HPCO released the 2012 edition of NHPCO Facts and Figures: Hospice Care in America (Facts and Figures) this past November. Through an easy-to-read narrative and 20-plus supporting tables, this annual report offers a national-level snapshot of utilization, patient and provider demographics, and payer sources during 2011.

As many of you know, the report’s findings are valued—and used—by a variety of sources, including the media, hospice advocates, and government agencies such as CMS. The data are also vital to our ongoing dialog on Capitol Hill. The NHPCO Hospice Action Network (HAN) makes certain the newest report is put into the hands of every Congressional health aide as soon as it comes out, but the HAN team also creates one-page fact sheets for Hill staffers, with select data points that correspond with the hot issues.

In this article, NewsLine has compiled some of the findings from the last six editions to give members a broader view of hospice care’s continuing evolution.

continued on next page
Hospice Utilization

More People Continue to be Served

As shown in Table 1, 1.65 million patients were served by hospice in 2011—up 70,000 from 2010. Included in this number are patients who died; patients who remained on the hospice census since admission during the year before (i.e., carryovers); and patients who were discharged alive.

Some Decline in Median LOS

Median length of service (LOS) is considered to be the more meaningful measure for understanding the experience of the typical patient since it is not influenced by outliers (i.e., extreme values).

As shown in Table 2, it was 19.1 days in 2011—the lowest it’s been in the past six years. While late referrals are certainly a factor, disease course and access to care are also contributing factors.

Where Patients are Receiving Their Final Care

As shown in Table 3, the settings in which patients received their final care have varied from year to year, with one exception—the hospice inpatient facility. Here, the percentage of patients served has steadily increased from 17 percent in 2006 to 26.1 percent in 2011. In part, this may be due to hospice’s changing population—a predominantly older one with co-morbid and more medically complex conditions.

continued on page 4
It’s often said that March comes in like a lion and out like a lamb. That is not likely to be the case for hospice providers in 2013.

As NHPCO recently shared in our GAR Update, in my February video message, and in a February Regulatory Alert (2/12/13), what makes this March different are the federal spending cuts, known as Sequestration, that (as we go to press), we expect will go into effect.

For those who might have missed some of this discussion on Sequestration, let me reiterate a few key points:

- Back in January, Congress took action to avoid the fiscal cliff, but that only provided short-term relief.
- We expect the Sequestration cuts to go into effect on March 1; these mandatory 2-percent cuts will impact almost every aspect of the federal budget. (For Medicare providers, the 2-percent cut begins with services provided on or after April 1, 2013—see below.)

What this means for hospice providers billing under Medicare:

- Hospices will continue to bill at the FY2013 rates.
- **For services provided on or after April 1, 2013**, MACs will deduct 2 percent from the reimbursement before paying the claim. Hospices should NOT bill at the 98-percent rate.
- These Sequestration cuts will continue for 10 years, unless there is Congressional action to discontinue them.

Based on comments coming out of Capitol Hill, Congress will be looking at the impact of Sequestration in late summer. Because there is no way to forecast the outcome, NHPCO stresses the importance for all providers to prepare for the future in a fiscally prudent manner.

Let me assure you that NHPCO and the Hospice Action Network (HAN) are strategically planning how to advocate for hospice and protect the high-quality care provided to patients and families.

The HAN Advocacy Intensive, July 29 and 30 in Washington, DC, will come at a significant time in the Congressional budget discussions. I hope you’ll consider joining us and help carry the voice of the hospice community to our Congressional leaders.

J. Donald Schumacher, PsyD
President/CEO
The Faces Behind the Numbers

Tables 4 through 7 provide a snapshot of the patients being served by hospice. Of note:

- More than half of patients are female
- More than one-third of patients are 85 years of age or older
- Whites/Caucasians still outpace other ethnicities in utilization of services
- “Debility unspecified” now leads the list of non-cancer diagnoses, followed by dementia, heart disease, and lung disease.

Table 4: Patients by Gender

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>55.6%</td>
<td>53.9%</td>
<td>56.6%</td>
<td>53.8%</td>
<td>56.1%</td>
<td>56.4%</td>
</tr>
<tr>
<td>Male</td>
<td>44.4%</td>
<td>46.1%</td>
<td>43.4%</td>
<td>46.2%</td>
<td>43.9%</td>
<td>43.6%</td>
</tr>
</tbody>
</table>

Table 5: Patients by Age

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>34 and Younger</td>
<td>.9%</td>
<td>.9%</td>
<td>.9%</td>
<td>.8%</td>
<td>.13%</td>
<td>.8%</td>
</tr>
<tr>
<td>35 to 64</td>
<td>17.3%</td>
<td>16.5%</td>
<td>15.9%</td>
<td>16.3%</td>
<td>16.1%</td>
<td>16.0%</td>
</tr>
<tr>
<td>65 to 74</td>
<td>17.1%</td>
<td>16.2%</td>
<td>16.2%</td>
<td>16.3%</td>
<td>15.9%</td>
<td>16.3%</td>
</tr>
<tr>
<td>75 to 84</td>
<td>31.4%</td>
<td>30.0%</td>
<td>29.2%</td>
<td>28.7%</td>
<td>27.9%</td>
<td>27.6%</td>
</tr>
<tr>
<td>85 and Older</td>
<td>33.2%</td>
<td>36.6%</td>
<td>37.8%</td>
<td>38.0%</td>
<td>38.9%</td>
<td>39.3%</td>
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</tbody>
</table>

Table 6: Patients by Race

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>80.9%</td>
<td>81.3%</td>
<td>81.9%</td>
<td>80.5%</td>
<td>77.3%</td>
<td>82.8%</td>
</tr>
<tr>
<td>Multiracial or Other Race</td>
<td>8.8%</td>
<td>7.8%</td>
<td>9.5%</td>
<td>8.7%</td>
<td>11.0%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>8.2%</td>
<td>9.0%</td>
<td>7.2%</td>
<td>8.7%</td>
<td>8.9%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Asian, Hawaiian, Other Pacific Islander</td>
<td>1.8%</td>
<td>1.6%</td>
<td>1.1%</td>
<td>1.9%</td>
<td>2.5%</td>
<td>2.4%</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>.3%</td>
<td>.3%</td>
<td>.3%</td>
<td>.2%</td>
<td>.3%</td>
<td>.2%</td>
</tr>
</tbody>
</table>

