COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

Pioneers in Palliative Care across the Continuum

Palliative Care Access Project

The Palliative Care Access Project (PCAP) brings together people with a passion for increasing access to palliative care. PCAP hopes to spur the growth and expansion of palliative care across the continuum of care in California by sharing ideas, discussing barriers, and highlighting successful models of community-based programs.

PCAP is led by the Coalition for Compassionate Care of California and funded by the California HealthCare Foundation. For more information, visit www.coalitionccc.org.

The following summaries were compiled for a meeting of the Palliative Care Access Project in September 2012 and updated in September 2013.

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Palliative Care Access Project September 27, 2012

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Palliative Care in the Continuum

Citrus Valley Health Partners & Hospitals

Program: Palliative Care
Contact: David Kessler, Chief Patient Support Operations

Program Creation

What was the motivation to start this service/program?

1. Ensure smooth discharge for last years-of-life patients
2. Continuity of care for our patients
3. Avoid unnecessary ER visits
4. Better pain and symptom management

Who instigated the service/program's creation? Was it the institution or the palliative care community?

- David Kessler, Palliative Care Director

Patients

How are patients identified for receiving these services?

- Complicated advanced illness patients
- Frequent re-admits
- Current inpatient palliative care patients
- Must be part of the Citrus Valley Health Partners system and its three hospitals.
- Most frequently referred by MD but can also be identified by hospital case managers and social workers as well as staff nurses.

What is the current average census?

- 25

How many patients are served annually?

- Community palliative care nurse sees 4 patients per day
- 20 visits per week
- Typical month is 72 visits and yearly 864 visits.

Services

What services are provided?

- RN visit where they live (ECF, assisted living, B&C, home)
- Home visits include education on medication regime, pain and symptom management, home safety, support resources.
- Support and education to family and staff
- MD office visits to ensure continuity in the home.
- 24 hour on-call service available by cell phone.

Delivery of Care

Where is the care delivered?

- Wherever the patient is, including a homeless woman who lived in her car in a parking lot at Denny's.

Who delivers the care?

- Cindy Cisneros, Palliative Care RN

How many staff (i.e., FTE) work on the service/program?

- One for post acute and one for inpatients.

Finances

How is the service/program funded?

- The hospital

Data

Are you collecting any data or conducting any evaluation of the service/program?

- For Joint Commission certification
- Collected data for first two years to prove cost savings and avoidance for hospital

Lessons Learned

What was your biggest surprise in developing this model?

- Small things cause big unnecessary readmissions
- Lack of medication understanding is most frequent problem in the home
- Meeting patients at their doctors office ensures continuity and compliance, and also gets more buy-in from Doctors
- Developing a relationship with MD and knowing his or her preferences helps in success of the program
- How supportive the oncology doctors were as they see Palliative care as an additional support that benefits their patients in their offices
- Having your own Hospice inpatient unit and home hospice is sometimes more a burden than a benefit

What mistakes can be avoided?

- Don't take patients just based on disease
- Get to know your doctors' preferences
- Help the patients problem-solve without interfering with the physician relationship
- Be bilingual (needed for our community)
- Get to know the patient prior to hospital DC so they are accepting of home services

Other

Anything else you would like to tell us about regarding your palliative service/program?

- Currently preparing to apply for Joint Commission Palliative Care Certification
- Received a grant from the LiveStrong Foundation for our inpatient palliative care services Joint Commission Certification
- We are also applying for grants for home social work and chaplain services

Palliative Care in the Continuum

Evercare Hospice and Palliative Care

Program: Palliative Care Consultation Service
Contact: Jim Mittelberger (James_a_mittelberger@uhc.com)

Program Creation
What was the motivation to start this service/program?
We want to provide services to patients that allow them to receive palliative care without having to give up curative care or meet the life expectancy requirements of the Medicare Hospice benefit.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
We developed the program.

Patients
How are patients identified for receiving these services?
Patients are generally referred to us, though we do partner with others to identify appropriate patients.

What is the current average census?
Approximately 200

How many patients are served annually?
Approximately 1100

Services
What services are provided?
Physician and nurse practitioner consultations.

Delivery of Care
Where is the care delivered?
Hospital, home and nursing home.

Who delivers the care?
Hospice physician or nurse practitioner.

How many staff (i.e., FTE) work on the service/program?
Approximately 8

Finances
How is the service/program funded?
Fee for service revenue in most markets. We are developing some managed care programs at present. The program supports our hospice's reputation and growth so it need not be profitable.

Data
Are you collecting any data or conducting any evaluation of the service/program?
Yes, but clinical outcome data are not easily obtained in a fee for service system.

Lessons Learned

What was your biggest surprise in developing this model?

It is often more challenging than expected to build referrals from specialists. Oncologists have expressed great interest, but have been difficult to get to refer.

What mistakes can be avoided?

A full needs analysis and preparation should precede implementation.

Other

Anything else you would like to tell us about regarding your palliative service/program?

We believe it will continue to be an important part of our health care delivery going forward.

Palliative Care in the Continuum

Health Care Partners

Contact: Stuart Levine, MD & Susan Stone, MD

Patients

How are patients identified for receiving these services?
Patients are referred by our medical group and high risk staff. We also receive referrals from our IPA physicians.

