A Plan to Support ADRs

By Russell Hilliard, PhD, LCSW, LCAT, MT-BC, CHRC

As many NHPCO members know, the Centers for Medicare and Medicaid Services (CMS) and its contractors have broad abilities to perform pre- and post-payment medical reviews of hospice Medicare beneficiary claims. Today these reviews are occurring more frequently as the hospice industry, like many other healthcare providers, faces an increasing level of scrutiny by the federal government. This, in turn, is resulting in more “Additional Document Requests” or ADRs, most commonly as part of a prepayment medical review.

These ADRs may be requested for a specific level of care, diagnosis, or length of stay—or may be randomly chosen. If the review determines that the documentation does not support CMS
criteria for hospice eligibility, payment can be denied. This is of course very problematic for the hospice agency which has already delivered the care and whose staff must now devote administrative time to copying medical records, reviewing documentation, and responding to the ADR process.

According to the Reinhart Hospice and Palliative Care Legal Service Group, “the most important strategy for successfully responding to an ADR is a proactive one—clearly and carefully document the patient’s condition and the services provided so that the documentation submitted with an ADR response leaves no doubt of the patient’s hospice eligibility.”

This article discusses the strategy we implemented at Seasons Hospice and Palliative Care (based in Rosemont, IL) which, based on internal audits, has dramatically improved the quality and accuracy of our psychosocial documentation.

**Before the Changes**

During our internal audits, we discovered that there were occasions when the nurses’ documentation painted the picture of hospice eligibility, but the psychosocial documentation did not.

For example, in one case where we were serving a gentleman with dementia, the nurse’s note indicated a FAST score of 7d while the social worker documented that the “patient was in the activity room putting together a puzzle upon arrival.”

A patient with a FAST score of 7d (see sidebar on page 6) is not able to cognitively engage in problem solving associated with a puzzle. When the social worker was interviewed, she said that she held the patient’s hand and placed the puzzle pieces in the correct spaces. With this information, hospice eligibility is more clearly documented. The note should have read: “Patient was so disoriented, he needed hand-over-hand assistance to pick up the puzzle pieces, and the social worker put them in place while holding patient’s hand.”

We quickly began to see trends in our internal audit results. Psychosocial staff (i.e., social workers, chaplains, music therapists) as well as volunteers were not including their observations of hospice eligibility.

The problems we were seeing in our documentation are not unlike those found in other hospices:

- Psychosocial notes do not match the RN’s assessment documentation, or the focus is on the patient’s well being and not on his or her terminality, and/or do not describe the patient’s physical limitations.

- Psychosocial team members do not recognize the terminal symptoms of the patient’s disease.

**The New Twofold Strategy**

Based on these observed problems, Seasons created a strategy to help guide staff in accurately documenting a patient’s hospice eligibility.

There were two primary components of this strategy. The first was to change our documentation format to prompt psychosocial staff to write their observations relating to the patient’s hospice eligibility within the scope of their practice. The second was to provide education on the signs and symptoms.
An Uneducated Board Can Mean Disaster

We are all keenly aware that hospice is under the regulatory microscope—and has been for several years. In fact, while not surprising, CMS recently noted that the average time spent conducting a hospice survey increased 53.9 percent in 2010. And this doesn’t even account for the myriad audits being conducted and, as Russ Hilliard notes in this month’s cover story, the increasing number of ADRs.

While this scrutiny poses its own set of additional demands on each of us, it poses yet another on hospice leadership: keeping your board members well informed of the issues and challenges. Yes, this takes time and extra effort, but I would argue that an uneducated board is not only ineffective and unengaged—but can also mean disaster.

Like hospice leadership, your board members are the public face of your organizations. While you don’t need to involve them in the day-to-day minutiae, you have a responsibility to keep them apprised of the big issues so they are not blindsighted when crises occur. This may seem obvious, but many CEOs are feeling so overwhelmed or preoccupied these days, they are not attending to this important task. So what can you do?

A few years ago, consultant Bill Musick offered very practical guidance on engaging boards in the NewsLine article, “Tapping Your Board’s Full Potential.” If you haven’t already, please make time to read it.

NHPCO also offers several ways to acquaint board members with the challenges, without a significant investment of time or money:

- Invite them to join our Executive Leadership Conversations. I host these quarterly, one-hour calls for hospice CEOs. Each focuses on a specific topic and features an expert guest. The next calls are scheduled for June 13 and September 12, from 1:30 to 2:30 ET. (For the call-in number and access code, consult the NCHPP CEO Section eGroup or call the Solutions Center at 800-646-6460.)

- Encourage them to attend all or part of NHPCO’s national conferences. HAN’s annual Hill Day, held each spring in conjunction with MLC, is also a helpful way to learn about the broader issues while networking with hospice and state-association leadership.

Lastly, a reminder that the HAN Advocacy Intensive is coming up on June 18 and 19. I hope to see some of you there!

J. Donald Schumacher, PsyD
President/CEO
of physical decline related to specific disease types which they should look for.

**New Documentation Format**

Our electronic medical record includes checklists, but the format is primarily narrative for psychosocial staff. Thus, we created a new structure for their narrative note that we refer to as DAROP.

The DAROP format is similar to SOAP or APIE notes, and stands for the five sections that comprise this narrative framework: Data; Action; Results; Observations; Plan.

Listed below are each of the five sections that comprise the DAROP format, with the instructions we provide to staff and illustrative examples based on a 62 year-old male patient with a hospice diagnosis of congestive heart failure. (Note that the section on Observations requires staff members to write their observations of the patient’s decline or hospice eligibility for each visit.)

**Data**

*Write what you observed at the beginning of the session and relate it to the hospice diagnosis. Write your assessment of need in this session and the care plan you are addressing.*

Sentences in this section should start with “patient” or “family” as you are documenting what you saw at the beginning of the session. For example, “Patient was received sitting up in the living room watching television with his wife. He appeared melancholic as evidenced by his flat affect and downcast eyes. He denied pain and stated, “I’m just kind of tired today.” Care plans being addressed: altered mood (depression) and anticipatory grief.

**Action**

*Write what you did in the session to address the needs you assessed.*

Sentences in this section should start with your position (e.g., chaplain, social worker, music therapist) as you are documenting your interventions for the patient and/or family. For example, “Social worker assessed patient’s mood as depressed and provided supportive counseling, empathetic listening, and validation. Social worker introduced the concept of a legacy project and offered to work with patient and family on documenting the patient’s life story. Encouraged life review and reminiscence. Contacted RN case manager, Betty Smith, and reported observations of patient’s depression.”

**Results**

*Write observable outcomes of your actions or interventions.*

Sentences in this section should start with “patient” or “family” as you are documenting what you observed as the result of your interventions. For example, “while the patient was relatively guarded when asked about his depression and current situation, his affect significantly brightened during life review. His wife shared stories of their courtship 30 years ago, and he joined in the discussion with additional stories. While reminiscing, they held hands and laughed. Overall, the patient continues to struggle with his depressed mood, and when the wife walked the social worker outside at the end of the visit, she shared her concerns for her husband. There were no signs of suicidal ideation. She agreed to a legacy project with him as a coping skill to lift his mood.”
Observations
Write all observations of physical decline related to the diagnosis. You are answering the question: “Within your scope of practice, what do you see that makes this patient hospice-eligible today?”

Sentences in this section should start with “patient” as you are describing your objective and subjective observations of his hospice eligibility. For example, “Patient was utilizing oxygen throughout the visit today whereas on previous visits, he would take it on and off. His feet were swollen and he had them raised on a foot stool. He said he gets dizzy when he stands, so he rises slowly. Due to his increased weakness, he said he avoids any activities other than moving from his bed to the living room.”