Table 7: Admissions by Primary Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>44.1%</td>
<td>41.3%</td>
<td>38.3%</td>
<td>40.1%</td>
<td>35.6%</td>
<td>37.7%</td>
</tr>
<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>
<td>62.3%</td>
</tr>
<tr>
<td>- Debility Unspecified</td>
<td>11.8%</td>
<td>11.2%</td>
<td>15.3%</td>
<td>13.1%</td>
<td>13.0%</td>
<td>13.9%</td>
</tr>
<tr>
<td>- Dementia</td>
<td>10.0%</td>
<td>10.1%</td>
<td>11.1%</td>
<td>11.2%</td>
<td>13.0%</td>
<td>12.5%</td>
</tr>
<tr>
<td>- Heart</td>
<td>12.2%</td>
<td>11.8%</td>
<td>11.7%</td>
<td>11.5%</td>
<td>14.3%</td>
<td>11.4%</td>
</tr>
<tr>
<td>- Lung</td>
<td>7.7%</td>
<td>7.9%</td>
<td>7.9%</td>
<td>8.2%</td>
<td>8.3%</td>
<td>8.5%</td>
</tr>
<tr>
<td>- Other</td>
<td>3.7%</td>
<td>6.5%</td>
<td>4.4%</td>
<td>4.5%</td>
<td>5.4%</td>
<td>4.8%</td>
</tr>
<tr>
<td>- Stroke or Coma</td>
<td>3.4%</td>
<td>3.8%</td>
<td>4.0%</td>
<td>4.0%</td>
<td>4.2%</td>
<td>4.1%</td>
</tr>
<tr>
<td>- Kidney (ESRD)</td>
<td>2.9%</td>
<td>2.6%</td>
<td>2.8%</td>
<td>3.8%</td>
<td>2.4%</td>
<td>2.7%</td>
</tr>
<tr>
<td>- Liver</td>
<td>1.8%</td>
<td>2.0%</td>
<td>1.5%</td>
<td>1.8%</td>
<td>1.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>- Non-ALS Motor Neuron</td>
<td>–</td>
<td>1.9%</td>
<td>2.1%</td>
<td>1.9%</td>
<td>1.2%</td>
<td>1.6%</td>
</tr>
<tr>
<td>- ALS</td>
<td>–</td>
<td>.4%</td>
<td>.4%</td>
<td>.4%</td>
<td>.4%</td>
<td>.4%</td>
</tr>
<tr>
<td>- HIV/AIDS</td>
<td>.5%</td>
<td>1.0%</td>
<td>.5%</td>
<td>.4%</td>
<td>.3%</td>
<td>.2%</td>
</tr>
</tbody>
</table>
A Look at Hospice Programs and Staff

Majority of Care Still Provided by Freestanding Hospices

As shown in Table 8, there continues to be a steady decline in care that is provided by hospital- and home-health-agency based hospices, while the proportion of hospices that are part of a nursing home jumped to 5.2 percent in 2011. Freestanding hospices continue to provide the majority of care.

Continued Decline in Small Programs

The proportion of small programs serving 1 to 49 patients has steadily declined over the past six years, while growth can be seen among those which serve 501 to 1,500 patients (Table 9).

Table 8: Agency Type

<table>
<thead>
<tr>
<th>Agency Type</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding/Independent Hospice</td>
<td>56.2%</td>
<td>58.3%</td>
<td>57.5%</td>
<td>57.7%</td>
<td>58%</td>
<td>57.5%</td>
</tr>
<tr>
<td>Part of a Hospital System</td>
<td>22.6%</td>
<td>20.8%</td>
<td>21.8%</td>
<td>21.4%</td>
<td>21.3%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Part of a Home Health Agency</td>
<td>20.1%</td>
<td>19.7%</td>
<td>19.4%</td>
<td>19.5%</td>
<td>19.2%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Part of a Nursing Home</td>
<td>1.2%</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.4%</td>
<td>1.4%</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Table 9: Agency Size by Patient Admissions

<table>
<thead>
<tr>
<th>Patient Admissions</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 49</td>
<td>17.9%</td>
<td>18.5%</td>
<td>18.1%</td>
<td>17.1%</td>
<td>15.9%</td>
<td>15.4%</td>
</tr>
<tr>
<td>50 to 150</td>
<td>29.0%</td>
<td>28.0%</td>
<td>29.5%</td>
<td>29.4%</td>
<td>30.1%</td>
<td>29.3%</td>
</tr>
<tr>
<td>151 to 500</td>
<td>34.1%</td>
<td>32.9%</td>
<td>32.1%</td>
<td>32.9%</td>
<td>33.0%</td>
<td>34.2%</td>
</tr>
<tr>
<td>501 to 1,500</td>
<td>14.5%</td>
<td>16.1%</td>
<td>16.1%</td>
<td>16.1%</td>
<td>16.3%</td>
<td>16.7%</td>
</tr>
<tr>
<td>More than 1,500</td>
<td>4.5%</td>
<td>4.6%</td>
<td>4.2%</td>
<td>4.5%</td>
<td>4.6%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

Table 10: Patients Served by Payer

<table>
<thead>
<tr>
<th>Payer</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Hospice Benefit</td>
<td>83.7%</td>
<td>83.6%</td>
<td>84.3%</td>
<td>83.4%</td>
<td>83.8%</td>
<td>84.0%</td>
</tr>
<tr>
<td>Managed Care or Private</td>
<td>–</td>
<td>8.5%</td>
<td>7.8%</td>
<td>8.6%</td>
<td>7.9%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Medicaid Hospice Benefit</td>
<td>5.3%</td>
<td>5.0%</td>
<td>5.1%</td>
<td>4.9%</td>
<td>4.9%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Uncompensated or Charity Care</td>
<td>–</td>
<td>1.3%</td>
<td>1.3%</td>
<td>1.6%</td>
<td>1.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>–</td>
<td>.9%</td>
<td>.7%</td>
<td>.7%</td>
<td>1.1%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other Payment Sources</td>
<td>3.0%</td>
<td>.7%</td>
<td>.8%</td>
<td>.8%</td>
<td>.8%</td>
<td>.7%</td>
</tr>
</tbody>
</table>

continued on next page
The Interdisciplinary Mix

Table 11 shows the distribution of paid full-time equivalent employees (FTEs) working in hospice during each of the last six years. Of note:

- Staff time continues to center on direct care and bereavement support, with 70.6 percent of home hospice FTEs designated for that purpose in 2011.
- The role of volunteer coordinator is now represented in the Facts and Figures report—and in 2011 reflected 6.3 percent of paid FTEs.

Volunteer Service

Facts and Figures also reports on volunteer service. In 2011, NHPCO estimates that 450,000 volunteers provided 21 million hours of service to hospice. While significant, this represents a downward trend when compared to the estimated 550,000 volunteers in 2008; 468,000 in 2009; and 458,000 in 2010. Next year’s numbers should provide a better understanding of whether the decline warrants concern.

