# SB 1004 / Palliative Care Stakeholder Meeting

**February 23, 2015**

**Sponsored by the Department of Health Care Services, California HealthCare Foundation, and the Coalition for Compassionate Care of California**

**Context**

DHCS leaders Jennifer Kent (Director), Anastasia Dodson (Associate Director for Policy), and Claudia Crist (Deputy Director Health Care Delivery Systems) described the Department’s desire to collaborate with the wide variety of stakeholders who are impacted by and can contribute to the successful implementation of SB 1004, and to build on existing knowledge and models of palliative care. Over time, in collaboration with stakeholders, DHCS will develop guidance for and provide technical assistance to Medi-cal plans around issues such as defining patient populations appropriate for palliative care, strategies for engaging with providers, payment models, and evaluation strategies.

**Understanding Palliative Care**

BJ Miller, MD, Executive Director of Zen Hospice Project and Palliative Care Specialist at UCSF, provided a comprehensive overview of palliative care: who can benefit from palliative care, where and how it can be provided, and evidence describing the impact such services have on patients and families, and on utilization outcomes. Dr. Miller’s slides contain specific details; some general issues addressed include:

* At its core, palliative care (PC) is aimed at relieving suffering – physical, emotional, social, intellectual, existential/spiritual, and logistical. It can be provided alongside or independent of disease-directed or curative treatments. While many palliative care programs work primarily with patients in the last 12-18 months of life, PC is appropriate at any stage of illness, regardless of prognosis.
* Because PC aims to address many types of suffering, it is inherently a team effort. Interdisciplinary teams are often comprised of physicians, nurses (including advance practice nurses), social workers, and chaplains.
* PC can be provided in the inpatient hospital setting, or in a variety of community-based settings including private residences, clinics, long-term care facilities, and through distance/phone services. Community-based palliative care services (CBPC) are sponsored by many types of organizations, including health systems and hospitals, hospices and home health agencies, medical groups, and post-acute care providers.
* Hospice is a particular type of PC designed for patients with a life expectancy of six months or less. Hospice is a defined benefit from Medicare and nearly all other payers. In most instances, patients must agree to forego curative treatment for terminal illness as a condition of accessing hospice supports. While widely available, it is underutilized.
* While 70% of Californians report that they would prefer to die at home, only about 32% actually do so. While the proportion of Californians who die at home has increased in past years, opportunities to align care with preferences remain.
* Numerous studies have demonstrated the benefits of PC services: improved patient and family satisfaction, reduction in symptom burden, prolonged life (in hospice and with outpatient PC services), and improved efficiency/reduced costs (see [slides](http://www.dhcs.ca.gov/provgovpart/Documents/2.SB1004_PalliativeCareOpportunities.pdf) for data and references).
* There are still challenges to broader availability and use of PC services include lack of awareness or understanding of PC among providers and the public, insufficient workforce trained in palliative care, and lack of defined funding streams for these services.

**Palliative Care in the Safety Net**

Anne Kinderman, MD, Director, Supportive & Palliative Care Service at San Francisco General Hospital (SFGH), described the services and supports available to seriously ill Medi-cal beneficiaries through the safety-net system. Medi-cal beneficiaries with serious illness often have multiple, complex needs and typically require assistance with managing pain and other symptoms, psychosocial issues, and advance care planning. Many have on-going and escalating need for assistance with activities of daily living. In the absence of PC services, these patients may be supported by a team of caring physicians, some limited support from a social worker, perhaps short-term home health services, and/or In-Home Services and Supports (IHSS). Even with these supports, coordination of care is a challenge and patients’ needs are often not met fully. On the inpatient side, all California acute care public hospitals now have PC consultation services, which were developed with support from a series of California HealthCare Foundation (CHCF) initiatives. Even with these inpatient services in place, challenges remain, especially in the areas of care coordination across settings and ensuring access to timely, sustained supports that allow patients to remain in their homes.

