Handling the Complex Issue of Discharge for Cause

When extraordinary circumstances impact a hospice’s ability to provide safe and effective care, the hospice may be compelled, as a last resort, to discharge a patient for cause. Ellen Green, LCSW, the senior director of counseling services for Hosparus, provides guidance on how to behave and respond skillfully, fairly and ethically.

University of PA Health System’s CLAIM Program

The University of Pennsylvania Health System has received $4.3 million from the CMS Innovation Center to test its Comprehensive Longitudinal Advanced Illness Management program. “The program will be based at Penn-Wissahickon Hospice and is an outgrowth of some of our efforts to reach patients for whom hospice is not yet appropriate,” says David Casarett, MD, MA. In this Q&A, Dr. Casarett provides details about the initiative, including some of the research that informed its development.

HMD Certification

A certification program is now being developed to help increase competencies and strengthen the knowledge base of hospice medical directors and should be ready to accept applications from physicians in late 2013. NCHPP Physician Section leader, Daniel Maison, MD, FAAHPM, explains.

A Hospice Provider’s Guide to Live Discharges

By Jennifer Kennedy, MA, BSN, RN

A patient may be discharged from hospice for any number of reasons. In many cases, a patient may improve due to the hospice’s consistent and expert care, or may be relocating outside the hospice’s service area. In other cases, the hospice may have identified safety issues or non-compliance with the plan of care. However, discharges are also occurring as the hospice landscape is changing, and more patients are coming onto hospice with non-cancer diagnoses and a less-predictable disease trajectory.

This article reviews the allowable reasons for live discharge from hospice, per the Medicare Hospice Benefit, and what hospices are required or advised to do when such action is needed.
Hospice-driven Discharges

Per the Medicare Hospice Conditions of Participation (Hospice CoPs), a hospice provider may discharge a patient for the following three reasons:

1. The patient moves out of the hospice’s service area or transfers to another hospice;
2. The hospice determines that the patient is no longer terminally ill;
3. The hospice determines (under a policy set by the hospice for the purpose of addressing discharge for cause) that the behavior of the patient (or other persons in the home) is disruptive, abusive, or uncooperative to the extent that delivery of care or ability to operate effectively is seriously impaired.

Patients who are discharged from hospice resume the Medicare Part A coverage that was waived when they elected the Medicare Hospice Benefit, and they may elect to receive hospice care at any time in the future, subject of course to their eligibility.

The Changing Face of Hospice Patients: A Closer Look

When the Medicare Hospice Benefit was created in 1983, the majority of patients receiving hospice care were those with a cancer diagnosis and lengths of stay that were predictable. As hospice care has evolved, however, more patients with end stage non-cancer diagnoses have become appropriate for hospice. A review of NHPCO’s Facts and Figures between 2006 and 2010 illustrates this continuing trend:

<table>
<thead>
<tr>
<th>Hospice Admissions</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
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<th>2010</th>
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<tr>
<td>Cancer</td>
<td>44.1%</td>
<td>41.3%</td>
<td>38.3%</td>
<td>40.1%</td>
<td>35.6%</td>
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<tr>
<td>Non-cancer</td>
<td>55.9%</td>
<td>58.7%</td>
<td>61.7%</td>
<td>59.9%</td>
<td>64.4%</td>
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Many of these non-cancer diagnoses have variable trajectories of decline that can prolong the dying process, extend lengths of stay, and make prognosis difficult for a physician. Add to this the consistent care management by the hospice interdisciplinary team, and it is not surprising that some patients, initially eligible for hospice, move into chronic care during the course of their illness.

Hospice stays of 180 days or more have captured the attention of the federal government in the last several years. Scrutiny by MACs has yielded increased clinical record reviews through the ADR process while the Affordable Care Act requires the physician face-to-face encounter for long-stay patients. This has prompted hospices to implement a process for reviewing and approving continued eligibility for patients still on service at 180 days or more, and is likely contributing to the increased occurrence of live discharges.

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We have expected for some time that quality reporting would become a requirement for hospice. And in August 2011, it became a reality.

Now, a year later, the deadlines for the first year of quality reporting are drawing near. Data collection for both required measures must begin on October 1, 2012, while data submission must be completed by January 31, 2013 for the Structural measure and April 1 for NQF 0209 (i.e., the Comfortable Dying measure).

NHPCO has long supported the use of quality measures in hospice. Quite frankly, we believe they are one of the most effective ways to demonstrate the fine work being done in programs around the country. In fact, as many members know, NQF 0209 is the Comfortable Dying measure that NHPCO helped develop and introduced in 2000—to help providers assess the quality of their care long before the federal government decided they needed to. So we were obviously pleased when it was one of two measures chosen by CMS to meet the new quality reporting requirements.

Many members, however, may not realize that our support of quality reporting extends far beyond this initial work. For example, over the past year, NHPCO has assisted CMS and its contractors with the development of training materials for NQF 0209, including the CMS Quality Reporting Webinars, the accompanying Q&A document, and the CMS User Guides that were just released a few weeks ago. This collaboration helps strengthen NHPCO’s positive working relationship with CMS while supporting an initiative that we believe will reinforce the role of hospice within the care continuum.

I recognize that the past year has been an especially challenging one, but I trust that you too have received the support you need from us—through our Quality tracks at national conferences, our 2012 Webinars, and the growing collection of resources on the NHPCO website. I know that over 2,000 members alone have availed themselves of the Webinars.

Looking ahead, please bookmark Countdown to Quality Reporting on the NHPCO website for updates and additional resources. Please also consider registering for our December 18th Webinar that will review what’s on the quality and regulatory horizon in 2013. And finally, consider attending our Clinical Team Conference in November. It will not only provide valuable updates, but a chance to network with other members who are facing the same challenges.

J. Donald Schumacher, PsyD
President/CEO
Relocation Outside Service Area

When a patient moves from the hospice provider’s service area, the provider may discharge at that time. The patient can then reelect hospice in his or her new community.

Change Request (CR) 7677, issued by CMS on February 3, 2012, updated CoP 418.26 (Discharge from Hospice Care) and opened the door a little wider for discharging a patient who has moved from a provider’s service area.

Effective July 1, 2012, providers are allowed to discharge a patient due to the patient’s unavailability or inability to receive services from the hospice that has been responsible for the patient, using the new discharge condition code 52. By way of example, this code can be used when a hospice patient moves to another part of the country; when a hospice patient leaves the area for a vacation and a travel hospice agreement is not an option; and when a hospice patient is receiving treatment for a condition (related or unrelated to the terminal illness) in a facility with which the hospice does not have a contract and is, therefore, unable to provide services.

