June 2011

in this issue

Emergency Preparedness

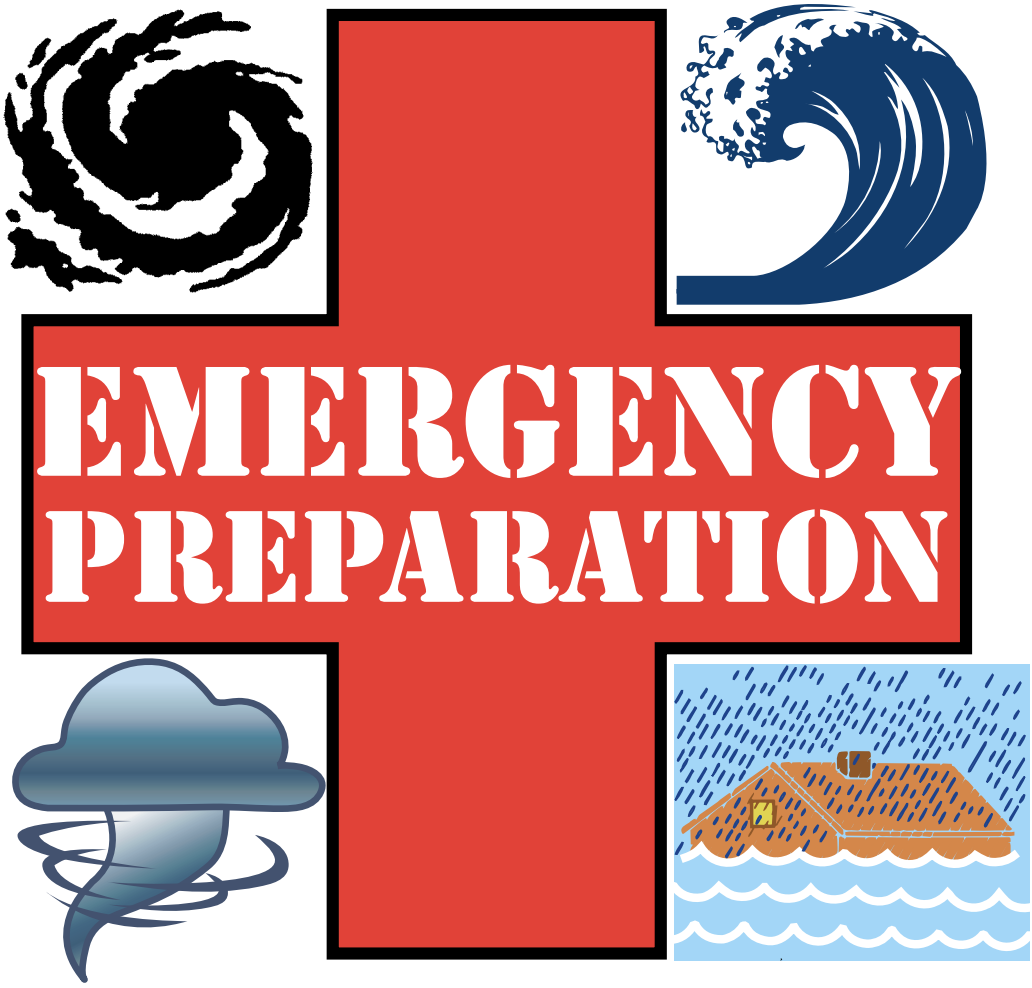
The Journal

of the Louisiana-Mississippi Hospice & Palliative Care Organization

The Impact of Hurricane Katrina on Gulf Coast Hospice Admissions

Cordt T. Kassner, PhD, Principal of Hospice Analytics

What impact does a catastrophic natural disaster have on hospice admissions? What can Louisiana and Mississippi hospices learn by examining pre- and post-Katrina Medicare data? How might hospices nationally prepare for the aftermath of a catastrophic natural disaster?



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The Louisiana-Mississippi Hospice and Palliative Care Organization is a 501(c)3 non-profit organization governed by a board of directors representing all member hospice programs. It is funded by membership dues, grants, tax-deductible donations and revenues generated by educational activities. LMHPCO exists to ensure the continued development of hospice and palliative care services in Louisiana and Mississippi. LMHPCO provides public awareness, education, research, and technical assistance regarding end-of-life care, as well as advocacy for terminally ill and bereaved persons, striving to continually improve the quality of end-of-life care in Louisiana and Mississippi.

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hospice education network, inc.

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- *Describe eight components of a written Emergency/Disaster Plan*
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- *Describe the importance of annual emergency rehearsals and drills*

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Hospice Emergency Operations Plan crosswalk

LA State Minimum Standards

Current as of December, 1999
Proposed Changes in Red

Subchapter D. Administration
§8235. Agency Operations
D. Operational Requirements
1. Hospice's responsibility to the community:
f. shall have policy and procedures and a written plan
for emergency operations in case of disaster;

Subchapter D. Administration
§8235. Agency Operations
D. Operational Requirements
1. Hospice's responsibility to the community:
f. shall have policy and procedures and a written plan for emergency operations in case of disaster including:

i. risk assessment for all hazards
ii. education (written and oral) of patients and family regarding hazards
iii. assist patient/family in developing an emergency plan
iv. alternate agency operations in the event of risk/hazards identified in assessment.

Medicare Conditions of Participation (CoPs)

Revised June 5, 2008 with
Effective Date of Revisions
December 2, 2008

§ 418.116 Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients.
The hospice and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations related to the health and safety of patients. If State or local law provides for licensing of hospices, the hospice must be licensed.

§ 418.110 Condition of participation: Hospices that provide inpatient care directly.
A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards:
(c) Standard: Physical environment.
The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.
(1) Safety management.
(i) The hospice must address real or potential threats to the health and safety of the patients, others, and property.
(ii) The hospice must have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. The plan must be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.

(2) Physical plant and equipment. The hospice must develop procedures for controlling the reliability and quality of—
(iii) Emergency gas and water supply; and
(iv) The scheduled and emergency maintenance and repair of all equipment.

MS State Minimum Standards

Current as of February 22, 2008

118 DISASTER PREPAREDNESS PLAN (Refer to Section 143)

143 EMERGENCY OPERATIONS PLAN (EOP)
143.01 The licensed entity shall develop and maintain a written preparedness plan utilizing the "All Hazards" approach to emergency and disaster planning. The plan must include procedures to be followed in the event of any act of terrorism or man-made or natural disaster as appropriate for the specific geographical location. The final draft of the Emergency Operations Plan (EOP), will be reviewed by the Office of Emergency Preparedness and Response, Mississippi State Department of Health, or their designates, for conformance with the "All Hazards Emergency Preparedness and Response Plan." Particular attention shall be given to critical areas of concern which may arise during any "all hazards" emergency whether required to evacuate or to sustain in place. Additional plan criteria or a specified EOP format may be required as deemed necessary by the Office of Emergency Preparedness and Response. The six (6) critical areas of consideration are:
• Communications – Facility status reports shall be submitted in a format and a frequency as required by the Office of EOP.
• Resources and Assets
• Safety and Security
• Staffing
• Utilities
• Clinical Activities.
Emergency Operations Plans (EOPs) must be exercised and reviewed annually or as directed by the Emergency Preparedness and Response. Written evidence of current approval or review of provider EOPs, by the Office of Emergency Preparedness and Response, shall accompany all applications for facility license renewals.

NOTE: The Crosswalk is not all inclusive of all standards. Providers are urged to make certain they have a current copy of the CoPs as well as the State Minimum Standards.

LMHPCO's 2011 At Risk Registry

With the encouragement of emergency managers in both Mississippi & Louisiana and the continued cooperation of **Secure Computing Systems** (*the makers of **MUMMS Software***), LMHPCO's ***At-Risk Registry*** to now cover all counties and parishes in both states, providing not only hospice but home health agencies as well with a year-round ***All Hazards Registry*** for the most vulnerable homebound patients. **The Registry offers a secure online website that agency users can manage from any computer simply by logging on to** https://atrisk.mumms.com/hospice

Hospice, as well as home health, agencies throughout Louisiana and Mississippi can now use the **Registry** to keep local emergency managers updated as to who, where and what ***At-Risk*** hospice patients need in terms of assistance, in the event of an emergency evacuation of their county/parish. While the ***Registry*** does not ensure transportation assistance to anyone in the event of an actual emergency, it does provides parish/county emergency mangers and state planners with critical and accurate information as to who and where these our most vulnerable patients reside, as well as what kind of assistance they will need in the event of an actual emergency.

At-Risk patients are defined as:

Hospice patient living alone, unable to evacuate self

Hospice patient living with caregiver (either mentally or physically) unable to evacuate patient and self.

Hospice patient/family without financial means to evacuate.

Hospice patient/family refusing to evacuate.

The ***Registry*** allows provider agencies to input basic patient information *(i.e., name, location and particular transportation needs)* into a secured database which produces weekly reports for local parish/county Emergency Managers, alerting them as to who and where these ***At-Risk patients*** reside within their jurisdiction. The ***Registry*** keep patients certified as ***At-Risk*** for **7 days** at a time. Provider agency only has to renew the patient's At Risk status once a week in order to keep the patient on the weekly report sent to the local parish/county emergency manager.

The ***Registry*** is easy to use and only requires an agency to register in order establish its individual username and password. Agencies that registered in last hurricane season can use their same user name and password this year. Agencies that did not previously register can now do so by calling Jamey Boudreaux at 888-546-1500.

Steps to Using the LMHPCO At-Risk Patient Registry

1. Using the ***At-Risk patient criteria*** (defined above), identify ***At-Risk patients*** currently enrolled into their hospice agency.

2. Secure the patient's signed ***Consent/Release*** to be included in the ***Registry*** and file the signed document into the patient's chart. Consent/Releases forms are found at: http://www.lmhpco.org/blahdocs/uploads/at_risk_registry_consent__release_2008_8924.doc

Please note: Patients cannot be included in the Registry without a signed Release

3. If you registered your agency in 2010, use your user name and password to Login to the Registry. If you're not registered or need to change your Login codes contact Jamey Boudreaux at 888-546-1500.

