

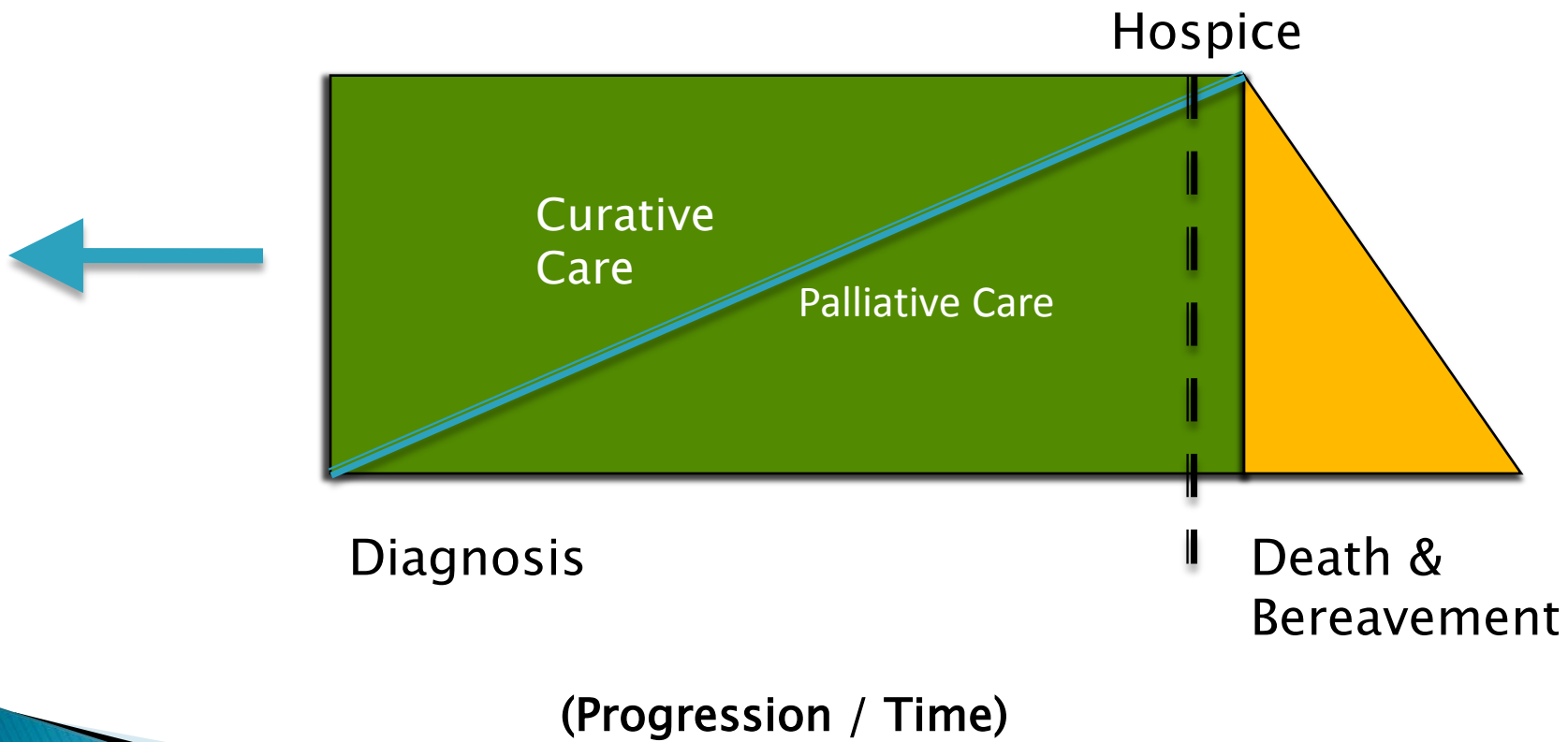
San Francisco Palliative Care Task Force

