Certain questionable practices by hospices and nursing homes may violate health care fraud and abuse laws enforced by the Department of Health and Human Services, Office of the Inspector General (“OIG”). Chief among these laws are the federal antikickback statute and the civil monetary penalties statute (“CMP”). Hospices and nursing homes should be familiar with the types of practices that the OIG could consider to be violations of the anti-kickback statute and CMP, and ensure that their policies address these questionable practices. Although the focus of this article is on hospice relationships with nursing homes, hospices should remember that the same anti-kickback statute restrictions apply to any hospice referral source.

By way of introduction, we will briefly describe the anti-kickback statute and CMP.

**Anti-Kickback Statute**
The anti-kickback statute makes it a criminal offense for any entity or individual to knowingly offer, pay, solicit or receive any remuneration to induce or reward referrals of patients for items or services that might be payable by a federal health care program. Courts have held that if one purpose of a remuneration arrangement is to reward referrals, this could violate the anti-kickback statute.

**CMP**
One provision of CMP imposes civil penalties on any person or entity that knowingly offers or provides any form of remuneration to a Medicare or Medicaid beneficiary that the entity knows, or should know, is likely to influence the beneficiary to select a particular entity to provide items or services for which payment may be made by a federal health care program. The OIG will ask three questions when confronted with a potential violation under this provision of CMP:

- Has anything of value been offered by an entity to a Medicare or Medicaid beneficiary?
- Is the remuneration offered likely to influence a Medicare or Medicaid beneficiary in selecting a particular provider of items or services reimbursable by a federal health care program?
- Does the entity offering remuneration know (or should the entity know) that offering the remuneration is likely to influence the beneficiary to choose a particular provider of items or services?

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If the OIG answers each of these questions in the affirmative, it could find an arrangement to be in violation of CMP.

**Guidance from OIG**

Hospice and nursing home arrangements have been an ongoing subject of regulatory scrutiny because of perceived vulnerabilities under such arrangements. The OIG has issued several forms of guidance related to hospice and nursing home arrangements, including:

- March 1998 Special Fraud Alert for Fraud and Abuse in Nursing Home Arrangements with Hospices
- October 1999 OIG Compliance Program Guidance for Hospices
- March 2000 OIG Compliance Program Guidance for Nursing Facilities
- OIG Work Plans in 2007 and 2006

The OIG has stated that arrangements between hospices and nursing homes are vulnerable to fraud and abuse because nursing homes have control over the hospices permitted to provide hospice services to their residents. Therefore, nursing homes may request (or hospices may offer) illegal inducements to influence a nursing home’s decision to do business with a particular hospice.

With respect to CMP, the OIG released an August 2002 Special Advisory Bulletin informing providers and suppliers of the CMP rules that affect an entity’s ability to provide gifts or other inducements to Medicare or Medicaid beneficiaries. The bulletin details the prohibition against providing inducements to influence a Medicare or Medicaid beneficiary’s selection of a particular provider or supplier, and includes information on exceptions to this general prohibition. One exception allows providers to offer gifts (other than cash or cash equivalents) or services that are valued at not more than $10 per patient individually, and not more than $50 in the aggregate annually per patient. Other exceptions include waivers of cost-sharing amounts based on financial need, copayment differentials in health plans, incentives to promote the delivery of certain preventative care services, and practices permitted under the anti-kickback statute.

The following are short responses to some questions that we have received regarding fraud and abuse considerations in nursing home arrangements with hospices, and in provider gifts to Medicare or Medicaid beneficiaries. We would like to emphasize that in discussing these arrangements, we are not addressing a hospice’s ability to provide charity care to its patients. Of course, as part of its mission, a hospice may provide medically necessary care at reduced rates to a person who cannot afford such care. Typically, we recommend that such care is provided on a sliding scale and in accordance with a hospice charity care policy that is consistently applied to all patients regardless of their referral source.

1. Can a nursing home violate the anti-kickback statute by requesting something of value from a hospice in exchange for referring patients to the hospice or for contracting with the hospice? Similarly, can a hospice violate the anti-kickback statute by offering something of value to a nursing home in exchange for patient referrals?

Yes. The anti-kickback statute covers both sides of a remuneration arrangement – the party offering or paying the remuneration and the party soliciting or receiving the remuneration. Therefore, if a nursing home knowingly solicits or receives anything of value from a hospice, or if a hospice offers or pays something of value to a nursing home, in exchange for referring patients to the hospice for services that are payable by Medicare or Medicaid, this would violate the anti-kickback statute.

2. How does the OIG define “remuneration”? If a nursing home solicits a free service or item from the hospice (instead of cash) in exchange for patient referrals, could that still violate the anti-kickback statute?

Yes. “Remuneration” includes not only cash or cash equivalents, but also free goods or services, or goods or services provided at below fair market value. Therefore, if a hospice provides staff to the nursing home at the hospice’s expense (or if a nursing home solicits such staff from the hospice) to perform duties that otherwise would be performed by the nursing home, this could violate the anti-kickback statute. Similarly, if a nursing home requests that the hospice automatically provide items, such as low air loss mattresses or Geri-Chairs, for hospice patients who are nursing home residents in order to serve patients within...
their facility, this could violate the anti-kickback statute. Hospices must provide these items to hospice patients if determined necessary as part of a patient’s individualized plan of care, but these items should not be provided automatically as a matter of course. Needless to say, if the hospice provides such items for free or for below market value to nursing home residents who are not hospice patients, this could also violate the anti-kickback statute.

3. Our hospice would like to pay for all of a potential hospice patient’s medications (including those unrelated to the patient’s terminal illness) by using funds from our hospice’s foundation. Is this OK under CMP?

In answering this question, we are cognizant of the fact that it is sometimes very difficult to ascertain whether medications are truly unrelated to the terminal illness. A hospice may take a liberal and consistent view for all patients, regardless of referral source, regarding which medications are related to and necessary for the palliation of the terminal illness. However, a hospice arrangement in which it (or its foundation) pays for all patient medications, even those clearly unrelated to the patient’s terminal illness, could violate CMP.

When reviewing this type of arrangement under CMP, the OIG would consider three questions. The first question is whether paying for a patient’s medications unrelated to a hospice patient’s terminal illness would constitute remuneration paid to the beneficiary who receives the drugs. Because the value of these medications could be considerable, the answer to this question is likely yes. A second question is whether the remuneration provided to the beneficiary is likely to influence the beneficiary to choose a particular hospice to provide hospice services. Again, the answer is likely yes, because the beneficiary could reasonably choose the hospice solely because of the value of the free medications provided by the hospice’s foundation. Finally, the OIG must determine whether the hospice foundation knows, or should know, that offering this remuneration is likely to influence the beneficiary’s choice in hospice providers. Again, the answer to this question is yes, because the beneficiary is likely to connect the hospice’s foundation to the hospice, and the presence of these free medications is likely to influence the beneficiary to choose the hospice for his or her hospice care. Therefore, this practice could violate CMP, and should be closely analyzed to determine whether it could fit within an exception to the law. Remember that it does not matter whether the remuneration comes from a hospice’s foundation or the hospice directly. The analysis is simply whether remuneration provided to a beneficiary is likely to influence that beneficiary’s choice of hospices.

