PATIENT PARTNERS: BETTER CARE
One of the most humbling things about the work we do at Dartmouth-Hitchcock is the trust our patients and families place in us. As physicians and caregivers, we never forget what an honor it is to be entrusted with our patients’ care.

With such trust comes responsibility. We must maintain the highest standards of clinical excellence, but we must also excel in making every encounter a patient or family member has with Dartmouth-Hitchcock the best it can be. From the initial phone call to make an appointment through the care process, follow-up and recovery, the experience for the patients and families who come through our doors—15,000 a day at the medical center alone—should be a good one.

In this issue, you’ll read about some of work we are doing across a broad spectrum to improve the patient and family experience throughout Dartmouth-Hitchcock and our affiliate sites. I’m pleased to say that, in six out of the nine measures used nationally to assess patient experience, Dartmouth-Hitchcock ranks higher than the national average. While we’re working to be at the very top in all nine measures, it is rewarding to know that our patients are expressing satisfaction in important areas such as physician and nurse communications, discharge instructions, and responsiveness to their needs.

Thank you for trusting us with your care and for helping us to improve for all the people and communities we serve, for generations to come.

Thank you.

Dr. James N. Weinstein
CEO and President

Dr. James N. Weinstein, CEO and President, with Thidwick, a sculpture donated by a grateful patient and family.
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Alejandra Casco, 36, recalls the moment in 2010 when she was diagnosed with Stage IV melanoma, and told there was a 6 percent survival rate.

“While I was praying, I entered into a moment of gratitude and gratefulness for all the good things I had been given in this life. And something just happened; I had a strong presence knowing that I wasn’t going to die against all the facts. I believed the truth in my heart,” says Casco.

Casco says her provider, Marc Ernstoff, MD, (no longer at Dartmouth-Hitchcock) along with all of her nurses at Dartmouth-Hitchcock (D-H), were incredible throughout her care.

“I felt very comfortable with Dr. Ernstoff. He was very kind. I know I was under the best care. I will always remember his words, as he considered the best options for treatments. He related his judgment based on what he would do if I were his own daughter. My nurse practitioner was nurturing and sincere at every step. Brian Highhouse, BSN, RN, and Susan Jones, BSN, RN, were the nurses who administered the infusions. Their presence made the hours in the hospital easier to endure; it was nice to see friendly faces whenever I came in. It was so important to have that be a part of the process. They never just put the needle in and walked away; they interacted with me,” says Casco. “It became my second home. I didn’t know it would be a five-year journey, but I was grateful to be surrounded by them.”

A powerful part of Casco’s healing has been her participation in a regular writing group with D-H’s Norris Cotton Cancer Center’s Marv Klassen-Landis and Laura Foley. The writing brought out a part of Casco that helped her start to journal what’s most important to her and the peace that guides her and comforts her soul. (See page 14 to learn more about the Writing Program at D-H.)

Her diagnosis and treatment made her realize that her passion in life is to meet people, and let them know they are loved, and that somebody cares about them.

Because of this, she has since started volunteering at her church, serving the homeless and visiting the elderly.

“They have a lot to teach me. They have so much to offer and teach about the joy it is to give and to love your neighbor. And, to appreciate the gifts that you didn’t know you had to offer when you are motivated by love,” she says.
Alejandra

our patients

their stories
“Most Americans prefer to die at home, but less than a quarter actually do.” That’s the opening sentence of a journal article on the mismatch in this country between the preferences of seriously ill patients and the reality of their experiences.
Achieving closer alignment between preference and reality is what motivates Kathy Kirkland, MD, Ellen Bassett, MD, and their colleagues in the Section of Palliative Medicine at Dartmouth-Hitchcock (D-H). Kirkland, who’s been at D-H since 1999, is the section’s interim chief. Bassett, who joined the D-H Palliative Care team in 2014 as a staff physician, was previously the medical director of the Concord Regional VNA Hospice House, which provides inpatient care in Concord, New Hampshire. Bassett is the director of Hospice Planning at D-H.

Because of a generous gift from the Jack and Dorothy Byrne Foundation, a new facility—called the Jack Byrne Center for Palliative and Hospice Care—will be built on the D-H campus in Lebanon. Fundraising to meet the construction and programmatic needs is ongoing. The Center’s programs and services will extend beyond the inpatient facility and into patients’ homes and communities. Kirkland and Bassett talk about the soon-to-be-built Center and what inspires their work.

How would you define palliative care and hospice?

**Kirkland:** I think of palliative care as an extra layer of support for patients facing serious, complex illness. And hospice is a subset of palliative care—a similar layer of support for people within the last six months of their lives. But lots of people don’t get into hospice until a few weeks or days before the end of life.

**Bassett:** When I have patients who aren’t sure what palliative care is, I tell them we do three things: manage symptoms; offer emotional support on the rollercoaster ride of a serious illness; and help them figure out what’s important to them, so they can make medical decisions that get them more of the care they want and less of what they don’t want.

**Kirkland:** We also support the family. One of my mentors said, “The patient gets the diagnosis, but the whole family experiences the illness.”

Are there distinctive aspects of D-H’s program?

**Kirkland:** We’ve always emphasized community partnerships, the new Center will strengthen that. We’re planning a facility that will serve the community’s need
for inpatient hospice care and will also become a hub for ongoing regional collaborations with providers of hospice and palliative care services in the region.

