

CIRCLE OF LIFE AWARD



2016



CIRCLE *o*f LIFE™

Celebrating Innovation in Palliative and End-of-Life Care

The 2016 awards are supported, in part, by the California Health Care Foundation, based in Oakland, California, and Cambia Health Foundation. Major sponsors of the 2016 awards are the American Hospital Association, the Catholic Health Association, and the National Hospice and Palliative Care Organization & National Hospice Foundation. The awards are cosponsored by the American Academy of Hospice and Palliative Medicine, the Center to Advance Palliative Care, Hospice & Palliative Nurses Association/the Hospice & Palliative Credentialing Center/ the Hospice & Palliative Nurses Foundation, and the National Association of Social Workers.

The Circle of Life Award is administered by the Health Research & Educational Trust.

INTRODUCTION

Beginning in 2000, the Circle of Life Award has recognized and honored innovation in palliative and end-of-life care in hospices, hospitals, health care systems, long-term care facilities and other organizations providing care. The Circle of Life Award Committee calls attention to the rapid advancements in the field of palliative care by shining a light on programs and organizations that are finding new ways to serve those with life-limiting illness and their families. The field of palliative care is experiencing tremendous growth and development as it demonstrates a unique effectiveness in meeting all aspects of the Triple Aim. Programs honored by the award serve as teachers and mentors and inspire further development and advancement in the field.

The Circle of Life Committee has had the true privilege and pleasure of reviewing hundreds of innovative palliative and end-of-life care programs throughout the years through its application process and then delving deep into structure and function of a select few through the site visits. The committee has witnessed the exponential growth of palliative care programs and services coupled with the increasing need and demand for delivery systems to involve palliative care early in the trajectory of illness, particularly for chronic progressive diseases. Palliative care helps in the management of symptoms and effectively supports a patient- and family-centered plan of care.

The committee is pleased to recognize the three Award and three Citation of Honor honorees for 2016; these programs provide mature and promising models for us all.

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- Catholic Health Association of the United States
- National Hospice and Palliative Care Organization & National Hospice Foundation

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More information about the Circle of Life Award, full award criteria and past recipients is available at www.aha.org/circleoflife.

Sincerely,



Martha L. Twaddle, MD, FACP, FAAHPM
Chairman, Circle of Life Committee

AWARD WINNER

PALLIATIVE MEDICINE
BON SECOURS RICHMOND HEALTH SYSTEM

Richmond, Virginia





The woman and her husband knew she was nearing the end of her life, but it still came as a shock when her condition declined suddenly. In a panic, he brought her to the emergency room. Right away, members of the Bon Secours Richmond Palliative Medicine team that had been caring for her were alerted and came down to help.

It was clear that the woman was actively dying and could not be transferred to another location, so the team consulted with her husband and supported her transition to comfort measures only. Palliative Medicine chaplain Amy Holtz and other team members hurried to turn off the harsh lighting in the ER bay where she lay and brought in a lamp from the waiting room that provided a warmer glow. “We facilitated her husband having some private time with her, and because faith was a significant part of their lives, we shared in prayer,” recalls Holtz. “As her husband shared with us stories of her life, she took her last breath.”

Because the Palliative Medicine team members knew the couple from months of outpatient visits — and because the team is organized to follow patients wherever needed — the team was available to make the woman’s final moments meaningful even as they took place in a hospital emergency room.

The Bon Secours team is centered around the patient, whether that patient is in a hospital, at home, in the office or in a nursing home. That consistency is vital for patients and families dealing with the end of life, says Robert Fortini, vice president of clinical operations for Bon Secours. “In the last weeks of life, changing every person you’re comfortable with is very traumatic to the patient, and it’s even traumatic to caregivers and families,” he said. In the Bon Secours model, “the same physician and nurse are taking care of them the whole time.” The team has a strong social work component and Holtz, a chaplain dedicated to palliative care.