Care management and house calls also refers to palliative care.

Attendance at CMCC meetings during case reviews is significant source of referrals. We have the entire team for a given region present and discuss those patients with long lengths of stay.

What is the current average census?
Our outpatient census for palliative care and housecalls is over 300 and growing.

Additionally we have patients in or ESRD program that we follow and the CHF and COPD programs.

How many patients are served annually?
Over 300 per month

Services

What services are provided?
Palliative care is provided as part of our Comprehensive Care Clinics which are those patients at risk for morbidity and mortality.

Patients can be seen in or High Risk clinic where they are not being seen by their primary but by our internist. These patients need more intensive follow up and more frequent visits monthly and often receive palliative care consults.

If a patient can't make it in for appointments they are moved onto our House Calls program where they are seen monthly (or more) by our NPs and oversight by a physician.

For both the High Risk clinic and House Calls they also are enrolled in our Care Management program where a nurse liaison calls them and problem solves weekly.

Palliative care consults are weaved into the programs.

We have social work, case management and psychosocial treatment along with medical.

Delivery of Care

Where is the care delivered?
In home, outpatient clinic, SNF, inpatient

Who delivers the care?
Nurse practitioners, physician, social work case managers and hospitalists

How many staff (i.e., FTE) work on the service/program?
- 1 FTE MD for House Calls/Palliative Care
- NP's 5 work 30%FTE each palliative care, the rest house calls and 2 also do ESRD program
- SW FT-1 FTE per site

Finances
How is the service/program funded?
Internally

Data
Are you collecting any data or conducting any evaluation of the service/program?
Yes, building an internal dashboard and metrics for outpatient.

Lessons Learned
What was your biggest surprise in developing this model?
Very different recruitment for outpatient. More complicated.

What mistakes can be avoided?
Make sure PCP's understand palliative care is NOT hospice.

Other
Anything else you would like to tell us about regarding your palliative service/program?
We have complete organizational support from the top down and a true commitment to integrate palliative care into every site of HCP.

Palliative Care in the Continuum

Health Essentials

Program: Community Based Palliative Care
Contact: Richard D. Brumley MD

Program Creation

What was the motivation to start this service/program?
Patients and health care providers were dissatisfied with current "usual care" that provided no alternative between acute care management of chronic conditions and hospice .

Who instigated the service/program's creation? Was it the institution or the palliative care community?
New program instituted by Health Essentials.

Patients

How are patients identified for receiving these services?
Physicians, Medical Group risk assessment staff, hospital DC planners and Social Workers, Hospice and Home Health staff.

What is the current average census?
Program under development.

How many patients are served annually?
Program under development.

Services

What services are provided?
MD Palliative Consultation in outpatient setting followed by development of plan of care (POC). Consultation includes discussion of pain and symptom assessment, plan of care, goals, advance care planning, home safety review, medication reconciliation/review for appropriateness, DME assessment. Patient may receive one time only visit with no follow-up. POC may suggest weekly, biweekly, or monthly MD/RNP visit along with periodic visits by the following providers as determined by the plan of care: RN, Social Worker, Rehab services, HHA, chaplain, volunteer services. Frequency of visits determined by need.

Delivery of Care

Where is the care delivered?
Non acute facility such as home or assisted living facility.

Who delivers the care?
Health Essentials staff

How many staff (i.e., FTE) work on the service/program?
Program under development, will staff based on need.

Finances

How is the service/program funded?

Under contract by referring Medical Group. Care may be capitated. Skilled visits may be billed under Home Health benefit for short term skilled needs.

Data

Are you collecting any data or conducting any evaluation of the service/program?

Yes

Lessons Learned

What was your biggest surprise in developing this model?

Learning the challenges of navigating through multiple payer sources with different services offered based on contracting agency.

What mistakes can be avoided?

Other

Anything else you would like to tell us about regarding your palliative service/program?

Will report in future after program initiated.

Palliative Care in the Continuum

Hoag Hospital

Program: CARES/Palliative Care
Contact: Vincent Nguyen, DO, Program Director
Kristyn Fazzalaro, LCSW, Supervisor

Program Creation

What was the motivation to start this service/program?
Our inpatient palliative care service has been in place since 1999. As the healthcare world changes, we have recognized the need to assist patients in the outpatient setting, to improve quality of care and assist with unnecessary readmissions.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
The palliative care team was created, with the support of the hospital, in response to unmet need in the community. We had a physician champion (Primary Care Physician) who was the visionary for bringing in our current Medical Director (V. Nguyen) to expand the service from inpatient to outpatient care.

Patients

How are patients identified for receiving these services?
Patients are identified via multiple sources. Often, patients seen for inpatient consultation (who do not opt for hospice care) are automatically enrolled in our outpatient program; direct physician referral from the community, Cancer Program staff, inpatient case managers who have not received palliative care consults.