**Bassett:** The facility and the larger program will be inextricably linked. The Center will serve a relatively small number of patients who need intensive symptom management that can’t be done at home and will also be an educational hub, while the regional home-hospice services will serve many, many more people. For example, we also have an outpatient palliative clinic, where we support patients, families and referring doctors, helping them with symptom management and decision-making. That’s another area where D-H is ahead of the curve.

**What will the facility be like?**

**Bassett:** The plan is for the facility to have 12 patient rooms, with the ability to expand to 18. All the rooms are private, each with a balcony big enough for an entire bed, so no matter how sick you are you can be outdoors. There’s space in every room for families to stay around the clock. There’s a great room with a fireplace where families can congregate, plus a kitchen, dining room and smaller rooms where they can have privacy outside the patient’s room. It will be as homelike as you can make a facility with 12 beds and lots of nurses.

**Kirkland:** There’s a chapel, too, and space to host concerts and readings for families and patients and educational sessions for community members.

**Bassett:** We want to demystify end-of-life care and help people appreciate that it can be a time of meaning and beauty.

**What’s the response from other clinicians?**

**Kirkland:** They welcome it. It’s hard to care for patients who are dying and who want to be at home, but end up in the hospital because it’s the only place where we can manage their symptoms. The idea of shifting their care to a more homelike setting (and ultimately to home, if possible) makes everyone feel good about providing the right care in the right place at the right time. Eighty percent of Americans say they want to die at home; we want to make that happen.

**Do people have misconceptions about your work?**

**Kirkland:** The most common is that palliative care and hospice mean giving up. People often feel “I have to go down fighting.” That’s why most patients don’t enter hospice until their last days or weeks of life, rather than letting it be a support throughout their final months.

**Bassett:** People think hospice is about dying well—but it’s really about living well in the context of the reality that you don’t have long to live. Our care is fully interdisciplinary; it’s not just nursing care and medical care, but social work, spiritual care, healing arts, creative arts, pet therapy and music therapy.

**Kirkland:** And some people worry that the new inpatient hospice facility is an attempt to institutionalize end-of-life care. But it’s envisioned mostly as a stopping-off

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**“So, what brings you here today?”**

is what a doctor often asks a patient at the beginning of an appointment. The answer is, at its heart, a story. It’s parsed in the medical record into various arcane terms: chief complaint, family history, systems review. But it behooves doctors to look at the patient’s story holistically, believes Kathy Kirkland, MD. She’s interim chief of Palliative Medicine, as well as the torchbearer for several initiatives in an emerging discipline called narrative medicine.

“You need to be able to ‘read’ patients,” she explains. Too often, “doctors approach patients the way you might read a book for plot or might pull out the Cliff Notes and say, ‘I just need to know what happens.’” Instead, Kirkland believes, doctors should pay attention to the structure of the patient’s story and “listen for the metaphors and imagery patients use, the silences and body language ... all the things that can lead to a deeper understanding of who a person is.” It’s like the difference between devouring a beach read and savoring a literary novel, she says.

“If you can train doctors to ‘read’ patients for more than just plot,” she continues, “it allows the medical
Heard, Valued

knowledge the doctor brings to the encounter to be truly integrated with the patient’s verbal and non-verbal input, with what’s important in the experience of that particular patient.” In turn, says Kirkland, that leads to more accurate diagnoses, treatment plans that are better aligned with patient preferences and often better outcomes.

Kirkland (whose college major was English) was intensively mentored by Columbia University’s Rita Charon, MD, PhD (whose doctorate is in English literature). At D-H, Kirkland has led an assortment of narrative medicine groups. Most involve reading and discussing a brief but profound text, then responding to a writing prompt. She’s conducted workshops with her palliative care colleagues, internal medicine residents and general internal medicine faculty. She also received a grant from the Arnold P. Gold Foundation to run a year-long program for surgery interns, designed to help them develop narrative medicine skills with the aim of promoting empathy and communication skills, “to influence their enculturation, to try to intentionally create compassionate surgeons.”

“I really believe” she concludes, “that if you think of science as a ‘way of knowing,’ humanities is one of the basic sciences of medicine.”

What about research?

Kirkland: An important part of the way we see our work is that embedded in the clinical care of patients and families is ongoing teaching and research.

Bassett: We will conduct research on the best way to achieve symptom relief, for example, or on the effects of this kind of care on quality of life for patients and on bereavement risk for survivors.

Kirkland: We also plan to measure whether closer partnerships with home hospice providers prevents unwanted hospitalizations and emergency room trips in the middle of the night and helps more people die comfortably at home.

What about the teaching component?

Kirkland: Our inpatient service has about three to six learners at any given time: a palliative-care fellow, residents and fellows from other programs who rotate on our service, and a medical student or two. We’re trying to increase the number of physicians across the spectrum who can offer primary palliative-care services and support patients with life-limiting illness. We also offer rotations for nurse practitioner students, social work interns and others. We envision increasing these educational offerings as we expand into hospice care. We try to equip learners from a range of specialties with the ability to have serious conversations with patients.
When Sandhya “Sandy” Rao started her first year at the Geisel School of Medicine at Dartmouth in the fall of 2015, she looked forward to getting to know her professors and to bonding with her fellow medical students. What she didn’t envision was the close relationship she would establish with longtime Hanover resident Genevieve “Gen” Williamson, who Rao was paired with through Geisel’s Patient Partner program.

