our mission  GIPPCC collaborates with its members to educate, advocate for, and partner with consumers, healthcare providers and the community in order to improve and increase access to palliative care and bereavement services for children and families throughout Illinois.

www.gippcc.org    admin@gippcc.org
In this issue

Letter from our President, Mimi Noonan

Overview of GIPPCC’s Nurse Mentorship Program

The Evolving Role of Pediatric Palliative Care in the Management of Infants with Hypoplastic Left Heart Syndrome

Conquer Congenital Heart Disease

Our Journey: Olivia, Asher and Rainbow Baby, Nina

Blood Clot Awareness: Asher James Congenital Heart Disease & Thrombosis Foundation

Making Our Voices Heard

2017 Illinois Summer Camps for Grieving Children, Teens and/or Families and Children and Teens with Illness

GIPPCC Travels to Phoenix

Welcome New GIPPCC Board Member, Ruby Roy

Ryan’s Story

Upcoming Conferences

Amazon Smile Shopping Program
Your support is vital to our mission to improve the lives of children with complex, chronic and life-limiting illness, assist their families and encourage the teams of caregivers vital to the quality of their lives.

GIPPCC is an actively growing, vibrant collaborative of hospices, hospital systems, families, and individuals that collectively strive to increase access to quality pediatric palliative care programming and bereavement support throughout the state of Illinois.

While children may represent only a small percentage of the overall census of patients served by hospice providers, we have witnessed the lasting impact that quality palliative care programs have on communities and families that love a medically fragile child. Sadly, we know that palliative care services are still not available to all the children and families that need it. Your support allows GIPPCC to reach more and more children across the state that could benefit from palliative care.

Our work is ongoing; with your help in 2016, we were able to offer our first Webinar with GIPPCC’s own Dr. Erin Flanagan as well as host pediatric palliative care pioneer, Dr. Sarah Friebert from Akron Children’s Hospital for an education event at JourneyCare. We continue to have success with implementation of our RN and Physician mentorship program, funded by Illinois Children’s Healthcare Foundation (ILCFH), with monthly meetings, case studies, and shadowing opportunities. We continue to partner with the Coleman Foundation in work to improve and streamline supportive oncology services. Additionally, GIPPCC staff has traveled to Springfield to advocate directly to Senators and Medicaid representatives. These important initiatives are part of our enduring commitment to increase both awareness and access to pediatric palliative care.

With your support, GIPPCC anticipates opportunities for additional outreach and growth in 2017; we simply could not touch as many lives without your generosity. We hope we can count on your continued partnership as GIPPCC sets even more ambitious goals for 2017 and beyond. We appreciate that you share our passion and thank you in advance for your generosity.

Sincerely,

Mimi Noonan
Board President

HOW YOU CAN BE INVOLVED

Learn how you can contribute your expertise and support to advance pediatric palliative care education.

Mailing List • Join a Committee • Contribute to the Newsletter
Attend an Educational Program • Host a Workshop
Provide Financial Support • Make a Referral • Be a Voice
The Greater Illinois Pediatric Palliative Care Coalition has developed an innovative mentorship program that has linked novice pediatric palliative care and hospice nurses with experienced professionals in this field. This mentorship has provided me with the opportunity to expand my knowledge and confidence in this growing field. For the past 10 months, I have been provided the opportunity to attend national and state conferences which focus on the care of children with terminal illnesses. These educational opportunities, whether through conferences or practicums, have provided me insight to specific disease processes as well as developing crucial communication skills in order to walk the journey with families in need of pediatric palliative care. The mentorship has provided funding to attend phenomenal educational opportunities such as HPNA’s Pediatric End-of-Life Nursing Education Consortium as well as spending invaluable time with Dr. Billie Winegard and the Pediatric Supportive Care at OSF Health Care, JourneyCare and Bridges Pediatric Palliative Care Team at Lurie Hospital. Additionally, Jen Misasi, APN, has been a priceless asset to this program as she has been serving as my mentor. Jen has a wealth of knowledge and expertise in dealing with pediatric palliative care in her role as an advanced practice nurse. She has been available to work with me on an individual basis and has provided me with knowledge and confidence to work more proficiently with the small population of pediatric palliative care and hospice patients in the rural 19 county area in which Carle Hospice serves. Jen has been a constant source of encouragement to me. She is a tremendous resource in providing relevant case studies, up-to-date articles, and encouragement when caring for and advocating for pediatric hospice patients and their families.