4 Login into the ***Registry*** at https://atrisk.mumms.com/ using your agency's individual username and password.

5. **Enter all of the required patient information.**

6. **Re-certify** the patient's ***At-Risk*** status **every 7 days; Login and check the update box next to the patient's name**

The ***Registry*** sends out weekly reports to parish/county and state emergency managers and planners, alerting them as to the existence and location of ***At-Risk*** hospice patients on a continuous basis.

During the 2011 Spring Mississippi River Flooding experience, we programmed the Registry to provide Emergency Managers with daily, rather than weekly updates, resulting (between May10 - June 2, 2011) in over 390 individual At Risk reports being sent out, alerting emergency managers as to the identity and location of At Risk patients along the Mississippi River.

LMHPCO is grateful to **Secure Computing Systems**

(the makers of ***MUMMS Software***) for their commitment developing this new resource for provider agencies throughout Mississippi and Louisiana. State emergency planners have recognized this system as a valuable tool for our respective states' Emergency Preparedness plan for vulnerable patient populations across various healthcare sectors.

LMHPCO and the Homecare Association of Louisiana (HCLA), in conjunction with DHH and MSDH Offices of Emergency Preparedness, are collaborating again this hurricane season to gather critical data that will assist state emergency planners to better understand the particular needs of hospice and homecare patients. LMHPCO and HCLA are jointly covering the cost of an **At-Risk Specialist** to continue gathering census and At Risk patient counts through the end of the 2011Hurricane Season (November 30, 2011).

Data collected each week is held in strict confidence and only released in an aggregate form. Weekly reports are sent to the Homeland Security and the Office of Emergency Preparedness in Jackson and Baton Rouge.

LMHPCO is committed to improving the safety of hospice patients this hurricane season. We ask your cooperation and assistance in making this commitment a reality!

Over the past several years, LMHPCO has gathered data from hospice agencies across South Louisiana and Mississippi to compile weekly reports for the respective states' Office of Emergency Preparedness and Homeland Security, as well DHH and MSDH. These reports are used by emergency managers and planners to access and allocate resources available to counties/parishes, as well as regions within each state in the event of an actual emergency evacuation of the coastline. For the second year, LMHPCO and HCLA (the Homecare Association of Louisiana) are collaborating in this project so as to learn more about the special needs of hospice and home care patients, especially those most At-Risk in the event of an actual emergency.

As in 2010, LMHPCO and HCLA have hired Suzanne Ritchie [pictures and bio below] this summer to gather this critical information during this hurricane season. Suzanne will be contacting coastal hospice agencies every other week to gather census and At Risk patient counts. At the request of GOHSEP (the Louisiana Governor's Office on Homeland Security and Emergency Preparedness) we will include Region 6 (Alexandria, LA) in this year's surveys.
LMHPCO ask for your cooperation and support in this effort to provide a greater level of safety for hospice patients living along the most vulnerable regions of the state during this hurricane season.

Suzanne Richter
At Risk Specialist
LMHPCO
225-752-7864
atriskregistry@lmhpco.org

- Graduated from University of Missouri in 2000 with a degree in Sociology
- Most recently worked for the Muscular Dystrophy Association as an Program Coordinator in Lafayette, LA, before becoming a stay-at-home mom in 2007
- From Missouri, moved to LA in 2004
- Married (husband: Rob)
- One 3 year old son, Cole

Area Code	Total Census (6/13/2011)	At Risk Patients (6/13/2011)
LA 225 (12 hospice agencies)	500	45
LA 318 (10 hospice agencies)	311	57
LA 337 (16 hospice agencies)	800	89
LA 504 (15 hospice agencies)	535	66
LA 985 (12 hospice agencies)	477	87
LA Totals (65 hospice agencies reporting)	2,623	344
MS 228 (8 hospice agencies)	305	59

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Consent & Release

I, _____, am a hospice patient, enrolled into

_____(hospice agency)

My address is _____ ,

_____ (City), _____ (State).

With my signature below, I grant the agency named above the right to include my name, address, phone number, medical conditions (including physician contact information), and living situation (including caregiver contacts and transportation/evacuation needs) in the LMHPCO At-Risk Hospice Registry. This Registry is designed to keep Emergency Managers aware of my location and special needs in the event of an emergency in my parish/county. This information will be updated by the hospice agency (named above) on an "as needed basis" (via telephone). Although inclusion in the At-Risk Registry does not guarantee that my transportation needs will be met in an actual emergency, my inclusion in the Registry allows Emergency Managers in my parish/county the awareness of my current health and living situation, as well as the opportunity to more accurately prepare for emergency situations in the parish/county and state.

I hereby release the hospice agency (named above), its agents and employees, the Louisiana-Mississippi Hospice and Palliative Care Organization, Secure Computing Systems, Inc. (sometimes doing business under the name "MUMMS"), and Emergency Managers from all liability under any and all state and federal health care information privacy laws, including, but not limited to, the federal Health Insurance Portability and Accountability Act, as well as state and federal health care privacy rules and regulations. I further hereby expressly release the hospice agency (named above), its agents and employees, the Louisiana-Mississippi Hospice and Palliative Care Organization, Secure Computing Systems, Inc. (sometimes doing business under the name "MUMMS") and Emergency Mangers, of and from any and all liability for any injury or harm to me or my property that may be or may have been caused by any negligence or carelessness committed by or on the part of any of those parties.

Patient Signature _____Date_____

Print Patient Name: _____

Print Hospice Provider's Name:_____

Signature of Representative of Hospice Provider: _____Date_____

Print Name: _____

Hospice Care in a Disaster…. The Need for Health Care Volunteers

The World Health Organization defines palliative care as "an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems."

A mass casualty event (MCE) or large disaster has the potential to overload health care and social service systems and disrupt existing services to persons who were already seriously ill. In any disaster, the first priority will be to save those who can be saved. However, there will be vulnerable individuals, i.e. the elderly, hospital patients, nursing homes residents, the disabled, who were already ill with severe pre-existing conditions and who may be negatively impacted by the resulting scarcity of resources. During a disaster or MCE, standards of care will require adaptation, supplies will be strained, and command structures will need to be established for decision-making and allocation of resources.

Recent disasters have shown that it is better to plan for worst case scenario than to be caught with too little, too late. This planning and preparing for emergencies should include every aspect of our daily living – or dying. Thus, the need for the integration of hospice and palliative care into emergency response planning. Health care personnel who are skilled in the principles of palliative care, long-term care, and hospice should be involved in disaster response planning in order to successfully integrate the two paradigms of care and insure continuity of operations with minimal disruption. The recruitment, advance registration and training of such health professionals is necessary in order to designate in advance certain leadership to remain in place and mobilize retired professionals and layperson volunteers.

So, why should health professionals volunteer their services in palliative or hospice situations in disasters or MCEs? During a disaster most skilled professionals who usually serve those with fatal chronic illness may be diverted to active treatment settings to treat the medically salvageable, so first responders, less well-trained health care personnel, and potentially laypersons may have to fill in to care for the dying. Because resources in hospice and palliative care are already severely limited, other health professionals who volunteer their skills and time in these efforts are crucial to assuring a more coordinated emergency response effort. Priority access to scarce resources (structural and personnel) may be applied to those with the greatest potential for survival. Therefore, in these situations volunteers are needed to help fill the gaps that a medical surge resulting from a major disaster or emergency will cause, such as the need for staffing of special medical needs shelters. Volunteers are needed… period. Health professionals, regardless of whether you are currently employed or retired, skilled in palliative, hospice care or other setting; whether you're a physician, nurse, dentist, EMT, phlebotomist, etc. can pre-register as a volunteer in advance of an emergency or disaster so that licensure identity, licensure status, privileges and credentials can be verified and thereby ensuring a swifter, more coordinated response to any disaster or all hazard emergency event.

The Volunteers in Preparedness Registry (VIPR) is Mississippi's secured online database of pre-registered and pre-credentialed volunteers who are trained to provide a coordinated response to emergencies in support of our established public health and emergency response systems. VIPR serves as our state's Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). Log on to the VIPR website at http://volunteer.msdh.state.ms.us and register to become a public health emergency volunteer! Participation in the volunteer registry does not obligate volunteers to serve. If an event occurs, volunteers will be contacted, given details regarding the event an offered the opportunity to accept or decline service.

For more information about VIPR and the benefits of becoming a public health emergency volunteer, call 601.933.6872 or send an email to Laveta.moody-thomas@msdh.state.ms.us.

Submitted by: Laveta Moody-Thomas, MPH, MSW, CHES LSW
State Volunteer Coordinator/State MRC Coordinator
Mississippi State Department of Health
Office of Emergency Planning and Response

VIPR

Volunteers in Preparedness Registry

What is VIPR?

VIPR is a database maintained by the Mississippi State Department of Health (MSDH) that contains contact and credential information on health care professionals and non-medical support personnel who have registered in advance to be volunteers in a disaster.

How does the program work?

In a disaster, MSDH will post standby information on our website. We will identify those of you who volunteered, and will contact you to advise you of the disaster, our needs, the anticipated time away, and your reporting location.

Who can register with VIPR?

A variety of medical and related health care professionals are greatly needed to register, including physicians, dentists, nurses, pharmacists, social workers, and mental health counselors.

What information is needed to register with VIPR?

MSDH will need contact information, two telephone numbers and/or an email address which absolutely can be relied upon for EMERGENCY ALERT and message delivery; professional license number; specialty certification (if any); and where, when, and for what duration you are willing to serve during a disaster.

How do you register with VIPR?

To register or for more information on VIPR and volunteerism, go to the Mississippi State Department of Health website at http://volunteer.msdh.state.us or please contact the Mississippi State Department of Health, Office of Emergency Planning and Response at 601-576-7680 or 1-866-HLTHY4U (1-866-458-4948).

