

# NewsLine

The quarterly membership publication of the National Hospice and Palliative Care Organization

Spring 2017

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Hospice

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Certification

Thoughts on Hospice  
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## FILLING IN THE GAPS IN PALLIATIVE CARE

How One Colorado Hospice Pioneered a  
Comprehensive Palliative Care Program

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**EDO BANACH**

**MONDAY KEYNOTE**

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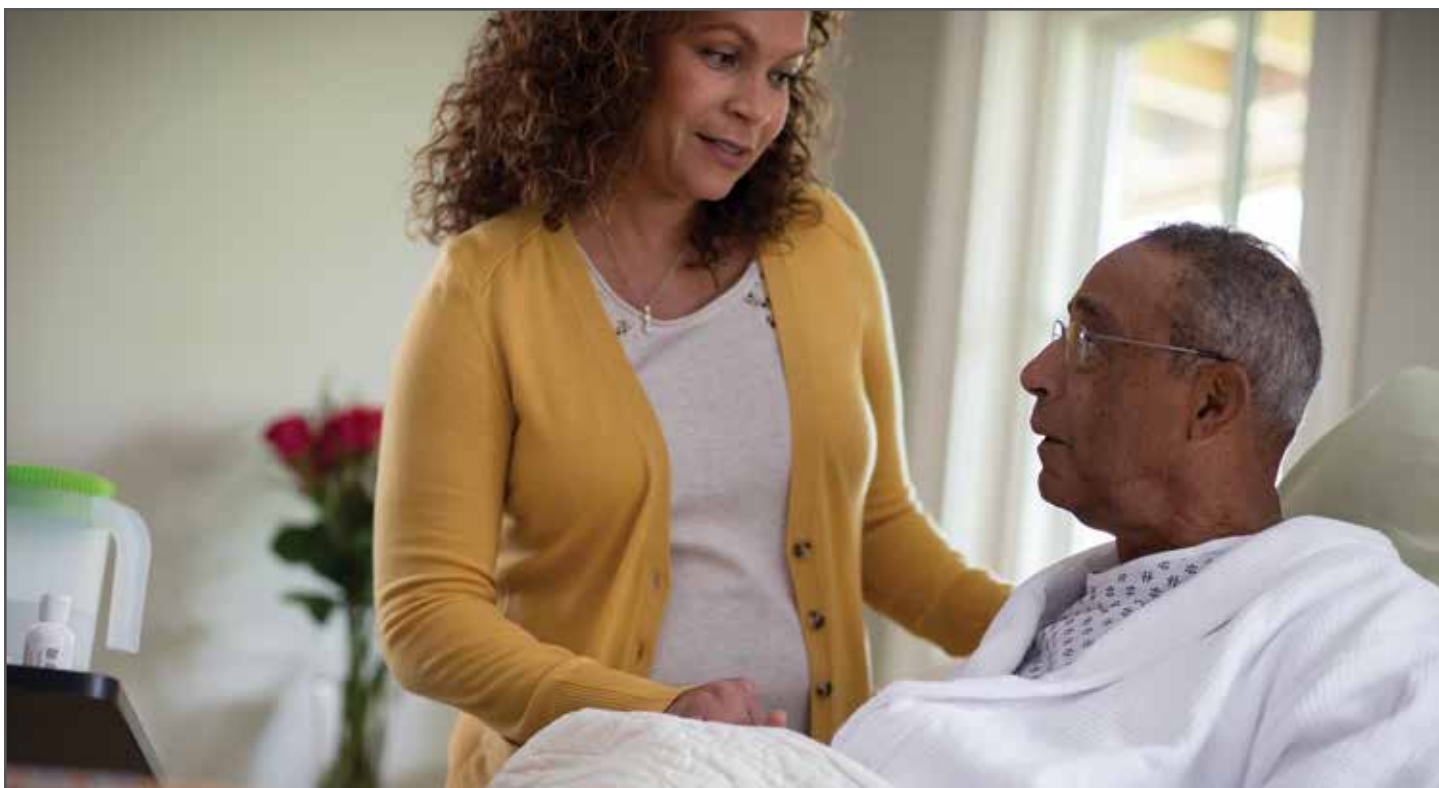
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# Welcome to our New President and CEO

It's an exciting time at NHPCO as it has only been a few weeks since we welcomed our new President and CEO Edo Banach. For those who might not have caught the press release announcing the appointment of Edo, *NewsLine* would like to share a little information about him.

Prior to joining our organization, Edo was a partner in the firm of Gallagher, Evelius & Jones in Baltimore, MD. Previously, he served as the Deputy Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services. Several of NHPCO's staff worked with him during his tenure at CMS.

Edo does indeed have hospice experience. Before his leadership role at CMS, he served as Associate General Counsel at the Visiting Nurse Service of New York. A number of our members at VNS of NY have expressed much excitement about Edo's move to NHPCO and our family of affiliated organizations.

Edo holds a B.A. from Binghamton University and a J.D. from the University of Pennsylvania Law School. Before attending law school, Edo worked for the New York City Department of Homeless Services and Mayor's Office of Operations. Additional professional experience includes time as General Counsel at the Medicare Rights Center.

When the news of his appointment was released, Edo offered some thoughts that *NewsLine* would like to share:

*Hospice in the 21st Century must combine the core hospice philosophy with a laser-like focus on quality and access to care. Hospice and palliative care must always be focused on patient and caregiver needs, and must be compliant with all federal and state laws and rules. I am honored to join NHPCO at this important time, and look forward to working with NHPCO and its partners on building a better, fairer and more accessible healthcare system.*

The selection of Edo as NHPCO's new president and CEO caps a thorough and year-long search process utilizing a nationally recognized recruitment firm and dedicated service from the NHPCO board of director's search committee.

Look for a more in-depth focus on Edo in the next edition of *NewsLine*. Additionally, attendees at the upcoming [Management and Leadership Conference](#), May 1-3, 2017, will have the opportunity to meet Edo and hear him address the membership from the plenary stage.

We welcome Edo Banach!



**Edo Banach.**





# Filling in the gaps in Palliative Care

By Nancy Lofholm

## How One Colorado Hospice Pioneered a Comprehensive Palliative Care Program

Nearly 40 years ago, when Christy Whitney was organizing an all-volunteer hospice in the small Colorado mountain town of Durango, she was struggling with a word, and with a void. The term “palliative care” hadn’t yet entered

the lexicon as the designation for what would eventually be a range of services encircling hospice care. And ill people were falling through cracks in the fledgling hospice system: There was a gap between those who qualified for hospice because they were close to dying, and those with serious illness who needed care at a lesser level.

Those issues were still conundrums in 1993 when Whitney moved on to Grand Junction, CO and became the

founding CEO of HopeWest. The non-profit hospice she organized would grow and expand services to become a respected model for creative and effective palliative care. Through trial and error and leaps of faith – with a cadre of committed volunteers and inventive financing – HopeWest was able to create a continuum of care that operates successfully beyond the confines of the healthcare and insurance industries.



*HopeWest utilizes a team-centered approach to their hospice and palliative care programs.*



**There was a gap  
between those who  
qualified for hospice  
because they were close  
to dying, and those with  
serious illness...**

“We wanted to do whatever we could so we would not become one more cog in the business of healthcare,” explained Whitney. “We learned early on to use philanthropy and volunteerism to create what we wanted.”

HopeWest was able to be creative in stepping outside the standard hospice lines because there was no template at the time for seamless care. The effort began with a miniscule hospice staff – so small

the staff directory fit on an index card. They gathered around a table in a rented office, brainstorming ideas. The nurses, nursing assistants and social workers in that room shared Whitney’s passion for improving a flawed system. They recognized how expensive and fragmented care could be if patients were forced into emergency rooms and had to be hospitalized while they were in hospice-care “gaps.”



*More than 2,500 patients and well-over 1,500 grieving individuals are served by HopeWest's hospice, palliative care and grief support programs every year across western Colorado.*

Their ideas – dozens of them – went on the whiteboard. It was an egalitarian process: Everyone's ideas had equal weight. Those that were unworkable were erased. Others were checked off as they were put into practice.

"It boggles my mind to think about where we started with all that," said Beth Brown, who was on the nursing staff then and is now the HopeWest Clinical Manager of Transition and Living with Cancer programs. "Still, we are always coming up with new and improved versions of what we do."

## Louise

In the beginning, one patient in particular helped to set the tone for HopeWest's continuity of care. Louise was a woman in her 80s with breast cancer. Her physician had recommended hospice care when

he estimated she had three months to live. That prediction proved far too short. Louise thrived on the care and attention she received as a hospice patient. She lived for three more years.

Finding creative ways to continue her care all that time helped to truly shift paradigms at HopeWest. Ideas about continuity of care were put into practice. HopeWest broke out of the healthcare realm and took on the added role of social service agency. Louise's case inspired the HopeWest staff to view the end of life as a human experience rather than a medical condition.

"Louise really set our course," Whitney recalled. "We realized that to discharge a person who needs our help is horrible."



