

CIRCLE OF LIFE AWARD



2007



CIRCLE *of* LIFE™

Celebrating Innovation in End-of-Life Care

Sponsored by the American Hospital Association in conjunction with
the American Association of Homes and Services for the Aging, the American Medical Association, and
the National Hospice and Palliative Care Organization.

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INTRODUCTION

It has been seven years since the first Circle of Life Awards were presented in 2000. The progress that has been made in end-of-life and palliative care in that short time has been nothing short of amazing. More and more organizations are providing this important service, and more and more families are experiencing the benefits. The Circle of Life Awards have chronicled these changes, and demonstrate how winners and honorees are expanding the reach and sophistication of palliative and end-of-life care.

This year's eight honorees include hospitals, hospices, and a long-term care facility, each of which is raising the bar in palliative care. They provide care at all stages of life, from childhood through old age. They affirm a commitment to help each person live as fully as possible through the end of life.

The American Hospital Association, the American Association of Homes and Services for the Aging, the American Medical Association, and the National Hospice and Palliative Care Organization are proud to sponsor the Circle of Life Award, with funding through grants from the Robert Wood Johnson Foundation. On behalf of all of these organizations, we thank the hospitals, systems, hospices, nursing homes, and community programs that shared with us their palliative and end-of-life programs through Circle of Life Award applications. Their commitment and dedication touches millions of patients and families every year.



Steve Franey
Chair
Circle of Life Awards Committee
2006–2007



Rich Umbdenstock
President and CEO
American Hospital Association

AWARD WINNER

COVENANT HOSPICE

Pensacola, Florida





A dedication to mission, and a sense of empowerment to achieve it, permeates into everything and everyone at Covenant Hospice in Pensacola, Florida. That's because Covenant Hospice invests in its people, from trustees and volunteers to senior leadership to front-line caregivers and support staff. Everyone receives education, empowerment, and encouragement to take responsibility.

Covenant runs a leadership academy that isn't restricted to people in top jobs. "Leadership does not mean you're an executive and doesn't even necessarily mean you're a supervisor," explains President and CEO Dale Knee. "We open up the leadership academy and development of leadership skills to everyone in the organization. There may be a home health aide in one of our satellite offices who is emerging and wants to develop additional skills in leadership. They're invited to come in and participate."

At the same time, Knee says, Covenant holds its employees to high standards to maintain the quality of its services. "Our overall goal is to end up with a cadre of employees and volunteers who are well trained and have longevity with us, want to stay, enjoy working, and are passionate about what they do," he says.

Protocols for patient care are developed by teams with members chosen from throughout the organization. The guidelines are intentionally flexible enough to be modified to fit the particular culture of an area, which can vary given the large area the hospice covers. Covenant operates in both urban and rural communities in 18 counties in Florida and 17 in Alabama, caring for more than 1,100 patients a day. Covenant has had to deal with the population growth throughout its service area, which includes very rural counties which the hospice has had to make special efforts to serve; Covenant retains its commitment to providing the same level of service there as in more populated areas.

Covenant boasts a particularly large and committed contingent of volunteers who support hospice activities across the broad swath of Northwest Florida and Southern Alabama. Covenant emphasizes education and training for volunteers — eight hours to start — and considers them part of the interdisciplinary team. Almost 1,300 volunteers contribute nearly 11,000 hours of service each month. Also dedicated and involved in the organization's mission and culture is Covenant's board of directors, with board members involved in protocols and in organization-wide performance improvement.

Covenant takes a long-term view of developing its employees and volunteers on the assumption that its impact on the community will continue to grow. The organization has remained flexible, examining its own performance and making changes as appropriate.

While changing to meet the needs of patients and families, Covenant has stuck to its strategic plan, which is based on six main principles — in keeping with its active and strategic role in developing the Studer Covenant Alliance, LLC aimed at leadership in hospice, they call them Pillars of Excellence — from which everything else flows. They are: service, quality, people, finance, growth and community. Those concepts flow into tactical plans, personnel evaluation, goal-setting, and even into meeting agendas. "All our meetings are focused on those six pillars to one extent or another," says Knee.

...Covenant has stuck to its strategic plan, which is based on six main principles...service, quality, people, finance, growth and community.



