



Welcome to the Fall Edition of NHPCO's NewsLine

Internet Explorer Users – Please Note:

Some of the links in NewsLine bring readers to member-only pages on the NHPCO website, requiring members to enter their email address and password to access the pages. If you find that your email address and password are not being accepted, please open NewsLine in a different browser, such as Google Chrome or Firefox.

This should correct the problem.

NewsLine

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

Fall 2015

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Resources

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Ready

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SHOULD OUR HOSPICE PROVIDE PALLIATIVE CARE?

Determining how you might
further serve your community

National Hospice and Palliative Care
Organization



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DEVELOPING OR ENHANCING YOUR COMMUNITY-BASED PALLIATIVE CARE PROGRAM?



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impacting hospice providers

As the largest membership organization representing hospice and palliative care programs and professionals in the United States, NHPCO is committed to expanding access to palliative care to enhance the quality of life for individuals and families coping with serious illness.

Join NHPCO as a Palliative Care Member for \$500 Per Year. Visit www.nhpco.org/palliativecaremembership or call 800-646-6460.

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Message **From Don**

The summer is over and we are well into autumn. In some northern parts of the country, it's already getting chilly, while others are still facing some unpredictable weather patterns that seem to have characterized the summer. I think it's safe to say that a number of things have felt different in recent months among the provider community. I want to assure you that NHPCO strives to make your workloads more manageable.

First, regarding some of the notable regulatory issues that are so important, please remember the wealth of materials we make available to members to help cope with some of the changes facing us. Whether it's understanding the new payment methodology that is part of the FY2016 Hospice Wage Index, preparing for the ICD-10 transition deadline on October 1, or adapting to the concepts of relatedness – we have tools to help you. The best place to find these would be in the Regulatory section of NHPCO's Website at www.nhpco.org/regulatory; search under "Hot Topics" and you'll find sections devoted to these issues I just mentioned, and more. In fact, there's a terrific article on relatedness that beings on page 18 of this edition of NewsLine.

Some of you among the membership may not be aware of many of the new resources we've created that are focused on community-based palliative care. As an NHPCO member, you have access to these materials that you'll find in the Palliative Care section of the website at www.nhpco.org/palliativecare. To the many experts in the field who have contributed to our library of issue briefs on palliative care, let me thank you for sharing your insight with our membership.

The 2015 [Clinical Team Conference and Pediatric Intensive](#) will be in Grapevine, Texas at the Gaylord Texan Resort and Convention Center which is only 6 miles north of the Dallas/Ft. Worth Airport. While online registration closes on September 20, we are always happy to have people register onsite. So, if you haven't made plans to attend CTC yet, there is still time. CTC is October 15 – 17 with preconference seminars being offered on October 13 -14. I hope to see you there!

Let me also thank you for the work you continue to do that makes such a profound difference to those you are serving in your community every single day.



J. Donald Schumacher, PsyD
President/CEO





Should our Hospice Providers Provide Palliative Care?

Conducting an
Organizational Assessment

By Gretchen Brown, MSW

INTRODUCTION

In the late 1990's and early 2000's hospice programs and state and national organizations, including NHPCO, added "and Palliative Care" to their names. Many organizations started palliative care (PC) programs; some were very successful, others floundered or functioned in fits and starts. The success was dependent on provider capacity, community partners and availability of staff. Other programs considered offering palliative care services, but were unable to make the business case to their governance.

Health Care Reform and its accompanying changes have altered the health care landscape. In many communities hospital systems have acquired physician practices. In other communities, large physician practices have joined with other providers to form care networks. Insurers and hospitals are focused on strategies to keep patients from being re-admitted to inpatient care and/or are joining other entities in new business ventures. All of these changes have resulted in a decreased length of stay for hospices.

This article will discuss the potential benefits for a hospice organization to create a palliative care program including the addition of a new service line and corresponding revenue and/or referral stream. Program development, needs assessments, program models and financial considerations will also be described.

HOSPICE AS THE PALLIATIVE CARE PROVIDER

A successful palliative care program directed by a hospice depends primarily on three factors: sufficient community need, adequate financial resources and clinical resources at the hospice itself or in collaboration with a partner. Hospices are a natural community resource for the provision of palliative care.

- Hospice team members understand palliative care concepts and interventions and are experienced at discussing patient/family preferences at the end of life.

- Hospice medical staff can comfortably describe the advantages and disadvantages of particular treatments with a wide variety of patient/families.
- Many hospice staff are certified and specifically trained to care for patients who are appropriate for palliative care.
- Hospice staff are experienced at providing care in a variety of settings including the home, the acute care facility, the skilled nursing facility and other sites.
- When offering hospice and palliative care, the hospice may benefit from cross-utilization of the same staff in both programs.

**Hospices are a natural
community resource
for the provision of
palliative care.**

IS PALLIATIVE CARE NEEDED IN MY COMMUNITY?

The first question any organization needs to ask is: Is palliative care needed in my community? If the community doesn't have any kind of palliative care program, the answer may seem obvious. The hospice organization still needs to determine the type of palliative care program it might offer and whether or not the provision of palliative care is feasible for the hospice.

Since hospices first began offering palliative care, many programs have emerged and in some communities there is an overlap in the continuum of care. A hospice organization seeking to initiate or re-energize a defunct or floundering palliative care program may begin with an internal staff

DEVELOP A COMPREHENSIVE LIST OF PROGRAMS PROVIDING PALLIATIVE CARE IN THE COMMUNITIES THE HOSPICE ORGANIZATION SERVES.

discussion about the pros and cons before involving governance. The team involved in discussions should include administrative and clinical leaders, the medical director, and financial staff and representatives from the partner or potential partner. Once assured of the need, the provider can form a planning team/committee.

PROGRAM DEVELOPMENT

Program development considers many issues including developing a list of community programs already providing palliative care; investigating program models, capacity and resources of the hospice provider; examining financial and budget issues and uncovering additional helpful resources.

Develop a comprehensive list of programs providing palliative care in the communities the hospice organization serves.

acute care setting. Today, palliative care is offered by most hospitals; particularly those with over 100 beds. Some hospitals also provide palliative home care. Nursing homes, home health agencies, private physician practices and even insurance companies may also provide services.

In addition, many communities have other services such as PACE programs that may enroll potential patients, transitions programs aimed at reducing hospital readmissions, (often provided by the area's Aging Agency), and private or institutional case management programs that may both limit the potential patient pool, and serve as future referral sources.

Evaluate the available services taking into account their history, competence, community reputation and locations to determine where your program might fill a need.

Is there an obvious gap in services? For example, a program may find that in the multiple county service area, one of three tertiary care hospitals has an inpatient PC program as does a large skilled nursing facility which serves only its residents. The hospice may explore a home care program with the acute care facility that values PC, an inpatient program with one or both of the other hospitals, a program offering PC to the other



When hospices began offering palliative care, competitors were few. If palliative care was offered in the community, it was likely that one hospital provided the service in its

nursing facilities in the area or a program of any type in the surrounding area. Many hospice organizations serve several hospitals and various communities, thus opportunities may be broader than originally anticipated.

Investigate models, capacity, and resources of your hospice and potential partners

The financial viability of a PC program is of paramount importance in determining whether and what kind of a PC program to initiate. The team should be brutally realistic about the financial and staff resources needed to operate the new program. New PC programs, and most programs of several years duration, rarely generate a positive bottom line. The program will need adequate financial resources to both fund and experiment with the model chosen for implementation. Every effort should be made to find partner(s) who can assist with the endeavor.

Investigate Program Models

Hospice planning committees, taking community needs into account, may explore the various models of palliative care as well as potential payers. Potential models include: an inpatient acute care model using from one to a full range of palliative practitioners in the hospital setting; an outpatient model that will provide services in

nursing facilities, and a patient's home or in a clinic or palliative medicine practice.

Determine Capacity

Hospice planning teams must identify their knowledge deficits. Palliative practitioners need advanced clinical knowledge of aggressive treatment for diseases.

The palliative care team also needs to understand the operation, regulations and goals of the settings in which they aspire to practice: home, hospital, nursing facility, long term acute hospital or other entity.

Most programs will require some type of 24 hour on call service,

INVESTIGATE MODELS, CAPACITY, AND RESOURCES OF YOUR HOSPICE AND POTENTIAL PARTNERS

The program will need adequate financial resources to both fund and experiment with the model chosen for implementation.



FINANCIAL CONSIDERATIONS

Palliative care programs can greatly decrease the cost of care for the most medically complex patients. However payment for provision of palliative care by an individual hospice organization's palliative care programs is limited. Medicare Part B and insurance payment for reimbursable practitioners such as physicians, nurse practitioners or other billable physician extenders, and in some outpatient settings, licensed social workers, represent the most usual income stream. Institutions such as hospitals, insurers and managed care organizations may augment reimbursement through subsidies or direct payments which reflect the additional costs of palliative care.

Healthcare Systems

Hospices that operate within healthcare systems anchored by hospitals, managed care or other insurers have an easier time funding a PC program as the financial incentives are aligned. In system "credit" for cost savings/cost avoidance to the overall system can fund the program, especially when combined with billing revenue. Successful examples of this model include organizations like Kaiser, a multi- state entity which serves as a healthcare provider and an insurer; Mt.

Carmel in Columbus, Ohio; the Sharp system in San Diego; Sutter in the Bay area; and comprehensive systems in which a health system owns the entire continuum of acute care, home care and hospice.

Collaborative Models

Collaborative models can also break even. In these models a health system funds palliative care by contracting to support a large percentage or the entire program, or offers subsidies for visits. In this model the system may collect for the billable service or allow the hospice to do so, perhaps subtracting the billings. In many of the models the healthcare system may provide non-billable staff or contract for those staff from the hospice. The collaborative model can be effective for both acute care, home and clinic models. Hospice of the Bluegrass is an example of this type of program.

Fee for Service, Per Diem or Capitated Rate

Some programs have partnered with a large insurance company like Blue Cross that agrees to pay either fee for service, a per diem or capitated rate for home-based palliative care services. Creative programs, such as Hospice of Michigan's @HOME support program, have

developed contracts which supply not only an adequate number of patients, but also an adequate payment, as well as a system for evaluating the savings generated to the health system, Accountable Care Organization (ACO) or insurer.

Medical homes have also contracted with specific hospice organizations to provide palliative care to their patients, particularly in California where capitated rates are common. Such contracts can provide a stable base for a homecare program. A contract with a dependable partner like an insurer, a union, an Accountable Care Organization, Medical or other entity guarantees both an income and referral stream.



Hospice as the Palliative Care Provider

The most difficult model for a hospice organization to sustain is one in which the hospice operates independently and is dependent on referrals from outside sources. Inpatient programs may have the greatest chance to break even if there are enough consults to support the program. The most difficult to support is a home care program since travel time further erodes the limited patient billing. The planning committee needs to be exceedingly careful in choosing this model.

