SAN FRANCISCO PALLIATIVE CARE TASK FORCE
ISSUE BRIEF #4

PALLIATIVE CARE PROGRAM INNOVATIONS

Heightened attention to the quality of life that palliative care brings to patients and families has resulted in creative and responsive palliative care programs throughout the United States. Many represent unique partnerships and collaborations across systems, settings, and payer sources. Gaining familiarity with the diversity of palliative care program innovations is an important first step for providers and communities designing new palliative care practices.

The following collection of innovative palliative care programs is presented to assist members of the San Francisco Palliative Care Task Force with their charge of developing practical, as well as bold, short- and long-term recommendations to meet San Francisco's current and future palliative care needs. This overview is intended to highlight, in abbreviated format, diverse and innovative approaches to delivering palliative care. For more information about each presented program or effort, see the footnoted link.

San Francisco Palliative Care Programs: Early Adopters

San Francisco is widely recognized as the home of some of the earliest innovative hospital, healthcare system, and community-based palliative care programs in the country. This esteemed group includes, among others, the University of California, San Francisco (UCSF), Kaiser Permanente, Sutter Health, Dignity Care, San Francisco VA Medical Center, Laguna Honda Hospital and Rehabilitation Center, and On Lok Lifeways. Each is briefly noted in this section—program information was obtained from organization websites, the report, *Palliative Care in California: Innovations in Hospital-Based Programs,* and Task Force member comments.[1]

The University of California, San Francisco (UCSF) hosts one of the oldest palliative care programs in San Francisco. The program has grown dramatically since its inception. Today it includes inpatient and outpatient services across several campuses, a home-based palliative care program, and a unique partnership with the Zen Hospice Project, a six-bed residential facility for terminally ill patients who can no longer remain at home due to progressive illness, limited finances, or lack of adequate social support.[2] Additionally, UCSF hosts a Hospice and Palliative Medicine Fellowship Program that trains physicians in all areas of hospice and palliative medicine, and is one of eight Palliative Care Leadership Centers established by the Center to Advance Palliative Care (CAPC). Palliative Care Leadership Centers provide intensive,

[1] California HealthCare Foundation, 2007: *Palliative Care in California: Innovations in Hospital-Based Programs.* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PalliativeCareInnovations.pdf
[2] UCSF Palliative Care. http://www.ucsfhealth.org/programs/palliative_care/; http://hospitalmedicine.ucsf.edu/fellowship/pallmed.html

operational training and yearlong mentoring for palliative care programs at every stage of development and growth.

Kaiser Permanente is the largest nonprofit health plan in the United States, and one of the largest health plans in California.[3] Divided into two California regions, northern and southern, Kaiser has demonstrated substantial benefits to patients and families through its systemwide palliative care approach that coordinates care across providers, care teams, and settings—medical and skilled nursing facilities, outpatient clinics, home health services, hospice services, and complex case management programs. To enhance quality of life for palliative care patients and families, Kaiser San Francisco focuses on three critical aspects of delivering patient-centered care: providing patients with the opportunity to discuss their preferences; educating them about their options; and, supporting them in their choices.

Sutter Health is a health system in California that includes a network of community-based health care providers and locally run hospitals throughout the state. Integrated hospital and home-based palliative care has been a central component of Sutter Health's commitment to patients and families. Advanced Illness Management (AIM), a Sutter Health initiative launched in two Sutter hospitals and three large medical groups in the Sacramento/Sierra region, is an integrated system of care for patients with late-stage chronic illnesses. AIM facilitates patient transitions from hospital to home, and provides nurse-led home-based patient services including palliative care in several California regions (AIM additionally highlighted on p.6). California Pacific Medical Center, a Sutter Health affiliate in San Francisco, has an established inpatient palliative care program and palliative care training program for medical residents that includes specialized training in psychological support by palliative care-trained psychologists.

