

IMPROVING RESPONSE TO LIFE-THREATENING ILLNESS

The Nationwide CALL Care Project Involved 11 Catholic Organizations

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The Full CALL Care Report

This article is adapted with permission from the full report, *CALL Care: Building on Organizational and Community Strength in Providing End-of-Life Care*, which, together with an executive summary and a video, is available for \$15 from Supportive Care of the Dying: A Coalition for Compassionate Care, 4805 Glisan St., Room 2E07, Portland, OR 97213; or contact www.carol.lieberman@providence.com. Some of the information contained in this article appeared in the Spring 2003 issue of *Supportive Voice*, the coalition's newsletter.

The way we die in America has changed dramatically over the past century. Advances in medicine, technology, and increased life expectancy have moved the locus of care out of the home and away from the family. Yet, when we listen to them, Americans tell us that they want to die at home, surrounded by their family and friends. Further, they want health care providers to understand that in the weeks and months preceding their deaths they are *alive* with all the needs for connection, a sense of well-being, and meaningfulness that that implies.

The Catholic health care ministry has a clear commitment to easing the journey as individuals move toward death. As the *Ethical and Religious Directives for Catholic Health Care Services* puts it: "Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death.

What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness."¹

Unfortunately, too often patients and families report themselves overwhelmed by the complexity of the health care organization, without the strength or knowledge to organize necessary resources, and feeling as if their lives have been "taken over" by the demands of the illness and the routines of the health system. Cognizant of this, a group of Catholic health care organizations developed an innovative demonstration project, "CALL Care," to address these very issues. The project was organized by Supportive Care of the Dying: A Coalition for Compassionate Care, which comprises 15 organizations, including CHA, dedicated to improving end-of-life care in this country. Funding was provided by a grant from the Robert Wood Johnson Foundation (through its Promoting Excellence National Program) and the coalition, with additional support from individual participating sites. The project was initiated in August 2001 and completed in February 2003.

BACKGROUND OF THE PROBLEM

In contrast to the situation a century ago, national data reports that 80 percent of those who die in the contemporary United States do so after lengthy, progressively debilitating illnesses. The illness may be cancer, heart disease, respiratory disease, dementia, or any one of a number of others. In any case, the timing of death is likely to be unpredictable. The patient may experience episodes of acute illness from which he or she temporarily recovers, or he or she may experience progressive decline without acute illness. Either way, energy and strength decrease over time. Typically, people make adjustments and seek to



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live their lives in a manner that is meaningful to them even as the disease progresses. They have goals, family, and friends with whom they enjoy spending time and sharing dreams for the future. None of those dreams or goals is likely to include spending their days in health care organizations or focusing all of their life energy on interactions with the health system. Yet for some, this is exactly what happens.

As the disease progresses, the sufferer's needs may increase beyond his or her ability to meet them. The person often requires practical assistance in order to maintain a satisfactory quality of life. For example, shopping for groceries, housecleaning, or meal preparation may require more energy than the ill person has. He or she may need assistance in scheduling and keeping doctor's appointments or in understanding and taking medicines. He or she may not be able to engage in a favorite and meaningful hobby. Especially poignant is the person who does not have close friends or family and experiences loneliness and isolation. As decline progresses, the complexity of interactions with the health care system increases just when the person has less energy to successfully manage the multiple interactions required for care.

The symptoms of life-threatening illness, which are usually progressive, may include pain, nausea, vomiting, shortness of breath, and many other physical changes. Without aggressive symptom control, physical distress increases. Patients may also experience spiritual "dis-ease" during the illness and treatment.

How can this scenario be different for the patients we serve? For some, hospice care will address many of the issues; the patients who get it will be supported in living fully through their last days. However, nationally only 21.5 percent of Medicare-age people receive hospice care prior to death, according to Means to a Better End (MTBE).² The remaining 78.5 percent may not meet the hospice enrollment criteria of a predicted six months of life remaining, even though they frequently require hospice-type services. Some patients may be referred to a palliative care team for support, but these teams tend to be hospital based. Their scope may be limited to health care concerns and is not intended to address the full array of problems that arise for a person who has a life-threatening illness.

CALL CARE: PHILOSOPHY AND INTERVENTION

CALL Care (comprehensive, adaptable, life-affirming, longitudinal care) is one approach that has the potential to address the needs of those for whom hospice care is not yet appropriate and for whom existing palliative care is incomplete. The

program's creators developed and implemented demonstration programs at 11 sites across the United States (see **Box**).

The staffs at each of the selected sites indicated a deep commitment to excellence in care for those with life-threatening illnesses. Some sites already had strong palliative care teams and services. Others did not. CALL Care services were based in urban and rural acute care, long-term care, and physician practices. Each site had a project coordinator who was responsible for linking services for the benefit of the patient, sometimes in unconventional ways. Regardless of where services were based, all sites provided services that reached across traditional boundaries to provide the continuity of care needed by seriously ill patients and their families.

