

# Newsline

NHPCO's Membership Quarterly | Fall 2021



## Finding Your Value and Sharing it with Others

Telling your story purposefully and strategically

### INSIDE

Hospice Wage Index and Quality Reporting Final Rule

New CaringInfo.org

Making POLST Portable

Advancing a Culture of Equity



**NHPCO**

National Hospice and Palliative Care Organization

# NHPCO's 2021 VIRTUAL INTERDISCIPLINARY CONFERENCE

THE PREMIERE CONFERENCE FOR HOSPICE  
AND PALLIATIVE CARE TEAMS AND INDIVIDUALS.



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**ALTON FITZGERALD WHITE** (Opening Keynote)

Broadway's longest-running *Lion King* performer shares his secret to fulfillment and joy in everyday work and life.



**JESSICA ZITTER, MD** (Tuesday Keynote)

Physician and Emmy & Academy Award nominated filmmaker Dr. Zitter will screen her new documentary, *Caregiver: A Love Story*, and discuss lessons to be learned.



**JUSTIN N. BAKER, MD** (Final Keynote)

Faculty member at St. Jude's and Chief of the Division of Quality of Life and Palliative Care will discuss the importance of the work we do and the difference we make.

VIRTUAL CONFERENCE / SEPTEMBER 20–22, 2021  
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# Message from Edo

Welcome to September. This is a rather interesting time for all of us. About this time last year, we were hosting our 2020 Interdisciplinary Conference virtually, the first time we had produced an event of such magnitude over the Internet. It was a challenge to be sure, but we certainly learned a great deal. None of us at NHPCO expected that we would be doing the 2021 Interdisciplinary Conference as a virtual event as well. Only a few months ago, we were looking forward to gathering in Memphis for the conference—a conference that from the get-go we planned with safety as a priority—but the situation changed.

We are all disappointed. Being together is one of the advantages of joining an association. We get it. Our buckets are refilled by being with people who understand what we are going through. But safety first. NHPCO is many things—an association of hospice and palliative care providers, an advocate for providers, patients and families.... However, we are also responsible for public health. This means that two of our toughest decisions—whether to move our in-person meeting to a virtual meeting and whether to support a vaccine mandate—were no-brainers from the perspective of an organization that must consider public health and the public good first. That said, I get it. This is hard, and we are right there with you.

If that were the only crisis facing us. In the past few months communities throughout the nation have been facing unrelenting forest fires, the hurricane season and resulting flooding has proven to be damaging and costly in many states. Add to this, Afghanistan and the 20th anniversary of September 11. Nobody who was more than ten by September 11, 2001, will forget where they were on that fateful day,

nor of the way we as a [nation seem to have changed](#) as a result of this event. And the ending of America's longest lasting war that began due to the events of September 11 has left us struggling for answers after two decades.

I haven't even mentioned the workforce challenges that so many healthcare providers are struggling with, and hospice and palliative care providers are coping with a problem that seems short on solutions.

This is a difficult time, to be sure. Well, one thing that continues to inspire me is the sense of duty, resilience, and compassion that seems to be part of the DNA of our provider community. Please know that all of us at NHPCO recognize the difficulties that you face in the field. In fact, we're hosting a listening session as part of the [2021 Interdisciplinary Conference](#), and it is our hope that this will get some valuable discussion about ways to assist you.

Until I see you in person, I will see you on zoom. Here's hoping that our community, and our nation, comes out of this crisis stronger and more determine to do whatever we can to lead person-centered care.

Onward—



Edo Banach, JD,  
President and CEO





# *Finding Your* **VALUE** and Sharing it with Others

By Robin Stawasz and Kevin Hohnbaum

Ask any hospice provider you know “what is the power of hospice?” and you will hear a litany of benefits that hospice provides – everything from decreased symptom burden to longer life to higher quality of life to lessened burden for families to lower costs. It has been said that if hospice were a drug, it would be the greatest wonder drug since penicillin. However, when you talk to someone outside of the hospice field, you are likely to get a very different response. They may see hospice and palliative medicine as a niche service for the last few days of life to be provided only after other, more standardized, interventions have run their course.

**This disconnection is not going to change unless WE CHANGE IT.**

How do we do that? We need to sharpen our empathy skills and start where others are today, address what is holding them in their current place, prove that change is in their best interest and show them rewards for achieving the desired change. This goes beyond education and persuasion and must be done purposefully and strategically.

Why do we want to do that? First, it is our mission. We would not be doing what we do every day if we did not believe in the power of palliative medicine and that families coping with serious illness should have access to that level of support. Second, it is time for palliative care providers to claim their place as a peer in the healthcare continuum. We have not yet done all we can to advocate and prove the value of palliative medicine.

Why now? The post-acute care world has hit a tipping point. The country is on the verge of recasting how care is delivered to the seriously ill and hospice providers must decide what role they will play in the new healthcare environment. Palliative care providers must build a purposeful strategy that defines their own value statement and describes how they can share their strength within their healthcare network. If we do not, we run the risk of becoming marginalized and replaced. Networks and coalitions are being built right now, and there is no requirement that everyone be included in this process. For those who choose to wait, there may not be any room at the table when you decide you want a seat.

The time to act is now for a variety of reasons. The transition from fee-for-service to value-based care is accelerating and may soon become mandatory. This switch is being fueled by the need to control health care spending and to improve clinical outcomes, mostly by increasing provider responsibility and decreasing care fragmentation. To accomplish this, the locus of care is moving away from facility and acute care to community and home-based care. The emphasis is on care coordination by an interdisciplinary team driven by the patients' goals of care while addressing the social determinants of health. Reimbursement will be based on outcomes, not volume.



**...hospices have an unprecedented opportunity to engage in the healthcare continuum in ways that we have never done before.**

Look at the above list of priorities for healthcare reform – community-based, holistic, interdisciplinary, patient-driven care paid on a capitated basis. Remind you of something? This is where hospice has lived since our inception. Not only is that our clinical model, but we have made it work while providing the highest quality of care with exceptional clinical outcomes for the sickest and highest need patients – and their families! – all while saving money.

So, you can see why the care model that we have perfected has its place in the current healthcare environment. With the recent emergence of new care models and payment models, hospices have an unprecedented opportunity to engage in the healthcare continuum in ways that we have never done before. But we need to take purposeful steps to claim that space. New potential partners and competitors are entering the post-acute and serious illness care field and – added to the rising tide of mergers, acquisitions, and large system growth - you can see where each hospice must find their place in the emerging new world.

All this can seem quite daunting, but it can be managed. The first step for your organization is deciding whether to engage in change at all. It is not a safe assumption that all hospices can/should/will change. It must be a purposeful decision made with

full consideration of all the variables. You also need to seek input from your key stakeholders, including:

- The families you serve, both presently and potentially
- Your governing bodies and/or ownership
- Staff
- Leadership within your organization
- Donors and other benefactors
- Referral sources
- Community representatives.

As with any decision-making process, you need to consider the potential risks and rewards. The rewards for maintaining the status quo include stability, avoiding risk, maintaining current relationships, confidence in the services you provide, and continuing with any long-term strategies already established. On the risk side for maintaining the status quo, you may start losing market share to other providers or other hospices that are more networked, your place in your healthcare continuum may become increasingly marginalized and your sustainability may be threatened. You may also get to the point where you will not be able to control your organization's destiny, but it will be decided for you through outside forces.

There can be a hesitancy to move towards change, especially for mission-driven organizations. Many feel they are diluting their purpose if they move from the



The process of taking advantage of the new opportunities that exist for hospices and other palliative care providers starts with educating yourself.



provision of only hospice care. Ask yourself "What is my mission?" Is your mission hospice or is your mission to care for families coping with serious illness, including at the end of life? Is hospice a tool to achieve that mission, or the mission itself? This is a crucial dynamic to examine and resolve and may be very telling in how ready your organization is to take on change.

If your mission is to care for all families coping with serious illness through the skills that you have developed through hospice, then you need to build access for more families to experience your higher quality care. By being part of a patient's care journey early on, you can provide the proactive care and planning to minimize crises and suffering. You will have more flexibility in the care you provide and who receives the care,

allowing you to provide for those in need prior to hospice eligibility. You can improve the sustainability of your organization and better support your staff by using the CMS Hospice Benefit how it was intended, not just in the last weeks or days of life. You can access reimbursement for non-hospice service lines while protecting and growing your market.

No matter what your organization decides – whether to stay with the status quo or engage in innovation – you will need to build consensus with the decision, facilitate buy-in with stakeholders, and develop a purposeful strategy to act on this decision. You will also need to confirm that your agency's identity, including your mission, your vision, your name, and your overall brand, aligns with your decision. If you are staying the

course, you will need to plan against mission drift and mitigate the risks that you may face as the healthcare continuum changes around you. And, if you are choosing to diversify and expand, you will need a strategy to identify, evaluate, and engage with the new partnership and payment opportunities out there. This is what we will focus on going forward.

## Engaging in Change

The process of taking advantage of the new opportunities that exist for hospices and other palliative care providers starts with educating yourself. You and your leadership team will need to build your understanding of and comfort level with the many different care models in the

post-acute/serious illness care world. Good sources for such information include industry advocacy groups (such as NHPCO, C-TAC, AAHPM, and others), CMS, online list services and consultants. What follows is a partial list of current post-acute care models. More may exist in your healthcare network and others may be introduced at any time.

- **Palliative care:** Non-hospice palliative care can be offered in a variety of settings, including acute care, home, clinics, and remotely. Palliative care can be focused on many different populations and includes a wide range of clinical provision models.
- **Primary care:** Primary care is offered in increasingly diversified settings, including the rapidly growing home-based primary care field which can be very appropriate for those coping with serious illness.
- **Transitional care management:** Often focused on supporting the transition from acute care to home, transitional care management can also be very powerful whenever patients are coping with any major changes such as transitioning into decreased independence and increased symptom burden.
- **Serious illness management:** Supporting patients with the medical, psychological, social, and practical impacts of a serious illness can have a tremendous impact on quality of life, symptom burden, need for acute care, success at staying home, and overall cost of care. More [information from CMS](#) can be found here.
- **Case management:** As serious illness progresses, care can become increasingly complex and fragmented. Coordinated management of all the care being provided for a patient on all fronts is increasingly impactful and necessary.
- **Care navigation:** The practical act of connecting families with the services that they need can create an incredible impact. Having someone who has a working knowledge of what services are available in a community and how to access them can really contribute to overall experience.
- **PACE:** CMS' Program for All-inclusive Care for the Elderly (PACE) is playing an increasingly powerful role in the post-acute field by offering community-based care that encompasses medical care, home care, acute care, transportation, and skilled nursing home stays. More [information on PACE](#) is available on the CMS website.
- **Home health:** Many changes are being seen within the field of home health care, with value-based payment models paying an increasing role. Home health as supported by CMS provides for the skilled level of need care for patients who are home-bound. More [information on home health](#) can be found on the CMS website.
- **Personal care:** Skilled assistance with activities of daily living, such as bathing, dressing, and other needs can be provided as part of other services or on its own. Much personal care assistance is supported as "private duty" which is paid for directly by the patient. More information from [CMS on personal care services](#) can be found online.
- **Remote patient monitoring:** Taking advantage of technology, home-based patient monitoring takes many forms, from the recording of clinical telemetry to the collection of patient experiences. This can greatly extend clinicians' connection to their patients and empower better in-home clinical management.
- **Telehealth:** While this can include remote patient monitoring, it also brings in video conferencing, allowing for more direct communication and remote assessment. Telehealth can improve clinical access and efficiency. More [information on telehealth](#) can be found on the CMS website.
- **Hospital at Home:** CMS has supported the Acute Hospital Care at Home program allowing some acute-level patients to receive their care in their homes rather than at a hospital. While a relatively new model, the impacts on quality and cost is promising. More [information from CMS on Hospital at Home](#) can be found online.
- **Traditional Part B services:** Many hospices are establishing the ability to bill Medicare Part B

directly and submit claims for non-hospice care, such as advance care planning and palliative care services. This can also include behavioral health services. Find more [information on Part B](#) is available on the Medicare website.