Dignity Health is another hospital and health care system in California dedicated to providing comprehensive palliative care.[4] Because palliative care is part of Dignity's overall mission, each Dignity Health hospital is given latitude in developing and operating a palliative care service that meets the needs of the community it serves. San Francisco's two Dignity Health Hospitals, Saint Francis Memorial Hospital and Saint Mary's Medical Center, have established palliative care inpatient services and systematically monitor care by collecting advance care planning, adult pain management, and Bereaved Family Survey data.

San Francisco VA Medical Center (SFVAMC) is a VA medical facility with a longstanding palliative care service.[5] The Palliative Care team of doctors, nurses, chaplains, psychologists, pharmacists and social workers—with expertise in palliative care and certification in end-of-life care—provides care and support to veterans, in conjunction with all other appropriate forms of medical treatment, across VA settings, i.e., hospital, nursing home, clinic. In addition to a ten-bed hospice unit within the nursing home setting that serves veterans at no cost and focuses

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[3] California HealthCare Foundation, 2007: *Palliative Care in California: Innovations in Hospital-Based Programs*. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PalliativeCareInnovations.pdf
[4] Dignity Health. http://www.dignityhealth.org/Who_We_Are/Holistic_Care/STGSS044520
[5] San Francisco VA Medical Center. http://www.sanfrancisco.va.gov/services/Geriatric_Services.asp

care on the unique needs of the veteran population (e.g., PTSD, substance abuse, homelessness, etc.), SFVAMC's Palliative Care clinic, formerly a half-day a week clinic for the past four years, was recently expanded to three-day a week clinic. The clinic provides services and support to other VA clinics, i.e., Primary Care, Oncology, Liver, etc.

Laguna Honda Hospital and Rehabilitation Center (LHH) is a county hospital specializing in skilled nursing and rehabilitation.[6] Dedicated to serving the underserved, LHH has been providing hospice services to residents since 1988. The hospital also provides multi-disciplinary palliative care service to residents. What distinguishes LHH most among nursing facilities, is its community of residents, staff, and volunteers fully committed to improving the quality of life of every resident, every day, until the last moment of life. LHH staff and volunteers are equally devoted to providing recognition of and support to caregivers and families after a resident's death, to honor their loss and survivorship.

On Lok Lifeways has been providing comprehensive services to frail, nursing-home-eligible elderly living at home for many decades.[7] Through its Program of All-Inclusive Care of the Elderly (PACE), On Lok delivers medical and long-term services and supports to seniors needing nursing home care, who are able to live safely in the community. PACE provides coordinated multidisciplinary support that includes advance care planning, symptom control, and support near death. PACE sites rely on integrated financing (Medicare, Medicaid, and private sources) to offer clients a range of health care services, transportation, food, and social activities, as well as physical, recreational, and occupational therapy. To promote effective and fiscally responsible care, PACE operates within a capitated payment system.

Hospital/Health System Palliative Care Innovators

Several innovative hospital/health system palliative care programs outside of San Francisco—cited by the Agency for Healthcare Research and Quality (AHRQ)—deserve recognition and are highlighted in this section.

Fairview Health Services based in Minneapolis, Minnesota has created a seamless palliative care program across the health system's seven hospitals, 37 primary care clinics, and 50 specialty clinics.[8] Services include inpatient palliative care (including pediatric palliative care), outpatient palliative care, perinatal palliative care, and palliative home care. Distinctive elements of Fairview's program include coordinated communication between inpatient and outpatient palliative care teams to ensure continuity of care; dedicated provider education efforts to enhance provider comfort with palliative care; family conference facilitation training for palliative care teams; fellowships and partnerships with The University of Minnesota Academic Health Center, including a palliative medicine fellowship and a 12-month fellowship

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[6] Laguna Honda Hospital. http://lagunahonda.org/ExploreLagunaHonda
[7] On Lok Lifeways. http://www.mywhatever.com/cifwriter/library/66/4299.html; *On Lok: A Successful Approach to Aging at Home*, http://pacepartners.net/wp-content/uploads/2012/04/GLi-OnLok-ASuccessfulApproachtoAgingatHome.pdf
[8] Fairview Health Services. http://innovations.ahrq.gov/content.aspx?id=263

in palliative social work; and, integration of palliative care into the academic health center education curriculum.

