



Welcome to the Summer Edition of NHPCO's NewsLine

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This should correct the problem.

NewsLine

The quarterly membership publication of the National Hospice and Palliative Care Organization Summer 2015

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Helping Us Move Further Down the Road

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National Hospice and Palliative Care
Organization



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Message **From Don**

Summer is here – and for those who have been suffering due to the extreme storms that have hit regions from Texas to Oklahoma and beyond – I want to let you know that all of us at NHPCO are thinking of you who are facing even greater challenges than we normally see.

It does seem as though new challenges are coming at us all with a greater pace than in years past. That's probably just perception; however, I do know that the stressors facing all of you who are providing hospice and palliative care in communities across the country are overwhelmed at times by all the change we see. So I am quite sincere when I encourage you to hang in there.

Those of you who attended the recent Management and Leadership Conference in April had the good fortune of hearing from Ian Morrison, PhD, at the opening plenary. In his discussion of the future of the healthcare marketplace, he specifically noted that acquisitions, consolidations and regionalization are going to be seen throughout all sectors of healthcare. Dr. Morrison also spoke of cost as it relates to value, quality metrics, empowered consumers, increased oversight, and integrated delivery systems as significant factors that all providers will have to face.

Those of us who are part of the hospice and palliative care provider community are already witnessing consolidations and acquisitions; all the while, we are grappling with increased scrutiny and oversight.

Many of these changes in our field are a result of growth – both in dollars spent by CMS, number of providers in the field, and the number of patients receiving care.

All of us at NHPCO are working, every single day, to help you maneuver through the complex environment around us. It is not something to be afraid of, but is something to be aware of and understand. What is important is that providers continue to do what's right for the patients and families they are serving – which I know is the mission we all share.

Thank you for all that you do,



J. Donald Schumacher, PsyD
President/CEO



RESEARCH ON HOSPICE CARE IN RURAL AREAS

Helping Us Move Further Down the Road

By Judi Lund Person, MPH, National Hospice and Palliative Care Organization; Brad Gibbens, MPA, Deputy Director, University of North Dakota Center for Rural Health; and Alana Knudson, PhD, Co-director, Walsh Center for Rural Health Analysis, University of Chicago.

While the number of hospice providers and hospice utilization in the U.S. has grown rapidly over the past two decades, rural Medicare beneficiaries may still encounter barriers to hospice care access. In rural areas, where residents are disproportionately older, sicker, and lower income, it is particularly important that hospice and palliative care are universally available and accessible to beneficiaries at the end of life.

Just over 30 percent of U.S. hospice providers who submit data to NHPCO's National Summary of Hospice Care define themselves as rural, while another 46.3 percent report serving both rural and urban communities.

To help address their challenges, NHPCO formed a Rural Task Force in 2010, comprised of 12 members from programs located in various regions of the country. This task force has focused on issues of significance to the delivery of hospice and palliative care to rural and frontier hospice providers.

What is defined as rural?

Rural areas, as defined by the U.S. Census Bureau, are "all territory, population and housing units located outside Urbanized Areas (50,000 or more people with a population density of 1,000 persons per square mile) or an Urban Cluster (population of at least 2,500 but less than 50,000 persons adjoining an urbanized area.)

For hospices, the rural areas are designated on each year's wage index as the "non-CBSA" counties.

Frontier counties have an additional distinction – a population density of six or fewer people per square mile, although other isolating factors may also apply.

An Important Beginning: Research Spotlights Rural Hospice Care

One of the early goals for NHPCO in its work involving rural hospice issues was to connect with resources available to the larger rural health care community. One such significant resource is the National Advisory Committee on Rural Health and Human Services, an advisory committee of the Health Resources and Services Administration (HRSA) Office of Rural Health Policy.

The National Advisory Committee is a 21-member citizens' panel of nationally recognized rural health experts that provides recommendations on rural issues to the Secretary of the Department of Health and Human Services. Each year, the committee selects one or more topics upon which to focus.

In 2013, the National Advisory Committee discussed challenges and innovations in hospice and palliative care in rural and frontier areas.

The Advisory Committee met at Hospice and Palliative Care

of Western Colorado in Grand Junction. The committee was hosted by Christy Whitney, founding president and CEO of the hospice who also serves on the NHPCO Public Policy Committee and the Rural Task Force. In April 2013, they visited two of its satellite hospice facilities in northwestern Colorado. A Rural Task Force member, Donna Roberts, from Wray, Colorado, spoke to the Advisory Committee about the challenges of delivering hospice care in rural Colorado.

The committee examined the modifications of the Medicare hospice benefit mandated by the Affordable Care Act in the context of recent changes in utilization patterns of hospice and palliative care in rural and urban areas.

The National Advisory Committee published a policy brief¹ which is available online on a special NHPCO webpage dedicated to [rural hospice issues](#). The brief provides analyses of ACA provisions which may have rural implications, provides background on the Medicare hospice benefit, describes unique features of hospice care in rural areas, and submits recommendations to the Secretary based on the outcome of the committee's deliberations.

Members of the National Advisory Committee with hospice

connections include Phyllis Fritsch, administrator of Upland Hills Health in Dodgeville, Wisconsin, operating a critical access hospital, nursing home, outpatient dialysis clinic, home health agency and hospice; Tom Hoyer, formerly of the Centers for Medicare and Medicaid Services and its predecessor organizations, who is credited as being one of the creators of the Medicare hospice benefit; and Christy Whitney, founding president and CEO, Hospice and Palliative Care of Western Colorado.

Policy Brief Spawns Further Research on Hospice in Rural Areas

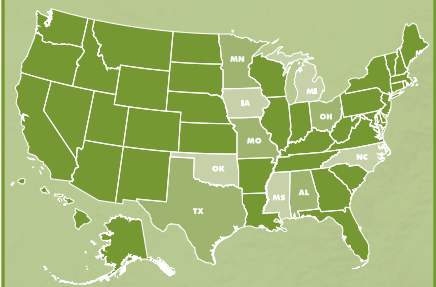
The policy brief published by the National Advisory Committee was only a beginning. The Office of Rural Health Policy continues its interest in hospice and palliative care in rural areas, most notably with a project calling for quantitative and qualitative research.

The Rural Health Reform Policy Research Center, a partnership between the University of North Dakota Center for Rural Health and the Walsh Center for Rural Health Analysis at the University of Chicago, were tasked with this important research assignment on rural hospice and palliative care which lead to a policy brief,

WHICH STATES HAVE THE MOST RURAL PROVIDERS?

Approximately 462 NHPCO provider-members report serving primarily rural communities.

1. **Mississippi (70)**
2. **Texas (68)**
3. **Oklahoma (51)**
4. **Iowa (49)**
5. **Alabama (43)**
6. **North Carolina (43)**
7. **Michigan (36)**
8. **Minnesota (36)**
9. **Missouri (33)**
10. **Ohio (33)**



*Source: CMS provider of services file, March 2015

1. HRSA, Office of Rural Health Policy, National Advisory Committee on Rural Health and Human Services Policy Brief, Rural Implications of Changes to the Medicare Hospice Benefit.

“Perspectives of Rural Hospice Directors,” published in March 2015.

Providers are encouraged to download the policy brief “Perspectives of Rural Hospice Directors” (PDF) available on the NHPCO webpage dedicated to [rural hospice issues](#).

From the beginning, NHPCO worked collaboratively with the researchers to identify rural hospice providers for interviews, identify a focus group for in depth discussions of rural hospice issues, and to review and comment on quantitative findings from the CMS claims data.

The project began with consultations with the NHPCO Rural Task Force and led to the task force serving as an expert panel providing an overview of operations, environmental conditions, terminology, and overall contextual development for rural hospice issues.

Methods for the research project included a qualitative study involving phone interviews with rural hospice directors (or key staff) in 47 states, a focus group of rural hospice directors, and a comprehensive literature review.

Qualitative Research on Hospice in Rural Areas: Key Findings

Based upon input from the NHPCO task force and the research components of the study, the

research team identified six primary issues (which are covered in more detail in the report):

Finance

Rural hospices struggle financially. Among shared concerns, interviews with study respondents indicated that the “level and adequacy of reimbursement, operational costs that are not factored into the per diem rate, equity with urban hospices, and other factors” were challenges to remaining financially viable.

Regulatory Environment

Perceptions of excessive regulatory requirements creates financial and workforce implications. Those interviewed focused almost entirely on federal regulations, like the “face-to-face” requirement for recertification. The impact of regulatory requirements that take staff time away from direct patient care was cited. Ways the perceived regulatory burden affect staff in terms of morale and burnout were discussed as well.

Workforce Issues

Rural hospice workforce availability is influenced by a number of contextual conditions that include supply and demand, workplace setting, competition, economics, rural factors (as mentioned below), and compliance. Recruiting and retaining qualified staff members is a challenge for rural providers when urban providers often offer better salaries, benefits, and hours. Issues



**The project
began with
consultations
with the NHPCO
Rural Task Force...**

involving future staffing needs are a concern. Other factors researchers found include heavy workloads, small staff size, the need to wear “multiple-hats,” and limited options for education and training.

Rural Factors

The most common theme researchers found involved issues of travel and distance – known as “windshield time” – that present unique workforce, financial, and management implications. Furthermore, the study found the elements in rural environments, while not necessarily unique to rural hospice organizations, do factor adversely in operations. Factors include population changes, volunteer availability, and perceived livability for recruitment purposes. Economic factors such as poverty rates, income levels, and fluctuating economic conditions were also important issues.

Relationships

Hospice providers cited relationships with other provider organizations as significant. These include such areas as referrals, purchasing, and employment. Competition with other providers raised concerns with perceptions that urban/larger hospice programs had greater resources available. Competition with nursing homes was noted by some respondents. It should be noted that relationships with critical access hospitals were positive.

