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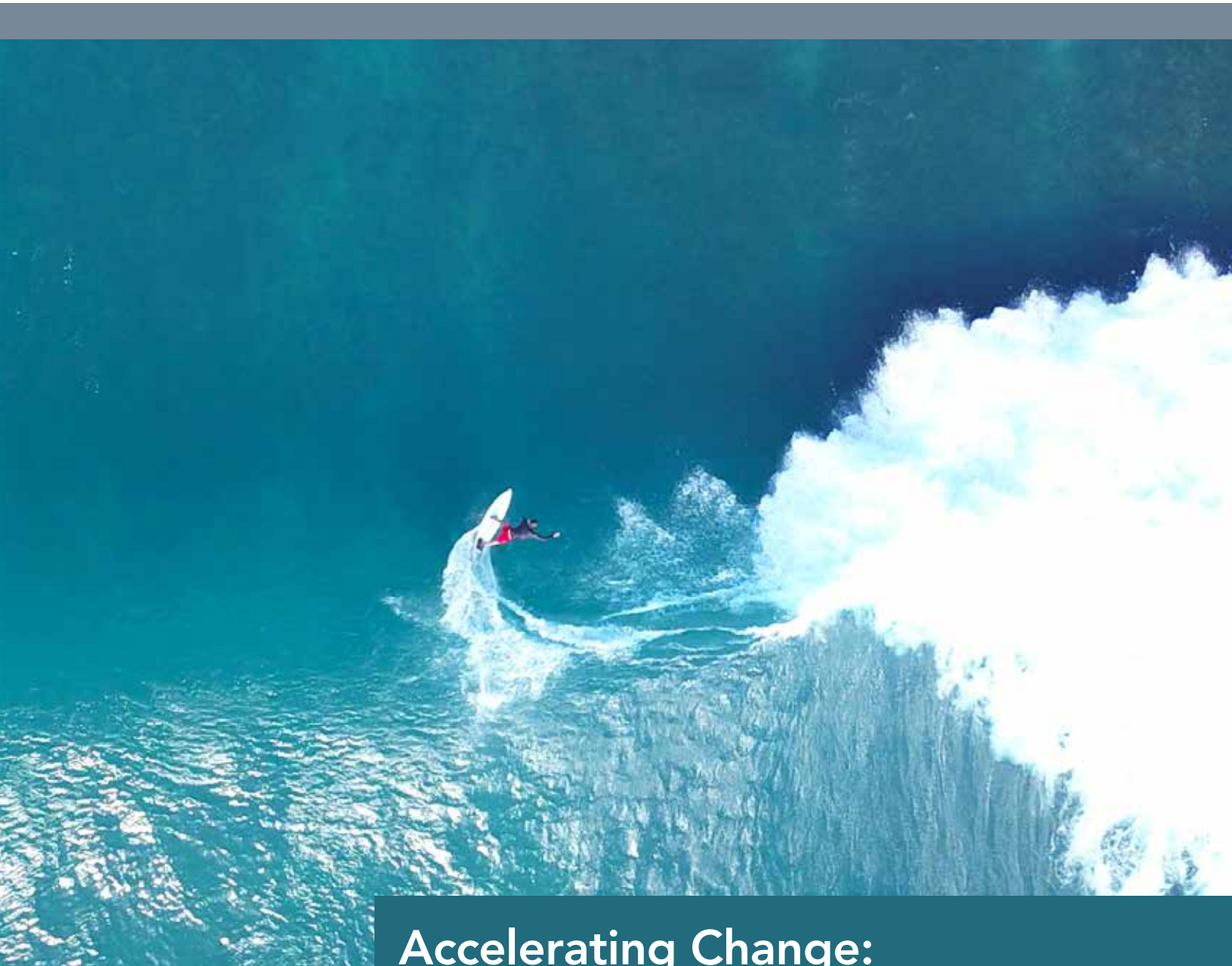
Accelerating Change:
Community-Based Palliative Care in Public Hospitals

Contents

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Recognized, Respected, Increasingly Valued

Evolution of the palliative care field in recent decades has increased access to this specialized medical care for patients and families facing serious illness. Guided by a commitment to ensuring equal access for low-income and underserved patients, the California Health Care Foundation (CHCF) has supported initiatives to develop sustainable inpatient and community-based palliative care (CBPC) programs in California's public hospital system. This paper describes CHCF's efforts to implement and expand CBPC services in California's public hospitals for health care systems, providers, and other stakeholders interested in expanding palliative care's reach to vulnerable and underserved communities.