Fairview's palliative care program offers several conferences each year on palliative care topics for providers and others, sponsors a systemwide Care Council that meets regularly to allow representatives from multiple care settings to share ideas and best practices about palliative care, and is developing palliative care programming in 24 rural communities. Fairview Health is also a CAPC Palliative Care Leadership Center.

Monarch HealthCare is an association of private practice physicians affiliated with a coordinated network of hospitals, laboratories, and urgent care centers in Southern California.[9] Working with its network hospitals, Monarch HealthCare implemented significant health systems change by expanding its High Risk Touch Team, which provides transitional care to frail elderly patients (including those with cognitive impairment) at high risk for complications, relapses, or accidents after they return home from a hospital stay, to include advance care planning. The program now provides in-home education and assistance in five areas: medication self-management, use of a personal health record, follow-up with primary care physicians and specialists, warning signs of potential problems and how to respond to them, and advance care planning. The High Risk Touch Team is comprised of licensed social workers, advanced practice nurses, clinical pharmacists, and social work interns. Analysis of hospital and emergency visits for a subgroup of program participants, before and after program participation, indicate the program has significantly reduced hospital readmissions and emergency department visits.

Outpatient Palliative Care Innovations

Outpatient palliative care is largely considered the next frontier in the dynamic and unfolding palliative care field. Community-based specialist palliative care teams are increasingly demonstrating responsive care that meets patient needs, while simultaneously reducing hospital and emergency room visits and hospital deaths at the end of life.[10] The following is a sampling of innovative outpatient efforts cited by either AHRQ or the Academy of Hospice and Palliative Medicine.

The University of Alabama at Birmingham Center for Palliative and Supportive Care expanded their comprehensive palliative care inpatient program to the outpatient setting, in recognition of the growing need to improve access to palliative care for patients.[11] The expansion offers symptom management and holistic emotional, psychosocial, and spiritual care to patients and their families in several outpatient clinics, select home-based services and support, and 24-hour palliative care access by phone. Patients and families reported high rates of satisfaction with the dedicated clinics (includes integrated palliative care in the human immunodeficiency virus

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[9] Monarch HealthCare. http://innovations.ahrq.gov/content.aspx?id=3042

[10] Seow et al., Impact of community based, specialist palliative care teams on hospitalisations and emergency department visits late in life and hospital deaths: a pooled analysis BMJ, 2014. 6:348.

[11] University of Alabama at Birmingham Center for Palliative and Supportive Care. http://innovations.ahrq.gov/content.aspx?id=2736

(HIV) clinic), home-based care option for individuals who feel more comfortable receiving services at home, and the 24-hour consult service. The program also facilitates supportive transitions for patients transferring between inpatient and outpatient services.

Providence Hospice and Home Care and the Everett Clinic (a multi-location, multispecialty group practice) partnered together to provide comprehensive outpatient palliative care services to patients living with complex medical conditions and those at the end of life.[12] The program has significantly reduced unnecessary hospital admissions and emergency visits by ensuring appropriate follow-up care in the physician's office, and coordinating community and end-of-life services. The primary determinant of success for this innovation is a palliative care nurse placed in each participating primary care clinic. The palliative care nurse works closely with the clinic medical team and staff to ensure responsive medical care, social supports, and service referrals for chronically ill elderly patients. In addition, the nurse discusses end-of-life issues with participating patients. An evaluation of the program revealed a significant reduction in hospitalization for program participants 60 days before death compared to patients not participating in the program. Additional findings demonstrated increased use of hospice and home care services for chronically ill elderly patients

