# DOWNLOAD PDF FLEDGLING HOSPICE

## Chapter 1 : Funeral Service and Hospice: Mutual Concern, Cooperation & Care*

*A fledgling Boulder hospice group is in a fight to hold on to a name that is close to the name once used â€" but since retired â€" by a far larger nonprofit that offers a broad array of services.*

Most programs will fall under one of three categories: Most hospice programs in this country are the home care type. Caregivers are available 24 hours a day. Services home care hospices may not be able to provide are usually sub-contracted to home health agencies. In most instances insurance or other third party reimbursement covers costs of care in part or whole. This is usually the least expensive form of care. Facilities, services, staff and expenses are shared but not necessarily duplicated. An area of a health care facility may be set aside and designated for "hospice. A free standing or independent hospice combines all the advantages of the above two or more, but unfortunately this form of care has proven to be more costly, and therefore, less feasible. This program provides all its care and services from a totally separate building and is usually not associated with a hospital. All staff are assigned only two or three hospice patients. The facilities are much more home-like than found in a hospital setting. A kitchen is often provided so that family members may prepare home cooked meals any hour of the day or night. Family members are encouraged to be present around the clock and additional beds are provided for that purpose. Friends, grandchildren and even pets may be welcome. However, basic to the hospice concept, the patient is still encouraged to remain at home as long as possible. Cost Of Hospice Care Cost of hospice care will range from very little to the same as traditional hospital care and occasionally more, depending on the type of program, services required and medical needs. Many organizations utilize all volunteer lay professionals and persons, charging nothing for their care or services. On the other hand, a program which has a full-time paid staff and a facility to maintain may charge comparable hospitalization fees. Most health insurance companies now pay for hospice care regardless of where it is provided, and many patients may be eligible for Medicare benefits. Most major employers provide hospice medical coverage. Hospice And The Funeral Hospice care, in its broadest sense, includes care of the patient and family prior to the time of death, at the time of death of the patient, and care of the family during the period of bereavement. Because hospice care includes attention to the many areas of need that can be present during this time of stress, it is common for hospice staff to discuss the need for spiritual support and to inquire into the patient and family interests regarding funeral services. There is no standard hospice approach toward religion or religious beliefs. Yet a chaplain is often a member of the hospice interdisciplinary team, and hospice programs recognize the value of religious beliefs and practices for the families they serve. Some persons may not desire spiritual support or religious services. This is recognized and respected. There is no standard hospice approach toward the funeral or funeral practices because of varying attitudes toward immediate post-death activities. Yet most hospice programs recognize the value of funerals and have established communication and working relationships with local funeral directors. The National Hospice Organization and its standards document recognizes the significant role of the funeral director in collaborating with the hospice team at the time of death. Through direct contact with funeral service, pre-arranged and pre-planned funerals of hospice patients have increased. In addition, arrangements have been made less emotionally stressful and more meaningful for families. Hospice care, by itself, does not exert any marked changes of interest in funeral customs among bereaved persons. But, at the same time, hundreds of hospice programs in all areas of the country work with families who will be faced with the question of what to do about the funeral and disposition of the person of whom they loved and helped care. Through hospice care, they have time and support in which to consider their options for a funeral or an alternative and the involvement of family and friends in whatever is decided upon. Many family members who will plan these post-death activities will have been involved in providing physical care during the last days of life of the deceased. This is a return to a role that was once common for family members. Yet so many other elements have changed in our society, culture and economics that it is impossible to offer firm speculation about trends that may become apparent in the years to follow. Many directors have provided leadership in bringing hospice care to their communities. When you consider the philosophy of hospice and funeral service, it is clear why