CR 7677 also requires that providers use occurrence code 42 for patient revocations of hospice benefits. (Note that, also effective July 1, 2012, no indicator code should be used for discharge for a missed or late hospice face-to-face encounter.)

CMS issued this change request to gather information specifically on patient revocations, separately from other hospice-initiated live discharges. Doing this will help identify different patterns of hospice care and their associated costs, and help inform the analysis for future payment reform.

Additionally, CMS has concern about possible program exposure when a patient is discharged from the Medicare Hospice Benefit, has an intervening hospital stay, and then reelects the Benefit. CMS has said that knowing the reason for the discharge will help focus efforts to strengthen the Benefit’s integrity and identify the care patterns associated with more costly hospice care.
No Longer Terminally Ill
A hospice provider must discharge a patient when he or she is deemed as no longer terminally ill and, thus, ineligible for the Medicare Hospice Benefit.

Evaluation of hospice eligibility is a continuous process during the hospice service period, so the decision to discharge is not an emergency event, but one that is collaboratively reached by the hospice interdisciplinary team over a period of time, in concert with the patient and family as participants in the discussion and decision.

The determination that a patient is no longer eligible for hospice care is ultimately a physician’s decision, based on his or her medical judgment of the patient’s status. Members of the interdisciplinary team may consider titrating hospice services to determine if the patient’s lack of noticeable decline is due to consistent care management or truly because the patient’s disease state has stabilized.

When it is decided that the patient is no longer terminally ill and will be discharged, the provider must issue a minimum two-day notice to the patient of the intent...
Discharge for Cause
A provider may also discharge a patient if the behavior of the patient or other persons in the patient’s home is disruptive, abusive, or uncooperative to the extent that delivery of care or the ability of the hospice to operate effectively is seriously impaired.

Discharge for cause must be the last option that a hospice provider considers. The provider must advise the patient that a discharge for cause is being considered and document its efforts to resolve the problem(s) presented in the clinical record. For example, multiple efforts to implement a contract with the patient to resolve a behavior issue or non-compliance with the plan of care would serve as provider evidence of discharge for cause. When the decision is made by the hospice to discharge, the patient should be informed in writing and the hospice must inform its MAC and state survey agency.

Patient-driven Discharges
A patient or the patient’s representative also has the right to discontinue hospice care for any reason. Listed below, however, are two of the most common reasons and the actions required by the hospice provider.

Changing Hospice Providers
A Medicare beneficiary or his or her representative has the right to change or transfer hospice providers once in each election period—and the provider may not deny the patient’s or representative’s decision.

The patient or representative must submit a signed statement to the current hospice providing the care as well as to the newly designated hospice. The signed statement should include, at a minimum, the name of the current hospice from which the individual has received care; the name of the receiving hospice; and the date the change is to be effective.

The patient remains in the same election period, so a new notice of election statement does not have to be initiated by the receiving hospice. However, the receiving hospice should obtain any records of the face-to-face encounter and
determine whether a new face-to-face visit is required as the patient makes the transfer. The current hospice must also ensure that the final bill is listed as a transfer, rather than a discharge.

It’s also worth noting that any time there is an anticipated break in service, it may be more efficient for a provider to discuss discharge from service versus a transfer to another hospice, so the patient is free to use the Medicare Part A coverage that he or she waived when hospice care was elected.

**Revocation of the Benefit**
The decision to revoke the Medicare Hospice Benefit is also that of the patient’s or patient’s representative. A provider cannot “revoke” the patient’s Benefit at any time or pressure a patient to do so.

A patient can take this action at any time and for any reason, and may also re-elect the Benefit anytime thereafter if deemed eligible. Revoking the Benefit returns the patient to the Medicare Part A coverage that he or she waived when the Benefit was originally elected.

Medicare does not accept verbal revocations. The revocation must be in writing, stating that the patient or representative is revoking the Benefit for the remainder of the election period. It must also include the effective date of the revocation (which cannot be back-dated) and must be signed by the patient or his or her representative.

Upon revocation, a patient gives up hospice coverage for all remaining days in that election period. The hospice must then provide a copy of the discharge summary to the patient’s attending physician, with a copy of the discharge summary also remaining in the patient’s clinical record. If the patient reelects hospice in the future, he or she will be admitted to the next sequential election period.

**The Discharge Process**
Hospices must have a discharge planning policy and process in place for the patient who will be leaving its service.

Prior to discharging a patient for any of the allowable reasons, the hospice must obtain a written physician’s discharge order from the hospice medical director or hospice physician. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge, and the...
attending physician’s review and assessment should be included in the discharge documentation.

In the discharge documentation, the hospice must compose a patient discharge summary noting, at a minimum, the following:

- A summary of the patient’s stay, including treatments, symptoms and pain management;
- The patient’s current plan of care;
- The patient’s latest physician orders; and
- Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

The hospice discharge summary must be given to the patient’s attending physician if requested, with a copy also kept in the patient’s clinical record.

The hospice must also implement discharge planning for the patient and family before the patient is discharged. Depending on the frequency of live discharges at the hospice, staff may lack skill with the implementation of a discharge planning process. To ensure high-quality discharge planning, all of the actual needs and potential needs of the patient and the family should be considered and these needs should be matched with the available resources in the community. For instance, if the patient will not receive home-based services after discharge and will need transportation to receive medical and supportive services, then a transportation resource should be investigated. Optimal discharge planning provides a seamless transition to other areas of the care continuum for the patient and family.

**Discharge and the Hospice ABN and NONMC**

Issuance of the Advance Beneficiary Notice (ABN) (Form CMS-R-131) and Notice of Medicare Non-coverage (NONMC) (Form CMS-10123) are required if a hospice is discharging the patient because he or she is no longer deemed terminally ill.

If no hospice services will continue after discharge, then only the generic NONMC is issued. If hospice services are expected to continue after
discharge, then both the ABN and the NONMC are issued together. If the patient wishes to appeal the discharge decision, the hospice must issue the detailed Notice of Medicare Non-coverage (Form CMS-10124).

It is important for hospice providers to include the patient and family in the decision-making process related to discharge whenever possible. When the decision to discharge is made by the hospice medical director or hospice physician, it should be with the patient’s and family’s full knowledge. Finally, hospice providers should take time to educate their staff about quality discharge planning and become familiar with the resources available in their community to support a seamless transition to another provider.

