California
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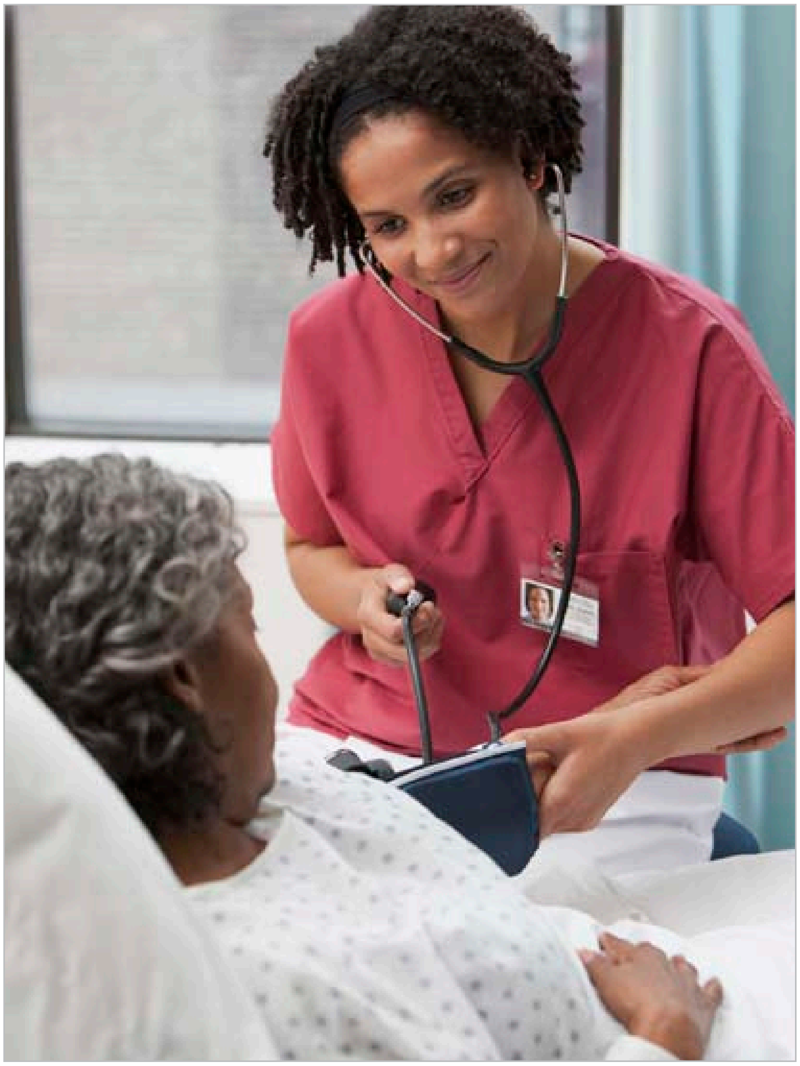

Creating a Palliative Care Program: Insights from Hospital Leaders

February 2010

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About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

Contents

I. Introduction

THROUGH PAIN MANAGEMENT, COMFORT care, and spiritual support, palliative care programs seek to optimize quality of life and relieve physical and emotional suffering for patients with a life-threatening condition. Unlike hospice, palliative care is not limited to the last months of life and can be provided simultaneously with curative measures, thus giving physicians, patients, and families maximum flexibility in tailoring care to each individual.

Palliative care programs typically offer benefits to hospitals in terms of substantial cost-savings, improved patient and staff satisfaction, and enhanced regional reputation. In California, palliative care programs are on the way to becoming the community standard in private as well as public hospitals. Among the 325 California hospitals responding to a recent CHCF survey, 43 percent now have palliative care programs and 90 percent of those were launched since 2000.

As part of its commitment to promote appropriate end-of-life care, the California HealthCare Foundation has embarked on several projects to encourage hospitals to develop new, sustainable palliative care programs. In addition to sponsoring a statewide survey of programs in California hospitals, CHCF is working closely with selected public hospitals to support expansion and enhancement of existing public hospital programs.

To enlighten leaders of California hospitals currently without palliative care services about how these services can work to the benefit of patients and hospitals, CHCF spoke with several hospital leaders from a wide variety of backgrounds, including:

- A district hospital;
- A community hospital within a for-profit system;
- A community hospital within a nonprofit system;
- A system-wide program;
- A large urban medical center that is part of a nonprofit system; and
- A program shared across a group of small community hospitals.

Their experiences with palliative care are summarized in the case studies beginning on page 13. Further resources can be found beginning on page 17.

