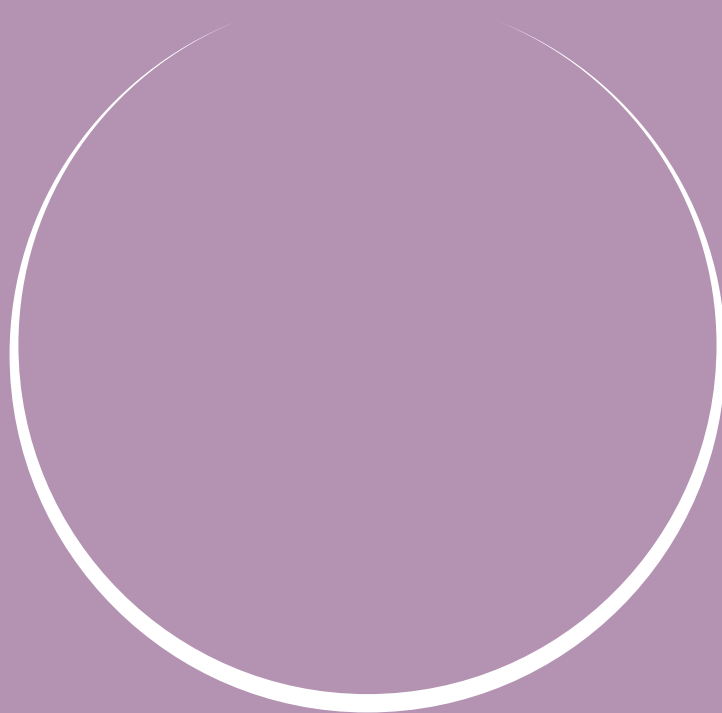


CIRCLE OF LIFE AWARD



2012



CIRCLE of LIFE™

*Celebrating Innovation in Palliative and End-of-Life Care*

The 2012 awards are supported in part by the California HealthCare Foundation, based in Oakland, California, and the Archstone Foundation.

Major sponsors for the 2012 awards are the American Hospital Association, the Catholic Health Association of the United States, and the National Hospice and Palliative Care Organization & National Hospice Foundation; the American Academy of Hospice and Palliative Medicine and the National Association of Social Workers are 2012 Circle of Life cosponsors. The Hospice and Palliative Nurses Association also supports the awards.

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

In health care today, perhaps the most frequent discussions on reshaping health care delivery focus on the need to create a coordinated care continuum. These words evoke a system where care is built around an individual's needs, where patients move seamlessly among providers and practitioners, and where chronic conditions are assessed, monitored, and treated before they reach a crisis stage.

Palliative and end-of-life care have a profound place in a coordinated care continuum — and not just at the spectrum's end. Often the best approach is to weave these services throughout the continuum — meeting the needs of individuals and families early in life-limiting illnesses or using palliative care expertise to ease pain, suffering, and other symptoms for patients of all ages and prognoses.

This focus on coordinated and seamless patient-centered care is a hallmark of the 2012 Circle of Life honorees. Their work contributes to a higher quality of life and satisfaction for patients and families and to reduced readmissions and more effective resource use for providers. The 2012 Circle of Life Award Winners and Citation of Honor recipients include hospices, acute care hospitals, an acute care specialty hospital, a children's hospital, and a health care system. We hope their stories will spark your thinking on how you can build and improve palliative and end-of-life care in your organization.

Our thanks to the foundations and organizational and professional associations that support the Circle of Life Awards. The awards are supported in part by grants from the California HealthCare Foundation, based in Oakland, California, and the Archstone Foundation. Major sponsors for the 2012 awards are:

- American Hospital Association
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- National Hospice and Palliative Care Organization & National Hospice Foundation

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More information about the Circle of Life Award and past recipients is available at [www.aha.org/circleoflife](http://www.aha.org/circleoflife).

