

Citizens Health Advisory Council Meeting Notes – February 10, 2012

Attending: Scott Wallace, Bob Juskevich, Jenny Wrenn, Jill Patton, Bill Warren, Bob Cox (physician, new to town, remote consulting), Missy Rodey, Emily Burns, Karen Zink, Terra Anderson, Kathleen McInnis, Erin Youngblood, Bridget Wagner, Dan Keuning (speaker), Pam Henkels (speaker), Eileen Wasserbach, Marsha Porter Norton, Suzanne Arms, Paula Dunne, Jaynee Fontecchio-Spradling (facilitator), Elizabeth Silverstein (meeting notes)

Jaynee welcomed the group, brief introductions were made and several CHAC business items discussed as follows.

Colorado Health Story-Joe Campe of Health Access Aurora will come to Durango to talk with people who have had experiences with the health care system (positive or negative). This service is offered for free as a part of their public will grant outreach. The stories gathered can be put on website, newspaper, and wherever else to help community members talk more about health care and the challenges in accessing the health care system right here at home. They will be in Durango on February 27 & 28, and need 7-8 people lined up to tell their story. Jaynee will set up a schedule. Please **contact Jaynee if you know of people willing to tell their story.**

Up to this time, CHAC has received few donations from group members. If you are a CHAC member and have not given in 2012 yet, please consider doing so today. Envelopes and donations forms were passed around; members can also donate on line at www.chaclaplata.org. There was a suggestion to spend some of the CHAC membership money on a community award for people who have gone above and beyond in helping with health care in La Plata County.

Jaynee introduced Pam Henkels, Director of Patient Services, *Alpine Hospice*.

Pam started by giving some of her background. She is an RN who has worked in Durango for 11 years. She helped set up Alpine Hospice in Durango that has been serving patients since August. One of the biggest challenges that she's seen is letting people know what services are available and how to access the services. Access is a huge problem. Patients don't understand the difference between home care, hospice and palliative care. How to choose where to go and who serves what area?

Alpine Hospice offers solely hospice care. It's been in Colorado, five years, and nationally for 20+ years. Alpine Hospice has 30,000 employees throughout the US.

What do people know and not know about hospice? 75% do not know the service can be at home. A lot of people don't realize that there's a choice. There were 1.58 million patients last year, of which 259 thousand were discharged alive. Hospice is not only a one-way path.

There are a large portion of folks that get better and get discharged. There is also confusion regarding hospice verses home health – you don't have to be homebound to be on hospice. You can be with grandkids and out and about, which is part of the goals and purposes for hospice. Not everybody dies on hospice. It's a lot like Florence Nightingale – doing what you went into nursing to do. Spend time with family and get to know the patient and their family.

90% of people do not realize that hospice is fully covered by Medicare. Hospice by Alpine is 100% covered. 41.95% of all patient deaths are on hospice care. This is up significantly.

Misconceptions about hospice:

- Hospice is a place
 - It is not. It's wherever the patient would like it to be (i.e. assisted living, nursing home)

- Hospice uses medications that can cause addiction
 - By the time patients are put on morphine, they have symptoms that require morphine to manage them
- Patients must die within 6 months if receiving hospice care
 - It really is if the disease were to take its natural course without intervention the person would die within 6 months-very different!
 - There are patients nationally on hospice 3-4 years. If they are not improving, they can remain on hospice.
- Hospice doesn't help younger patients or those without Medicare or money
 - There is a sliding scale fee to help all those in need
- There is not much difference between home health and hospice
 - There is a big difference. They are separate programs for distinctive reasons. There are some crossovers, but these are minimal. Hospice does not require that you stay in your home, hospice provides the management of symptoms.

Hospice's philosophy

Death is a natural part of the life cycle. Hospice offers nothing to hasten or slow down the death process. Hospice is there for support. Hospice helps patients to make a plan – what does death look like? How do you want it to happen? Tube fed? Antibiotics? Die at home? Hospice works actively with patient to write a patient controlled plan. Hospice is a guest. There are similarities between hospice and palliative care. Both want you to get out of the house, go fishing or to ball games. If you're well enough to go out, you're having quality of life. Home health is NOT palliative care. If a patient has a life-threatening illness, Medicare requires that the patient would only have 6 months left **if the disease were to take its natural course** in order to get hospice care. However, if a doctor is added, the disease's natural course is changed. Infections are caught. The regulation was not intended to mean that the patient must only have six months left to live in order to receive hospice care. The end points move, and Medicare is okay with the natural course being affected. Some of the biggest diseases that qualify patients are hospice are: Cancer, Alzheimer's, Dementia and Parkinson's. At times, old and dying does qualify for hospice. Other times, just being old does not qualify for hospice. She gave an example of a 90-something man who didn't need hospice, but his family was concerned and didn't want him driving. With hospice help, he lost the spark plugs in his car.

By the time a patient qualifies for hospice, they must be a number 7 on a set scale. They are not talking, barely walking and incontinent. However, families start needing help when the patient is a 3. It can take 5 or 6 years for a patient to go from a 3 to a 7, and until they qualify for hospice, they don't qualify for anything else. Families struggle.

Pam's wish for help from CHAC is to find something for the 3-7 group. There is a huge need that far exceeds the services we have. There are daycares that offer scholarships. But it's a lot for people without money. She doesn't know how many people in La Plata are in the 3-7 group, but it is a significant amount. There are approximately 1,000 people in the spectrum of Alzheimer's in La Plata.

Our Place is a day care run by the Methodist Church and survives on money from donations and charging a small fee. It is a good facility providing families with a much needed break.

