Navigating the Hospice

Erica Honoŕe & Sharon Brubaker

Grief Specialists

Tony (00:02):

Erica and Sharon, her sisters who began a grief journey in 2006, when Erica's 10-year old son, Austin drown together, they participated in a grief education program were so moved by this experience. They studied and became specialists so they could help the broken hearted find recovery. In 2015 tragedy struck the family. Once again, when Eric, his oldest son, Donovan was killed in a motorcycle accident, Eric and Sharon are committed to sharing their experiences of love, loss, and healing through this podcast. Now your grief specialists, Sharon and Erica.

Sharon (00:41):

Hey ladies, how are you today with healing starts with the heart. How exciting we have a beautiful guest today?

Tamra (00:50):

Oh, that's sweet.

Erica (00:52):

Good morning, everyone. This is my wonderful friend Tamra Moss, and she has come to speak out on our behalf quite a bit. But today we have a different show today. We are going to be here supporting her and her industry, which is very important. Camera works in hospice and what hospice care. And what I have learned recently is hospice is not just for when you're dying. I think there's a misconception out there that hospice is only when you call hospice when only when someone is dying. And I thought because I learned something new, it would be good to share with all of our listeners out there, because this is an important message. So welcome to the podcast today, Tamra.

Tamra (01:40):

Thank you.

Sharon (01:41):

Hey, Tamra.

Tamra (01:42):

Glad to be official.

Erica (01:50):

Well, Tamra, let's start. Give us, give us a name of your company and where you're located. And also let's start with your information right up front. So people have additional questions they can contact you, and then I will make sure to put these in the show notes as well.

Tamra (02:05):

Okay. So the company I work for is R to R M. It stands for Rainbow to Rainbow, but it's R, to R hospice and palliative care. So we do both we're based out of Lewisville and our Jimmy get the office number, but put that up later.

Erica (02:22):

Give it all.

Tamra (02:23):

You can contact our office and me at my cell phone, which is (903) 357-9788. And our office number is (972) 219-0020.

Sharon (02:37):

Perfect.

Erica (02:37):

That's awesome.

Tamra (02:39):

And we service all of Dallas Fort worth mid cities all the way over to East, Texas and up to the Oklahoma border.

Sharon (02:50):

How long have you been with them tomorrow?

Tamra (02:52):

So I've only been with them since July, but I've been doing hospice for four years now. And prior to that, I did long-term care, skilled nursing for 15.

Sharon (03:02):

Wow. Wow. So I guess the first question I want to throw out is that hospice is a choice. It's a choice that the family and the patients make together, right?

Tamra (03:13):

Yes. That's the, that's what we're hoping we hope for. Right. You know, we and that's actually one part of our service as well. If there is some struggle between the family member and the patient who actually needs it, we try to bridge that gap because sometimes there's resentment from children who feel like their parents are giving up, or sometimes it's a child who needs hospice. I'm an adult child and the parents feel like they're given up. So we have social workers and chaplains who help with that because everybody needs to understand what's really going on. And have a good idea of where the illness is going to take us.

Sharon (03:48):

Why do you think the choice is so scary sometimes?

Tamra (03:52):

Well, you know, even as, as short, a time as five years ago, you waited until you were on your death bed or actively dying. As we say to call hospice. And people think that if you decide you want hospice, we're going to medicate you to the point that you can no longer speak. You can no longer get up and move around. And that's just not the facts. Medicare actually has started to realize the benefit of hospice and that it keeps people out of the hospital. So it costs them lists and only that, but you get to spend the time with your family. So it's about quality of life is over quantity, but Medicare says, now they want you to be on a minimum of six months when it used to be maximum of six months to really get to benefit because you can't get a social worker, a chaplain really involved in six months. They need, you know, there's a lot of things in between other than healthcare that we help with.

Sharon (04:47):

So Erica, six years ago, we had to make this choice with our father. We, we all came together as a family. Do you remember what, cause you were in, you were in Texas. I was in California and we were giving all the information when they said the word hospice. What was that like for us? You kind of remember what was it like for you? And then I'll share for me.