funeral service is a "natural extension" of hospice care. With funeral planning and more open discussion of at-death needs encouraged by hospice, funeral directors and hospice caregivers are working closely in order to meet the total needs of families. In other words, at no time will family members be without support. These strong attachments and feelings made from one supportive environment are shared and transferred to another as they move through the process of dying, death and bereavement. Hospice workers and funeral directors possess experience and professional information that converge on a common meeting ground providing services to families at the time of death. Other disciplines, especially the clergy, are also directly involved. For effective interaction to take place, there must be a sharing of information, a willingness to dialogue and an establishment of effective means to communicate and facilitate necessary change to lay the foundation for a sense of mutual trust and respect. Hospice workers are familiar with problems inherent in establishing effective working relationships among different professional disciplines. However, hospice care requires that such relationships be developed and maintained. Likewise fledgling hospice programs have learned that they must develop open dialogue with clergy, funeral directors, the local medical community and with medical examiners and coroners. To facilitate this sort of interdisciplinary sharing and cooperation, it has been found helpful to: Communicate with local funeral directors and all other care providers. Ask funeral directors to develop "inservice" training sessions for hospice workers on a variety of subjects including funeral customs, functions of the funeral, a visit to a funeral home and an opportunity for discussion regarding feelings and misunderstanding about funerals. Develop workshops involving hospice, clergy, funeral directors and medical staff to seek ways of sharing information and improving service to families at the time of death. Share resources on funerals and hospice practices. Develop dialogue between the clergy, funeral directors, hospice workers and organizations at the local, regional and national levels. Most programs include a funeral home tour as part of required initial hospice training. This is an excellent opportunity for dialogue and explaining the value of the funeral, services of the funeral director and related needs of the family. This is but one way a funeral director may participate in hospice. Other directors participate in more active roles such as serving on a hospice board, as an advisor, by offering educational programs dealing with dying, death and bereavement of in other capacities. Most directors have elected to leave the "hands on" care to the nurses and lay volunteers or may just not have the time to become personally involved. Simply sponsoring programs or providing some financial assistance is always appropriate and appreciated. The funeral director can also be a liaison for hospice with the medical examiner or physician to assure a smooth transition at death. Communicating and advance planning can help prevent insensitive investigators entering the home and upsetting the tranquil environment creating by hospice and causing unnecessary delays. Some Special Considerations As with all activities in which funeral directors engage, hospice activity requires a commitment of belief and time. Though the concept of hospice is an old one, its implementation demands a dedication that conveys its importance to the public. No funeral director should become involved unless willing to work diligently to further the aims and goals of a hospice in the community. In communities where there is more than one funeral home, it is desirable that representatives of all of them become supportive and active in a hospice. However, reluctance or inability to participate by all of the funeral homes should in no way preclude individual funeral directors from participating. In addition, if there is more than one hospice in the area, funeral directors should be supportive of them all. This would eliminate conflict of interest issues. In Conclusion Hospice is a vital and valuable concept worthy of establishment in any community dedicated to support the concept. Hospice and funeral service have high principles and standards of care. Both serve the family, providing care and concern for dying patients and supporting the family in their bereavement, thus hospice and funeral service should be mutually supportive of each other. Slater, author and educator, has written, "Funeral service should be an integral part of hospice to extend the very hospice concept for the dying to the caring concept of the bereaved. The funeral director who is privileged to serve such families will find that to them, death has become a part of life, and as such, deserves loving and caring actions both on the part of the family and the funeral director who serves them. This information is made available through the cooperative efforts of the National Funeral Directors Association and the National Hospice Organization. It is not available in brochure format.

## Chapter 2 : Los Angeles Times - We are currently unavailable in your region

*A fledgling hospice program has local administrators excited about what could be a major shift in how people think about the service. Last January, Mountain View Hospice & Palliative Care first.*

She spent a couple of years working in Queensland hospitals, before moving back to Tasmania to start GP training. She completed her GP training in Tasmania and has worked at several practices in and around Hobart over the last 20 years. Karen has been working part-time at Barrack Street Practice since  She then went on to work for several years through Melbourne based hospitals prior to moving to Tasmania. She has made the move from hospital practice to Barrack Street in as part of general practice training. She joined Barrack Street Practice in then known as Dr Davenport and Associates and after completing 18 months training in obstetrics, gained a diploma in this area. Sue has a great passion for general practice. She loves the variety and the diversity of challenges that appear in day-to-day general practice. General practice remains a challenge that Sue really enjoys, especially caring for her patients in a family setting. She did her intern year in her hometown of Launceston and then spent the next 5 years working across England, gaining experience in paediatrics, obstetrics, anaesthetics and finally a GP trainee year near Oxford. After returning to Tasmania, she worked as a locum in several country towns before moving to Hobart again, gaining a RACGP fellowship and becoming involved in college affairs and the fledgling Hospice Care Association. More recently, she has developed an interest in aged care, along with a continuing interest in the broad areas of general practice. After completing her Intern year at Albany Medical Centre as Internal Medicine trainee, she moved to Tasmania to be nearer to her extended family. On moving to Tasmania, she continued her training at the Royal Hobart Hospital, initially in general training then in physician training before switching to pursue general practice. Patricia has a strong interest in the early detection and management of breast cancer, spending 10 years as Clinical Director of Breast Screen Tasmania. When not working at Barrack Street Practice, she undertakes work as a surgical assistant to neurosurgeon Mr Arvind Dubey. Patricia is dedicated to providing ongoing and comprehensive health care for her patients. She particularly enjoys having long-lasting patient relationships and working in partnership with them to address their health care needs within the context of family and community. She has an interest in mental health and has taken special skills training in adolescent and mental health. She enjoys working with families and young people and does procedures such as Implanon insertion and removal.

