



Volunteers

At the heart

A NEWSLETTER FOR OUR HOSPICE VOLUNTEERS

How to have a better death

Excerpts from *The Economist*, April 29, 2017

For the full article: <http://www.economist.com/news/leaders/21721371-death-inevitable-bad-death-not-how-have-better-death?cid1=cust%2Fednew%2Fn%2Fbl%2Fn%2F20170427n%2Fowned%2Fn%2Fn%2Fnwl%2Fn%2Fn%2Fna%2F26763%2Fn>

In 1662 a London haberdasher with an eye for numbers published the first quantitative account of death. John Graunt tallied causes such as “the King’s Evil”, a tubercular disease believed to be cured by the monarch’s touch. Others seem uncanny, even poetic. In 1632, 15 Londoners “made away themselves”, 11 died of “grief” and a pair fell to “lethargy”.

Graunt’s book is a glimpse of the suddenness and terror of death before modern medicine. It came early, too: until the 20th century the average human lived about as long as a chimpanzee. Today science and economic growth mean that no land mammal lives longer. Yet an unintended consequence has been to turn dying into a medical experience.

How, when and where death happens has changed over the past century. As late as 1990 half of deaths worldwide were caused by chronic diseases; in 2015 the share was two-thirds. Most deaths in rich countries follow years of uneven deterioration. Roughly two-thirds happen in a hospital or nursing home. They often come after a crescendo of desperate treatment. Nearly a third of Americans who die after 65 will have spent time in an intensive-care unit in their final three months of life. Almost a fifth undergo surgery in their last month.

Such zealous intervention can be agonising for all concerned. Cancer patients who die in hospital typically experience more pain, stress and depression than similar patients who die in a hospice or at home. Their families are more likely to argue with doctors and each other, to suffer from post-traumatic stress disorder and to feel prolonged grief.

Most important, these medicalised deaths do not seem to be what people want. Polls, including one carried out in four large countries by the Kaiser Family Foundation, an American think-tank, and *The Economist*, find that most people in good health hope that, when the time comes, they will die at home. And few, when asked about their hopes for their final days, say that their priority is to live as long as possible. Rather, they want to die free from pain, at peace, and surrounded by loved ones for whom they are not a burden. ...

But too often patients receive drastic treatment in spite of their dying wishes—by default, when doctors do “everything possible”, as they have been trained to, without talking through people’s preferences or ensuring that the prognosis is clearly understood. Just a third of American patients with terminal cancer are asked about their goals at the end of life, for example whether they wish to attend a special event, such as a grandchild’s wedding, even if that means leaving hospital and risking an earlier death. In many other countries, the share is even lower. Most oncologists, who see a lot of dying patients, say that they have never been taught how to talk to them. ...

More palliative care is needed. This neglected branch of medicine deals with the relief of pain and other symptoms, such as breathlessness, as well as counselling for the terminally ill. Until recently it was often dismissed as barely medicine at all: mere tea and sympathy when all hope has gone. Even in Britain, where the hospice movement began, access to palliative care is patchy. Recent studies have shown how wrongheaded that is. Providing it earlier in the course of advanced cancer alongside the usual treatments turns out not only to reduce suffering, but to prolong life, too. ...

Most people feel dread when they contemplate their mortality. As death has been hidden away in hospitals and nursing homes, it has become less familiar and harder to talk about. Politicians are scared to bring up end-of-life care in case they are accused of setting up “death panels”. But honest and open conversations with the dying should be as much a part of modern medicine as prescribing drugs or fixing broken bones. A better death means a better life, right until the end.

What is Palliative Care?

Adapted From the May 2017 ed. of *The Tribute, a Newsletter for Hospice Volunteers*

Palliative care, as defined by the Centers for Medicare & Medicaid Services (CMS), is *patient and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information, and choice.*

The primary goal of palliative care is to improve the patient and family's quality of life when dealing with a serious illness by providing relief from the symptoms and stress of a serious illness.