II. California: A Call to Action

"When you've got a 92-year-old in the ICU who has six co-morbidities and is still pain-responsive, how could you possibly believe that dialysis and everything else is the right thing to be doing at that time in the patient's life?"

This was one of the questions that Martin Brotman, M.D., former CEO of California Pacific Medical Center (CPMC) in San Francisco, considered while taking the first steps to create a palliative care program at the hospital in the late 90s. "Just as we provide the best in prenatal care, and at the other life bookend we provide hospice, we felt that part of the continuum of excellent care is palliative care," Brotman explained.

Having appropriate end-of-life care is very important to Californians, nearly half of whom will likely spend their final days in a hospital. When recently asked to think about death and dying, California residents voiced the following as their greatest concerns:[1]

- Having pain and discomfort — 68 percent;
- Being a burden to family or friends — 63 percent;
- Not being able to get or pay for care — 62 percent;
- Finding health care providers to understand and respect values — 59 percent; and
- Being at peace spiritually — 56 percent.

Palliative care is responsive to such concerns. While focused primarily on the relief of symptoms, palliative care — unlike hospice — does not preclude attempts to cure disease or to prolong life, and does not require a prognosis of a short lifespan. This "blended care" approach is focused on ameliorating symptoms at any stage of an illness. Further, it provides patients with education and information that enables some to care for themselves more effectively outside an institutional setting. For many people — especially those whose illness is characterized by alternating periods of debility and relative wellness — combining palliative and curative care offers a comprehensive regimen sensitive to individual needs and input.

For many people, palliative care, with its attention to relieving pain, is also more humane than conventional medical care. A national study published in 1999 revealed that 40 percent of all patients experienced moderate to severe pain at least half the time in the last three days of their lives.[2]

When CPMC initiated its palliative services nearly a decade ago, there were few models to emulate. Since then, California has begun to emerge as a national leader in structuring and promoting palliative care services in hospitals. For example, California is among the few states that required physicians (except radiologists and pathologists) to have at least 12 hours of continuing education in pain management and palliative care. More than half (57 percent) of the state's teaching hospitals have a palliative care training program for new physicians.

State programs have also gotten a boost from several sources, including the California Hospital Initiative in Palliative Services (CHIPS) — a pioneering effort that helped hospitals establish programs from 2001 to 2003 — and the Palliative Care Leadership Centers initiative at the University of California, San Francisco, which trains and mentors providers.

III. Hospitals Benefit

Brotman and others who have started palliative care programs in California emphasize that while enhancing the quality of care is the main impetus behind these initiatives, the programs also offer other benefits—including financial savings, increased satisfaction of staff and patients, and even a competitive edge in the market.

Palliative care programs can help hospitals avoid costs in several ways: by eliminating redundant, unproductive, and unwanted care and related supplies and services, and by reducing lengths of stay and ICU days. With average variable costs for an ICU day close to $1,000 higher than the costs of an acute care day, potential savings are substantial. Since many patients have ICU stays of longer than ten days, a palliative care team can achieve large savings by influencing the care of only a few dozen patients.[3]

According to Andrew Lasher, M.D., director of palliative medicine at CPMC, the savings afforded by reduced lengths of stay and improved utilization more than paid for the costs of the program there. “Nobody will ever love you for the money you save the hospital versus the money you generate,” Lasher noted. “But in our palliative care program, it’s a large enough sum that it’s really meaningful.” A recent study of 282 patients in CPMC’s palliative care consultation service documented $2.2 million in annual savings as well as improved clinical outcomes, including:[4]

- 33 percent reduction in mean daily costs;
- 30 percent reduction in mean length of stay;
- 14.5 percent lower daily costs for palliative care compared to usual care patients;
- 86 percent reduction in pain scores;
- 64 percent reduction in dyspnea scores; and
- 87 percent reduction in secretion scores.

Additional direct savings come from adjustments in the use of supplies, lab tests, radiology, respiratory care, and medicines. A recent study found that palliative care programs save the typical 300-bed hospital $1.3 million in annual direct costs by avoiding aggressive care.[5]

Indirect savings also accrue as the result of efficiencies such as improved patient flow, which helps relieve bed shortages and decreases the need for emergency services.

A Cost Savings Comparison

A recent comparison of care for patients during their last three days of life showed an average per patient cost savings of $2,179 for patients who received palliative care services at the University of California, San Francisco, Moffitt-Long Hospital.