## Chapter 3 : Medicine Without Borders

*cracks in the fledgling hospice system: There was a gap between those who qualified for hospice because they were close to dying, and those with serious illness who.*

About Mission of Community Hospice, Inc. CHI is a non-profit organization providing medical, nursing, emotional, spiritual and educational support to individuals, their families, loved ones, and caregivers coping with grief or a life-threatening illness. Hospice Services in the Central Valley The modern concept of hospice, first established in Great Britain, made use of pain management techniques and ministered compassionate care to the dying. Hospice care was introduced in the United States in  The concept was brought to Modesto in by Mary Jean Coeur-Barron, a nurse whose husband, an oncologist, wanted to alleviate the pain of children suffering from leukemia. While working on their degrees in Public Health Nursing at Stanislaus State University, Coeur-Barron and classmate Kathy Oberg-Erlenbeck involved local hospitals, home health agencies, and others in creating a local hospice program. Thirty-five health care providers met with a consultant in Modesto on January 23, to examine whether the community would support hospice services. A board of directors was formed with representatives from all five area hospitals and most home health agencies. Two physicians and two nurses from the community completed the member board. By , the hospice service area had expanded to include residents of Oakdale, Riverbank, Escalon and Salida. On October 31, Community Hospice achieved another milestone by becoming the first freestanding hospice in the nation to receive accreditation by the Joint Commission on Accreditation. It was then that the organization began to provide services to anyone facing any terminal illness and bereavement services to anyone faced with the terminal illness or death of a loved one, regardless of the cause of illness. Support for hospice services also came from private companies and community leaders that generously contributed major gifts, making it possible to reach more patients. Julio and Aileen Gallo were the first to lend critical financial support to the vision of the fledgling organization. Gallo family members continue to support hospice services and they encourage others to do so. In June the Community Hospice Foundation was established to raise funds and awareness to support patients and their families. The community donated gently-used merchandise and all proceeds supported patient care. A third store opened February on Yosemite Blvd. The fourth store, located in Ceres, held a grand opening March  The Community Hospice, Inc. Automotive Division began accepting donations of used cars, motorcycles, trucks, etc. All proceeds support patient care. Broadening the Scope of Services As awareness of hospice spread through the Central Valley and nationwide, greater numbers of people asked for and received hospice care in their homes, thus increasing the need for more volunteers and specialized staff. The Community Hospice Volunteer Program provides a vital link with the patient, family, and community members. Hospice volunteers provide thousands of hours of service annually to patients, families, and Community Hospice staff. Volunteer opportunities include family visiting and support group facilitation, and which require special volunteer training classes. Other volunteer opportunities include office support and special projects. As the nineties came to a close, Community Hospice officials recognized that some patients needed more care than can be provided in their homes. With this in mind, the Community Hospice vision was broadened to include a Hospice House. After a year-long campaign, and with strong community support, a significant gift came from Leonard and Jean Cohen. The 20, square foot Hospice House includes 16 private rooms with adjoining patios, a chapel, and activity and music rooms for patients and families. Shortly after the Alexander Cohen Hospice House opened its doors, another dream was fulfilled: The new building paves the way for the continuing work of Community Hospice, and allows the organization to grow with the community. Becoming CHAP accredited was a multiyear process for the leadership and staff and fulfilled a key strategic aim for the organization. To continue to accommodate organizational growth, in Community Hospice opened a 20,square-foot logistics center in the River Bluff Business Park in Modesto. Peterson III retired and was replaced by C. In , the Community Hospice San Joaquin Branch was relocated to a larger facility to meet the need of expanding patient services and programs in San Joaquin County.

