

San Francisco Palliative Care Task Force Meeting #3 Highlights

The San Francisco Palliative Care Task Force held its third meeting on Thursday, July 10, 2014 at the Jewish Home in San Francisco. Task Force Co-Chairs, Anne Hinton, Executive Director of the San Francisco Department of Aging and Adult Services, and Christine Ritchie, MD, MSPH, UCSF Department of Medicine, Division of Geriatrics, Center for Research on Aging, Jewish Home, facilitated the meeting. Meeting objectives included the following: finalize Task Force palliative care definitions; understand quality and palliative care, and San Francisco's Transitional Care Program; and advance development of workgroup recommendations. The following are meeting highlights.

Discussion Task Force Palliative Care Definitions

Dr. Anne Kinderman Director, Supportive & Palliative Care Service, San Francisco General Hospital, Assistant Clinical Professor of Medicine, UCSF, facilitated a continued discussion of the revised draft Task Force Palliative Care Target Population and Task Force Palliative Care definitions—presented below.

Task Force Palliative Care Target Population Definition:

The San Francisco Palliative Care Task Force supports educating people of all ages about palliative care and developing systems to ensure that patients and their families have access to palliative care starting at the moment they are diagnosed with a serious illness. Recognizing the importance of addressing patients with greater need more urgently, the Task Force endorses focusing in the near-term on the following two sub-population targets:

- Patients with high illness burden; and,
- Patients in their last year or two of life.

Task Force Palliative Care Definition:

Guiding Principles of Palliative Care Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Practical Principles of Palliative Care Palliative care treats people suffering from serious and chronic illnesses including cancer, cardiac disease such as Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), kidney failure, Alzheimer's, HIV/AIDS and Amyotrophic Lateral Sclerosis (ALS). Palliative care relieves the symptoms of these diseases, such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and difficulty sleeping. It helps patients gain the strength to carry on with daily life. It improves patients' ability to tolerate medical treatments and it helps patients have

more control over their care by better understanding their choices for treatment options. The point of palliative care is to relieve suffering and provide the best possible quality of life for both the patient and their family.

The following features characterize palliative care philosophy and delivery:

- Care is provided and services are coordinated by an interdisciplinary team;
- Patients, families, palliative and non-palliative health care providers collaborate and communicate about care needs;
- Services are available concurrently with or independent of curative or life-prolonging care;
- Patient and family hopes for peace and dignity are supported throughout the course of illness, during the dying process, and after death.

Several members requested clarification regarding the Task Force Target Population definition intent, but did not propose any changes. The Task Force accepted the current definition. Numerous changes were suggested however, to the Task Force Palliative Care definition. These are listed below.

Member Suggested Definition Changes

1. Under Practical Principles, first paragraph, first sentence, add “including but not limited to...”
2. Enumerate palliative care goals in Practical Principles paragraph, i.e., Palliative care goals are: 1) to relieve suffering..” 2) to help patients gain strength..; and 3) to improve patients’ ability..”
3. Replace “the point of palliative care” in the Practical Principles paragraph, with the “aim of” and move to the top of the paragraph.
4. Reconsider use of the word suffering since it means different things to different people; additionally, suffering is not necessarily predicated on a diagnosis or prognosis.
5. Include “devastating neurologic injuries, debility, and multi-morbidity of older adults” to the conditions listed under Practical Principles, first paragraph, first sentence.
6. Remove the word “hope” from the last bullet—this is a word that my mean different things to different people. Recommend replacing it with “Patient and families desire for peace and dignity are supported.”
7. Reconsider the descriptor, “non-palliative health care providers,” in the second bullet. Several members expressed concern that this expression was too limiting. It was suggested it be replaced by, “non-palliative providers.”

Dr. Kinderman acknowledged the value of the suggested edits to the current draft definition for palliative care but wanted to be sure members knew the draft was a composite of palliative care definitions used by several national organizations. She noted the first and third sections (*Guiding Principles of Palliative Care* and *The following features characterizing palliative care philosophy and delivery*), represent the palliative care definition used by the US Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), and the National Quality Forum (NQF); the middle section (*Practical Principles of Palliative Care*) is from

part of the Center to Advance Palliative Care (CAPC) palliative care definition. In light of this information, Dr. Ritchie agreed to run any final changes to the CAPC part of the Task Force definition by CAPC.