Palliative care is a dynamic patient- and family-centered practice of care that focuses on improving quality of life for people living with serious illness. It aims to relieve the symptoms and stress of serious illness, and provide patients and families with an extra layer of support. Interdisciplinary teams of doctors, nurses, social workers, and chaplains provide palliative care at any age and at any stage of illness, often alongside all appropriate curative treatments.[1]

The benefits of palliative care range from improved patient symptoms, quality of life, and patient and family satisfaction, to greater clarity in patient goals of care, avoided health crises, and lower overall health care costs.[2]

In 2015, close to 90% of large hospitals (with 300 beds or more) across the United States had palliative care programs.[3] An analysis of hospital palliative care programs participating in the Center to Advance Palliative Care's National Palliative Care Registry revealed a 91% increase in palliative care service penetration between 2008 and 2016 (*penetration* refers to the percentage of annual hospital admissions seen by the palliative care team).[4]

Hospital-based palliative care continues to gain traction, but two major developments in the field have been redefining its reach. The first involves the growth of CBPC programs. To support patients earlier in their illness and to provide them with greater access to palliative care, CBPC programs have begun to proliferate. CBPC is palliative care delivered outside the hospital in a range of settings — for example, outpatient clinics, office practices, private residences, skilled nursing facilities, and assisted living facilities.

Like inpatient palliative care services, CBPC programs are provided by specialty palliative care teams. Services can be delivered face-to-face or through telephone and videoconferencing technology. Providing palliative care earlier in a patient's serious illness and providing it in the community offers substantial quality-of-life benefits to patients and families. It also reduces health care costs associated with avoidable emergency room visits, hospitalizations, and use of intensive care.[5] Numerous studies have reported that CBPC additionally increases patient satisfaction.[6]

While gaps in coverage and reimbursement for both inpatient and CBPC remain, many insurers are recognizing that palliative care's ability to improve the quality and experience of patient care, while ensuring appropriate use of health care services, justifies investing in palliative care across settings.[7]

IN THE FIELD

As palliative care has become increasingly prevalent, so too have leading organizations supporting the delivery of quality palliative care services. Examples include:

➤ American Academy of Hospice and Palliative Medicine

➤ Ariadne Labs

➤ California State University Institute for Palliative Care

➤ Center to Advance Palliative Care

➤ Coalition for Compassionate Care of California

➤ End-of-Life Nursing Education Consortium

➤ Hospice and Palliative Nurses Association

➤ National Hospice and Palliative Care Organization

➤ VitalTalk

The second major development for the field is the growth of primary or generalist palliative care — palliative care processes integrated into primary care and other medical specialties and care settings. Because there are not enough specialists to meet all the current or future palliative care needs of patients, developing the skills and capacity of primary care providers and other medical specialists to provide basic palliative care is essential to meeting growing patient needs.[8]

The many advances in the field of palliative care have confirmed its role as an essential component of serious illness care.

Increasing Access in the Safety Net

Shortly after the Affordable Care Act (ACA) was signed in 2010, California began closely studying how best to achieve the triple aim — improving the patient experience of care, improving the health of populations, and reducing the cost of health care.[9] To achieve this goal, in 2012 the state developed a 10-year plan, Let's Get Healthy California, and included palliative care as a core objective.[10]

In 2014, California governor Jerry Brown signed Senate Bill (SB) 1004, a law that requires the California Department of Health Care Services (DHCS) to establish standards and to provide technical assistance for Medi-Cal managed care health plans (MCPs) to ensure the delivery of palliative care services to eligible members (Medi-Cal is California's Medicaid program).

As defined by DHCS, SB 1004's required services include (1) advance care planning, (2) palliative care assessment and consultation, (3) development and maintenance of a care plan for palliative supports and services, (4) access to a palliative care team, (5) care coordination, (6) pain and symptom management, and (7) mental health and medical social services. Optional but recommended services include spiritual support and access to round-the-clock symptom management support. These services must be available to qualifying adults with diagnoses of congestive heart failure, chronic obstructive pulmonary disease, advanced cancer, and liver disease. The law was implemented in January 2018. (Requirements for pediatric palliative care were added in December 2018.)

Complementing efforts under SB 1004, palliative care components were included in California's renewed Section 1115 Medicaid waiver, Medi-Cal 2020 (2015–20) and in the waiver's pay-for-performance delivery system transformation program, Public Hospital Redesign and Incentives in Medi-Cal (PRIME).[11] It was also included as a service component in the state's Medi-Cal Health Homes Program, Section 2703 of the ACA.[12]

Public Hospital Palliative Care

For more than a decade CHCF has supported initiatives to increase access to palliative care in the state's public hospitals. The catalyst for the initial effort was a 2008 study that showed that 43% of all California hospitals had inpatient palliative care programs, but only 22% of public hospitals were operating such care programs.[13]

The data underscored a hard reality: Many public hospitals lacked the start-up funds to establish or expand palliative care services and the capacity to develop the business case to establish services. Because public hospitals serve racially, culturally, and ethnically diverse populations, many of whom are poor, uninsured, and burdened with serious and complex illness, increasing access to palliative care in these settings was critical.