As part of Geisel’s “On Doctoring” course, first-year students are paired with senior citizens in the local community. Joseph O’Donnell, MD, who recently retired from his role as Geisel’s associate dean for Academic and Student Affairs, started the program a few years ago as an elective course. Roshini Pinto-Powell, MD, who oversees the course, made the program part
of the formal curriculum last fall, partly as a tribute to O'Donnell, but also because she felt it was “an important formative experience for all Geisel students to have.

“The Patient Partner program is a good way to combine student involvement and wellness in the community,” says Pinto-Powell, who is also Geisel’s associate dean of admissions. “And if their partner feels comfortable, students are encouraged to go on hospital or clinic visits with them. But we don’t want this to be entirely about medicine. It’s about the experience they have with these community members and the relationships our students build with them. Getting to know these Patient Partners as people will only help our students to be better and more compassionate doctors.”

CONNECTING WITH THE COMMUNITY

More than 50 residents of the Upper Connecticut River Valley area are participating in the program during the 2015-16 academic year, so most of the 94 first-year Geisel students share a patient. The Geisel students meet with their partners a minimum of two times each semester, going to lunch with them, accompanying them to medical appointments or, as in the case of Rao and Williamson, learning more about each other’s lives over tea and homemade cookies at Williamson’s apartment at Kendal at Hanover, a continuing care retirement community.

“I wanted to get involved with the program because I enjoy interacting with students,” says Williamson, a retired Dartmouth College librarian. “I’m awfully interested in hearing about her courses and what she’s learning, and I’m also very interested in her as a person.”

Rao clearly enjoys the friendship and easy repartee she has developed with Williamson. When Rao is asked what area of medicine she wants to specialize in, she smiles when Williamson kiddingly interjects, “I might try to push her into gerontology for selfish reasons. I think she’s going to be a great doctor.” Rao says Williamson, who hikes three miles most Saturdays with a group of Kendal residents, does yoga and plays cello in a small orchestra, inspires her.

“I know one of the goals of this program is for us to get to know our partners as a patient and accompany them to medical appointments,” says Rao. “But I’ve learned a lot from Gen about how to stay healthy, how to stay busy and active.

LIFE-LESSONS FROM DR. GEORGE LITTLE

Geisel students Eric Ndikumana and Sean Sun are also learning the importance of staying active from their Patient Partner, retired DHMC pediatrician and neonatologist George Little, MD. Little still travels the world, attending conferences and volunteering in third-world nations for a program called “Helping Babies Breathe,” which is “an evidence-based educational program to teach neonatal resuscitation techniques in resource-limited areas.” Through the “open-ended conversations” he’s had with Ndikumana and Sun, Little says he tries to make them think about what it means to be a patient, especially an older patient. “I’ve talked to them about my end of life and the medical challenges I face,” he says. “I’m in my mid-70s and relatively healthy so I’ve had to use the medical system less. But it’s still something I think about and something they will need to talk about with older patients.”

Ndikumana and Sun were initially nervous when Little broached the topic of death, but they ultimately appreciated being pushed outside their comfort zone. “One of my big takeaways is that there are delicate issues like death that we
shouldn’t always avoid talking about because often patients do want to talk about them,” says Sun. “George gave us a good opener that we can always use with patients, which is, ‘What might you be concerned about?’”

In addition to “making us comfortable talking about issues that are ordinarily intimidating,” Ndikumana says that Little has also made them think about work/life balance and their personal and professional goals. “He talks about how he’s trying to calculate how much time he has left to do all the things he wants to do, which makes you think about how you want to find the perfect balance in your life before you get too far down the road,” says Ndikumana. “George was just in Nigeria and then he went to Kosovo. When he was younger he did a lot of work internationally, so it’s interesting to see him doing that now again. I would like to emulate that at some point.”

Sun adds, “I feel like Eric and I are very lucky to have someone who is not just the patient but also a professional role model. George is still really engaged in the community and pretty much everyone knows him at the hospital. That’s a big part of why I want to be a doctor; it’s where I find community. So it’s amazing to see that even though he’s retired he still has such a huge impact and lasting legacy.”

GETTING INSIGHTS INTO CHRONIC ILLNESS

Since being matched with her Patient Partner last fall, Geisel student Delaney Osborn has seen firsthand what it’s like to live with a chronic illness. Osborn’s partner, Emily Jones, has a lung condition called mycobacterium avium complex (MAC) and has had pneumonia 22 times. Osborn and fellow Geisel first-year student Joshua Ramos accompanied Jones to one of her pulmonology appointments, where they both listened to her lungs with a stethoscope.

“Emily’s doctor [Harold Manning, MD] is one of our respiratory physiology professors and he was very good about conducting the appointment and teaching us at the same time,” says Osborn. “It was nice seeing what her doctor appointments are like and what a patient with a chronic disease has to do to maintain her health. It was also good to see what he does to put her at ease since this is something I think about a lot in terms of my future patients.”

Jones, a former librarian at Dartmouth and Colby-Sawyer College, has participated in the Patient Partner program for the past two years. “Being around young people is very interesting and you learn a lot,” she says. “I’m also hoping to help guide them in the problems they’ll face, particularly the sensitivity they’ll need to work with older patients and learning to not be distracted and to look people in the eye.”

