May 2009

The Journal

in this issue

Hospice Chaplains with Crosswalk of Newly Revised CoPs

All Pain Is Not Physical

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LMHPCO is proud of our hospice chaplains and salute the work they do as they assess spiritual needs and provide spiritual counseling to meet the needs of hospice patients and families. The value of the Interdisciplinary Team (IDT) can never be underestimated. Each member brings a special skill to the team and it takes communication and working together to make sure the patient receives the very best. The role of the hospice chaplain in the IDT is crucial.

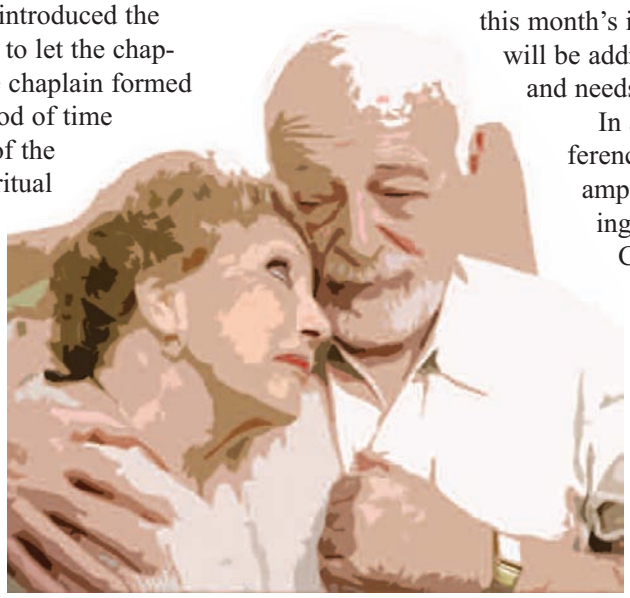
I am reminded of the patient who was in severe pain. The RN worked diligently in conjunction with the attending physician and Medical Director to help get the pain under control - all to no avail. The patient had originally refused chaplain services on admission but due to the astute observation and keen assessment by the RN she creatively reintroduced the idea of chaplain services. The patient agreed to let the chaplain come for one visit. Long story short, the chaplain formed a bond with the patient and over a short period of time was able to address deep spiritual concerns of the patient. The patient managed to have his spiritual needs met, the pain resolved and the patient died a peaceful death in just a short matter of time. The family was ever grateful to the hospice nurse for the role she played in getting their loved one to accept a visit from the chaplain.

Moral of the story? All pain is not physical. Spiritual pain can oftentimes hurt just as much as physical pain. This case is a beautiful example of what can happen when a team works together, each one utilizing his/her special skills, for the best interest of the patient.

This month's focus for The Journal is on Hospice Spiritual Counselors - also referred to as Hospice Chaplains. The Spiritual Counselor is a vital member of the IDT and is one of the core services identified in the Conditions of Participation (CoPs).

Recently, the MSDH surveyors have identified a need for on-going education for hospice chaplains. Surveys indicate there are chaplains who have not received any continuing education in end-of-life care to better equip them to serve hospice patients and families. LMHPCO has stepped forward to assist in this area. In-services have been offered in three separate locations in MS since January 2009 to enable hospice chaplains to gain further education. Attendance has been overwhelming. Plans are underway to present these in-services in LA as requested.

LMHPCO is also pleased to announce a day-long Post-conference track this year at our Annual Leadership Conference. The Post-conference will take place on Friday, July 31, 2009. We are excited to have Rev. Kathleen Rusnak, Ph.D. as the presenter for this track. You will find information on Dr. Rusnak as well as her presentation in this month's issue of The Journal. She will be addressing the spiritual issues and needs of Alzheimer's patients.



In addition to the Post-conference track, there will be ample concurrent sessions during the Leadership Conference on Wednesday and Thursday, July 29-30, 2009 for hospice chaplains to take advantage of. Make plans now to attend the LMHPCO 2009 Annual Leadership Conference and Post-conference in beautiful New Orleans, LA.

LOUISIANA~MISSISSIPPI
HOSPICE AND PALLIATIVE CARE ORGANIZATION

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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HEN NOTES

The Hospice Education Network applauds you in celebrating ***National Volunteer Week***, April 19-25, 2009.

CHALLENGE: Your volunteers have completed their initial volunteer training. How do you provide and document that they are receiving ongoing hospice-specific education while managing the challenge of scheduling them to come into the office for educational presentations?

SOLUTION: The Hospice Education Network (HEN) can suggest e-learning courses that are appropriate for your volunteers' ongoing hospice education and enrichment needs that they can access twenty four hours a day, at home or in the office.

Courses could include: *Abuse, Neglect & Exploitation; Adverse Events/Incident Reporting; Adverse Medical Device Events; Decision Making and Advance Directives; Effective Communication; Fire Safety; Grief and Loss; HIPAA Privacy Training; Home Visit Safety; Hospice 101; Infection Control; Interdisciplinary Team; Introduction to Quality Assessment & Performance; Just One More Bite; Levels of Care; Managing Stress, Boundaries and Burnout; Medicare Hospice Benefit; Patient Rights and Responsibilities; Professional Boundaries; Safety in the Home; Safety in the Workplace; Sexual Harassment; Signs and Symptoms of Approaching Death; or Through the Fire: A Dying Exercise.*

The annual subscription price to many HEN programs includes continuing education credits for social workers and nurses. Certificates are available for printing once the post test has been successfully completed.

To learn more about HEN, call 866-969-7124 or email info@hospiceonline.com to join our regularly scheduled online demonstrations; or you may schedule a review of HEN's features at your convenience.

