PC in the Safety Net: Developing specialist services and leveraging community resources

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Roadmap

• Landscape for seriously ill Medi-Cal patients
  – Past
  – Present
  – Future

• Illustrate opportunities for collaboration
  – Partnership: Health Network & SF Health Plan
  – San Francisco Palliative Care Task Force
What is the landscape like for seriously ill Medi-Cal members?
Common needs and concerns for patients like Ms. O

• Symptom management
• Advance care planning
• Assistance with activities of daily living
• Psychosocial support
Typical resources to support Ms. O

• Caring physicians
• (Limited) social work support
• Short-term home health services
• IHSS

Providers have excellent intentions but run into many barriers in coordinating care in current system
What support would be available to Ms. O while she is in the hospital?
Mid-SPCPHI, 2011
12 Palliative Care Sites

- UC Davis
- Contra Costa Regional Medical Center
- Alameda Health System
- Santa Clara Valley Medical Center
- San Francisco General Hospital
- San Mateo Medical Center
- OliveView-UCLA
- Arrowhead Regional Medical Center
- LAC + USC
- Riverside County Regional Medical Center
- UC Irvine
- UC San Diego
Supportive & Palliative Care Team

Included on team:
Physician, RN, social worker, chaplains
SFGH Palliative Care Service

- Launched Dec 2009
- Interdisciplinary, expert consultation, available hospital-wide, 24/7 phone support
- Support for patients and family
- Support for staff
- Participation in educational & quality improvement initiatives
- Steady increase in consultation requests
Who are our patients?

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>SFGH PC</th>
<th>CA average (2010 census)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Caucasian</td>
<td>40%</td>
<td>21%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>38%</td>
<td>21%</td>
</tr>
<tr>
<td>African American</td>
<td>24%</td>
<td>6%</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>33%</td>
<td>13%</td>
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</tbody>
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Communication Barriers

- **Language Other than English**
  - US: 21%
  - California: 44%
  - SFGH PC: 20%

- **Limited English Proficiency**
  - US: 9%
  - California: 20%
  - SFGH PC: 42%

*2010 US Census*
Who are our patients?

- >20% marginally housed or homeless

- Medical Conditions
  - Cancer (40%)
  - Devastating brain injuries (14%)

- 10% unbefriended
  (no surrogate/caregiver)
What do we do for our patients?

• Help clarify wishes/goals (62%)
• Manage distressing symptoms
  – Pain (22%)
  – Shortness of breath, Nausea, other (20%)
• Hospice discussion/referral (23%)
• Counseling/support for patient, family (18%)
What happens to our patients?

25% of patients could have benefitted from additional community-based palliative care
What about patients we’re NOT seeing?

• “Too soon”
  – Diagnosis not confirmed
  – New diagnoses
  – Still seeking life-prolonging treatments

• Providers have difficulty prognosticating
  – Heart failure
  – Emphysema/chronic bronchitis
  – Dementia
  – AIDS

What about QOL & support needs?

Can we help to identify patients?
What happened to Ms. O?

- Continued with life-prolonging treatments
- Limited, short-term home nursing
- Fragmented care across health systems

What will she do if she gets short of breath at home?
Planning Ahead: Better Care for Patients Like Ms. O

• More support (patients, families)
• Attention to symptom management
• Advance planning
  – Clarifying goals and wishes
  – Urgent/Emergent issues
• Proactive identification of patients at high risk
  – Distress
  – Discomfort
  – Unwanted/unnecessary care
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Planning Ahead: Community-Based Palliative Care

Slide courtesy Center to Advance Palliative Care
Dreaming Big: Efficient, High-quality Services

• Flexible options for community palliative care
  – Clinic-based services
  – Home-based services
  – Case management/telephone support

• System for providing appropriate services to the patients who need them most

How do we identify patients in need?
Ways to identify patients

• Clinician-dependent
  – Referrals from inpatient palliative care team
  – Referrals from outpatient providers

• Automatic “triggers”
  – Specified diagnoses
  – Screening tools

• Payer data
  – Utilization patterns
Forecasting need for community-based palliative care in SF

- Cancer patients
  - High proportion of patients referred to inpatient PC
  - High symptom burden
  - Easier to prognosticate
  - Partnership with oncology
  - Many studies demonstrate benefits of early PC

What impact could “early” PC have on cancer patients in our system?
SFGH Study: Utilization Patterns of Cancer Patients

• Retrospective analysis of cancer patients who died over 3-year period

• Data sources
  – Tumor registry
  – Finance/quality management departments
  – Palliative care database

• Examined care utilization patterns in last 6 months of life
SFGH Study: Utilization Patterns of Cancer Patients