The ultimate objective with this aspect of the mentorship is designed to keep specialists abreast of the benefits of concurrent care and how pediatric patients diagnosed with a terminal disease can benefit from the holistic approach of hospice nursing. I have considered myself fortunate and honored to be part of the first groups of nurses to enroll in this year-long journey which started in July 2016. All of the educational opportunities associated with this mentorship have been superb and a phenomenal chance to network with national experts in the field of pediatric palliative care and hospice care. Additionally, the mentorships is providing support, in coordination with my hospice organization, to present information about pediatric hospice and concurrent care to Carle Foundation Hospital pediatricians, neonatologists, perinatologists and the nursing staff associated with these departments. The ultimate objective with this aspect of the mentorship is designed to keep specialists abreast of the benefits of concurrent care and how pediatric patients diagnosed with a terminal disease can benefit from the holistic approach of hospice nursing. In summary, this program has been an exceptional experience. Because on this innovative mentorship program, I hope to provide the best care to our pediatric hospice population and hopefully be a mentor to other hospice nurses in my community. I have a deep respect for the GIPPCC staff and Board Members who have worked tirelessly to develop and support this endeavor. GIPPCC has set a stellar example of a tremendous mentorship program. I believe their exceptional educational model will continue to grow and inspire other hospice nurses to provide exceptional care to pediatric patients diagnosed with a terminal disease. GIPPCC’s mentorship program has effectively integrated educational and networking opportunities with national experts with the personal touch of an individual mentor. I am so grateful for this opportunity to work with such a talented group of people and be a part of an important organization.

Interested in learning more about the GIPPCC RN/Physician Mentorship? Please contact Kristin James, kjames@gippcc.org
Hypoplastic left heart syndrome (HLHS) is one of the most severe forms of congenital heart disease. Without surgery mortality for infants with HLHS in the first year of life is nearly 100%. Despite improving surgical outcomes, some parents choose not to pursue surgery for their infants. We present the case of an infant with HLHS whose parents underwent a dramatic shift in goals of care. As a result, the case demonstrates the potential longitudinal involvement of Pediatric Palliative Care from prenatal diagnosis and throughout the often complicated course of staged surgical “palliation.” (The word palliation here is a term of art used in some medical and surgical communities to indicate interventions that cannot fully correct a condition. This use differs somewhat from the way palliative medicine clinicians use the term, where it refers to relief of suffering.)

A.W.’s mother presented to Advocate Children’s Hospital (ACH) at 35 weeks gestation due to an abnormal prenatal fetal ultrasound. Clinicians made a diagnosis of hypoplastic left heart syndrome with a small mitral valve and retrograde flow with a more detailed fetal echocardiogram. The parents indicated at their initial visit with a pediatric cardiologist that they were likely to decline surgical intervention. The cardiologist referred the parents for consultation with cardiovascular (CV) surgery and also pediatric palliative care.

After consultation with subspecialists, including pediatric CV surgery, the parents made the decision to forgo staged surgical palliation in favor of non-surgical palliative care. The parents worked with our Palliative and Supportive Care Team to create a perinatal care plan focused on their infant’s comfort, rooming in with mother, and memory making. The parents expressed their wish that the baby not go to the NICU at delivery, indicating their understanding that the infant might not survive to home discharge.

A.W. was delivered at 39 weeks via scheduled C-section, without complication. APGARS were 9/9. The parents’ wishes were honored and their son remained with his mother and was not taken to NICU. A.W. remained stable and breastfed well. The parents reiterated their wish to take A.W. home with hospice care on DOL #2-3 and arrangements were made for the mother and her infant to be discharged home together. The parents completed and signed a POLST form that indicated the parents’ wish for no CPR in the event of cardiac arrest, with all medical interventions directed at comfort only.