In addition, if a hospice would target only nursing home patients under such an arrangement, this could lead to criminal penalties under the anti-kickback statute, because this action could be viewed as an inducement to the nursing home to refer patients to the hospice.

4. Our hospice informs patients that they can receive a set number of days of inpatient care in our inpatient unit, without charge to the patients. If a patient is not clinically appropriate for general inpatient care, our hospice foundation pays the difference between the standard rate for inpatient care and our rates for inpatient care. Could this violate CMP or the anti-kickback statute?

Yes, this practice could potentially violate both statutes. With respect to CMP, the OIG could affirmatively answer the three key questions in a potential CMP violation: (1) does paying the difference between routine home care and the standard rate for inpatient care constitute remuneration; (2) are these payments likely to influence a beneficiary’s choice of the hospice to provide services; and (3) should the hospice foundation know that offering this remuneration is likely to influence the beneficiary’s choice of hospice providers? Therefore, this practice could violate CMP, and should be closely analyzed to determine whether it could fit within an exception to the law.

With respect to anti-kickback, if the inpatient care is provided to patients in a facility other than the hospice’s own inpatient facility, there is a potential anti-kickback violation. If a hospice is promising (or a nursing home or hospital is requesting) that patients will be treated at the general inpatient level of care, this could be viewed as remuneration in exchange for future referrals. A hospice patient receiving general inpatient care in a nursing home or hospital facility will bring the facility more revenue under the contract with the hospice, and could serve to fill otherwise empty beds in the facility. Therefore, this practice could violate the anti-kickback statute.

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The Clinician’s Corner ...

Nurses Praise Critical-Care Pain Observation Tool As A Valuable Pain Scale

Nurses evaluated the feasibility and clinical usefulness of the Critical-Care Pain Observation Tool to assess pain in patients receiving mechanical ventilation and found that nurses liked the tool, with 90% of them saying that directions about its use were clear, that it was simple to understand, and it was easy to complete. More than 70% of the nurses testing it said that the tool was helpful for nursing practice and suggested its regular use. The tool provided the nurses with a common language and way to evaluate patients’ pain. [link]

Intervention Increased Hospice Services For Elderly Dialysis Patients

Tufts University researchers found that reaching out to end-stage renal failure patients with a poor prognosis and familiarity among hospice and hemodialysis staff led to greater hospice use among elderly patients with the disease, according to a study in Journal of Palliative Medicine. The team lead by Lewis M. Cohen, MD, at Tufts, enrolled 133 hemodialysis patients at five clinics and randomized them by clinic site to receive information about hospice, advance directives, and other end-of-life information or standard treatment. Hospice services at the intervention sites, especially among patients age 65 and older, increased. [link]

Curriculum In Spiritual Care for Palliative Care Professionals

Hillel Bodek, MSW, LCSW-R, BCD, who is Chairperson of the Committee on Palliative and End-of-Life Care of the New York State Society for Clinical Social Work, has created a curriculum on spiritual care which can be self-taught or used to teach others. The curriculum includes a guide to the curriculum, an article about Hillel’s ACE project (Advocating for Clinical Excellence Project - Transdisciplinary Palliative Care Education), a project funded by a major 5-year National Cancer Institute grant to the City of Hope Cancer Center, the consensus report on spirituality in palliative care, a PowerPoint presentation educational module with teaching points, along with a PDF version of the PowerPoint educational module, spirituality questionnaires for clergy and for healthcare professionals, and a pre-test and post-test with an answer key. The curriculum can be downloaded from Growth House without charge. [link]

Palliative Oxygen No Better Than Room Air For Relief of Dyspnea

An international study led by Amy P. Abernethy, MD, at Duke University Medical Center in North Carolina, and reported in The Lancet, compared the outcomes of palliative oxygen therapy delivered by nasal canula with room air for 239 patients with dyspnea at the end-of-life and found little difference in the relief of breathlessness. Quality of life and frequency of side effects were similar in the two cohorts. The authors concluded that since oxygen provided no additional symptomatic benefit compared to room air, other less burdensome strategies should be considered after a brief assessment of oxygen therapy. [link]

Use of Anticoagulation In Lung Cancer Patients Receiving Hospice Care

A retrospective study from the University of Texas M.D. Anderson Cancer Center in Houston, found that patients with lung cancer often receive anticoagulant therapy while enrolled in hospice. The team reviewed data from 16,896 hospice patients diagnosed with lung cancer and learned that one in 11 patients had been prescribed an anticoagulant, most commonly warfarin. Hospices in the Northeastern United States were more likely to prescribe low molecular weight heparin than in other parts of the country. Patients who were white, older, had three or more comorbidities, and had spent a longer time under hospice care were more likely to receive warfarin than low molecular weight heparin. [link]

Medical Societies Issue Tip Sheet For Prescribing Controlled Substances

The American Geriatrics Society, the American Medical Association, the American Academy of Family Physicians, the American Academy of Hospice and Palliative Medicine, and the American Medical Directors Association have developed a tip sheet for “Prescribing controlled substances in long-term care,” to help physicians and other prescribers meet Drug Enforcement Administration (DEA) regulations for prescribing these medications to residents. The societies created the tip sheet in response to recent enforcement actions by the DEA. Prescribers must write the order themselves on a prescription form that meets state requirements. The societies suggest that providers carry such a pad with.

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them, know the legal requirements and mandatory elements for ordering controlled substances, fax prescriptions to the provider pharmacy, and in emergency situations, when no fax or prescription pad is available, call the pharmacist directly. http://www.americangeriatrics.org/files/documents/tip_sheet_fly.pdf

Long-Acting Opioids Prescribed More By Pain Physicians Than Primary Care Practitioners

A recent study from Beth Israel Deaconess Medical Center reports that primary care practitioners (PCPs) treat “approximately 52% of chronic pain patients, pain physicians treat 2%, chiropractors treat 40%, and acupuncturists treat 7%.” Long-acting opioids such as methadone, anti-depressants or anticonvulsants are prescribed 50-100% more often by pain physicians than by PCPs. Twenty-nine percent of PCPs and 16% of pain physicians reported “prescribing opioids less often than they deem appropriate because of regulatory oversight concerns.” PCPs are less likely than others to be confident of their ability to manage musculoskeletal and neuropathic pain, and least likely to favor mandatory pain education for all PCPs. (Obesity, Fitness & Wellness Week, 8/28; Southern Medical Journal, 2010;103(8):738-47)

Heart Failure Patients Often Not Receiving Hospice or Opioids

Researchers from Brigham and Women’s Hospital and Harvard Medical School in Boston assessed the use of hospice, opiates, and acute care by heart failure and cancer patients at the end-of-life. Using Medicare data for 5,836 heart failure and 7,565 cancer patients, they determined that 20% of the heart failure patients and 51% of the cancer patients received a referral to hospice care, and 22% of the heart failure patients filled an opioid prescription within 60 days of dying, compared with 46% of the cancer patients. Use of hospital services within the last 30 days of life were higher in the heart failure cohort, and more heart failure patients died in the hospital than cancer patients, 39% compared with 21%. The team concluded that opportunities exist to improve hospice and opiate use among patients with heart failure. http://www.ahjonline.com/article/S0002-8703(10)00316-9/abstract

Employment Laws Vary on Use of Medical Marijuana

Although residents of Washington D.C. and fourteen states can legally use medical marijuana, employment laws and practices have not kept up with that trend. Only Rhode Island’s law offers any employment protection for students, tenants and employees. In Hawaii, one employee who used medical marijuana and whose employer, Home Depot, knew it, still lost his job when he tested positive for THC. A Wal-Mart employee in Michigan was also fired. His supervisors knew of his use of marijuana for inoperable brain and sinus cancer, but a required blood test after a knee injury came back positive, and he lost his job. One employment lawyer said, “The current state of affairs puts employers in a very difficult situation. But the reality is that there are no federal guidelines like there are when dealing with other types of prescription medications.” (The New York Times, 8/28, http://www.nytimes.com/2010/08/29/us/29marijuana.html)

Benton Hospice Service

Position Available: Executive Director

Benton Hospice Service is currently seeking a highly qualified individual who is committed to quality end-of-life care to fill our Executive Director position.

