Know Us Before You Need Us

Understanding Hospice (& Palliative) Care

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www.volunteerhospice.org

Understanding Comfort-Focused Care

Palliation: *Relieving symptoms, reducing suffering, and improving comfort & quality of life (even when a cure may not be possible)*

Palliative Care
Care focused on improving comfort, relieving symptoms, & enhancing quality of life

Hospice Care
End-of-life care

"Our ultimate goal, after all, is not a good death, but a good life to the very end."
~Atul Gawande, Being Mortal

When Palliative Care Helps

Serious,
Life-limiting illness

+

Nursing-Level Need
(managing pain, breathing, etc.)

- Patient & Family-centered care
- Focuses on quality of life & easing symptom burden
- Care is generally delivered where the patient calls home

Benefits of Palliative Care

Physical

- Relieve pain
- Manage symptoms
- Mitigate discomfort

Psychosocial

- Emotional & mental support
- Fulfil goals & desires

Spiritual

- Empowerment
- Purpose & closure

- Relieves suffering
- Supports informed choices
- Works with your existing providers
- Care team based on patient needs

Comfort-Focused Care

Palliative Care

Care focused on improving comfort, relieving symptoms, & enhancing quality of life

Hospice Care

End-of-life care

Hospice Care – A Form of Palliative Care

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Life-limiting illness

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- Hospice Focus: End-of-life

- Medicare requires prognosis of <6 months
- Medicare requires stop of curative treatments
- Medicare requires that hospice take over patient care
- Medicare requires disciplines (Physician, Nurse, CNA, Spiritual Counselor, Grief Counselor, Therapists, Dietitian, Volunteers)

Benefits of Hospice Care

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Psychosocial

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Spiritual

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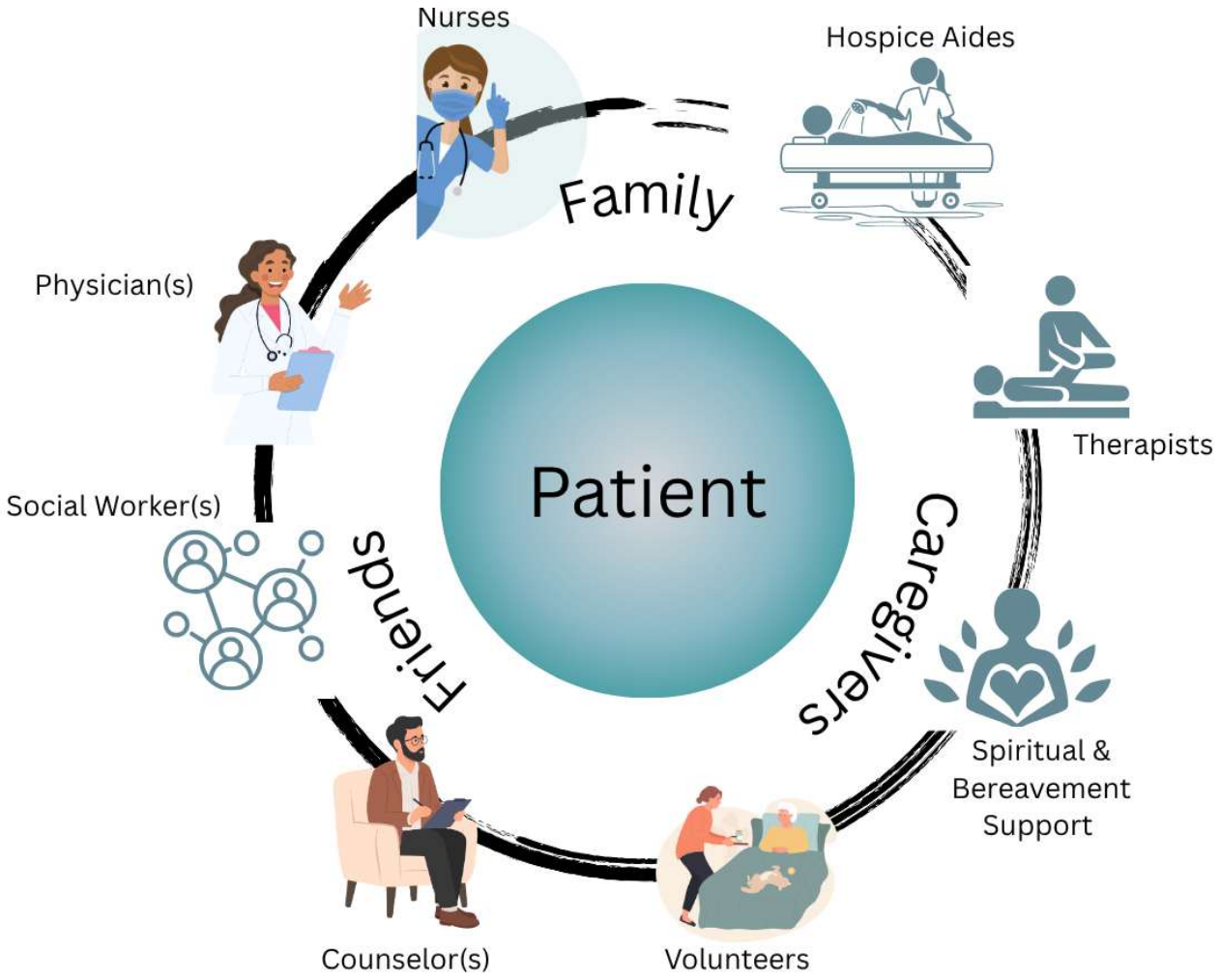
The Hospice Interdisciplinary Team