What is the current average census?
- Community LCSW: 124 active patients (followed monthly or bi-monthly)
- RN/CNS symptom management clinic: 14/month
- Physician Clinic: Average of 8 patients/month

How many patients are served annually?
- Community LCSW (CY 2011): 273 telephonic and face-to-face visits.
- RN/CNS symptom management clinic (CY 2011): 56 patients (with 145 touches – either telephonic or in person)
- Physician Clinic: 59 patients clinic patients seen since February 2013

Services

What services are provided?
- LCSW – telephonic case management, in office counseling/ACP visits, link to resources, support on re-admissions, bereavement support to patients who die while not on hospice.
- RN CNS – symptom management clinic
- Physician – outpatient clinic for pain and symptom management and defining goals of care; episodic residential visits for specific bed/home-bound patients

Delivery of Care

Where is the care delivered?
Palliative Care offices, Cancer Center Outpatient Treatment Clinic, Selected patients in their residence.

Who delivers the care?
LCSW, RN/CNS, Physician

How many staff (i.e., FTE) work on the service/program?
1.3 FTE (1 FTE LCSW, 0.1 RN/CNS, 0.2 Physician)

Finances
How is the service/program funded?
Hospital funded and Physician billing.

Data
Are you collecting any data or conducting any evaluation of the service/program?
- Collected data includes: demographics, Advance Directive completion, POLST completion, transitions to alternate level of care (i.e. home health, hospice, etc.), symptom management focus (pain, N/V, breathlessness)
- We do not have program evaluations such as patient-family satisfaction in place at this time.

Lessons Learned
What was your biggest surprise in developing this model?
- Volume/Need in the community
- The need for Physician/Physician relationship; overall Physician-centric culture in our community
- Physician receptivity once they realize how we can help their patients (i.e. requesting our LCSW to come to their office to see an elderly patient and assist with advance care planning and POLST completion).

What mistakes can be avoided?
- Have a comprehensive marketing plan to community Physicians to ensure strong link to PCPs. This would allow us to recruit them for on-going follow up and to reduce silos of practice.
- Define what data is important to collect so that you do not overwhelm the service with meaningless information.

Palliative Care in the Continuum

Kaiser Permanente, Northern California

Program: Advanced Illness Coordinated Care Program
Note: AICCP is in all service areas / medical center regions. Other programs vary by medical center within our region and include clinic, telephonic, SNF and home-based Palliative Care.
Contact: Julie Sandoval, MD
Danica Orsino, Quality and Operations Support Consultant

Program Creation

What was the motivation to start this service/program?

- Palliative care started in KP-NCAL in 2004 with an initial focus on inpatient services. Our programs overall were developed to address unmet needs of the seriously ill – including their physical, psychosocial, spiritual, and emotional needs.
- Advanced Illness Coordinated Care program (AICCP) was implemented in 2009, based on research showing its effectiveness in supporting patients and their families during serious illness.
- Additional outpatient palliative care work was formally implemented in 2009 based on patient needs identified by the palliative care teams, with a particular focus on reaching patients earlier in their disease trajectory. There was also regional-level encouragement for the local teams to innovate and create outpatient palliative care programs.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
Regional leadership and the local-level palliative care community (clinicians, staff, etc.) within the medical centers.

Patients

How are patients identified for receiving these services?

- AICCP: In most medical centers patients are targeted for AICCP based on a Stage 3 or 4 Cancer diagnosis. Some programs also identify other seriously ill patients (ESRD, Heart Failure, etc.)
- Other services: Identification of patients varies, but includes provider referral, inpatient team referral, patient/family request, and in some cases is disease-specific or specific to site-of-care (SNF).

What is the current average census? How many patients are served annually?
We don't currently capture all patient contacts. Based on existing date our PC services outside the acute setting touch 8,000 pts per year. Because of gaps in our current data collection, there are an additional 2,500-3,500 pts that are touched by outpt PC that are not counted in the existing data.

Services

What services are provided?
Interdisciplinary consults and family meetings; individual provider consults; pain and symptom management; advance care planning, emotional and spiritual support, referrals and resources

Delivery of Care

Where is the care delivered?
Ambulatory clinics, Telephonic, SNF, Home Health, home-based

Who delivers the care?
Physicians, nurses (RN and NP), social workers, sometimes chaplain involvement (but less so on outpatient side)

How many staff (i.e., FTE) work on the service/program?
FTEs vary by medical center and staff often flex across areas of palliative care work, so may not be exclusive to ambulatory.

Finances
How is the service/program funded?
The program is funded jointly by hospital and medical group. Services are available to all members.

Data
Are you collecting any data or conducting any evaluation of the service/program?
Yes, we have a database and dashboard. These are currently undergoing updates.

Lessons Learned
What was your biggest surprise in developing this model?
Key learnings for our group were in the following areas: (1) the challenges of coordinating care across settings, (2) how to best ensure seamless care for the patient, and (3) also training staff outside of palliative care to ensure we respect and follow through on patients' wishes (the reach of the program needs to be beyond the immediate palliative care staff; focus on culture change and education).

Effectively integrating palliative care services into medical specialty areas requires good relationship building, establishing clinician trust in the intentions and skills of the palliative care team, and providing the specialty clinicians with background information and talking points to ease the referral conversations with patients. Making referrals to palliative care a standard for all patients can also ease the discomfort in telling a patient they are being referred based on their more advanced stage of illness.