Dr. Kinderman agreed to continue working with members of the planning group on a revised Task Force palliative care definition to be presented to members as soon as possible.

Presentations

Discussion Task Force Palliative Care Definitions

To assist members with addressing the issue of quality in palliative care in the development of Task Force short- and long-term recommendations, Dr. Christine Ritchie gave a presentation on the subject entitled, *Quality and Palliative Care: Where are We Now and Where Might we Go?* The presentation addressed quality from multiple vantage points, beginning with recognition of the quality chasm in health care and the definition of quality in palliative care.

Addressing aspects of quality identified as important by the Task Force Quality Workgroup—specifically, the “don't do to me” concept—Dr. Ritchie presented a case study of an older woman patient whose care was not reflective of quality. While hospitalized, the patient's pain was not addressed, there was inadequate communication by clinical providers about her care plan, she experienced a lack of control and privacy, and her discharge plan was unclear. After discharge, she received minimal supportive assistance at home.

The case presentation emphasized the need for quality measures. Dr. Ritchie encouraged Task Force members to assess quality—the degrees to which health services increase the likelihood of desired health outcomes and are consistent with current professional standards of care—using the Donabedian framework, which has three primary categories for collecting information related to quality:

- Structure: (presence of a palliative care team)
- Process: (patient seen by members of the team as indicated)
- Outcome: (pain and satisfaction improve as a result)

Equally important to the process of measuring quality, is that it be assessed as an ongoing and essential component of providing good care. Dr. Ritchie highlighted the *Plan-Do-Study-Act* cycle as an effective tool for identifying where along the spectrum of delivering care, change should be implemented and assessed to improve quality outcomes. Subsequently, Dr. Ritchie shared a second case study of an 85-year-old male patient, whose needs, preferences, and goals were thoughtfully addressed, demonstrating how palliative care can be synonymous with quality.

Dr. Ritchie discussed the National Consensus Project Tenets of Palliative Care, and recognized quality measures from the National Quality Forum, *Measuring What Matters* project. She also noted various registries dedicated to quality: Palliative Care Quality Network, Palliative Care Research Cooperative Group Quality Data Assessment Collection Tool, Home-based Primary Care and Palliative Care Network, and the Center to Advance Palliative Care Hospital Registry.

Dr. Ritchie concluded her presentation with the following next steps for the Task Force:

- Needs assessment regarding quality
- Identify instruments currently used
- Determine how organizations are defining, measuring and monitoring quality
- Examine current state in San Francisco

San Francisco Transitional Care Program

Anne Hinton, the second speaker, addressed systems integration (hospital-community-based) with a presentation on the *San Francisco Transitional Care Program*. The San Francisco Transitional Care Program is a program funded through Section 3026 of the Affordable Care Act entitled, The Community-Based Care Transitions Program (CCTP). CCTP was created to test models for improving care transitions from the hospital to other settings and simultaneously reduce readmissions for high-risk Medicare beneficiaries. It is also part of the Partnership for Patients—a nationwide public-private partnership that aims to reduce preventative errors in hospitals by 40 percent and reduce hospital readmissions by 20 percent.

San Francisco's Transitional Care Program is one of eleven CCTP participants in California. A formal partnership between the San Francisco Department of Aging & Adult Services (DAAS), Northern California Presbyterian Homes & Services/San Francisco Senior Center and multiple community-based organizations and hospitals, the program has two primary goals:

- Help eligible older adults and adults with disabilities to transition safely from hospital to home
- Reduce unnecessary acute hospital readmissions

The program primarily targets older adults and adults with disabilities with the following characteristics: cognitive impairment; little or no formal or informal supports and/or living alone; chronic illness and/or more than three medical co-morbidities; two or more readmissions within the last six months; difficulty managing medications and/or taking eight or more routine medications; needs assistance with two or more activities of daily living; and, demonstrated need for service/resource to avoid readmissions.

Additionally the program has several eligibility criteria such as, participants must be Medicare Fee-for-Service or Medicare/Medi-Cal beneficiaries, seniors age 60 and older or adults with disabilities age 18-59, a resident of San Francisco, etc. DAAS operates the Transitional Care Program centralized intake system and program staff, the latter serve as hospital liaisons for program information and referral and as Transitional Care Specialists. Transitional Care Specialists provide an array of transitional care services including home visits and follow-up; arranging service packages (transportation, meals, or homecare); stabilizing and referring to long-term resources; and completing the Patient Activation Survey. Staff has the capacity to serve a wide range of non-English speaking clients.

