



# IHO Update

*In-sightly News for Hospice Professionals in Iowa*

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November 30, 2007

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## **Peter Benjamin Conference Call Date Change**

The date has been changed for IHO's hosting of a conference call from Fall Conference faculty, Peter Benjamin with The Huntington Consulting Group. **The new date will be Tuesday, December 11, at 10:00 a.m.** This will be a follow-up to his presentation, "How Hospice Fits: Key Trends in Health Care Impacting Hospices." This call is taking place due to a large request to get more in-depth details from his session that was cut short at the Fall Conference. Please complete the enclosed RSVP form if you plan to participate. Return the form to Crystal Peters, IHO, by Friday, December 7.

## **Clinical Excellence and Safety: The Heart of What We Do**

As a follow-up to the article in the October issue of the *IHO Update* on patient and family centered care, understanding and responding to patients' real needs, measuring outcomes of care delivery, and assuring both the safety of patients under our care and their families' confidence and perceptions of that safety all contribute to the quality of life experienced by patients and families.

In fact, this orientation to care may be so fundamental to what we do every day — and to what happens at the bedside — that we might fail to step back and assess how well we are actually performing in pursuit of these goals. Quality Partners challenges every hospice to step back and make that evaluation on a routine basis.

### **What Are Clinical Excellence and Safety?**

Clinical excellence and safety encompass 15 pages in NHPCO's recently revised *Standards of Practice for Hospice Care* — an essential document for anyone concerned about the quality of care. The Standards outline a number of principles and practice examples of clinical excellence and safety in a number of broad areas, including:

- The comprehensive assessment of the patient and family's care needs;
- Pain assessment, treatment and management;

- Professional management of patient care across levels and settings of care, including clear and complete clinical documentation;
- Patient safety concerns, including medication errors, falls and other adverse events, which should be minimized but also tracked and studied; and
- Plans for environmental safety and security, including emergency preparedness and infection control.

### **How One Hospice Implements Safety Standards**

Whether a patient is dealing with a condition that will soon improve or is coping with a life-limiting illness, patient safety is an issue that must be taken seriously. In the case of hospice patients, just mobilizing resources to minimize injurious falls is hugely important to their quality of life, and that is why some experts recommend a fall risk assessment for every enrolled hospice patient.

“Safety also refers to families, who are part of our unit of care,” says Sandy Kuhlman, director of Hospice Services, Inc., in Philipsburg, Kansas, and a member of NHPCO’s Quality Council.

Safety, broadly defined, encompasses many dimensions and requires a thorough assessment of risks and how to address them by the hospice program. How fearful are hospice patients and families? What are they really afraid of?

“In Kansas, we talk a lot about tornados, the risk they represent for hospice patients and what we can do to keep them safe.” Kuhlman says. It may not be possible to move the patient to the basement during a tornado watch, but the center of the house often is safer than near the windows.

The potential loss of electrical power should also be anticipated, especially for patients dependent on oxygen equipment or other electrical appliances. Winter snowstorms and inaccessible roads are an important safety consideration, as is the personal safety of hospice staff and volunteers when they are out in the field. The hospice should be looking at a range of collaborations across the community, from hospitals and nursing homes to the state Department of Transportation, to better address these concerns, she noted.

Kuhlman’s program is challenging itself to address clinical excellence — and all 10 quality components — as a participant in Quality Partners.

“So often in the past, we did quality assurance and quality improvement activities, but didn’t look as broadly as we could at our performance and how to make it better. For me, the Quality Partners initiative is an opportunity to look at things that are being tested nationally across our field. Working on quality in this way sometimes brings things to mind that we wouldn’t otherwise think about,” she added.

For the hospice team, the best way to get started is by asking questions. What are team members’ biggest clinical challenges? What are their nagging safety worries? What do they wish they could do better? Then visit the Quality Partners web pages at [www.nhpc.org/quality](http://www.nhpc.org/quality) for resources and ideas that can help.