Osborn is thankful for the insights the Patient Partner program has given her into patient care and patients’ lives. “I was very excited about this program and we’re happy to be matched with Emily, who is so sweet and who we like getting together with,” says Osborn. “The reason I went into medicine was because of the interactions I was going to have with patients and the people I was going to meet. I see this program as a grounding aspect. I think it’s very easy in your first two years of medical school to get caught up in the academics, and this is a way to take a step back and say, ‘This is why you’re here. It’s because of these people and these patients.’”
Evidence shows that the better a person’s relationship with his or her health care provider, the more engaged he or she is in their own health,” says Carol Majewski, MS, MHCDS, RN, and director of Dartmouth-Hitchcock’s (D-H’s) Office of Patient Experience. “To significantly improve population health, people have to want to come to us for care.”

The important relationship between a person’s health and health-care experience inspired the creation of D-H’s Office of Patient Experience, which includes D-H Volunteer Services, the Office of Patient and Family Centered Care, and the Chaplaincy Office. In its busy first year, the Office has begun to engage individuals, departments and advisory groups in an effort to standardize a culture of high-quality service. “With the whole organization on the same path, we’ll draw people to our services and have a bigger impact on individual and population health,” says Majewski.

What is the patient experience?

Majewski: The patient experience includes the feelings and perceptions of all D-H interactions, which are shaped by our organizational culture and the needs and expectations of the individuals we serve. Our goal is for every patient to have an exceptional experience every time they interact with our services.
Is the patient experience a new concern?

Majewski: The patient experience isn't a new concern, but it is changing. We used to think of the patient experience as a doctor visit or a hospital stay. Now we recognize the patient experience often occurs without a person even crossing our threshold. It includes phone calls to make appointments or ask questions, website visits and online consultations, such as using online video chat software system.

The new patient experience definition increases the importance of listening and communication skills. As students, we concentrate on the science of health care. As providers, we have to develop skills that are essential to the patient experience—understanding a patient's values so we can deliver the care he or she wants, making sure patients and families have the information they need to make decisions, earning trust and ensuring safety.

How do you improve the patient experience? Where do you start?

Majewski: We asked ourselves that question and then realized we should ask our patients. We’re here to help them and they have the answers. We’re getting people who have been D-H patients and patient family members involved in committees, and we collect their feedback to decide how we can most effectively improve the quality of our service.

How are you collecting and using patient feedback?

Majewski: Our traditional Patient Satisfaction Survey collects information from patients after a clinic visit, procedure or hospital stay. We use a randomization method to make sure we’re getting enough information without over-surveying people. We use this tool at all of our locations throughout the system. The survey helps us identify trends and themes, but it’s what I call a “rearview mirror” perspective. Survey feedback isn’t actionable. We can’t fix an experience that’s already happened.

We are collecting actionable, real-time data through leadership rounding by nurse managers and the Patient Voices program (see sidebar on next page). Volunteers visit patient rooms to check on how things are going. If there is a problem, it’s reported and solved. For example, a patient might say that he’s having trouble getting rest. Maybe he or she is sensitive to machine noises, or voices at the nursing station are too loud. Family visits might be too frequent or too long. The Nurse Manager can work with the team to make sure the patient is getting some undisturbed hours and a chance to rest. He or she can explain the importance of rest to visitors.

Actionable feedback allows us to improve an individual’s experience and teaches us how to make changes that benefit everyone. Because this program has been successful at our Lebanon campus, we are introducing the concept at our affiliate hospitals as well.

You mentioned that improving the patient experience requires changing the culture and learning new skills. How do you measure progress?

Majewski: We’re using a tool, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which is used across the nation, to capture patient satisfaction levels. And we’re collecting data through other surveys and the Patient Voices program. We’re working on ways to put all that information together to track progress. Eventually I’d love to have a scorecard that captures the patient experience across the continuum of care, every touchpoint, every site that reports patient comments and the metrics that matter most to patients and their families.

How does the patient experience work you’re doing relate to ongoing employee satisfaction work and measurement?

Majewski: When we focus on employee satisfaction, we also see improvements in the patient experience, and vice versa. D-H is working on both in parallel to make this an institution the community chooses for health care and where people are happy and proud to work.

By focusing on the patient experience, we bring employees back to their own “Why?” Why did they choose a career in health care? We re-ignite their passion not only for clinical excellence, but to create meaningful connections with our patients and their families that reflect our culture of caring.

No one thinks of themselves as a patient. “Patient” is our word in health care. People want to be understood, to be treated with dignity and respect, to be safe.”

Carol Majewski, MS, MHCDS, RN
As often as twice a week, Patient Voices volunteers go to their assigned inpatient units to round with patients. “They introduce themselves as volunteers—not staff—and ask patients to describe their Dartmouth-Hitchcock (D-H) experience,” says Licia Berry-Berard, manager, Patient Family Centered Care. “They’re collecting information because we want to understand our patients’ experience, to share with staff what is working well or to improve an experience that has not met expectations.”

The conversations volunteers invite are open-ended and last as long as the patient wants to share his or her story. Patients point out aspects of care that they appreciate, mention nurses and providers who have been helpful or describe problems they’ve encountered. Volunteers encourage them to be as specific as possible so that feedback is actionable and directive.