Sincerely,



Steve Franey  
*Chairman*  
*Circle of Life Award Committee*



Rich Umbdenstock  
*President and CEO*  
*American Hospital Association*

AWARD WINNER

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HASLINGER FAMILY  
PEDIATRIC PALLIATIVE CARE CENTER  
AKRON CHILDREN'S HOSPITAL

*Akron, Ohio*





Lauren Gartner, like many 10-year-olds, loved to draw, and it was the most fun when she could make pictures with her best friend, Maddy. Unlike other kids, however, Lauren had a tumor that would ultimately shorten her life. “Her hospital room was lit up with her art work,” recalls William Considine, CEO of Akron Children’s Hospital, where she spent much of her six-month illness. “She had such a positive energy and spirit that inspired all of us.”

That spirit also inspired the palliative care program to build on Lauren’s love of creativity to create a special place where children and families can experience holistic healing through the arts. The result, eight years later, is a new, colorful, sunny 3,000-square-foot space called the Expressive Therapy Center, built with the support of a major donor, Emily Cooper Welty. Children and families can use its resources there or in a patient’s room. “Sometimes they’ll just take something out and play while they’re talking,” explains Marlene Hardy-Gomez, a nurse practitioner on the hospital’s palliative care team.

The center is just one part of a comprehensive palliative care program at Akron Children’s, which was created and developed by Sarah Frieber, M.D., a pediatric hematologist/oncologist and palliative medicine physician. Frieber is credited with evangelizing the cause of palliative care so effectively that the hospital now has one of the nation’s leading pediatric palliative care programs after just 10 years.

“We built a community-based model that recognizes children in the hospital need palliative care,” says Frieber. “But what we also need to be doing is reducing the fragmentation of medical care,” she adds, “and getting them back to where they want to be — in the community.”

The program offers in-hospital consults but much of the care takes place in other settings through connections with home care and hospice agencies, schools, and long-term care facilities scattered around 44 of Ohio’s 88 counties. “We drive a lot,” says Frieber.

Families can choose from an array of palliative services using a colorful painter’s palette, with each service (such as nurse case management, social worker support, massage therapy, chaplaincy, art and music therapy, etc.) a different color. “It helps our families understand better that they really are part of the team and we look to them to know their child best,” says Hardy-Gomez.

Frieber’s enthusiasm for palliative care was infectious and fit well with the mission of the 122-year-old children’s hospital, says Considine. “The idea of palliative care is very strongly tied to the hospital’s family-centered care focus and mission,” he says.

In just a decade, the palliative program grew from three staff members to 29. Akron Children’s became one of the first hospitals to maintain a pediatric palliative care fellowship and the first to endow a chair in pediatric palliative care. The chair, which bears Frieber’s name, as well as the center itself receive extensive financial backing from the Haslinger family, whose generosity has inspired other donors to support the program and the hospital.

The program maintains an advisory board of community leaders who get personally involved in the center’s activities and often come up with their own ideas of how to be supportive. For instance, board members created a project called “Holiday Elves,” during which they go on home visits and deliver a Christmas tree and set it up in the living room, along with stockings and cakes.

*(The Palette of Care) helps our families understand better that they really are part of the team and we look to them to know their child best.*



#### INNOVATION HIGHLIGHTS

##### EXPRESSIVE THERAPY CENTER

##### FOCUS ON RESEARCH AND EDUCATION

##### COLLABORATION WITH OTHER HOSPITALS, HOSPICES, AND MEDICAL SCHOOL

The program's bereavement services are essentially unlimited in time, as they find that families go through stages of grief over many years. "We never stop following families," says Friebert.

Akron Children's is a training site for other organizations seeking specialty training and guidance on developing palliative programs. Its fellowship program feeds research, and everyone on the palliative care team is expected to undertake research projects. "Because of our large volume of patients, we are sitting on a mountain of data," says Friebert. "The Expressive Therapy Center gives us a laboratory to test interventions that will be helpful to families." The center studies family stress, bereavement, and what happens during transitions when children move into adult medical care.

Dr. Friebert and her team are active advocates on the state and national level to push for reimbursement models that make sense for what sick children need. "We've moving away from high-intensity, ICU-based care," she says. "Palliative care is continuum-based care, and we need to legislate for appropriate payment so every child who needs it can have it."