Technology

While not seen as a primary issue – none of the 53 respondents identified it as their highest rated concern – technology issues did generate a number of specific concerns, such as connectivity in rural areas, efficiency, the possible utilization of more technology in direct patient care, financial and added cost implications, and adaptability to new and/or complex technology. For example, access to Internet service was a significant issue which included: no Internet service available, speed constraints, blackouts, dead zones, power outages, and other factors. A typical problem identified was access in a private residence. While the central hospice site may have Internet

access, it was difficult to access in many patient homes.

The six foremost issues described in the study are not mutually exclusive as they tend to overlap and influence each other.

Quantitative Research on Hospice in Rural Areas: Key Finding

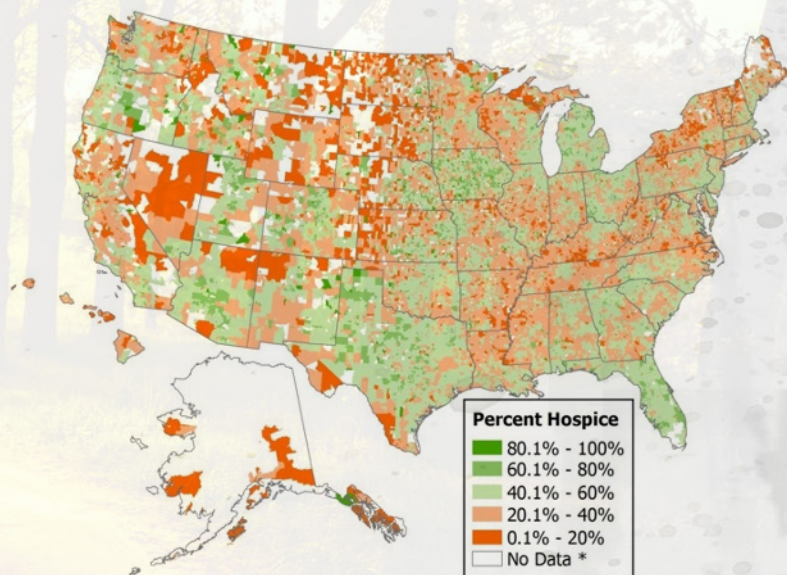
The researchers at the Walsh Center for Rural Health Analysis at the University of Chicago, led by Alana Knudson, PhD, studied hospice availability in urban, rural, and isolated rural areas by county in the country. Dr. Knudson presented this research at the 2015 NHPCO Management and Leadership Conference on May 1, 2015. This research is expected to be published shortly.

Hospice Wage Index Proposed Rule brings changes to the designation of urban and rural counties:

In the FY2016 Hospice Wage Index proposed rule, the results of the 2010 Census will be implemented, with 37 counties currently urban becoming rural, and 105 counties (*and county equivalents*) currently designated as rural becoming urban. In addition, CMS continues to implement a “hospice floor” calculation on the wage index, applying a 15% increase to the original hospital wage index data, to a maximum wage index value of 0.8. This is of particular help to the nation’s rural hospice providers.

Among the findings was that 23.5 percent of Medicare beneficiaries receiving hospice care in 2009 and 2010 lived in a rural area – large rural, small rural, or isolated rural.

The percentage of Medicare beneficiaries enrolled in hospice care at the end of life during 2009-2010 – **urban and rural**



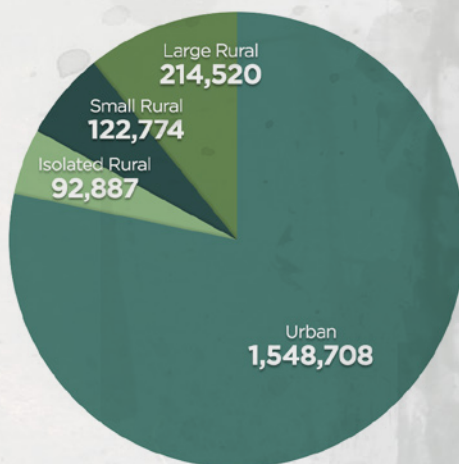
New Research will Focus on Rural Hospice Workforce Issues

NHPCO is pleased to report that research continues. An additional research topic was identified to accompany the qualitative and quantitative work on rural hospice care. Shortly, providers will receive a survey on hospice workforce issues impacting hospice care in rural areas. NHPCO is proud to partner with the researchers on this issue.

NHPCO has a webpage specifically devoted to [rural hospice issues](#). If you have questions about hospice care in rural areas, please contact NHPCO at regulatory@nhpc.org for more information or to share with the Rural Task Force.

[PRINT-FRIENDLY PDF](#)

23.5 percent of Medicare beneficiaries receiving hospice care in 2009 and 2010 lived in a rural area...



NHPCO's Rural Task Force Looks at Key Issues

Providing some of the findings from research undertaken by such noteworthy agencies and research institutions is important to NHPCO's Rural Task Force. However, the task force continues its own work focusing on issues that are so critically important to our community.

The work of the Rural Task Force has always been a clear priority among NHPCO's board and leadership. Currently, the task force is chaired by board member Sandy Kuhlman while the previous task force chair was Linda Rock, current NHPCO board chair.

At NHPCO's recent Management and Leadership Conference, Rock stressed the importance of access to hospice in rural areas during her plenary remarks on May 1, "Every person in this country should have access to hospice care regardless of where they live whether it's in an urban, rural or frontier area. And we're committed to making sure that remains the case."

*By Judi Lund Person, MPH,
and Jon Radulovic, MA*

“While the entire hospice community faces challenges, there are challenges that are more unique to rural and frontier hospice providers,”

—Linda Rock

NHPCO’s Rural Task Force has identified five areas of importance that they have focused on. They share some insight below.

Critical Access Hospitals

One of the primary issues identified by NHPCO’s Rural Task Force is the use of critical access hospitals, both as a location for inpatient care as well as for the provision of ancillary services. Previously a critical access hospital (CAH) was penalized when general inpatient care is provided in the CAH under contract with a hospice because the reimbursement rate for GIP is significantly lower than the rate the hospital receives for a day of inpatient care. However, manual changes for the CAH cost report published in September 2013 indicate that hospice days should now be deducted from the average cost per diem calculation. Whatever the amount of the contractual agreement between the CAH and the hospice goes “above the line” in the CAH cost report.

CMS published Appendix W, with revisions to the State Operations Manual for Critical Access Hospitals, in April 2015. In these regulations, CMS states that a “CAH can dedicate beds to a hospice under arrangement, and the beds must count as part of the maximum bed count. The computation contributing to the 96 hour annual average length of stay **does not apply to hospice patients.** The hospice patient can be admitted to the CAH for any care involved in their hospice treatment plan or for respite care... Medicare does not reimburse the CAH for the hospice CAH benefit. Medicare reimburses the hospice. The CAH must negotiate payment for services from the hospices through an agreement.”

Attending Physicians in Rural Health Clinics

The second issue is the inability of rural health clinic physicians to continue to serve as a patient’s attending physician once the patient has been referred to hospice. The Medicare regulations have been quite clear – because of the payment structure for rural health clinics, a physician employee may not serve as a hospice patient’s attending physician unless they also have a Part B billing number, and see the hospice patients “during a time when he/she is not working for an RHC or FQHC (unless prohibited by their RHC or FQHC contract or employment agreement).”¹

One of the primary issues identified by NHPCO’s Rural Task Force is the use of critical access hospitals...

1. Medicare Benefit Policy Manual, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services, Section 200.

CR8504 reiterates this policy:

RHCs and FQHCs can treat hospice beneficiaries for medical conditions not related to their terminal illness. However, if a Medicare beneficiary who has elected the hospice benefit receives care from a RHC or FQHC related to his/her terminal illness, the RHC or FQHC cannot be reimbursed for the visit, even if it is a medically necessary, face-to-face visit with a RHC or FQHC provider, since that would result in duplicate payment for services.

Some rural and frontier areas have few or no physicians who work outside the rural health clinic. At a recent Rural Task Force meeting, one provider reported that there was only one NON rural health clinic employed physician in a radius of 16,000 square miles. This presents significant challenges for

hospice providers, who must rely on physicians to serve as hospice medical directors and attending physicians. If there is no way for the RHC physician to continue to serve, patients may not have access to much needed hospice services – a reality in some places in the country.

In the fall of 2014, NHPCO convened the Rural Task Force and members of the NHPCO Regulatory Committee to meet with officials in the CMS Chronic Care Policy Group to discuss rural issues in hospice. Of particular concern was the rural health clinic physician issue, which task force and committee members described in great detail. CMS agreed to look at issues we presented for possible solutions and appreciated the input from hospice providers.

Physician Assistants in Hospice

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

NHPCO and the Hospice Action Network both believe that physician assistants should be able provide care to those patients who elect hospice and have endorsed the Medicare Patient Access to Hospice

Act of 2015 (H.R. 1202), sponsored by Congresswoman Lynn Jenkins and Congressman Mike Thompson.

At a time when hospice programs are threatened by rising transportation costs, as well as a lack of physicians and nurse practitioners, H.R. 1202 takes a practical step by allowing physician assistants (PAs) to provide hospice care to those patients who elect Medicare's hospice benefit. By allowing certified PAs to provide hospice care, programs will be able to keep up with the ever-growing population of Americans choosing to elect hospice at the end of life, regardless of location.

Hospice Face-to-Face Requirement

The hospice physician face-to-face regulation has certainly posed its own set of unique challenges.

The task force has received a great deal of information from members on the burden this regulation puts on all providers. For rural providers with limited capacity for medical director time, it's even more burdensome.