INNOVATION HIGHLIGHTS

CULTURE OF LEADERSHIP THROUGHOUT ORGANIZATION

STRONG EDUCATIONAL OUTREACH

EVIDENCE-BASED TOOLS AND PROTOCOLS

Those principles have led Covenant to establish a number of innovative policies, often taking the lead among hospices. It also has a flexible access policy that provides care to all appropriate patients that are referred to the hospice, regardless of their insurance status or their need for palliative chemotherapy or radiation.

The organization has a strong educational component, presenting 1,002 educational programs in 2006. Those efforts are not just geared toward its own employees and volunteers, but extend to personnel at nursing homes and emergency rooms, as well as the general public. Presentations in the community numbered 1,136 in 2006. The education department, headed by Debra Brousseau, is constantly seeking new and relevant topics to address and modalities to use. Curriculum Development Manager Julie Patton has developed a “growth at the end of life” program that is presented not just at professional conferences but also at churches or places where the elderly gather. It discusses how goals and values change in the second half of life and emphasizes that growth is important throughout the life cycle. Brousseau has a strong background in instructional design, and under her leadership over 20 online courses are now available to Covenant staff.

Quality of patient care is a top priority, and Covenant uses information technology to track patient care and outcomes. Policy requires that staff respond to inquiries about hospice care within two hours, and enrollment, if chosen, occurs within 24 hours of initial contact. When a patient is admitted, clinicians from several disciplines complete an interdisciplinary plan of care on the computer within 48 hours and place it in the electronic record.

Covenant Hospice served 5,526 patients in 2006, in hospitals, nursing homes, assisted living facilities, inpatient facilities, and at home. The organization tracked the experiences of those patients through surveys and chart reviews after the death. 97 percent of patients reported their pain was relieved within 48 hours of admission and 97 percent of families also reported they received enough instruction to do what was needed for the patient. 93 percent of patients had someone at their bedside at time of death and 99 percent died in their place of choice, whether home or hospital.

Some of those patients and families were the subjects of a powerful exhibit of photographs and inspiring stories that were created as part of National Hospice Month in November 2005. Families shared their stories of hope, life, and the human spirit. Ultimately, the Faces of Life exhibit became a 96-page hardback book that won the Image and Grand Image awards from the Florida Public Relations Association and the Bronze medal under the category of Aging/Death and Dying in the Independent Publisher Book Awards. It can be purchased from the website and reflects the organization’s philosophy, “life is not about how you die, but how you live.” •

BAYLOR UNIVERSITY MEDICAL CENTER
 PALLIATIVE CARE AND CLINICAL ETHICS CONSULTATION SERVICE
Dallas, Texas

For Robert Fine, MD, it's all about doing the right thing. He's spent 20 years developing a sophisticated and widely-used clinical ethics consultation team at Baylor University Medical Center. Because it was often used to determine the right course of action in difficult end-of-life crisis situations, the next logical step was to create a palliative care team to avert such crises by ensuring the needs of seriously ill patients and their families were being met.

The palliative care team at Baylor got its start in 2004, and Fine wasn't even sure it was necessary given the hospital's already high rate of hospice referrals. "It was an eye-opener to me to see how it can further change culture," he said, noting that hospice referrals can come late and the palliative care team can ensure appropriate care sooner in a patient's illness. "What's been gratifying is to see how the palliative care service gives us access to a whole other group of patients."

Baylor doctors decided to focus on palliative care after looking at the statistics: about 1,500 patients die at Baylor each year; about 400 of them were on hospice, and the ethics consult team saw about 120. "That meant that at best, we were serving about a third," recalls Fine. "We didn't want it to be only about patients who are dying, but primarily focus on the patients with the need for palliative services."

A unique aspect to Baylor's palliative care service is its close links both with the ethics team and with the outpatient geriatrics program, three



areas that mesh well when exploring the complex issues of older patients nearing the end of life.

While there is some overlap between ethics and palliative care teams — two of the doctors and two of the nurses serve on both teams — there are definite differences between them. While ethics focuses on communications and reflecting on treatment decisions, palliative care can bring in complementary therapies, symptom management, and spiritual support.

