



CIRCLE of LIFE™

Celebrating Innovation in Palliative and End-of-Life Care

The 2010 awards are supported, in part, by the California Healthcare Foundation, based in Oakland, California, and by the Archstone Foundation.

Major sponsors of the 2010 awards are the American Hospital Association, the Catholic Health Association of the United States,
the National Consensus Project for Quality Palliative Care, and the National Hospice and Palliative Care Organization & National Hospice Foundation;
the Hospice and Palliative Nurses Association and the National Association of Social Workers are 2010 Circle of Life cosponsors.

he Circle of Life Award proudly shares with you the stories of its 2010 Award and Citation of Honor recipients and, in a special retrospective, highlights of the continued achievements of past Circle of Life honorees. The growing sophistication in palliative and end-of-life care goes hand-in-hand with creating a coordinated care continuum — and providing value to our patients and our communities.

As is so often true in health care, improvements in palliative and end-of-life care come from determining and implementing best practices — innovations that, as these Circle of Life honorees demonstrate, can be found in health care systems and freestanding organizations, in community hospitals and hospices, and in urban, suburban, and rural settings.

The Circle of Life Awards are intended not only to honor these organizations but also to provide a platform from which other providers and practitioners may learn. We hope that as you read about these innovative programs, you will see ways to apply elements of their work in your organization and your community.

Thank you to the foundations and organizational and professional associations that support the Circle of Life Awards. Both the Archstone Foundation and the California Healthcare Foundation, based in Oakland, California, provide funding for these awards. In addition, major organizational sponsors for the 2010 awards are the American Hospital Association, Catholic Health Association of the United States, National Consensus Project for Quality Palliative Care, and National Hospice and Palliative Care Organization & National Hospice Foundation. Cosponsors for the 2010 awards are the Hospice and Palliative Nurses Association and the National Association of Social Workers.

Thank you to all who applied for the Circle of Life Award. We encourage all providers to consider applying for the 2011 awards and sharing the stories of your palliative and end-of-life care programs. Additional information about the Circle of Life Award, past recipients, and expanded retrospective information is available at www.aha.org/circleoflife.

Sincerely,

Steve Franey Chairman

Circle of Life Award Committee

Rich Umbdenstock President and CEO

American Hospital Association

AWARD WINNER

KANSAS CITY HOSPICE & PALLIATIVE CARE

Kansas City, Missouri





laine Riley, a second grade teacher in Kansas City, Missouri, recalls the event that prompted her to spend the next 14 years volunteering with hospice patients. Riley was seriously ill with a heart condition and her hospital roommate was a very sick woman who had just bought her first new bed. It was delivered to her home while she was hospitalized.

"Here she was, in the hospital wanting to return home to sleep in her new bed," Riley explains. "Instead, she was sent to a nursing home. When she died, I was filled with sorrow that her request was not honored. It broke my heart." Not long after this experience, Riley saw a flyer for volunteer training with Kansas City Hospice and found the work fit her perfectly. Among Riley's volunteer activities for the hospice is helping patients use poetry to express their feelings and tell stories about their lives.

The hospice, which has since added "palliative care" to its name, just celebrated its 30th anniversary, and at the celebration Riley was struck by how much the organization does for people in need. "I'm just so impressed with the quality of the people who work for them and how they dedicate their lives to helping people," Riley says.

"This organization has a wide-angle lens on this subject matter and a commitment to providing services that meet whatever people's real needs are, which don't always fit neatly into a certain box such as hospice or home health," says Elaine McIntosh, president and CEO. The hospice has been working outside the box for all of its 30 years, possibly because it was started before the Medicare hospice benefit put a six-month prognosis parameter on end-of-life services.

Kansas City Hospice House, a 32-bed freestanding facility, opened in 2006 to provide expert medical care 24 hours a day and to support families and friends of patients by providing a space where they can share time with their loved one. Demand was so high for the original 24 beds that another eight were added in fall 2009.

Riley has spent a lot of time in the hospice house and finds it provides a peaceful environment for patients and their families. "There's a cooking area where families can go have a meal together," Riley notes. "And written on the wall is a saying: 'Let absolute peace gently descend." Lots of outdoor space, a chapel, and several family areas are also part of what makes the atmosphere so welcoming.

She is one of about 500 volunteers who provided 29,527 hours of service in 2008. Among them are specially trained volunteers who provide respite care support for caregivers through visits to homes, nursing homes, and Hospice House.

The organization's relationships with local medical schools and hospitals maintain palliative care at a high level. Kansas City Hospice & Palliative Care's senior medical director and first full-time physician, Ann Allegre, MD, is a nationally recognized figure in palliative care who received the American Academy of Hospice and Palliative Medicine's community leadership award in 2007. In 2009, so did another Kansas City Hospice & Palliative Care medical director, Christian Sinclair, MD. The hospice's physicians provide the medical component of the palliative care team at Providence Medical Center. Also, the hospice collaborates with the University of Kansas Medical Center to offer a palliative medicine fellowship that prepares physicians to become subspecialists in palliative medicine.

Ensuring the most advanced care is important to the hospice. "We really do not want to sacrifice depth to achieve breadth," McIntosh says. "We have a commitment to make sure we have the medical and nursing knowledge within the organization to be sure we are truly expert."