■ **Inclusive care systems:** Some healthcare systems have taken on both payment and provider responsibilities – known as “payviders” – and are providing “womb to tomb” care. They are offering all-inclusive care that focuses on patient-driven, home centered care for the patient’s entire life.

Some very impressive new care models are emerging, such as utilizing ambulance services to provide in-home triage and support services, leveraging new technology to monitor patients in the home for their safety, educating patients and caregivers in effective disease self-management, and utilizing peer education and support. You can use your knowledge of the populations you serve, your connection with community resources, your experience in what truly makes a difference, and your creativity to develop the care models that will move your mission forward.

Even with a better understanding of the care models available, as well as some insight into how to make such models sustainable, you may still face obstacles to diversification. One such barrier may be your size. If you are a smaller provider, especially in a crowded market, you may lack resources and find it difficult to get noticed by some of the larger payer or provider systems.

One option is to combine forces with other hospices and like-minded providers. You can build informal and formal networks between partner organization to share expertise, combine advocacy and outreach efforts, and mutually problem solve. Then, these collaboratives can look to empower collective bargaining and contracting efforts, allowing you to go to potential contractors as a group. This provides the contractor an ease of effort and economy of scale to a much greater extent than having each individual organization approaching them separately. With such contracts in place, your

organizations can explore sharing certain back-office efforts, such as billing or QA, as well as some clinical work, such as telephonic on-call and care management. This can even be taken to the next step of merging or creating a new collaborative organization. Acquisitions are also possible to increase your scope and market.

## Making Change Happen

Once your organization has committed to change as part of your overall strategy and you have explored your clinical and payment model options, the next step is making the change a reality. While this is structured and methodical process, it also calls for creativity, flexibility, continual communication, and persistence.

**Build your data:** Historically, hospices have not taken full advantage of the data available to us. We know that we have a positive impact on outcomes – cost, patient satisfaction, acute utilization, provider satisfaction – but have not been able to quantify that impact. The first step is using the data you have. Use your own financial and clinical records to understand your costs, including your per visit costs, your average costs per unit of service, your staffing costs per clinical discipline, and whatever additional segmentation is meaningful to you and your situation.



The first step is using the data you have.

Develop your insight into your outcome measures, including symptom burden, patient and family satisfaction levels and on-call utilization. Know the acuity of those you serve, including their acute utilization levels, their length of stay, their diagnoses, and other utilization and clinical factors that segment them from the general patient population. Understand your referral sources, including their referral and attending rates, their specialties, their system affiliations, their utilization over time and the timeliness of their referrals. Try to recognize what else your data may be telling you and see what connections may stand out across these data classifications.

Be mindful of what matters to your potential partner, not just what matters to you. For instance, once a patient is on hospice, you may not be focused on past hospitalization and rehospitalization rate. But those metrics do matter to any payer system that you are going to talk to, especially if you have impacted that rate. Break down the data by stakeholder. Know the referral patterns for an entire practice. Know the rehospitalization rate for a provider group. Know the number of patients you served that were beneficiaries of a specific MA plan or ACO. This will all be impactful when you are meeting to discuss a partnership.

Once you have a handle on the data you already have, you need to reach out for any missing data. There is a wealth of knowledge available publicly, from quality reports and public reporting to CMS provider data. You can also access up to 3 years of CMS claims history for any traditional Medicare patient you have cared for through [Blue Button](#) or [Data at the Point of Care](#), two CMS programs that can connect providers with their patients' holistic medical picture to an effort to improve care. You can also work with your partners within your healthcare continuum to set up a data share relationship in observance of all HIPAA and HITECH requirements. With strong data, predictive data analytics can be applied to not only provide a depth of insight into a patient and/or population's current clinical state, but also make predictions for their future journey.

Once you have strong insight into your clinical measurements and a solid understanding of the patients' and providers' picture, you will need to examine your healthcare continuum system. The goal is to identify unmet needs in your patient population and gaps in care. The best way to do that is by performing a gap analysis. First, take advantage of any gap analyses already completed by community providers and advocacy groups. If none are readily available, you can do your own research.

Conversations with stakeholders, including patients and their families, providers, your staff, community agency staff, your leadership peers, your referral sources, and others can provide great insights into what potential barriers to patient success are out there. Is there a lack of accessible transportation support? Are patients with specific diagnoses, such as heart failure, COPD, or diabetes, consistently showing poorer quality or utilization metrics? What public perceptions may be getting in the way of access? Are patients avoiding getting the care they need because they do not want to leave pets alone at home? Do cultural and ethnic barriers exist? Is loneliness and isolation an issue? Once a barrier is identified, you can be much more precise in your strategy to overcome it.

You can do similar analyses for your potential partners. Examine their public quality metrics to identify areas of strength and need. For instance, how do they compare to benchmark in providing cardiac care? What is their readmission rate? If they are in a shared savings arrangement, have they met their metrics and received any savings? Knowing this, you can better match your value to their need. If they have high readmission rates, for instance, a transitions support care model that will help discharged patients stay home successfully will be of great value to them.

For potential partners, you want to have a solid understanding of their background. You will want to get to know their history, their relationships with other systems, their ownership and corporate

structure, their mission, the make-up of their provider network, any value-based contracts that they are a part of, their level of patient or beneficiary engagement, and their utilization metrics. Much of this is available on-line as well as through annual reports and conversations. Specific to you and your organization, you will need to have a firm grasp on their history with you. This should include their referral history, the outcome of those referrals, any impact your service had on their metrics such as lowering costs or acute utilization, any variation between the referral patterns of their providers, past collaborative efforts, and common, personal connections that may exist.

Just as important as this empirical data, you must also attend to the more qualitative perceptions, or – more commonly – misperceptions, that may exist. Such prejudices can be true impediments to moving forward in a partnership and are best addressed directly. Having some insight into those misperceptions allows you to provide evidence to the contrary or explain why that barrier can be addressed head-on. Here is a list of potential roadblocks to partnerships:

- You are perceived to be too “niche” of a service.
- You do not impact enough of their coverage area/ patient population.
- Palliative medicine is not respected as a medical specialty.
- You do not offer the type of service they are looking for.
- You are not seen as a peer in the healthcare continuum.
- You are not a “player” in the value-based contracting world.
- You are not willing to work with patients without a palliative care plan.
- It is more worthwhile to only work with the larger organizations.
- They want to provide all services from in-house.
- They do not realize the impact you have on patient outcomes and utilization.
- They do not know their current hospice utilization levels.

**Build your partnerships:** Once you have a handle on your agency’s overall change strategy, as well as the internal and external data that you need, you can start building your partnerships.

Identify where your best opportunities lie. List the possible sources of contracts for you to pursue. This could include ACOs you want to approach for a contract or to become a preferred provider. It could be a [Direct Contracting Entity](#) (DCE) that you want to enter into a Participant Provider contract with. It could be a local health care system with whom you want to contract with to provide inpatient palliative care. It could be another hospice or group of hospices that you would like to build a collaborative with. It could be another community provider, such as a behavioral health provider, that you want to develop shared services with. It could be CMS payment models that you want to apply for. Whatever fits best with your agency’s strategies, your resources, and your system’s needs is the best place to start.



Just as important as this empirical data, you must also attend to the more qualitative perceptions, or – more commonly – misperceptions, that may exist.

Next, reach out to those potential partners to get the conversation started. Develop specific strategies of how such outreach will take place. Utilize any personal and professional connections that may exist, even if that connection is an entry point for another conversation. For instance, you may have a relationship with a front-line provider. You can reach out to that individual and explain the value that you are proposing. They can then advocate on your behalf to get a conversation started with those in their organization who may have more decision-making capacity. If no personal connection exists, you can research possible contact points through websites and public reporting. When making the outreach, focus on their opportunity as a reason to meet. Tell them briefly what value you are offering and what need of theirs you will be meeting. If necessary, build a coalition between providers and come to the potential partners as a group, greatly increasing your impact and value.

Once you are able to meet, focus the conversation on them. Just as we start where the patient is when providing hospice care, listening to your potential partner's priorities, needs, and questions is crucial. As much as possible, try to speak their language like a native. This means knowing their jargon and abbreviations and using it appropriately. Keep the conversation concise and focused, making good use of their time and attention. Focus on how you are going to meet their needs and show them what is in it for them. Demonstrate that you have done your research and are knowledgeable about them specifically, both their strengths and needs. Include their own data and how you specifically have brought value to them already by providing them a review of how many of their patients you have already served, how much you have already saved them, how their providers already use your services, or any other pertinent data.

Differentiate yourself from other providers in ways that are meaningful for them, such as common coverage areas, clinical alignment within specific patient populations whom you both serve, unique clinical offerings that you provide, or close mission alignment. Avoid the "hospice is good" conversation, not that that is not true, but you can assume that all involved already

take that for granted and now need to focus on the practical pieces. Try to anticipate any potential roadblocks, misconceptions, or hesitations that they may have and, when appropriate, brings those up yourself. Those thoughts may be on their minds, but they may not feel comfortable bringing them forward.

When you come into this conversation, have a focused proposal prepared and ready to present, but be open and willing to change as needed. You should be prepared to discuss the following:

- **Goal of the proposal:** Show what you intend to accomplish and a very brief outline of what the partnership will look like.
- **Potential gains for all involved:** Provide the "what's in it for me" for the main stakeholders, including them, your mutual patients, yourself, and any other pertinent parties.
- **Potential risks and mitigation plans:** The best way to avoid risk is to face it head on. Show that you have identified potential downsides and unknowns and have taken steps to minimize those risks.
- **Sustainability plans:** Demonstrate that this proposal has staying power over time. This includes financial sustainability, but also that the partnership will remain relevant and applicable as the healthcare environment changes.
- **Costs to be incurred by all with outlines of a budget:** Show them that you have run the numbers and they work. Be realistic on potential revenue and expected costs.
- **Clinical resources that would be required:** Outside of financial outlay, provide what additional resources would be needed, including the need to hire or reposition staff, added responsibilities to existing staff, back-office needs, and any other impact that the partnership would create.
- **Timeline:** Give a realistic timeline for the project, including any application deadlines, timelines outside of your control, and deadlines that they would have to meet.
- **Next steps:** Provide a concise list of the immediate next steps that would keep the project going, including who would be responsible for each.

If possible, have a proposal in a written form that can be left with them when you go. While there is a great deal involved in this business plan, be as concise as possible and do not have more than two pages. Know what your limits will be if you are called on to alter your plans and have decision makers as part of the conversation so they can hear the discussion firsthand and respond in a timelier manner. Set next steps before concluding with full clarity on who is responsible and when the next communication will be.