Plan
Document your plan for further addressing the patient’s needs.

For example, “Social worker will visit patient next week to further facilitate a legacy project and will continue to assess his and his wife’s needs.”

Education on Signs and Symptoms
The second component of our plan was to educate the psychosocial staff about the signs and symptoms of hospice eligibility or prognostic indicators. Since we noticed that in our audits staff was having the most trouble documenting decline in dementia, debility, and heart failure, we focused education on these diagnoses.

Three inservices were held. In the first, we explained the ADR process and the importance of documenting decline related to the hospice diagnosis. We also explained the new DAROP format, reviewed several examples to illustrate its use in practice, and provided examples of ways to document decline in general that would be applicable for several other diagnoses.

The second and third inservices then focused on dementia, debility and heart failure. One of our internal auditors, Kevin Singer, RN, discussed how to observe and document patient decline for each of the disease presentations, starting with an explanation of the different types of dementia (Alzheimer’s, Lewy Body, Vascular, and Organic Brain Syndrome) as well as an explanation of the FAST scale (see sidebar on page 6).

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Shown on pages 7 and 8 is the guidance Kevin shared with staff to help improve psychosocial documentation for patients with dementia.

Seasons used this same format for inservices that focused on debility and heart failure by first providing an overview of the disease and then offering concrete signs and symptoms to observe within the psychosocial staff’s scope of practice.

**Educating by Example**

Each inservice concluded with sample incorrect notes and corrected notes for the same patient and session. For example:

**Incorrect Note:**
Patient smiled and greeted chaplain upon arrival into patient’s room. Talked about her husband and family members while holding chaplain’s hand. Chaplain provided a ministry of presence, prayed with patient, and provided a follow-up phone call to the daughter. Patient denied pain and appeared comfortable.

From reading this note, do you know the hospice diagnosis? Do you know why this patient needs hospice care? Is the patient eligible for hospice services? Why would CMS pay for this patient’s hospice care?

In reality, this patient had a FAST Score of 7d, which means she could not maintain posture without supports; was unable to maintain a reality-based conversation even though she smiled upon the chaplain’s arrival; coughed after the hospice aide finished feeding her; needed support pillows and was leaning to the side; and stared through the chaplain rather than actually “greeting” him.

**Correct Note:**
Data: Patient was received in her wheelchair, leaning to her left side with support pillows as aide was completing feeding her lunch. Patient was coughing after eating and stared into space. Care plans being addressed: altered mental status; spiritual presence needs.

Action: Chaplain greeted patient, held her hand, encouraged eye contact, read scriptures and prayed with patient.

Results: When chaplain brought up husband’s name, patient began to talk about him as if he were still alive, although he has been deceased for years. Patient appeared comforted by prayers and scripture reading as evidenced by calm affect and closed eyes.

Observations: Patient coughed after mealtime, leaned to side, and was unable to engage in reality-based conversation.

Plan: Chaplain will visit patient in two weeks to provide spiritual presence and will phone patient’s daughter to offer support for anticipatory grief.

Not all hospice patients decline on our services and, in fact, some patients improve as a result...
Guidance for Patients With Dementia

Documenting Increased Weakness
Previously:
- Was able to pivot
- Slept 12 of 24 hours
- Ambulated independently with walker
- Able to sit upright in chair
- Able to self propel wheelchair
- Was interested in [XYZ] activities

Now:
- Unable to bear weight
- Sleeps 18 to 24 hours
- Ambulates with walker, but now requires assistance
- Requires lateral arm support, support with pillows, geri chair, foot rests, etc.
- Unable to self-propel in wheelchair
- Only able to listen to songs; unable to sing along
- No longer able to participate

Documenting Mental Status
Is/Does the Patient:
- Able to make needs known?
- Recognize family members?
- Respond to name only?
- Wander aimlessly?
- Stare blankly or stare off into space?
- Respond to tactile/auditory stimuli?
- Combative/irritable/paranoid?
- Maintain eye contact or visually track?
- Able to smile? Flat affect? Hold head upright?
- Drool?
- Laugh inappropriately?

Documenting Observations
Is Patient’s Speech:
- Nonsensical?
- Responds to yes/no questions only?
- Garbled?
- Inappropriate responses?
- Is speech repetitive?
- Sing-song?

Music Therapy Note: Patients who cannot put words together to make sense in speech will often be able to sing song lyrics. You must document both (e.g., “patient was able to sing the lyrics of her favorite song, but her spoken speech was garbled and she was not able to put words together that made sense.”)

Mealtimes:
- 1:1 feed required?
- Unable to utilize silverware?
- Requires prompting/encouragement to accept food, chew, swallow?
- Exhibits prolonged chewing time/difficulty swallowing?
- Pockets food?
- Expresses no interest in food?
- Plays with/throws food?
- Takes food from others’ plates?
- Finger food only?
- How much does patient eat? Percentages are subjective, so be specific (e.g., patient consumed 2 bites of sandwich and 4 teaspoons of Jell-O). 100 percent of a piece of toast and 6 oz of tea cannot be compared to 100 percent of a steak dinner with potatoes, salad and dessert!
- Does the patient cough after eating or drinking?
- Is it taking longer to feed the patient?
- Is the patient refusing food?

Weight Loss:
- Is weight loss evidenced by loose-fitting clothes, belt that is now too big, and/or extra skin folds?
- Are bony prominences evident or is patient skeletal in appearance?
- Does the patient look thinner when compared to a photo taken in healthier days?

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of hospice care. At Seasons, we encourage our staff to confer with the RN case manager and the interdisciplinary team when this appears to be happening. In some cases, the RN is able to document decline related to lab results or other clinical measures. In other cases, the RN is able to educate the psychosocial staff on the nursing assessment of decline and teach the staff what to look for. Finally, some patients will no longer meet the criteria for hospice care, and the team will have to discharge them. We call it a “graduation” from hospice and remind the patient and family that we are available should their needs change in the future.

**Staff Reactions and the Results**

After holding the three inservices, staff initially felt that it was taking them longer to document, especially since they were accustomed to writing the narrative note from the beginning to the end of the session instead of “by action.” Within three months, however, the feedback changed remarkably.

Our staff members now report that the DAROP format is clear and concise, and its repetitive nature affords them the ability

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**Ambulation/Transfers:**
- Requires standby, one or two person assist?
- Requires Hoyer lift?
- Does patient lean to the side in wheelchair? (This relates to FAST score 7d and indicates patient cannot maintain posture.)
- Has patient lost the strength to lift feet off the ground when transported in a wheelchair?
- Does patient need a geri chair or Broda chair?

**Dyspnea:**
Respiratory issues are a consequence of the disease process in patients with dementia. Due to the inability to swallow correctly, patients with the disease are prone to aspiration. Thus, it is important to observe and document respiratory problems exhibited by the patient:
- Short of breath during a visit?
- Short of breath or coughing with eating?
- Wheezing sounds?
- Gurgling sounds that are loud, raspy, sputtering?
to document more efficiently. It also assures them that they have covered the core elements of good hospice documentation.

Prior to implementing the DAROP format, we found some psychosocial notes were too short and did not include key elements needed while others were too long and included anecdotal stories rather than a clinical summary of the visit. In using the DAROP format, these problems were largely eliminated and we see good clinical summaries from our psychosocial staff. Lastly, our internal audits have shown that our psychosocial documentation has dramatically improved. While we are not wishing for ADRs, we now feel better prepared to address them. We are more confident that our psychosocial documentation supports the nursing assessments by painting an accurate and consistent picture of the patient’s health status and his or her eligibility for hospice care.