Erica (05:07):

And thankfully at the time we started with palliative care, I was still in California, living there just about to make the move. And,you know, in my mind it was like, what you see in the movies? I thought you're going to have 24 hour nursing and someone will be there every minute of every day. And when we actually got it signed up and they, the social worker came out and the nurse came out and of course they fell in love with daddy on the first day, because he was such a charmer. I quickly learned that that's not what it is. It's not what it looks like in the movie. They come and they sit down with you and they make a plan. And then they come back in on regularly scheduled visits. It's not 24 hours a day, which I thought was good because I think even though he was putting up a strong front, he was scared of that.

Sharon (06:01):

Yes. Yeah. Even the night when the nurse came is what I loved. You know, they sent a nurse practitioner. She sat with all of us for three hours and she really did an intensive history with him. He really wasn't understanding what she was doing there. And it's part of my memory with him. And part of what I've had to grieve was he looked over at me and said, Sharon, that's how he would call me really harsh. What is she, what is she here for? It was after the whole point was done. I said, well, she's going to start the palliative care. And he just said to me well, I'm not ready for that because he was scared. He was really scared, but it w it was an amazing experience. So let's go into that. And I just want to share this. I think he wasn't ready to make the decision, but as a family, we were at that point. And so as a family, we had to all make the decision. It was my mom who needed the help. And we were all working. Some of us had moved to another state. So it was like, as a family, we all came together and he didn't really, he wasn't really ready, but he knew it, it had to happen. So there's a difference between palliative and hospice. Can you give is that?

Tamra (07:13):

There is a difference. So palliative care, you have to have had an episode like a fall. It's very similar to home health. You don't get the one-on-one attention with palliative care that you do hospice, it's kind of the bridge and the step between, and unfortunately Medicare has not set forth specific guidelines yet on how palliative care is supposed to work or how they can bill. So everybody kind of does it differently. There's not a pattern or, you know, a set of regulations to go by. It's basically a beefed up version of home health because you get a social worker and a chaplain and a little bit of medication management. So it's really, for those people who, you know, are gonna need hospice, but they're afraid to say the word hospice. And so it's a kind of a, a short period where you can say, okay, well, let's do palliative care first because it eases them in mentally. And allows them to say, okay, I haven't completely given up yet.

Even though with hospice, that doesn't mean you're giving up either. It just means that you're dealing with symptoms that are uncontrolled.

Sharon (08:17):

Yeah. Why do you think? Well, I, I mean, I know the answer, but there's something happens. It's like this, no, she's put on hospice. It's like a whisper. It's like, I'm just going to say it it's like the death sentence. Right? And that, that seems like what you're saying is we're trying to get away from that, which we need to get away from the death sentence. I've actually heard people that I've actually been taken off of it.

Tamra (08:43):

That's exactly right. We call those, our graduated vacations a lot in the business. So what you see is sometimes patients, they may have a, you know, a Parkinson's diagnosis for example, but their biggest issue is the depression because of the grief they're going through for the quality of life. They're no longer having. They may still be five years from actually passing away or even more. And so when they start seeing that one-on-one care, that hospice gives them having a nurse come and check on once a week, a nursing assistant who comes by five days a week, a chaplain, a social worker. And we try to start healing that family and preparing them for what you know is going to happen. Eventually we've discharged many patients because they've improved. They started learning how to accept the diagnosis and realize, okay, but what can I still do? And, you know, that's the best scenario for us. We, we prefer that, but we know there are also patients who are gonna, you know, continue to decline. Sometimes failure to thrive is all, you need to be a hospice candidate because you're just in a state where you cannot see yourself getting better. And the diagnosis is too overwhelming. And that's where folks like you and Erica coming in and doing grief really helps them. Because it's hard to accept you have an illness. You know, and then, then we have some who, when we sign them up, they look like they could stay on services forever. My mom was on our hospice service a little over two years ago. And from the moment we got the diagnosis till we lost her was six weeks, but I'll never forget when I took her to the hospital. I thought, what do you mean? She's not making it out of here. She looks fine. She's acting fine. You know? And it just, they were like, well, yeah, that's not, you know, it's worse than it looks. So sometimes families see that they see mom and they think she didn't look that sick. She still cooks her own breakfast. She can still shower by herself. She still goes to the bathroom by herself. But what we have to look at is the whole patient and say, while they can do that every day, it's going to get harder and harder. And like you said, families need help as well, but we need to be there when the pain sets in or the anxiety or the depression. And that's, that's really the most important part

Sharon (11:06):

For us we can, I'm sorry, Erica. We could see him drop to a new level. You know, he would drop, he would lose certain things and then we would lose those things. He couldn't do those anymore. I feel like having somebody guiding us and telling us, okay. Yes. So now we need to bring in this chair for the shower and now we need to bring in the hospital bed and here are the pads and, you know, the way that we set everything up, having somebody to guide us, I think it was a immeasurable, you just can't even.