For Akron Children's, palliative care is not an add-on or second-tier service, Considine says. It is part of the overall planning for children with chronic and life-threatening illnesses, impacting inpatient, home care and school health services. "It has to become part of who you are," he says.

The program has changed the medical culture of the hospital, says Pediatrics Chair Norm Christopher, M.D. "It's required us to think a little bit differently about children with complex medical conditions and chronic conditions," he says. "It called into question how we address these very complicated situations that families find themselves in."

He remembers when a young palliative care fellow presented during grand rounds several years ago, when the concept was still new. "The fellow gave a list of the conditions and situations where palliative medicine could really make a difference. The audience was restless and when it was over the tone in the Q&A was, 'We already do that. We care about families and about kids. Why do we need you to do that for us?'"

But over time, medical staff members were won over when they saw how a more holistic approach focused more on the family's needs and the child's anxiety made a real difference in their experience with the hospital.

Palliative care has now become an intrinsic part of medical care at Akron Children's, Christopher says, even if it doesn't fit neatly into an organizational box. "A few years ago we reorganized the Department of Pediatrics into practice clusters and everything fit pretty nicely, but not palliative medicine. So we thought about it as a golden thread that pulls all those other service lines together." •

COMMUNITY PEDSCARE  
 COMMUNITY HOSPICE OF NORTHEAST FLORIDA  
*Jacksonville, Florida*

Community Hospice of Northeast Florida in Jacksonville had tried several times over the years to expand its end-of-life services to children, but the adult model just didn't work. So, to move gently into the pediatric world, the hospice hired a pediatric nurse and social worker. "We told them to spend time at the children's hospital and find out what the children and their families need," explains Susan Ponder-Stansel, hospice president and CEO. "We came to understand what was different about that environment. The grief and bereavement come earlier. The knowledge that your child has a life-limiting illness is a death of a kind itself."

This specialized care filled a huge unmet need, and the palliative specialists found themselves welcomed in the hospital and beyond. "Soon we were consulted for our expertise and invited to be part of the team," says Ponder-Stansel, explaining the beginnings of Community PedsCare in 2000.

Community PedsCare provides comprehensive palliative and end-of-life care to children and families across all venues, including home, community, hospital and outpatient clinic. It includes a perinatal program, community-based palliative and hospice care, an inpatient pain and palliative care consult service, an outpatient pain and palliative care clinic, integrative medicine services, a transition program, respite care, parent/child support groups and activities, a summer camp, and memorial and bereavement services.

The program maintains a family-centered and community focus, providing opportunities for children and families to do the kinds of things other families not dealing with serious illness are able to enjoy. The program's teen advisory



board sponsors an annual day at a horse ranch with hay rides, games, and fishing; the organization hosts an Easter egg hunt each spring and holiday party in the winter; the PGA Tour Wives, who have made Community PedsCare their special charity, annually hosts a special event for patients and families during the PGA Players Tournament.

Community PedsCare grew into a comprehensive program in part because of the partnerships with Wolfson Children's Hospital, the University of Florida-Jacksonville, and Nemours Children's Clinic. The program also receives about \$1 million in philanthropy yearly.

"The partners generate synergy, building on one another's strengths," says Jeff Goldhagen, M.D., administrative medical director of Community PedsCare. "No one sector owns palliative care; it has to be developed as a community collaborative," Goldhagen says. "Each of the sectors...leverage(s) the resources of the others."

Children admitted to the hospital for certain diagnoses are automatically considered for referral to the Community PedsCare team. A nurse liaison ensures

continuity. "She'll check in with the family, physician, and subspecialists and be a conduit between what's going on in the hospital and at discharge to make the transition back to the community," explains Kelly Komatz, M.D., associate medical director.

The program also benefits from a Florida Medicaid waiver that provides supportive services to children with complex diagnoses and their families, allowing the child to continue with life-prolonging treatments.

