

CIRCLE OF LIFE AWARD



2013



CIRCLE of LIFE™

Celebrating Innovation in Palliative and End-of-Life Care

The 2013 awards are supported, in part, by the California HealthCare Foundation, based in Oakland, California, and Cambia Health Foundation. Major sponsors of the 2013 awards are the American Hospital Association, the Catholic Health Association, and the National Hospice and Palliative Care Organization & National Hospice Foundation. The awards are cosponsored by the Alliance for Excellence in Hospice and Palliative Nursing, the American Academy of Hospice and Palliative Medicine, and the National Association of Social Workers.

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

This year's Circle of Life honorees are actively creating and championing the role of palliative care throughout the health care continuum. The Award Winners and those receiving the Citation of Honor include hospices, academic medical centers, and regional and national health care systems. These programs highlight effective patient- and family-centered models that diminish the symptom burden of those with advanced disease. At the same time, their efforts support improved population health, contribute to more effective use of health care resources, and reduce unnecessary hospital readmissions.

Palliative care is provided under a variety of names—palliative or supportive care, advanced illness management, or when services are focused more exclusively on the needs of the dying, hospice care. Regardless of the name, this interdisciplinary model effectively manages the symptoms of serious disease and most importantly, helps patients and families navigate the health care system when they are struggling with the impact of complex and serious illness. The efforts of palliative care teams help to alleviate patient and family suffering and allow individuals to live as fully as possible, whether in active treatment of serious illness or at the end of life. We hope their stories will inspire you and that you, too, will seek to actively develop palliative care as a vital element of your community's health care.

Our thanks to the foundations, organizations, 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 Cambia Health Foundation. Major sponsors for the 2013 awards are:

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

Cosponsors are the Alliance for Excellence in Hospice and Palliative Nursing, the American Academy of Hospice and Palliative Medicine, and the National Association of Social Workers.

More information about the Circle of Life Award and past recipients is available at www.aha.org/circleoflife.

Sincerely,



Martha L. Twaddle, MD, FACP, FAAHPM
Chair
Circle of Life Award Committee



Rich Umbdenstock
President and CEO
American Hospital Association

AWARD WINNER

THE DENVER HOSPICE

Denver, Colorado





It's often a struggle to pay for palliative care. But Kaiser Permanente members in the Denver area have had it covered for the past 12 years. That's because The Denver Hospice worked with Kaiser to create the first palliative care benefit in the country.

"We've had a very pioneering culture," says Bev Sloan, CEO of The Denver Hospice, citing the looming Rocky Mountains as inspiration. "It's a progressive culture within our organization. There's an opportunity to try new ideas in the West."

The Denver Hospice's fearless culture of innovation has produced partnerships that bring hospice and palliative services to a wide variety of people who might not otherwise have access to them. The safety net provider for end-of-life services in the Denver metro area, The Denver Hospice, established in 1978, never turns away a patient and provides services at home, in assisted living and skilled nursing facilities, and in hospitals.

"We saw so many people not yet ready for hospice but not being served well by the mainstream medical care system," explains Sloan. "They needed help in managing and understanding their disease, setting goals, and coping with the system."

The Denver Hospice's palliative care program—Optio Health Services—cares for seriously ill patients, including those undergoing curative treatments, with a team of nurse practitioners, social workers, chaplains, and registered nurses backed up by after-hours telephonic and visit support. Optio's Palliative Inpatient Care Program provides consultation by palliative care physicians in the acute care setting. Optio's Care Support program contracts with insurers and physician groups to expand services to members for advanced illness management.

Those unusually broad arrangements with payers and provider groups "position us for the future as we look to move away from fee-for-service medicine and the fragmentation our care system creates today, to more coordinated care," Sloan says. "Advanced illness and palliative care programs really help fill in those gaps as a major form of coordinated care for people with very serious illness."

Most striking about the hospice has been its interest in partnering with a variety of organizations in innovative ways:

- Kaiser Permanente: The Denver Hospice has a 20-year relationship with Kaiser that has served more than 10,000 patients with hospice as well as outpatient palliative care. "People would always say outpatient palliative care is a bad business model," says hospice Chief Operations and Quality Officer Janelle McCallum. "But it was so needed by our community, and Kaiser in Colorado has been such a good partner; they said very early on that outpatient palliative care is important, so we're going to help pay for it. That was totally revolutionary at the time."
- The Veterans Administration has worked with The Denver Hospice to identify special needs of veterans, who make up 31 percent of the hospice's patients. "We've found that if they saw combat, it ends up complicating the end of life," explains McCallum. "Their experience starts resurfacing." The Denver Hospice Inpatient Care Center maintains a veterans wing with a scroll of honor and photos of veterans that often draws visits from families.