“Most of the feedback collected during patient conversations is positive,” says Berry-Berard. “When a volunteer hears about an opportunity to improve the patient experience they bring the feedback to the nurse manager. It allows the unit to address the patient experience and problem solve in time to improve the experience of the patient who reported the problem.”

All patient comments are categorized in a database to allow tracking and reporting. “The database is a very valuable part of the program,” says Berry-Berard.

“Positive and negative comments are organized by topic—meals, communication, noise, environment, pain and other variables that describe the patient experience. We can report on each category across the system or by unit to help leaders define quality projects and measure improvement.”

The most valuable part of the Patient Voices program is its staff of volunteers. “They are so invested,” says Berry-Berard. “If they find comments that don’t fit in the database categories, they make sure it’s still reported. One volunteer was invited to a unit retreat to add patient perspective. And nurse managers have come to count on collected data and use it as a management tool.”

Berry-Berard is in the process of recruiting more volunteers to increase the number of patient conversations. This spring, two outpatient units will pilot their own version of Patient Voices that invites patients to provide feedback through phone conversations. “We’re hoping to gather information about the patient experience and address areas of opportunity throughout the D-H system,” says Berry-Berard.
Deb Beaupre began an intensely emotional as well as physical journey in February of 2013. A teacher who lives in the Upper Valley, Beaupre was diagnosed with breast cancer and treated with surgery, radiation and chemotherapy at Dartmouth-Hitchcock’s (D-H) Norris Cotton Cancer Center. She has also participated in several Writing Circles where she has written in the company of other patients and loved ones. “Writing about my illness revealed my emotions in a way that two therapists couldn’t. Interestingly, it still continues to peel layers of understanding for me to help process three years out from diagnosis. Sharing helps in ways I couldn’t have anticipated,” she says.

Writing Circles are led by the Cancer Center’s creative writing specialist Marv Klassen-Landis and by poet and volunteer Laura Foley. Typically, group members write in response to a prompt—a quotation or short poem. Each person writes for several minutes and then decides whether to share.
what they’ve written. “Sharing is easier than I anticipated because the audience is always sympathetic; they are others who are ill or caregivers. They understand and appreciate small things like a word or a phrase that evokes an image or a feeling. I leave feeling lighter because I had no idea what was going to be asked of me, so I didn’t get all tensed up, even if I didn’t know beforehand what I was going to write or say. And no one is pitying anyone and no one is passing out meaningless platitudes,” says Beaupre.

In addition to the Writing Circles, Klassen-Landis works with patients and their loved ones individually, offering free journals and anthologies of patient writing, and sometimes “scribing” patients’ words as they speak—helping them take form as stories, poems, letters or song lyrics. For him a highlight of his work is “our annual event, ‘Telling Our Stories,’ which brings all the arts together and celebrates everyone’s voices: patients, loved ones and staff. We eat together, view patients’ art and listen as we read our poetry and stories or sing our songs.”

Kathy Kirkland, MD, interim chief in the Section of Palliative Medicine, read several of her poems at the 2015 Telling Our Stories event. “I’m both a family member of a patient and a provider. Having your story heard is part of the healing process and the creative process—full meaning is realized by being heard,” she says adding, “Telling Our Stories was like a Bach fugue, the same themes recurring in different forms—poignancy, humor, prose, poetry, singing. It created a sense of shared experience that was healing for all of us. It created a sense of richness and solidarity."

THE ARTS PROGRAM OFFERS MORE THAN JUST WRITING

The Cancer Center’s arts program also includes visual arts, crafts and music. Palliative Care physician Max Vergo, MD, says that hospitals “often take good care of patients’ medical issues, but often are not the best place to have your emotional or ‘soup for the soul’ needs met. The creative arts team helps us care for people in a very personalized way and to process their emotions around illness. A patient’s anxiety about a new diagnosis or complications from a surgery can be supported with calming harp music, with being in nature with the visual artist’s help or in playful engagement around expressing oneself through words. People require more than just medical information to take stock and accept where they’re at with their health.” Vergo adds that for some patients, “being sick makes them more willing to explore the arts and express themselves in a way that helps them cope with their medical problems.”

BRINGING OUT THE INNER ARTIST

Christine Orcutt Henderson brings art supplies and her upbeat, you-can-do-this approach to patients and their companions in the Cancer Center’s Infusion Suite, to patients’ rooms and to Art Play groups. Klassen-Landis recalls the first day he observed her working with a patient. “When she first introduced herself to a patient who was getting chemotherapy, the patient said that she liked to draw as a child, but hadn’t done it for a long time."

Continued on page 17
Ask what has surprised her most in her work as coordinator of the Dartmouth-Hitchcock Arts Program, and Marianne Barthel says, "With how many people—patients, visitors, staff—take the time to comment on the positive effects of the program. A doctor told one of our exhibiting artists how he has an interior office and how much he values the beautiful art as he walks around. And, many people tell me that the art on the walls, the sculptures and live music have soothed them during difficult times or have taken their mind off waiting on test results."

Barthel was amazed at the level of response to her request for names for “Thidwick” the life-sized sculpture of a bull moose installed at the north end of the mall: “We had 1,700 entries for the name suggestion!” The sculpture, created by Rita Dee from driftwood and installed in the summer of 2015, has been a big hit. “Every day I see people of all ages stop and photograph each other with the moose.”

