

CIRCLE of LIFE™

Celebrating Innovation in Palliative and End-of-Life Care

2011

How do ideas spread in a society...in a profession...in a community? They spread from individual to individual, from organization to organization. And as they spread, they are adapted to meet the needs of different organizations and communities.

The Circle of Life Awards not only honor organizations providing innovative palliative and end-of-life care but also provide ideas and models from which other providers and practitioners can learn. We hope that as you read the stories of these programs, you will consider ways to spread elements of their work in your organization and your community.

The end result: More effective care for those you treat; a better experience for patients receiving care and for their families; education on advance directives and end-of-life care for community members; and a seamless continuum where palliative care reaches individuals as early as possible.

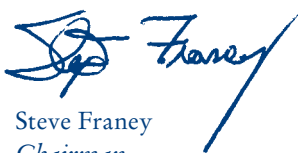
Many thanks to the foundations and organizational and professional associations that support the Circle of Life Awards. The awards are supported in part by grants from the California Healthcare Foundation, based in Oakland, California, and the Archstone Foundation. Major sponsors for the 2011 awards are:

- American Hospital Association
- Catholic Health Association of the United States
- National Consensus Project for Quality Palliative Care
- National Hospice and Palliative Care Organization & National Hospice Foundation

The American Academy of Hospice and Palliative Medicine and the National Association of Social Workers are 2011 co-sponsors.

Thank you to all who applied for the Circle of Life Award. Please continue to share with the Circle of Life Award information on your palliative and end-of-life care programs and, in so doing, continue to help raise the bar in coordinated high quality care. More information about the Circle of Life Award and past recipients is available at www.aha.org/circleoflife.

Sincerely,



Steve Franey
Chairman
Circle of Life Award Committee



Rich Umbdenstock
President and CEO
American Hospital Association



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The Circle of Life Award is administered by the Health Research and Educational Trust.

AWARD WINNER

THE CENTER FOR HOSPICE & PALLIATIVE CARE

Cheektowaga, New York



The Center for Hospice & Palliative Care (CHPC) has been caring for the people of the Buffalo, New York, area for more than 30 years. But the organization keeps fresh and innovative by constantly strategizing for the future.

For instance, the organization recognized that entering hospice can present a psychological barrier for patients and families fighting an illness. “So we embedded oncology-based nurse practitioner palliative specialists in with oncology practices,” explains CHPC CEO Flint Besecker. The nurse practitioners offer aggressive symptom management and open conversations about the long term. “This partnering strategy with physician practice groups is unique. We’re trying to keep patients out of the ER and hospitals.”

The alignment with medical groups is also consistent with the current focus in federal health policy on coordinating care through Accountable Care Organizations (ACOs). “We believe hospice will have a big part in ACOs, and we are thinking today about how we align ourselves with health systems that are likely to be the key drivers in ACOs,” says Besecker.

Collaboration across the health care continuum has always been a strength of hospice and palliative care, putting the field in a strong position as health care delivery restructures, the center’s leadership believes. “If we’re going to be successful in our mission of taking palliative care to patients in our community, we can’t own 100 percent of the care,” he says. “So that means we have to be partnering with a lot of different aspects of the care community.” Of course, he adds, successful partnerships will be with organizations that value palliative care and hospice services.

CHPC takes a strategic approach to stay abreast of community needs, says Besecker. “We have regular conversations with other key leaders in the delivery system so we understand where the gaps are, where certain needs are being fulfilled well and not well,” he says. “We align our organization and its resources to fulfill those needs in the community. It’s a strategic cycle for us. What’s important to us strategically today might be less so five years from now, so you might see different programming five years down the line.”

This strategic thinking starts at the top of the organization but reaches deep to pull innovative thinking from throughout the ranks.

CHPC is the parent organization to seven not-for-profit corporations including Hospice Buffalo, Caring Hearts Home Care, Home Care Buffalo, Life Transition Center, Palliative Care Institute, Hospice Foundation, and Saunders Properties. Originally founded in 1978 as Hospice Buffalo, it was one of the first hospices established in New York state. It maintains a hospice center, widespread home care service, a hospice in-patient unit, and two residences and also provides services in 13 area hospitals, 42 nursing homes, 29 assisted living facilities, and 23 facilities for the developmentally disabled. The organization maintains nurse liaisons in all 13 Erie County hospitals, along with the area’s cancer center.

