A Study in Green Building
In 2006, Hospice and Palliative Care of Northeastern Illinois set its sights on building a 42,000-square foot hospice home. But instead of the “usual,” it built the first freestanding hospice home in Illinois to receive “Silver” LEED certification. “We paid about 4 percent more in upfront construction costs,” says Facilities Director Marjorie Pullinger, “but the benefit of that commitment is robust.” What is LEED certification and what does it involve? Why should hospices care? Marjorie, a registered architect, explains.

Hospice Savannah’s Palliative Care Services
For Hospice Savannah, the expansion into non-hospice palliative care has evolved over an eight-year period. Today it includes consultation services at a local medical center, outpatient services at Andersen Cancer Institute, and a volunteer-supported transitions program. President/CEO Debra Anthony Larson discusses their expansion and future plans.

The Changing Role of CT
“Complementary therapies are becoming increasingly recognized as non-pharmacological adjunct treatments to help manage high stress and clinical symptoms,” says NCHPP Allied Therapist Section Leader Valerie Hartman. As this month’s Voice of NCHPP feature, she discusses the treatment plan of one patient to illustrate just how effective CT can be.
First, Some Background

From the advent of the Medicare Hospice Benefit (MHB) in 1982, physicians have been responsible for providing certification of terminal illness. Hospice medical directors and attending physicians together must sign certifications documenting that in their clinical judgment, if the illness runs its normal course, the patient is more likely than not to die in six months or less. The certification process occurs at regular benefit period intervals, initially every 90 days and then after the third benefit period, every 60 days.

In recent years, two pieces of legislation altered the Medicare Hospice Conditions of Participation, adding additional steps to the certification process.

The Physician Narrative

Beginning on October 1, 2009, CMS mandated that all certifications for hospice care (both initial certification and any recertification) include a physician-composed narrative explaining the rationale used by the physician to determine that the Medicare beneficiary has a prognosis for a life expectancy of six months or less if the terminal illness runs its normal course. The presence of this narrative is now a prerequisite for CMS, through its fiscal intermediaries, to provide payment for hospice care.

CMS has stated that the narrative statement must be based on a review of the medical record or examination of the patient, and be written to include information that explains the rationale used by the hospice medical director to determine the patient has a six-months-or-less prognosis. CMS has not been very specific in detailing all the critical components of a compliant narrative statement, but it has clarified in the Medicare Regulations several mandatory elements:

- The narrative cannot utilize preprinted check-boxes;
- The narrative must be written by the physician performing the certification;
- The narrative, itself, cannot consist of preprinted or standardized language.

For the regulations regarding the physician narrative, see Medicare Regulations [42 CFR 418.22(b)(3)].

The Physician Face-to-Face Visit

Beginning on January 1, 2011 (as part of the Patient Protection and Affordable Care Act), CMS also requires that patients who enter their third or later hospice...
Attendees of the Advocacy Intensive Served Us Well

As I write this, I am still energized by the success of the NHPCO Hospice Action Network’s Advocacy Intensive. This event, held on June 18 and 19, brought together a wonderfully representative group—hospice leaders, administrators, clinicians and caregivers—to educate key decision makers here in Washington about the importance of end-of-life care and the Medicare Hospice Benefit. And by all accounts, it was a resounding success!

This Intensive, which was a first-time offering for NHPCO and HAN, provided three important opportunities for the hospice community: to gain insight into the federal policies that shape our industry; to learn best practices in how to shape that policy by engaging with elected officials; and, perhaps most importantly, to allow the hospice staff who are providing the care to explain firsthand to our congressional representatives how hospice works in their state or district.

Attendees had over 240 meetings with their senators and members of congress. This included meetings with almost every member of the influential Senate Finance Committee and House Ways & Means Committee—the committees which have jurisdiction over hospice issues. They also benefited from learning sessions with some of the best and brightest in Washington, including a member of the Obama Administration; staff from the Senate Finance Committee; and representatives from the Congressional Management Foundation. Based on the feedback I’ve received, I think we all emerged with a deeper understanding of hospice public policy and advocacy.

This event would not have been the success it was without the support of providers and their staff. Our goal was to convene a small but diverse group to represent the hospice community during this particularly important election year. And we achieved that.

Thank you for your continued support.

J. Donald Schumacher, PsyD
President/CEO
benefit period receive a face-to-face visit by a hospice medical director or nurse practitioner. This visit is designed to allow the certifying physician to gather clinical information necessary to determine if the patient remains eligible for the benefit.

Both of these requirements have added significant administrative burden to hospice organizations. They also put hospices at significantly increased risk of denied payments if hospice staff fails to meet them.

**Insights From the Project**

As soon as my organization became aware of the details concerning these CMS mandates, we provided training to the medical directors in the form of newsletters, conference calls and in-person training sessions at regional meetings. We emphasized the individual requirements, especially the requirement for narrative documentation and the need for the information to describe the clinical condition of the patient and how that led to the conclusion of a less-than-six-months prognosis. We shared sample narratives that illustrated these principles and were excellent examples of compliant statements. Additionally, we showed poorly written statements that we felt were potentially non-compliant with the requirement.

Following this education, we developed an audit process in which we randomly sampled three narrative statements from each medical director. We reviewed the forms and the presence of demographic material, such as the proper name, date, diagnosis, benefit period, physician signature and date of signature. We then examined the narrative statement itself to audit for an acceptable narrative.

**Good and Bad Narratives**

For narrative statements to be acceptable, they had to consist of several phrases or sentences that described the particular clinical factors that led to the conclusion that the patient was eligible for hospice:

- We looked for objective clinical indicators such as the patient’s palliative performance status, body mass index and oxygen saturation;
- We required that the physician illustrate specifically how the clinical factors gave the patient a poor prognosis, allowing them to sign the certification.

Not surprisingly, the initial results of the audit were quite disparate. Some physicians wrote excellent short but thorough narratives that clearly illustrated hospice eligibility. Others wrote illegible minimally descriptive bullet points that were insufficient to establish a less-than-six-months prognosis.

An example of a well-written compliant statement looked like this:

“78 year-old male with NYHA class IV heart failure who has been aggressively treated with diuretics, ACE-inhibitors and nitrates continues to experience massive peripheral edema, dyspnea even during conversation requiring frequent doses of morphine. He has been hospitalized 3 times in the last 2 months. He has comorbid peripheral
vascular disease with several lower extremity ulcers. He is not a candidate for invasive cardiovascular procedures. He has a PPS of 50%, down from 70% 3 months ago. Based on his severe heart failure he has a prognosis of months.”