The key to success at all sites was a focus on the person being served, not on the structure and limits of current services. Many patients and families were visited in their homes or at clinical appointments as part of the program. Although each site developed its own approach, congruent with the site's strengths and culture, there was consistency across all sites in who was served and how services and outcomes were evaluated. Thus CALL Care was conceptualized and designed to build on organizational and community strengths in providing end-of-life care.

IMPLEMENTING THE PROGRAM

At each of the 11 sites the program's leaders:

- Built on existing local initiatives and community strengths
- Developed strategies to identify those for whom the services would be beneficial
- Created a fabric of comprehensive, continuous, and adaptable life-affirming services and support
- Measured the effectiveness of the programs and services involved, using consistent measurement methods and tools, thus allowing for comparisons across project sites

Services were available through the participating health care system or in the community within which the person lived. The services' structures and methods of delivery differed according to the site involved. Despite these differences, all sites provided:

- A holistic approach to patient care, including assessment and treatment of discomfort in all symptom areas, psycho/social assessment and counseling and/or support, and spiritual assessment and support
- Care management/care coordination
- An interdisciplinary care team that included the patient and his or her family
- Palliative care and pain- and symptom-man-

The Participating CALL Care Organizations

The 11 CALL Care sites are:

Good Samaritan Health Center of Merrill, Merrill, WI (Catholic Health Initiatives)

Holy Cross Hospital, Silver Spring, MD (Trinity Health)

Mercy Rehabilitation and Care Center, Roseburg, OR (formerly part of Catholic Health Initiatives)

Our Lady of Lourdes Regional Medical Center, Lafayette, LA (Franciscan Missionaries of Our Lady Health System)

Sacred Heart Medical Center, PeaceHealth-Oregon Region, Eugene, OR (PeaceHealth)

Providence Hospital and Medical Centers, Southfield, MI (Ascension Health)

St. John Neumann Nursing Home, Philadelphia (Catholic Health Care Services, Archdiocese of Philadelphia)

St. John's Regional Medical Center, Joplin, MO (Catholic Health Initiatives)

St. Joseph Mercy-Oakland, Pontiac, MI (Trinity Health)

St. Mary's Hospital and Medical Center, Grand Junction, CO (Sisters of Charity of Leavenworth Health System)

Via Christi Regional Medical Center, Wichita, KS (Via Christi Health System)

agement services

- Patient/family education concerning the health care system, illness treatment and symptoms, care giving, and approaching death
- Advanced care planning, including assessment of life goals
- Communication of the patient's preferences, values, and care needs to all those providing care

across the continuum

- Access to medication assistance programs, including education and financial support
- Other needed services (e.g., homemaker services, personal aide, etc.)
- Family support throughout care giving and bereavement, including respite and long-term support during bereavement

What Participants Have Said about CALL Care

"This approach is about caring for the person and the family—getting to know them, providing what they need when they need it, being open to their timing, and loving them while respecting the dignity of the person and the mystery of the journey. Each person and family is so different, the approach and services need to be tailored to them."

—Susan Stempky, RN

CALL Care Coordinator
St. Joseph Mercy-Oakland
Pontiac, MI

CALL Care is comprehensive. Its services include strategies to meet physical, emotional, spiritual, and relationship needs. These services are designed for both the ill person and the family caregiver, as defined by the ill person (from CALL Care: Building on Organizational and Community Strength in Providing End-of-Life Care).

"We have one patient who is a 55 year old woman with advanced cancer. Her daughter is pregnant and [the patient] really wanted to be there for the birth of her grandchild, so she could hold it. It became clear she would not live that long. One member of the team went to OB and asked if they could do an ultrasound so [the patient] could see her grandbaby. The nurse and an OB physician came over on their lunch break. The grandma held her daughter while they did the ultrasound. . . . [They] showed her the baby, its finger and toes and other features. She was able to hold both her daughter and the grand-baby. She 'saw' the baby. It was beautiful!"

—Peggy Nelson, RN, MSN

Director of Clinical Health Initiatives
St. Joseph Mercy-Oakland
Pontiac, MI

CALL Care is adaptable. Its services are flexible, designed to fit the needs of both the patient and the caregiver. The approach focuses on linking appropriate existing services, developing new services only when gaps in continuity of services between the community and health care organizations are evident. Services should be accessible within the context of a variety of funding or reimbursement strategies.