In addition to the permanent collection of artwork gracing Dartmouth-Hitchcock Medical Center (DHMC), the Arts Program hosts quarterly art shows in seven galleries throughout the hospital. Recent exhibits have included quilts, photographs of elderly athletes, abstract painting and photography, and acrylic paintings honoring traditional Native American clothing. “Eventually, I’d like to see artwork in every patient room in the hospital!” Barthel also enjoys working with the musicians. “A Dartmouth student came in for an audition and said, ‘Would it be ok if I play some Coldplay on the violin?’ How cool is that?”

Barthel also coordinates arts volunteers, including musicians who bring the sounds of lute, violin, hammered dulcimer, guitar, piano and voice to DHMC. Three piano players have performed for over 20 years, while another has played her guitar and sung folk songs for over ten years. Barthel believes that “music takes people away from their problems and reaches them emotionally, sometimes even more quickly than the visual arts.”

The Arts Program also works in partnership with the Creative Arts Team (see main story on page 14). Through the proceeds from the Gertrude Mertens Arts Fund, Barthel has supported the Telling Our Stories event, as well as a creative writing pilot program at the Children’s Hospital at Dartmouth-Hitchcock. She says she would love to have the harp, visual arts and creative writing services of the Creative Arts Team extended to patients and family throughout DHMC.
Henderson chatted a bit with her about her life and then pulled some paper and colored pencils from her knapsack and soon the two were talking animatedly as the patient drew imaginary animals. She then turned her attention to the patient’s husband who was quietly observing. Soon he was also drawing—he drew his favorite semi-truck. Both exclaimed that they hadn’t known the other one liked to draw.”

Henderson believes that “it’s important for patients, for their loved ones and for staff to incorporate the joyfulness of visual art into their everyday lives. The grace of art can be uplifting and meditative; it can open up doors to one’s personal journey.”

**CREATING A “CRADLE OF SOUND”**

Certified Harp Practitioner Margaret Stephens says she chooses her music and how she relates to people based on careful listening to what people say and how they respond nonverbally. “I try to be sensitive to where people are emotionally. If someone’s quiet and depressed, I may start with quiet music and transition to something uplifting. Conversely, if someone’s upbeat, I may play a waltz or Parisian café song in a major key. Then I may play something more soulful in a minor key and see how they respond.

Sometimes it brings people into a more thoughtful, inward place. Every situation is different; I hope I give the person the best for their situation and what they need,” she says.

People often tell her that the harp music takes them to peaceful places in their imaginations: “I feel like I’m in the mountains... in a field... in my family’s place of getting together.” She adds that family members often notice on the monitors that their loved one’s heart rate stabilizes or the pulse rate lowers as her harp music creates what she calls “a cradle of sound.”

**THE ROLE OF THE ARTS IN PATIENT CARE**

Deb Steele, MA, ATR, who supervises Stephens, Henderson and Klassen-Landis in her role as manager of the Cancer Center’s Patient and Family Support Services, says that she often receives comments from patients that a session with one of the artists “changed the energy of my day” or “made me feel like my old self for the first time in a month—the self that likes to draw or write or play or try something new.”

Steele cites research that shows arts activities affect the brain. “The arts calm the mind, the emotions, the nervous system; the arts are refreshing, like mindfulness. And the effect doesn’t end when the activity ends. There are feel-
Her graceful form, quiet confidence and flowing blue dress have attracted admiration from many and provided comfort for even more. The Blue Lady, a ceramic sculpture created and donated by the renowned artist Barbara Kaufman, has graced the pathway just outside Dartmouth-Hitchcock Medical Center’s (DHMC’s) cafeteria since 1995. Kaufman donated the sculpture in memory of her husband, Ralph. In April 2014, the sculpture was vandalized and the head destroyed.

“Reports from staff and visitors came flooding in immediately after it was discovered,” says Marianne Barthel, coordinator of the Dartmouth-Hitchcock (D-H) Arts Program. “People were genuinely sad that such a beloved piece of art could be the subject of someone’s anger. Quite a few staff members asked to be kept apprised of her reconstruction and return.”

Recognizing the value of art in the health care setting and the importance of the Blue Lady, D-H administration paid for the restoration; however, the incident highlighted a pressing need for the Arts Program—a fund to maintain, and restore when needed, the paintings, sculptures, and other installations that create a healing environment for patients and families.

Through several months of painstaking work, artists Eric O’Leary and Sheldon Austin restored the Blue Lady to her original beauty. The pair was chosen for their familiarity with Kaufman’s work—O’Leary, in fact, has known Kaufman since he was a teenager.

In November 2014, O’Leary and Kaufman, then 96, attended a small re-dedication ceremony. Kaufman passed away the following year.

Since her restoration, the Blue Lady has continued to comfort countless patients and visitors. She even inspired a painting by artist Carla Zwahlen, who spent many hours wandering the halls of DHMC when her husband was battling cancer.

“During our final week together, his hospital room became our home,” Zwahlen notes. “During those warm June days, he often said, ‘it is good for you to go for a walk outside.’ I did. Along the garden path, I met The Blue Lady. I stopped. Right away, I noticed her graceful stance, hand on hip. She symbolized defiance in the face of something that happened in her world.”