A poorly done narrative summary read in barely legible script:

“Continues to decline. Losing weight, poor appetite.”

You can see from the poorly written statement that specific details such as age, PPS, weight and clinical indications that indicate a six-months-or-less prognosis were absent. In contrast, the well-done narrative summary stands on its own and clearly describes a patient who is eligible for the Medicare Hospice Benefit.

Legibility issues, the lack of objective clinical factors indicating a six-months-or-less prognosis, and the absence of truly narrative material were the most common problems seen.

**Improving the Bad Ones**

Our review findings were communicated in writing to the medical directors and were accompanied by a two-page statement of the narrative summary requirements. We then conducted several more rounds of narrative statement reviews.

Most physicians improved readily from our feedback, while others needed multiple rounds of review before improvement could be seen. A few physicians needed progressive corrective action, requiring them to document that they had reviewed instruction materials and had listened to a...
recorded seminar on the proper way to complete narrative statements.

**Lessons Learned**
During this review process, we learned several important lessons:

- First, we realized that new hospice medical directors needed thorough education on the narrative statement process as part of their orientation to the company. Physicians who didn’t receive this initial training generally required more intensive educational and corrective efforts.

- Second, we learned that education on the process was best delivered by physicians and verbally delivered training that accompanied written material was generally the most well received.

- Finally, we concluded that a comprehensive quality improvement project with a focus on improving documentation was more effective than a punitive approach.

Ultimately, over a two-year period, we documented significant improvement in the quality of randomly selected hospice narrative statements. Given the increased regulatory focus on the hospice certification process, hospices would be well served to conduct formal quality review processes of medical director narratives.

Kevin Henning is a family physician and board-certified in both family practice and hospice and palliative medicine. He currently serves as senior vice president and chief medical director for the home health care and hospice operations of Amedisys, Inc., where he leads the clinical strategy of more than 500 home health care centers and 94 hospice care centers. Prior to joining Amedisys, he was national medical director for the hospice division of Gentiva Health Services.

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**NHPCO Resources for Physicians**

**Physician Guide to Hospice Care**
This Guide explores the current regulatory landscape and provides hospice physicians with practical advice and resources. It includes appendices on the Hospice CoPs; Criteria and Lab Values for Non-cancer Diagnoses; Evaluative Scales for Determining Functional Limitations; Patient and Family Resources; and a complete copy of the “Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases.” (Item 714384; Member Price: $10.99) See the display ad on page 27.

**Certification & Recertification of Hospice Terminal Illness**
This laminated pocket guide—with maps to guide hospice admissions—has just been updated to reflect the most recent regulatory changes. (Item 821733; Member Price: $9.95)
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The way is in sight
In 2006, Hospice and Palliative Care of Northeastern Illinois (HPNI) set its sights on building a 42,000-square foot hospice home, realizing its then-current 10,000-square foot administrative space in downtown Barrington no longer met the community’s needs. Instead of the “usual,” however, HPNI built Pepper Family Hospice Home and Center for Care, the first freestanding hospice home in the state that’s been awarded LEED “Silver” certification.

In conjunction with the designer, Tom Mullinax of Hospice Design Resources, the architects, Harley Ellis Devereaux, and the contractor, Pepper Construction Company, HPNI embarked on a development that would increase its capacity to offer inpatient hospice care, while also caring for the local environment and the planet. But what exactly is a “green” building and what does the LEED designation signify? Perhaps more importantly, how does that impact a hospice agency in the way it cares for its patients, families, and staff?
LEED Certification Defined

Leadership in Energy and Environmental Design, or LEED, is a points-based building certification system for building designers, contractors and owners that determines the environmental merits of a building. It was created by the U.S. Green Building Council (USGBC), an internationally known, non-profit organization whose goal is to encourage the design and construction of energy-efficient, water-conserving buildings that use sustainable or green resources and materials—and improve quality of life.

For most projects, there are four levels of LEED certification: Certified, Silver, Gold and Platinum. For new construction, such as the Pepper Family Hospice Home, the level awarded is based on the number of points the project earns under six strategic categories.

Measuring Up

This article discusses several of the categories for LEED certification, within the context of our experience in building the Pepper Family Hospice Home.

Sustainable Sites

Sustainable Sites is the category that focuses on low environmental impact accomplished, in part, by conservation, restoration, and sensitivity to the surrounding neighbors. This category focuses on the health and well being of the local community and the planet as a whole.

Quick Facts About Pepper Family Hospice Home

- Situated on 6.2 acres in Barrington, Illinois.
- Took 13 months to construct, opening in July 2010.
- Includes 16 private suites to accommodate patients and their families, with views of gardens and nearby parks.
- Amenities include a formal dining room, meditation room and hydro-therapy spa.
- Also houses HPNI’s administrative offices, palliative care services, and education and training program.

continued on next page
The Cost of Going Green

“We paid about 4 percent more in upfront construction costs to build a LEED-certified facility,” says HPNI facilities director, Marjorie Pullinger, “but the benefit of that financial commitment is robust. HPNI projects the return on that investment will be realized within 10 years, primarily through lower utility bills.”

For the Pepper Family Hospice Home, the designers were able to situate the building so that 90 percent of the significant old growth trees on this previously undeveloped site were conserved. Further, new native trees were planted and over 35 percent of the land was seeded with native prairie grass to help restore the Midwest eco-system and provide a natural habitat for native insects, birds and animals.

In addition to paying close attention to the native environment, the designers focused on minimizing the impact of the project’s development on the surrounding properties. For example, the project’s engineers calculated the amount of runoff that would be generated from the building and hard surfaces installed, and created a detention pond to hold the runoff which allowed it to soak into the undeveloped areas of the lot. This eliminated potential issues with flooding of neighboring properties and allowed the water to gradually soak back into the earth, thereby recharging the underground waterways or aquifers.

Energy and Atmosphere
The Pepper Family Hospice Home’s highly efficient heating, ventilation and air conditioning systems (HVAC) earned it points in this LEED category. While there were clearly higher upfront costs associated with these systems, the payback has been lower monthly energy use—which will result in significant savings over the entire life of the building. The Center currently experiences a 25 percent reduction in energy demand when compared to typical HVAC systems. Additionally, particular attention was paid to specifying and installing highly insulated building components. For example, the underside of the roof, above ceiling cavities as well as the walls and windows all have highly rated insulation. This has helped to keep heat gain out of the building during summer months and warm conditioned air inside the building during winter months. Again, these highly insulated measures required higher upfront costs for the materials, but the building will realize a reduction in energy use over the life of the building.