"I have one patient I only contact and hear from by e-mail. I get an e-mail from him and figure out how to address his concerns or problems. I e-mail him the answers and then I

never hear back until another situation occurs. I know that he depends on our connection to get his care needs met. Also, I don't worry about him because I know he will contact me if he needs any assistance. We have that kind of relationship."

—Bonnie Patrick, MSW

Social Worker
Providence Hospital and Medical Centers
Southfield, MI

CALL Care is life-affirming. Although people identified for its services are likely to be facing the last phase of their lives, those services focus on assisting the patient and family caregivers to live fully and meaningfully within the limits of the illness and each person's goals.

"One patient has severe anxiety attacks when leaving the house. I was able to work with him to take his medicine before he left so he was more comfortable being out. Also, he was very alone, so our chaplain reached out to him. They have become friends and they actually went golfing. This man loved golfing and had not been able to go for more than a year."

—Michelle Sparling, RN

Palliative Care Coordinator
Providence Hospital and Medical Centers
Southfield, MI

CALL Care is longitudinal. Program plans are designed to identify people whose illnesses are progressive and will potentially lead to death. The selection criteria focus from the time an illness is identified as life-threatening, even if prognosis or life expectancy is unknown. This strategy addresses problems associated with timely referrals to end-of-life services and programs.

"I followed one patient as she was hospitalized in three different hospitals and health organizations within a year. The son would call me with each change. In a couple of situations, I was able to offer suggestions that improved her level of comfort, because I knew her so well. Her doctor lost track and I was able to keep him up to date. At the end, the son called me to be with him as he made the decision on behalf of his mother to discontinue the ventilator."

—Michelle Sparling, RN

Because CALL Care programs were designed to meet the individual needs of patients and families, interventions varied widely from site to site. These various interventions included:

- Providing excellent symptom management
- Creating the opportunity for the patient and family caregivers to have a facilitated discussion concerning the possibility of the patient's dying and to clarify goals and issues
- Linking patients and families with community programs that provide excellent supportive services
- Arranging, in one case, for legal consultation for a worried grandmother
- Reminding a patient by e-mail to keep physician appointments
- Arranging for oxygen for a woman who "did not qualify" but for whom the oxygen made a significant difference in her quality of life
- Arranging transportation
- Helping patients apply for benefits under Medicare or Social Security
- Assisting patients to enroll in medication-assistance programs
- Providing spiritual support for patients and family members
- Interpreting medical and medication instruction

At all sites, CALL Care was about being an advocate for the patient who had difficulty managing the health care system or—if advocacy was not needed—simply being a loving, caring presence in a complex system. The patients served were very ill, with complex physical, psychosocial/emotional, and spiritual needs. Their needs—and thus the services required—likely would have gone unmanaged without CALL Care. The program did not duplicate other services—it aligned itself with and enhanced available services.

DIMENSIONS OF CALL CARE

Outcomes and Successes The leaders of CALL Care programs assessed outcomes from the perspectives of the patient, family, and the health care organization. In this article, we highlight a sample of information about the outcomes for those who participated in those programs. It is important to note that although 295 participants were enrolled in CALL Care, the response rate from questionnaires significantly declined over time. Thus the information regarding outcomes should be considered as a set of possible outcomes that others may achieve with similar programs (see **Table: Completed Forms**).

Patient and Family Data The program's participants were primarily white, of Medicare age and lower

**Table:
Participant
Demographics**

Race	Caucasian: 88%
Residence	Home: 70%
Income	Less than \$25,000: 64%
Age	Medicare age (Average 72)
Gender	Female: 62%