Palliative Care

- ▶ Also known as “comfort care.”
- ▶ Focuses on relief from suffering.
- ▶ The patient may be being treated for a disease or may be living with a chronic disease, and may or may not be terminally ill.
- ▶ Addresses the patient's physical, mental, social, and spiritual well-being, is appropriate for patients in all disease stages, and accompanies the patient from diagnosis to cure or end of life.
- ▶ May use curative or life-prolonging medications.
- ▶ Consists of a multi-disciplinary approach made up of highly trained professionals.
- ▶ Is usually offered where the patient first sought treatment.
- ▶ Common diagnoses of patients receiving Palliative Care are: heart disease, stroke, diabetes, renal disease, cancer, Parkinson's and Alzheimer's disease.
- ▶ There is no specific Palliative Care reimbursement from Medicare.

Hospice Care

- ▶ Hospice is available to terminally ill patients, who have a life expectancy of 6 months or less to live if the disease runs its normal course.
- ▶ The focus of hospice is to keep the patient comfortable.
- ▶ Hospice prepares the patient and the patient's family for the patient's end of life when it is determined curative treatment for the illness will no longer be pursued.
- ▶ Hospice does not use curative medications.
- ▶ Relies on a family caregiver and a visiting hospice team.
- ▶ Is offered at a place the patient prefers such as in their home; in a nursing home; or, occasionally, in a hospital.
- ▶ Care is delivered by an interdisciplinary team (IDT) with a plan of care developed by the team.
- ▶ Hospice is reimbursed by Medicare, Medicaid & Insurance.
- ▶ Volunteers are a part of the IDT.

The Basics of HIPAA

Adapted From the June 2017 ed. of *Partners in Quality Care*, a newsletter for hospice in-home aides published by the Association for Home & Hospice Care of North Carolina

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

The Privacy Rule protects all “individually identifiable health information” held or transmitted, in any manner. This information is referred to as “protected health information,” or PHI (called ePHI when referring to electronic protected health information).

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We all have access to information about patients that should not be shared – such as name, address, diagnosis, medical history, etc.

“Individually identifiable” health information is information, including demographic data that relates to:

- the individuals past, present, or future physical or mental health condition
- care provided to the individual
- information related to the payment for care

The definition of HIPAA was expanded to ensure each patient has more control over their personal data. HIPAA recognizes the importance of privacy, dignity, and making informed choices by limiting personal release of information, and by allowing patients to examine a copy of their own health records and request corrections. It can be empowering for patients to have control over their personal information. HIPAA mandates that agencies provide current, updated, written information to the patient stating how their information will be used.

HIPAA laws and practices have changed over the years, as new situations and technologies emerge. Agencies must show efforts of privacy protections and how a breach would be handled. It is imperative that you know how to handle confidential information to protect yourself, your patient, and your agency. Never take information regarding another patient into your current patient’s home. Even if you feel this information is secure in your bag or notebook, others can still have access to it when you are not looking or busy in the home.

Maintaining confidentiality means that the information that you are entitled to about your patient is privileged information and should not be shared with anyone other than members of your health care team and your supervisor.

- Never have your family or friends take you to your patient’s home. If you do not have transportation, then discuss this matter with your supervisor.
- Never store your patient’s phone numbers in your cell phone. If the cell phone is lost, so is identifiable information.
- Never discuss your patients with your friends, family, church members, etc., even in general conversation, breaches of confidentiality may happen.
- Never leave patient care information where others could possibly see (including in your home). This includes any type of demographic information containing name, address, phone number, social security number, medical diagnosis, etc..
- Sharing pictures or selfies from your patient’s homes is a breach of confidentiality.
- Do not “friend” or accept friend requests from patients or their families.
- Even using location-based cell phone features or apps while with patients, that friends and/or family have access to and can see your exact location is a breach of confidentiality.

Volunteers are always a welcomed *treasure* for special events.

