LAUGHTER IS THE BEST MEDICINE

Laura Maiberger, RN, CHPN; PIC Program Coordinator, Pensacola & Milton

We've all heard the old adage, "Laughter is the best medicine." And we all know laughter can make us feel better by lifting our spirits or cutting the tension in stressful situations. Until now, it has been something we felt with no empirical evidence. Dr. Michael Miller of the University of Maryland School of Medicine now has proof—laughter is truly good medicine.

Mental stress has been shown to constrict blood vessels, and therefore, reduce blood flow. Dr. Miller theorized that since laughter reduces mental stress it might also promote healthier arteries.

Twenty volunteers had their blood pressure, cholesterol, blood sugar levels and blood vessels monitored to ascertain the reaction to stress. The volunteers watched scenes from two movies, "Saving Private Ryan" and "Kingpin." The blood vessel reactivity of the volunteers after they watched the movie lasted a minimum of 30 to 45 minutes. After watching the movie clip that caused mental stress, 14 out of the 20 volunteers showed a reduction in the blood flow of their brachial arteries. Inversely, 19 of the 20 volunteers exhibited vasodilation or blood vessel relaxation after watching the laughter-inducing movie clips. On average, the blood flow of the group decreased 35 percent during the clips that produced mental stress and increased 22 percent with the humorous laughter-producing clips.

Per Dr. Miller, "… So, given the results of our study, it is conceivable that laughing may be important to maintain a health endothelium, and reduce the risk of cardiovascular disease. We don't recommend that you laugh and not exercise, but we do recommend that you try to laugh on a regular basis. Thirty minutes of exercise three times a week, and 15 minutes of laughter on a daily basis is probably good for the vascular system."

So take a few minutes and get your daily dose of laughter!

A bicycle can't stand alone because it is two-tired.
A backward poet writes inverse.
A chicken crossing the road is poultry in motion.
When a clock is hungry it goes back four seconds.
A boiled egg in the morning is hard to beat.
One good turn gets most of the blankets.
Change is inevitable, except from a vending machine.
Shin: A device for finding furniture in the dark.

FHA Annual Meeting and Trade Show
November 16-18, 2005

Hilton in the Walt Disney World Resort
Lake Buena Vista, Florida
For more information, go to www.fha.org or call 407.841.6230.

11TH HOUR VOLUNTEER PROGRAM:

Our Covenant, "No One Should Die Alone"

Sandi Huster, Volunteer Program Manager

Did you know Covenant Hospice has volunteers who are specially trained to be with patients who are nearing death? The 11th Hour Volunteer program provides compassionate care for patients whose death is imminent and who are without the supportive presence of loved ones. We know this program is especially important in facilities where some patients may not have relatives nearby. During those last days and hours, we believe that volunteers are in a unique position to enhance the support given by facility staff and other Covenant Hospice staff to provide bedside vigil, emotional and spiritual support to dying patients.

Eleventh Hour Volunteers complete an initial eight-hour Covenant Hospice volunteer training and an additional two-hour training module that prepares them to provide a supportive presence at the bedside of patients nearing death. Training topics include:

- *Description of the 11th Hour Volunteer Program*
- *The role of the 11th Hour Volunteer at the bedside of a dying patient*
- *Care and comfort measures*
- *Signs of approaching death and when death occurs*
- *Role of the 11th Hour Volunteer after the death*

The 11th Hour Volunteer Program is our final covenant to the patients and families that "no one should die alone." For facilities, this program enhances the compassionate care that staff provides to patients during the dying process. In the words of Dame Cicely Saunders, founder of hospice care, "How people die remains in the memories of those who live on." Our hope is that patients we serve will die in peace and comfort, with dignity and in the presence of a caring person. Eleventh Hour Volunteers bring these parting gifts to dying patients.

Please contact the Covenant Hospice office in your area to find out more about the 11th Hour Volunteer Program.