The palliative care team uses a variety of practitioners, including hospitalists, nurses, a pharmacist, two occupational therapists, speech therapist, nutritionist, social worker, and chaplain. A Sacred Vocations program, started in 2005, provides training for patient care techs, assistants, and unit secretaries to help them see themselves as healers. They become an extension of the pastoral care team to help patients and family members when they are in spiritual distress, a role that adds meaning to their jobs.

The occupational therapists are trained in complementary and integrative therapies such as therapeutic breathing, aromatherapy, and guided imagery. "An occupational therapist's focus is in improving a patient's performance of life roles," explains OT Suzy Edmonson. "In palliative care a patient's life role is to be able to say goodbye and leave a legacy for family members. That's what we work on."

For the future, Fine would like to see the palliative care service's referral numbers go up, but he notes that those numbers are sometimes hard to pin down with a program as organic as the ethics and palliative care services have become at Baylor.

And he wants that trend to continue to the point where a separate palliative care team isn't even necessary. "One of our goals is to change the culture in such a way so that people who come into the hospital with life-limiting illnesses and life expectancies of one, two, or three years don't have to be seen by palliative care team members to get the best care," says Fine.



INNOVATION HIGHLIGHTS

**STRONG LINKAGES AMONG
 PALLIATIVE CARE, ETHICS COMMITTEE,
 AND GERIATRICS PROGRAM**

SACRED VOCATIONS PROGRAM

**EFFECTIVE USE OF END-OF-LIFE AND
 PALLIATIVE CARE DATA**

BROADWAY HOUSE FOR CONTINUING CARE

Newark, New Jersey

AIDS, despite all the education, is still a disease that carries a significant stigma. Those living with it may find they lose contact with others, particularly the kind of healing contact that makes it easier to cope.

The caregivers at Broadway House for Continuing Care, a Newark nursing home for people with HIV and AIDS, have found that therapeutic touch and other alternative treatments are particularly helpful for this patient population. “Most people who are that sick get minimal touch or negative touch,” explains Nancy Urff, RNC, CDONA/LTC, assistant executive director at Broadway House, “It’s essential to realize how critical touch is. It’s very important to who we are, in connecting with each other.”

Leaders at Broadway House have opened themselves to both ancient and modern approaches to their patient’s physical, emotional, and spiritual paths.

Broadway House, an affiliate of the University of Medicine and Dentistry of New Jersey, opened in 1995 and serves more than 250 residential clients and 200 outpatients each year. Most are poor or low-income, male, African-American or Hispanic, and average 40 years old with a history of substance abuse. With antiretroviral cocktail therapies, patients are living longer. But they are also developing other diseases and must deal with co-morbidities, including dementia.

The average stay at Broadway House is four to six months. The care includes more than 10 complementary therapies, palliative care and pain management, social and educational activities, GED and life skills training, mental health and substance abuse



counseling, and referral to other community services. Complementary therapies range from the familiar such as chiropractic and acupuncture to more unusual energy therapies like therapeutic touch, acupressure, and therapeutic drumming.

The organization’s effective pain management approach takes into account patient substance abuse histories and has become the state model for treatment of New Jersey’s HIV/AIDS population, and Broadway House staff teaches it to staff at other long-term care facilities.

Staff members come to work knowing they’ll be dealing with a complex and difficult illness. Recognizing the special nature of the job, Broadway House cares for its staff in many ways from providing monthly massages and facials to free lunch — small benefits that aren’t expensive but respond to staff needs and generate such loyalty that Broadway House’s employee turnover is less than two percent per quarter.

The core of this approach is that the organization’s leadership respects its employees and listens to them. Certified Nursing Assistants (CNAs)

are empowered well beyond what’s typical. Broadway House CNAs serve on teams that develop curricula on long-term care issues such as infection control; caregivers make presentations to CNAs in other facilities and participate in quality improvement research. In recognition of their important internal and external role, the CNAs carry business cards.

“Everybody’s job is important,” says Director of Nursing Lois Beatty. “We really do follow through on suggestions they have and value their input.”

“When you come to work here it’s to be with like-minded people with the same goals and objectives,” says James Gonzalez, president and CEO. “You don’t consider it a job. It’s like a mission.”

