MARYLAND
HEALTH CARE
COMMISSION

Hospice & Palliative Care Network
OF MARYLAND

Hospice Education and Outreach Work Group Meeting

June 9, 2015

MEETING SUMMARY

Attendees:

Jennifer Belgarde, Seasons Hospice
Reggie Bodnar, Gilchrist Hospice

Phil Carpenter, Community Hospices
Kelly Fields, Heartland Hospice (Beltsville)
Sue Fortuna, Holy Cross Hospice
Altonia Garrett, Capital Caring
Sharon Garrick, Seasons Hospice
Leslie Gee, Carroll Hospice
Heather Guerieri, Compass Regional Hospice

Millie Higgins, Montgomery Hospice

Linzy Laughhunn, Calvert Hospice
Ben Marcantonio, Hospice of the Chesapeake
Linda Maurano, Holy Cross Hospice
Mark McKenzie, Heartland Hospice
Ann Mitchell, Montgomery Hospice
Joy Sexton, JSSA
Joe Shannon, PHRI
Mary Ellen Shea, Talbot Hospice
Shelley Steiner, Hospice of Washington Co.
Lisa Stone, Stella Maris

Speakers:

Cozzie King, Diversity Council, NHPCO
Christina Puchalski, George Washington Institute for Spirituality and Health
Diane Hill Taylor. NHPCO

MHCC:

Linda Cole
Erin Dorrien
Bruce Kozlowski
Paul Parker
Ben Steffen

Hospice & Palliative Care Network of Maryland:

Peggy Funk

Welcome and Introductions:

This meeting was jointly sponsored by the Maryland Health Care Commission and the Hospice & Palliative Care Network of Maryland. For the Commission, Paul Parker thanked everyone for coming to the meeting. He explained that this is a follow-up to meetings held last fall in Baltimore City and Prince George's Counties for hospices serving those jurisdictions. The goal of this meeting is to open the discussion to all hospices. Peggy Funk welcomed all participants on behalf of the Hospice Network.

As part of the introductory portion, Linda Cole presented data to the group. One table (see attached), which included trends in hospice use rates from 2007-2013 had been previously distributed. In this table, hospice use rates are defined as hospice deaths divided by total population deaths for those aged 35+. This table will be updated as soon as 2014 utilization and death data become available.

The second table (see attached) entitled "African American Hospice Patients as a Proportion of Total Hospice Patients, 2013-2014, Maryland", is a new table. This measure is African American hospice patients as a proportion of total patients served during the year. She offered several caveats about the data: some hospices have very small numbers of patients; some serve other minority groups not represented here; only hospices serving 10 or more African American clients were counted, unless they were the sole provider for the jurisdiction; and the final column is intended to provide context, not as a standard. With these caveats, overall there is an increase in the proportion of African American patients served; the exception is the small counties served by a single hospice.

Inclusion and Access: Engagement, Education, Evaluation, and Assessment:

The NHPCO presentation was done jointly by Diane Hill Taylor and Cozzie King. Ms. Taylor started the presentation by stating that there is no magic bullet to solve health care use by minorities. It takes time to build trust and to develop cultural competency. She also stated that the black church, which is central to the community, is based on hope, which is inconsistent with hospice.

Ms. Taylor then explained the structure and divisions of NHPCO and how they can serve members. She stated that the African American population is about 8.4% of hospice patients, and that nationally less than 1/5 of hospice patients in 2013 were minority patients. She stated that the Diversity Council is helping hospices to serve minority patients.

Ms. King then explained the Diversity Council and its work. She stated the view that "we speak to our own", and that there is a need to see diversity in staff and course presentations. She cited the work of Dr. Kimberly Johnson at Duke University on barriers to reaching African American patients. NHPCO's work on awareness will focus on a public awareness campaign.

Ms. Taylor then discussed the work on engagement. NHPCO is working with Morgan State University on continuing education programs to educate the African American community. They are also working with both undergraduate and graduate Hispanic students to engage younger people. They also work with the faith-based community. She stated that she would like to hear from hospices what has worked and not worked for their programs.

__There is Going to be a Miracle-Decision When Religious Beliefs and Medical Realities Conflict__:

Dr. Christina Puchalski explained her various roles as an internist, a palliative care physician, a professor, and director of the George Washington Institute for Spirituality and Health. She focuses on inpatient geriatric patients, a population not yet ready for hospice. She said that they all want to live longer. Palliative care needs to be about living well.