Scope of Position: The Executive Director is responsible for directing the development, coordination, and delivery of hospice services; for developing systems and standards for the delivery of services; for assuring the delivery of high quality patient care, including adherence to professional standards of care, licensing and regulatory requirements; and for effective and efficient use of resources.

For position description, application process, and more information about our hospice, please visit our website at http://www.bentonhospice.org or call 541-757-9616
This position closes Sept. 30, 2010

BHS is an independent, nonprofit organization certified by Medicare and accredited by the Oregon Hospice Association. We are located in the beautiful Willamette Valley in Corvallis, Oregon, a quiet university town regularly included in lists of "most livable cities."
Bereavement Debriefing Sessions for Healthcare Professionals

“Bereavement Debriefing Sessions: An Intervention to Support Health Care Professionals in Managing Their Grief After the Death of a Patient” appears in the July/August issue of Pediatric Nursing. Harriet Lane Compassionate Care, the pediatric palliative care program of Johns Hopkins Children’s Center, created a support program for their staff. One facet of that program is the bereavement debriefing session. Other parts of the program include “palliative care educational forums for information support, patient care conferences for clinical support, bereavement debriefing sessions for emotional support, and rituals of remembrance as opportunities for meaning-making.”

The bereavement debriefing sessions are always offered after a patient death. Staff members are not required to attend, and there are occasions when no one attends. The two main reasons offered for not attending are “we did not know the patient” or “the death was expected and everything went well.” There may be more than one session per patient if multiple services or units were involved in care.

Sessions are scheduled and invitations are issued by the bereavement coordinator, who also facilitates the discussions. The structure of the sessions borrows from the Critical Incident Stress Debriefing (CISD) sessions developed for trauma workers, but focuses on the emotional responses of the staff rather than any critical incident. Unlike CISD sessions, which are often held within hours of an incident, the bereavement debriefing sessions may occur as much as a week later, and are often held after the funeral.

The facilitator welcomes participants to the sessions, and participants answer “How were you involved in care for this patient/family?” as a way of introducing themselves. Then the circumstances of the death are reviewed. Questions such as “What was it like taking care of this patient?” and “What have you experienced since the death?” allow personnel to express both positive and negative emotions and experiences regarding the patient. Asking what participants have experienced since the death is an opening for discussing “emotional, behavioral and spiritual” responses.

The portion of the session devoted to “What will you remember most about this patient and family?” is “often the most emotionally vulnerable segment.” After memories are shared, the discussion shifts to coping strategies and a more “cognitive level.” The last question to be discussed is “What lessons did we learn from caring for this patient and family?”

Data on the sessions collected between 2002 and 2005 revealed strong interdisciplinary participation (54% nurses, 15% physicians, 8% child life specialists, 5% social workers, plus chaplains, allied health therapists, nutritionists, clerical associates, foreign language interpreters and even the librarian.)

Sessions were most often requested by the oncology service, and the most frequent reason cited was professional distress. The second most frequent reason was a sudden or unexpected death. Respondents said the most distressing aspects of care were the emotional impact of the death, witnessing the parents’ pain, sudden and unexpected deaths, and providing aggressive treatment while the patient was dying. The most satisfying aspects of care were “team collaboration, end-of-life care, and the relationship with the family.”

The evaluations of the sessions indicated that participants found them “helpful (98.4%), informative (97.8%), and meaningful (97.8%).” Many participants noted that it was helpful to see how other disciplines viewed the events.

The authors emphasize the importance of the role of the facilitator, saying, “It is important that the person leading the session has training in group process and grief and loss to recognize potential complications of grief or help foster healthy therapeutic relationships. If the facilitator can offer a quality of presence that creates a safe and trustworthy environment, the staff will have a level of comfort that allows them to participate fitly and honestly in vulnerable conversations.” Another key factor in the success of the groups is the support of nursing leadership. Both at Johns Hopkins and elsewhere the “provision of opportunities for nurses to share or reduce emotional distress have led to decreases in staff turnover.” (Pediatric Nursing, 2010,36(4):185-189, http://www.pediatricnursing.net/ce/2012/article36185189.pdf)
Disabilities and End-of-Life Planning

“Disability Perspectives on Health Care Planning and Decision-Making,” in the Journal of Palliative Medicine, is a review of the literature on the significance of disability on health care decision-making, advance care planning, and end-of-life care.” The authors paid particular attention to “assessing the life values or preferences of persons with intellectual disability with limited decisional capacity.”

Persons with disabilities have “similar experiences of stigma, isolation, rejection, and discrimination” which create a “minority … community whose unique concerns should be considered, addressed, and included in policy analyses of end-of-life decision-making and advance care planning.” But in spite of their needs for planning for serious illnesses in order to get good end-of-life care, “this community has often been overlooked in the extensive research, programs, and policies regarding advance care planning and end-of-life care. Following a history of societal abuse, neglect, and prejudice, it is necessary to ensure that people with disabilities participate in planning their care, services, and supports, as well as in societal dialogue about care near the end of life.”

One significant finding is that healthcare professions often hold negative attitudes toward people with disabilities, perhaps even more than the general public. “More specifically, health professionals significantly underestimate the quality of life of persons with disabilities compared with the actual assessments made by persons with disabilities themselves. … Such pessimistic professional views of life with disability are implicitly conveyed to patients and their families while they are in the midst of decision making about new disabilities … [and] are related to professionals’ views about whether or not to offer life-sustaining treatment options to persons with disabilities.” One commonly expressed concern is, “Doctors need to realize that I have a real life and it’s a valuable life.”

Another area for exploration is the difference in viewpoint of persons with and without disabilities regarding some life-supporting interventions. “People with no significant history of disability may clearly indicate in their advance directives preferences to forgo life-sustaining measures, such as ventilators or artificial feeding and hydration. However, for some people with disabilities, these interventions may represent routine care that supports everyday life.”

The authors cite a study which says that patients with intellectual disabilities “have historically been excluded from various spheres of decision-making about their lives, on the presumption that they are incapable of making informed decisions.” All those around such patients have “commonly assumed a protective stance toward people with intellectual disabilities, even when decision-specific capacity may have existed.”