As the conversation moves forward, be prepared for course changes. Because you have established a firm foundation regarding your options, resources, goals, and opportunities, you should have the flexibility to be creative and responsive while not overextending or taking on too much risk. This includes knowing when to walk away if the partnership is going to put your organization at risk or not accomplish your goals. You will need to be prepared for failure and that your potential partner may not recognize the value that you bring. You will probably need to persevere, reframe your strategies, and restart many times. You will need to persist and maintain your focus on your overall mission.

Engaging in change is an ongoing process. For the good of your organization and all whom you serve, both internally and externally, you will need to continue to educate yourself, connect within your community and continuum, advocate for the power of what you do, and move the mission forward. There are many sources of support and encouragement along the way – do not hesitate to take advantage of them. Know that what you do makes an incredible difference in the lives of many and never stop striving.



**Robin Stawasz, LMSW**, is the program development executive with Acclivity Health Solutions, Inc. in Corning, New York.

**Kevin Hohnbaum**, is the business development manager at Willamette Valley Hospice in Salem, Oregon. Kevin and Robin both serve on the MyNHPCO Development/PR/Marketing steering committee, where Kevin is the section leader.



As the conversation moves forward, be prepared for course changes.

# PAYMENT MODEL PRIMER

There are many new payment models emerging as healthcare transitions from fee-for-service (FFS) to value-based payment models. Value-based care is sometimes referred to as pay for performance (P4P). FFS is the traditional payment model where when a service is provided, a bill or insurance claim is generated, and the provider of the service gets paid. The more services a provider performs, the more they get paid. Volume of service is incentivized, even if that service is not producing the desired outcome.

Under value-based payment models, positive outcomes of the service are incentivized over volume. A provider gets “paid more” if they achieve a desired outcome, especially if it was done efficiently. There is a full continuum of value-based models ranging from bonus payments for quality metrics to shared risk/ shared reward to fully capitated payments where the provider takes on full financial and clinical responsibility for a patient. Through the CMS Hospice Benefit, hospices have always been fully capitated, another reason why hospices are well positioned within the emerging healthcare landscape.

Recent indications from CMS point to a move to accelerate the transition from FFS to value-based payment models and perhaps move it to becoming mandatory for providers. The following list explores some of these options, though new payment models are emerging, and others may be available within your healthcare care network.

## ACO – Accountable Care Organization

ACOs are groups of providers that take on quality and cost accountability for Medicare FFS patients assigned to them. For this they receive enhanced administrative flexibility and can share in upside, and sometimes downside, risk, as well as quality incentive payments. There are many types of ACOs, but most of these models have ended or will end soon. Direct Contracting is being seen as the next step for ACOs.

The ACO models include:

- **Medicare Shared Saving Program (MSSP)** is an ACO caring for FFS Medicare beneficiaries. There are currently 477 MSSP ACOs.
- **ACO Investment Model** is for MSSP ACOs in rural and underserved areas and employs pre-paid saving arrangements. There are currently 45 Investment ACOs but this program has ended.
- **Advance Payment ACO Model** is for MSSP ACOs who need capital to invest in infrastructure and staff. There are currently 35 Advance Payment ACOs but this program has ended.
- **Comprehensive ESRD Care Initiative** is for ACOs caring for patients receiving dialysis treatment. There are currently 33 Comprehensive ESRD ACOs but this program is ending this year.
- **Next Generation ACO Model (NexGen ACO)** is for ACOs who have demonstrated more experience and care management ability than a MSSP ACO and allows them to take on more risk and higher financial rewards. There are currently 35 NexGen ACOs but this program is ending this year.
- **Pioneer ACO Model** moves from shared savings into a population-based payment model which more closely aligns with private payers’ provider incentives. There are currently 9 Pioneer ACOs but this program has ended.

Hospices and other palliative care providers can contract with ACOs to offer non-hospice services and/or to become a preferred hospice provider which will help an ACO meet their savings and quality incentives. More [information on ACOs is available from CMS online](#).

## VBID – Value Based Insurance Design

Medicare Advantage (MA) plans are private insurances who have contracted with CMS to offer Medicare beneficiaries an alternative to traditional FFS Medicare. In addition to covering all Medicare services

(Part A and Part B), some MA plans also offer extra coverage through supplemental benefits such as vision, dental and hearing services, as well as non-traditional health-related benefits such as transportation, gym memberships and food support. Some MA plans also offer prescription drug coverage (Part D). Beneficiaries voluntarily sign up for MA plans to access these additional services. MA plans are incentivized through increased administrative flexibility and value-based contracts that allow for shared savings. Until VBID, the Medicare Hospice Benefit has been "carved out" for MA plans. This means that even MA plan beneficiaries had their hospice covered through traditional, FFS Medicare (Part A).

VBID is often referred to as the "Medicare Carve-in." Through VBID, CMS is testing an array of value-based health plan innovations for Medicare Advantage (MA) plans. Currently, 9 of the 19 MA plans participating in VBID are also participating in the Hospice Benefit Component, with applications open for greater participation in 2022. Under the Hospice Benefit Component of VBID, the MA plan retains financial responsibility for hospice (no Medicare "carve out") and can contract directly with hospices to offer a more flexible benefit and must include coverage for palliative care and concurrent treatment while on hospice. While all VBID providers must cover all hospices at this time, this requirement will change by 2023, giving hospices that have contracted as networked providers with the MA plan an advantage. More [information on VBID is found on the CMS innovation page](#).

## PCF/SIP – Primary Care First/ Seriously Ill Population

This 5-year payment pilot out of CMS' Center for Medicare and Medicaid Innovation (CMMI) is an effort to support the delivery of advanced primary care. It is offered in 26 regions in the country. PCF includes 3 models:

- **PCF-Only** which focuses on transitioning primary care practices to a value-based payment model for all traditional Medicare patients in their practice;

- **SIP** which focuses increasing care coordination for traditional Medicare patients who are both seriously ill and receiving fragmented care; and
- **Hybrid** model for practices that want to provide both PCF and SIP.

Hospices can apply for SIP and the Hybrid models, though the applications are currently closed. Hospices also have the opportunity to coordinate with PCF providers which are incentivized to limit acute utilization and maximize care coordination. More [information on PCF is available from CMS](#).

## DCE – Direct Contracting Entities

A DCE is an Accountable Care Organization (ACO)-like organization which includes Medicare providers and suppliers. Through CMS, DCEs accept overall accountability for quality and cost of the medical care provided to Medicare patients assigned to the entity. A DCE will receive capitated payments and assume both upside and downside risk, which means that they get to keep at least some of the savings they create, but also may have to pay CMS back if their spending goes over the benchmark. This is an innovation model that is just being launched by CMMI and currently has 53 participants. There are currently three DCE models:

- **Global Direct Contracting** model offers 100% savings/losses sharing and offers either full or partial capitation payments.
- **Professional Direct Contracting** model offers 50% savings/losses sharing and offers partial capitation payments.
- **Geographic Direct Contracting** model is currently on hold by CMS and under review.

For the Global and Professional Direct Contracting models, often referred to collectively as GPDC, there are four types:

- **Standards DCEs** are providers that have experience serving Medicare FFS beneficiaries, such as through an ACO or Medicare Shared Savings Program (MSSP) and have at least 5,000 Medicare FFS beneficiaries assigned to them.

- **New Entrant DCEs** are providers who do not have as much experience serving Medicare beneficiaries (only 1,000 beneficiaries are required to apply) but are allowed to build their patient assignment as the program grows.
- **High Needs Population DCEs** serve Medicare FFS beneficiaries with complex needs through specific care delivery strategies, such as PACE. The number of beneficiaries required is even lower than New Entrant DCEs (only 250 beneficiaries to start) but needs to grow over time.
- **Medicaid Managed Care Organization (MCO)** Based DCEs serve full-benefit dual eligible beneficiaries. This model is also currently on hold by CMS and under review.

While some hospice and other palliative care organizations have built coalitions with other providers and applied to be participants in DCEs or DCEs themselves, this does require a high level of sophistication and a very large population base. Other organizations may choose to contract with DCEs as preferred providers to provide a flexible hospice and palliative care benefit. There are two contracting options for providers looking to join a DCE:

- **Direct Contracting Participant Providers** share patients with the DCE, must accept payment from the DCE, must provide quality reporting, and can benefit from shared savings.
- **Preferred Providers** do not share patients with the DCE, can accept payment from the DCE, and can benefit from shared savings.

More [information on GPDC is available from CMS](#).

**Private payer innovation** – Private payers, including Medicare Advantage (MA) providers are facing the same pressures to increase quality of care, increase provider satisfaction, and control costs. They are taking some of the same approaches as CMS to create this change, including building outcome-oriented, holistic, community-based care models paid on a value-based, predictable schedule. Just as hospices and other palliative care providers can bring value to CMS, they offer the same strength to

private payer and provider systems. Where private systems may not have the standardized structures that CMS has, they more than make up for this through their flexibility and willingness to find one-off successes.

#### **Future innovation, including a Palliative Care Benefit**

– While we all know that making predictions can be hazardous, there have been indications at CMS that support for a federal palliative care benefit is growing. Many private and Medicaid plans are offering such a benefit already. The Medicare Care Choices Model, a CMMI project that allowed concurrent care for some hospice patients and that demonstrated both savings and good patient outcomes, is coming to an end by 2022 and a palliative care benefit seems to be the next step for CMMI. The timing of this is unknown but it is not likely in the relatively near future.

The better prepared hospices are to offer services as payment structures arrive, the better positioned they will be in that market. It is vital that you stay up to date on the latest innovations and never give up on your advocacy efforts.



**The better prepared hospices are to offer services as payment structures arrive, the better positioned they will be in that market.**



# 2022 LEADERSHIP & ADVOCACY CONFERENCE

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March 5-6, 2022 Preconference  
March 7-9, 2022 Main Conference

Gaylord National Resort & Convention Center  
National Harbor, MD

REGISTRATION OPENS IN DECEMBER AT  
[NHPCO.ORG/LAC2022](https://nhpc.org/lac2022)



**NHPCO**  
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# FY 2022 HOSPICE WAGE INDEX AND QUALITY REPORTING FINAL RULE



## Information Providers Should Know

As shared with the membership in an initial Regulatory Alert issued on July 29 and in a more comprehensive Regulatory Alert published on July 30, the FY 2022 Hospice Wage Index and Payment Update Final Rule went on display on the Federal Register website for public inspection on July 29, 2021. It was published in the Federal Register on August 4, 2021.

ALL REGULATIONS WILL TAKE EFFECT ON OCTOBER 1, 2021.

### Regulatory Components of the FY 2022 Hospice Final Rule

Providers will find information on reimbursement, rates, and cap. There are updates to the Hospice Election Statement Addendum and two 1135 waivers were made permanent. Please note that there are adjustments from the FY 2022 Hospice Proposed Rule that went on public inspection on April 8, 2022.

Key rate and calculation changes to note from the final rule:

- **Final hospice rate:** The increase for FY 2022 is 2.0%.
- **Cap Amount:** The final hospice cap amount for FY 2022 is \$31,297.61.
- **Wage index values have changed:** The wage index values for every county have been adjusted from those published in the proposed rule. Please check carefully to ensure that the final wage index values are used. NHPCO has prepared the FY 2022 Final Wage Index State/County Rate Chart, which is found on the [Regulatory Medicare Reimbursement](#) page of the website for members.
- **% of FY 2022 increase has dropped:** Note that the final rate increase is 2.0%. Use the State/County Rate Chart to accurately predict your hospice's rates for each level of care in each county served.
- **Rebasing and revising the labor component of the rates:** CMS confirms that they have used cost report data for freestanding hospices from 2018 to rebase and revise the rates.