What mistakes can be avoided?
Language, talking points, and messaging are critical in communicating with non-pc providers and patients. Ensuring resources, core competencies, and infrastructure for care is critical to ensure quality of care for pts.

Other
Anything else you would like to tell us about regarding your palliative service/program?

Palliative Care in the Continuum

Permanente, Southern California

Program: Palliative Care Programs
Contact: Nancy Gibbs, Brenda Thomason

Program Creation

What was the motivation to start this service/program?
Grow over time, as you put one component in place see the need in other care settings. Combination of trying to get to: Right Care in the Right Place at the Right Time and Honoring Patient Preferences

Who instigated the service/program's creation? Was it the institution or the palliative care community?
Came from local champions, external research, senior leadership support.

Started with hospice, then home-based palliative care, then defining the expanding need for palliative care in the inpatient and ambulatory settings. Adoption of POLST by the state provided a leveraging moment. Starting pilots in ambulatory setting with various models

Patients

How are patients identified for receiving these services?
Primarily through physician identification and referral, although some case finding in the inpatient setting

What is the current average census?
HB-PC about 1,000, IPC – see about 30 new consults a day over 13 medical centers. Hard to define volume in nursing homes, ambulatory – no current data

How many patients are served annually?
Hospice about 7,000 per year, HBPC, 2,500, IPC 5,000 consults

Services

What services are provided?

Delivery of Care

Where is the care delivered?
In all of our medical centers and in most settings

Who delivers the care?
Generally multidisciplinary teams, MD,SW, RN, chaplain or some lesser combination

How many staff (i.e., FTE) work on the service/program?

Finances

How is the service/program funded?
Both the medical group and the health plan fund

Data

Are you collecting any data or conducting any evaluation of the service/program?

Have numerous dashboards – still looking to collect better Quality and satisfaction data

Lessons Learned

What was your biggest surprise in developing this model?

That you keep having to make the argument about the benefits over and over again

What mistakes can be avoided?

Other

Anything else you would like to tell us about regarding your palliative service/program?

Palliative Care in the Continuum

Mercy Medical Group / CHW Medical Foundation

Program: Care Teams/ Geriatric
Contact: Parag Agnihotri M.D., 916-379-2933

Program Creation

What was the motivator to start the service/ program?

- Are we following and documenting patient's wishes in a meaningful way?
- Total cost of care.
- High readmissions and root cause analysis showing higher rate of potentially avoidable utilization of services.
- Late referrals to hospice with an average enrollment period in 7 days.

Who instigated the service/program creation?

- The Physician champion with a team approach towards addressing the needs of our seniors which has gradually evolved into addressing and documenting patients' wishes and providing palliative care services across the continuum.
- The principles of 'Palliative care' are regularly practiced by Care Teams and Geriatric service.

Patients

How are patients identified for receiving these services?

- Care teams: a Chronic Disease registry identifies patients with multiple chronic illnesses and at risk for frequent exacerbation of chronic illnesses.
- Geriatric service at SNF: Patients with POLST documenting patients' wishes as Comfort care or no life-saving additional interventions.

What is the current average census?

- Care Team Average census : 750
- Annual 2000+
- Geriatric service average monthly census : 800 (high turn around)

How many patients are served annually?

Services

What services are provided?

- Advance Directive, Social, mental health counseling, placement services, coordination of care.
- Family expectations.
- Symptom management.

Delivery of Care

Where is the care delivered?

- Home based service, SNF, Outpatient clinics (Care team conferences with PCP), Geriatric consult clinic, Home health service, Hospice.
- Hospital based Physician led Palliative care service coming soon.

- Nurse led Palliative care service exists at our Hospitals.

Who delivers the care?
Licensed Social workers, Home visit Nurse practitioner, Geriatricians, Home Health nurse.

How much staff work on the service/program?
- All the staff have multiple roles in the care delivery but all follow the principles of palliative care within their confines of their individual scope of practice.
- Care Team: 8 (RN+ LCSW)
- Geriatric Division: 11
- Mercy Home Health nurse: 20+
- Plan to hire 2 Palliative care fellowship trained MD for the Palliative care consultation service.

Finances
How is the service/program funded?
- Dignity Health supports the finances.
- The financial value is in cost avoidance.
- Geriatric division is on Fee for service model and provide additional value by cost avoidance.

Data
Are you collecting any data or conducting any evaluation of the service/program?
- Yes. We evaluate the effectiveness of 'Care Team' with process and outcome measures.
- For Geriatrics one example is measuring the readmission from SNF to Hospital.

Lessons Learned
What was your biggest surprise in developing this model?
- Culture change towards advancement of Palliative care takes time.
- Managing patient and family expectations among multiple providers can be a challenge.
- It takes time and resources to have those crucial conversations.
- There is no reform without payment reform.

What mistakes can be avoided?

Other
Anything else you would like to tell us about regarding your palliative service/program?