COST	WITHOUT PALLIATIVE CARE	WITH PALLIATIVE CARE	SAVINGS
Pharmacy	$793	$31	$762
Laboratory	138	7	131
Radiology	57	2	55
Room and Care	837	412	425
Services	616	16	600
Supplies	230	24	206
All Costs	**$2,671**	**$492**	**$2,179**

Source: *When Compassion Is the Cure: The Case for Hospital-Based Palliative Care*, California HealthCare Foundation, 2008.

One way to estimate savings is to consider the number of new palliative care consultations that would be generated per week, since palliative care patients are less expensive to treat than acute care or ICU patients. For example, if the hospital serves a target population of 500 over the course of a year, and 25 percent opt for palliative care, that would result in an average of about two to three new consultations per week.[6]

The Center to Advance Palliative Care offers an overview of potential consultation volume and hospital cost avoidance over five years of operation in its Cost Avoidance Calculator (www.capc.org/tools-for-palliative-care-programs/finance/programs-in-early-development/cost-avoidance-calculator.xls).

IV. Paying for the Programs

Start-up costs — especially for consultative programs — can be minimal, according to program administrators, and other costs can be scaled to fit available resources. Salary and benefits for the clinical team and support staff are usually the biggest expenses involved. Most palliative care teams are composed of several types of professionals. Physicians are included in 87 percent of programs; spiritual care professionals — 81 percent; social workers — 76 percent; registered nurses — 74 percent; and nurse practitioners or clinical nurse specialists — 66 percent.[7]

Additional expenses may include: costs of advanced training, marketing and educational materials for referring providers; patient educational materials; and patient amenities.

CPMC's Andrew Lasher advises CEOs to work within a realistic budget: "It's critical to use the resources that are strong in your hospital, because we don't live in Shangri-la," he said. "We may not have a dedicated, full-time social worker and a dedicated full-time case manager and dedicated chaplain and bereavement services all provided by the hospital. It's the rare palliative care service that provides all of those things."

The large majority of palliative care programs — 85 percent — receive some financial support from their hospitals, according to a recent survey. The breakdown of support dollars shows:

- 48 percent receive direct support;
- 24 percent get both direct and in-kind; and
- 13 percent receive in-kind only.

For programs that received no financial support from their hospitals:

- 33 percent relied on fee billing by physicians or nurse practitioners;
- 28 percent received donations;
- 11 percent got hospice funding; and
- 6 percent received money from grants.[8]

According to Martin Brotman, one gauge of success is the community's willingness to support the program. "One of the ways that I can test whether we're doing the right thing for the community is whether or not our philanthropic foundation is prepared to raise money for or invest in a program that we want to do," he said. "And our foundation was very interested in helping."

V. Offering Quality Care

Many hospital administrators say they were motivated to add a palliative care program because they viewed it as part of their institution's mission of meeting patients' needs with quality care. Among them is Robert Beehler, CEO at San Joaquin Community Hospital: "Palliative care is a growing new medical specialty that improves the quality of life for those with serious or advanced-stage disease and focuses on patient-centered goals of care. That is very consistent with our mission," he said.

Rob Curry, president and CEO of Citrus Valley Health Partners, put it simply: "There should be dignity in the last years of life. There should be awareness of patients' expectations and wishes. That may sound glib," Curry added, "but I mean it as genuinely and passionately as I can say it."

Palliative care supports patient dignity in a number of ways. The approach calls for openly discussing sensitive issues of treatment goals and quality of life, encouraging patient input, and tailoring care to the patient's preferences. Clinicians help patients assess the potential benefits of their treatment choices against the downside factors of risk, side effects, and discomfort.

"Palliative care makes the important distinction between care that will add value to a patient and care that will simply sustain life without considering the value of that life from the patient's perspective," said Lindsay Mann, CEO of Kaweah Delta Health Care District in Visalia. "That helps patients and family members ask how an organization can respond to their needs and their desires and to question the value of various medical treatments that might be offered. Those are questions that we too infrequently ask," he said.

Because palliative care patients generally have continuing needs after they leave the hospital, all programs either provide for post-discharge services or make referrals for community care. The program at Citrus Valley Health Partners, for example, has a community-based RN who follows up with patients. David Kessler, vice president of patient services and co-author with Elisabeth Kübler Ross of two books on end-of-life care, recalls learning the value of these services while caring for a young patient who was hospitalized repeatedly after a catastrophic injury: "We would get him home, and something would always go wrong," he said. "We could never quite figure out why he would keep turning up at our emergency room." The nurse went to the home and found that the patient would get short of breath and his family went to an illegal DME provider and bought expensive oxygen canisters that they had to change every two hours throughout the day and night.