Hospice medical directors may spend an entire day seeing one patient for a face-to-face encounter if they have to drive long distances on dirt roads to reach the patient. In addition, many rural hospice providers employ part-time medical directors who have their own private practices or clinic

Rural Hospice Providers: A Strong Policy Presence

NHPCO has always had a strong commitment to meeting the needs of our rural providers, something reflected in our policy efforts on Capitol Hill. We realize that rural providers face unique challenges and we strive to look for opportunities to meet those challenges with positive policy solutions. Among the many initiatives NHPCO has engaged in on behalf of rural programs, we wanted to highlight a few key notes:

- **Linda Rock**, former executive director of Prairie Haven Hospice in Scottsbluff NE, is the ex-officio of the NHPCO Public Policy Committee, and currently serves as the NHPCO board chair.
- **The NHPCO Public Policy Committee** identified “Addressing the unique needs of hospice providers that serve rural communities.” as one of their key legislative effort areas in their agenda for the 114th Session of the United States Congress.
- **Between the NHPCO Public Policy Committee, the NHPCO Regulatory Committee, and the Hospice Action Network Board of Directors**, there are over 25 programs who serve counties designated as ‘rural’ in the wage index.
- **The Hospice Action Network’s Advocacy Intensive** has a scholarship fund generously provided by Outcome Resources that provides critical travel scholarships so that rural hospice providers who have key Members of Congress can afford to send frontline caregiving staff to advocate on Capitol Hill.

The Hospice Action Network has a strategic commitment to engaging in coalition advocacy in rural states (notably in Kansas and South Dakota), taking the time to bring rural hospice providers together, address their unique concerns, and help them to present a united front before their key Members of Congress.

responsibilities. The face-to-face requirement is especially hard on that group of physicians. Since this a regulation mandated by CMS, there is little that can be done to change how this affects programs.

The task force has had some discussion about advocating for some type of waiver for rural programs,

one that would give more time to complete the face-to-face encounter. We also believe that allowing physician assistants (PAs) to do these visits could be very helpful since, in many rural areas, PAs are the primary providers of care. Since adding PAs as a ‘healthcare professional allowed in hospice’ requires a statutory change, this is on the list for Hospice Action

The hospice physician
face-to-face regulation
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Network staff and lobbyists in conversations with members of Congress and their staffs.

Distance

Rural and frontier providers are dealing with larger geographic areas and covering thousands of square miles. This leads to increased travel time for clinicians which can be challenging for providers that have a limited number of staff. Weather concerns, whether it is snow and ice, flooding, rain which makes roads muddy and impassable are among the daily challenges for hospice staff in rural areas.

The reimbursement rate is typically lower for rural and frontier hospices. Rural and frontier hospices usually have a smaller census. A lower

reimbursement rate multiplied by a smaller census equals a challenge to cover administrative services and the infrastructure required to comply with the current regulatory and compliance environment.

Summary

The issues for rural hospice providers with critical access hospitals and rural health clinics have been around for many years. With the new “light shined on rural hospice care” by the Office of Rural Health Policy, and the additional research being published and conducted now and into the future, rural hospice providers have the opportunity to solve some of the vexing issues in the delivery of rural hospice care.

NHPCO is pleased to continue its focus on hospice care in rural areas and to connect with other parts of rural health care to ensure that the issues and needs of rural providers are included in policy discussions. There is new attention on these issues at CMS and at the Office of Rural Health Policy. Change may happen even though the solutions are complex and slow to solve. NHPCO is proud of the care delivered by rural hospice providers throughout this country and commits to continued support for all so that citizens, no matter where they live, have the opportunity to access their hospice benefits.

[PRINT-FRIENDLY PDF](#)



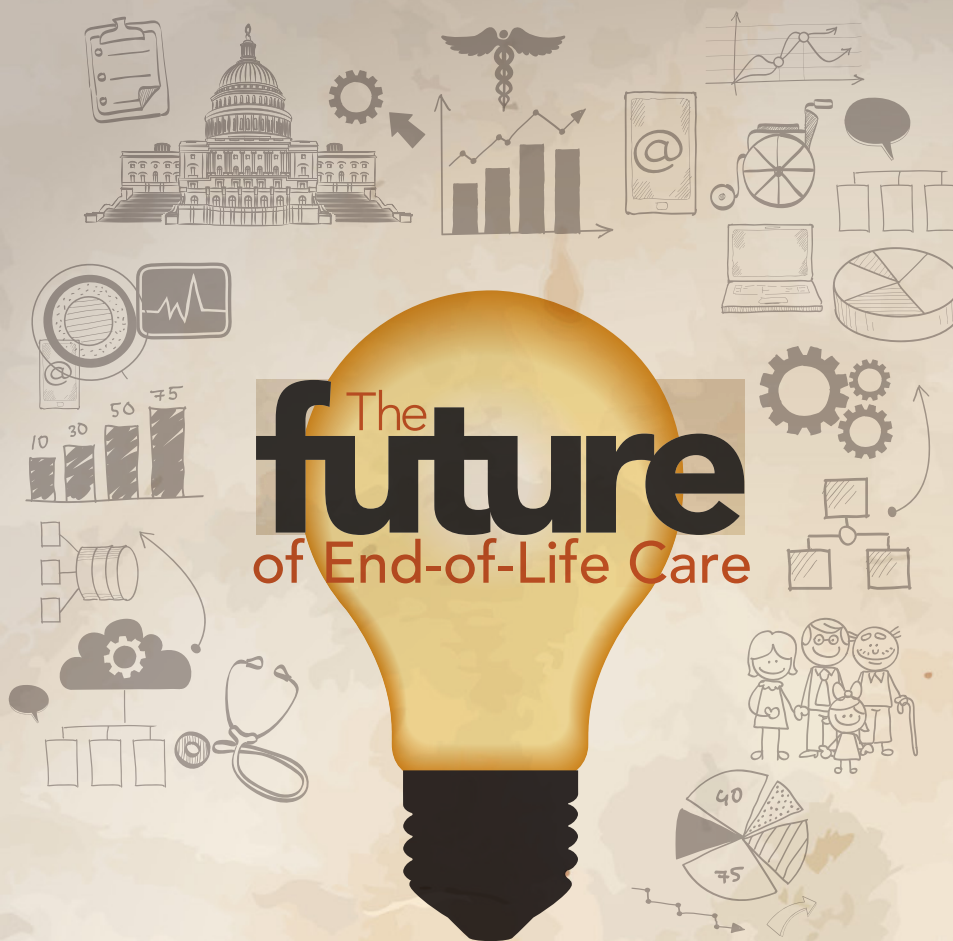
A Provider's Story

Greg and Noreen Wells Hospice Care Center, Hazard, Kentucky

This is the road to a patient's home in South Eastern Kentucky. The patient was in great need of nursing care. When the roads are clear we have to use a 4-wheel drive vehicle or the family picks staff up on a 4 wheeler and takes them to the home. The photo (left) was taken during this past winter. The snow had melted on all main roads. Two staff members traveled to this home in a very heavy duty 4 wheel drive and made it to the patients home.

When leaving the home, as they started down the mountain they began to slide toward going over the mountain. The driver held the brake and the vehicle kept inching its way to the edge and came close to going over the mountain.

We were able to get some help to them. A larger 4-wheel drive backed up the mountain, let the staff's vehicle hit the back of it and helped them inch down the mountain. They did make it safely back to the office but was a very terrifying situation. We kept them on the phone while this situation unfolded.



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IMPROVING MORALE THROUGH AUTHENTIC APPRECIATION

By Paul White, PhD



When stress levels in a workplace are high and continue over time, burnout often follows, with team members leaving their jobs not far behind. These issues have been particularly challenging for supervisors, managers, and employers in the healthcare field, including those who work in hospice.

The overall turnover rate among hospice staff has been relatively high. According to a [recent study](#) published in the *Journal of Health and Aging*, 30 percent of staff will not be employed at the same agency one year later. While lower, the rate of nursing staff turnover at home health and hospice agencies is also significant, ranging from 10.2 percent for registered nurses to 14.3 percent for licensed practical nurses.

As managers and employers also know, volunteers are a critical part of the hospice team. According to NHPCO's latest [Facts and Figures](#), an estimated 355,000 hospice volunteers provided 16 million hours of service in 2013, with over 60 percent of the volunteers spending direct time with patients and families. While hospice care volunteers generally

do not experience the same levels of stress and burnout as paid staff, they do have concerns, such as how they fit within the team dynamic and to what extent they will be involved in patient care.

Part of a Widespread Concern

Unfortunately, these challenges are not limited to hospice and palliative care. The reality is that most Americans are not satisfied at work. A Gallup poll completed in 2012 found that only 30 percent of U.S. employees are actively involved in and emotionally committed to their place of employment, with over 25 percent strongly disliking their job. This is the highest level of disengagement found since the research began in 2000.

A brief search on the Internet will turn up a significant number of articles and books addressing many of the reasons for this discontent, from generally toxic workplaces to office bullies. For example, one study found that one third of nurses who left their first workplace within three years, said they left due to the bullying behaviors of fellow nurses.

At the same time, most American workers do not feel appreciated or valued even though almost 90 percent of organizations and businesses in the U.S. report having some form of employee recognition program.


According to the Society for Human Resource Management,

while 51 percent of supervisors believe they are doing a good job of recognizing their employees, only 17 percent of employees at the same organizations agree. Additionally, U.S. Department of Labor statistics show that individuals who voluntarily leave their employment cite “not feeling appreciated” as the top reason for leaving.

Through our work with a wide variety of medical treatment providers, businesses and non-profit organizations, we too have found that the most common responses by employees when discussing employee recognition range from apathy to cynicism. One employee stated, “I haven’t heard anything positive for two years and now you expect me to believe that they value me?”

Why Most Employee Recognition Programs Aren’t Working

Although the purpose of employee recognition programs is certainly well intentioned, they often have a negative impact. For example, the “generic nature” of the typical award—the recognition plaque or certificate that every winner gets—has an impersonal feel. Other forms of awards tend to be tangible as well—gift cards, coupons and small tokens—when most people place greater value on such intangibles as verbal praise, personal attention or lending assistance.



**...individuals who
voluntarily leave their
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for leaving.**

What's more, it has been reported that 90 percent of all recognition awards are given for length of service, which has very little impact on motivating staff.

Another problematic aspect of most programs is the venue in which the awards are given. We find that 30 to 35 percent of employees don't want to get up in front of a large group of their peers and management to accept the award.