## Chapter 4 : About - Hospice Heart

*The Beginning and Early Years of Hospice of the Valley By the Rev. Q. Gerald Roseberry, DMin. Hospice has not always been a familiar, publicly-approved mode of caring for terminally ill patients, and our experience in establishing Hospice of the Valley, the first hospice in Phoenix, the second in Arizona, and the 51st in the nation, was neither simple nor easy.*

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## Chapter 5 : Opening of new campus fulfills dream for FirstHealth Hospice & Palliative Care | FirstHealth

*A proud history of delivering care and compassion In the spring of , it all began. Rev. Barrie Gray became chairman of the Hospice Development Board that year, after he and board members including Allen and Jean Lovejoy visited fledgling hospice agencies around the country.*

Hospice has not always been a familiar, publicly-approved mode of caring for terminally ill patients, and our experience in establishing Hospice of the Valley, the first hospice in Phoenix, the second in Arizona, and the 51st in the nation, was neither simple nor easy. From my perspective, the origin of Hospice of the Valley was pastoral, serendipitous, humble, controversial and blessed. The origin of HOV was pastoral. Two womenâ€"both elementary school teachersâ€"who were members of my congregation became ill with cancer. Maxine, a very articulate, attractive third-grade teacher, along with her husband Charles, had participated in a religious studies group with nine other couples. The benefits of this kind of support for the patient and family were obvious. Neither couple had extended family to assist in the care of the afflicted wife, and each spouse was a busy professional. Members of the group took turns providing various services such as running errands, delivering an evening meal, sitting with the patient, reading to her, or merely being there as a strong, caring presence. We could not endure this without them. Joann had a mastectomy several years earlier. After several years of remission, the cancer reappeared. Joann and Jim had heard of the strong support given Maxine, and knowing they were entering a time of trial and suffering, they came to First Presbyterian Church. They, too, received the same emotional and spiritual support Maxine had received. Although it was distressing for us to leave Joann and Jim while they were still in the throes of her illness, we knew she was in the strong, loving care of the support group. I continued to keep in touch with Joann and Jim and the support group until Joann died a month or so after we moved to Phoenix. The origin of HOV was serendipitous. It was the experience with Maxine and Joann, their families and the support group and my acquaintance with the writings of Elisabeth Kubler-Ross, especially her book, On Death and Dying, which prepared me to recognize the universal appeal and benefits of a new way of caring for the dying. It was obvious that many terminally ill patients would benefit from the kind of strong, caring, faithful, accepting support that Maxine and Joann had received, but I had no clue as to how that support could be organized and delivered outside a religious congregation. It was just as obvious that many people are not affiliated with a religious group or congregation and would have no background of experience which would lead them to invite the assistance of such a faith-based support group. It was an experience of serendipity such as I had never had before nor have had since which gave me the answer I was searching for. I was one of those parents. We were required to sit for an hour and a half, with small cotton pads under our arms, in a small room in which the temperature was raised to cause profuse sweating. At intervals, we were taken one at a time to have our cotton pads weighed on a very sensitive scale. It was a very boring hour and a half. Usually, I took a book to read or writing material in order to prepare my article for the church newsletter. Thinking I might be distracted by the jokes and perhaps a short story, I began thumbing through its pages when I discovered a one-column article about the work of Hospice Inc. Hospice work with the terminally ill, although new to the U. Cecily Saunders at St. I returned to my office and wrote a letter to Hospice, Inc. Within a week or so I had several articles from professional journals which served to convince me that indeed hospice was the model of care for the dying which could serve them in a way hospitals at that time were unprepared to serve. Furthermore, I knew we needed a hospice in Phoenix and that I must share with others the information I had gathered. I called three members of my congregation â€" Dr. James Callison, a reconstructive surgeon, Dr. Our luncheon meeting, in April , produced a steering committee. I was elected chairman of the steering committee, and we set about informing ourselves thoroughly on the hospice concept of care for the dying. After meeting several months, we found that there was another group in Phoenix that was also discussing the possibility of organizing a hospice. Joseph Hospital were two of their leaders. The two groups arranged to merge their efforts, and I was again chosen to be chairman. Eventually, Sister Madonna Marie chose to separate from our steering committee to establish her own hospice at St. While we had hoped fervently to avoid the splintering of our forces and potential funding