Upcoming online demos:

Tuesdays 1:00-1:30 EST: April 21, 28 and May 5, 12, 19, 26.
Thursdays 1:00-1:30 EST: April 30 and May 7, 14, 21,28.

Visit our website at www.hospiceonline.com to see the new courses that are added each month.

Do you have pictures from your Volunteer Recognition Activities? Submit them to **Nancy@LMHPCO.org** for possible inclusion in *The Journal*. Please include captions.

December 4-6, 2009
NHPCO's 6th National Conference on Volunteerism & Family Caregiving
Walt Disney Swan Hotel, Orlando, FL
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

The Leslie Lancon Memorial Education Nursing Scholarship was established in 2005 by LMHPCO. The annual scholarship will be awarded to support hospice nursing excellence and education throughout Lousisiana and Mississippi. The awards will focus not only on excellence for those seeking academic degrees in hospice nursing, but also those seeking advanced certification in hospice and palliative care nursing.

Donations may be sent payable to LMHPCO, 717 Kerlerec • New Orleans, LA 70116

Hospice Chaplains crosswalk

LA State Minimum Standards

Current as of December, 1999
Proposed Changes in Red

Subchapter A. General Provisions
§8201. Definitions
Chaplain— a member of the clergy.

Core Services— nursing services, physician services,
medical social services, and counseling services, including bereavement counseling, ~~dietary counseling~~, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and dietary counseling services may be provided through contract.

Interdisciplinary Group (IDG Interdisciplinary Team (IDT))— an interdisciplinary group (Team) or groups (teams) designated by the hospice, composed of representatives from all the core services. The IDG (IDT) must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor and a representative of the volunteer services. The interdisciplinary group (team) is responsible for participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary group

Medicare Conditions of Participation (CoPs)

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

§ 418.3 Definitions.
Clinical note means a notation of a contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial or spiritual condition during a given period of time.

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

MS State Minimum Standards

Current as of February 22, 2008

101 DEFINITIONS
101.11 Chaplain – Means an individual representative of a specific spiritual belief who is qualified by education received through accredited academic or theological institutions, and/or experience thereof, to provide counseling and who serves as a consultant for and/or core member of the hospice care team.

101.16 Core Services – Nursing services, physician services, medical social services, and counseling services, including bereavement counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.

101.35 Interdisciplinary Team (IDT) – An interdisciplinary team or group(s) designated by the hospice, composed of representatives from all the core services. The Interdisciplinary Team **must** include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The interdisciplinary team is responsible for participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each

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.

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(team), it must designate in advance the group (team) it chooses to execute the establishment of policies governing the day-to-day provision of hospice care and services. Spiritual Services— providing the availability of clergy as needed to address the patient's/family's spiritual needs and concerns. ***Terminally Ill***— a medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate. ***Terminally Ill***— a medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice if the disease runs its normal course, for which therapeutic strategies are directed toward pain and symptom management of the terminal illness.		individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary team; it must designate, in advance, the team it chooses to execute the establishment of policies governing the day to day provision of hospice care and services. **101.60 Spiritual Services** – Providing the availability of clergy, as needed, to address the patient's/family's spiritual needs and concerns. **101.61 Terminally Ill** – A medical prognosis of limited expected survival of approximately six months or less, if the disease follows its normal course, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone is no longer appropriate.
Subchapter B. Organization and Staffing **§8217. Personnel Qualifications/Responsibilities** D. Counselor— Spiritual 1. Qualifications. Documented evidence of appropriate training and skills to provide spiritual counseling, such as Bachelor of Divinity, Master of Divinity or equivalent theological degree or training. The Spiritual Counselor shall obtain at least 2 hours of continuing education related to end of life care annually. 2. Responsibilities. The counselor shall provide spiritual counseling based on the initial and ongoing assessment of spiritual needs of the patient/family, in a manner consistent with standards of	**Core Services** **§ 418.64 Condition of participation: Core services.** A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare	**PART V POLICIES AND PROCEDURES** **111 PERSONNEL POLICIES** **111.04 Employee Health Screening** – Every employee of a hospice who comes in contact with patients shall receive a health screening by a licensed physician, nurse practitioner or employee health nurse who conduct exams prior to employment and annually thereafter. The employee health screening shall include, but not be limited to, tuberculosis screening. **111.05 Staffing Schedule** – Each hospice and alternate site shall maintain on site current staffing patterns for all health care personnel including full-time, part-time, contract staff and staff under arrangement. The staffing pattern

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practice including, but not limited to, the following: a. serve as a liaison and support to community chaplains and/or spiritual counselors; b. provide consultation, support, and education to the IDG (IDT) members on spiritual care; c. supervise spiritual care volunteers assigned to family/care givers; and d. attend IDG (IDT) meetings.	certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: Unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area. (3) ***Spiritual counseling.*** The hospice must: (i) Provide an assessment of the patient's and family's spiritual needs. (ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires. (iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability. (iv) Advise the patient and family of this service.	shall be developed at least one week in advance, updated daily as needed, and kept on file for a period of one year. The staffing pattern shall indicate the following for each working day: 1. Name and position of each staff member. 2. Patients to be visited. 3. Scheduled on call after office hours. **113 ORGANIZATION AND STAFFING PERSONNEL QUALIFICATIONS/RESPONSIBILITIES** **113.04 Counselor – Spiritual** **1. Qualifications** – Documented evidence of appropriate training and skills to provide spiritual counseling, such as Bachelor of Divinity, Master of Divinity or equivalent theological degree or training. 2. Responsibilities – The counselor shall provide spiritual counseling based on the initial and ongoing assessment of spiritual needs of the patient/family, in a manner consistent with standards of practice including, but not limited to, the following: a. Serve as a liaison and support to community chaplains and/or spiritual counselors; b. Provide consultation, support, and education to the IDT members on spiritual care; c. Supervise spiritual care volunteers assigned to family/care givers; and d. Attend IDT meetings.
§8221. Plan of Care (POC) A. Prior to providing care, a written plan of care is developed for each patient/family by the attending physician, the Medical Director, physician designee, or nurse practitioner and the IDG (IDT). The care provided to an individual must be in accordance with the POC. 3. At a minimum the POC will include	**§ 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.** The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hos-	**114.02 Plan of Care (POC)** 1. Within 48 hours of the admission, a written plan of care must be developed for each patient/family by a minimum of two IDT members and approved by the full IDT and the Medical Director at the next meeting. The care provided to an individual must be in accordance with the POC. b. At a minimum the POC will include