By tracking what happened to their inpatient PC patients, the SFGH team determined that 25% could have benefited from the types of supports that are typically offered by a CBPC service. Such supports include addressing unresolved symptoms, clarifying patient goals and wishes, developing long-term and crisis care plans, and ensuring that overburdened families are adequately supported. Providing these types of services improve the patient and family experience of care, and also have been shown to reduce utilization of hospital and emergency services. An analysis of utilization patterns of SFGH cancer patients and modeling to predict the impact of an outpatient PC clinic showed that the health system could expect to realize a 10-fold return on investment, should it deploy resources needed to create a CBPC service.

Looking forward, for California to provide efficient, high-quality palliative care services we will need to develop flexible options that can be adjusted according to patient needs. For example, a patient may initially be offered case management / telephonic support, be transitioned to clinic-based services as needs increase, and then be offered home-based services, as function declines. We will also need to promote provision of primary PC, give additional training to those with an interest in becoming PC champions (e.g., ELNEC training for nurses and the educational resources available through CSU’s Institute for PC ) and reserve specialty PC for those patients that need that expertise the most.

**Prevalence and Sufficiency of Palliative Care Services in California**

Kathleen Kerr of Kerr Healthcare Analytics described the methodology and results of the CHCF’s Palliative Care Mapping Project. The objectives of the project were to assess current inpatient and CBPC capacity and estimated need in California by county, and to estimate sufficiency of PC services across the state.

Ms. Kerr’s [slides](http://www.dhcs.ca.gov/provgovpart/Documents/4.Demand_and_Supply-Kathleen%20Kerr.pdf) contain complete details on the methodology for determining capacity and estimating need, as well as limitations of the analysis. Key findings include:

* Inpatient Palliative Care(PC): Out of 369 acute care hospitals in California, 186 (50.4%) were found to have active inpatient PC programs, in 39 of California’s 58 counties (67%). These programs serve more than 72,000 inpatient admissions per year; current capacity is estimated to be between 33-50% of need.
* Community-Based Palliative Care (CBPC): This assessment identified 189 CBPC programs in the state, sponsored by 147 organizations, in 36 of California’s 58 counties (62%). These programs serve more than 53,500 individuals annually; current capacity is estimated to be between 24-37% of need.

All data are available and can be displayed in interactive maps on the CHCF website at: <http://www.chcf.org/publications/2015/02/palliative-care-data>

**Efforts to Increase Access and Capacity**

Judy Thomas, CEO of the Coalition for Compassionate Care of California (the Coalition), described two key tools for aligning care with preferences and spreading knowledge about palliative care models and approaches.

* POLST: Physician Orders for Life-Sustaining Treatment (POLST) is a medical order form used to document patient preferences for treatment. The form is not meant to replace written advance directives or critical conversations between patients and providers; instead, it translates the information from advance directives and patient-provider conversations into actionable medical orders. In California, the Coalition and the CHCF have led the development of a strong and collaborative POLST network, with over 25 community coalitions supporting the use of POLST, sharing best practices, and offering train-the-trainer sessions to equip providers to have POLST conversations with patients and families. More information on POLST is available at: <http://capolst.org/>
* Palliative Care Access Project (PCAP): The Coalition’s PCAP aims to spread CBPC across California, and provides a forum to share information, approaches, and tools. A variety of materials are available at: <http://coalitionccc.org/PCAP>

Kate O’Malley, Senior Program Officer at the CHCF, described some of CHCF’s recent initiatives and resources aimed at increasing palliative care capacity in California.

* Palliative Care Action Community (PCAC)/The Field Guide: The PCAC brought together 21 California provider organizations with CBPC services in 2013-2014, with an emphasis on peer learning and networking through in-person and web-based meetings. Learnings from the PCAC have been captured in a CHCF resource, “Up Close: A Field Guide to Community-Based Palliative Care in California,” available at <http://www.chcf.org/cbpc>. The Field Guide provides case studies, with practical information on how PCAC members staff and operate their services. It also includes approaches and tools for measuring opportunities and impact, descriptions of innovative models, and other resources.
* Payer/Provider Partnerships: This initiative provided six-month grants and technical assistance to enable 10 payer/provider pairs (or triads) to develop plans to increase access to CBPC. Supported by two in-person meetings, monthly webinars, and coaching from faculty, the participating teams are developing implementation plans that define a target patient population, model of care and staffing, funding approach, and metrics.