Palliative Care in the Continuum

Monarch HealthCare

Program: Compassionate Care Program
Contact: Rena Smith, Palliative Care Program Manager, rsmith@mhealth.com

Program Creation

What was the motivation to start this service/program?
Better care for frail and seriously ill patients at the end of life. Ensuring their symptoms are managed and treatments rendered are consistent with their wishes.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
Dr. Vincent Nguyen and the blessings of the Monarch Board of Directors.

Patients

How are patients identified for receiving these services?
Patients are referred into the program by case managers, hospitalists, and primary care physicians, using pre-established criteria.

What is the current average census?
85

How many patients are served annually?
YTD, we've touched 230 patients

Services

What services are provided?
Clinical – 0.5 FTE MD & 1 FTE NP. Pending 1 FTE MSW and 0.5 FTE Chaplain

Delivery of Care

Where is the care delivered?
Patient's place of residence (private home, assisted living, SNF) 95%; 5% in acute.

Who delivers the care?
MD-NP team.

How many staff (i.e., FTE) work on the service/program? 4 FTEs

Finances

How is the service/program funded?
Through the Medical Group

Data

Are you collecting any data or conducting any evaluation of the service/program?
Yes: LOS; readmission to the Acute, ED; # admitted to Hospice, % of POLSTS completed.

Lessons Learned

What was your biggest surprise in developing this model?
How open people are to this service. Well supported by CM & PCP.

How few programs of this nature existed on an outpatient basis; How much confusion there is in the medical community with regard to difference between hospice and palliative care; The extent of the need for this type of service.

What mistakes can be avoided?
Ensure adequate administrative and clinical support. Can't do it alone.
Be patient and grow the program strategically; Make sure that you can serve the patients that are referred.

Other
Anything else you would like to tell us about regarding your palliative service/program?
This is an evolving program that we hope to integrate into main-stream healthcare through education and collaboration.

Palliative Care in the Continuum

Palo Alto Medical Foundation

Program: Palliative Care and Support Services
Contact: Sharon Tapper, MD/ tappers@pamf.org/831-458-5511

Program Creation

What was the motivation to start this service/program?
I helped to create and have been working in an inpatient palliative care (pc) program for the last 8 years and it is very clear that there is a lack of comprehensive, coordinated follow-up for these patients. Also, for many of the patients seen in the hospital, the hospitalization could have been avoided if adequate care systems were in place.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
I instigated the program's creation and it took 2 years to plan the pilot with institutional support.

Patients

How are patients identified for receiving these services?
Any patient already in an inpatient PC program or on hospice is an automatic referral and it is otherwise by physician referral only (to get cultural shift in physician thinking). We use the surprise question.

What is the current average census?
Program saw 350 patients in the first year with a current census of 160 patients/day. Once fully operational across entire region (700,000 PAMF patient base across 3 counties) will have estimated 800-1,000 patients on service/day.

How many patients are served annually?
In Santa Cruz pilot, 350 first year. Estimate will be 2,500-3,000/year when fully operational across entire region

Services

What services are provided?
Comprehensive team based care with symptom management, advanced care planning, goals of care, discussion of disease processes and care coordination across all settings, regardless of the patient's physical location. All of this is coordinated with the patient's PCP and all involved specialists.

This care is provided across un-integrated health care systems. For example, in the Palo Alto region where we will begin implementation in June, there are 8 unaffiliated hospices, 10 unaffiliated home health agencies, 3 unaffiliated hospitals and 5-10 unaffiliated nursing homes.

Delivery of Care

Where is the care delivered?
Wherever the patient is located: home/ SNF/RCFE/outpatient clinic/hospital. Sometimes it is "in person" with the team and sometimes it is "virtual" with coordination with hospice or the impatient team.

Who delivers the care?
Team composed of PC BC/BE specialist/ NP/ MSW/RN coordination/care coordinator
How many staff (i.e., FTE) work on the service/program? 4.63 in Santa Cruz pilot with projected census of 200 patients/day on service.

Finances
How is the service/program funded?
Billings, philanthropy and institutional support

Data
Are you collecting any data or conducting any evaluation of the service/program?
Yes

Lessons Learned
What was your biggest surprise in developing this model?
How long it took to pilot.
What mistakes can be avoided?
Be flexible in the implementation phase-plan for clinic space way in advance.

Other
Anything else you would like to tell us about regarding your palliative service/program?
I am most proud that…
We have a consistent >95th percentile press ganey patient satisfaction rate and 100% of our docs who competed our survey would use us again!

Palliative Care in the Continuum

VA Palo Alto Health Care System

Program: Palliative Care Program
Contact: James Hallenbeck, MD

Program Creation
What was the motivation to start this service/program?
Expand from out inpatient unit/consult team.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
Instigated by our palliative care team

Patients
How are patients identified for receiving these services?
Referred by other clinics

What is the current average census?
Not sure this a meaningful metric for the clinic. Currently a ½ day clinic and recently added two other half days.

How many patients are served annually?
Unclear

Services
What services are provided?
Both outpatient clinic consultation and some primary care

Delivery of Care
Where is the care delivered?
VA Palo Alto outpatient clinics

Who delivers the care?
Palliative medicine physicians, fellows, with some support from other interdisciplinary staff, especially social workers.