Zwahlen’s own Blue Lady, a vertical pastel piece, hangs near the North Entrance of DHMC.

“During those days when my husband fought for his life, the art [at the hospital] became more than beautiful decorations,” Zwahlen notes. “With each stop, I found a momentary hiding place from all things medical.”

To learn how you can support the D-H Arts Program and the comfort it provides to patients and families, contact Marianne Barthel at 603.650.6187 or by email at Marianne.L.Barthel@hitchcock.org; or Rick Peck, in the Office of Development, at 603.653.0735 or by email at Richard.C.Peck@hitchcock.org.
RUN
by Alejandra Casco

Get up! Get up! You have a race to run!

With the wind all dressed in green I ran fast

Letting go of my fears that I collected when I ran from them

And fell to my knees, but it was there I stood up and turned to chase them like a whirlwind.
A Mother’s Vision:
Empower Patients, Families and Their Communities
At Mary Hitchcock Memorial Hospital in the 1970s, remembers William “Bill” Boyle, MD, a bell would ring at 8:30 pm followed by an announcement: “Visiting hours are over. Please leave.” It’s almost unimaginable today to think of family members of patients being asked to leave the hospital, especially when those patients are children. But the concept of patient- and family-centered care didn’t take root nationally until the early 2000s, explains Boyle, a longtime pediatrician at the Children’s Hospital at Dartmouth-Hitchcock (CHaD) and one of the earliest proponents of such care.

In 1997, the mother of one of Boyle’s young patients called on him to help change the way the hospital and the health care system interacted with families. That mother was Jane Stetson. Her second daughter had just completed three-and-a-half years of successful chemotherapy for acute lymphoblastic leukemia.

“The medical community was incredibly good at working with children, technically,” she recalls. “But in terms of emotional understanding of what the entire family was dealing with, it was pretty marginal, with the exception of Bill Boyle and the nurse who worked with him.”

So Stetson and Boyle teamed up. With Stetson’s generous financial support, they founded the Boyle Community Pediatrics Program at CHaD with the goal of empowering patients and families dealing with chronic conditions, both within the health care system and within their communities. Those activities include:

- **Family Advisory Board**, which works closely with CHaD leadership to create positive changes for patients and families.
- **CHaD Schwartz Center Rounds**, which provides a forum for professional caregivers to maintain and cultivate compassion.
- **Community Pediatrics Rotation**, which embeds pediatric residents into community practices.
- **Community Faculty**, staff at community agencies that serve children, promote health and partner with the Boyle Program.
- **Family Faculty**, parents who take an active role in teaching pediatric residents about living with chronic conditions.
- **Molly’s Place at the CHaD Family Center**, funded by generous donations, offers support, resources, services and a welcome respite for families while at Dartmouth-Hitchcock Medical Center.
- **Bridges out of Poverty**, a partnership with the Upper Valley Haven to train Dartmouth-Hitchcock caregivers and community workers to engage effectively with families in poverty.
- **The Boyle Fund**, an affiliated fund housed within the Vermont Community Foundation. The fund provides grants to community organizations that work closely with the Boyle Program and share its vision.

For more on how you can support the Boyle Community Pediatrics Program, contact Carol Olwert at 603.653.0723 or by email, Carol.Olwert@Hitchcock.org.

**PATIENTS AND FAMILIES AS TEACHERS**

Among the Boyle Program’s first actions was to create the CHaD Family Advisory Board, made up of parents, community members and CHaD professionals. Then and now, the board works closely with CHaD leadership and has initiated numerous changes, large and small. Examples include creating a separate kid-friendly entrance to the pediatric blood-draw room, inviting parents to participate in physicians’ morning rounds and interviewing patients and families about their experiences in the hospital. Family members from the advisory board also interview every physician being considered for a position at CHaD.

“Parents and children are the most skilled teachers of family-centered care for our residents and physicians,” says Toni LaMonica, MSW, who was the program manager for the Boyle Program until 2011 and still serves on the CHaD Family Advisory Board.

Jennifer Hotz, a parent, has served on the board for nine years. “My daughter is 17 years old and has a significant neurological disability that affects every aspect of her life,” says Hotz. “That I have been able to serve on so many committees and in so many other ways is a reflection on the institution and how much it values family, patient and community input.”

Another initiative that lies at the core of the Boyle Program is CHaD Schwartz Center Rounds. Fourteen years ago, CHaD became one of the first hospitals in the nation to hold Schwartz Center Rounds, a monthly interdisciplinary forum centered on compassion and teamwork. Schwartz Center
Rounds are now held in nearly 500 health care organizations worldwide. “Schwartz Center Rounds asks the questions, ‘How do we provide compassionate care? Are we compassionate to ourselves and to those we work with so we can be compassionate to those we serve?’” explains Steven Chapman, MD, whom Stetson and Boyle recruited to lead the Boyle Program in 2011.

Chapman also oversees the Boyle Program’s Community Pediatrics rotation that all CHaD residents must do every year. The rotation places CHaD residents in community-based physician practices, so residents can understand how children and their families interact with community health care, community agencies and schools. The residents also complete an advocacy project for kids in a community-based setting and meet with families who have children with chronic conditions.

“The idea is to train pediatricians to think of the clinic and medical services as only part of the solution to good health,” notes Chapman.