Russell Hilliard is a music therapist, social worker and administrator with over 18 years of experience in the hospice field. He is the founder of the Center for Music Therapy in End of Life Care and currently serves as vice president of supportive care, research and ethics at Seasons Hospice and Palliative Care based in Rosemont, IL. Dr. Hilliard also serves on the NHPCO Research Committee and frequently presents at NHPCO’s national conferences.

In using the DAROP format... we now see good clinical summaries.

References

1 Reinhart Hospice and Palliative Care Legal Service Group (2009) Ten Hospice Tips for Dealing with ADRs and Probe Edits, Headlines in Hospice and Palliative Care e-Alert.
One-third of U.S. hospice providers which submit data to NHPCO’s National Summary of Hospice Care define themselves as rural, while another 44.5 percent report serving both rural and urban communities. Addressing the many issues of concern for these providers has been one of NHPCO’s longstanding priorities. Today, however, it’s even more critical as new regulations and looming budget cuts place greater demands on these providers.

To help address their challenges, NHPCO formed a Rural Task Force comprised of 17 members representing programs from all regions of the country. The Task Force was formed in May of 2010, with the first meeting held in November.

Linda Rock, the executive director of Prairie Haven Hospice and Palliative Care in Scottsbluff, NE, and a member of the NHPCO board of directors, chairs the Task Force. In the following interview, she discusses the group’s current goals—and how NHPCO members can lend support.

**What have been the group’s top priorities since its formation?**

After reviewing and dialoguing about the numerous and complex needs and challenges for rural providers, our group decided to begin by focusing on three areas as they relate to access.

The first issue is the use of critical access hospitals, both as a location for inpatient care as well as the provision of ancillary services. The critical access hospital (CAH) can be penalized when general inpatient care (GIP) is provided in the CAH because the reimbursement rate for GIP is significantly lower than the rate the hospital receives for a day of inpatient care.
The second issue is the inability of rural health clinic physicians to continue to serve as a patient’s attending physician when the patient has been referred to hospices. There has been confusion in the regulations for rural health clinics about the process for continuing to follow that group of patients.

The third issue is the use of physician assistants in hospice. There are rural areas in the country where physician assistants are the primary physician extender, yet physician assistants cannot continue to follow patients once they have been referred to hospice.

How did you come up with these priorities?
Members of the Task Force spent time during our first few meetings identifying the challenges that are specific to or particularly burdensome to rural providers and a broad range of issues were raised. Then, by consensus, we narrowed down the list and prioritized the three that were the most consistently challenging.

The hospice physician face-to-face regulation has certainly posed its own set of unique challenges. Is the Task Force looking at ways to ease the burden?
The Task Force has received a great deal of information from members on the burden this regulation puts on all providers. For rural providers with limited capacity for medical director time, it’s even more burdensome.

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We know medical directors may spend an entire day seeing one patient for a face-to-face encounter if they have to drive long distances on dirt roads to reach the patient. In addition, we know that many of our rural providers employ part-time medical directors who have their own private practices or clinic responsibilities. The face-to-face requirement is especially hard on them. Since this a regulation mandated by CMS, we have little we can do to change how this affects programs. We have had some discussion about advocating for some type of waiver for rural programs, one that would give us more time to complete the face-to-face encounter. We also believe that allowing physician assistants (PAs) to do these visits could be very helpful since, in many rural areas, PAs are the primary providers of care. Since adding PAs as a ‘healthcare professional allowed in hospice’ requires a statutory change, we are strongly behind the NHPCO proposed HELP Hospice legislation (H.R.3506) which proposes to add PAs for hospice patients.

Can you discuss the Task Force’s other concerns on the regulatory side?

Rural programs are often small programs and, more often than not, the leaders as well as the clinical team members wear many different hats. This makes it hard for them to keep track of all the regulatory changes. Knowing this, we’re concerned about quite a few things. Are these providers up to date on all the requirements? Are they receiving the information, resources and tools they need to meet them? What can NHPCO do to make sure we are providing a wide array of opportunities to help them get the information they need, along with guidance on incorporating the information into their operations? We are challenging ourselves as Task Force members to develop as many options as we can to provide education and outreach related to our regulatory responsibilities.

Does the group have some educational initiatives in the works?

Over the last few months, we have been working on an assessment tool, in conjunction with NHPCO’s Office of Health Policy, that providers can use internally to evaluate their current program operations and plan for the future. It will help them assess their strengths, challenges, opportunities and threats. While it requires them to ask a lot of questions and gather data, it also includes resources they can draw upon as they complete the tool. It could be used by any hospice provider, but we are targeting our efforts toward rural programs. Our hope is to have this assessment tool available this summer.

We also think that conference calls with rural providers will be an effective way to help educate and support them while also gaining further knowledge about their other needs and challenges. These conference calls would be geographic-area specific, and provide time to dialogue together as well as offer education. We also believe this format would encourage providers to share best practices centered around what is working for them as it relates to access in their areas, funding, clinical

Which States Have the Most Rural Providers?

1. North Carolina (33)
2. Minnesota (30)
3. Iowa (29)
4. Alabama (24)
5. Pennsylvania (24)
6. Ohio (21)
7. Texas (20)
8. Wisconsin (20)
9. Mississippi (19)
10. Michigan (17)

Source: Self-reported Data from NHPCO Membership File (4/16/2012).
**Rural Providers on the Hill**

During Hill Day 2012, held in conjunction with MLC in late March, providers from all around the country met with their legislators on Capitol Hill.

Pictured here are some of NHPCO’s rural providers who made the trip to Washington to advocate for rural issues of concern.

**Top:** Stephanie Schedler, Elizabeth Duncan Harper, and Jamey Boudreaux from the Louisiana-Mississippi Hospice and Palliative Care Organization with Congressman John Fleming.

**Bottom:** Rural Task Force member Sandy Kuhlman (center in white) with Renee Hahn, Karren Weichert, Julie Pinkerton, Kevin Kentfield and Denis Viseck.
and team services, and meeting regulatory requirements. Both NewsLine and My.NHPCO would also be great vehicles to share this information with all members.

**What’s been some of the Task Force’s challenges?**
I think the major challenge has been the ability to convene on a regular basis. So many of our Task Force members do wear multiple hats and are committed to so many other projects that it has been a challenge to have us all together for meetings. I think this mirrors the challenges that leaders of rural programs encounter every day.

**Are there ways that rural providers reading this can help?**
We welcome the feedback from any rural provider about any of the solutions they’ve found to help address their challenges as well as best practices they’ve developed. We have found My.NHPCO to be a great resource for communication, resources and feedback. We would encourage all rural providers to join our Rural eGroup (see the sidebar at below).

**How will the future work of the Task Force be shared with members?**
We would like to engage NHPCO’s Council of States and Geographic Area Representatives (GARs) in sharing information about the work of the Rural Task Force with members within their states and regions.

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**Joining the Rural eGroup**

One of the best ways to exchange ideas and tips with colleagues who share your challenges and concerns is through the Rural eGroup on NHPCO’s professional networking site, My.NHPCO. It’s a free benefit to all staff and volunteers of NHPCO provider-members.

**What are eGroups?**
My.NHPCO’s eGroups are much like NHPCO’s former listserves, but better. Plus, each eGroup has an eLibrary where members can post information and resources to help one another.

**How Do I Join?**
If you are 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 (8:30 a.m. to 5:30 p.m. ET) or email solutions@nhpco.org.

If you are a My.NHPCO user, be sure to subscribe to the Rural eGroup! Go to the eGroups landing page, and click “Add/Change Subscriptions” to add this group to your “community.”
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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.
Methodist Healthcare is an integrated, not-for-profit healthcare delivery system based in Memphis, Tennessee. The seven-hospital system includes home health services and a hospice residence as well as outpatient surgery centers and minor-medical and diagnostic centers.