In Summary

Live discharges in the hospice industry are occurring more frequently—and for a variety of reasons as described in this article. Discharges for cause, however, pose the greatest challenge. This issue of NewsLine also includes an article by Ellen Green, LCSW, the senior director of counseling services for Hosparus, with guidance on how best to handle these rare but difficult situations with care and compassion (see page 10).

Jennifer Kennedy is NHPCO’s regulatory and compliance director, and has worked in the hospice field for over 15 years, including 10 years as a hospice nurse and five years as a director of education, quality and compliance.

References:
Medicare Hospice Regulations, Centers for Medicare and Medicaid Services, Subpart B- 418.26, 70 FR 70546, November 22, 2005.
Ms. G is a divorced, 58-year-old woman who is dying of ovarian cancer. Her 23-year-old son (and only child), Steven, is her primary caregiver. Ms. G raised Steven single-handedly and they have always had a close relationship. She is now totally dependent on him for her care. He is reportedly a recovering drug addict. He is devoted to his mother and seems to be providing excellent care. During a routine visit on the third week of hospice care, Steven requests a medication refill prior to the expected date, and the nurse discovers missing medications. Both Ms. G and Steven deny any drug use or diversion activities. Ms. G is distraught, Steven is defensive, and the team is suspicious.
Hospice care providers aspire to behave and respond skillfully, fairly and ethically to complex situations that arise. Determining the “right thing to do” requires clear attention, wisdom and compassion. When extraordinary circumstances present a hindrance to safe and effective end-of-life care, the team must assess the best interests of the patient, family and staff as well as the community and the organization. Then, if indicated, act honorably and respectfully to discontinue hospice care. This is our responsibility and this is no easy task.

Approaching such a serious issue requires a clear understanding of organizational policies and regulations that govern and guide care and services. Both NHPCO and the Centers for Medicare and Medicaid Services (CMS) give guidance about discontinuing hospice care in such circumstances:

- In “The Discontinuation of Hospice Care: Ethical Principles for Policy and Practice,” NHPCO states that the “hospice-patient relationship is a covenant of trust and commitment. It amounts to a promise of non-abandonment, and it cannot be severed except for the most serious and compelling reasons.”

- In CFR 418.26, CMS indicates a hospice may discontinue services under certain circumstances, including when the hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the behavior of the patient (or other persons in the home) is disruptive, abusive, or uncooperative to the extent that delivery of care or ability to operate effectively is seriously impaired.

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“For cause” is a legal term defined by Webster’s New World Law Dictionary as an “action, such as the termination of a contract or a relationship of employment, that it is based on a breach, misfeasance, or other inappropriate action of the other party.” Considering this definition, the discharge of a hospice patient for cause may set up a polarizing and sensitive situation for all parties involved, with an increased likelihood for blame and negativity.

How can the hospice team transcend the potentially upsetting aspects of these situations and model compassionate service even in the midst of a “for cause” discharge?

Intentional, examined attention to a situation in which a patient or family member’s behavior is threatening the integrity of care can lead to a clear and a wise understanding that then results in skillful and compassionate action. Let me explain.

**Intentional, Examined Attention**

CMS states that before a hospice seeks to discharge a patient for cause, it must advise the patient that discharge for cause is being considered and make a serious effort to resolve the problem(s) presented by the patient’s behavior or situation. In other words, a discharge for cause should occur only as a “last resort” and should never be a surprise to a patient or family! (An exception to this could be a situation that presents a clear and immediate danger to staff and this should be determined on a case-by-case basis by the hospice organization.)

The team should facilitate a dialogue with the patient and family as soon as possible upon recognizing a serious concern. Suspending judgment, approaching the situation initially with curiosity, and listening to the patient and family’s perspective can set the tone for respect and fairness as options for resolving the problem are explored. The influence of cultural issues needs to be considered as well—in terms of expectations and behaviors. Seeking to understand what is happening and why from the patient, family and team’s perspective will be critical to developing a clear and mutually agreed-upon plan for resolution.
Clear and Wise Understanding

If the initial and mutually agreed-upon efforts to resolve the situation are unsuccessful, further exploration of factors that may influence a decision to discharge for cause must occur. Special team case conferences to address complex situations allow for more focused, intensive planning and can involve the patient and family as well as others within the organization who have the necessary expertise. An Ethics Committee consultation can provide the team with an opportunity to consider ethical principles, organizational mission and values, and professional/organizational values. Recognize that ethical considerations and values are likely to be in conflict as the team assesses and responds to such situations. For example:

- Autonomy (aka self-determination) calls for the team members to respect the individual’s right to make choices and decisions, even if those choices and decisions are in conflict with their own personal values.
- Beneficence (aka doing good) requires the team to enhance the welfare of the individual and family.
- Nonmaleficence (aka do no harm) cautions the team to avoid any intentional or negligent harm to the person.
- Justice (aka fairness) underlies the expectation that everyone is treated fairly and consistently within the framework of the existing allocation of resources.

In a team case conference or Ethics Committee consultation, it is helpful to have one person serve as a patient/family advocate and another to serve as a mediator/facilitator when values conflict and create tension. This will help to ensure that the tension is viewed and responded to in a creative and skillful manner.

Skillful and Compassionate Action

If, after all reasonable efforts have been made to resolve the problem, it is determined that hospice services cannot safely be provided, a discharge for cause may be in order. Such decisions must be applied fairly and consistently within the hospice organization and the universal hospice goal of reducing suffering at the end of life must remain the goal as the
discharge plan is put into place. However, if we are truthful and self-aware, we know this is not always easy to uphold.

We know that when our expectations are not met by others (including our patients and families), our habitual and conditioned tendencies to react unskillfully can surface. It can be easy to “blame” the patient or family member for his or her seeming unwillingness to do what is needed to continue safe care. Casting blame is often a way to soothe our own hurts and anger at a situation. But there is a difference between accountability and blame.

According to Karuna Clayton, a psychotherapist and the author of *Misleading Mind: How We Create Our Own Problems*, blame is a “destructive emotion that expresses anger, hostility and the desire to move the problem off of the self and onto anywhere else (or someone else).” On the other hand, Clayton describes accountability as an objective acknowledgement of actions—a non-emotional assessment of someone’s role in an event.

A discharge-for-cause situation should proceed, then, without blame while still creating the condition for the patient or family to own responsibility for the situation.