One of the organization’s goals is to provide care to all who need it without being constrained by reimbursement rules. The hospice maintains an open access policy, using complex case management review. In 2009, CHPC admitted 700 open access patients. “We want the latitude to make adjustments when the need is overwhelming,” says Medical Director Christopher Kerr, M.D.

The hospice’s electronic medical record is used in all settings and is accessible to team members on laptop computers. Daily notes are left in the hospital chart as

...to be successful in our mission of taking palliative care to patients in the community, we can't own 100 percent of the care.



INNOVATION HIGHLIGHTS

BROAD RANGE OF SERVICE

STRATEGIC APPROACH TO UNDERSTANDING AND MEETING COMMUNITY NEEDS

COLLABORATION ACROSS THE HEALTH CARE CONTINUUM

well as the CHPC EMR. The hospice also has access to EMRs of all of the local hospitals. Patient care is further coordinated by CHPC's partnership with a single local pharmacy, which provides all prescriptions and deliveries for hospice-covered medications. The pharmacy has access to the EMR, reducing the potential for error.

Another CHPC innovation is Home Connections, a home-based palliative care program carried out in partnership with two major insurance providers in Western New York. The program is designed for patients with chronic, incurable disease who are "upstream" of the hospice Medicare benefit or who are receiving aggressive, life-prolonging therapies. The team consists of an expert palliative care nurse, a social worker, and a palliative care-certified physician, along with volunteers who provide companionship, phone checks, shopping, light housekeeping, and other assistance. The program, which is supported by the insurers on a per-diem basis, has resulted in a reduction in ED visits and hospitalizations as well as many hospice referrals.

Another program, Optimum Care, is designed to provide specialized, goal-directed home care for patients with advanced heart or lung disease. It has reduced hospitalizations and emergency department visits by 60 to 70 percent for participating patients.

Responding to needs in an inner-city neighborhood of Buffalo, CHPC and St. John Baptist Church established a working committee of volunteers who conceptualized, raised funds for, and built an eight-bed hospice residence. It has successfully cared for 76 minority patients over two years.

Recognizing the financial strain on families of a life-limiting illness, the organization spearheaded The Family Care Fund, which ensures that patients and families have basic necessities such as food, clothing, and utilities.

CHPC supports education and research into palliative and end-of-life care through its Palliative Care Institute and Center for Excellence. Through its Hospice University, clinical staff receives up-to-date training on advanced pain and symptom management, assessment skills, and effective communication. It also offers tailored classes to both clinical and non-clinical staff to firm up skills in response to job evaluations.

The hospice's 22-bed inpatient unit runs at capacity and there are plans to expand it by 10 beds. "We have more requests for either symptom management or end-of-life care than we can handle," says Kerr. The benefit of the inpatient unit is that it is an environment that can be controlled, which improves care for complex patients. "It's been one of the most successful aspects of our hospice program. But it's also created a greater demand for our services."

But given the center's strategic approach, it's prepared to be flexible to face the future. "We have some pretty innovative collaborations going on" that will lead to caring for many people, says Besecker. "That's where we're headed and we're really repositioning the entire organization to go there." •

DARTMOUTH-HITCHCOCK MEDICAL CENTER
PALLIATIVE CARE SERVICE

Lebanon, New Hampshire

When Ira Byock, M.D. came to Dartmouth-Hitchcock Medical Center (DHMC) in 2003, he didn't want to build a large palliative care program that would see every seriously ill patient. Instead, he wanted medical staff to learn the benefits of palliative care and how to apply its techniques. "We wanted to help other teams and clinicians manage symptoms, clarify goals of care, and have conversations with patients," he recalls.

It was challenging to convince physicians focused on treatments intended to save lives at all costs of the value of palliative care. "We were tested many, many times by oncologists or intensivists, who would describe their most difficult patients receiving aggressive treatments and say, 'You want to deal with this?'" Byock says. "And we'd say, 'Yes, that's exactly who we want to care for.' Over time, they understood that the term palliative care doesn't mean you're dying; it means a person is sick and mortal and needs help getting through whatever care they choose to pursue."

When Byock came to New Hampshire after running the Robert Wood Johnson Foundation's Promoting Excellence in End-of-Life Care program, his first task was creating an interdisciplinary team that models true collaboration among physicians, nurses, and other members.