Your time and talents are so appreciated. In fact, events can’t happen without our valuable volunteers. Review the opportunities available for the events listed below.

LOOKING AHEAD: Mark your calendar for these events.

Dine Out for Hospice at Trio’s

Thursday, July 13, 11am-9pm
10709 McMullen Creek Pkwy., Charlotte
A portion of the day’s proceeds donated to HPCCR

Bullshooter’s Beach Party Concert

Saturday, August 12, 6pm
BarnStock
15300 Black Farms Rd., Huntersville

10th Annual Pedal the Park – Ride & Run

Monday, September 4, 7:30am
Bike ride and 5k run-walk will begin and end at the
Levine & Dickson Hospice House
11900 Vanstory Drive, Huntersville

Taste of Birkdale

Sunday, September 10th, 3pm-7pm
Birkdale Village Shopping Center, Huntersville

Hit The Brixx 10K/5K Run-Walk for Kids Path[®] Pediatric Hospice Care

Saturday, September 16th, 7:45am
Brixx Wood Fired Pizza, Uptown Charlotte

Shoot for Joy

Saturday, September 16th, 8am
Kidd Farm, 5900 Stephens Rd., Huntersville
*Memorial sporting clay shoot. All skill levels
of shooters welcomed*

Please reach out to Nancy Cole, Director of Special Events for more event details. P: 704.335.4312 | E: colen@hpccr.org

Thank You

Our special thanks to the following community members, churches, civic organizations and others who have generously donated prayer shawls, lap robes, stuffed animals, snacks, meals and other items that make life happier for our patients and easier for our families.

Thank you...

St. Gabriel Catholic Church	Masayo McCormick
BB&T Insurance Services	Natalie & Corbin Meek
Brookdale South	North Mecklenburg Woman's Club
Carol Gominiak	Paw Creek Presbyterian Church
Davidson United Methodist Church	Robin Warren
Deepti Sidana	Ross Wade
Dilworth Prayer Shawl Ministry	Royce Cummins
Girl Scout Troop 875	Sally Aurigemma
Holy Trinity Students	Sheryl Brown
Hopewell Presbyterian Church	St Mark's Catholic Church
Independence Hill Baptist Church	St. Gabriel Catholic Church
Jamie Christhilf	St. Thomas Aquinas
Jessica Cary	St. Vincent DePaul Catholic church
Joan Hoffman	Trinity UMC Prayer Shawl Ministry
Lee Decker	Vera DeGrassi
Marilyn S. Valeo	

Thinking of You...

Marianne Alfaro	Wayne Goode	Renee Snyder
Penny Barr	Jan McCreery	Dolores Weems
Teresa Brinkley	Gwen Moore	Geri Williamson
Malynda Cress	Joe Notaro	
Frank DeLuise	Robin Smith	

Congratulations!

To **Peggy Byrne** on her retirement
To **Shannon Dougherty** on her retirement
To **Emily Franklin** on her graduation
To **Leigh Holt** on the birth of her grandchild.
To **Diane Reel** on the birth of her grandson.

Sleep and Wellness

Adapted From the May 2017 ed. of *Trinity Consulting-NFP Newsletter*

On average, adults need seven to nine hours of sleep each night. Lack of sleep and weight gain go hand in hand. If you get less than 6 hours of sleep each night you are 23% more likely to be obese. (*Samuels, 2005*)

Getting the proper amount of sleep is an important part of good health.

Not getting enough sleep over the long term has been linked to obesity, high blood pressure, heart disease, depression and type 2 diabetes.

Practice good sleep “hygiene” - establish relaxing pre-sleep rituals that send a message to your body and brain to relax so you can enjoy a good night’s sleep. Create a pre-sleep routine such as taking a warm bath or reading. Avoid naps during the day. Don’t go to bed hungry or too full. Limit alcohol, caffeine and nicotine. Be physically active, but not within a few hours of bedtime. Make sure your bed is comfortable and avoid using it for other things such as work, watching t.v. or listen to music.