So a keen awareness of our own personal reactions to the behavior or situation that could not be resolved is essential to assuring a balanced perspective and blameless framework within which to approach a for-cause discharge with skill and compassion. A healthy examination of our intentions as we proceed will support a wise choice and an ethical response.

As the team proceeds with a discharge, it is important to do what can be done to assure the patient does not experience a sense of abandonment. In some situations, the patient or family will initiate the withdrawal of hospice care when the expectations are beyond their willingness or ability to meet them. Perhaps obstacles or hindrances cannot be overcome or they may feel trapped in a particular situation. In those cases, the team should assist the family in the revocation process that includes information about alternative resources and supports.
In the case of a discharge for cause, of course, the proper procedure must be followed according to agency policy, payer source and regulatory requirements. For instance, if a patient is being discharged due to safety, and efforts have been unsuccessful in resolving issues, some states require that the state survey agency be notified.

The hospice provider is also expected and required to develop a discharge plan that includes appropriate referral information to other supportive services. Whether the situation ends in discharge, revocation, or continued care, the team will also need to determine the need to refer and report to any state protective services authority. Complete and clear documentation in the patient’s medical record should reflect all efforts to resolve the issues, as well as the final plan for discharge. (This month’s cover story also discusses some of these requirements.)

As the team members have their last communication with the patient about the discharge, they may include information about eligibility for readmission. Consider, for example, the case of Ms. G that was presented at the beginning of this article. It was determined that she was the one with the addiction problem which eventually led to discharge for cause. However, Ms. G may request readmission when her condition is such that she can no longer access drugs illegally and/or is moved to a supervised setting.

**In Summary**

The team’s ability to approach the discharge with calmness, a non-judgmental attitude, truthfulness, clarity, helpfulness and kindness will provide a positive experience in the worst of circumstances. Leaving the patient and family with a sense of respect and hope at the time of a discharge for cause can be the team’s final gift of compassion to a patient and family living in a complex and difficult situation. Whether spoken or held privately, the team’s closing thoughts for the patient and family’s well-being and reduced suffering leaves the heart open for continued service.

For the past 14 years, Ellen Green has served in a variety of leadership roles at Hosparus in Louisville, KY. In her current role as senior director of counseling services, she is responsible for the psychosocial, spiritual and grief counseling and support services offered to the communities served by Hosparus. Ellen also serves on the NCHPP Social Work Section Steering Committee.
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.
This past June, the CMS Innovation Center announced that 81 additional organizations are receiving Health Care Innovation Awards, made possible through the Affordable Care Act. The goal of these awards is to support projects nationwide that are designed to deliver high-quality medical care, enhance the health care workforce, and save money.

Among the award recipients is the Trustees of the University of Pennsylvania, which is receiving roughly $4.3 million over a three-year period to test a “Comprehensive Longitudinal Advanced Illness Management” (CLAIM) program.

The CLAIM program will evaluate a comprehensive set of home care services for Medicare and/or Medicaid beneficiaries with advanced cancer who are receiving skilled home care and have substantial palliative care needs—but are not yet eligible for hospice. It will serve five counties in the metropolitan Philadelphia area and, per University estimates, will train roughly 64 workers and create 16 new jobs for home health aides, social workers, and licensed practical nurses.

“The program will be based at Penn-Wissahickon Hospice, which is part of the University of Pennsylvania Health System,” says David Casarett, MD, MA, an associate professor of medicine at the University of Pennsylvania Perelman School of Medicine and chief medical officer for hospice and palliative care. “It’s an outgrowth of some of the hospice’s efforts to reach patients for whom hospice is not yet appropriate.”

In the following interview, Dr. Casarett discusses the new program, elaborating on the goals and implementation plans.

**What are the CLAIM program’s overarching goals?**
CLAIM’s overarching goals are to improve the care that patients with advanced cancer receive, while controlling costs by avoiding unnecessary hospitalizations. CLAIM will do this through careful attention to pain and other symptoms, and intensive care coordination.
What services will be provided to this cancer population?
CLAIM is built on a foundation of the Medicare Skilled Home Care Benefit, so all of our patients will receive care from visiting nurses. One difference, though, is that our nurses will all be cross-trained as hospice nurses, and will have experience in goals discussions and symptom management. In addition, we’re offering CLAIM patients a 24-hour triage line for crisis management, as well as nurse case management, a social worker, a chaplain, a pharmacist, and a home health aide.

Why did you decide to focus on this population?
There were two reasons. First, this is the logical extension of years of research that our group has been doing with patients who have advanced cancer. That research has described the hospice decision-making process, and has found that a focus on comfort care can be a substantial barrier for patients with cancer. In that research, we’ve also used techniques of preference assessment—really a form of marketing research—to figure out what hospice care should look like. In a series of interviews funded by a grant from the National Cancer Institute, we identified services that patients with cancer, and their families, say they need. We used those preferences to guide the development of CLAIM, ensuring that CLAIM’s services are truly patient-centered.

Second, in selecting the CLAIM population, we looked carefully at where the opportunities to make a difference were greatest. We saw that many patients with advanced cancer were being admitted to the hospital 10 times or more in the last year of life. We also knew that many of these patients would prefer to stay at home if possible. CLAIM is designed to help those patients avoid the hospital if they can, resulting in better quality of life, and better care overall.

Can you elaborate on some of the other research that informed CLAIM’s development?
CLAIM is based on a series of studies designed to understand some of the barriers to hospice enrollment among patients with cancer—and determine what the Medicare Hospice Benefit might look like if patients and families were given a role in its design. At the heart of that research were the patient and family interviews I mentioned earlier, which were funded by the National Cancer Institute.

This series of studies used a method called “conjoint analysis” to assess patients’ and families’ preferences about a range of home care services, such as a visiting nurse, transportation, a counselor, and meal delivery. Conjoint analysis gets its name from the process by which preferences are assessed. Unlike typical surveys that ask people to rate the importance of something, conjoint analysis presents people with choices among various combinations. In this case, we used groups of services. So our patients and families considered various combinations of services, and selected the ones that they needed most. Then we used those choices to determine which services were most important to people.

What we found was very interesting. First, many patients and families had needs for services that no one else had recognized. People told us they needed a visiting nurse to help with pain, for instance, when no one—not even their oncologist—knew they had pain. Second, we were surprised by the services
that were important to people. Although a nurse, chaplain and social worker were valued, people also said they needed services such as transportation to and from appointments, help with meals, and care for dependents, either children or parents.