"We have a wonderful, vibrant, hard-working team that is as non-hierarchical as we could make it," he says. "We work hard together, but also laugh a lot. We share a sense of the importance and seriousness of what we do but also the joy of what we do."



Patients' emotional experiences are top priority. "Physicians and nurses want to do a good job caring for the personal well-being of patients and families. Unfortunately, we are not taught how in clinical training, and the health system's focus is treating disease, often giving only lip service to caring for people's emotional and spiritual well-being. "We actually show you can do both," he adds.

The team uses integrative therapies such as massage, Reiki, relaxation, and meditation. In the ICU, "Get to Know Me" posters allow families to list personal information about patients, including their preferred name, glasses or hearing aids, and preferences in prayer, music, food, and TV; and to attach photos of patients prior to their illnesses.

The No One Alone program uses volunteers to reduce patient loneliness, isolation, and boredom. "They also serve as gracious, roving hosts for patients and their families at the medical center," Byock explains.

Caregivers and staff are considered too, with Tea for the Soul carts visiting periodically with tea, cookies, and music,

and a chaplain offering conversation and hand massage.

Dedicated to improving care for people with advanced illness throughout northern New England, where DHMC is a major referral center, the palliative care program sponsors collaborative projects with hospitals, home care, and hospices to improve supportive and end-of-life care. Community palliative care providers can consult with the Dartmouth-Hitchcock team during bi-monthly video conferences. The team has designed a hospice medication SOS kit for home hospice nurses to manage symptoms of patients in crisis.

Five years ago, a social worker, chaplain, and volunteer coordinator joined the team. They screen patients and families for social needs and teach screening techniques to their medical colleagues so they can get the information while collecting patient history. The team uses the Missoula-Vitas Quality of Life Index to explore the patient's emotional sides, explains Chaplain Linda Piotrowski. "It asks them to assess their quality of life while in the midst of this medical emergency," she says. "We want our patients to know we see them as a person above and beyond their illness."



INNOVATION HIGHLIGHTS

REGIONAL FOCUS

PALLIATIVE CARE KNOWLEDGE SPREAD TO OTHER CLINICIANS

RESEARCH AND EDUCATION

AWARD WINNER

GILCHRIST HOSPICE CARE

Hunt Valley, Maryland



Patients with serious illnesses move through the health care system quickly and unpredictably, confounding efforts to keep track of them and their wishes. And yet, careful coordination is crucial to high-quality care and to supporting the patient and family through their challenging journey.

Because the geriatricians at Gilchrist Hospice Care monitor patients and oversee patient care in multiple settings, ranging from home to skilled nursing facilities to hospital to hospice, their patients benefit from the greatest possible coordination. They do it so well that the physician group, Gilchrist Greater Living, gets regular inquiries from other health care organizations looking to move toward more coordinated, patient-centered care.

W. Anthony Riley, M.D., medical director of Gilchrist Hospice Care, explains that it has been challenging for physicians to track patients so closely and across so many care settings, but the results are well worth the effort.

Providers have had to learn to function across the continuum of care. “Each setting has not only different cultures, but different regulations, staffing models, and business models,” Riley says. “That’s a challenge. But our clinicians have learned to communicate, coordinate, and collaborate around the patient’s goals of care as a large, integrated team.”

Ultimately, everyone benefits, says Gilchrist Executive Director Cathy Hamel. Providers are happier in their jobs, improving clinician retention and satisfaction. And, perhaps most importantly, the needs of frail elderly, a vulnerable group who need compassionate, comprehensive, and coordinated care, are not lost in the shuffle among care settings.

“The frail elderly are worthy of our highest attention and need our care wherever they are. When the care is done well, there are many rewards and satisfactions,” Hamel says.

“Gilchrist Greater Living physicians, nurse practitioners, and social workers are all triple skilled in internal, palliative, and geriatric medicine and are adept at both managing transitions between care settings and conducting difficult family meetings about advance care planning,” Riley says. “They are there for the patient no matter where they are in their medical journeys, both literally and figuratively.” Gilchrist calls this a “medical home” model for palliative and hospice care.

As part of this medical home model, Gilchrist geriatricians serve as medical directors at 22 local long-term care facilities, including nursing homes and assisted living facilities, as well as at two hospital care units that serve mostly elderly patients and at hospice. A Gilchrist Greater Living physician, board-certified in palliative care, directs the palliative medicine program at the hospital. This structure helps break down the traditional “silos” created by reimbursement, regulatory, and professional development systems that have, in the past, created a more rigid and less coordinated health care system.