Mississippi State Department of Health

Volunteer to Help Save Lives

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SOCIAL WORKERS
CHAPLAINS
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We also request your help to:

- Educate your clients concerning expectations of MSNS
- Ensure client medical records are with your client
- Discuss alternative evacuation plans with your client and client's family. Complete and continue to update the At Risk Registry for those clients who are considered most vulnerable. If a hospice agency does not enroll in the At Risk Registry Program encourage the clients who will need evacuation assistance to contact their local Office of Emergency Preparedness.
- Promote personal preparedness to get a game plan before hurricane season (www.getagameplan.org<http://www.getagameplan.org>)
- Education your clients to prepare for all types of emergencies (flooding, oil spills, pandemic influenza viruses, disease outbreaks, tornadoes, explosives)

Meeting Criteria for MSNS Admittance

- Evacuees having no means of evacuation who have any of the following conditions may qualify:
- Physical or mental conditions that limit mobility and/or ability to function and are dependent on others for assistance
- Requirements for special equipment or medication to sustain life
- Chronic, debilitating medical condition that requires intermittent assistance and are medically stable

Steps for those who may Qualify for MSNS Admittance

- Those who think they may qualify for MSNS may call a toll-free shelter hotline number prior to their evacuation in order to be interviewed and find out their eligibility status.
- Stay tuned to local radio/TV stations for shelter hotline numbers and evacuation information.
- Individuals will be triaged at the MSNS location to determine the eligibility for admittance.
- For Non Emergency Information and referrals call 211.

What Hospice patients Need to Bring to the MSNS

- Medical folders
- Do Not Resuscitate (DNR) orders
- Oxygen tank- if possible, make arrangements ahead of time with suppliers to resupply oxygen
- One caregiver and/or service animal
- Make other arrangements for family members
- Medications in prescription bottles and any over-the-counter medications
- If possible, a pharmacy printed list of medications
- Written medical instructions regarding medical care
- Required medical supplies and equipment –walker, wheelchair, cane, wound care supplies, hearing aids
- Special, non-perishable dietary foods (Ensure)
- Personal Clothes- 7 days
- Personal hygiene items such as toothbrush, toothpaste, deodorant, comb
- Identification, medical insurance, social security cards and emergency contact information
- Extra eyeglasses
- Means to carry personal items
- Flash light/batteries
- If applicable, food for service animal
- Non-essential valuables should not be brought to shelter

Evacuee/Caregiver Requirements:

- Evacuees/caregivers are responsible for all activities of daily living (ADLS) and for storage of medications that do not require refrigeration and administration of medications
- Evacuees/caregivers must register and log in/out when entering or leaving the shelter.

The MSNS is not a provider of long term care; accordingly, planning for discharge begins at admission.

Any evacuee or caregiver under the influence/possession of alcohol, illegal substances, or weapons will be requested to leave shelter.

The Impact of Hurricane Katrina on Gulf Coast Hospice Admissions

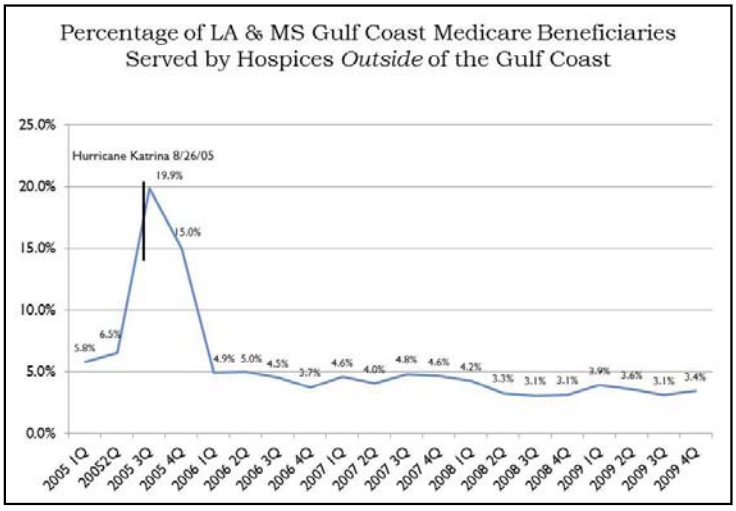
Cordt. T. Kassner, PhD
Hospice Analytics, Inc.

Questions: Specifically, this LMHPCO Journal article examines two questions:

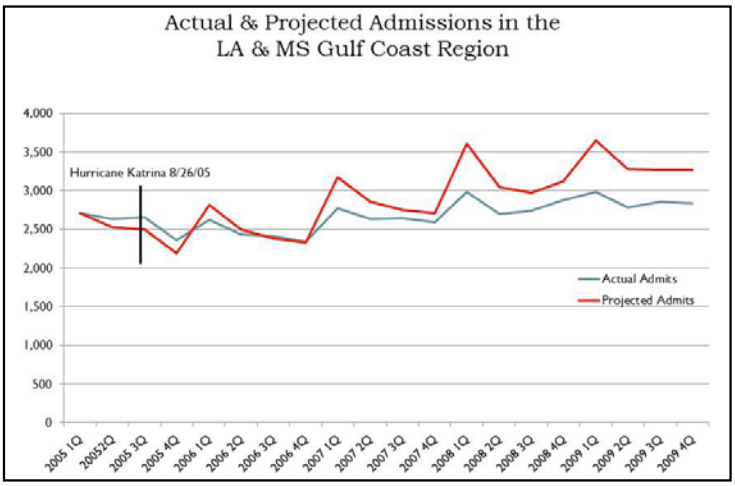
1. How quickly did Gulf Coast Medicare beneficiaries return to Gulf Coast hospices after Hurricane Katrina?
2. How has Hurricane Katrina impacted long term hospice admissions in the Gulf Coast?

Methods: We examined national Medicare hospice claims data quarterly from 2005-2009 to understand how Hurricane Katrina impacted where Gulf Coast Medicare beneficiaries received hospice services. The most current Medicare data available is through 2009. By "Gulf Coast", we mean Medicare beneficiaries and Medicare certified hospice providers located in the 35 Louisiana parishes and 6 Mississippi counties south of the Louisiana "boot". Admission projections in the second question were made based on the percentage change in national hospice quarterly admissions from 1st quarter 2005. This projection was compared to actual Gulf Coast quarterly hospice admissions.

Question #1: In 1st and 2nd quarter 2005, 6% (n=164) Gulf Coast Medicare beneficiaries received hospice services by hospices geographically located outside of the Gulf Coast. This appears to be a reasonable percentage, allowing for beneficiaries receiving hospice service north of the "boot" and with loved ones residing in others parts of the country. During 3rd quarter 2005, when Hurricane Katrina hit the Gulf Coast, the percentage of Gulf Coast beneficiaries receiving hospice outside of Gulf Coast hospices significantly increased to 20% (n=528). However, this phenomenon was short lived – in 4th quarter 2005 this percentage dropped to 15% (n=354), and in 1st quarter 2006 through 4th quarter 2009 this percentage returned to lower than the pre-Katrina baseline averages of 4%.



Question #2: In 1st and 2nd quarter 2005, Gulf Coast hospices averaged a higher percentage of admissions compared to projections based on national quarterly admission averages. After Hurricane Katrina hit during 3rd Quarter 2005, Gulf Coast hospice admissions gradually dropped off until 1st quarter 2006, when the projected average rose above actual admissions. Despite 2006 hospice admissions near projected averages, actual hospice admissions have continued at a pace slower than the national average through 4th quarter 2009 (4th quarter 2009 actual admissions= 2,742, compared to the projection= 3,262). Hurricane Katrina is an influential variable explaining slower hospice growth than might otherwise be expected – in part due to hospices closing, relocating, rebuilding, etc. However, certainly other variables have contributed to this slowed growth – e.g., changing hospice regulations, impact of hospice aggregate cap enforcement, etc.



Summary: Hurricane Katrina resulted in a sudden and significant percentage of Gulf Coast Medicare hospice beneficiaries seeking hospice services outside of Gulf Coast hospice providers (increasing from 6% to 20%) – however this trend quickly reversed within 6 months (dropping to 4% average). However, the impact of Hurricane Katrina on actual vs. projected hospice admissions has been smaller and long term through at least 2009.

LMHPCO Leadership Conference 2011
Wednesday, July 27, 2011

7:00 – 8:30
Registration / Breakfast **Exhibit Hall Open**

8:30-8:45
Opening Ceremony **Color Guard**

8:45 – 9:00 **Welcome**
Stephanie Schedler, CHCE, *LMHPCO President*

9:00 – 10:00
Opening Plenary: "A View from Washington"
Donald Schumacher, PsyD
President and CEO National Hospice and Palliative Care Organization (NHPCO)

10:00 – 10:30
Morning Break

10:30 – 12:00
Morning Concurrent Sessions

A1 Corporate Compliance in an Era of Government and Provider Accountability and Responsibility
Julie B. Mitchell, J.D., LL.M, *Mitchell Day Health Law Firm*

A2 Palliative Care and Intensive Care: Collaboration and Cultural Transformation
Gary Hsin, MD, FAAHPM, *Physician, VA Palo Alto HCS*
Clinical Assistant Professor,
Stanford University School of Medicine

A 3 REMS, Hospice Patients and Access to Medications
Mary Grace Mihalyo, BS, PharmD
Executive VP and General Manager, ProCare Hospice Care

A4 Employee Engagement-Finding and Keeping the Best Employees
Robert Lonto, BS,
VP of Employee Feedback Services, Deyta

A5 Things Your "Mama and Dem" Never Told You About Death & Dying
Marilyn A. Mendoza, PhD, *Counseling Psychologist*

A6 Enhancing Quality in End-of-Life Care: Getting Back to the Basics
Janet P. McMillan, DSN, FPMHNP-BC
Psych Nurse Practitioner/Educator
Forrest General Home Care & Hospice

A7 Anticoagulation in the Hospice Patient
Myra T. Belgeri, PharmD. CGP, BCPS, FASCP
HospiScript, Services, LLC

12:00 – 12:15 **Break**

12:15 – 1:30 **Lunch/LMHPCO Annual Meeting (Lunch provided)**

1:30 - 1:45 **Break**

1:45 – 3:15 **Afternoon Concurrent Sessions**

B1 T02 or not T02: Respiratory Problems in Palliative Care
Edgar W. Hull, MD, ABHPM
Medical Director, Hospice of Light

B2 Impact of Military Service & Psychosocial Issues for Veterans in Hospice & Palliative Care
Gary Hsin, MD, FAAHPM
Physician, VA Palo Alto HCS
Clinical Assistant Professor, Stanford University School of Medicine

B3 Compliance Simplified
Debbie Goings, RN, BSN, LNC, *Clinical Compliance Educator Accreditation Commission for Health Care* (ACHC)

B4 Why Hospice Satisfaction Matters – Now More than Ever
Dianne Gray, BS
VP of Communications and Development, Deyta