## The Bucket

At HopeWest, that course eventually led to the creation of four channels for palliative care, or what Whitney calls “the bucket” of services. These channels, with continued tweaking, and with team work on complex case management, ensure all patients are cared for in as seamless a fashion as possible:

- **Transitions:** RNs provide palliative care case management with the support of an interdisciplinary team that includes social workers, occupational therapists, chaplains and volunteers. The majority of patients in this program are admitted with a prognosis greater than six months with chronic disease and advanced illness. More than 95 percent of them are not eligible for hospice and don’t qualify for a home health benefit through their health-care provider. HopeWest served 171 patients in this program last year.
- **Journeys:** This program serves patients who initially are enrolled in hospice but, after receiving care, no longer have a terminal prognosis of six months or less. So, they no longer qualify for hospice care under Medicare guidelines. They do still need specialized care to address medical symptoms as well as emotional and spiritual needs. To give these patients continuity of care, they are followed by the same hospice interdisciplinary care team they had as hospice patients. The continuity of care helps to reduce emergency room visits and hospitalizations and makes it easy to re-enroll in hospice once a patient becomes eligible again. Last year, 72 patients were served in this program.
- **Living with Cancer:** This program focuses on survivorship. The format is similar to Transitions, but it has a unique planning and evaluation partnership with three cancer centers. More than half the patients in this program could be eligible for hospice if they were not pursuing aggressive curative therapies. Living with Cancer patients receive services at home, such as hydration, blood draws and dressing changes, when they are too sick to travel to their medical providers. This lessens the burden on caregivers and families and addresses the concerns beyond treatment, to how a cancer diagnosis is impacting someone on a day to day basis. Social workers from the cancer centers and from the Living with Cancer program work together to connect families to resources that cover everything from medical expenses to everyday needs. A hospice nurse attends oncology team sessions. This program helped 129 patients last year.
- **Palliative Care Consults:** All palliative care patients qualify for consultations. So do ill community members who are experiencing uncontrolled symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and depression. When a referral for consultation is made – usually by a HopeWest team member or a primary care physician – HopeWest medical directors make visits to patients to assess their needs and come up with suggestions for symptom management. They work in



...that course eventually  
led to the creation  
of four channels for  
palliative care...

conjunction with the patient's primary care physician to make changes that help to control symptoms.

"With these layers of programs, we can tell physicians to call us and we will figure it out. We will find where a patient fits," said Brown.

## Speed Bumps and Education

Those channels all flow together now, but there were missteps along the way. What Whitney refers to as "speed bumps" included not training hospice nurses in palliative care in the early days. It took HopeWest time to zero in on the concept of educating employees to the job. Caregivers needed to be taught to look at the whole person – to make sure patients' toenails were trimmed and they had food in the refrigerator, as well as ensuring they had their pain under control and their dressings changed. As HopeWest's total patient census grew from 30 to the current 635, another growth-related problem surfaced: there was a lack of coordinated care between different caregivers in the palliative and hospice channels. Coordination is still a work in progress. HopeWest continues to fine tune that system so that patients aren't handed off to different caregivers as they move through the channels of palliative care and hospice.

HopeWest's learning experience with building a palliative care program has evolved into an educational effort. HopeWest holds annual training conferences that have educated more than 300 providers each year. The conferences are headlined by nationally recognized visionaries in hospice and palliative care, Dr. Frank Ferris and Dr. Charles F. von Gunten of OhioHealth Hospice. The two hospice and palliative care physicians share Whitney's mission to make palliative care a standard part of the healthcare system.

HopeWest has incorporated the concept of telemedicine to open this training to a wider audience. Internet training is bringing palliative care concepts to an

expanding network of partners that include emergency department physicians, pharmacists, ICU staff, and employees of assisted living centers and nursing homes. Online training also is being used to build satellite HopeWest programs and to instruct volunteers in rural areas, including the ski town of Telluride and the ranching community of Meeker.

## Funding

It goes without saying that all-encompassing care brings costs that don't fit in the parameters of insurance coverage. HopeWest relies on a dossier of funding sources. Holly Howell, a social worker who serves as Director of Palliative Care at HopeWest, said one of her biggest chores is "getting really creative" about funding.



*Christy Whitney  
and Holly Howell.*

The palliative care programs at HopeWest create a deficit of about \$255,000 annually. Medicare and Medicaid don't pay for those services. Even Medicare supplements rarely cover palliative care. Most private insurances don't pay. To cover the cost of the palliative care programs, HopeWest charges patients a sliding fee for monthly care that ranges from \$10 to \$150. Total annual palliative care expenses of about \$410,000 are covered by these fees, by Veterans Administration benefits, by a

small amount of private insurance, and by United Way donations. A very active HopeWest Foundation annually adds another \$100,000 to the palliative care program.

"Don't get caught in the paradigm of not doing anything that isn't being paid for," Whitney advised. "Use philanthropy and volunteerism to do what people need."

The uncertain finances of palliative care are balanced by the fact that more patients choose HopeWest covered hospice care after they have experienced the palliative-care benefits. These patients tend to enter hospice care earlier rather than waiting until their final few days. The length of stay at HopeWest has doubled over the years, from 45 days to 90 days.



## Horse Rides and Mardi Gras

Community support and financial buy-in is essential for a non-profit palliative care program to work. So is a volunteer-intensive focus. HopeWest has 1,400 volunteers. Those volunteers have made for sky's-the-limit care to become the norm at HopeWest. Whitney's philosophy about volunteers is to recognize their unique talents and put them to work where they fit. At HopeWest volunteers offer aromatherapy and hair cutting. They notarize documents and knit blankets. Volunteers record patients' life stories. They help patients decorate pillows with handprints for loved ones to have for keepsakes. They make iPads available, and instruct in their use, for communication with distant family members.

If a patient has always dreamed about violin lessons, a volunteer with musical talent arranges lessons. If a patient is having trouble reading on a computer, a tech-savvy volunteer puts larger font on the screen. If a patient's caregiver can't buy milk at the grocery store because it is too heavy to lift from the cooler, a volunteer steps in as a shopping companion.

When a couple in hospice care longs to make one last visit back to their Louisiana hometown, but are too ill for the trip, HopeWest staff and volunteers cook southern fare and hold a Mardi Gras event at their home. When a woman who has loved horses all her life wishes for one more ride, it is arranged at a HopeWest board member's stable. For a former smoke jumper in WWII pining for one final jump from an airplane before he dies, a volunteer with pilot connections coordinates a skydiving adventure.

Volunteers have made these emotional and practical support services possible. They have also helped give the HopeWest medical staff the flexibility to treat patients more broadly on the healthcare side. There are success stories in this realm, too:

- Gary entered the Living with Cancer program with a pre-leukemia syndrome that was causing a succession of devastating infections and requiring debilitating treatments. After the 58-year-old began receiving palliative care in the form of weekly home visits for blood draws and coordinated symptom control, his chain of hospital admissions stopped. His infections were brought under control.
- Laurie had stopped seeing a doctor for her emphysema because of the cost before she was referred to the Transitions program. The uninsured 54-year-old was suffering worsening symptoms before HopeWest became involved and helped treat her lung problems. A nurse and social worker also helped her apply for Medicaid and disability benefits. She began regular visits with a pulmonologist and a primary care physician. For the first time in years, she has been able to leave the house and is participating in pulmonary rehabilitation.



**Volunteers have made  
these emotional and  
practical support  
services possible.**

“This program saves lives,” a grateful Laurie said. “It’s not just medical care.”

## Good Ratings

Kudos from patients like Laurie are common in the five western Colorado counties now served by HopeWest. Their praise is underscored by the results of telephone surveys begun in 2012. The surveys show the HopeWest palliative care teams have helped reduce patients’ pain 95 to 98 percent of the time. One hundred percent of respondents credit their HopeWest teams with assistance in managing symptoms. More than 90 percent say the palliative care program had increased knowledge about a patient’s diagnosis. Respondents also give high praise to the efforts of palliative care teams related to emotional support, family involvement, and to generally increasing quality of life for patients.

HopeWest has also earned national recognition. Whitney has been tapped to lend her expertise and bring her vision to the Health and Human Services

National Rural Advisory Committee and the National Hospice and Palliative Care Organization. She wrote the first American Hospice Nursing Standards of Practice. She currently serves on the board of the National Partnership for Hospice Innovations and the Caring for Colorado Foundation.

HopeWest recently was named one of 141 hospice organizations in the United States to be a demo site for Medicare’s Care Choices Model. This demonstration program is attempting to quantify a benefit for patients who receive hospice-like support services while also receiving curative treatments. This program aligns with what HopeWest has already been doing successfully.

## Proof it Works

National studies have already begun to chart the benefits of palliative care. A recent study published in the *Journal of Palliative Medicine* shows that home-based palliative care for individuals with advanced illnesses is linked to a \$12,000 reduction in the mean total cost of care per person. It is also associated with



*Patients have a range of options to choose from and have the freedom to develop a customized plan of care to suit their needs.*



fewer hospital admissions and emergency room visits and a greater use of hospice in the last three months of life.