- OMB Revised CBSA Delineations:** The final rule maintains the proposal to implement revised Office of Management and Budget (OMB) statistical delineations for the hospice payment system adopted in the FY 2021 final rule. CMS reiterates that the one-year transition policy (resulting from these changes) of a 5 percent cap on wage index decreases applied only to FY 2021. Thus, CMS notes that no cap will be applied to wage index decreases for the second year (FY 2022). Some providers will see a significant decrease in their wage index values as a result of these OMB policies.
- Wage Index Values:** The CMS files with final FY2022 wage index values can be found [on the CMS website](#).

CMS charts showing the FY 2022 FINAL rates for each level of care, both for hospices that do and do not submit quality data, are included below.

**TABLE 2: FINAL FY 2022 HOSPICE PAYMENT RATES (WITH QUALITY REPORTING)**

Code	Description	FY2021 Payment Rates	Wage Index Standardization Factor	FINAL FY 2022 Hospice Payment Update	FINAL FY 2022 Payment Rates
651	Routine Home Care (days 1-60)	\$199.25	X 1.0002	X 1.02	\$203.40
651	Routine Home Care (days 61+)	\$157.49	X 1.0001	X 1.02	\$160.74
652	Continuous Home Care Full rate = 24 hours of care	\$1,432.41	X 1.0006	X 1.02	\$1,462.52 (\$60.94 per hr)
655	Inpatient Respite Care	\$461.09	X 1.0014	X 1.02	\$473.75
656	General Inpatient Care	\$1,045.66	X 1.0019	X 1.02	\$1,068.28

**TABLE 3: FINAL FY2022 HOSPICE PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA**

Code	Description	FY2021 Payment Rates	Wage Index Standardization Factor	FINAL FY2022 Hospice Payment Update of 2.0% minus 2 percentage points = +0.0%	FINAL FY 2022 Payment Rates
651	Routine Home Care (days 1-60)	\$199.25	X 1.001	X 1.000	\$199.41
651	Routine Home Care (days 61+)	\$157.49	X 1.0009	X 1.00	\$157.58
652	Continuous Home Care Full rate = 24 hours of care	\$1,432.41	X 1.0004	X 1.00	\$1,433.84 (\$59.74per hr)
655	Inpatient Respite Care	\$461.09	X 1.0014	X 1.00	\$464.46
656	General Inpatient Care	\$1,045.66	X1.0019	X 1.00	\$1,047.33

**Percentage of Labor Component has changed:** There is a slight adjustment in the labor component for each level of care. Table 1, included below, provides details on the labor component percentages.

**TABLE 1: FINAL, PROPOSED AND 2021 LABOR SHARES BY LEVEL OF CARE**

	Final FY 2022 Labor Share	Proposed FY 2022 Labor Share	FY 2021 (Current Year) Labor Share
Routine Home Care	66.0%	64.7%	68.71%
Continuous Home Care	75.2%	64.7%	68.71%
Inpatient Respite Care	61.0%	60.1%	54.13%
General Inpatient Care	63.5%	62.8%	64.01%



The wage index values for every county have been adjusted from those published in the proposed rule. Please check carefully to ensure that the final wage index values are used.

CMS comments on using freestanding hospice cost reports to rebase and revise the labor component of hospice rates: CMS responded to stakeholder comments on using the Medicare Hospice Cost Report data by saying: "Response: We believe that our proposal to revise the labor shares based on MCR data for hospice providers is a technical improvement to the current labor shares. We disagree with commenters that the hospice MCR data does not provide adequate or appropriate measure of labor expenses." They also stated that the "proposal to use the 2018 MCR data recognizes that providers have had 4 years to familiarize themselves with the form and, thereby, improve the accuracy of the data."

Frequency of updating labor shares in the future: CMS states that they tentatively plan to rebase the hospice labor shares on a schedule of every 4-5 years, similar to other Medicare provider types. However, in light of the COVID-19 PHE, they plan to monitor the upcoming MCR data to see if a more frequent revision to the hospice labor shares is necessary in order to reflect the most recent cost structures of hospice providers.

## Hospice Election Statement Addendum

The FY 2022 Hospice Final Rule includes proposed clarifying regulation text changes for the Hospice Election Statement Addendum. Based on questions from stakeholders, and hospice providers' experiences with using the election statement addendum, CMS is making several changes to the regulation text regarding the addendum.

- A. 5 days:** CMS is implementing the proposal to allow the hospice to furnish the addendum within 5 days from the date a beneficiary or their representative requests it if the request is within 5 days from the date of a hospice election.
- B. If the patient dies:** CMS has clarified that if the beneficiary requests the election statement addendum at the time of hospice election but dies within 5 days, the hospice would not be required to furnish the addendum as the requirement would be deemed as being met in this circumstance. If the patient is furnished an addendum but dies before signing it, hospices should note that in the patient record and include the addendum in the record. This final rule implements regulatory text changes at § 418.24(c) to reflect this policy.
- C. 3 days rather than 72 hours:** CMS confirmed regulatory text changes at § 418.24(c) in alignment with subregulatory guidance indicating that hospices have "3 days," rather than "72 hours" to meet the requirement when a patient requests the addendum during the course of a hospice election.
- D. Mailing the addendum:** CMS responded to a question about whether a mailed copy of the addendum form would be acceptable. The commenter stated that they believe their patients and their representatives would welcome this option; however, it is unclear whether mailing the form is acceptable for CMS. Response: There is nothing precluding hospices

from furnishing an addendum through mail. We expect that hospices would take steps in working with patients and their representatives to better understand which methods (that is, in person, mail, etc.) of delivery would work best in furnishing the addendum.

- E. Updated model election statement addendum:** Many commenters encouraged CMS to update the model hospice election statement addendum on the CMS hospice center webpage to illustrate these clarifications. Response: We will post an updated model election statement addendum on the Hospice Webpage, along with the publication of this FY 2022 Hospice Wage Index and Payment Rate Update final rule. This is an illustrative example for hospices to modify and develop their own forms that meet the content requirements at § 418.24.
- F. Date clarification:** CMS also clarified that the date the hospice furnishes the addendum must be within the required time frame (e.g., 3 days or 5 days), rather than the signature date. The hospice would include the "date furnished" in the patient record and on the addendum. If the patient/representative refuses to sign the addendum, hospices must document the reason it is not signed.
- G. Non-hospice provider requests addendum:** If a non-hospice provider requests an addendum, CMS does not expect a signed copy in the patient medical record. Hospices can develop processes to address this, and how to document it.
- H. Effective date:** October 1, 2021.



**CMS is making several changes to the regulation text regarding the addendum.**



There are updates to the Hospice Election Statement Addendum and two 1135 waivers were made permanent.

## 1135 Waivers Made Permanent in FY 2022 Final Rule

CMS has made permanent the following two 1135 waivers that were implemented during the pandemic.

**§418.76 Condition of participation:** Hospice aide and homemaker services.

**(c) \* \* \* (1):** The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient or a pseudo-patient during a simulation.

**(h) \* \* \* (1) \* \* \* (iii):** If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skill(s) in accordance with paragraph (c) of this section.



# UPDATES TO THE HOSPICE QUALITY REPORTING PROGRAM

The FY 2022 Hospice Final Rule includes extremely important information on quality reporting that providers must be familiar with.

## **A. The Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment at Admission measure (HIS Comprehensive Assessment Measure)**

- CMS is finalizing its proposal to remove the seven individual HIS process measures from public reporting as individual measures on Care Compare no earlier than May 2022.
- In addition, CMS will remove the "7 measures that make up the HIS Comprehensive Assessment Measure" section of Care Compare, which displays the seven HIS measures.
- These will be effective no earlier than May 2022.
- Hospice providers must report HIS data used for the HIS Comprehensive Assessment Measure in order to meet the requirements for compliance with the HQRP.

## **B. Hospice Care Index (HCI)**

- CMS has finalized a new hospice quality measure, called the Hospice Care Index (HCI), which is a composite measure that is comprised of ten indicators calculated from Medicare claims data and represents different aspects of hospice service. The sum of the points earned from meeting the criterion of each indicator results in the hospice's aggregated single HCI score, with 10 as the highest hospice score which indicates a broad overview of the quality of hospice care provision. The ten indicators are:
  - Provided CHC/GIP (% days)
  - Gaps in skilled nursing visits
  - Early live discharges
  - Late live discharges
  - Burdensome transitions (type 1)
  - Burdensome transitions (type 2)

- Per-beneficiary Medicare spending
- Skilled nursing care minutes per routine home care day
- Skilled nursing minutes on weekends
- Visits near death

- CMS is finalizing the proposal to add composite HCI measures to the HQRP as of FY 2022 and will monitor the measure. The measure will be publicly reported in Care Compare no earlier than May 2022.
- CMS will continue to monitor the HCI after implementation to ensure the measure reflects hospice quality, differentiates between hospices, and does not become topped out.

### C. Update regarding the Hospice Outcomes & Patient Evaluation (HOPE) development

- CMS thanked commenters for their feedback on the HOPE tool. CMS states that they "will continue to host HQRP Forums to allow hospices and other interested parties to engage on the latest updates and ask questions on the development of HOPE and related quality measures."
- CMS has also established a dedicated email account to the HOPE assessment at [HospiceAssessment@cms.hhs.gov](mailto:HospiceAssessment@cms.hhs.gov) to receive ongoing questions and comments.
- CMS will use field test results to create a final version of HOPE to propose in future rulemaking for national implementation and they will continue to engage all stakeholders throughout this process.
- Future updates and engagement opportunities regarding HOPE can be found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE.html>

### D. Update on Quality Measure Development for Future Years

- CMS received many comments on the development of future quality measures.
- Commenters urged CMS to monitor duplication of measures when HOPE-based and other future measures are under development. Many commenters emphasized the need to engage providers to share information and for CMS to seek feedback when developing quality measures.
- CMS thanked all the commenters for their thoughtful suggestions and feedback related to future of quality measure development for the HQRP and appreciates suggestions for new quality measures, as well as comments about the public reporting of quality measures.
- CMS will take these comments under advisement for future consideration of quality measures and the Meaningful Measures System Blueprint.

### E. CAHPS® Star Ratings

- CMS will display CAHPS® Hospice Survey Star Ratings no sooner than FY 2022.
- CMS intends to build additional claims-based measures in the future as well develop outcome measures from the HOPE assessment tool.
- CMS is also considering developing hybrid quality measures that would be calculated using claims, assessment (HOPE), or other data sources to allow for more comprehensive set of information about care processes and outcomes (Assessment data can be used to support risk-adjustment).
- CMS will also explore the feasibility of conducting a dry run of the Star Ratings with reporting to hospices via preview reports, which would occur prior to the start of the public display of the ratings.

- The stars would range from one star (worst) to five stars (best) similar to other post-acute provider types and will be calculated based on “top-box” scores for each of the eight CAHPS Hospice Survey measures.