FAST FACTS

99%
On a 2004 survey, 99 percent of families reported that they were satisfied with the dignified care that Covenant Hospice provided for their loved one.

4,600
In 2004, Covenant Hospice provided supportive care to more than 4,600 patients — and many thousands more family members and loved ones.

PARTNERS IN CARE CONTACTS:

DEE LESLIE, RN, CHPN
Director, PIC Program

CHRISTINE MORRISON, MDIV
PIC External Education Coordinator

TERI HOWARD, RN, CHPN
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Daphne Office

DIANE DACOSTA, RN, CHPN
PIC Program Coordinator
Crestview & Niceville Offices

JAY THURMAN, BSW
PIC Program Coordinator
Marianna, Panama City & Tallahassee Offices

DONNA MCGEE, RN, BSN, MEd
PIC Program Coordinator
Dothan Office

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Andalusia, AL 36420
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CRESTVIEW
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Crestview, FL 32536
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COMMUNITY SUPPORT CENTERS:

ENTERPRISE
208 West Brunson Street
Enterprise, AL 36330
334-393-7571

ATMORE
611 East Laurel Street
Atmore, AL 36502
251-446-7617

CRESTVIEW
Crescent Park Medical Complex
370 West Redstone Drive
Crestview, FL 32536
850-682-3628

DESTIN
910 Airport Road
Suite A
Destin, FL 32541
850-654-9176

BREWTON
1023 Douglas Avenue
Suite 106
Brewton, AL 36426
251-867-6993

PERRY
2057 South Byron Butler Parkway
Suite 9
Perry, FL 32347
850-584-9886

JOYCE GOLDENBERG HOSPICE INPATIENT RESIDENCE:
10075 Hillview Road • Pensacola, FL 32514 • 850-484-3529

For more information about Covenant Hospice's Partners in Care Program, visit our website at www.covenanthospice.org/pic

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PARTNERS

A NEWSLETTER FOR FACILITIES FROM COVENANT HOSPICE • Spring 2005 • Vol. 4, No. 1

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11TH HOUR VOLUNTEER PROGRAM

AN ULTIMATE PLAN OF CARE

Donna McGee, RN, BSN, MEd; PIC Program Coordinator, South Central Alabama
Erica DaCosta, BA, MFA; Hospice Volunteer

In December 2004, Rex Henderson, a patient being served by the Dothan Covenant Staff, was found on the floor beside his bed in the Henry County Nursing Home in Abbeville, Alabama. The nurse who discovered him assumed he had fallen, but in fact he was on his knees in prayer. He was praying for his son, Philip, who was also under the care of Covenant Hospice, 150 miles away in Panama City. He was terrified that his son would die before he got a chance to see him again.

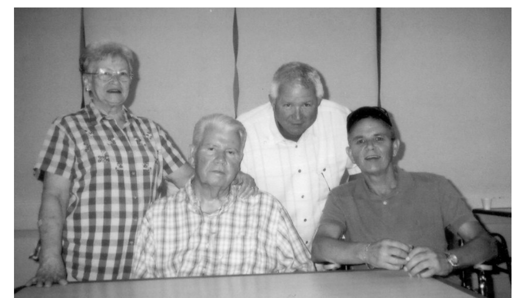
In January 2005, Rex Henderson attended his Henry County Nursing Home care plan meeting; he wanted to express his fear in person. Both patients were extremely ill, but the father, a retired minister, was more stable of the two and longed to see his son to say goodbye. Covenant team members, Renee White, RN Case Manager and Leslie Turner, Social Worker listened to Rex and understood that this need of his was paramount. The task of uniting them was going to be risky, difficult and would require a great deal of cooperation between the nursing home and various departments of Covenant Hospice, but Renee and Leslie knew that Rex's desire to see his son superceded all other considerations.