A University of California cancer study finds patients who received palliative care for 90 days or more saved thousands of dollars in medical costs per patient based on reduced emergency room visits and hospital stays. *The New England Journal of Medicine* reports that patients with an aggressive form of lung cancer had less depression and less pain and discomfort if they received palliative care in addition to oncology treatments. Those receiving palliative care lived 2.7 months longer than those receiving only oncology services.

Whitney said she sees all that as validation that palliative care is a valuable safety net for the healthcare system. It is an impetus for establishing a more seamless system of delivering palliative care nationwide.

She hopes more hospice organizations will take the same philanthropic view HopeWest has embraced – a mission that it carries out and refines every day. It hasn't been easy. It hasn't been without stumbles. But it has proven that gaps can be filled. It has shown a way forward for delivering the expanded care that didn't even have a name when Whitney entered the hospice field.

Whitney's overarching advice for other hospices who want to join this mission is daringly simple: "Decide what you want to do. And jump off that cliff."

#### HopeWest Advice About Adding or Expanding Palliative Care

- Have a leader with the right philosophy about palliative care.
- Draw ideas from every level – from nursing assistants to physicians.
- Create a continuum of care.
- Become an integral part of the community, churches and neighborhoods.
- Look beyond the obvious for partnerships.
- Broaden your view of volunteers.
- Integrate palliative care into hospitals.
- Seek buy-in from physicians.
- Keep a focus on the non-medical parts of end of life care.


### About HopeWest

HopeWest is a non-profit hospice, palliative care and grief support organization dedicated to profoundly change the way the community experiences serious illness, aging and grief – one family at a time. Founded in 1993 through a community-wide vision, HopeWest now serves more than 2,500 patients and well-over 1,500 individuals coping with grief each year across 7,000 square miles of western Colorado in Mesa, Delta, Montrose, Ouray and Rio Blanco Counties. For more information visit [HopeWestCO.org](http://HopeWestCO.org).

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**This program saves lives...  
It's not just medical care.**



# On why I wrote life after the diagnosis

Expert Advice on Living Well with Serious Illness for Patients and Caregivers

By Steven Pantilat, MD

Even as a pioneer in palliative care, researcher, professor and physician, losing my mother was deeply painful and difficult. The impact of serious illness and loss in my own life resonates in my heart each day as I care for patients and their families facing their own challenges and opportunities. It strengthens my work in palliative care to bring peace, comfort and dignity to people in any way that I can.

I started writing [\*Life After the Diagnosis: Expert Advice on Living Well with Serious Illness for Patients and Caregivers\*](#) just before my mother was diagnosed with inoperable lung cancer. The journey after her diagnosis instilled a firm commitment to write this book and make it accessible to anyone and everyone in need. At the time, writing was a private act to process the work that is honoring the sacredness of life. What came out of that was a practical guide to help care for the whole person.

Palliative care isn't something everyone understands or knows is available.

Unfortunately, [only 24 percent of Americans](#) consider themselves very prepared for dealing with serious illness. Palliative care provides people with serious illness the best possible quality of life for as long as possible at any stage of illness. One aspect of palliative care that really resonates for me is that it focuses on the whole person, not just the disease. It acknowledges the truth about the nature of life, offers patient-centric decisions based on their values and ultimately finds a better way to take care of people.



*Steven Pantilat, his mother and three sons.*

Too many people with serious illness receive care that they do not want and from which they cannot benefit, and fail to receive what they do want from which they will benefit. In palliative care, communication is often the best medicine for this imbalance. I like to ask patients, “What’s most important to you now?” and “When you look to the future what do you hope will happen?” Talking with our patients openly about values, goals and preferences helps us collaborate and make better decisions based on their wants and needs. It truly determines the quality of care a patient receives.

In *Life After the Diagnosis* I discuss symptom control, hospice care, interpreting what doctors say, making decisions, caregiving and the end of life, topics that will help patients and their families improve their quality of life, and live better and longer with serious illness. The stories in this book offer a means of connection, empathy and a precedent for dignity.

I wish I could speak to everyone who needs help. I get calls and emails from colleagues, friends and strangers daily asking about how to better help loved ones with serious illness. Since I cannot talk to everyone, this book stands as a guide to give others the same information, support and guidance that I give to those who contact me. My hope is that *Life After the Diagnosis* will serve as a resource for caregivers, patients, chaplains, social workers, nurses, therapists and physicians as they work with people living with serious illness and that it will be used as a resource for the community that cares for life in all of its stages.

**Steven Z. Pantilat, MD**, is the Founding Director of the University of California, San Francisco Palliative Care Program and Professor of Medicine in the Department of Medicine at UCSF. He is the Kates-Burnard and Hellman Distinguished Professor in Palliative Care and the Director of the UCSF Palliative Care Leadership Center that trains teams from hospitals across the country on how to establish palliative care services.

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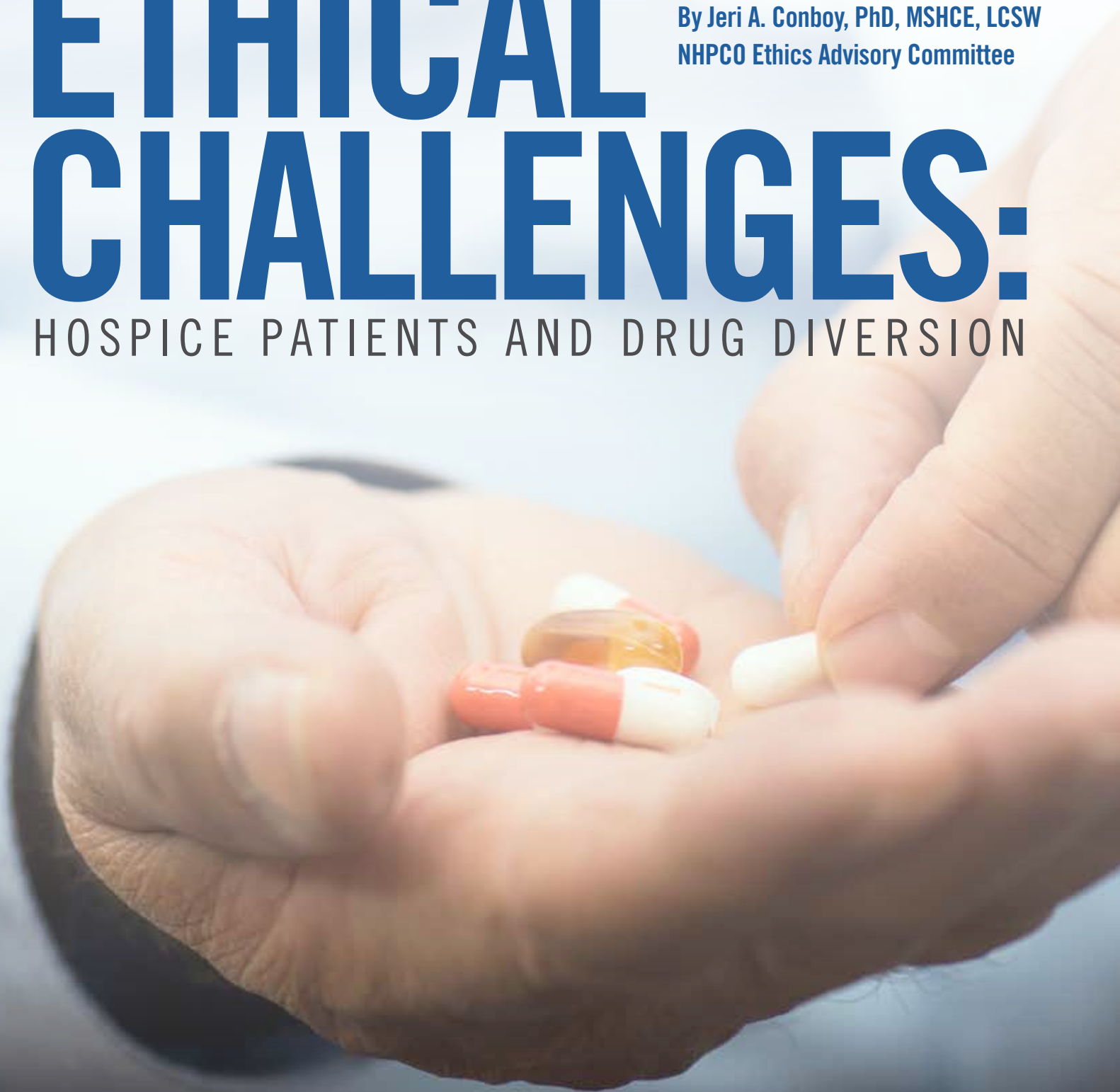
**Too many people with serious illness receive care that they do not want and from which they cannot benefit...**



# ETHICAL CHALLENGES:

By Jeri A. Conboy, PhD, MSHCE, LCSW  
NHPCO Ethics Advisory Committee

HOSPICE PATIENTS AND DRUG DIVERSION



## A HISTORY LESSON

In the early days of hospice, effective pain management was both a primary goal and a challenge to achieve. Barriers to effective pain management included fear of using opioids, lack of knowledge regarding how to prescribe, and a limited supply of effective medication. Morphine was seen as a vestige of the battle fields of WWII; effective for temporary pain, but not intended for long term use, in part due to concerns of addiction.