The Palliative Medicine program draws strength from being organized as an outpatient medical practice, within the Bon Secours Medical Group, which provides flexibility and a focus on the entire continuum of care, explains Leanne Yanni, MD, the program’s medical director since 2011.

The collegial structure makes it easier to work as a team, Yanni says. “It’s a collaborative and consensus-driven practice. We are not driven by any one specialty. We don’t focus just on physicians or social workers; we have a good balance on the team and really emphasize that.” Each of the disciplines also has its own cooperative group for social workers, nurse practitioners and other providers that address issues unique to their own practice.

Another benefit to working out of a medical group model, Yanni says, is that she answers to a single person in system leadership rather than the four hospital CEOs. “That person is really supportive and really understands the key financial and quality drivers of how to make palliative care successful,” Yanni says. “You really have a streamlined way of managing the practice.”

Being a specialty practice in a larger medical group enhances relationships with primary care physicians and specialists, notes Seth Roberts, MD, another Palliative Medicine team physician. “It puts us on a similar footing as some of the other specialties and helps us clarify our role better and build relationships,” he says.

The structure also supports the program’s efforts to provide primary palliative care skills to physicians throughout the system. “A significant part of our work along the continuum involves education and training and really empowering primary care physicians and other providers to feel they can begin to approach some of these issues as they come up with their patients,” Roberts says. These skills include advance care planning and managing pain.

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We are not driven by any one specialty.*



INNOVATION HIGHLIGHTS

INTERDISCIPLINARY TEAMS WITH STRONG PSYCHO-SOCIAL COMPONENT

PARTICIPATION IN ALTERNATIVE PAYMENT MODEL

EMBEDDED NAVIGATORS IN PRIMARY CARE

Patients are tracked throughout their care by 60 nurse navigators embedded throughout the health system. The nurse navigator is involved in the initial meeting with the patient and family and is responsible for follow-up and ongoing care. Nurse navigators also stay vigilant for potential crises that could prompt a hospital visit.

The model is resource-intensive, but it fits with a population health-oriented, accountable care model, explains Fortini. Bon Secours is committed to accountable care, with five ACOs. Fortini said the program is a good fit for health systems working to reduce unnecessary hospital admissions and was part of the reason the Bon Secours' Medicare shared savings plan's costs went down six percent last year.

The program has gained The Joint Commission's Advance Certification for Palliative Care for all four hospitals, a process that enhanced its focus on quality measures. Continuity and quality are also maintained by a Palliative Care Collaborative, a systemwide interdisciplinary work group that holds monthly conference calls and collaborates online to develop policy, best practices, educational initiatives and quality pilot projects.

Bon Secours has partnered with two other health systems in the Richmond area to introduce a comprehensive advanced care planning initiative based on the Respecting Choices® model. "While most people in Richmond thought this was important, very few had had conversations about it with anyone, and even fewer had filled out a document," explains Rebecca Gruszkos, who heads the advance care planning effort for Bon Secours. Each health system chose pilot sites, and 100 patients at each site are invited to participate in having conversations about their wishes at the end of life.

The unique thing about the Bon Secours Palliative Medicine, Fortini says, is the without walls approach; caring for the patient no matter where they are in their disease process or where they are receiving care. "In a lot of organizations, programs remain as silos," he says. "Here we've broken down the walls, which makes all the difference to patient-centered care."

It also helps to have a strong leader in Yanni, he says, who "has an army of nurses, social workers and chaplains who can be dispatched to help coordinate care. Dr. Yanni is driven and brilliant and inspires everyone on the team." •

MEMORIAL HERMANN PHYSICIAN NETWORK AND
SYMPTOM MANAGEMENT CONSULTANTS

Houston, Texas

Increased understanding and appreciation for palliative medicine is resulting in patients receiving this care earlier in their disease trajectory. Houston Nurse Practitioner Kelli Gershon tells about a man who worked as a science teacher in Michigan, where he lived in a beautiful lakeside home. He was diagnosed with pulmonary fibrosis, and as the disease progressed he was forced to retire and move to Houston to seek medical care. For 18 months the patient received curative treatment for his pulmonary fibrosis concurrently with palliative care services through the Memorial Hermann Physician Network’s Supportive Medicine program.