#### **F. Proposal for Public Reporting of HIS-based Measures with Fewer than Standard Numbers of Quarters Due to PHE Exemption in February 2022**

- CMS is finalizing their proposal that, in the COVID-19 PHE, 3 quarters of HIS data would be used for the final affected refresh, the February 2022 public reporting refresh of Care Compare for the Hospice setting.
- Using 3 quarters of data for the February 2022 refresh would allow CMS to begin displaying Q3 2020, Q4 2020, and Q1 2021 data in February 2022, rather than continuing to display November 2020 data (Q1 2019 through Q4 2019).
- CMS states that updating the data in February 2022 by more than a year relative to the November 2020 freeze data would assist consumers by providing more relevant quality data and allow hospices to demonstrate more recent performance. Testing results indicate to CMS that providers can achieve these positive impacts while maintaining high standards for reportability and reliability.
- CMS is also finalizing their proposal to publicly report the most recently available 8 quarters of CAHPS® data starting with the February 2022 refresh and going through the May 2023 refresh on Care Compare.
- CAHPS® data cannot be publicly reported for Q1 2020 and Q2 2020 data due to the COVID-19 PHE.

#### **G. Update on Transition to iQIES**

- CMS thanked submitters for their comments, especially the requests that CMS provide adequate advanced notice regarding the transition of hospice to the iQIES systems.
- CMS plans to communicate with the provider community via sub-regulatory guidance about the upcoming transition to iQIES as the timing becomes clear. CMS’ intention is to provide sufficient time and appropriate information for a smooth transition.

#### **H. Proposals for calculating and publicly reporting “claims-based measures” as part of the HQRP**

- CMS is finalizing as proposed to publicly report the HCI and HVLDL claims based measures beginning no earlier than May 2022, and to include it in the Preview Reports no sooner than the May 2022 refresh.
- CMS will update the claims-based measures used for the HQRP annually and will refresh claims-based measure scores on Care Compare, in preview reports, and in the confidential CASPER QM preview reports annually.
- Claims-based measure scores will be calculated based on one or more years of data and which publicly shares only the most up-to-date information and best reflects current realities.
- CMS also states that having only the most recent data can also help incentivize hospices with lower scores to make changes and have the results of their effort be reflected in better scores.



CMS is also finalizing their proposal to publicly report the most recently available 8 quarters of CAHPS data starting with the February 2022 refresh...

- The HCI and HVLDL measures will utilize 2 years (8 quarters of Medicare claims data) of data to publicly report in 2022.
- Should a hospice provider believe they have found an error with an HIS or claims-based measure calculation as displayed in their preview reports, they can request a review, and data will be suppressed if the review finds the calculation problematic.
- In addition to the Preview Report, Hospice Agency-Level QM Report in CASPER CMS will also include claims-based measure scores. Measure scores will be updated annually in the QM Report as they will in the Preview Report and on Care Compare and the Provider Data Catalogue.
- CMS will remain open to reconsidering the frequency of reporting claims across all PAC settings in the future, should data after implementation indicate that such change is warranted.

### Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs – Request for Information

- CMS received many comments about the use of standardized patient assessment data in the hospice setting to assess health equity and social determinants of health (SDOH).
- Notable comments included:
  - CMS consideration about additional factors which should be considered when collecting data about health equity and disparities.
  - CMS was encouraged to stratify quality measures by demographic data, social risk factors, and social determinants of health.
  - Encouragement for CMS to implement a best-practice assessment for the collection of demographics and SDOH data.



The FY 2022 Hospice Final Rule includes extremely important information on quality reporting that providers must be familiar with.



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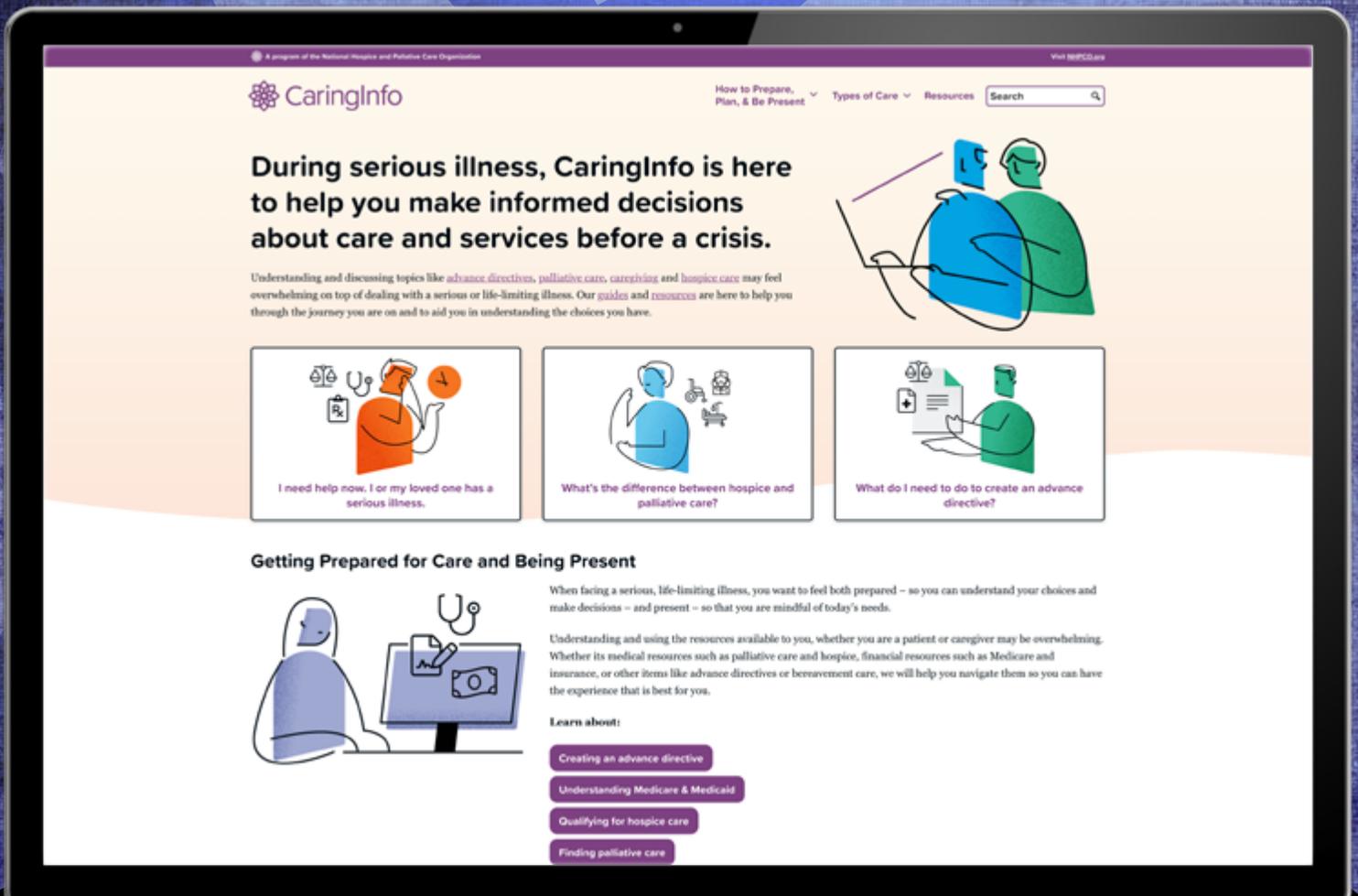
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# NHPCO

## Launches Re-Envisioned CaringInfo.org Consumer Website

Website offers information on range of topics that include advance care planning, caregiving, palliative care, hospice, grief and more



**On June 15, NHPCO proudly launched the new and expanded CaringInfo.org website. CaringInfo.org, a program of NHPCO, is a consumer-focused website that offers information on a breadth of topics related to serious illness and end of life. The site includes information on hospice, palliative care, grief and bereavement, caregiving, planning ahead, and more.**

The mission of CaringInfo.org is to provide consumers with unbiased, easy to understand information to help people make informed decisions about care and services for themselves or their loved ones. The website was first launched in 2006 as part of NHPCO's Caring Connections community engagement program funded by a grant from the Robert Wood Johnson Foundation. The new CaringInfo.org builds on its success over the last 15 years. It is easier to navigate, uses clear and simple language, and connects users to a variety of resources and support.

"All too often we hear people say, 'I wish I had known about choices I could have made earlier in the course of my illness.' Our hope is that with the new CaringInfo.org, more people will learn about the care options available to them before a crisis happens and they will feel prepared and empowered to get the care they want when they want it," said NHPCO President and CEO Edo Banach.

One of the most utilized resources from CaringInfo has been the state-specific advance directive forms

that can be downloaded free-of-charge, along with information explaining the value of advance care planning. More than 1.5 million directives have been downloaded from CaringInfo in the past decade.

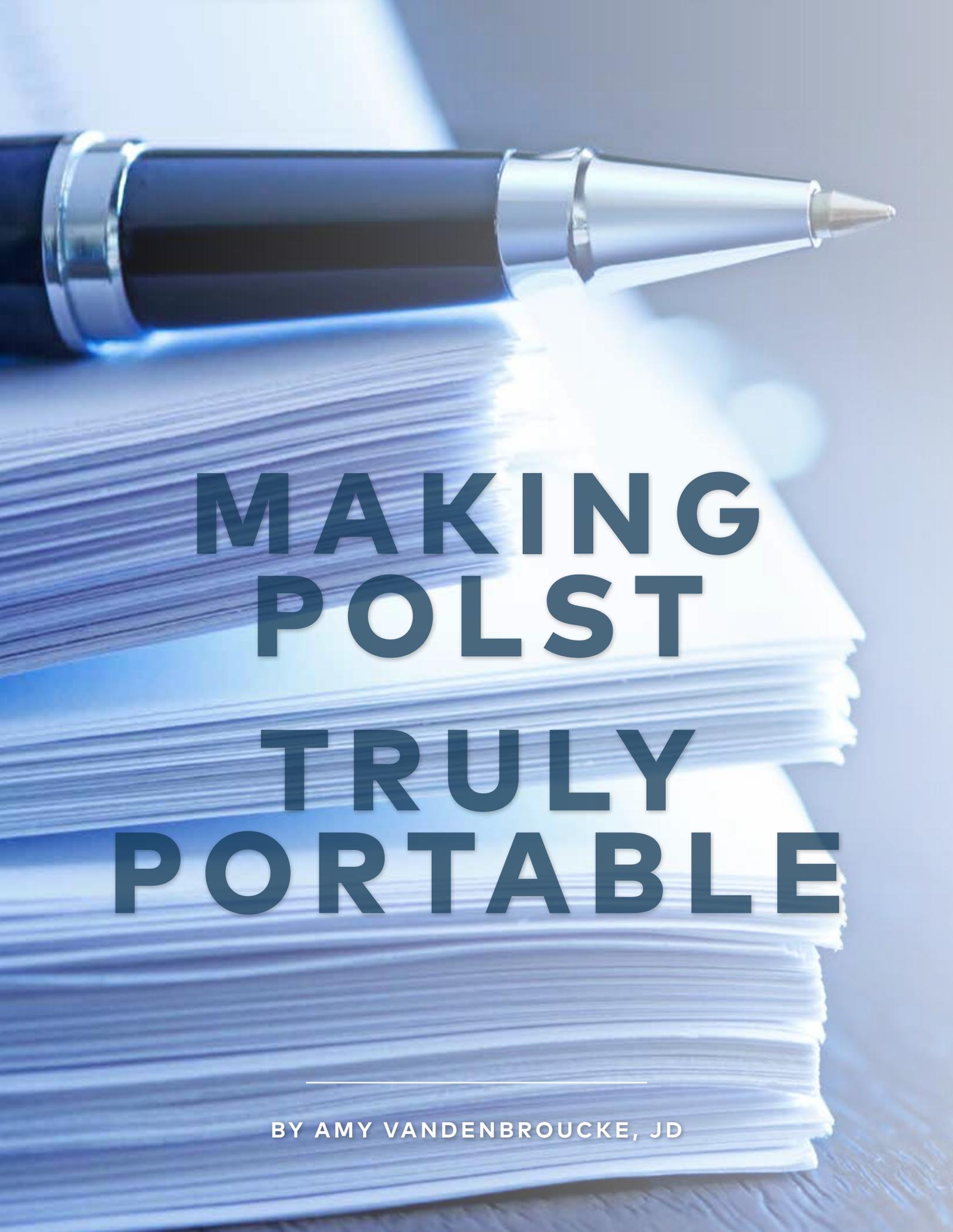
In addition to the updated website, NHPCO will be updating the PDF topic-specific informational guides and one-pagers available on CaringInfo throughout the year.