ANALYZING THE DEMAND AND MAKING THE BUDGET

Once a model is chosen, the hospice organization must put pen to paper to determine the revenue and expense of that model. One of the values of partnership is that the insurer or hospital partner will know more about their patients or beneficiaries, including the value of the cost avoidance when the palliative care program reduces costs, prevents inpatient admissions or leads to earlier and more hospice admissions. Some knowledge of the volume of services is needed to estimate both income and expenses. In most models, space, administrative and some clinical staff can be shared with the hospice.



Additional important to do's for the hospice provider includes the following:

- Hospice providers who chose to provide palliative care will need to obtain a Medicare Part B billing number.
- Billable practitioners also have to be credentialed with other payers including Medicaid and private insurers.
- Payments will vary based on the setting in which the service is rendered (i.e. the inpatient setting versus the patient's home or a facility), the type of service provider (MD, ARNP) and type of visit (initial or follow-up) and the duration of the visit.

The most difficult model for a hospice organization to sustain is one in which the hospice operates independently...

- The number and type of each visit will need to be estimated to determine the revenue stream. The hospice may know the cost of staff and can estimate the number of hours for each person working in the program.

Before a hospice organization makes the final decision to provide palliative care, the difference between cost and income must be calculated. Most likely, particularly initially, the bottom line will be negative. Decision makers need to determine if the deficit will be offset by potential service differentiation, partnership or customer development and the potential for additional patients and/or increased length of stay.

OTHER CONSIDERATIONS

Pilot Programs

Pilot programs can be very helpful in determining the potential success of a full-fledged palliative care program. An inpatient program might cover one service or one floor in a facility for a specified period of time. A home-based program could begin with 20 referrals from a hospital or insurer. Pilot programs help staff understand the strengths and weaknesses of their program and may reveal unexpected challenges and opportunities.

State and Federal Regulations

State and federal regulations impact how any program can be organized and implemented. Legal advice from a healthcare attorney should be sought early in the planning process. The hospice organization can benefit from a partner's legal counsel, but should also be represented by its own counsel.

Additional Resources

Some communities have philanthropic resources which can be accessed for startup and support. Since palliative care has been around now for nearly two decades, start-up funding is not as available as it was in the early days and is almost never available from governmental or national philanthropies. However, family, healthcare system and community foundations are definitely worth exploring.

Educational resources are available from NHPKO and other programs. Studying the many resources is a wise investment of staff time and will be helpful in the process. The hospice organization may also

consider hiring a consultant to help insure success and help inform decision makers.

CONCLUSION

Education and planning are the keys to making the best decision about providing palliative care. Hospice organizations are ideal palliative care providers and partners, but only if they can provide quality services at a cost that does not negatively affect the hospice.

Gretchen Brown, MSW is former president and CEO of Hospice of the Bluegrass based in Lexington, Kentucky. She previously served on the NHPKO board of directors and was chair from 2009 to 2010.

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Overview of
**NHPCO'S
PALLIATIVE CARE
& MEMBERSHIP
RESOURCES**

by Judith A. Skretny
NHPCO, Director of Palliative Care

NHPCO is committed to improving end-of-life care and to expanding access to palliative care for individuals and families coping with serious illness.

Palliative Care membership has always been an option at NHPCO. Unfortunately, many non-hospice palliative care providers have not been familiar with this opportunity. This past year, NHPCO has been working to address that issue among the end-of-life provider community.

In February of 2015, NHPCO began actively recruiting new palliative care members. As community-based palliative care continues to grow, relationships between hospices and palliative care providers will strengthen and expand. To that end, we are focusing on providing opportunities for palliative care education, access to resources developed by “experts” in the field, assistance in program development and growth, and continued advocacy.

For a look at the resources and materials available, visit the Palliative Care page on NHPCO’s website at www.nhpc.org/palliativecare. It provides an overview of available benefits – and includes a link to our website’s Palliative Care Resource section exclusively for members.

As 2015 moves to a close, NHPCO is offering a special membership rate for palliative care providers of only \$500 available now. NHPCO hopes that this special discounted membership rate will encourage

palliative care providers to join the organization and take advantage of the resources we offer.

If you are a palliative care provider (and not a hospice), we invite you to print off the [palliative care membership application \(PDF\)](#) available on the NHPCO website. Or, you can contact the NHPCO Solutions Center at 1-800-646-6460 to inquire about palliative care membership.

For NHPCO’s current hospice members who are providing palliative care, you already have access to all palliative care resources that NHPCO has created.

Palliative Care Resources

So, what are some of the new resources that NHPCO has created?

The place to begin exploring what we have available is the [Palliative Care Resources](#) section of our website. This is a “members-only” page at www.nhpc.org/resources/palliative-care-resources and serves as your portal to a range of materials.

Palliative Care Resource Series

Issue briefs that address a variety of topics of relevance to community-based palliative care providers are available. Many of the briefs have a companion PowerPoint presentation to help you train your teams and other staff.

Issue briefs that address a variety of topics of relevance to community-based palliative care providers are available.

Here is a list of currently available documents and authors:

Jean Acevedo, LHRM, CHC, CENTC – Acevedo Consulting

- *Chronic Care Management*
- *Transitional Care Management*
- *Advance Care Planning*
- *Split/Shared Visits Palliative Care – Part B Only*
- *PQRS and the Value Based Payment Modifier*

Stan Massey, Partner/Chief Branding Officer – Transcend Hospice Marketing Group

- *Key Considerations for Branding and Marketing Your Palliative Care Program*

Gretchen Brown, MSW – Former President and CEO of Hospice of the Bluegrass

- *Should Our Hospice Provide Palliative Care? – Conducting and Organizational Assessment*

Daniel Maison, MD, FAAHPM

- *Creating Support for Your Community-Based Palliative Care Program*

Todd Cote, MD

- *Hospice-Hospital Collaborations: Making the Case to Hospital Administrators*

Parag Bharadwaj, MD, AAHPM, et.al

- *Palliative Care for Heart Failure Patients: Practical Tips for Home-Based Programs*

Steven M. Radwany, MD, FACP, FAAHPM

- *Finding Calm in the Storm: A Palliative Care Approach to Navigating the Family Meeting*

Carolinas Center for Hospice & End of Life Care

- *Accountable Care Guide for Hospice & Palliative Care*

Issue briefs from such well known professionals as Janet Bull, MD, Russell Hilliard, PhD, Kathleen Kerr, and Stephen Leedy, MD will be available soon.

MJHS Institute Collaboration

Webinars offering advanced level training for members of the interdisciplinary team will be offered through collaboration between the MJHS Institute for Innovation in Palliative Care and NHPCO. As an organization focused on education, research, and quality, MJHS Institute for Innovation in Palliative Care brings great expertise to this collaboration, and together NHPCO and MJHS Institute will enhance access to high quality education and support the

professional development of those who provide frontline care.

Beginning in September 2015, a series of low-cost Webinars will be presented monthly. Each Webinar includes a 45-minute presentation lecture with slides followed by 15 minutes of interactive Q&A. Physicians, nurses, social workers and pharmacists may obtain 1.0 continuing education credits, depending on the topic. See the [list of Webinars](#) for 2015 and 2016.

CSU Institute for Palliative Care

Collaboration with the CSU Institute for Palliative Care is another valuable component of the new palliative care offerings. This exciting collaboration was announced during last spring's Management and Leadership Conference. The goal of the collaboration is to help hospices expand into providing community-based palliative care and obtain the quality educational content needed in this challenging health care environment. NHPCO members have expanded access to educational programming that is currently available from CSU Institute for Palliative Care – all at a special, discounted rate.

A one-day preconference seminar developed by CSU Institute for Palliative Care and NHPCO will be offered as part of this year's

Clinical Team Conference in October. *Leading the Way to Community-Based Palliative Care Success (PC03)*, will feature faculty Helen McNeal, BBA and Stacy Starkka, PhD(c), MBA, CT, both with the CSU Institute for Palliative Care, Kathleen Kerr of Kerr Healthcare Analytics, and Karl E. Steinberg, MD, CMD of Stone Mountain Medical Associates, Inc. This highly interactive workshop will ensure that you and your organization know what it takes to deliver palliative care, and to create a clear, defined path that is right for your organization and will lead to success.

Additional Links & Networking

By visiting the Palliative Care Resource section, members will also find relevant news articles and links to online videos that may be of interest. Other NHPCO offerings looking at aspects of palliative care will be highlighted as well.

Members will be able to virtually network with other members interested in the provision of palliative care through the Palliative Care community that has been created as part of My.NHPCO.org, the online web resource that allows members to engage in discussions, share resources, and provide thoughts on the work they do in their programs across the country. Palliative Care members will not only be able to participate in the Palliative Care e-group but they also will be able to access any of the other

e-groups that cover all disciplines comprising the IDT and specific areas of interest such as rural issues, compliance, and caring for Veterans.

In his introduction to the January Virtual Event, *Hot Topics in Palliative Care*, NHPCO Executive Vice President and COO John Mastrojohn shared, “As presented in the Institute of Medicine report on care of the dying, there is a need to make palliative care available to all individuals across the continuum of care. NHPCO’s commitment is consistent with those recommendations and we strongly believe that palliative care is not just for those at the end of life but is beneficial to patients and families in a variety of settings.”

NHPCO is committed to making a wealth of useful tools and practical resources that advance community-based palliative care available and is excited about a deeper engagement with all palliative care providers.

Judith Skretny is currently Director of Palliative Care for NHPCO and has more than 30 years of experience in end-of-life care. Prior to joining NHPCO, she was Vice President of The Center for Excellence in End-of-Life Education, Research and Practice at the Center for Hospice & Palliative Care in Cheektowaga, New York.

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...we strongly believe
that palliative care is
not just for those at
the end of life...



YOU WANT ME TO PAY FOR WHAT?

Becoming Relatedness Ready

By Gail Austin Cooney, MD, HMDC, FAAHPM

The concept of “relatedness” in healthcare seems unique to genetics and hospice.

Wikipedia only recognizes its genetic applications—it’s one way of denoting the kind of risks you run if you marry your first cousin! Only in hospice is “relatedness” used to determine Medicare coverage of a service. So what is actually being discussed here are coverage decisions – who pays for a given medication or treatment? And in Medicare-certified hospice, these decisions are guided by first determining if the condition is related to the terminal prognosis and, second, if the treatment is “reasonable and necessary for the palliation and management” of the condition at this stage of the illness.

How did the concept of “relatedness” begin? In August 1983, the [proposed rule for the Medicare Hospice Benefit \(MHB\)](#) stated, “Medicare coverage [for services outside the hospice program] is determined by whether or not the services are for the treatment of a condition **completely unrelated to the individual’s terminal condition.**” The flip side of this directive is that the Medicare payment to the hospice covers all services that are related to the terminal condition.

For many years, most hospices chose one diagnosis per patient: the “terminal diagnosis.” In fact, Medicare’s requirement that hospices identify a “primary diagnosis” on claim forms further reinforced this approach and many hospice software

programs originally only allowed entry of a single diagnosis.