"Many of our public hospital patients have their own understanding of the negatives and positives of their conditions. We try to normalize the negatives and support the positives."

— Palliative care team member

The first initiative, Spreading Palliative Care in Public Hospitals (SPCPH), 2008–13, was dedicated to assisting California's 17 public hospitals in developing new, sustainable inpatient palliative care programs, or to support expansion and enhancement of existing programs, with an emphasis on reaching diverse communities. At the start of the initiative, 4 of the 17 public hospitals had inpatient services. By the end, 15 of the 17 palliative care programs were sustained.[14]

In 2015, CHCF launched a follow-up effort, Community-Based Palliative Care in California Public Hospitals: Supporting Next Steps. This second initiative was developed in response to public hospitals identifying CBPC programs as a natural extension of and companion service to their inpatient programs. The initiative consists of three phases: planning, implementation/expansion, and learning community.

Planning (2015). Fifteen public hospitals participated in a yearlong planning process. The primary objective was to assist hospital teams with developing a potential business case and clinical service plan for outpatient palliative care. Participating hospitals received individualized technical assistance and participated in a learning community to share best practices and learning through educational webinars and in-person meetings.

Implementation/expansion (2016–17). Nine public hospitals that demonstrated readiness to implement or expand sustainable CBPC programs were awarded two-year implementation or expansion grants (see the appendix for a list of grantees). Funding was used to offset initial staffing start-up costs (or the costs of adding staff to existing services) and data collection. Throughout the two-year project, grantees received tailored technical

assistance to help them with their business case and to resolve operational and clinical challenges. Grantees also participated in a continued learning community.

Learning community (2018–19). To maintain the shared learning and cross-site support that public hospital palliative care teams experienced during the planning and implementation/expansion phases, CHCF designed a two-year extended-learning community. Small stipends were given to 13 public hospital palliative care teams participating in learning community activities: monthly educational webinars, data collection, and annual in-person meetings.

The learning community phase is constructed around and driven by the specific needs of its members. Members identify topics of interest and relevance to them, and then volunteer workgroups (addressing various topics) develop content to share with the larger group via webinars or at in-person meetings.

Since the launch of the CBPC initiative, nine public hospitals have created or expanded CBPC programs. A summary of programs, as well as highlights of what was hard, what was learned, and what the next steps are for California's dynamic public hospital palliative care programs, are presented here.

"The importance of staff being able to develop relationships with public hospital palliative care patients in the outpatient setting, establish trust, and then have the same clinic staff see these patients through very difficult medical and emotional experiences in the hospital is critical."

— Palliative care team member

The Right Fit: Community-Based Palliative Care in California Public Hospitals

Each public hospital CBPC program reflects the unique features of its hospital and county administrative structure and culture.

Nine Programs

Among the nine implementation/expansion CBPC project grantees, five established new programs and four expanded existing programs. Common program characteristics and variations are highlighted in the descriptive metrics presented in this section and in Table 1 (page 7).

▶ **Stage of development and setting.** Eight of the CBPC programs operated outpatient clinics (one provided a home-based palliative care program). Most of the palliative care clinics were embedded in outpatient oncology practices, with others partnering with liver, family medicine, and cardiovascular clinics, and one Federally Qualified Health Center.

During the two-year project period, five of the eight clinic-based programs expanded the number of palliative care clinics they offered per week, increasing the number of people they could serve.

▶ **Patient age: mean and range.** The average age of these public hospital palliative care patients skewed slightly younger than the general population with similar diagnoses.[15] The difference may be linked to socioeconomic and health care disparities that contribute to higher disease burden, and the fact that most public hospital patients are poorer, sicker, and less likely to have health insurance than private hospital patients.[16]

▶ **Primary diagnoses.** Most of the CBPC programs focused exclusively or primarily on cancer patients. Several addressed patients with a mix of diagnoses (cancer, congestive heart failure, chronic obstructive pulmonary disease, liver disease). One addressed predominantly end-stage liver disease.

▶ **Patient referrals, capture rates, and days on service.** Programs received between 107 and 805 referrals to their clinics or home-based services annually, with the variation reflecting differences in the number of clinic sessions offered per week (one to four) and the maturity of the programs (i.e., the number of years in operation — the range was 1 to 10). Of these referrals, sites saw between 46 and 527 unique patients in their clinics or home-based services annually.