Table: Completed Forms

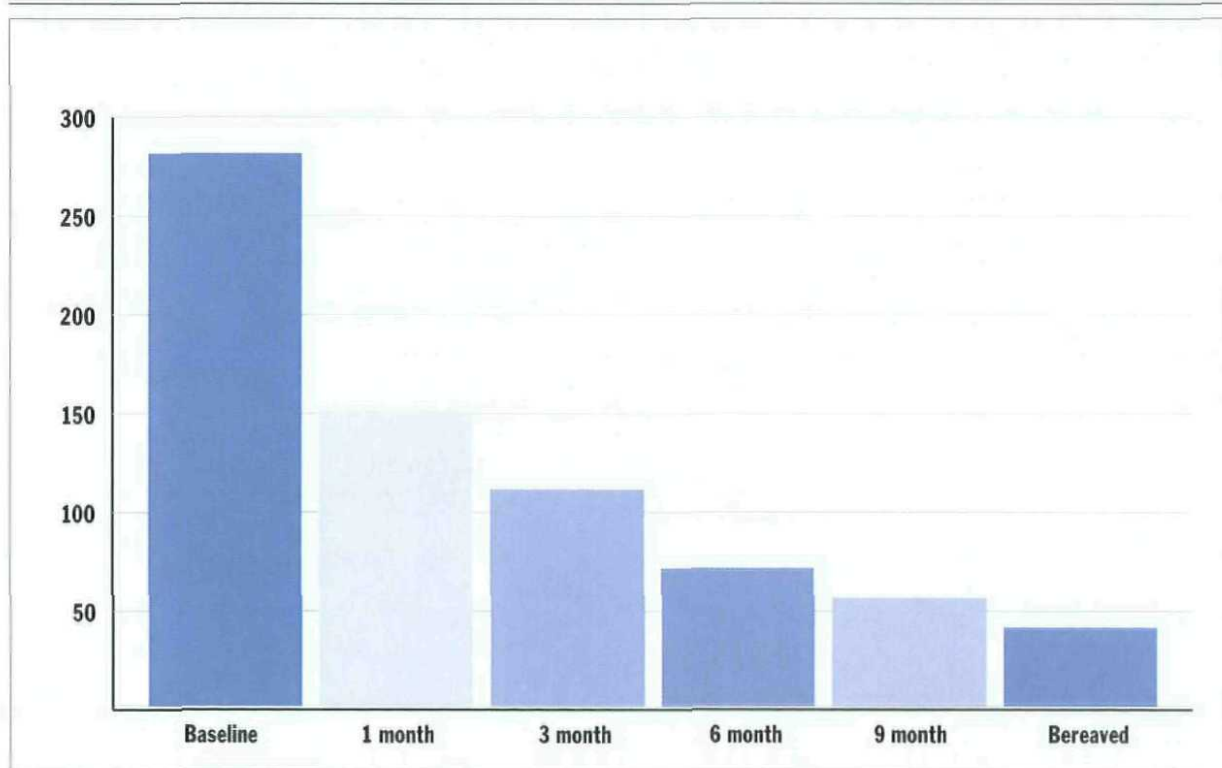


Table: Hospice Referrals

Patients Approached (N = 681)	15% (N = 103)
Overall CALL Care (N = 285)	21% (N = 55)
CALL Care Living (N = 179)	8% (N = 15)
CALL Care Died (N = 82)	49% (N = 40)

income, living at home, and female. These statistics are consistent with expected demographics for this population with the diagnoses and admission criteria as defined (see **Table: Participant Demographics**, p. 29).

Pain Rating Survey data indicated that successful pain management for the CALL Care population was strong (see **Table: Average Pain Scores**). The baseline rate, using a 0 (least) to 10 (highest) scale, is very similar to the mean pain rating of 4.39 when the Modified City of Hope Patient Questionnaire was administered in 1999.³

Important also were the increase over time in the number of patients reporting their pain at a 0-3 level (low) and the decrease over time in those reporting pain at the 7-10 level (high). The number of people reporting low pain increased from 32 percent to 56 percent, while the number reporting high pain decreased from 38 percent to 20 percent.

This indicates a trend but may also reflect the bias of those who were well enough to respond or chose to respond. Still, all participants had progressive illnesses and, at a minimum, the population experienced no worse pain over time. Even among those patients who eventually died, pain and other physical symptoms showed an improvement from the baseline.

Hospital Experiences Of the progressively ill participants receiving CALL Care services, only 29 per-

cent had any inpatient hospital stays; an additional 7 percent had critical care admissions (see **Table: Inpatient and Critical Care Admissions**, p. 31).

Although we don't have comparison data for those 65 or over by diagnosis, the MTBE report indicates that 3.4 percent to 17.3 percent (mean 10.1 percent) of Medicare participants who died had critical care stays greater than seven days during the last six months of life.⁴ Also, a study reported in the *New England Journal of Medicine* indicates that 70 percent of Medicare expenditures in the last 12 months of a person's life were for inpatient hospitalizations.⁵

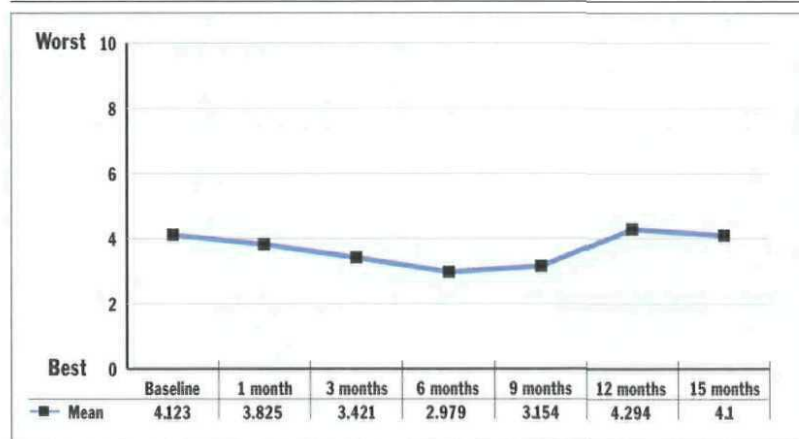
Hospice Referrals Hospice as a "gold standard" of care is important to consider in the equation. In this area, there is still much room for improvement. Of the 681 people approached, 295 were already enrolled in CALL Care (see **Table: Hospice Referrals**). Of the others, 103 were referred directly to hospice because hospice care was determined to be more appropriate. MTBE reports hospice referrals for Medicare enrollees who died ranging from 4.9 percent to 42 percent across all states, with a mean referral rate of 21.5 percent.⁶ For all participants, the rate was similar. However, it is important to remember that not all of those enrolled in CALL Care would qualify for a hospice referral. Referral criteria to CALL Care required that death was not imminent and that patients and/or their physicians had not indicated a readiness for hospice.