### *The Ten Components of Quality in Hospice Care*

1. Patient and Family Centered Care
2. Ethical Behavior and Consumer Rights
- 3. Clinical Excellence and Safety**

*Ensuring clinical excellence and promoting safety through standards of practice.*

4. Inclusion and Access

5. Organizational Excellence
6. Workforce Excellence
7. Standards
8. Compliance with Laws and Regulations
9. Stewardship and Accountability
10. Performance Measurement

## **NHPCO News**

- **Partnering for Children Launched at NHPCO CTC**

A national awareness campaign to help get the word out about compassionate, family-centered health care for children with life-threatening conditions was officially launched at NHPCO's Clinical Team Conference in New Orleans. Melissa Gilbert, the actor, director, producer, and activist who currently serves as board president of the Children's Hospice and Palliative Care Coalition (CHPCC), was the plenary speaker who shared her experiences advocating on behalf of seriously ill children.

"It's time for all of us to recognize that we can make a profound and lasting difference by joining together to bring comfort and hope to children and families when they need it most," said Gilbert in her plenary presentation.

Sponsored by NHPCO, CHPCC, and the National Hospice Foundation, the campaign offers information and materials on the campaign's new Web site, [www.partneringforchildren.org](http://www.partneringforchildren.org).

- **Call for Proposals Open!**

NHPCO's 2nd Annual Conference on Access to Hospice and Palliative Care, *Access: Obstacles, Options and Opportunities*, to be held in cooperation with Hospice Minnesota, will take place on August 28 - 30, 2008, in Minneapolis. Join hospice and palliative care professionals who are committed to changing end-of-life care by promoting a culture of inclusion, who push through obstacles to create opportunities for all those who would benefit from hospice and palliative care.

Submit a proposal and increase your visibility and recognition as a hospice and palliative care leader and contribute to the advancement of the field by submitting a proposal that highlights significant work and achievement in these key areas. Follow the following link to access the proposal, which is open through January 18, 2008.  
<http://www.nhpc.org/i4a/pages/Index.cfm?pageID=5401>.

- **New Facts and Figures Released**

NHPCO's research team released a new Facts and Figures document that offers an important look at hospice usage in the U.S. NHPCO tracks key demographics and outcomes measures on hospice patients, caregivers, and providers. This updated version will be of interest to providers, referral sources, media, and others looking to learn more about hospice throughout the nation. [Download the Facts and Figures document in PDF](#) here.

- **Highlights from the CMS Home Health, Hospice & Open Door Forum**

NHPCO's regulatory team would like to share some highlights from the Open Door Forum held on November 28, 2007.

*1. NPI Update - Key dates for providers:*

Beginning January 1, 2008, Medicare will Require NPIs to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields.

Beginning March 1, 2008, Medicare Fee-For-Service 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. CMS recommends that providers voluntarily test claims now with only the NPI number.

*2. CR 5567 Update*

Carol Blackford reiterated that July 1, 2008, is the new implementation date for mandatory submission of visit data on hospice claims forms. Hospice providers have the option of voluntarily submitting visit data beginning January 1, 2008. CMS confirmed that contractors will be ready to receive and process claims beginning January 1. Ms. Blackford also stated that additional Q&A's were posted on the CMS Hospice Center Web site (this news was shared with NHPCO members in a [Regulatory Alert](#) from 11/20/07).

*3. Status of New CoPs*

Danielle Shearer, one of the architects of the new Conditions of Participation, confirmed that they are on track to publish in May 2008.