Four Keys to Doing It Right

In our work, we have found that it's "authentic appreciation" that has the most positive impact on staff morale and on-the-job satisfaction. So how do you convey that?

1. Consider How You Express Appreciation

Not everyone feels appreciated in the same ways. Some people appreciate words of affirmation, while others are encouraged when someone helps them with a task. Spending time is another way to demonstrate support. One staff member reported, "I just want my supervisor to check in with me every two weeks, and listen to me vent for 10 minutes so she knows what's going on." Bringing a colleague a special cup of coffee when you know they've had a long day is yet another way to show them you appreciate what they're doing. Even a "high five" or a "fist bump" can be a form of acknowledgement when a difficult situation has been handled well.

As one manager shared with me, "It's good we are doing this training, but I don't really need to be told that I'm appreciated. I try to encourage myself." It turned out that his "language of appreciation" was quality time. He was a youth sports coach, and if you took time to stop by practice, he "lit up" and almost couldn't stop talking about his players.

2. Make It Personal

While group-based recognition is a good start ("You all have been doing a great job of getting your charting done on time"), if the appreciation communicated doesn't relate to what the individual team member did to help achieve the goal, the communication can fall flat. A team member wants to know (and hear about) what he or she has done that is valued.

We have found a good formula for effectively communicating appreciation through words of affirmation:

- **Use the staff member's name** — People like to hear their own name, and in larger residential settings, staff will especially appreciate that the nursing manager really knows who he or she is.
- **State specifically what they did that you value** — We all respond best to specific praise. Describe the specific behavior or action ("Juanita, I really appreciate how you answer the phone and greet visitors cheerfully" rather than just "You are doing a great job!").
- **Tell them why their actions were important to you, the organization, and/or the patients and families they serve** — Oftentimes, team members follow through on actions, but they are not sure why it is important to do so. ("Jerry, when you get your reports to me on time, it really helps me get my reports to administration on time. Thank you!")

3. Always Be Genuine

If the communication of appreciation is not perceived as being genuine, nothing else really matters.

When we explored this issue with numerous groups to find out what contributes to a perception of inauthenticity, several factors were identified. Here were some of the most common:

- **The appreciation** came about suddenly after training or implementation of a program on appreciation
- **The person's tone** of voice, posture, or facial expression did not match what he was saying
- **The person's interactions** with you differ in public and in one-on-one situations
- **The person** has a history of saying one thing and doing another
- **There has been** some relational conflict in the past, and the person communicates appreciation without addressing the past issue
- **There is an overall question** of the person's motivation — does she have an ulterior motive?

4. Provide It Regularly

How often appreciation is expressed varies, depending on many factors — the work setting, the frequency of interaction between co-workers, and the nature (length, history and closeness) of the relationship. That said, it should be more than a perfunctory “once a year occurrence,” such as during an employee's performance review.

A common question we're often asked is “how to “get past” someone's perception that you don't truly value them?” Unfortunately, there is no magic bullet. Ultimately, it comes down to their assessment of your actions and motivation, over which you have no control. But the best course of action is to repeatedly — and regularly — communicate appreciation in the language and through actions that are important to them. Hopefully, over time, you may be able to convince them that you truly mean what you are saying.

Not Just From the Top Down

We have made two important discoveries during our school- and work-group trainings: (1) appreciation can be communicated by anyone; and (2) any team member, regardless of position, can positively impact their workplace culture.

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Initially, our workplace trainings involved only managers and supervisors, but over time we kept receiving feedback that other team members wanted to know how to encourage one another as well. This has impacted our application of the appreciation model in two specific ways.

First, we have found that the most significant impact in a workplace culture occurs when both co-workers and supervisors are engaged in communicating authentic appreciation. A “top down” approach does not work as well as an “any direction” model. Volunteers can communicate appreciation to the clinical director. Clinical care nurses can communicate appreciation to housekeeping staff. And certified nursing assistants can encourage the transportation personnel. An important implication is that team colleagues need to know the languages and actions that effectively communicate appreciation to their co-workers.

Secondly, we argue against doing a system-wide, “top down” implementation of an appreciation program. This may seem counter-intuitive, but when

communicating appreciation is a mandate to all staff, supervisors and administrators, then that edict automatically undermines the perception of authentic appreciation. Instead, we suggest exposing all team members to the concepts of authentic appreciation and give them the resources to apply the concepts to their work group. It is up to them to “opt in” if they choose.

We have found a number of interesting dynamics through this process. First, “champions” often emerge who are extremely supportive and enthusiastic about implementing the concepts with their team — and eager to lead a pilot program which others can observe and evaluate. Secondly, a response similar to envy sometimes emerges (“Why do they get to do the appreciation training and we don’t?”) which creates positive pressure that compels leaders to become engaged. Finally,

A FREE TOOL TO ASSESS JOB SATISFACTION

NHPCO introduced the Survey of Team Attitudes and Relationships (STAR) in 2007 as a benefit of membership.

The survey was developed by the University of Pennsylvania in collaboration with NHPCO for the sole purpose of helping hospice and palliative care providers assess the job satisfaction of their employees — both clinical and non-clinical staff.

As one CEO put it, “STAR is a snapshot in time, no different than a financial balance sheet. It takes the temperature of any organization’s culture.”

If you don’t yet utilize this tool, visit the [STAR page on the NHPCO website](#) to learn more.

the training and resulting culture change goes “viral” — seemingly because leaders and teams go through the process because they want to and in the timeframe that works for them. (It has been our observation that many programs and initiatives don’t succeed because the timing isn’t right for the participants.)

What You Can Do: Now

If you or your colleagues wish to improve the morale of your workplace, consider the following:

Focus on Yourself First

Commit to do what you can to communicate your appreciation to others. Don’t look to your supervisor or administrator to take the lead. Start by doing what you can, where you are.

For example, do you know what “language of appreciation” your staff and colleagues value? Is it spending time with them? Offering to lend hands-on assistance when they are in a crunch? Or would sending them a note of support or encouragement resonate more? If you are unsure, ask them by posing the question in this way: “When you are discouraged, what is something that someone can do or say that would encourage you?”

Team Up With Others

Any behavior change is more likely to occur (and to continue over time) when others are involved. Ask a friend, a colleague, your supervisor,

or the team you lead to do some reading together and discuss how it could apply to your setting. Commit to work on a plan of action together.

Learn From the Work of Others

There is nothing new under the sun. Other hospices have undoubtedly tried a variety of employee recognition programs and activities, with some having been helpful and others having been a waste of time. Learn from those who have gone before you. [Note: As an NHPCO member, you can utilize the My.NHPCO egroups to query your colleagues. To learn more about this free service, see <http://my.nhpc.org/home>.

Persevere

Most things that are worthwhile take time and effort. There will be obstacles or delays encountered. You will try something and it will “sort of” work. Learn from it, make corrections and try again.

Our experience has shown that true, significant change can occur within workplaces when the right actions are implemented (i.e. those that are authentic) by the right people (i.e. anyone, regardless of position) at the right time (i.e., when people choose to, and have the time and energy to commit to the process). I challenge you to give it a go and then enjoy the benefits of your actions!

**NHPCO introduced
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Paul White is a psychologist, speaker, and consultant whose expertise has been requested by Microsoft, Princeton University, the Milken Institute, Napa Valley Community Foundation, Dartmouth College, Houston Community Foundation, and numerous national organizations. He is also the co-author of several books, including the “5 Languages of Appreciation in the Workplace.” To learn more about Dr. White’s work, visit www.appreciationatwork.com and www.drpaulwhite.com.

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A CLOSER LOOK AT

REBRANDING

This feature includes two articles by NHPCO members who were involved in the rebranding of their organizations. The first article by Robin Stawasz provides a general overview of the rebrand process, while the second article by Tammy Bracken recounts the actual process her organization followed.



THE KEY STEPS IN A REBRAND

BY ROBIN STAWASZ, LMSW

Rebranding is not for the weak. Done right, it is an expensive and time-consuming process fraught with drama, difficult decisions and a lot of work. However, done right, rebranding is also an agent for growth and a catalyst for positive change.

My organization underwent rebranding in 2012 that involved changing our name from Southern Tier Hospice and Palliative Care to CareFirst, with the goal of reinforcing our position as the community's source for high-quality hospice care as well as palliative care and grief services. While it took a full two years to implement this major change, it has been well worth it. This article highlights the key steps to take in a rebrand, based on our experience.

FORMALIZE WHY YOU SHOULD

First and foremost, it is vital to decide on the purpose of your organization's rebrand:

- It can reflect the growth that your hospice has achieved and can promote your organization as a peer in the health care field
- It can create renewed public interest in who you are and what you do, giving you an opportunity to challenge misconceptions
- It can encompass new services that you offer, such as palliative care or care transitions (and, in so doing, help doctors and discharge planners promote your services more accurately).

Of course, just as there are benefits, there are also hazards. Your organization has probably toiled for years to establish its identity and any type of change could challenge that. It can create confusion and is clearly an investment in terms of time and money. So if you do decide to go ahead with a rebrand, you need to prepare.

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THE BUSINESS PLAN

As an initial preparatory step, you should develop a business plan. This plan should include:

- a clear definition of the purpose behind the rebranding (as noted above) as well as the expected pay-offs
- a needs/gaps assessment to identify what niches in the health care continuum you are working to fill
- how success of the rebrand will be measured
- the specific risks and expected outlays.

Unfortunately, this initial step in the process is often skipped despite the fact that it can really help determine the make-or-break decision before too much of an investment is made.

THE DEVELOPMENT PLAN

Working off the business plan, you should then create a development plan. This development plan will be the basis for your fundraising strategy and, as such, should include input from key donors and players as well as a detailed time-and-expense budget so everyone involved is on the same page — including your board of directors.

Your staff needs to feel some level of involvement as well. One way to do this is by establishing a specific customer services structure that incorporates everyone within the organization, with marketing staff involved in each step of the process. You will also need to identify a clear process for decision making that balances inclusion of individuals with efficiency. Whether or not you pull in outside consultants must be decided with a firm vision as to how much control you are willing to give over.