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INNOVATION HIGHLIGHTS

OUTPATIENT SERVICES IN COMMUNITY ONCOLOGY CLINIC

MENTAL HEALTH PROGRAM

STRONG PALLIATIVE CARE
PHYSICIAN LEADERSHIP

ELNEC (End-of-Life Nursing Education Consortium) training is made available regularly to all clinical staff, and the organization provides study groups for RNs and LPNs taking their certification exams and pays for the process as well.

Kansas City Hospice & Palliative Care offers palliative home health, which focuses exclusively on helping people with life-threatening diagnoses. Patients range in age but often are in their 30s, 40s, or 50s with children still at home. They are aggressively fighting their disease though their prognosis is not good. "It's remarkable how little there is out there for people facing this situation," says McIntosh. From the hospice's point of view, it's another example of providing services where patients need them rather than where they fit in a reimbursement scheme. "It's a very challenging model within the home health licensure category but it's one way we can bring hospice-type care to people upstream in their illness," she explains.

For outpatients, the organization's physicians see patients in its palliative medicine clinic and also provide a physician consultation service at local oncology offices.

The hospice recently joined with Solace House, a grief support center started primarily for children, but which has grown to provide support for adults as well. It is designed on a peer support model and can accommodate families, who arrive together but break into support groups designed for their own age group.

Families are also served through Camp Carousel, an annual weekend camp experience for 12 to 15 grieving families with school-aged children. The hospice maintains a broad array of services for children and families, including perinatal loss counseling.

A counseling program called Passages provides specialized counseling to people with complicated grief who are long-term caregivers, are challenged by a difficult treatment decision, or face other issues which arise from a life-threatening illness or loss. "People who are caring for a family member at home or on a long-distance basis — that is such a lonely spot to be," notes McIntosh, adding that resources are not generally well developed for people in those situations. Passages gets referrals from nursing homes, disease-specific organizations, and sometimes individuals who recognize they are overwhelmed. "Once they get this kind of support, it is incredibly helpful."

In 2008, the organization began an outreach program to the African-American community in Kansas City to bring the hospice message to a group that is often underserved in end-of-life care.

These are just a few of the ways the hospice continues to expand its services to meet the needs of its community, says McIntosh. "If you're facing a life-threatening diagnosis we would hope somewhere in our family of programs is something that will help." •

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

New York, New York

he challenge might seem almost insurmountable: Develop a palliative care program for the largest municipal health care system in the country, with a patient population of 1.3 million, 450,000 of whom are uninsured. Adding to the challenge, patients speak 120 languages and receive care through 11 acute care facilities, 4 nursing homes, more than 80 community-based clinics, and a large home care agency.

A daunting prospect, but when Alan Aviles, president and chief executive officer of the New York City Health and Hospitals Corporation (HHC), heard about the compelling work of Diane Meier, MD, and the Center to Advance Palliative Care, he realized that "making palliative care available to patients was the morally right thing to do. I really felt that in order to have true patient-centered care, and to empower patients to control their end-of-life decisions, we needed to provide this option."

One HHC facility, Coney Island Hospital, had initiated a palliative care program in 1998, directed by Donna Leno-Gordon, RN, MS, MPA. At the time, "nothing was in place here at all," Leno-Gordon says. "It was groundbreaking even to establish a pain scale for patients."

With the Coney Island program achieving good results, in 2005 HHC approved a business plan for a system-wide program. A year later, after a kick-off conference featuring Meier and other palliative care leaders, the program launched. Referrals from in- system physicians immediately took off — from 237 in 2005, to 560 in 2006, 1,250



in 2008, and 1,400 in 2009. Since 2009, HHC palliative care teams have seen more than 4,426 inpatients and 1,864 outpatients. The percentage of patients with advance directives has soared from seven percent of HHC's population to 45 percent in just two years. "It has taken off like wildfire," Leno-Gordon says. "And that's because our administration believed in this program."

The system's patient population is so diverse that "it is a real challenge to educate the patient and family about their illness and options," Leno-Gordon says. "We have patients who come from so many different cultures, speak so many languages, and have so many different belief systems." To help meet the diversity challenge, HHC offers a phone-based translation service, where patients can get information on palliative care topics, including advance directives. The organization also has spiritual counselors from a wide variety of faith backgrounds, including Christian, Russian Orthodox, Buddhist, Jewish, and Muslim.

To bridge the differences among programs in the HHC facilities, a Palliative Care Council meets regularly to coordinate data collection, establish policies, and generally support and educate staff. And to further develop its own professional team, in 2007, with funding from the Fan Fox and Leslie R. Samuels Foundation, Metropolitan Hospital became the first public hospital in the country offering a palliative care fellowship (it takes two fellows each year). "We felt this was an important investment, not only in the broad field of palliative care but in our own development," Aviles says. "One of our fellows has already come back to work for us."

There is more work to be done—Aviles would like to see palliative care integrated into the system's 3,000-bed long-term care facilities, as well as broadening the hospice care program. But the work so far is noteworthy in its own right. "When we started this in 2006, I never in my wildest dreams thought the program would blossom and flourish in all 11 HHC facilities," Leno-Gordon says. "It is inspiring to see how we have improved the lives of so many patients and families here in New York. And that's why we'll keep going."