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the following:
a. an assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief;
b. in detail, the scope and frequency of services needed to meet the patient's and family's needs;
c. identification of problems with realistic and achievable goals and objectives;
d. medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal illness and related conditions;
e. patient/family understanding, agreement and involvement with the POC; and
f. recognition of the patient/family's physiological, social, religious and cultural variables and values.
4. The POC is incorporated into the individual clinical record.

B. Review and Update of the Plan of Care. The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes, and a minimum of every 14 days for home care and every 7 days for general inpatient/continuous care, collaboratively with the IDG (IDT) and the attending physician or NP. (In the event that a holiday falls on the day of the regularly scheduled IDT meeting, fifteen (15) days would be acceptable.)
.
2. The agency shall have documentation that the patient's condition and POC is reviewed and the POC updated, even when the patient's condition does not change.

C. Coordination and Continuity of Care. The hospice shall adhere to the following additional principles and responsibilities:
1. an assessment of the patient/family

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pice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.
(a) Standard: Approach to service delivery.
(1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial,
emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement.
Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services.
The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:
(i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).
(ii) A registered nurse.
(iii) A social worker.
(iv) A pastoral or other counselor.
(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.
(b) Standard: Plan of care. All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient

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the following:
1. An assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief;
2. In detail, the scope and frequency of services needed to meet the patient's and family's needs. The frequency of services established in the POC will be sufficient to
effectively manage the terminal diagnosis of the patient, provide appropriate amounts of counseling to the family, and meet or exceed
nationally accepted hospice standards of practice;
3. Identification of problems with realistic and achievable goals and objectives;
4. Medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal
illness and related conditions;
5. Patient/family understanding, agreement and involvement with the POC; and
6. Recognition of the patient/family's physiological, social, religious and cultural variables and values.
c. The POC must be maintained on file as part of the individual's clinical record. Documentation of updates shall be maintained.
d. The hospice will designate a registered nurse to coordinate the implementation of the POC for each patient.

114.03 Review and Update of the Plan of Care
The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDT and the attending physician.
2. The agency shall have documentation that the patient's condition and

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needs and desire
for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services;
2. nursing services, physician services, and drugs and biologicals are routinely available to hospice patients on a 24-hour basis, seven days a week;
3. all other covered services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;
11. maintenance of appropriately qualified IDG (IDT) health care professionals and volunteers to meet patients need;
13. coordination of the IDG (IDT), as well as of volunteers, by a qualified health care professional, to assure continuous assessment, continuity of care and implementation of the POC;
14. supervision and professional consultation by qualified personnel, available to staff and volunteers during all hours of service;
15. hospice care provided in accordance with accepted professional standards and accepted code of ethics;
16. each member of the IDG (IDT) accepts a fiduciary relationship with the patient/family, maintaining professional boundaries and an understanding that it is the responsibility of the IDG (IDT) to maintain appropriate agency/ patient/family relationships;

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or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

(c) Standard: Content of the plan of care. The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

(1) Interventions to manage pain and symptoms.

(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.

(4) Drugs and treatment necessary to meet the needs of the patient.

(5) Medical supplies and appliances necessary to meet the needs of the patient.

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

(d) Standard: Review of the plan of care. The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less

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POC is reviewed and the POC updated, even when the patient's condition does not change.

114.04 Coordination and Continuity of Care

1. The hospice shall adhere to the following additional principles and responsibilities:
a. An assessment of the patient/family needs and desire for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services;
b. Nursing services, physician services, and drugs and biologicals are routinely available to hospice patients on a 24 hour basis, seven days a week;
c. All other covered services are available on a 24 hour basis to the extent necessary to meet the needs
of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;
k. Maintenance of appropriately qualified IDT health care professionals and volunteers to meet patients need;
m. Coordination of the IDT, as well as of volunteers, by a qualified health care professional, to assure continuous assessment, continuity of care and implementation of the POC;
n. Supervision and professional consultation by qualified personnel, available to staff and volunteers during all hours of service;
o. Hospice care provided in accordance with accepted
professional standards and accepted code of ethics;

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	frequently than every 15 calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care. ***(e) Standard: Coordination of services.*** The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to— (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided. (2) Ensure that the care and services are provided in accordance with the plan of care. (3) Ensure that the care and services provided are based on all assessments of the patient and family needs. (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement. (5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.	
§8233. Clinical Records A. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record (either hard copy or electronic) for every individual receiving care and services. The record shall be complete, promptly and accurately documented, legible, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social, and other therapeutic infor-	**§ 418.104 Condition of participation: Clinical records.** A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. (a) Standard: Content. Each patient's record must include the following: (1) The initial plan of care, updated	**114.10 Clinical Records** 1. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record for every individual receiving care and services. The record shall be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social and other therapeutic information, including the current POC under