Variation in the proportion of referred patients who were seen by the CBPC services was driven by multiple factors, including differences in the number of available clinic or home-visit slots (with resulting differences in wait times), how well known the palliative care service is among referring providers, and referring providers' perceptions of the value of sending patients to a palliative care clinic.

Low capture rates (percentage of patients referred that were seen by the clinic or service), a common problem in any palliative care clinic due to the illness burden of patients, were particularly acute in these safety-net clinics. Reasons for these low rates can be linked to the host of challenges faced by public hospital patients (lack of transportation, housing instability, substance use disorder, comorbid mental illness), which make it difficult for many who might have benefited from palliative care to engage with the clinic and follow through with a scheduled visit.

Overall, programs were able to see between 41% and 100% of referred patients.

The one program that was able to see every referred patient did so by operating as an "instant clinic," where the palliative care team would meet a patient to provide a clinic visit only after the patient had already presented to be seen by a different specialty provider, such as an oncologist.

▶ **Interdisciplinary team.** All the CBPC teams were interdisciplinary, with the majority of teams including a physician (board-certified in palliative care), social worker, registered nurse, nurse practitioner, and chaplain. (See Figure 1, page 8.)

Table 1. Characteristics of Nine Public Hospital Community-Based Programs, November 2016 to October 2017

	DEVELOPMENT STAGE / SETTING	YEAR STARTED	PATIENT AGE	PRIMARY DIAGNOSES	DAYS ON SERVICE
Alameda Health System (236 beds)	New clinic	2017	Mean: 59 Range: 33–88	Cancer: 96% Other: 4%	Not reported
LAC+USC Medical Center (600 beds)	New clinic	2016	Mean: 53 Range: 30–77	Liver failure: 78% Coincident cancer: 22%	Mean: 145 Range: 5–365
Olive View-UCLA Medical Center (377 beds)	Expanding clinic	2012	Mean: 56 Range: 26–88	Cancer: 98% Other: 2%	Mean: 73 Range: 1–630
San Joaquin General Hospital (196 beds)	New clinic	2016	Mean: 61 Range: 26–88	Cancer: 58% CHF: 20% COPD: 7% Liver disease: 7% Other: 8%	Mean: 182 Range: 30–365
UC Davis Medical Center (625 beds)	Expanding home-based service	2016	Mean: 67 Range: 19–101	Cancer: 78% COPD: 14% CHF: 8%	Mean: 49 Range: 1–247
UC Irvine Medical Center (417 beds)	Expanding clinic	2008	Mean: 56 Range: 22–84	Cancer: 67% CHF: 15% Neurological: 3.4% Pulmonary: 0.8% Liver disease: 0.4% Other: 13%	Mean: 61 Range: 1–548
UC San Diego Medical Center (390 beds)	Expanding clinic	2008	Not reported	Cancer: 97% CHF: 3%	Mean: 94 Range: 1–827
Ventura County Medical Center (208 beds)	New clinic	2017	Not reported	Cancer: 61% CHF: 6% Pulmonary: 3% Liver disease: 18% Neurological: 6% Other: 6%	Not reported
Zuckerberg San Francisco General Hospital (403 beds)	New clinic	2016	Not reported	Cancer: 100%	Not reported

Notes: *CHF* is congestive heart failure; *COPD* is chronic obstructive pulmonary disease. For a map of California public hospital CBPC implementation grantees, see the appendix.

▶ **Scope of work.** Figure 2 summarizes the range of palliative care services provided by the nine teams. All the teams provided symptom management and advance care planning. Most teams provided emotional support, caregiver support, medication reconciliation, and care coordination.

Initiative Outcomes

Grantee teams encountered and persevered through a variety of challenges as they worked to create or expand CBPC services within their institutions and demonstrate positive impact.

Challenges

Throughout the project period, program leaders faced a host of system, clinician, and patient difficulties in their resource-constrained settings.

Major **system challenges** included hospital and county authorization delays for new staff hires, senior administration leadership changes, difficulty obtaining adequate clinic space, and disruptions associated with the implementation of new electronic health record (EHR) systems. Regarding the latter, several teams also struggled to incorporate referral triggers into and extract service metrics from their EHR systems.

Clinician challenges included difficulty recruiting trained palliative care staff (physicians, nurses, social workers), staff turnover, insufficient operational staffing for the palliative care program (such as a program coordinator to schedule patient visits), and limited understanding among potential referring providers about what palliative care is.

Alongside difficulties in meeting the substantial medical and psychosocial needs of a vulnerable, diverse, predominantly low-income public hospital patient population, patient no-shows represented the most significant **patient challenge** for programs. As previously noted, reasons that patients do not keep appointments range from illness burden, to transportation difficulties, to unstable housing, to substance use or mental health issues.