Optio works with Colorado Access, which provides services to people dually eligible for Medicare and Medicaid, providing complex case management to help avert unneeded hospitalizations. In one quarter, the program averted 19 hospitalizations

Really identify what the population and your major partners need, what are the gaps, and find unique and innovative ways to fill those gaps.



INNOVATION HIGHLIGHTS

STRATEGIC APPROACH TO ROLE OF
PALLIATIVE CARE IN HEALTH DELIVERY

COMPLEX CARE MANAGEMENT FOR
DUAL ELIGIBLE

STRONG PARTNERSHIPS IN
COMMUNITY FOR CARE DELIVERY,
RESEARCH, AND EDUCATION

for a total cost savings of \$174,800. While Colorado Access was already doing case management, The Denver Hospice began a pilot program of home visits for dual eligible patients with serious illness, adding a crucial psychosocial component to the care. “For instance, we’ll know a certain patient has a problem on a Friday night when her anxiety goes up, so we would note to call her on Saturday to see how she was doing,” explains McCallum.

Other notable innovations include:

- Separate grief centers for adults and children
- A bilingual team to care for the Hispanic population
- Information sheets for family caregivers on a wide variety of topics, including anxiety, breathing problems, nausea, and nutrition

Optio’s palliative care team focuses on ensuring patients achieve their goals. For example, a young man in his 30s receiving chemotherapy treatments wanted to take his young children to Disney World, where he could talk to them about what was happening. “He told the clinical team he would continue chemo until he got his family in order; that was his primary concern,” recalls Beth Ryan, director of Optio Health Services. “He was able to talk to his girls about dying and being in control of when and how that would happen. It was amazing how prepared he was and how smooth a transition it was, because he’d accomplished his goals with his family.”

The Denver Hospice has partnered for 14 years with the University of Colorado Health Sciences Center on research projects, as well as with Kaiser. A teaching affiliate for the University of Colorado, it provides clinical experience for medical, nursing, and physician assistant students in the inpatient care center and home care. The hospice also funds a hospice and palliative care physician fellowship and serves as a clinical site for three-month medical rotations.

A charter member of the Population-based Palliative Care Research Network (PoPCRN), The Denver Hospice is currently involved in a study of statins at the end of life. The hospice worked with PoPCRN on a grant-funded project looking at ways to sustain researcher partnerships. “We learned that it’s important to take time to learn about your partner’s world,” McCallum says, so both sides can understand the other’s approach to the work.

Hospice Medicare reimbursement is dropping at the same time hospices are being challenged to prepare for coordinated care-oriented payment. “We’ve got one foot in the boat and one on the dock,” says Sloan, during the presumed transition away from fee-for-service. But she expects her organization to continue to thrive by using the strategy that has worked so well so far: “Really identify what the population and your major partners need, what are the gaps, and find unique and innovative ways to fill those gaps.” •

HOSPICE OF DAYTON

Dayton, Ohio

When a patient arrives at Hospice of Dayton in Ohio, the ambulance travels on a verdant, forested road with birds and other wildlife; the connection to nature continues as the doors open and they are greeted with a waterfall and pond. Inside, the overhead lighting features blue and white streams of color. The tranquil surroundings and emphasis on nature comfort patients and families at the hospice house.

Hospice of Dayton, established in 1978, serves more than 4,000 patients each year and has one of the nation's first free-standing hospice facilities. It combines its focus on caring for individuals and families with a drive for innovation and creativity. Strongly integrated in the community, it has built close relationships with hospitals and other health care organizations in its service area.

Quality of life is a central principle for the hospice, which combines traditional and complementary therapies to achieve maximum patient comfort. Patients are offered massage, music, spa services, pet therapy, and even gardening. The same thoughtful design that characterizes its facilities and landscaping is evident in a luxurious spa that serves all patients. "We created a day spa program that brings patients in from home care," explains Terri Gross, director of quality and informatics. "They can have a nice relaxing day here. It's had a very positive impact on pain control."