- Manages pain & symptoms
- Assists with emotional, psychosocial & spiritual aspects of dying
- Provides medications & medical equipment
- Instructs caregivers on how to care for patient
- Provides grief support to patient & family
- Provides specialized therapies

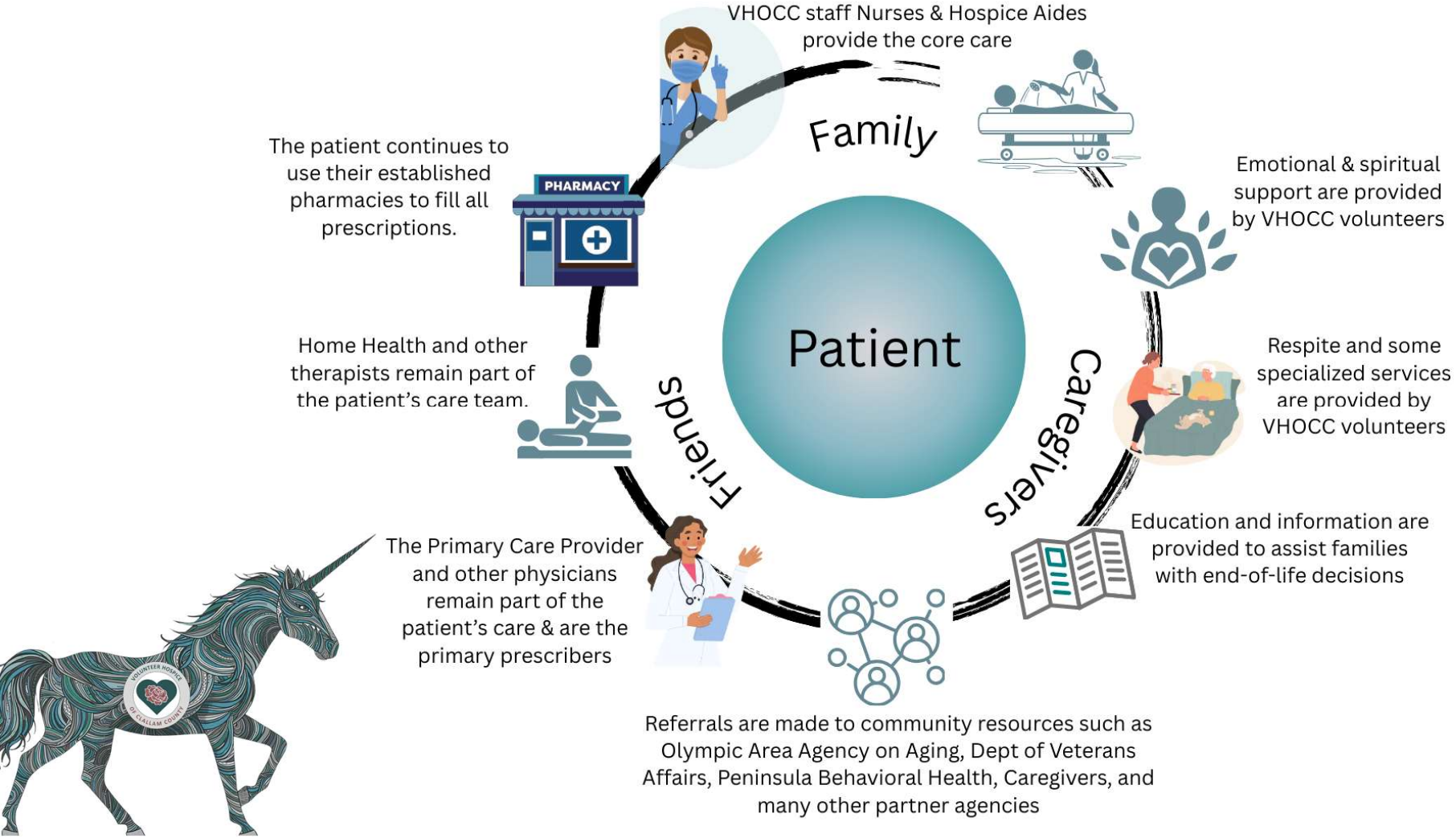
Hospice in Clallam County

- Assured Hospice
  - Medicare-licensed hospice for Clallam & Jefferson
  - Part of UnitedHealth Group
    - Part of the health services division Optum

- Volunteer Hospice of Clallam County (VHOCC)
  - Independent, local, community-supported nonprofit
    - RCW 70.127.050 carved out exemption from licensure
  - Provide free hospice & palliative services from Joyce to Diamond Point

Different from a Medicare hospice

Volunteer Hospice of Clallam County is Different



VHOCC Is Unique

Same as the rest	Distinctive
Provide end-of-life care for patients with life-limiting condition	Can support patients with prognosis >6 month (Medicare: Palliative)
Follow hospice standards of practice with focus on: - comfort - reduced stress - symptom relief - physical & psychosocial relief	Partnership with existing care team (PCP's, specialty providers, home health, etc.)
HIPAA-compliant & quality focused	Patient can continue curative measures (patient can still call 911, go to ER, etc.)
Provide medication support, medical supplies, and DME	Independent hospice with no billing*