The Palo Alto Medical Foundation (PAMF), a multi-specialty physician group under Sutter Health covering four midpeninsula regions of Northern California, offers patients a comprehensive outpatient palliative care and support services program, staffed by a highly experience specialized palliative care-trained team of professionals.[13] The program was developed to eliminate the complications patients experience moving between silos of care and to ensure appropriate patient follow-up care. PAMF's unique approach to medication management, symptom management, advance care planning is supported through their use of electronic health records—anyone receiving inpatient palliative care or hospice services within PAMF is an automatic referral to the program—and coordination between hospice, home health agencies, nursing facilities, and hospitals serving PAMF patients. The program bills Medicare but also supplements the cost of running the program with philanthropic gifts.

Community, Hospice, and Home-Based Programs

In response to CMS's triple aim—better health, better care, lower costs—innovations in palliative care are occurring across health and social service systems, the community, and within patients' homes. The following home-based care innovations highlight complementary opportunities to engage individuals with serious and advanced illness in the home setting.

Doctors Assisting Seniors at Home (DASH), funded by a Center for Medicare and Medicaid Innovation (CMMI) award, is a community-based medical program that offers medical treatment to Santa Barbara, California older adults and persons with chronic illness in their home or in a senior housing or care facility (the program is offered by Palliative Care Consultants of Santa Barbara, California—a medical group that has provided palliative care and

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[12] Providence Hospice and Home Care. http://innovations.ahrq.gov/content.aspx?id=1738
[13] Palo Alto Medical Foundation. http://www.pamf.org/palliativecare/, and http://aahpm.org/inform/palo-alto

hospice physician services to the Santa Barbara South Coast community for more than ten years).[14] DASH offers rapid-response medical care to participants too ill to wait for an office appointment or too weak to get there. The program has helped participants avoid unnecessary hospital stays and emergency room visits. An indispensable component of the program takes place during the initial program home visit; all program participants are provided an opportunity to discuss the kind of medical treatment they would like at the end-of-life. They are additionally introduced to Advance Health Care Directives and the POLST form (Physician Orders for Life-Sustaining Treatment), and given a chance to complete both if appropriate.

Advanced Illness Management (AIM) is a Sutter Health innovative palliative care program developed more than a decade ago. AIM addresses the needs of individuals with late-stage chronic illness and their families through an integrated program of care coordination and improved care transitions, palliative care, and self-management.[15] Central to AIM is bridging the gap between acute care and end-of-life care for Medicare patients with late-stage chronic illnesses. The program facilitates transitions from hospital to home, provides home-based care, monitors patients by phone—intervening as needed, and supports the transition to hospice care if desired. Team members additionally provide ongoing counseling to help patients and families understand their care and medical treatment options. They help patients clarify and achieve their care goals and care plan, while managing the symptoms of their advanced illness. The interdisciplinary AIM team physically meets enrolled patients where they are, e.g., the hospital, doctor's office, home, residence, or facility. A CMMI awardee and cited palliative care innovation project by AHRQ; AIM is now being piloted in multiple regions in California.

Kaiser Permanente developed a home-based model of palliative care for Kaiser members in the TriCentral Service area of Los Angeles.[16] The program uses an interdisciplinary team of providers to manage symptoms and pain, provide emotional and spiritual support, and educate patients and family members on an ongoing basis about changes in the patient's condition. The palliative care nurse completes an initial in-home assessment for participants that includes the following: a basic assessment of health care status and pain management; discussion of advance care planning; and development of goals of care and a care plan. AHRQ assessed this innovation as "strong," the highest rating, due to results from one randomized controlled trial and one comparison-group study that showed that the program increases patient satisfaction, as well as the portion of patients dying at home rather than in the hospital. Findings also indicated reduced emergency department visits, inpatient admissions, and costs. With organizational assistance from the Partners in Care Foundation, Kaiser Permanente developed the in-home palliative care program as an alternative to its underutilized hospice program.