**In addition to the stated benefits, do you expect that services will improve access?**

We expect that CLAIM will improve access to care in at least two ways. First, we know from our previous research that hospice’s focus on comfort [versus life-sustaining treatment] can be a significant barrier for African Americans. Because CLAIM offers many hospice services without the required focus on comfort care, we expect that African Americans will be among those most likely to benefit. Second, reluctance to enroll in hospice is certainly not limited to African Americans. Many patients delay enrolling in hospice, or avoid enrolling altogether, because they want to continue receiving aggressive or expensive treatments that hospices don’t routinely provide. These patients can all benefit from CLAIM services when hospice is not yet appropriate.

**Will Penn-Wissahickon Hospice be collaborating with other divisions of the University of Pennsylvania Health System on implementation?**

CLAIM is an ambitious collaboration that extends across Penn’s health system. Some of our key partners include the three Penn hospitals, the Abramson Cancer Center, and Penn’s home care and home infusion agencies. We worked very closely with all of these partners to make sure that our recruitment targets are reasonable and, more importantly, to make sure that we are offering services that will meet their patients’ needs.

**Can you briefly discuss its implementation—what you expect to accomplish in years one, two and three?**

CLAIM’s targets for recruitment, provision of services, and cost savings are ambitious. We set a high bar in planning for implementation, and we expect to be very, very busy in the next three years. One of the overall aims of this initiative is training and jobs creation, so hiring will be an important goal in the first year. However, we won’t wait until hiring is complete to begin serving patients. Midway through the first year, in fact, we expect to be close to our capacity. We’ll

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Many patients had needs for services that no one else had recognized.
maintain that pace throughout the three-year project, continuing to enroll patients as long as funding continues.

What are some of the challenges you expect to face? Our timeline for recruiting and training new staff is going to be particularly challenging. We’ll need to find, recruit and train a large cohort of talented people very quickly. That won’t be easy, because we’ll be looking for dedicated, talented people who can help make CLAIM a success.

But the biggest challenge we’ll face is demonstrating enough of a benefit (in terms of quality improvement and cost savings) to make CLAIM sustainable. We’ll need to be very careful that we measure and document CLAIM’s benefits to patients, and savings to insurers. Without evidence to support better quality and lower costs, CLAIM will fall by the wayside as a failed experiment.

Do you think it will be a replicable model? Even for those hospices which are not part of a large health system? CLAIM could be a model for any organization, whether or not it’s part of a large health system. I’m a firm believer that it’s always good strategy to provide innovative, high-quality care, and that’s what CLAIM is all about. Having said that, though, some of the most significant advantages of CLAIM will be apparent to hospice organizations that have close relationships with hospitals and health care systems. Particularly as health care financing moves toward Accountable Care Organizations and bundled payments, hospitals and health care systems will experience increasing incentives to be responsible for the quality of care their patients receive not just in the hospital, but also at home. They’ll also need to find creative ways to avoid unnecessary hospitalizations. If CLAIM can accomplish its goals of improving quality while avoiding unnecessary hospital visits, it will have benefits that could be replicated widely.

As a hospice physician and researcher, what excites you most about the program? Early in my career, much of my work focused on understanding and improving the way that patients and families make difficult decisions about hospice enrollment. I began to realize, though, that although efforts to improve hospice decision-making are important, that line of research was missing the larger picture. The problem is not that the decision-making process is not as smooth as it could be, but rather, the decision we ask patients and families to make is illogical. Why should patients embrace a plan of comfort care in order to obtain access to hospice services? There’s no medical reason for this. In fact, our research has found that patients with cancer who want aggressive treatment actually have greater needs for hospice services than do patients who are willing to accept comfort care.

Furthermore, the requirement that patients give up some treatment to receive services is unprecedented in our health system. Do we ask patients to give up their cholesterol drug in order to receive a blood pressure medicine? Patients should have access to treatments and services that they need, and which are medically indicated.

So, for me, CLAIM is the culmination of this line of thinking. It’s a chance to ask what hospice services might look like if they are designed with patients’ preferences in
mind. Most importantly, it’s a chance to see if those services can produce outcomes that will get the attention of insurers and policymakers.

**Any final thoughts?**
The writer William Gibson once said, “The future is here today. It’s just not evenly distributed.” What he meant, I think, is that somewhere, someone has an idea that we’ll all accept as obvious 10 or 20 years from now. Eventually that idea will gain traction, if we wait long enough. But things are changing too fast in the hospice industry—we can’t afford to wait. We need to be exploring new ideas and testing the limits of what’s possible.

While I’m obviously excited about CLAIM and what it might accomplish, it’s important to keep in mind that CLAIM is just one innovative approach to providing high-quality compassionate care to patients with advanced disease. There are other ideas out there, and perhaps there are better approaches.

In fact, it was Gibson’s quote that inspired the partnership, **CHOICE**. It stands for the “Coalition of Hospices Organized to Investigate Comparative Effectiveness” which I helped form with hospice researchers, Laura Hanson and Joan Teno. With support from the software company, Suncoast Solutions, CHOICE aims to identify best practices and effective strategies. Using funding from the National Institutes of Health, the American Cancer Society, the Commonwealth Fund, and Suncoast Solutions, we’re looking for successes today that can tell us what the future will be tomorrow.
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 Physician Section, and an article by Daniel Maison....
Hospice medical directors may be stymied at times by the myriad of administrative duties they face. Whether the patient census is 50 per day or ranges into the thousands, whether the hospice is a small independent organization or a multi-site program connected with a hospital system, the hospice medical director is a key partner with the hospice administrators in ensuring high-quality patient care as well as adherence to local, state and national regulatory standards. In this era of increased scrutiny and accountability, every hospice program needs to attend carefully to operational details. At the same time, however, the hospice medical director may have little preparation for these important responsibilities.

Fortunately, a certification program is now being developed to help increase competencies and strengthen the knowledge base of hospice medical directors and this program will be ready to accept applications from physicians in late 2013. But why a certification program?

Professional certification of a specialized skill set affirms a knowledge and experience base for practitioners in a particular field, be they software engineers, counselors or physicians. It signifies to employers and the public-at-large that the professional is competent, committed to career development, and dedicated to customer service and patient care. The professional standards inherent to a certification process also assures regulators and consumers of consistency across the spectrum of practitioners who work in that given field.