Despite some program challenges with client enrollment and completion, CCTP has made substantial progress coaching clients in the areas of using their Wellness Plan, managing their medications, scheduling and keeping their first post-discharge medical appointment, identifying

“red flags” related to their health condition, and accessing community-based services. With compelling outcome data demonstrating reduced readmissions, the program hopes to continue serving this target population with ongoing CMS funding.

Small Workgroup Report-Outs

Task Force members met in their small workgroups to continue focusing on development of their workgroup recommendations. The following is a brief summary of each workgroup report-out.

Quality Workgroup

Lead: Scott Endsley, MD, San Francisco Health Plan

Workgroup Session Focus/Next Steps:

1. Discussed selection process and criteria for quality measures in relation to the workgroup’s four domains: Access, Team-Based Care, Patient-Family Centered Experience, and Clinical Quality.
2. Reviewed NQF and *Measuring What Matters* measures, and identified a preliminary set of measures that will be further reviewed and refined by the workgroup.
3. Next step is to put the selected measures in a matrix for review, and to additionally identify measures in areas of interest, that currently have no measures.
4. The workgroup will focus on measures that have been proven for reliability and validity.

Systems Workgroup

Lead: Anne Kinderman, MD, San Francisco General Hospital

Catherine Seeley, MD, California Pacific Medical Center

Workgroup Session Focus/Next Steps:

The workgroup divided itself into two areas of focus: intake and access, and communication. Intake and Access are exploring the following issues—which may form the basis of recommendations:

1. Knowing what patient/family palliative care needs are and getting folk to the right services.
2. Creating a central intake form for all hospices.
3. Exploring legal issues, e.g., obtaining a release to share, as appropriate, patient goals, and documentation of patient surrogates.
4. Developing a Web-based system to upload and access appropriate patient documentation.
5. Creating a central navigation center for palliative care in San Francisco that would eventually represent a centrally managed and coordinated palliative care service.
6. Share, with Community Engagement workgroup, a speaker bureau comprised of palliative care subject matter experts to educate and engage the public and providers on palliative care.
- 7.

Communication identified key issues as well:

1. Establish communication channels between entities, for example, provider-to-provider (e.g., address palliative care, POLST, advance care planning); provider-to-client (e.g., support Respecting Choices); health plan-to-provider (would include clarification of eligibility for palliative care and delineation of which services are eligible for which payments).
2. Explore best practices and models to address the needs of high-users of health and emergency medical care; leverage appropriate technology, e.g., My Life Directive, Respecting Choices.
3. Integrate palliative care into San Francisco's Transitional Care Program—additionally develop and implement advance care planning with a high-risk population (Tenderloin).

Finance Workgroup

Lead: Ed Chow, MD, Laguna Honda

Michael Smithwick, Executive Director, Maitri

Workgroup Session Focus/Next Steps:

1. Discussed opportunities to show that palliative care reduces health care costs and improves quality. Workgroup members identified the following opportunities:
 - a. Implementation of a pilot that can demonstrate reduced health care costs and improved quality—the workgroup discussed integrating palliative care in San Francisco's Care Transitional Program and evaluating outcomes and obstacles. The California HealthCare Foundation was identified as a potential funder for the pilot.
 - b. Implementation of a second pilot, modeled on the first, but targeting non-Medicare or Medicare/Medi-Cal beneficiaries to respond to the needs of disenfranchised and marginalized residents.
2. Discussed recommending an ongoing Steering Committee post the Task Force, to ensure quality in palliative care for city residents. The Steering Committee would support and guide implementation of Task Force recommendations.

Community Engagement Workgroup

Lead: Ann Hughes, RN, PhD, Laguna Honda

Redwing Keyssar, RN, Jewish Family and Children's Services

Workgroup Session Focus/Next Steps:

1. Discussed and decided to change the workgroup name from Community Education to ***Community Engagement***.
2. Recognized that an end-of-life conversation is and can be as important as end-of-life documentation, and that advance care planning is a part of health maintenance.
3. Workgroup members presented their "show and tell" inventory of innovative palliative care community engagement models. Identified the Institute for Healthcare Improvement's (IHI) *The Conversation Project* as a dynamic program, along with *Respecting Choices*.
4. Discussed how best to engage the community on palliative care and advance care planning, e.g., bus campaign, opportunities to educate providers and consumers.

