

AWARD WINNER

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HIGH POINT REGIONAL HEALTH SYSTEM

*High Point, North Carolina*





A lot of hospitals talk about collaborative care. High Point Regional Health System has been living collaborative care for more than a decade. Before they had ever heard of *palliative care*, the physicians and clinical and ancillary staff at the hospital were using a team approach to treat illness, manage symptoms, and address anxiety and spiritual needs for each patient... working with patients and families to define the goal of care.

The hospital's long-standing Collaborative Patient Care Management system actively involves the patient and family in the health care process and promotes health awareness, prevention, education, and disease management across the continuum. A registered nurse patient care coordinator leads the team, which defines the standard of care, practices, and activities that promote health outcomes for a given diagnosis or procedure. This strengthens the voice of each discipline, including medicine, nursing, physical therapy, pastoral care, social work, nutrition, and pharmacy. It also clarifies that the organization is responsible for the health needs of the community *before* its members become patients and for ensuring continuity of care *after* they are discharged. This approach has led to *life-long palliative care*, with a long-term goal of building relationships.

And so a few years ago when the ethics committee at High Point Regional Hospital began talking about a more formalized approach to end-of-life care, it had a strong patient-centered foundation already in place.

The formal palliative care program evolved out of the ethics committee's concerns that it was too often being called to help resolve an end-of-life issue during a crisis. "That stimulated our awareness of where patients, staff, and families were struggling and that we needed to be better prepared to really address these patients' needs and goals," observed Chaplain Janice Wakefield.

High Point's approach built on its strengths and traditions of patient-centered care. "This means our program has a slightly different look, and that it is uniquely tailored to the specific needs of our system and patients, makes effective use of existing resources, and is likely to win acceptance and be integrated into our overall delivery of care," the team explains. "Our program does not have walls; our program does not have a designated location. Palliative care is multi-layered and integrated into the delivery of care on every inpatient unit." To help ensure this integration, nurses complete ELNEC training, an end-of-life nursing education program, during their orientation.

All disciplines understand the concept of palliative care, and any staff member can seek out a palliative care consultation, which are facilitated by clinically trained chaplains, reflecting the strong spiritual traditions of the patient population. The chaplain is seen as both part of and separate from the medical team, trusted by families as an unbiased party who can help translate medical information and also communicate the patients' needs back to the team. "It kind of emerged from who we are," explains Wakefield. "We have a sense of collaboration with that patient or family. We're helping the patients and families redefine what this part of their life looks like, and (we're helping our) staff redefine what it means to offer medical care and to care."

And on the other end, when a pastoral caregiver approaches a physician about a consult, the chaplain is seen as conveying *the big picture* understanding of the patient and family situation and needs rather than directing the physician's medical practice.

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#### INNOVATION HIGHLIGHTS

INTEGRATION OF PATIENT-CENTERED  
CARE AND PALLIATIVE CARE  
THROUGHOUT

STRONG TEAM MODEL FOR PATIENT CARE

LEADERSHIP BY CHAPLAINS

Another part of the palliative care program helps physicians who often deal with dying patients talk about their own feelings. Just as conversations and on-going dialogue is key to understanding patient needs, conversations are also helpful in understanding how physician beliefs and values influence their care decisions. To increase understanding, chaplains have invited these doctors to engage in private, voluntary conversations about the physician's own feelings about the end of life. These talks have strengthened the respect and trust among the doctors, chaplains and the health care team.

A unique development at High Point is a spiritual assessment and care planning tool, a list of questions asked of all patients upon admission that explores their own hopefulness, inner resources, family situation, personal distress, and recent major changes in their lives. The responses help the team gain a deeper understanding of patients' emotional needs.

Staff members help patients and families resolve difficult end-of-life issues the same way they handle all other issues in the hospital — seeking a win-win solution. A health care team conference is held for every palliative care patient, and problems are discussed until resolved. "You pull in these folks and sit down and come up with the plan," explains social worker Karen Chance. "You include the patient in the planning, along with the family, and talk about the options."

This global, team-oriented approach — in which patient choice is a central tenet — has made High Point unique for many years, and not just in terms of palliative care. "I'll go to meetings with social workers from other hospitals, and our model is very unique," says Chance. "We work hand in hand. It's very much the culture here."

These changes have resulted in more patients having plans in place for end-of-life care. Advance directives, which are tracked in a pastoral care database, were completed prior to admission for 64 percent of patients in 2004, up significantly from 47 percent the year before. Also, more patients with diagnoses other than cancer are being referred to hospice, an indication that there is a broader understanding among the staff and physicians about the appropriateness of palliative care for all chronically- and terminally-ill patients.

The hospital ethics committee, where the end-of-life issue began, now sees very few wrenching crises because decisions are made earlier in the patient's illness. Direct patient caregivers feel more confident that patients' values and wishes are being honored. "People were really struggling with end-of-life care," says Wakefield. "We're creating a culture where we're not seeing the end of life as giving up hope, but redefining hope." •