In the fall of 2006, the organization made some significant changes in its palliative care service and, based on the almost-immediate success, expanded the service across its network of hospitals as well as at nearby St. Jude Children’s Research Hospital.

In the following interview, medical director, W. Clay Jackson, MD, discusses the palliative care service, including its impact on hospice access and lengths of stay.

First, can you provide a little background about the home care and hospice services at Methodist Healthcare?

Methodist Hospice began as a community-based organization in 1979, and is now approaching its fourth decade as part of the Methodist Healthcare family of integrated healthcare services. Methodist Home Care, also in existence since the 70s, became a part of the Methodist system in the early 80s as well.

When did you introduce palliative services?

One of Methodist’s four adult hospitals had an existing team prior to 2006 that was called palliative care. In reality, this team functioned more as a Monday-through-Friday ethics committee, with a volunteer physician. They received 10 to 20 consults per month. Then in the fall of 2006, we shifted strategically to offer a truly integrated, physician-led consultation team with 24/7 availability at the same hospital. The team was comprised of a physician and nurse practitioner, with a pharmacist, social worker and chaplain brought in as determined appropriate.

Quick Facts About Methodist Healthcare’s Hospice Services

- Founded in 1979.
- Based in Memphis, TN.
- Serves residents of three counties in Tennessee and four counties in North Mississippi.
- Employs 78 FTEs and 85 volunteers.
- Introduced Palliative Care Services in 2006.
- Opened a hospice residence in 2011.
- Average Daily Hospice Census: 145 in the home program and 12 in the hospice residence.

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With this strategic change, consults skyrocketed to about 80 consults per month within the first quarter. We then grew the concept to the other three adult hospitals in our system. Later, we added two adult hospitals from another healthcare system, as well as our system’s pediatric hospital, Le Bonheur Children’s Hospital, and St. Jude Children’s Research Hospital. So today, we are offering the palliative care component in eight area adult and children’s hospitals.

**Are the palliative care services provided in the home as well as the hospital?**
The lion’s share of our palliative work is done in the inpatient setting. Two of our doctors have primary care offices where palliative patients may receive outpatient care as needed. In addition, our doctors occasionally make home palliative visits, but the majority of these patients are served by a community physician who focuses exclusively on non-office-based geriatrics. We partner with him to ensure that these patients receive effective home care. In addition, the Methodist Healthcare system works closely with our accredited, certified Home Care and Hospice agencies, along with the hospice residence that we opened last year.

**How often do the palliative care teams see patients?**
Patients are seen daily.

**What are the demographics of your patient population?**
About 90 percent of our hospice and palliative care patients are adults. However, through our partnership with St Jude and Le Bonheur Children’s Hospital, we also serve a fairly large number of children. Many of the children at St. Jude have malignancies while the majority of children served at Le Bonheur have cardiac or genetic disorders that are not compatible with prolonged survival. We also do a good deal of pain management consultation at Le Bonheur.

In the adult hospitals, we see all types of patients for palliative consults, from patients needing straightforward symptom management to those whose caregivers need complex decisional support to ‘tough cases’ when medical and surgical teams are unsure of which care plan would be most appropriate.

On the hospice side, our census typically is composed of a little less than 50 percent of cancer patients; the remainder comprises neurologic diseases such as strokes, neurodegenerative diseases and Alzheimer’s/dementia, and cardiac and pulmonary diseases. Of course, we also have a good number of patients with multiple medical comorbidities who have experienced multi-modal decline and qualify for hospice under ‘debility’ or ‘adult failure to thrive.’ We are particularly proud that our hospice serves a large number of African-American patients. The brand equity that Methodist Healthcare has built through decades of service and innovative initiatives, such as our Congregational Health Network, have helped us to overcome the historical patterns of underservice in the African-American community.

**How have you structured and staffed your palliative care team?**
We employ eight doctors and four nurse practitioners (NP) for our core hospitals. St. Jude also has a doctor and an NP. Each hospital is designed to have a lead physician and an NP as the core ‘medical partnership’ of the palliative care team. Some of our hospitals, however, do not yet generate the volume of
consultations to warrant a full-time NP, so those hospitals share NP time with the others. Our doctors work in both hospice and palliative care; our NPs work exclusively in palliative care. At our larger hospitals, pharmacists, social workers and chaplains round out a true interdisciplinary team. At the smaller, lower-volume hospitals, we often rely on voluntary or ad hoc support from these disciplines within the hospital system.

**Has communication between patients and their multiple care providers been difficult to manage—especially when serving patients in the hospital setting?**

Yes and no. It’s difficult, yes, but that is one of the valuable assets that our palliative care teams bring to the table. We consider comfort and communication to be our two core skills. When we liaison among a large and/or challenging family system and a multidisciplinary team of specialists (whose members may or may not be acting as a team), we provide instant value that patients, families, and clinicians can readily recognize.

**What have been some of the other challenges in providing palliative care within a large hospital system?**

Maintaining consistent quality while experiencing exponential growth was a formidable task. We relied on the goodwill of our system leaders to provide resources, trusting that we could produce revenues from billing and reduce spending by cost savings in large enough volume that our services would ‘earn their keep.’ Tasks as straightforward as keeping the call schedule straight, and as nuanced as promoting a continual sense of an organic team, keep us looking for new ways to improve.

**What are some of the ways your palliative care service reaches out to referral sources?**

We have utilized web-based and analog information transfer, bought local television airtime, and presented at numerous CME events to help educate clinicians and the broader community about the importance of high-quality hospice and palliative care. In the end, however, we have relied most heavily on the classic “three-A’s” approach to building a consultative practice: availability, affability, and ability.

Continued on next page
In addition to providing more seamless care for patients, is the palliative care service helping patients come onto hospice sooner?
In truth, the hope that this would happen was a motivating force in creating the palliative care services in the beginning. However, we haven’t seen an uptick in length of hospice stay. If anything, our median length of stay is shorter now than it was six years ago. Paradoxically, some of that effect is probably caused by our palliative services—more patients are converted from traditional hospital care to GIP hospice care and these patients are often imminently terminal. So it’s certainly not an easy way to generate hospice referrals, at least in our experience. However, we do get the qualitative sense that we serve a broader demographic of patients in hospice owing to our commitment to palliative care.

Have there been any hidden benefits in working so closely with hospital staff who may have a much different mindset than hospice staff?
From the beginning, our administrative and clinical leaders at Methodist Healthcare have been overwhelmingly supportive of our vision. The rapid growth at the beginning of our consultation service surprised us, as well as the rather slow growth at some other hospitals that we added later. Much of the uptake of palliative care seems to be dictated by the unique culture of the individual hospital, including the size and composition of the medical staff as well as the patient population. We did find, however, that the value of a full-time, onsite NP at a facility was highly correlated with robust growth.

From the hospital’s perspective, what advice can you offer to the hospice program which wants to partner with its area hospitals?
Get ready for a thrilling adventure that will keep you very, very busy. Be sure that you have the clinical and administrative resources to handle the demand that may be generated, as a proper palliative care program will certainly compete for time and energy from some of your most talented staff. Partner with individuals (inside and outside the hospital setting) who know billing inside and out—for both inpatient and outpatient services! Don’t pursue this project to build the hospice alone; there are more efficient ways to accomplish that task. And, finally, dive in if you’re committed to excellence in patient care, regardless of setting or placement on the illness trajectory.