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LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
mation, including the current POC under which services are being delivered. I. Entries are made for all services provided and are signed by the staff providing the service. J. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement.	plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes. (3) Responses to medications, symptom management, treatments, and services. (4) Outcome measure data elements, as described in § 418.54(e) of this subpart.	which services are being delivered. 9. Entries for all provided services must be documented in the clinical record and must be signed by the staff providing the service. 10. Complete documentation of all services and event (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement. **122 RECORDS** **122.02 Content** - Each clinical record shall be comprehensive compilation of information. Entries shall be made for all services provided and shall be signed and dated within 7 days by the individual providing the services. The record shall include all services whether furnished directly or under arrangements made by the hospice. Each patient's record shall contain: 6. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)
§8239. Quality Assurance/ Performance Improvement A. Agency shall have an on-going, comprehensive, integrated, self-assessment quality improvement process which provides assurance that patient care, including inpatient care, home care, and care provided by arrangement, is provided at all times in compliance with accepted standards of professional practice. G. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes: 1. services provided by professional and volunteer staff; 2. outcome audits of patient charts; 3. reports from staff, volunteers, and clients about services; 4. concerns or suggestions for improve-	**§ 418.58 Condition of participation: Quality assessment and performance improvement.** The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to	**115.05 Quality Assurance** 1. The hospice shall conduct an ongoing, comprehensive integrated self-assessment quality improvement process (inclusive of inpatient care, home care and respite care) which evaluates not only the quality of care provided, but also the appropriateness care/services provided and evaluations of such services. Findings shall be documented and used by the hospice to correct identified problems and to revise hospice policies.: 6. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes: a. Services provided by professional and volunteer staff; b. Outcome audits of patient charts; c. Reports from staff, volunteers, and

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.

LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
ment in services; 5. organizational review of the hospice program; 6. patient/family evaluations of care; and 7. high-risk, high-volume and problem-prone activities.	CMS. ***(c) Standard: Program activities.*** (1) The hospice's performance improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect palliative outcomes, patient safety, and quality of care.	clients about services; d. Concerns or suggestion for improvement in services; e. Organizational review of the hospice program; f. Patient/family evaluations of care; and g. High-risk, high-volume and problem-prone activities.
	Subpart D--Conditions of Participation: Organizational Environment **§ 418.100 Condition of Participation: Organization and administration of services.** (a) Standard: Serving the hospice patient and family. The hospice must provide hospice care that— (1) Optimizes comfort and dignity; and (2) Is consistent with patient and family needs and goals, with patient needs and goals as priority. (c) Standard: Services. (1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice: (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling. (g) Standard: Training. (1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact. (2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties. (3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education pro-	**PART VI BASIC HOSPICE CARE** **116 CORE SERVICES** 116.01 Hospice care shall be provided by a hospice care team. Medical, nursing and counseling services are basic to hospice care and shall be provided directly (Medical Director only may be contract). Hospice care will be available twenty-four (24) hours a day, seven (7) days a week. 3. Counseling services shall be provided in a manner which best assists the patient and family unit to cope with the stresses related to the patient's condition. These services may be provided by a member of the clergy who is qualified through training and/or experience to provide such services, or by other qualified counselor(s). Such counselors shall be licensed, if applicable. **117 OTHER SERVICES** 117.02 Spiritual services shall be available and offered to the patient and family unit; however, no value or belief system may be imposed. **121 IN-SERVICE TRAINING** 121.01 The hospice shall provide ongoing, relevant in-service training for all members of the hospice care team. 121.02 For each direct-care employee, the hospice shall require training of twelve (12) hours inservice education, at a minimum annually. Documentation of such training shall be maintained.

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.

LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
	grams where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months	

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.

TOP 10 REASONS EVERY HOSPICE CHAPLAIN SHOULD ATTEND

The LMHPCO 2009 Annual Conference and Post-Conference

July 29-31, 2009
Loews Hotel
New Orleans, LA

1.) Hear the controversies surrounding death bed experiences
2.) Participate in a Centering Prayer
3.) Experience the power of forgiveness and acceptance through the life of a terminally ill patient
4.) Journey into the world of the dying
5.) Learn about issues affecting African Americans and End-of-Life Care
6.) Learn coping and caring methods for health care professionals
7.) Learn about spiritual and psychosocial issues of Alzheimer's patients before **and** after they forget
8.) Network with peers –establish new relationships and renew existing ones
9.) Hear latest trends affecting the hospice industry in LA & MS
10.) Earn 16 hours of continuing education and keep the surveyors happy

July 29-31, 2009

LOUISIANA~MISSISSIPPI
HOSPICE AND PALLIATIVE CARE ORGANIZATION

THE 2009 ANNUAL LEADERSHIP CONFERENCE

MISSION POSSIBLE

CERTAINTY IN UNCERTAIN TIMES

July 29-31, 2009

OPENING PLENARY

Wednesday Morning, July 29, 2009

"You Have To Know What Is Coming To Be Prepared For It"

Presenter: Peter Benjamin

This presentation will help providers to have a better understanding of overall healthcare spending, consumer attitudes about EOL and how hospice fits into the overall health care continuum. Mr. Benjamin will discuss common practices among US hospice providers as well as help hospices understand non-hospice EOL providers. Mr. Benjamin will explore best practices in sales and marketing for hospice providers as well as non-hospice EOL providers.