Patients find it comforting to see the same physicians from setting to setting. “It reduces the redundancy for the patient having to repeat their story and aids in transition planning,” explains Hamel. “It also provides patients with a stronger advocate, who will have difficult conversations about a patient’s prognosis and care earlier.”

The coordination is echoed throughout care teams in each setting, which provides Gilchrist physicians with up-to-date information so that the “patient stories” can travel with them. In addition, the teams’ social workers who work in a single setting link with their counterparts. “I give the hospice social worker

They are there for the patient no matter where they are in their medical journeys, both literally and figuratively.



INNOVATION HIGHLIGHTS

COMMUNICATION AND COORDINATION
ACROSS SETTINGS

INTEGRATION OF PALLIATIVE AND
GERIATRIC CARE

STAFF EDUCATION, ORIENTATION,
AND MENTORING

- feedback on where we’ve been on the journey to this point and ask for feedback, so we’re able to come full circle,” explains Carla Jackson, a social worker for the palliative medicine program.
- In 2009, Gilchrist received a Circle of Life Citation of Honor. Since then, Gilchrist, an affiliate of Greater Baltimore Medical Center (GBMC), has continued to formalize its coordination efforts. In 2010, it combined geriatric medicine, palliative care, and senior services into Gilchrist Greater Living, which focuses on the complex frail and/or gravely ill patients, regardless of age.
- Other Gilchrist innovations:
- Palliative care referral triggers are built into the electronic medical record and used on hospital admission and in intensive care. GBMC’s Cancer Center also offers palliative medicine services to all patients with Stage IV cancer diagnoses and others with complex concerns related to their diagnoses.
 - Gilchrist’s strong relationships with the largest hospital providers in Central Maryland, Johns Hopkins Home Care, and the University of Maryland Medical Center, result in more timely referrals to hospice while allowing patients to maintain ties with the medical teams that have cared for them for months or years.
 - All new clinical staff members, including nurse managers, nurses, hospice aides, and social workers, are required to achieve palliative and end-of-life care credentialing, and existing staff are encouraged to do so. Physician certification in palliative care is also strongly encouraged, with several physicians triple board certified in internal or family medicine, as well as geriatrics and palliative care.
 - The hospice added a pediatric home hospice program and a second inpatient center in the past year.
 - Gilchrist created its version of open access, called Expanded Care, in 2009, formalizing its acceptance of patients who receive advanced treatments that would normally disqualify them from the Medicare hospice benefit.

Gilchrist supports Expanded Care and other aspects of its palliative care services through fundraising. However, hospice leaders have found that private insurers are increasingly willing to pay for palliative care for a wider range of patients, because it is both cost-effective and high quality. “They have discovered that when those services are available earlier, patients are less likely to seek costly emergency or inpatient hospital care,” says Hamel.

Gilchrist has found that patient satisfaction is high and outside interest in Gilchrist Greater Living’s approach has grown. Increasingly, Gilchrist officials are approached by residential facilities that want to take advantage of its sophisticated and integrated medical home program for frail elders. Administrators of these facilities are drawn to Gilchrist because of the long-term, comprehensive approach to following older patients wherever they are.

“The fact that we have been tackling those issues has been noticed,” says Riley. •

JOHN H. STROGER, JR. HOSPITAL OF COOK COUNTY
PALLIATIVE CARE PROGRAM

Chicago, Illinois

When you’re poor, uninsured, and speak little English, health care is usually episodic and a lasting relationship with a health care professional is rare. But when patients are referred for palliative care at Chicago’s main public hospital, they meet a team who will be with them not only while they’re in the hospital, but also in outpatient clinics, hospice, and even in their living rooms. Because so many of their patients rarely saw a doctor before their life-limiting diagnosis, the team goes to great lengths to establish a relationship with them and help them through the medical, emotional, and practical issues of serious illness. “When patients know it’s a doctor from County coming, they have a sense of trust,” explains Catherine Deamant, M.D., program director.

From its beginnings in 2001, the palliative care team at John H. Stroger, Jr. Hospital of Cook County (formerly Cook County Hospital) has maintained this close bond with patients throughout their illnesses. The palliative program has forged strong relationships with five local hospices and continues to care for its patients after they enroll in hospice, providing symptom control and addressing a wide array of psychosocial needs.