Medicare coverage is independent of location yet access to hospice remains difficult. Anybody can make a referral to a hospice program. People who are qualified are 100% covered. The biggest key to the hospice program is accessing it early. Patient has a lot more control instead of going in and out of a hospital when this may not be their intended wish.

People who can't pay and who are undocumented are still able to access hospice. They're here and they shouldn't die alone.

Non-profit hospice gets paid exactly the same Medicaid that Alpine Hospice (a for-profit hospice) does, dollar for dollar. For profit pays taxes and non-profits don't. They can fundraise. The

classification depends on how the organization is managing funds. Alpine does offer some of what is essentially charity care but can't call it that. It can't write-off charges but chooses to provide the care. Alpine is an active member of the community and get away from "for or not for profit". Alpine wants to serve patients regardless of ability to pay or access to care. We see it as a real need and we want to be viewed as a member of community and want to be seen as actively involved and giving as much as possible in whatever shape or form.

There is no formal communication between the three hospice entities, but if there is a patient that can't be taken care of, they will work together to find the needed help.

What will help: education? The culture of death and end-of-life is changing in La Plata county.

Hospice is no longer the "h" word. It is now acceptable to talk about Palliative care and hospice.

There are 49% to 65% people dying on hospice. The complicated part is two business entities out in different areas and the local players are here in the same pool. Educate, give options and give the best care possible to patients, regardless of organization.

Erin Youngblood, the volunteer coordinator at Alpine, mentioned that Medicare has certain guidelines that are required. All agencies must provide volunteers, four levels of care for hospice. At end of day, we're all trying to reach the same goal: providing high quality care for end of life.

Jayne then introduced Dan Keuning, NP, stepping in for Michelle Appenzeller, Director of Mercy Home Care and Hospice. He provided an update on HOME-Hospice of Mercy Experience-Residential Hospice and Palliative Care. With palliative medicine, patients can be taken care of when they have symptom management or an illness that doesn't fall under the 6-month requirement for hospice. They are adding a nurse practitioner to the program to start in March because they now have 65 patients on home palliative care (in conjunction with other services). Dan would rather a patient sit at the kitchen table over a cup of coffee and make decisions instead of while people are hovering over them with tubes. It's a privilege to be in people's homes and helping them make these decisions.

The hospice residence will be on 1.33 acres on campus by hospital. Dan provided several posters of the facility passed around to members. There is a capital campaign to raise money for the 12-bed hospice residence. There is a specific need for those at end of life who cannot be at home and should not be at the hospital. It will be a hospice home but is also a medical facility. It will be a place of peace and comfort, having that peaceful setting at the end of life for families and patients to spend those last moments. There will be a room and board fee (\$140-\$160 to begin with, going up depending on facility to \$250/day). All insurances have a hospice benefit that patients fall into without the 6-month prognosis.

How many visits do the patients receive? Palliative care has a range of patients seen twice a week to once every other month, yet available if there is a sudden decline. Pain and symptom management can be difficult when adjusting meds and morphine – even for someone not terminal. They have been able to discharged 10 people from PC doing so well PC is no longer needed. If the patient requires a one-time visit, they are billed on time as if a visit to clinic. A patient can't be on PC and hospice. He may do a social visit but that time is not billable.

How do home health and palliative care intersect? Patients can get palliative care while getting home health. PC can tag team with a nurse. It depends on how the patient is doing. Once they're on hospice benefit, PC steps back. They might call for opinion, but falls on hospice or the primary physician. What PC is doing now is not bad, but PC can do better.

Possible speaker: Eileen Stumpo from Alzheimer's Association.

Does anyone do a program with retirees who have health backgrounds that can do respite in the home? Is that on the plate to think about? Yes, they do a lot of that, offering 2 hour breaks. More volunteers are always welcome. Alpine offers training. The volunteer team makes a huge impact on the family. They would love it have the program grow.

The Senior Center is hosting a free all-day training from 8:30 to 4:15 pm on the availability of senior care. The training is on March 28. **CHAC will send out more information as it is available.** This year, there will be a resource fair all day at the training. They are requiring people to be at their booth for interactive and free information. **Erin will send out more information.**

There were problems with the power point projector, so the review of the website will be done first at the next CHAC meeting. CHAC is considering a Facebook page and perhaps a blog on the home page of our website.

Announcements:

Health Alliance/CHAC Board-Bob will request a set time on HA agenda for capacity project updates and to continue to support HIE effort in community.

HIE-Scott announced that the interface agreement between QHN and COHRIO now contains data-sharing elements to assure the exchange of patient information throughout CO. This is good news!

Donated Care/Health Voucher-Jaynee announced that these groups are making some progress with a team now working with Manna Soup Kitchen on offering integrated care within their new multipurpose building-timeline this summer.

Other:

- Alpine is hosting a food drive for Manna on March 10th, Pam will send out more information
- The 9 Health Fair will happen on March 30 at the Senior Center and March 31 at Escalante. Carmen Ritz at Mercy is in charge of the day. Karen will send out more information when available. **They are in need of volunteers.**

Next meeting: March 9, 2012 Community College update-Nora Flucke

Future dates/ topics:

April 13, 2012- Integrated Health/Pediatric Health Care Homes (proposed)-Cecile Fraley, MD or Alzheimer's Association (proposed) - Elaine Stumpo

May 11, 2012 -Community Assessment report-results and plans -Emily Burns /Joe Theine

June 8, 2012- Long term sustainability progress update/discussion (proposed)-TBA or Beginning of Life Care-Suzanne Arms

July 13, 2012-Advocacy/Policy discussion (proposed)-Ellen Roberts