Are you offering a non-hospice service too? And would you like your work spotlighted in NewsLine? Complete our brief questionnaire.
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Faculty: Christine Longaker, author of *Facing Death and Finding Hope*, Kirsten Deleo, MA, Ann Allegre, MD, Pam Russell, MSW, and Ira Byock, MD.
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 Nurse Section, and an article by Catherine Sweeney.…

continued on next page

Featured This Month:
NCHPP Nurse Section
Empowering Hospice Aides
The Educational Program at HCN

By Catherine Sweeney, RN, CHPN

Working with hospice aides was one of the best experiences I had during my 15 years as a hospice nurse. Hospice aides were the staff who could share what was really happening at the patient’s bedside and within his or her family network. Hospice aides were the way for the best care to be given, and the information they shared helped make our patients’ final days more comfortable and peaceful. Now, in my role as a clinical educator at the Hospice Care Network (HCN), I have become both their teacher—and their biggest cheerleader!

Help Them Recognize Their Value

The first thing that hospice aides need is to understand how much the work they do matters to both patients and staff—and teach your new nurses to ask, listen and respect their input. As aides start to feel their worth, they will become more interested in their own development and will be more eager to learn.

Help Them Connect With Other Team Members

The education program for hospice aides at the Hospice Care Network is set up before the year begins, with speakers arranged and dates set. The education comes from the different disciplines, and guest speakers such as physical and respiratory therapists.

This year, for example, a physical therapist taught techniques for self-care as well as use of the transfer belt. The bereavement department is planning a memorial service as a way for our aides to remember the patients who have died. And in sessions presented by our CWCN and dietician, aides learned more about wound care and the use of Arginade in helping wounds heal in patients who are not too close to dying. We are also very lucky to have a diverse group of pastoral care members, so aides have had the opportunity to learn about different faiths.

In terms of learning from the nursing discipline, we have conducted educational sessions on COPD, heart failure, and dementia. Later this year, they will learn about leukemia. Why teach these topics? Some topics are taught because aides asked for information about the disease and others were chosen because they are common diagnoses in hospice care.

In the session on COPD, aides learned about the causes and physiology of the disease as well as how to provide care for patients with this diagnosis. In teaching the anatomy, a diagram was used to illustrate how the air travels through the respiratory system. When teaching how breathing...
occurs, using a deflated balloon to represent the alveoli worked nicely. Reviewing what aides can do to help the COPD patient find comfort—such as opening a window, raising the head of the bed, turning on a fan—were also discussed. This gives aides the knowledge and confidence to help the patient while the nurse is notified of a problem.

In teaching about heart failure, anatomy and physiology were also discussed, in addition to admission to hospice, the New York Heart Association functional classification system, and injection fraction.

In teaching the session on dementia, I learned more myself while preparing the program! The aim was to understand the different types of dementia, but also to learn and discuss the different ways to care for these patients, including the importance of being calm even if the patient is not.

**Teaching Tips**

Using diagrams, pictures and clear language will improve learning when it comes to addressing fairly complex diseases like these. Adult learners fall into one of three different categories: Visual learners; auditory learners; and kinesthetic learners (Russell, 2006).

Visual learners need pictures and diagrams to help them understand new concepts and information. Auditory learners learn best when they can talk about the topic, so discussion works well with these individuals. Kinesthetic learners do best when they have something in their hands, such as the deflated balloon to represent how an alveoli works. Nearly all adult learners benefit more from active learning rather than from verbal instruction alone (Russell, 2006).

Finally, always use the right word in presentations, even when it is a hard-to-pronounce, multi-syllable word. Just be sure to explain it! For example, when my manager saw that I had used the word “Frontotemporal Lobar Degeneration” in a presentation about dementia,
she questioned it. I chose to use it anyway since it gave me the chance to discuss the term fully (and reinforced to my students that I knew they were capable of understanding it).

In Summary

Working with other disciplines to provide education for our hospice aides is one way to help develop valuable connections between all members of the team, while helping aides understand more about why they are asked to do what they do. Investing in educational programming for aides benefits all members of the team. Aides see patients more than any other discipline; when they understand the different diseases, they will be better able to share information that can help other members of the team do their job that much better too.

Catherine Sweeney has been working in hospice for 15 years, including five years as a clinical educator for Hospice Care Network, based in Woodbury, New York. She also serves on the NCHPP Nurse Section Steering Committee.

References

Every NCHPP Section has an eGroup where members post information to help one another.

My.NHPCO—a Great Resource for Hospice Nurses

One of the best ways to exchange ideas and tips with your colleagues is through the NCHPP Nurse 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 Member Services Department at 800-646-6460 (8:30 a.m. to 5:30 p.m., ET).
“Other state organizations can benefit from what HPCANYS has done,” said NHPCO president/CEO, Don Schumacher. “Hospices and those they serve benefit from a strong state organization that can advocate on behalf of quality end-of-life care.”

The Hospice and Palliative Care Association of New York State (HPCANYS) was the honored recipient of NHPCO’s inaugural Trailblazer Award which was presented in late March during the NHPCO Management and Leadership Conference.

The Trailblazer Award was created to recognize state organizations that demonstrate high levels of excellence, innovation and leadership which expand access to hospice and palliative care, promote quality, and increase awareness. This year’s inaugural award was presented to HPCANYS in recognition of its successful advocacy program to increase access to hospice and palliative care.

HPCANYS’s efforts resulted in the inclusion of hospice and palliative care in the New York State Medicaid Redesign and passage of three important pieces of legislation—the Hospice Modernization Act, the Palliative Care Access Act, and the Family Health Care Decisions Improvement Act. All were signed into law in 2011.

“It is a great honor to accept the Trailblazer Award on behalf of our Board of Trustees, whose vision and leadership made our advocacy successes possible, said HPCANYS president/CEO, Kathy A. McMahon. “Collaboration and partnership with a number of healthcare organizations, as well as the strong support of the New York State Assembly and Senate, were key to these legislative achievements.”

Left to Right: NHPCO President/CEO Don Schumacher; Kathy McMahon; NHPCO Board Chair Mark Murray; and Michele Fedderly, the Council of States representative on the NHPCO Board.
A new study by Dartmouth researchers examined the intensity of health care delivered to Medicare enrollees who were terminally ill with cancer, and found that the overall intensity of care was high—probably far more so than many patients would prefer.

What’s more, the nation’s most elite cancer care centers performed only modestly better than community hospitals at meeting recognized quality standards for treating these dying cancer patients, displaying similar patterns of relatively aggressive, high-intensity treatments in the final weeks of life.

More than a twofold variation was observed within hospital groups with common features, such as cancer center designation and for-profit status, but these hospital characteristics explained little of the variation in intensity of care and none reliably predicted a specific pattern of care.

The researchers also found that even among hospitals with a specific clinical focus on cancer care, such as those in the National Comprehensive Cancer Network and at designated National Cancer Institute centers, there were significant variations in how they treated patients at the end of life. The analysis found twofold differences among these institutions in the rates of intensive care unit use in the last month of life, chemotherapy in the last 14 days of life, deaths occurring in the hospital—and the use of hospice care for fewer than three days.

The analysis included more than 215,000 Medicare patients with poor-prognosis cancer (meaning that they were likely to die within a year) and the care provided to them at approximately 4,400 hospitals nationwide from 2003 through 2007. For each patient, researchers studied the care received in the six months preceding their death, such as hospitalizations, hospice use, intensive care unit use and the number of physicians providing care.

The study (“End-of-Life Care for Medicare Beneficiaries With Cancer is Highly Intensive Overall And Varies Widely”) was published in the April 2012 edition of Health Affairs. The lead author is Dr. Nancy Morden, a researcher at the Dartmouth Institute for Health Policy and Clinical Practice, assistant professor at the Dartmouth Medical School, and investigator in the Cancer Control Research Program at the Dartmouth-Hitchcock Norris Cotton Cancer Center.
Run to Remember Proceeds Can Now Support African Hospices

Run to Remember is a fundraising and training support program offered by NHPCO affiliate, the National Hospice Foundation, where proceeds can be designated to support NHF and any U.S. hospice of the participant’s choice. Now, Run to Remember participants also have the option of raising money for African hospice or palliative care programs.