Although the patients' family was very supportive of efforts to unite their loved ones, the son was simply too ill to travel. So Leslie initiated plans to transport the father from Abbeville to his son's home in Florida, and the father's nursing home collaborated in the effort. The Dothan Interdisciplinary Team suggested that a nurse travel with the family to decrease their anxiety. Beth Peters, the RN Case Manager, had a personal connection to Rex since he had presided at her grandparent's funeral and at her mother's wedding to her stepfather, so she volunteered to accompany him.

Rex's daughter was anxious about taking the risk to drive her parents to Panama City due to the gravity of her father's condition. She saw him in his wheelchair with his head down and shoulders slumped and whispered in his ear. "Do you want to go see Philip?" she asked. "I surely do," he said, and she knew they were doing the right thing. The trip went smoothly, and they were met at Philip's home by Roger, another of Rex's sons, as well as Philip's daughter and Covenant's continuous care nurse Barbara Burch.

Both patients were quickly declining. When Roger wheeled Rex into the room, Philip was able to smile faintly and wink one teary eye before lapsing back into sleep. Roger placed his father's hand on Philip's hand and heard him whisper, "Come on, boy, let's go fishing." It was one of those beautiful, creative flowerings of the spirit we at hospice are sometimes blessed to witness. The love that flowed from father to son encompassed everyone in the room and felt like a rich and spontaneous gift.

Mrs. Henderson remained with Philip while Rex's son and daughter drove him back to the nursing facility. Beth Peters followed in her vehicle. When Rex returned to his own nursing facility, Covenant Chaplain John Withrock was waiting to have prayer of thanksgiving. In the hours following the farewell visit, both men lapsed into unconsciousness. Philip died January 24, 2005, and Rex died January 25, 2005, 17 hours after his son. The families expressed confidence that Rex and Philip are again united, fishing together where the water is calm and the fish are leaping.



Left to right: Doris, Rex, Roger and Philip Henderson.

MESSAGE FROM THE CEO

Dale O. Knee, President/CEO, Covenant Hospice

The Centers for Medicare and Medicaid Services (CMS) has long recognized the value of hospice care in the facility setting. In 2003, CMS issued a transmittal to that effect, and I have included it here for your perusal. I hope you find the information helpful, and as always, I thank you for truly being our Partners in Care.

The following article is quoted from, **"Hospice Care Enhances Dignity and Peace As Life Nears Its End,"** *CMS Transmittal AB-03-040.*

Much of the pain and sense of hopelessness that may accompany terminal illness can be eased by services specifically designed to address these needs. Hospice care, a fully reimbursable Medicare Part A benefits option for beneficiaries and providers since 1983, offers the services designed to address the physical and emotional pain through effective palliative treatment when cure is not possible. In the event that a beneficiary has been advised by his/her physician, that a cure for his/her illness is no longer possible, Medicare beneficiaries may discuss hospice care as an option. Physicians and other health care practitioners can be encouraged that the Medicare program includes a hospice benefit that provides coverage for a variety of services and products designed for those with terminal diagnoses. When properly certified and appropriately managed, hospice care is a supportive and valuable covered treatment option.

Physicians and health care providers in the community, skilled nursing facilities, and hospitals are urged to raise awareness among their patients about the hospice benefit and its availability. Further, a beneficiary may independently elect hospice care. The beneficiary may discuss this option in the event that he or she has a terminal diagnosis; however, in all such cases, a physician must certify that the beneficiary has a terminal diagnosis with a six month prognosis, if the illness runs its usual course.

Generally speaking, the hospice benefit is intended primarily for use by patients whose prognosis is terminal, with six months or less of life expectancy. The Medicare program recognizes that terminal illnesses do not have entirely predictable courses, therefore, the benefit is available for extended periods of time beyond six months provided that proper certification is made at the start of each coverage period.

Recognizing that prognoses can be uncertain and may change, Medicare's benefit is not limited in terms of time. Hospice care is available as long as the patient's prognosis meets the law's six month test. This test is a general one. As the governing statute says: "The certification of terminal illness of an individual who elects hospice shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

CMS recognizes that making medical prognostication of life expectancy is not always an exact science. Thus, physicians need not be concerned. There is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill.