Palliative Care Today

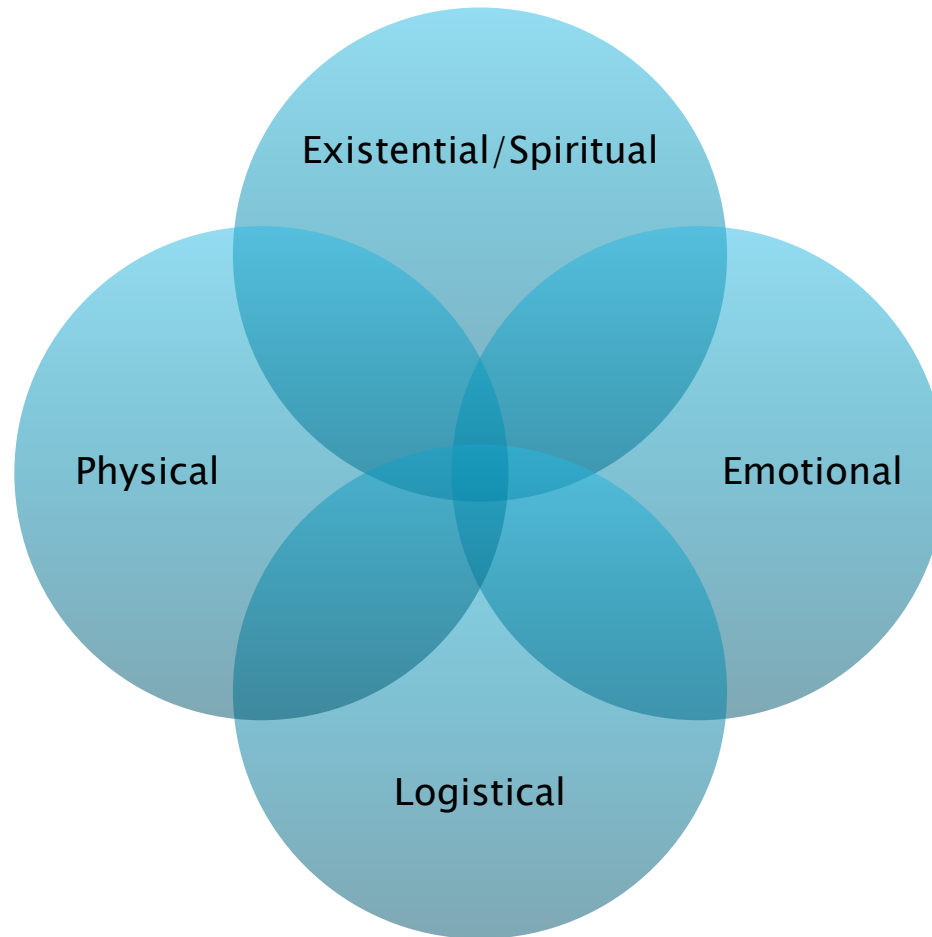
BJ Miller
Zen Hospice Project
May 29, 2014

Palliative Care

Hospice



Suffering



Interdisciplinary Team

▶ Traditional

- Doc
- Nurse
- Social Worker
- Chaplain

▶ Expanded

- Admin
- HHA/CNA/PCA
- Psychologist
- Pharmacist
- Physical therapist
- Volunteer
- Informal caregiver
- Lawyer
- Artist
- Architect
- (etc)

A profession

A Movement

Case in point

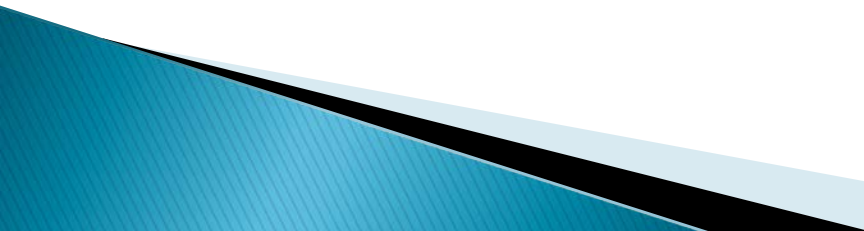
68 yo woman with hepatitis C, diabetes, renal insufficiency, and increasing immobility. Recently discharged from Laguna Honda Hospital following rehab stay for hip replacement. Presents to St Francis ED with shortness of breath, and diagnosed with heart failure.