The hospice is experimenting with light therapy to reduce anxiety and with occupational therapy for targeted strength to reduce falls and enable patients to stay at home as much as possible. "More people are



able to transition to home rather than skilled care" with those capabilities, Gross explains.

Hospice of Dayton takes complementary services seriously, measuring their effectiveness in controlling pain, anxiety, and dyspnea that cannot be controlled with medication or other conventional therapies. These measures are audited each month, with an organizational goal of reducing symptoms 90 percent with the combination of conventional and complementary therapies.

The hospice actively solicits suggestions for new services and improvements from patients and their families, and each year, chooses a list of priority projects compiled from the suggestions. For example, when the hospice learned that patients had long waits in hospitals for transport to hospice, it set up its own transportation service. "We take our own ambulances designed for comfort, and family members are allowed to ride along," says Mary Murphy, chief nursing and care officer. "We're constantly looking to see what we can do to improve for patients, families, and the community too."

Hospice of Dayton emphasizes staff empowerment so that employees are actively involved in workplace decisions through shared governance. Every employee attends at least six internal continuing education classes each year on clinical, psychosocial, and personal improvement topics. All direct care nurses and personal care specialists get hospice certified within three years, and the hospice supports their study efforts and gives them a pay increase upon certification.

The hospice has two hospice houses and two additional community care stations. It has teams of certified hospice and palliative care physicians and advanced practice nurses in the four community hospitals to help identify patients hospice could help. It also has a presence in several area emergency departments to enable immediate referral if needed and provides dedicated nursing staff at the local Veterans Administration hospital and military hospital.

But some patients still faced challenges in accessing hospice care, so the hospice placed four beds at a local hospital where they can be seen by a hospice physician. "The community was saying to us that these patients really needed to stay," says Murphy. "That's what we do when people identify a need."



INNOVATION HIGHLIGHTS

FOCUS ON PATIENT-FAMILY EXPERIENCE

STRONG PARTNERSHIPS AND COMMUNITY INVOLVEMENT

EMPHASIS ON QUALITY AND PROCESS IMPROVEMENT

AWARD WINNER

HERTZBERG PALLIATIVE CARE INSTITUTE
MOUNT SINAI MEDICAL CENTER

New York, New York





A major New York City academic medical center, Mount Sinai Medical Center has embraced palliative care not just as a service to patients and families but also as a mission focused on research, education of the next generation of health care professionals, and development of new models of palliative care delivery.

Under the direction of the hospital's Hertzberg Palliative Care Institute, primary palliative care in the inpatient setting is a major priority. As the inpatient program expanded to two consultation teams, with a third in development, its leaders realized that to truly meet the needs of all seriously ill patients and their families in the 1,000-bed hospital, they couldn't keep adding teams indefinitely, particularly given the shortage of trained palliative care professionals.

Through the development of palliative care order sets and protocols for hospitalists, primary care physicians, and specialists and the education of physicians on palliative care skills—a particularly effective strategy in a teaching institution where residents, fellows, and attending physicians “grow up” with the palliative care team—primary palliative care is becoming a reality at Mount Sinai. “We’re at a big turning point,” says Jay Horton, ANP and director of the Consultation Service. “We need to transform how we think about inpatient palliative care.” Some of this transformation has already begun at Mount Sinai.

A key part of this transformation is the Wiener Family Palliative Care Unit (PCU), a 13-bed inpatient palliative care unit where patients with complex needs can be cared for around the clock by a dedicated team. Half the beds have Central Park views. Creating it took 10 years of planning given the hospital's competing needs and limited space. “The hospital gave up quite a lot of beds to have our palliative care unit built,” says Emily Chai, MD, Hertzberg's associate director. The PCU, like the consultation teams, is staffed by an attending physician, nurse practitioner, social worker, and a post-graduate fellow. Additional supportive care is provided by a chaplain, registered nurses, six licensed massage therapists, a yoga specialist, and an art therapist. The unit's strong emphasis on complementary care dates to the program's earliest roots.

The team's intensive focus on the needs of both patient and family offers a unique type of solace, explains Gabrielle Goldberg, MD, director of the PCU. She recalls a patient with advanced cancer—a man in his 40s—who had learned of his disease three years prior when his wife was pregnant with their first child. He came to the inpatient palliative care unit for pain management and transitioning to go home with hospice care. “He was met by our whole medical team, and we had the art therapist meet with his wife and their three-year-old son,” recounts Goldberg. “She reported back that within the first 72 hours on our unit they felt more cared for as a family unit than they had for three years. They had a wonderful relationship with an oncologist who provided superb care, but we were able to focus on them as a family unit.”