Figure 1. CBPC Programs: Interdisciplinary Teams, 2016–17

CBPC TEAMS WITH EACH DISCIPLINE (*n* = 9)

Medical doctor / doctor of osteopathic medicine
100%

Social worker
89%

Registered nurse
78%

Chaplain
67%

Advanced practice registered nurse
56%
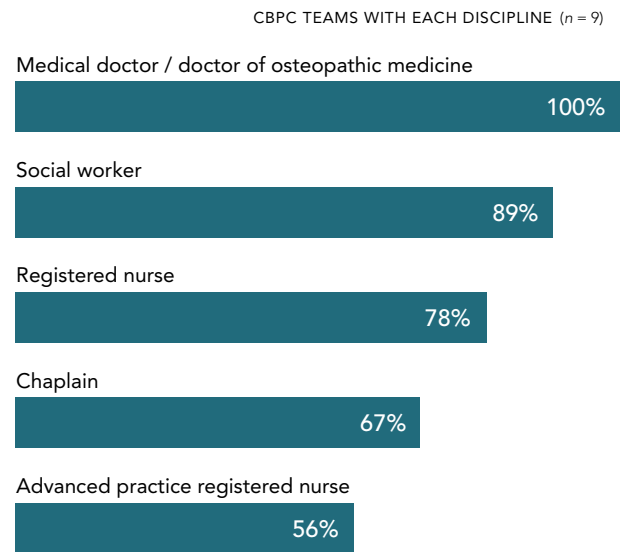
Figure 2. CBPC Programs: Scope of Work, 2016–17

SERVICE OFFERED AS A MATTER OF ROUTINE (*n* = 9)

Symptom management
100%

Advance care planning
100%

Emotional support
89%

Caregiver support
78%

Medication reconciliation
78%

Care coordination
67%

Social service referrals
56%

Spiritual care
56%
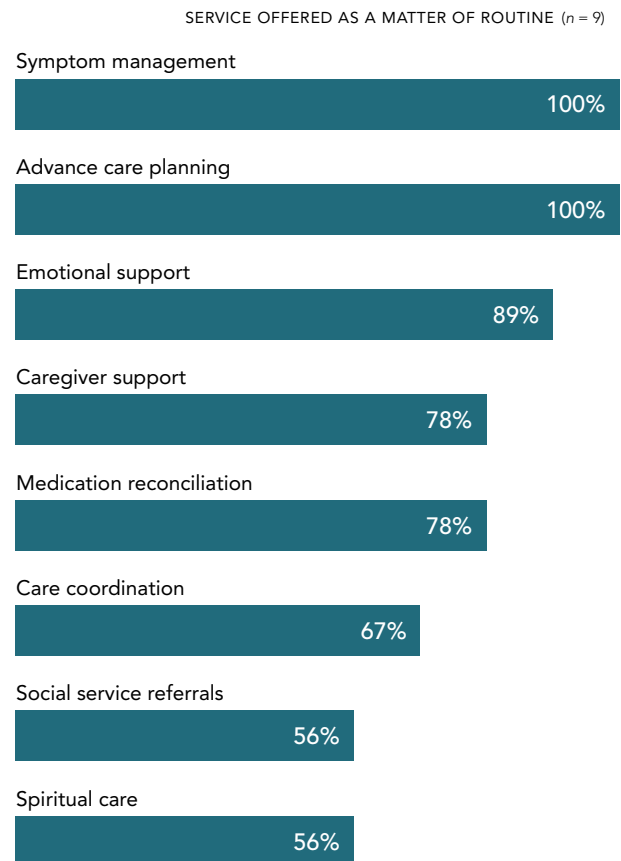
Notes: *CBPC* is community-based palliative care. *Offered as matter of routine* means services generally offered to all patients.
Source (Figures 1 and 2): Data reported to CHCF by nine public hospital grantee teams describing scope of service as of October 2017.

Learning

Teams reported several key lessons learned. The first was the importance of building leadership support and cultivating champions across medical specialties. Teams learned that both were essential for obtaining funding, resources, and clinic space.

The second was the importance of adapting to changing circumstances or challenges. No team learned this lesson more fully than the LAC+USC Medical Center team, which created an innovative group visit model for people with advanced liver disease in response to limitations in space and resources. While the program was unable to secure organizational funding to continue after the grant, during its active phase the team provided critical education and services that improved care quality and lowered unnecessary hospitalizations in a highly vulnerable and complex population. Equally important, the team applied principles learned from this experience to its inpatient and other clinic-based palliative care services.