During that time, Gershon says, the supportive medicine team talked with the patient and his family about managing his symptoms and how he would want them treated as they worsened. “I helped him grieve his home by the lake and his job,” Gershon says. “When his health declined...we went out and did a family meeting. We told him, ‘You know you can go back to the hospital or transition to hospice here at home.’ He trusted us and he knew what readmission would look like and said no. His quality of life was not good.” The man transitioned to home hospice and died 15 days later.

To be most effective, supportive care needs time to build relationships among the team, patient and family, and that’s happening as the Houston program is reaching more physicians to get early referrals. “Now we’re getting patients at diagnosis,” explains Bernadette Brown, RN, nurse coordinator for Memorial Hermann’s Supportive



Medicine program. “They might have breast cancer with a great prognosis, but we know they are going to battle things and will need support through that.”

Earlier referrals are happening because of the way the Houston program is designed — supportive medicine is based out of the Memorial Hermann Physician Network, in partnership with Symptom Management Consultants, an independent medical group providing resources for supportive care.

Early on, says program founder Sandra Gomez, MD, the program’s name changed from palliative medicine to supportive medicine because of lingering misconceptions that palliative care is the same as hospice. “The program grew three times faster” once the name was changed, Gomez says. “We realized the term ‘palliative care’ had been confusing for some of our referral sources.”

Being based in the medical group allows flexibility so supportive care team members visit patients in the hospital, home, outpatient clinic and long-term care facilities. The physician group also helps integrate supportive care with the group’s ACO, so it works with fee-for-service or coordinated care payment.

“We’re trying to be strategic about caring for patients who are at higher risk,” Gomez explains. “Rather than seeing it as end-of-life care, it’s chronic at-risk care.”

The large physician group provides wide access to resources, explains Lafe Bauer, director of Supportive Medicine for the physician network. “Very few programs have the sheer mass of physicians, nurse practitioners, nurses, social workers and chaplains that we do,” Bauer says. “It’s allowed us to promote and grow the program and also to obtain some grant and federal funding.”

Supportive Medicine is one of about 50 physician network committees, and its members collaborate with other committees, such as critical care, to develop best practices to improve care for seriously ill patients.

The Memorial Hermann Supportive Medicine program is well situated to adjust to care and payment models that emphasize population health, Bauer said. “Physicians need to be champions for this frail, chronic, at-risk patient population,” he says. “Our physicians can be leaders in our field and help motivate other physicians to see the bigger picture.”



INNOVATION HIGHLIGHTS

INTEGRATED CLINICALLY

ACADEMIC AND COMMUNITY
SETTING MODELS

CARE ACROSS THE CONTINUUM

AWARD WINNER

CAMBIA PALLIATIVE CARE CENTER OF EXCELLENCE
AT UW MEDICINE

Seattle, Washington





When a moment of crisis comes for a patient whose life hangs in the balance, pain and fear can send family members in opposite directions, in intense conflict over whether medical interventions should continue. “By using narrative medicine — techniques to learn the patient’s own individual story and let it inform decisionmaking — families can be brought together,” says Carol Kummet, social worker with palliative care at Harborview Medical Center in Seattle.

She tells of a family shocked by a woman’s sudden brain death from an aneurysm, and the husband and daughter disagreed vehemently about organ donation. “We went into a family meeting and the daughter said she hoped her death would make a difference for others, while the husband said he wanted a comfortable and dignified death for his wife.” The palliative care team, asking more about her, heard story after story about her helping people. “She reached out to people new to the country and held English-as-a-second language classes in her home; she would walk people to government offices to help them fill out forms; she would bring food to people in the neighborhood who needed it,” Kummet recalls. “Everything she did in her life was to help others. Her husband then said, ‘Of course she would want to donate her organs; that would be a dignified death to her.’”