“Relatedness” seemed straightforward: if a palliative treatment was for symptomatic management of the terminal diagnosis, then it was the hospice’s financial responsibility. Treatments for other diagnoses were not.

That is no longer the case.

The Center for Medicare and Medicaid Services (CMS) has been building the case that under the Medicare Hospice Benefit “virtually all” conditions—and therefore virtually all costs—are related to the patient’s terminal prognosis and therefore are the hospice’s financial responsibility. CMS continues to acknowledge that there will be rare, exceptional circumstances but the emphasis is clearly on “rare.” The most recent guidance in the FY2016 Final Hospice Payment Rate Update (CMS-1629-F) states that “it is our general view that hospices are required to provide virtually all the care that is needed by terminally ill individuals and we would expect to see little being provided outside of the benefit.” As these changes are made, it became more and more evident that hospices should be prepared to think through what is related and what is not.

These changes in interpretation may require both a change in thinking and a change in process for your hospice program. It’s important to address both. The hospice medical director plays a key

These changes in interpretation may require both a change in thinking and a change in process...

role because the most recent FY2016 Final Hospice Payment Rate Update designated the hospice physician as responsible for determining the diagnoses and treatments related to the terminal prognosis. Here are four basic steps to help your hospice become “relatedness ready.”

1. Think prognosis, not diagnosis.
2. Learn to explain the prognosis using ICD codes.
3. Collaborate with the hospice medical director to determine related (and unrelated) conditions and the medical indication of proposed treatments.
4. Document and communicate coverage decisions.

STEP ONE: THINK PROGNOSIS, NOT DIAGNOSIS

The language in the FY2015 Final Hospice Payment Update and the FY2016 proposed rule has shifted towards an emphasis on the terminal prognosis, rather than a terminal diagnosis. A terminal prognosis of less than six months, if the illness follows its usual course, has always been required to establish eligibility for the Medicare Hospice Benefit. It’s at the bottom of every certification of terminal illness (CTI). But in the past, many hospice programs focused on the

terminal diagnosis and still made relatedness decisions on the basis of that single diagnosis. For example, in the FY2015 Payment Update, CMS described the expenses charged to Medicare Part D for medications treating the symptoms of chronic obstructive pulmonary disease. There is no way to know why those expenses were accrued – it could have been a prescription for a specific drug that the hospice did not cover, it could have been a prescription sent directly from the physician office and not reported to the hospice. But it may also have included treatments for dyspnea in patients with a primary terminal diagnosis of congestive heart failure (CHF) or dementia who also had COPD. Should these be covered by the hospice? CMS argues that often more than one diagnosis contributes to the terminal prognosis and expects that hospices will cover all costs related to the terminal prognosis, not just to a terminal diagnosis.

One of the ways that CMS approaches this concern is by calculating the percentage of hospice claims that list only a single diagnosis. This seems to be a litmus test for how closely the industry is listening. But the issue goes beyond listing two or more diagnoses on the claim.

Shifting our mindset from terminal diagnosis to terminal prognosis starts with the admission assessment. Does this

patient have a prognosis of less than six months? The attending and hospice physicians are responsible for determining and documenting the prognosis. On admission, the nurses and physicians review the patient’s condition. What illnesses contribute to the patient’s prognosis? Most patients are elderly and have multiple advanced chronic conditions and more than one may contribute to the terminal prognosis.

The good news is that hospices no longer need to feel pressure to choose a single diagnosis to support eligibility and coverage; the challenging news is that there may be additional costs when multiple diagnoses are used to establish prognosis and eligibility. For example, a 78 year old woman may have chronic heart and lung disease and advanced dementia. Alone, none of these diagnoses meets the guidelines for hospice eligibility. However, the physician may determine that together they result in a terminal prognosis of less than six months. Here’s what a CTI narrative might look like for this woman:

Mrs. Jones is a frail 78 year old woman who lives in an assisted living facility. She has advanced congestive heart failure, chronic obstructive pulmonary disease, and Alzheimer’s type dementia. Despite maximal medical treatment, she becomes short of

breath with walking 10 feet, has persistent stage 3 pedal edema, and uses oxygen at night. She has been hospitalized twice in the past three months for pneumonia. Because of her dementia, she is unable to comply with recommended respiratory treatments and often confuses her medications. She is able to ambulate within her home but frequently falls. She is incontinent of bowel and bladder. She has limited speech and does not initiate conversation. Her appetite is poor and she has lost 10 pounds over the last six months, now weighing 110 pounds, height 65 inches. Because of her advanced frailty, CHF, COPD, and Alzheimer's disease, Mrs. Jones is terminally ill with a prognosis of less than six months.

In this case, CHF, COPD, and Alzheimer's disease all contribute to the terminal prognosis. Hospice physicians are directed to choose the "most contributory" diagnosis to place in the first position on the claim but all three should be listed. This brings us to the second step in becoming relatedness ready: using International Classification of Disease (ICD) coding effectively.

STEP TWO: EXPLAIN THE PROGNOSIS IN ICD CODES

Once the team begins thinking in terms of prognosis, not diagnosis, the next challenge is to translate that thinking into ICD coding for the Medicare claim. Many hospices still mourn the loss of the ICD-9 codes for

"Debility" and "Adult Failure to Thrive" as primary diagnoses (although they may still appropriately be used to describe the secondary effects of another primary diagnosis). Now hospice must make the switch to ICD-10 and determine and document multiple ICD-10 codes for diagnoses that describe the terminal illness and contribute to the prognosis.

Start with the case of Mrs. Jones. What diagnoses describe her terminal prognosis?

1. Alzheimer's disease
2. COPD
3. CHF

But wait! Her Alzheimer's disease is FAST 6, her CHF New York Heart Association (NYHA) Class 3, and she doesn't have resting dyspnea from either her COPD or her heart disease. What gets listed first? Before October 2014, many hospice programs might have described Mrs. Jones as being terminally ill because of "Debility" or "Adult Failure to Thrive" because she did not meet the guidelines for a single diagnosis. Now, CMS instructs the hospice physician to choose the diagnosis that contributes "most" to the terminal prognosis and list that first. For Mrs. Jones, it might be any one of the three – and it might change over time if one disease progresses more rapidly or develops new complications.

What's clear is that CMS now expects to see all diagnoses contributing to the terminal prognosis listed on the

**Shifting our mindset
from terminal diagnosis
to terminal prognosis
starts with the
admission assessment.**

claim and charges the hospice with both management and financial responsibility.

The next question might be, “But what if Mrs. Jones has NYHA Class 4 congestive heart failure? Then she meets the guidelines with one diagnosis. Why should my hospice take on financial responsibility for the others?” This argument may apply to the rare patient who has only a single advanced diagnosis, for example a young woman with widely metastatic breast cancer, but it is rarely correct for people with multiple significant chronic diseases such as the example of Mrs. Jones.

When the hospice physician determines that a diagnosis does NOT contribute to the terminal prognosis, CMS expects to see clear documentation supporting that decision. This leads to the third important step which is determining relatedness through a close collaboration with the hospice medical director and attending physician.

STEP THREE: DETERMINING RELATEDNESS – PARTNER WITH YOUR HOSPICE MEDICAL DIRECTOR

Gone are the days when the Hospice Medical Director (HMD) sits in Interdisciplinary Group (IDG) meetings and signs papers. These new expectations require a trained, collaborative physician partner who helps to determine the conditions related

to the terminal prognosis, the treatments that are indicated for these conditions, and then updates these as the patient condition changes. CMS designates the hospice physician as the decision maker about relatedness. Many hospice programs will need to change their processes and some will have to make changes in the roles of their medical director and team physicians. The national professional associations (American Academy of Hospice and Palliative Medicine and National Hospice and Palliative Care Organization) have training programs to help hospice physicians gain the knowledge and skills needed for their expanded responsibilities and there is a national certification specifically for hospice physicians to document this achievement.

Decisions about relatedness and coverage begin at admission. The hospice physician must determine both the conditions contributing to the terminal prognosis and the medically indicated treatments that are related to these illnesses. This includes all treatments and services a patient receives, such as drugs, physician services, DME, and medical supplies, among others. Patients need to understand the treatments and coverage that are included, those that are not covered, and those that are waived by hospice election.

As the patient’s condition changes, decisions about treatment coverage may change. New medications may be added for symptom management; other medications may be stopped because they no longer benefit the patient. A previously unrelated condition may worsen and become related to

MORE ON HMDCB

Hospice Medical Director Certification Board is an independent not-for-profit organization that certifies the knowledge and skills of physicians who practice in the hospice setting. It addresses the core roles and administrative, regulatory, legal, and ethical responsibilities of the hospice physician. The goal of HMDCB is to improve the quality and consistency of care to hospice patients.

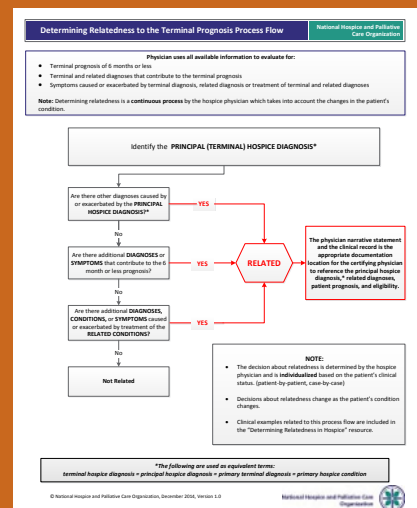
the terminal prognosis. The IDG meeting is the ideal place to discuss changes in relatedness. NHPCO created a [useful tool to help guide decisions](#) about related conditions and their treatment coverage. A hidden issue that underpins decisions about related and covered treatments is the question of medical necessity. Medicare only covers medically necessary services. As a Medicare provider, hospice is expected to cover services that are “reasonable and necessary for the palliation and management of the terminal illness as well as related conditions.” The hospice physician makes the decisions regarding the medical necessity of a treatment or service for a hospice patient; this sometimes creates conflict and confusion when a community attending physician offers a treatment that the HMD does not consider medically necessary. CMS seems to consider this a situation where the patient may choose to revoke the Medicare Hospice Benefit to access Medicare coverage for the treatment, or may opt to remain in hospice but pay for that treatment out of pocket. Those of us who work in hospice, however, see that choosing to revoke the hospice benefit may rob the patient of the support and care offered by the hospice program. Becoming skilled in discussing prognosis and the benefits and burdens of a treatment at the end of life may help to shift these conversations from “what is covered” to “what is beneficial.” More training and resources are now in development that will help hospice physicians with this very important task.