About the Presenter:

Peter Benjamin is the founding partner for The Huntington Consulting Group (HCG). For the past twelve years HCG has worked with hospice providers around the country to help them understand key trends in health care as well as key trends in end of life care. In addition, HCG has worked with hospice providers to help them understand the organizational implications of external trends and to best position themselves for success in their communities. In addition to working with hospice providers HCG works with home health providers, HME companies, pharma/biotech organizations, health systems, payors and disease management entities. By working with a broad array of healthcare organizations HCG is able to offer hospice providers a broad perspective on how they should position their organizations.

AFTERNOON PLENARY

Wednesday Afternoon, July 29, 2009

"Hospice Care in the Nursing Home - Advocating for the Pros and Overcoming the Cons"

Presented by: Gerald Holman, MD, FAAP, FRCPC

The relationship and understanding of the culture of nursing facilities and the culture of hospice will be discussed. The seminal importance of true collaboration will be stressed. The positive effect of quality hospice care in nursing facilities will be outlined. How to develop an environment of trust while exploring any inherent difficulties will be explored. Concerns of CMS and their work plan toward nursing facilities and hospice will be outlined and solutions offered. The role of each member of the hospice team relative to nursing facility staff will be reviewed and the legal and ethical relationships summarized..

About the Presenter:

Dr. Gerald H. Holman, B.Sc. (Med), MD, FAAP, FRCPC (Ret.) is the founding Medical Director of the Hospice Care of the Southwest in Amarillo and Livingstone Texas. He has held several distinguished positions nationally and internationally in hospice/palliative medicine. He is a past President of the American Academy of Hospice and Palliative Medicine and was the founding Chairman of the American Board of Hospice and Palliative Medicine. He was Vice-Chairman of the International Hospice Institute and College and past member for six years of the Board of the National Hospice and Palliative Care Organization. He was chairman of the Board of the American Hospice Foundation (AHF) for eight years and recently became their Emeritus Chairman.

Dr. Holman has been a faculty member for the American Medical Association's Education for Physicians in End-of-Life Care (EPEC) program. He has lectured and led workshops in hospice care for adults and children in the United States, Canada, China, and Great Briton. He served for five years (1992 -1996) as Chief of Staff at the Amarillo, TX, Department of Veteran's Affairs Medical Center, where he was involved with the Department of Veterans Affairs National Hospice Initiative.

Make plans for the LMHPCO Leadership Conference

The LOEWS NEW ORLEANS HOTEL has again been selected as the site for the 2009 LMHPCO Leadership conference site.

http://www.loewshotels.com/en/Booking/RoomTypeSelection.aspx?h=LNOH&ci=2009-

or

call 866-211-6411.

The room rate is $105 per night and is guaranteed through June 27, 2009.

www.loewsneworleans.com

MORNING PLENARY

Thursday Morning, July 30, 2009

"Because You've Never Died Before: The World of the Dying"

Presenter: The Rev. Dr. Kathleen Rusnak, Ph.D.

Once individuals receive a terminal prognosis, they embark upon an unexpected new journey. Their worldview is forever changed. An amazing journey into a previously unimaginable spiritual terrain is automatically set into motion, and discoveries into the meaning of life and the essence of the self, the other, and God emerge. What the dying learn about living at the end of life is their gift to us in the midst of life.

About the Presenter:

Kathleen is an ordained Lutheran pastor with a doctorate in Psychology and Religion. All of her endeavors throughout her career or vocation have been directed by interests developed as a child of the sixties, from civil rights, to the Holocaust and post-Holocaust theology for Christians and Jews, to her work in hospice. Kathleen has always been interested in the ultimate questions of life, the psychology behind religious beliefs and actions, and human transformation. She, in her own thinking, felt her only choice was to become a pastor and theologian. She was convinced that this was her niche to influence and change the world. To that end, Kathleen has been the pastor of three Lutheran congregations, has served as a hospice chaplain in two hospices, was the director of spiritual care and bereavement at another hospice. She lived and worked in Israel for over two years as the director of the theological department of a post-Holocaust Christian European kibbutz in the Galilee, and focused on repentance and renewal towards the Jewish people.

Kathleen is a thought-provoking, humorous, and dynamic speaker. Her insights and introspective and reflective talks on relationships and spiritual care are motivating and conscious lifting.

CLOSING PLENARY

Thursday Afternoon, July 30, 2009

"Palmetto-GBA Analysis of Claims for LA and MS Hospice Providers"

Presenter: Mary Jane Schultz, RN

This presentation is designed to give participants a better understanding of the hospice data analysis for the states of LA and MS as well as national comparisons.

About the Presenter:

Mary Jane Schultz is the Director of Medical Review at Palmetto GBA. She is a Registered nurse and a graduate of Weber State University in Utah. She has over 22 years of experience in the Medical Review unit at Palmetto GBA and is a frequent speaker at provider education seminars. Prior to joining Palmetto GBA, Mary Jane had many years of experience in medical surgical nursing, dialysis, labor/delivery, patient education and staff training and development.