Three reasons are given for questioning such a paternalistic approach. One, medical advances allow people with intellectual disabilities to live longer. Second, the cultural changes surrounding end-of-life care and medical decision making have “evolved from a paternalistic to an autonomy-based approach.” And third, providers and advocates have brought the concerns of those with intellectual disabilities to the table when discussing health care and advance planning. The authors recommend the 1996 guidelines issued by the Center for Practical Bioethics for facilitating “individual decision-making and more accurate professional assessments of decisional capacity.” The guidelines help assess “whether patients meet a minimum level of understanding (for example, nature of the health problem, treatment options, including nontreatment, and their consequences).”

Another useful document is the position statement on “Caring at the End of Life, issued by the American Association on Intellectual and Developmental Disabilities in 2005. It advocates discovering and honoring the treatment wishes of persons with intellectual disabilities through observing and interacting with individuals over time to understand what is important to them; encouraging expressions of preferences regarding end-of-life care ‘before situations requiring decision-making occur’; and for capable individuals, documenting preferences through ‘living vision statements, health care proxy instructions, and other indicators of one’s wishes.’”

In conclusion, the authors say, “Advance directives guiding care toward the end of life are irrelevant when one’s concern is the denial of care: unwanted interventions at the end of life are not the central issue (although individuals could specify in their directives a preference for continuing with aggressive, curative care). There is a need for more information on access to and quality of end-of-life care for people with disabilities, and how this may be different or the same from nondisabled individuals generally.

“In addition, for people with intellectual disability, there is a need to replace paternalistic attitudes and stereotypes about cognitive limitations with skilled, careful assessments of decisional capacity and abilities, strategies for assisted and shared decision-making and life-planning, and more thoughtful communication about medical options.” (Journal of Palliative Medicine. 2010.13(9), dx.doi.org/10.1089/jpm.2010.0159)
Public Policy Notes ...

Washington State Plans to Restrict Opioid Prescribing

An article in The New York Times reports that Washington may become the first state in the country to require that physicians refer pain patients, who need escalating doses of opioids, to a specialist for evaluation, if they are not improving. The state adopted voluntary guidelines three years ago, but the Times reports that a survey conducted last year indicated that many doctors are not following them. Therefore, the legislature has convened an expert panel of physicians, nurses, and regulators to draft proposed regulations that prescribers would be expected to follow. The new rules would not apply to prescriptions for patients with cancer pain or at the end-of-life. http://www.nytimes.com/2010/07/29/business/29pain.html?r=1&scp=1&sq=opioid&st=cse

New York Governor Signs New Law Requiring That Patients Be Offered End-of-Life Options

New York Governor David A. Paterson (D) recently signed a new law which will require patients to be offered information about “options for end-of-life care including hospice, aggressive pain management, palliative sedation, and other palliative care” at the time they are diagnosed with a terminal condition. Patients who do not want the information are not required to receive it, and those who lack the capacity to understand it will have it offered to a proxy or a family member. (New York Assembly Health Committee Press Release, 8/16; Crain’s Health Pulse, 8/17)

Some New York Doctors Support Bill, But Medical Society Opposes It

Many New York doctors support the new law that requires them to have conversations with patients with terminal illnesses about all treatment options, including end-of-life care. Dr. Mary Ellen King, geriatrician at Orange Regional Medical Center, says, “It is ingrained in our hearts and our minds that we can’t face death, that we shouldn’t talk about it,” she said. “It’s quite uncomfortable and it’s not easy, but not talking about it is not fair to the person facing their death. They are facing it, whether we are talking about it or not.” The Medical Society of the State of New York opposes the law. (Times Herald-Record, 9/15, http://www.recordonline.com/apps/pbcs.dll/article?AID=/20100915/HEALTH/9150316/-1/NEWS)

Ad Offensive Planned In Support of New Health Care Agenda

Supporters of the nation’s new healthcare law “plan to kick off a nationwide, multimillion-dollar ad offensive being organized in consultation with the White House and with funding from wealthy individual donors and groups sympathetic to the administration’s health agenda.” Consumer groups, patient associations and medical groups are also working to publicize the law’s benefits. According to the article, “The effort is designed to counter the aggressive Republican campaign to paint the health care bill as a symbol of all that’s wrong with Democratic-dominated Washington.” (The Kansas City Star, 8/26, http://www.kansascity.com/2010/08/26/2179135/supporters-of-health-care-law.html)

Budget Woes Plague Non-Profit Hospices

In Silicon Valley, nonprofit hospices are being “put through a slow death” by Medicare, one CEO says. Increased competition and “budget woes” may drive some hospices out of business, the article says. The article notes that all hospices face the same Medicare cuts, but for-profits tend to be larger and can achieve economies of scale not available to small non-profits. (Silicon Valley/San Jose Business Journal, 8/27, http://www.bizjournals.com/sanjose/stories/2010/08/30/story1.html)

FDA Announces REMS For Opioids On Schedule For 2011 Approval

Medscape Today reports that the FDA recently told Medscape Medical News that the risk evaluation and mitigation strategies (REMS) for opioids are on schedule for approval in 2011, and that roll-out and implementation will follow. The approval had originally been scheduled for this summer, but an advisory committee voted against the agency’s plan, resulting in reevaluation and delay. (Medscape Today, 8/13, http://www.medscape.com/viewarticle/726875)
This and That ...

College Uses Computerized Manikin To Teach End-Of-Life Care

North Dakota’s Medcenter One College of Nursing uses a computerized manikin to teach nursing students about end-of-life care. Nursing student Amanda Schmidt found the process helpful, because the students get experience in a safe setting. After the simulated death, oncology nurses talk with the students, answering questions and suggesting ways of dealing with issues such as physical symptoms and talking with families. (The Bismarck Tribune, 9/16, http://www.bismarcktribune.com/news/national/article_c142dc64-c145-11df-b629-001ccc4c03286.html)

Review Praises Intimate Death

Columnist Jesse Kornbluth’s review of Intimate Death, by Marie de Hennezel, says, “These 182 pages are loving and wise. Even more, they are thrilling…” In a personal interview with de Hennezel, Kornbluth writes, “What I really got: that her book helps me to learn to help others die and it helps others to help their loved ones move into position for their final passage. No wonder the readers of Intimate Death feel mostly... gratitude.” (The Huffington Post, 9/13, http://www.huffingtonpost.com/jesse-kornbluth/before-someone-you-love-d_b_714686.html)

No One Dies Alone Program Established

The No One Dies Alone program at Christiana Hospital in Delaware was established because a nurse practitioner had seen too many patients die alone, and the volunteer coordinator was still disappointed that she had not been present when her brother died. So nurse Shirley Brogley and manager Margarita Rodriguez-Duffy looked over the existing programs, and adapted the procedures from one in Oregon. Their program now has 25 volunteers who can be called at any time to sit with a dying patient at the end of life. (The News Journal, 8/17, http://www.delawareonline.com/article/20100817/LIFE/8170301)

NY Times Columnist Discusses End-of-Life Care

Jane E. Brody, The New York Times Personal Health columnist, recently discussed end-of-life treatment options, providing details regarding the New York State law that requires physicians to offer patients with terminal conditions information about their prognosis and care options, if they want to know them. The author also mentioned recent findings that lung cancer patients receiving palliative care lived longer than those receiving cancer treatment alone, and that clinicians need more education to increase their competency in palliative care. http://www.nytimes.com/2010/08/24/health/24brod.html?_r=4

Position Available

At Children’s Hospital & Research Center Oakland, the only independent children’s hospital in Northern California, we have an opportunity for a professional with your experience and expertise.