"Community PedsCare is in a good position as the health care system moves toward coordinated care," says Ponder-Stansel. "Medically complex children cost the system a lot of money, and it doesn't do a good job with them," she says. She advises that end-of-life care organizations need to be prepared. "You have to be there providing the service, and you have to have the metrics and the business case," she says.

Comprehensive pediatric palliative and end-of-life care can't be tacked onto an adult model, she says, but must be designed for children and families. "You just have to have the commitment... You have to understand the investment. But it will pay off in so many ways."



#### INNOVATION HIGHLIGHTS

CREATING COMMUNITY-WIDE  
CULTURE CHANGE

COMMUNITY-BASED INTEGRATED CARE

COALITION BUILDING TO PROVIDE CARE



AWARD WINNER

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CALVARY HOSPITAL

*Bronx, New York*







Calvary Hospital has a unique and dramatic place in the history of the care of the dying in New York City. It was established in 1899 by a woman who observed the “calvary homes” of Europe that cared for poor, mortally ill widows abandoned by society to literally die in the streets. Long before palliative care became part of mainstream medical care, the concept was in practice at Calvary’s first location in Greenwich Village and later at its facility in the Bronx. Because of its unique history, Calvary Hospital is not likely to be replicated wholesale in another city. But the innovations it has developed, informed by a devotion to caring for the dying, are models for other end-of-life programs.

Today, Calvary Hospital is a far bigger, more sophisticated, complex organization. It sees fully one-third of those who die from cancer in New York City. It offers palliative and end-of-life care both at its main 200-bed hospital in the Bronx and at a 25-bed unit at Lutheran Medical Center in Brooklyn. The hospital provides a comprehensive, integrated palliative care program across a continuum including home care, ambulatory services, home hospice and nursing home hospice. And it has been a model for end-of-life care delivery around the world, welcoming many foreign visitors from areas where palliative care is very new, including Turkey, Oman, Japan, and the Middle East.

Calvary also plays an enormous role in training new practitioners. Nearly all the medical students in the city cycle through Calvary at some point during their education. It has a special training program for cancer care technicians, who take on the difficult and time-consuming tasks of the everyday care of cancer patients. They take a rigorous six-month course to learn to feed, wash, and do basic wound care, and what Michael Brescia, M.D., executive medical director, calls “glorifying the body,” even if that body is failing and hard to face. They become an important part of the care team, and many technicians have stayed on and gained nursing education, becoming registered nurses. One ended her career as a vice president and director of nursing.

Calvary takes pains to ensure that both hospital-based and home care staff reflect New York’s many cultures and languages, including having many Spanish-speaking social workers and nurses. A wide variety of faith traditions are reflected in the chaplaincy.

An extensive bereavement program follows families for 13 months after the loss, and many people remain connected with the many weekly support groups that Calvary runs for both the families of its patients and the community at large. The program runs workshops focusing on holidays that might be difficult for the bereaved; it has a summer camp for children who have suffered a significant loss; it also trains medical professionals and funeral directors in its approach to bereavement. “Our focus is huge because we are encompassing the community as well as the families of Calvary patients,” explains Sherry Schachter, bereavement director.

Calvary’s leadership and caregiving staff are passionate about Calvary’s mission and work. Michael Brescia, M.D., the executive medical director, left a promising career in nephrology and transplant surgery in the mid-1960s to help dying patients at Calvary. He and his nephrologist colleague James Cimino, M.D. were involved with the invention of the arteriovenous fistula (the procedure that made kidney dialysis practical) when they both became caught up in the compelling mission of Calvary. Dr. Cimino died in 2010 after many years as director of Calvary’s palliative care institute.

*What we try to show is that when  
you enter a room you can make that  
room a sanctuary.*



#### INNOVATION HIGHLIGHTS

DEPARTMENT OF FAMILY CARE AND  
FAMILY INTERVENTION TEAM

CENTER FOR CURATIVE AND PALLIATIVE  
WOUND CARE

CANCER CARE TECHNICIAN  
TRAINING PROGRAM

While dedicated to advancing evidence-based care, Brescia also recognizes the deeply spiritual in much of what happens in Calvary Hospital. “What we try to show is that when you enter a room you can make that room a sanctuary,” he says. “You have to be present, to touch and to hold, you have to speak to these patients.”