Table 11: Distribution of Paid FTEs

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical (direct patient care)</td>
<td>71.9%</td>
<td>71.6%</td>
<td>72.0%</td>
<td>65.5%</td>
<td>66.9%</td>
<td>66.3%</td>
</tr>
<tr>
<td>- Nursing</td>
<td>30.7%</td>
<td>33.8%</td>
<td>34.8%</td>
<td>30.7%</td>
<td>30.1%</td>
<td>30.2%</td>
</tr>
<tr>
<td>- Nurse Practitioner</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>.4%</td>
</tr>
<tr>
<td>- Home Health Aides</td>
<td>23.9%</td>
<td>19.8%</td>
<td>18.6%</td>
<td>18.1%</td>
<td>19.4%</td>
<td>18.8%</td>
</tr>
<tr>
<td>- Social Services</td>
<td>8.5%</td>
<td>8.2%</td>
<td>9.1%</td>
<td>9.0%</td>
<td>8.5%</td>
<td>8.6%</td>
</tr>
<tr>
<td>- Physicians (excludes volunteers)</td>
<td>2.6%</td>
<td>3.4%</td>
<td>3.4%</td>
<td>2.2%</td>
<td>2.7%</td>
<td>2.9%</td>
</tr>
<tr>
<td>- Chaplains</td>
<td>–</td>
<td>4.2%</td>
<td>4.1%</td>
<td>3.9%</td>
<td>4.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td>- Other Clinical</td>
<td>6.9%</td>
<td>4.8%</td>
<td>3.8%</td>
<td>2.1%</td>
<td>2.0%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Nursing (indirect clinical)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>8.1%</td>
<td>7.5%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Non-clinical (administrative/general)</td>
<td>23.5%</td>
<td>23.7%</td>
<td>23.4%</td>
<td>22.4%</td>
<td>21.9%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Bereavement</td>
<td>4.6%</td>
<td>4.7%</td>
<td>4.6%</td>
<td>4.2%</td>
<td>3.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Volunteer Coordinator</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>6.3%</td>
</tr>
</tbody>
</table>
While NHPCO’s Facts and Figures report provides the “big picture” for the benefit of a very diverse audience, NHPCO produces another, lesser-known report that can be of more value to hospice providers in the management of their programs—the National Summary of Hospice Care (National Summary).

Like Facts and Figures, the National Summary is produced annually and is available to members free of charge. However, over the course of 20-some pages, it provides more in-depth estimates and statistical trends that can help hospice leaders and managers in their planning, budgeting, and in setting new goals and targets for future work.

Take the important issue of referrals. National Summary findings on referral conversion rates and sources provide a national-level benchmark against which you can assess the performance of your community education and outreach.

For example, according to data in the newest edition—the FY2011 National Summary—75.6 percent of referrals were converted to admissions in 2011, with 39.8 percent coming from hospitals, 23.8 percent coming from physicians, and 12.3 percent coming from patients themselves, or their friends or family. How do these findings compare with those for your program?

<table>
<thead>
<tr>
<th>Referrals</th>
<th>2011 – Agency Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals Converted to Admissions</td>
<td>75.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral Sources (% of Total)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>23.8%</td>
</tr>
<tr>
<td>Hospital</td>
<td>39.8%</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>9.8%</td>
</tr>
<tr>
<td>Self, Family or Friend</td>
<td>12.3%</td>
</tr>
<tr>
<td>Other</td>
<td>12.5%</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

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Other Ways It Can Inform Your Work

The National Summary provides data on inpatient facilities; length of service; palliative care services; patient visits; payer mix; revenue and expenses; and more. This data can help you with a variety of tasks:

**Projecting Fundraising Revenue and Expenses**
A large hospice organization with sites throughout the country referred to the National Summary when making budget projections for fundraising revenue and expenses. For example, Table 16 of the FY2011 National Summary includes average revenue and expenses for nonprofit organizations, broken out by hospice service; fundraising and contributions; and other revenue.

**Assessing LOS at Freestanding Facilities**
Table 7 of the FY2011 National Summary provides information on length of service, including LOS by agency type. With the majority of hospices operating freestanding facilities, this targeted data has helped many to make more-informed assessments of their operation.

**Setting Census Rates for Start-up Programs**
New programs have also turned to the National Summary when making daily census and demographic projections for their first year of operation. Table 1 of the FY2011 National Summary provides extensive information on hospice agency demographics while Table 2 sheds light on agency characteristics according to patient volume.

**Evaluating Volunteer Utilization**
The National Summary also sheds light on how hospice programs are utilizing volunteers. Total volunteer service, total volunteer hours, and volunteer hours per volunteer are detailed in Table 12. More helpful still, these findings are broken out according to the type of volunteer service performed.

**Providing Your Hospice Board With Industry Perspective**
National Summary findings can be incorporated into your orientation for new board members or can be used during annual “state of the industry” discussions.

Download the complete FY2011 National Summary now.
WE ARE HIRING!

Health Essentials, a leading healthcare organization that specializes in caring for the most frail and vulnerable patients, is pleased to announce the following positions in its hospices:

- **Director of Patient Care Services for Gerinet Healthcare (Burbank, CA):** Leads the Patient Care Team in assuring continuity of care from admission to discharge. Must be a RN in CA and a minimum five years of experience leading a hospice with a census of over 150.

- **Executive Director for Gerinet Healthcare (Downey, CA); Executive Director for Health Essentials (Santa Ana, CA):** Oversees operations and leads business development for hospice site. Must have a minimum five years of experience managing a hospice with a census of over 300.

If you or someone you know is interested in joining our team, please contact our Human Resources Department by emailing HR@healthessentials.net.

Join Us in Celebrating Social Work Month!

Among their many contributions to society, professional social workers help us discover our potential as human beings and help us improve our lives and those of our loved ones. There is no better example of this than the dedicated professionals who work in the hospice and palliative care field. Each and every day, they help patients and their families live fully—and find peace and dignity—during the most challenging stage of life.

Join NHPCO and the National Council of Hospice and Palliative Professionals in recognizing these dedicated colleagues during National Professional Social Work Month.

NHPCO encourages members to visit the Web site of the National Association of Social Workers for information and resources about this national observance: www.socialworkers.org.
Serving Veterans:

Does Storytelling Help or Hinder?

A Pilot Study by Delaware Hospice Inc. and the University of Delaware Sheds Light

By John J. Carmody, BA, MAT; Vicki Costa, LCSW, ACHP-SW; Evelyn R. Hayes, PhD, APRN, BC; and Jane P. Taylor, MS, RN
Military service is often identified by Veterans as one of the major events affecting the purpose and meaning of their lives. As Veterans approach the end of life, we, as hospice professionals, have a responsibility to assess their needs and give them every opportunity to address the potential stressors related to their military experiences. Does the process of storytelling serve as one such opportunity?

In this article, we review the findings of an 18-month pilot study that was completed as a joint effort between Delaware Hospice Inc. and the University of Delaware between March 2010 and September 2011. The purpose of this pilot study was to explore that question from the perspective of both the Veteran patient and his or her primary caregiver. Specifically:

- Do Veterans in hospice care, who tell their military service stories, express improved satisfaction at the end of life?
- Do the primary caregivers of these Veterans perceive that their loved ones experienced improved satisfaction at the end of life after telling their stories?

These questions will be answered as we share what we learned through the process of conducting this study—from listening to the stories as they were audio-recorded and from reviewing the Veterans’ photos, citations and medals, personal letters and other memorabilia.