B5 MSDH Update
Marilynn Winborne, MBA, *Bureau Director, Bureau of HFLC, MSDH*

B6 DHH Update
Marian Tate, RN, BSN
DHH Medical Certification Program Manager

B7 Keys to Documenting Clinical Eligibility for Non-Cancer Diagnoses
Susan Drongowski, RN, MA, *Senior Consultant & Project Specialist, Weatherbee Resources, Inc.*

3:15 – 3:45 **Afternoon Break**

3:45 – 4:45 **Afternoon Plenary:**
"Innovative Leadership: The Power of Data"
Cordt T. Kassner, PhD
Principal, Hospice Analytics

4:45 – 6:30
Exhibitor's Cocktail Reception

LEADERSHIP CONFERENCE
Thursday, July 28, 2011

7:30 – 8:30 **Breakfast & Exhibit Hall Open**

8:30-9:00 **Morning Remarks:**
Jamey Boudreaux, MSW, M.DIV., *LMHPCO Executive Director*
Nancy Dunn, RN, MS, CT, *LMHPCO Education Director*

9:00 – 10:00 **Morning Plenary: "The Coach"**
Gary Golden, MBA
Owner Golden Opportunities

10:00 – 10:30
Morning Break

10:30 – 12:00 Morning Concurrent Sessions

C1 The 5 P's of Praise
Gary Golden, MBA, *Golden Opportunities*

C2 Prognostication: The Good, the Bad and the Irrelevant
Deborah Grassman, ARNP
Director of Hospice & Palliative Care, Bay Pines VAMC

C3 Fundamental Health Law for Hospice and Palliative Care
Christopher DeMeo, JD, *Munsch Hardt Kopf & Harr, P.C.*

C4 Hospice Medical Director Update
Jennifer Kennedy, MA, BSN, RN, *Regulatory & Compliance Director, National Hospice & Palliative Care Organization*

C5 MS Emergency Management Update
C.J. Davis, Ph.D.
Senior State Planner
Office of Emergency Planning and Response
Mississippi Department of Health

C6 Strengthening Emergency Preparedness Efforts: All Hazards Response
Doris Gray Brown, M.Ed., MS, RN, CNS
Public Health Executive Director
Louisiana Department of Public Health

C7 Management Considerations for Anxiety, Agitation, Delirium and Dementia in Hospice Care
Curt Bicknell, BS, Pharm D
Client Relations Liaison, Hospice Pharmacia

12:00 – 12:15 **Morning Break**

12:15 – 1:30 **Lunch / Heart of Hospice Awards (Lunch Provided)**

1:30 – 1:45 **Break**

1:45 – 3:15 **Afternoon Concurrent Sessions**

D1 Applying the Power of Data to the Hospice Industry
Cordt T. Kassner, PhD., *Hospice Analytics, Inc.*

D2 Spiritual Care and Meaning: A Perspective from Viktor Frankl
Deborah Grassman, ARNP
Director of Hospice & Palliative Care, Bay Pines, VAMC

D 3 Regulatory Compliance for Marketing Hospice Services
Christopher DeMeo, JD, *Munsch Hardt Kopf & Harr, P.C.*

D4 Here an Audit, There an Audit . . . Current Trends in Hospice Audits
Jennifer Kennedy, MA, B.S.N., RN
NHPCO Regulatory & Compliance Director

D5 LA Medicaid Update
Rodney Wise, MD, *Medicaid Medical Director*

D6 MS Medicaid Update
Ron Ritchey, MD, MBA
Corporate Medical Officer for eQHealth Solutions (parent company of HealthSystems of Mississippi)
David Williams, MD
Medical Director, HealthSystems of Mississippi
Heather Lott, RN
Hospice and Outpatient Therapy Review Team Leader for HealthSystems of Mississippi
Jennifer Gholson, MD
Medical Officer for Magnolia Health Plan
Lee Reilly, RN
Management and Quality for Magnolia Health Plan

D7 Emergencies in Palliative Care
Glen Mire, MD, ABFM, Certificate of Added Qualifications (CAQ) Geriatric Medicine, CAQ Hospice and Palliative Medicine
Medical Director, Hospice of Acadiana, Clinical Associate Professor LSU Family Medicine

3:15 – 3:45 **Afternoon Break**

3:45 – 4:45 **Closing Plenary: "Palmetto GBA Update"**
Charles Canaan, RN, MPH
Senior Provider Education Consultant, Palmetto GBA

LMHPCO Annual Leadership Post Conference
Friday, July 29, 2011

7:30 -8:30 **Registration**

8:30-10:00 **Morning Concurrent Session**

PC1 Introduction to Symptom Management
Glen Mire, MD, ABFM, Certificate of Added Qualifications (CAQ) Geriatric Medicine, CAQ Hospice and Palliative Medicine
Medical Director, Hospice of Acadiana, Clinical Associate Professor LSU Family Medicine

PC2 2011 Palmetto GBA Hospice Workshop Series: Hospice Billing
Tammy Tucci, BS
J11 MAC Provider Outreach & Education, Senior Ombudsman, Palmetto GBA

PC3 Cultural Diversity in Hospice Care
Martha Webb MSW, LCSW-BACS, CT
Social Work Team Leader, Life Source Hospice
Raynell Smith
Chaplain. Life Source Hospice

PC4 HITECH – Are You Compliant?
Jennifer Kennedy, MA, BSN, RN
Regulatory & Compliance Director
National Hospice & Palliative Care Organization

PC5 I Want to be on the Board: What Do I Need to Know?
Sandra Bishop, DNS, RN
Academic Coordination and Assistant Professor
The University of Southern Mississippi

PC6 We Honor Veterans
Isabel Cordua, BA
Director of Support Services
Hospice Ministries, Inc.

PC7 Medications in End of Life: To Withdraw Or Not To Withdraw, That's The Question!
Dominique Anwar, MD
Associate Professor of Medicine, Tulane SOM
Director, Palliative Care Program
Jack McNulty, MD, F.A.C.P., FAAHPM
President, Palliative Care Institute of Southeast Louisiana, Medical Director, Hospice of St. Tammany, Associate Professor, Clinical Medicine, LSUHSC

10:00 – 10:30 Break

10:30 – 12:00 Concurrent Sessions

PC8 Why Seek Certification?
Jack McNulty, MD, F.A.C.P., FAAHPM,
President, Palliative Care Institute of Southeast Louisiana, Medical Director, Hospice of St. Tammany, Associate Professor, Clinical Medicine, LSUHSC
Melody Eschete, RN,
Governor Jindal's Hospice Advisory Committee – Volunteer Representative & Member Secretary, Volunteer Coordinator - Clarity Hospice Baton Rouge
Glen Mire, MD, ABFM, Certificate of Added Qualifications (CAQ) Geriatric Medicine, CAQ Hospice and Palliative Medicine,
Medical Director, Hospice of Acadiana, Clinical Associate Professor LSU Family Medicine
Connie Malcom, RN,CHPN
Director-Hospice of Light

PC9 2011 Palmetto GBA Hospice Workshop Series – Clinical Topics
Charles Canaan, RN, MPH
Senior Provider Education Consultant
Palmetto GBA

PC10 Honoring Our Patients Wishes to Give the Gift of Sight through Eye Donation
Christine Castillo, RN, BSN
Hospice Liaison, Southern Eye Bank

PC11 Hospice Regulatory Update
Jennifer Kennedy, MA, B.S.N., RN
Regulatory & Compliance Director
National Hospice & Palliative Care Organization

PC12 Grieving on the Internet: The Effects of World Wide Web on Grief
Sarah McAllister, MSW
Newcomb Scholars Program Coordinator, Tulane University

PC13 Veteran to Veteran
Isabel Cordua, BA
Director of Support Services
Hospice Ministries, Inc.

PC14 Effectively Marketing Your Hospice Agency
Denise Clayton, M.Ed.
Community Liaison, Hospice of Natchitoches, LA
Rebecca Pardue, RN
Patient Care Manager, Forrest General Hospice, Hattiesburg, MS

EMERGENCY PREPAREDNESS
Questions & Answers

1. Are state surveyors looking for a special type of Disaster or Emergency Preparedness Plan? Any special key features required?

The only regulatory requirement specified in the Hospice Licensing Standards is found at §8235. Agency Operations D. Operational Requirements 1. Hospice's responsibility to the community:
(f.) shall have policy and procedures and a written plan for emergency operations in case of disaster. Nothing in the regulations specifies what must be in that written plan. Home Health Agencies are required to have a written plan that includes reporting and training responsibilities as well as fostering communication and rapport between the agency and the local Office of Emergency Preparedness. There was a Model Plan developed by OEP that may be useful in developing the hospice plan. You may contact your local OEP to request a copy of the Home Health Model Plan. You could then adapt the plan to better meet the hospice rather than the home health patient's needs. If the hospice has an inpatient unit, they should look at actually having a contract with other facilities to evacuate to as the nursing homes do. Basically, patients should be evaluated to determine their care category- Hospital Admit, Hospital Shelter, or Minimal Needs patients. Patients who have caregivers should be encouraged to work with their caregivers to plan for emergency. When an emergency is declared,

Marion Tate

Art Sharpe

the local OEP should be notified of specific names and contact information of those patients requiring community assistance. You should have contracts with local hospitals for those patients that require hospitalization. LMHPCO is working to get information from hospices to determine the needs of individuals who are unable to evacuate without public assistance. I would urge you to update the website that they are using as in the event of an emergency, it will be shared with those that need the information. It is not something that will be used to determine how many patients a particular provider may have, it's not to be used to determine competition, it's only for emergency preparedness.

The Mississippi State Board of Health recently adopted regulations requiring an emergency operations plan for each licensed facility and specifying the requirements for facility emergency operations plans. In concert with the Louisiana-Mississippi Hospice and Palliative Care Organization and other healthcare industry representatives, the Mississippi State Department of Health is developing specific guidelines which will be passed on to health care facilities as they become available. Because the guidelines are not fully developed, facilities with existing emergency operations plans will be provisionally approved pending an in-depth review.

