Merrimack Valley Hospice

New Employee Orientation

History of Hospice

- 5th to15thC: Hospice was a way station for travelers and religious pilgrims
- Late 1800s: Nun in Dublin, Ireland donated her house as a special home for dying patients
- 1965: Dame Cicely Saunders became visiting faculty for Yale School of Nursing
- 1967: St. Christopher's Hospice, London opened by Dame Cicely Saunders
- 1969 *On Death & Dying* by Dr. Elisabeth Kubler-Ross published; contained 500 interviews with dying patients

History of Hospice

- 1972: Kubler-Ross testified at 1st national hearings on death & dying conducted by US Senate
- 1974: The Connecticut Hospice was established with funding for 3 yrs by NCI
- 1978-1980: NCI funded additional hospices
- 1979: HCFA initiated 26 demonstration programs to access hospice cost effectiveness & to determine what a hospice is and should provide

History of Hospice

- 1980: Kellogg Foundation gave JCAHO grant to investigate status of hospice & to develop standards for hospice accreditation
- 1982: Congress enacted funding for Medicare Hospice Benefit (MHB); set to expire in 1986
- 1986: MHB made permanent by Congress; states given option to include hospice in Medicaid

Hospice Industry

- 36 states include hospice in Medicaid programs
- 3,600 hospices in US
  - 53% non profit
- 2004:
  - 1.5 million received hospice care
  - $6.7 billion industry
- NHPCO
  - NHPCO.org
  - Emember (Provider ID: 1261)

Merrimack Valley Hospice

- Hospice of Greater Lawrence: 1973
- Merged with Andover VNA, name changed to MVH: 1984
- Andover VNA, MVH, & Haverhill VNA merged: 1995

Hospice Philosophy

- Death is part of life cycle
- Patient and family are unit of care
- Care takes place in the "home"
- Meet patient and family "where they are at" emotionally
- Respect choices of patient and family
- Do not hasten or postpone death

Hospice Goals of Care

- To provide quality of life
- To prevent symptoms
- To manage symptoms alleviating pain and discomfort
- To assist patient with life closure
- To assist patient & family with preparation & acceptance of impending death
- To provide bereavement services to family following the death

Hospice Team Model of Care

- Nurses
  - Case manager
  - Aggressively assess patient to prevent symptoms causing pain and discomfort
  - Symptom management
- Social workers
  - Provide emotional support
  - Assist in developing plans for patient
  - Assist IDT with info on family system & dynamics
- Chaplains
  - Spiritual support
  - Loss of self, despair, hopelessness
  - Not about organized religion or God
- Medical Directors
  - Consults with IDT
  - Makes home visits
  - Talks with physicians
  - Makes presentations to physicians
  - Remains current with medical care in hospice

Hospice Model of Care

- HHAs
  - Personal care
- Volunteers
- PT, OT, Speech

MVH Vision

- Top 10 hospices in US
- Cutting edge of hospice care including symptom management
- Service excellence
- Culture of performance improvement

Service Excellence

- Respect, courtesy, professionalism
- YOU are a *guest* in homes, nursing homes, hospitals – act accordingly
- Notify YOUR families when appointment time changes
- Report pt/family concerns to clinical manager
- Never discuss YOUR workload, performance expectations, meetings, etc. with families
- Families are impressed with YOUR expertise & your compassion – must have both!
- Our fundraising depends on the quality of service YOU deliver
- Never forget what our families are experiencing
- Remember: if YOU don't provide excellent care, our competition will!
- Good experience with MVH: Families will tell 5 people
  Bad experience with MVH: Families will tell 20 people
- YOU are representing the staff and MVH at all times – we are being judged by YOUR behavior and care