This core tenet of the organization’s culture is ingrained in everything it does, and it’s something that every staff member, whether they care for patients or not, must adopt, says Brescia.

For many cancer patients and their families, a diagnosis and treatment plan has been put in place but there’s been little in the way of explanation of what it all means, and what their journey may involve. The social work department has adopted the term “family care” for its name and formally admits the family just as it does a patient. Another Calvary innovation, the Family Intervention Team, is particularly helpful for family members who have not fully accepted the seriousness of the illness, explains Robert Brescia, M.D., a cousin of Michael Brescia and director of psychiatry for Calvary. The team includes caregivers and senior Calvary administrators, who sit down with a struggling family member with an open approach that often starts with, “Tell us what we’re doing wrong.” “We have a high success rate in really calming family difficulties down, really easing their pain and suffering,” the younger Brescia explains.

Despite the growth and evolution of its programs to accommodate modern medicine, the core central values of Calvary Hospital haven’t changed since the 19th century — boiled down to a single phrase: “no one is abandoned.” •

## ST. JOSEPH PALLIATIVE CARE PROGRAM

*Orange, California*

As palliative care increasingly moves upstream to benefit patients earlier in the disease process, it's becoming apparent that nurses and physicians with knowledge and training in palliative care raise the standard of care for all their patients.

That's why, at St. Joseph Hospital in Orange, California, the techniques of palliative care are being taught to the nursing staff. "The more people who understand how to take care of palliative care patients, the better it is for everybody," says Pamela Hockett, executive director in the hospital's Center for Cancer Prevention and Treatment. Nurses learn symptom management and essential skills that allow them to talk with patients facing life-threatening diagnoses. The palliative care service is on call for particularly difficult situations.

The palliative care team includes nurse practitioners, physicians, a medical social worker, and a chaplain, who together can meet the multifaceted physical, psychosocial, and spiritual needs of the patients. "With some difficult patient situations nurses call in the palliative care team for assistance," says Hockett. "The team started including the nursing staff so they could see how the experts model the process and facilitate the conversation. Not only has it helped the patients and families immensely, but it's also grown the nursing staff."

By providing palliative care training to all nurses, doctors become more familiar with the techniques as well, explains Melvyn Sterling, M.D., one of two physicians on the palliative care team. "The way to a doctor's mind is through the nurse," he says.



To help patients and their family play an active role, the team members have developed a brochure to teach patients how to get the information they need from medical professionals. "The patient is in such a vulnerable spot," says Hockett. "We realized that some patients are not able to articulate their questions, or are too stressed to know what to ask." The brochure helps patients formulate their concerns into questions and conversations with their doctor. "It's made all the difference in the world," says Hockett.

St. Joseph's palliative care program is integrated into both inpatient and home care, with the goal of preventing hospital admissions. Members of the inpatient team overlap with palliative care staff at St. Joseph's Home Health Network and Hospice, which includes a perinatal program along with inpatient and outpatient hospice. "We try to provide a seamless transition," explains Peggy Delmastro, a nurse practitioner on the palliative care team. "You can write a whole beautiful plan but if it doesn't translate into people's homes you'll see them back in the hospital."

St. Joseph uses tools for a palliative care consult, making those referrals easy for anyone on the care team. One is known as "Sacred Care Triggers for Goals Clarification," and lists eight situations that could trigger a consult, such as admission with one or more chronic life-limiting conditions or two or more ICU admissions during the same hospitalization. Another similar list was developed for non-critical care settings in the hospital.

The Perinatal Program provides support to pregnant women whose babies are not expected to survive after birth. The team works closely with the mother and family to prepare them long before the birth and provides bereavement support to the family for at least a year after the birth.

The palliative program fits with St. Joseph's hospital-wide goal to achieve perfect care, which the organization defines as evidence-based, delivered with technical expertise and compassion that promotes the fullest possible physical, psychological, and spiritual healing and comfort. Delmastro notes. "This is the right thing to do for the patient and family. It's about the dignity of the person and the family."