This article discusses the new certification program, including what led to its development, its overarching goals, and the individuals charged with implementation.
**First, Some Background**

With the formation of the American Board of Hospice and Palliative Medicine in the mid-1990s, the groundwork was laid to achieve recognition for the practice of hospice and palliative medicine in the U.S. by certification and accrediting bodies. Then in 2006, three watershed actions paved the way for hospice and palliative care to be integrated into mainstream medicine:

- The Accreditation Council for Graduate Medical Education (ACGME) voted to approve an accreditation process for hospice and palliative medicine fellowship training programs.
- The American Board of Medical Specialties (ABMS) voted on the recognition of hospice and palliative medicine as a subspecialty—sponsored by an unprecedented 10 specialties.
- Four primary boards of the American Osteopathic Association (AOA) sponsored that organization’s recognition of the subspecialty.

Over the past six years, hospice and palliative medicine fellowship training programs have been established across the country, with 95 now in operation. Many physicians have successfully completed the intensive 12-month fellowship curriculum and have become board certified. Hundreds of physicians already working in the field also took advantage of a five-year grandfathering period—confirmed by ABMS and AOA—that was created to help build the workforce. This opportunity, which ends in 2013, offers a direct pathway to subspecialty certification for qualified practicing physicians without having to complete a fellowship.

In addition to the certification process for hospice and palliative medicine specialists, recognition of both specialist- and generalist-level palliative care practice in other disciplines has grown over the past decade, including specialist credentials for nurses and social workers. These credentialing programs validate competency levels of health care
professionals who choose to specialize in providing palliative and hospice care. However, there are no recognized, demonstrable competencies or credentials specifically for those who fill the role of hospice medical director and no credentialing system that is consistent with this specialist level of care.

**Development of the New Certification**

It is within this environment that the American Academy of Hospice and Palliative Medicine (AAHPM) and other organizations began discussing the viability and need for a certification program for hospice medical directors, one that would be a stand-alone certification to complement the hospice and palliative medicine specialty board certification.

Hospice medical directors are a diverse group of professionals, many of whom have followed varied career paths leading to their affiliation with hospice programs. Thus, some may be unable or choose not to undertake full hospice and palliative medicine specialty board certification. These same physicians, however, do desire a formal recognition process that will validate their commitment and provide a solid foundation for their work as hospice medical directors. “Having a mechanism whereby I could attain certification as a hospice medical director is a great opportunity for someone like me for whom the path to board certification is not an option. It would serve to validate my competency,” notes Bernice Burkarth, MD, chief medical officer and vice president of Treasure Coast Hospice in Stuart, Florida and a member of the NCHPP Physician Section Steering Committee.

The HMD certification is, in fact, distinct from the ABMS and AOA specialty certifications, which are designed for physicians who wish to become subspecialists and pursue a long-term career as a clinician or academician in palliative medicine. The added HMD certification for a specific role can enhance the work of the hospice and palliative medicine specialist who chooses to become a hospice medical director. The knowledge base and competencies required of a hospice medical director include a unique subset of hospice and palliative medicine that may not be covered fully in broader training in the field.

**New Certification Highlights**

The HMD certification program will provide the tools to help hospice physicians and medical directors better handle their leadership positions and be more effective partners with hospice administrators. In essence, it will:

- Define and uphold standards for competent practice for this specific role.
- Address the core roles and administrative, regulatory, legal, and ethical responsibilities of the hospice physician.
- Serve as a verification of the mastery of a minimum level of competence in the skills and knowledge required by the hospice physician.
- Improve the quality and consistency of the practice within hospice and palliative medicine and the care provided by local hospices.

The program’s core elements will focus on the administrative, leadership, and regulatory skills necessary for the functioning of both the interdisciplinary team and the responsible hospice program.
One of its key aims is to promote consistency in quality and practice among those physicians in hospice and palliative medicine. The valid and professional standards set for hospice medical directors through this certification program will help to ensure uniformity. Furthermore, it is expected that by enhancing the credibility of practicing hospice physicians through this new certification—by recognizing their education, knowledge, and professional expertise—the practitioners may be able to take on additional responsibilities and/or train other physicians. Individual hospice programs will likely benefit from a more effective and efficient medical workforce.

Since many hospice medical directors are working part time in small or medium-sized hospice programs and have minimal background in palliative medicine or little knowledge of the governance and operational responsibilities that are a mandated part of this role, the HMD certification will be particularly valuable to them.

**Governance and Timeline**

To ensure autonomy in decision making regarding essential certification activities, an independent nonprofit organization—Hospice Medical Director Certification Board (HMDCB)—has been established to administer and oversee the HMD certification program. Establishing this firewall that is separate from membership organizations within the field also reduces liability and eliminates the conflicts of interest that could occur if AAHPM or NHPCO were to generate the educational or preparatory materials for prospective candidates.

In 2012, startup funding was provided by the AAHPM board of directors, which also appointed the organizing voluntary board, chaired by Gail Austin Cooney, MD FAAHPM. “HMDCB represents the fulfillment of my longstanding dream,” she says. “It will improve the care we all deliver to terminally ill patients and their families by encouraging hospice medical directors to seek expanded knowledge and skills.”

The new certification board is staffed by executive director, Sally Weir, who is the former director of operations for AAHPM. As she guides the certification process through its infancy to full maturity, she will draw on her experience leading other governance and certification initiatives.

The organizing voluntary board is composed of individuals who took differing pathways toward their current hospice affiliation, to continued on next page
better reflect the diverse group of hospice medical directors across the country whom they are representing. Each of the seven board members, listed below, have demonstrated leadership and earned recognition within the field:

**Chairperson**
Gail Austin Cooney, MD, FAAHPM
Hospice of Palm Beach County

**Treasurer**
David M. McGrew, MD, FAAHPM
Hospice & Palliative Physician Services

**Members at Large**
Kimberly A. Bower, MD
Institute for Palliative Medicine at San Diego Hospice
Bruce H. Chamberlain, MD, FACP, FAAHPM,
Palliative Consulting
John H. Manfredonia, DO, FACOFP, FAAHPM
Gentiva Health Service/Hospice Division
Brian Murphy, MD, MBA
Nathan Adelson Hospice
Tanya Stewart, MD, FAAHPM
Evercare Oregon

HMDCB began the process of incorporating as a nonprofit organization and creating a governance structure in early 2012, and is now collaborating with a testing company that will guide the development of the certification process.

Conducting a job analysis survey of hospice medical directors currently practicing will be the first step to verifying the competency and assessment recommendations made by the AAHPM Medical Director Education Committee, which spearheaded the initiative under the direction of Russell K. Portenoy, MD.