Hospice care also is covered by Medicaid in many states. Medicare covers a number of specific services as defined in regulation and in the Medicare Hospice Program Manual. Most of these services are familiar to health care professionals and other practitioners who have worked with skilled nursing facilities (SNFs) and home health services. Covered services include:

- Medical & nursing care
- Medical equipment (such as wheelchairs or walkers)
- Pharmaceutical therapy for pain relief & symptom control
- Home health aide & homemaker services
- Social work services
- Physical & occupational therapy
- Speech therapy
- Diet counseling
- Bereavement & other counseling
- Case management

Hospice is not about death, but rather about the quality of life as it nears its end, for all concerned – the patient, family and friends, and the health professional community. For more hospice information, go online to *www.medicare.gov/Publications/home.asp* and *www.cms.gov/medlearn*.

FHCA & FALA 2005 Annual Conference and Trade Show July 5-8, 2005

The Westin Diplomat Resort and Spa
Hollywood, Florida
For more information, go to www.fhca.org or call 850.224.3907.

FAST FACTS

#1

In 2004, the National Council of Hospice and Palliative Professionals gave its Award of Merit to Covenant Hospice's *Patient and Family Handbook* as the best patient and family educational program in the United States.

94%

On a 2004 survey, 94 percent of families reported that Covenant's education helped them fully meet the needs of their loved one.

MESSAGE FROM THE DIRECTOR

F314 Guidelines for Pressure Ulcers

Dee Leslie, RN, CHPN; Director, Partners in Care

Pressure ulcers, as always, are an important concern for all patients. While it is a great resource, the F314 Guidelines for Pressure Ulcers can be difficult to digest. To make it easier, Connie Watson has taken those guidelines and put them into PowerPoint format. If you or your facility would like a copy, feel free to call Connie at 850-729-1800 or email her at connie.watson@covenanthospice.org. Also, Covenant staff have protocols that follow the F314 Guidelines. We have laminated our pressure ulcer protocols and are making them available to facilities as we do our education for

(Continued on next page)

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your management staff (known as our "Toolkit Training"). If you have not received copies for your facility, and would like them, contact Connie or the PIC Coordinator for your area listed on the back of this newsletter. Please remember we offer inservices on pain control, too. These inservices may help your staff address the pain related to pressure ulcers. You can set up this training with your Covenant Hospice Community Educator or by contacting Christine Morrison at 850-729-1800 or christine.morrison@covenanthospice.org. Together, we already make a difference in so many lives through continued excellence in patient care. I am so proud of how well we work together. Call on us any time you need us.

WHO'S PAYING?

Teri Howard, RN, CHPN; PIC Program Coordinator, Mobile

Hospice and facility billing can be a challenge. Patient's needs can change daily requiring a change in level of care or types of services required, and these changes directly affect the billing process. To further add to this billing challenge, items such as adult briefs, tube feedings, catheters and wound care supplies are reimbursed under Medicaid room and board and the Medicare hospice benefit.

The question of who pays for what comes up quite often and, at times, can be very confusing. The facility matrix located in the Partners in Care toolkit is a great place to answer most questions, but, at times, there are still gray areas. These gray areas include radiation, chemotherapy, physical therapy, etc. These require further investigation by the interdisciplinary team to evaluate appropriateness, thus affecting billing. Covenant Hospice never wants a patient to incur the cost of a procedure that may not meet hospice criteria but that could be covered by the patient's primary insurance. It is vital the facility and hospice staff, along with the patient and family, communicate all concerns and discuss all aspects of these types of services to avoid billing miscommunications and allow the patient to receive appropriate care and coverage. Other areas prone to billing miscommunication are pharmacy, durable medical equipment and appropriate dates of service. It is important that the facility and hospice work together to avoid unnecessary billing delays for the facility and billing issues for the patient and family. The billing challenges for hospice and the facility can be alleviated if we continue to work closely together, communicate often and address quickly and accurately the patient's needs and families concerns.