Provide coaching to family on how to care for patient	Flexibility to provide extensive support when needed
Provide emotional support & spiritual care	Patient's Medicare/Insurance $ continue to be used as before
Provide grief & bereavement support	

*RCW 70.127.050 carved out exception to exempt us from licensure

VHOCC Admission

Provider referral

- Medical history
- VHOCC Standing Orders
- VHOCC Emergency Prescriptions

2-3 Business Days

Screening Call

Not admission appropriate → Not scheduled

Admission appropriate → (Urgency / Capacity) → Scheduled

Scheduled → Day Before Confirm Appointment → Full Assessment

Full Assessment → Meets Criteria & Sufficient Caregiving Support & Ready to Accept Service

- ✓ Palliative Case Load
- ✓ Hospice Case Load

Full Assessment → Team Consult

- ✓ Hold
- Not Admitted

Reasons for Patient Non-Admission

- Insufficient caregiving to support needs
  - Once resolved, admission can proceed
- No local provider to partner with us
- Patient refuses service
  - Chooses alternate provider
  - Chooses not to use palliative/hospice care
- Insufficient organizational capacity

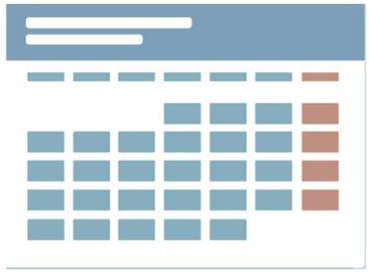
Patient Care

Hospice Patients

- RN contact weekly; visit minimum every 2 weeks & PRN
- CNA visits weekly; ↑ frequency PRN
- Volunteers from admission to death
  - Varying specialties: grief support, respite, community outreach, etc.