Deaths Of the people enrolled in CALL Care, 94—or 32 percent—died during the study. We were able to identify, earlier in their illnesses, people who would benefit from CALL Care-type services. Those who died received CALL Care services for a mean of 64 days, with a median of 38 days. Of those, 53 participants (38 percent) died at home. Given that MTBE reports that 70 percent of us indicate a desire to die at home, this compares favorably to the national rate of 24.9 percent of deaths occurring at home.⁷ Additionally, only 34 percent of the CALL Care enrollees died in the hospital, compared to a national rate of approximately 50 percent (see **Table: Location of Death**, p. 31).⁸

GUIDING PRINCIPLES

The outcomes reported by the sites involved in the CALL Care project can serve as guidelines for other organizations striving to improve their delivery of end-of-life services. Two guiding principles, both of which can be instructive to health care providers, emerged from the experiences of the CALL Care sites.

CALL Care Leads to Cultural Change At each site, the project was implemented to complement current strengths in a way that honored the culture of

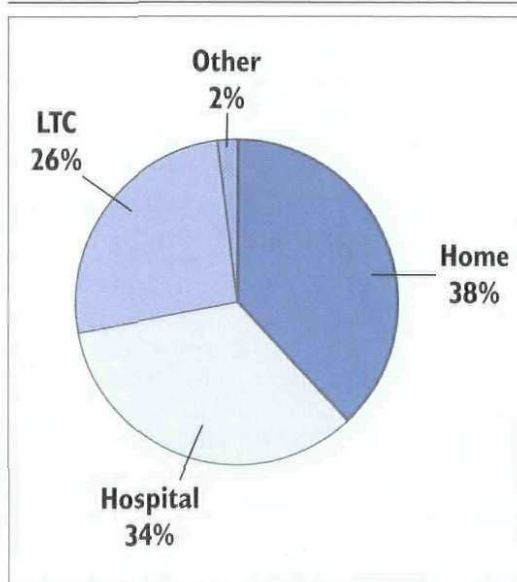
Table: Average Pain Scores

that site. Referrals started slowly. However, at most sites the need for the services outgrew the resources identified for the project, and team members needed to continually reassess priorities of service and establish collaborative partnerships with other programs, both those in the health care organization itself and those in the community.

There is evidence that, within the 18 months of the grant services (12 months for some, due to a delayed start-up phase), a cultural change in the organization had occurred. This is supported by the continual growth in number of referrals and consults, requests for additional education, the use of standardized order sets by a variety of physicians, and the establishment of quality-improvement initiatives for care of those with life-threatening illnesses. At even the sites that were unsuccessful in identifying people who could benefit from the services and enrolling them in the services, there was a growth in understanding of the possibility of care needs and greater understanding of the culture of the community. This allowed for redefinition of programs and services.

CALL Care Is Economical With the cost pressures on health care today, it seems paradoxical to suggest that enhanced services may in fact reduce costs. Yet the data suggests that this is one outcome of the CALL Care approach. CALL Care services were not necessarily reimbursable, yet they proved to be of great benefit to patients with complex needs. The services focused on improving the quality of living with a life-threatening illness.