How many staff (i.e., FTE) work on the service/program?
Approximately 1.5

Finances
How is the service/program funded?
Part of overall capitated healthcare of VA

Data
Are you collecting any data or conducting any evaluation of the service/program?
Not in a systematic way.

Lessons Learned

What was your biggest surprise in developing this model?

Difficulty in establishing a palliative care "medical home" – limited referrals

What mistakes can be avoided?

Other

Anything else you would like to tell us about regarding your palliative service/program?

I've answered the above questions narrowly in terms of our palliative care outpatient clinic. We also have a number of other programs, such as home based primary care, where the bulk of care provision is palliative in nature. One issue I hope gets addressed in the conference is the boundaries of what constitutes a palliative care program. My sense is that people have too narrowly constructed this.

Palliative Care in the Continuum

Sharp Health Care

Program: Transitions Advance Illness Management Program
Contact: Suzi Johnson R.N., and Daniel Hoefer, M.D.

Patients
How are patients identified for receiving these services?
Patients are identified by primary care physician or case manager.

What is the current average census?
150 patients

Services
What services are provided?
- In home medical consultation planning
- Evidence based prognostication – prepare the patient and family for the inevitable consequences of the natural disease process
- Care for care giver
- Advance care planning (include stakeholder in the planning)

Delivery of Care
Where is the care delivered?
- Primarily in the home. May occur in other places as well.
- Referrals are from the MD offices or case managers.

Who delivers the care?
- Nurse Practitioner
- Social Worker
- Primary Care Physician
- Specialist

How many staff work on the service/program?
2 RN's, 1 PD MSW, 1 ACP Coordinator, .8 Intake LVN. The Clinical Director of Hospice manages the program.

Finances
How is the service/program funded?
Services are provided to enrollees in a capitated financial arrangement. The savings from decreased hospitalization fund the program.

Data
Are you collecting any data or conducting any evaluation of the service/program?
Yes.

Lessons Learned

What was your biggest surprise in developing this model?

How successful the program became without having all parties on board initially.

What mistakes can be avoided?

Showcase the successful programs. Solicit opinions from all physician stakeholders before implementing.

Other

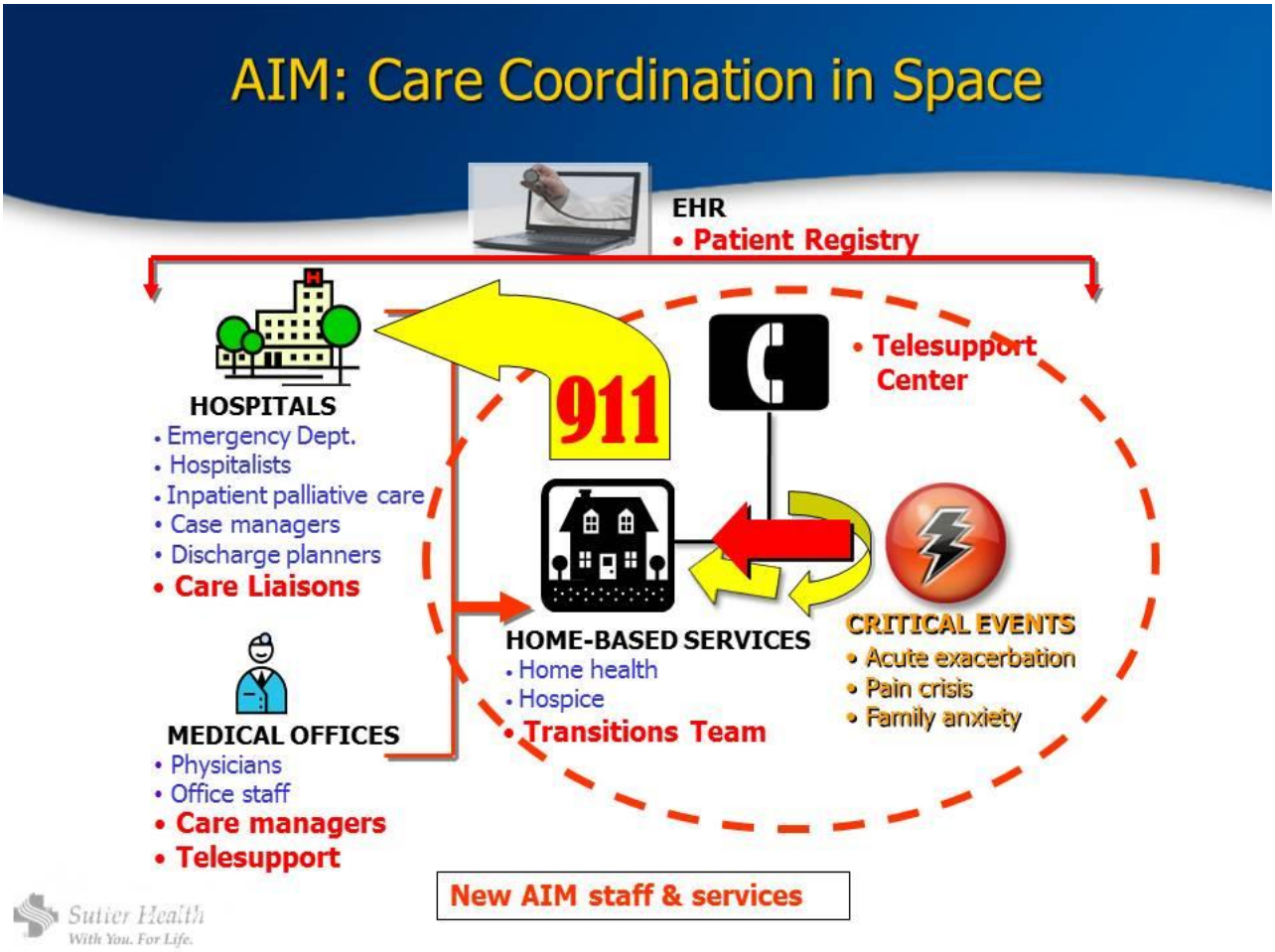
Anything else you would like to tell us about regarding your palliative service/program?