Water Efficiency
Understanding that water is one of Earth’s most precious resources, this LEED category is a very important one. To address water efficiency, the Pepper Family Hospice Home incorporated low-flow plumbing fixtures,
landscaping that requires little to no watering, and a passive water collection system for rain runoff.

While low-flow plumbing fixtures have been around for some time, over the past 10 years the technology has improved to the point where these fixtures will function well within the commercial setting. It is this technology that was installed at the Pepper Family Hospice Home.

As mentioned previously, native plants were also included throughout the gardens and in the surrounding 6.2 acres. But the benefit of using these native plants goes beyond supporting the native eco-system. Because they can thrive in the local climate and are adaptive to the harsh weather and droughts common in the Midwest, they require little to no watering once established, further reducing dependence on our municipality’s water supply. To reduce the use of municipal water even further, rainwater collection barrels were installed to collect water from the roof downspouts during the spring rains. During the heat of summer, this water is used to water the plants as needed. This strategy is particularly effective for smaller developments with gardens close to the building and rain barrels that have adequate storage capacity to utilize the water throughout a long drought period. Due to the size of this development, however, the passive water collection system is really only effective for a small portion of our planted gardens.

**Materials and Resources**

Selection of building materials is another key aspect of being a LEED-certified building—and an important part of being a sustainable development.

Fluorescent lighting was used extensively, along with occupancy sensors in nearly every room. Fluorescent fixtures are increasingly common today because they use much less energy than common incandescent fixtures and reduce the amount of heat gain within a building. Occupancy sensors will turn off the lights if no motion is detected in the room after a period of time, thereby eliminating the human factor of

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Some of the Financial Incentives

The U.S. Green Building Council notes several financial incentives that may be available for buildings which qualify for LEED certification, depending on the building’s location:

**Tax Credits and Abatements:**

Many municipalities offer tax credits and abatements. Abatements exempt property owners from paying taxes for a defined period. Credits work by crediting specific tax liabilities back to the property’s owners.

**Fee Reductions or Waivers:**

Some municipalities that charge fees for permit review or other permitting processes offer reductions or waivers for developers or contractors who commit to verifiable green building practices.

**Grants:**

Grants for green building developers are being established by state and local governments to entice construction and renovation teams to go green. These programs can be funded through taxes or fees, or through federal and state funds goals.

To learn more, visit the U.S. Green Building Council website.
forgetting to turn off the lights when one leaves the room.

Additionally, extensive use of daylight was incorporated. All perimeter offices, common spaces and patient rooms have large windows, and the office spaces also make use of interior glass that allows the light from the exterior window to penetrate deep into the center of the building. Approximately 75 percent of all occupied spaces in the building benefit from natural daylight. While staff members who occupy cubicles in the interior spaces of the building truly appreciate the connection to the outside, we did find one discipline for which this openness was an issue: the bereavement staff. Since privacy was an issue for them when meeting families, we installed semi-opaque window film in a vine-and-leaf motif with an open, organic design that created the appearance of etched glass. This offered staff needed privacy while also allowing daylight to illuminate the hallway.

Another noteworthy strategy was our use of materials with recycled content and materials that were manufactured within a 500-mile radius of the Pepper Family site. There are two significant benefits associated with this. First, materials made with recycled content are helping to eliminate waste in our landfills and use less energy to produce. And, by specifying materials that are made locally, there is also significantly less energy or fuel used to transport them to the site. This, in turn, enables us to do our part in reducing emissions to the Earth’s atmosphere and minimizing the effect of global warming. Secondly, by employing this strategy, our general contractor was able to recycle 95 percent of all construction waste.

Indoor Environmental Quality

Finally, this LEED category speaks directly to the health and well being of all building occupants. In this category, the significant strategies we incorporated included use of low VOC materials; ventilation to ensure air quality; and accommodations for individual environmental comfort.

VOC, or volatile organic compound, is a label used for those materials that let off a gas which can sometimes be detected by odor. I liken it to “new car smell.” There are many studies as well as personal experiences which suggest that materials with high VOCs cause headaches, discomfort and even debilitating allergies. By specifically installing low VOC building and finish materials (such as adhesives, carpets, paint and wood products), we are ensuring better health for staff and visitors.

Before Pepper Family Hospice Home opened, the HVAC systems were also “flushed” for over a week, pushing highly filtered fresh air throughout the building. Air samples were also taken to ensure that air quality met the minimum thresholds for particulates prior to occupancy.

As a third strategy, the systems and spaces were designed to ensure individual comfort, with individual controls in each patient room. The zoned HVAC system is also monitored for CO2 levels and easily controlled by a building management system. Staff and patients also have numerous lighting level options available, via dimmable fixtures, customized control of overhead fixtures, task lights and daylight. These strategies allow the individual to customize his or her environment for maximum comfort. The USGBC and others have conducted several studies recently that prove occupants of green buildings have higher productivity, in part due to a healthier building and in part due to the flexibility to accommodate individual preferences.
An Ongoing Commitment

There were many strategies used during the construction of this project in addition to the ones noted here. All of these strategies were intended to ensure the continued health of the planet, the community and the individual. Of course, an ongoing commitment to building operations is also required. We have adopted a Green Cleaning Policy, using green certified products whenever possible. We also remain diligent in supporting the recycling of trash and consistently research new products that are made by sustainable measures and incorporate recycled content.

HPNI paid about 4 percent more in upfront construction costs to build a LEED-certified facility, but the benefit of that financial commitment is robust. We expect the return on that investment will be realized within 10 years of building operations, primarily through lower utility bills. This project has also created a significant amount of goodwill in the community and reflects well on HPNI as a responsible developer and neighbor. Another benefit is increased staff satisfaction—there is a strong sense of pride among employees who feel good about being part of an agency that focuses on a healthy environment. But, in the end, building green is very much about “doing the right thing” for the building occupants, the community, the planet, and generations to come.

Marjorie Pullinger is a registered architect who obtained her LEED accreditation in 2009. She served as the construction manager and HPNI’s representative on this construction project, where she worked closely with the design professionals and contractors to ensure that the building met HPNI’s needs, along with coordinating the purchase and installation of the furniture and fixtures. Currently she serves as HPNI’s director of facilities, a position she assumed in 2010.