The Hertzberg Palliative Care Institute also provides an active and expanding community palliative care program. After discharge, patients can be followed by the team at the Martha Stewart Center for Living Outpatient Facility. And, as of February 2013, a palliative care team is embedded in the new Ruttenberg Cancer Center providing palliative care to patients and their loved ones in conjunction with regular oncology care. Hertzberg also maintains close relationships with the Mount Sinai Visiting Doctors Program, which provides care to homebound adults in Manhattan, and the Visiting Nurse Service of New York's hospice program.

Palliative care is one of the few proven models that addresses the triple aims of health care—improving quality, improving satisfaction, and reducing costs.

For grieving family and friends, Hertzberg’s bereavement program offers continuing support, including:

- After a death, the clinical team signs and sends a card to the next of kin/families/caregivers. A pamphlet entitled *Coping with Loss and Grief* is mailed on the one-month anniversary of death, and additional letters are mailed on the six-month and one-year anniversaries.
- A bi-annual memorial service and reception organized by the palliative care chaplain gives family and friends an opportunity to visit with the clinicians who cared for their loved ones during their last illness.



INNOVATION HIGHLIGHTS

LEADING RESEARCH AND EDUCATION

PRIMARY PALLIATIVE CARE

STRONG COMPLEMENTARY THERAPIES

The Hertzberg Institute also supports health care professionals caring for seriously ill patients. A provider self-care program includes brief meditation or yoga sessions at the beginning of clinical meetings, massage therapy sessions, de-briefing opportunities with the team chaplain, and weekly team discussions of complex cases.

Education of new palliative care clinicians and learners at all levels of training is central to Hertzberg’s mission. These programs include:

- A one-week rotation with the palliative medicine consultation service for all third-year medical students at the Icahn School of Medicine at Mount Sinai
- A palliative medicine fellowship that trains seven post-graduate physician fellows per year
- A massage therapy continuing education program for licensed massage therapists
- Ongoing continuing education programs in palliative care for practicing professionals
- A Speaker’s Bureau that provides lectures in key topics in palliative care to the public
- “GeriTalk,” an innovative program that educates geriatric and palliative care fellows on effective communication with seriously ill patients and their caregivers

Hertzberg has also been a leader in recognizing the importance of data in improving quality and helping to refine and develop its clinical services. It has collected clinical and research data since its inception in 1997.

As Hertzberg looks to the future, its director, R. Sean Morrison, MD, FAHPM, sees tremendous opportunities to further improve care for seriously ill patients and their families through new payment mechanisms under the Affordable Care Act (ACA). “Palliative care is one of the few proven models that addresses the triple aims of health care—improving quality, improving satisfaction, and reducing costs. We are optimistic that emerging reimbursement models that favor coordination of care and community-based care will support further integration of palliative care into the fabric of our health care delivery system,” said Morrison. •

NATHAN ADELSON HOSPICE

Las Vegas, Nevada

In Spanish, the word *hospicia* means orphanage or homeless shelter. So for many Latinos, the word “hospice” does not conjure up a desirable service. That means the 30 percent of Las Vegas residents who are Latino might be reluctant to seek hospice and palliative care.

“If people have never heard of hospice it initially doesn’t sound like something good,” says Nora Luna, Latino program manager for Nathan Adelson Hospice in Las Vegas. Luna helps the hospice better serve the Latino community, just one of the ways Nathan Adelson Hospice reaches out to its entire community and service area. A community advisory board—separate from its governing board—helps to ensure that voices throughout its broad service area are heard.

The hospice currently provides palliative care in five hospitals, offers education about palliative care in all types of health care settings, and provides traditional hospice services to all who need it.

The not-for-profit organization is creative when it comes to financing its services. For example, in an entrepreneurial spirit, the hospice helps finance its extensive complementary care program by selling its popular skin care and aromatherapy products online and to community members. “We want to ensure that this valuable program is here for a long time,” explains hospice CEO Carole Fisher.