Final Task Force Meeting Speakers

The Co-Chairs announced that the focus of the final Task Force meeting, scheduled for August 14th, is workgroup presentations of recommendations. Each workgroup will have 30 minutes to present and discuss their recommendations (10 AM to 12 Noon). The first hour of the August 14th meeting (9 AM – 10 AM) however, will be devoted to speakers, beginning with a 30-minute panel of consumers responding to questions about their experiences with palliative care related to quality, systems, finance, and community engagement—the Task Force workgroups. The remaining 30 minutes of presentation time will be given to Task Force members who would like to give five to seven-minute presentations on innovative work they are doing in palliative care. Two members have already indicated their desire to present; two to three member presentation slots remain open.

Members were encouraged to e-mail Task Force project manager, Monique Parrish (mparrish@lifecourse-strategies.com), both the names of consumers/caregivers for the August 14th consumer panel and their names, if they would like to present at the meeting.

Closing Comments and Next Steps¹

Members were reminded the next Task Force meeting would be held Thursday, July 24, 2014 at the Jewish Home, 9 AM – 12 Noon. The meeting was adjourned.

¹ San Francisco Palliative Care Task Force is co-sponsored by the San Francisco Department of Health and the San Francisco Department of Aging and Adult Services with additional support from the California Health Care Foundation, the University of California, San Francisco, California Pacific Medical Center, and Saint Francis Memorial Hospital.

Task Force Members in Attendance

First	Last Name	Position	Organization/Affiliation
Anne	Hinton, Co-Chair	Executive Director	DAAS
Christine	Ritchie, Co-Chair	Professor of Medicine	UCSF, Jewish Home
Monique	Booth	Caregiver/Consumer/Asst. Nurse Mgr.	Kaiser Permanent
Mark	Burns	<i>for Margy Baran</i> Executive Director	In-Home Supportive Services Consortium
Deborah	Borne	MD, San Francisco Department of Public Health Homeless Services	Department of Public Health
Ed	Chow	MD, President	SF Health Commission/Chinese Hospital
Kelly	Dearman	Executive Director	In-Home Supportive Services Public Authority
Norma	del Rio	MSW, MA, ASW Medical Social Worker,	Laguna Honda Hospital
Traci	Dobronravova	MSW, Assoc. Director, Seniors At Home	Long Term Care Coordinating Council
Scott	Endsley	MD, Health Services Consultant	SF Health Plan
Sharon	Ezekiel	LCSW, Palliative Care Coordinator	San Francisco VA Medical Center
Gary	Herzberg	MD, Medicare Medical Director	Blue Shield of California
Carvel	Tefft	MD, VP for Medical Services	Hill Physicians Medical Group
Anne	Hughes	Adv. Practice Nurse, Palliative Care	Laguna Honda Hospital
Pam	Johnson	RN, BSN, MBA Continuum of Care	Kaiser Permanente
Redwing	Keyssar	RN, Director, Palliative Care Program	Jewish Family and Children's Services
Anne	Kinderman	MD, Director, Supportive & Palliative Care	San Francisco General Hospital
Perry	Lang	Executive Director	Black Coalition on AIDS
Mary	Lanier	Chief Administrative Officer	California Pacific Medical Center
Ralph	Marchese	Developer	The Marchese Company
Sheldon	Marder	Rabbi/ Director, Department of Jewish Life	Jewish Home
Leslie	McGee	Continuum of Care Services Director	Kaiser Permanente SF Medical Center
BJ	Miller	MD, Director/Assistant Professor	Zen Hospice Project/UCSF
Kaushik	Roy	Executive Director	Shanti Project
Michael	Smithwick	Executive Director	Maitri
Abbie	Yant	RN, MA, VP Mission, Advocacy, Community Health	St. Francis Memorial Hospital/Dignity Health
Christina	Irving	<i>for Hilda Uribe-Escobar</i> Family Consultant	Family Caregiver Alliance
Eric	Weiss	Rabbi/ Executive Director	Bay Area Jewish Healing Center
David	Zwicky	Director of Business Strategy	Hospice by the Bay