UCSF Housecalls and Bridges Programs are two home-based innovations that provide palliative care to San Francisco residents. UCSF's Housecalls Program, started in 1999, is a primary medical care service offered to frail, homebound elders in their homes—in all neighborhoods of

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[14] Doctors Assisting Seniors at Home. http://www.dashsb.com/
[15] Advanced Illness Management. http://innovations.ahrq.gov/content.aspx?id=3370, and, http://www.sutterhealth.org/quality/focus/advanced-illness-management.html
[16] Kaiser Permanente TriCentral Service Area Los Angeles. http://innovations.ahrq.gov/content.aspx?id=2366

San Francisco—that enables participants to live safely in their home.[17] The Housecalls team consists of physicians and a nurse practitioner trained in the care of older adults, including palliative medicine and hospice care. Housecalls is also a teaching program for medical and other health professional students, Internal Medicine and Family Practice residents, and Geriatrics fellows. UCSF's Care at Home Bridges Program is another home-based program providing palliative and transitional care support to UCSF patients with serious illness.[18] The program offers home-visits by palliative care trained physicians who specialize in symptom management, communication (including coordination with the patients' other medical providers) and safe transitions from hospital to home.

Sharp HealthCare in San Diego took its successful community-based palliative care program, Transitions, that it designed for heart failure patients—providing culturally responsive state-of-the-art care to heart failure patients outside of the hospital—and expanded it to include patients with chronic obstructive pulmonary disease, recurrent stroke, neurological diseases, and cancer.[19] Transitions staff is an interdisciplinary palliative care team that includes the patient's primary care physician, specially trained nurses, medical social workers, spiritual care, and complementary care such as Healing Touch, aromatherapy and music therapy. The team manages symptoms, i.e., nausea, pain, anxiety, shortness of breath, and fatigue; discusses and creates, with patients and families, realistic and effective health care plans that are coordinated with patients' physicians and other health providers; and specifically provide emotional and spiritual care and advance care planning support. Palliative and end-of-life care represent one of five major priorities for Sharp Healthcare senior administrators. To date, the program has proven effective in reducing emergency room visits and hospitalizations, enhancing caregiver support, higher rates of executing advance directives, and earlier referrals to hospice. Its success has inspired Sharp to move toward offering enhanced end-of-life care systemwide.

Statewide System Innovations: California

At the same time that innovative palliative care programs are developing between and among hospitals, health systems, and community organizations, changes in the field of palliative care have been taking place at the state level too. A number of states have moved forward with integrating palliative care into their state systems and services, including California. In this section, California's palliative care system integration efforts are briefly presented.

Partners for Children was initiated in 2011 as a pediatric palliative care waiver for California. The California Department of Health Care Services, Children's Medical Services Branch, and the Medi-Cal program in partnership with the Centers for Medicare and Medicaid Services manage the waiver.[20] The program allows eligible children (under the age of 21) and their families to receive palliative care services during the course of the child's illness, while concurrently pursuing curative treatment for the child's life limiting or life threatening medical condition. Partners for Children services include the following: care coordination, family training, respite,

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[17] UCSF Housecalls Program, http://geriatrics.ucsf.edu/care/housecalls.html
[18] UCSF Care at Home Bridges Program, http://geriatrics.ucsf.edu/care/geritraccc.html
[19] SHARP Healthcare Transitions. https://www.sharp.com/professionals/upload/HC137-TransitionsBroFINALPIECE.pdf
[20] Pediatric Palliative Care Waiver. http://www.dhcs.ca.gov/services/ppc/Pages/ProgramOverview.aspx

expressive therapies, and family bereavement counseling. To participate, a child must meet all waiver criteria including: age limit, residence in a participating county, full-scope Medi-Cal coverage, and medical/level of care requirements.