STEP FOUR: DOCUMENT AND COMMUNICATE COVERAGE DECISIONS

After determining the diagnoses contributing to the terminal prognosis, describing them in ICD codes, and making decisions about related conditions and medically necessary and covered treatments, the next step is to document and communicate these decisions. Decisions about relatedness determine coverage and financial responsibility. There are four basic categories of relatedness for hospice patients:

Drug, Service, Treatment	Palliative and Medically Necessary?	Covered/Not covered by the hospice?	Who pays?
Related	Medically Necessary	Covered	Hospice pays
Related	Not Medically Necessary	Not covered	Patient pays, but only if the patient wishes to have the item/service even after being told it is not medically necessary
Unrelated	Medically Necessary	Not covered	Insurer pays
Unrelated	Not Medically Necessary	Not covered	Patient pays, but only if the patient wishes to have the item/service even after being told it is not medically necessary

NHPCO has a range of resources to help providers understand issues involving relatedness in the Regulatory Section of the NHPCO website.



WHO DOCUMENTS?

The FY2016 Hospice Payment Update states that “It is also the responsibility of the hospice physician to document why a patient’s medical need(s) would be unrelated to the terminal prognosis.” Many programs require that the hospice physician complete this documentation. Although there are different practices among hospices, documentation completed by the hospice physician meets the compliance requirements in the regulations.

WHERE IS THE DOCUMENTATION?

It is imperative that hospices have a designated location for documenting decisions about relatedness. Some programs document alongside the medication list; others use a specific note that can be easily retrieved. Because “relatedness” determinations need to be made for all treatments and services that a patient receives, hospices need to consider where in the medical record determinations regarding treatments other than drugs are documented. CMS does not mandate a specific location or content but a consistent process is critical, especially if the decision is questioned.

WHAT DOES THE DOCUMENTATION SAY?

As with the physician CTI narrative, it’s clearly not enough to say, “Because I say so.” For unrelated treatments the hospice is not covering, CMS wants to know why this is “completely unrelated” to the terminal prognosis. The HMD might document “Hypothyroidism is long-standing and stable on replacement therapy; it does not contribute to the terminal prognosis” or “Diabetes mellitus is long-standing and stable on oral medications; this condition does not contribute to the terminal prognosis from lung cancer.”

If the HMD determines that a treatment is not “reasonable and necessary” for the palliative management of a related condition, it is important to record that decision, also. For example, “Trastuzumab has not been shown to improve the quality of life for patients with locally advanced or metastatic breast cancer; it is related to the terminal prognosis but is not a palliative therapy.”

WHO NEEDS TO KNOW ABOUT THE COVERAGE DECISIONS?

It’s also important to have clear, written communication that clarifies what treatments hospice covers and what treatments are not covered. I would recommend

using the term “covered” rather than “related” in these documents – remember that hospice is the only health care provider that uses this concept! Who needs to know? Certainly the patient and family need this information but other treating providers, including physicians and long-term care facilities and pharmacies, also need this in order to bill correctly. I’ve found that education on appropriate billing is often a way to gain access to providers who may not understand the benefits and coverage of the hospice program—and perhaps help them to better identify hospice eligible patients under their care.

A reminder: even though a diagnosis is unrelated to the terminal prognosis, it may be important to address the benefits and burdens of its treatments at this stage of the patient’s life. For example, a patient with widely metastatic cancer may still be taking statins for elevated cholesterol. According to Kutner JS, et al, 2015, there is no benefit to statin therapy for someone with a prognosis of months and the side effects can be significant (1). In addition, as research continues about benefits and burdens of treatments as the patient approaches the end of life, this list of no longer effective treatments will expand.

SUMMARY

Many hospice providers are anxious about the potential for increased costs as CMS expands its definition of “relatedness,” hence the title of this article. But I am an incorrigible optimist and I see ways that we, as hospice providers, have the potential to increase access and improve the care of terminally ill patients and their families.

Access to hospice services may be increased by a movement away from using a single diagnosis to explain a patient’s terminal prognosis. In clinical practice, most patients have more than one condition that contributes to their prognosis. The use of a single diagnosis on the hospice claim in the past may have lured us into believing otherwise (and sometimes lured our payers into that artificial construct as well). Focusing on the way multiple conditions interface in terminally ill patients can only help us to better identify and provide the best possible care to an even broader range of patients.

Patient care may also be improved by recognizing multiple related diagnoses. It reminds us that we care for the whole person, not just a terminal diagnosis. Hospice providers may look more closely at the medications and treatments of previously “unrelated” conditions when they are financially responsible for them. We may more often ask, “Is this treatment beneficial for someone with a

prognosis of months or does it only pose the risk of side effects or medication interactions?”

I am a firm believer that hospice provides the best possible type of care to the terminally ill. The hospice and palliative field has consistently shown that it reduces costs to the medical system while giving a comprehensive patient care experience like none other. Being “relatedness ready” is imperative in the midst of an ever-changing definition for what we do best: taking care of the whole patient.

REFERENCE

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Patient care may also be improved by recognizing multiple related diagnoses.

Spiritual CARE INTERVENTIONS TO REDUCE SYMPTOMS AT *end*

A Quality Improvement Project

Introduction

In the fall of 2014, Spiritual Care Providers at Gilchrist Hospice Care of Maryland came together to participate in a quality improvement project. Chaplains, Music Therapists and Spiritual Care Volunteers strategized to re-consider spiritual care interventions in a broader sense: Could using interventions of prayer, meditation, guided imagery, music and poetry help relieve pain, shortness of breath and other symptoms that burden people and their families at the end of life? The Spiritual Care group hoped that as hospice patients felt relief from their symptoms, there would be an opening for them to explore meaning in their lives and to participate in life review and other developmental tasks associated with the dying experience. The overall goal for this work was to improve the patient and family experience by integrating spiritual care interventions to alleviate physical symptoms and provide a space to engage in life.

The Improvement Process Structure

The group adapted an “A3” methodology for this improvement work. The A3 Lean method aims to eliminate waste while improving the quality of the product. It is a narrowly-focused problem solving process based on the theory that if we keep the improvement process simple, we allow space for “deep thinking,” which will lead to innovation and transformational changes

(Jimmerson, 2007). The “problem” for this A3 was the underutilization of spiritual care providers’ interventions and misconceptions of what spiritual care may offer. The “waste” for this group was not using the full range of spiritual care interventions to help alleviate physical symptoms. If this waste were eliminated, it would result in improving the experience of care for patients and families. The secondary goal of this project was to raise awareness of using spiritual care providers for other than religious concerns and more broadly include them in symptom management when appropriate.

Steps in the Process

A charter outlining the purpose and parameters for this project was written and circulated among the spiritual care participants and approved by Leadership before the group commenced. The group met five times over six weeks for two-hour sessions. Follow up work was done via conference calls to decrease the amount of time spiritual care providers were away from their patients. During the first meetings, the group mapped out the current state of providing spiritual care from admission to bereavement for hospice patients and their families. Looking at this current state made it easy to identify opportunities for spiritual care providers to utilize the full range of their “tools” to help improve the patient experience of care. The group then mapped out a future state to

IONS of life:

By Gilchrist Hospice Spiritual Care Providers



A patient with cancer, experiencing loss of mobility and fear of loss of control due to the limitations of her disease, begins to come to terms with her disease when a Chaplain draws the patient's attention to what she loves and where she finds her strength.

show what the process should look like after the A3. The future state for spiritual care providers included using their communication skills, knowledge of alternative therapies, the arts and music to enhance symptom management as well as tend to patient and family “religious” needs.

Once this was done, the group tested changes to see if they would lead to enhanced patient and family care. The change they tested was twofold: first, learn more about physical symptoms at the end of life through joint visits with hospice nurses; and second, use spiritual care interventions to reduce the symptoms identified. The group decided against a quantitative measure to see if this change resulted in an improvement in scores of some kind. Instead they opted for a qualitative measure and used narrative analysis to understand the effectiveness of their tests and to promote further learning from the work.

Each spiritual care provider joined in on a nursing visit to learn more from the nurse and the patient about the experience of pain, shortness of breath, fatigue and memory loss. Then the spiritual care provider visited patients with similar symptoms and wrote up the visit in a narrative format. The stories were reviewed to identify interventions used and their effectiveness in symptom management.

Findings

The group found that as they increased their awareness of the patient’s experience of shortness of breath and other symptoms, they were able to create, or co-create with the patients in some cases, strategies to reduce the burdens of symptoms. The following stories demonstrate the effectiveness of not only reducing the physical symptoms using spiritual care interventions, but also how these interventions allow space for people to engage in living more fully.

Poetry and Reminiscence to Reduce Agitation and Connect with Meaning of Life

By John Yoo, Chaplain

There was an Irish patient in her late 80s with advanced dementia. She immigrated to the US with her newly wedded husband shortly after WWII. She used to be verbal, which progressively deteriorated over the period of about a year. She would speak in short sentences or phrases, mostly out of context. This particular visit took place when she was no longer able to communicate verbally. The patient was quite agitated when I arrived that day. From previous knowledge, I suspected she may have learned Robert Burns’ poetry in her schooling as a youth. I presumed she may have recited a number of poems by heart. I quickly turned to my smart phone to Google a Robert Burns site and started reading some of his poems aloud.

At first I did not think she was listening; so I was going to stop. But when I came to one of the poems, “Sweet Afton,” she became very quiet, closed her eyes, put her hands together and brought them to her chest while attentively listening to the first stanza. I waited a few seconds and intentionally re-read the first stanza again. I noticed she was moving her lips, like mimicking... then I read for the third time the same stanza and she joined me in reciting the poem.

Spiritual Care Clinical Reference Tool
When Spiritual Care Providers Can Help

Signs of Suffering

Physical signs of suffering	Psychosocial signs of suffering
<ul style="list-style-type: none"> Shortness of breath Mental status changes/confusion/delirium Agitation/functional decline/fatigue Decreased appetite Unresponsive Unrelieved pain Confusion or distortions of the physical body caused by disease 	<ul style="list-style-type: none"> Agitation Sadness Anxiety Guilt Fear Shame Depression Respect Powerlessness Loneliness Embarrassment Isolation Anger Lack of control

Practices Often Used

- Legate: Encourage the creation of a written document about what was important to the patient
- Help the patient accomplish things they are still capable of doing (brushed hair)
- Create artwork, music, collage, a memory book, scrapbooking
- Life review: written form, spoken on a recorder, spoken to others
- Coming to terms with (revelation) dying
- Helping others come to terms with the patient dying
- Patient forgiving themselves, forgiving others
- Peace of mind, hope
- Act as a liaison to promote healing between the patient and caregiver, e.g. he hit me and I don't want to help him anymore.

*“Flow gently sweet Afton!
Among thy green braes,
Flow gently, I’ll sing thee a
song in thy praise,
My Mary’s asleep by the
murmuring stream,
Flow gently, sweet Afton,
disturb not her dream.”*

I could literally see her agitation becoming subsided in the process; she eventually became calm, comfortable, and engaging. Patient’s symptoms can be managed by medicine, but we should never overlook other resources.