“We work to alleviate physical and psychic distress and allow our residents to literally thrive in bodies that have given up long ago,” says Executive Director Jeanine Reilly. “And with some, where the ravages of AIDS have become simply too much, death, like birth, becomes a journey. Here pain is managed, fear is controlled, business is finished, families are reunited, and because of the unique presence of our dedicated staff, no one dies alone.”



INNOVATION HIGHLIGHTS

**BROAD AND GROUND-BREAKING RANGE
OF COMPLEMENTARY THERAPIES**

**PAIN MANAGEMENT FOR
SUBSTANCE ABUSERS**

STAFF CAREGIVER SUPPORT

GEORGE MARK CHILDREN'S HOUSE

San Leandro, California

It is a house on a hill, spread among lush trees and colorful flowers. In back are a play structure and basketball hoops. The only clue this isn't a typical home is the child being pushed in a wheelchair along a garden pathway.

This is the George Mark Children's House (GMCH), a one-of-a-kind resource for families of seriously ill children in northern California.

The home provides transitional, respite, and end-of-life care to children who are sick enough to need skilled nursing. But its model isn't entirely medical, it is patterned around the idea of providing a true home away from home. "We focus on the child and the family, and however we can serve the family best is what we do," explains Judith Dunlop, program director.

Dunlop tells of the boy too sick to leave his bed to see the miniature horses visiting for pet therapy, so the staff brought one to his room. "The horse actually laid its head down on the boy's shoulder, and you should have seen his face, I thought that kid would explode with joy," she recalls.

About 60 percent of families served at GMCH are seeking respite from the full-time care of a child with a long-term, life-threatening disease. Sometimes the parents take a long-delayed vacation (Dunlop tells of one couple who hadn't had time to themselves in eight years). Parents transitioning their child from hospital care to home can get training in caring for their child. Other families use GMCH to ease the end of life for a sick child.



The building, constructed in 2004, looks like home, with high ceilings, Craftsman-style wood trim, and plenty of windows letting in views of the lush landscaping and the San Francisco Bay below. GMCH — with its eight patient rooms and two family suites — is nestled in the foothills near Oakland. Families often gather in the kitchen area, and the house has a playroom, art room, computer room and multisensory room of colors and light. Children's rooms are decorated with colorful murals and themes and include a daybed so a family member can comfortably stay right next to their child all night.

GMCH was started by Kathleen N. Hull, PsyD, in memory of her two brothers who died earlier in life and Barbara Beach, MD, a pediatric oncologist at a nearby children's hospital, with the shared idea that families needed a better place to care for a dying child.

Because there is little reimbursement for this care, George Mark relies almost exclusively on fundraising of between \$3 million and \$5 million a year. It provides free care for all medically-eligible families, many of whom are

low income. The organization's leaders are working to implement a waiver that would cover some services.

Those looking to learn from GMCH's model come from all over the nation to learn about how they can create similar homes in their communities. Visitors are told about both its successes — high family and patient satisfaction and filling a gap in end-of-life care — and the things it would have done differently, including building more family suites and starting out with a solid business plan rather than developing one as it went along. Program staff estimates that at least 11 other similar projects are underway around the country and are working closely with them to share the model.

Organization leaders expect continued growth as the local medical community gets used to making referrals to this unique resource. "We're always asking ourselves how we can care for an acutely ill child and make the experience as non-institutional as possible," says Dunlop.



INNOVATION HIGHLIGHTS

HOMELIKE ENVIRONMENT FOR CHILDREN AND FAMILIES

EDUCATION AND TRAINING FOR FAMILY CAREGIVERS

EXPANDING CONTINUUM OF CARE FOR CHILDREN

AWARD WINNER

UNIVERSITY OF CALIFORNIA SAN FRANCISCO
PALLIATIVE CARE PROGRAM

San Francisco, California





A truly collaborative palliative care team uses the skills of all its members to provide the most appropriate care for each patient. With that open attitude and a commitment to research and sharing what it's learned, the palliative care team at the University of California San Francisco has created one of the leading programs in the country.

The number of patients receiving palliative care has increased from about 120 annually eight years ago to more than 450 patients annually today, with care provided throughout the hospital and in two comfort care suites. The service is popular among referring doctors — ranking high in internal surveys — and benefits from the unusually collaborative clinical atmosphere at UCSF, where research and clinical work inform one another throughout the hilltop medical campus.