Hospice care changed all that. Pioneers in the hospice movement advocated for the need and rights of patients to have their pain effectively managed and educated the health care and regulatory community to make resources available. Pharmacological companies followed suite to develop long acting opioids effective for management of pain. In the intervening years the use of opioids to manage pain has become the rule, not the exception. Could one of the results of this progress be an unintended consequence? Has the success of hospice to raise the level of consciousness regarding pain management helped to create one of hospice providers' biggest challenges; the diversion of drugs placed in hospice patient homes?

## DRUG DIVERSION

Drug diversion can be defined as the “illegal distribution or abuse of prescription drugs or their use for unintended purposes” (CMS, 2016). Medication diverted may be used by the person who took it or that person may give or sell it to another person. Opioid diversion can occur out of curiosity to experience a “buzz,” to impress friends, to make money, or to feed an addiction. Whatever the reason, the consequences can be tragic and costly on an individual and societal basis.

The costs to society can be seen, in part, in the opioid addiction crisis in the United States. This is not to say that drug diversion in hospice patients is responsible for this crisis; it is more a symptom than a cause. Yet it begs the question: how did we get to this point? Advocacy for effective pain management created a chain reaction of events in the health care community. The search for better means to manage patient pain created an incentive for pharmaceutical companies to increase research & development and manufacture different varieties of opioids. This created a market for selling this supply which required contacts with physicians to provide education regarding the use of the new medications. With increased knowledge, both from within the physician community and from pharmaceutical companies, physicians became more willing and skilled at prescribing opioids. This put more opioids in the hands of patients, through their own physician, a hospital episode, pain clinics, and services such as hospice designed to deliver and administer medications in an individual's home. And so we return to the ethical dilemma that hospice organizations confront routinely: if needed medications are placed in the home, will they be used by

**Pioneers in the hospice movement advocated for the need and rights of patients to have their pain effectively managed...**

someone other than the patient and not benefit the patient; if they are not placed in the patient home to avoid diversion, will the patient experience pain causing harm to the patient?

## THE ELEPHANT IN THE ROOM

An ethical dilemma can be much like an elephant in the room; no one wants to talk about it. When facing a situation that requires action the dilemma has three components. First, there are at least two courses of action that can be taken. Secondly, neither course is clearly the right one; both have downsides. Lastly, if you don't pick one course of action the other will occur anyway. These dilemmas can be resolved by the application of ethical principles to guide the hospice team to a practical resolution that protects the patient and the hospice. Beauchamp and Childress (2009) identify ethical principles that provide tools used to examine ethical dilemmas in health care some of which are autonomy, beneficence, nonmaleficence and justice.

In situations where drug diversion is a possibility, these principles can be applied to create an understanding of the situation at hand and provide guidance to an ethically justified resolution. A foundational part of the hospice philosophy is patient choice; the hospice patient has a right to understand their care options and make informed choices regarding how they choose their quality of life. This is the principle of autonomy which states that individuals with the

capacity to do so, have a right to self-determine their decisions. The principle of autonomy is also extended through advance directives. Because hospice patients often cannot speak for themselves and are dependent on others to make decisions on their behalf, they are especially vulnerable to their autonomy being compromised.

The principle of beneficence is an imperative to take actions that benefit others. Beneficence directs hospice providers to provide for the patient's comfort and well-being and to relieve patient suffering. While we do this in many ways, one primary means of promoting comfort is through achieving pain management through the use of medication placed in patient homes. Because medications placed in patient homes are intermittently observed at best, meeting the principle of beneficence is at risk when drugs are diverted from patient use.

Nonmaleficence means to not cause harm. The expectation to avoid harm through inadequate pain management can sometimes become a philosophical barrier when the hospice provider considers possible alternatives to reduce the risk of drug diversion. From a broader view, the principle of nonmaleficence is related to the possibility that the increased prevalence of opioids to manage pain for hospice (and non-hospice) individuals has a negative consequence for society by making opioids easily accessible.

The last principle, justice, emphasizes fairness among individuals. When drugs prescribed to hospice patients are diverted for another purpose, the principle of justice is failed.

Resources are unfairly expended by the use of Medicare or other benefits to pay for drugs not used for patients and by using society's resources to address opioid addiction.

## A CASE IN POINT

There is probably not a hospice provider that has not encountered a situation where drug diversion was suspected. The following case is an example that will be used to show how these four ethical principles play out in real life.

Jack was a 67 year old Caucasian male admitted to hospice with diagnoses of lung cancer and COPD. He lived in a small rural community with his daughter, son-in-law and an adult son with developmental disabilities. He had another son who lived in the same town but not in the same house. At the time of admission to hospice, Jack was bedbound and required a lift to transfer. He was dependent upon caregivers for most of his needs. To address Jack's primary symptom of pain and dyspnea, liquid morphine was placed in the home shortly after admission. In addition to physical needs and symptom management, family dynamics complicated the care situation. The family disagreed about current and future care needs for Jack's developmentally disabled son.



Additionally, the daughter Jack lived with was in charge of paying bills and other financial matters for the patient and his son.

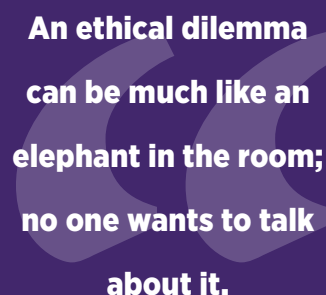
Two weeks after his admission to hospice, Jack's caregiver's reported to hospice staff that patient's money was missing as well as doses of morphine. The patient stated he could not recall if he had been given the medication. His daughter stated that they had suspicions that the patient's son might take the medication and had started keeping it at her mother-in-law's nearby home. The patient told the hospice nurse that he felt he received good care, yet also told the RN that he didn't trust any member of his family to provide his care.

## TAKING ACTION

The patient's RN and social worker identified the following questions in this situation: was medication missing, was the patient getting the medication needed to achieve needed symptom management, and how could hospice ensure that needed medication was available for the patient? In addition there were concerns regarding the patient's overall care needs being met and if he was being financially exploited by his family. Did Jack feel that he could disclose to his hospice caregivers any concerns he may have regarding these questions? The task at hand in this and in any similar situation is to develop a plan that addresses these questions in an ethically justified way.

Jonsen, Siegler, and Winslade (2002) suggest four topics to consider when confronted with an ethical dilemma: medical indications, patient preferences, quality of life, and contextual features. Examining these topics can clarify the multiple ethical principles that must be addressed simultaneously to effectively resolve the situation when drug diversion is suspected. Meeting the principles of beneficence and nonmaleficence are primary concerns; how can hospice ensure that good is done by promoting patient comfort and harm caused by medications diverted from appropriate patient use is avoided? In the case example, the report of misuse of the patient's money raised additional issues of beneficence and nonmaleficence. The principle of autonomy was honored by recognizing the patient's need to express concerns and have input into any plan made to account for all medications placed in the home. The principle of justice lies in the use of Medicare resources to provide medication diverted from patient use, as well as society's resources utilized to stem the tide of diversion and the broader epidemic of drug addiction.

In the case example, the first step was to document a complete inventory of all medications in the home compared to the patient's medication profile. This accounting substantiated that morphine was missing. Patient input did not explain the missing medication and the patient's daughter stated her belief that her brother took the medication. In consultation with the patient, a decision was made to put a lock box in the patient's home. Medication was placed in the box and both the patient and the hospice RN each had a key. Three doses of morphine were kept



**An ethical dilemma  
can be much like an  
elephant in the room;  
no one wants to talk  
about it.**

outside of the lockbox to use if needed with directions to call the hospice RN when the 2nd dose was used to provide time to assess and obtain additional medication as needed. This plan met the principles of autonomy, beneficence and nonmaleficence by allowing the patient to be a part of the plan while ensuring medication was appropriately available. Next, the family was asked to keep a log of all medications. This was used to verify both symptom management needs and adherence with the plan. Lastly, a report was made to the elder abuse hotline regarding potential financial exploitation and drug diversion impacting the patient's health care. Each step of this plan was discussed with the patient and his family who verbalized understanding and agreement.

Five days after this plan was initiated, the patient reported to the hospice RN that his son had brought him the lock box, telling him that the only medication in the home was in the lock box. There had not been a prior report to the RN that the 3 available doses had been used. The RN and SW met with the patient and his caregivers to review the current situation and discuss options. Following the wishes of the patient and the principle of autonomy, the remaining morphine was destroyed by the family and witnessed by hospice staff. To ensure the availability of adequate symptom management the hospice RN obtained an order to have rescue doses at a 24 hour

pharmacy for the family to pick up when the pharmacy was notified by the RN. Until these were needed, over the counter pain medication was in the home and nonpharmacological methods to reduce anxiety were reviewed. A follow up report was made to the elder abuse hotline. All of these steps addressed the principles of beneficence and nonmaleficence by balancing patient comfort while preventing further diversion of drugs.