We will also explore how the process of storytelling affected their spirituality and the themes that surfaced during the study, along with the lessons learned from our experience and some recommendations to help you in your practice.

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The Participants

The 21 Veterans who were asked to participate were all hospice patients under the care of Delaware Hospice. They were selected by the hospice staff, under the guidance of Delaware Hospice’s medical director, based on the following criteria:

- They had not been diagnosed with Post Traumatic Stress Disorder, nor did they exhibit cognitive impairments
- They were physically able to speak English and answer questions
- They had a primary caregiver

Of the 21 selected, seven of the Veterans died prior to completing the study. The 14 who completed the study were all male Caucasians who had served in either World War II (64%) or the Korean (25%) or Vietnam (11%) Wars. Three branches of service were also represented: 50 percent had served in the Army; 43 percent in the Navy, and 7 percent in the Merchant Marine.

The sample group also represented a variety of military service, including a medic, cook, torpedo bomber, air cavalryman, educator, machinist, infantryman, machine gunner, and combat center technician.

The Procedures

As part of the recruitment process, a Delaware Hospice social worker met with the selected Veterans and their caregivers to explain the study and ask if the interviewers could visit with them.

This was followed by four visits, one by the social worker and three that were made by members of the Study’s Research team: a hospice volunteer and Vietnam War Veteran; a University of Delaware nurse educator and Veteran; and a volunteer hospice nurse. For each visit two members of the Research team were present.

1. During the first visit, the study was introduced and written informed consent was obtained, with time set aside to answer any questions the Veteran or caregiver had.

2. In the second visit, the Veteran shared his story via a guided and recorded interview that addressed six general areas: biographical details; early days in service; wartime service; war’s end, coming home; and reflections.

3. One-to-two weeks after the interview, a third visit took place. At that time, a member of the Research team asked if the Veteran or his caregiver
had observed any changes in his quality of life as a result of telling his story. Each was also asked to (independently) complete a Post-Storytelling Survey to identify any perceived changes that resulted from the sharing. The survey was an 11-item investigator-developed survey that reflected concepts typically found in quality-of-life instruments.

4. In the final visit, about one month after the Veteran shared his story, one member of the Research team followed up to once again review any changes that the Veteran or his caregiver perceived from having shared his story. At this time, the Veteran and caregiver were asked to complete the Post-Storytelling Survey a final time.

**Feedback From Participants**

**From the Veterans:**
The majority of Veteran participants said their spirituality was affected by their military service. This was observed in the comments they shared about the impact of war, their return home, and the end of life:

“[It] helped me to think about God and the Bible…”

“The sense of God’s presence never left me…”

“[It]…made me think more about my spirituality and how my parents nurtured me…”

“After I was wounded, I accepted the fact that God had other plans for me.”

Of the 14 Veterans who completed the study, 13 said that the storytelling was helpful while the 14th Veteran said it neither helped nor hurt. Some of the most notable comments among the majority of participants included:

“I was heard”

“I was appreciated for service”

“[I found] comfort in relating experience”

“[I felt a] sense of closure”

The Veterans also appreciated receiving a copy of the audio recording of the interview as well as a written transcript, with many noting that it provided a “legacy” for their loved ones.

**From the Caregivers:**
Eight of the caregivers were spouses of the Veterans; five were either the Veteran’s son or daughter; and one was the Veteran’s granddaughter.

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Like the Veterans themselves, the majority of caregivers (i.e., all but one) also perceived that the Veteran’s spirituality was affected by his military service. Their specific comments included:

“War had big impact on beliefs about family and life…”

“[He] feels stronger every time he tells his story about his trust in God…”

“[He] felt God left him here for a purpose and hopes he has been able to do so…”

“[He] made peace over earlier feelings of anger and hostility…”

All the Veterans’ caregivers were very appreciative of the opportunity to have their loved ones tell their story, and perceived that the experience had been helpful.

**Some of the Takeaways**

Listed here are some tips and recommendations, based on our work with Veterans at Delaware Hospice and our experience in conducting this pilot study:

- Appreciate the importance of storytelling as a healthy process for all individuals, but especially for the Veteran patient—and communicate this to all staff.

- Don’t miss the small window of opportunity to help Veterans share their stories—which can be a challenge since many wait until their final days to elect hospice.

- Make sure you have a referral process in place so the Veterans who are admitted to hospice can share their military service experiences as soon as possible. [See the We Honor Veterans website for information on identifying Veterans at intake/admission.]

- Emphasize to staff the importance of engaging fully in reflective listening while a Veteran shares his or her story.

- Ask the caregiver to listen as well. (Several caregivers in the study had never heard the stories their loved ones shared until the guided interviews took place. Their presence added another dimension of support and insight to the process.)

- If you choose to administer a Post Storytelling Survey, consider doing so only once, versus twice, and place greater focus on the use of the “guided interview” as an integral part of the process.

- Offer to make an audio recording of the guided interview(s) as a legacy for the family.

- Match a hospice patient who is a Veteran with a volunteer who is a Veteran, unless the Veteran prefers otherwise. [See the We Honor Veterans website for information on Vet to Vet Volunteer Programs.]
Final Thoughts

All three members of the pilot study’s research team found the experience of witnessing the Veterans’ stories to be both remarkable and moving. “Their level of cooperation and their enthusiasm impressed each of us,” noted one researcher. “It was not uncommon that the spouse or a surviving son or daughter would notify us when one of the Veterans died. And on several occasions, we were invited to attend the memorial or funeral service for the Veteran.”

One researcher who attended a Quaker Memorial Service for a Veteran patient had felt deep connections with him in having been witness to his stories: “As the friends and loved ones stood to share their stories of the deceased, as is the Quaker tradition, I felt compelled to stand as well and share how my life was affected by having him share his stories with me…. It was at that moment that I felt a deep sense of unity with the family. Could it be that this sharing of stories reflects the central importance of narratives…. It seems that such stories may be passed from generation to generation to help keep the human soul alive.”

But perhaps one grateful daughter of a Veteran patient and participant said it best. “His stories brought him back to life [for me].”

John J. Carmody is a Vietnam War Veteran and former captain in the U.S. Marine Corp, and now serves as a Delaware Hospice volunteer. Vicki Costa is the associate director of family support services at Delaware Hospice, with 15 years of experience as a hospice social worker, bereavement counselor, and manager. Evelyn R. Hayes is a professor of nursing, and a family nurse practitioner at the Nurse Managed Health Center at the University of Delaware as well as a Colonel (ret) from USAR Nurse Corps. Jane Taylor is a retired nurse-educator who now serves as a volunteer nurse through Delaware Hospice’s RN Volunteer Program.

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“War had big impact on beliefs and family and life”
Related Resources

Summary of The Pilot Study
We Honor Veterans Website
Military History Checklist and Guide
Family Evaluation of Hospice Care Veterans Survey (See NewsLine for a brief summary.)