UCSF's program has not only grown within its own hospital but, as one of six Palliative Care Leadership Centers (PCLC) initially funded by the Robert Wood Johnson Foundation and now jointly funded by the JEHT, Archstone, and California HealthCare Foundations, it also provides training for other hospitals starting palliative care programs. Through the PCLC, the UCSF team mentors other hospital consult services. The team continually develops new curriculum, such as a recent set of lectures on collecting outcomes data to help make the case for funding with hospital administration. "We have a good model now and we're training hundreds of them," said Steve McPhee, MD, who helped start the consult service in 1999.

At the same time, the team's doctors are busy with research, not just to provide quality and outcomes data for their own program but also to shed light on the entire practice of palliative care. Team members have led a total of 16 projects, and their scholarship includes 24 peer-reviewed articles and more than a dozen book chapters and reports.

At the basis of all the research and mentoring, though, is dedication to patient care.

"The most important thing is that we provide really good care for patients and their families," McPhee says. "We do a lot of work with families to help them get real, get practical, realize they are going to have a loved one die here or soon after at home, and they need to make plans."

The UCSF model uses hospitalists as the core to its palliative care team. Steve Pantilat, MD, the service's director, points out that because hospitalists are always on hand they are a natural resource to be trained in palliative care. Research suggests the presence of hospitalists is associated with having a successful palliative care service, he adds.

Social worker Jane Hawgood became a full-time team member in 2005 after volunteering on the service for a year while continuing to work in the surgery department. With more than 20 years of work at the hospital, primarily in oncology and surgery, she knows a lot of people at UCSF, so her addition to the palliative care team has resulted in many hallway referrals.

"It's an incredibly cohesive team," she says. "Everyone is philosophically on the same page. That's pretty unusual for a hospital this size."

UCSF serves a wide variety of cultures, and the palliative care team works to be sensitive to their divergent needs. "We've had people come up from different ethnic communities and meet with us and tell us what their issues (around end-of-life) are," says Hawgood. "I also like to get more feedback from our interpreters."

We do a lot of work with families to help them...realize they are going to have a loved one die here or soon after at home, and they need to make plans.



INNOVATION HIGHLIGHTS

USE OF HOSPITALISTS IN END-OF-LIFE AND PALLIATIVE CARE

COMMITMENT TO RESEARCH AND SHARED LEARNINGS

EMPHASIS ON EDUCATING NEXT GENERATION OF PRACTITIONERS

After starting one of the first inpatient palliative care teams in the country, McPhee says, they have spent the intervening years working to provide the service earlier in patients' illnesses. Fewer of their patients are dying in the hospital because they are being reached earlier so they can make plans for hospice or other end-of-life care outside the hospital. UCSF has also recently added pediatrics palliative care, an area that has not had as much attention as adult palliative and end-of-life care.

As the program evolves, the team learns new lessons about a maturing palliative care service. For instance, McPhee says, it's an intensive job and the doctors who do it often have a limit on the number of years they can focus on end-of-life care. Recruiting new consultants, particularly those with hospitalist, geriatric, and pediatric backgrounds, is key to the continuing health of the service. He is optimistic about recruiting because of the strong interest medical students show in palliative care. The Palliative Care Service has been one of the most popular electives in the medical school, he says, as has been its lecture series on palliative care and breaking bad news and managing the consequences afterwards.

McPhee, Pantilat, and Michael Rabow, MD, who leads outpatient palliative care efforts at UCSF's Mt. Zion Hospital, edit an ongoing series in the *Journal of the American Medical Association* on the practical aspects of palliative care, called *Perspectives on Care at the End of Life*. It is based on real cases from UCSF and elsewhere; more than 30 have been published so far.

In working with dozens of nascent palliative programs and conducting research on the topic, the UCSF team has found that not all hospital-based programs succeed. They have identified some of the factors necessary for success: funding, recruiting to replace key leaders if they leave, and collecting data to prove value to the institution.

Interestingly, having a lot of money to spend does not guarantee success, Pantilat says. "We're not necessarily the best funded, but we have enough support to do the work we need to do," he says. They also emphasize that every program is unique, and a hospital shouldn't simply copy a program from another organization. "The answers are all unique but the questions you have to answer are all the same: who leads the team, choosing a minimum data set to collect, how to market the service."