Other examples of team adaptations include using nurses, social workers, and chaplains more effectively to address patient education, scheduling, and psychosocial support needs. Seeing a need for more administrative support in their clinics, several teams successfully lobbied their leadership to fund program coordinators to manage clinic and patient schedules. These creative responses to CBPC challenges contributed to improved patient care, the ability of medical providers to practice at the top of their license, and reduced staff burnout.

All project teams submitted data on a limited number of items during the project period, including staff full-time equivalent (FTE) by discipline, scope of services provided, number of new patients referred and seen, patient primary diagnosis, length of service (number of days followed by the CBPC program), and discharge disposition.

Because teams were collecting additional information about their services, they were asked to list all the metrics they were using (see Table 2, page 10). The range of metrics reflects the diversity of service and patient needs across the nine CBPC programs, as well as differences in resources the teams had available to evaluate their services.

SAMPLE CBPC OUTCOMES

LAC+USC (preliminary outcomes)

Among 37 palliative care (PC) clinic patients who had either been discharged or died, compared to a control group of 65 patients who attended the same liver clinic the year before the concurrent PC clinic started:

➤ PC clinic patients had 50% fewer ICU and ER visits, and 66% fewer non-ICU hospital days compared to control patients.

➤ 80% of PC clinic patients had documented goals-of-care discussions, compared to just 15% in the control group.

➤ 56% of PC clinic patients had documented advance directives completed, compared to 6% in the control group.

Olive View-UCLA Medical Center

➤ 79% of patients received advance care planning counseling with documentation of treatment preferences by the third visit.

➤ Among new patients who completed a satisfaction survey after a minimum of three visits, 80% rated symptom control, communication, care coordination, and spiritual support as excellent, 20% as good to excellent.

➤ 47% of discharged patients were referred to or enrolled in home hospice.

Ventura County Medical Center

➤ 100% of patients with cancer had Palliative Performance Scale and Eastern Cooperative Oncology Group Performance Scale scored at initial consultation.

Zuckerberg San Francisco General Hospital

➤ 90% of patients were screened for shortness of breath at their initial visit.

➤ 96% of patients were screened for pain at their initial visit.

➤ 85% of patients seen by palliative care were asked to identify their preferred surrogate decisionmaker(s).

➤ 85% of all patients were screened for distress at least once while receiving clinic services.

Note: Reporting periods varied (2017–18).

Table 2. Selected Metrics Used by CBPC Initiative Teams

Palliative Care Service Operations

➤ Number of new patients seen in clinic

➤ Percentage of referrals seen in clinic (no-show percentage)

➤ Time from referral to first appointment

➤ Number of visits per patient

➤ Number of patients seen only once (in clinic)

➤ Average cycle time (check-in to checkout)

➤ Percentage of patients referred who could not be reached after three attempts

Screening, Assessments, Plans

➤ Percentage of patients with comprehensive evaluation documented

➤ Percentage of patients reporting moderate or severe pain, dyspnea, or nausea with documented treatment plan

➤ Percentage of patients reporting moderate or severe anxiety with documented treatment plan

➤ Percentage of patients with documented social plan

➤ Percentage of families with a bereavement care plan in place after a patient death

➤ Percentage of patients with recorded pain, shortness of breath assessment on visit one

➤ Percentage of patients with recorded distress score by visit two

➤ Percentage of patients screened for spiritual needs

➤ Frequency of determining the Palliative Performance Scale and Eastern Cooperative Oncology Group Performance Scale at initial consultation

➤ Percentage of patients referred to psychosocial supports

➤ Percentage of patients with comprehensive evaluation documented

Goals, Preferences, and Advance Care Planning (ACP)

➤ Percentage of patients for whom code status was clarified

➤ Percentage of patient visits with goals-of-care discussions

➤ Percentage of patients that had their surrogate decisionmaker identified

➤ Percentage of patients that had their surrogate decisionmaker documented in the correct location in the EHR

➤ Percentage of patients who completed an ACP document

➤ Percentage of patients who had their completed ACP results documented in the correct location in the EHR

Patient-Centeredness

➤ Percentage of patients who had their religion documented

➤ Percentage of non-English-speaking patients for whom professional interpreters were used

For example, teams interested in decreasing lengthy — and for some patients exhausting — visit times tracked the average cycle time from visit check-in to checkout. Teams interested in knowing how many patients they were unable to reach measured the percentage of patients that could not be contacted after three attempts; the teams then brainstormed alternative outreach efforts.