Amy Turnipseed, Director of Policy and Program Development at Partnership HealthPlan of California (PHC), a County Organized Health System (COHS), described her organization’s efforts within the CHCF Payer/Provider Partnership project. Building on past experience with and recognition of the importance of advance care planning, PHC joined with several hospice partners to develop a viable approach to providing PC services. Through a series of workgroup meetings and one-on-one interactions, PHC and their hospice partners have developed a plan for a pilot CBPC program. Features of the proposed pilot include:

* Contracted hospice organizations will provide PC through an interdisciplinary team, with services to include initial assessment, 24/7 telephonic support (including nurse consultation and care when necessary), pain and symptom management, advance care planning, support in completing POLST forms (when appropriate), acute care management plan, assessment of caregiver needs and referral to resources, assistance with transitions, and case management.
* PHC and the hospice partners have agreed to a per member per month payment model, which can be supplemented by a per member per quarter incentive payment for meeting quality metrics related to patient satisfaction, completed advance care plans, and completed acute management plans.

**Core Elements, Clinical Models , and Key Challenges**

Steven Pantilat, MD, Professor of Clinical Medicine at UCSF, facilitated a panel discussion with Dr. Kinderman, Ms. Kerr, and Ms. Turnipseed about some of the key issues that need to be considered as SB 1004 implementation work moves forward.

* Defining a patient population: Defining which patients should receive specialist PC is a challenge for the field and for the health care system as a whole. While palliative care can benefit a variety of people, limited specialty PC resources necessitate careful consideration of where efforts can have the greatest impact on quality.
* Selecting a service delivery model: Questions of what care should be provided and who should provide it are important – but the focus should be on outcomes and quality of care, with the understanding that a variety of models and staffing approaches can achieve comparable results. We have the opportunity to think creatively – what do patients and families really need, and how can the system provide what they want?
* Figuring out how services will be paid for: We need to encourage the delivery of the right services, without overuse. Generally speaking, the things you pay for, you’ll get more of. The things you don’t pay for, you’ll get less of.
* Metrics to assess opportunity and impact: At minimum, we need to understand what care is being provided, to whom, and what the impact those services have on a variety of outcomes (physical, psychological, care experience, costs). We need to recognize there may be things we should do to improve quality that do not reduce costs. Key challenges around assessing impact include timely access to death data, as well as leveraging and developing data systems that provide easy access to accurate information describing what care was delivered and when, across settings.

**Themes from Discussions**

Throughout the day, each presentation was followed by group discussion and questions and answers. While these discussions covered a wide range of topics, some themes included:

* Understanding potential sensitivities: Responding to a question about potential pushback from patients if their health plan approaches them regarding PC, DHCS leaders emphasized that the key to successful provision of PC rests with an individual provider (or care team) and their patients, and their collaboration to develop care plans that align care with preferences. The role of the health plan is to make PC services available and accessible, and to support providers in developing the skills to have conversations around goals of care.
* Workforce: Several discussions touched on workforce gaps, including the need for more specialty PC providers, the need for broad training in primary PC skills for all health care providers, and the relationship between the workforce and what services can be provided and to whom. Efforts to increase the public’s awareness of and “demand” for PC needs to be balanced with our capacity to deliver care. Opportunities exist to bolster PC skills among the existing home care workforce, including home health and In-Home Services and Supports (IHSS). Plans may want to consider their role in strengthening skills of their provider workforce, and may consider expanding the types of disciplines that can be part of a PC team. To date, DHCS leaders said they have not been working with the state medical board around mandated education for physicians in PC.
* Relationship between PC and other programs: Some participants wondered if a Medi-Cal member’s IHSS hours might be reduced if a patient received home-based PC services. DHCS leaders acknowledged the need to coordinate activities between plans and county-based IHSS services, which is likely to be easier in the counties participating in the Coordinated Care Initiative.
* Data limitations: As plans and other stakeholders consider metrics to assess impact of PC services over time, one key limitation is timely access to death data. PC leaders at the meeting described these data as incredibly important to forecast the need for and assess impact of PC services over time.
* Access to services: Plans and stakeholders will need to consider how to make their PC services fully accessible across the spectrum of physical, developmental, and socio-economic needs present in their Medi-Cal populations.