Case

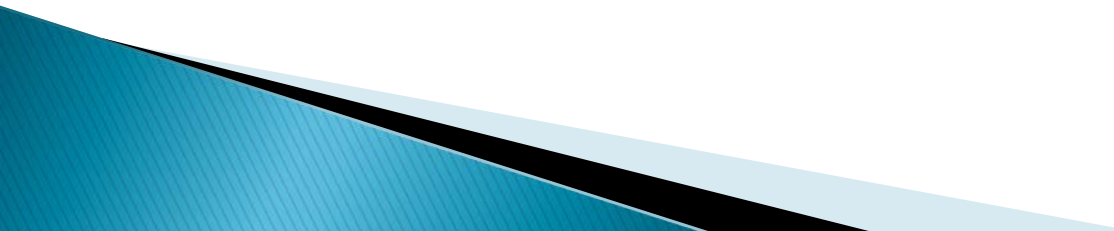
68 yo woman with hepatitis C, diabetes, renal insufficiency, and increasing immobility. Recently discharged from Laguna Honda Hospital following rehab stay for hip replacement. Presents to St Francis ED with shortness of breath, and diagnosed with heart failure

- Chronic neuropathy
- Increasing fall risk
- No children
- Lives with 94 yo father with advanced dementia

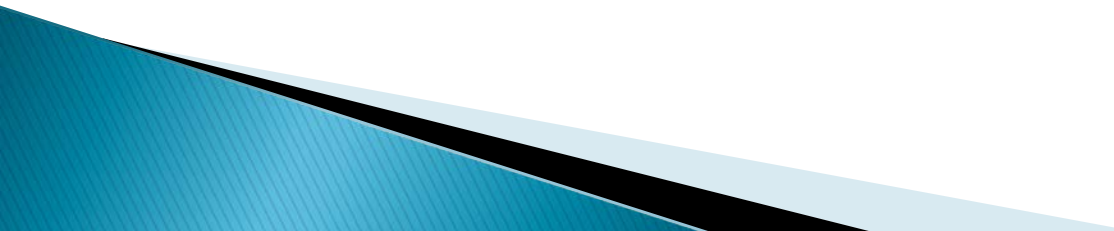
Case – Issues for Palliative Care

- ▶ Pain mgmt
 - ▶ Fall Risk/Conditioning – involve PT/OT, behavior modification & education
 - ▶ Advance Planning (name healthcare proxy and complete advance directive)
 - ▶ Tend to her father and plan for his care provision into the future
 - ▶ Case mgmt & communication – turns out LHH PC team had done much of this work but that information was lost in transition!
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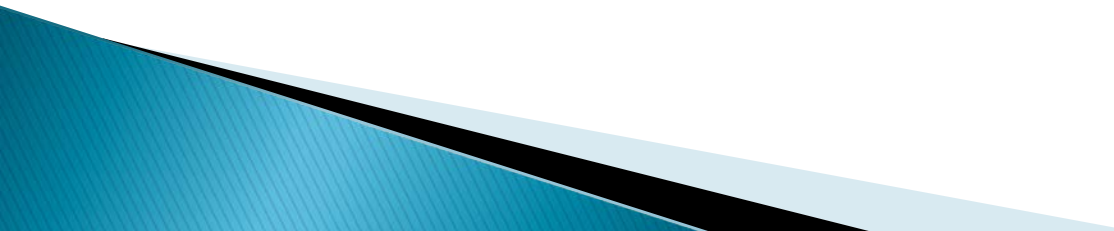
PC Elements

- ▶ Relieves symptoms and stress of serious illness (no matter what the diagnosis)
 - ▶ Facilitates communication with patients & families about goals of care, and provides support and coordination for complex clinical decision-making across the healthcare continuum
 - ▶ Improves QOL for patient & family
 - ▶ Is provided by interdisciplinary team of docs, nurses, social workers, chaplains, and other specialists (eg psychologists, pharmacists, etc)
– in conjunction with all other appropriate treatments and interventions, including potentially curative and life-prolonging
 - ▶ Is appropriate at any stage of serious illness
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PC Evidence Base

- ✓ increases patient and family satisfaction and QOL
 - ✓ increases survival
 - ✓ improves staff satisfaction and retention
 - ✓ improves appropriate use of resources
 - ✓ reduces total costs
- 