Looking back at the evolution of UCSF's palliative program, Pantilat credits a collaborative atmosphere and support from hospital leaders. "The clinical team worked with hospital leadership to develop the very best service we could, and by remaining open to collaboration, we have established a service that provides the highest quality care to our patients and their families," he says. •

HAVEN HOSPICE COMMITMENT TO CARING

Gainesville, Florida

It's a sign of the evolution in the end-of-life and palliative care movement that hospice organizations are starting to focus on how business management practices can help provide optimal care to patients and families.

Haven Hospice in Gainesville, Florida, has taken management a step further by developing a comprehensive customer-service initiative called *Commitment to Caring*. Executive Director Tim Bowen describes it as a tremendous internal shift in traditional hospice care.

"We needed to make some significant changes in our organization, its culture, and dynamics for us to be successful into the future," Bowen says. "It was meant to be a qualitative, holistic change, not just small tinkering."

The first step in this process involved holding focus groups that included staff, families, physicians, and administrators of long-term care facilities and hospitals. The purpose was to learn what was missing between the services currently provided by Haven Hospice and the services customers wanted.

A top priority emerged: responsiveness. For example, the hospice learned customers wanted a shorter patient referral response time. Prior to *Commitment to Caring*, Haven Hospice staff would wait until medical records had been obtained to contact a patient, which could take two or three days. "Today, we would have a visit scheduled within two hours of that phone call," Bowen says.

A Consultative Sales Team was created to serve as a liaison between health care professionals and Haven Hospice staff. A Customer Service Center was implemented to help



ensure a rapid response to referrals and inquiries. Service Promises — declarations of what can be expected from Haven Hospice — were created for each customer group.

These changes appear to have had an impact. The percent of admissions increased from 61 percent in June 2005 to 78 percent in June 2006. The total number of patients served increased 20 percent, and this number continues to increase. Changing to a more customer-focused business culture was difficult for some staff. It required staff shift their focus from doing things in a way that may have been easier for them to doing what was easier for the customer — patient, family, hospital, doctor, or nursing home. "It was a total paradigm shift," recalls Jackie Hart, manager of Haven Hospice's Customer Service Center. "But with time, staff saw that we were able to provide more care to more people, which helps fulfill our mission."

Commitment to Caring is consistent with the organization's overall emphasis on quality improvement. Haven's 15-member quality improvement committee plans quality-related research and develops an annual quality assessment

and performance improvement plan. Haven Hospice also participates in clinical studies on specific pain therapies and protocols, and its Pharmacy and Therapeutics Committee makes recommendations on the use of medications. Internal quality metrics, called Key Performance Indicators, are tracked on a daily and monthly basis, and Haven Hospice is a test site for a Medicare hospice quality improvement project. Haven Hospice also serves as a catalyst for palliative care and has created a consult service in one hospital and is pursuing the same in two additional hospitals. Haven is working to create an endowed faculty position in palliative care at a university medical school.

Bowen sees Haven's focus on quality and customer service as necessary to thrive in an evolving, quality-focused health care world.

"I think this is what every hospice or palliative care organization needs to be thinking about," says Bowen, who has been in the hospice movement for more than two decades. "Serving patients and families at the end of life is a very special privilege. Utilizing business and quality improvement practices can help provide care to more patients and families, which is our mission."



INNOVATION HIGHLIGHTS

EMPHASIS ON QUALITY AND
PERFORMANCE IMPROVEMENT

CUSTOMER-SERVICE FOCUS TO
EXPAND SERVICE USE

OUTREACH TO PROVIDERS
AND COMMUNITIES

AWARD WINNER

WOODWELL

A PROGRAM OF PRESBYTERIAN SENIORCARE AND
FAMILY HOSPICE AND PALLIATIVE CARE

Oakmont, Pennsylvania





Taking the lead in the next frontier in end-of-life care — long-term care — two non-profits in western Pennsylvania have created a successful partnership that provides top-quality palliative and end-of-life care. Woodwell, a partnership of Presbyterian SeniorCare and Family Hospice and Palliative Care, resulted from a realization that long-term care facilities need to better address end-of-life issues.