This first step will provide valuable data about the knowledge, skills, abilities, and tasks performed by hospice medical directors. Once the competencies (i.e., roles and responsibilities) are verified through this process, a content outline for the certification examination will be created. HMDCB then will draw on the expertise of hospice professionals nationwide to help draft items for the examination and to contribute in other ways to the development of the program. The goal is to begin certifying hospice medical directors in early 2014.

With the advent of a certification process for hospice medical directors, the administrative and regulatory challenges can become more manageable. Ideally, we will also see improvements in the quality and consistency of the practice within hospice and palliative medicine and in the care provided by local hospices. Ultimately, access to hospice as a compassionate end-of-life care option will be fostered, and our patients and their families will have increased confidence in the quality of care available to them through their local hospice program, whether in rural America or the hundreds of suburbs or major cities across the country.

Daniel Maison is the medical director for the Palliative Care Program at Spectrum Health, based in Grand Rapids, MI, as well as the Physician Section leader for NHPCO’s National Council of Hospice and Palliative Professionals. He is board certified in both internal medicine and hospice and palliative care, and is a Fellow of the American Academy of Hospice and Palliative Medicine. Dr. Maison also presents frequently at NHPCO’s national conferences.

The author extends special thanks to Sally Weir, executive director of the Hospice Medical Director Certification Board, for her assistance with this article.
One of the best ways to exchange ideas and tips with your colleagues is through the NCHPP Physician 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).
The Situation

Mr. B is a 65-year-old widower who is suffering from end-stage cardiac disease. He has been a patient of XYZ Hospice in southern Arizona for the past nine months, receiving the care from his residence at an assisted living facility.

His condition suddenly worsened last night and the facility staff rushed him to the hospital in respiratory distress (EF of <15%). He is exhibiting severe congestion, low blood pressure, non-responsiveness and mottling in his lower extremities. He appears to be actively dying.

Rather than intubate Mr. B., the intensivist would prefer to make him comfortable and return him to his home at the assisted living facility. His two adult children, on the other hand, want “everything” done to save him.

If the parties involved cannot arrive at consensus within the next hour, Mr. B will need intubation followed by a “full court press.”

The Patient’s Preferences

Mr. B does not have the capacity to make medical decisions at this time. When he was admitted to XYZ Hospice nine months ago, he was alert and oriented, and chose to sign a DNAR; however, he did not complete a living will or a health care power of attorney form.

Some Background

Maureen lives nearby and visits her father on a weekly basis. Being a LCSW herself, she has become friendly with Anne, the social worker at the hospice. Mr. B’s son, Kevin, lives on the East coast, but is very involved in his father’s life and speaks with Maureen frequently to keep abreast of changes. Kevin also travels to Arizona at least four times a year to visit his father. Mr. B loves the visits with both children—and cherishes time with his three grandchildren.

Recommendations

There is no doubt to the clinicians involved in this case that Mr. B is actively dying. The only people who feel more treatment is required are his two children.

The Ethics Committee recommends that the hospice social worker hold a family meeting with his two children and...
the hospital’s intensivist to explain that Mr. B made an autonomous decision when he opted for hospice nine months ago. (Since Maureen has developed a relationship with the hospice social worker, the Ethics Committee thinks it would be prudent to include her in the family meeting.)

The social worker should clarify that Medicare required a probable terminal prognosis of six months or less at the time Mr. B elected hospice and, after full disclosure about hospice care, Mr. B chose to sign a DNAR. The intensivist should discuss how unlikely it is that Mr. B would survive CPR and that the team has done everything medically possible. In addition, he might wish to discuss beneficence and non-maleficence which are in concert with Mr. B’s choice for DNAR. The social worker, together with the physician, should assure the children that by allowing Mr. B to return to his home, they will be allowing him a comfortable, natural and peaceful death.

Providing this information will help the children understand the gravity of the situation—and hopefully get them to recognize that their father actually made his decision nine months ago when he elected hospice care. More than anything else, they need to be heard and listened to. They are still grieving the death of their mother and are experiencing anticipatory grief for the loss of their father.

An appropriate course of action might be for the hospice social worker to follow up with the hospice bereavement staff to ensure the family is provided support during and after Mr. B’s death.

In addition, the Ethics Committee also suggests a palliative care consult so that Mr. B’s return to hospice can be facilitated quickly.

**Addendum**

The family meeting went very well. The children were accepting of the situation and actually said they knew their dad didn’t want his life extended by any means and that they overreacted because he had been stable for so long. They also said their mother and father were Catholic and believed would be together again when their father died.

The palliative care nurse called a priest for the Sacrament of the Sick and Mr. B returned home within four hours. He died peacefully within three days, surrounded by his children and grandchildren.
Hospice care may provide the last opportunity to honor Veterans for their service to our country. And the simple acts of gratitude that we extend to these patients can make up for a lack of appreciation or recognition during their lifetime.

Many hospice providers already honor the Veterans under their care. For those which do not, or those looking for new ways to express their appreciation, the We Honor Veterans website is a great resource. With Veterans Day now around the corner—on Sunday, November 11—be sure to visit the website for guidance and ideas. Here’s a sample of what you’ll find.

Memorials and Salutes for Veterans and Caregivers
This PowerPoint was produced by the VA and speaks to the value of salutes, memorials and pinning services, with tips and considerations when planning an event.

Veteran Pinning Ceremony
This one-page tip sheet discusses the two primary types of ceremonies and the protocol for conducting them.

Military Service History Pocket Card
This is a fact sheet that includes sample questions to help staff engage Veterans—and encourage them to share their experience.

Veteran Appreciation/Recognition Certificates
Six template certificates are provided in this PowerPoint file, each for a different branch of service, so you can add the patient’s name to the appropriate version, and print and frame it for presentation.

Gifts for Veterans
NHPCO’s Marketplace offers a range of small gifts for purchase, including Veteran/Volunteer acknowledgment cards, lapel pins and books.

For more resources, visit the “Exchange Ideas and Tips” section of the We Honor Veterans website.

To learn more about becoming a We Honor Veterans Partner, see “Enroll Your Hospice.”

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The second edition features a thoroughly current guide to clinical processes and symptom management, providing hospice professionals with a concise summary of changes that have influenced clinical practice over the last several years. Moreover, each chapter now concludes with a list of recommended readings, culled from the complete literature searches were done for each symptom complex.