Situations like these — family members at deeply emotional odds about medical choices — are relatively common in hospitals and could easily tear families apart. Instead, Harborview’s palliative medicine team uses narrative medicine as one of many tools to help patients and families make choices focused on the person, not the technology.

Palliative care in the University of Washington system’s four hospitals, outpatient clinics and home health has been brought together under an umbrella organization. The Cambia Palliative Care Center of Excellence was established in 2012 to identify best practices in palliative care and provide it consistently across the UW health system’s continuum of care. The Center also brings together educational programs about palliative care across multiple disciplines and multiple schools. “Each hospital had its own service, and there were a number of individual educational programs in the schools of medicine, nursing and social work,” explains J. Randall Curtis, MD, MPH, the Center’s director and professor of medicine at UW. “It wasn’t coordinated in any way, so the Center was developed to allow all these efforts to coordinate activities, learn from each other and speak with a single voice.”

The Center coordinates palliative clinical care, education and research. A palliative care clinical strategic planning committee includes representatives from each hospital and meets monthly to share information and resources across the system. Quality is measured the same way at each hospital, and hospitals cooperate on pilot projects for care improvement. The four hospitals recently worked together to apply for and receive The Joint Commission Advanced Certification for Palliative Care.

“Through the Center, we have created a central place where people can come together and share ideas; the Center allows us to collaborate and be aware of what other people are working on,” explains Caroline Hurd, MD, director of education operations. The Center’s work to update comfort care orders, for instance, is a resource not just for UW but for other health care organizations in the region as well, she said. The Center is also developing an integrated curriculum for primary palliative care for students in nursing, social work, medicine and chaplaincy. “It’s a way for us to have a common language across all disciplines,” Hurd says.

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INNOVATION HIGHLIGHTS

**SHARED BUT ADAPTABLE
DELIVERY MODELS**

**CUTTING-EDGE RESEARCH
AND EDUCATION**

**STRONG COMMITMENT TO PRIMARY
PALLIATIVE CARE**

Even with palliative care teams at each hospital and a robust outpatient program in 11 neighborhood clinics and 14 assisted living facilities, leaders recognize that there aren't enough palliative care-trained professionals to meet the growing demand. So they have developed an extensive program to educate post-graduate trainees and practicing clinicians in the basics of palliative care, gaining skills such as determining goals of care and symptom control. "Those basic skills should be part of everybody's routine care," says Hurd.

Tuesday morning palliative care conferences include an hour of grand rounds and a second hour of training for learners of all types. To address the palliative care workforce shortage, the Center has developed a nine-month Graduate Certificate Program that trains interdisciplinary clinicians to become palliative care specialists. The Center also sponsors a yearly two-day conference that draws over 200 participants.

The Center also supports increased palliative care research at the University of Washington — from \$2.1 million in research grant funds in 2012 to well over \$7 million in 2015.

Patients and families have access to Harborview's Community House Calls services, where cultural mediators provide interpretation and support in the patient's language. The mediators are trained to assist patients facing complex medical and social circumstances.

The Center's Community Advisory Board provides input, such as hands-on editing of patient education materials. Priscilla Armstrong, a workforce development executive who serves as co-chairperson of the advisory board, joined after her mother received palliative care before her death from pulmonary fibrosis. The board advises center leaders on the patient and family perspective and also works in the community to provide education about palliative care. "We're not just a group of people sitting on the sidelines providing feedback," Armstrong says. "We feel like we're an integral part of the Center's work, which is incredibly rewarding."