“The reality in long-term care is that the acuity level is higher and the aging population is increasing,” explains Teresa Barber, manager of patient and customer relations at Family Hospice and Palliative Care. “Our residents come to us much frailer than in the past,” adds Fatemeh Hashtroudi, senior director at Presbyterian SeniorCare. “A majority of our residents spend their final years in a long-term care setting so how we care for them as they are dying is very important.”

Woodwell arose from a strategic planning session at Presbyterian SeniorCare, a regional network of care and services for older adults based in Oakmont, Pennsylvania, serving over 6,000 people annually in a nine-county region. Its board of directors raised the issue of improving end-of-life care, and management responded to the challenge by seeking out a hospice partner with a similar mission and philosophy of care. “Presbyterian SeniorCare is very well known for person-centered care, flexibility, and respecting people’s wishes,” says Paul Winkler, president and CEO of Presbyterian SeniorCare. “We were looking for the same thing in a hospice provider.”

Pittsburgh-based Family Hospice and Palliative Care was selected. It is the largest non-profit hospice in western Pennsylvania, which provides care in patients’ homes, nursing homes, assisted living facilities, and hospitals. It also maintains a strategic relationship with medical ethicists and palliative care programs at the University of Pittsburgh and several area hospitals. “The strength of the Woodwell program is our partnership with Presbyterian SeniorCare,” states Rafael Sciuillo, president and CEO of Family Hospice and Palliative Care. “We can serve not only people who wish to stay at home, but also offer a complete array of hospice and palliative care services to people no matter where they live in the SeniorCare continuum of care.”

Recognizing the needs and desires of the baby boomer generation, Presbyterian SeniorCare set about re-creating its nursing homes in 2000. A demanding and well-educated group, baby boomers actively participate in choosing care for their parents and, in some cases, for themselves. One specific goal that Presbyterian SeniorCare targeted was improving end-of-life care and pain management. “We ended up totally changing the culture of our nursing homes to be more flexible and more agile so we can respond to the wishes of our residents,” Hashtroudi explains.

That person-centered vision has allowed hospice team members to be on site at all times, working closely with nursing staff on pain and symptom management and with families on end-of-life planning and other aspects of palliative care. Woodwell care is offered to anyone who needs it, not just those residents who have been identified as qualifying for hospice.

As part of this new flexible culture, staff receives training in end-of-life care from Family Hospice and Palliative Care. “We had always addressed pain without realizing what different types there are, and what better route you might take,” explains Linda Coulter, director of nursing for Presbyterian SeniorCare. “This training brings us to the next level.”

A majority of our residents spend their final years in a long-term care setting so how we care for them as they are dying is very important.



INNOVATION HIGHLIGHTS

PARTNERSHIP BETWEEN LONG-TERM CARE
REGIONAL NETWORK AND HOSPICE

TRAINING FOR ALL STAFF, INCLUDING
MAINTENANCE AND HOUSEKEEPING

SEAMLESS END-OF-LIFE AND PALLIATIVE
CARE DELIVERY BY NURSING HOME AND
HOSPICE STAFF

As with any major organizational culture shift, it was difficult for some longtime employees to make the adjustment. Staff becomes attached to residents, and some of the nurses felt the hospice team was taking their residents away. Some employees also questioned the change, expressing that they'd been providing excellent care all along. The partners learned to make changes gently to allow the staff to adjust. "Nurse by nurse, you have to educate people and show that we're not here to compete, but to complement what we do and work in unison for the good of the person who's dying," explains Coulter. "We're not surrendering; we're working as a team."

The training in end-of-life care hasn't been limited to caregivers. Staff in all departments such as maintenance and housekeeping also learn about end-of-life care. "We felt strongly that everybody needed to know what this was all about," says Hashtroudi. As a result, staff members from any department may suggest hospice when they recognize a resident who can benefit. And they do — hospice has been suggested by dietitians, speech pathologists, and housekeepers. A referral goes to the hospice team, which evaluates the referral, gets a physician's order, talks to the family, and creates a joint care plan with the facility team.