Similarly, the hospice developed a smart phone application that makes it easy for physicians to refer to hospice. It’s worked so well Nathan Adelson is selling the app to other health care organizations. “It speaks to our



innovation and understanding that the way we used to do business will not work in today’s environment,” says Fisher.

Nathan Adelson has forged relationships with local hospitals to provide palliative care, adjusting its model to the cultures of each institution. At one hospital, palliative care is routed through social workers, while at another it goes through a hospice-sponsored full-time physician. “The doctors, case managers, and nurses are very interested in palliative care,” says Fisher. “It’s just about how you position yourselves coming into a new organization. Hospitals are particularly looking to us for help in reducing readmissions and enhancing quality of care,” Fisher says.

The hospice also contracts with 14 nursing homes and 11 hospitals to provide general inpatient care. It works with medical groups, HMOs, and accountable care organizations in Southern Nevada and is developing palliative care programs for patients cared for by these entities.

Always looking to better serve its community, the hospice sponsors a program that delivered 4,800 meals to

patients and caregivers in 2011. “We make sure people have food,” says Fisher. “We do that for folks who are overwhelmed with being a caregiver and for people who are financially challenged.”

It also maintains three vans to transfer patients to their homes, living facilities, inpatient facilities, or medical appointments.

The hospice traces its successes and community emphasis back to its activist and well-informed board. Fisher says, “They’re always willing to stop and take time to review strategy and tactics. A board is as engaged as you engage them.”

While the hospice looks ahead and plans for the future, it never loses focus on serving patients and their families. Luna tells of a seriously ill mother with daughters who lived in Mexico and also teenage daughters who had grown up in the United States. They had different cultural views about their mother’s final days, so the hospice sent a bilingual social worker to help. “We were able to sit down and talk to them all in Spanish and address all their questions,” says Luna. “It makes a bad situation a little better by being able to communicate.”



INNOVATION HIGHLIGHTS

CREATIVE OUTREACH TO LATINO COMMUNITY

PARTNERSHIPS THROUGHOUT WIDESPREAD SERVICE AREA

STRONG ORGANIZATIONAL CULTURE AND STAFF DEVELOPMENT

AWARD WINNER

UNITYPOINT HEALTH

Iowa and Illinois





Just a few years ago, innovative palliative care programs were germinating in several of Iowa Health System's communities, but lacking a unified approach, the system couldn't ensure all its patients had access to the same range of services when experiencing a serious illness.

Eight years later, these initial programs have guided the system in developing the best way to deliver palliative care in its communities. Now known as UnityPoint Health, the system has disseminated the model across its 280 physician clinics, seven home health care regions, and 26 hospitals in Iowa and Illinois.

"We started in 2005 with very small programs, and they weren't across the continuum," explains Monique Reese, DNP, ARNP, FNP-C, ACHPN, chief clinical officer of UnityPoint at Home. "We now have programs across the continuum and across the region too."

UnityPoint Health took a data-driven approach when it embarked on a system-wide palliative care review. An examination of two years of palliative care metrics found that the best outcomes resulted from hospital/home care/clinic collaboration with dyad leadership—physician and clinical administrative leads, explains Lori Bishop, RN, CHPN, executive director of palliative care and hospice for UnityPoint at Home. "Instead of having the patient move between an inpatient program and an outpatient program, our intent was to have one program," Bishop says.

Now, throughout the system, patients and families have access to:

- Palliative care services that follow the patient across the care continuum
- Goals of care discussions and advanced care planning that includes patient and family
- Timely intervention for symptom management to avoid unnecessary emergency room visits and hospitalizations
- Collaboration with the attending physician, home care, and hospice to ensure patients are connected to the right service at the right time

In the case of an elderly couple in Fort Dodge, Iowa, the palliative care team maintained a dialogue with the couple and their five actively involved daughters throughout a lengthy journey for the woman, 85 and suffering heart and kidney disease, and her husband, who had heart disease and dementia. "We met at the house with the whole palliative care team, the couple, and all five daughters," recalls palliative care physician Tim Ihrig, MD. "It was the largest care conference I've been involved with. It was a manifestation of what palliative care is supposed to be. We just sat down as a team and listened...and put together a care plan to meet everybody's needs and expectations."

The result: the couple were able to stay at home, chemodialysis was ended for the wife, and the husband entered home hospice services, meeting the couple's strong wish to remain in their home as much as possible.