- 403 patients died in 3-year period
- Heavy inpatient utilization
  - In last 6 months
    - 76% of patients were admitted to SFGH
    - 39% had multiple admissions (avg. 1.9 admissions)
  - In last month of life
    - 47% of patients visited the SFGH Emergency Dept.
    - 45% of patients were admitted to SFGH
    - 21% had multiple admissions
    - 16% were admitted to the ICU
  - 1/3 of patients died in hospital
SFGH Study: Impact of Inpatient Palliative Care

- Inpatient palliative care reaches many patients, but too late
  - Cared for 44% of the entire decedent population and 58% of those who were hospitalized
  - Median of 22.5 days between first inpatient PC contact and death
  - In 60% of cases the initial contact with the PC team took place in the final month of life
SFGH Study: Predicting Impact of Early PC

• Greatest impact when contact with patients is at least 3 months prior to death
  – Symptom management
  – Clarification of goals of treatment, goals of care
  – Advance care planning

• Outpatient PC programs for cancer patients have shown 40% reduction in ED visits, hospitalizations for patients seen early
SFGH Study Conclusion: We Can Make an Impact!

- About 1/3 of SFGH patients who die of cancer present early enough (>3 months prior to death) to be referred to an OP PC clinic.
- Based on analysis, OP PC clinic could expect to make an impact on 50 patients/year.

  Expect 40% reduction in inpatient utilization (38 admissions, $25,814 ea.)

  Expected cost avoidance: $980,932
SFGH Study: Business Case

- Would only need 0.2 FTE for team to see expected patient volume in 2 half-day clinics/week
- Salary for MD, APRN, SW + 17% Benefits = $88,290

$980,932
Direct costs avoided

$88,290
Staffing Cost

>10x ROI!!
SFGH Study: 
Next Steps

• Submitted business plan to City/County
• Partnering with SF Health Plan
  – Service delivery model
    • Staffing
    • Location
    • Triggers for referral
  – Analysis of utilization patterns for patients with other serious illnesses
Gap analysis:
Opportunities to Improve Care

- From SFGH perspective
  - Which patients need PC post-discharge?
  - In what setting(s) would CBPC services have the greatest impact (for which patients)?
  - What are the priorities of our partners, stakeholders?

- From system’s and payer’s perspective
  - What quality standards should we track?
  - How can we most efficiently use limited resources?
    - Leverage existing resources
    - Add new programs/providers where critical gaps exist
SF Palliative Care Task Force

• Community collaboration, June-Aug 2014
• Supported by CHCF, co-sponsored by:
  – SF Dept of Public Health
  – SF Dept of Aging and Adult Services
• Mix of community and hospital-based providers, social service agencies
• **Purpose:** “to develop strategic recommendations to meet San Francisco’s current and future palliative care needs”
SF Palliative Care Task Force

• 3 main deliverables:

  1) Definitions for palliative care and a palliative care target population;

  2) Inventory of dedicated palliative care services currently available in San Francisco; and

  3) Short- and long-term recommendations aimed at improving access to quality palliative care
SF Palliative Care Task Force: Outcomes

• Successfully produced deliverables over short time-frame, on voluntary basis
• Report written, presented to SF Health Commission, LTC Coordinating Council
• Creation of new workgroup to carry recommendations forward
  – Community education
  – Finance
  – Quality
  – Systems issues, including gap analysis
Existing Palliative Care Services

- Ambulatory Care
  - Primary Care
  - Behavioral Health
  - Jail Health

- Transitions

- SFGH
  - Acute Care
  - Maternal, Child, & Adolescent Health

- Laguna Honda Hospital (SNF)
  - SNF
  - Specialty Care
SF Health Network: Next Steps

• Piloting community-based PC for cancer patients
• Partnering with SF Health Plan
• Formal needs assessment
• Develop strategic plan for improving care
Strategic, Efficient Approach to Palliative Care Delivery

- Specialty PC
- Trained PC
- Primary Palliative Care
Strategic, Efficient Approach to Palliative Care Delivery
Strategic, Efficient Approach to Palliative Care Delivery: Ms. O

- Specialty PC
- PC champions (GMC, Chest Clinic, Home Health, Rheumatology)
- Education for Providers (System-wide; focus on primary care)
Take-Home Messages

• Tremendous need
  – Uncontrolled symptoms, distress
  – Heavy inpatient utilization as members approach end of life

• Tremendous opportunities
  – Early PC delivery improves outcomes
  – Early PC is feasible in resource-limited systems
  – Natural partnerships between public health systems and managed care payers
THANK YOU

Juliet Wood, *Arbol de la Vida*