PATIENT ADVOCACY

An early referral can benefit patient and family

Diane DaCosta, RN, CHPN; PIC Program Coordinator, Crestview & Niceville

Referral of nursing home patients to Covenant often comes so late in the disease trajectory that many of the benefits of hospice cannot be realized. Many times a patient and family have hospice care for only a few days or weeks. Even with short-term stays, the patient and family frequently receive great comfort and a wonderful life-closure experience. However, an earlier referral can be of enormous benefit to both patient and family. Indeed, our most frequent complaint on the satisfaction surveys that are sent to families after the death of a patient, is the wish that they had been referred to hospice earlier. With that in mind, I encourage all of our Partner Facilities to screen patients regularly for earlier referrals to Hospice. It is important to remember that as long as a patient meets criteria, there is no time limit for hospice care, and it is important for patients and families to know that accepting hospice is not giving up hope; it is a different focus of care. And as always, our hospice staff is happy to come talk to families who may not understand the hospice philosophy of care. Thank you to all of our Partner Facilities for the wonderful care you provide to our mutual patients.

SHOUT-OUTS

A heaping helping of praise from the Covenant Hospice Staff

Ann Barrow, LPN at The Healthcare Center of Pensacola, always keeps us well informed about our patients. She also works hard to meet the needs of our patients and families.
~ Mary Ellen Huston, RN; Pensacola

Because Lashon, ADON on the 300-400 hall at Bay Breeze nursing facility, has worked with Covenant Hospice before, she is a good resource for our Hospice patients and their families. Thanks, Lashon!
~ Nancy Williamson, RN; Pensacola

I'd like to say how grateful I am to be able to collaborate with Joanne Thomas, Unit Manager on 100 East at Parthenon Healthcare in Crestview, (and all of the staff). They are just superb!
~ Pat Kelley, RN; Crestview

Lezette Jones, ADON on the 2nd floor at Bayside Manor, is always there to help me in any way I need. She's very sweet and understanding. She's a pleasure to work with.
~ Tiffany Judson, HHA; Pensacola

Angelique Vanderville, LPN at Destin Healthcare, is very energetic and goes above and beyond the call of duty to our hospice patients. Thank you!
~ Benny Shadwick, RN; Niceville

Bonifay Health and Rehab recently had a softball game that two of our residents participated in and they really enjoyed it! Thanks so much for all you do. Also, Washington Rehab and Nursing recently held a birthday party for one of our patients who turned 100 years old! It's wonderful to know what great care they give!
~ Beverly Hallford, RN; Marianna

(Continued on next page)

SHOUT-OUTS *(continued from previous page)*

I really want to send a special thank you to Deborah Butz, Admissions at Emerald Shores, for being so friendly and helpful any time we need her.
~ Janice McEuen, RN;
Panama City

Linda Blackshear, Administrator at Riverchase, is always very supportive of hospice and has helped make the transition to my new position an easy one. Carol Arroyo, Administrator at Broadview ALF, is also fantastic, and I really enjoy working with her. Thank you so much to all of our partners!
~ Sharon Sherred, RN; Tallahassee

Karla Schwartz, LPN, and Sue McCree, LPN, on the west hall at Westside Terrace, are always very tuned in to what is going on with the patients on their hall, and they are always willing to go beyond expectations to make sure the patient's needs are met.
~ Beth Peters, RN; Dothan

Thank you to Phillip Parker, Administrator at DW McMillan Hospital! He is so supportive and has a thorough understanding of hospice inpatient.
~ Vicki Langham, RN;
South Central Alabama

Angela Meadows, Social Worker, and Rebecca Frolik, Admissions at Robertsdale Healthcare, are always very helpful, courteous, and do whatever they can to locate a room for a hospice patient. We are so grateful to know they are there!
~ Sharon Cochran, RN; Daphne

CONGESTIVE HEART FAILURE

Toby Murray, RN, CHPN; Admission Nurse, Marianna

There are a multitude of medical conditions that can cause a patient to suffer from symptoms of end-stage cardiac disease. One of the most prevalent conditions is congestive heart failure (CHF). As the population continues to age, this condition becomes more widespread and the need for adequate symptom management grows.