Capturing how frequently team members documented patient scores on the Palliative Performance Scale (PPS) and Eastern Cooperative Oncology Group Performance Scale (ECOG) at initial consultation enabled teams to measure the quality of their assessment approach, since these are best-practice standardized tools. It also allowed them to quantify symptom burden among referred patients.[17]

Tracking the percentage of patients with a completed advance care planning document correctly documented in the EHR allowed teams to assess not only the extent to which the PC team supported patients in identifying and documenting their wishes, but also the extent to which that information would be available to other providers via the EHR.

Tracking the number of non-English-speaking patients that used professional health care interpreters both assessed service adherence to best practices and allowed teams to make the case for extended visit times, to enable more effective communication.

CASE EXAMPLE

Expanded CBPC Services to Meet Patient Needs

Although head and neck cancer patients were initially not a target population for one public hospital's CBPC clinic, medical staff treating these patients in the Otolaryngology Head and Neck Surgery (OHNS) clinic recognized that many of their patients needed more support to address the impact of their cancer and treatment. In particular, many head and neck cancer patients have complex psychosocial needs, but the OHNS clinic did not have a social worker. To address these needs, OHNS staff began inviting the outpatient palliative care social worker to initial appointments for newly diagnosed head and neck cancer patients. After her initial assessment, the social worker would engage the full outpatient palliative care team, as needed, to provide interdisciplinary care and support. See the example of Mr. M's story below.

Mr. M is a middle-aged man referred to the head and neck cancer group with a diagnosis of tongue cancer. In addition to managing his new diagnosis, Mr. M experienced childhood abuse, adult trauma, and post-traumatic stress disorder. He also had a diagnosis of autism spectrum disorder. A knowledgeable student of naturopathy, Mr. M told his OHNS team that he might be interested in pursuing surgery, radiation, and chemotherapy, but only if his cancer progressed. Respecting Mr. M's treatment goals and preferences, the OHNS team referred him to the outpatient palliative care service for additional support.

After meeting the palliative care social worker and developing a relationship with her and the palliative care physician and chaplain, Mr. M agreed to accept medication to manage his difficult symptoms. He remained steadfast, however, in not accepting other treatments at the time, because of concern that he would not be able to tolerate them. The palliative care and OHNS teams supported Mr. M's decision. Not long afterward, his condition progressed to the point that he could no longer swallow. Mr. M began to fear he might aspirate. Weighing his options, he agreed to pursue surgery and treatment.

Mr. M underwent removal of his tongue, which was semi-reconstructed by plastic surgery. Members of the OHNS and palliative care teams supported Mr. M and worked together to ensure that his beliefs and right to manage his medical treatment were honored. Mr. M is working hard to adapt and manage his health post-surgery. With support from both teams, Mr. M was able to make informed decisions about his treatment and care that aligned with his values and preferences.

Impact

At the conclusion of the project period, teams high-lighted the value that palliative care services provide to patients, families, hospitals, and the community.

Value was demonstrated in many ways, including the metrics described in the previous section. With mounting evidence supporting the association between early palliative care and improved quality outcomes and cost savings at the end of life for patients with cancer, teams leveraged their inpatient presence and relationships to encourage specialists to refer their patients to palliative care clinics.[18] They also ensured that discharged palliative patients were seen in the palliative care clinic for follow-up and continuity.

By the completion of the two-year implementation/expansion project, five of the nine teams had successfully secured institutional funding for a social worker for their CBPC program (most of the funding supported a percentage of a social worker FTE), and several teams received funding for a percentage of a chaplain FTE. Adding these disciplines enhanced services provided to patients and families and underscored for hospital leadership the value of interdisciplinary palliative care teams in the outpatient setting.

As teams found their outpatient palliative care footing, they began seizing opportunities to further expand their value, such as partnering with a broader group of specialists (see the case example in Mr. M's story on page 11) and offering group advance care planning sessions. Sustained impact, teams learned, requires working through challenges, integrating lessons learned, and moving forward with moxie.

The Future

California's public hospital palliative care teams are continuing to explore innovative ways to increase access to palliative care. They are exploring partnerships with MCPs and other organizations, developing new service delivery models, and expanding the reach of palliative care by teaching basic palliative care skills to non-palliative care providers.

Partnering with Others

The implementation of SB 1004 created new opportunities to provide palliative care to eligible Medi-Cal managed care members throughout the state. In response, a number of MCPs are partnering with their county public hospital palliative care teams.

San Joaquin General Hospital and one of its local MCPs, Health Plan of San Joaquin, began working together shortly after the law was signed. The health plan funded room renovations in the palliative care clinic at the hospital, and then initiated regularly scheduled meetings with the hospital palliative care team to improve patient identification, referrals, and care coordination. As a result of the meetings, the collaborative interdisciplinary team established a direct communication path with one another (to discuss treatment and discharge plans), and added home-based palliative care organizations to the partnership to complement the hospital's clinic services.