Table: Location of Death

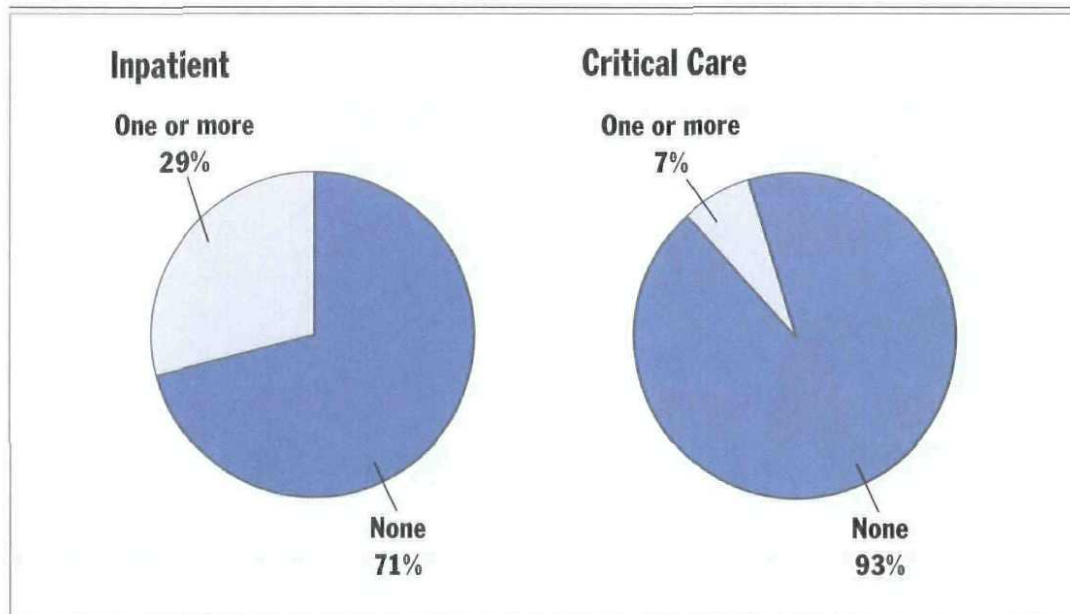


ening illness.

The full report of the data concerning CALL Care's outcomes and successes indicates that providing services to the patients involved may have resulted in cost avoidance. The implementation of CALL Care services could, therefore, be considered "good economics" from a cost-avoidance standpoint for health care.

Sometimes, for example, referrals to hospice were facilitated from the person's home without

Table: Inpatient and Critical Care Admissions



requiring an intervening, expensive hospitalization. Moreover, the avoidance of costly hospital stays—and even more expensive intensive care stays—was made possible by the interventions provided. Care coordinators helped patients and their families prevent crisis events and articulate goals. (Emergency department visits were not tracked, which is one weakness of the data). And because the care was focused on specific patients, it tended to ensure that the treatments most likely to achieve the patients' and families' goals were arrived at quickly. Thus, even considering the cost of paying the care coordinator, the economies built into the approach made CALL Care economically feasible.

ADOPTING A CALL CARE APPROACH

This article provides an overview of CALL Care's processes and outcomes. Those organizations considering a CALL Care-type program should review the full report for a more in-depth discussion. Despite their differences, the 11 sites offered some recommendations in common. The sites were clear about the factors that made their programs successful.

The sites agreed that a health care organization considering the adoption of a CALL Care approach should:

- Identify an administrative "champion" and a physician "champion"
- Appoint as the program coordinator a person

Oregon Facility Forms a Terminal Care Team

As one of two care centers chosen nationwide to participate in a CALL Care project, Umpqua Valley Rehabilitation and Nursing Care Center (formerly Mercy Rehabilitation and Care Center), Roseburg, OR, has worked to build upon organizational and community strengths to provide innovative end-of-life care. This includes comprehensive strategies to meet the physical, emotional, spiritual, and relationship needs of ill people and their families.

Every year approximately 62 to 80 patients/residents, none of whom were admitted specifically for it, receive terminal/palliative care at Umpqua Valley. Because of the great need for such service, in 1999 a group of professionals who served what was then Mercy Rehabilitation and Care came together to form what they called the Catherine McAuley Terminal Care Team.* The team consists of social workers, licensed nurses, CNA caregivers, pharmacists, and clergy members. The McAuley Team attempts to assign a team member to each terminal-care patient/resident. The team member follows the case and

remains in touch with the patient/resident and family, helping identify any physical, psychosocial, or spiritual needs that may arise. The team looks at the person holistically, making every effort to maintain the highest quality of life for both patient and family. It provides the care and support that allow both patient and family to live as abundantly and comfortably as possible during the patient's remaining days.

The McAuley Team is highly motivated, having a great desire to move to the cutting edge of palliative care and to live out the core of Umpqua Valley's mission: "creating a healthier community." The team has developed expertise in managing pain and has a great deal of pastoral support and psychosocial support. It saw, however, that developing new traditional and nontraditional methods to support both patients and their families through the dying process was the next step it must make to improve services.

When Umpqua Valley became part of the CALL Care Project, it sought volunteers from among staff members. These volunteers were given initial training and have received continuing education at bimonthly meetings. The new recruits brought with them fresh insights and recommendations for improved care. Meanwhile, McAuley Team leaders continue to seek new CALL Care volunteers, closely observing staff members' behaviors and habits and recruiting those who seem committed to providing high-quality care and are especially sympathetic to

the terminally ill.