Congestive heart failure (CHF) can be defined as the heart's inability to pump blood effectively to the body. In essence, the heart of a patient with CHF can be compared to a rubber band that has lost its elasticity. Because of this, there will be a decrease in cardiac output, and other major organs throughout the body will suffer. Once this begins, the patient will begin a roller coaster ride of exacerbations and plateaus, where he/she may suffer from anxiety, fluid build-up and shortness of breath.

Anxiety is common in patients suffering from CHF. Decreased oxygenation because of fluid build-up or anemia can trigger episodes of anxiety. It is common for these patients to be prescribed anti-anxiety medications such as Lorazepam (Ativan), Diazepam (Valium) or Alprazalom (Xanax). Sedation is a common side effect with use of anti-anxiety medications. Progression of a patient's disease may be mistaken for over sedation and attempts may be wrongly made to wean a patient off their medications. Because anxiety is frequently related to a physiological reason, medical interventions are typically chosen.

Edema to extremities is seen with patients who suffer from CHF. In the beginning, the amount of edema may vary from day to day. However, as the disease progresses edema will continue to increase and may spread to the entire body. Patients with CHF are usually prescribed medications such as Furosemide (Lasix), Bumetanide (Bumex), or Spironolactone (Aldactone). Bumex and Lasix can be administered orally or intravenously. When given intravenously, their onset varies from 15 to 45 minutes. If the medication is going to be effective, diuresis will begin within this time frame. However, eventually diuretics will become ineffective. Interventions geared toward comfort should be maximized at this time. Because of the heart's inability to pump effectively, an increase in fluid build-up will occur in the extremities and eventually in the lungs leading to increased shortness of breath.

Shortness of breath is subjective and should be whatever the patient says it is. Patient's self-report of shortness of breath should always be believed and acted upon even if pulse oximetry readings register in the nineties. Vascular congestion of the alveoli or pulmonary edema is common in patients with CHF. Oxygen is one medication used to treat shortness of breath. If the patient has a needed order for Morphine Sulfate, it should be used at this time. It can be given sublingually or via nebulizer, depending on the physician's order and is the drug of choice in treating shortness of breath related to CHF. Frequently, Albuterol via nebulizer is mistakenly given to treat shortness of breath related to CHF. Albuterol only acts to dilate the airway and is used in reversible airway obstruction. The physiology of CHF does not support the use of this medication. Non-medical interventions are used in conjunction with medical interventions. Elevating the head of the bed along with cooling the room are effective means of managing minor episodes of shortness of breath. The use of blow-by air is another non-medical intervention that has proved successful. Shortness of breath that escalates to respiratory distress can be upsetting to families and staff, therefore effective management is vital in providing comfort to the patient and their loved ones.

Collaboration between the patient, family, nursing staff and doctors are needed at frequent intervals to evaluate the effectiveness of the current plan of care. The highs and lows of the patient are sometimes deceiving to the family. Adequate education on disease process and symptom management are necessary to allay the fears of all those involved in the care of the patient.

ANHA 2005 Annual Convention and Trade Show

September 26-29, 2005

The Winfrey Hotel
Birmingham, Alabama
For more information, go to www.anha.org or call 334.271.6214.

FAST FACTS

1,285

In 2004, Covenant's Community Educators presented almost 1,300 in-service programs to provide CEU-level training to staff in health care facilities and offices.

11,000+

In 2004, Covenant Hospice provided more than 11,000 hours of clinical training to staff members in hospitals, nursing homes and assisted living facilities.