INNOVATION HIGHLIGHTS

FOCUS ON MEETING NEEDS OF DIVERSE PATIENT POPULATION

PALLIATIVE CARE COUNCIL

STRONG CORPORATION LEADERSHIP COMMITMENT IN A PUBLIC SYSTEM

AWARD WINNER

SNOHOMISH PALLIATIVE PARTNERSHIP

Everett, Washington





f you have a life-threatening illness in Everett, Washington, it's likely that the Snohomish Palliative Partnership is going to find you...one way or another. Maybe it will be in the clinic where you see your primary care doctor; maybe it will be in the hospital emergency department when the palliative care team helps control your pain...or in a nursing home, or through at-home hospice services. The partnership's goal is to reach every person who can benefit from palliative care, and it has woven a remarkably dense web in the Everett community.

The partnership encompasses the continuum of care in its 700,000-person county and has enjoyed rapid growth over the past five years. Leaders say that's because it benefits all parties and, most importantly, patients and their families. "If we respect patients' goals, it's likely to result in fewer hospitalizations and fewer costs to the community; it makes hospice a healthier organization; and it's doing what patients really want to do in the first place," says Joanne Roberts, MD, a palliative physician and chief of the division of medicine at Providence Regional Medical Center Everett. "There are no losers in this collaboration."

It has benefited from being based within the county's largest physician group and system, which has allowed care to be coordinated to an unusual degree. The Everett Clinic, which hosts palliative care nurses from Providence Hospice and Home Care in the primary care setting, also employs many of the hospitalists who see patients at Providence Regional Medical Center Everett. They get palliative care support in the hospital from a three-person palliative care team, which is also part of the partnership. In the past year the collaboration has been extended to cancer patients cared for by the Providence Regional Cancer Partnership.

The palliative partnership's origins date back to 2004, when hospice nurse Velda Filzen approached the Everett Clinic about placing palliative care nurses in the primary care setting. The goal was to reach frail elderly people who could benefit from palliative services much earlier in their physical decline than if they were identified during a medical crisis in the hospital. She patterned the program after one pioneered at Franciscan Health System in Tacoma (winner of the Circle of Life award in 2000), particularly its practice of having clinicians help identify people who could benefit from palliative care by asking themselves, "Would I be surprised if this patient died within a year?"

Filzen says the clinic physicians and nurses were apprehensive, worried about their patients being approached for hospice before they were ready. But once they understood the difference between hospice and palliative care and that a patient could change his or her mind at any time about using palliative or hospice services, they were quickly won over. "Once they saw the value for the patient, their support for the program moved it forward, and it has been a win-win for everyone," Filzen says.

Around the time the primary care clinic project launched, Roberts approached hospital leaders about setting up an inpatient hospice program and later a palliative care consult service to resolve problems with patients' complex pain and symptoms with serious illness. She found her hospital colleagues quick to embrace the help. "When we formed the inpatient hospice program, I was shocked at how easy it was to change the culture," Roberts recalls. "It only took a couple of years." Now about 80 percent of patients who die at Providence Regional Medical Center have been seen by the palliative care team, and most of those die with hospice services.

If we respect patients' goals, it's likely to result in fewer hospitalizations and fewer costs to the community...



INNOVATION HIGHLIGHTS

COLLABORATION AND SHARED VISION
AMONG DIFFERENT ORGANIZATIONS

PALLIATIVE ADVANCED PRACTICE NURSE ON HOSPITALIST TEAM

COMMUNITY FOCUS ON PROVIDING
PALLIATIVE CARE ACROSS THE CONTINUUM

By giving all the partnership members a clearer view of what others in the continuum are doing, they've expanded their perspective on which patients might benefit from a palliative care referral, says Filzen. "It's broadened everyone's point of view," she says.

The palliative programs in the clinic and hospital evolved over the next few years along with the hospice's palliative services for patients at home or in skilled nursing. Because they often handed patients off to one another from setting to setting, staff and leadership of the various programs formed a good working relationship, which was formalized in 2009 at the Snohomish Palliative Partnership. The formal designation allows it to find and fill any gaps in palliative care in Snohomish County. Some of its goals include extending palliative services to all long-term care facilities, including adult family homes; providing more systematic palliative consults in the emergency department; and encouraging more universal use of Physician Orders for Life-Sustaining Treatment (POLST). It is also working with Premera on a pilot "palliative care" health insurance benefit.

The partnership is interwoven economically as well, with the hospice paying for the primary care nurses' time and Everett Clinic managing the inpatient team for the hospital. All parties are convinced that keeping patients out of unnecessary intensive care stays and emergency room visits makes palliative care cost-effective.

The partnership has some evidence to that effect: the Everett Clinic participated in a national Medicare demonstration project to test methods of improving quality of care through more efficient clinical care and patient transitions. In 2008 the project found that Medicare payments were \$3,210 lower per year per patient enrolled in palliative services, and hospitalizations during the last 30 days of life were 17.3 percent less than for patients who did not receive those services.

The partnership, particularly the primary care piece, has gotten attention from national quality organizations such as the Institute for Healthcare Improvement, which sponsored a visit to the Everett Clinic so others could learn more about the model. Many were impressed by the idea of identifying frail elderly patients in the clinic for palliative care and wondered how to get such a program started, says James Lee, MD, associate medical director for the clinic.

"Anywhere there's a need is a good place to start," Lee says. Physician champions within the clinic and management support are also vital, he says, and it's a good idea to identify potential outside partners with a similar point of view. "There has to be a passion to jump in," he says.