Shortness of Breath and Legacy

By Lisa Foster, Music Therapist

I went in to see a young man, 46 with lung cancer. He appeared somewhat breathless when I introduced myself but presented as relaxed and quiet, despite his use of oxygen. After our introductions and an offer of live music, to which he gladly agreed, this gentleman shared vignettes of his life between various selections of music. Soon I asked him if he and his wife had a special song that best described their love for each other. He answered, “No, we don’t have one.” I took the opportunity to invite him to write his own, to which he replied, “Oh I couldn’t do that.” I assured him that the words and phrases he had shared with me about his wife, their courtship and marriage, as well as his

thoughts about his 8 year old daughter and young son would be quite appropriate for song lyrics. He chose the melody of George Harrison’s “Here Comes the Sun” and with the addition of “my” a reference to “C” his wife, in the opening phrases, we completed the new song. Throughout this song-writing exercise, I became aware that the breathlessness seemed to have subsided, just enough to be noticeable. As I sang back the new lyrics, the gentle man took his phone and recorded the music to be played for his family. He knew his wife would love it, but he also shared that his daughter would get a kick out of this. “She loves the Beatles and this is her favorite song.”

When I came to the IPU for my next visit, I found that the patient had died unexpectedly right before I arrived and his family was gathering in his room. Since I had never met any of the family, and saw another pastor with them, I decided not to go in the room and instead set up my keyboard in a sitting room across the hall. I started playing “Here Comes the Sun,” singing his lyrics. The patient’s daughter came out of the room and stood by the keyboard to listen, and when the song was finished she said, you knew my daddy - he wrote that song and played it for us on his phone last night. Thank you.

A hospice patient with CHF was having shortness of breath during a visit with me. I began to play a calming tune and the patient’s breathing slowed to the rhythm of the

An 89-year old patient with dementia, who most days could barely utter a word or two, answered an emphatic “no” when a Chaplain asked if she could say her name; she subsequently uttered, “But, I know who I am.”

beat of the music. I subsequently created lyrics to a popular tune on the keyboard and sang to the patient. The patient loved the song. The family learned of the intervention and saw me in action. After the patient's death, the family requested that I sing and play the song at the patient's funeral service.

Guided Meditation and Life Review

By Dedera Baker

Mary, a 92-year-old lady with COPD, was now experiencing moderate to severe SOB even with her oxygen throughout the day. I would pray with this patient and by the end of the visit she seemed to calm and settle her breathing for just a short while. I then had the idea to describe guided meditation with the patient. The patient described the areas she grew up in Tennessee - details like churning butter, washing clothes on a wash board, getting water from one creek for cooking and from another spring for drinking and bathing. The patient said it surprised her to remember these childhood memories and it gave her comfort. I asked the patient to close her eyes and describe her memories with as many details as possible. The patient's breathing slowed down during that visualization. I suggested the patient try this on her own when her breathing gets

really labored. Her son reported she "does the memory the pastor suggested" and usually falls asleep which gives her some rest from her shortness of breath.

These stories were reviewed by the A3 group to identify symptoms that might be amenable to spiritual care interventions and which interventions seemed to work. The participants developed a [clinical reference tool](#) for themselves and for use by other members of the IDT. The tool describes physical, psycho/social/spiritual issues as well as tasks of people who are dying that are amenable to spiritual care provider interventions and expected outcomes. This tool is posted on the intranet as a quick guide so that referrals could be made easily to spiritual care providers. This work was also disseminated to IDT meetings where spiritual care providers told their stories and the benefits they experienced as they broadened their work beyond the traditional roles of spiritual care providers.

Discussion

In her reflections on working in hospice, Dame Cicely Saunders (1996) described "total pain" as a complex of physical, emotional, social, and spiritual elements. In the preceding stories, it is easy to see that other end of life symptoms, like pain, have

emotional, social and spiritual elements. It is also easy to see that interventions beyond medication are effective and seem to have a holistic effect greater than symptom relief for the hospice patient. This quality improvement project provided the spiritual care team with confidence in their abilities to reduce physical symptoms with tools they had previously used for spiritual issues. The project also heightened the awareness of their fellow IDT members to the benefits of this approach which results in greater utilization of the spiritual care team members in caring for our patients.

Using the A3 Tool for Improvement Projects

Eiji Toyoda and Taiichi Ohno developed the A3 problem solving tool in Japan for Toyota many years ago to improve the quality of cars coming off a production line. It's hard to say what they would think about using the A3 tool for improving care by spiritual care providers in hospice, but it worked. The A3 proved to be a simple improvement tool that kept the group on time and on task. It also led to "deeper thinking" and the re-discovery of the usefulness of spiritual care interventions to improve the experience of patients and families at end of life. Jimmerson (2007) comments in

her book, *A3 Problem Solving for Healthcare*: “It’s easy to let the way we’ve always done things sponge the efficacy of our jobs. And with that efficacy goes the fun, creativity (and sadly) the quality and profit of our work.” Testing interventions they had never associated with physical symptom relief led spiritual care providers to learn more about their patients and the powerfulness of their own tools.

As we all work towards improving the patient and family experience of care as measured by the CAHPS Hospice Survey, in an environment of doing more with less, we will need to continue to test novel ways of engaging staff with the patients and families to improve outcomes. The A3 tool can be manipulated to fit most settings and most improvement challenges to accomplish this end.

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A patient with COPD was experiencing shortness of breath. When a music therapist sang a song with a slow, steady rhythm, the patient’s breath became regulated by the beat of the music and ultimately slowed down her labored breathing.



FY2016 Hospice Wage Index Final Rule

On Friday, July 31, 2015, the [FY2016 Hospice Wage Index Final Rule](#) posted to the public inspection page of the Federal Register with the expected publication date of August 6, 2015. An [NHPCO Regulatory Alert](#) went out to members on August 3.

NHPCO reminds members of some of the key points pertaining to the rule.

- An estimated rate increase of 1.1% for FY2016.
- Implementation of hospice payment reform, effective January 1, 2016, with a two-tiered routine home care rate (RHC) based on a beneficiary's length of stay, with a higher rate for the first 60 days of care and a lower rate starting on day 61.
- A service intensity add-on (SIA) payment is established, effective January 1, 2016, for services provided by an RN or social worker in the last seven days of a hospice patient's life.

- Changes in the aggregate cap calculation and an alignment of the cap accounting year to conform to the Federal fiscal year of October 1.
- Updates to quality reporting include the establishment of thresholds for data submission compliance and an update on public reporting.
- Clarification on the requirement for reporting all diagnoses on the claim form.
- The final rule also provides detailed analysis of hospice claims for FY2013.

Members are encouraged to visit the NHPCO Regulatory & Compliance Center on the NHPCO website to track the most current information, analysis, and advice from the regulatory and compliance team. Look under "Hot Topics" for the [FY2016 Hospice Wage Index Final Rule](#) page.

2015 Circle of Life Award® Honorees

Award Celebrates Innovation in Palliative and End-of-life Care

Care Dimensions in Danvers, Mass. is the recipient of the prestigious Circle of Life Award for 2015.

Hospice of Frederick County in Frederick, Md., has earned a Citation of Honor. The awards were presented at the American Hospital Association's annual summit in San Francisco on July 24.

The award celebrates innovation in end-of-life care and the two

programs honored this year demonstrate a commitment to providing palliative care services within the continuum of care and outreach to traditionally underserved communities.

NHPCO and the National Hospice Foundation honor these distinguished recipients. Both of these exemplary programs are members of NHPCO.

Care Dimensions serves 90 eastern Massachusetts communities and an average 650

hospice patients and 140 palliative care patients each day. It provides care in a variety of settings including patients' homes, assisted living facilities, long-term care facilities, hospitals, group homes, veterans' facilities and an inpatient hospice facility. Care Dimensions provides a broad range of services including hospital consultation services; a program to transition from home care to hospice; an early access program that provides both curative and palliative care at the

same time; and dedicated skilled nursing facility and assisted living facility teams.

Hospice of Frederick County is part of Maryland's Frederick Regional Health System. This rural-based hospice emphasizes continuity of care, providing a broad range of services to patients in the hospital, long-term care facilities and even at home. It has an effective outreach to traditionally underserved groups, including to minority communities and to deaf patients and volunteers, and a collaborative program with behavioral health services.

The 2015 awards are supported, in part, by the California HealthCare Foundation and the Cambia Health Foundation. NHPCO and NHF are among the major sponsors of the Circle of Life Award. Further information about the honorees and the Circle of Life Award is available at www.aha.org/circleoflife.



L to R: John Mastrojohn, NHPCO; Angela Hult, Cambia Health Foundation; Kate O'Malley, California HealthCare Foundation; Eric Bush, Hospice of Frederick County; Diane Stringer, Care Dimensions; Christine Ritchie, AAHPM representative; Mike Rodgers, Catholic Health Association; James H. Skogsbergh, AHA chairman-elect of the board of trustees.

Hospice Advocates Share Their Stories on Capitol Hill

Nearly 300 Hospice Advocates representing 200 Congressional districts converged on Capitol Hill to call on Congress to support the Care Planning Act of 2015 and the Hospice Care Access Improvement Act of 2015 during the Hospice Action Network annual Advocacy Intensive held on July 13 & 14. Congressional meetings were held with nearly 400 offices.

Attended primarily by members from the hospice interdisciplinary team – physicians, nurses, social workers, chaplains, hospice aides and volunteers – storytelling was a key component of this year's strategic approach with a focus on the role of the bedside caregiver.

In addition to sharing their personal hospice caregiving experience, advocates called for support of two key issues of importance to the hospice community. The Care Planning Act of 2015 is legislation that includes provisions to assist in navigating complex health care needs and address challenges in advance care planning. Advocates also asked their representatives to support the Hospice Care Access Improvement Act of 2015 (H.R. 3037).

continued on next page



In addition to the work of hospice advocates on the ground on Capitol Hill, advocates and hospice supporters across the country participated virtually by contacting their elected officials in an outreach effort coordinated by HAN's "Click to Call" campaign.



Both the grassroots efforts on Capitol Hill and the "Click to Call" campaign netted positive results. As of the end of July, the sign-on letter asking CMS to test hospice payment reform had 27 signatories, including 11 from the Senate Finance Committee. The Hospice Care Access Improvement Act of 2015 continues to gain co-sponsorship.

New York Program Receives Advocacy Award

During the Intensive, the Advocacy Innovator Award was presented to a hospice that exhibits exemplary advocacy efforts. This year's recipient was CareFirst in Elmira, New York. CareFirst has built and sustained a successful relationship with Representative Tom Reed, inviting him to visit their program and maintaining contact with the Congressman and his staff.

CareFirst brings a large team to the Advocacy Intensive every year and is utilized as an advocacy resource for the hospice and palliative care community.

"CareFirst is honored to be recognized as the winner of the Advocacy Innovator Award by the Hospice Action Network. This award recognizes the determination of our staff, volunteers and board to further the mission of

hospice through advocacy. We thank HAN for their support and encouragement, and certainly for this award," says CareFirst CEO Mary Ann Starbuck. "We would be remiss not to also acknowledge Congressman Tom Reed and his staff for their exceptional working relationship with both CareFirst and HAN."

