are shining examples of personal philanthropy, making a difference where they can. I am so proud that they work with us here at the National Center.”

Successful Fundraising Event, From San Diego to Africa, Raises More Than $50,000 for FHSSA

With 200 guests and great San Diego weather, this year’s FHSSA fundraising event, *From San Diego to Africa*, at NHPCO’s Clinical Team Conference was a big success. Conference attendees, board members, and special guests mingled, danced, and bid on over 100 auction items, which included authentic African treasures and a safari trip in South Africa. The grand total raised to support FHSSA was $51,487.

An exclusive VIP reception was held for top level sponsors with a beer tasting from Stone Brewing Co. Guests enjoyed learning about and sampling beers not available to the public.

As they moved to the Tiki Pavilion for the main event, guests were greeted with the sounds of Sene Africa, a group originally from Senegal and gaining much recognition in the San Diego area. Drums, guitar, and a traditional African kora filled the air and set the stage for a wonderful evening.

NHF and FHSSA are grateful for all of the sponsors for their generous support.
NHF Trustee Receives Lifetime Achievement Award

Eleanor Clift, NHF Trustee since 2006, received a Lifetime Achievement Award from the National Association for Home Care and Hospice (NAHC) Foundation in October 2011. The award was presented during NAHC’s fall meeting in Las Vegas in recognition of her long-standing commitment to improving care at the end of life.

Clift is a political commentator who serves as a contributing editor for Newsweek Magazine and a regular panelist on the syndicated talk show, The McLaughlin Group. NHF congratulates Ms. Clift on this prestigious and well-deserved recognition.

Eleanor Clift, NHF Trustee since 2006, is recognized with a Lifetime Achievement Award for her dedication to improving care at the end of life.

Special thanks to those who have made gifts and/or pledges to the Campaign for the National Center for Care at the End of Life (as of December 10, 2011)

$100,000 and above

- Paul (posthumously) and June Ebensteiner
- Good Shepherd Hospice
- Haven Hospice
- Hope Hospice and Community Services
- LifePath Hospice
- The Morfogen Fund for Arts and Education
- The Staff of NHPCO and Affiliates
- Suncoast Hospice and Suncoast Solutions

$10,000–$99,999

- Beacon Hospice
- Eleanor Blayney
- Matthew Branam
- The Center for Hospice and Palliative Care
- The Corridor Group
- Covenant Hospice, Inc.
- The Elizabeth Hospice
- Evercare Hospice and Palliative Care
- Family Hospice and Palliative Care

Family LifeCare
- Cathy Gibney
- Glatfelter Insurance Group
- Home Healthcare Solutions
- HospiceCare of Boulder and Broomfield Counties
- Hospice By The Bay
- Hospice of the Bluegrass
- Hospice of the Miami Valley
- Hospice of the Valley
- Hospice of the Western Reserve
- Cami and Brad Hunter
- Jonathan Keyserling
- Jay Mahoney
- John Mastrojohn III and D. Michael Davids
- Jeannee and Mike Martin
- Galen Miller and Bob Ward
- Mark Murray
- San Diego Hospice and the Institute for Palliative Medicine
- J. Donald Schumacher
- Cindy Hasenzahl Susienka

*For a complete donor listing, please visit: www.nationalhospicefoundation.org/i4a/pages/index.cfm?pageid=576

Correction: In the NHF 2011 Summer Quarterly Report, an article about the National Center misreferenced donor “Home Healthcare Solutions” as “Home Healthcare Services.” We apologize for this error.

What are you grateful to hospice for?

Our Facebook Friends Named Three Things Related to Hospice for Which They Are Grateful

On our Facebook page, we share information, but we also like to engage in dialogue. In November, we investigated gratitude about hospice. Here are the answers:

“Pain management, social services support, 11th hour volunteers”

“Kindness of staff, come when called, skill”

“Home, comfort, caring”

“Compassionate volunteers, supportive guidance, bereavement support”

“Comfort, peace of mind, understanding”

“Patience, understanding, perspective”

“Compassionate staff, being able to make a difference, appreciation for being alive and healthy”

Have you “liked” us on Facebook yet? Please do! www.facebook.com/NatHospFdn
THANK YOU!

The National Hospice Foundation would like to extend special thanks to the following:

- **Erin Heramb** for editing **Colin Skinner’s blog** about his walk from North Dakota to California. (You can read about his adventures—which are ongoing—at [www.nationalhospicefoundation.org/colin](http://www.nationalhospicefoundation.org/colin).

- **The Nationwide Insurance Columbus Marathon** for the $5,000 gift presented in person by race director Darris Blackford.

- **Eleanor Blayney** and **Jim Smith** for their extraordinary Run to Remember efforts this year.
  - **Eleanor**, an NHF Trustee, raised $24,365 for the Campaign for the National Center for Care at the End of Life.
  - **Jim**, an elite athlete and good friend of NHF, raised $17,365 in support of We Honor Veterans. (Jim will be doing even more for NHF in 2012; we will share details with you soon!)