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Oxford American Handbook of Hospice and Palliative Medicine
Edited by SRIRAM YENNURAJALINGAM and EDUARDO BRUERA
This handbook provides an easily navigable source of information about the day-to-day management of patients requiring palliative and hospice care. Succinct, evidence-based, topically focused content is supplemented by extensive tables and algorithms.

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Ronda Macchello Appointed Medical Director of Pathways Home Health & Hospice

Pathways Home Health & Hospice, based in Sunnyvale, CA, has appointed Ronda Macchello, MD, as medical director.

Macchello brings over 22 years of experience as a practicing physician to this position, including specific expertise in pain management. She was also recently ordained as an interfaith minister, and has completed a program in spiritual and psychological counseling for clinical professionals at the Metta Institute.

James Avery Named CEO of Hospice of the Piedmont

James Avery, MD, CMD, FACP, FCCP, FAAHPM, has been named CEO of Hospice of the Piedmont, based in Charlottesville, VA.

Most recently, Avery was senior vice president/CMO of Golden Living, a nationwide senior care company that provides nursing home care, rehabilitation, hospice, home health care, and pharmacy services.

Great Lakes Caring Names New Vice President of Michigan Hospice Operations

Great Lakes Caring, based in Jackson, MI, has named Trisha Crissman vice president of hospice for its nine Michigan branches.

Crissman has over 20 years of experience in direct patient care, clinical services, and hospice and home care management. Most recently, she was responsible for 16 agencies in Wisconsin, Illinois and Iowa as a regional director of operations for Heartland Home Care and I.V. Care.

Samira Beckwith Receives Honorary Doctorate From Southwest Florida College

Samira K. Beckwith, president/CEO of Hope HealthCare Services, based in Fort Myers, FL, received a Doctor of Humane Letters when she delivered the commencement speech during Southwest Florida College’s recent graduation ceremonies.

“Samira is the quintessential professional...very innovative, forward-thinking, bright, articulate, compassionate and caring. She is worthy of the highest recognition we could bestow,” said Dr. Stephen Calabro, president of Southwest Florida College.
Hospice By the Sea Honors its CNAs

Hospice by the Sea, Inc., based in Boca Raton, FL, honored the work of its 90 CNAs during a “Peer Recognition” ceremony held in June during National Nursing Assistants Week.

The event recognized all CNAs to acknowledge their integral part on the organization’s multidisciplinary team, with seven of the staff selected by their peers for special recognition—Leone Derilu; Fallieres Paris; Marie F. Pierre; Viergenie Aime; Sara Scott; Serge Lucien; and Coleen Taylor.

HCI Care Services Volunteer Coordinator Enjoys an Unexpected Exchange

On August 14, President Obama made a surprise stop in Knoxville, Iowa, while on the road from Des Moines to Oskaloosa. That stop included a break at a coffee shop on East Main Street—next to one of the offices of HCI Care Services. Among the 25 residents who gathered outside the coffee shop was volunteer coordinator, Rosy Harrington. In addition to this commemorative photo snapped by a colleague, she also received a word of thanks from the President himself, who mentioned how appreciative he was when hospice cared for his grandmother.

Hospice Chef From the UK Selected as Olympic Torchbearer

David Taylor is a hospice chef at St. Oswald’s Hospice in Newcastle, England. When not preparing meals for the patients of St. Oswald’s, Taylor raises money for local families and, taking inspiration from the patients and families he meets, has completed many grueling challenges—including running three marathons in 2010 alone! In recognition of his service, he was selected to carry the Olympic torch through nearby Morpeth during the Summer Olympics. Kudos to Taylor for his dedication, commitment—and enthusiasm!.

NCHPP Welcomes New Social Worker Section Leader

NHPCO’s National Council of Hospice and Palliative Professionals (NCHPP) welcomes Sandy Jones-McClintic, LCSW, ACHP-SW, as the new Social Worker Section leader, succeeding Sherri Weisenfluh, who served as the Section leader since 2006. Jones-McClintic has worked in hospice since 2000 and is currently a direct practice social worker at an inpatient unit with Hospice of Arizona.
Nurse practitioners (NP) are becoming a welcome addition to a hospice team these days, but they have limitations in their role. If chosen by the patient, the NP can serve as a patient’s attending physician regardless of whether he or she is a direct hospice employee or a community NP. The extent of the NP’s authority to sign orders is determined by individual state Nurse Practice Acts.

NPs can also complete hospice physician face-to-face encounters which provides the hospice organization with additional options for staffing this requirement. The NP must be an employee of the hospice to complete a face-to-face encounter, or if the hospice is part of a larger health system, the NP can be an employee of the health system.

However, an NP may not certify or recertify a patient’s terminal illness as this is deemed a physician-only function. Also, an NP may not serve to replace the physician in the interdisciplinary group. This means that an NP cannot substitute for a physician during an interdisciplinary group meeting.

Finally, NPs may only bill Medicare for symptom management if they are the patient’s chosen attending physician. If an NP completes a face-to-face encounter and provides symptom management to the patient as a portion of the visit, Medicare billing for that portion can only occur if he or she is the patient’s chosen attending physician.

**Related Resources:**

NHPCO’s Regulatory and Compliance Center includes information and helpful links on billing for nurse practitioner services. Bookmark the resource for future reference.
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with Therese A. Rando, PhD, BCETS, BCBT

General Plenary II
Hospice and Palliative Care — Simply the Best
with Ira Byock, MD and J. Donald Schumacher, PsyD

Closing Plenary
Shed or You’re Dead: How to Stay Alive and Thrive in the Midst of Turbulent Healthcare Change
with Kathy B. Dempsey

Learn more and register at www.nhpco.org/CTC2012
On June 13, two NHPCO members—Karren Weichert, the president/CEO of Midland Care Connection, and Gail Austin Cooney, the associate medical director of Hospice of Palm Beach County—joined several members of the end-of-life care community to provide testimony before the Senate Special Committee on Aging on “Empowering Patients and Honoring Individual’s Choices: Lessons in Improving Care for Individuals with Advanced Illness.”

Their testimony is now available online, as part of an archived Webinar—watch it now. (To hear their individual testimonies, scroll to about the 51-minute mark. Karren’s testimony follows Gail’s.)

Links to Some Resources on the NHPCO Website

Quality and Regulatory
Quality Reporting Requirements
QAPI Resources
Regulatory Center Home Page
Past Regulatory Alerts
Past Regulatory Roundups
Hospice Compliance Calendar
Staffing Guidelines
Standards of Practice
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