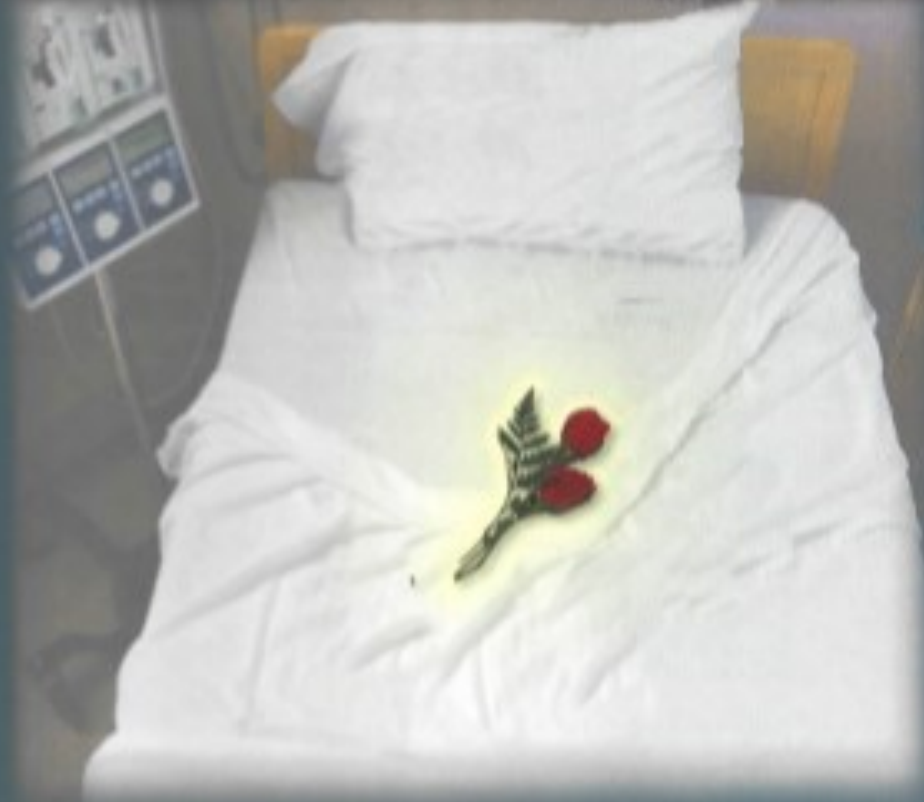
PROCEEDINGS OF THE VA NATIONAL LEADERSHIP CONFERENCE ON

Pain Management AND End of Life Care

PAIN



A CME/CE ACTIVITY

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Questions and Responses

Q: How did you ever get the Medicare piece in place?

R: *(Ellis)* Well, it was not easy, but since all of our VA Hospitals are JCAHO accredited, they agreed to look at JCAHO accreditation as being the status for Medicare certification.

Q: Is this something that could apply then to other VA hospices?

R: *(Hallenbeck)* This is by no means the only model or even the best model. There are other models that are being explored. For instance, if you have a vacant ward, a different model would be to go into a sharing agreement with a home hospice to develop their own inpatient facility there and have veterans cared for by that home hospice. In many ways, that's a much easier model. We did not take the easy way up the mountain.

Q: On the Medicare question, I'd like to put in a word for Senator Jay Rockefeller, who's been trying for years to allow the VA to bill Medicare. How are you billing the acute side?

R: *(Hallenbeck)* We don't directly bill Medicare. Our contract is with the Home Hospice Agency. They're technically sort of a firewall between Medicare and us because nobody really wanted deal with that question. The other thing that everybody felt was important was not to double dip. Veterans, who are also Medicare eligible, have to either be seen under the VERA model as veterans or under Medicare.

Q: Who admits to your supported care units? The residents?

R: *(Ellis)* Pretty much anybody who has admitting privileges can do that. Most commonly, it's the residents. An example might be someone admitted with renal failure by a dialysis team. I would be there to help them deal with the nausea and other symptoms that might come up in uremia, because nephrology's cure for that is giving dialysis. They're not quite as aware how to treat it in other ways.

Q: Then who would follow the patient?

R: *(Hallenbeck)* Technically, the resident team would follow them. Since this is subacute care, they only have to write a note a week.

Q: If you have trouble getting a resident to pronounce patients, our nursing home care unit wrote a policy on nurse pronouncement and this has worked very successfully.

R: *(Ellis)* We could do that, too, but we see this as an educational opportunity.

Bedside Patient Care Conferencing*

Deborah Grassman, ARNP; Daniel Hummer, MD; Marlene Lewis, RN; Sheila Lozier, RN; Lori Powers, LPN

Hummer: Our patient care conference for our inpatient unit has evolved over the last 5 years. The conference started out as the typical patient rounds that we all know from acute care medicine. We tried to switch the location to our living room and had the patient and family join us, but the patient was often too sick to come, and if the family came without them, they were anxious about leaving the patient behind and anxious about coming into a room full of professionals. We were uncomfortable with the result, so we switched back to bedside rounds. But when we stand and look down on the patient, it is an intrusion of their space. Finally, we came up with the idea of chairs with casters on them.

Grassman: We literally wheel into patients' rooms, sitting in our chairs, where we're on the same eyelevel with the patients. Our patients have dubbed us the holy rollers, hell on wheels, and soul train, but the point is we are empowering patients and families by making them the center, by coming down to their level and not making them look up to ours.

When our interdisciplinary team meets sitting around patients' bedsides, we notify the families ahead of time so they can attend. We teleconference with family members from out of state who want to be involved in the process. We see 2 patients every day for a half an hour each, so we get through our 10 patients once a week.

We deal with a lot of things there. We sit and connect with them and listen to them and understand what their special concerns are. As people come closer to death, they need to know that they made a difference in this life. We can do a formal life tribute, based on the Life Review Form they and their families complete. When their story is compiled, it's really quite overwhelming to them to hear it.

When we know there will not be time to do a formal presentation, we invite the family at the conference to share stories, asking questions like, "What's the most special thing you remember about your uncle?" We get some wonderful testimonies by families. This affirmation of importance in the lives of their families is very special to them.

If they give us permission, we sing together and pray together with the patients and families. We try to be sensitive to where they are in those areas and make a clear distinction between spiritual care and religion. People are very fertile ground for healing at that point in time, and the spiritual dimension has to be a part of that.

Lewis: This patient care conference has come back in our family satisfaction questionnaires as being one of the most important events of their loved one's life and in their life. And many have said it really has changed their life. It is the major therapeutic modality that we provide.

Hummer: There's a very different patient care conferencing that we do every Wednesday morning at 6:00 a.m. Dr. Hull and I, along with very committed volunteers, fix a community breakfast in the hospice unit for staff, patients, and families. We serve 8 to 10 dozen eggs. We make peanut butter chocolate milk shakes. It's really a celebration of life. So hospice is really more than just a focus on death; it's an emphasis on life and you would have to come there to experience that to really appreciate it.

Grassman: I think the important thing is that they're not just serving food; they are serving food for the soul. Because that's what laughter is. The singing, the prayer, is all a huge part of it. When we started this breakfast, we really didn't anticipate what a wonderful prehospice intervention this would be. People from the nursing home or the GEM unit or subacute care come and join us for breakfast, too. They see the laughter and the joy, and it takes away a lot of the fears of hospice that might be down the line for them as well.

*See also "Bay Pine Hospice—The Dying Healed: Curing Diseases of the Spirit in Medicalized Communities" by this team of presenters on pages 32–35.