The creation of the new CaringInfo was supported by funding from the Cambia Health Foundation.

Learn more by visiting [www.CaringInfo.org](http://www.CaringInfo.org).



The new CaringInfo.org builds on its success over the last 15 years. It is easier to navigate, uses clear and simple language, and connects users to a variety of resources and support.



# **MAKING POLST TRULY PORTABLE**

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BY AMY VANDENBROUCKE, JD

## I answer National POLST's general phone line. While the story being shared with me is personal, it is not unique and neither is the question...

- "I live in New Hampshire, work in Vermont and get medical care in New York...."
- "I am traveling from Georgia to visit my daughter in Maryland but may receive care in DC or Virginia if there is an emergency..."
- "I live [insert Northern state] but am spending [3-6 months] in [Arizona, Florida]..."

**Then:** "will my POLST form work where I'm traveling or staying?"

If you are unfamiliar, a POLST form is a portable medical order and National POLST, where I serve as the Executive Director, was created to encourage and promote implementation and uniformity among state POLST Programs to ensure portability and standardized elements that reflect best practice across provider disciplines and settings. Our vision is for all patients to have a standardized form that is recognizable, portable and consistent across state lines and the continuum of care.

My answer to the caller depends on the states they are talking about:

**Rare answer:** All states have either adopted or adapted the national POLST form (adopted means using without edits; adapted means using with minimal changes required by state law, but the form is fundamentally the same). For both, I can answer they are likely fine with their one copy.

**Normal answer:** If the states all already meet National POLST's form endorsement requirements, it may be okay, but I advise them to get a POLST form for each state they plan to spend significant time in to be sure. (I used to check my answer with the leaders of whatever states were involved with the particular situation but, after nine years, I know the answer is the same for them too: while they may accept out of state forms, the best advice to ensure that the form will be recognized and honored is for the POLST form to be the one from that state.)

**The worst situation answer:** There are a few states with forms substantially deviating from endorsement requirements and, for those, my answer is a definitive yes, they need another POLST form.



Our vision is for all patients to have a standardized form that is recognizable, portable and consistent across state lines and the continuum of care.

I look forward to the day where intimate knowledge of individual state POLST forms and reciprocity laws is not required to answer the question. Wouldn't it be nice if POLST were like a driver's license? You only need one and you can travel throughout the US without thinking about whether it will be valid when you cross a state line. That is the goal with the national POLST form.

Today, however, the caller is typically unhappy with my answer because it means they must spend time and effort on multiple provider visits in multiple states and then keep track of the multiple forms they need to keep in their possession. (Remember, the appropriate population for POLST are those who are seriously ill or frail so adding another burden on them is generally not well received.)

For POLST to really be part of the standard of care throughout the US it is necessary it be simple, meaning that it is easily portable across state lines, recognized and understood.

## RECIPROCITY IS A RED HERRING

When given a problem to solve people "systematically default to searching for additive transformations, and consequently overlook subtractive transformations." Focusing on adding reciprocity laws or regulations to address POLST portability, rather than subtracting the 45 POLST forms to just one, is an example.

Every state variation of POLST unnecessarily limits the value of POLST and creates unnecessary administrative burdens and worries on the very patients POLST intends to help. Consider that we have:

- 45 different POLST forms exist (the order of the treatment orders on the form, what orders are included, etc)
- 6 colors (excluding the various shades of pink)
- 17 different acronyms (20 names when you spell them out).

Addressing reciprocity is a poor workaround to achieving true POLST portability. On paper it looks great, but the reality is that 45 variations of what could be the same document creates real challenges for health care professionals and, by extension, patients.

Consider the emergency medical service (EMS) personnel showing up during an emergency. The information that drives the patient care decision-making process outside of medical facilities is unique from other care settings. Within seconds, EMS must elect to begin or deescalate patient resuscitation. These decisions are often made with less information and with fewer personnel present than in a hospital emergency department or floor unit – in the hospital setting, staff have the advantage of searching for available records and orders, while EMS personnel may or may not have access to a hardcopy of patient care documentation. Fewer personnel on scene also means that anyone present dedicated to looking for records or documentation are not providing direct care, and in particularly resource-lean environments, this can mean critical interventions are delayed or not performed at all.

Further, EMS is protocol-driven work and, if staff are trained on POLST at all, they are being trained to their specific state POLST form. How do you think an EMS provider, trained on the pink TPOPP form (the Kansas-Missouri version of the POLST) in an emergency situation will react to seeing a goldenrod LaPOST form (the Louisiana version)? Or the green POLST form from New Jersey? Even if they immediately recognize it as the same form as the TPOPP (which is a question in and of itself), they must immediately next wonder if they are legally permitted to follow it and take time (if they have the manpower or ability to do so considering the patient's condition) to talk with medical command or dispatch to get instructions—all the while the patient is being treated as aggressively as possible in an attempt to save their life (something they may not have wanted).

It is not just EMS having trouble: part of my initial POLST work included leading the Oregon POLST

Coalition and I remember the leader complaining that medical students coming from other states, like New York that used the term "MOLST", did not recognize Oregon's POLST form as the same document or know how to use it. Despite their having been trained about MOLST, they were not aware different states had different versions of the form. Over the years I can attest that this is not a unique complaint.

The goal should be subtracting anything that creates a barrier to POLST portability and simplicity: rather than adding new laws or regulations that add complexity, fail to address the root cause of portability, and that may give the deficient current situation some credibility, resources should be focused on subtracting variation and simplifying to a single form.

As Hans Hofman stated, "the ability to simplify means to eliminate the unnecessary so that the necessary may speak." The necessary is the patient expressing their autonomy by using the POLST form to state what treatments they want to receive towards the end of their life. The value of POLST orders cannot be understated for the patient who has them: these orders can make the difference of dying comfortably in their own home or dying in a hospital after going through the brutality of resuscitation.

There are so many possibilities as more states adopt or adapt the national form, including:

- **Patient (and caregiver!) happiness.** It would make all the patients calling National POLST happy to hear that their current POLST is all they need, regardless of where they are traveling in the US. (It would make me happy too.)
- **Health care professional happiness.** I would assume that if their patients are happy, health care professionals are happy. Further, health care professionals could become more comfortable with the POLST process, the form and be able to easily advise their traveling patients.

- **Education.** National education in medical schools, conferences, CMEs about how to recognize, use and honor POLST forms and how they differ from advance directives becomes easy.
- **Research & quality improvement.** Any creation and subsequent revision of a POLST form should be informed by robust data. Since a larger data set has a better chance of meaningfully improving POLST, a single national form creates an opportunity to nationally conduct research and quality assurance activities, creating shared data for generalizable knowledge that can identify and answer outstanding questions, and evaluate rationale for all POLST form elements. Quality assurance activities can be more easily created, and results pooled. This data could inform improvements to the POLST form and process, strengthening POLST overall.

## NOTHING WORTH DOING IS EASY: THE REWARD IS WORTH THE EFFORT

Letting go or subtracting is not easy. A few years ago, leadership reconsidered the POLST acronym. By this time, the name "physician orders for life-sustaining treatment" had existed for over 15 years. The leaders immediately agreed the name was inaccurate: it gave the wrong impression that only physicians can sign (lamentably still true in a few states) and that the form was focused on "life-sustaining treatments" when the goal—from the start—is about honoring treatment wishes from life-sustaining through allowing natural death. Despite this agreement, it took a couple of years of discussion about how to proceed. As you would expect, trying to work within the confines of keeping the acronym "POLST" (which was recognizable), many of the solutions were wordy or cumbersome. In the end, however, subtracting the outdated and incorrect name and simplifying POLST to be a term, rather than an acronym, allowed National POLST to better highlight the purpose of the form: it is a "portable medical order". It is still a challenge to educate about this, but it feels better to speak more positively about what POLST is as opposed to apologizing or defending an inaccurate name or description.



The goal should be subtracting anything that creates a barrier to POLST portability and simplicity.

Going back to the national form, while there are several states that have already adopted or adapted the national form (and a few more getting ready to announce), not all POLST Programs are able to easily adopt the national POLST form because legislative or regulatory barriers. There is momentum but the process may take years. If you want to find out what is going on in your state, connect with your leadership: <https://polst.org/state-programs/>

Thank you to The Gordon & Betty Moore Foundation and The John A. Hartford Foundation for supporting the National POLST form project. Some POLST resources that may be valuable:

- [Appropriate POLST Use Policy.](#)
- [National POLST Form & Guide.](#)

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**Amy Vandembroucke, JD**, is the Executive Director of National POLST which supports the work of National POLST and serves as a resource to all POLST Programs.



“

When it comes to finding qualified professionals in Hospice and Palliative Care, where better to look than the association that represents them?”



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Although you may see lots more resumes on the monster-sized job boards, chances are, only a small percentage of those will have the qualifications of NHPCO members. The NHPCO Career Center gives you a better way to find exactly what you are looking for. **Why look any further?**





# Advancing a Culture of Equity in Hospice & Palliative Care

by Nicole McCann-Davis

A guiding principle of hospice and palliative care is that every human life matters. Central to this guiding principle is whole-person care which acknowledges that each patient is their own individual with their own history, objectives, identity, beliefs, and values.

While this is a North Star for hospice organizations, it is imperative that we ask ourselves as hospice and palliative care providers a sensitive - and oftentimes challenging - question: How are we working to improve our understanding of what it means to provide a true culture of equitable care to those we are honored to care for, and just as importantly, providing access for those communities often underserved by hospice?

To address the need for equitable care, we must acknowledge that equity requires us to provide the necessary support to meet the individual physical, spiritual, and psychosocial needs of each patient and family. This is no small mission especially as concerns of barriers in access to high-quality care continue to engulf our healthcare system, and specific to hospices, we find underserved communities are often most impacted. Patients and their families often associated with underserved communities and underutilizing hospice care include, for instance but not limited to, racial and ethnic minorities, diverse religions populations, members of the LGBTQ+ community, patients living in rural areas, and individuals experiencing economic insecurity.

Several factors do impact the existing disparities regarding hospice utilization by members of underserved communities. Experience tells us that lack of awareness or understanding of hospice, culturally-based apprehension regarding cessation of curative treatment, and even a refusal to acknowledge the dying process contribute to the gaps in utilization. It's important to identify and act upon the additional factors that are preventing many from benefiting from a higher quality end-of-life experience and the accompanying bereavement support.