2. What type of patient/family education are you expecting to see?

Patient education should begin upon admit and should be an ongoing process. They should be informed of the hospice's role and responsibilities as well as the patient or family responsibility. Patients and families should be informed of the potential danger from the impending disaster. Patients should be encouraged to evacuate with family in the event of a disaster. Patients should be informed that the hospice also has a responsibility to their staff and therefore will not be able to put staff in danger to rescue the patient who chooses not to evacuate when the need arises. Hospices should give patients an alternate means of communication in the event that telephone land lines are not available. Hospices should, in the event of a disaster, ask for alternate cell numbers for the patient and/or family and ask what their plans are. We need to stress that using a Medical Special Needs Shelter should be the last resort rather than what is planned for the patients. There are limited resources, limited space, and rather primitive conditions in

the MSNS. They would be much better off if they have their own plan and attempt to follow it rather than simply thinking "shelter".

LMHPCO is doing an outstanding job of coordinating resources for individuals who have no existing resources or plans to evacuate. The software package you have developed is quite useful and, if properly utilized, will be of great assistance to your clients. One opportunity I see for disaster preparation might be to help patients with a disaster preparation inventory and checklist that would ensure adequate preparation for home-health based hospice patients to shelter in place or evacuate.

3. In the event of hurricane or other disaster, what is the hospice's responsibility relating to transportation during an evacuation? Who is financially responsible for this transportation?

Hospices have not typically been responsible for transportation costs and should not be responsible for that cost in the event of a disaster either with the exception of inpatient hospice facilities. While in an inpatient hospice, there should be plans for evacuation in the event that it is necessary. Those plans should include transportation to a receiving facility as well as staff to continue providing care during and after evacuation. Hospices should assist in coordinating the transportation needs of their patients in the event of a disaster. You must take into consideration that the time required to get a response will increase with the severity and magnitude of the event. As part of your disaster planning, you should have determined prior to a disaster, which patients will require transportation and which have caregivers that will accept that responsibility.

The hospice's responsibility is to first, develop a plan. Second, obtain evacuation transportation resources commensurate with the hospice patient's medical condition. Third, arrange a point for the patient to be transported to that can provide care commensurate with the hospice patient's needs. Fourth, to care medically, socially and psychologically for the hospice patient during transport. Fifth, (especially for residential facilities) don't "abandon" the patient to the mode of transportation. If you evacuate a residential facility, send caregivers who can care for them until they safely arrive at the receiving facility.

4. What about continuing services during a mandatory or other evacuation? Does the hospice have to stay if an evacuation is called? Can the hospice provide services outside of the 50-mile radius if they are evacuated and patients/ families have also evacuated to the same area? Example: patients are sheltered in a school gym or city hall outside of your service area and you have a nurse in the area. Can you visit them and provide care even when it is outside of your normal 50-mile service area?

DHH does not expect a hospice to break the law (by remaining when there is a mandatory evacuation) or to put their employees in danger. Patients should be made aware that if they choose to remain in their home, there will be no one from the hospice available to provide services due to the fact that the hospice is being forced to evacuate. Of course, you should return to business as usual as soon as possible after the emergency situation.

Does the hospice have to stay if an evacuation is called?

No. Can the hospice provide services outside of the 50-mile radius if they are evacuated and patients/ families have also evacuated to the same area? Example: patients are sheltered in a school gym or city hall outside of your service area and you have a nurse in the area. Can you visit them and provide care even when it is outside of your normal 50-mile service area? There has been no legislation passed to enable a hospice provider to see patients outside their service area in the event of a disaster. However, if the hospice patient does not require transfer to another hospice for immediate attention, there is nothing that forces the hospice to discharge or transfer a patient. Special Needs Shelters seemed to welcome volunteers. On a case by case basis, I would expect the hospice to evaluate the situation and determine whether the patient in the shelter needs the hospice nurse to follow up and assist in care. Providing care to a hospice's current patients who have temporarily relocated should not be an issue-unless that hospice is also seeking referrals for other patients outside the service area. Hospices should be encouraged to make every effort to follow their patients and continue services within reason. This may be a challenge, depending on where patients go and how many nurses may have also evacuated to that area, however, if the hospice has the ability to locate the patients and have staff in the area, please encourage the staff to continue to

follow the patients when possible.

No, but logically you should evacuate when arrangements have been made for your patients.

Under a declaration of emergency many existing laws, rules and regulations may be waived, enabling you to provide services at whatever location the patients evacuate to.

5. How long can you keep a patient on service during evacuation? What documentation is necessary? Could telephone assistance and referral if necessary be sufficient or until return to area is announced if it does not exceed 2 weeks?

There is no set time frame as to how long a patient can be kept on service during an evacuation. However, if the patient is due for recertification, you must be able to assess and develop that Plan of Care.

Documentation should include any information available about the circumstances- for example, a case conference indicating that the patient evacuated with family to wherever they are, due to the hurricane.

Any phone calls or other communication should be documented in the patient's record as soon as feasible. Even if you don't have your normal computer system, a hand written note documenting the situation and what was done should be available for surveyors to see as well as available for communication between hospice staff.

Could telephone assistance and referral if necessary be sufficient or until return to area is announced if it does not exceed two weeks?

Yes. There's not actually a 2 week deadline. If you can't have the IDT meeting, you can still keep the patient on service, documenting what is going on and attempting to follow the patient. You may not have a formal IDT, but perhaps there could be telephone meetings. The key is documenting what is going on and what you are doing,

This is a matter for you and CMS to work out. You should provide care to patients who have evacuated and with whom you have evacuated until you are relieved of that responsibility by competent authority.

6. What if when your return to your area there is a curfew i.e. no one allowed out of their homes between 6 pm and 6 am? Can you tell returning patients that you can only provide service between those hours to ensure safety of your staff and comply with local authorities? After those hours, you will triage calls and they may have to access emergency services if available.

Yes, you can inform patients that if they choose to return to the area, your staff will be available for telephone assistance only during times of a city imposed curfew. They would be expected to make home visits only during the time that they are allowed on the streets. DHH should never expect a hospice to break the law or endanger their staff by being out after curfew.

Exceptions are usually granted to medical personnel. Get with your local emergency manager and get an exemption, an exception, a pass, or whatever is necessary for you to travel.

7. How many hours of oxygen must you supply for evacuation and backup in the event of loss of electricity? Suppliers often limit supplies as they wait to see where the hurricane will most effect. What responsibility do you have to provide enough oxygen for evacuation if none is available in your area?

DHH cannot specify how many supplies you provide. You must provide what you determine to be necessary. You must make every effort to provide oxygen if the patient requires oxygen.

The same responsibility you have to provide oxygen to your patients under normal circumstances. A realistic planning process, properly implemented, will result in no interruption of oxygen therapy to your patients. Plan ahead.

8. In this type of major disaster with disruption of essential services in the service area of the hospice, do all services have to be provided to resume care? Example: Nurses, Hospice Aides and Spiritual Care staff is available but the Social Workers have not returned.

All services should be provided, however, there is nothing to prevent a Registered Nurse from providing some of the services that a Social Worker would typically provide.

Your plan should include provisions for competent contract or volunteer personnel to enable you to resume providing care at your location as soon as practical after your return..

9. When receiving evacuated patients from a disaster area and the nursing facility records indicate they are a hospice patient but no legal representative is available for admission, may the hospice admit on good faith until family is located? If so, how long can we provide hospice care for this patient without legal consent? We found that the hospice and the family were often displaced and the patients needed hospice care. Please give guidance to the receiving programs as well as to the evacuating program. What should the evacuating program provide with each patient? If not present, can the receiving hospice still provide care that is needed with the best information they have?

If the patient is not their own legal representative, the hospice would not have the authority to admit the patient if the legal representative is not available.
When the patient is being evacuated, the evacuating program, (if they are aware that the responsible party will be going in a different direction) could possibly send written authorization from the responsible party, to give the receiving hospice authority to care for the patient. Another option would be for the evacuating hospice to contract with the receiving hospice to provide services. That way, the receiving hospice would not admit the patient as their patient-it would still be a patient of the evacuating hospice which had the authorization to provide services.

The hospice can admit based on several factors, including the patient's record, CMS billing records, a patient census, a letter from the hospice administrator, or other competent records. Additionally, under Mississippi law, a person of legal age otherwise competent may consent to medical or surgical treatment on their own behalf. There are other provisions for emergency treatment without consent which may also apply.

10. Regarding hospice patients residing in nursing facilities: does the hospice have any responsibility for arranging transportation? Providing staff to the facility during evacuation? Any special guidance to hospices in regards to residential hospice care in nursing facilities?

Coordinating-yes. Arranging and/or paying for transportation-no. The hospice does not have a responsibility for providing staff to the facility at any time. The hospice does retain responsibility for ensuring coordination of care for their patients. When a hospice accepts a nursing home patient, the nursing home is still responsible for providing the care that they would provide to any other nursing home resident (including transporting the resident to wherever they are evacuating the rest of the residents to). The hospice is responsible for the management of that resident's care.

Yes. Your plan should include provisions to return evacuated patients and staff to your hospice facility or hospice care location. Your plan should also include keeping your hospice patients together if possible so that you don't have to provide staff and services in multiple locations.

11. What can the hospice do when a patient/family refuses to evacuate the area, then at the last minute when it is too late for hospice to assist, they decide they need help? Would referral to the local OEP or agency responsible for assistance be sufficient?

The hospice should be informing the patient/family of the need to evacuate and trying to educate and encourage them to evacuate. Then, in the event that they refuse, let them know that the hospice will be evacuating and therefore unavailable to assist them. If it is safe to assist, then assist them in evacuating. But, if your staff have evacuated as they should, then please call the local authorities and inform them of the situation.

12. What is the hospice's responsibility during a death of a patient in the event of evacuation during a storm or other emergency situation? Examples of situations that did occur are:

- The patient did not evacuate and the family calls for hospice staff to return to the area and handle the death / destruction of medications. They were very hostile that the hospice did not leave staff in the area under mandatory evacuation nor did they return before authori-

ties allowed return.

- 911 operator calls the hospice to come pick up the body during Katrina during a mandatory evacuation of the New Orleans area.

The hospice must follow the law. If they were advised to evacuate, then they should do so. A hospice should inform the patients/families that they will not be available due to the mandatory evacuation. They should then instruct the family (when they are called regarding a death) that they (the hospice) will call the local authority to deal with the death in their absence (just as would be done for a death of a non-hospice patient) Hospice does not transport bodies whether it be during an evacuation or not. The hospice should not accept the responsibility for transporting a body during an evacuation when they would not be responsible for such at other times.