The partners in Everett have dropped turf and finance barriers to make the collaboration work, and Roberts believes that other communities can do the same. "When it comes to this work, if people just trust each other, everybody can benefit," she says. •

HOSPICE & PALLIATIVE CARE OF WESTERN COLORADO

Grand Junction, Colorado

n 2000, an elderly rancher unexpectedly walked into the offices of Hospice & Palliative Care of Western Colorado (HPCWC) stating his wife wanted to make a gift of stock. To the surprise of all, the gift was more than \$193,000. Shortly thereafter, when a board member gave the organization an historic Victorian house and an acre of land in Grand Junction, Colorado, the dream of a Hospice Campus was launched. "At the time we decided to build, we estimated we would need to raise about \$7 million to do all we wanted," says Christy Whitney, RN, MS, president and CEO of the HPCWC. "We knew it was a big investment and a big risk. But we were confident our community would rise to the challenge."

The hospice actually raised more than \$13 million to construct a new campus that includes a 13-room, stateof-the-art facility with rooms large enough for families (and pets) to sleep overnight, as well as kitchens and fireplaces. The designers devoted more space to private rooms than common rooms, Whitney says, to give the facility a different feel than a nursing home or hospital. They also designed the nursing stations to be unobtrusive. The second largest hospice in Colorado, HPCWC cares for 50 percent of those who die in its 7,000 square mile service area and has an average daily census of over 400 and an average length of stay of more than 100 days. The hospice facility currently serves more than 480 patients every year.

In addition, HPCWC each year reaches out to more than 450 children. Bereavement counselors run six-to eight-



week grief groups in every school in the county, a service which is vital because, Whitney notes, the rate of suicide and violent death is high in its region, yet "the grief of children tends to be invisible." The school grief program started when in one school alone, five boys lost five dads in one year, and the school asked for help. Having the programs in schools, on school time, ensures that parents don't have to worry about having transportation to take the kids to counselors. HPCWC also sponsors overnight camps for bereaved children, where they can get the "oneon-one time" with an adult that they might not get at home.

HPCWC emphasizes evidencebased practices and professionalism on all levels. Certification goals are written into the CNA job descriptions, and study groups and training are provided to help CNAs achieve certification.

The organization's astounding volunteer base — it has drawn 1,200 volunteers from a 210,000 population region — fosters community ownership and involvement. "We have people gardening, working at our camps and

fashion shows, putting on our gala fundraisers, staffing our upscale re-sale shops, and of course, working with our patients," Whitney says. The center's coffee shop and restaurant are open to the public, and currently more than 80 percent of customers are not affiliated with the hospice program.

Adds Kathy O'Shea, vice president of development for HPCWC, "Christy has made this a community hospice. She spends a lot of time in the community talking to people one-on-one, establishing relationships with donors, giving presentations to church and fraternal groups, offering fundraising tips to other non-profits, and connecting people who have capacity with programs that interest them. She has made that a priority. We try to weave ourselves into the tapestry of the community."

"The fabulous work of caregivers is possible because of the support of our community," O'Shea says. "We couldn't do it without that support. It's all part of a circle."



INNOVATION HIGHLIGHTS

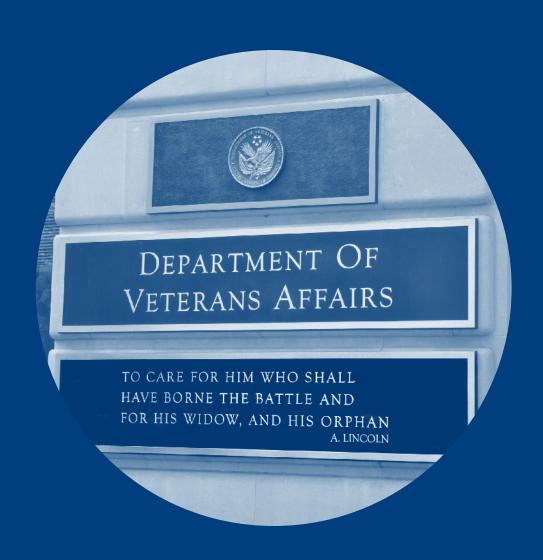
EMPHASIS ON CERTIFICATION AND PROFESSIONALISM FOR CNAs

EXTENSIVE SCHOOL-BASED GRIEF PROGRAMS FOR CHILDREN

HOSPICE CAMPUS, INCLUDING COFFEE SHOP, USED BY THE PUBLIC

AWARD WINNER

DEPARTMENT OF VETERANS AFFAIRS VA NEW YORK/NEW JERSEY HEALTHCARE NETWORK Brooklyn, New York





he words of Abraham Lincoln, "To care for him who shall have borne the battle, and for his widow, and his orphan," is the Veteran's Administration motto and underscores the hard work of a multitude of dedicated caregivers, clinicians, and leaders in the VA New York/New Jersey Healthcare Network, which serves military veterans in the five boroughs of New York City, Long Island, Northern New Jersey, and the Hudson Valley region. This VA Network, also known as the Veterans Integrated Service Network (VISN 3), includes five VA hospitals and five Community Living Centers (VA nursing homes).

VISN 3 has been building an impressive end-of-life program since 2003 and, in 2006, was recognized with a Circle of Life Citation of Honor for its innovations. Over these seven years, palliative care consults in VISN 3 facilities nearly quadrupled and today 76 percent of veterans dying in VA facilities receive palliative care services.

VISN 3 has emerged as a leader not just in VA but for health care organizations across the country. It has succeeded by promoting a collaborative culture around palliative care throughout its health care system and beyond, by organizing and analyzing the care with an advanced electronic medical record, and by extending training in palliative care both to its own caregivers and to those in related settings.