As the Pediatric Palliative Care Coordinator you will manager, oversee and coordinate the care and services of patients and their families who have been referred to the Pediatric Palliative Care Team. Other members of the team include physician, social worker, child life specialist, chaplain and administrative assistant, as the program develops. The nurse actively works in collaboration with the interdisciplinary team to deliver palliative care to patients and families. As a member of the Hospital’s interdisciplinary healthcare team, the Pediatric Palliative Care Coordinator assists the Hospital in creating an environment and attitude responsive to meeting patient and family needs through understanding psychological, socioeconomic, cultural, emotional and spiritual factors influencing health and illness.

POSITION REQUIREMENTS:

Minimum Education: Bachelor’s degree in nursing required, Master’s degree in Nursing or Healthcare-related profession required.

Required Licensure: Registered nurse with current California license required. Current certificate as a Nurse Practitioner in California preferred.

Minimum Experience: Two or more years Pediatric Palliative Care in hospital or home preferred. Experience in program development preferred. Demonstrated knowledge about home care, hospice, palliative care, advance directives, pain management, symptoms control and discharge planning preferred. Bilingual Spanish preferred.

We offer highly competitive salaries, comprehensive benefits and a wonderful environment for our employees.
VA & Hospice: Working Together

CHAPCA Regional Meetings & Workshops

These workshops are being made available through a generous grant from the Department of Veterans Affairs.

WORKSHOP DESCRIPTION: One in four dying Americans is a Veteran. California has one of the largest Veteran populations in our nation. This course will provide attendees with the knowledge and tools to assess the unique needs of Veterans. By recognizing their needs and effective ways to meet those needs, you will be better prepared to improve the quality of end of life care for Veterans and their families.

FACULTY: Ann Hablitzel, RN, BSN, MBA, Executive Director, Hospice Care of California and a local representative from the Department of Veterans Affairs in each region.

CONTINUING EDUCATION: This program has been approved for two (2.0) BRN contact hours; and two (2.0) Social Work contact hours.

MEETING DATES & LOCATIONS:

October 12, 2010 - Modesto - Region 3
11:00 a.m. to 1:00 p.m.; lunch is provided
Alexander Cohen Hospice House
2201 Euclid Avenue, Hughson, CA

October 19, 2010 - San Diego - Region 8
10:00 a.m. to 12:00 p.m.
Chamber of Commerce, 720 N. Broadway, Escondido, CA

October 20, 2010 - Orange County - Region 6
1:00 p.m. to 3:00 p.m.
Location to be determined

October 21, 2010 - San Bernardino - Region 7
10:00 a.m. to 12:00 p.m.
Vitas Healthcare, 1845 Business Center Dr., Suite 120
San Bernardino, CA

October 26, 2010 - Redding - Region 2
10:00 a.m. to 12:00 p.m. VA/12:00 p.m. to 1:00 p.m. Meeting
Mercy Hospice Redding, 1544 Market Street, Redding, CA

Meeting for Region 5 will be held December 10; Meeting for Region 9 will be held in November

ATTENDEE INFORMATION

Please let us know who is planning to attend the workshop:

Last Name, First Name
Title
Organization
Mailing address
City, State, Zip
Phone
Email
License # and Type of License Requested for Continuing Education

Please Sign Me Up For:

☐ Tuesday, October 12 - Modesto
☐ Tuesday, October 19 - San Diego
☐ Wednesday, October 20 - Orange County
☐ Thursday, October 21 - San Bernardino
☐ Tuesday, October 26 - Redding
☐ November - Sacramento Area
☐ Friday, December 10 - San Jose Area

There is no fee to attend these workshops, just a great opportunity to meet with the local Veterans Administration representative in your area and to network with your fellow hospice providers. Please RSVP so that coordinators for each location know how many to plan on. If you cannot attend the workshop in your region you are welcome to attend a nearby workshop that fits your schedule.

FAX: 916-925-3780 / Email: babramson@calhospice.org
Mail: 3841 No. Freeway Blvd., Suite 225,
Sacramento, CA 95834
Additional forms available at:
http://www.calhospice.org/included/docs/education/VA_Regional_Meetings.pdf
Questionable Practices

Continued from page 3

Finally, this practice could also violate the Medicare conditions of participation for hospice care, because each patient is to be treated at the appropriate level of care according to his or her individualized plan of care. To automatically place a patient in a higher level of care, regardless of the patient’s individualized plan of care is improper under Medicare hospice rules.

5. If a hospice offers a nursing home a predetermined number of aide hours for hospice patients residing in the nursing home, could this violate the anti-kickback statute?

As with all other services provided by a hospice to its patients, the frequency of hospice aide services must be determined by the interdisciplinary team as part of each hospice patient’s individualized care plan. Because of the individualized nature of hospice care, it is impossible for a hospice to credibly guarantee a nursing home a certain number of aide hours when contracting with the facility. A hospice making such a promise is exposing itself (and the nursing home) to scrutiny by the OIG and other government fraud and abuse investigators. If even one purpose of the hospice’s offer of a predetermined number of aide hours to the nursing home is to gain access to patients residing in the nursing home, or to secure referrals of hospice patients from the nursing home, this may violate the anti-kickback statute.

Conclusion

Hospices and nursing facilities should carefully analyze their relationships with one another, and any programs offering incentives or other remuneration to Medicare or Medicaid beneficiaries, to ensure that none of their practices could violate the antikickback statute or CMP.

References:


Amazing Fundraising

Here are more unusual and successful fundraising events and ideas, initiated both by and for hospice programs. Great ideas are always worth sharing.

Chill Out Days Benefit Hospice
The Grove House in Hertfordshire, England, will present a series of Chill Out days this year to raise money for the hospice. People went to the hospice on September 12, 2010, for facials, pedicures, massages, hair styling, and other pampering. Therapists from different salons in the area donate their time. And on October 17, 2010, attendees can receive massages, reiki, color therapy, Indian head massages, and other holistic therapies. [http://www.grove-house.org.uk/News-and-Events/Community/Chill-Out-Sunday--dates-throughout-the-year](http://www.grove-house.org.uk/News-and-Events/Community/Chill-Out-Sunday--dates-throughout-the-year)

Hounds for Hospice Event Raises Funds for Rainbow Kidz
More than 100 people and their dogs turned out for the first Hounds for Hospice Charity Dog Walk event. Funds raised benefited Hospice and Palliative Care of Iredell County in North Carolina’s Rainbow Kidz program, which provides services to young children and their families. The Ryan Newman Foundation co-sponsored the event, which attracted many fans of the NASCAR race car driver. Through the foundation, Newman created a program to supply meals for the animals of hospice patients. [http://www.ryanneormanfoundation.org/node/249](http://www.ryanneormanfoundation.org/node/249)

Losing Football Players Raise Money for Hospice
After a losing year, two football players from the Mudford Club in the United Kingdom decided to do something they could succeed at: raising money for St. Margaret’s Somerset Hospice in Somerset, U.K., as a way of saying thank you for care the agency provided to a friend of one of the players. The pair walked 30 miles from Weymouth to Yeovil, hoping to collect £500, but in the end raised £1,155.80. The hospice is a local charity dedicated to providing specialist palliative care, advice, support, and respite to patients and their families. [http://www.thisisthewestcountry.co.uk/news/8329906.Footballers_put_their_best_foot_forward_for_hospice/?ref=rss](http://www.thisisthewestcountry.co.uk/news/8329906.Footballers_put_their_best_foot_forward_for_hospice/?ref=rss)
Annual Conference Exhibitors

ACHC, Inc. (Accreditation Commission for Health Care, Inc.) - Booth #: 206
You have another choice for Hospice Deemed status accreditation. ACHC takes a multidisciplinary approach to hospice accreditation that includes the social and nursing components.