Other Providers Who’ve Gone Green:

In addition to Hospice and Palliative Care of Northeastern Illinois, six other provider-members have reported building LEED-certified sites:

- Albany Community Hospice (Albany, GA)
- Baptist Memorial Homecare (Memphis, TN)
- Home Care and Hospice of New England (Providence, RI)
- Hope Healthcare Services (Fort Myers, FL)
- Lower Cape Fear Hospice & LifeCare Center (Wilmington, NC)
- Methodist Hospice Residence (Memphis, TN)

Do you operate a LEED-certified site? Please let us know, via email, noting the certification level awarded.

Resources

U.S. Green Building Council
Green Building Certification Institute
Green Guide for Healthcare
Practice Green Health
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.
In June 2004, Hospice Savannah, Inc. launched the Steward Center for Palliative Care to provide inpatient consultations for patients of Memorial Health University Medical Center. In 2008, the Center then introduced outpatient palliative care services at the Anderson Cancer Institute and, in 2011, expanded yet again with “Steward Companions,” a volunteer-supported transitions program.

In the following interview, president/CEO, Debra Anthony Larson, MSW, discusses Hospice Savannah’s expansion efforts as well as its future plans.

**How did the partnership with Memorial Health University Medical Center come about?**

In 2003, the Hospice Savannah leadership and board began working with the health system to address how best to improve the quality of life for patients with life-limiting illnesses who were being cared for in the hospital setting. As a result of those discussions, Hospice Savannah launched the Steward Center for Palliative Care in 2004, providing non-hospice palliative care services on an inpatient basis.

Prior to that, however, Hospice Savannah had been responding to calls from physicians and discharge planners who needed assistance in managing the pain of some of their patients who were not hospice-eligible. In fact, beginning in 1994, Hospice Savannah began offering informal palliative care advisory assistance at no charge. So, really, the seeds—and the relationships—had been established much earlier. It was just time to define and offer a more formal palliative care program.

**Quick Facts About Hospice Savannah, Inc.**

- Founded in 1979.
- Serves residents of Georgia’s five southeastern counties.
- Employs 210 FTEs and utilizes 250 volunteers.
- Average daily hospice census: 220.
- Operates Hospice House, a 28-bed inpatient facility.
- Opened “Full Circle” in February 2001, a community center for education and grief support for adults and children.
- Launched the Steward Center for Palliative Care in 2004.
- Introduced Steward Companions in 2011.
How did your partnership with Anderson Cancer Institute come about?
The Anderson Cancer Institute (ACI) is affiliated with Memorial Health University Medical Center and provides outpatient services to cancer patients and their caregivers, so our work with the Medical Center led to our work at ACI. Through The Steward Center, we provide outpatient clinic services to help address these individuals’ palliative care needs. The clinics are housed at the ACI twice a week and are staffed by two nurse practitioners under the medical direction of Hospice Savannah’s chief medical director, who serves in this dual role. Memorial Health University Medical Center provides the social work and chaplain services. In addition, we host monthly “Caregiver Coffees” to provide support and education to caregivers. These Coffees are open to anyone and we have provided reflexology, massage, and music and art therapy as well as other presentations that we know would interest and benefit caregivers.

How is your palliative care service staffed and what services do you provide?
The Steward Center is now staffed by two full-time nurse practitioners. In terms of our inpatient services, we provide consultations in the ICU, nephrology and oncology units as well as other units as requested. On average, we are receiving about 20 consults per month and make approximately 40 follow-up visits. In terms of our outpatient clinic services, we have eight initial clinic referrals per month and 75 follow-up clinic visits.

Do you offer palliative care services to the broader community or limit your work to referrals from Memorial and ACI?
We have begun to work with our community nursing homes and assisted living facilities to provide these palliative care services. This past June, we also started offering an outpatient clinic at another cancer center located in Savannah.

Do you think that, for most hospices, partnering to provide palliative care is the best course to follow?
With the focus on preventing re-hospitalization, reducing healthcare costs, and improving the quality of life for patients with serious illness, I do recommend partnering with community hospitals or, at the

You follow a Nurse Practitioner Model. Can you elaborate on why?
Hospice Savannah researched and visited several like-programs in other states as we explored palliative care services for our community. We ended up choosing a nurse practitioner to provide the service because our physician resources were limited. As it turned out, however, we were able to use full-time physicians to provide direction and oversight, with the day-to-day services provided by the nurse practitioner. But as the program has grown, we have chosen to remain with this model since it brings needed patient care skills—such as care planning, an interdisciplinary focus, bedside communication, and relationship building—while also being more economical.
very least, exploring such. But, based on our experience, hospice leaders should also be prepared for a few challenges, including lack of adequate reimbursement for non-hospice services and medical professionals who will probably need education on the benefits of non-hospice palliative care. Many are just not aware of how we can help improve the lives of their patients. It’s also important to recognize that the current fiscal climate is equally challenging for hospitals, frequently requiring administrators to make difficult resource-allocation decisions. It takes good data, time and persistence to ‘make the case’ for non-hospice palliative care.

The name, the Steward Center, suggests an actual facility, yet the services you provide are offered at the hospital and Cancer Institute. Can you share the thinking behind this?
The Center was named after local philanthropists, Helen and Peter Steward, who believed in the concept of palliative care as a community based program where comprehensive assistance is provided for symptom management. The Center is a separate 501(c) 3 and has

The NP Model brings needed patient care skills... while also being economical.

Left to Right: Steward Center Director and Nurse Practitioner Laura Wiggins and Medical Director Kelly Erola, with Jennifer Curren, a social worker with Memorial Health University Medical Center/ACI.
its own board of directors comprised of representatives from both health care and the local community. Even though our services are provided in hospitals, clinics, or other facilities, we see ourselves as the “community center/resource,” providing expertise in non-hospice palliative care and symptom management.

How is the Steward Center funded?
We receive revenues from a variety of funding sources. Third party billing covers 50.7 percent of our costs while 19.2 percent of our revenues come from philanthropic contributions and 30.1 percent come from the Hospice Savannah Foundation via unrestricted gifts and endowments.

Has the Steward Center and expansion into palliative care helped increase your philanthropic support?
Yes, it was a philanthropic endowment that enabled us to bring palliative care services to our community, and we have received other local support to keep it going, including donations from Savannah-based Gulfstream Aerospace and individuals who are proponents of palliative care.

Have you seen an increase in hospice referrals since introducing palliative care?
Yes we have. In 2011, Hospice Savannah admitted 172 patients from the palliative care program, an increase of 85 patients from the previous year. We think our utilization of the nurse practitioner model is one of the reasons for the increased referrals since the nurse practitioner is able to see more patients both in the hospital as well as the clinics. As I mentioned, we have since added a second nurse practitioner to the palliative care team.