“We serve such a large population of disenfranchised patients we want to be sure they don’t feel abandoned when they enter hospice,” explains Orlanda Mackie, M.D., associate director of the palliative care program. The palliative care program sees more than 700 patients each year at the hospital, has four outpatient clinics, provides palliative and end-of-life care to patients from



the Cook County detention facility, and works closely with local hospices. It also supports a palliative care fellowship and is engaged in research on the value of outpatient palliative care.

Treating a large immigrant community, the palliative care team has become skilled in working with those with other cultures and languages. Interpreters are specially trained to participate in end-of-life conversations, and the team has developed a unique program emphasis: helping seriously-ill patients realize their dreams of returning to their home countries, particularly Mexico and Poland. The palliative care team connects distant family members with patients and works closely with the consulates and the airlines to arrange homecomings. The team has even developed a checklist protocol for identifying and assisting people who want to return to their home country.

Compared with other safety net institutions around the country, Stroger is making faster and deeper inroads in improving patients’ end-of-life experience. Dartmouth Atlas statistics

show that a lower percentage of Stroger patients die in the ICU (9.2 percent compared with others in the 20–30 percent range) and a higher rate of hospice enrollment (38.6 percent compared with a range from 5–35 percent).

To keep their morale high and refresh their spirit, the palliative care team participates in a monthly reflective reading and discussion session. It’s been so well received that the team has developed a toolkit for other palliative and hospice teams to use to develop similar programs. Others at the hospital contribute to the program by participating in weekly lunch session where they knit and crochet comfort shawls for patients with serious illness.

Providing palliative care services to an uninsured population is challenging financially, but the county hospital’s administration has consistently supported the program even as leadership changed. “The initiative for the program came from Cook County Hospital’s decision to put resources and time into allowing this program to develop,” explains Deamant. “There is support for our goal, which is to be truly attentive to patients with very diverse backgrounds and complex needs, and even with limited resources provide them care with respect and dignity.”



INNOVATION HIGHLIGHTS

TEAM FOLLOWS PATIENTS IN ALL SETTINGS

REFLECTIVE READING PROGRAM

DYING IMMIGRANT PATIENTS HELPED TO
RETURN TO HOME COUNTRIES

ST. JOHN PROVIDENCE HEALTH SYSTEM

Detroit, Michigan



Inpatient palliative care is often focused on those parts of the hospital with the sickest patients. But not at St. John Providence Health System in Detroit. There, every admitted patient is now screened for palliative care needs, using nine triggers tested by the system's palliative care team.

As a result, more patients who would benefit receive palliative care services... and they receive services at an earlier point in their illnesses. The comprehensive screening process has the side benefit of placing palliative care in the mainstream of everyday medical practice at the system's six hospitals. "The health system associates have become comfortable with palliative care; it has become part of usual care for patients with need," says palliative care nurse practitioner Mary Hicks. "That's one of the remarkable things that I see in this institution."

St. John Providence has emphasized staff education to spread the word about palliative care. Annually, the health system sponsors a train-the-trainer conference and educates 150 multidisciplinary associates on basic palliative care. Trainers return to their departments and share what they learned about symptom control or other aspects of palliative care. Lunch-and-learn sessions have also proven successful in capturing small groups of associates for a hour at a time in between their duties. Palliative care is also incorporated into resident education and the ongoing education programs for nurses and physicians.

And the training is comprehensive, including all types of hospital staff. "We found that some of the most engaged individuals were people we did not anticipate, including dietary and housekeeping staff," says Liz DiStefano, the system's coordinator of palliative care. "They are sometimes by themselves with people who are suffering, and they were empowered by this education to respond." Education even went beyond hospital walls with a television commercial explaining palliative care to the public.

Once referred by attending or consultant physicians for palliative consultations, patients receive a comprehensive assessment by a palliative care physician or nurse practitioner, along with spiritual care and social work providers. Most of the system's hospitals maintain a multidisciplinary palliative care team. Patients are also screened for social work and case management needs that can be met by non-palliative care staff.

The program also includes four multi-disciplinary, cross-system workgroups and a palliative care network that includes the palliative care teams, senior administrators, a financial analyst, and foundation representation.

The workgroups resulted from a 2006–2009 partnership with Duke University's Institute on Care at the End of Life. The workgroups continue to meet and explore opportunities for innovation in the areas of screening palliative care patients, integration of spiritual care with palliative care, palliative care education and training, and faith community engagement.