base into competing entities, we were convinced that our work must proceed to develop the hospice model which accepts death as a natural process of existence, devotes energies and resources to the control of the symptoms and the delivery of compassionate care and support of the terminally ill and their families. Volunteers would be absolutely essential in providing such support. Along the way the committee brainstormed regarding the name for our hospice. But we also wanted to include the general public in our efforts, so we made a failed attempt to organize The Valley of the Sun Hospice Association, a membership organization with dues. A staff artist of the Phoenix Gazette, Tony Bustos, created our first logo. It consisted of a circle containing a stylized dove in flight over a valley below. With the help of Cocanower, we were incorporated in the summer of as Hospice of the Valley, a non-profit corporation, the first hospice in metropolitan Phoenix, the second in the state after Hill Haven Hospice in Tucson which eventually failed , and the 51st in the nation. Members of the steering committee became the first board of directors, and I was elected the first chairman. The beginnings of HOV were humble. In fall , our board of directors was fortunate to enlist a new member, Sister Louise Marie Benecke of Catholic Charities, who was an expert in writing grant proposals. She had information from the U. Department of Health, Education and Welfare, now the Department of Health and Human Services, inviting groups to send grant proposals for the organization of hospices. We also applied for a grant from the Flinn Foundation to help us open an office and begin training volunteers. We moved quickly to open an office and found space, through Eleanor Curran and Genie Eide, in a storefront owned by the County at 24th Street and Roosevelt. We had space enough for two small offices and a meeting room. We furnished the space with used furniture, an electric typewriter and a file cabinet. Approximately 50 people attended. Members of the board of directors conducted the classes. Genie Eide, director of home health Care of Maricopa County, dealt with home health care; Dorothy Gerrard, executive director of Visiting Nurse Service, covered nursing care of terminally ill patients; and attorney Cocanower addressed the group on legal aspects of terminal illness. MaryAudrey and Blanche became a team of two volunteer staff at a time when HOV could not afford to provide the number of professional staff needed. With their loving, wise and generous service, they helped our fledgling hospice through its infancy and stayed with it, as it became known throughout the state for its compassionate professionalism and willingness to help other cities organize their own hospices. The beginnings of HOV were blessed. Her coming to us at the beginning when we had no funds at all, was a providential blessing. With a sense of achievement and celebration, we began to look about for more attractive, commodious quarters. David Cocanower and I discovered the perfect quarters for HOV in a lovely, peaceful setting at First Congregational Church at 2nd Street and Willetta near downtown Phoenix, which had plenty of space for all our needs, including volunteer training classes. We hired the late Al Hamby as our first full-time administrator and Greta Wiseman as nurse practitioner. We were on our way, but there would be hard times ahead as we cast about for ways to finance the services of HOV. We knew that the HEW grant would carry us only so far and that fees for service would not suffice because health insurance carriers did not yet recognize hospice care. Strange as it may sound today, HOV began by giving its services free and accepting any amount patients and their families were willing to contribute. It was a practice that could not be sustained, of course, but it helped spread the word about the unique form of care for terminally ill patients. In order to become a full-fledged hospice, HOV had to find a physician to serve as medical director. James Callison, a member of the original steering committee and the succeeding board of directors, knew someone who, he felt, would fill the position admirably. Albert Eckstein, a vital, vigorous, compassionate physician was nearing retirement. He was widely known and highly respected by the medical community. We were overjoyed when he accepted the position as medical director. Not only was he highly competent in that capacity, he also became a father figure to the staff, provided wise counsel to the Board of Directors, and was a steady, wise, strong, calming influence when personality conflicts threatened effective teamwork of the staff in the early years. One day, in early , Mary-Audrey Mellor came to see me at my office at Camelback Presbyterian Church and asked me to speak to her class in the School of Nursing at ASU regarding the hospice concept of care. Out of that first meeting and my speaking to her class grew an acquaintance and friendship, which would lead to one of the most fortuitous openings to the future HOV could possibly hope for. Anna Andrini Brophy had come to the rescue earlier with an Annual Wine Tasting that