In the home hospice program, A.W. continued to remain well, breastfed normally and gained weight as expected for a healthy baby. The pediatric home hospice team provided support to patient and family on a weekly basis. A.W.’s parents took him to routine pediatric visits and pediatric cardiology follow up at 2 and 3 months respectively. At 3 1/2 months of life A.W. experienced acute respiratory distress at home. Parents called the hospice team and informed them they wished to call EMS and have the infant taken to the closest ED. In that ED the baby experienced cardiopulmonary arrest, and with parents’ permission, underwent full resuscitation and emergent transport to ACH. At parental request, A.W. underwent emergent shunt placement and the first surgery of a staged sequence of surgeries for HLHS.
The ACH Pediatric Palliative and Supportive Care Team continued to provide support and advocacy for A.W. and his family throughout his complicated post-surgical course, prolonged hospitalization and re-admissions. Upon discharge, the parents re-engaged with the home-based palliative care program. The hospital and home-based palliative care teams continue to maintain communication, and provide continuity both in the hospital and at home for parents as they embark on life with their son with plans for additional procedures constituting the surgical palliation for HLHS.

Over the past 40 years, with the development of cardiac transplantation as well as the Norwood sequence of staged surgical palliation for infants with HLHS, controversy has emerged over the decision on how best to manage an infant with HLHS. In fact, studies in 2007 and 2008 cite continued disparity between what providers recommend to parents of infants with HLHS and what they would choose for their own children. In a recent review of HLHS patient outcomes from 2000-2012, investigators found that overall surgical mortality decreased from 35.3% to 22.9%, and the percent of infants discharged home without surgery declined from 21.2% to 14.8%. As surgical innovation continues, there will be impact on what options will be presented to parents, and the decisions they will face.

The ethical debate about whether to allow parents to decline surgery for these infants will evolve with improved surgical and anesthetic techniques. However, the literature still suggests significant controversy among pediatric cardiologists and CV surgeons about non-surgical management of HLHS. Some of the controversy involves concern about suboptimal neurodevelopmental outcomes related to multiple surgeries in early life and to recognition that each operation carries additional risks of death and complications. While this divergence of opinion continues, it is more important than ever to involve palliative care teams as early as possible to explore all post-natal options and support informed parental decision making. Consulting palliative care for infants with HLHS does and should not imply counseling parents to decline surgical management. Pediatric palliative care offers parents skilled, nonjudgmental support in reaching difficult decisions, an interdisciplinary approach to care, attention to relationship building, and enhanced professional communication and collaboration in the care of the child. As a result, palliative care teams work successfully with maternal-fetal medicine specialists, pediatric cardiologists, and CV surgeons in the care of infants with HLHS. This case emphasizes the supporting role pediatric palliative care can play in the care of infants throughout their HLHS trajectory, regardless of the choice to pursue surgical or non-surgical management.


Conquer Congenital Heart Disease

The Pediatric Congenital Heart Association’s mission is to “Conquer Congenital Heart Disease.” We are founded on the key purpose to be the resounding voice of the pediatric patient population and are accomplishing this through collaboration with patients, parents, providers, and partner organizations in order to improve quality and outcomes through CHD education, support, research and awareness. The Congenital Heart Network is a program of PCHA, aimed at improving the lives of those with congenital heart disease and their families through direct support and education – meeting families where they are. Through local activities like peer-to-peer support, care package distribution and educational materials, we are working directly with patients, families and medical professionals impacting one life at a time.

Link: http://conqueringchd.org/

- Congenital Heart Disease is the #1 Birth Defect
- Nearly 1 in 100 Newborns are born with CHD
- 25% of children born with CHD will need heart surgery or other interventions to survive
- 15% of babies born with CHD will not see their 18th birthday
- An estimated 2-3 million people are living with CHD
Jen DeBouver has been on a 5 year journey filled with excitement, sorrow, grief and joy. In June 2011, she learned that she was expecting her first child Olivia but that excitement ended way too soon. In November, 27 weeks into the pregnancy, she learned that her daughter no longer had a heartbeat. The nurse kept saying “this machine isn’t working, let me get another one” before finally bringing in the doctor to tell us the unthinkable. Jen knew right away before even hearing the words.

A couple months later Jen and her husband JD learned she was pregnant again; this time with a son they named Asher. They were very hopeful for this pregnancy but learned at a 26 week ultrasound that Asher had a critical congenital heart defect (CHD). They were told about a fetal intervention that could correct his heart before he was born. A week later they flew out to Texas Children’s Hospital to have the procedure done. Upon arriving and getting all the tests done, they learned that Asher’s heart was much worse and that he wouldn’t make it to birth without the procedure and they were unsure he would survive the procedure. Asher was their little fighter and made it through with no problems. He was born in September 2012 and had a cath procedure the night he was born and heart surgery at 11 days old. After having surgery Asher started having issues which his parents later learned was because he had developed staph infection and he also developed blood clots. He was treated for blood clots for 2 weeks using different procedures and adult medications but Asher ended up losing his fight on October 23, 2012 at 6 weeks old.