Presbyterian SeniorCare maintains a number of different facilities at a variety of levels, and Woodwell is being adapted to each facility's culture. Its facilities approach the end-of-life experience in a fundamentally different way now. In the past, a nursing home resident who died would be taken out a back door only after all the resident room doors were closed. Now the death is acknowledged and the person is honored with a special shroud and respectful journey through the front door. Another innovation is a hospitality cart that brings food and beverages to families who are spending a lot of time at the bedside of an actively dying resident. In addition, to improve the consistency of pain control, pain management drugs are kept in the building 24 hours a day.

Presbyterian SeniorCare and Family Hospice and Palliative Care have worked hard over the past few years to ensure their collaboration is successful. They have placed representatives on one another's boards of directors; they have standardized the Woodwell policies and procedures; and they meet quarterly to review outcomes and plan future programming.

Given the complexities of working with an outside organization, it might be tempting for a long-term care organization to go on its own in developing an end-of-life program. But Hashtroudi said the benefits of working with a group that already fully understands these issues are advantageous and worth the effort. "At first glance, it might seem a more difficult path to go, but in reality the expertise of both organizations and the synergy they create are invaluable," Hashtroudi says. •

NATHAN ADELSON HOSPICE

Las Vegas, Nevada

In Las Vegas, a town that has seen constant growth and change over the past 25 years, one thing has remained constant: Nathan Adelson Hospice's commitment to keeping its doors open to all.

The hospice treats anyone regardless of their ability to pay, a policy backed by fundraising from the southern Nevada community that provides over \$1 million in charity care each year. "Being able to provide that level of uncompensated care is a high point for us," says Dawn Metcalfe, the hospice's vice president of finance and administration. "Our number one commitment is to the members of our community."

The open door also extends access to people who don't always fit neatly into the typical hospice definition. Nathan Adelson Hospice has long practiced open access, a policy that allows for treatments such as palliative radiation or chemotherapy that might not normally fit the hospice criteria.

"The attitude of limiting therapies puts a lot of people into a difficult situation," explains Stewart Stein, MD, director of medical affairs. "We had a woman in her 30s who had advanced lung cancer and a young family. She wanted to continue chemotherapy, saying if it gave her one extra day with her family it was worth it. We took care of it."

Nathan Adelson was the nation's third freestanding hospice when it was opened in 1978. It now has two inpatient units totaling 34 beds, along with home care teams and an office in rural Pahrump, less than 60 miles away. The



organization, the only not-for-profit hospice in southern Nevada, serves about 3,000 patients a year.

The hospice has extensive educational and grief counseling programs for the community. A caregiving class called *Yes You Can* is offered in a one-day version geared toward the public and a two-day version for people coming into the profession. "A phenomenal number of Americans are doing caregiving for family members," says Barbara Ronnow-Bunker, senior director of the hospice's Center for Compassionate Care. "We discuss how to work with an individual who's housebound and have a harmonious relationship, how to allow them to feel empowered and respected and maintain their dignity."

The center provides education for professional caregivers in the community and offers a nurse apprentice program that provides hands-on training for nursing students who need practical experience. In addition, it has found innovative ways to reach those in rural areas. One method is through an audio conference series targeted to rural hospices that may not have a training

budget. The monthly audio conferences have provided learning opportunities to over 100 hospices throughout the country.

The hospice also works closely with local hospitals. Several, in fact, are collaborating with the hospice to develop inpatient palliative care teams.

A strong senior leadership team is aware that even with its long track record in the community, the hospice must strategically plan for the future, solidifying the organization's management, business practices, and outreach to succeed in the long term. The leadership group has background in both for-profit and not-for-profit hospice, combining the skills from each. "We bring the best of both worlds because we have people who are reminding us to stay on track with both our budget and our mission," says Metcalfe. Ultimately, though, the organization's reputation in the community is paramount. "We have such strong ties to the community," says Metcalfe. "Because of our reputation, it is important to all of us that when our day here is done, Nathan Adelson Hospice will be here for the next generation."



INNOVATION HIGHLIGHTS

COMMITMENT TO OPEN ACCESS AND CARE FOR INDIGENT

EFFECTIVE OUTREACH TO URBAN AND RURAL COMMUNITIES

EDUCATION FOR PROFESSIONAL CAREGIVERS, INCLUDING NURSE APPRENTICE PROGRAM

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