When something works, UnityPoint Health is quick to share it. "We use data to identify evidence-based practices and then share those across our programs," explains Reese. The before-and-after data on patient-centered, team-based care show dramatically improved outcomes in patient satisfaction, health status, symptom management, and goals of care identified. "Financially we're experiencing a bending of the cost curve."

You meet people's needs where they're at and give control where control can be given. We have to be responsive in real time. You just meet whatever comes your way.



INNOVATION HIGHLIGHTS

PATIENTS FOLLOWED ACROSS CONTINUUM

DATA DRIVEN

PALLIATIVE CARE INTEGRAL TO ACO

Over the past two years, the system has built a sharing structure so that palliative care clinicians and program administrators from throughout the system can compare notes on a monthly or quarterly basis to improve care. “We really try to look at best practices in each site and share information so we’re all on the same page and not reinventing the wheel,” says Kimberly Shadur, RN, MPH, palliative care coordinator for UnityPoint Hospice in Des Moines, Iowa.

UnityPoint Health recognizes the potential for palliative care in evolving reimbursement that rewards coordinated care. However, it’s still a largely fee-for-service world, so providers that get out ahead of the coordination trend are likely to take a financial hit, at least temporarily. UnityPoint Health has been willing to accept the short-term loss from reduced hospitalizations for seriously ill patients because it’s better for the patient. “We knew we were making an investment in the future,” says Reese. “We were willing as a system to take that leap of faith. We felt it would promote the best outcome for the patient and family, and leadership was on board with that.”

The system is actively participating in Medicare payment reform projects, including the Pioneer ACO program at UnityPoint Health’s Fort Dodge, Iowa location. Nadine Schlien, RN, CHPN, manager of palliative care at Fort Dodge, said palliative care is essential to the ACO model. “We’re showing Medicare we can deliver health care at a more affordable cost to them. We’re working to show we can take care of patients in a home setting, wherever it may be.” The team sends a nurse to local nursing facilities to follow patients and keep them out of the hospital. Schlien says the nursing homes are happy to see the palliative care nurse coming.

Brenda Oberhelman, ARNP, is the nurse practitioner who works with nursing homes in Fort Dodge. “Having a nurse practitioner available to go into the facility really connects the dots for the patients,” Oberhelman says. “I have the ability to write orders and be efficient in responding to patient needs. Having discussions about end of life, that’s something primary care physicians don’t have time to do. We can sit down and have a candid conversation about goals of care and realistic options at this stage of life.”

UnityPoint Health also provided leadership on a statewide initiative to allow patients and families to work with their primary care provider to establish treatment preferences that reflect their goals and values through the use of a one-page, standardized form, called IPOST or Iowa Physician Orders for Scope of Treatment.

Ihrig says that to keep palliative care truly patient-centered, the clinicians must remain flexible. “From our team all the way up our ladder to those in the administration, there’s recognition that palliative medicine does not have a blueprint,” says Ihrig. “You meet people’s needs where they’re at and give control where control can be given. We have to be responsive in real time. You just meet whatever comes your way.” •

NORTH SHORE UNIVERSITY HOSPITAL PALLIATIVE CARE PROGRAM

Manhasset, New York

It's a common hospital scenario: a terminally ill patient expected to decline does so, and caregivers rush to respond to the code. The family is there, but there's never been a conversation about the patient's wishes or code status. "Usually the least trained intern muddles through a difficult discussion with a family member in crisis. Interns said it was easier to put tubes into dying patients than to have these distressing conversations," notes Dana Lustbader, MD, palliative medicine section head at North Shore University Hospital in Manhasset, New York.

So North Shore University Hospital developed simulation training on emergent end-of-life discussions for internal medicine and surgery interns with actors playing family members. The interns receive expert training in communication, then have two minutes to have a goals of care discussion with an actor during a simulated code, followed by structured feedback on their performance. It's just one way North Shore is training the next generation of physicians in palliative care.

North Shore established one of the nation's first inpatient palliative care units in 2007, and since has expanded its program to include inpatient consults throughout the hospital; relationships with hospice, home care, and nursing homes; a palliative care fellowship program; and leadership to improve care for people with advanced illness throughout the 15-hospital integrated North Shore-LIJ Health System.