L to R: HPCANYS President Kathy McMahon; CareFirst Access Director Robin Stawasz and CareFirst CEO Mary Ann Starbuck.



Council of States Honors Retiring Leaders

NHPCO's Council of States committee members gathered for their annual meeting in Washington, D.C. on July 15, 2015. During the meeting, attendees took time to recognize four retiring hospice state organization leaders.

Deborah Whiting Jacques is the current CEO and leader of the Oregon and Washington hospice and palliative care organizations. She has served as the voice of hospice and palliative care in the state of Oregon for nine years and assumed management of the Washington State Hospice and Palliative Care Organization upon Anne Koepsell's retirement in January 2015. She is a member of NHPCO's Regulatory, Governance and Ethics Committees, and serves on the board for the State Hospice Executives Roundtable. She is retiring soon to spend more time with her family, especially her grandchildren.

Jeff Lycan served as the CEO of the Midwest Care Alliance for more than 16 years. He helped create numerous regulatory and

legislative initiatives that support home and community-based services. During his tenure as CEO, he was appointed by the Governor to the Long-Term Care Advisory Workgroup and sat on the state's Prescription Drug Abuse Task Force. He was a board member of Ohio KePRO, the Medicare Quality Initiative Organization, chaired the Hospice Coalition which works collaboratively with Palmetto GBA, and served on the board of directors for NHPCO. Jeff is now the vice president of mission advocacy at Hospice of Dayton.

Kathy McMahon has served as the CEO of the Hospice and Palliative Care Association of New York State for 15 years. Kathy has been the voice of hospice and palliative care in New York State and has shepherded its improvement and advancement through multiple statewide initiatives. Kathy served as chair of NHPCO's Council of States from 2007-2009 and on the NHPCO board. She is a member of the NYS Palliative Care Education and Training Council and under her leadership HPCANYS was the recipient of NHPCO's first annual Trailblazers Award in 2012. Kathy will be retiring at the end of this year to enjoy some well-deserved time off.

Virginia Fry is the director of the Hospice and Palliative Care Council of Vermont, a post she has held since 1985. She also serves as the bereavement coordinator of Central Vermont Home Health and Hospice, where she continues her clinical practice. She is a consultant to the Departments of Children & Families, Disabilities and Independent Living, and Education for the State of Vermont. Ginny teaches at four state colleges, including graduate programs in counseling, focusing on issues of death, dying, grief and creative topics throughout the country. Ginny plans to leave her position as director of the state organization this year after 30 years of service.



Pictured left to right are COS Steering Committee Chair Jane Moore, Kathy McMahon, Deborah Whiting Jacques, and Jeff Lycan.

CTC 2015 Plenary Speakers Will Educate and Inspire You

The theme for our 16th Clinical Team Conference and Pediatric Intensive will focus on “expanding the mission” to ensure that the right care is provided at the right time to all patients and families appropriate for hospice and palliative care.

Our plenary speaker line-up includes some dynamic, internationally-known experts – here’s a glimpse.

Passages in Caregiving



During our opening plenary Gail will share strategies for helping caregivers manage the eight crucial stages of the caregiver journey.

Gail Sheehy

Dignity and Insights into the Culture of Caring



Through dignity therapy, Harvey reviews ways to help patients prepare for their dying with a sense of purpose to their living.

Harvey M. Chochinov, OM, MD, PhD, FRCPC, FRSC, FCHAS

Stop Global Whining



Even on the final day things get off to a thoughtful start as Christine discusses strategies for accomplishing more with less and the secret to getting what you want with what you’ve got.

Christine Holton Cashen, MAEd, CPAE, CSP

Attendees will also have a choice of two Clinical Practice Plenary sessions on Friday, October 16: *Engaging Diverse Communities – A Study in Innovation* and the pediatric-focused *Care Coordination in Palliative Care for the Medically Complex Child – Palliative Care to the Rescue!*

There are also several preconference seminars and education programs offered as part of the Clinical Team Conference. Highlights include the two-day *Pediatric Palliative Care Training* (PC01) for new and developing pediatric palliative and hospice care professionals and the one-day preconference seminar, *Best Practices for Improving Access and Outreach to Communities of Color in End-of-Life Care* (PC02) featuring a distinguished faculty, and *Leading the Way to Community-Based Palliative Care Success* (PC03), a highly interactive workshop developed by CSU Institute for Palliative Care. [Learn more about our preconference offerings.](#)

CTC also includes over 50 concurrent sessions, preconference seminars, networking opportunities, exhibit hall, a special event for Global Partners in Care, celebration of *We Honor Veterans* fifth anniversary, and much, much more. [Learn more and register online.](#)



REGISTER NOW



EXPANDING THE MISSION



20
15

16TH CLINICAL TEAM CONFERENCE
AND PEDIATRIC INTENSIVE

PRECONFERENCE DATES:

October 13–14, 2015

MAIN CONFERENCE DATES:

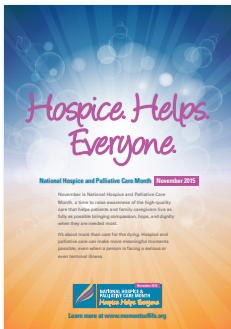
October 15–17, 2015

GAYLORD TEXAN RESORT AND CONVENTION CENTER
GRAPEVINE, TEXAS

National Hospice and Palliative Care
Organization



Outreach Materials for November



Hospice. Helps. Everyone. This is the theme for November's National Hospice and Palliative Care Month. NHPCO has created some outreach materials that providers can use to promote this important month of awareness in the community. Materials include an ad in different sizes, a poster, digital graphics and more. We encourage providers to be as creative as possible in using these materials that are linked in the Outreach Tools section of the website, www.nhpcoco.org/outreach.

Diversity Resources Available



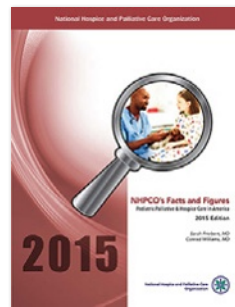
In addition to tools to help raise awareness of hospice and palliative care month, we have

new resources to help members reach out to diverse communities, they can be found on a new web page for providers. NHPCO's Diversity Initiative seeks to increase access to hospice and palliative care services within diverse communities, especially African American, Latino and other communities of color.

Visit www.nhpcoco.org/diversity to read about our Diversity Initiative, access materials, learn about upcoming educational programs, discover networking opportunities, and more.

For those interested in some focused training on diversity outreach, NHPCO is offering a special, one-day **preconference seminar**, *Best Practices for Improving Access and Outreach to Communities of Color in End-of-Life Care*, as part of NHPCO's Clinical Team Conference in October.

New Pediatric Facts and Figures Report



A new report released by NHPCO provides insight into the care needs of young people who might benefit from pediatric palliative/hospice care. These are children with chronic, complex and/or life-limiting conditions. Due to the complexity of care involved,

children with life-threatening conditions and complex chronic conditions are likely to benefit from PP/HC services. The U.S. Department of Health and Human Services reports that the number of children with special health care needs is increasing. Overall, 15.1 percent of U.S. children ages 0 – 17 (11.2 million children) are in this category.

The 11-page report, *Facts and Figures: Pediatric Palliative and Hospice Care in America*, can help professionals to better understand both the current challenges and the unmet needs of children and their families across the country.

Additional resources on pediatric palliative and hospice care, including our free pediatric e-journal, are available at www.nhpcoco.org/pediatrics. Also, learn more and attend a special, **pediatric palliative care two-day training** that's a featured preconference seminar at NHPCO's 2015 Clinical Team Conference and Pediatric Intensive.

It's Time...

Are You Ready for Palliative Care Success?

NHPCO in Collaboration With the CSU Institute for Palliative Care Present:

Leading the Way to Community-Based Palliative Care Success

A Preconference Seminar at the NHPCO Clinical Team Conference
October 14, 2015 – 9:00-5:00

Learning Objectives:

- Compare and contrast multiple inpatient & community-based palliative care models
- Provide overview of strategies for filling palliative care services
- Undertake an organizational needs assessment
- Identify essential clinical, financial and organizational metrics
- Create a multi-year business plan
- Plan the necessary culture change, education and marketing to ensure success
- Develop an actionable implementation plan and more

Sign up now or learn more at NHPCO.org

CSU The California
State University

Institute for Palliative Care

National Hospice and Palliative Care
Organization




Hallmark Channel Focuses on Hospice

In July, NHPCO communications staff worked with Jeanette Pavini, a reporter for the Hallmark Channel doing a piece for their program “Family and Home.” The reporter had a very positive hospice experience with her father in the San Francisco area. We were able to provide her facts about hospice and palliative care, as well as ‘b-roll’ of our newest Moments compilation video. The result is very positive and personal [hospice affirming segment](#).

Resources from NHPCO’s *Moments of Life* campaign as well as our “Find a Hospice” search tool are recommended resources on the [Hallmark Channel website](#).

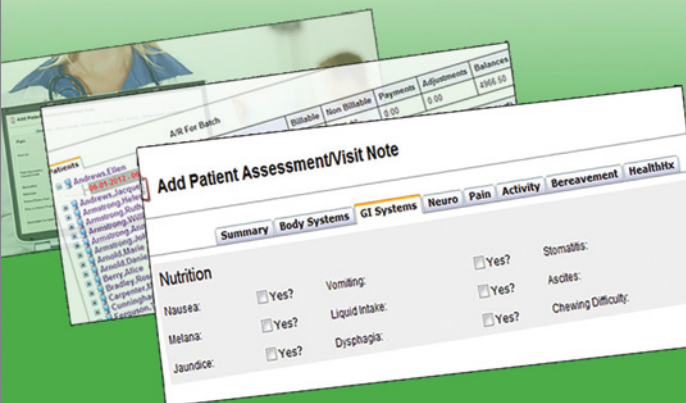


Hospice EMR built by Nurses & Admins



Elara has produced an EMR that was designed by hospice staff, designed specifically for hospice, and designed to be Easy-to-Use while being affordable for “any-size” hospice.

Web-based, Easy to Use EMR (Desktop, Tablet, Mobile)
 2 Hour Training, No Classroom
 Easy and Quick Startup & Implementation
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 40+ Reports, HIS, CAHPS, ICD10, EDI Billing



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CSU The California State University
Institute for Palliative Care

NHPCO's Marketplace

The one-stop source for all your hospice and palliative care related materials

NHPCO's 2014 National Star Report



The STAR (Survey of Team Attitudes and Relationships) is the first and only job satisfaction survey designed specifically for the hospice field. The survey was developed by researchers at the University of Pennsylvania in collaboration with NHPCO. The annual STAR National Report allows hospices to compare their individual STAR survey results to national level results for benchmarking. The report also includes hospice staff salary and demographic information that can be used for budget preparations and strategic planning.