## INNOVATION HIGHLIGHTS

PALLIATIVE CARE INTEGRATION ACROSS SETTINGS AND IN HOSPITAL VALUES

USE OF MULTIPLE PALLIATIVE CARE TRIGGERS

FAMILY PARTICIPATION ON COMMITTEES AND IN DESIGN

AWARD WINNER

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SHARP HEALTHCARE

*San Diego, California*





Helping patients and their families through the physical and emotional pain of a chronic and then life-limiting illness has great value to providers, patients, and families. But traditional episodic delivery and payment approaches seldom reimburse for these services. Wouldn't it make sense for health care to be organized and financed in a way that palliative care could provide the utmost value to the maximum number of patients and families?

At Sharp HealthCare, a large integrated health system in San Diego, that fantasy scenario appears to be playing out. Sharp's system covers the care continuum, following patients from one setting to the next. That makes it easier to provide palliative care whenever it is needed, rather than trying to fit it into one reimbursable episode of care. And Sharp's participation in new models of coordinated care means that palliative services, for the first time, actually fit well with the financial side.

"We can do this transition because we're compensated for people's care, so we're figuring out how best to manage their health over the long term," explains Nancy Pratt, senior vice president of clinical effectiveness for Sharp. "It gives us an opportunity to innovate and create." Sharp has been providing its Medicare managed care patients with new palliative care options and will be able to expand as a participant in Medicare's new Pioneer Accountable Care Organization (ACO) program.

The care models are just as innovative as the reimbursement models. Sharp has devised a program called Transitions that takes a population-based approach to identify people at the very beginning of an illness that may prompt a need for palliative services. Transitions focuses on specific diagnoses; first up was congestive heart failure. The program manages patients closely to keep them from cycling in and out of the hospital.

"The model is evidence-based...we know the typical course of heart failure patients, and if we look two years upstream, we help anticipate what they need to do to successfully manage their disease," explains Suzi Johnson, MPH, RN, a Sharp vice president. "We know that falls, medication issues, and caregiver problems are the drivers of hospitalization."

The Transitions model is built on four pillars of care: in-home skilled care, evidence-based prognostication, care for the caregiver, and goals of care discussion. "We give physicians another tool so they don't have to use the word 'hospice' with their patients" who aren't ready for it, says Johnson. "We help patients avoid a crisis by putting them in this program. We're really helping to create a roadmap for patients and families." Patients can continue on curative care while in Transitions.

The prognostication piece in particular has taken some thought and some work with physicians to be more open about the likely course of a patient's illness, explains the program's medical director, Daniel Hoefer, M.D. "We stopped teaching prognostication 30 years ago," he says. "We used to think it was just as important as diagnosis and treatment, to tell the family about the natural course of disease."

Helping families with the symptoms and crises likely to occur at home helps them from panicking and calling 911, he says. A detailed manual on dementia, for instance, helps families know what to expect and what to do when the patient becomes agitated.

*We're really helping to create a roadmap  
for patients and families.*



#### INNOVATION HIGHLIGHTS

STRATEGIC INTEGRATION OF  
PALLIATIVE CARE TO MANAGE HEALTH  
OF POPULATION

CASE FINDING APPROACH AT PRIMARY  
CARE LEVEL

STRONG CULTURE OF QUALITY  
IMPROVEMENT

The results so far are “stunning,” program leaders say — huge reductions in the number of emergency department visits and hospitalizations, substantial improvements in quality of life, patient satisfaction, and earlier hospice referral. Among heart failure patients there was a 94 percent reduction in emergency department visits. Transitions has since moved on to COPD, dementia, and end-stage cancer.

Sharp’s sophisticated use of data from its electronic medical record system allows for early identification of patients who could enter Transitions, and makes it easier to analyze patient outcomes as well. “The better we get at informatics, and at identifying patients who would benefit, the more robust the program will be,” says Johnson. Sharp is moving into skilled nursing facilities with the same concept of intense management of patients to keep them out of the hospital.