Recent Articles by Hospice Providers:

    How a Veteran’s Experience Can Inform Bereavement Practice
    Six WHV Partners on How They Recognize Veterans

Veterans History Project: www.loc.gov/vets

Audio Presentation Also Available:
The authors of this article presented on this project at the NHPCO 2012 Clinical Team Conference and an audio recording of the session is now available for just $10. Visit www.dcprovidersonline.com/nhpco, and enter “9K” in the Keyword Search. Then scroll to the session listing, “Does Storytelling Help or Hinder?”

HFA’s Improving Care for Veterans Program: Available April 17 on DVD

The Hospice Foundation of America’s 20th Annual Living With Grief Program, “Improving Care for Veterans Facing Illness and Death” will be available on DVD to registered sites, beginning April 17, 2013. Sites can then schedule their own dates and times to show the program for a full year after April 17.

This 2.5-hour continuing education program is designed to foster better understanding and sensitivity of Veterans’ issues among end-of-life care staff. (It’s a great opportunity for WHV Partners to provide staff education and advance to the next Partner Level!)

Register Online—at Special Savings

NHPCO providers can register for $170 (a $30 savings). Visit register.hospicefoundation.org, and enter Discount Code 30NHP. To learn more about the program, visit the HFA website.
IN CONJUNCTION WITH NHPCO’S 28TH MANAGEMENT AND LEADERSHIP CONFERENCE

Save the Date

2013

NATIONAL HOSPICE FOUNDATION GALA

FRIDAY, APRIL 26, 2013
Gaylord National Resort & Convention Center
National Harbor, Maryland

6:30 pm Cocktails and Silent Auction
7:30 pm Dinner, Awards, Live Auction and Dancing

To learn more, contact NHF at (877) 470-6472, or visit www.nationalhospicefoundation.org/2013gala
By Erika Tedesco

Do you recall those little toys that come from bubblegum machines? My son recently put his quarter in the machine and out popped a little latex hand that, when flung onto the wall, sticks. As an educator, I was struck by that simple toy. If only learning would ‘stick’ with us that easily?

For hospice providers, that challenge is even greater. With most of our workforce being a mobile one, it is often even a struggle to find time to schedule education and training.

In this article, I share some of what we are doing at Hosparus Inc., including how we are using a few of the new technologies to re-energize and improve the learning experience.

First, a Look at Blended Learning

Years ago Hosparus Inc. conducted all of its education in the classroom, but as our organization has grown, that became less effective (we currently have over 500 employees in two states). Instead, we now use a blended-learning approach.

Blended learning means learning that is extended through a variety of mediums, including online, classroom and experiential learning. One way to make learning stick is by utilizing a combination of these mediums, but you can also go one step further by trying different approaches within a single medium.

For example, if you conduct classroom training, don’t just use a traditional lecture style. Couple a lecture with a hands-on learning lab where your employees can receive firsthand experience with the subject.
Another strategy is to use online learning, but conduct a discussion group to supplement the learning. Team meetings are a great opportunity to conduct quick learning activities to reinforce the education that employees may have received online.

**Consider the Topic**

When deciding on the primary approach to take, it is important to consider the topic. Nursing skills are best taught in an experiential-learning lab where clinicians can practice the skill. Social worker, chaplaincy and bereavement education is more situational and best done in a live environment where discussions can take place. Annual mandatory education, such as a safety or HIPAA session, is a good candidate for online education as are knowledge-based competencies. Education such as ethics or big-change initiatives are also best done in a live setting. The difficult part of deciding which methodology to use is balancing resources with the best learning approach. A live course might be optimal in terms of “stickability,” but unrealistic in terms of time, money or space.

At Hosparus, we recently identified a learning need that impacted several disciplines—nurses, social workers and chaplains—at all of its locations. Identifying the appropriate learning medium was difficult because the topic was a philosophical shift in how clinicians would be practicing and some resistance was anticipated. It would have been more efficient and cost-effective to use an online learning approach, but it was important to ensure that the staff fully understood the content and ample opportunity was provided for discussion.

We ultimately decided on a live-classroom environment and, to demonstrate the import of the topic, our vice president of clinical services taught every four-hour class herself! Not only did the staff realize how important the content was, but through discussion and questions, many opportunities for process improvement were identified.

**Online Learning**

Online learning has been a popular response to addressing the challenges presented by having a mobile workforce. It
does not require groups of your employees to be in the same place at the same time, it’s easy to schedule, and employees can complete the education at their convenience.

Unfortunately, online learning does not always mean adequate learning transfer or “stickability,” but making the sessions more interactive can certainly help improve retention.

Rather than just clicking through text, try to incorporate activities that require your staff to participate in the online class. The rule of thumb is that the more mouse clicks an activity requires, the better the information will be retained.

For example, as part of our corporate compliance online training, employees must use a drag-and-drop technique to move icons for types of proper identification to the compliance officer’s desk. They can’t advance in the session until they successfully move all the icons to the appropriate place on the screen. Such activities keep staff more engaged which helps them remember the content longer.

Using Some of the Newer Technologies

Podcasts
For those employees who must cover large territories and spend significant time offsite, the podcast may be an excellent way to provide certain educational programming. A podcast is the modern equivalent of a radio story—you create your own recording and upload it to your website. Your employees can listen to it via an MP3 player, smart phone or laptop, and take an online test later to confirm their participation and understanding of the content.

Custom Online Tutorials
Hosparus has also begun using new video technology that allows us to record activity on our computer screen and add instructional voice-overs. This type of product is a good choice to communicate any simple process to a large group of staff, but not suitable for sharing longer, more complex information. (Hosparus’s software of choice is Camtasia, which has proven to be a very user-friendly option for the video creator. It retails for less than
$300 per license, with a discount for purchasing five or more licenses.)

**Video Conferencing**
Video conferencing is a useful technology when one-on-one learning or coaching is needed, but doesn’t warrant the time and expense of conducting an onsite session.

For example, clinical staff can utilize the live chat option in this technology to speak with an educator in between patient visits. After the initial education is completed, online discussion rooms and even private Facebook pages can then be used to pose questions or offer insights as staff members apply the new information to their practice. (Hosparus uses GoToMeeting for video conferencing. It costs just $500 per year to host up to 25 conferences with an unlimited number of attendees. If you are interested in hosting your own webinars, which allows for better interaction than online tutorials, GoToWebinar is a companion product that costs from $1,000 to $5,000 per year. Of course, there are many products available, but we have found these to be user-friendly for the creator, administrator, and front-end user.)

Of all these technologies, video creation and video conferencing are the easiest to manage from an IT perspective. Usually, it can be done from a standard personal computer and even from a smart phone.

**Finally, Make Your Staff Aware of the Benefits**
Helping staff to get comfortable with using these newer technologies will of course be necessary—and challenging at times. We have found that laying out the benefits of learning in these new ways will help staff adapt to the changes more easily. Also be sure the new technology works before rolling it out to everyone! This may seem obvious, but testing with a variety of users is critical.