Documented success of the Partners for Children program in the areas of improving quality of life, reducing hospitalization, and managing health care costs, was the catalyst for California Senate Bill 1004, which requires the California Department of Health Care Services (DHCS) to develop, as a pilot project, a similar palliative care benefit for beneficiaries who are 21 years of age or older, and to evaluate whether, and to what extent, that benefit should be offered under the Medi-Cal program.[21] Under the proposed legislation, the pilot would provide specialized medical care and emotional and spiritual support for people with serious advanced illnesses, as well as relief of symptoms, pain, and stress of serious illness. Current analysis of the bill by the Assembly Committee on Appropriations indicates the pilot project could be cost-neutral or cost saving for the state, and that if the state's Health Care Innovation Plan is approved by CMMI, some of the grant funds could be used to develop the waiver program. SB 1004 remains under legislative review.

Let's Get Healthy California and California's State Health Care Innovation Plan (SHCIP) reflect California's understanding and acknowledgement of palliative care as a critical success factor in promoting health care delivery system transformation in the state. Building on the inclusion of palliative care as a key indicator in the *Let's Get Healthy California* (LGHC) Task Force Framework [Governor Jerry Brown issued Executive Order B-19-12 establishing the Let's Get Healthy California Task Force to "develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity."],[22] California included palliative care as a central focus in its SHCIP application to CMMI.[23] In the Plan, palliative care is identified as a fundamental element of health system and payment reform, because of its focus on care coordination, team-based care, and link with community-based organizations. The Plan, which is still under review by CMMI, includes the following key objectives to support and improve the provision of palliative care:

- Incorporate palliative care capacity within Health Homes for Complex Patients.
- Identify and adopt new benefit and payment approaches to better meet patient preferences for palliative and hospice care.

Out-of-the-Box Palliative Care Programs & Planning Efforts

The visionary approach employed by the following palliative care programs and planning effort merit their own category. All three programs highlighted, *Respecting Choices*, *The Conversation*

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21 Senate Bill 1004. http://legiscan.com/CA/bill/SB1004/2013
22 Let's Get Healthy California Task Force. http://www.chhs.ca.gov/pages/LGHCTF.aspx
23 CalSIM State Health Care Innovation Plan. http://lahealthaction.org/library/CalSIM_State_Health_Care_Innovation_Plan_Final.pdf

Project, and the *Los Angeles Advance Care Planning Council* address a distinctive palliative care need with creativity, determination, and commitment to change on a large scale.

Respecting Choices® (owned and operated by Gundersen Lutheran Medical Foundation, Inc., La Crosse, Wisconsin) is an advance care planning approach integrated into the routine of patient-centered care and appropriately staged to the individual's state of health.[24] Respecting Choices is different from most advance care planning approaches because it honors the advance care planning process as complex and challenging, not necessarily a one-time event. The model identifies and embeds all stages of care planning into the routine of healthcare—making it a norm for the people in the community—through four essential elements:

- Systems redesign
- Competency training of healthcare professionals and others including the creation of the advance care planning (ACP) facilitator role
- Patient and community engagement
- Continuous quality improvement of the other three elements so they create an effective, organized approach that improves people and family-centered care.

Adding to its unique features, Respecting Choices has created a patient-centered process that both explores and addresses patients' fears, gaps in health care knowledge, experiences, values, goals, etc. Last, it promotes articulated patient advance care plans for any stage of illness, so all involved can correctly understand and utilize the plans when and if needed.

The Conversation Project emerged in 2010 following a conversation. Columnist and author Ellen Goodman and a group of colleagues, clergy, medical professionals, and media shared stories of "good deaths" and "bad deaths" within their own circle of loved ones.[25] From the discussion, what became clear to Goodman and her colleagues was that none of the loved ones had discussed what they wanted at the end of their lives. This realization inspired the launching of the Conversation Project—in collaboration with the Institute for Health Improvement, a public engagement campaign dedicated to getting everyone's end- of-life wishes expressed and respected. In recognition that the difference between a good death and hard death is often whether the person had a conversation about death, The Conversation Project is a place to start. The Conversation Project website offers a virtual kitchen table for people to share their stories, explore end-of-life wishes and to learn. A free Starter Kit is available to guide individuals in their process of expressing what they want for end-of-life care, or for someone they would like to help them with their process.