[Patient + Family]



[Patient + Family + Care Team]



Sites of Care

- ▶ Home
 - ▶ Hospital
 - ▶ Community
 - Clinic
 - LTC/SNF & Rehab
 - Residential
- 

The Problem

There is a gap between the care people want and the care they receive

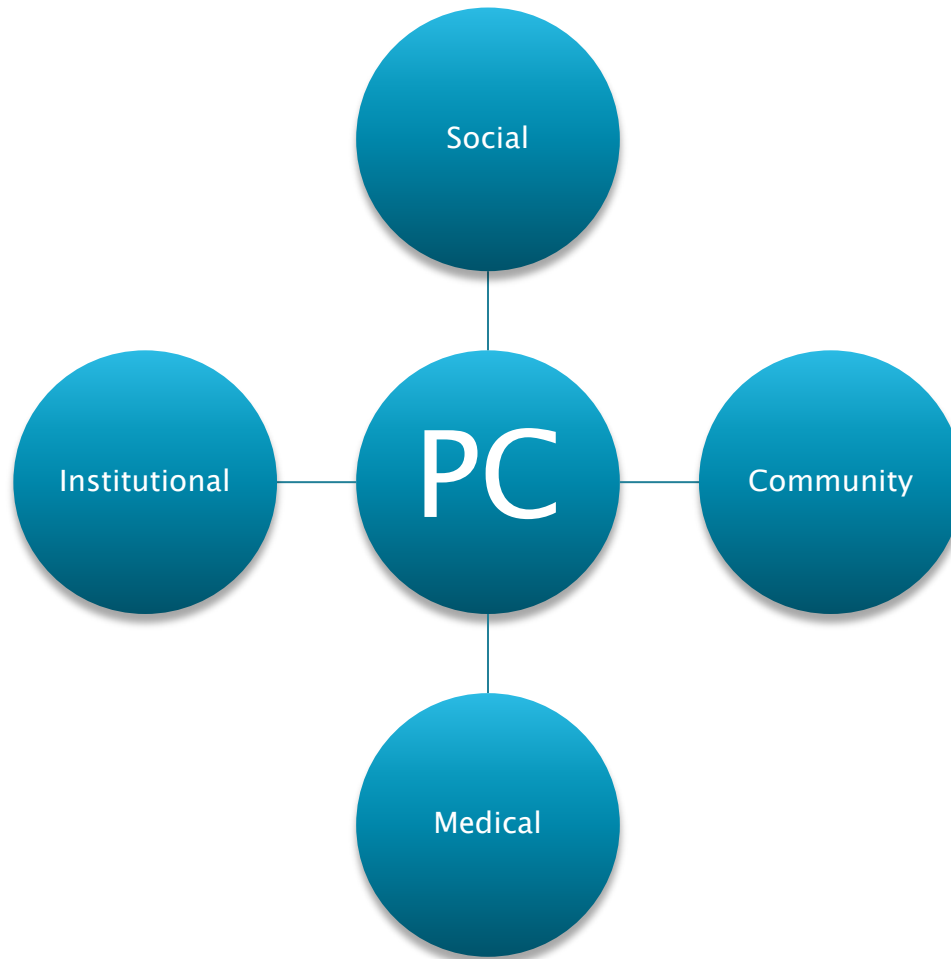
- More invasive, futile, costly care than desired
- Disparities of access across populations, regions, and settings
- ... Squanders time and *creates* suffering!

See: 1) *Tracking Improvement in the Care of Chronically Ill Patients: A Dartmouth Atlas Brief on Medicare Beneficiaries Near the End of Life*. And, 2) *Measuring Up? End of Life Cancer Care in California*

The Solution*

1. Grow and incorporate PC capacity within health systems across the *full continuum* (medical + social, institutional + community-based)
2. Seek and implement new benefit/payment mechanisms for PC
3. Utilize community agency skills/assets

* See: 1) *Let's Get Health California*. 2) Berkeley Forum: *A New Vision for California's Healthcare System*. And, 3) California HHS Agency: *California State Health Care Innovation Grant*



Challenges

1. Lack of knowledge regarding magnitude of need
 2. Awareness
 3. Workforce
 4. Policy/Payment
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