Zuckerberg San Francisco General Hospital's palliative care team and the county MCP, San Francisco Health Plan, represent another SB 1004 collaboration example. The hospital's palliative care clinic currently sees the majority of health plan patients who are receiving SB 1004 services. For patients too sick or unable to attend clinic, the health plan contracted with an area hospice organization to provide home-based palliative care services.

"We see ourselves as the community health plan; we have to take care of our patients and their needs. We try to do what is best for the member."

— Chief Medical Officer
Medi-Cal Managed Care Plan

MCP-Public Hospital Partnership

Ms. T, a woman in her mid-60s with a diagnosis of advanced ovarian cancer, was being seen in a public hospital outpatient palliative care clinic for treatment. Managing Ms. T's needs in the clinic setting, however, had become increasingly challenging. She was growing weaker and was intermittently hospitalized for dehydration for recurrent bowel obstruction. The palliative care team thought Ms. T would benefit from hospice services, but she was not ready to stop curative treatment because she had an unresolved relationship with her incarcerated, alcoholic son.

As Ms. T became sicker, she was hospitalized for worsening intestinal obstruction related to her cancer. Unable to eat, the hospital placed her on total parenteral nutrition (TPN) and inserted a 24/7 nasogastric (NG) tube to decompress her bowel. She was not a candidate for venting gastrostomy tube placement. Still cognitively intact, Ms. T wished to see her son, whom she had not seen in many years. The palliative care team helped her to successfully connect with her son. Afterward, Ms. T agreed to transition to hospice.

Although Ms. T had accepted hospice, it was unclear if she could be discharged home because she was on TPN and had a NG tube that was suctioning gastric content constantly. Most hospice organizations do not provide TPN, since it has to be managed by home health, which is a separate benefit from hospice. The patient's MCP, however, approved covering her hospice care, TPN, home health nurse, and supplies. Ms. T was subsequently rehospitalized. At discharge, her MCP again covered these services. Ms. T died peacefully in her home.

Service Delivery Models for Palliative Care's New Frontier

Complementing efforts to reach new payers and community provider partners, teams are exploring opportunities to develop responsive service models, such as palliative telehealth and primary (generalist) palliative care services.

Used for many years to reach rural residents, telehealth is increasingly widespread in urban and suburban communities.[19] Telehealth benefits include eliminating costly or difficult travel for patients (or for providers that typically do home visits), reducing patient "no-shows," improving provider-patient communication, and lowering health care costs.[20]

Albeit a promising tool for delivering palliative care, implementing palliative telehealth in the public hospital setting is difficult. Beyond patient-level barriers that include access to and comfort with technology to communicate with providers, safety-net systems are often slow adopters of new technology. Change is frequently challenged by costs, culture, and difficulty integrating new technology into existing technology — for example, incorporating telehealth data into EHR systems. Despite these hurdles, the majority of public hospitals are committed to exploring implementation of this service delivery model for palliative care.

Another rapidly developing service frontier is building basic palliative care skills among non-palliative care specialists — generalist or primary palliative care. This model enables all clinicians managing patients with serious illnesses to provide basic services and support in the palliative care domains of assessing and managing symptoms and function, psychosocial issues, communication and decision support, and social support.[21]

Because of the current and anticipated future shortage of palliative care specialists to meet patient demand, palliative care teams around the country are expanding the capacity of the field by teaching and training non-palliative care clinicians. These efforts are buoyed by programs designed to facilitate this skill acquisition among health care providers. Examples include VitalTalk, Ariadne Labs' *Serious Illness Conversation Guide*, and the Center to Advance Palliative Care's training and technical assistance program.

California public hospital palliative care teams are also engaging in this effort. In addition to informally and formally teaching basic palliative care skills to a broad range of other provider groups (via trainings, palliative care immersion, in-services), CHCF recently funded a needs assessment addressing generalist palliative care in California public hospitals, to identify opportunities to spread these essential skills.

Increasing palliative care access for underserved people remains a challenge. But California's public hospital palliative care system and vanguard SB 1004 legislation ensure that low-income Californians with serious illness have increased opportunities for improved care and quality of life.

Appendix. California Public Hospital Community-Based Palliative Care Implementation Grantees

1. Alameda Health System
2. LAC+USC Medical Center
3. Olive View-UCLA Medical Center
4. San Joaquin General Hospital
5. UC Davis Medical Center
6. UC Irvine Medical Center
7. UC San Diego Medical Center
8. Ventura County Medical Center
9. Zuckerberg San Francisco General Hospital

Endnotes

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