Tamra (11:35):

Yeah. And, and I didn't know, y'all's dad, but I've heard lots of stories about him. And so I'm pretty sure, like most of the Honoŕe he could be, he was a little stubborn and he was very prideful. And there's only certain things that you want your wife to do for you. There's only certain things you want your daughters to do. So it's nice to have that person come in, that you're not worried about, you know, them seeing you at your most vulnerable state. And it's not because he gets to build that relationship with the staff that's coming in and he learns to trust them and they can guide you and say, okay, here's what you can expect next. You know? And you don't have to rush them to the hospital because, you know, he doesn't want to go back to the hospital.

Speaker 3 (12:20):

You have that person to call that you can say he fell again. What do I do? And you know, and we send people out, we check them, we do an assessment. Our goal is to honor whatever the health program is. If the patient wants, if they don't want to go to the hospital, we don't want them to go to the hospital. Right. and I think they've given them back some of their decision-making and some of the responsibility for their own life and what's happening. I think that that helps as well, because if he says, I don't want a male nurse, I only want to cute ones. Well, we gave them the cute ones. Yeah, yeah. Or they say, we don't want to go to the hospital or we don't want to go to the hospital. We don't, you know, I don't want, I don't want to shower five days a week. I want it two days a week. You know, they still have a little bit of control over their lab because they get to make those decisions.

Erica (13:09):

Right. I want to come in with you said you had a patient with Parkinson's and I think if another misconception out there that hospice is just for cancer, that's right. Some of the other illnesses that you've worked with and that you guys cover.

Tamra (13:24):

Sure. We've done, you know, the list is endless. And just because it's not a terminal disease in the minds of, you know, the community, if it's pick it up with something else, it's something that your body can overcome. So Parkinson's is a big one. Muscular dystrophy EMS of course we do see a lot of cancer, but sometimes it is things Lewy body dementia. There are certain diseases that are caused from years and years of alcoholism. Certain types of dementia that are caused from that. So they're not considered terminal, but you can no longer function as you would have. I think cancer probably is one of the biggest one, but COPD is huge because not only can you not breathe, you retain so much fluid and then your heart starts to work extra. So, you know, pulmonary issues, heart issues, anything like that. If you're having a failure to thrive scenario, meaning it may not look like it's terminal, but you're just not able to figure it out. Then it's time to call in hospice to see what the problem is.

Sharon (14:39):

I've seen that in some States we're doing hospice in the home, but then there's also hospice hospitals. I don't, I'm just not aware is that state to state.

Tamra (14:51):

No, so hospice is a federal program. So it's under Medicare. We're, we're, you know, we have to do their guidelines. So a lot of times you'll hear somebody say, well, my dad's in hospice as opposed to on hospice. Right? So it works the same. There are lots of companies that have inpatient hospice, and that's normally for patients who have, you have to meet the criteria. So if you have if you're running fever or you have pain, that's uncontrollable nausea, vomiting, severe anxiety, or new behaviors, those types of things. And there's no one in the home to help you. A lot of times they'll do a facility. Or if the wife is just adamant that he can't die here or, you know, which was our situation with my mom, she lived with my sister and she shared a room with my 12 year old niece. And they kept trying to send her home from the hospital. And I said, there is no way that's happening. Sonormally you have to meet those inpatient criteria. However, the same criteria goes for what we call crisis care or continuous care in the home. So like your dad being at home, you do get the 24 hour nursing care under crisis care or continuous care. And that is the same criteria that's required for inpatient hospice. So you can, it just depends on if you want them at home or if you're that's more than you can handle.