The Cambia Palliative Care Center of Excellence has found a balance between standardizing care and practices across all of its sites while at the same time celebrating innovation, such as a small program providing palliative care outreach to people with marginal housing or who are homeless. "This is an institution that has always been very supportive and interested in improving patient- and family-centered care," says Curtis. "I came here to train and I stayed in large part because I felt palliative care was valued throughout the organization." •

MERIDIAN HEALTH PALLIATIVE CARE SERVICE

Neptune, New Jersey

Soon after Meridian Health, an integrated health system in New Jersey, established its palliative care program with a hospital-based team, it was clear that patients needed to be followed out of the hospital.

Program leaders expected to sign up a few hundred participants for an at-home Medicare pilot, funded by the Centers for Medicare & Medicaid Services (CMS). But the program ultimately enrolled 3,800 patients. “We were amazed — we blew everyone away, including CMS,” recalls Teri Cox, RN, administrator of Meridian’s palliative care program. And while the demonstration was funded for just four years, Meridian is taking the successful elements of the pilot and building a program it hopes will be supported by commercial payers.

“The demonstration was an amazing program and it allowed us to grow our service and learn so much about home-based palliative care,” says Amy Frieman, MD, the palliative care program’s medical director.

Because Meridian is an integrated health system that includes an accountable care organization, it is already oriented toward providing care across the continuum. Palliative care fits in well with that approach and supports efforts to avoid unnecessary inpatient stays and emergency department visits by supporting patients wherever they may be, including at home or in long-term care.



The home health demonstration provided valuable lessons, prompting the program to build up its social work component significantly. Started with one social worker, it now has five, explains Cox. “We found that the patient at home has a huge amount of psychosocial needs,” she says. “Many of the reasons they end up in the ER are not medical — they can’t afford their medications or couldn’t pay for their oxygen, so off they go to the ER. So we built up a very active social work component and brought that into the hospitals as well.”

Stephanie DePiano, the palliative care social work supervisor, says an essential element of successfully reaching seriously ill patients and resolving their problems is to take time to sit down with them one-on-one and develop a trusting relationship. “Then they open up, and you can help them with their coping skills, their quality of life,” DePiano says. Many also needed help with “concrete” resources such as transportation to a doctor’s appointment.

Coordinating palliative care from one setting to the next is eased through the use of an electronic medical record

system specific to the palliative care team; the system was customized in-house for the team’s use and can be accessed via the internet in any care location. Through that system, for instance, the palliative care team is notified when a patient on its service is hospitalized. A team member can see the patient in the hospital or ER and also update the hospital-based care team about the patient’s recent health status.

The program’s fastest growing component is its work in building a team to cover five skilled nursing facilities, Frieman says. “It was a process of building relationships and understanding that even though they are all Meridian facilities, they each have their own unique culture,” she says. “We had to learn how best to fit in and feel we are part of that facility and part of that team.”

DePiano credits the program with strong leadership from Frieman and the health system itself and with a culture that supports a true team approach. “Every member of the team really values the others’ abilities and skills,” she says. “We really work together to advocate for patients.”



INNOVATION HIGHLIGHTS

NEW DELIVERY STRUCTURES

COMMUNITY AND POST-ACUTE FOCUS

PAYMENT MODEL EXPERIMENTATION

AWARD WINNER

SUSQUEHANNA HEALTH HOSPICE
AND PALLIATIVE CARE

Williamsport, Pennsylvania





Williamsport is a small city nestled in the rural, forested, often mountainous part of north-central Pennsylvania. Susquehanna Health, the local hospital system, offers palliative care from a compassionate yet hearty team who go to unusual lengths to visit their patients wherever they may be — sometimes that means driving an hour outside of town, up a snowy mountain road into a hollow where people live without electricity, much less easy access to medical care.

“Much of our service area is very rural ... mountains all around us,” says Alexander Nesbitt, MD, the doctor who founded the palliative care service after seeing the need during his stint as a hospice medical director. “We worked really hard to be sure we are extending hospice care out of the home. And when somebody is sick and not ready for hospice we wanted to get them extra support and symptom management.”