This level of detailed planning is absolutely vital because a rebrand is not just about changing your name or your logo. It affects everything you do:

- At the public level, it affects all your marketing material, be that print, broadcast or social media (It even affects how your receptionist answers the phone).
- At the clinical level, it affects all of your forms (internal and external) and charting, as well as all patient and family education tools, staff ID badges and much more.
- At the legal level, it affects your registration with local, county, state and federal agencies; contracts, policies and procedures; and financial materials such as

checks and credit cards. (It will also require approval from your state health department which can be a very lengthy process.)

Note too that you will need legal assistance to ensure use and exclusive rights to the name and logo that your organization selects.

THE ROLL-OUT

Since this is such an all-encompassing proposition, rolling out the rebrand has to be done strategically so that the right people know at the right time and find out in the right way.

This must start with the board of directors being fully invested in providing the resources and direction to move forward. Next, management should reach out to all staff to bring them on board, followed by individual outreach to major donors, healthcare partners and providers.

When the date of the roll-out is definitely set to happen, current patients and families need to be informed. Then all families that are currently enrolled in your bereavement programs should be brought on board. Next, donors at all levels can be informed as well as other community partners such as pharmacies, equipment vendors, other community agencies, churches and funeral homes. Only at this point should media be contacted or involved

with a very purposefully timed and staged reveal (such as a ribbon cutting). Only now should the rebranding process be made public.

To make this all happen, you will need a specific outreach strategy and tools to ensure that everyone working on behalf of your organization is consistent in their messaging and goals. To assist in this, you will need a style guide that directs how all printed, electronic and verbal communications should look and sound like, with measures in place to enforce conformity. A customer service strategy must be devised to direct face-to-face communications and develop key talking points. A binding schedule for the roll-out has to be set and adhered to.

REINFORCING THE BRAND

Just when you thought you were done, you find out that you are never really done. Reinforcing the brand within your community and holding your staff accountable to the standards of the brand require ongoing commitment and effort. And you must also be sensitive and attuned to your staff's morale as they adjust to this change — which for some is a sense of loss.

As you can see, a rebrand is far more than changing a name or a logo. Done right, rebranding is your chance to move forward — as Tammy Bracken illustrates in the article that follows.

BECOMING “SERENITY HOSPICECARE”

BY TAMMY BRACKEN

The motivations to embark into the world of rebranding will vary, depending on the organization. For our hospice, it was nothing less than being enveloped by the “perfect storm” of marketing dilemmas: a name that was painfully generic (“HospiceCare, Inc.”); an abundance of competitors in the area; and a census that was slowly being eaten away over the years. While we didn’t know exactly what to do or where to start, we knew that sitting on our reputation and relying on good ole “word of mouth” was no longer an option.



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Our process began in late 2009 when we received a brochure from an Ohio-based firm that specializes in hospice marketing (Transcend Hospice Marketing Group). A few phone calls later, and members of its marketing team were scheduled to make a visit after the holidays. We had (gulp) taken the first step into the world of “rebranding.”

Our first official meeting came when the marketing team arrived at our facility in early January of 2010 to do an exercise called “Compression Planning” — a “game” of sorts in which the goal was to determine the personality of the organization from the perspective of our managers. Although most of us felt the findings would be limited given the session was just a half-day, the synopsis that the team delivered to us weeks later — the good, the bad, and the ugly — was spot on.

The next step in the process involved finding out just how much people knew (or didn’t know) about our organization via focus groups and a telephone survey.

We were warned about the likely results of this outreach, but I remember thinking, “We have been here 20 years! People not only know us, they love us!” To say we were disappointed with the focus group results would be a huge understatement, and we

didn’t fare any better with the phone surveys.

The marketing firm offered encouragement with a “good news/bad news” summary: The bad news was that the community couldn’t clearly identify us. The good news was that the community couldn’t identify any of our competitors, either. If we had debated the need for marketing direction up to this point, we certainly questioned it no more.

Several weeks later, we received the marketing firm’s strategic plan that had been specifically created for us, and there it was in black and white: The firm recommended that we “seriously consider” changing our name. They felt so strongly about our need to rebrand that they even provided us with a list of suggested names and tag lines.

After discussing the proposal (on many occasions) with our board members, our organization decided to follow the marketing firm’s recommendations and begin the rebranding process.

This was not an easy sell to our board of directors, and we all understood why. For some, the idea of marketing such a private, emotion-filled service like hospice was taboo. Others felt marketing was needed, but doubted it could be done in a tasteful, professional manner. Still others found it difficult to get past the

cost of such a project because we had never spent more than a nominal amount on marketing (pens, notepads, and a few other miscellaneous PR items). In the end, we agreed to partner with the marketing firm for a three-year period.

Even though we felt confident that we had made the right decision about partnering with the firm, there was still a lot of caution about the rebranding process. The firm’s team made themselves available to speak directly with our board members and ease any concerns. I believe this made all the difference in securing support from our board, and is something I would highly recommend to any organization — even if the board embraces the idea of rebranding.

Armed with the marketing firm’s suggestions and a few ideas of our own, we held brainstorming sessions with our board members and Core Team administration, and came up with a list of potential names. It was a challenge, but we were able to narrow that list down to three. Our board, executive director, and Core Team administration then held a vote and chose “Serenity HospiceCare.”

The next several months were a blur — a new name, new logo and new tag line. We worked with the marketing firm for the remainder of the year, preparing a range of media

pieces from TV and radio commercials to print ads, billboards, and web vignettes. For all the media tools except billboards, we identified family members of past patients who we thought would be willing to tell their hospice story (real people sharing real stories was our goal). Then these individuals were interviewed to see which stories fit the message of our particular campaign.

Before any new media was released, a letter from our executive director was sent to everyone we worked with (e.g., physicians, hospitals, pharmacies, nursing facilities, oncology clinics, veteran organizations, senior centers) that explained we had changed our name and, most importantly, why. We also took the opportunity to reassure them that, although many changes had been made, our commitment to end-of-life care would never change.

As if changing our name, logo, and tag line weren't enough, one of the many internal changes that took place (because of the marketing firm's recommendation) was the creation of a new dress code policy. This was done in an effort to be consistent with the new look of Serenity HospiceCare. It was one more way of reinforcing our new identity within the community.

The uniform colors selected for our frontline staff were the same colors found in our logo. All shirts had our embroidered logo along with staff names, and all PR materials

also shared the same colors. We were beginning to be noticed and identified in our community as Serenity HospiceCare staff, which was the goal all along.

We also worked very closely with staff and volunteers to create a unified response so they were prepared when the inevitable question was asked, "Why in the world would you change your name?" We even put on funny skits that showed examples of the response (and not-so-preferred responses). In other words, we made it a point to have fun during all the changes.

In January of 2011, we were finally ready to show off all our hard work. We held our first ever "Media Kick-off" event a week before we planned to release the new media materials we had created. In addition to staff and volunteers, we invited the board members and individuals who participated in the commercials as well as their families. It was our own "sneak peak."

To our delight, all the media tools we had created were very well received and generated some wonderful feedback — even from some of our competitors! Our new logo won a national award and, better still, according to a second phone survey completed 14 months after its introduction, it was more recognizable than our old logo had been (after being around for 20 years!).



**The next step in
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our organization...**

We worked with the marketing firm on two additional “awareness campaigns,” coming up with a different set of media tools every 12 months to emphasize that year’s particular message. It’s important to note that our plan all along was to learn as much as we could from the marketing firm and then use our own resources to create the media tools, branding message, etc. — which is exactly what we’ve done. It’s been five years since we began the rebranding process, and it’s been an incredibly fascinating learning experience.

So what did we learn?

- You must figure out exactly who you are as an organization before you make any changes
- Spend as much (if not more) time doing your homework than rolling out the changes
- Keep your staff well-informed and involved in the entire process
- If your management isn’t excited about the changes, your staff won’t be either
- Have ONE consistent message to explain the “whys” behind the changes
- Changing the way people think about your organization takes time

- Rebranding, much like motherhood and aging, is NOT for sissies!

Many of you may be thinking, “We just can’t afford to do any type of big-time marketing!” At least in our situation, it came down to recognizing that we couldn’t afford not to. What’s more, we knew we had to develop a top-shelf plan. We truly believed that if we did nothing (aside from hoping the competition would simply give up), we might not have survived long-term. For our organization, rebranding was the best way to honor our past and invest in our future for the great good of our community.

Lastly, and I believe most importantly, you can have the finest marketing campaign that money can buy, but if everyone involved in your organization isn’t completely committed to the needs of patients and families —heart and soul, day in and day out — no amount of high-quality media will bring you lasting success. It’s the commitment behind the marketing that matters the most.



ROBIN STAWASZ joined CareFirst (then Southern Tier Hospice and Palliative Care) in 1990, and currently serves as access director.

TAMMY BRACKEN joined Serenity HospiceCare (then HospiceCare, Inc.) in 2004 as director of public relations, volunteers, and fund development, and just left the position this past May to become a stay-at-home mom.

Robin has been a longstanding member and Tammy is a former member of the Development/Public Relations/Marketing Steering Committee of NHPCO's National Council of Hospice Palliative Professionals, as well as frequent presenters at NHPCO's national conferences.

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For our organization,
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NHPCO Re-establishes Diversity Advisory Council

Research has shown that hospice utilization among diverse populations is disproportionately low, accounting for less than one-fifth of hospice patients in 2013.

As reported in NHPCO's [Facts and Figures: Hospice Care in America](#), African Americans accounted for approximately 8.4 percent of patients served in 2013, and 6.8 percent of patients were identified as being of Hispanic or Latino origin.

Asians and Pacific Islanders accounted for 2.9 percent of patients.

Studies have concluded that many African Americans, for example, are distrustful of the government and the healthcare system, a distrust that is rooted in both historical and present day experiences, and may play a role in the decisions families make when facing the challenges of a life-limiting illness.