Palliative care is available across VISN 3's continuum, including intensive and acute care, nursing home care, and at home in concert with local hospice agencies. "Having a health care system that provides care in all those venues throughout the course of illness is one strength our program has over non-VA settings, where care can be discontinuous," says Carol Luhrs, MD, FAAHPM, director of Palliative Care for VISN 3.

But caregivers at the various settings work together using the collaborative tools that any health care organization can model. The palliative care teams working in different settings and locations in VISN 3 have developed a culture of cooperation and learning from one another through regular phone meetings and quarterly face-to-face sessions. They also rely on one another for ideas and problem-solving by consensus. "If you have a question or concern, you can always pick up the phone or send an e-mail to other team members," notes Loveleen Sidhu, MD, director of Palliative Care for the VA New Jersey Healthcare System.

Maintaining those connections is made vastly easier by the VA's robust electronic medical record. The electronic record provides palliative care teams with rapid feedback on their performance. Data is extracted and imported directly into a web-based palliative care report card used for quality improvement and strategic planning, explains Therese Cortez, NP, ACHPN, program manager of Palliative Care for VISN 3. "We've been able to provide our teams with site-specific data that is benchmarked to national data and shows how they have improved over past fiscal years," Cortez says. "That drives team performance." Among the data points tracked are percentage of patents dying with palliative care consults; penetration of palliative care services in acute care, ICU, and Community Living Centers; time from admission to consult; and time from consult to death.

Having that information at hand is a conversation starter for the teams to work together to improve care for their patients and furthers the culture of collaboration, Cortez says.

It has succeeded by promoting a collaborative culture around palliative care throughout its health care system and beyond...



INNOVATION HIGHLIGHTS

USE OF DATA AND ANALYSIS FOR PROGRAM IMPROVEMENTS

SUPPORT FOR ALL PATIENTS WITH CRITICAL ILLNESS IN ICUs

FOCUS ON CONTINUITY AND HOSPICE PARTNERSHIPS

A strong education and training program keeps team members up-to-date on palliative care methods and extends that knowledge to medical students, physicians and chaplains in training, RNs, advanced practice nurses, nursing assistants, psychology residents, social workers, and staff members of hospices that work with VISN 3.

Along with maintaining an overall culture of collaboration, the teams also work on specific improvement projects, such as expanding palliative services in the intensive care unit (ICU). Palliative care teams work with ICU teams to provide support for all patients with critical illness, not just those with life-threatening diagnoses. That includes emotional and spiritual support, symptom control, and establishing clear goals of treatment and goals of care. "We've found it to be a really rewarding initiative where palliative care teams and ICU teams provide care together and in concert with aggressive treatment if that is the family's and patient's preference," explains Luhrs.

With a goal to provide family meetings for all patients in the ICU, VISN 3 is providing nurses with access to a Communication Skills Laboratory where they are trained to more effectively initiate and participate in family meetings. The Network's palliative care leaders also have built unusually strong connections with community hospice agencies and Veteran Service Organizations through the development of Hospice Veteran Partnerships. The organizations maintain ongoing dialogue to ensure coordination of patient-centered care for veterans.

VA is carrying out a comprehensive initiative to provide networking and sharing of best practices across the country, and the VA New York/New Jersey Healthcare Network is leading the way in palliative services, notes Judith Feldman, MD, MPH, chief medical officer for VISN 3. "It's not often that we have the opportunity to enable staff to get together on a regular basis under very strong leadership and participate in a wide variety of educational and collaborative activities," she says.

Team members point to the network palliative care leaders, Luhrs and Cortez, who have been innovating since 2003. "We have two excellent leaders," says Sidhu. "They are always seeking excellence from everyone but doing it so nicely that you may not even realize what great things we're achieving."

The ultimate goal of the palliative care and hospice programs in VISN 3 is to carry out its primary mission, "To honor veterans' preferences for care at the end of life." "Building and sustaining our palliative care program to provide them with high quality, compassionate care at the end of life is one of the greatest ways we can honor our veterans and thank them for serving our country," says Cortez. •

PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER TORRANCE PROVIDENCE TRINITYCARE HOSPICE

Torrance, California

len Komatsu, MD, had a thriving, 20-year practice as a neonatologist at the Providence Little Company of Mary Medical Center Torrance (PLCMMCT) when he decided it was time to switch gears. "I love neonatology and I love babies," explains Komatsu, who is now the chief medical officer of Providence TrinityCare Hospice (PTCH) in Torrance, California. "But I was looking for something more....[W]hile taking part in a study of ethics consultations in adult ICU units, I learned about palliative care and realized this could be what I was looking for."

Komatsu went to Boston to take a two-week palliative care and practice course. "I realized that the emphasis on communication, pain and symptom management, and helping families was the reason I went into medicine in the first place," he recalls. "It's all about helping people in some of the most profound, gratifying ways possible. It was one of the best experiences of my professional life."

Providence Little Company of Mary Medical Center paid for Komatsu's fellowship in adult palliative care at Boston's Dana Farber Cancer Institute. He then returned to Los Angeles to create a palliative care program for Little Company of Mary. "The administration and the sisters and the board were willing to take a chance on this," he says now.

That initial program has now grown into a thriving palliative care program that provides consultative services to 500 patients per year at Providence Little Company of Mary Medical Center Torrance. In addition, PTCH serves more than 1,800 patients yearly both at home and in the hospital, including



children served by TrinityKids Care (TKC) program, the only pediatric hospice and palliative care service in Los Angeles and Orange counties. TKC primarily serves children at home but occasionally sees them at Providence Little Company of Mary Medical Center Torrance.

