

#### PULLMAN REGIONAL HOSPITAL'S PALLIATIVE CARE **JOURNEY** 2006.....



#### END OF LIFE CARE NURSING EDUCATION CONSORTIUM (ELNEC)



### COMMUNITY – WIDE POLST FORM TRAINING AND FACILITATION 2010



# PALLIATIVE CARE SABBATICAL AT THE VA HOSPITAL IN FRESNO CALIFORNIA 2012



### TO QUALITY OF LIFE TEAM



## WHITMAN COUNTY ADVANCED CARE PLANNING FACILITATORS 2013



## PARTICIPATION WASHINGTON STATE HONORING CHOICES PACIFIC NORTHWEST 2014 - CURRENT



## PULLMAN COMMUNITY CARE TRANSITIONS INTERAGENCY CONVERSATIONS BEGAN 2014



## NATIONAL HEALTHCARE DAY OF DECISION WAS RECOGNIZED WITH VARIOUS ACTIVITIES ANNUALLY

Advanced Care Planning
Being Mortal movie review
Gift of Grace game



# PARTICIPATION WITH THE UNIVERSITY OF WASHINGTON PALLIATIVE CARE TRAINING PROGRAM 2015

https://www.youtube.com/watch?v=XsULh\_Y5fqw



PALLIATIVE CARE IS SPECIALIZED CARE FOR PEOPLE WITH CHRONIC ILLNESS AT ANY STAGE OR SERIOUS ILLNESS. THIS TYPE OF CARE IS FOCUSED ON PROVIDING RELIEF FROM THE SYMPTOMS AND STRESS OF A SERIOUS ILLNESS. THE GOAL IS TO IMPROVE QUALITY OF LIFE FOR BOTH THE PATIENT AND THE FAMILY. PALLIATIVE CARE FACILITATES PATIENT AUTONOMY, ACCESS TO INFORMATION, AND CHOICE. THE PALLIATIVE CARE TEAM **HELPS PATIENTS AND FAMILIES UNDERSTAND THE** NATURE OF THEIR ILLNESS, AND MAKE TIMELY, INFORMED **DECISIONS ABOUT CARE.** 

PALLIATIVE CARE IS APPROPRIATE AT ANY AGE AND AT ANY STAGE IN A SERIOUS ILLNESS, AND IT CAN BE PROVIDED ALONG WITH CURATIVE TREATMENT.



Quality of Life Team

End of Life Nursing Education Consortium Training

Follow up phone calls

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Center for Advancing
Palliative Care
members

Health coaching

**CISM** 

#### Palliative Care Services

**ACO** 

Continuum of care relationships

Advance Care Planning Team

Follow up phone calls

PCP and behavioral health integration with PFM and PM

My Gift of Grace

#### **PULLMAN'S NEXT STEPS**

- 1. Train palliative care consultants
- 2. Create a palliative care referral service
- 3.Educate healthcare providers on the chronic care management resources available in the community
- 4. Create a Transitional Care Team