Technology can be intimidating, but it can turn what may be viewed as a tedious and obligatory educational session into an innovative learning opportunity.

_Erika Tedesco has spent the last five years in corporate learning for a variety of healthcare organizations. She currently serves as the manager of education and training at Hosparus Inc., based in Louisville, KY, a position she has held since 2011._
As the medical needs of hospice patients become more complex, we run the risk of focusing on symptom management and losing sight of the importance of interdisciplinary care and the family caregiver. All organizations face this challenge of assuring clinical excellence and consistency of services across care settings. As hospice is defined as a concept and philosophy of care, we must translate expectations in care and service to our staff in ways that enhance clinical practice while maintaining standards and accountability.

Hospice and Community Care, based in Lancaster, PA, developed the MODEL TEAMS concept in 2005 to help address this challenge. We use it as a framework to help strengthen the concept of the interdisciplinary team, function better as a team, and stay focused on all of the patient’s and caregiver’s needs—the emotional and spiritual as well as the medical.

A Closer Look

MODEL TEAMS is an acronym where each letter stands for an essential element of hospice care and includes key questions that every staff member—across all disciplines—is asked to be mindful of and answer at the end of each day:

**M—Management** of physical, emotional and spiritual distress to alleviate suffering:

- Are the symptoms managed or addressed at a level acceptable to the patient and family?
- Have I initiated daily interdisciplinary team visits for assessment, management of symptom exacerbation and/or imminent death?

At Hospice and Community Care, we expect daily interdisciplinary visits until the patient and caregivers achieve comfort. If the patient is experiencing spiritual distress, the chaplain will make the visit. Or, if the caregiver needs an emotional break, we will increase volunteer services.

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*The National Council of Hospice and Palliative Professionals (NCHPP) is the individual membership within NHPCO that is organized into 15 discipline-specific Sections. To learn more about the NCHPP Nurse Section, visit the NHPCO website.*
O—Orders that are current, complete and appropriate to the patient’s plan of care:

- Are orders consistent with HCC protocols?
- Is the medication profile reconciled across EHR, the nursing home chart and the in-home medication sheet?

Hospice and Community Care expects each member of the team to ask patients if they have received new medications or treatments. Non-nursing disciplines must report this to the nurse for follow up. If the patient is in a nursing home, new orders can be faxed to the clinical staff to be entered into the patient’s medication profile. Staff has a responsibility to simplify the treatment plan and understand the goals of the interventions as they meet the patient and family goals (i.e., not just continue something because it was already in place).

D—Documentation is complete and entered on the day of service:

- Does my documentation support the patient’s limited prognosis and level of care?
- Have I documented throughout my shift/day?
- Is my documentation accessible to all members of the team?

E—Effective provision of care to meet the unique culture of all households and the patient’s needs and goals for their plan of care:

- Did I honor the customs and culture of each individual, conveying respect both directly and indirectly?
- Did I demonstrate acceptance of the choices and decisions made, regardless of my personal view?

We want to ensure that Hospice and Community Care provides equal access to all aspects of care across all settings. Thus, continuous home care should be offered to patients in the nursing homes when it is appropriate; and visit frequency and the length of visits should be determined by the patient’s needs and goals of care. There should not be a standard because each patient’s plan of care is individualized.

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**L—Limitation** of risks related to compliance, confidentiality, infection, safety and satisfaction:

- Did I follow agency policies and procedures? Was information shared on a need-to-know basis only?
- Did I wash my hands and practice other infection control measures for every patient?
- Have I identified and addressed actual or potential risks concerning my patient?

Everyone coming into contact with the patient needs to wash their hands and practice other infection-control measures. Actual or potential risk factors for patient, caregivers and staff need to be identified and a plan of action needs to be developed regardless of the patient setting.

**T—Timely** and thorough coordination of care by responsiveness, assessment, collaboration, interventions and communication:

- Have I balanced the needs of the moment with the needs of the day?
- Have I communicated changes to the entire IDT?
- Have I updated the family with the patient’s status and condition?

**E—Equip** patients, families and caregivers with the information they need to feel confident in their plan of care:

- Have I asked the patient and family: “How confident do you feel that you know what to expect and what to do?”
- Did I affirm the caring and caregiving role of the patient and family?

When it comes to educating patients and families, think about “equipping them” instead of simply “talking to them” because educating is really about empowering. Think about the number of times we report that we provided education. Did the patients and families feel confident that they now had the tools they needed to use what they learned?

**A—Appropriate** use of time and resources:

- Did I anticipate/meet our patient and family’s needs wisely?
- Have I prioritized and sensibly utilized my time and the resources of the organization?
- Did I recognize and respect healthy boundaries?

Thinking across disciplines, Hospice and Community Care looks at how we utilize our biggest resource: our staff. We do not limit which discipline can provide a time of death visit unless it is required that an RN be present. All disciplines can respond in a crisis until the appropriate discipline can be there. And yes, an RN can provide personal care to a patient.

**M—Measurable** outcomes for established goals of the MODEL TEAMS:

- Have I asked—and satisfactorily answered—all of the end-of-the-day MODEL TEAMS questions?

Hospice and Community Care takes all specific outcomes and assigns accountability. Staff are provided with results from our participation in the Family Evaluation of Hospice Care survey, and chart audits are done to assure that we are following policies, procedures and regulations.
S—STAFF support for each other to deliver care within MODEL TEAMS:

• Have I experienced and contributed to a supportive work environment?

Framework is the promise of what we do for the family, it’s not about staff. The “S” is the ‘how’ we do what we do every day—it’s about what supports us and keeps us together in order to deliver this promise. The elements of the MODEL TEAMS framework are held together by having staff support each other.

So Is It Working?

The very process of posing these questions has helped to ensure that the expertise of all disciplines is utilized for the timely and thorough coordination of care. It helps us to remember that “we” are hospice, not “The Nurse” or “The Social Worker” or “The Chaplain.” Every member of the team must be the eyes and the ears of the team when caring for the patient and family.

The model has also helped us to establish trust among the different disciplines. Staff members seek and share knowledge and skills, and demonstrate an appreciation for the contributions of their colleagues.

The direct feedback from staff has also been positive. As one staff member shared, “When I have answered the questions at the end of the day, I know I have done my job and don’t have to worry about anything that night.” Another said that she has seen a shift in the culture, that nearly all staff has a greater appreciation of each discipline and what each brings to the table. While anecdotal, this feedback has clearly been validated in our Joint Commission and Department of State survey results.

Teresa Wheatley is a registered nurse with 27 years of experience in the hospice field. She has been certified in hospice and palliative care for 18 years and currently serves as director of access for Hospice and Community Care, based in Lancaster, PA. Teresa also serves as NCHPP’s Nurse Section leader.
Despite some impressive outreach on the local and national levels, the percentage of Americans who have completed advance directives still hovers between 25 and 30 percent of the nation’s adult population.