From inception, the program had support from senior leadership. The Palliative Care Unit was partly funded by philanthropy related to the work of



a hospital leader whose wife had suffered a terminal disease. The program evolved from a pilot by a handful of dedicated staff. "We really thought about...what was the experience like for a patient who died in our facility, and what was the experience of family and loved ones," recounts hospital Executive Director Susan Somerville. "Like many facilities, if we were honest with ourselves, the answers were not what we'd hope for."

Anyone can request a palliative care consultation—patients, family members, nurses, chaplains, physicians, etc. In fact, more than 65 percent of all inpatients who die at North Shore receive a palliative care consultation.

The inpatient unit also provides opportunities for research and improving care. "Some of the research we've done has come about from observations by the nursing staff," says Somerville. For instance, the unit produced an important article demonstrating that some skin injuries in terminally ill patients are actually unavoidable "terminal tissue injuries due to skin failure" that develop at the end of life and not a breach of standard of care.

A new initiative to provide palliative care to patients at home is being implemented by a consortium of the system's inpatient palliative care teams, its outpatient palliative care, and advanced illness house calls program. The consortium is also working across the continuum with skilled nursing facilities to improve handoffs during care transitions. "We frequently discharge terminally ill patients to skilled nursing facilities and have found our geriatric colleagues eager to partner with us to ensure these patients receive palliative care and have realistic goals for care post hospital discharge," says Lustbader. For the initial group of 30 seriously ill patients, hospital readmission rates dropped from 25 to 10 percent.

She described a patient 40 years old with metastatic pancreatic cancer receiving hospice services at home. When his ascites worsened, instead of a difficult, time-consuming emergency room visit, he was immediately admitted to North Shore University Hospital's Palliative Care Unit. Two days later he was back home with his wife and four children. "It really is seamless care for seriously ill patients," explains Lustbader.



INNOVATION HIGHLIGHTS

**COLLABORATION ACROSS HEALTH
CARE CONTINUUM**

**STRONG DATA COLLECTION/INFORMATICS,
RESEARCH, AND EDUCATION**

**COMMUNICATION SIMULATION TRAINING
FOR INTERNS**

HOSPICE AND PALLIATIVE CARE PROGRAM DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

In 2002, nearly a third of the Department of Veterans Affairs (VA) medical centers were making no referrals to community hospices, and most centers had no palliative care team. Today, VA has a wide-ranging, innovative palliative care program that builds on the nation's largest integrated health system's advanced information technology capabilities and culture of performance improvement to care for veterans with serious illness and their families.

Each of the VA's 21 regions has a palliative care program manager and clinical champion, and each of its 152 medical centers has an interdisciplinary palliative care team. All are supported by three national quality centers.

The program began with a small nucleus of committed people, says Scott T. Shreve, DO, national director, and grew by focusing on what worked rather than what didn't. "We identified regional champions, 'shining stars'... And we gave them the resources to really make things happen."

Today 47 percent of inpatient deaths in the VA system are in designated hospice beds. "No other health system in the world has that kind of integration," argues Shreve.

Performance improvement in each region is encouraged through "gentle but firm pressure to be as good as their peers," Shreve says. "You shine the light on the high performers and let the threshold be determined by the VA's peer leaders."

Because veterans also receive care from community providers, it's not enough to change the VA system itself. Ensuring non-VA providers understand the special problems faced by veterans at the end of life—such as when



traumatic memories from combat come to light—is critical. Through the VA's collaboration with the National Hospice and Palliative Care Organization, the *We Honor Veterans* program creates collaborative models to increase all veterans' access to community hospice and palliative services designed to meet their needs.

A powerful tool for internal improvement is the nationwide Bereaved Family Survey, which offers leaders of the 21 regional networks feedback on how end-of-life care services are satisfying families. Mary Zuccaro, who oversees palliative and hospice services in northern California, northwest Nevada, and Hawaii, depends on those metrics to "take the temperature" of the program.

"I'm all over it every time I get it," she says of the quarterly results report. "I look through it for themes of where did we make a difference and where did we miss the boat. I disseminate that through all our programs."

On a national level, the VA's hospice and palliative care program identifies quality improvement interventions that are tested in pilots and then further

refined based on feedback from teams before being disseminated throughout the system.

Local programs have access to the Implementation Center—an internal consulting team for palliative care programs that have specific questions about how to get something done, such as integrating palliative care into the ICU.