There are currently 89 NHPCO provider-members which partner with an African program through FHSSA’s Partnership Program, so this change will create a new way for U.S. partners to support their colleagues in Africa.

With this change, Run to Remember participants simply need to list the African hospice’s name and address on the online form when registering. Then, at the conclusion of their race (and after fundraising is complete), NHF will wire 50 percent of the funds raised directly to the named African hospice and transfer the other 50 percent to FHSSA for general programmatic support.

To learn more, visit the FHSSA website, or contact NHF’s Susan Messina.

About Run to Remember
Run to Remember provides online fundraising infrastructure and training support for runners (and walkers) in races ranging from 5Ks to marathons and beyond. In 2011, $55,000 was raised for local American hospices. For details about this program, visit www.runtoremember.org.

About FHSSA
FHSSA was founded in 1999 with the goal of building partnerships to enhance compassionate care in Africa. At present, 89 U.S. hospices partner with hospice programs in 14 different African countries. To learn about the many benefits of partnering from the U.S. hospice’s perspective, read the article in December 2011 NewsLine.

Pictured Above: Physician and Run to Remember supporter, Aluko Hope.
NHPCO’s set of End Result Outcome Measures, known as EROM, has been renamed “Patient Outcomes and Measures” (POM) to reflect a focus on patient-centered outcomes and align more closely with the U.S. Department of Health and Human Services’ National Quality Strategy.

POM now includes two measures, with plans for a third under way:

- **Comfortable Dying (NQF #0209):** Pain brought to a comfortable level within 48 hours of initial assessment.
- **Self-Determined Life Closure:** Unwanted hospitalization and unwanted CPR.
- **Coming Soon—Patient Safety:** Falls, infections, and adverse events.

As many members know, the Comfortable Dying Measure has been approved by CMS for use in meeting the new quality reporting requirements (and is often referred to as NQF #0209).

With the quality reporting requirements taking effect in January 2013, providers should be well on their way to integrating quality reporting processes into business practice. For information about the requirements and details about POM, visit NHPCO’s Countdown to Quality Reporting webpage.
Who doesn’t want to work smarter—or save their organizations hard-earned dollars? Unfortunately, these days we are usually inundated with sales promotions and well-meaning information that are not tailored to “our world.” The information below is different—it comes from experts and colleagues in the hospice field with one simple goal: To make your worklife easier and your organizations that much better.

**Hiring a Vendor**
Outside experts and service providers can become invaluable partners in helping you provide high-quality care. But before you leap into a relationship with a new partner, there are 8 tips you should consider. Some may seem obvious and others may surprise you—read them now. (Be sure to consult NHPCO’s new *Buyer’s Guide* too.)

**Hospices Beware: Scams and Worthless Bargains**
While no longer accurate, scammers who make their living by selling fake, fraudulent and worthless advertising often think of hospices as unsophisticated organizations just ripe for ripping off. Learn how to quickly identify scams and worthless bargains from communications expert, Mark Cohen.

**Using Your Volunteers’ Many Talents**
In a recent NewsLine article, NCHPP Volunteer/Volunteer Management Section Leader, Sandra Huster, reminded us of the many ways that hospices can tap the talents and expertise of their volunteer workforce—including service as Diplomat Donor volunteers and Volunteer Advocates. Take a look at Sandra’s guidance, along with information she shares about Covenant Hospice’s successful Tuck-in Volunteer Program.
Improving Staff Productivity
NHPCO members who work in the area of clinical and operations management compiled a list of eight ways to help staff and volunteers improve productivity. Read their advice—and share it with your colleagues.

Making the Inter-generational Workforce Work
Corporate-culture experts, Megan and Larry Johnson, addressed this very timely topic at NHPCO’s 26th Management and Leadership Conference—and their plenary is now available as a Webcast. Use this Webcast as a cost-effective way to educate your entire team during an inservice or more casual brown bag (member-providers only pay a flat $105 fee). Counselors, nurses, physicians and social workers can also earn CE/CME when attending. Learn more about this Webcast now—or see all 14 NHPCO Webcasts. They are a smart way to support staff without spending big dollars.

Do you have a tip that’s working for your team or organization? Email newsline@nhpco.org.

Plus, Promoting Hospice: Free Stuff!

Marketing Tools and Tips... NHPCO’s Caring Connections offers many resources that can help members create a comprehensive marketing plan on a shoestring budget. The tools are available online and include such items as Marketing Hospice: A Core Competency; If You Promote It, They Will Come; Strategic Outreach Using Printed Materials; and much more. Visit Outreach Strategies.

Display Ad Templates... Each year NHPCO produces a collection of display ads that highlight key aspects of hospice and palliative care. Utilizing these ads, which are available as high-res PDFs, can make community education easier and more affordable. Versions are available with and without copy, so members can customize them as they wish. View and download the ads now. (For an overview of the entire Outreach collection, see the October 2011 issue of NewsLine.)
Staff from the Centers for Medicare and Medicaid Services (CMS) announced results of its annual compliance audit at NHPCO’s 27th Management and Leadership Conference in late March. These results were based on 1,169 hospice surveys conducted during FY 2011-2012, and include a compilation of the top 10 most frequently cited survey deficiencies.

The areas cited (shown below) include aspects of care planning, staff supervision and oversight, and the provision of certain services. Understanding them—and identifying those areas where your organization may be falling short—is the key to becoming survey-ready!

### Top 10 Areas Cited

1. L543: §418.56(b) Standard: Plan of care
2. L629: §418.76(h) Standard: Supervision of Hospice Aides
3. L545: §418.56(c) Standard: Content of the Plan of Care
4. L530: §418.54(c)(6) Drug Profile
5. L555 – §418.56(e)(2) Ensure that Care and Services are Provided in Accordance with Plan of Care
6. L591 – §418.64(b) Standard: Nursing Services
7. L552 – §418.56(d) Standard: Review of Plan of Care
8. L596 – §418.64(d) – Counseling Services
9. L615 – §418.76(c) Standard: Competency Evaluation
10. L523 – §418.54(b) Standard: Timeframe for Completion of the Comprehensive Assessment

For details, see the NHPCO Tip Sheet.

### Tip Sheet and Audit Tool

The NHPCO Regulatory team has developed its annual Top Ten Hospice Survey Deficiencies Tip Sheet and Compliance Audit tool that can help you educate staff and conduct a compliance self assessment.

The Tip Sheet lists the survey deficiency by the L-Tag Identifier and Medicare hospice CoP; provides an example of the deficiency based on CMS survey deficiency data; offers suggestions for compliance from clinical and administrative perspectives; and lists the standard and practice example from the NHPCO Standards of Practice for Hospice Programs (2010).

The Compliance Audit tool will help you perform a self assessment to identify areas of risk that require action.

Both resources can be found in the Regulatory and Compliance Center—on the Tools for Care and Compliance page.
Three popular plenary sessions from the 27th Management and Leadership Conference are now available as Webcasts through NHPCO’s End-of-Life Online. For just $105 per Webcast, members can share these plenaries at team meetings or at more casual brown bags.