To help reach the other 70-or-so percent, NHPCO’s Kathy Brandt proposed a new and simpler strategy in the December issue of NewsLine: Ask Americans to focus first on naming a healthcare agent.

“Naming a healthcare agent is far more palatable than addressing the bigger task of choosing what healthcare treatments you’d want in an advance directive,” notes Brandt. “Yet it accomplishes one of the most important aspects of the process.”

To help bring this message to consumers, NHPCO created the social media campaign, “#Speak4me,” that launched in early January and will culminate in April after National Healthcare Decisions Day on April 16 and NHPCO’s Advance Care Planning Policy Symposium on April 23.

A Simple 4-Step Process

The campaign urges Americans to name a healthcare agent by following four steps:

1. Select a Person (and a Backup) to be Your Healthcare Agent
2. Talk With Your Healthcare Agent About Your Wishes
3. Complete Your Healthcare Agent Document
4. Give Signed Copies to Your Agent(s), Family and Doctor.

More details about these four steps, plus links to related resources, are provided online—on NHPCO’s Caring Connections website. Here, healthcare professionals will also find tools that can help them spread the word in their communities, including a PowerPoint presentation to customize; an informational flyer; and a #Speak4me sign.

Photos to Create Positive Energy

As part of the campaign, NHPCO is asking everyone who has named a healthcare agent to snap a picture of themselves with their agent—and share it on Facebook and/or Twitter. This will help create positive energy and enthusiasm around a topic that has not garnered the greatest press since Sarah Palin’s infamous tweet of 2009.

To learn more, visit www.caringinfo.org/speak4me.
Every spring, NHPCO develops new outreach materials to help members honor the hospice volunteers in their programs during National Volunteer Week—and beyond. (It’s one of the exclusive benefits of NHPCO membership!)

Shown here are the three display ads in this new collection. They feature the same theme of “comfort.love.respect” that NHPCO chose for the 2012-2013 hospice outreach collection to help ensure consistent messaging.

Members can add their logo to these ads, or use the images or copy in other promotional materials being prepared to honor their hospice volunteers.

Instructions for inserting your organization’s logo, as well as a range of additional resources, can be found online.
One of the free survey tools that NHPCO makes available to members is the Survey of Team Attitudes and Relationships (STAR). Introduced in 2007, STAR is the first and only survey that is specifically designed to assess the job satisfaction of all employees working in the hospice and palliative care field—administrative, non-clinical and clinical staff.

While providers which use STAR receive individualized reports with their survey results, each year NHPCO also aggregates the results and produces the National STAR Report for the benefit of all members.

This month NHPCO released the 2012 report. As shown in the chart below, this new report reflects valuable feedback from the 3,568 staff working in clinical and non-clinical areas.

The report is organized into three primary sections:

- The first section provides demographic details about the organizations and individual staff surveyed;
- The second section provides compensation information for salaried and hourly employees for 2012 as well as two-year average compensation information for 2011/2012;
- The final section provides results from the 45 core questions asked in the survey concerning individual work rewards, workload issues, the work environment, teamwork, organizational support and global job satisfaction.

As one CEO put it, “STAR is a snapshot in time, no different than a financial balance sheet. It takes the temperature of any organization's culture.” The National STAR Report, in turn, provides national-level comparison results, making it a valuable tool for more comprehensive evaluation.

The new 2012 National STAR Report is now available in the NHPCO Marketplace.

Use This Free Tool in Your Own Organization!

If you don't yet take advantage of this benefit of NHPCO membership, visit the STAR page on the NHPCO website to learn more.
NHPCO’s Hospice and Palliative Care Professional Scholarship Program
Supported by an educational grant from Glatfelter Healthcare Practice

Applications are now being accepted for the Hospice and Palliative Care Professional Scholarship Program.

Scholarship recipients will receive one complimentary full conference registration to the 28th Management and Leadership Conference. For eligibility criteria and to apply, visit www.nhpco.org/mlc2013. Space is limited, so submit your application today.

www.nhpco.org/mlc2013

NHPCO’s Affinity Program is an exclusive NHPCO member benefit designed to:
• Enhance your NHPCO membership investment
• Offer unique benefits on price, products, and services
• Increase value in your organization

The following selected Affinity Program Partner programs and services are available to NHPCO members, their employees and volunteers:

Visit www.nhpco.org/affinity to more info. For membership information, contact NHPCO Solutions Center at 800/646-6460 and ask for the Membership Department.

NHPCO’s Hospice and Palliative Care Professional Scholarship Program
Supported by an educational grant from Glatfelter Healthcare Practice

Are budget constraints restricting you from attending the MLC?

www.nhpco.org/mlc2013
Look Who’s Coming to MLC

NHPCO’s 28th Management and Leadership Conference in April will give attendees a great opportunity to see some of the newest and most innovative products and services that are coming to market. Here’s a partial list of this year’s exhibitors:

501(c) Agencies Trust  
Accreditation Commission for Health Care, Inc.  
Advacare Systems  
Aging With Dignity Allscripts  
American Academy of Hospice & Palliative Medicine  
American Board of Wound Management  
Amplicare  
Avanti Health Care Services  
Beyond This Day  
BlackTree Healthcare Consulting  
CareAnyware, Inc.  
Celltrak Technologies, Inc.  
Cerner Technologies, Inc.  
Community Health Accreditation Program  
Community Hospice Group  
Consolo Services Group, LLC  
Crowe Horwath, LLP  
Delta Care Rx  
Deyta, LLC  
Elder Pages Online  
Enclara Health, Inc.*  
Glatfelter Healthcare Practice*  
Global Medical, LLC  
Healthcare Concepts  
Healthcare Market Resources  
Healthcare Provider Solutions, Inc.  
HEALTHCAREfirst  
HealthWyse, LLC  
Hertz Supply Co., Inc.  
Hill-Rom  
Homecare Homebase  
Hooven & Hooven Porcelain  
Hopkins Medical Products  
Hospice Education Network  
Hospice Fundamentals  
Hospice Medical Director Certification Board  
Hospice Pharmacia*  
Hospice University, Inc.  
Hospiscr, a Catamaran Company  
iRefer Dr  
JBA Benefits, LLC  
Maney Publishing  
Matrix Architects Incorporated  
McBee Associates  
McKesson Provider Technologies  
Medline Industries, Inc.  
MMS - A Medical Supply Company  
mumms® Software  
National HME, Inc.*  
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Therapy Support, Inc.  
Touching Lives Magazine  
Transcend Hospice Marketing Group  
VITAS Healthcare Corporation  
Weatherbee Resources, Inc.

A Welcome Reception will be held in the Exhibit Hall on Thursday, April 25, from 5:15 p.m. to 7:30 p.m.  
The Hall will re-open on Friday from 7:00 a.m. to 2 p.m.  
Learn more about MLC—there’s still time to register!