Palliative Patients

- RN contact monthly & visit minimum = every 2 months & PRN
- CNA visits weekly, ↑ frequency PRN
- Volunteers from admission to death
  - Varying specialties: grief support, respite, community outreach, etc.



Available as much or as little as needed – a phone call away

- Not restricted by Medicare guidelines
- Care based on:
  - Patient acuity
  - Individualized needs
  - Family/caregiver needs

Jun 2026 census: 122

- 45% hospice, 55% palliative
- 50% PA, 50% SQ
- 10-25 admits/mo
- 13-25 deaths/mo

#More Than Hospice

Complementary Services

Grief & Bereavement

- Individual grief support
- Grief support groups
- Practical workshops
- Annual Remembrance Ceremony

Information

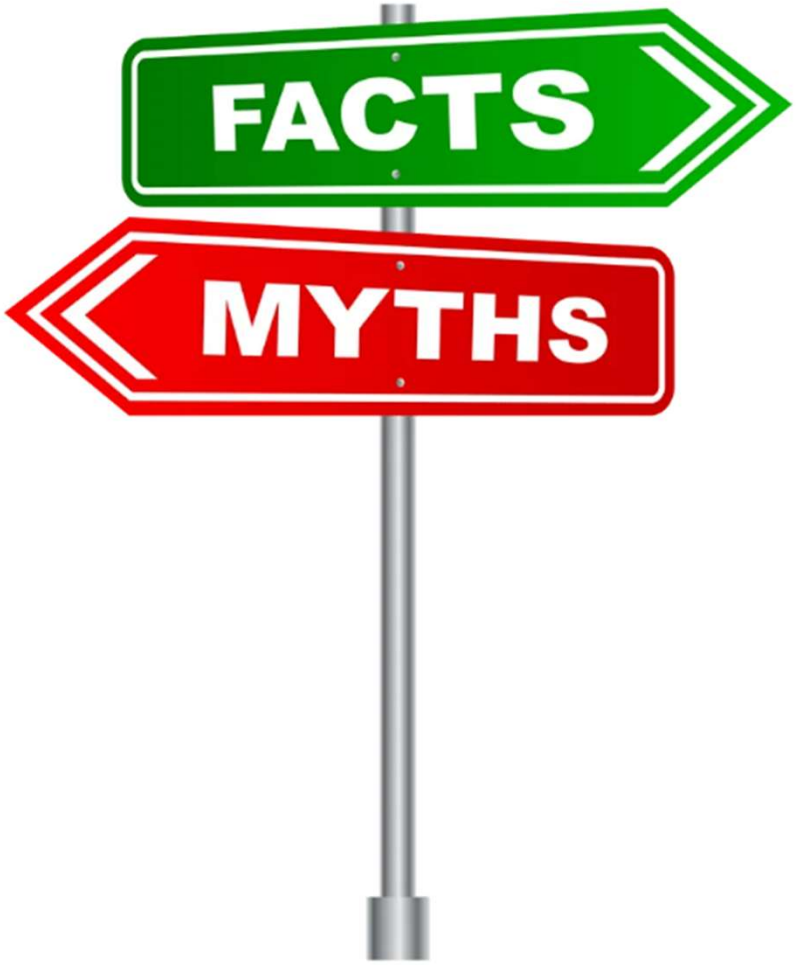
Soul Care

- Death Cafes "Tea To Die For"
- Speaker Series
- End of Life Companions

Equipment & Supply Lending

- Open to the community
- No time limit on loans
- Donations accepted

Common Misunderstandings About Hospice



Hospice: Myth vs Fact

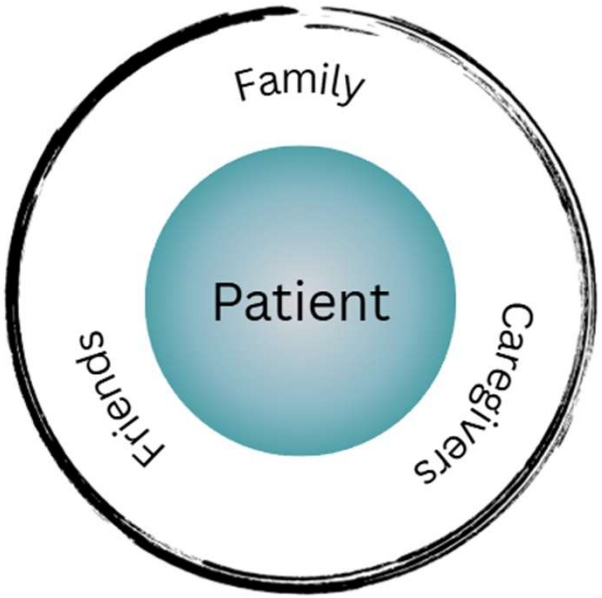
Myth: Hospice is a physical place you move to

FACT

- Hospice usually comes to you wherever you call home.
- Temporary respite care can sometimes occur in a facility.
- Inpatient care is usually short-term to address specific severe symptoms.

Hospice: Myth vs Fact

Myth: Hospice provides all the hands-on care



FACT

Hospice works with family and caregivers; it doesn't replace them.

- Family, friends, and paid caregivers continue to provide most day-to-day care.
- The hospice team teaches, supports, and guides caregivers every step of the way.
- Hospice staff are available 24/7 to answer questions, manage symptoms, and provide expert support.

Hospice: Myth vs Fact

Myth: Hospice provides continuous bedside care

FACT

Hospice provides expert care and support when needed.

- The hospice team visits regularly based on each patient's needs.
- Families & caregivers have access to hospice professionals 24/7 by phone.