**What Got You Here Won’t Get You There**  
Presenter: Marshall Goldsmith, PhD  
Member Price: $105.00  
“Excellent easy techniques to make lasting changes”

**Letting Go: How Hospice and Palliative Care Can Transform the Healthcare System**  
Presenter: Atul Gawande, MD  
Member Price: $105.00  
(Only available until February 2013)  
“Dr. Gawande is simply brilliant at communicating the human side of medicine”

**Appreciative Leadership: Building a Thriving Organization**  
Presenter: Diana Whitney, PhD  
Member Price: $105.00  
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**To Place Your Order:**  
Simply click on the Webcast link and follow the prompts to register and pay for the session. You will then receive a confirmation of your order, with a link to access the Webcast from the E-OL website.  
You can also receive a discount when you purchase 25 or more E-OL courses and/or Webinars. Learn more.

**Questions?**  
Contact the NHPCO Solutions Center at 800-646-6460 (8:30 a.m. to 5:30 p.m., ET, Monday through Friday).
“Care Beyond Cure” is one of 50 short films produced by the filmmakers of the multi-award winning documentary series, *LIFE Before Death*.

Each short film (about 5 minutes or less) provides global perspective from noted healthcare professionals, activists, and others on topics related to pain control and end-of-life issues. See the list of short films, with links to view them online.

To learn more about the documentary, see *LIFE Before Death*.
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National Center for Care at the End of Life Hosts Room Dedication Ceremony

Guests Enjoy Tour of Center and Visit Their Named Spaces

In conjunction with NHPCO’s Management and Leadership Conference this March, The National Center for Care at the End of Life hosted a Room Dedication Ceremony to celebrate the spaces within the center that have been named as part of a campaign commitment by an individual, provider or business.

The National Center is the home of four affiliated organizations with one vision: a world where individuals and families facing serious illness, death and grief will experience the best that humankind can offer. Those four organizations: The National Hospice and Palliative Care Organization (NHPCO), The National Hospice Foundation (NHF), FHSSA (originally known as the Foundation for Hospices in Sub-Saharan Africa), and the Hospice Action Network (HAN), had the opportunity to create the National Center for Care at the End of Life in 2008 and began a capital campaign to encourage investments in its future.

Forty spaces within the National Center have been named to date, and the Room-Dedication Ceremony was an opportunity for contributors to experience the space and see the area they selected to name in honor of someone important to them as an individual or organization.

Long-time Hospice Supporters, Susan and Dennis Gilardi Lend Their Support to the Capital Campaign

When Dennis Gilardi’s uncle was cared for by Hospice by the Bay 35 years ago, he had no way of knowing that it was the start of a lifetime of involvement in the hospice movement. A year after his uncle’s passing, Dennis joined the board of directors of that hospice program.
Show the ones you love that you really care. Each time you make a purchase from one of these vendors, they will donate $10 to the National Hospice Foundation.

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!

www.nationalhospicefoundation.org/Shop

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NHF would like to thank Bobby McKey’s piano bar and restaurant at the National Harbor for donating the space for our Evening of Gratitude Event!

Samira Beckwith, president and CEO of Hope Healthcare Services and J. Donald Schumacher, president and CEO of NHPCO.

Teresa Craig, president and CEO of Suncoast Solutions

“The National Center is so much more than bricks and mortar,” said J. Donald Schumacher, president and CEO of NHPCO. “It is a space that represents the important work being done across the country to improve care at the end of life, and houses professionals working on critical issues related to improving quality patient care, education, consumer services, research, data analysis, regulatory assistance, advocacy and philanthropy. We are so grateful to each of our contributors for making this space possible.”

“The center is strategically positioned to challenge conventions about hospice care and press the boundaries of what is possible. This is a place where future leaders can set an example for collaborative thinking and acting in ways that inspire innovation and advance best practices. We are delighted to be able to contribute to the future in this way,” said Teresa Craig, president and CEO of Suncoast Solutions.

To find out more about the National Center for Care at the End of Life or the Capital Campaign, contact Heather Slack-Ratiu at (703) 837-3155 or hslackratiu@nationalhospicefoundation.org. To see more pictures of the Room Dedication Ceremony, visit: www.nationalhospicefoundation/roomdedication

From there he became a part of significant milestones in the movement, including attending the first National Hospice Organization meeting in Washington, DC, and became a member of the original Healthcare Financing Administration’s Medicare Demonstration Project.

“Given my experience with hospice over the years, and my semi-retirement, when the opportunity came to support the movement on the national level by contributing to the National Center for Care at the End of Life, I knew it was something that would mean a lot to both Susan and me.” The Gilardis elected to lend their name to the office of Senior Vice President, Office of Philanthropy (pictured on previous page).
8th Annual
NHF Gala Raises Funds for Programs to Expand Hospice Care

More than 600 Guests Gathered to Honor the Women Who Have Shaped Hospice

More than 600 guests gathered this spring for the 8th Annual National Hospice Foundation Gala, “Celebrating the Women of Hospice: A Salute to Heroines and Humanitarians” at the Gaylord National Resort and Convention Center, National Harbor, MD.

The event, held during the National Hospice and Palliative Care Organization’s 27th Management and Leadership Conference, raised nearly $300,000 through ticket sales and a silent auction to support NHPCO programs such as the We Honor Veterans program in partnership with the Veterans Administration focused on improving end-of-life care for veterans, and Caring Connections, a national consumer and community engagement initiative.

“The theme of this year’s Gala gave us the opportunity to reflect on the women who have shaped hospice into what it is today through their dedication, compassion and unique contributions throughout the years. Without them, we would not be where we are today, changing the way we live and the way we die,” said J. Donald Schumacher, president and CEO of the National Hospice and Palliative Care Organization.

Several awards were presented at the event:

- **The Today Show** received the *Buchwald Spirit Award for Public Awareness* for its dedication to sharing compassionate stories. This award was presented by actress and hospice advocate and volunteer, Torrey DeVitto.

- **Bernice Catherine Harper**, a social worker and hospice advocate with a long history in health policy and minority access to care was honored with the *Global Vision Award* for her work in expanding palliative care services in Africa and her role in establishing FHSSA (originally known as the Foundation for Hospices in Sub-Saharan Africa).

- **Ann Morgan Vickery** was granted the *Healthcare Architect Award* for her many years of dedication to hospice beginning with her involvement in the enactment of the Medicare Hospice Benefit in 1982 and advising on a regulatory and policy level since.

- **Center for Hospice Care** received the *Morfogen Art of Caring Award* for its work in collaboration with the University of Notre Dame Film School on the film “Okuyamba,” about the challenges and triumphs of providing palliative care in Uganda.

Eleanor Clift, a hospice heroine in her own right, having generously shared her personal experience with hospice care in a book about her husband’s death, served as Mistress of Ceremonies.

In addition to these awards, several women were honored by their hospice programs for their contributions with cards at each gala table describing their work in shaping hospice care in the U.S.

Next year’s gala will be held on Friday, April 26, 2013, also at the Gaylord National Resort and Convention Center in conjunction with NHPCO’s 28th Management and Leadership Conference.
NHF Wishes to Express Sincere Gratitude to the Sponsors of the Gala as well as the staff and volunteers who made the event a tremendous success!

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NHF Welcomes Samira Beckwith as Chair

Earlier in the year, the hospice community lost a true pioneer and trailblazer with the death of Mary L. Labyak. Mary died peacefully at home on February 4, 2012 under the loving care of her colleagues at Suncoast Hospice, the organization she helped create and where she served as President and CEO.

At the time of her death, Mary was the Chair of the National Hospice Foundation, Co-chair of the Capital Campaign for the National Center for Care at the End of Life, and a member of the NHPCO Board. For many in the hospice and palliative care community, it seems that no one can replace Mary. However, she would be the first person to say that we must keep moving forward with the important work we share.

At the Gala on March 30, the National Hospice Foundation proudly welcomed Samira K. Beckwith, LCSW, FACHE, as the new chair of the NHF Board of Trustees.