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Good Shepherd Hospice has been providing compassionate care and support for terminally ill patients and their families for over 30 years. We embrace the philosophy and concept of hospice services to help enable people to make informed decisions regarding end of life care. This is your chance to enhance their quality of life…while keeping quality in yours. Flexible hours offered. We currently seek the following:

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Master’s degree required with focus on theology/pastoral care, along with a minimum of 3 years demonstrated leadership skills. Must have experience in interpreting and implementing the Catholic Ethical and Religious Directives in a Hospice setting; proven knowledge and experience in clinical ethics and CPE/certification through NACC or ACPE are essential. Strong interpersonal skills and the ability to relate to the terminally ill and their families. Possess a valid NYS driver’s license, transportation and ability to travel to the homes of patients/families.

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Michelle Backlund Named Executive Director

Chapters Health System (Tampa, FL) has named Michelle Backlund, MBA, the executive director of its Senior Independence program which offers nursing home diversion services and PACE.

Most recently Backlund was vice president of a managed care company in Hernando County. Prior to that, she held roles with Chapters Health as director of business development and director of palliative care.

Spectrum Health Hosts Gandalf’s Gala, Raising Nearly $24,000

Last December, Spectrum Health (Grand Rapids, MI) hosted a gala event at a local cinema where guests arrived in costume and enjoyed an early viewing of “The Hobbit,” one day before its official release.

Spectrum Health Hospice had cared for the cinema owner’s mother who was so impressed by the care she had received, he wanted to give back. The event, which included dinner and a live auction, was attended by 430 people and raised nearly $24,000.

San Jose Mercury News and Hospice of the Valley Co-host Free ACP Forums

Hospice of the Valley (San Jose, CA), in collaboration with the San Jose Mercury News, hosted two free community forums on advance care planning.

Attendees received a complimentary copy of an advance healthcare directive as the hospice’s manager of social work and spiritual care, Gary Bertuccelli, and Mercury News science and medicine journalist, Lisa Krieger, discussed the document and shared their respective insights on advance planning. (Krieger has published several outstanding pieces to help educate Americans about end-of-life care, including her award-winning series, the “Cost of Dying.”)

Third Graders Help Sandy Hook Students Through a Fundraiser for Healing Hearts Bereavement Center

When students at Gibbs Magnet School of International Studies and Foreign Languages in Little Rock, Arkansas decided to send a gift to those affected by the Sandy Hook Elementary School shooting, they chose a fundraising project to support the Healing Hearts Bereavement Center for Grieving Children and Families, where many of the victims’ families and loved ones are receiving support.

Their project is called “Kids Stick Together,” and its money-making products are decorative and useful items made from duct tape!
Do you know what the hospice conditions of coverage are? It’s critical that you do.

A hospice provider’s inability to evidence compliance with these conditions can be the basis for payment denial by the provider’s Medicare Administrative Contractor (MAC). In fact, this is specifically documented in Chapter 3 of the Medicare Program Integrity Manual (i.e., the IOM Manual).

Let’s revisit these conditions, as outlined in the Medicare Hospice Conditions of Participation (CoPs), in §418.20. To be covered:

- Hospice services must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions.
- The individual must elect hospice care in accordance with §418.24.
- A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the hospice interdisciplinary group as set forth in §418.56. (That plan of care must be established before hospice care is provided.)
- The services provided must be consistent with the plan of care.
- A certification that the individual is terminally ill must be completed as set forth in §418.22.

To review the above-referenced CoPs, see the PDF, Part 418—Hospice Care, from the Medicare CoPs.

Another Reason to Take Note

In 2006, the Office of the Inspector General (OIG) completed an analysis of hospice claims for Medicare beneficiaries residing in nursing facilities to determine compliance with these hospice conditions of coverage. The OIG’s analysis, which was published in 2009, found that:

- 82 percent of the hospice claims did not meet at least one Medicare coverage requirement;
- 33 percent of claims did not meet election requirements;
- 63 percent of claims did not meet plan of care requirements;
- 4 percent of claims did not meet certification of terminal illness requirements.

What’s more, for 31 percent of the claims, hospices provided fewer services than outlined in the beneficiaries’ plans of care.

A Tool to Help You

These findings point to the need to be both knowledgeable and compliant. To help, refer to the Compliance Audit Tool developed by the NHPCO Regulatory team.
# 2013 Webinar Topics

<table>
<thead>
<tr>
<th>Interdisciplinary</th>
<th>Quality and Regulatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 14: Evidence-based Wound Care Management</td>
<td>February 26: Discharges, Transfers and Revocations: Oh My!</td>
</tr>
<tr>
<td>March 14: Appreciative Inquiry for the Interdisciplinary Team</td>
<td>March 26: Medicaid Managed Care: The Latest Trends and a New Reality for Hospice</td>
</tr>
<tr>
<td>May 9: Responding to Suicidal Intent or Completion</td>
<td>May 23: Performance Improvement Project Successes: Learn from the Leaders!</td>
</tr>
<tr>
<td>June 13: Palliative Chemotherapy and Radiation: What Every Clinician Needs to Know</td>
<td>June 25: Regulatory Requirements for Counseling Disciplines in Hospice Care</td>
</tr>
<tr>
<td>July 11: Providing Optimal Care for People with Agitation and Delirium</td>
<td>July 23: The Seven Elements of a Compliance Program: How Do You Measure Up?</td>
</tr>
<tr>
<td>August 8: Children’s and Teen’s Grief and Bereavement Needs</td>
<td>August 27: Operating within the Regulations: Marketing “Do’s and Don’ts”</td>
</tr>
<tr>
<td>September 12: Falls: Assessing Risk and Preventing Injury</td>
<td>September 17: Palliative Care: State of the Art</td>
</tr>
<tr>
<td>October 10: Addressing Spiritual Despair and Distress</td>
<td>October 22: Office of Inspector General (OIG) Risk Areas for Hospice Programs</td>
</tr>
<tr>
<td>November 14: Palliative Sedation Primer for the IDT</td>
<td>November 19: Accountable Care Organizations and New Models of Care: Expanding the Continuum</td>
</tr>
<tr>
<td>December 12: What About Me? Professional Boundaries and Compassion Fatigue</td>
<td>December 17: Pharmacy: Issues and Updates Impacting End-of-Life Care Providers</td>
</tr>
</tbody>
</table>

Please visit www.nhpco.org/webinar to register.
The healthcare performance management firm, MedeAnalytics, has posted on YouTube a “two-minute drill” about Accountable Care Organizations. According to the firm, “ACOs are an inexorable part of the ‘fee-for-value train’ that has left the station—they’re here to stay.” At just two minutes, this video provides a helpful overview. Watch it now.

[Hospice of Michigan CEO Dottie Deremo and Greg Berger, medical director of the Michigan Pioneer ACO, will discuss their model program at the Innovation Intensive at April’s MLC. Learn more.]