Said Kessler: "How would you ever know a family was doing something like that until you reached into their home to help them? You just don't see those things from inside the hospital." The doctor's office would get reports that showed he was on oxygen and there were no problems. Yet the family was exhausted from staying up every night, changing oxygen canisters, and would eventually run out of money. The palliative care program was able to teach the family about managing shortness of breath and that there were resources to pay for oxygen at home.

VI. Catalysts for Change

While there are several different models for offering palliative care in hospitals—including consultation services, inpatient units, and swing-bed units—research shows that the most important success factor is the presence of clinician advocates committed to making it succeed.

At some hospitals, it is the CEO listening to key medical leaders who fosters the move to embrace palliative care. According to Kaweah Delta Medical Center's Lindsay Mann, "A lot of great services start because the chief executive is prepared to understand someone else's vision and make sure the path is clear to implement that vision." Said Mann, "It's very important that the chief executive create a supportive environment, a place where change is welcome, where new services will be considered and be given full support."

Other CEOs were more skeptical of palliative care, at least initially. Robert Beehler, CEO at San Joaquin Community Hospital, acknowledged: "I guess I was the hardest sell" when a program was first proposed in 2005. However, Beehler agreed to a test of palliative care and to track the reduction in ICU length of stay. "The data looked good when we verified it," he said, "and the rest is history."

Staff physicians often serve as the catalysts for change. Recalled CPMC's Martin Brotman: "It usually begins with very thoughtful physicians who try to practice both the art and the science of medicine—and palliative care is an excellent component of the art of medicine," he said. "We had physicians who said you can't just have science, science, science, science—and then death."

San Joaquin Community Hospital's palliative program began as "a nurse-driven change," according to Karen Garner, director of palliative care and the step-down unit. It was championed by an individual RN who also has a background in chaplain work. "She saw the need for palliative care and also saw that we had patient circumstances where palliative care consults and the team approach would be very helpful," said Garner. "And she's also the one who gathered up some of the statistical information and took it to the vice president of nursing and the CEO."

Physicians were encouraged to participate in San Joaquin's program through a number of tactics, according to CEO Robert Beehler. A physician champion was identified, staff doctors were oriented through meetings and a newsletter, and a great deal of energy went to strengthening working relationships among staff physicians and palliative care team members. "Palliative care supports the primary physician in many ways—most importantly, by providing the time-intensive patient and family conversations and follow-up that are necessary," Beehler said.

Rob Curry, who was CEO at O'Connor Hospital in San Jose before heading up Citrus Valley Health Partners, emphasized the importance of having a physician on the palliative care team. "From my experience at O'Connor, I found that a physician presence really did help give the program some real credibility and even—I'll use the word authority," he said. "We had a medical director—a very well-trained and very energetic physician part-time; also a family nurse practitioner and staff of nurses, social workers, even chaplains and pharmacists. So it was a team there, under the direction of a medical director. I was pleased to come to Citrus Valley and see the fine job our COO, Elvia Foulke, and David Kessler had done in setting up palliative care here."

Several hospital CEOs reported that staff satisfaction increased following the creation of a palliative care program. Andrew Lasher at CPMC pointed out that palliative care can be most satisfying for both patients and practitioners if the referral is made early. "It's very hard, as a consultant, to come in and do your best work in a situation where you have a patient who is actively dying," he said. "It's much easier to earn trust, to be able to change a situation overall, if you're able to build that relationship. And it's much easier to do that when you can come in and focus on the symptoms and the situation rather than the sheer fact that someone's dying. We're talking about how to make the last chapter of someone's life better in every sense — whether that's hours, days, weeks, months, or longer."

Karen Garner at San Joaquin Community Hospital described the staff reaction at her organization: "Not only has the staff satisfaction grown, but we had champions for End-of-Life Nursing Education Consortium or ELNEC training,[9] and they have then gone out and recruited end-of-life experts on all of the units to try to champion dignity during end-of-life care," she said. Garner's experience underscores a point made by others with experience in palliative care programs — that having multiple champions is preferable to having only one.

VII. Overcoming Resistance

It is not unusual for some medical staff members to resist the creation of a palliative care program because of a variety of perceptions: that patients will be removed from their care, that "cure" will no longer be the goal of care, and that patients will feel abandoned.

Educating physicians about palliative care can reduce such resistance, according to some hospital executives. A number said that having a physician medical director for the program also helps build acceptance among medical staff. San Joaquin Community Hospital's Robert Beehler noted: "Most physicians are quite happy for the help once they realize what palliative care is and is not—and that we won't steal their patients."

