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?
Pre-SPCPHI, 2007
4 Palliative Care Sites

- Alameda Health System
- Santa Clara Valley Medical Center
- LAC + USC
- UC Irvine
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>
</tr>
</tbody>
</table>

Percent Population
Communication Barriers

Language Other than English

Limited English Proficiency

US | California | SFGH PC
---|------------|--------
21% | 44% | 42%
9%  | 20% |

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?

- Palliative care: 2%
- Acute care: 3%
- Home nursing: 14%
- ECF: 8%
- Died in hospital: 35%
- Hospice: 38%

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 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
Planning Ahead: Better Care for Patients Like Ms. O

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Planning Ahead: Community-Based Palliative Care

SYSTEM-BASED PRACTICE
* HOSPITAL/HEALTH SYSTEM
* HOSPICE

Clinic Practice
- Stand-Alone
- Co-located
- Embedded

Community Practice
- Facility Visits (SNF, AL)
- Home Visits

INDEPENDENT PRACTICE

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
- Transitions
- SFGH
- Laguna Honda Hospital (SNF)
- Acute Care
- SNF
- Specialty Care
- Maternal, Child, & Adolescent Health
- Primary Care
- Behavioral Health
- Jail Health
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*