Komatsu now serves multiple roles. In addition to being the CMO of PTCH, he is medical director for both PLCMMCT's Doak Center for Palliative Care and TrinityKids Care, as well as a faculty member in Loyola Marymount University's Master of Bioethics program.

The palliative and hospice care programs have launched some novel initiatives, including the "Smarties" simulation lab, which teaches staff and volunteers about caring for dying patients by working with robots programmed to simulate the dying process. "They are the size of adults and they are programmed to speak, manifest the physical symptoms, and make the sounds of a dying patient," Terri Warren, executive director of PTCH, explains. "They are indispensable for our volunteers and staff."

In 2009, PTCH also opened three hospice/palliative care suites in the medical center's Transitional Care Center. The suites are designed to look "home-like," with flat screen TVs, refrigerators, and convertible sofas so that family members can stay with their loved ones. "The rooms are physically beautiful and the family response has been phenomenal," Warren says.

This summer, Providence will be launching a home-based pediatric palliative care program for Orange County. The hope, says Warren, is that "we'll be able to help patients not just in the last year of their lives but the last three to four years." Adds Komatsu, "The vast majority of our patients are at home. Our mission is specifically to help the poor and the vulnerable. As such, the needs are huge. We want to see patients sooner, prevent unnecessary hospitalizations and ER visits, and transition patients to hospice sooner."

"This is the right service at the right time," he says. "And it is amazing what you can accomplish when you have this much interest, enthusiasm, and administrative and organizational support."



INNOVATION HIGHLIGHTS

USE OF SIMULATION TRAINING FOR VOLUNTEERS AND OTHERS

PEDIATRIC TRINITYKIDS CARE PROGRAM

FOCUS ON CONTINUITY OF CARE
ACROSS SETTINGS

SHARP HOSPICECARE

San Diego, California

he dying patient was a 44-year-old, Roman Catholic Hispanic woman, who was, as Lisa Goodman, the Integrative Therapies coordinator with Sharp HospiceCare in San Diego, describes, "very traditional in her beliefs." A breast cancer patient, "she wore a rosary around her neck and was skeptical of pretty much everything," Goodman says, "especially anything that was not customary." But her pain was also "out of control."

Staff was hesitant to try anything but traditional pain management with her," Goodman says. "They were concerned about honoring her religious and cultural beliefs. But what I do has everything to do with honoring both. I went into her room and sat down next to her and said 'could I just gently touch you to see if it makes you feel better?' She very quietly placed my hands on her tumors, saying, 'this was my first one, this was my second one, and this was my third one.' I was so honored she trusted me by guiding me to those places which caused her so much pain." Through healing touch, her pain level went down from a 6.5 to a 3."

Sharp HospiceCare's Integrative Therapies Program is a leader in alternative therapies. In addition to healing touch, the hospice provides aromatherapy, gentle reflexology, and guided imagery to palliative care and hospice patients throughout Sharp's health care system, which includes four hospitals, three specialty hospitals, two skilled nursing facilities, in-home hospice care, two residential hospice homes, and a home-based palliative care program throughout San Diego County.



The hospice foundation funded both the program and training and certification in Healing Touch for all hospice aides. As a result, "our family satisfaction scores have increased and we have pretty much eliminated turnover among our hospice aides," says Sharp Vice President Suzi K. Johnson. "It has become a preferred place to work."

Sharp HospiceCare also has created innovative hospice houses by renovating two homes in residential areas. From the outside, the houses blend with other homes, but inside, they offer private and semi-private rooms, large living rooms, and gardens to any hospice patient, regardless of ability to pay.

Another innovation that has touched more than 4,000 grieving families in an intimate and gentle way is the Memory Bear initiative. Volunteers sew bears using clothing worn by deceased family members, even those not cared for by Sharp HospiceCare. "When the bear arrived, my 19-year-old daughter, who had not been able to show grief, grabbed the bear and slept with it," the wife of one HospiceCare patient writes. "The bear

provided her comfort when she needed it most...and it's been a quiet way to embrace my husband."

Sharp HospiceCare's disease-specific home-based palliative care Transitions program helps manage the progression of illness for patients with heart failure, COPD, and dementia. "We're working to change the culture of health care from a reactive model to a proactive model," Johnson says. "We do this through education, early symptom recognition, and most importantly, helping patients and families create a road map for their individual goals of care."

"We know the progression of these diseases," Johnson says. "We know what's going to happen. Frequently there is a disconnect between what's happening in the patient's home, compliance, lifestyle, and the medical system...[P]atients often land in the ER, when symptoms could be managed safely and effectively at home. By teaching patients about their own disease process, managing medications, diet, exercise, and early symptom recognition, we help them stay in their own home environment."



INNOVATION HIGHLIGHTS

TRAINING OF CNAs IN HEALING TOUCH AND INTEGRATIVE THERAPIES

TRANSITIONS PROGRAM TO KEEP
CHRONICALLY ILL OUT OF THE HOSPITAL

COMMUNITY-BASED RESIDENTIAL HOUSES

SUMMA'S PALLIATIVE CARE AND HOSPICE SERVICES

Akron, Ohio

elissa Soltis, MD, 29, first experienced palliative care medicine during her third year at the Northeastern Ohio Universities' College of Medicine. During her internal medicine rotation, she chose a hospice and palliative care elective and studied for three weeks under Steven Radwany, MD, Summa Health System's medical director of Palliative Care and Hospice. Those three weeks, combined with experience with family members through the dying process, led her to apply to Summa's fellowship program. "I felt that end-of-life care was really important," she says, "both in terms of the patients and the family members."