Calling All Hospice Chaplains

Make Plans Now to Attend the Post-Conference Spiritual Track
Friday, July 31, 2009

Session PC 6

"Before They Forget: Spiritual Issues and Dementia"

1. **Participants will be able to define and describe the "brick Wall" phenomenon experienced by persons diagnosed with early Alzheimer's.**
2. **Participants will be able to describe the spiritual dimensions and the questions and tasks that emerge for persons with Early Alzheimer's.**
3. **Participants will be able to use this knowledge to counsel persons with early Alzheimer's to meaningfully utilize time before "they forget."**

Session PC 13

"After They Forget: Spiritual Issues and Dementia"

1. **Participants will be able to identify several philosophical and theological assumptions of what constitutes personhood and human worth, especially as it relates to persons who have a diminished cognitive capacity. Participants will be able to describe the moral, ethical, and historical implications of those positions.**
2. **Participants will be able to discover their own assumptions regarding the issue of personhood and human worth, which directly influences their attitude towards persons with advanced AD, and the frequency and quality of their visits.**
3. **Participants will be able to identify the main psychological and spiritual needs of persons with advanced AD and identify what caregiver attitudes and interventions are necessary to meet those needs and to maintain the personhood of those with advanced AD.**

"Kathleen is an ordained Lutheran pastor with a doctorate in Psychology and Religion. All of her endeavors throughout her career or vocation have been directed by interests developed as a child of the sixties, from civil rights, to the Holocaust and post-Holocaust theology for Christians and Jews, to her work in hospice. She is deeply influenced by Martin Luther King and by the German Lutheran theologian Dietrich Bonhoeffer, who, at 39, was hanged in a concentration camp by the Nazis for his active resistance to Hitler.

Kathleen has always been interested in the ultimate questions of life, the psychology behind religious beliefs and actions, and human transformation. She, in her own thinking, felt her only choice was to become a pastor and theologian. She was convinced that this was her niche to influence and change the world. To that end, Kathleen has been the pastor of three Lutheran congregations, has served as a hospice chaplain in two hospices, was the director of spiritual care and bereavement at another hospice. She lived and worked in Israel for over two years as the director of the theological department of a post-Holocaust Christian European kibbutz in the Galilee, and focused on repentance and renewal towards the Jewish people.

Kathleen is a thought-provoking, humorous, and dynamic speaker. Her insights and introspective and reflective talks on relationships and spiritual care are motivating and conscious lifting."

Excerpt taken from Kathleen's web-site
www.thebrickwall2.com

DID YOU KNOW?

The MS Hospice Chaplains Association meets quarterly. To find out more check out their web site www.mschaplains.org

SAVE THE DATE

July 29-31, 2009

LOUISIANA~MISSISSIPPI
HOSPICE AND PALLIATIVE CARE ORGANIZATION

THE 2009 ANNUAL LEADERSHIP CONFERENCE

MISSION POSSIBLE

CERTAINTY IN UNCERTAIN TIMES

Heart of Hospice Award Nominations Requested

LMHPCO is seeking nominations for the Annual Heart of Hospice Award. This award recognizes an individual who has attained repeated outstanding achievements in hospice and end-of-life care. Award presentations will be held on Thursday, July 30, 2009, at the lunch meeting of the LMHPCO Annual Leadership Conference in New Orleans.

Enter your submission today!

Download form at: http://www.lmhpco.org/blahdocs/uploads/2009 hoh award nomination form 5630.doc

LMHPCO Heart of Hospice Award 2009 Nomination Form

Deadline for Nomination is Monday, June 1, 2009

The Heart of Hospice Award recognizes an individual from each of the two states who has attained repeated outstanding achievements in hospice and end-of-life care. This award will be presented on Thursday, July 30, 2009 at the Lunch Meeting of the LMHPCO Annual Leadership Conference in New Orleans.

Information requested includes all of the following:

Name of **Nominee**
Hospice/Palliative Care Program Affiliation:
City: State: Zip:
Phone number: Fax:
E-mail address:
Nominee's Curriculum Vitae/Resume

Narrative: Describe nominee's history and relationship to hospice/palliative care, including accomplishments and contributions to hospice/palliative care.

Reference Letters (at least 1)

Name of **Nominator** (Your Name):
Hospice/Palliative Care Program Affiliation:
City: State: Zip:
Phone number: Fax:
E-mail address:

All requested materials may be e-mailed or mailed by June 1, 2009 to:
E-mail: nancy@LMHPCO.org
Mail: LMHPCO • 717 Kerlerec • New Orleans, LA 70116

briefs

Governor Bobby Jindal finalizes appointments to his Advisory Committee on Hospice Care. *They are (from left to right):* ***Hilda Jarboe, MSW*** *of New Orleans, a medical social worker at Community Hospice will serve as the representative for medical social workers;* ***Dr. Michelle Self****, of Shreveport, a hospice and family practice physician for Willis-Knighton Health System and the associate medical director for Hospice of Shreveport-Bossier will serve as the representative for physicians;* ***Reverend Sandra Huber****, of Elm Grove, a chaplain at Hospice of Shreveport-Bossier and former pastor at United Methodist Church in Shreveport will serve as the representative of spiritual counselors;* ***Robin Loucke, RN*** *of Bossier City, a veteran of the United States Air Force and the director of Hospice and Grace Home within the Christus Schumpert Health System will serve as the representative for registered nurses;* ***Dr. John McNulty****, of Covington, a veteran of the United States Army and the medical director of Hospice of St. Tammany will serve as a consumer who has been as recipient of hospice services;.* ***Alan Levine*** *(not pictured), of Baton Rouge, Secretary of the Department of Health and Hospitals serves as an ex-officio member of the Advisory Committee but was unable to attend this first meeting due to a Legislative Appropriations Committee Hearing;* ***Ray Dawson****, Medicaid Deputy Director served as Secretary Levine's designee at this meeting;* ***Paul Breaux****, of Lafayette, a self-employed attorney and member of the American Health Law Association, the Louisiana State Bar Association will serve as the representative from the business community with an interest in hospice care;* ***Melody Eschete, RN*** *of St. Francisville, a certified corrections nurse manager, employed with the Department of Public Safety & Corrections and member of the Quality Guidelines for Hospice & Palliative Care in Corrections Task Force serves as the representative of volunteers; and* ***Kathryn Grigsby****, of Baton Rouge, CEO of Hospice of Baton Rouge and member of the National Hospice and Palliative Care Organization serves as the representative for hospice administrators. The Advisory Committee met for the first time on April 15th and elected Dr McNulty as Chair and Melody Eschete as Secretary. The Committee plans to meet each month while the Legislature is in session and then quarterly afterwards.*