Have you found the reverse to also be true? Does Hospice Savannah refer to your outpatient palliative care?
When a patient is not eligible for hospice services, we will make a referral to the Steward Center to assess the patient and potentially provide services through the outpatient clinics. However, these numbers are relatively low, only about one to two patients a month. That said, we do anticipate an increase in these referrals as we continue to focus on providing non-hospice palliative care in area nursing homes and assisted living facilities.

Can you tell us about the newly launched Steward Companions program? What prompted it? What services are provided?
The Steward Center’s director and nurse practitioner, Laura Wiggins, and our volunteer and community outreach directors, Beth Logan and Jamey Espina, identified a program located in Florida which was providing volunteer support to palliative care patients. Following a site visit there, we decided to implement the model in July of 2011 as part of The Steward Center’s services.

Through Steward Companions, volunteers visit patients and their caregivers for up to four hours a week in their homes. These volunteers can just sit and talk, help with errands, or stay with the patient so caregivers can receive some respite. The volunteers are also trained to provide information and education on end-of-life services, care planning, etc. The goal is to begin building a relationship...
with patients and families so, should they need hospice later, the connection is already there. They know us and we know them. We will also refer hospice patients to The Steward Center for ongoing support and continuity of care when they are no longer hospice-eligible.

**What have you found to be the intangible benefits of expanding into palliative care?**
Being able to improve the lives of patients in our community who are dealing with a serious illness as well as knowing that we’re doing our part to enhance the continuum of care. This work will only become that much more important as the nation’s healthcare reform initiatives continue to take root.

**What’s next?**
The Hospice Savannah Foundation has launched a $3 million fundraising effort to build a “Center for Living.” Over $1.7 million has been committed and we hope to break ground in 2013. This Center will be much more than just “bricks and mortar.” It will allow us to provide unique services to caregivers through our Caregivers Institute; expand our grief and loss programs for children and adults; and expand our educational classes to health professionals in our area as well as throughout the state. It will also serve as a new location for coordination of The Steward Center’s operations.

Are you offering a non-hospice service too?  
And would you like your work spotlighted in NewsLine?  
Complete our brief questionnaire.
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 Allied Therapist Section, and an article by Valerie Hartman....

Featured This Month:
Allied Therapist Section
Case Study: Mr. A

Mr. A suffered a stroke at age 84. After one year and several strokes later, he found himself on hospice home services. He was weak, had difficulty swallowing, and complained of chronic head pain every day. Mr. A described his pain as a constant ache. With a self-reported pain score of 4/10, he was prescribed Percocet before he signed onto hospice care. On the day of hospice admission, the nurse case manager discussed the impact of pain on his daily living and introduced a few other medication options for consideration. Mr. A was taking one to two Percocet every four to five hours around the clock, and still had incomplete relief of his head pain and was at risk of liver toxicity from Tylenol intake.

Mr. A’s case was presented at the interdisciplinary team meeting. In addition to head pain, Mr. A was described by his hired live-in caregivers as “stoic” and his son observed facial grimacing that concerned him. Mr. A would rub the back of his head often, but denied feeling anxious or excessively worried. He was alert and oriented, but forgetful at times. The home was set up for safety with a hospital bed, commode, shower chair and walker, allowing him to be as independent as possible. He had also been given a physical therapy referral. He rested 16 hours a day, sitting in one of two reclining chairs in the living room. One chair was for his wife and the family cat that curled up on her lap every day. He chose the chair closest to the fireplace with the well-tended fire and the fish tank emanating soothing water sounds. The two of them watched their favorite television shows together. Friends would come and read to them. The social worker reported no outstanding concerns. The spiritual care counselor noted that Mr. A was well integrated into a spiritual community. Managing Mr. A’s head pain became the priority discussion at this meeting. The team was in agreement that the ideal plan of care would relieve his pain while preserving his mental clarity, safety, independence and quality relationships for as long as possible. The physician suggested a trial of muscle relaxant versus a change to low-dose short-acting narcotic analgesic, in addition to ongoing physical therapy and a complementary therapy referral for massage.
Implementing Mr. A’s Care Plan

Mr. A was resistant to narcotic use out of fear of addiction. He was agreeable to a trial of a muscle relaxant and, although he had never had massage therapy, he was willing to try it since it was introduced as a purposeful treatment to manage his pain.

Massage therapy was started first. The nurse massage therapist found that Mr. A held a rated 6/10 tension state in his head, neck, shoulders, and upper back. After a comprehensive evaluation and informed consent, a 30-minute, light-pressure massage was provided, focusing on head and neck, back, and scalp and facial massage techniques. In addition, a hand reflexology session was added to the protocol to target any tension state that was related to anxiety and psychological stress resulting from the condition of his illness. Immediately before the massage, and within two hours of taking Percocet, Mr. A rated his head pain at 3/10. Thirty minutes after the massage, Mr. A rated his head pain at 0/10. This relief from pain lasted four hours.

The trial of muscle relaxant was added next. After two days, Mr. A was incontinent of bowel and bladder, and required much more assistance with ambulation and ADLs. His self-reported pain score was 1/10 while taking the muscle relaxant and he stated he was getting a lot of good sleep; however, he wanted to stop taking the relaxant because both he and his hired caregivers were very concerned about the change in his quality of life. The hospice nurses were also concerned about his risk of falls, and were in close communication with the physical therapist.

The change to concentrated morphine was trialed next due to Mr. A’s fear of taking a narcotic analgesic. Mr. A experienced improved relief from his pain with low-dose morphine. After three weeks of adjusting the dose, increasing massage therapy to two times weekly, and converting him to long-acting MS-Contin, his self-reported pain score lowered to a consistent 0/10 to 1/10 with few side effects, improved eating, sleeping, and contentment.

Mr. A found a good balance between symptom relief, safety, and preserved quality of life.

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Today's Range of Roles and Uses

Complementary therapies have taken a place in the hospice mainstream of services. While many hospices appreciate and have grown their volunteer complementary therapy programs, other hospices remain committed to the sustainability of hired therapists and signature programs. For example, there may be one hospice program in California committed to the growth of a longstanding clinical aromatherapy, massage and art therapy program and another in Missouri taking on its first volunteer massage therapist. With such a divide in utilization of these kinds of services over the years, complementary therapies are in a very interesting position within the hospice field.