In part because of the system's spiritual mission, spiritual care is elevated to the same level as physical care. The five hospital-based palliative programs work with five hospital spiritual care departments.

Jeanne Lewandowski, M.D., director of palliative medicine at St. John Hospital and Medical Center, believes that, for those patients facing spiritual crisis in dealing with their illness, resolving those issues goes a long way toward

We found the faith community was quite hungry for information and wanted to be engaged with providing good holistic care.

ST. MARY’S HEALTH CARE SYSTEM
Athens, Georgia

- INNOVATION HIGHLIGHTS
- CULTURE CHANGE IN THE ORGANIZATION
- EDUCATION TO SPREAD PRIMARY PALLIATIVE CARE
- ATTENTION TO SPIRITUALITY AND ENGAGEMENT WITH FAITH COMMUNITY

better coping with symptoms. “No amount of morphine is going to make a spiritual crisis go away,” she says. “But if patients believe their spiritual needs are being addressed, they often need less medication.” Finding that peace also makes the process more comfortable for the family.

Staff recognizes that many of their patients rely on the counsel of both their medical team and their faith leaders, and it serves patients well to receive a consistent message about end-of-life care. So they contacted the community’s faith organizations to start a dialogue about how to best help parishioners being treated for a serious illness.

“We found that the leaders in the different faith communities very much want to be part of the health care ministry and want to be part of their congregants’ lives even as they experience a serious illness,” explains Lewandowski. “They are individuals who people turn to at times of difficult health care decision making. They felt somewhat unprepared to enter into those conversations with their parishioners. We wanted to help them understand better what serious and advanced illness is like.”

A survey of more than 95 faith organizations found that two-thirds rated ministry to the seriously ill and dying as high priority, but few respondents felt their congregations are prepared to help with this ministry. These response details helped the health system design an educational program focused on common end-of-life treatment and experiences and ethical issues surrounding choices at the end of life. “We found the faith community was quite hungry for information and wanted to be engaged with providing good holistic care,” says Hicks.

This elevation of the spiritual side is in keeping with St. John’s position as one of the two faith-based health systems in the Detroit metro area and with the organization’s mission, explains Sister Betty Granger, senior vice president of mission integration for the health system. “Our mission is the provision of spiritually centered, holistic care. Palliative care is consistent with our commitment to coordinated whole person care,” she explains.

The palliative care program has made other innovations, including developing its own advance directive booklet, order sets, and tools to document culture change around palliative care; it will also be expanding palliative care consultations to the home, assisted living, and outpatient settings.

The team credits health system leadership for supporting the program, which was under growth and development just as Detroit’s auto industry was suffering a painful contraction. “So while cuts were going on everywhere, there was investment in system wide palliative care services,” recalls Hicks. “This was a truly leadership-driven project.” •

At the heart of hospice and palliative care is the ability to take tragedy and make it meaningful; to take despair and replace it with comfort. At St. Mary’s Hospital in Athens, Georgia, a mother was to give birth to a baby who would not survive. It would be the second time she lost an infant, and the grieving mother, sure that she couldn’t handle it, asked not to see, hear, or touch the baby.

The hospital’s obstetrical palliative care and hospice teams understood her decision, and the baby boy was cared for in the neonatal ICU and then transferred to the health system’s Hospice House. Ultimately, with a great deal of support, the mother decided to spend time with him before he died. “There is no greater love than that of a mother,” recalls Tanya Adcock, RN, St. Mary’s palliative care manager. “It was clear that regardless of how many days that precious little boy lived, he had a purpose.” To the palliative care and hospice staff at St. Mary’s, that infant was a special reminder of the way they approach their work. “Care and compassion are what fuel the staff every day,” says Adcock. “There are no limitations when it comes to providing dignity, respect, and compassion.”

St. Mary’s has provided hospice care for about 20 years and began a palliative care service in 2009, opening two palliative care suites in 2010. Both programs emphasize innovation and education.

Understanding of palliative care spread quickly through the nursing and medical staff of the hospital after Adcock



was brought on to establish the service in early 2009. She introduced online order sets for comfort care and withdrawal of life support in the ICU and a list of clinical triggers for a palliative care consult. Along with providing palliative care education sessions for staff and working directly with hospitalists and specialists on particular units, these measures in the first year resulted in about 350 consultations in the 196-bed hospital. Multidisciplinary rounds in the ICU are led each morning by intensivists and include a variety of medical and social professionals, including pastoral care, dietary, case management, and pharmacy. The rounds address the holistic needs of the patient including advance care planning.