American Hospice Equipment Company, Inc. - Booth #: 406
We provide DME exclusively to hospices. No other customers, no part B, only hospice DME.

Bellevue Healthcare Orange County - Booth #: 208
Bellevue Health Care is a home medical supply and respiratory company located in Santa Ana, California specializing in hospice since 2000. We are Joint Commission accredited.

Broda Seating - Booth #: 401
Broda Seating manufactures tilt and recline chairs for long-term care that improve quality of life. They provide comfort and aid in pain management.

C3 - Booth #: 201
Our aim is to raise awareness of new solutions as well as to improve the level of care for hospice and palliative care patients.

California Hospice & Palliative Care Association & California Hospice Foundation - Booth #: 421 & 423
Information on the services provided by CHAPCA and CHF, including newsletters, upcoming professional educational programs, market report order forms, membership applications, and community education resources.

Deis Consulting - Booth #: 309
Clinical consulting for homecare and hospice agencies, regulations, compliance, QAPI, education and training.

Deyta - Booth #: 212
For over 15 years, Deyta has specialized in a “perception of care” survey system that helps improve the reputation and quality of an agency.

Greene Health Care, Inc. - Booth #: 408
A leading provider of web-based hospice software solutions, we collaborate with our clients to integrate technology into critical business functions in innovative and productive ways.

Hospice & Community Care Insurance Services (HCCIS) - Booth #: 202
Property and liability insurance for hospices and home health care agencies.

Hospice Pharmacia - Booth #: 214
Hospice Pharmacia, a market leader in comprehensive pharmacy services for hospice, provides expert clinical consultation, medication distribution services and drug profile review documentation for hospices nationally.

HospiScript Services, LLC - Booth #: 415
HospiScript is a leading pharmaceutical services company working exclusively with hospices and dedicated to improving patient care and reducing pharmacy costs.

IIAM (International Institute for the Advancement of Medicine) - Booth #: 407
Taking care of families with legacy of 25 years in doing body donation program for medical research and training.

The Institute for Palliative Medicine at San Diego Hospice - Booth #: 316
Get access to the free Palliative Medicine Resource hotline: Pal-Med Connect 1-877-PAL-MED4; www.palmedconnect.org and check out our pocket-sized palliative care educational products.

MasterCare Services, Inc. - Booth #: 416
Complete administrative and billing software for hospice agencies for Medicare, Medi-CAL, Medicaid and private insurance.

MedCure - Booth #: 400
MedCure serves as a bridge for persons to donate their body in support of medical research and education at no cost; cremation included.

Medline Industries - Booth #: 409
Medline is the nation’s largest privately held manufacturer and distributor of medical supplies. Our programs and technology help hospice agencies focus on their patients.

Mumms® Software - Booth #: 312
Mumms® Software is a multi-user medical management system that offers complete clinical and business software to the hospice and palliative care community. Developed in 1989, the Mumms® EHR System is the most innovative in the industry.

Origins Pharmacy Solutions - Booth #: 215
Origins provides pharmaceutical expense management services, convenient formulary options, online administration and streamlined statements and reports for more efficient processing of information.

Outcome Resources, LLC - Booth #: 301
Outcome Resources is committed to increasing patient care while decreasing costs through clinical consulting managing pharmacy contracts and drug efficiency analysis.

Palliative Drug Care/PDC Rx - Booth #: 313
Palliative Drug Care enables hospices nationwide to achieve the lowest pharmacy costs with local dispensing, custom delivery options, clinical excellence and free CoP solutions.

ProCare HospiceCare - Booth #: 403
ProCare HospiceCare specializes in customized pharmacy technology services that will enhance your hospice program, reduce your pharmacy spend while allowing you to maintain your current providers.

Sacred Vigil Press - Booth #: 402
Sacred Vigil Press (SVP) offers booklets to support the hospice patient and their caregiver through all aspects of the dying process with information about symptom management, emotional, spiritual and social needs and issues.

Science Care - Booth #: 204
Science Care is the leading whole body donation program for medical research and education. our no-cost, accredited program is available nationwide. Visit www.sciencecare.com for information.

Southwest Technologies - Booth #: 303
Southwest Technologies, Inc. offers innovative technologies (glycerine-based gel sheets, highly absorbent fillers and our new addition of collagen) for simple wound management solutions. Call 1-800-247-9951 or visit our Web site: www.elastogel.com.

StateServ - Booth #: 413
StateServ provides best in class durable medical equipment management services to hospices across the United States.

Suncoast Solutions - Booth #: 200
Suncoast Solutions offers innovative hospice, end-of-life and home care software. Capabilities include comprehensive interdisciplinary clinical point-of-care, outcome measurement, client data management, scheduling, billing and receivables management.

Synergy - Booth #: 317
A pharmacy benefits administrator dedicated to hospice medication management and providing first calls customer service so you can focus on what matters most, your patients.

Vitas Innovative Hospice Care - Booth #: 307
Vitas Innovative Hospice Care employs professionals who care for terminally ill patients daily, in patients’ homes, inpatient hospice units as well as in hospitals, nursing homes and assisted living facilities.
Hospice Education - Aide Resource Teleconferences

The California Hospice & Palliative Care Association, in partnership with the Association for Home & Hospice Care of North Carolina, with the support of Poyner Spruill, LLP, is proud to present this teleconference series for your valuable team members - the hospice aides. Each teleconference is an hour in length and will cover topics as diverse as pain management and palliative care, cultural differences regarding end of life and empowering patients and their families. Hospice Volunteers may also find the teleconferences useful. For one fee, unlimited participation is allowed from each individual site.

♥ Pain & Symptom Management – October 12, 2010
This presentation will discuss the issue of pain and symptom management of the hospice patient. Pain management is an essential part of hospice care. We will discuss the role of the Hospice Nurse Aide in this management. We will also discuss some of the other more common symptoms that the Nurse Aide may be confronted with when caring for the hospice patient. Interventions that may prevent symptoms will be discussed.

♥ Documentation – November 9, 2010
We all know the age old saying, “If it’s not documented it is not done.” This presentation will focus on the answers to How, What, When, Why and Where of documentation. We will discuss how your documentation affects the entire organization’s performance.

♥ Non-Cancer Diagnoses – December 14, 2010
As you probably already know, the number of patients we see in hospice who have a diagnosis other than cancer continues to grow. In 2008, almost 62% of hospice patients had non-cancer diagnoses. We will discuss some of the more common of those diagnoses such as heart disease, dementia, neuromuscular disease as well as tips for caring for these patients.