Soltis chose Summa's fellowship program because she was a native to the area and "I wanted to help people from my hometown," she says. And she already knew many people in Summa's Palliative Care and Hospice Services (SPCHS). "I knew this was the kind of place where I wanted to learn how to care for people at the end of their lives," she says.

SPCHS's palliative care fellowship (which takes three fellows per year) is just one aspect of what Radwany describes as "our deep commitment to education in hospice and palliative care." The curriculum includes rotations in inpatient palliative care, pediatric palliative care, geriatric medicine, outpatient oncology, and research. Based in Summa's busiest teaching hospital in Akron, the palliative care unit and hospice program now provides clinical rotations for more than 60 residents, medical students, nurses, social workers, pharmacists, visiting scholars, and



fellows each year. Program leaders also helped set up a mandatory four-year hospice/palliative medicine curriculum at the medical school. And Summa's Health Services Research and Education Institute is engaged in cutting-edge palliative care and geriatric research on a wide range of issues, including home-based palliative care, cross-cultural attitudes on end-of-life care, family meetings, interactions between ER and palliative care consultations, and the cost-effectiveness of hospice and palliative care.

Spread across a six-hospital integrated delivery system, SPCHS includes a hospice program, palliative care consult service, inpatient acute palliative care unit, and hospice and palliative care services (including PC consults) in 22 extended-care facilities. Each hospital works from the core model of the system's palliative and hospice care program, but "our hospitals serve a wide diversity of patients," Radwany says. "Each of our hospitals serves a different population and each has its own medical culture. They need to be able to build their own programs from the ground up so that they can meet the needs that exist, not the needs that we presume." SPCHS also recently initiated an African-American community outreach program to identify influential individuals in the African-American and faith-based communities who can help educate their members about SPCHS's services.

One service available to all hospice and palliative care patients is Summa's "massotherapy" program. Initially funded in 2002 through a United Way grant, the massotherapy program now has two full-time and four part-time massage therapists. In 2009, the program funded 3,200 patient visits, all at no extra charge to the patients or their families. "Massage therapy can be so helpful for managing both pain and anxiety," says SPCHS director Kim Kousaie, BSN, CHPN. "This is a vital part of our program."

Former fellow Soltis now works as the medical director of the Acute Palliative Care Unit for Summa's Akron City Hospital. "The people who work here don't just see this work as a career but as a calling," she says of her decision to stay in Akron. "Their hearts are in the right place. And those are the best people to learn from and work with."



INNOVATION HIGHLIGHTS

INTEGRATION AND ROLE OF MASSAGE THERAPY

IMPACT ON MEDICAL EDUCATION

FOCUS ON MANAGING POPULATIONS



Highlights of the Continuing Journeys of Past Circle of Life Winners



ince the first *Circle of Life Awards* were presented in 2000, the award has evolved in several ways. The criteria and name expanded to encompass palliative as well as end-of-life care. And the award has evolved from an American Hospital Association award to one that is more expressly owned by those who provide palliative and end-of-life care through the sponsorship of the award by their national associations as well as support from grants from the California Healthcare Foundation, based in Oakland, California, and the Archstone Foundation.

Throughout, however, the award's overarching goals of helping to change the way care is provided to the seriously ill and providing models from which the field can learn have remained constant.

In the last decade, the Circle of Life winners have evolved as well. To better understand what these innovators have accomplished and contributed to the field since receiving Circle of Life recognition, the California Healthcare Foundation has provided funding for this look at their circles of influence. This publication includes highlights from the full report, which is available on the Circle of Life website, www.aha.org/circleoflife.

OVERVIEW

IMPACT OF THE CIRCLE OF LIFE AWARD

- More recognition, credibility, and support within the organization and in the community
- More opportunities to assist other organizations in developing their programs
- More opportunity to collaborate with other providers
- · Boost to staff morale
- Affirmation of work and commitment
- Opportunities to educate their own in organizations and community about palliative and end-of-life care value
- Important factor in receiving grants from foundations and other organizations

AWARD PROCESS

- Lengthy and difficult application; valuable in forcing organizations to define their programs' mission and goals and quantify outcomes
- Stimulating and enjoyable site visit

CHANGES SINCE WINNING THE AWARD

- · Growth in numbers served
- Expansion of types of services
 (e. g., most of the early winners
 making the transition from end of-life to palliative care; others
 moving palliative care upstream)
- Expansion of the interdisciplinary team (particularly in hospitals)
- Greater focus on education and mentoring of others

LESSONS LEARNED

- The programs need strong champions and commitment from the top
- Support and funding are not automatic, no matter how respected and recognized the program
- Ultimately, a program must be financially sustainable as well as the "right" thing to do

HIGHLIGHTS



2000

LOUISIANA STATE PENITENTIARY HOSPICE PROGRAM Angola, Louisiana

This innovative prison hospice that uses prisoners as volunteers, has moved upstream to provide palliative care for the general prison population and outward so that palliative care patients can stay in their own areas. In the process, they've trained additional volunteers to care for patients in their areas. This program continues to mentor other correctional institutions in creating hospice/palliative care programs. Since receiving the Circle of Life Award, it has been the focus of an award-winning photographic documentary, *Grace Before Dying* (www.gracebeforedying.org).