On one hand, these therapies can be perceived as gentler, comfort-related modalities that enhance the hospice experience in meaningful ways. With training on some simple techniques, volunteers, caregivers and hospice team members can use certain complementary therapies to create quiet presence, and provide safe and comforting touch that communicates compassionate care. For example, music can be used for relaxation or recreation without a music therapy referral or lavender essential oil can be applied to a cotton gauze and tucked into a pillowcase at bedtime to help induce sleep without a clinical aromatherapy referral.

On the other hand, complementary therapy modalities are becoming increasingly recognized as non-pharmacological adjunctive treatments that help manage high stress and clinical symptoms. For example:

- Nurses, physical therapists and massage therapists certified in manual lymphatic drainage can adapt techniques that help manage edema;
- Certified clinical reflexologists, acupuncturists or acupressure therapists can oftentimes ease intractable nausea and vomiting due to adjunct medication use;
- Healing Touch practitioners can help address behavioral changes in end-stage dementia;
- Music therapists can help patients suffering from PTSD or family members experiencing complicated grief after a loss; and
- Art therapists can be enormously helpful in supporting children who are grieving or are dealing with a life-limiting illness.

The case study of Mr. A is a good example of a hospice program that has learned how to utilize complementary therapy as a treatment option to help achieve a patient and family’s goals.

Some Complementary Therapies Being Used in End-of-Life Care

- Acupressure/Acupuncture
- Animal-assisted Therapy
- Art Therapy
- Aromatherapy
- Healing Touch
- Harp Thanatology
- Horticultural Therapy
- Manual Lymphatic Drainage
- Massage
- Music Therapy
- Reflexology
- Reiki
Adding Therapies into Your Service

There are three key ways to introduce complementary therapies into your organization’s offerings:

1. Develop simple competencies to train the hospice interdisciplinary team on comforting techniques.

   An example would be a basic hand massage that focuses on the palm, a practice that calms the nervous system. One hospice in New Hampshire trained the entire hospice team in hand massage and encourages five minutes of this simple touch therapy at every visit with a patient who is no longer verbal.

2. Initiate and grow a volunteer complementary therapy program.

   Commit to providing hospice training and mentorships for therapists who often come from schools that do not teach hospice practice—being careful to refer them to the level of service that is most comfortable to them or less-complex cases that focus on relaxation, meaning and nurturing until they become skilled enough and well-acquainted with the end-of-life care environment.

3. Hire and grow a professional program that gives the hospice team a referral base for complex and high-stress cases that respond to non-pharmacological treatments and solutions.

   Much gratitude goes out to the pioneering efforts of Dawn Nelson, CMT, MFA (hospice massage), Theresa Schroeder–Sheker (music thanatology), and Russell Hilliard, PhD, LCSW, LCAT, MT-BC (music therapy) as well as many other individuals who have helped bring complementary therapies into end-of-life care. Their work

continued on next page
continues to drive our industry to look closely at the clinical benefits of holistic therapies that contribute to pain and symptom relief for hospice patients, stressed caregivers, and the bereaved.

Valerie Hartman has 25 years of holistic hospice nursing experience and, for the past 14 years, has included the integration of massage and bodywork therapy into her practice. Since 2002, she has coordinated the complementary therapies program of Holy Redeemer Hospice (Philadelphia, PA). She also serves as NCHPP's Allied Therapist Section leader.

My.NHPCO—a Great Resource for Allied Therapists

One of the best ways to exchange ideas and tips with your colleagues is through the NCHPP Allied Therapist 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).
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.
Twenty-seven of your peers and colleagues serve on the NHPCO Ethics Committee and, together, perform a key role in identifying ethical issues in hospice practice that need to be addressed at the national level.

Much of the Committee’s work has resulted in materials that support the provider’s day-to-day practice. A recent example was the group’s development of a position statement and accompanying PowerPoint Presentation on Ethical Marketing Practices.

List below is a complete summary of the materials developed by the Committee as well as some new projects now under way.

**Now Available**

**Technical Publications:**
- Ethical Principles
- Starting an Ethics Committee

**Position Statements:**
- Hospice and Palliative Care: Ethical Marketing Practices (June 2011)
- Artificial Nutrition and Hydration (Sept 2010)

**New Projects Under Way**

The Ethics Committee has formed Workgroups to focus on the following five topics:

**Discontinuation of Hospice Care: Ethical Principles for Policy and Practice**
This Workgroup is revising and updating NHPCO’S 2004 publication by the same title, adding case studies to reflect current dilemmas facing hospices. The section on “Discharge Protocol and Forms” is being reviewed and edited to reflect not only general ethical considerations, but also the letter and spirit of the current Hospice Conditions of Participation.

(Revisions to this document are being made in collaboration with the NHPCO Regulatory Committee.)

**Futile Care**
Futile care is often misunderstood because of the way it is framed. Futile care policies are similar to DNR policies in that both should be the starting point of a collaborative discussion. Determining what care is futile is about knowing and understanding the goals of the patient and family, professional caregivers, and the healthcare organization, and clearly communicating that information between all parties. This Workgroup will focus on developing case studies, with supporting educational materials to assist staff in working through the many issues of this topic.

**Aid-in-Dying**
As more and more states are considering Death with Dignity Acts and other similar initiatives, hospices should be as clear as possible as to how they understand their professional caring relationship with patients and families. This Workgroup is exploring the role of hospice care
teams and institutional involvement with requests for medically induced death. It is also examining cases in states where physician-assisted death is illegal and in other states where the practice is deemed legal in order to highlight the complexity of this issue and raise questions that hospice care teams need to think about in order to provide quality palliative care to patients and families.

**Smoking and Oxygen Therapy**
What ethical issues arise when patients refuse to stop smoking while using oxygen? The patient may be making his or her own decision, but the risks of smoking around oxygen extend to family, neighbors, and first response firefighters should combustion occur. This particular case is just one example of when discontinuation of hospice care may be warranted. This Workgroup is examining this issue, with the goal of offering guidance to assist providers in the development of their own policies.

**Balancing an Organization’s Financial Health with Expensive/Optimal Therapies**
This Workgroup is developing an ethical framework for guiding how hospices approach the balance between facilitating access and serving patients’ needs while also controlling costs in an environment of ever-changing therapy options. Often, patients are referred to hospice while they are receiving costly, but potentially effective, palliative therapies. The goal of this project is to assist hospices in deciding, prospectively, how to address current and future expensive palliative therapies.