Although this answer does not define the legal standard of care, you should continue to assist hospice patients to evacuate until it is no longer humanly possible. Referral to local emergency management authorities at that point may be your only option. LMHPCO's patient tracking software may prove invaluable in such instances.

13. Are there any special provisions for Hospice Inpatients Units that can safely provide care in their facility but can't meet the 80/20 rule since housing is not available for residents to return to the area?

This is a reimbursement issue-not a regulatory issue. To my knowledge, there are no provisions to ignore the 80/20 rule, however, if the patient does not require inpatient care, but you would like to keep them in the inpatient unit for other reasons, you can bill the patient room/board, and bill Medicare for routine home care rate. You may also admit to your inpatient unit, patients from other hospices that may need inpatient care. You would contract with the other hospice and bill that hospice for the inpatient care. That patient would not count as part of your 20%. It would be counted against the hospice that actually is billing Medicare as part of their 20%. In addition, just for clarification, that 20% is determined for the year-not just for the few weeks during a certain time frame. So, technically, this should not really be an issue as you should also be providing care to outpatients all year long.

There is no all-inclusive answer for this question. The answer is entirely situational and depends on the severity of the disaster.

14. Please address any other issue that you have heard from providers relating to hurricane preparedness and the provision of hospice care surrounding a hurricane or other disaster.

Just to reiterate, hospice agency staff should not be sent into hazardous areas or be required to operate under hazardous conditions during disasters. The biggest issue to help you in the long run, is to educate the patients and families. You cannot compel people to follow specific emergency plans, but you can educate them regarding the dangers.

You must also ensure not only that you have an Emergency Plan, but test that plan and evaluate the effectiveness. You should also encourage your staff to have plans regarding their families and their responsibilities to the hospice. Planning ahead is paramount for your staff.

Learn from the experiences of previous hurricanes. Many people didn't have alternate phone numbers to contact patients/families/staff of their agencies. You may consider giving/receiving alternate numbers for communication. Perhaps there is a family member in another state that the patient/family will be checking in with. Would they be willing to give you that person's contact information so you can check on the patient-or even your staff.

Please also address recertification during evacuation. I understood you to say that we had to transfer or discharge a pt if recert came up and we could not physically see them. If a patient is due to be recertified during the time of an evacuation, if you have been able to assess that patient and work out the plan of care, there is no reason to discharge-unless they need to be transferred to another hospice during that time. If you have not been able to assess the patient and develop the PoC, then you would need to discharge.

Please address the acceptable way to handle a recert during evac. We complete our documentation usually 2 weeks before the recert so proper discharge planning can be completed if will not recert. If you have assessed that patient early, and have met with the IDT and developed the PoC, even if the recert is during the evacuation, you still continue with care as much as possible. You would not discharge, but resume care when the patient and your staff return to the area or when you are able to see the patient wherever they evacuated to. Med. Director reviews and writes a note verifying appropriateness along with rationale.

Could a visit that early be acceptable? Yes. Would need to know about signatures if can't meet the time requirements. If you have assessed the patient and the IDT has meet (even if in these rare circumstances it was a telephone team meeting with minimal participation, document who was participating in that phone conference meeting and get signatures later.

Also, how to handle IDT during evac. Is it acceptable to document that did not have IDT due to mandatory evacuation?

Yes, if you are unable to hold IDT meetings due to an evacuation or other disaster, document the fact that the meeting did not occur and then hold the meetings as soon as possible thereafter. Documentation is vital. You may loose computers and therefore your documentation is not the same as previously, but you must maintain professional standards. Handwritten documentation (physician's order, skilled nurse's notes, aide visit notes, etc.) is necessary in the event that you don't have your computer generated documentation.

The Mississippi State Department of Health has issued a Request for Proposals to provide emergency operations plan review expertise and planning assistance to licensed healthcare facilities, including hospices. We look forward to working with each of you either in person or via a contractor to achieve reliable, realistic and workable emergency operations plans for your facilities, staff and residents.

Editor's Note: Questions were submitted to both the Louisiana Dept. of Health (Marion Tate, Hospice Program Director) and the Mississippi State Department of Health (Art Sharpe, Director, Offices of Emergency Planning and Response). Their respective responses to those questions follows.

Calendar

www.LMHPCO.org

July 26, 2011
LMHPCO Board of Directors Meeting
Loews New Orleans Hotel
3:00 – 5:00 PM

July 27-29, 2011
LMHPCO Annual Leadership Conference
Loews New Orleans Hotel
http://tinyurl.com/44sh64n

September 23, 2011
"End of Life Care and Spirituality: Bridging the Gap for Hospice Chaplains"
Jackson, MS

October 6-8, 2011
NHPCO's 12th Clinical Team Conference and Pediatric Intensive
Town and Country Resort and Convention Center,
San Diego, CA
Preconference Events:
October 4-5, 2011
Main Conference:
October 6-8, 2011
www.nhpco.org

October 20-21, 2011
SW End-of-Life Education Project
Jackson, MS • Location TBD

November 11, 2011
"End of Life Care and Spirituality: Bridging the Gap for Hospice Chaplains"
Shreveport, LA

Winter 2012
SW End of Life Education Project
Shreveport, LA
Date and Location TBD

Mississippi State Department of Health

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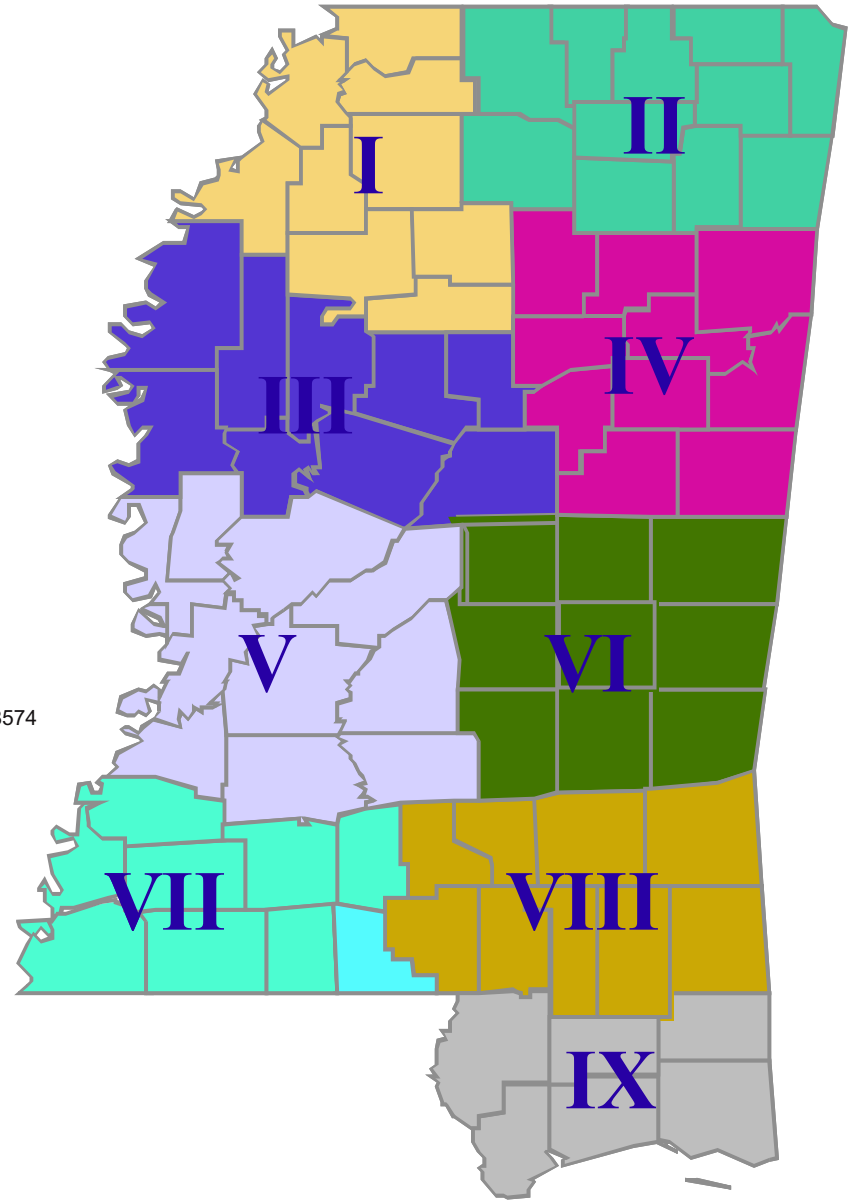