A post script to this case: the patient's daughter obtained a restraining order against her brother, preventing him from coming into the home. Following this no further concerns regarding financial exploitation or drug diversion were expressed by the patient or evidenced when hospice staff was in the home. Liquid morphine was successfully placed back in the home when Jack's symptoms increased. The patient died in his home seven weeks after the first report of drug diversion. Developing a plan based on ethical principles allowed the patient to safely stay in his home and the hospice team to fulfill its mission while sustaining a beneficial relationship with the patient and family.

## SUMMARY

As long as there is an opioid abuse epidemic and hospice places opioids and other medications in patient homes, drug diversion will be a potential issue. Hospice organizations need to be proactive in every situation to assess risk and develop a plan to minimize risk. The

plan to minimize risk should consider and resolve ethical principles present in each individual situation. The case study provides one example of how strategies to minimize risk can be implemented.

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*Jeri A. Conboy, PhD, MSHCE, LCSW, is Director of Blessing Hospice and Palliative Care in Quincy, Illinois, where she has worked for 27 years. She is also Director of Clinical Ethics at Blessing Hospital.*

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# **RECOGNIZING THE SPECIAL SKILL SET OF THE HOSPICE MEDICAL DIRECTOR**

By Larry Beresford



Roles, responsibilities and expectations for hospice medical directors have advanced rapidly in recent years, says John Manfredonia, DO, FACOFP, FAAHPM, HMDC, Division Vice President and West Regional Medical Director of Kindred At Home and president of the Hospice Medical Director Certification Board® (HMDCB®).

HMDCB was created in 2012 to define, test and recognize the particular skill set developed by experienced hospice medical directors—not just clinically but also operationally and in mastery of the increasingly complex regulatory environment in which hospices must operate. To date, some 650 physicians have passed the voluntary exam to become a certified hospice medical director, demonstrating to their CEOs, their hospice teams, referring physicians and the larger community that they have mastered this skill set and can bring its specialized knowledge to bear on the day-to-day work of hospice care.

As the hospice marketplace evolves under the harsh glare of heightened regulatory scrutiny, the skill set becomes ever more important, Dr. Manfredonia says. Hospice and palliative care have grown in recent years—to a \$16 billion hospice sector under Medicare, with palliative care programs in most U.S. hospitals and, increasingly, in community settings.

At one time, hospices tended to be nurse-driven agencies, with physicians sometimes seeming more like add-ons in volunteer or very part-time roles, he says. The evolution of standards for hospice physicians has taken the better part of the past decade, as the government has advanced a number of specific requirements for the doctor to meet. These include writing a persuasive physician narrative statement to justify the patient's prognosis of six months or less to live; the face-to-face visit for recertifying the patient's continued eligibility for

**...some 650 physicians  
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hospice medical  
director...**

third or subsequent benefit periods; and, more recently, the certifying physician's responsibility to determine and document the primary hospice diagnosis and all related diagnoses for the patient.

Failure to meet these requirements could put the hospice in significant financial jeopardy should it experience pre- or post-payment reviews by its Medicare Administrative Contractor or the alphabet soup of other governmental agencies and contractors charged with protecting the integrity of the Medicare program. The doctor is also needed with gray area or borderline patients to document that they really are terminally ill and qualify for hospice.

But understanding the regulatory environment is only part of it, Dr. Manfredonia says. There is also the ability to lead the hospice multidisciplinary team in caring for increasingly complex patients, some who may only spend a few days on service. They require so much more care because of the severity of their disease. Communication skills that traditionally weren't emphasized in medical training are a bigger part of the job. And the physician's role as a leader on the hospice management team also comes to the fore, helping to create the agency's environment of professionalism.

## **An Experiential Path to Certification**

HMDCB was launched, with funding support from the American Academy of Hospice and Palliative Medicine, as an independent non-profit organization to develop and administer a certification exam for hospice medical directors. "The goal for our organization really is the development of benchmarks and expectations for the hospice medical director," Dr. Manfredonia says.

Although many physicians working in hospice and palliative medicine (HPM) have earned sub-specialty HPM board certification through the American Board of Medical Specialties and its constituent subspecialty boards or through the American Osteopathic Association's Bureau of Osteopathic Specialists, the

hospice and palliative medicine board credential now requires completion of a full-year, full-time fellowship in order to qualify.

For hospice medical directors, many of them in mid-career, taking a year off for a fellowship may not be possible, Dr. Manfredonia says. HMDBC provides another pathway to professional credentialing—reflecting a somewhat different but complementary set of skills, competencies and knowledge specific to the hospice medical director.

For physicians, it is a clear statement to their peers of their dedication to this specialty. For patients, it provides assurance of the skills of their hospice providers. It signifies that the medical director is trained and knowledgeable in the latest information about medical treatment in addressing all of the components that contribute to suffering at the end of life.

For the agency, it provides confidence in knowing that the physician has demonstrated the skills and knowledge that are essential to the hospice's success. Certification for the medical director can also distinguish the hospice from its competitors—standing apart based on its commitment to clinical quality and enhancing its credibility in the community. It's a way to recognize and reward the physician's commitment to obtaining these additional skills and credentials.

"How do we make sure that CEOs understand the importance of certification?" poses Judi Lund Person, BA, MPH, CHC, Vice President for Regulatory and Compliance at the National Hospice and Palliative Care Organization. "You can advertise to the community that you have board-certified physicians on your staff. It could also be beneficial in pursuit of accreditation, and the knowledge shared with other clinical staff helps to bring more learning and more skills into the organization," she says.

"It is worth getting more specific training and education in order to succeed with the underlying Medicare regulations, such as judging eligibility using the MACs' local coverage determination (LCD)



policies—and what those are. What are things you would need to document in order to show to someone who is reviewing the chart that this patient truly is eligible for hospice? It's also about clarifying goals of care for the patient and family, and having difficult conversations about them. How do these interactions with patients work in different care settings?"

## Getting Ready for Certification

How do hospice doctors get certified? First they have to study for it—they have to do the work if they want to do well on the exam, Dr. Manfredonia says. "This is an experiential pathway toward hospice medical director certification. The distinction is focused toward a specific role and skill set. We provide resources, as do AAHPM and NHPCO. The [AAHPM Medical Director Manual](#) is a very good resource for this." AAHPM's "UNIPAC" self-study series offers nine modules in the principles of hospice and palliative medicine, and "[HMD Prep](#)" is a 75-item multiple-practice test based on the HMDCB exam blueprint.

"It sounds simplistic, but if you want to pass this exam, you need to prepare. As you prepare for the exam, you may identify areas of strength and weakness in your current mix of competencies, areas where you are more or less comfortable and might want to do more in-depth self-study. So preparing for the exam provides motivation to increase your skill set, not just on the medical side but understanding the continuum of care and essential communication skills," Dr. Manfredonia says.

"Then, if you pass, you get that badge, and you can use it for whatever purposes you want to pursue in order to advance your career. It could lead to higher salaries and professional recognition, and it exemplifies your commitment to this specialty of hospice as a true calling." The fourth exam for HMD certification will be offered starting May 19, 2017; visit the [HMDCB website](#).

**Larry Beresford** is a freelance medical journalist in Oakland, Calif., editor of the Hospice Compliance Letter monthly subscription newsletter and contributor to the Lancet's United States of Health blog page. [larryberesford@hotmail.com](mailto:larryberesford@hotmail.com)

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**For the agency, it provides confidence in knowing that the physician has demonstrated the skills and knowledge that are essential...**



# The End of an Era for Hospice Facilities

**By Sue Lyn Schramm, MA**  
**Director, Consulting Services, NHP CO**

Earlier in my career as a hospice consultant, I spent a great deal of time conducting feasibility studies for hospice inpatient facilities. The common wisdom, from the late 1990s right up until a few years ago, was that while dedicated GIP facilities were unlikely to break even on the basis of their operating revenue, they were nevertheless valuable because they fulfilled a need for patients and families. A hospice facility was often seen as a tangible symbol of the hospice's service to the community, and many clients told me that their freestanding buildings were reliable magnets for fundraising. At that time, many laypeople found it hard to understand that hospice is not a place. By conducting the fundraising to support a visible physical hospice building, and by taking care of the most acutely ill patients, many hospices found that their roots

within a community were both deepened and broadened.

At that time, the economics of such facilities were not unfavorable. In spite of the fact that General Inpatient, or GIP, reimbursement rarely covered all a facility's costs, hospices with their own dedicated facilities usually found that as many as 40 percent of their home care patients could be billed at GIP for at least part of their stay. That guaranteed that a hospice with a large-enough home care volume could assume that occupancy rates would be reliably high, so the high fixed costs of operating such a facility would receive a steady contribution of revenue.