♥ Communicating with the Dying Patient – January 11, 2011
Communicating with the dying patient can some times be difficult for the care provider. We may find it hard to talk about some of the issues that the patient may bring to your attention, since you do spend a great deal of one to one time with the hospice patient. This presentation will give guidance on communication in general but more specifically to the end-of –life discussion with patient and family that you may encounter during your workday with hospice patients.

The presenter for this series is Cindy R. Morgan, RN, MSN, COS-C. Cindy is a certified trainer in coaching supervision and has worked in various director level positions in Home Care and Hospice. Her background is in education and staff development. She has been a past Board member of the NC Center for Nursing and currently she serves on the NC Board of Nursing. Cindy is AHHC’s Associate Vice President of Innovations & Professional Development.
Hospice Education - Aide Resource Teleconferences – Select Your Choice Below

- Pain & Symptom Management – October 12, 2010
- Documentation – November 9, 2010
- Non-Cancer Diagnoses – December 14, 2010
- Communicating with the Dying Patient – January 11, 2011

Registration: CHAPCA Members: $95 per phone line per topic (unlimited participants at that site)
Non-Members: $190 per agency line per topic.

CD Alternative: If you prefer a CD rather than the live presentation, please indicate that below – the CD price is the same as your registration fee. If you want both you must pay two registration fees.

Enjoy the convenience and cost-efficiency of a teleconference workshop. There is no travel time involved and no limit to the number of attendees from your agency who may participate at your site through one phone line. All you need to participate is a speaker telephone and a room large enough for your staff. It is a controlled, radio-like environment where you will gather your staff, dial a toll free number, state your verbal password and you’re connected. Registrations must be received in writing and will not be accepted without payment.

The teleconference will take place from 12:00 p.m. until 1:00 p.m. PST. (3:00 p.m. EST) Each registration covers the access of only one phone line into the teleconference. Agencies must do a separate registration for each phone line requested. Registration confirmation will be emailed to you upon registration to the email address you provide. A detailed confirmation, including the toll-free dial-in number, sign-in sheet, the handout, evaluation, will be sent via e-mail approximately one week prior to the workshop.

CEU: HHAs, CNAs & RNs may report up to one (1) hour of continuing education credit for each workshop participated in. A $15 per person fee will be required for each CEU certificate requested.

Registrations will not be accepted without payment.  Select: ☐ Live Presentation ☐ CD

Agency Name: _____________________________________________________________
Contact Name: __________________________________ Phone: ________________________
Agency Address: _____________________________________________________________
E-mail Address (please print): _________________________________________________

Payment Information: Enclosed is my payment for $ ____________
☐ Visa  ☐ MasterCard  ☐ American Express  ☐ Check (payable to CHAPCA)

Card Number: _______________________________ Exp. ______ Sec. Code________
Name (as it appears on card): __________________________________________________________________________
Address (where credit card bill received): __________________________________________________________________
Signature (required): __________________________________________________________________________

Cancellation Policy: Refunds, less a $40 administrative fee, will be sent upon written notice of cancellation received two weeks prior to each scheduled workshop. No refunds will be given for cancellation requests received less than two (2) weeks prior to the scheduled session being cancelled, or for “no shows.” Please contact the CHAPCA office if you have changes to your registration.

Fax completed registrations to: (916) 925-3780
or mail with payment to:
CHAPCA, 3841 North Freeway Blvd., Suite #225, Sacramento, CA  95834.
More info: CHAPCA - (916) 925-3770 or babramson@calhospice.org
Organization Issues Guidelines for Evaluation of Suicidal Tendencies in Elderly Male Hospice Patients

Staff members at West Virginia’s Hospice Care recently reviewed the charts of five completed suicides among their patients in the last 10 years. All were elderly men (ages 64-78), retired, with a mean hospice stay of 50 days. All five were alone when they used a firearm to kill themselves. The article briefly summarizes each of the cases, then describes the organization’s recommendations.

According to the authors, none of these suicides were expected. They note that anywhere from one-third to four-fifths of all suicide attempts are impulsive. One cited study reported that less than 10 minutes passed from the thought of suicide to the actual attempt in nearly half the patients.

The article recommends “a need for heightened awareness of suicide risk in terminally ill men with a history of military service, especially as they reach a point in their illness when they are no longer able to care for themselves in their own home.” Other factors which may have played a role include “autonomy as a strong theme in the face of ongoing losses,” the opportunity to be alone, and access to a firearm.

The authors recommend establishing an annual staff education program on suicide prevention. Staff are also encouraged to:

* Develop a checklist for use in identifying patients at risk for suicide.
* Implement a protocol for following high-risk patients. Include inquiries about firearms in the home, “meticulous attention to symptoms,” “enhanced continuity of care by staff,” and possible consultation by a psychiatric nurse specialist.
* Identify a cleaning agency that can respond promptly to the site of a firearm suicide.
* Provide prompt and ongoing debriefing and support services to employees, and specifically tailored bereavement services to families.
* Establish “a baseline for completed suicides in hospice patients by national and/or regional tracking to include pertinent demographics, risk profile data, and mode of executing the act.” (Journal of Palliative Medicine, 2010,13(8):937-938. http://www.liebertonline.com/doi/pdf/10.1089/jpm.2010.0107)
Around the Association

Tracey Truscott is the new administrator for Silverado Hospice in San Diego. Tracey’s email address is ttruscott@silveradohospice.com. Bobbie Rosenblatt has become a member of the board of directors of Visiting Nurse and Hospice Care in Santa Barbara, CA.

San Diego Hospice Psychiatry Program Receives Recognition

A local television station highlighted San Diego Hospice’s psychiatric program, explaining how the program works to relieve patients’ anxieties, improve mood, and address their fears as they prepare to die and go about saying goodbye to loved ones. Staff psychiatrists may prescribe fast-acting medications to control anxiety and depression and teach relaxation and visualization techniques. The hospice also offers dignity therapy. [http://www.kpbs.org/news/2010/aug/19/san-diego-hospice-offers-psychiatric-care-ease-suf/](http://www.kpbs.org/news/2010/aug/19/san-diego-hospice-offers-psychiatric-care-ease-suf/)

Claremont Hospice Starts Ambassador Program

Janice Brown’s experiences when her mother was dying led her to start an ambassador program for The Visiting Nurses Association and Hospice of Southern California in Claremont.” The purpose of the program is to “help get the word out about end-of-life issues and hospice care,” and the ambassadors are mostly already volunteering with the hospice. They are asked to “simply keep an ear open and if they come across a situation where a person may be comfortable, then talk.” Informational meetings are held every three months, and ambassadors attend to answer questions that participants may have.” ([Inland Valley Daily Bulletin, 8/13](http://www.dailybulletin.com/news/ci_15768573))

Welcome New Professional Members

Elissa Marie DeWolfe, RNC, MN, ACHPN
Hospital Liaison/AIM
Sutter VNA & Hospice - Santa Rosa
6412 Meadow Creek Lane, Santa Rosa, CA 95409
PH: (707) 539-6187 / dewolfe@sutterhealth.org

Linda Earley, RN
4200 Manzanita Avenue, #34, Carmichael, CA 95608
PH: (916) 485-6874 / learley@calweb.com

Noune Geovorgian, CFO
MidValley Hospice
4737 Lankershim Blvd., Suite 206
North Hollywood, CA 91602
PH: (818) 506-1700 / midvalleyhospice@yahoo.com