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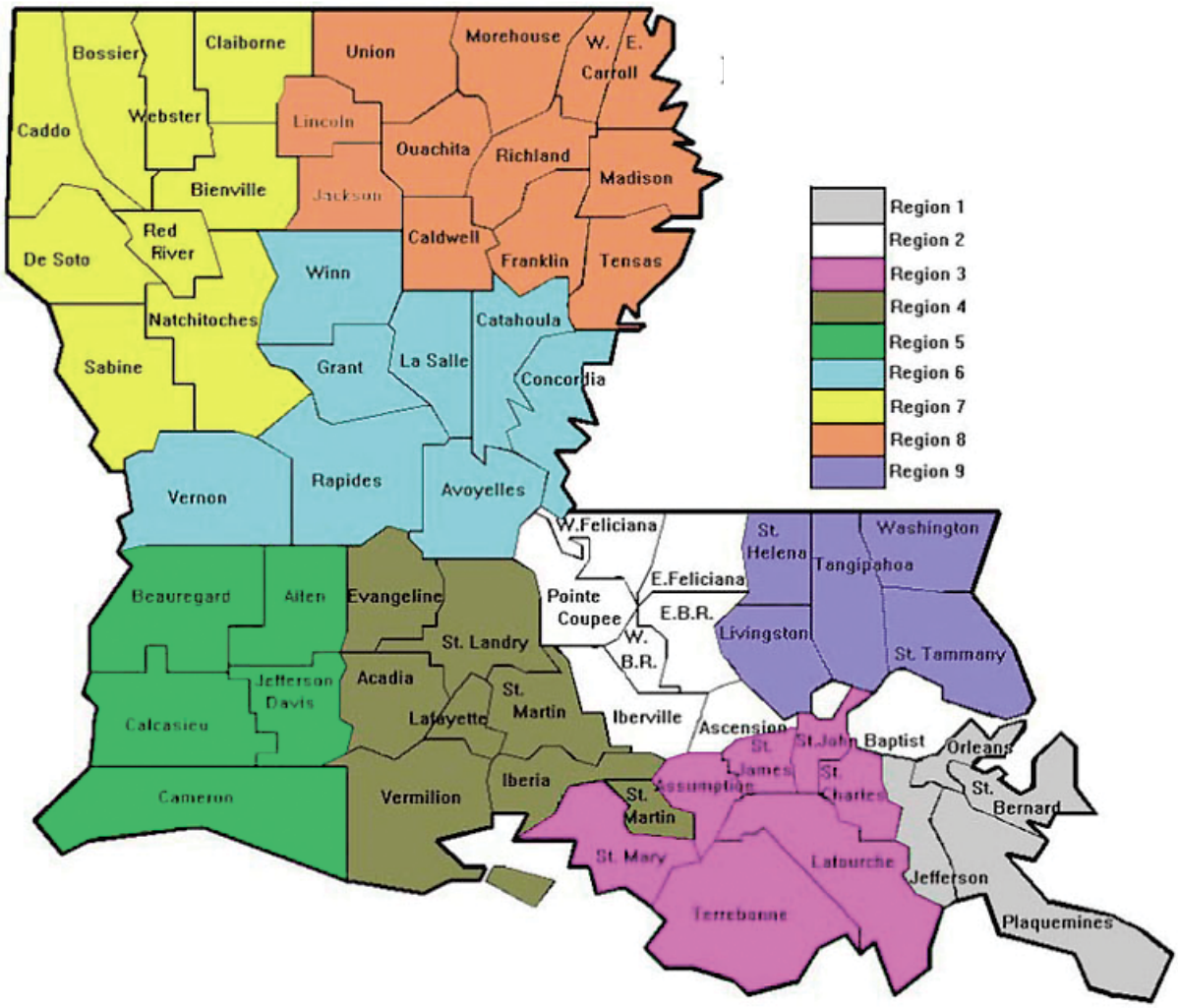

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Livingston	Mark Benton	(225) 686-3066	(225) 686-7280	mbenton@lpoep.org

Parish Homeland Security & Emergency Preparedness Contact Numbers

Madison	Earl Pinkney	(318) 874-3907	(318) 874-3910	earl_pink_99@yahoo.com
Morehouse	James Mardis	(318) 871-3907 (318) 281-4141	(318) 281-1773	mpsojmardis@bellsouth.net
Natchitoches	Victor Jones	(318) 352-6432	(318) 357-2208	jperkins@nppj.org
Orleans	Jerry Sneed	(504) 658-8700	(504) 658-8701	jsneed@nola.gov
Ouachita	Butch Beckham Tracy Hilburn	(318) 322-2641 (318) 322-7356		bbeckham@ohsep.net thilburn@ohsep.net
Plaquemines	Michelle Tassin	(504) 274-2476	(504) 297-5316	michelle_tassin@plaqueminesparish.com
Pointe Coupee	Donald Ewing	(225) 694-3737	(225) 694-5408	daewing@pcpso.org
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Red River	Russell Adams	(318) 932-5981	(318) 932-5802	ra1160@netzero.net
Richland	Joey Evans	(318) 728-2061	(318) 728-7004	rppj@inetsouth.com
Sabine	David Davis	(318) 256-2675	(318) 256-9652	spoep@suddenlinkmail.com
St. Bernard	David Dysart	(504) 278-4267	(504) 278-4493	ddysart@sbpg.net
St. Charles	Scott Whelchel	(985) 783-5050 Dispatch (24 hr)	(985) 783-6375	swhelchel@scpeoc.org communications@scpeoc.org
St. Helena	Jessica Strickland	(225) 222-3544	(225) 222-3696	gordon571@hotmail.com
St. James	Eric Deroche	(225) 562-2364	(225) 562-2269	eric.deroche@stjamesla.com
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St. Martin	Sheriff Ronnie Theriot	(337) 394-3071	(337) 394-5705	ohsep@stmartinsheriff.org
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St. Tammany	Dexter Accardo	(985) 898-2359	(985) 898-3030	daccardo@stpgov.org
Tangipahoa	Dawson Primes	(985) 748-3211	(985) 748-7050	dawson.primes@tangipahoa.org
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Vermilion	Rebecca Broussard	(337) 898-4308	(337) 898-4309	vpoep@cox-internet.com
Vernon	Howard Hudgens	(337) 238-0815	(337) 238-9025	jhudgens@vpso.org
Washington	Tommy Thiebaud	(985) 839-0434	(985) 839-0435	tthiebaud@wpgov.org
Webster	John Stanley	(318) 846-2454	(318) 846-2446	websterohsep@wildblue.net
West Baton Rouge	Deano Moran	(225) 346-1577	(225) 346-0284	deano.moran@wbrcouncil.org
West Carroll	Peggy Robinson	(318) 428-8020	(318) 428-8025	wcpoep@bellsouth.net
West Feliciana	Chief Tommy Boyett	(225) 635-6428	(225) 635-6996	tboyett@wfpso.org
Winn	Harry Foster	(318) 628-1160	(318) 628-7182	winnparishohsep@bellsouth.net

WE HONOR VETERANS

Are you aware that:

- *Of 2.4 million deaths in the United States each year, approximately 680,000 are Veterans; basically, one in four dying Americans today is a Veteran.*
- *Veterans often carry experiences from their military service that present unique challenges at the end of life.*
- *A vast majority of Veterans are not enrolled in VA and may not be aware of end-of-life services and benefits available to them, including the Medicare Hospice Benefit and VA-paid hospice care. Of those who are enrolled, nearly 40% of them live in areas that are considered rural where many healthcare services are not often readily available.*
- *Also, in rural and urban areas, more than 200,000 veterans are without shelter and lack basic health care. The challenges are even greater for those homeless Veterans with life-limiting disease.*

Even though your hospice may already be serving Veterans, you may not be aware of a patient's detailed service in the armed forces or if so, you may need more information and resources to help you better care for the unique needs of Veteran patients at the end of life.

We Honor Veterans is a national hospice provider awareness campaign conducted by the National Hospice and Palliative Care Organization (NHPCO) in collaboration with the Department of Veterans Affairs (VA) to improve care Veterans and their families receive at the end of life. Because the VA continues to have substantial variability in the availability, quality and expertise of care delivered at the end-of-life, they have strategically partnered with NHPCO to help hospices across the country be better prepared to:

- Build professional and organizational capacity to provide quality care for Veterans;
- Develop and/or strengthen partnerships with VA and other Veteran organizations in their community;
- Increase access to hospice and palliative care for Veterans living in their community; and
- Network with other hospices across the country to learn about best practice models.

By recognizing the unique needs of our nation's Veterans who are facing a life-limiting illness, your hospice can accompany and guide Veterans and their families toward a more peaceful ending. And in cases where there might be some specific needs related to the Veteran's military service, combat experience or other traumatic events, ***We Honor Veterans*** also provides you tools and resources to help support those you are caring for. Through ***We Honor Veterans***, NHPCO is committed to helping your hospice understand and better serve Veterans at the end of life and work more effectively with VA medical facilities in your community.

If your hospice has not already done so, join the ***We Honor Veterans*** campaign at no cost by signing and submitting the Partner Commitment form, found on the website. Your hospice can then "earn your stars" and receive a matching ***We Honor Veterans*** logo by completing activities for each of the four Partner levels of commitment. By displaying the logo, Veteran organizations and community members can easily identify that your hospice has made a commitment to offer veteran-specific care and services which, in return, can ultimately increase access to more Veterans and their families.

For more information and to enroll your hospice, visit www.WeHonorVeterans.org.

WE HONOR VETERANS

WE HONOR VETERANS

We Honor Veterans a program of the National Hospice and Palliative Care Organization (NHPCO) in collaboration with the Department of Veterans Affairs (VA) invites hospices, state hospice organizations, Hospice-Veteran Partnerships and VA facilities to join a pioneering program focused on respectful inquiry, compassionate listening and grateful acknowledgment. By recognizing the unique needs of America's veterans and their families, community providers, in partnership with VA staff, will learn how to accompany and guide them through their life stories toward a more peaceful ending.

Become a WHV Partner

Through this program, local community hospices can join hospice providers across the country in honoring our Nation's Veterans and be listed as Partners on the We Honor Veterans website. By becoming a We Honor Veteran Partner, hospices will be better prepared to:

1. Build professional and organizational capacity to provide quality care for Veterans
2. Develop and/or strengthen partnerships with VA and other Veteran organizations
3. Increase access to hospice and palliative care for Veterans in their community
4. Network with other hospices across the country to learn about best practice models www.WEHonorVeterans.org

Here are LMHPCO members in the process of building their competency with regards to Veterans.

AseraCare Hospice
Corinth, MS • Level One

Brighton Bridge Hospice
Oberlin, LA • Recruit

Christus Hospice & Palliative Care - Schumpert
Shreveport, LA • Recruit

Deaconess Hospice
Biloxi, MS • Recruit

Doctors Hospice - Livingston
Walker, LA • Recruit

Faith Foundation Hospice
Alexandria, LA • Recruit

Gentiva Hospice of Booneville
Booneville, MS • Recruit

Hospice Care of Avoyelles
Alexandria, LA • Recruit

Hospice Compassus
Monroe, LA • Recruit

Hospice Compassus - Slidell/New Orleans
Metairie, LA • Recruit

Hospice Ministries, Inc.
Ridgeland, MS • Recruit

Hospice of Acadiana, Inc.
Lafayette, LA • Level One

Hospice of Light
Gautier, MS • Recruit

Hospice of Shreveport/Bossier
Shreveport, LA • Recruit

Hospice of South Louisiana
Houma, LA • Level One

Lakeside Hospice
Metairie, LA • Recruit

Louisiana Hospice & Palliative Care
Opelousas, LA • Level One

Louisiana Hospice & Palliative Care
Mamou, LA • Recruit

Louisiana Hospice & Palliative Care - Jennings
Jennings, LA • Level One

Notre Dame Hospice
Slidell, LA • Recruit

Odyssey Hospice of Jackson, MS
Flowood, MS • Recruit

Odyssey Hospice of Lake Charles
Lake Charles, LA • Recruit

Odyssey Hospice of New Orleans
Metairie, LA • Recruit

Odyssey Hospice of Northwest Louisiana
Shreveport, LA • Recruit

Paramount Hospice
Lafayette, LA • Recruit

Patient's Choice Hospice & Palliative Care
Tallulah, LA • Level One

Patient's Choice Hospice & Palliative Care
Vicksburg, MS • Level One

Premier Hospice, LLC
Bastrop, LA • Recruit

Quality Hospice Care, Inc
Philadelphia, MS • Recruit

St. Joseph Hospice - Acadiana
Lafayette, LA • Recruit

St. Margaret's Hospice
Gretna, LA • Recruit

Sanctuary Hospice
Tupelo, MS • Recruit

Members make the work of LMHPCO possible!