The Conversation Project's powerfully simple message and approach has inspired a group of organizations to become "Conversation Ready" within one year. Participating organizations will develop and pilot processes, methods, and tools to create systems within health care, to reframe patient-provider relationships around the question "What matters most to you?"[26] At

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24 Respecting Choices. http://www.gundersenhealth.org/respecting-choices
25 The Conversation Project. http://theconversationproject.org/
26 http://www.ihi.org/Engage/Initiatives/ConversationProject/Pages/ConversationReady.aspx

project conclusion, each will develop a "Conversation Ready" change package that they will implement first in their own organizations and then will be shared throughout the industry.

Los Angeles Advance Care Planning Council is a palliative care planning effort among eleven leading healthcare providers in Southern California (Cedars-Sinai, HealthCare Partners Medical Group and Affiliated Physicians, Kaiser Permanente Southern California, Keck Medical Center of USC, Los Angeles County-USC Medical Center, MemorialCare Health System, Olive View-UCLA Medical Center, Providence Little Company of Mary Medical Center Torrance, Providence TrinityCare Hospice and the UCLA Health System). The Council's goal is to encourage doctors and other healthcare professionals to engage all adult patients in advance care planning that respects patients' values and goals, and avoids treatments that can do more harm than good.

In May 2014, the group unveiled a joint set of recommendations to reduce suffering and promote greater dignity for patients approaching the end of life. In particular the guidelines call on doctors to explain clearly to patients when a medical treatment under consideration — including interventions such as feeding tubes, intubation or dialysis — "may deprive the person of life closure (the ability to say 'forgive me,' 'I love you' or 'goodbye') or preclude a peaceful death."

Los Angeles Advance Care Planning Council Guidelines:

- Encourage all patients to engage in advance care planning, and make this approach standard so providers can deliver appropriate care that reflects each patient's values and preferences
- Facilitate timely access to palliative care and other support services such as hospice care for patients with chronic and progressive illnesses
- Advise patients about the potential benefits and drawbacks of medical treatments, and whether such care can deprive individuals of a peaceful death
- Engage in "shared-decision making" with patients to reach conclusions about what constitutes optimal care in particular situations

Conclusion

Although not specifically addressed in this overview, it is important to note that funding for palliative programs, traditional and innovative, continues to evolve. Beyond the fee-for-service model used by most hospitals and outpatient clinics, new payment models are emerging. Some are predicated on capitation or bundled payments. In the report, *Next Generation of Palliative Care: Community Models Offer Services Outside the Hospital*, the authors state that, "health care increasingly will move toward these types of financial arrangements [capitation and bundled payment], where the potential efficiencies generated by palliative care would more obviously justify its support.[27]" As examples, the report cited two risk-bearing groups, CareMore and HealthCare Partners that developed cross-cutting teams and short-term post-

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[27] Beresford L. and Kerr K., *Next Generation of Palliative Care: Community Models Offer Services Outside the Hospital*. 2013, California HealthCare Foundation: Oakland; http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NextGenerationPalliativeCare.pdf

discharge clinics, using “extensivists”—hospitalists that provide complex medical care outside the hospital setting—to improve patient care and reduce hospital readmissions. The proliferation of palliative care across all settings, guarantees the emergence of innovative palliative care financing models for years to come.

Analysis of the presented innovations reveals three shared characteristics likely to have contributed to the success of each program: 1) an emphasis on **partnership** within or across organizational and system boundaries; 2) recognition of palliative care as a **comprehensive care approach** that needs to extend beyond medical parameters to address the whole person (e.g., addressing patient and family psychosocial and spiritual needs, values, and preferences); and 3) **respect for patient and families** as true partners in the delivery of palliative care services and supports.