Sharon (16:13):

Mm. Yeah. Oh, that's great. That's great to know. I didn't know how that, how that really back out. Okay. So let's switch to the family real quick. I tried to really go back to was it really active, grieving that was going on? Erica, you'e still there wasn't really active grieving that was going on when,when we first were doing it, I feel like, and that might be some of my trying to be strong, always trying to be strong. Was I so busy and trying to get everything set up that I didn't allow the grief in, or I was so concerned about him and my mom, and there was so much setting up that the grief didn't actually,and I, we were already grief specialists. So,we knew kind of what to expect in that sense. How, how do you feel that I don't even know if you can answer this most families approach that the grieving is actually starting and they talk, call it a lot of anticipatory grief. Like, you know, we're, we're anticipating what's getting ready to happen and the feelings that are coming up with that,how has that, how do you see that with the families?

Tamra (17:28):

So what we try to prepare them for is, you know, the actual time of death, you know, we, we try to prepare them for what they're going to see. Try to have a plan in place. And that's where the social worker and the chaplain are so extremely important. Because they come in and they help make a plan. So, you know, if, if mom or dad's oxygen level drops to this, or you know, they, they take only so many breaths a minute. That means this is happening. And so that's when we have the nurse there, but we want to have a plan. So when that's happening, do you want your kids there? Do you want the grandkids there? Do you, do you want us to call you as soon as we notice a decline, do you want us to call you women's the very last minute? So they they're kind of taken a little bit of control of their grief. Cause for some people, like we know it's out of sight out of mind, right? So if they know the hospice nurses only going to call them to come, when it's the very end, they're able to go through their day without thinking the dad's at bed, because he knows somebody's going, gonna call or then, or there might be the child that says any change I want to know because they can't let go of the control of knowing exactly what's happening. Well, I didn't want to say your name, but

Erica (18:44):

I was just, I was like, okay, Sharon, she knows, she knows we're right here.

Tamra (18:50):

So, you know, and, and like Erica being in Texas, you know, if, if she gets called every 10 minutes by the hospice nurse, her anxiety's through the roof, right. So if she knows a hospice nurse is only going to call her if it's important or it's a drastic change, or she needs to get there, then she's going to be much more tuned into those conversations. And she still feels like it's not her job to take care of him, which is what hospice is there for. We're there to, to provide that care. So it allows the family to kind of make their own plan as what they want. And I think that that helps some of the grief, but afterwards we have a bereavement program and that's really super important. We follow the family for 18 months after death we make weekly visits in the beginning and then we, you know, it goes two weeks and then monthly. I have one, one lady right now, her husband passed away recently. And he was her whole world. And I think, and I'm not even the grief specialist or the social worker or chaplain, but I was the one that she made the connection with. And so I think I talked to her three or four times a week because she just she's lonely. And, you know, I can, my mom was lonely over there when my dad passed away and I don't want anyone to feel that way. So hospice is definitely love centered people.

Erica (20:18):

Hold on, I just wanna jump in. And I just want to add two things. One Tamra is a graduate of our free programs. So I think that that's awesome that you are able to talk about grief and the process and everything. Cause you've experienced it personally, one with your mom passing and two going through our program. So you bring something different, which is probably why you were able to make the connection rougher, which is so awesome. I'm sure she, that so much. But the other thing I want to ask and talk about is, you know, grief is not just for the family. That's right. And the people you as staff members get attached to these people. I'm sure. So what is that like for you guys when someone passes away?

Tamra (21:04):

Yeah. And you know, not even just us as staff, our families who have never met these patients because when we come home and I'm like, I'm at the sweetest guy today, you know, cause sometimes people just touch your heart in a way that, you know, you were there for the right reason. So we do offer our chaplain does support groups for our staff, but you know, I think that's definitely an area where we can improve as an industry. I think we're expected to be that's our job, you know, but that, that's kind of the way they look at it. And it's important that you have a good work environment, a good set of people around you who are sensitive to that. And that's where we're trying to go, which is, you know, we're looking at bringing in some grief for our staff. You know, Erica, we've talked about that. We're looking at doing that because it is important. And that is where as an industry, we fall short. SoI think that it's, we attend the funerals, we attend the memorials, we help plan them, you know, when the families need our help. But we do have our own chaplain and social workers who we talk to quite often.