An incentive compensation system was used at Catholic Healthcare West (CHW) for senior officers, hospital presidents, and some of the others involved in the hospital system's palliative care program. Said George Bo-Linn, M.D., former CHW chief medical officer, "We measured the capacity of those who were to execute the project and their understanding of and skills in doing the basic implementation. We also ensured that there was a database that allowed timely and transparent data uploads to an Excel spreadsheet and Access database so everyone knew where they were. We set up a template tracking each specific program target in red or green. If it was red, then you had to fix it within a certain period of time. If it was green, then you had to keep making progress," he recounted.

Bo-Linn said it was this rigorous documentation that got the CEOs at 41 CHW hospitals in three states to buy into the concept of palliative care—and to assure them that specific tasks would be accomplished within a particular timeframe, with demonstrable costs and savings.

Dennis Litos had the benefit of experience in instituting palliative care in a Michigan hospital before endeavoring to start up a program at Tenet's Doctors Medical Center of Modesto. In Michigan, he said, the greatest resistance came from the executive committee of the medical staff. "This time around, I will play a lead role with the chief of staff and our chief medical officer," he said. "We'll meet in advance with our two hospitalist champions and address any concerns before we meet with the executive medical staff." Litos added: "One convincing argument to physicians is that any arrangement with managed care and managed Medicare is the incentive for physicians to provide care in the most cost-effective way possible."

Proximity to palliative care in a nearby facility can also be helpful in overcoming resistance, according to Citrus Valley Health Partner's David Kessler, whose bilingual palliative care team is in each of their three hospitals. "We have many of our physicians in the buildings next door. It's a geographical advantage that some hospitals have, some don't," Kessler said. "So many times physicians would call us to their offices because they realized that we could help them break bad news in the hospital, but we could also help them in their offices and begin that relationship early on. And once you help a physician in his office, he's certainly going to be willing to help you throughout the process and make sure that we have an ongoing relationship with that patient."

Kessler also pointed to the importance of outreach, of explaining to physicians that palliative programs can help lighten their load. "I went to our physicians and introduced this as a program that originated from them and for them to help with their medically complex patients. It's a timesaver for them," he said. "When they go into the patient's room to do a code discussion, to give the facts, it takes three to five minutes; but the family may want to discuss the what-ifs for 45 minutes — and we could stay behind and discuss all the what-ifs and let the physician just give the main points."

Lindsay Mann of Kaweah Delta Medical Center pointed out a subtle potential form of resistance to palliative care in hospitals — that many physicians are uncomfortable talking about death. "Some physicians are naturally oriented to recommend palliative care to a patient, where others are much more reticent to actually having that discussion with a patient and family members about palliative care or hospice as opposed to providing the nth level of potential intervention," said Mann. "It's an education process for physicians that I would characterize as ongoing."

Physician education about the specifics of pain relief is also important, according to Karrie Decker, director of Kaweah Delta Home Services and Skilled Nursing. "A significant area of concern to people who are dying or who have a severe chronic disease is they don't want to die in pain," she said. "A tremendous amount of palliative care education is based on the pharmacology around successful pain management. It's about finding a way of controlling pain without leaving people so snowed that they can't communicate, balancing those meds and getting the right dosing so that they'll feel comfortable and able to enjoy life."

It is also important to address the unease of pain management professionals who are already on staff and may not welcome palliative specialists. CEOs can help ease this wariness by underscoring that palliative care complements pain management by providing psychological and spiritual services for patients, and dealing with family conflicts surrounding care.

Another way to garner the support of existing professionals is by involving them in developing a new program. David Kessler of Citrus Valley Health Partners said, "We looked at the barriers that people were facing with palliative care programs being introduced, and did not want to go in and say, 'We're replacing the social worker, the chaplain; we have a whole team.'" He added, "We found that with three hospitals and so many different units, we could design a program best suited to our patients by integrating the people who were already working with those patients."

By listening to and learning from staff, said Kessler, Citrus Valley helped overcome the common misperception that hospitals already provide palliative care. "One of our oncologists said, 'At first, I was a little suspect, but we had a very young patient in our ICU that we worked with, and the patient's family explained to us that they understood what they were doing might be futile, but that, culturally, they needed to do it,'" Kessler recalled. "And palliative care fought very hard for them to get all the care they wanted. Afterward, that oncologist said, 'You know, I realized if you were going to fight for aggressive care as well as comfort care, that then I could truly believe in a palliative care program.'"