evolved into an annual silent auction of art and other valuables and high quality services. Proceeds from the Tournament each year were given to a local charity. His second wife, Monique, became a vital member of the team. John has continued to be the most generous friend and supporter of Hospice of the Valley through the years. This unfamiliarity created suspicion and misunderstanding. Underlying much of the resistance to our efforts was the unstated objection of physicians that we were intruding on their professional turf. He was able to convince them that hospice could help them provide even more effective service to their patients. James Callison, through his publication of an article in the Maricopa County Medical Journal and speaking to the Maricopa County Medical Society, was also instrumental in winning physician approval of hospice. Eckstein was a mentor and model for his successor, Dr. Howard Silverman, and his influence continues even after his death on October 20,  Three strategic decisions of the Board of Directors. There were three very strategic decisions taken by the Board of Directors in the early years. The first was to defer acquiring an inpatient facility until HOV achieved a very solid financial footing, as we were aware of the high costs of owning and operating such a facility. We had followed the experience of several hospices that moved too quickly to open an inpatient facility and found that they could not sustain the operational costs. The second decision in those early years with far-reaching results was to become a Medicare-approved hospice. Medicare had become an important source of payment for services to the elderly and now recognized that hospice home-care is a cost-effective alternative to hospitalization of terminally ill patients. Although some board members at that time advocated against HOV becoming a Medicare-approved hospice, most members concluded that HOV would not survive otherwise. Hospice of the Valley had three executive directors in the space of four years. During her year administration, she gathered a fine staff that was able to work harmoniously together and achieved public recognition and approvalâ€”including that of the medical establishment. Surely someone will take up the narrative where I have left off, for it continues to be a story worth telling.

## Chapter 6 : Barrack Street Practice - Book Online with HotDoc

*The Beginnings of Stein Hospice When Rosalie Gdula Perry entered the nursing profession in as a young nun she was appalled at the way terminal patients were treated.*

Self-inflated leaders assume clinicians give until their backs break, given no raises for years. Others have a sorrier job and must be motivated by money. I no longer experience the tension of fulfilling my hospice calling within a for-profit enterprise. Before our fledgling hospice company went public this tension seemed manageable. Executives showed support by showing up and their words and actions had a heartfelt component. Pressure came to meet or beat the numbers. When the company disappointed Wall Street expectations executives sold out to a new group, each more charlatan than the last. Executives rewarded themselves at greater levels with each buyout. Christ operated within persecution of the Romans, Pontius Pilate and local religious leaders. Hospice workers are present day saints trying to navigate the hostile aspects of their job in order to serve, be with, minister, love, support, and care for the dying. Saints did not go with the flow. They did not pray for census or for stock prices to rise. They had a unique calling which required persevering, even challenging others in its achievement. With each buyout our voice diminished. With each name change hospice leaders became more intolerant of anyone standing up on principle. Dialogue did not occur in order to find a better way forward. The principled simply got branded as negative, not a team player. Official leaders prioritized image and surface contact over depth and real relationship. Executives cared for themselves. Their pay increased with each buyout. Their visits became more infrequent and their words increasingly insincere. They tried to bear hug the best of us, hoping it would somehow rub off on them. Our management was limited, so we looked to one another for leadership, inspiration, support and relationship. When co-workers sought favor with ignorant and divisive managers this too became difficult to maintain. Resist the call from above to label and divide. You are a spiritual person navigating a material world. Do so with presence, awareness, courage and faith.

## Chapter 7 : Ira Byock - Wikipedia

*Keeping the fledgling hospice afloat in those early days required the support of many unpaid hours of work and contributions of generous donors. The organization outlasted the many challenges of its early years.*

## Chapter 8 : Hospice History | Hospice of Eastern Idaho

*A social worker by training and a patient advocate by nature, Labyak began her work in end-of-life care in as a volunteer for a small, fledgling hospice. Since , she has served as its leader, transforming it from a small, "typical" hospice to Suncoast Hospice, one of the most recognized and respected end-of-life care organizations.*

## Chapter 9 : Generic Hospice: Labor Day Calling

*The treatment had ended, and he was in hospice care there. Our small family had rallied around him over the previous year: He was unquestionably the sun we had always circled. His grueling work ethic became our work ethic; his effusive and biting humor, our humor.*