Sharon (22:13):

That's good. I think, I think that goes right along with the fact that society falls short on grief and grieving. We as a society, everybody, and I'm taking responsibility for that as well. And so it would make sense. Well, it's your job. Just get used to it three years ago, Eric and I got a call from a hospice program out here and they had a nurse and she had been with her patient for two years and it was an elderly woman and they became friends. Yes. And she was going to her every week and seeing her and taking care of her. And they were really good friends. She was shopping for her. They started this friendship and then her patient, but more importantly, her friend died and she could not function. Like she didn't even want a new patient. She didn't want to leave the house. And it, it shocked her as much as it, it shocked hospice program, but we worked with her and we helped her, but that was deep. And when you think of years of losing friends after friend of friends, because you become friends with them, right. It's tough. You know,

Tamra (23:18):

Before I did hospice, I worked in long-term care, which is nursing home environments. And I'll never forget that I came home one time and I told Winston, I said, I need you to know if I ever need to go to a nursing home. It's okay. And he said, why are we talking about this? We're 30? And I said, well, first of all, I'm putting you in one wig as soon as I can. I just want you to know it's okay. Because the men had such a time placing their wives in nursing homes because they felt like they were supposed to be there to protect her and the provider. That was instantly something that struck me all those years and for nursing homes. And so we were having to do reach out to them and have our social worker keep reaching out to the husbands to make sure they were okay with the fact that their wives were no longer at home. It's the opposite with hospice. The wives do not like signing their husbands up because they're because men are prideful normally more prideful. And they, the wives feel like they should be able to take care of them. Cause, and they apologize. And that's where we come in and had to explain to them, you're not doing anything wrong, you know? Yeah. You weigh a hundred pounds. The fact that you think you can lift this 400 pound man and help him to the restroom, that's not in your capabilities unless you want to be laying in the bed next to him. You know, we have to come in and help them deal with that on the front part of it's okay, it's okay to need help. And they have a really difficult time. So the chaplain, the social worker get involved quickly.

Sharon (24:53):

Recently Tony had surgery on his shoulder and they did a whammy to me instead of putting him in a splint. They did a block on his arm and they put this cast right, all the way down his arm. I kid you not that thing must have weighed 75 pounds. And it was like, I was picking it up with two arms. I was, I, it, something went through my head. If this man gets sick, I want to take care of him. I want to be the one that's there for him. I want him to have his dignity and autonomy. And I are a few years, a party's 17 years older than, than I am. But if he gets sick, if he gets sick, body-wise I'm not going to be able to lift him. That's right. He had the surgery, he was, the arm was still numb. And I got insurance you know, long-term care insurance. I went out and bought a long-term care policy and you know, we're, I laughed about it. Just like you did. I laughed about it. But the truth is I want to be able to be by his side and talk to him. I'm not going to be able to list him, lift him. He weighs 240 pounds. That's to need men in there to move him. But I want to be the one that's there to tell him how much I love him and how much he means to me. And yeah, I could see that, that game

Tamra (26:05):

Very difficult. Yeah. And, and you talked about not being able to lift, and that's another thing with hospice that people don't think we provide the medical equipment. So if they need a hospital bed, we provide that. If he needs a Hoyer lift, because with Tony specifically, he's not an obese man, but he's large. And it would take a minimum of two nursing assistants to be able to lift him and move him. So something like a whole year lift that helps pick him up and helps get that would start without hurting and injuring someone's back. Those things are provided incontinent supplies, you know, medications, and the worst thing to see your loved one in when they're in the, you know, when they're in the dying process is pain or anxiety. And if you have to, we all know calling doctor's offices, it's a train wreck, especially right now with COVID. So you have to call them, wait for somebody to call you back, tell them what's going on. They got to talk to the doctor. Then they got to call in a prescription. You gotta wait for the pharmacy to get it ready. And it could take two or three days. And you're in your loved one is in, you know, anxiety or, or pain ridden. So the benefit of hospice is our physicians are licensed differently by the DEA. So our nurses can go and do an assessment and call our doctors directly and say, look, he's an extreme pain. XYZ is going on. Don't forget. These are his allergies. Our doctor just instantly approves her call the pharmacy. And each hospice has their own pharmacy and they deliver the medication directly to the home. So it's like, you're looking at a four hour process as opposed to, you know, three or four days. Cause it's about comfort. And wherever we're at, whatever your comfort level is, that's what we want to keep. Because if, I don't know, if you've ever tried to talk to somebody, when they're in severe pain, you can't even have a conversation. Right. And you as a loved one, then you start getting anxious because there's nothing you can do to help them. So, you know, it's, that's where it's important. We don't want to see anybody just laying there in pain because their doctor doesn't agree or disagree or you know, or just stubborn.