[CLICK HERE TO PURCHASE](#)

Member Price: \$200 Non-Member Price: \$350

What is Hospice



TOP SELLER! You matter to the last moment of your life... What is Hospice? is full of facts about hospice and the hospice philosophy, and includes a very effective "20 Commonly Asked Questions" section. Use it for patient/family education, public outreach, and volunteer recruitment! It's also idea for use in mailing programs.

[CLICK HERE TO PURCHASE](#)

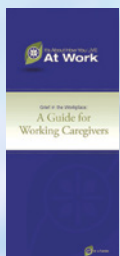
Personalization available upon request: 1-800-646-6460

Minimum order of 200

Member Price: \$0.65 if over 500 / \$0.78 under 500

Non-Member Price: \$1.28 if over 500 / \$1.48 if under 500

A Guide for Working Caregivers



This booklet shares insightful information about the demands of caregiving and how to deal with the daily stresses of this position.

[CLICK HERE TO PURCHASE](#)

Member Price: \$1.15 Non-Member Price: \$1.75

Guidelines for Bereavement Care



These guidelines gather the collective knowledge, expertise, experience, practice and wisdom of over 80 hospice professionals whose work takes them to the very depths of human experience. Intended to enhance applicable local, state, and federal regulations and standards, they provide information that will help hospice bereavement professionals put regulations and standards into practice, ensuring that they are including and addressing essential components of an effective hospice bereavement program.

[CLICK HERE TO PURCHASE](#)

Member Price: \$17.99 Non-Member Price: \$35.98

Staffing Guidelines for Hospice Home Care Teams



The Staffing Guidelines for Hospice Home Care Teams present an innovative approach to determining staffing caseloads that recognizes the wide variety of care delivery models used by hospices today. No longer "one size fits all," the guidelines utilizes an assessment process to estimate optimal staffing levels for hospice programs that includes an analysis of the model of care delivery, characteristics of the patient population served, environmental considerations, and other circumstances unique to each hospice.

[CLICK HERE TO PURCHASE](#)

Member Price: \$14.99 Non-Member Price: \$25.99

QAPI: A Step by Step Approach



UPDATED in 2014! A practical guide to planning, developing and implementing a meaningful quality assurance and performance improvement program. This workbook will prepare you with a foundation of understanding how to gather data, analyze the data, and make the "real-life" improvements that will greatly affect your outcomes.

[CLICK HERE TO PURCHASE](#)

Member Price: \$189.00 Non-Member Price: \$228.00

For all NHPCO resources, visit www.NHPCO.org/marketplace.



Delaware Hospice's President/CEO Wins State Award



Susan Lloyd, MSN, RN, president and CEO of Delaware Hospice received The Excellence Award for Administrator from the Delaware End-of-Life Coalition. Each year, the Delaware End-of-Life Coalition awards individuals in several professional categories with The Excellence Awards honoring those who provide extraordinary care in the community.

Avow Chief Medical Officer Honored



Dr. Paul Mitchell, chief medical officer with Avow, based in Naples, FL, was honored by the Collier County Medical Society as Physician of the Year. This is the inaugural presentation of this award created to recognize a member who deserves special recognition for exemplary contributions to the practice of medicine and/or outstanding service to the Collier County, Florida community. "Being selected as the Medical Society's Physician of the Year is a tremendous honor and I am humbled," remarked Mitchell.

New Appointee to Florida Center for Nursing Board



Samira K. Beckwith, president and CEO of Hope HealthCare Services, has been appointed to serve on the Florida Center for Nursing board of directors for a three-year term. The center was established by Florida statute to recommend solutions to address Florida's nursing shortage. "Serving on the Florida Center for Nursing board provides the opportunity to help shape strategies and develop programs to address healthcare industry issues as the demand for qualified nursing care increases," said Beckwith.

Connecticut Gov. Malloy Honored



At a reception at its new Center for Comfort Care & Healing, Regional Hospice and Home Care honored Governor Malloy for his advocacy and support of the new facility and its mission. His concern for grieving families following the Sandy Hook tragedy in 2012 led to more comprehensive bereavement services in the new facility recently opened in Danbury, CT. To this day, the Healing Hearts Center team continues to support the Newtown community and their family members from throughout the region. "On behalf of thousands of children and families we have the privilege to care for, we thank him for recognizing the needs of dying patients and the community members who are grieving the loss of loved ones," said Regional Hospice President & CEO Cynthia Emiry Roy.

HealthCare Chaplaincy Honors Two Trailblazers



HealthCare Chaplaincy Network presented its prestigious Pioneer Medal for Outstanding Leadership in Health Care to Richard Payne, MD, of Durham, NC, an internationally-known expert in the areas of pain relief, palliative care, oncology and neurology; and Larry Vandecreek, DMin, of Grand Rapids, MI, a trailblazing researcher for the profession of health care chaplaincy. "Their rich accomplishments and profound commitment to science and, moreover, to people in need make each of them deeply deserving of this recognition," said Rev. Eric J. Hall, HCCN's president and CEO.



— *In Memory of* —
DENNIS REZENDES
1929 – 2015

NHPCO remembers one of the original founders of NHO, Dennis Rezendes, who died peacefully on June 16, 2015 at his home in Colorado under the care of TRU Community Care (formerly Hospice Care of Boulder and Broomfield Counties); his family was at his side. Considered to be one of this nation's hospice pioneers, Dennis was the first administrator for Connecticut Hospice, recognized as one of the first hospices in the country. In the late 1970s, he led a small, passionate group to form the National Hospice Organization. In 1985, he was awarded the National Hospice Organization Founder's Award.

In memory of Dennis, we share some reflections from the book *Hospice Care: A Celebration* published by NHPCO over a decade ago:

Professionally, Dennis hadn't planned to make hospice his life's mission. In earlier years he had worked for the City of New Haven and the Rouse Company. He had eventually become an independent business owner, leaving Rouse to start his own consulting firm. But Dennis realized that he had a personal experience that made the idea of hospice resonate with him in a special way.

My father had become terminally ill and had died. When they described hospice and the program – well, having had the experience with my father, I related right away. I realized, hey, I could have used this program. So I closed down my consulting firm and did the hospice thing full-time. I had a wife and two kids who were ready to go to college, but I said, "This is my memorial to my father."

News From **National Hospice Foundation**

Alex's Family BBQ

The Lighthouse of Hope Fund helps complete a wish on a hospice patient's bucket list.



Alex Fernandez, diagnosed with terminal brain cancer, still had living to do. The three tumors that had invaded his body could not break his resolve to make every moment count. The 20 year-old's bucket list consisted of things like going to the beach, one last family portrait, a 49ers game, and a family BBQ.

Alex, determined to focus on quality over quantity of life, told a reporter covering his story, "I'm not really counting my days right now, I'm counting moments."

Kaweah Delta Hospice in Visalia, California, wanted to help Alex reach his goals so they contacted the National Hospice Foundation to apply for the Lighthouse of Hope Fund. Social Worker, Suzette DeHaan, applied for funds for a family BBQ. On the application, she stressed how important this event was to Alex: "As the hospice MSW, I am visiting with Alex and his



mother two times a week and Alex continues to mention how important his family is to him and how much he loves them. Alex is very excited about this BBQ." [READ MORE...](#)

Learn more at www.nationalhospicefoundation.org.

We Honor Veterans and Global Partners in Care Awarded for Excellence

Programs supported in part by the National Hospice Foundation are recognized.

The American Society of Association Executives has selected We Honor Veterans and Global Partners in Care as Power of A award winners this year. WHV has been selected as a 2015 Summit Award winner, ASAE's highest honor for associations. The National Hospice Foundation is proud to support both WHV and Global Partners in Care and has raised funds for the programs through various initiatives. [READ MORE...](#)



WE HONOR VETERANS
Hospice Professionals on a Mission to Serve



Join in Supporting Hospice Through Your Workplace Giving Campaign!

You can make a big difference through payroll deduction.

NHF's parent organization, the National Hospice and Palliative Care Organization (NHPCO), is honored to participate in the CFC and receive gifts through this and many other employee campaigns. CFC donations to NHPCO go directly to programs that help hospices across the country serve everyone, including Veterans, children, caregivers, and grieving families. [READ MORE...](#)

The CFC number to use: NHPCO #11241
To support Global Partners in Care's work #11018.



National Hospice
Foundation

GLOBAL PARTNERS IN CARE EVENT:

A NIGHT AT THE *Taj Mahal*

In conjunction with NHPCO's 16th Clinical Team Conference

Friday, October 16, 2015

Gaylord Texan Resort, Grapevine, Texas

6:30 pm – 9:30 pm

Cocktails, Hors D'Oeuvres, Silent Auction
Program and Entertainment



www.globalpartnersincare.org

Take a journey at Global Partners in Care's annual fundraising celebration (free for Main Conference registrants*). Network with colleagues and make new friends as we raise funds and awareness to improve access to hospice and palliative care worldwide, building partnerships to enhance compassionate care globally.

Join others who are already making an impact by becoming a sponsor, auction donor, or purchasing a ticket. For more information, please contact Joy Nguyen at jnguyen@nationalhospicefoundation.org, (703) 647-5167, or go to www.globalpartnersincare.org/2015CTC

* Not a conference registrant? Sponsorship opportunities and tickets are available.

Thank You Sponsors

Diamond Sponsor

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Gold Sponsor

Center for Hospice Care and Palliative Care Association of Uganda

Silver Sponsor

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Quality of Life Publishing Co.
Simione Healthcare Consultants

Sponsors as of August 1, 2015

News From **Global Partners in Care**

Global Partners in Care Receives National Award



Global Partners in Care is being recognized by the American Society of Association Executives with a 2015 Power of A Gold Award. A select number of associations from across the country are awarded each year for innovative, effective, and far-reaching programs and activities.

“We are honored to receive the 2015 Power of A Award and we thank ASAE for recognizing our work,” says Global Partners in Care Executive Director, John Mastrojohn. “Our national and international impact is largely based on the dedication and work of the hospice and healthcare organizations across the U.S. that provide resources to advocate for and assist in the provision of quality, compassionate hospice and palliative care in Africa, India, and Nepal and the collaboration with international associations including the African Palliative Care Association, India Association of Palliative Care, and World Hospice and Palliative Care Alliance.” *Read more...*

Congratulations to the 2015 African Palliative Care Education Scholarship Recipients!

Global Partners in Care in collaboration with the African Palliative Care Association (APCA) have awarded education scholarships to further the knowledge and skill of African nurses and social workers in the provision of palliative care. Congratulations to the follow recipients:

Nurses:

- Mary Nyabate Omare, Kenya
- Jane Nakibuka, Uganda
- Felicity Ntombifuthi Lukhele, Swaziland

Social Workers:

- Mildred Ndamukaneyi, Zimbabwe
- Peggie Chiwara, Namibia
- Olasupo Bosede, Nigeria

Read more...



How YOU Can Support a Nurse or Social Worker Scholarship

To continue our African Palliative Care Education Scholarship program, Global Partners in Care is actively fundraising NOW to provide nurse and social work scholarships in 2016. We need YOUR financial support so that we can have an even greater impact next year!