Samira is president and CEO of Hope HealthCare Services in Ft. Myers, Florida, and has a long history with NHF and our affiliate organization the National Hospice and Palliative Care Organization. She was a founding member of NHF’s board and its executive committee and has served in many leadership roles. In her service to NHPCO, she served as board chair when the organization was still National Hospice Organization.

NHF Executive Director John Mastrojohn said, “We are delighted to have Samira serving as our Board Chair. She is an experienced and nationally respected leader who is strongly committed to our vision of a world where individuals and families facing serious illness and grief will experience the best that humankind can offer.”

We extend a warm welcome and look forward to Samira’s dedicated leadership.


Advance Healthcare Planning Ensures Last Wishes are Honored

When the unexpected occurs, it’s important that your loved ones know your wishes regarding your medical care. Advance Directives provide a means for documenting your preferred treatment options if you are unable to speak for yourself in a medical emergency.

Caring Connections, a program of NHPCO supported by funds raised through the National Hospice Foundation, provides information and guidance on Advance Directives and now, through a collaborative effort with MedicAlert Foundation, these written documents are safely and confidentially stored, communicated and made available when and where they are needed.

“This is a great opportunity not only to encourage these important discussions among family members and loved ones, but to make the process of storing and accessing advance directives secure and easy,” said J. Donald Schumacher, president and CEO of NHPCO.

Honoring the passion at the heart of hospice, this new t-shirt was designed by actor and hospice advocate Torrey DeVitto. All proceeds from the new “comfort.love.respect” shirt will support Caring Connections awareness and outreach efforts.

TO ORDER, VISIT: www.nationalhospicefoundation.org/shop
NHF Recognizes Hospice Pharmacia for Its Contributions to Hospice

Pioneer in Meeting Hospice Medication Needs Continues Long-Standing Commitment

The National Hospice Foundation is grateful for the continued support of Hospice Pharmacia, pioneers in hospice pharmacy service solutions. Hospice Pharmacia, a division of excelleRx, has long supported the work of hospice programs as vendor partners in patient care as well as through contributions of time, professional resources, and financial gifts to the programs of the Foundation and NHPCO.

Hospice Pharmacia was the first pharmacy to focus on expert management of medication for end-of-life patients and exists on the belief that all people, especially those dealing with end of life symptoms, have the right to appropriate medications. Hospice Pharmacia works directly with hospice and palliative care organizations to design program-specific pharmacy service that meets the unique needs of the hospice staff and patients. With a 15-year focus on customer service and innovation and expertise in medication management, formulary design, and symptom management education, Hospice Pharmacia continues to grow with our industry.

“For most of us working in hospice, it is so much more than a job, it’s a commitment to making an impact on the lives of the patients we care for and their families. Hospice Pharmacia is no exception. Not only have they been leaders in improving pain management, but through their support of educational and policy initiatives, they have made a real contribution to ensuring our field remains innovative. We are so grateful for this commitment and contribution,” said J. Donald Schumacher, president and CEO of NHPCO.

HP’s commitment to education is evidenced by their years of support of NHPCO conferences and educational opportunities for members. As an important partner in assuring the integrity and fortitude of our work, they have answered our calls whether for NHF’s Gala sponsorship requests or the Hospice Action Network’s need for pharmacy experts when addressing material legislative issues.

“It continues to be an honor to work with hospices that provide such critically important care at the end of life. We view our work as a noble calling and it has been or privilege to empower the good work of NHPCO for so long,” said Michael Cinque, PharmD, vice president of Medication Therapy Management Services for Hospice Pharmacia.

Consumers may purchase the Advance Directive Management Service for $50 which includes five years of document storage and accessibility, live 24/7 emergency response and family notification services, and an emergency wallet card with information on how to access the individual’s Advance Directives.

“We are committed to providing consumers and our members with the best quality healthcare available. For people with no existing health condition, the quality and choice of care is still a big concern. Through this advance directive service, we give patients who are unable to speak for themselves in an emergency situation a voice in deciding their preferred medical treatment,” said Andrew Wigglesworth, MedicAlert president and CEO.

For more information about Advance Directives, visit Caring Connections at: www.caringinfo.org. To learn more about this MedicAlert service, visit: www.medicalert.org.

Make a decision today… to make a gift tomorrow.

Learn about the opportunities to give and save—meeting your financial goals and maximizing your charitable intentions through gift planning with the National Hospice Foundation.

Visit www.nationalhospicefoundation.org/give
Two Pairs of Siblings Tackle Marathons as Run to Remember Participants

The opportunity to memorialize loved ones was irresistible

This year, two pairs of siblings are running marathons as part of Run to Remember. John and Mike O’Connor will tackle Bank of America Chicago Marathon on October 7 in memory of their father, Emmett O’Connor. On October 29, Sara Garcia and Michelle Reitz will run the Marine Corps Marathon in memory of their grandmother, Elizabeth Prior.

Neither O’Connor brother has ever run a marathon. Mike explains, “I’ve always wanted to run a marathon, even though I’m not a huge runner. We always get together around the anniversary of our father’s death to remember him. I tried to think of something different this year and when I saw Run to Remember on the Chicago Marathon website, I knew that was it. My brother, John, runs every day so he had no problem saying ‘yes’ to my idea.”

Sara and Michelle, along with their brother and sometimes other siblings, have a long tradition of doing endurance events together. Sara says, “We’ve done marathons and triathlons for a number of years. It’s been a few since we did one together. When our group of friends and family decided on the Marine Corps Marathon, Sara and I were surprised at how fast the race closed. We were so pleased to find that NHF had charity slots available. All four of our grandparents have passed away and all of them received hospice services.”

All four participants find great meaning in running in memory of their loved ones. Michelle remembers her grandmother Elizabeth as “really kind, extremely strong, and very independent. She worked for an airline early in her life and had the unusual opportunity to do a lot of travel.”

About his father, Mike says, “He was the greatest guy in the world. He was laid back, worked as a painter. He raised five kids and was married to my mom for 30 years. He was only in hospice one day, but it was so helpful. The hospice has a ‘memorial box’ outside each room and we were able to put a baseball with his name on it in the case, as my dad was a huge Yankees fan. Sometimes we visit there, instead of making the 1.5 hour drive to the cemetery.”

The two brothers and two sisters are all looking forward to their marathons this fall, knowing that they will be sharing something special with each other.

Would you and a sibling like to do a race together? You could! Learn more at www.runtoremember.org or email info@nationalhospicefoundation.org
I have a pretty strong personal connection with hospice and here are some of the reasons. I am no stranger to death. The scary word that no one wants to talk about has been the most common topic talked about in my personal and professional life. My experience with death started very young with my grandfather dying. Later in the fifth grade my teacher collapsed and went in to a diabetic coma and soon after passed; she was very young. My father had a heart attack and died when I was 14. His mother could not handle losing her son and died shortly after my father. My cousin was shot and killed at 14 not long after that. I lost two close friends to suicide in high school. My youngest, at age 7 months, died in her sleep and went to be with Jesus on September 28, 2010. Six months after that my stepfather died on Hospice, the same hospice I was working for at the time. With hospice my mother called her second husband’s death a beautiful death; only hospice can provide that. So I am no stranger to death and have also been on a few different sides of hospice.

One of my messages that I share with people is this: if you have ever had a sudden death in your family who was close to you, you know how difficult it is. After the pouring in of support for a month or two, everyone gets back to their lives and you are left alone to grieve and have no REAL support for yourself or your family. When you have someone close to you that you know is going to die and they choose hospice care for the short period of life they have left, you reap the benefits and receive REAL support. Hospice provides so much for families that NO OTHER profession can. If you ever have the opportunity to choose Hospice please do so for you and your family.

—Tim L. Pape