Erica (28:07):

So, right. That's so good. That is the, I think this is such great Information.

Sharon (28:12):

I'm so glad. It's amazing information. We are fortunate. We have a sister, that's a nurse, but we were able to transform everything. We need it. Like we took everything out of the linen closet and all his supplies were right there. And we had a whiteboard with all the information on it. And along with the hospice program, they helped us set all that up. So every nurse or doctor that walked in there, they were just could look anywhere and find the information that we need it. Plus we, as the children could walk in, see what his vitals were, see how he was doing, you know, cause he was a little bit of a, of a pain sometimes. So Erica never got that dad cause she was spoiled, but I don't want to talk about that.

Erica (28:56):

Yeah, you're right. And I am the baby, so I never got any flack. He always did what I asked him. I.

Sharon (29:02):

He take it all for me.

Tamra (29:03):

Yeah. That's what I always do. I'm the oldest. I can do all the work. Well, you know, and you saying that brought something else up to hospice and Medicare. We don't care what your status is. Socially. Every patient is treated the same. Medicare sets the guidelines. So I have a, we have a patient we just signed up and he lives in an RV. So tell me right now, how are you supposed to really set up a a conducive pain management system for somebody who lives in an RV? You can't put a hospital bed in there. So luckily right now he's still mobile, still able to get around. So our social worker is diligently working on, what's going to be our plan. Where are we going when we get to the point where you're bedridden, because your wife can't take care of you in this RV, your children can take care of getting this RV. It's going to be very difficult for us to do it. So what are we going to do? So, you know, we have a little bit of time that way to really work on what his health plan is going to be and planning out the financial end of it. Okay. Are you going to have to pay yours or somebody we can move you in with so that when that time comes, it's not a scramble and the wife's not going to feel like her whole world's upside down because she knows what's coming. She knows what to expect.

Sharon (30:13):

Right? So I, after doing some, a deeper dive into hospice recently one of the things that came up for me, Erica was the Elizabeth Kubler Ross and the study that she's done and the five stages of death and dying. And this is where it really pertains her work really went into this because she actually was one of the major founders that led towards us. Absolutely having hospice and how patients were treated because she and her thesis was really on the five stages that the dying patient goes through. And we saw it, you and I saw it real time. And daddy, I saw real time again. And Sharon, you know, that, that denial, that acceptance, that not wanting to go there, not wanting to talk about it, but she was really a groundbreaker where it came to. They actually setting up the hospices and getting to understand that these, these dying patients, or even the now we're changing the rules of sick patients needed to be treated with dignity and respect and the love. And now what I see growing is we're also incorporating the families into that, which is so important. One of, I think the most amazing experience for me were those, the two books that you guys give to the families and one is called the Final Farewell, I believe. Right. But there was the other one and I don't, I don't know the name of it. It was a blue, but it gave the step-by-step. And these are the things you could see. You might see this, you might see that they will start talking in in the dream state, you know, sharing their dreams vividly and talking about things that this was at the end with our dad and had I not had that book, I don't think I would have been prepared the way that it, it made it so natural for me, Tamra to step into that. And I was able to share with them and we pass the book around. I mean, it was just, it was a beautiful experience because of hospice.

Tamra (32:24):