In addition, a pilot program using remote monitoring for heart failure patients is focused on unfunded, Medi-Cal, and Medicare fee-for-service patients to reduce readmissions.

Sharp has also developed a comprehensive advance care planning consultation program that helps patients and families through planning and decision making at all stages of life. Sharp’s palliative care program also works with high-risk chronic care patients in its medical group, collaborating with physicians on case management. This service was developed at the request of physicians seeking expertise in talking to patients and families about goals of care.

The palliative care program makes referrals easy by assigning two physicians board certified in hospice and palliative care as liaisons to coordinate with hospitalists, emergency room physicians, hospital-based palliative care teams, primary and specialty physicians, other health care team members, patients, and families across the continuum.

Sharp HospiceCare also maintains a bioethicist to serve on a hospital ethics committee and in an advisory role for consultations throughout the Sharp system.

Palliative care gets executive-level attention at Sharp HealthCare — it’s a strategic priority for the health system and was listed as a major goal of the organization’s application to be among the country’s first Pioneer ACOs.

For organizations that follow Sharp into the world of ACOs, palliative care will be an essential part of managing care for those with serious chronic and life-threatening illnesses, says John Jenrette, M.D., CEO of Sharp Community Medical Group and a leader of the Pioneer ACO initiative. “There’s a huge opportunity both in quality and cost savings,” Jenrette says. “The palliative piece is just an obvious fit. And just as important, there are the improvements in care for patients and families.” •



## UNITY

*De Pere, Wisconsin*

People with life-limiting illnesses don't always fit the neat definitions of health care reimbursement rules, particularly the six-month prognosis required by the Medicare hospice benefit. Lisa McMahon, director of patient services for Unity, a Wisconsin hospice, recalls a patient who personified that problem.

She was an older woman with a poor prognosis who transferred to Unity's hospice residence directly from the hospital. Eventually she moved home, where her condition improved to the point where she went off hospice, but she still needed care and help with medication management. The Unity care team shifted her to palliative care, allowing her to remain at home in comfort. "We engaged the family in determining a plan of action, working toward her goal of becoming stronger," says McMahon. That included reviewing her medications and finding community resources that could help the family keep her at home.

Unity, a joint venture of three area hospitals, began its palliative care program in 2002 in response to hospice patients whose lives didn't run a predictable course. It provides care to those who do not qualify for the hospice benefit, while easing transition into hospice when needed. Approximately 73 percent of its palliative care patients currently go into hospice.

"Just hospice alone wasn't enough," says Rance Hafner, M.D., Unity's medical director. "We had challenges when a patient graduated from hospice eligibility. What happens when they go back to the way they were but had failed in that situation before? Having



the palliative program allows us to transition patients to a different level of care for awhile."

Unity care teams are geographically based throughout the 12 northeast Wisconsin counties it serves. One of Unity's innovations is that the same interdisciplinary team cares for patients whether they are getting palliative or hospice services, bringing consistency and familiar faces to patients and their families throughout the course of a life-limiting illness. The teams focus on symptom management and work closely with the patient's primary care providers.

Serving a large number of rural underserved communities, Unity provides palliative and hospice care to more than 830 patients each day in private homes, nursing homes, assisted living facilities, hospitals, and its own hospice residence, which opened in 2007 and was the first hospice residence in northeast Wisconsin. Strongly committed to meeting the needs of its communities, Unity has also developed a pediatric program and is working to build relationships with the Children's Hospital of Wisconsin system.

Unity provides a comprehensive orientation for new staff, along with continuing education, through both an education department and committee. Three of its nurses are Hospice and Palliative Nurses Association-approved educators who teach nurses and nursing assistants and work with a state organization that certifies nurses and hospice aides.

The palliative care program is supported, in part, by philanthropy of appreciative families and communities throughout the broad area, and palliative care services are provided on a sliding fee scale. From Unity's perspective, palliative care saves the health system — and patients — from less-than-necessary health services and "it's just the right thing to do for patients," says Hafner. Unity provided about \$1.4 million in charity care services in 2011.