IMPROVING CARE THROUGH THE END OF LIFE FRANCISCAN HEALTH SYSTEM

Tacoma, Washington

Now called *Palliative Care Outreach*, this program has worked with four other hospices that have also implemented the program. It is currently working on disparities in endof-life care. The program is transitioning from a clinic-based to a home-based approach.



"A lot of our program is about choice.

It's about true informed consent,
making sure patients really understand
what their options are."

Improving Care Through the End of Life, Franciscan Health System

200I

DEPARTMENT OF PAIN MEDICINE AND PALLIATIVE CARE BETH ISRAEL MEDICAL CENTER

New York, New York

This leading hospital palliative care program continues to emphasize education and an interdisciplinary approach, and have added many physicians, a psychologist, and a PharmD to the team. The department offers palliative care fellowships for physicians, nurse practitioners, and social workers. New initiatives include a special program for the MICU.

2002

HOSPICE OF THE BLUEGRASS

Lexington, Kentucky

Since receiving the award, this hospice's palliative care program has grown, and the award helped propel the hospice to become one of the Center to Advance Palliative Care's Palliative Care Leadership Centers. The hospice partners with a university to offer a fellowship and also offers specialized programs for hematology-oncology fellows and residents.

POPULATION-BASED PALLIATIVE CARE
RESEARCH NETWORK (POPCRN)
UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER
Denver, Colorado

A special award winner, PoPCRN continues to do collaborative research on palliative care. Recent focuses have included symptom management and caregiver issues. More than 240 organizations nationally have participated in PoPCRN's research activities.

HIGHLIGHTS



2003

PROVIDENCE HEALTH SYSTEM Portland, Oregon

This bottom-up program now has strong administration support and is working to embed palliative care in all settings. A steering committee was established to promote information sharing throughout the system. A spirituality initiative focused on training nurses to recognize when patients need to talk, and the system is currently developing nurse practice guidelines for end-of-life care and looking forward to developing a physician order set as well.

UNIVERSITY OF CALIFORNIA DAVIS HEALTH SYSTEM Sacramento, California

This academic medical center has continued to expand its palliative work both in patient care and in education. An inpatient consult service is now available, and its outreach program is expanding in scope. It is now looking at making palliative care education a more coordinated and integral part of medical education.

2004

ST. MARY'S HEALTHCARE SYSTEM FOR CHILDREN Bayside, New York

This long-term hospital is expanding palliative care to all of its young patients and now offers complementary and alternative therapies to all patients. It is also actively disseminating its model of care.

UNIVERSITY OF TEXAS M.D. ANDERSON CANCER CENTER SYMPTOM CONTROL AND PALLIATIVE CARE PROGRAM Houston, Texas

A new support care center outpatient unit is bringing patients to palliative care closer to the time of diagnosis. The palliative care program gets more visitors coming to observe than any other hospital program. The award has helped raise visibility and credibility for palliative care in the cancer center, resulting in increased referrals.



"We can help families make this difficult transition with a sense of support and grace and peace."

Providence Health System

2005

PALLIATIVE AND END-OF-LIFE CARE PROGRAM AT HOAG MEMORIAL HOSPITAL PRESBYTERIAN Newport Beach, California

Focus has shifted to moving palliative care upstream to months and years before end of life...working with nursing homes to ensure that when patients are transferred, they continue to get palliative care. The addition of a palliative care nurse from the UK and a palliative care physician has greatly accelerated its progress, strengthening the focus on symptom management and teaching physicians about symptoms at the end of life and training hospital social workers in palliative care as well.

THOMAS PALLIATIVE CARE UNIT VCU MASSEY CANCER CENTER Richmond, Virginia

This leading program has been teaching others how to provide palliative care — internationally and closer to home, working with the Veterans' Administration hospitals.

HIGHLIGHTS



2006

TRANSITIONS AND LIFE CHOICES FAIRVIEW HEALTH SERVICES Minneapolis, Minnesota

This system continues to emphasize integrating palliative care throughout its system. In addition, it is working to spread palliative care into rural areas and through the entire continuum of care, working with ten communities.

2007

UNIVERSITY OF CALIFORNIA SAN FRANCISCO PALLIATIVE CARE PROGRAM

San Francisco, California

This academic medical center is working with public hospitals to develop palliative care programs as well as with more established programs to measure and improve quality.



"I try to be very open in saying,
"What are your needs, what are your
resources, and what do you think is the
best way to make that happen?""

Transitions and Life Choices, Fairview Health Services



"Instead of making sick children and their families come to them, the palliative care team follows the children."

Pain and Palliative Care Program, Children's Hospitals and Clinics of Minnesota

2008

PAIN AND PALLIATIVE CARE PROGRAM CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA Minneapolis/St. Paul, Minnesota

The hospital is starting a pediatric palliative care fellowship for physicians and has developed a national collaboration website for pediatric palliative care. Its goal is to ensure that any child can get palliative care at home in their community from their own provider who has access to 24-hour a day phone support.

PEDIATRIC ADVANCED CARE TEAM CHILDREN'S HOSPITAL OF PHILADELPHIA Philadelphia, Pennsylvania

The hospital has expanded its home visit program and is working on formalizing a pediatric palliative care research network with other hospitals. Its focus is on improving evidence-based care.

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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.



CIRCLE of LIFE™

Celebrating Innovation in Palliative and End-of-Life Care