One of the biggest questions in these building projects was always how big to make it. (Rarely was the question whether to build.) I had a number of rules of thumb in helping clients plan their facilities. While a typical hospice without a

GIP facility might expect to see one to two percent of their patient days at the GIP level of care, hospices with their own dedicated inpatient beds routinely exhibited much higher proportions. Utilization as high as six percent of total patient days was much more typical for them, and that was usually the metric I used to estimate the need for beds.

Even after using that aggressive six percent planning target, one of my clients reported after an expansion project that their facility occupancy was running far ahead of my projections. More than once I heard colleagues and clients use the phrase, "If you build it, they will come."

My, how times have changed.

These days I frequently find myself advising disappointed clients not to build at all. One such client had already lined up donated land and



was set to launch the capital campaign to raise building funds.

However, when shown the size of the probable operating deficit their proposed facility would carry year after year, the board decided to put the project on indefinite hold. Another client came to NHPKO Edge for help in developing a communications strategy when their board reluctantly decided to pull the plug on a building capital campaign that was already in progress. The hospice's leadership had updated their facility volume forecasts using newer, more conservative estimates for occupancy. In the process of revising their analysis, its leaders realized with alarm that in good conscience, they would have to halt the campaign.

What happened to bring about these changes? I chalk it up to the transformed environment for compliance oversight and the increased regulatory scrutiny of

general inpatient level care.

Ironically, the primary concern of regulators regarding GIP was originally that too many hospices under-used that level of care. MedPAC, the Medicare Payment Advisory Commission, reported its own analysis that 28 percent of all hospices did not bill for a single day of GIP care in calendar year 2013.

However, at some point within the past 18 to 24 months, the primary concern flipped from one of under-use, to over-use. We live in an age of the Z-PIC audit and a newly skeptical and active Office of the Inspector General. In March 2016, the OIG released a study with the alarming title, "Hospices Inappropriately Billed Medicare for \$250 Million for General Inpatient Care." It reported findings that as much as 31 percent of all hospice

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find myself advising  
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build at all.**



GIP use was billed inappropriately. By the OIG's estimate, in 20 percent of cases the patient did not need GIP care at all.

There is no doubt this analysis is guiding enforcement actions and encouraging both ADRs and audits for inpatient hospice care. NHPCO staffers report hearing from hospices across the country that their MACs are aggressively rejecting claims and requiring much more thorough documentation of the appropriateness of each and every day of GIP level care. In response, many hospices are now aggressively self-policing their own use of GIP. In some cases, I worry providers may run the risk of reacting so conservatively that they reduce GIP use even further than the regulators would require.

The predictable result has been financial crisis for hospices with freestanding inpatient facilities. These structures were built using a different set of assumptions about their use and occupancy than now applies. NHPCO Edge has modeled the changing revenue structure of such facilities. For a medium-sized hospice with 60,000 patient days annually, a drop from having five percent of days at the GIP level down to only two percent would mean a loss of almost \$1.3 million in revenue. No amount of residential use can cover the costs of a facility built to an inpatient operating and staffing standard.

The good news is that there are constructive things that hospices can do, and there are strong case examples out there of hospices with inpatient facilities that are still thriving. Those facilities have found ways to adapt and respond to the current environment, keeping occupancy rates (and revenues) high enough to continue to support their organizations.

This article allows space for only a mere taste of successful tactics, but best practices can include the following:

- Use guidelines and language from your own fiscal intermediaries in GIP documentation
- Be thorough in identifying the precipitating events that lead to a transfer to the GIP level of care
- Make sure your patient record includes narrative that is individual and supports the level of care for EACH day the patient remains at GIP
- Manage the patient's and family's expectations—have a clear approach for what to do when a patient no longer qualifies for GIP
- Prepare the family up front for the fact that GIP is for short-term crises
- Be clear about your facility's policies regarding room and board
- Maximize GIP admissions from hospital referral sources

- Conduct an internal analysis to look for internal barriers to GIP use

If we assume that today's tight scrutiny is here to stay, and I do, then it is incumbent on us as hospice leaders to find new ways to ensure that our facilities receive their best and highest use while remaining compliant with Medicare regulations. That won't be an easy job, but we owe it to ourselves, to our patients, and to our donors and supporters to adapt to the new realities for hospice facilities. I have full faith that as an industry, we're up to the task.

**Sue Lyn Schramm, MA**, is the Director of NHPCO Edge, the consulting services division of NHPCO. Sue Lyn has more than 20 years' experience in healthcare consulting and strategy and has specialized in hospice for more than 15 years. NHPCO Edge offers guidance to hospice and palliative care providers in strategic planning, business development and market analysis. For more information, see [nhpc.org/resources/nhpc-edge](http://nhpc.org/resources/nhpc-edge).

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## Additional Resources

In recent months, NHPKO Edge has published several resources regarding the topic of hospice inpatient facilities. For more information, please see:

- NCHPP Webinar on [GIP and Hospice Facilities](#)
- The NHPKO Podcast Series, with special episodes on [GIP](#) and [Strategy](#).

On April 30, prior to the start of the NHPKO Management and Leadership Conference in Washington, DC, Sue Lyn Schramm, MA, Director of NHPKO Edge, will lead a pre-conference seminar, [Stemming Hospice Facility Losses in an Era of Shrinking GIP Utilization](#). Joining Sue Lyn as faculty for this half-day session will be two of the nation's current leaders in hospice facility management:

### **Robert Phillips-Plona**

Director of Residential Services

Hospice of the Western Reserve, Cleveland, OH

### **Apollo Townsend Stevens, DNP, RN**

Director of Hospice Home

Transitions LifeCare, Raleigh, NC

The [2017 Management and Leadership Conference](#) offers a wealth of valuable concurrent sessions that will benefit hospice leaders and managers who are interested in innovation, quality and organizational excellence.

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things that hospices  
can do...

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# Insight and Leadership at MLC 2017

Washington, DC, is without question, one of the most important cities in the world – and the site for NHPCO's [2017 Management and Leadership Conference](#). More than a conference, this is an event for leaders from throughout the end-of-life community to unite, interact, and focus on timely issues that will lead us into the future. It will be an opportunity to amplify the voice of the hospice and palliative care community in our nation's capital. And it will provide us with an opportunity to acknowledge and celebrate all that we do to advance the continuum of care.

In addition to our noted plenary session speakers, MLC offers a wealth of preconference seminars and concurrent sessions on timely topics taught by expert faculty from throughout the hospice and palliative care professional community and related fields.

Throughout the MLC, May 1–3, attendees are welcomed to choose from any of the more than 70 concurrent sessions that span multiple focus areas. Or participants might choose to take a deep dive into one specific area. The preconference seminars offered April 29–30 are an excellent way to add to your MLC learning experience or serve as a stand-alone offering.

Review Preconference Seminars and Concurrent Sessions by Focus Area:

- [Access](#)
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We invite you to search our current session offerings by keyword, title, or presenter by using our [2017 MLC Session Search feature](#).





## Advocacy at MLC



The first 100 days are a critical time in any presidency. It's when key personnel are confirmed, policy agendas are set, and strategies are developed. As the Trump Presidency and 115th Congress begin, NHPCO will be educating new Administration officials and members of Congress, reinforcing the importance and value of hospice and palliative care, and advocating for policies that ensure access to high quality care. The 2017 Management and Leadership Conference convenes at this critical time, and gives YOU the chance to advance this important work.

On Wednesday, May 3 (day three of MLC), conference attendees will be briefed about the 115th Congress, the new administration, the changing health policy landscape, and NHPCO's efforts to preserve, protect and promote hospice and palliative care. That afternoon, in coordination with the

Council of States, participants will take to Capitol Hill to advocate in support of NHPCO's legislative agenda.

Advocacy at MLC is a preview to our signature Congressional Event, the Advocacy Intensive. We will provide attendees with a high-level overview of the major policy issues and connect them with key policymakers.

Participation in Advocacy at MLC is free for MLC attendees, but you must register with the Hospice Action Network to alert us to your participation. You will receive a link to register for Advocacy at MLC once [you have registered for MLC](#).

Visit the [Hospice Action Network](#) website for Advocacy Intensive information available in late spring 2017. If you have any questions, please email [info@nhpcohan.org](mailto:info@nhpcohan.org).

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with the Hospice  
Action Network**

# 2017 NHPCO Board of Directors

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## A Message from Board Chair Jan Jones

First, let me say how honored I am to be serving as chair of the NHPCO board of directors. It's certainly a highlight of my professional career but that's not the important thing, what's most significant to me is the opportunity to serve and be a strong advocate for each one of you.

I've been a hospice CEO for 29 years and have been a member of NHPCO for much of that time – this includes many years serving on the NHPCO board and on numerous committees and workgroups. Like many of you, I've experienced the changing hospice landscape and faced challenges and opportunities firsthand. I want to assure you that all of us on the NHPCO board of directors and among NHPCO's staff are dedicated to working on your behalf with the best interests of our nation's broad hospice and palliative care provider community.