Jen felt that Asher’s battle did not end when he passed away so her and her husband started Asher James Congenital Heart Defect and Thrombosis Foundation to spread awareness regarding blood clots in children so that other parents knew what to look for after their child had surgery. Jen also became involved in Mended Little Hearts of Chicago (now Pediatric Congenital Heart Association – IL), a support group for CHD families.

She was the Bereavement Coordinator until recently. Jen has become a big advocate in the CHD community and on blood clots, going to Washington D.C. to advocate on both topics. Jen is also a big advocate in the baby loss community, helping others to understand grieving parents.

This past July, Jen and JD welcomed their Rainbow Baby (baby born after a loss), Nina. Nina was born 6 1/2 weeks early due to Jen developing severe preeclampsia but spent only 4 weeks in the NICU and is doing really well. Nina really doesn’t even know she is a preemie. Jen is working on a new project called Rainbow of Hope Project to bring awareness to Rainbow Babies, the joy they bring but also awareness that the grief still continues.

**Project:** dearoliviamadilynn.com
**Foundation:** asherjamesfoundation.org
Approximately 1 in 110 newborn infants are diagnosed with congenital heart defects/disease (CHD) a year. These children require advanced supportive care to treat their underlying problem. Although significant advances have been made in treating children with congenital heart diseases, these children are at increased risk of development of blood clots due to multiple reasons. These infants/children are critically sick and require central venous catheters to provide medications and nutrition. Due to small diameter of their blood vessels compared to their catheters, these catheters cause mechanical obstruction and stasis for blood flow. Stasis of blood flow is the primary cause for development of blood clots. Besides central venous catheters, multiple surgical procedures, high hemoglobin concentrations (in children with cyanotic congenital heart disease) and poor hydration further increases their risk of blood clots. These blood clots can be very serious and can lead to loss of life, loss of organs or loss of limbs.

It is important to underscore that the problem of thrombosis in children is under appreciated and there is an urgent need to develop better strategies to prevent and treat these clots. Asher James Congenital Heart Disease & Thrombosis Foundation strives to advance the therapy of children with congenital heart diseases with or without blood clots. The Foundation will support basic science, clinical and translational research activities that will directly impact the clinical care of these children.

**Signs & Symptoms of Blood Clots**
- Redness
- Puffiness
- Pain
- Limb Swelling
- Shortness of Breath

**Risk Factors**
- Immobility or lack of movement
- Dehydration
- Preexisting condition (cancer, CHD, etc)
- Central Venous Line
- Surgical Procedures
- Cath Procedures
Making Our Voices Heard

On April 4th and 5th, GIPPCC Program Coordinator, Kristin James and I joined board members and staff from the Illinois Hospice and Palliative Care Organization to make our voices heard in Springfield for an Advocacy Day. Kristin and I learned a lot about how to reach out to legislators to educate them about the importance of making palliative care available to their most vulnerable constituents, children with chronic, complex and life threatening illness. To be sure, when we were able to catch a legislator’s ear, hearing that we were advocates for sick children did give them pause, but only for the few minutes each had to share with the many people seeking their attention.

We met very briefly with Dale Righter, the State Senator from Mattoon, who co-sponsored the still-unfunded bill making palliative care available for Illinois children covered by Medicaid. He reiterated his support for our cause and voiced frustration over the budget stalemate that has prevented implementation. We were delighted to sit down with Julie Morrison, the Senator from my home district in Deerfield, and learn that she is planning a Children’s Caucus this summer aimed at examining both challenges and opportunities for children in the state. GIPPCC plans to put pediatric palliative care on the agenda with Senator Morrison’s help. Additionally, retired senator Art Turner shared some insight about making connections with local legislators during their summer recess when many are working on projects at their local offices and their time is more available. We plan to put together some printed materials and talking points so each of you can visit your local legislator and urge them to support palliative care for children. If every supporter of pediatric palliative care found some time to reach out to their legislator while they are in their district office this summer, surely, we would make progress for our kids!! One of GIPPCC’s 2017 goals is to increase legislator education about palliative care for kids. This will need to be a team effort!