“These education efforts allow the staff and physicians to see palliative care in action, to actually see the outcomes from having this type of service for our patients,” says Adcock.

Hospice at St. Mary’s continues to innovate after 20 years. Karen Joyce, director of home health and hospice for

St. Mary’s, has established close working relationships with emergency department physicians and hospitalists, leading to direct admissions to hospice from the ED and other medical units. Adcock and Joyce also participate in length-of-stay meetings for any patient in the hospital more than four days, which has helped identify patients with complex needs.

St. Mary’s serves a very large rural area in a low-income part of Georgia, and hospice and home health care reach more remote patients with telehealth and work with rural pharmacies on formularies. The hospice hires local staff to develop trust with residents and increased its volunteers from about 30 people to 150. Volunteers serve on vigil teams in long-term care facilities for residents at the end of life so that no one dies alone.

Both palliative care and hospice services have worked to open the health system’s culture to responding to the special needs of people with serious illness and at the end of life. “It’s part of our mission and person-centered care to offer our patients a peaceful and dignified death,” Joyce says.

- INNOVATION HIGHLIGHTS
- PALLIATIVE CARE EMBEDDED THROUGHOUT THE HOSPITAL
- AGGRESSIVE CASE-FINDING APPROACH, WITH ELECTRONIC MEDICAL RECORD TRIGGER
- CULTURE CHANGE ON A COMMUNITY LEVEL

UNIVERSITY OF PITTSBURGH MEDICAL CENTER
SUPPORTIVE AND PALLIATIVE CARE PROGRAM*Pittsburgh, Pennsylvania*

As a leading academic medical center, the University of Pittsburgh Medical Center has patients with complex medical and social needs. One patient is a 19-year-old with cardiomyopathy that developed during pregnancy. Now, as a single mother, she faces the likelihood of a heart transplant. She wonders: Should I give my baby up for adoption? What's in store for me? With UPMC's Supportive and Palliative Care Program, she has an experienced, knowledgeable team to help her.

"She's dealing with anxiety and depression and wonders how to live either on continuous IV medications or with an artificial heart, for now," explains Barbara Usher, a team clinical nurse specialist. "We're helping her through her difficulties." "Our patients don't look like the typical hospital patient," she adds. "We don't get called for easy cases."

The 13-year-old palliative care program has grown by gaining the trust of medical personnel throughout UPMC's three larger hospitals. "Trust built over the years from having one success after another," explains Usher.

The program is now upstream in outpatient clinics for cancer, heart, and HIV patients, providing palliative care consultations with patients and families earlier in the course of illness and easing transitions when patients require hospitalization. It's also downstream in the ICUs and transplant units, providing consults for symptom management, decision-making, and family conferences.

Most recently, the UPMC Health System embraced the Supportive and Palliative Care Program as an exemplar for system-wide goals of maintaining "Dignity and Respect" and of "Care and Compassion." This regard for palliative care allows extension of services throughout the 26 site health



- Establishment of a social work fellowship in palliative/end-of-life care.
- Strong regional and state leadership in palliative care, advocating for policy changes.
- Work with nonprofit organizations on end-of-life care education for the public.

In keeping with the system's teaching mission, the program is strong on education, incorporating palliative care at all levels of medical education, including residencies and fellowships. "Our (team) members provide excellence in palliative care and excellent palliative care education for health care providers so that the next generation of providers gives better care," says Arnold. For example, "We do a fair amount of helping doctors, nurses, and social workers learn how to communicate with seriously ill patients and families."

Much of UPMC's model can be replicated by other academic medical centers, Arnold says. "We like to emphasize that providing quality care is measurable and an important element of the Pittsburgh program. We have metrics, we know what we're doing, and we are glad to show other programs how to succeed."



INNOVATION HIGHLIGHTS

INTEGRATED PALLIATIVE CARE ACROSS
FULL CONTINUUM OF GEOGRAPHICALLY-
DISPERSED HEALTH CARE SYSTEM

IMPLEMENTATION OF METRICS

STATE-LEVEL PALLIATIVE CARE ADVOCACY

system, including community hospitals, skilled nursing facilities, assisted living, and home care. "The UPMC Health System encourages palliative care and hospice utilization, regardless of where you are in Western Pennsylvania," says program director Robert Arnold, M.D. "The dedication to vertically integrate palliative care in such a large health system is unique and pretty incredible."