CPMC's Lasher also stressed the importance of forging strong alliances among staff. "At our hospital, the oncology social worker and I are joined at the hip," he said. "She comes to our weekly interdisciplinary team meetings, and she brings patients to me who may benefit from my help so I can talk to the doctors and work the back channels. We have a chaplain supervisor dedicated to us. And our hospital has a brilliant complementary-medicine clinic, the Institute for Health and Healing, that provides services such as massage therapy and guided imagery and outpatient acupuncture. These are important alliances."

VIII. Conclusion

SEVERAL OF THE EXECUTIVES INTERVIEWED for this report indicated that because palliative care is in sync with current standards of care, it is simply part of being a full service hospital. They were also sensitive to the importance of doing what is right for patients, particularly those facing final illnesses.

"If you don't give these patients the right care at the right time, there are only two alternatives," asserted CPMC's Brotman: "Either they will suffer miserably because the physicians don't have anything to offer them, or they will continue in an acute care setting with care that does not help them. You're not going to do surgery without the availability of anesthesia," he said. "Why would you take care of end of life without having palliative care? Futile care is cruel."

Such treatment is also financially unsustainable, asserted Mann, because it is not cost-effective. "Chief executives have to look at the bottom line and the impact of their decisions in a very resource-constrained world — right now particularly," he said. "And as futile care is avoided, the hospital will find itself with more, not less, resources to care for the patients requiring medical intervention."

IX. Palliative Program Case Studies

California Pacific Medical Center

CPMC is a large, private, community-based, nonprofit teaching medical center with several urban San Francisco locations, including: California Campus with 281 beds; Pacific Campus with 293 beds; Davies Campus with 212 beds; and St. Luke's Campus with 215 beds. CPMC is affiliated with Sutter Health.

People Interviewed

- Martin Brotman, M.D., former president and CEO; now president of the West Bay region of Sutter Health
- Andrew Lasher, M.D., director of palliative medicine

Type of Palliative Care Program

The program began in 2004 with a nurse practitioner providing consultation services, and has expanded to three locations, with a palliative care physician, nurse practitioner, and clinical nurse specialist now providing care to 80 to 100 new consults per month. Additional models in place include a dedicated palliative care unit and a swing unit.

Other Salient Details

The palliative care programs receive substantial financial support through donations from the philanthropic foundation.

Catholic Healthcare West

Based in San Francisco, CHW is the largest hospital system in California, with 33 locations and 9,700 licensed beds in rural and urban areas throughout the state.

Person Interviewed

George Bo-Linn, M.D., former chief medical officer; now chief program officer of the Gordon and Betty Moore Foundation

Type of Palliative Care Program

All CHW hospitals have consultative palliative care services. The teams vary in composition, but most consist of a nurse, social worker, chaplain, and physician, many of them certified in palliative medicine. In fiscal year 2009, they treated more than 14,000 consults.

Other Salient Details

An initiative launched in 2003 resulted in 36 hospitals within the tri-state system covering California, Arizona, and Nevada adopting palliative care programs. The programs are self-funded and financial incentives are offered to participating hospital administrators. Since their inception, the programs have been monitored by quality improvement metrics — such as discharges to hospice, patient satisfaction with pain management, and advance care planning. Advance care discussions with a patient and family cover code status, options for treatment, and pain and symptom management. The baseline systemwide mean for advance care planning was 15 percent in 2003 and 80 percent in 2009.

Citrus Valley Health Partners

Nonprofit Citrus Valley has three California community-based hospitals and a freestanding hospice unit, including: Inter-Community Campus, with 222 beds, in Covina; Queen of the Valley Campus, with 325 beds, in West Covina; Foothill Presbyterian Hospital, with 105 beds, in Glendora; and Citrus Valley Hospice, a freestanding hospice unit with ten beds, in West Covina.

People Interviewed

- Robert Curry, president and chief executive officer
- David Kessler, vice president of patient care services and chairperson of the Palliative Care Committee, Hospital Association of Southern California

Type of Palliative Care Program

Inpatient consultative service operating across three hospitals, as well as a community-based outpatient palliative care service. The palliative care team includes a physician medical director, social workers, chaplain, pharmacist, nurses, and dietician. It also has a freestanding hospice unit as well as home hospice and home health care.

Other Salient Details

Established in 2001 with a start-up grant of $560,000 for three years from the UniHealth Foundation and now funded directly by the hospital, the palliative care programs take in about 300 new consults annually through a physician order process. A community-based nurse follows patients post-discharge. Special care was taken to hire bilingual nurses to meet the needs of the communities served. Cost savings in the early years of program operation tracked $248,000 in hospital savings, $213,000 in bed opportunity, and more than $176,000 in hospice revenue.