- If an urgent issue arises, a hospice team member can come to the home outside of scheduled visits.
- Continuous care for short periods can sometimes help stabilize crisis situations.

Hospice: Myth vs Fact

Myth: Choosing hospice means giving up hope

FACT

- Hospice reframes hope from seeking a cure to focusing on comfort, dignity, and quality of life.
- Hospice allows patients to live as fully as possible in the time they have remaining.

Hospice: Myth vs Fact

Myth: Hospice is only for the final days or weeks of life

FACT

- Medicare qualification for hospice: when a doctor believes someone has ≤6-months if their illness follows its expected course.
- The earlier hospice begins, the more time patients & families benefit from its care and support.

Hospice: Myth vs Fact

Myth: If you are on hospice, you can no longer see your primary doctor

FACT

A patient's primary care physicians, specialists, and the hospice team can work together to develop an individualized care plan

Hospice: Myth vs Fact

Myth: Medications like morphine are used to overmedicate or speed up death

FACT

- Medications like morphine are used to relieve pain & ease breathing.
- The hospice team carefully adjusts the dose to keep patients as comfortable and alert as possible.

Hospice: Myth vs Fact

Myth: The patient is going to get addicted to hospice medications

FACT

- The hospice team carefully tracks & adjusts doses to ensure safety and comfort.
- If the medications are being taken as prescribed for true symptoms, addiction is very unlikely.
- Needing more medicine over time happens because the body gets used to the drug, not because of addiction.

Hospice: Myth vs Fact

Myth: Medication is the only way hospice helps relieve discomfort.

FACT

Hospice care relies on a wide range of non-medical, holistic therapies alongside medication to bring comfort, emotional peace, and physical relief.