And I think with you, you're a, you're a tactile learner. You need to be able to see it. You need to be able to prove it. You need to and that's where those types. So that's where the, the connection really comes in with the family and the staff. So if that nurse knows, okay, this she's a little OCD, it needs lots of attention. I'm going to give her this book cause she can reference back to it. And, and what you notice is by the end of it, that book is tattered. It looks like, you know, it's been through the wringer, it's been read. It's kind of like the, what to expect when you're expecting to pregnancy. But you know, you, you read every page a hundred times because you want to make sure you're prepared. And then we have those who they don't want to see it. They don't want to hear it. They just want to know that he's being, they're being taken care of. So it's really important for the care team to figure out who, who falls, where, and let's coordinate a plan to be able to make sure everybody's involved and that everybody's comfortable with what's happening. You know, and, and we, we talked about the pain medicine, you know, that's the big myth is that we're just going to put them on morphine and keep them vegetative. And what people need to understand is it's still their healthcare plan. So even though there's a nurse and there's a doctor who says, this is what normally happens with hospice, that doesn't mean that's what you have to do. It doesn't mean that's, what's best for your dad. You may tell us, look, he's been on pain medication before and he had a bad reaction. We need to try something else. So we go to something else. There are some patients that we, there are points in time where we have to give higher doses of pain medication such as morphine, because you just can't keep them comfortable. And that's part of the process, but that's not where we start. You know, we start with just getting a comfort level. And the ability for the loved one to pass somebody, to call for the silliest of questions they may think is the true benefit. You know, if they call and they say, Hey, my dad just called me my sister's name. Is that okay? Well, yeah, that's okay. You know, but just having somebody to tell you that's okay, or, you know, dad has a fever, do I need to call nine one one? No, we're, we're coming. You know, it can be something silly or something serious, but you have that go-to contact. And we are actually as hospice providers, the only service covered by Medicare to a hundred percent. So, and that's, that's fairly new. So that should tell people how important this service is. It keeps them from having to go to the hospital for every little thing. It keeps them from having to go to the doctor. It doesn't mean you can't go to your physician. It means you don't have to because we have doctors and nurses and nurse practitioners to coordinate that care for you. If you're, if you think that that's taken away your independence and you still want to see your primary care doctor on hospice, you can, but hospice takes nothing away from you. We're an added service. And if people could start understanding that, I think that'd be a lot less afraid. I've heard it referred to as the H word, you know what we don't, don't tell mom the H word, just tell her you're with palliative care. And I'm like, well, okay, that might work for you, but mom needs to know what's going on. You know? And so we have to work with the family and educate them. And they're like, well, once she's comfortable with you, we can tell her. We're like, well, it don't really work that way, but,

Sharon (35:46):

And they want, they need to know they, because ultimately they need to be the ones making the decisions when they're, when they're absolutely ready. So I wanted to go to another area. One of the programs that Eric and I have created is called Processing the Pain of Grief. And it is for the new griever, the new griever that absolutely has just embarked upon the grieving experience. Okay. What do I do now? What do I do now? Especially, let's say for, I was so busy trying to make sure everything was set up that the day after he was gone, you know, it's like, okay, what do I do now? There's this big dive, right? Erica, when you're not the caretaker anymore, or you're not having to make sure the meals are there and the medication time, there's this huge dive. And one of the things we know is that grievers need, and that's where you, where your lady that you're talking about, they just need to talk and they need somebody to listen to them. And that's where that is so, so important. Right?

Tamra (36:51):

Yeah, it is. Cause like you said, y'all had time to kind of process and you knew what was going on. I'm not sure how long he was on hospice, but you, you know, you had time to set up that plan. We have also have patients who we sign up and they may last 24 hours. So the family that's a lot to happen in 24 hours. So just imagine if they had no one to help them assist with, you know, in a lot of times we said that those were much younger patients, you know, thirties, forties, fifties. So you know, they'll say, what do I do now? Who do I call? What you call us when we handle everything. Right? So it takes some of that pressure off. And then we know, cause just imagine if you walk in one day and your husband's fine and the next day he's gone and you didn't have hospice. Who do I call? What do I do? What in this way with hospice, there's somebody who's there to check on you, somebody to help you go through the steps. And, and I just can't imagine that you know, if they were trying to do this on their own and our little lady who calls me every day, her husband we only had him on service for four days and they'd been married for 66 years. So after four days he was gone and she instantly went to blame mode for herself that I'm not signing him up soon enough that I'm not putting that up, put him to bed too early. Did I feed him the wrong thing? So that's constantly going through her head. So she didn't have us to call because she has no children. She didn't have us to call. I don't, I don't know that she would be able to manage this.

Erica (38:29):

I want to ask one question Tamra about like we all know any service provided in this country. There are people out here who are just looking to get a check, right? They don't really care about the quality of care. What would be some red flags you would advise people to look out for if they're getting involved with one of those companies that just about a job, you know?