Doctors Medical Center

Part of the Tenet system, Doctors Medical Center is a for-profit community hospital in Modesto with 456 beds. Tenet operates 11 acute care hospitals in California and 50 nationwide.

Person Interviewed

Dennis Litos, chief executive officer

Type of Palliative Care Program

Consultative model started in early 2010, staffed by a medical director, with clinical nurses, social workers, and hospitalists

Other Salient Details

Doctors Medical Center is one of the few hospitals within the Tenet system to offer a palliative care program. Impetus for the program came from two physicians working with the hospital's inpatient and outpatient hospice services, who rallied support from other staff physicians.

Kaweah Delta Health Care District

Operating as a political subdivision of the state, the Kaweah Delta Health Care District operates a nonprofit, single-hospital system in Visalia with 581 beds.

People Interviewed

- Lindsay Mann, chief executive officer
- Karrie Decker, director of the home health agency

Type of Palliative Care Program

Program is staffed by a medical director with specialized palliative care training and a palliative care RN who is a former hospice nurse. A chaplain, social services, and other specialists are pulled in as needed, not dedicated to program. The estimated number of patients treated annually includes: 500 to 600 hospital patients, 80 to 90 home health patients, and 50 to 60 transitional care patients.

Other Salient Details

Kaweah Delta Health Care District's palliative care program, initiated in November 2005, is funded by the hospital through the reduction in costs associated with aggressive care. Site functions as the sole palliative care provider in the area; other hospitals in the two-county vicinity do not offer it.

San Joaquin Community Hospital

Part of the Adventist Health System, San Joaquin Community Hospital in Bakersfield is a nonprofit institution with 259 beds.

People Interviewed

- Robert Beehler, president and CEO
- Karen Garner, director of palliative care

Type of Palliative Care Program

Inpatient consultative service, with team members including a physician, registered nurse, social workers, and a chaplain. Extends care to 300 to 500 patients annually.

Other Salient Details

San Joaquin Community Hospital has had a palliative care program in place since May of 2005, funded directly as a department of the hospital. The program has provided consultation to four other hospitals within the 17-hospital Adventist Health System that have now instituted their own palliative care services.

Getting Started — Questions to Consider

Before embarking on a palliative care program, there are a number of questions to consider — the answers to which may determine the program's look and feel.

Among the questions to ask:

- Does the hospital patient population include patients with terminal illness or exacerbations of chronic illness, who require prolonged stays and repeated admissions?
- How many patients with terminal illness are discharged without referrals for hospice care?
- What conditions do most of the hospital's potential palliative care patients suffer from (e.g., cancer, stroke, heart failure, cirrhosis, dementia, trauma)?
- What is the acuity level of most of these patients (e.g., intensive care, step-down, medical/surgical, skilled nursing)?
- Which physicians and nurses provide care for most of these patients now (oncologists, hospitalists)?
- What resources (personnel and space) are available or could realistically be secured for palliative care?
- Will the team treat patients with chronic pain, life-threatening illnesses, or both? While treating all groups might help relieve a backlog in the burden of care, defining the patients too broadly can dilute the focus of a new program.
- Who can request an initial palliative care consultation? Requests can come from a physician, nurse, social worker, respiratory therapist, chaplain, pharmacist, patient, or family member. Experience shows it is best to be consistent with a particular hospital's general practice when setting up a new program.
- How will consultation requests be communicated? Options include a pager, voicemail, email, or by written document.
- How will the team operate? The challenge is to make meaningful contact and communicate with the patient effectively. It is best to avoid overwhelming patients with visits from large teams en masse, while avoiding numerous visits from various team members that may feel uncoordinated.

Source: Adapted from *Palliative Care in California, Fundamentals of Hospital-Based Programs,* California HealthCare Foundation, May 2007

Additional Resources

California HealthCare Foundation Publications

Palliative Care in California: The Business Case for Hospital-Based Programs, May 2007
www.chcf.org/topics/view.cfm?itemID=132878

Explains the costs and benefits to hospitals of operating a comprehensive palliative care service and shows how those benefits can be measured and demonstrated.

Palliative Care in California: Fundamentals of Hospital-Based Programs, May 2007
www.chcf.org/topics/view.cfm?itemID=132878

Discusses challenges and barriers to introducing hospital-based palliative care programs, as well as tips for sustaining them; targeted to hospital administrators, clinicians, and patients and their families.

Palliative Care in California: Innovations in Hospital-Based Programs, May 2007
www.chcf.org/topics/view.cfm?itemID=132878

An overview of cutting-edge palliative care services and programs offered in California and throughout the nation. Underscores the educational and clinical training programs available.