662 Area Code attendees listened intently as Steve Egger, Division Director 1, with MSDH gave an update on survey findings. The meeting was held April 16, 2009 in Oxford, MS.

briefs

Attendees enjoyed the in-service as well as the networking. Nancy Dunn, LMHPCO Education Director, was the presenter for "The Needs of the Mourning".

***Clark photo**: Due to an overwhelming response the Chaplain in-service on "The Needs of the Mourning" was repeated once again, this time at Delta Regional Medical Center Pavilion in Greenville, MS. A special thanks to **Cindy Clark**, RN, BS, COS-C, HCS-D, Director of Home Health and Hospice for Delta Regional Medical Center for hosting the location.*

Calendar

www.LMHPCO.org

May 19, 2009
Area Code 318 Quarterly Luncheon. For more information, contact Martha McDurmond at hosbmcm@bellsouth.net

July 29-30, 2009 (Wednesday & Thursday)
LMHPCO Annual Leadership Conference & Annual Meeting
Loews Hotel, New Orleans, LA

July 31, 2009 (Friday)
LMHPCO Annual Leadership Post-Conference
Loews Hotel, New Orleans, LA

September 24-26, 2009
NHPCO's 10th Clinical Team Conference
Hyatt Regency, Denver, CO
For more information go to:
http://www.nhpco.org/i4a/pages/ index.cfm?pageid=3259

December 4-6, 2009
NHPCO's 6th National Conference on Volunteerism & Family Caregiving • Walt Disney Swan Hotel, Orlando, FL
For more information go to:
http://www.nhpco.org/i4a/pages/ index.cfm?pageid=3259

Members make the work of LMHPCO possible!

(2009 memberships received as of 5/5/2009)

PROVIDER MEMBERS:

A&E Hospice, Inc, Olive Branch, MS
Agape Hospice of Shreveport, LLC, Shreveport, LA
Agape Hospice Care of Ruston, LA
Agape Northeast Regional Hospice, LLC, West Monroe, LA
Agape Northwest Regional Hospice, LLC, Minden, LA
AseraCare Hospice, LLC, Corinth, MS
AseraCare Hospice, LLC, Flowood, MS
AseraCare Hospice, LLC, Philadelphia, MS
AseraCare Hospice, LLC, Senatobia, MS
AseraCare Hospice, LLC, Starkville, MS
AseraCare Hospice, Tupelo, MS
Baptist Hospice - Golden Triangle, Columbus, MS
Bayou Region Hospice, Houma, LA
Brighton Bridge Hospice, LLC, Oberlin, LA
Circle of life Hospice, Inc, Shreveport, MS
Christus Cabrini Hospice, Alexandria, LA
Christus Schumpert Community Hospice, Shreveport, LA
Camellia Home Health & Hospice, Bogalusa, LA
Camellia Home Health & Hospice, Columbia, MS
Camellia Home Health & Hospice, Hattiesburg, MS
Camellia Home Health & Hospice, Jackson, MS
Comfort Care, Laurel, MS
Community Hospice of America, McComb, MS
Community Hospice of America, Meridian, MS
Community Hospice of America, Natchez, MS
Community Hospice of America, Shreveport, LA
Community Hospice, Inc, Sherman, MS
Community Hospice, LLC, New Orleans, LA
Continue Care Hospice, Hollandale, 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
Destiny Hospice Palliative care & Specialty Services, Inc, Tutwiler, MS
Elayn Hunt Correctional Center, St Gabriel, LA
Eternity Hospice, Inc, Gulfport, MS
Eternity Hospice, Inc, Indianola, MS
Eternity Hospice, Inc, Laurel, MS
Faith Foundation Hospice, Inc, Alexandria, LA
First Choice Hospice, Inc, Olla, LA
Forrest General Hospital, Hattiesburg, MS
Generations Hospice Service Corp, Denham Springs, LA
Gilbert's Hospice, Flowood, MS
Gilbert's hospice, McComb, MS
Gilbert's Hospice, Tupelo, MS
Guardian Hospice Care, LLC, Alexandria, LA
Guardian Hospice, Inc, Jefferson, LA
Gulf Coast Hospice, Ocean Springs, MS
Heritage Hospice, Amory, MS
Heritage Hospice, Corinth, MS
Hospice Associates, Metairie, LA
Hospice of Acadiana, Lafayette, LA
Hospice of Many, LA
Hospice of Natchitoches, LA
Hospice of St Tammany, Mandeville, LA
Hospice Care of Avoyelles LLC, Alexandria, LA
Hospice Care of Avoyelles LLC, Marksville, LA
Hospice Care of Avoyelles LLC, Opelousas, LA
Hospice Care of Louisiana, Alexandria, LA
Hospice Care of Louisiana, Baton Rouge, LA
Hospice Care of Louisiana, Lafayette, LA
Hospice Care of Louisiana, Monroe, LA
Hospice Care of Louisiana, New Orleans, LA
Hospice Care of Louisiana, Slidell, LA
Hospice Care of Mississippi, Waveland, MS
Hospice In His Care, Baton Rouge, LA
Hospice in His Hands, Carthage, MS
Hospice in His Hands, Kosciusko, MS
Hospice in His Hands, Magee, MS
Hospice in His Hands, Walnut Grove, MS
Hospice Ministries, Brookhaven, MS
Hospice Ministries, McComb, MS
Hospice Ministries, Natchez, MS
Hospice Ministries, Ridgeland, MS
Hospice of Acadiana, Lafayette, LA
Hospice of Baton Rouge, Baton Rouge, 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. TammanyHospice of South
Hospice of Shreveport/Bossier, LA
Hospice of South Louisiana, LLC, Houma, LA
Hospice TLC, Winnsboro, LA
IBC Hospice, Youngsville, LA
Infinity Care Hospice of Louisiana, LLC, New Orleans, LA
Jordan's Crossing Hospice, LLC, Shreveport, LA
Journey Hospice, LLC, Alexandria, LA
Journey Hospice of Southwest Louisiana, LLC Lafayette, LA
Journey Hospice of the Shores, LLC, Metairie, LA
LifePath Hospice Care Services, LLC, Shreveport, LA
Life Source Services, LLC, Baton Rouge, LA
Livingston Hospice Associates, LLC, Walker, LA
Louisiana Hospice, Mamou, LA
Louisiana Hospice & Palliative Care, Jennings, LA
Louisiana Hospice & Palliative Care, Opelousas, LA
Louisiana State Penitentiary Hospice, Angola, LA
Magnolia Regional Health Center Home Health & Hospice Agency, Corinth, MS
Memorial Hospice at Gulfport, Gulfport, MS
Memorial Hospice & Palliative Care, LLC, Slidell, LA
Mid-Delta Hospice, Batesville, MS
My Hospice, Metairie, LA
North Mississippi Hospice, Oxford, MS
North Mississippi Hospice, Southaven, MS
North MS Hospice of Tupelo, MS
North Mississippi Medical Center, Tupelo, MS
North Oaks Hospice, Hammond, LA
Odyssey Healthcare, Jackson, MS
Odyssey Healthcare of the Gulf Coast, Gulfport, MS
Odyssey Healthcare of the Gulf Coast, Biloxi, MS
Odyssey Healthcare of Lake Charles, LA
Odyssey Healthcare, New Orleans, LA
Odyssey Healthcare of NW Louisiana, Shreveport, LA
Odyssey Healthcare, Shreveport, LA
Patient's Choice Hospice & Palliative Care of Tallulah, LA
Patient's Choice Hospice & Palliative Care, LLC, Vicksburg, MS
Pax Hospice, Madison, MS
Pointe Coupee Hospice, New Roads, LA
Premier Hospice, LLC, Bastrop, LA
Quality Hospice Care, Inc Philadelphia, MS
Regional Hospice & Palliative Services-Southeast, LLC, Lafayette, LA
Richland Hospice, LLC, Rayville, LA
River Region Hospice, LLC, River Ridge, LA
River Region Hospice House, River Ridge, LA
St Catherine's Hospice, LLC, LaPlace, LA
St Johns Hospice & Palliative Care, Ruleville, MS
St Joseph Hospice, Baton Rouge, LA
St Joseph Hospice Bayou Region, Thibodaux, LA
St Joseph Hospice – CenLa, LLC, Alexandria, LA
St Joseph Hospice & Palliative Care Northshore, Covington, LA
St Joseph Hospice of Acadiana, LLC – Lafayette, LA
St Joseph Hospice of CenLA, Pineville, LA
St Joseph Hospice of Shreveport, LLC, Shreveport, LA
St Joseph Hospice & Palliative Care, LLC, New Orleans, LA
St Theresa's Hospice & Pallaitive Care, Lafayette, LA
Sanctuary Hospice House, Inc, Tupelo, LA
Serenity Hospice Services, New Orleans, LA
Truecare Hospice, Raymond, MS
Unity Hospice Care, LLC, Grenada, MS
Unity Hospice Care, LLC, Oxford, MS
Unity Hospice Care, LLC, Southaven, MS
Unity Hospice Care, LLC, Starkville, MS
Unity Hospice Care, LLC Tupelo, MS
Vital Hospice, Inc, Hammond, LA
Willis Knighton Hospice of Louisiana, Shreveport, LA

ASSOCIATE MEMBERS

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Leonard J Chabert Medical Center, Houma, LA
Deyta, LLC, Louisville, KY
Granec Hospice Billing, Inc, Tuscaloosa, AL
Gulf South Medical Supply, Lafayette, LA
HealthCare ConsultLink, Ft Worth, TX
Health Wyse, LLC, Wilmington, MA
Hospice Pharmacia, Philadelphia, PA
HospiScript, Montgomery, AL
MUMMS Software, New Orleans, LA
Mutual of America
Outcome Resources, Rocklin, CA
Patio Drugs, Metairie, LA
ProCare Hospice Care, Duluth, GA
The Hospice Pharmacy Group, Grapevine, TX

ORGANIZATION MEMBERS

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Palliative Care Institute of Southeast LA, Covington, LA

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Susan Drongowski, Las Vegas, NV
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PROFESSIONAL MEMBERS

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Heather Liao, RN, Madison, MS
Jo-Ann D Moore, MSW, LSW, Chalmette, LA
Matthews, Cutrer & Lindsay, PA, Jackson, MS

PALLIATIVE CARE MEMBERS

Our Lady of the Lake RMC, Baton Rouge, LA