"This is the community we live in, and this is how we will support our community," he says. The goodwill engendered by filling a vital gap between hospital and hospice care comes back to Unity in the form of community support for its fundraising efforts.

"This helps people on a very personal basis," Hafner says. "It makes you feel good and proud of your community to be able to help patients at this stage of their life."



## INNOVATION HIGHLIGHTS

CAREGIVER CONTINUITY ON HOSPICE/  
PALLIATIVE CARE TEAM

EMPLOYEE EDUCATION AND DEVELOPMENT

COLLABORATION AMONG LOCAL HOSPITALS



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## PAST AWARD WINNERS\*

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2000

The Hospice of the Florida Suncoast  
*Largo, Florida*

Louisiana State Penitentiary  
Hospice Program  
*Angola, Louisiana*

Improving Health Care Through the  
End of Life  
Franciscan Health System  
*Gig Harbor, Washington*

2001

Department of Pain Medicine and  
Palliative Care  
Beth Israel Medical Center  
*New York, New York*

Palliative CareCenter & Hospice of the  
North Shore  
*Evanston, Illinois*

Compassionate Care Focus  
St. Joseph's Manor  
*Trumbull, Connecticut*

2002

Children's Program of San Diego  
Hospice and Children's Hospital  
and Health Center  
*San Diego, California*

Hospice of the Bluegrass  
*Lexington, Kentucky*

Project Safe Conduct  
Hospice of the Western Reserve  
and Ireland Cancer Center  
*Cleveland, Ohio*

Population-Based Palliative Care  
Research Network (PoPCRN)  
Special Award Winner  
*Denver, Colorado*

2003

Hospice & Palliative CareCenter  
*Winston-Salem, North Carolina*

Providence Health System  
*Portland, Oregon*

University of California Davis  
Health System  
*Sacramento, California*

2004

Hope Hospice & Palliative Care  
*Fort Myers, Florida*

St. Mary's Healthcare System  
for Children  
*Bayside, New York*

University of Texas M.D. Anderson  
Cancer Center  
Symptom Control and Palliative  
Care Program  
*Houston, Texas*

2005

High Point Regional Health System  
*High Point, North Carolina*

Palliative and End-of-Life Care Program  
Hoag Memorial Hospital Presbyterian  
*Newport Beach, California*

Thomas Palliative Care Unit  
VCU Massey Cancer Center  
*Richmond, Virginia*

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

## PAST AWARD WINNERS\*

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2006

Continuum Hospice Care  
*New York, New York*

Mercy Supportive Care  
St. Joseph Mercy Oakland  
*Pontiac, Michigan*

Transitions and Life Choices  
Fairview Health Services  
*Minneapolis, Minnesota*

2007

Covenant Hospice  
*Pensacola, Florida*

University of California San Francisco  
Palliative Care Program  
*San Francisco, California*

Woodwell  
A Program of Presbyterian SeniorCare  
and Family Hospice and Palliative Care  
*Oakmont, Pennsylvania*

2008

Pain and Palliative Care Program  
Children's Hospitals and Clinics  
of Minnesota  
*Minneapolis/St. Paul, Minnesota*

Haven Hospice  
*Gainesville, Florida*

Pediatric Advanced Care Team  
Children's Hospital of Philadelphia  
*Philadelphia, Pennsylvania*

2009

Four Seasons  
*Flat Rock, North Carolina*

Oregon Health and Science University  
Palliative Medicine and  
Comfort Care Program  
*Portland, Oregon*

Wishard Health Services  
Palliative Care Program  
*Indianapolis, Indiana*

2010

Kansas City Hospice & Palliative Care  
*Kansas City, Missouri*

Snohomish Palliative Partnership  
*Everett, Washington*

Department of Veterans Affairs  
VA New York/New Jersey  
Healthcare Network  
*Brooklyn, New York*

2011

The Center for Hospice &  
Palliative Care  
Cheektowaga, New York

Gilchrist Hospice Care  
Hunt Valley, Maryland

St. John Providence Health System  
Detroit, Michigan

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