The VA program focuses on both technology and simple human kindness. The Care Assessment Need score, for instance, is a robust predictive model that scans the electronic medical record to identify veterans "at-risk" for needing supportive services rather than waiting for a clinician to notice the need. The VA Medical Foster Home program is a lower tech solution to keep veterans out of nursing homes; families "adopt" a seriously ill veteran under the close watch of VA clinicians.

The future for the VA is "proactive, personalized, and patient-driven care," says Madhulika Agarwal, MD, MPH, deputy under secretary for Health Policy and Services for the Veterans Health Administration. "It's now about proactively meeting the needs of an individual patient, which is based on their preferences and their goals. That is what our focus needs to be."



INNOVATION HIGHLIGHTS

INFRASTRUCTURE TO SPREAD PALLIATIVE CARE THROUGHOUT SYSTEM

OUTREACH TO UNDERSERVED

INTEGRATED APPROACH AND COLLABORATION WITH COMMUNITY PROVIDERS

GUNDERSEN HEALTH SYSTEM

La Crosse, Wisconsin

In 1981, two nurses at a Gundersen Health System hospital wanted to do more for bereaved parents when their baby died. That was the beginning of the *Resolve Through Sharing* perinatal bereavement program. An interdisciplinary group designed an unusual decentralized model—instead of assigning a team, Gundersen chose to educate a cadre of professionals working in all units of the hospital where perinatal loss occurred.

“We started off with a perinatal bereavement program with absolutely no intention of it being anything more than a better way of caring for families in our own hospital,” explains Rana Limbo, PhD, RN, FAAN, manager of faculty, research, and development, Bereavement and Advance Care Planning Services Department.

But it did grow from there. Groups met to determine how to provide that kind of support more widely throughout the system, which serves about 560,000 people in a mostly rural 19-county area in Wisconsin, Minnesota, and Iowa. In 1986 Gundersen began advance care planning; in 1987, hospice; in the early 1990s, bereavement for all who died in the hospital; in 1997, a formal palliative care service; and in 2001, care coordination for the sickest patients.

Today, Gundersen provides palliative care across the continuum and offers patients and families seamless care. Nurse and social worker care coordinators help patients and families manage complex health care needs, providing advanced illness support. “Patients who have a multitude of issues have a one-stop shop of someone to contact that helps them navigate care,” explains Waneeta Everson, BSN, RN, Gundersen’s clinical manager of hospice and palliative care.



Gundersen’s approach is called Advanced Disease Coordination (ADC). ADC combines advance care planning, care coordination, and palliative medicine. Eligible patients are identified daily using triggers in the electronic medical record, looking for Medicare fee-for-service patients who have had at least three visits in six months to the hospital or primary care and have a diagnosis of congestive heart failure, chronic obstructive pulmonary disease, renal failure, or cancer.

Gundersen uses staged advance care planning, aimed at middle-aged and older adult patients, often during a routine doctor visit. They discuss a basic advance care plan (First Steps®) and develop increasingly detailed plans (Next Steps, Last Steps®) for patients with progressive, life-limiting conditions so their end-of-life care preferences are known and honored. Gundersen’s *Respecting Choices* program is shared widely with other organizations through the health system’s medical foundation.

Gundersen’s hospice serves patients in eight counties within a 50-mile radius of La Crosse. Staff members are in clinics throughout the region and even do

telemedicine palliative care consults. “We always have had to consider the rural population because they are a large part of who we are,” says Everson.

Gundersen Health System has won the Medal of Honor Award from the Health Resources and Services Administration (HRSA) every year for having a conversion rate greater than 75 percent for organ donation and has incorporated these life-giving gifts into the bereavement program’s healing process.

Even as the system has expanded its services for seriously ill patients and their families, the original perinatal bereavement program remains a touchstone for Gundersen’s culture of person-centered care. The system’s CEO, Jeffrey Thompson, MD, a neonatologist, noticed that in previous hospitals where he worked, people often scattered when there was an impending death in the neonatal intensive care unit. But when that happens in a Gundersen hospital, staff members congregate to do what they can to help, Limbo said. “If they’re not dealing directly with the family, they know the staff needs them,” she said. “It says something about what we value and what’s important to us.”



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SEAMLESS CARE DELIVERY AND
INTEGRATION OF PALLIATIVE CARE

ADVANCED DISEASE COORDINATION

RESPECTING CHOICES PROGRAM

2012-2013 CIRCLE OF LIFE
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