Mimi Noonan
Board President

PHOTOS (from top to bottom)
Mimi with Diane Bergan, ILHPCO/JourneyCare & Art Turner
Mimi & Kristin in front of the Capital, Spring 2017
Kim, Kristin & ILHPCO representatives at the Capital, Fall 2016
2017 Illinois Summer Camps For Grieving Children, Teens and/or Families and Children and Teens with Illness

North Star Reach
(A Serious Fun Camp founded by Paul Newman)

Palliative Care Family Camp
May 19 – 21, 2017
Pinckney, MI
They also offer various summer camps for children and teens at no cost.
Contact: sarah@northstarreach.org

Spring Family Camp

• April 21 – 23
  Families with a child who has a neuro-oncology (brain tumor) diagnosis
• May 5 – 7
  Families with a child diagnosed with sickle cell disease
• May 19 – 21
  Families with a child receiving palliative care

Fall Family Camp

• September 22 – 24
  Dance Marathon at the University of Michigan families
• October 6 – 8
  Families with a child who has received an organ transplant
• October 20 – 22
  Families with a child who has a heart-related condition
• November 3 – 5
  Families with a child who has Phenylketonuria [PKU]

JACH Children’s Day Camp
(Joliet Area Community Hospice)

June 19-22, 2017
9am – 3pm
CW Avery YMCA And Ira Jones Middle School
Contact: Mary Ann Burns, Bereavement Coordinator,
815.460.3282
mburns@joliehospice.org

Camp Courage for Bereaved Children
(JourneyCare Hospice)

July 10-14, 2017
Camp Duncan
Volo, Illinois
Contact: 224.770.2273

Camp COCO (Children’s Oncology Camp Organization by The department of Pediatrics at SIU School of Medicine)

For children ages 6-17
Siblings of young campers may also attend.
Second week of July
Central Illinois
Contact: 618.453.4900

Grief Takes a Hike (Fox Valley Hands of Hope)
For children 5 -18
August 4-6, 2017
Inspiration Retreat Center
Walworth, WI
Contact: Jill Thorson 630.232.2233 x 225

Camp Quality Illinois

For Children 5-17 with cancer diagnosis
August 6-12, 2017
Camp Manitoqua
Frankfort, Illinois
http://www.campqualityusa.org/il/

Camp Erin Chicago
(AMITA Health Adventist St. Thomas Hospice)

Weekend long grief support camp ages 6-17
October 20-22, 2017
Camp Manitoqua
Frankfort, Illinois
Contact: Laura Cottrell
630.856.6985
Laura.cottrell@amitahhealth.org

Tommy’s Kids Bereavement Summer Camp
(AMITA Health Adventist St. Thomas Hospice)

For Children ages 5-12
June 26 – 30, 2017
9:00am – 3:30pm
Katherine Legge Memorial Park
Hinsdale, Illinois
Contact: Laura Cottrell
630.856.6985
Laura.cottrell@amitahhealth.org

Camp Boggy Creek, Eustis, Florida
(A Serious Fun Camp founded by Paul Newman)

They offer various summer camps for children and teens at no cost.
Contact: 866-462-6449
http://www.boggycreek.org/
Dr. Ruby Roy has been a pediatrician for almost 30 years. Prior to working with our Pediatric Team at JourneyCare she worked at LaRabida Children’s hospital and Loyola University Medical Center. Based on her medical experience and background, her focus on medical humanities and ethics and her interests in caring for children with complex medical needs, hospice and palliative care seemed like a natural evolution for her. Medical humanities and ethics highlight the limits of medical knowledge and certainty and support the ethics of patient centered medical care. The parents of children with complex health care needs have taught her about patience and resilience in the face of disability, uncertain prognosis and the negative effects of aggressive care on the whole family. The palliative care approach values patient and family goals and quality of life above all, and this empowers families to think about living their life, not merely going from treatment to treatment. This family support and advocacy role is really personally satisfying for her. Dr. Ruby Roy is excited about the opportunity to partner with GIPPCC because their program and JourneyCare are aligned in mission and purpose: we are both agencies focusing on pediatric palliative care and hospice in the community. We also both collaborate with different medical and academic institutions across the region. She hopes that our partnership with GIPPCC facilitates pediatric palliative care education and advocacy for both our palliative care community as well as our patients and families.