Nesbitt, a longtime local family doctor, began the palliative care program in the hospital in 2005. “At the time nobody knew what palliative care was,” he recalls. Eventually the hospital in Williamsport opened a seven-bed hospice unit. Nesbitt was spreading the word among his medical colleagues at the system’s three small community hospitals, along with an unaffiliated critical access hospital, about the difference between hospice and palliative care and gaining referrals for seriously ill patients who needed attention to their symptoms and social needs well before the end of life. As the palliative care service became busier, it raised the question of what happened to these patients when they were discharged from the hospital.

That’s how Susquehanna’s outreach to local nursing homes began in 2007, well before it was common to offer palliative care in that setting. Nancy Patchen, RN, a longtime hospice nurse, was hired to start working with patients at one of the local nursing homes. Since then, the program has grown to eight nursing homes and three assisted living facilities, served by three advanced practice nurses.

They introduced the program one nursing home at a time, explaining to administrators and staff the value of working with elderly or very sick people and their families about goals of care and symptom control to avoid hospital stays and improve their quality of life. “We work our way into the culture of the facility,” Patchen says. “Each one is different. You have to figure out how each one works.” Those where administrators are supportive are easier, but every time there’s a process of educating physicians and nursing staff at the facilities about what palliative care can offer.

Palliative care techniques can be particularly helpful in helping elderly patients voice their preferences and having the family hear that, Patchen says. “Sometimes people are ‘full codes,’ and they are 90 years old,” she says. “We help people understand that a full code is not what you see on television and explain the success rates may not be what people expect.” At the same time, they realize that sometimes residents want to have every medical treatment available. “Some people definitely want to go back and forth to the hospital. That’s OK too; we don’t try to change people’s minds.”

To expand the types of care elderly residents of long-term care can receive, Susquehanna has started providing a geriatric medicine component. Karen Clark, RN, a certified registered nurse practitioner who started the palliative care program with Nesbitt, has been the nucleus for this developing element. “I specialized in geriatrics before I did palliative care, and I like doing it,” says Clark. She spends

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INNOVATION HIGHLIGHTS

EMBEDDED WITHIN CARE SYSTEM

LONG-TERM CARE FACILITY IMPACT

COORDINATED OUTREACH TO
RURAL COMMUNITIES

one day a week at the inpatient hospice and then splits the rest of the week between two nursing facilities where she provides basic medical care but can also offer palliative services and referral to hospice if needed.

That kind of flexibility has allowed a small health system in a rural area with modest resources to grow a palliative care program that is responsive to the community's needs and culture. Because Susquehanna's service area includes people with a variety of religious and cultural backgrounds (including Amish), the palliative care team has had to be sensitive to patients and families with varying levels of trust in the health care system and issues around end-of-life care. Nesbitt says they learned that in many communities they served, trust was more about relationships and less about filling out paperwork. So their approach to advance care planning is to talk about the individual and what they want, but to do so in the context of their families and loved ones and how end-of-life care could impact those relationships.

The Susquehanna palliative care program promotes advance care planning in the community, obtaining grant support to provide training for more than 450 facilitators throughout the community to foster discussions about end-of-life care and preferences and to support the broad use of the POLST form. Local nursing homes now routinely use the form among residents.

The program educates physicians and nurses in primary palliative care techniques both formally and informally. "If in the hospital we realize the nurses are really afraid to give opioids for a person short of breath because they are afraid they will die, we offer a focused talk by one of our team about the facts behind opioid use, what is safe and what isn't and how to treat the symptom," Nesbitt says.

They've looked for other ways to improve the quality of inpatient care for the sickest patients. For instance, the team established an ICU trigger system that prompts a request to the attending physician for a palliative care consultation for any of six illnesses or conditions for which patients might do better being transitioned to a different setting once their goals of care and preferences were identified.