Other innovations with system-wide impact include:

- Design of an EMR palliative care "power note."
- Work with the system's Aging Institute and health insurance plan to identify frail elderly who may benefit from geriatric and palliative consultations and help them transition back to the community.
- Inclusion of a librarian on the palliative care team to inform members of the latest research and evidence-based practice.
- Training of MICU nurses to use 2006 American Academy of Critical Care Guidelines for communication in the patient/family-centered ICU.

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For more information on the Circle of Life Award program or to receive materials for future Circle of Life Awards, please e-mail circleoflife@aha.org, call the AHA Office of the Secretary at 312-422-2700, or write the Office of the Secretary, American Hospital Association, 155 North Wacker, Suite 400, Chicago, Illinois 60606.

PAST AWARD WINNERS*

2 0 0 0	2 0 0 3	2 0 0 7
The Hospice of the Florida Suncoast <i>Largo, Florida</i>	Hospice & Palliative CareCenter <i>Winston-Salem, North Carolina</i>	Covenant Hospice <i>Pensacola, Florida</i>
Louisiana State Penitentiary Hospice Program <i>Angola, Louisiana</i>	Providence Health System <i>Portland, Oregon</i>	University of California San Francisco Palliative Care Program <i>San Francisco, California</i>
Improving Health Care Through the End of Life Franciscan Health System <i>Gig Harbor, Washington</i>	University of California Davis Health System <i>Sacramento, California</i>	Woodwell A Program of Presbyterian SeniorCare and Family Hospice and Palliative Care <i>Oakmont, Pennsylvania</i>
2 0 0 1	2 0 0 4	2 0 0 8
Department of Pain Medicine and Palliative Care Beth Israel Medical Center <i>New York, New York</i>	Hope Hospice & Palliative Care <i>Fort Myers, Florida</i>	Pain and Palliative Care Program Children's Hospitals and Clinics of Minnesota <i>Minneapolis/St. Paul, Minnesota</i>
Palliative CareCenter & Hospice of the North Shore <i>Evanston, Illinois</i>	University of Texas M.D. Anderson Cancer Center Symptom Control and Palliative Care Program <i>Houston, Texas</i>	Haven Hospice <i>Gainesville, Florida</i>
Compassionate Care Focus St. Joseph's Manor <i>Trumbull, Connecticut</i>	2 0 0 5	Pediatric Advanced Care Team Children's Hospital of Philadelphia <i>Philadelphia, Pennsylvania</i>
2 0 0 2	High Point Regional Health System <i>High Point, North Carolina</i>	2 0 0 9
Children's Program of San Diego Hospice and Children's Hospital and Health Center <i>San Diego, California</i>	Palliative and End-of-Life Care Program Hoag Memorial Hospital Presbyterian <i>Newport Beach, California</i>	Four Seasons <i>Flat Rock, North Carolina</i>
Hospice of the Bluegrass <i>Lexington, Kentucky</i>	Thomas Palliative Care Unit VCU Massey Cancer Center <i>Richmond, Virginia</i>	Oregon Health and Science University Palliative Medicine and Comfort Care Program <i>Portland, Oregon</i>
Project Safe Conduct Hospice of the Western Reserve and Ireland Cancer Center <i>Cleveland, Ohio</i>	2 0 0 6	Wishard Health Services Palliative Care Program <i>Indianapolis, Indiana</i>
Population-Based Palliative Care Research Network (PoPCRN) Special Award Winner <i>Denver, Colorado</i>	Continuum Hospice Care <i>New York, New York</i>	2 0 1 0
	Mercy Supportive Care St. Joseph Mercy Oakland <i>Pontiac, Michigan</i>	Kansas City Hospice & Palliative Care <i>Kansas City, Missouri</i>
	Transitions and Life Choices Fairview Health Services <i>Minneapolis, Minnesota</i>	Snohomish Palliative Partnership <i>Everett, Washington</i>
		Department of Veterans Affairs VA New York/New Jersey Healthcare Network <i>Brooklyn, New York</i>

*For updates on the work of these organizations, see
<http://www.aha.org/aha/news-center/awards/circle-of-life/circofinfluence.html>