**Follow the Committee’s Work Online**
The NHPCO Ethics Committee has its own eGroup on NHPCO’s professional networking site, My.NHPCO. My.NHPCO is a free benefit to all staff and volunteers of NHPCO provider-members—and joining the Ethics eGroup is an excellent way to follow its work.

**Current My.NHPCO Users:**
Go to the eGroups landing page, and click “Add/Change Subscriptions” to add the Ethics eGroup to your “community.”

**New My.NHPCO Users:**
Visit the site’s 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) or email solutions@nhpco.org.

Learn more about the Ethics Committee on the NHPCO website.
April 16, 2012 marked the fifth annual National Healthcare Decisions Day, launched in 2007 to help educate Americans about healthcare planning and inspire them to make their wishes known.

Each year, more organizations participate and more Americans take the proactive step of completing their advance directives, as this year’s numbers show:

- Over 110 national organizations and 1,100 state and local organizations participated.
- National and local media helped spread the word, with articles or columns appearing in The New York Times, Wall Street Journal, USA Today, CNN, the Huffington Post, LIVESTRONG, and others.
- Social media lent a powerful hand. The NHDD Facebook page had more than 35,000 visits during April alone, while NHDD supporters generated interest through their posts, tweets and releases. (For example, LIVESTRONG single-handedly reached more than 1.6 million people through its posts, while Twitter generated over one million NHDD “impressions” between April 11 and 18.)

Please make a note of next year’s event, which falls on Saturday, April 16, 2013, and bookmark the National Healthcare Decisions Day website for future reference—www.nhdd.org. It includes some great facts and tools to use in your outreach.

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**Results From 2012 NHDD: It’s Working!**

Special Thanks to Providers Like Rockbridge Area Hospice

Rockbridge Area Hospice, based in Lexington, VA, hosted stations across Rockbridge County on 2012 NHDD, where staff and volunteers distributed information and helped residents complete advance directives. “We reached about 626 members of our community,” said Outreach Coordinator Michelle Jones.
Sponsored annually, the prestigious Circle of Life Award celebrates innovation in palliative and end-of-life care. In 2013, up to three organizations will win the award while others may be recognized with citations of honor.

All organizations or groups in the U.S. that provide palliative or end-of-life care are eligible for the award. To nominate an organization (either your own or another), visit the website of the American Hospital Association to request an application—it’s been newly revised so the questions and data requests are now far more streamlined!

Applications must be submitted by August 8, 2012.

As most members know, We Honor Veterans (WHV) is an NHPCO program developed in collaboration with the Department of Veterans Affairs (VA). One of its goals is to provide educational tools and resources that will help providers meet the needs of Veterans under their care.

Listed here are some of the newest resources to help you in your work:

**Smartphone Apps**: Five apps were developed by the VA to help Veterans, their families, and the professionals who care for them deal with stress, mood management and mild traumatic brain injury.

**WHV Survey Findings**: Approximately 593 community-based hospice providers from 44 states participated in a WHV survey to characterize and benchmark the business relationships between community hospices and VA medical centers. The National Summary Report and state-specific findings are now available online.

**Guide to Long Term Care**: This Guide was developed by the VA to help Veterans and their families understand the many options for long term care.

Visit the WHV website for these resources and more—including News from the Field and Best Practices.
NHPCO produces the ChiPPS e-newsletter several times a year to help members keep abreast of timely issues and innovative work being done in the highly specialized area of pediatric palliative care.

The current issue offers a collection of articles that explore the role of palliative and hospice care in our nation's schools. The goal is to encourage dialog between providers and the educators and school personnel in their community to help ensure the complex needs of children and their families are being met.

Listed below are a few of the featured articles in the current issue.

**Children with Complex/Chronic Conditions in School: The Role of Pediatric Palliative Care**
*By Denise Powers Fabian, MSSA, LISW-S*

**Education and Civil Rights Legislation to Support Students with Serious Illness**
*By Kathy Davis, MSEd, PhD*

**School Reintegration: Tips and Tools for Students, Parents, and Teachers**
*By Sima Zadeh, MA, and Lori Wiener, PhD*

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**Tools for Supporting Siblings in a School Setting**
*By Valerie Johnson, MSW, and Jill Meyers, MA, CCLS*

Download a copy of the issue now (or visit [www.nhpco.org/pediatrics](http://www.nhpco.org/pediatrics)).

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**Exploring Palliative Care Support in Our Schools**

The Children’s Project on Palliative/Hospice Services (ChiPPS) is a program of NHPCO, and the e-newsletter is edited by Charles A. Corr, PhD, Christy Torkildson, RN, PHN, PhDc, and Maureen Horgan, LICSW.
At one time a household name, the Dear Abby advice column still reaches an impressive audience—with syndication in about 1,400 U.S. newspapers that represent a combined circulation of 110 million.

On May 3rd, Dear Abby (now penned by daughter, Jeanne Phillips) provided a nice plug for hospice—directing readers to “About Hospice” on the NHPCO website for more information. As a result of this brief column, traffic to that webpage more than doubled in the week following publication. [See the post on NHPCO’s Facebook page.]

**Plus, Monkey See Reports Nearly 1.5 Million Views**

Another, less-traditional media outlet is also helping Americans understand more about hospice—the Internet educator, Monkey See.

In 2010, NHPCO and the National Hospice Foundation partnered with Monkey See to develop six short videos that look at the basics of hospice care. Each video runs between two and four minutes, is narrated by NHPCO President/CEO Don Schumacher, and follows an actual hospice patient and family (courtesy of Gilchrist HospiceCare in Maryland).

The Monkey See administrator has just reported the series is nearing 1.5 million views. This doesn’t even include the videos’ exposure through other outlets, such as NHPCO’s YouTube channel or the websites of NHPCO provider-members.

Two of the videos are shown above. All six are still available to members for their free use. For information and instructions, see [www.nhpco.org/videos](http://www.nhpco.org/videos).
Delegation From Japan’s Ministry of Health Meets With Evercare

Representatives from Japan’s Ministry of Health, Labor and Welfare recently visited the Evercare office in Elkridge, MD, to learn more about the Advanced Nurse Practitioner Model.

Given Japan’s aging population and rapidly changing healthcare needs, these representatives are looking to adopt this model in their country. The delegation was particularly interested in Evercare’s nurse practitioner program, where NPs with advanced training provide care coordination for residents in skilled nursing facilities.