Meanwhile, the team spends time reaching out to the community to encourage conversations about living with serious illness and preferences at the end of life. "Palliative care is this medical movement, but it's very important that we reach beyond the medical world and work closely with other elements of the community," Nesbitt says. "We're working with the legal, social services and faith communities. That's really important if we're going to change the culture broadly speaking." •

CITATION OF HONOR

OSF HEALTHCARE

Peoria, Illinois

When Karen Renken was training for her position leading advance care planning for OSF Health, a large Midwest integrated health care system, she had to work through challenging scenarios with patients played by actors who provide a surprisingly realistic experience. In one scenario, she had to help a young single mother with cancer trying to fill out an advance directive while distracted by intractable pain. She chose to put off the paperwork and instead have an introductory conversation about the woman's expectations as her illness progressed.

"We go in there and know what we want to accomplish — to get the discussion record completed and talk with them," says Renken. "But in real life, sometimes it doesn't happen in the first visit because there's so much information to be shared, so many questions to be answered."

OSF's advance care planning program has been in place since 2008; simulations with actors are a recent addition. The program trains health care professionals in all of OSF's 11 hospitals, home care and medical group and in four other non-system hospitals. OSF care managers, home care staff and nurses must carry out at least 10 advance care planning sessions with patients each year to remain certified.

Advance care planning is a major part of OSF Health's supportive care program, which also includes palliative care and hospice, both of which are



well integrated throughout the system. Supportive Care got its start in 2005, when OSF took a closer look at how it could help patients plan sooner and more thoughtfully about the end of life. "We recognized very quickly that you cannot do great end-of-life care if you wait until the end of life," says Robert Sawicki, MD, senior vice president of OSF Supportive Care. "Instead of focusing just on a good model of end-of-life care, we wanted to develop something more comprehensive."

Communication with patients and families around goals of care and symptom management is central to supportive care, which is managed both at the system level and individually at each of OSF's hospitals, which range from its 600-bed flagship medical center to small critical access hospitals and may each have different needs and approaches.

Supportive care has also become an essential part of OSF's accountable care organization. OSF used data analysis supporting population health efforts to determine a patient's risk score for serious illness. The risk score can prompt advance care planning conversations and potentially referral

to palliative care. "An ACO environment needs a good, strong supportive care service to do well," explains Sawicki.

The system is also focusing on care transitions and patients' needs post-discharge; those leaving the hospital or entering a nursing home go through an advance care planning review. An outpatient palliative care program developed through a pilot is now widespread; analysis shows patients have lower readmission rates and better satisfaction. Patients can always change their advance directives but having it on record is helpful as a reminder during conversations with their providers later in their illnesses, explains Linda Fehr, RN, director of OSF Supportive Care.

Fehr says the emphasis on advance care planning helps patients, families and the health system as well. "It gives the patient more decisionmaking power and encourages them to be informed about what options are available to them," Fehr says. "It also saves money and readmissions, but that's not the reason we do it. Our organization's mission is to treat patients with the greatest care and love, and supportive care is an essential part of that."



INNOVATION HIGHLIGHTS

ADVANCE CARE PLANNING ACROSS GEOGRAPHIC AREA

STANDARDIZING CONVERSATIONS

GOAL COMMUNICATION ACROSS PROVIDERS

2015-2016 CIRCLE OF LIFE
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For more information on the Circle of Life Award program or to receive materials for future Circle of Life Awards, please e-mail circleoflife@aha.org, call the AHA Office of the Secretary at 312-422-2700, or write the Office of the Secretary, American Hospital Association, 155 North Wacker, Suite 400, Chicago, Illinois 60606.