Sharon Gray, RN
12400 Stardust Circle, Victorville, CA 92392
PH: (760) 954-4471
yesican63@gmail.com

Penelope Hunt, RN
Director of Professional Services
Heartland Hospice - Santa Rosa
2455 Bennett Valley Road, Suite 214-B, Santa Rosa, CA 95404
PH: (707) 523-0111 / 4686don@hcr-manorcare.com

Pamela Pagano, RN
Quality and Education Coordinator
Kaiser Permanente Hospice - Vallejo
1761 Broadway, Suite 101, Vallejo, CA 94589
PH: (707) 645-2192 / Pamela.J.Pagano@kp.org

Welcome New Associate Members

Deyta
7400 New LaGrange Road, Suite 200
Louisville, KY 40222
(502) 896-8438 / (888) 893-1937
www.deyta.com
Dianne Gray/ dgray@deyta.com

Anahid Satarian, CEO
MidValley Hospice
4737 Lankershim Blvd., Suite 206
North Hollywood, CA 91602
PH: (818) 506-1700 / midvalleyhospice@yahoo.com

New Members

Welcome New Provider Members

Heartland Hospice - Santa Clara
2005 De La Cruz Blvd., Suite 271
Santa Clara, CA 95050-1902
PH: (408) 450-7850 / FX: (408) 986-8282
Romelia Garcia, Administrator
4687admin@hcr-manorcare.com
The CHAPCA Market Report will give your hospice organization access to detailed, county-level and hospice data for your select service area based on the latest Medicare 100% Hospice Analytic file (claims data) from 2008 (the most current year available). Available for 2010, enhanced hospice patient data for Long Term Care Facilities, Home Health Agencies or Hospitals, for only $199.00 per setting when ordered with your 2010 Market Report. With the reports in hand, you will have the tools to compare your program to others in your service area including invaluable details on patients served, total patient days, & Medicare deaths for each hospice in selected counties, length of stay, diagnosis information, patient demographics, revenue per patient, and much more. Perfect for developing QAPI programs, marketing and strategic plans.

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- Comes complete with a prepared PowerPoint presentation CD
- Includes all data tables for your own internal research

NEW for 2010, enhance your report with hospice patient data for Long Term Care Facilities, Home Health Agencies or Hospitals for only $199 for each setting when ordered with your 2010 Market Report

2010 market report (2008 data) $699 OR SAVE with 3 year trend report ('06, '07, '08) $1,499

*Report examples available upon request

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California Counties:
- Alameda
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- Kings
- Lake
- Lassen
- Los Angeles
- Madera
- Marin
- Mariposa
- Mendocino
- Merced
- Modoc
- Mono
- Monterey
- Napa
- Nevada
- Orange
- Placer
- Plumas
- Sacramento
- San Benito
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Siskiyou
- Sonoma
- Stanislaus
- Tehama
- Trinity
- Tuolumne
- Ventura
- Yolo
- Yuba
- Shasta

Nevada Counties:
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- Churchill
- Clark
- Douglas
- Elko
- Esmeralda
- Eureka
- Humboldt
- Lander
- Lincoln
- Lyon
- Mineral
- Mono
- Nye
- Pershing
- Storey

Select report type

Enhanced market report data for 2008
- Long Term Care
- Home Health Agencies
- Hospitals $199 per setting (Must purchase market/trend report)

Your report data includes hospice utilization (Medicare hospice deaths/total Medicare deaths in each selected county), patients served and total patient days by each hospice in selected counties, Medicare reimbursement, diagnosis information, location of care, and much more. Enhanced market reports include total patients, total patient days, and mortality data by each provider type in selected counties.

PAYMENT INFORMATION
Advanced Payment Required - Available to CHAPCA members only - Limit 8 counties per report

Name __________________________________________________________________________________________
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Card Number________/______/______/______ Exp. ______/______ Billing Zip Code________________
Print name of cardholder __________________________________________________________________________
Authorized Signature ___________________________________________________________________________
September 24, 2010
Region 1 Meeting
12:00 noon to 3:00 p.m.
Walter Cafe’
920 North State Street, Ukiah, CA
Info: (415) 927-2273
Contact: Sandra Lew
slew@hospicebythebay.org

October 3, 2010
CHAPCA Board of Directors Meeting
1:30 p.m. to 5:00 p.m.
CHF Board of Trustees Meeting
630 p.m. to 9:30 p.m.
Caesars Palace Hotel, Las Vegas, NV
Info: (916) 925-3770
Contact: Susan Negreen
snegreen@calhospice.org

October 12, 2010
Pain & Symptom Management
Part of the Hospice Education - Aide Resource Teleconference Series
Presented by CHAPCA & AHHCNC
12:00 p.m. - 1:00 p.m.
Info: (916) 925-3770
Contact: Bonnie Abramson
babramson@calhospice.org

October 15, 2010
Region 5 Meeting
Special Guest: Donald Schumacher
Health Care Reform: What It Means for the Hospice Community
time tbd
Hospice of the Valley Conference Room, 4850 Union Avenue
San Jose, CA 95124
Info: (408) 559-5600
Contact: Sally Adelus
sadelus@hospicevalley.org

October 19, 2010
Region 8 Meeting - VA Workshop
10:00 a.m. to 12:00 p.m.
Chamber of Commerce
720 North Broadway, Escondido, CA
Info: (619) 667-1900
Contact: Suzi Johnson
suzi.johnson@sharp.com

October 20, 2010
Region 6 Meeting - VA Workshop
1:00 p.m. to 3:00 p.m.
Location tba
Info: (714) 577-9679
Contact: Ann Hablitzel
ahablitzel@hospicecareofca.org

October 21, 2010
Region 7 Meeting - VA Workshop
10:00 a.m. to 12:00 p.m.
Vitas Healthcare
1845 Business Center Dr., Suite 120
San Bernardino, CA
Info: (909) 386-6000
Contact: MaryBeth Wadding
MaryBeth.Wadding@vitas.com

October 26, 2010
Region 2 Meeting - VA Workshop
10:00 a.m. to 12:00 p.m. - VA
12:00 p.m. to 1:00 p.m. - Meeting
Mercy Hospice Redding
1544 Market Street, Redding, CA
Info: (530) 842-3160
Contact: Audrey Flower
aflower@madronehospice.org

November 6, 2010
Quality of Life Hospice Clinical Conference
Sponsored by Community Hospice
8:00 a.m. to 4:00 p.m.
Community Hospice,
Patient Services Center
4368 Spyres Way, Modesto, CA
Info: (209) 578-6345
Contact: Carlene Bettencourt
carlene.bettencourt@hospiceheart.org

November 9, 2010
Documentation
Part of the Hospice Education - Aide Resource Teleconference Series
Presented by CHAPCA & AHHCNC
12:00 p.m. - 1:00 p.m.
Info: (916) 925-3770
Contact: Bonnie Abramson
babramson@calhospice.org

December 12, 2010
Non-cancer Diagnoses
Part of the Hospice Education - Aide Resource Teleconference Series
Presented by CHAPCA & AHHCNC
12:00 p.m. - 1:00 p.m.
Info: (916) 925-3770
Contact: Bonnie Abramson
babramson@calhospice.org