Dr. Ruby Roy has been working with JourneyCare for a little over a year now and she loves the team’s passion and dedication to helping families at the hardest times of their life. She loves the multidisciplinary aspect and having learned so much for the different perspectives of the team. We are very excited to have her working with us! We look forward to further growth of our program and an enhanced relationship with GIPPCC with her as our Medical Director.

Jennifer Mangers, MS, CCLS Interim peds North Team Manager
Life is what happens to us while we are making other plans. This describes our journey with our son Ryan perfectly. We found out about part of Ryan’s health issues at our 16 week ultrasound. At that time he was diagnosed with a complex congenital heart defect - Tricuspid atresia. After consulting multiple specialists we were told this was repairable with a series of 3 surgeries. We met with a cardio-thoracic surgeon and he showed us a healthy little boy running down his hallway that had the same issue and had completed all 3 surgeries. We knew the road would be difficult but did not imagine what was to come.

Ryan William Foley was born after a planned induction at 6 lbs and 21 inches. He was immediately taken to the NICU and intubated and on day 2 had his first cardiac catheterization. He proceeded to pull out his own ET tube, an indication of his tenacity and strength to come. He spent a month in the NICU thanks to a case of necrotizing enterocolitis. While there he was found to be low tone with a large head (thanks to his Irish roots). An MRI revealed partial polymicrogyria(abnormality in brain formation). The neurologist could not tell us what this would mean for Ryan, anything from mild intellectual disabilities to severe intellectual and physical disability with seizures and early death. Not helpful but also left the window open for all possibilities.

Ryan and the family had a long road ahead of us. He spent about 6 months of his first year in the hospital with my husband and I splitting days and nights with him and trying to work full time. Finding daycare was difficult due to his level of care needed and the amount of time he was in the hospital. Over the following 5 years, we pursued Early Intervention, 6-8 hours of physical, occupational and speech therapy weekly and endless doctors appointments. Ryan had 4 instead of the original 3 planned heart surgeries. At one point he developed pulmonary hypertension which threatened his further care. The additional heart surgery was proposed by the cardiologist. At this point I was several months pregnant with our second child. In an effort to be educated I asked the doctor what would happen if the surgery didn’t work and was told we would be out of options. This lead to some panic and a very teary ride home. Thankfully the surgery was a success and he could finish his series. Due to his low oxygen levels we would have oxygen tanks in the house for much of those 5 years. At about 2 years of age he went on a hunger strike. After trying many options for calorie intake we were down to discussing a G tube. After discussing choices, our pediatrician gave us a short term options for TPN (total IV nutrition) and we gave it a try. This was the key to take the pressure off feeding and gave a treatment until Ryan started eating again (3 months). He had his last surgery at 5 years of age, in 2000. Once he had normal oxygen levels his development progressed. He was able to start walking and participating in schools.

Ryan has persevered despite his difficult beginnings. He is now 22 years old and is facing new challenges as he has aged out of the school system and we are looking into future options. The neurologist’s original description of Ry’s future was correct in many ways. He continues to have severe apraxia (difficulty with speech) and moderate intellectual disabilities. His heart remains stable and we are down to every 2 year rechecks. We don’t know what will happen with his heart in the future as his surgery was developed 40 years ago and the first children to have it are just reaching their forties. It has been a group effort of our doctors, therapists and family support to get him here. We now have 4 children and a very busy life. Little did we know after the joy of a positive pregnancy test the difficult road we would be on.
UPCOMING CONFERENCES
Hosted by GIPPCC

August 24-25
Peds ELNEC
Rush Medical Center / Chicago

September 22
Downstate Illinois Training
SIH/Carbondale

October 27
ALLIANCE/Vicarious Trauma
NCH/ Arlington Hgts

October 12
ILHPCO
NIU/Naperville

November 10
Dr. Stefan Friedrichsdorf
Lurie Childrens / Chicago

Shopping online anyway?

Why not give back to GIPPCC at the same time!! Please take 30 seconds to sign up GIPPCC as your charity of choice.

When you shop at smile.amazon.com 0.5% of all your eligible orders will be donated to GIPPCC at no additional cost to you!

Support your favorite charity every time you shop.

Learn more, please see http://smile.amazon.com/about for complete program details.