As providers, we are positioned to improve access by shifting our often long-held organizational beliefs – if not implicit biases. It is our responsibility to elevate and increase cultural sensitivity training for



**Be Present**  
**Respect**  
**Confidentiality**

**Assume**  
**Positive Intent**

**Speak**  
**Your Truth**  
**Suspend**  
**Judgement**

**Make Room**  
**For All Voices**  
**Expect & Accept**  
**Non-Closure**

those who impact the patient experience, while also increasing education and awareness to better understand cultural implications of every community we serve. Asking the right questions and acting with intention will address areas such as understanding family dynamics, the patient's previous healthcare experiences, and traditions and health beliefs.

One example of asking the right questions when meeting with a new hospice patient would be, "Are there any previous experiences with healthcare providers that weigh upon you? Positively or negatively?" This simple question can open the door that leads to an insightful dialogue with the patient and/or their family. By understanding what their personal feelings are regarding previous engagement with their providers, it positions us to incorporate the positive behaviors into the patient's plan-of-care and avoids the negative behaviors, thus ensuring that the patient feels that their needs are valued and taken into consideration beyond what's traditionally in their medical records.

Sadly, there are often too many people who are in pain and dying alone without the support that hospice and palliative care can offer. There are opportunities for us all to do better at collaborating with our teams to address the needs of our patients. Empowering our patients and communities through targeted marketing and outreach will help those who underutilize the Medicare hospice benefit to make informed decisions about their care when facing a prognosis of six months or less to live. Engaging the community before these decisions need to be made and when they're not in a state of crisis, also positions individuals and their families to proactively consider what is best for them.

To provide the highest quality care possible, we must meet our patients and their families where they are, with a respectful understanding of the background and traditions of those we are serving. Efforts need to be continued to market to specific segments and further engage with community-based organizations, faith-based groups, and other entities that can not only stimulate the establishment of hospice and palliative care programs in healthcare settings in their communities but can also provide support for dying people and their families.

Matters of diversity, equity, and inclusion are significant topics of many news stories and research in our industry. For instance a [2021 Industry Trends Report by Axxess](#) showed that more than 70% of home-based care organizations indicated that they would increase resources in 2021 for staff diversity, equity and inclusion, with 91% of respondents from larger organizations indicating that they are focused on the issue and addressing it. Accepting the impact this makes on the patient care experience and acting to ensure diversity, equity and inclusion should be top of mind and must be recognized as a best practice throughout the continuum of care.

.....

**Nicole McCann-Davis** serves as the Associate Vice President of Health Equity & Access at Seasons Hospice & Palliative Care-an AccentCare Company and is Chair of the NHPCO Diversity Advisory Council.



Earlier this year, NHPCO's Diversity Advisory Council released the LGBTQ+ Resource Guide. The topics covered include LGBTQ+ healthcare disparities, serving LGBTQ+ patients in your community, and strategies for reaching out to LGBTQ+ communities. [Learn more on page 47.](#)



# NHPCO QUALITY CONNECTIONS PROGRAM.

If your organization has not made the commitment to ongoing quality improvement by registering for Quality Connections, do it today at

[nhpc.org/qualityconnections.](http://nhpc.org/qualityconnections)

Education



Application



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# Short Takes

## Hospices Earning Recognition in 2nd Quarter of NHPCO's Quality Connections Program

*NHPCO Congratulates Calvert Hospice, First Provider to Earn All Four Quality Connections Rings*

As the results from the 2nd quarter of the National Hospice and Palliative Care Organization's [Quality Connections](#) program were tabulated and released, NHPCO celebrates the QC participants who have earned rings at this point in the inaugural year of the program.

The four rings are based on foundational pillars: Education, Application, Measurement, and Innovation. Each Ring has specific activities incorporating practical resources to progressively track and improve both clinical and organizational quality.

"As Quality Connections was created over the course of the past year, the team at NHPCO was anxiously waiting to see how

our members would respond to the structure of the program and the focus on these four pillars. As we mark the second quarter of Quality Connections, we are pleased to see how engaged participating hospice organizations have been," said NHPCO President and CEO Edo Banach. "These hospice providers that have earned rings are proving that their commitment to quality is real and is part of their organizational culture."

"The commitment of our Quality Connections participants matters to those they serve and to the payers and other providers that they work with," Banach added.

NHPCO thanks the Quality Connections Gold Level Sponsors

Curitec and Optum Hospice Pharmacy Services as well as Silver Level Sponsor ADVault, Inc. for their support to advance continuous quality improvement.

### Honoring Calvert Hospice

Of the many hospice organizations participating in the program, particular recognition goes out to Calvert Hospice based in Prince Frederick, Maryland. Calvert Hospice is the first QC participant to earn all four rings in year number one of this innovative program.

"While many quality metrics are focused primarily on medical and nursing care, we found tremendous value in the true interdisciplinary nature of the Quality Connections program. Completing all four rings requires representation of the full scope of services that are necessary to provide high-quality hospice care, and we are grateful to NHPCO for developing this program with a focus on the variety of interdisciplinary expertise that contributes to being a quality hospice provider," said Calvert Hospice's Interim Executive Director Sarah Simmons, RN, MSN, CHPN.



...we found tremendous value in the true interdisciplinary nature of the Quality Connections program.

## Quarter 2 Achievements

As of June 30, 2021, the following organizations have earned rings.



### ✔ Earning Four Rings:

Calvert Hospice

### ✔ Earning Three Rings:

Heart's Way Hospice

### ✔ Earning Two Rings:

Bluegrass Care Navigators

BridgingLife Hospice

Caring Circle

Delaware Hospice, Inc.

Harbor Hospice

Hope Healthcare

Hospice & Community Care

Hospice of the Chesapeake

Hospice of West Tennessee

Lightways Hospice and Serious Illness Care, formerly Joliet Area Community Hospice

Notre Dame Hospice

Partners In Home Care-Hospice

Providence Hospice of Seattle

Serenity Hospice and Home

St. Croix Hospice

Suncoast Hospice

Tidewell Hospice, Inc.

Trellis Supportive Care

UnityPoint at Home

VITAS Healthcare

VNA Hospice and Palliative Care of Southern California

Yolo Hospice

### ✔ Earning One Ring:

Arizona Care Hospice

Arkansas Valley Hospice, Inc.

Avow Hospice

BSA Hospice of the Southwest

Carris Health-Rice Hospice

CentraCare Hospice

Community Hospice Care

East End Hospice

Freedom Hospice

Good Shepherd Hospice

Goodwin House Palliative Care and Hospice

HealthPartners Hospice & Palliative Care

HoriSun Hospice, Inc.

Hospice & Community Care

Hospice & Palliative Care Buffalo, Inc.

Hospice of Douglas County - A Division of Horizon Public Health

Hospice Of Dubuque

Hospice of Hilo dba Hawaii Care Choices

Hospice of Humboldt

Hospice of Huntington

Hospice of Jackson County, Inc.

Hospice of Limestone County

Hospice of North Idaho

Hospice of Southern West Virginia, Inc.

Hospice of the Ozarks

Hospice of the Panhandle

Hospice of the Red River Valley

Hospice of Yuma

Hospice Services Of NWKS

Interim Hospice of the Twin Cities

Intrepid USA Healthcare Services

Karen Ann Quinlan Hospice

Lakeside Hospice, Inc.

MJHS Hospice and Palliative Care Program

Northern Illinois Hospice

Pathways

Presbyterian Homes Hospice, Inc.

ProMedica Hospice

Providence St. Joseph Health - Home and Community Services

Sangre De Cristo Community Care

Seasons Hospice

Southwest Medical Hospice

Tabitha Hospice

The Elizabeth Hospice

Topkare Hospice, Inc.

Transitions LifeCare

Trustbridge, Inc.

Unity Point Hospice

UnityPoint Hospice, Cedar Rapids

Upland Hills Health Hospice

UVMHN Home Health & Hospice

Village Hospice

Visiting Nurse Association of NWI

VITAS Healthcare Chicago South

## Quality Connections Map

NHPCO has created a [Quality Connections map of the United States](#) that lists participating hospice programs who have made advances in the Quality Connections program to date.

## Join Quality Connections

It's not too late for your program to become a participant in Quality Connections! Quality Connections is a benefit of NHPCO provider membership. For organizations that already have an established quality improvement program, QC can build on and streamline what they already have in place. If a provider needs to enrich their quality improvement efforts, QC will provide the guidance and resources they need.



Check out your state to see which programs are earning their rings with Quality Connections.

## STAR Upgrades Complete

*STAR is a Powerful Tool Available to NHPKO Members at No Additional Cost*

The first major upgrade to the [Survey of Team Attitudes and Relationships](#) (STAR) performance measurement tool was completed earlier this year. Included as a benefit of membership, this staff satisfaction survey tool is used by hospice and palliative care leaders to “take the temperature” of their workforce in order to create the best possible work environment.

By utilizing the online STAR tool, program leaders will gather valuable data from staff to gain insight into staff satisfaction. Additionally, programs participating in STAR have access to the national-level STAR report that can be used to determine workforce trends. Recent upgrades to STAR include:

- **Survey questions** are updated to reflect a broader approach beyond just clinical staff.
- **STAR consists** of 13 core categories to gain valuable insight into your workforce: Collaboration, Communication, Company Leadership, Patient and Family Focus, Employee Engagement, Growth and Development, Inclusion, Job Enablement, Performance and Accountability, Alignment, Work Process, Demographics, and Compensation.
- **Six optional categories** have been added to help capture a more detailed understanding of your staff: Corporate Responsibilities and Ethics, Managing Change, Pay and Benefits, Safety, and Work-Life Balance.
- **The upgraded STAR** will offer dashboards for the data through Qualtrics, with multiple ways to splice the data making it a tool to help leadership focus on staff satisfaction.

Visit the NHPKO website at [nhpco.org/STAR](https://nhpco.org/STAR) to download the FAQs and learn more about STAR and begin participating to reap the benefits of STAR.



By utilizing the online STAR tool, program leaders will gather valuable data from staff to gain insight into staff satisfaction.

## 2021 Interdisciplinary Conference: Cost-Effective and Convenient

The IDC21 taking place September 20 – 22 is the virtual event for hospice & palliative care teams and individuals that offers a robust professional development experience that is cost-efficient and flexible.

Participants will enjoy inspiring and informative keynote presentations, educational sessions in eight different focus areas, presentation of the Volunteers are the Foundation of Hospice Awards, an online exhibit hall, and the opportunity to network with other conference participants via our new conference website portal and chat feature.

### IDC21 Educational Focus Areas

The eight content focus areas have been created by our conference planning committee and staff to reflect the most relevant issues facing providers today and highly requested topics from the community:

- Clinical Care
- Community-Based Palliative Care
- Emerging Issues
- Interdisciplinary Team Leadership
- Pediatrics
- Quality
- Regulatory
- Supportive Care

### CE/CME Access to December 31

IDC21 content is available on-demand through December 31, 2021, giving participants ample time to take advantage of the content – including time to earn CE/CME. Imagine having the opportunity to earn 60+ CE/CME from one conference. The IDC21 provides continuing education credit for Nurses and Physicians. A Certificate of Participation for Non-physician Healthcare Professionals is also available. Addition [information on CE/CME](#) is available online.



**IDC21...offers a robust professional development experience that is cost-efficient and flexible.**

**NHPCO's 2021 VIRTUAL INTERDISCIPLINARY CONFERENCE**

THE PREMIERE CONFERENCE FOR HOSPICE AND PALLIATIVE CARE TEAMS AND INDIVIDUALS.