To help address this disparity in end-of-life care, NHPCO has brought back its Diversity Advisory Council, made up of hospice and healthcare professionals and experts who are working to increase access to hospice and palliative care services to communities that are underserved or may not be taking advantage of the many benefits of hospice and palliative care. The council will assist with the development of additional resources and tools related to serving diverse populations.

The Diversity Advisory Council is being chaired by a long-standing champion and advocate for hospice access, Dr. Bernice Catherine Harper – a social worker by profession. She is joined by one of NHPCO's committed and passionate board members, Greg Wood.

Additionally, NHPCO is identifying and engaging with a range of other providers and organizations to partner with us. Together with the council, our membership, and other partners we will work to increase access to hospice and palliative care services and help hospice and palliative care providers build the capacity to cultivate diversity and inclusion throughout their programs.



“With guidance from the Diversity Advisory Council and our members, we will build a strong initiative to ensure that we’re reaching all those who need hospice care,” said NHPCO Senior Vice President, Office of Education, Access, and Philanthropy, Diane Hill Taylor. “We must learn to adapt

our messaging about hospice care to better align with a community’s healthcare practices and end-of-life cultural beliefs and attitudes.”

“Informing, caring for and genuinely hearing the needs of the African American community, and all underserved communities, are essential elements in creating a successful outreach initiative,” says Diversity Advisory Council Co-Chair Dr. Bernice Catharine Harper.

The council will also address other diverse groups with low hospice utilization rates including Latino and Asian populations.

To support the work of hospice providers, newly-revised version of NHPCO's [African American Outreach Guide \(PDF\)](#) and the [Latino Outreach Guide \(PDF\)](#) are available online, free of charge in the Access section of [NHPCO's website](#). The guides outline key principles and insights to help hospices better serve these diverse communities.

Global Partners in Care...Around the World and Back

In May of 2014, FHSSA (formerly known as the Foundation for Hospices in Sub-Saharan Africa) became Global Partners in Care. Global Partners in Care now operates under an expanded global mission to include more countries, in addition to continuing the commitment to Africa, where the need for palliative and hospice care is great but the resources are limited. One year later, the organization continues to serve tens of thousands of people in Africa and now India and Nepal.

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

In 2014, the direct impact of the services provided by Global Partners in Care resulted in \$524,235.00 sent directly to international partners who supported approximately 55,500 patients, 1,930 international medical workers, and over 3,000 hospice volunteers.

Also, since rebranding, the organization has gained eight new partnerships:

- **Halifax Health Hospice, Port Orange, FL**
Izimbya Lutheran Hospital, Kagera, Tanzania
- **Arm in Arm in Africa, Minneapolis, MN**
St. Luke's Hospice, Cape Town, South Africa
- **VITAS Healthcare—Chicago Region, Chicago, IL**
Matthew 25 House, Koforidua, Ghana
- **Hospice of Kankekee Valley, Bourbonnais, IL**
Narikeldaha Prayas, West Bengal, India
- **Akron Children's Hospital, Akron, OH**
Happy Feet Home, Mumbai, India
- **Optum Hospice Denver, Englewood, CO**
Mbale Regional Hospital, Mbale, Uganda
- **At Home Health and Hospice, Schnecksville, PA**
Drakenstein Palliative Hospice, Paarl, South Africa
- **Delaware Hospice, Newark, DE**
Hospice of Nepal, Kathmandu, Nepal

continued on next page

**Global Partners in Care
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expanded global mission to
include more countries...**

One of the program's newest partners had this to say about their commitment to Global Partners in Care, "While almost half a world apart, the Haslinger Family Palliative Care Center at Akron Children's Hospital and the Happy Feet Home in Mumbai have the same primary goal—to provide children who have life-shortening conditions with every opportunity to live a high-quality and dignified life," says Chair of the Department of Pediatrics Dr. Norm Christopher when asked why his organization chose to partner with Happy Feet Home. "We are pleased and proud to be sharing our experiences with our international partner to help us be even better prepared to advance our common mission: comprehensive, compassionate care for the world's most vulnerable citizens."

"Since the rebranding of Global Partners in Care, the team has continued to work hard to match international partners with U.S. partners," says Executive Vice President & Chief Operating Officer John Mastrojohn. "Now that we have opened up our services to more countries, we have a growing list of international hospice and palliative care organizations waiting to be partnered with an organization in the U.S."

Information on what is involved in being part of an international partnership is available on the [Global Partners in Care website](http://www.globalpartnersincare.org).

Additional information on other ways to support the organization is available at www.globalpartnersincare.org.



IOM "Dying in America" National Action Conference

At a national conference hosted by the Institute of Medicine and held in Washington, DC, on March 20, NHPCO wholeheartedly voiced its support for the findings and recommendations of the comprehensive IOM report that highlights the critical need for improvement in end-of-life care in America.

The IOM brought together leaders from the healthcare sector, policy area, and stakeholder organizations to explore ways that the recommendations in the IOM report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* could be implemented.

Victor J. Dzau, MD, president of the IOM welcomed participants, provided an overview of the landmark report, and facilitated a discussion between Senator Susan Collins (R-ME) and Senator Mark Warner (D-VA). The senators stressed the importance of care planning. Legislation supporting this as well as existing efforts were discussed.



**The IOM brought
together leaders from
the healthcare sector,
policy area, and stakeholder
organizations...**

NHPCO President and CEO J. Donald Schumacher, PsyD participated in a stakeholder panel discussion that also included leaders from National Quality Forum, American Nurses Association, U.S. Department of Veterans Affairs, American Hospital Association, American Medical Association, and American College of Physicians.

In his remarks, Schumacher said, “We support it as the national organization representing the majority of hospice and palliative care providers in the U.S., as well as a member of the National Coalition for Hospice and Palliative Care.”

Current members of the coalition are the American Academy of Hospice and Palliative Medicine, The Association for Professional Chaplains, The Center to Advance Palliative Care, the Hospice and Palliative Nurses Association, National Hospice and Palliative Care Organization, The National Palliative Care Research Center, and the Social Work Hospice and Palliative Care Network.

Additional key messages shared by NHPCO and members of the National Coalition for Hospice and Palliative Care are available in an [NHPCO press release](#) issued on March 27.

Collaboration Announced Between California State University Institute for Palliative Care and NHPCO



Institute for Palliative Care

On the opening day of NHPCO's 30th Management and Leadership Conference, a new collaboration between the CSU Institute for Palliative Care (Institute) and NHPCO giving NHPCO members expanded access to affordable online and in-person educational programming was announced.

The collaboration between NHPCO and the CSU Institute for Palliative Care gives NHPCO members access to current and future educational programming, providing NHPCO members with a discounted price for all educational offerings.

NHPCO President and CEO J. Donald Schumacher stated, "The collaboration between NHPCO and the Institute will help hospices expand into providing community based palliative care and obtain the quality educational content needed in this challenging health care environment. Hospices nationwide are delivering more facility, clinic, and home-based palliative care programs and now our members will have greater access and discounted rates for the in-depth educational content created by the Institute."

Since its inception in 2012, the CSU Institute for Palliative Care has trained over 800 health care professionals from across the U.S. and around the world - nurses, social workers, chaplains and allied health professionals. The Institute knows and

understands workforce development. California State University trains 15 percent of the nation's graduating health care workforce. The Institute's palliative care faculty includes experts in all the core palliative care disciplines. In addition to training professionals, the Institute works with organizations, teaching leaders how to build, promote and grow palliative care services.

The Institute's Executive Director, Helen McNeal said, "Our palliative care programs incorporate best practices and proven tools and techniques. Our online and in-person education is delivered using state-of-the art interactive techniques that ensure learning that is immediately applicable in the workplace. One of the biggest barriers to the expansion of palliative care, both inpatient and community-based, is the availability of a trained workforce. By collaborating with NHPCO, we help hospices who want to expand into palliative care and train new and existing staff about delivering palliative care from point of diagnosis onwards."

[Learn more about all the programs available for NHPCO members online.](#)



Helping Parents Talk to Terminally Ill Children

A new Pediatric Starter Kit launched by The Conversation Project will help parents facilitate the critical and necessary conversation about end-of-life with their terminally ill children.

Research has shown that parents who talk about death with their children do not regret it – while many of those who do not talk about it regret not having done so. Medical literature and stories from the field show that children often sense that they are dying well before their care teams and families. Children don't talk about it because they don't want to upset, and feel an urge to protect, their parents.

Helping families overcome the communication barrier is the goal of [The Conversation Project](#), a public engagement campaign with the mission to have everyone's end-of-life care wishes expressed and respected.

At the heart of the project is the Conversation Starter Kit, a free downloadable step-by-step guide that helps adults have “the conversation” about their preferences for end-of-life care. Once the Starter Kit became widely used by adults, parents and pediatricians began contacting The Conversation Project to express the need for a guide specifically designed to help parents have the conversation with their seriously ill children, often not just once, but over time as the disease progresses.

The new [Pediatric Starter Kit: Having the Conversation with Your Seriously Ill Child \(PDF\)](#) is now available for download. The Pediatric Starter Kit offers advice and provides stories from parents and palliative care specialists who have been there. It provides questions that can help parents navigate the approach to the conversation based on the personality and cognitive level of the child.

A reminder that NHPCO's Pediatric Work Group, ChiPPS, offers a host of pediatric hospice and palliative care resources, including the free e-journal, available at www.nhpc.org/pediatric.

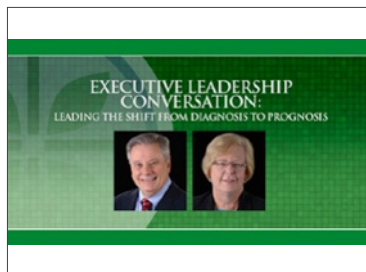


Tools to Help Members Determine Terminal Prognosis

In recent months, NHPCO has offered members some resources regarding the issue of determining terminal prognosis.

As providers of hospice care, we must reframe the way we think about and characterize our patients and the scope of our responsibility in providing care to them, shifting from submitting a single diagnosis on the claim form to providing a more comprehensive and accurate picture that validates each patient's eligibility for hospice care by focusing on the basis for their terminal prognosis.