- ✓ Physical relief: massage, repositioning, skin care
- ✓ Emotional/psychological care: companionship, counseling
- ✓ Spiritual care: chaplains, counselors
- ✓ Sensory therapy: music, aroma, lighting
- ✓ Guidance: caregiver training

Hospice: Myth vs Fact

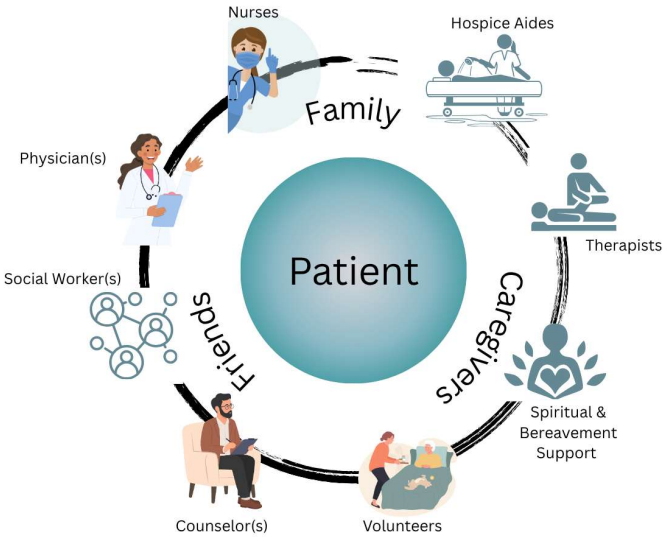
Myth: Hospice is only for cancer patients

FACT

- 1970's & 80's: most hospice patients had cancer.
- 2024, hospice patients:
  - >25% nervous system disorders
  - 23% cancer
  - 22% circulatory disease

Hospice: Myth vs Fact

Myth: Once you choose hospice, you can't change your mind

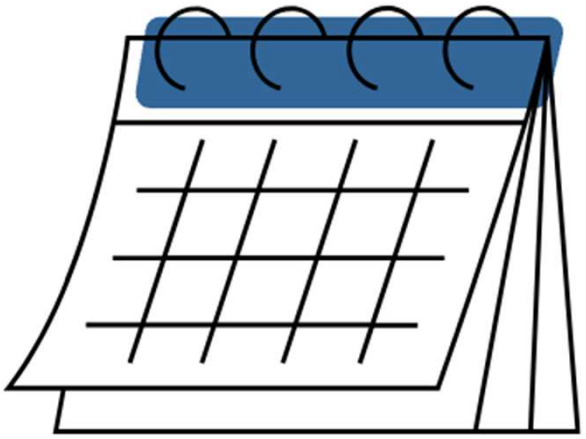


FACT

- Patient always has choice.
- Before opting out, consider:
  - Potential loss of hospice-supplied medications/equipment
  - Need to coordinate with PCP
  - Resumption of medical copays
  - Need to notify insurance plans

Hospice: Myth vs Fact

Myth: Hospice care ends after 6 months



FACT

- Hospice can continue as long as a person remains eligible. The six-month timeframe is a medical estimate, not a limit.
- If a person continues to meet hospice eligibility, their hospice care can be renewed.
- After the first six months, eligibility is reviewed every 60 days.

Hospice: Myth vs Fact

Myth: Once you leave hospice, you can never return

FACT

You can leave hospice at any time and re-enroll later if you meet the eligibility requirements

Why Hospice & Palliative Care?

Benefits of Referring to Hospice/Palliative Care

- Provides a team to manage pain & other symptoms of discomfort
- Provides **medication support**, medical supplies, and DME
- Provides coaching to family on how to care for patient
- Reduces symptom burden
- Reduces depression
- Provides needed end-of-life education to patient/family/caregivers, allowing the patient to stay at home through EOL per their wishes
- Increases patient/caregiver satisfaction with care
- Supports emotional, psychosocial & spiritual aspects of caring for someone with serious illness and/or is dying
- Provides bereavement care and counseling
- May increase survival (controversial)

BOTTOM LINE: Improves quality of life, before & after the patient's death

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Thank you!

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