Register at [nhpco.org/2021idc](https://nhpco.org/2021idc).

# Short Takes



As the world works to build back better from the pandemic shut down, NHPCO has retooled the hospice and palliative care community's premier educational offerings.

## Submit Your LAC22 Session Proposal

*Submission Deadline is September 24, 2021*

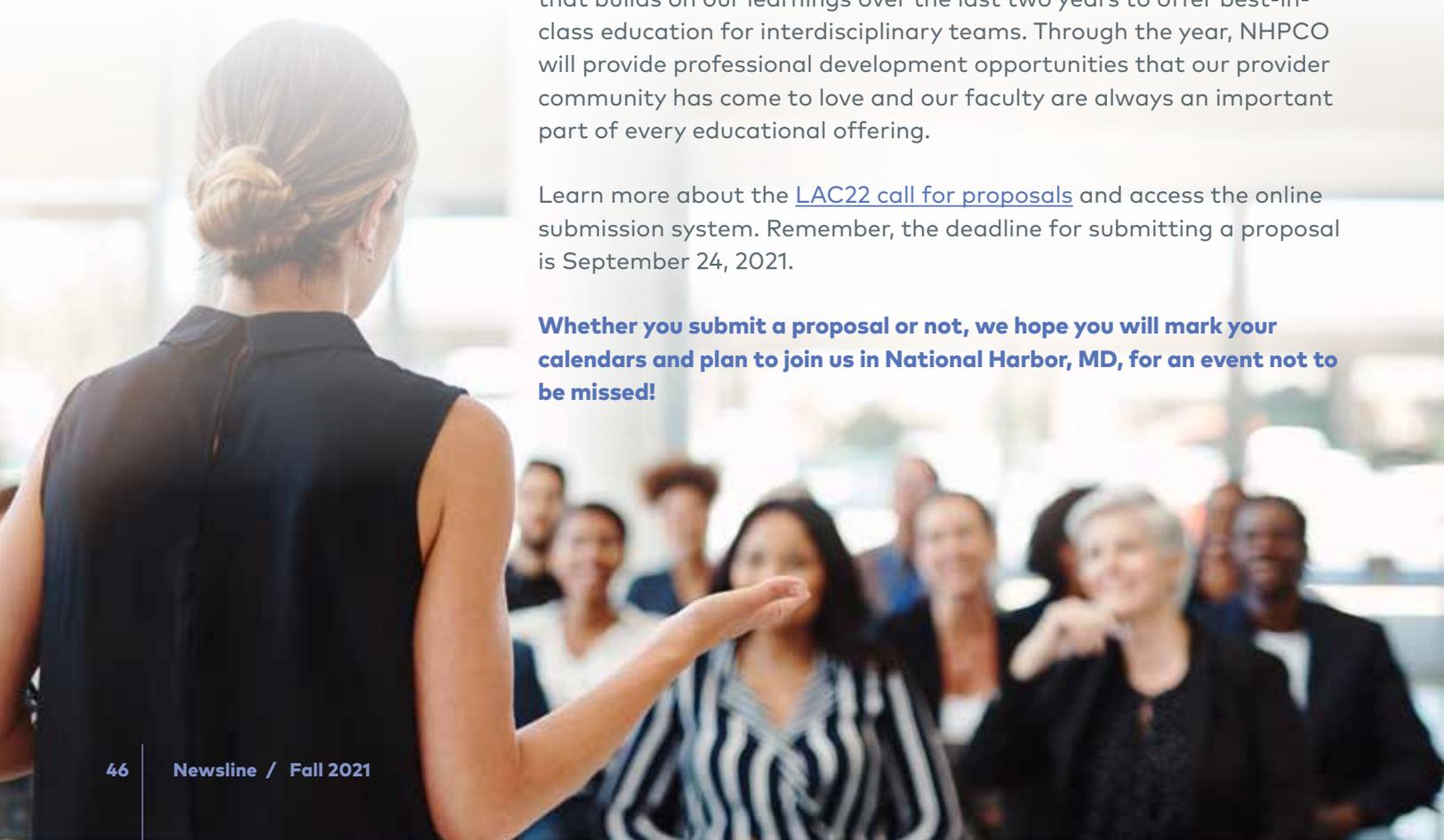
You could be among the esteemed faculty at [NHPCO's 2022 Leadership and Advocacy Conference](#), the premier conference for leaders and aspiring leaders working to advance the field of hospice and palliative care. The pandemic has kept us apart for so long—we look forward to gathering in person, March 7 – 9 for LAC22 at the Gaylord National Harbor Resort and Convention Center for the first time in two years (preconference seminars are March 5 and 6). To prepare for this momentous occasion, the planning committee has redesigned the conference program and is seeking interactive content focused on four distinct areas:

- **Managing** the Health Care of Individuals Living with Serious Illness
- **Transforming** the Health Care Delivery System
- **Navigating** a Post-Pandemic World
- **Building** Interdisciplinary Team Leadership

As the world works to build back better from the pandemic shut-down, NHPCO has retooled the hospice and palliative care community's premier educational offerings. Starting in 2022, we will offer one premier in-person gathering, with options for hybrid participation, which will be the LAC22. In the fall, we will offer a virtual conference that builds on our learnings over the last two years to offer best-in-class education for interdisciplinary teams. Through the year, NHPCO will provide professional development opportunities that our provider community has come to love and our faculty are always an important part of every educational offering.

Learn more about the [LAC22 call for proposals](#) and access the online submission system. Remember, the deadline for submitting a proposal is September 24, 2021.

**Whether you submit a proposal or not, we hope you will mark your calendars and plan to join us in National Harbor, MD, for an event not to be missed!**



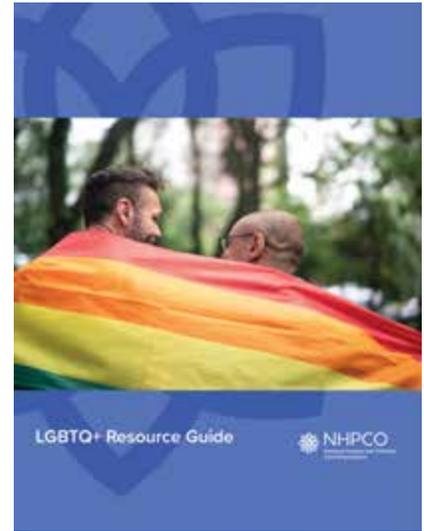
## New Resource Guide for LGBTQ+ Communities

In June 2021, NHPCO released a new resource for the hospice and palliative care community, [LGBTQ+ Resource Guide](#), with content developed by NHPCO's [Diversity Advisory Council](#) (DAC). Available free-of-charge, the guide was released in conjunction with a DAC social media day, where NHPCO's social media platforms were used to share information about disparities that exist in hospice and palliative care.

The topics covered in the resource guide include LGBTQ+ healthcare disparities, serving LGBTQ+ patients in your community, and strategies for reaching out to LGBTQ+ communities. The resource guide emphasizes the importance of open communication and allowing patients to self-identify who they are and who is important in their lives.

"That's what we really want to do when we're serving our patients, is to show that we respect them, we hear them, we see them just as they are," said Edie Moran, social worker with Prospero Health in Chicago and member of NHPCO's Diversity Advisory Council.

NHPCO thanks SAGE and Cambia Health Foundation Sojourns Scholar Carey Candrian, PhD for their contributions to the guide.



[Download the LGBTQ+ Resource Guide \(PDF\)](#). Additional free resource materials from NHPCO are available at [nhpco.org/diversity](https://nhpco.org/diversity).

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## Updates from We Honor Veterans

### Trauma-Informed Care Resources – New VA PTSD Tip Sheet

The VA National Center for PTSD has developed a “Caring for Veterans with PTSD at the End of Life” provider handout, offering straightforward guidance for community hospice staff to recognize trauma related symptoms. This is available on the [Trauma-Informed Care page](#) on the WHV website, which has additional resources and free trainings on providing care to Veterans. The page includes a report on the pilot Trauma-Informed Care for Veterans on Hospice Initiative, recordings of VA trainings covering PTSD, Suicidal Ideation, and Moral Injury, and much more. Providers are encouraged to utilize these resources in their care and stay tuned for an updated screening and interventions guide and webinars coming this Fall.

### Veterans Day Resources from WHV

Veterans Day is coming up on Thursday, November 11, 2021. We Honor Veterans has a wealth of resources for partners on the WHV website:

- [Outreach Packet](#) (includes resources for Veterans Day and throughout the year, including template press releases, letters to the editor, and more)
- [Virtual Pinning Ceremony Guide](#)
- [Veterans Day Social Media Graphics](#)
  - [Facebook](#)
  - [Twitter](#)
- [Social Media Guide for WHV Partners](#)
- [WHV Advocacy Toolkit](#) (Veterans Day can be a great opportunity to engage your federal, state and local representatives. For additional help, contact the Hospice Action Network at [info@nhpcohan.org](mailto:info@nhpcohan.org).)



Providers are encouraged to utilize these resources in their care and stay tuned for an updated screening and interventions guide and webinars coming this Fall.

# Caleb Tiller Joins NHPCO as Vice President of Marketing, Communications, and Membership

## Bringing a wealth of valuable experience

NHPCO has welcomed its new Vice President of Marketing, Communications, and Membership – Caleb Tiller. Tiller comes into the role with more than 20 years of communications, marketing, and membership experience. He spent nine years supporting trade and professional associations and 11 years serving mission-driven nonprofits working to advance global health, climate action, and other pressing international issues.

Prior to joining NHPCO, Tiller led the global communications and marketing function for EngenderHealth, an international organization working to advance gender equality and to improve sexual, reproductive, and maternal health outcomes. Previously, he served for eight years in leadership roles with the Communications & Public Affairs team of the United Nations Foundation, working on a variety of campaigns that built communities and expanded support for issues including malaria, polio, vaccines access, clean cooking, climate action, gender equality, and more. Before joining the UN Foundation, Tiller worked for a decade in leading travel industry organizations, including the Global Business Travel Association, the Airlines Reporting Corporation, and the American Society of Travel Agents, taking on roles of ever-increasing responsibility in the areas of member communications, marketing, and external affairs. In each of these roles, Tiller has provided communications support to steer organizations through major strategic transitions or periods of significant growth.

Tiller welcomed his new role by saying, "Joining NHPCO is an opportunity for me to work with an incredible staff and leadership team to support a community of organizations across the country who every single day make a difference in people's lives at the most critical times. Hospice and palliative care providers deserve the best possible support

organization to keep them updated on regulatory and industry changes, to advocate for their priorities, and to help them learn and grow. NHPCO is that organization. I'm excited to join the team, and I look forward to working alongside hospice and palliative professionals to ensure the community has everything it needs to continue focusing on helping patients, their families, and their communities."

Tiller is a graduate of the College of Wooster in Wooster, OH. Before starting his communications and marketing career, he worked for four years as a college tutor and high school teacher focused on literature and writing. His first exposure to the hospice movement was as a young child, helping prepare mailings, tending a memorial garden, and doing other important volunteer tasks for the hospice where his mother provided bereavement care. He lives in Washington, DC, with his wife, son and daughter (both teenagers), his father-in-law, and the family dog. His favorite activities include walking, jogging, and biking in Rock Creek Park and going to concerts.





# NHPCO

National Hospice and Palliative  
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