The Relatedness Workgroup, a subcommittee of the NHPCO Regulatory Committee, was formed in 2013 after the issuance of the CMS proposed FY2014 Hospice Wage Index rule which contained proposed clarification from CMS about hospice care and coverage responsibility for related diagnoses. The Workgroup has focused on creating tools to help providers.



- **Leadership Conversation Video:** “Leading the Shift from Diagnosis to Prognosis” – a discussion between NHPCO’s Don Schumacher and Judi Lund Person.
- **Video “Conversation on Terminal Prognosis”** – an explanation outlining some of the key issues at hand.
- **Determining Relatedness to the Terminal Prognosis Process Flow online tool** – an animated version of the flowchart created by the Relatedness Workgroup.
- **Determining Relatedness to the Terminal Prognosis Process Flow** – a hard copy flowchart to help staff determine relatedness (PDF).

Additional information and further resources may be found at www.nhpc.org/relatedness.

Listed above are some of the resources, available online, designed to provide a decision making framework of what is related and what is not. Determination of relatedness should be case-by-case for every patient decided by the hospice physician and the interdisciplinary team.

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

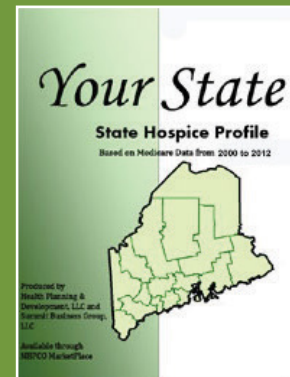
Look No Further... The 2015 State Hospice Profile™ contains comprehensive hospice care details for each county based on Medicare data from 2000-2013, providing the critical information needed to learn more about the competitive environment of your state.

Produced by Health Planning & Development, LLC & Summit Business Group, LLC and marketed exclusively through the NHPCO Marketplace, each 2015 State Hospice Profile™ provides vital county-level information. Full-colored charts and graphs provide information from an analysis of the last eleven years of Medicare claims data.

Here are examples of the valuable information included in the 2015 State Hospice Profile™

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

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



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

National Hospice and Palliative Care
Organization



Marketplace

To view an example of a State Hospice Profile visit:
www.nhpc.org/stateprofile

Congratulations to Rick Kasper



NHPCO congratulates Rick Kasper as 2015's first Hospice Manager Development Program's Level III Designee. MPD Level III participants undergo a rigorous assessment process, then identify, work on and complete a specific and individualized

professional goal. Components of the Hospice MDP Level III are tied to the participant's organization and the individual's professional responsibilities.

Rick explains: "As the chief executive officer of Joliet Area Community Hospice, I want to continually improve. The outcome for end-of-life care is for a dignified, pain-free death for all of our patients. This is a very sensitive topic for patients, their family members, and their caregivers. What I learned in Hospice MDP Level III focused on me. I learned that I need to become comfortable with the other person's communication style in order to improve the communication between us. This program really made me step out of my comfort zone and evaluate myself. This has been very helpful to me professionally as well as personally."

The Hospice MDP is designed to develop competent and confident hospice leaders that can effectively manage the complexities of their responsibilities in the hospice organization. For more information, visit www.nhpc.org/mdp.

New NCHPP Physician Section Leader



Bernice Burkarth, MD, of Treasure Coast Palliative Care is the new Physician/Advance Practice Provider Section Leader.

Dr. Burkarth earned her medical degree from Temple University School of Medicine and went on to practice general neurosurgery in the Treasure Coast of Florida until 2005 when she dedicated herself to the practice of hospice and palliative medicine. She also serves as an assistant clinical professor at Florida State University School of Medicine, Fort Pierce campus.

Karen Rubel Named one of Vegas Inc. 2015 Women to Watch



Karen Rubel, vice president of development for Nathan Adelson Hospice, has been named among the 2015 Women to Watch by Vegas Inc., a top weekly business publication in Southern Nevada.

The annual Women to Watch award celebrates outstanding women from industries such as real estate, gaming, health care, law and the nonprofit sector, who will have a strong impact on the year to come and who have demonstrated significant business accomplishments in their industries.

"We are very proud of Karen's accomplishments within our hospice and thrilled that she is a recipient of this well-deserved recognition," said Carole Fisher, president and chief executive officer of Nathan Adelson Hospice. "Our organization is very fortunate to have her as a part of our senior leadership team."

David Rehm Receives Distinguished Career Award



HopeHealth President and CEO David W. Rehm was recognized by the Simmons School of Social Work as this year's Maida Solomon Distinguished Career Award recipient. Each year Simmons Alumni Awards Committee, in collaboration with the School of Social Work, identifies three outstanding alumni whom they honor and publicly recognize.

Mr. Rehm was selected based on his over 36 years of service to the community and leadership as a social worker since his graduation from Simmons, and his distinguished career in end-of-life care with Hospice Care of Rhode Island, Lifespan Health System, Vistacare, Washington Home and Community Hospices, and most recently HopeHealth.

"I am deeply honored to be recognized by the Simmons School of Social Work," said David Rehm, CEO & president, HopeHealth. "It is truly gratifying to be acknowledged by my professional colleagues in this manner."

Ribbon Cutting at New Center for Comfort Care & Healing in Connecticut

Calling it "a journey that has been stressful, energizing, loving and worth every minute," Cynthia E. Roy, CEO and president of Regional Hospice and Home Care, cut the ribbon at the hospice's new Center for Comfort Care & Healing in Danbury, Connecticut, on January 26, surrounded by approximately 200 major donors, political supporters and others who helped bring a new era in end-of-life care to the people of Connecticut.



The 36,000-square-foot state-of-the-art facility is Connecticut's first and only nonprofit, family focused, all-private-suite hospice center. More than 1,000 patients, many of them children, are expected to come to the Center during the first year.

After thanking many of the key people who helped to make the Center a reality, Roy honored the entire Regional Hospice staff. "A passing should be sacred. It should be honored. It should be witnessed," said Roy. "We are hospice workers. We are witnesses to this final sacred moment in someone's life. We are blessed and honored to help our patients and their families at this deeply personal time."

Cynthia E. Roy, CEO and president of Regional Hospice joined by members of the leadership staff and the board at the ribbon cutting.

North Carolina Bikers Join Together to Grant Final Wish

Shelby, NC – Several local biker organizations in Shelby, North Carolina, recently came together to help make a wish come true for a patient at Hospice Cleveland County. While cleaning Caroline McAlister's room one day, Kim Messick learned of her wish. "Mama Ann" as she is better known, shared with Kim how much she would love to hear the sound of motorcycles one last time.

Messick shared the conversation with Angela Hollifield, a certified nursing assistant with the hospice, who is also a member of Cleveland County Concerned Bikers Association. Angela's husband Skip Hollifield is the president of the group and together

they began calling other local motorcycle groups to help make Mama Ann's wish come true. Within one week, they had the support of Windjammers, CCIB, Wings of Eagles, ST12, Guardians of The Children, Carolina Faith Riders, UYA, Gargoyles, Crimson Crusaders, Sons of Thunder, and more.

Over 95 bikers showed up on January 31 to greet Mama Ann and show their support. There was hardly a dry eye in this group of tough men and women who lined up to hug Mama Ann who was even able to take a spin on a bike giving everyone cheering her on a big thumbs up as she passed by.



Caroline "Mama Ann" McAlister enjoying a ride from the local bikers who made a wish come true.

SAVE  DATE

★

EXPANDING 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



Dana's Final Wish – A Lighthouse of Hope Story



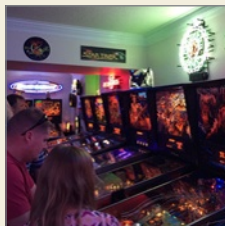
Pictured are twin sisters Dana Robbins and Deanna Shannon.

The Lighthouse of Hope Fund fulfills a hospice patient's special experience to visit the beach with her family

When Dana, a 43-year-old Circle of Life Hospice patient, thought back to her favorite memories, she remembered most fondly going to the beach with her twin sister Deanna. This inspired her final request to go to the beach to feel the sand and lay in the sun one last time. Debbie, Dana's hospice social worker, had recently learned about the National Hospice Foundation's Lighthouse of Hope Fund and applied for funds to honor Dana's last wish.

[READ MORE...](#)

Become a Fundraiser-Playing Pinball for Hospice



Pinball tournament participants in action!

South Carolina man holds pinball tournament and raises funds for NHF

Kevin Shanus and Lori Goodell wanted to do something meaningful in memory of Mark Hartley. In April of 2015, Kevin held the National Hospice Foundation Charity Pinball Competition to honor Mark and raise funds for the National Hospice Foundation. [READ MORE...](#)

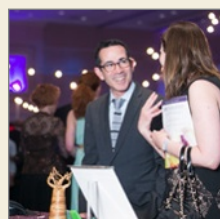
Speak up! Make Your Healthcare Wishes Known



April 16 has been designated as National Healthcare Decisions Day. The NHDD Initiative is a collaborative effort of national, state and community organizations committed to ensuring that all adults with decision-making capacity in the United States have the information and opportunity to communicate and document their healthcare decisions.

[READ MORE...](#)

The 2015 National Hospice Foundation Gala Raises Funds for NHPCO Diversity Initiative



Gala guests mingle at the silent auction tables.

The 2015 NHF Gala was held on May 1, 2015 in conjunction with NHPCO's 30th Management and Leadership Conference held at the Gaylord National Resort and Convention Center, National Harbor, Maryland.

The evening began with an intimate Board of Governors VIP Reception for sponsors and special guests. They were then joined by all guests to peruse the silent auction treasures before being seated for the program and dinner. [READ MORE...](#)

Learn more at www.nationalhospicefoundation.org.