2000-2015 CIRCLE OF LIFE
AWARD WINNERS*

2000

The Hospice of the Florida Suncoast
Largo, Florida

Louisiana State Penitentiary
Hospice Program
Angola, Louisiana

Improving Health Care Through the
End of Life
Franciscan Health System
Gig Harbor, Washington

2001

Department of Pain Medicine and
Palliative Care
Beth Israel Medical Center
New York, New York

Palliative CareCenter & Hospice of the
North Shore
Evanston, Illinois

Compassionate Care Focus
St. Joseph's Manor
Trumbull, Connecticut

2002

Children's Program of San Diego
Hospice and Children's Hospital
and Health Center
San Diego, California

Hospice of the Bluegrass
Lexington, Kentucky

Project Safe Conduct
Hospice of the Western Reserve
and Ireland Cancer Center
Cleveland, Ohio

Population-Based Palliative Care
Research Network (PoPCRN)
Special Award Winner
Denver, Colorado

2003

Hospice & Palliative CareCenter
Winston-Salem, North Carolina

Providence Health System
Portland, Oregon

University of California Davis
Health System
Sacramento, California

2004

Hope Hospice & Palliative Care
Fort Myers, Florida

St. Mary's Healthcare System
for Children
Bayside, New York

University of Texas M.D. Anderson
Cancer Center
Symptom Control and Palliative
Care Program
Houston, Texas

2005

High Point Regional Health System
High Point, North Carolina

Palliative and End-of-Life Care Program
Hoag Memorial Hospital Presbyterian
Newport Beach, California

Thomas Palliative Care Unit
VCU Massey Cancer Center
Richmond, Virginia

*For updates on the work of these organizations, see
<http://www.aha.org/aha/news-center/awards/circle-of-life/circofinfluence.html>

2000-2015 CIRCLE OF LIFE
AWARD WINNERS*

2006

Continuum Hospice Care
New York, New York

Mercy Supportive Care
St. Joseph Mercy Oakland
Pontiac, Michigan

Transitions and Life Choices
Fairview Health Services
Minneapolis, Minnesota

2007

Covenant Hospice
Pensacola, Florida

University of California San Francisco
Palliative Care Program
San Francisco, California

Woodwell
A Program of Presbyterian SeniorCare
and Family Hospice and Palliative Care
Oakmont, Pennsylvania

2008

Pain and Palliative Care Program
Children's Hospitals and Clinics
of Minnesota
Minneapolis/St. Paul, Minnesota

Haven Hospice
Gainesville, Florida

Pediatric Advanced Care Team
Children's Hospital of Philadelphia
Philadelphia, Pennsylvania

2009

Four Seasons
Flat Rock, North Carolina

Oregon Health and Science University
Palliative Medicine and
Comfort Care Program
Portland, Oregon

Wishard Health Services
Palliative Care Program
Indianapolis, Indiana

2010

Kansas City Hospice & Palliative Care
Kansas City, Missouri

Snohomish Palliative Partnership
Everett, Washington

Department of Veterans Affairs
VA New York/New Jersey
Healthcare Network
Brooklyn, New York

2011

The Center for Hospice &
Palliative Care
Cheektowaga, New York

Gilchrist Hospice Care
Hunt Valley, Maryland

St. John Providence Health System
Detroit, Michigan

2012

Haslinger Family Pediatric Palliative
Care Center
Akron Children's Hospital
Akron, Ohio

Calvary Hospital
Bronx, New York

Sharp HealthCare
San Diego, California

2013

The Denver Hospice
Denver, Colorado

Hertzberg Palliative Care Institute
Mount Sinai Medical Center
New York, New York

UnityPoint Health
Iowa and Illinois

2014

Baylor Health Care System
Supportive and Palliative Care Services
Dallas, Texas

Lehigh Valley Health Network
Allentown, Pennsylvania

Yakima Valley Memorial Hospital
and Foundation
Yakima, Washington

2015

Care Dimensions
Danvers, Massachusetts

*For updates on the work of these organizations, see
<http://www.aha.org/aha/news-center/awards/circle-of-life/circofinfluence.html>



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