The journey has just begun. Shifting the paradigm from a paternalistic to a shared decision model will evolve over time as more programs like Transitions are adopted in the community.

Palliative Care in the Continuum

Sutter Health

Program: Advance Illness Management (AIM)
Contact: Brad Stuart, MD See below.



Palliative Care in the Continuum

University of California, Irvine

Program: Palliative Care Service
Contact: Solomon Liao, MD

Program Creation

What was the motivation to start this service/program?
The motivation was twofold: One to provide follow up for patients we saw in the hospital who did not go onto hospice, and two a forum to provide education to our fellows.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
I instigated the clinic.

Patients

How are patients identified for receiving these services?
Patients are referred by their surgeon, oncologist or primary care physicians. They also come as follow up from our inpatient consults.

What is the current average census?
We see 30 patients a week.

How many patients are served annually?
We see approximately 300 individuals a year.

Services

What services are provided?
We provide pain and symptom management and in the long run goals of care and referrals to home palliative care and hospice.

Delivery of Care

Where is the care delivered?
In our cancer center.

Who delivers the care?
The patients and families see a physician, a nurse, a social worker and a pharmacist.

How many staff (i.e., FTE) work on the service/program?
0.4 physician FTE, 1 nursing FTE, 0.3 social work FTE, and 0.3 pharmacist FTE

Finances

How is the service/program funded?
Funded through the cancer center and palliative care service

Data

Are you collecting any data or conducting any evaluation of the service/program?
No

Lessons Learned

What was your biggest surprise in developing this model?
How difficult it was to get started.

What mistakes can be avoided?
Get buy-in for a nurse sooner.

Other

Anything else you would like to tell us about regarding your palliative service/program?
For a clinic that was pieced together based on need, it is running pretty well and expanding at a steady pace.

Palliative Care in the Continuum

University of California, San Francisco

Program: The Symptom Management Service
Contact: Mike Rabow, MD

Program Creation

What was the motivation to start this service/program?

- Recognition that most patients at EOL spend most of their time as outpatients
- Initial attempt to create an outpatient PC program in General Medicine was not supported by General Medicine.
- Needs assessment showing oncologist receptivity to increased patient support, especially with social work and pharmacy.

Who instigated the service/program's creation? Was it the institution or the palliative care community?

- Dr. Rabow (a palliative care doctor at UCSF) initiated the needs assessment and program.
- The early supporters and adopters included GU Oncology and GYN Oncology.
- Early support from the administrative head of the cancer center.

Patients

How are patients identified for receiving these services?

- Almost all patients are referred by their primary oncologist, although nurse practitioners often initiate these referrals.
- Most common reasons for referral are pain and depression.
- Some referrals from the Integrative Medicine practice and from primary care physicians.
- Rarely, patients self-refer

What is the current average census?

- Patients seen on average for just under 3 visits
- 1300 visits/year

How many patients are served annually?

- 30-40 patients referred monthly = 420/year

Services

What services are provided?

- Core is MD or NP-led SMS visit focused on symptom control and the goals of care
- SW in visit in < 50% of the time
- Chaplain sees select patients
- Nutritionist sees select patients
- Small portion also seen by psycho-oncology
- IDT includes 2 psychologist

Delivery of Care

Where is the care delivered?

Office

- SMS has an office (shared space with Psycho Oncology) across the street from the main cancer center building
- Formerly saw patients within the GU Oncology clinic space
- Some visits are conducted in the General Medicine faculty clinic space

Home

- "SMS Bridge" for homebound patients not in hospice and without home care (0.1 FTE)

Inpatient…Coming in 2012-13

- Cancer center hospital inpatient consultation

Who delivers the care?

- 0.5 NP
- 0.5 clinical MD (split between 3 physicians)
- 0.4 palliative care Fellow (split between 4 fellows)
- 0.2 pharmacy residents

Social work, nutrition, chaplaincy is donated time from their regular UCSF service Pharmacy time is donated by the pharmacy residency program

How many staff (i.e., FTE) work on the service/program?

- 0.5 NP
- 0.4 clinical MD (split between 2 physicians)
- 0.2 MD preceptor for fellow clinics
- 0.4 palliative care Fellow (split between 4 fellows) (supported by the PC Fellowship)
- 1.0 program coordinator
- 0.25 medical director

Finances

How is the service/program funded?