MAKE NHPCO YOUR SOURCE FOR CUTTING-EDGE, COST EFFECTIVE EDUCATION

WHETHER LIVE OR ONLINE WE HAVE YOUR PATH TO PROVIDING THE HIGHEST QUALITY CARE TO PATIENTS



NHPCO WEBINARS PROVIDE THE KNOWLEDGE YOU NEED

Informative live Webinars offer fresh insights, pioneering practices and successful strategies to ensure your program is ahead of the curve. Areas of focus include key quality and regulatory issues as well as topics for the interdisciplinary team.

Visit www.nhpco.org/webinars to view our 2015 Webinar schedule.

NHPCO END-OF-LIFE ONLINE IS ON-DEMAND LEARNING AT YOUR FINGERTIPS

Robust online courses address a wide variety of topics including clinical, interdisciplinary, psychosocial, medical, hospice regulatory, pediatric palliative care, and leadership. All courses are available 24/7 and accessible for 90 days.

Visit www.nhpco.org/eol to view our courses.

Visit us at www.nhpco.org/education to learn about other NHPCO Educational Programs and Conferences.

**EARN VALUABLE CONTINUING
EDUCATION/CONTINUING
MEDICAL EDUCATION
CREDIT!**



News From **Global Partners in Care**

Conference Attendees Enjoy Breakfast with Global Partners in Care

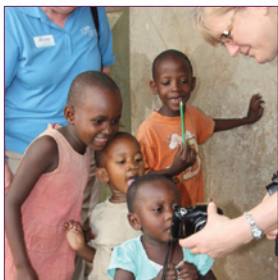


Global Partners in Care team and Foundation board chair present the 2015 Global Partnership Award to staff from Samaritan Healthcare and Hospice.

NHPCO's Management and Leadership Conference (MLC) attendees were invited to a special breakfast hosted by Global Partners in Care before the opening plenary session on April 30. Attendees were welcomed by leadership

from NHPCO, the Foundation Board and Global Partners in Care, and learned about the many successes of the organization since their rebranding and expansion one year ago. [Read more...](#)

US and Ugandan Hospices Celebrated for Outstanding Partnership



Samaritan Healthcare & Hospice Licensed Social Workers Sherri Brake and Susan Cedrone show an excited group of children their photo on a digital camera.

Global Partners in Care presents the 2015 Global Partnership Award to Samaritan Healthcare and Hospice of New Jersey and Kawempe Home Care of Uganda.

Samaritan Healthcare and Hospice is over 7,000 miles away from Kawempe Home Care of Uganda yet the two organizations are partners in caring. Global Partners in Care presented the 2015 Global Partnership Award to the two organizations at NHPCO's annual Management and Leadership Conference, an event that brought over 1,200 hospice and palliative care leaders to the Washington, DC area. [Read more...](#)

Support Scholarships for Nurses and Social Workers in Africa

As part of our mission to expand the availability of hospice and palliative care in Africa and globally, Global Partners in Care has a special scholarship fund to support the African Palliative Care Association (APCA) in providing education scholarships to further the knowledge and skill of African nurses and social workers in the provision of palliative care.

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

[Read more...](#)

9.6 million
adults and children across Africa
are in need of palliative care.

- South Africa has only 1 specialist nurse per 39,400 cancer patients...
- Tanzania, 2 doctors and 37 nurses per 100,000 people...

YOU CAN MAKE A DIFFERENCE.

Help send an African nurse or social worker to palliative care training so they can make a difference where the need is great and resources few.



Learn more at www.globalpartnersincare.org.

Your gift will allow...

A family to find the right care in their community for their child

A seriously ill child to live life to the fullest through specialized care and support for the family

The family of a seriously ill child to get the right emotional support through a specially skilled healthcare team

Visit us at www.nationalhospicefoundation.org/fundraise



National Hospice Foundation

donate your
Birthday
this year

Moments of Life: Video Collection

NOW AVAILABLE!

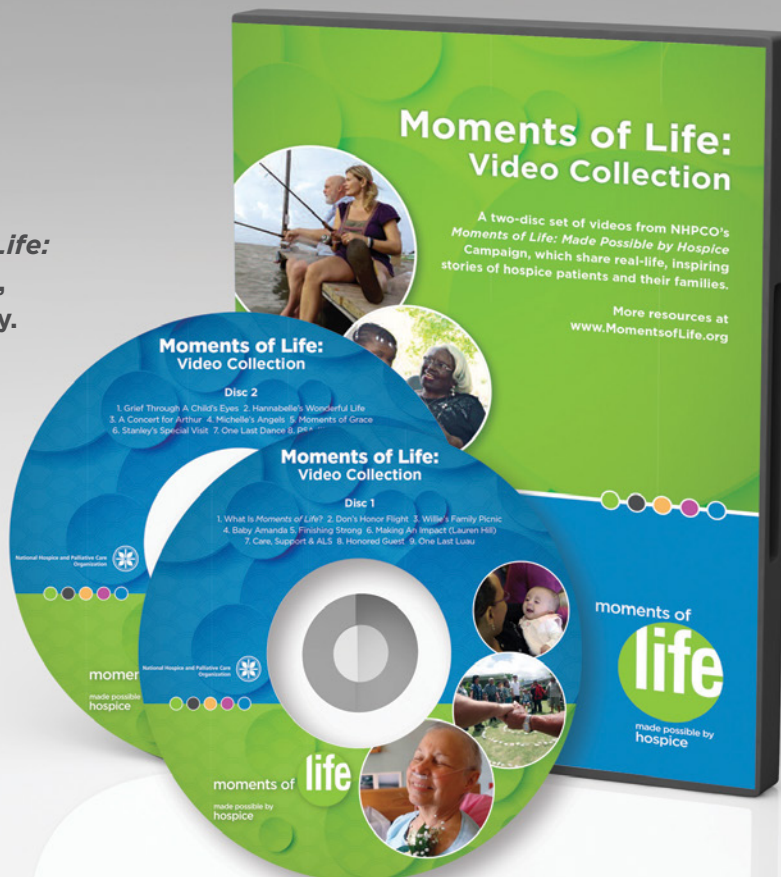
NEW from NHPCO...

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-disk video collection, please contact NHPCO at 1-800-646-6460.



National Hospice and Palliative Care Organization



moments of



made possible by hospice

Telling the Stories of Hospice



Our lives are full of stories. From happy childhood memories, to reflections during our elder years, we all have stories to tell. But the professionals who work in hospice and the patients/families they serve have a different story to tell. Hospice cares for people during the journey at life's end. It is this unique context that provides hospice patients and their families with an opportunity to experience some of life's most beautiful moments, even during its most challenging times.

The Moments of Life: Made Possible by Hospice Awareness Campaign

The *Moments of Life: Made Possible by Hospice* awareness campaign was conceptualized with the goals of positively shaping public opinion and combating disinformation about hospice care in the U.S.. The [Moments of Life website](#) includes several [short online videos](#) and [original blogs](#) which highlight the personal experiences of real hospice patients and their families. Every story is unique and each one is inspirational.

Moments of Life goes viral

Time and time again, the videos and blogs featured online have far surpassed their expected circulation. In some cases, stories have even gone “viral” and were seen by online audiences numbering in the tens-of-thousands.

The photo all the way to the right was taken from the blog, [Jordan's Journey](#). The piece tells the bittersweet story of baby Jordan's short life, and how pediatric hospice allowed his parents to spend as much quality time with him as possible. On Facebook alone, the touching article popped up in over 110,000+ Newsfeeds and received over 1,500+ “likes/comments/shares”.

Doctors told college basketball player, Lauren Hill that she would not live to see the start of the 2014 season. But despite the odds, Lauren made it to her season open and even took the floor, netting 4 points. The footage from this game was featured on several national broadcasts, including ESPN News.

The Moments of Life featured video, *Lauren Hill talks about Hospice Care* follows Lauren off the court and showed how hospice made an impact on her life for the better. Lauren had a rare form of brain cancer and died on April 10, 2015 yet she leaves a legacy by sharing her thoughts in this video that has been viewed more than 59,000+ times to date.

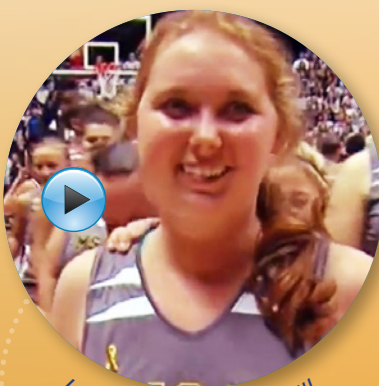
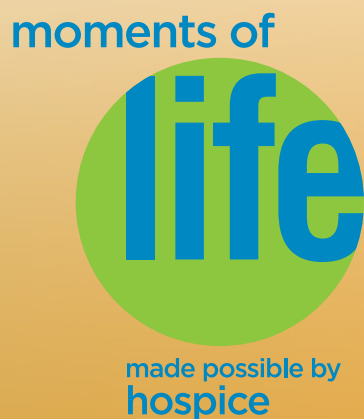
Choosing stories for Moments of Life

Submissions to the Moments of Life campaign come from providers, professionals and even family members from all over the United States. A team of staff at NHPCO regularly reviews these submissions to determine which stories will be featured in the campaign.

We feel both honored and privileged to be able to work with these submissions. The most difficult part of the process is deciding which stories to feature because there are so many compelling submissions to choose from.

Submissions come in all shapes and sizes

There are no requirements for submissions and NHPCO has accepted a wide variety in the past. Interested individuals are encouraged to submit their content, or their question, by using the online form found on the [Share your Story – Submission Page](#).



Inspirational Lauren Hill

32,000
YouTube views
of Lauren Hill video



Baby Jordan Clapp

118,000
impressions
of Baby Jordan's blog
on Facebook

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

- ☐ 2014-15 Outreach Materials
- ☐ Social Media Resources
- ☐ Caring Connections

Publications

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

Affiliate Publications

- ☐ Giving Matters
- ☐ Focus on Compassion



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Committed to compassionate
care at the end of life



Hospice Action Network



**GLOBAL
PARTNERS
IN CARE**