In many African nursing and social work courses, there is no palliative care training. Formal training in palliative care is greatly needed to provide nurses and social workers with the much needed skills to provide quality care to patients with life threatening illnesses such as HIV/AIDS and cancer. *Read more...*

World Hospice and Palliative Care Day is October 10th



Global Partners in Care proudly supports World Hospice and Palliative Care Day.

According to the Worldwide Hospice Palliative Care Alliance, this day is a “unified day of action to celebrate and support hospice and palliative care around the world.”

The theme this year is “Hidden Lives, Hidden Patients” and will focus on patients living in unique conditions that often struggle with access to palliative care including children, LGBT individuals, HIV prisoners, soldiers/Veterans and those living in rural settings.

Read more...

Learn more at www.globalpartnersincare.org.



National Hospice and Palliative Care Organization's
31st Management and Leadership Conference & 12th National Hospice Foundation Gala

LEADING THROUGH THE CURRENTS OF CHANGE

**EDUCATION PROGRAMS
& PRECONFERENCE SEMINARS**

April 19 – 20, 2016

MAIN CONFERENCE

April 21 – 23, 2016

NATIONAL HOSPICE FOUNDATION GALA

April 22, 2016

**GAYLORD NATIONAL RESORT
& CONVENTION CENTER**

National Harbor, Maryland



National Hospice and Palliative Care
Organization



More From **Moments of Life**

Showing people that hospice makes more meaningful moments possible is what the National Hospice and Palliative Care Organization's public awareness campaign, **Moments of Life: Made Possible by Hospice** is all about. Since its launch in May of 2014, NHPCO member hospices from across the US have submitted patient stories, videos, photos, and articles. This real-time, constantly evolving campaign has reached millions of people already, through media coverage, television PSA

placement, social media engagement and public relations/digital advertising strategies.

While NHPCO continues to drive home the unique benefits of hospice and palliative care with Moments, we want to share with you some of the ways hospices have already contributed to the campaign; in turn, they have been able to utilize this involvement to enhance their own community and media outreach efforts.

Hospice of Orange and Sullivan Counties, Inc

Submitted by Janice Valentino, Director of Marketing and Development



The first time I received information on this new NHPCO Campaign, *Moments of Life: Made Possible by Hospice*, I immediately reached out to Anita Brikman (SVP of Strategic Communications at NHPCO) to let her know that I thought this was a great campaign that offered the

opportunity for all hospices to “level out the playing field” so to speak... for those hospices who did not have as big of a marketing budget.

Our message is the same... Hospice care helps make more moments of life possible, for patients and families. This branding is beneficial to us all who are passionate about educating our communities about hospice.

Hospice of Orange and Sullivan Counties, Inc. created its own touching video, featuring a patient who was a well-known local artist and teacher in upstate New York. Caroline Prieur Schulz-Chechen's last wish was to have one more art show. I filmed the event myself, and wrote a blog for www.MomentsofLife.org, in which the video was imbedded. Caroline's story was featured in a local magazine, and we continue to use images and themes from *Moments of Life* in community outreach efforts.

Hospice of the Western Reserve *Submitted by Laurie Henrichsen, Public and Media Relations*



Hospice of the Western Reserve, which serves the Cleveland area in northern Ohio, was one of the first participants in the *Moments of Life* campaign, and became an avid and engaged supporter. Our hospice identified the first patient whose story would be

showcased. Michele Tripi was a wife, mother and grandmother who chose hospice care to help her cope with ALS. Michele's hospice team included not only clinical staff to help keep her as comfortable and active as possible as the disease progressed, but also an **art therapist** who helped create collages and other momentos with Michele and her grandchildren. **Michele's Angels** was premiered at the Management and Leadership Conference in May of 2014. HWR later submitted a second video, **Stanley's Special Visit**, which profiled the special moment when this prostate cancer patient returned to the vocational school from which he graduated.

Hospice of the Western Reserve worked closely with NHPCO to create a national/local outreach strategy. We began promoting the campaign in the spring, when it launched, and continued promoting it during National Hospice and Palliative Care Month by creating a **dedicated webpage** with links to videos and resources,



moments of **life**

made possible by hospice



including a link back to MomentsofLife.org.

We re-tweeted and re-posted several NHPCO updates on the campaign throughout the year, and partnered with NHPCO on a regional media tour to gain additional exposure on local media outlets in the greater Cleveland market.



Hospice of the Western Reserve and NHPCO jointly participated in the “WKYC Channel 3 Health and Wellness Expo” at the Cleveland Convention Center,



which included an interactive showing of the PSA, an educational exhibit and more.

Participation in the Health Expo also included several mentions of the campaign on WKYC’s noon news show “Live on Lakeside”; in addition, NHPCO was able to secure valuable airtime for the campaign’s first **public service announcement**.

Houston Hospice

Submitted by Karla Goolsby, Communications Specialist



Houston Hospice was pleased and honored to share the remarkable story of Bryan Caldwell through the *Moments of Life* campaign. This was a beautiful contribution that featured former NFL offensive

lineman Bryan Caldwell and his wife Krista, who happens to be a hospice nurse. Bryan was an exuberant, active man who had always relished a life lived fully. After painful and futile treatments for Non-Hodgkins Lymphoma, he became a disciple for hospice, sharing his story at every opportunity. Bryan was excited to participate in the *Moments of Life* campaign for that reason.

Houston Hospice shared the Caldwell’s *Moments of Life* video on social media, where it was engaged by thousands – **more than any other content we have ever posted**. It was also shared with local print and television media outlets. The story was picked up by national and local print publications. Bryan and Krista were especially thrilled when they were invited to be featured guests on “Great Day Houston”, the most popular morning television talk show in greater Houston. The producer praised the *Moments of Life*

More From Moments of Life

video and it was aired in its entirety prior to the Caldwell's interview on the show. The show was broadcast on November 3, 2014.



Winning at the Game of Life (Great Day Houston Television Show featuring the Caldwell's and their *Moments of Life* video)

The taping and broadcast of the "Great Day Houston" show created even more opportunities to share the Caldwell's story on social media. When Bryan died on January 3, 2015, several print publications mentioned his appearance on "Great Day Houston". The Caldwell's *Moments of Life* video is still featured on the home page of the Houston Hospice website. When I speak to community groups about hospice, I show the video prior to my talk. I ask the audience to close their eyes and imagine what a hospice patient looks like. Then I start the video and ask them to open their eyes so they can see Bryan Caldwell fishing, riding his bike, having fun with his family and talking about his experience as a hospice patient. Houston Hospice remains grateful to NHPCO and the *Moments of Life* campaign for providing an invaluable resource to help us educate our community about the benefits of hospice care.

Silverado

Submitted by David Gill



Participating in NHPCO's *Moments of Life* campaign was a valuable experience. The campaign's ability to touch lives is very much in line with Silverado's commitment to making a positive impact on the lives of those we serve. Through *Moments of Life*, we highlighted a

Silverado volunteer, and her role in enhancing the quality of life of patients and their families. It was an honor to share this story with a broad audience as it became a part of our efforts to communicate the joy in what we do. From a marketing perspective, we began by featuring the video as a story on our website, using that story page to measure interest in the video. The following tactics then linked to that page: a photo from our homepage, an email distributed to families and professionals, and posts on Facebook.

Additionally, we use the NHPCO volunteer week release to pitch industry bloggers. At least one outlet, HospiceTimes.com, ran the story. The video was also shared with Silverado leaders and associates, and continues to be shared with new associates and other

hospice professionals. And because the video is timeless, we'll continue to look for new audiences and new ways to share it!





These special moments help people understand the difference that hospice care can make. We value and appreciate your support in this campaign. We will continue to share your stories; please reach out to communications@nhpco.org if you would like to participate. And stop by www.momentsoflife.org anytime to see *Moments of Life: Made Possible by Hospice*.

moments of **life**
made possible by hospice

Moments of Life: Video Collection

NOW AVAILABLE!

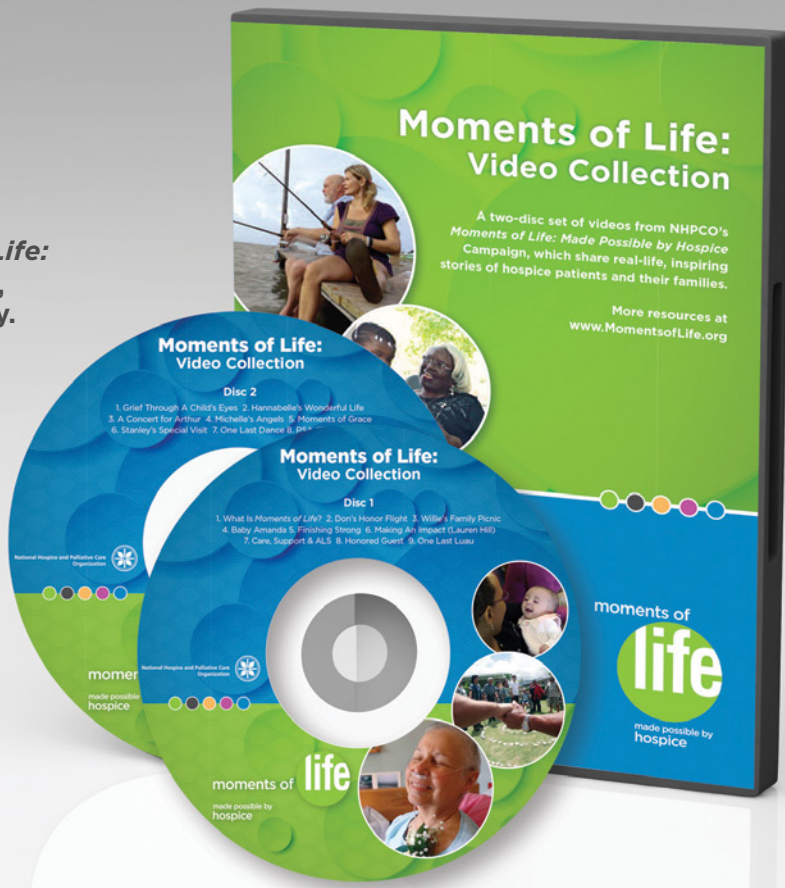
NEW from NHPCO...

A two-disc video collection from *“Moments of Life: Made Possible by Hospice”*. Share these real-life, inspiring stories of hospice with your community.

This first-time DVD release features video vignettes and campaign PSA’s.

For more information about this public awareness campaign visit: www.MomentsofLife.org

To order the two-disc video collection, please contact NHPCO at 1-800-646-6460.



National Hospice and Palliative Care Organization



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

Outreach

- Outreach Materials
- Social Media Resources
- Caring Connections

Publications

- Weekly NewsBriefs
- NewsLine
- ChiPPS E-Journal

Affiliate Publications

- Giving Matters
- Focus on Compassion



National Hospice and Palliative Care Organization



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