Tamra (38:52):

So while like I said, we're only serviced that Medicare pays at a hundred percent. We're probably the most underutilized service, but probably one of the highest fraud services by Medicare as well, because you have to really trust your nurses and your doctors to say that these patients are appropriate. I don't know if you remember, a couple of years ago, there was a company in Dallas that they had signed people up very early in the disease process, who they knew were going to last much longer than they expected timeframe and Medicare doesn't want you putting everybody on. They need to meet criteria. So as these people were still not meeting criteria years in, but they were, this company was making millions of dollars because they were on service. Well, then Medicare starts cracking down on them. Well, this particular company in Dallas, the owner started having his nurse administer medications inappropriately that did cause deaths and these patients. And and it's, you know, they're, they're still going through court now and they've been several of them been arrested and lost their licenses. And it's that type of thing that makes people afraid of hospice. And so I think what you have to do is, you know, you don't look for the bells and whistles. You had to kind of go with how you feel about the people when they come and talk to you, do they answer your questions? If you ask them how to reach their medical director or their physicians, are they willing to give you those phone numbers? Are the nurse practitioners willing to come out and see the patient as opposed to just signing them up? And then what does your primary care doctor say? If they tell you, you don't have to call your primary care, doctor we'll handle everything. That's true. But you know, if you've had that doctor for a long time, you want to know their opinion. Now sometimes the doctors don't want to do it because they don't want to lose their patients, but you can kind of gauge that. You can kind of tell. But if they start trying to put you on lots of pain medications instantly, you know, that's a red flag, you know, you, you only want what you feel like you need. Or if they tell you that they're only going to send a nursing assistant at once or twice a week, if they're not willing to give you the program that, that you feel is appropriate, then they're not the right company.

Sharon (41:17):

Wow. That's great. That's great. Great information. I just have to say for us, our experience with hospice was absolutely amazing. It was at the right time, we needed that support. It was actually a support. Like we didn't stop doing what we were. I was still there every day. We took turns spending the night there that was to give my mom a break. Like we literally did our part, but without the hospice doing their part, we would have had a huge hole. We would have know just the supplies that we needed and someone to talk to that's right now we didn't because Erica and I agree specialists, we didn't take part in the aftercare that that hospice provides the grief program, but I can see where that is just so valuable. Even your, your little friend calling you. So just where it just so valuable to to the families that just needed and, and the materials that you guys get. So thank you so much for allowing us to go into this conversation and take a deeper dive.

Tamra (42:17):

Yeah. Well, and, and I gotta give a shout out to y'all cause I know y'all have heard, you know, the benefit my mom had gone through your service, but Erica still stays on me about work in my program for everything. So, cause I've actually had, you know, three of your major times I've had you know, the process I went through with y'all was my dad who actually is still living, but we don't have a relationship. And then I have the person I considered my dad. We lost him instantly, you know, suddenly in a car accident, it's been 10 years. And then my mom was a slower process. It's still quick, but it was a slower process. We knew what was coming. So I've actually had three pretty traumatic ones, but I don't know that I could have been as open. And I don't know that I could continue doing what I do working with hospice. Had I not been through the program because I'm able to talk about it easier. And, and I do see the, you know, I have those good memories now as opposed to just the ones that made me want to curl up in a ball and go back to bed. So yeah. So I appreciate that from you ladies.

Sharon (43:27):

Yeah, no, I think the two were they work so well together for sure.

Tamra (43:32):

It's important.

Erica (43:34):

Well, thank you so much.

Tamra (43:36):

You're welcome.

Erica (43:36):

So this will not be one and done. I think we're gonna, you know, continue to get this message out there. And as we variance different clients with different issues, then we'll have you back on again. Be great. She's so great.

Sharon (43:50):

Well, I think it's great because I think we could absolutely take a deeper dive into women on hospice, as opposed to men on hospice children, when this, the significant others aren't married. I mean, this could go so many deep conversations, so yes, we definitely need to keep this going because it's a great conversation and it's going to help people when they're at that time to make that decision. Right. So thank you so so much.

Tamra (44:14):

You're welcome. Thank you.

Erica (44:17):

Bye bye.

Erica (44:20):

Hi friends, Erica Andre here with healing starts with the heart Sharon and I are so glad you joined us for another great episode of our pod cats. We hope you enjoyed this episode. We want to let you know for more information you can go to our website@healingstartswiththeheart.com. There you will find not only today's podcasts, but all of our podcasts, along with our blogs, the information on the programs that we offer and the griever's guide, which is something Sharon and I put together to document how we came to be your grief specialists. We also have a quiz to take, to identify if you are truly grieving. And if you want to talk specifically with either Sharon or myself, you can schedule an appointment there. You will also find a place to join our private face book group at hope, heal and recover. Thank you so much for being with us. Have a great day friends.