(2011 memberships received as of 6/13/2011)

2011 PROVIDER MEMBERS:

A& E Hospice, Inc, Olive Branch, MS
Agape Hospice Care of Shreveport, LA
Agape Northeast Hospice, West Monroe, LA
Agape Northwest Regional Hospice, Minden, LA
Angelic Hospice & Palliative care, Greenwood, MS
Aseracare Hospice, Corinth, MS
Aseracare Hospice, Senatobia, MS
Aseracare Hospice, Tupelo, MS
At Home Hospice Care, Fayette, MS
Baptist Hospice Golden Triangle, Columbus, MS
Baptist Memorial Homecare & Hospice of North MS, Batesville, MS
Baptist Memorial Homecare & Hospice of North MS, Southaven, MS
Brighton Bridge Hospice, Oberlin, LA
Camellia Hospice of East Louisiana, Vidalia, LA
Camellia Home Health & Hospice, Biloxi, MS
Camellia Home Health & Hospice, Bogalusa, LA
Camellia Home Health & Hospice, Hattiesburg, MS
Camellia Home Health & Hospice Jackson, MS
Camellia Home Health & Hospice, McComb, MS
Christopher B Epps Palliative Compassionate Care Unit (MSP), Parchman, MS
Christus Hospice & Palliative Care – St Frances Cabrini, Alexandria, LA
Christus Hospice & Palliative Care – St Patrick Hospital, Lake Charles, LA
Christus Hospice & Palliative Care Schumpert, Shreveport, LA
Circle of Life Hospice, Inc, Shreveport, LA
Clarity Hospice of Baton Rouge, LA
Comfort Care Hospice, Laurel, MS
Community Hospice, New Orleans, LA
Community Hospice, Inc, Batesville, MS
Community Hospice, Inc, Hattiesburg, MS
Community Hospice, Inc, Verona, MS
Continue Care Hospice, Cleveland, MS
Continue Care Hospice, Hollandale, MS
Continue Care Hospice, Yazoo City, MS
Crossroads Hospice, LLC, Delhi, LA
Deaconess Hospice, Biloxi, MS
Deaconess Hospice, Brookhaven, MS
Deaconess Hospice, Hattiesburg, MS
Delta Regional Medical Center Hospice, Greenville, MS
Delta Soul Medical, LLC, Cleveland, MS
Doctors Hospice - Livingston, Walker, LA
Elayn Hunt Correctional Center End of Life Care, St Gabriel, LA
Faith Foundation Hospice, Alexandria, LA
Forrest General Hospice, Hattiesburg, MS
Generations Hospice Service Corporation, Denham Springs, LA
Gentiva Hospice, Booneville, MS
Gentiva Hospice, Starkville, MS
Gentiva Hospice, Tupelo, MS
Grace Community Hospice, Cleveland, MS
Guardian Hospice Care, Alexandria, LA
Harmony Life Hospice, Shreveport, LA
Harmony Hospice, LLC, Metairie, LA
Heart of Hospice, Lake Charles, LA
HL Haydel Memorial Hospice, Houma, LA
Hospice Associates, Baton Rouge, LA
Hospice Compassus, Alexandria, LA
Hospice Compassus, Baton Rouge, LA
Hospice Compassus, Lafayette, LA
Hospice Compassus, Mc Comb, MS
Hospice Compassus, Meridian, MS
Hospice Compassus, Monroe, LA
Hospice Compassus, Natchez, MS
Hospice Compassus, New Orleans, LA
Hospice Compassus, Shreveport, LA
Hospice Compassus, Slidell, LA
Hospice Care of Avoyelles, Alexandria, LA
Hospice Care of Avoyelles, Marksville, LA
Hospice Care of Avoyelles, Opelousas, LA
Hospice Ministries, Brookhaven, MS
Hospice Ministries, Mc Comb, MS
Hospice Ministries, Ridgeland, MS
Hospice of Acadiana, Lafayette, LA
Hospice of Caring Hearts, LLC, Dubach, LA
Hospice of Light, Gautier, MS
Hospice of Light, Lucedale, MS
Hospice of Many, LA
Hospice of Natchitoches, LA
Hospice of St Tammany, Covington, LA
Hospice of Shreveport/Bossier, LA
Hospice of South Louisiana, Houma, LA
Infinity Care Hospice of Louisiana, LLC, Gretna, LA
Jordan's Crossing Hospice, Shreveport, LA
Lakeside Hospice, Metairie, LA
LifePath Hospice Care Services, LLC, Shreveport, LA
Life Source Services, LLC, Baton Rouge, LA
Louisiana Hospice & Palliative Care, Jennings, LA
Louisiana Hospice & Palliative Care, Mamou, LA
Louisiana Hospice & Palliative Care, Monroe, LA
Louisiana Hospice & Palliative Care, Opelousas, LA
Louisiana State Penitentiary Hospice, Angola, LA
Magnolia Regional Medical Center Home Health & Hospice, Corinth, MS
Mid-Delta Hospice of Batesville, MS
Mid-Delta Hospice of Canton, MS
Mid-Delta Hospice, Belzoni, MS
Mid-Delta Hospice, Charleston, MS
Mid-Delta Hospice, Clarksdale, MS
Mid-Delta Hospice, Cleveland, MS
Mid-Delta Hospice, Greenville, MS
Mid-Delta Hospice, Greenwood, MS
Mid-Delta Hospice, Indianola, MS
Mid-Delta Hospice, Lexington, MS
Mid-Delta Hospice, Yazoo City, MS
North Mississippi Medical Center Hospice, Tupelo, MS
Notre Dame Hospice, Slidell, LA
Odyssey Hospice, Flowood, MS
Odyssey Hospice, Lake Charles, LA
Odyssey Hospice, Mandeville, LA
Odyssey Hospice, Metairie, LA
Odyssey Hospice, Shreveport, LA
Odyssey Hospice of the Gulf Coast, Gulfport, MS
Patient's Choice Hospice, Tallulah, LA
Patient's Choice Hospice, Vicksburg, MS
Pax Hospice, Ridgeland, MS
Pointe Coupee Hospice, New Roads, LA
Paramount Hospice Acadiana, Lafayette, LA
Premier Hospice, Bastrop, LA
Professional Hospice Care, Jonesboro, LA
Professional Hospice care, Ruston, LA
Providence Hospice South, Hattiesburg, MS
Quality Hospice Care, Philadelphia, MS
Regional Hospice & Palliative Services, SW, Baton Rouge, LA
Regional Hospice & Palliative Services, SE, Lafayette, LA
Regional Journey Hospice, Mandeville, LA
Richland Hospice, Rayville, LA
River Region Hospice, LLC, River Ridge, LA
River Region Hospice House, River Ridge, LA
St. Catherine's Hospice, LLC, LaPlace, LA
St. Joseph Hospice of Acadiana, Lafayette, LA
St. Joseph Hospice, Baton Rouge, LA
St. Joseph Hospice of CENLA, Alexandria, LA
St. Joseph Hospice, New Orleans, LA
St. Joseph Hospice , Shreveport, LA
St. Joseph Hospice & Palliative Care Northshore, LLC, Covington, LA
St. Margaret's Hospice, Gretna, LA
St. Teresa's Hospice & Palliative Care, Lafayette, LA
Sanctuary Hospice House, Tupelo, MS
Serenity Hospice Services, LLC, New Orleans, LA
Serenity Premier Hospice, Vicksburg, MS
Unity Hospice Care, Oxford, MS
Unity Hospice Care, Southaven, MS
Unity Hospice Care, Tupelo, MS
Willis-Knighton Hospice of Louisiana, Shreveport, LA

2011 ASSOCIATE MEMBERS

Accreditation Commission for Health Care, Inc, Raleigh, NC
All Saints Hospice, Marksville, LA
American Medical Technologies, Lafayette, LA
Arthur J Gallagher, Baton Rouge, LA
AvaCare, Inc, Greensboro, NC
Calyx Pharmacy & Medical Services, Madison, MS
First Option Infusion Pharmacy
Gulf South Medical Supply, Hernando, MS
Hospice Pharmacia, Philadelphia, PA
HospiScript Services, Montgomery, AL
MUMMS®Software, New Orleans, LA
Outcome Resources, Rocklin, CA
Southern Eye Bank, Metairie, LA
Ultimate Technical Solutions, Harvey, LA

2011 ORGANIZATIONAL MEMBERS

ALS LA-MS Chapter, Baton Rouge, LA
CommCare Louisiana, Marksville, LA
Palliative Care Institute of Southeast Louisiana, Covington, LA

2011 PALLIATIVE CARE PROVIDER MEMBERS

East Jefferson General Hospital, Metairie, LA
Our Lady of the Lake Regional medical Center, Baton Rouge, LA

2011 PROFESSIONAL MEMBERS

Martha B Darby, R.Ph, Lafayette, LA
Susan Drongowski, RN, MA, New Orleans, LA
Deborah Guidroz, New Orleans, LA
Dr Flyda Jan Hicks, Winnsboro, LA
Gerry Ann Houston, MD, Jackson, MS
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Marilyn A Mendoza, PhD, New Orleans, LA
Susan Nelson, MD, Baton Rouge, LA
Linda Glick Schmitz, Water Valley, MS

2011 INDIVIDUAL MEMBERS

Patty Andrews, New Orleans, LA
Sandra Bishop, Long Beach, MS
Delaine Gendusa, Springfield, LA
Ronald L Marlow, New Orleans, LA
Debbie Thibodeaux, Lafayette, LA