There is often a conflict between religious beliefs and scientific evidence. Patients are defensive if they feel that you do not take their belief system seriously. Physicians fear that religion will block their work. Dr. Puchalski said that chaplains need to be involved early in the process. Conversations need to focus on physical, social, emotional, and spiritual factors. A clinician can share hope without offering unrealistic expectations.

Dr. Puchalski then asked the hospices about their experiences. All hospices stated that they have adequately trained chaplains.

Reggie Bodnar, Gilchrist, stated that caring for children is much harder. They use a team approach, involve the chaplain in the care plan, and include debriefing after the case.

Joy Sexton, JSSA, said that hospice providers often want to reframe hope, but people do not want it reframed. Hospice providers do not want to give up hope, but do need to offer a plan.

Phil Carpenter, Community Hospices said that a question that works to open conversations is “what is keeping you up at night?”

Jennifer Belgarde, Seasons, stated that you need to ask and talk to the patient to fully understand. You cannot make assumptions.

Ben Marcantonio, Hospice of the Chesapeake, suggested that hospice providers need to let patients have the conversations that they need to have.

Sue Fortuna, Holy Cross, said that physicians often do not take the time to walk with patients before the handoff. They often dump patients on hospice and then do not respond to calls.

Dr. Puchalski said that we are still not good at communications. We need to find a balance and offer individualized care. This affects the level of trust. She then discussed communication strategies including the AMEN protocol. An important statement is: “no matter what happens, I will be with you every step of the way.”

Wrap-up and Next Steps:

Ben Steffen, Executive Director of the Commission, then summarized the meeting. He stated that the Commission has sponsored various hospice education and outreach meetings and now it was up to hospices to engage residents in Prince George's County and Baltimore City. He asked participants what else is needed. Mr. Steffen asked what engagement hospices have with hospitals and the broader community to support the new hospital payment model that requires hospitasl to operate under fixed global budgets.

Peggy Funk replied that she had done a survey asking hospices about new initiatives. She noted that Coastal Hospice has a community foundation grant to do outreach to the African American community, and to work with media partners on the Eastern Shore. Hospice Caring has a Montgomery County Council grant to use bilingual volunteers for outreach and to do a community needs assessment.

Mary Ellen Shea, Talbot Hospice, said that they are working with Dr. Johnson at Duke to learn about barriers African American patients face in accessing hospice. They are doing a pilot program with six churches.

Reggie Bodnar stated that the Annual Hospice Conference will focus on transitions in care. Every hospice gets calls from the ER of hospitals. These are people who have no relationship with the hospice. Hospice should not be an emergency, but hospitals are under pressure to reduce readmissions. She also stated that Gilchrist received an Innovations Grant from CMS to offer choices for concurrent care.

Leslie Gee, Carroll Hospice, spoke about the need to reach out to the faith-based community to offer choices. She also spoke about ERs transferring patients to hospices. All the participants agreed that more needed to done to inform hospitals and physicians about the benefits of an early referral to hospice. Ms. Gee said that there is need for community-based talks about quality of life early on.

Ann Mitchell, Montgomery Hospice, said that this is a tenuous time in health care and it is difficult to measure improvements in utilization by minority patients. She noted that Montgomery Hospice serves a very diverse community and offers many educational programs. Increased competition from large national chains could diminish the ability of Montgomery Hospice and other community hospices to continue education program that had proven valuable in the past.

Ben Marcantonio, Hospice of the Chesapeake, said that hospices need to access late referrals and identify processes that would support earlier intervention and referral to hospice.

Shelley Steiner, Hospice of Washington County, said that they have one hospice and one hospital. They have a good relationship. However, younger physicians (hospitalists) who come under contract do not understand the role of hospice.

Mr. Steffen suggested that hospices describe their position to hospitals and explain what they need to serve patients. He also asked what hospices have done to work with Med Chi to explain the need for early referral and to educate physicians. He also stated the need for health care literacy and to promote advanced directives.

Ms. Bodnar said that the Network would like to be part of the discussion on advanced directives and that they have submitted comments to Delegate Morhaim.

Regarding next steps, Mr. Steffen said that use of hospice has increased in some areas. He emphasized that the Commission is open to new ideas and could foster new approaches that offered benefits to patients. He reiterated that the Network and the community hospice members would have to take the lead in implementing the new approaches.