CALL Care has helped Umpqua Valley establish a strong rapport with other health care facilities and with its own community. A close relationship has been built with local high schools and the community college. Parish nurses play an active role in the care given to members of their congregation. Continued support from hospice, local churches, and senior services provide support to patients and their families, along with members of the McAuley Team.

Patients helped by the CALL Care project ranged in age from 40 to 90 years of age. Some were near death; others were people who, unsupported by either the family or the community, were in the beginning stages of a terminal disease. Each patient's physical, psychosocial or spiritual needs (and those of his or her family members) were assessed by a member of the McAuley Team. In the cases of all terminal-care patients, the team looks at the person holistically and makes every effort to maintain the highest quality of life for both patient and family. This approach develops strong bonds among the patient, the team member, and family members. After the loved one has died, the team makes continued counseling available to family members.

While they are at Umpqua Valley, patients have access to a variety of services that can help ease the stress placed on them at this time in their lives:

*In September 2003, Mercy Rehabilitation and Care Center became Umpqua Valley Rehabilitation and Nursing Care Center, a for-profit institution. Terry Klein, Umpqua Valley's administrator, said in a November 20 phone conversation that the McAuley Team would continue to provide end-of-life care at the facility.

who will be passionate about the work and charismatic in his or her approach

- Educate all local health care providers (physicians and others) about the program's referral criteria, emphasizing the potential benefits for existing hospice and home health services, physicians, clinicians, patients, and families

- Develop a systematic strategy to identify those who would benefit from the approach. In addition to considering disease status criteria, ask referring physicians, "Would you be surprised if this person is still alive in 12 months?"

- Develop relationships with existing services, such as clinics for chronic congestive pulmonary disease or congestive heart failure. This helps

establish an early-referral pattern and can perhaps prevent crisis events for the patient and family, as well as reduce costs to the organization

- Implement an interdisciplinary team case-review process

- Collect longitudinal data from the organization, patient, and bereaved family

- Benchmark services and outcomes against other, similar organizations

- Network and partner with existing community programs

- Partner with community faith-based parish nurse programs and/or health ministries

- Reach into the patient's home environment

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music therapy, pet therapy, arts and crafts activities, and massage therapy. Counseling services are also available to the patient and his or her family. Student volunteers spend time with patients, chatting and being comforting. A pharmacist is available to answer patients' questions about medications. Other services are:

- Advanced care planning, which begins at time of admission, when the care team interviews the patient and family

- Access to medication-assistance programs, which help patients get medications they are unable to pay for

- Family/caregiver support, which offers in-house education and community educational programs to caregivers

- Hospice care; Umpqua Valley has its own palliative care team

Pain management is a round-the-clock service, beginning at the time of admission. Using the "1 to 5" pain scale, the nursing staff assess patients during every shift for signs and symptoms of pain. The staff—which has been educated on pain management and consults with a pharmacist or hospice liaison on an as-needed basis—sees to it that appropriate pain relief is provided to each patient and adjusted when necessary.

The majority of Umpqua Valley patients choose to use spiritual support, which also begins at the time of admission. Patients and their families are visited at least four times a week; Umpqua

Valley has three different faith services that patients and families can attend weekly in-house. Pastoral care is in-house six days a week and on-call on the seventh day.

For the care of the body after death, Umpqua Valley has established a ritual to soften the harshness of an institutional setting, affirm that all life is cherished by God, and yet be simple and easy to perform by staff. An atmosphere signifying reverence, dignity, and the sacredness of the occasion prevails in these rituals.

Sr. Mary Kenny, RFS, the chaplain at nearby Mercy Medical Center and a member of the McAuley Team, initiated the ritual. For it she selected a brief prayer, readings from Scripture, and appropriate hymns. During the ritual a CD, created especially for such occasions, softly plays instrumental music to the hymns. The body is anointed with perfumed oil, and an air of sacred presence pervades the ritual. A three-ring binder holding the prayer, readings, and hymn lyrics is provided to staff and family members.

The final blessing, with perfumed oils, takes place as care center personnel wash and care for the body of the deceased. This action allows staff to say goodbye to a patient for whom they may have provided care for months or even years. It reminds all who are present that the heart of our vocation as health care providers is a call to compassion and healing. It gives family members the

solace of seeing their loved one honored and sent with hope into the eternal.

As the deceased patient is blessed, those present thank God for the gifts, joys, and happiness he or she shared with family and friends. It is recalled that the body is sacred, created in the image and likeness of God. Those present call upon God's mercy and love and ask that angels accompany the deceased to the throne of God. In anointing the patient's forehead and feet with holy oil, they are reenacting Jesus' anointing at Bethany and "sealing" the patient in the hope of life everlasting, with a gentle hand.