Meridian Health to Conduct CMS Demonstration Project

CMS’s Center for Medicare and Medicaid Innovation recently awarded the New Jersey-based healthcare organization, Meridian Health, with a multi-year demonstration project to determine the positive effects of an expanded and fully integrated palliative care program on patients and families facing serious and advanced chronic disease.

The demonstration project will focus on patients, 65 years or older, with advanced cardiac disease, end-stage renal disease, chronic obstructive pulmonary disease, metastatic cancer, advanced forms of liver disease, dementia, stroke or any combination of these conditions. The goal is to improve the care provided to these patients through coordinated pain and symptom management, patient education, specialist consultation and home care services.

NHPCO member, Meridian Health, is the largest healthcare provider in New Jersey’s Ocean and Monmouth counties, and serves 43 percent of the region’s Medicare population.

Florida Hospices and Palliative Care Announces New Name and Website

Last April, Florida Hospices and Palliative Care (Tallahassee, FL) announced its new name—Florida Hospice and Palliative Care Association (FHPCA)—and new website!

Hospice education and advocacy are the main drivers of FHPCA’s continued growth and the organization has put forth great effort to clarify that hospice is not just about dying, but about living. “Our goal with this new site,” says Executive Director Paul Ledford, “is to continue to speak to that fact, and to show the public that hospice is a wonderful option for those at the end of their life.”
Jill Campbell Helps LHJ Dispel Myths About Hospice Care

The July issue of Ladies' Home Journal (LHJ) features a moving account of dying patients in their final days through the eyes of a hospice nurse. That nurse is Jill Campbell, an RN case manager for Gilchrist Hospice Care in Hunt Valley, MD.

Under the compelling title, “It Doesn’t Have to Be Sad: The Life of a Hospice Nurse,” Reporter Diana Sugg followed Campbell over the course of several months as she visited patients.

“The health editor from Ladies’ Home Journal contacted us last fall, after hearing of our Circle of Life Award,” said Gilchrist Executive Director Cathy Hamel. “We didn’t have to think twice about taking part in the article. We knew it could spark a national dialogue about the benefits of hospice care. And the final story was extraordinary on so many fronts. Jill helped showcase hospice beautifully.”

Campbell joined Gilchrist three years ago—her first job in hospice. Her past nursing experience included work in the OR and with home care for developmentally disabled adults. What led her to hospice? “Both of my grandparents died with hospice care,” she said. “When I was returning to nursing full-time three years ago, I knew I wanted a position that would allow me to really care for the patient both physically and emotionally. Hospice has been the perfect fit.”

NHPCO extends special thanks to Gilchrist and to Jill for conveying to LHJ readers what hospice care really means. NHPCO president/CEO, Don Schumacher, had the pleasure of speaking with the reporter as well. “We could not have asked for better representation on behalf of the field,” he said.

Alva Baker Joins Hospice of Washington County

Alva (“Buzz”) Baker, III has joined Hospice of Washington County, Inc. as chief medical officer. Dr. Baker is certified in hospice and palliative medicine, with specific expertise in the areas of gerontology, Alzheimer’s disease and other forms of dementia. He is also a member and past president (2007-2008) of the American Medical Directors Association.
The role of the hospice physician has expanded significantly in the last few years due to changes in the process for certification of a Medicare beneficiary’s terminal illness.

As Dr. Kevin Henning notes in this month’s cover story, beginning on October 1, 2009, CMS mandated that all certifications for hospice care (both initial certification and any recertification) include a physician-composed narrative statement explaining the rationale used by the physician to determine the Medicare beneficiary’s eligibility for hospice.

The narrative statement can either make or break the outcome of a variety of audits that CMS and its contractors may conduct at any time.

If hospice providers and their physicians view the narrative statement as a mere “checkmark on the initial or recertification process list,” then they have missed the rationale and benefit of imposing this requirement.

The narrative statement should not only describe why a patient is eligible for hospice, but should also provide an all-important framework for interdisciplinary team documentation throughout the benefit period. The narrative should be concise, but also “paint the picture” of the patient’s eligibility. It is from this narrative statement that other members of the interdisciplinary team take their cue in all other notes thereafter concerning the patient’s eligibility.

Making It Happen

So, how can your organization ensure that its hospice physicians are composing adequate narratives? You may need to educate these physicians on how to compose meaningful narrative statements as well as educate other members of the interdisciplinary team on how the statements should be used as a “beacon” for their ongoing documentation.

Finally, there should be an internal process in place to review your organization’s physician narrative statements on a periodic basis to proactively ensure they accomplish what they were intended to do.

(Dr. Henning shares the process his organization followed to both audit and improve its physician narrative statements. Click the purple button on page 6 to save a print-friendly copy of the article to share with others.)
The National Hospice and Palliative Care Organization presents:

COLLABORATE
ASSESS
RELIEVE
EVALUATE

It’s About How We CARE
The 13th Clinical Team Conference and Pediatric Intensive

Preconference Seminars: November 4, 2012
Main Conference and Pediatric Intensive: November 5-7, 2012

Whether you are providing care to patients and families through interdisciplinary practice, managing interdisciplinary team staff, leading quality efforts or responsible for related practices and processes, you need the same critical information at your disposal.

Information that helps you CARE: collaborate, assess, relieve and evaluate. Such vital information can help you keep pace with evidence-based practice, adapt and respond to impending changes, work in partnership across the care continuum and ensure that the CARE you provide is of exceptional quality.

Learn more and register at www.nhpco.org/CTC2012
Bereavement counseling is one of the services that sets hospice care apart. Hospice & Palliative Care of Western Colorado created two moving videos to help educate consumers about the importance of bereavement support for children and teens and how its services can help: The Child and Teen Program and Grief Through the Eyes of a Child. The latter video won first place in NHPCO’s 2011 Creative Arts Contest (in the social media category)—but both are worth watching.

Links to Some Resources on the NHPCO Website

New NCHPP Home Page

Quality and Regulatory
New Reg Center Home Page
Quality Reporting Requirements
QAPI Resources
Past Regulatory Alerts
Past Regulatory Roundups
Hospice Compliance Calendar
Staffing Guidelines
Standards of Practice
Quality Partners Self-Assessment System

Professional Education
2012 Monthly Webinars—including new Quality and Regulatory track.
Upcoming Conferences
End-of-Life Online (distance learning courses)
Webcasts

Publications
Past issues of weekly NewsBriefs
Past issues of monthly NewsLine
Past issues of ChiPPS Newsletter

Outreach
2011-12 Outreach Materials
2012 Volunteer Week Materials
Resources to Reach Underserved Populations