This is a special time for us at NHPCO as we welcome our new President and CEO Edo Banach. Having the opportunity to get to know him as he prepared to join us has been a pleasure and I look forward to working with him. He's passionate about our mission and I'm sure you'll find him to be as engaging as I have.

We all share a common mission to deliver the highest quality care to patients and families facing serious and life-limiting illness. Our work together and our many accomplishments would not be possible without the support of you, our members, so let me offer my sincere gratitude for your commitment to NHPCO.

Yes, the challenges we as a field face are great—but the opportunities are many. From my view as board chair, I continue to be impressed by our collective ability to meet those issues head on and continue to advance our shared mission.

Thank you,  
Jan Jones  
Chair



Board Chair Jan Jones

**...what's most  
significant to me is  
the opportunity to  
serve and be a strong  
advocate for each one  
of you.**



# Global Partners in Care Has a New Home



*Mike Wargo, Hospice Foundation COO (back right), and Rose Kiwanuk, Palliative Care Association of Uganda Country Director (front row, third from left) are pictured with students that Hospice Foundation is currently sponsoring in the Diploma in Palliative Care Course at the Institute of Hospice and Palliative Care in Africa on the campus of Hospice Africa Uganda.*

Earlier this year, NHPCO proudly announced that its affiliate, Global Partners in Care, a non-profit organization consisting of partnerships committed to supporting hospice and palliative care organizations in developing countries, became an affiliate of the Hospice Foundation, headquartered in South Bend, Indiana. The Hospice Foundation is the supporting foundation for Center for Hospice Care. CHC is one of Global Partners in Care's most successful partner programs; they have worked with the Palliative Care Association of Uganda since 2008.

"This is a bittersweet transition because although we are sad to see Global Partners in Care leave the NHPCO family, we are thrilled to hand the baton to Hospice Foundation," says Executive Director John Mastrojohn III. "We know the program is in good hands and that the mission to increase access to hospice and palliative care where the need is great and resources few, lives on."

Global Partners in Care was once known as the Foundation for Hospices in Sub-Saharan Africa. FHSSA was founded in 1999 to mobilize a response to the sub-Saharan HIV/AIDS pandemic and support Africa's hospice and palliative care programs' ability to provide compassionate care. In 2004, FHSSA became an affiliate of NHPCO. In 2014, NHPCO recognized the need to expand the mission beyond Africa and rebranded FHSSA to Global Partners in Care.

Today, the partnership network extends to several African countries, India, and Nepal. Since 2004, over \$4.5 million has been sent to hospice and palliative care organizations. Through the course of Global Partners in Care's history, more than 80 U.S.-based hospices have partnered with similar care providers in 18 countries creating not only constructive partnerships but friendships between nations, communities and individuals.

"We are very excited to take on this new challenge," commented Hospice Foundation Chief Operating Officer Mike Wargo. "We've been actively engaged in supporting CHC's partnership with PCAU for nine years. During that time we've seen substantial evidence of the impact the Global Partners in Care model can have on organizations on both sides of the equation. When properly executed, these partnerships are a win-win for both the U.S. and international organization. Ultimately these partnerships improve the quality of living for patients and their families in underserved areas of the world."

Global Partners in Care provides partnership opportunities for U.S. hospice and palliative care organizations to make a commitment to support a hospice and palliative care organization in a developing country. Partners engage in capacity-building, strategic planning, education, fundraising, and technical assistance to expand and improve services for those in need.

To learn more about international partnership opportunities and other ways to support the organization, visit the [Global Partners in Care](#) website.

Have questions about the transition? Please access our [Q&A document](#) (PDF).

# 2017 NATIONAL HOSPICE

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CARE OF NORTHWEST KANSAS, INC  
INFINITY HOSPICE CARE

MUMMS SOFTWARE  
ONEPOINT PATIENT CARE  
PROCARE HOSPICECARE  
SIMIONE HEALTHCARE CONSULTANTS  
THE STATESERV COMPANIES  
STOLADI PROPERTY GROUP  
TRANSITIONS LIFECARE

\*As of February 22, 2017



### **Avow Hosts Ribbon Cutting of Lyon Center**



**THE LYON CENTER RIBBON CUTTING.**

The Avow Foundation hosted a ribbon cutting ceremony for the new Lyon Center for palliative care, hospice and bereavement on January 6, in Naples, Florida. Avow President and CEO Jaysen Roa said the new center was made possible thanks to the generosity of Thelma Lyon. “Thelma has been engaged in the national conversation about palliative care for a number of years and she is extremely passionate about advancing this new kind of care in our local community.”

The new two-story, 24,000 square foot building serves as the new home for Avow’s palliative care and hospice clinical teams plus children’s bereavement. The center is located adjacent to the Ispiri Community Center on the southeast side of the campus and is the fourth building added to the 15-acre campus.

### **New CEO at Circle of Life Hospice**



**CATHERINE GRUBBS**

Catherine Grubbs was recently appointed Chief Executive Officer for Circle of Life Hospice in Northwest Arkansas. She served as the organization’s Chief Operating Officer since 2014 and before that as the Director of Administration. A Bentonville resident, Grubbs holds a Master’s Degree in Healthcare Administration and Community Health from the University of Arkansas. Prior to joining Circle of Life Hospice she served as Vice President of Performance Management and Business Optimization for Mercy Northwest Arkansas.



**LAWRENCE KAY, MD, FAAFP**

### **Empath Health names new Chief Medical Officer**

Lawrence Kay, MD, FAAFP, has been named Chief Medical Officer of Empath Health. Dr. Kay is first named CMO to manage the nonprofit and all of its member programs. As CMO, he is a key member of the senior executive team, overseeing medical programs throughout the organization, providing clinical strategic direction, and managing all physicians throughout Empath Health’s integrated network of care. Dr. Kay is a board-certified family physician with extensive patient care and health care management experience.



## New CEO at Visiting Nurse Service of New York



CHRISTOPHER T. OLIVIA, MD

The VNSNY Board of Directors is pleased to announce that Christopher T. Olivia, MD is the organization's new President and Chief Executive Officer. In addition to his experience as a physician, Dr. Olivia holds an MBA degree and has worked as a healthcare industry executive for 25 years, collaborating closely with clinicians and administrative staff at all levels of the healthcare industry. In coming to VNSNY, he brings a commitment to giving back to the community and a deep interest in developing innovative methods of care delivery.

## Lower Cape Fear Hospice's New CEO



GWEN WHITLEY

Lower Cape Fear Hospice, serving North and South Carolina, named Gwen Whitley as its new Chief Executive Officer. Whitley was selected by LCFH's Board of Directors after years of succession planning and evaluating. A 34-year healthcare professional, Whitley most recently served LCFH as Chief Operating Officer and has been with the organization since 2008. Prior to taking on the COO position she served as Clinical Director of Patient Services and Vice President of Clinical Operations.

Share news of your  
organization's  
leadership changes with  
[communications@nhpco.org](mailto:communications@nhpco.org).

### **Amedisys Welcomes New CFO and CDO**

Amedisys, Inc. is proud to welcome two new members of the leadership team.



**GARY D. WILLIS**

Gary D. Willis joins Amedisys, Inc., as Chief Financial Officer. Willis is a senior financial executive with more than 25 years of experience, including 14 years in the healthcare industry. As CFO, Willis oversees Amedisys' financial operations, capital and financing strategies, accounting, public reporting (SEC) and investor relations for the company. Most recently, he served as Executive Vice President and Chief Financial Officer for Capella Healthcare Inc., based in Franklin, Tennessee.



**DAVID MIKULA**

David Mikula joins the company as Chief Development Officer. Mikula has held key leadership roles across the healthcare spectrum in operations, sales and marketing, with experience ranging from occupational health and rehab services to hospitals and post-acute care. Most recently, he served as Senior Vice President and Chief Operating Officer for the Texas Region of Kindred Healthcare's hospital division.

### **HPCG Announces New CEO**



**KRISTEN WITHER YNTEMA, MBA, MHSA**

Following a six-month national search, Hospice and Palliative Care of Greensboro (HPCG), one of the largest nonprofit hospice and palliative care organizations in central North Carolina, announced Kristen Wither Yntema, MBA, MHSA, as its new President and Chief Executive Officer. Yntema will be the third CEO to lead the 36-year-old nonprofit hospice. She succeeds Patricia A. Soenksen, who retired in March 2017 after nearly 10 years with the organization.

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## **Name Change for Bluegrass Reflects Expanded Services**

Hospice of the Bluegrass, based in Lexington, Kentucky, is now Bluegrass Care Navigators. Having cared for thousands in the region since 1978, service offerings have been expanded and the organization has outgrown its name. Bluegrass Care Navigators will guide and provide care to more people in more ways at earlier stages of serious illness. The same compassion and commitment that has always defined Hospice of the Bluegrass continues as Bluegrass Care Navigators.