Umpqua Valley staff members who have participated in the CALL Care project say that four things are essential to good care. Such programs should:

- Educate staff members concerning life-threatening illnesses and end-of-life care

- Recruit a good holistic care team, including a representative from social services, a pharmacist, someone from pastoral care, and the activities director

- Develop a system whereby patients likely to benefit from the program are identified and their needs are analyzed

- Acquire instruments with which the program's success can be measured

When instituting a CALL Care program, a facility's leaders should inform the community about it, in the expectation of receiving community referrals. This information should be continually improved so that it reaches as deeply as possible into the community.

MINISTRY LEADERSHIP

Continued from page 11

always transformative in some way. In our pilgrimage, we will be emphasizing the themes of openness, attentiveness, and responsiveness, strengthening these characteristics for leadership." Speier said that during the retreats, participants will work with poetry and wisdom stories as an entry point to examining leadership. "We will give them some food for thought, questions to think about, and ways to process them such as silent reflection, Tai Chi, a process of structured dialogue and silence in triad groups known as 'the power of threes,' and peaceful walks in nature."

Also, during the retreats, participants will work with concepts about relationship and open dialogue from Margaret Wheatley's book, *Turning to One Another: Simple Conversations to Restore Hope to the Future* (Berrett-Koehler, San Francisco, 2002). Speier said the pilgrimage will focus on the self-awareness that is necessary for a leader to be in right relationship with self, others, creation, and the sacred. "Personal transformation may lead to community transformation and even global transformation," she said.

Dates for the 2004 Leadership Pilgrimage retreats are February 26-28, June 3-5, and September 30-October 2. All the retreats will be held at the Canyon of the Eagles Resort and Retreat Center just outside Austin. The fee for the entire program, inclusive of room and board, is \$3,000 per person. For more details and to register, contact Speier at pspeier@seton.org.

PATHWAY TO FRANCISCAN EXCELLENCE

The Franciscan Missionaries of Our Lady (FMOL) Health System in Baton Rouge, LA, has implemented a new approach to developing leadership throughout its workforce. On page 49 of this issue of *Health Progress*, FMOL Health System President and CEO John J. Finan, Jr., the system's vice president for health ministry, Cindy Heine, and its sponsor, Sr. Barbara Arcenau, OSF, describe the process of creating "My Pathway to Franciscan Excellence." □

CALL CARE PROJECT

Continued from page 33

- Continue to seek feedback from the population served regarding changing service needs and recommendations for addressing them

CALL CARE ACCOMPLISHMENTS

Although the 11 CALL Care sites faced some challenges as they developed their programs and recruited participants for them, they succeeded in improving coordinated care for the people enrolled. The participating organizations:

- Identified appropriate patients and referred them to the service
- Made more frequent hospice referrals
- Managed symptoms well over time
- Continued to build the infrastructure for excellent palliative care
- Formed partnerships and networks in the community to work for better care
- Provided care that may have helped preclude crisis events and inappropriate and expensive hospitalizations

By working to carry out the healing ministry of Jesus, CALL Care represents a visible statement of Catholic identity in health care. People served by the Catholic health care ministry should expect no less: care that honors their lives and their human dignity and strives to comfort and heal even when cure is not possible. □

NOTES

1. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Introduction to Part Five, Washington, DC, 2001, p. 29.
2. Last Acts, *Means to a Better End: A Report on Dying in America Today*, 2002, which can be found at www.lastacts.org/scripts/la_tsk01.exe?FNC=BetterEndHome_Ala_newtsk_laxlike.html.
3. The questionnaire can be seen at www.careofdying.org/default.asp?goto=Tools/family_quest2001.html.
4. Last Acts.
5. J. D. Lubitz and G. F. Riley, "Trends in Medicare Payments in the Last Years of Life," *New England Journal of Medicine*, vol. 328, no. 15, April 15, 1993, pp. 1,092-1,096.
6. Last Acts.
7. Last Acts.
8. Last Acts.



A Shared Statement of Identity For the Catholic Health Ministry

We are the people of Catholic health care, a ministry of the church continuing Jesus' mission of love and healing today. As provider, employer, advocate, citizen—bringing together people of diverse faiths and backgrounds—our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit.

We work to bring alive the Gospel vision of justice and peace. We answer God's call to foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved, and most vulnerable. By our service, we strive to transform hurt into hope. ✎

As the church's ministry of health care, we commit to:

- Promote and Defend Human Dignity
- Attend to the Whole Person
- Care for Poor and Vulnerable Persons
- Promote the Common Good
- Act on Behalf of Justice
- Steward Resources
- Act in Communion with the Church