## **HNN Notes**

*(Glatfelter Insurance Group is the national sponsor of Hospice News Network for 2007.)*

- **Illinois Implements Regulations for End-of-Life**

Illinois' new Hospice & Palliative Care Advisory Board will work with the Illinois Department of Public Health to implement regulations for end-of-life services. The board, which will meet at least four times a year, will be composed of a nurse, a physician, four persons recommended by hospice organizations, one person from a hospice consumer organization, two persons from the public, a chairman, and several non-voting representatives from state agencies. The board will guide the Department of Public Health as it writes new regulations and will examine the economic and regulatory impact of any proposed rules. (*Nurse.com*, 11/19)

- **Challenge to Providing Hospice Care Found in Education**

An article in *Chicago Hospital News (CHN)* cites a National Association of Social Workers article saying that oncology social workers have an overwhelmingly positive view of hospice philosophy and care. But fewer than 50 percent of their patients are referred to hospice because patients' families don't want to stop active treatment. *CHN* states that one of the great challenges in providing hospice care is educating those who can most benefit from it – at a time when they are not interested in listening. (*Chicago Hospital News*, 11/2007)

- **Study Explores Cultural Aspects of End-of-Life Care**

A recent study from the Center for Gerontology and Health Care Research, Brown Medical School in Rhode Island, and NHPCO, titled *African American Bereaved Family Members' Perceptions of the Quality of Hospice Care: Lessened Disparities, But Opportunities to Improve Remain*, was published in the November issue of the *Journal of Pain & Symptom Management*.

Authors Ramona L. Rhodes, MD, MPH; Joan M. Teno, MD, MS; and Stephen R. Connor, PhD, examined data from the 2005 Family Evaluation of Hospice Care (FEHC) survey to see whether the previously documented disparity in African American and white families' perceptions of the quality of end-of-life care persisted if African American patients were enrolled in hospice. Results showed that though disparities in perception of care at the end of life persist, on hospice they improve to some degree.

The authors cite a 2005 study by Welch, Teno and Mor ("End-of-life care in black and white: race matters for medical care of dying patients and their families," *Journal of the American Geriatric Society*, 2005;53:1145-1153) which found that family members of African American decedents were more likely to report problems with absent or problematic physician communication than family members of white decedents. Also, African American patients were less likely to have treatment wishes or advance care planning documents and family members of African American decedents reported more concerns with communication, higher rates of unmet needs, and lower satisfaction with care than did family members of white decedents.

In that study, the responses of families of non-Hispanic African Americans who died in hospice care were compared to non-Hispanic whites, with the following results:

- African Americans were more likely than whites to report that pain needs were unmet (8.2% vs. 5.6%), dyspnea was not adequately treated (6.1% vs. 4.9%), and more emotional support was needed (14.5% vs. 9%).
- African Americans were more likely than whites to express one or more concerns about information regarding the patient’s symptoms (16.4% vs. 10.6%) and at least one or more concerns about emotional or spiritual support to the family (15.3% vs. 11.6%). African Americans and whites were equal in expressing one or more concerns about information to family regarding patient’s conditions and what to expect while the patient was dying (22.9% vs. 23%).
- African Americans reported more concerns about coordination of care (21.7% vs. 17.9%), but fewer said that the referral to hospice came too early or too late (10.8% vs. 12.6%).
- Both groups gave high ratings of satisfaction with hospice services, with African Americans rating the services as “excellent/very good” 92.1% of the time and whites 94.4% of the time.

The overall satisfaction ratings of both groups were the same – 47.3 out of a possible 50. The current study compared the 2005 study with persons who died using hospice. The researchers found that there was less of a disparity between African Americans and whites regarding concerns of family emotional support and African Americans viewed information about what to expect as the patient was dying more favorably and recorded more overall satisfaction with services.

The authors say that although there is evidence of lessened disparities, important opportunities remain to improve the quality of care. An important next step is to better understand the concerns of bereaved family members through in-depth interviews and focus groups with participants of various ethnic backgrounds. Additionally, examining the variation among health care institutions will provide evidence of the opportunity to improve and, potentially, lead to organizational interventions to lessen the disparities. (*Journal of Pain & Symptom Management*, 2007;34(5):472-479)

## **Enclosure**

Peter Benjamin Conference Call RSVP Form