Palliative Care in California: An Overview of Hospital-Based Programs, May 2007
www.chcf.org/topics/view.cfm?itemID=132878

Introduces the concept of palliative care—with special attention to hospital-based services—and differentiates it from hospice and other types of end-of-life care. Also makes the case for incorporating such services into hospitals.

When Compassion Is the Cure: The Case for Hospital-Based Palliative Care, September 2008
www.chcf.org/topics/chronicdisease/index.cfm?itemID=133742

A look at the current state of hospital-based palliative care programs in California, as well as an analysis of the costs and the measures used to ensure quality.

Organizations

American Academy of Hospice and Palliative Medicine
www.aahpm.org

Professional organization for physicians and other health care providers specializing in hospice and palliative medicine.

Center to Advance Palliative Care
www.capc.org

Provides health care professionals with tools, training, and technical assistance to start and sustain palliative care programs in hospitals and other health care settings.

Coalition for Compassionate Care of California
www.finalchoices.org

A partnership of more than 95 regional and statewide organizations dedicated to the advancement of palliative medicine and end-of-life care in California.

Education in Palliative and End-of-Life Care (EPEC)
www.epec.net

Web site offers course schedules and free downloadable course materials to educate physicians about caring for dying patients—with an emphasis on communication, ethical decisionmaking, aspects of suffering, and pain and symptom management.

End-of-Life Nursing Education Consortium Project (ELNEC)
www.aacn.nche.edu/elnec/about.htm

National education initiative to improve end-of-life care. Provides training for undergraduate and graduate nursing faculty, CE providers, staff development educators, nurses, and specialty nurses in pediatrics, oncology, critical care, and geriatrics.

End of Life Palliative Education Resource Center
www.eperc.mcw.edu

Educational materials and information about end-of-life issues to assist physician educators and others in locating high-quality, peer-reviewed training materials.

Hospital Association of Southern California,
Palliative Care Community
www.hasc.org/ps.palcare.cfm

Web site includes palliative care resources, links, articles, and a list serve, as well as basic information about programs and upcoming educational events.

National Quality Forum
www.qualityforum.org

Offers a set of quality measures deemed most important for best practices in palliative care that apply across all health care settings and professions.

Palliative Care Leadership Centers (PCLC)
www.capc.org

Provides customized training for palliative care programs in diverse settings, whether they are in the planning stages or established programs. In California, the University of California, San Francisco, offers PCLC training. For more information contact Kathleen Kerr at kkerr@medicine.ucsf.edu.

PAL-MED CONNECT
www.palmedconnect.org

A palliative care hotline set up by the Institute for Palliative Medicine in San Diego with funding from UnitedHealth Group. It has a toll-free number—1-877-PAL-MED4.

Endnotes

1. *When Compassion Is the Cure: The Case for Hospital-Based Palliative Care.* (See California HealthCare Foundation publications on page 17.)
2. "Patient Age and Decisions to Withhold Life-Sustaining Treatments from Seriously Ill, Hospitalized Adults," by Mary Beth Hamel, Joan M. Teno, Lee Goldman, Joanne Lynn, Roger B. Davis, Anthony N. Galanos, Norman Desbiens, Alfred F. Connors Jr., Neil Wenger, and Russell S. Phillips, *Annuals of Internal Medicine,* Vol. 130, No. 2, pp. 116–25, 1999.
3. *Palliative Care in California: The Business Case for Hospital-Based Programs,* p. 22. (See California HealthCare Foundation publications on page 17.)
4. "The Economic and Clinical Impact of an Inpatient Palliative Care Consultation Service: A Multifaceted Approach," by Elizabeth L. Ciemins, Linda Blum, Marsha Nunley, Andrew Lasher, and Jeffrey M. Newman, *Journal of Palliative Medicine,* Vol. 10, No. 6, 2007.
5. "Cost Savings Associated with U.S. Hospital Palliative Care Consultation Programs," by R. Sean Morrison, Joan D. Penrod, J. Brian Cassel, Melissa Caust-Ellenbogen, Ann Litke, Lynn Spragens, and Diane E. Meier, *Archives of Internal Medicine,* Vol. 168, No. 16, pp. 1783–1790, 2008.
6. See Note 3.
7. See Note 1.
8. Survey of Palliative Care in California Hospitals, National Health Foundation and University of California, San Francisco, 2008, www.chcf.org/press/view.cfm?itemID=133748.
9. For more information on ELNEC, see the training and initiatives offered by the American Association of Colleges of Nursing End-of Life Care, www.aacn.nche.edu/ELNEC.

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