CORE PASSIONS
With so many varying activities (see sidebar on page 21), the unifying theme of the Boyle Program initiatives may not be immediately obvious.

“One of the ways I sort out what fits with the Boyle program is by asking, ‘Does it patch into the core passion of serving families in a meaningful way?’” explains Chapman. “Invariably, this involves engaging with and listening to families. It involves partnering with community agencies. As Dartmouth-Hitchcock and our health-care system pivot to a population health approach, we’re there already.”

“From my perspective, empowering families to walk the walk through an illness makes all the difference,” adds Stetson. That vision of empowering citizens to take a more active part in their own health care and that of their community continues to inspire Stetson and those with whom she works.

In 2014, Stetson served as the founding chair of Dartmouth-Hitchcock’s Partners for Community Wellness (PCW), which is now chaired by Boyle. PCW consists of more than 300 citizen representatives who work with Dartmouth-Hitchcock to inspire and advance healthier communities across New Hampshire and Vermont through education, advocacy, and philanthropy.

“I think PCW is an extension of what we’ve accomplished with the Boyle Program, which is to connect community and health-care providers on a more level playing field instead of the patriarchal relationship that has existed in health care for too long,” says Stetson.

Today, thanks to Stetson’s ongoing generosity and involvement, and gifts from other donors to CHaD, the Boyle Community Pediatrics Program continues to make an impact on patient care, on the training of future pediatricians and in the community.

“It’s been Jane’s vision, passion, engagement, and support that continues to make the Boyle Program possible,” says Chapman.
Win Dezaine: Paying it Forward

Winston Dezaine’s school days ended when he finished eighth grade in Johnson, Vermont, in 1938. That same year, 13-year-old “Win” left home after his mother died of a heart attack. “I never spent any extra time on education,” he says. Instead, Dezaine followed a different path to success, with a 42-year career in Vermont’s talc-mining industry, working for Johnson & Johnson.

When Johnson & Johnson sold its Vermont talc operations in 1988, Dezaine and his wife, Dorothy, retired to Craftsbury, Vermont. Dorothy’s health deteriorated, and she lost her vision to macular degeneration. Before she died, the Dezaines established a bequest to benefit Dartmouth-Hitchcock (D-H) in appreciation of her care, especially from ophthalmologist Christopher Chapman, MD. Later, Dezaine established a Charitable Gift Annuity to benefit ophthalmology and to enhance the patient care programs and services that D-H offers to the rural communities of Vermont and New Hampshire.

“I live in the northeast of Vermont, the poorest part of the state,” notes Dezaine. “I’ve been poor, and I know what it is like. I was very fortunate in life. I’d like to see my money used to do some good. I’m sure it will.”

To learn more about planned gifts, including charitable gift annuities, and their lasting impact, visit dh.planmygift.org or contact Rick Peck at 603.653.0735 or by email at Richard.C.Peck@hitchcock.org.
INSPIRED BY PAM

Even during the months when she was receiving chemotherapy, Pam Gile still walked two-plus miles a day, no matter how long it took her to finish her loop. Pam, a lifelong athlete, inspired many in the Upper Valley by serving on non-profit boards, fundraising for Dartmouth-Hitchcock’s Norris Cotton Cancer Center as a member of The Prouty TGIF team and supporting other women with breast cancer.

Among her passions was an exercise class at the Cancer Center which became known by the participants as “Pam’s Class” after her death in December 2014. To honor Pam and support the exercise class she cared so deeply about, her husband, Peter Gamble, other relatives and several friends made generous gifts to the Cancer Center.

“Pam was so determined with everything she did,” notes PJ Hamel, a fellow TGIF team member and friend. “We actually walked a marathon several years ago for the Prouty. Just like Pam, she walked it all in one day,” Hamel says.

FUEL FOR FAMILIES

Children receiving care at the Children’s Hospital at Dartmouth-Hitchcock (CHaD) come from all over New Hampshire and Vermont. For many families, scraping together enough money for gas can be a challenge and can mean the difference between canceling and keeping an appointment. That’s why Irving Oil’s Fuel the Care program helps families with the cost of travel between home and hospital.

Since 2004, Irving Oil has provided CHaD families with more than $600,000 in Irving Oil gift cards.

“It’s hard to imagine anything more worrying than having a sick child in the hospital,” says Andrew Carson, Director of Public Affairs for Irving Oil. “We are deeply committed to Fuel the Care, which helps remove at least one small worry for families who have more important matters to focus on.”

Irving Oil has also given generously to cancer research at CHaD and Dartmouth-Hitchcock’s Norris Cotton Cancer Center, and the STAR program at CHaD, which helps teens with chronic health conditions transition to adulthood.

The generosity of donors is vital to Dartmouth-Hitchcock’s mission of advancing health through research, education, patient care and community partnerships. Thanks to all who help us sustain our mission.
Imagine a health system that focuses on health, not just health care

Imagine a health system where care is based on value, not volume

Imagine a health system grounded in population based strategy, not market share

Imagine a health system that rewards quality, not quantity of procedures

Imagine a health system where patients, when well informed, receive only the care they want and need
Imagine highlights Dartmouth-Hitchcock’s leadership role in providing the best in patient care, translational research, medical education and community service. The stories featured in this publication exemplify our mission to create a sustainable health system to improve the lives of the people and communities we serve, for generations to come.