- Billing for MD and NP time for about 46%
- Dedicated philanthropy from the cancer center (10 year time frame) for about 45%
- Research grants (American Cancer Society, Mount Zion Health Fund)
- Individual, small philanthropic gifts

Data

Are you collecting any data or conducting any evaluation of the service/program?

- Clinicians complete data form with each visit, including reason for consult, problems identified, clinicians in the room
- Patients complete ESAS before each visit
- SMS is included in cancer center-wide Press Ganey evaluation around patient satisfaction
- Quarterly patient satisfaction survey initiated by the SMS

Lessons Learned

What was your biggest surprise in developing this model?

- Referrals easier than expected (although program not pitched as palliative or EOL care)
- Most oncologists more than happy to cede control of pain and mood management
- There is a subset of clinicians who are personally deeply dedicated and participate in the program without explicit support built into their job description.
- Figure out how long you'll follow patients. Long-term continuity takes a lot of resources.
- No shows are expensive, but there is a limit on how much can be avoided.
- Now cancer centers need palliative care programs (for Commission on Cancer, for US News and World Report)

What mistakes can be avoided?

- Establish models/plans for scaling the program before or soon after launching the program.
- Plan for growth in light of the recognition that billing will never support much more than ½ of expenses.
- Don't underestimate the need for administrative support
- Need a good financial analyst to support the program (the doc likely cannot do it)
- Providing care in the home is very expensive in clinician time (about ½ or less efficiency)

Other

Anything else you would like to tell us about regarding your palliative service/program?

Palliative Care in the Continuum

VITAS Innovative Hospice Care and CPMA

Program: Palliative Medical Associates of California
Contact: Bruce Schlecter, MD and Alen Voskanian, MD

Program Creation

What was the motivation to start this service/program?
The need to provide palliative care services earlier to patients with life-shortening illness. We saw a significant unmet need in patients that were referred to hospice very late and could have benefited from palliative care services earlier in the disease trajectory.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
Both the institution and the physicians involved in the program. The parent organization, Vitas HealthCare, created a separate legal entity for the medical practice.

Patients

How are patients identified for receiving these services?
Some by using triggers that were given to the medical groups and some by referring physicians.

What is the current average census?
We do not maintain a census – we are consulting practice only.

How many patients are served annually?
This program is new and any numbers provided would not accurately reflect our scope of work.

Services

What services are provided?
Physicians, RNs, and social workers, and occasionally chaplains.

Delivery of Care

Where is the care delivered?
Wherever the patients are – Home, clinic, RCFE/ALF, SNF and hospital.

Who delivers the care?
Physicians, RNs, and social workers, and occasionally chaplains.

How many staff (i.e., FTE) work on the service/program?
We are a new program with multiple sites, each with about 5 to 10 physicians.

Finances

How is the service/program funded?
Billing/FFS

Data

Are you collecting any data or conducting any evaluation of the service/program?
We are starting to collect data in order to perform various performance improvement projects.

Lessons Learned

What was your biggest surprise in developing this model?

Reimbursement barriers and financial incentives that are misaligned when it comes to referring patients to palliative care. Plus, anticipating the need and growing to meet it fast enough.

What mistakes can be avoided?

New programs will discover this on their own, based on the dynamics of the communities they serve.

Other

Anything else you would like to tell us about regarding your palliative service/program?

There is significant confusion in the community on how out-patient or community-based palliative care should be provided.

Palliative Care in the Continuum

Woodland Healthcare

Program: Bridge Program for Palliative and Supportive Care
Contact: Jeff Yee, MD and Joanne Hatchett, FNP

Program Creation

What was the motivation to start this service/program?
Patient needs, recognizing that patients have increasing needs for palliative care in all healthcare settings.

Who instigated the service/program's creation? Was it the institution or the palliative care community?
Dr Jeffrey Yee and Joanne Hatchett, FNP

Patients

How are patients identified for receiving these services?
Hospital Census review, Skilled Nursing Facility (SNF) resident identification, PCP referral

What is the current average census?
5-8 patients, active engagement in the home
2-5 patients in acute care, care review of 10-12 patients/day in acute care hospital
50-60 patients, active engagement in the SNF

How many patients are served annually?
375 active engagement
1,200 case review and minimal involvement

Services

What services are provided?
Clinical support, case management with promotion of palliative care in both primary care and through formal consultation

Delivery of Care

Where is the care delivered?
Acute care, SNF, assisted living and home

Who delivers the care?
NP, MD

How many staff (i.e., FTE) work on the service/program?
1 FTE NP, 2 part-time NP, 1 part-time MD

Finances
How is the service/program funded?
Medical group/ Hospital

Data
Are you collecting any data or conducting any evaluation of the service/program?

Census data.

Lessons Learned
What was your biggest surprise in developing this model? What mistakes can be avoided?

We have integrated clinic NP's and one internal medicine/palliative care MD to provide improved continuum of care services to patient/residents in acute care, SNF and at home.

Other
Anything else you would like to tell us about regarding your palliative service/program.

A novel effort has been to implement an advance care planning system in the outpatient clinic setting.