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## **The Corridor Group announces the acquisition of Transpirus**

The Corridor Group Holdings, LLC (Corridor) announced that it has acquired Transpirus, LLC, a leading national provider of outsourced coding, revenue cycle management and strategic consulting solutions for the home health and hospice industry.

“Transpirus is a top service provider in our space, with expert staff and an excellent reputation for quality,” said Des Varady, Chief Executive Officer of Corridor. “Combining with Transpirus strengthens Corridor’s ability to deliver services at scale and in a tailored way to meet each client’s needs. Additionally, both companies have unique capabilities in technology, consulting and education that further expand the value we can deliver together.”



**...offerings have  
been expanded...**



### Global Partners in Care Has a New Home



A program that the National Hospice Foundation has supported and raised funds for since 2004 has a new home. Global Partners in Care, a non-profit organization consisting of partnerships committed to supporting hospice and palliative care organizations in developing countries, has become an affiliate of the Hospice Foundation, headquartered in South Bend, Indiana. The Hospice Foundation is the supporting foundation for Center for Hospice Care. CHC is one of Global Partners in Care's most successful partner programs; they have worked with the Palliative Care Association of Uganda since 2008.

"This is a bittersweet transition because although we are sad to see Global Partners in Care leave the NHPCO family, we are thrilled to hand the baton to Hospice Foundation," says Executive Director John Mastrojohn III. "We know the program will be in good hands and that the mission to increase access to hospice and palliative care where the need is great and resources few, will live on." [READ MORE...](#)

### Lighthouse of Hope Fund: Letters of Gratitude



Teresa Lord was able to visit her new grandson because of the Lighthouse of Hope Fund.

The National Hospice Foundation received several generous donations for the Lighthouse of Hope Fund in 2016. These gifts help ensure that NHF can continue to offer experiences to hospice patients across the country.

The NHF Lighthouse of Hope Fund offers children and adults with a life-limiting illness, such as cancer, heart failure, liver disease, end-stage renal disease and ALS the chance to take a break by allowing them to have their wishes and dreams come true. Such dreams, big or small, can help people with life-limiting illness improve the quality of their lives in ways medicine alone cannot. [READ TWO LETTERS OF](#)

[GRATITUDE FROM LIGHTHOUSE OF HOPE FUND RECIPIENTS...](#)

### Donor Feature – Why I Support Hospice & Palliative Care



Frish Brandt

Frish Brandt is a hospice and palliative care champion. In addition to supporting NHF, she helps those facing end of life challenges write letters to their loved ones. In the latest addition of Giving Matters, she tells us why she supports hospice and palliative care, and what her volunteer practice entails. [READ MORE...](#)





## Interested in starting a pet care program for your patients?

Pet Peace of Mind offers a turnkey program for nonprofit hospices that covers all aspects of pet care for your patients.



## MAKE A SPECIAL MOMENT POSSIBLE FOR YOUR PATIENT



National Hospice  
Foundation

LIGHTHOUSE OF HOPE FUND

## PROVIDING MEANINGFUL AND MEMORABLE MOMENTS

FOR THOSE LIVING WITH A LIFE-LIMITING ILLNESS.

[www.nationalhospicefoundation.org/lighthouseofhopefund](http://www.nationalhospicefoundation.org/lighthouseofhopefund)

### The Lighthouse of Hope Fund is available to patients

- ❖ Who request special wishes and experiences (ex. flying people in to visit, special events like fishing trips or special dinners, opportunities to spend time with family and friends in a memorable way, etc.)
- ❖ Who are cared for by one of NHPCO's provider members
- ❖ Who have a life expectancy of one year or less
- ❖ Who have no other means to fund the specific request

### Selection Criteria

The hospice provider must submit a completed Lighthouse of Hope Fund Application

### **We Honor Veterans Partners with StoryCorps**



*World War II Veteran and Hospice of the Chesapeake patient Charles Dixon shared some of his amazing stories with StoryCorps via the StoryCorps app.*

In 2016, the National Hospice and Palliative Care Organization's We Honor Veterans program partnered with StoryCorps to launch a pilot program to record and preserve the stories of America's Veterans and their families. The pilot was created to give partner programs the ability to capture

their Veteran patients' stories easily through the StoryCorps app. Recorded stories are archived at the American Folklife Center at the Library of Congress. [Read more...](#)

### **Veterans Bond Over Coffee and Conversation**

Written by Katherine Kemp,  
Access Manager, NHPCO



December 7, 2016 marked the 75th anniversary of the attack on Pearl Harbor. As a day to honor and remember, many organizations and We Honor Veterans partners held events to pay tribute to all Veterans, particularly those who served in WWII. I was lucky enough to attend a special event held

in Welcome, North Carolina by We Honor Veterans Level 3 partner Hospice & Palliative CareCenter.

Many partners hold coffee events in their community as a way to bring Veterans together to share stories, giving them an extremely rare outlet. As a special commemoration event, Hospice and

Palliative CareCenter organized an event of epic proportions. It was held at the Richard Childress Racing Museum and over 700 people were in attendance, including about 500 Veterans. What made the biggest impression was not the turnout, community collaboration or volunteers running around ensuring everyone had a seat and was taken care of – it was the comradery and the friendships that have come out of something as simple as getting together for a cup of coffee. [Read more...](#)



### **No Veteran Dies Alone: Volunteer Training Resource Manual Available**

The No Veteran Dies Alone program is designed to honor Veterans and meet the needs of those who,

for whatever reason, find themselves alone at the end of life. This comprehensive manual assists educators in engaging the community, especially Veteran volunteers, in improving care and providing presence, companionship, and reassurance to dying Veterans. [Learn more...](#)

### **Memorial Day Social Media Resources Available**

Looking for Memorial Day social media graphics to honor and remember those who served? We've done the work for you! You can access professionally designed Facebook and Twitter graphics by visiting the We Honor Veterans partner resources page. We Honor Veterans partners are encouraged to use the graphics for outreach. Don't forget to use hashtag #wehonorveterans when posting on social media. [Learn more...](#)



# As a Hospice Executive Are You Looking for Critical Competitive Data to Stay Ahead of the Curve?

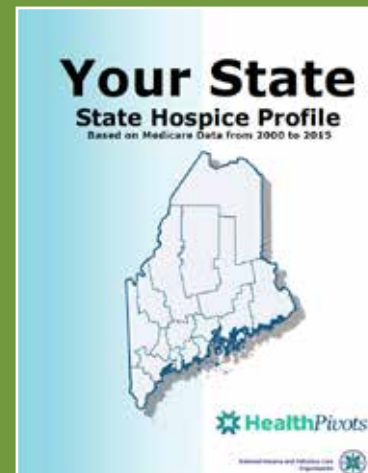
Look No Further... The annual **State Hospice Profile™** contains comprehensive hospice market characteristics for each county based on Medicare data from 2000-2015, providing the critical information needed to learn more about the competitive environment of your state.

Produced by HealthPivots and available exclusively through the NHPKO Marketplace, each 2015 **State Hospice Profile™** provides vital county level information. Full-colored charts and graphs provide information from an analysis of the last fifteen years of Medicare claims data.

Here are examples of the valuable information included in the **State Hospice Profile™**

- Estimated Medicare Cap usage
- Major hospice providers in the county
- Comparative hospice penetration data/market share trends
- Average Length of Stay
- Distribution of hospice census

As an added bonus, each State Hospice Profile™ also contains a National and Statewide Profile of hospice care based upon Medicare claims data going back to 2000, as well as county level National and State penetration maps.



State Hospice Profiles™ are individually priced based upon the number of counties in each state. Please call 1-800-646-6460 for pricing details and to order. Profiles are available for all 50 States.

National Hospice and Palliative Care  
Organization



*Marketplace*

To view an example of a State Hospice Profile, visit:  
[www.healthpivots.com/stateprofile](http://www.healthpivots.com/stateprofile)

# Links to Some Helpful Online Resources

## Quality and Regulatory

- ☐ Quality Reporting Requirements
- ☐ QAPI Resources
- ☐ Regulatory Center Home Page
- ☐ Fraud and Abuse
- ☐ Past Regulatory Alerts and Roundups
- ☐ Staffing Guidelines
- ☐ Standards of Practice
- ☐ State-specific Resources
- ☐ Survey Readiness

## Professional Education

- ☐ Education Home Page
- ☐ Webinar Schedule
- ☐ Upcoming Conferences
- ☐ End-of-Life Online
- ☐ Pediatric Palliative Care
- ☐ Palliative Care Resources

## Outreach

- ☐ Outreach Materials
- ☐ Social Media Resources
- ☐ NHPCO's CaringInfo

## Publications

- ☐ Weekly NewsBriefs
- ☐ NewsLine
- ☐ ChiPPS E-Journal

## Affiliate Publications

- ☐ Giving Matters
- ☐ Focus on Compassion



National Hospice and Palliative Care Organization



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Committed to compassionate  
care at the end of life



**Hospice Action Network**