

San Francisco Palliative Care Task Force Final Report

September 2014



Letter from Task Force Co-Sponsors

We are very pleased to present the San Francisco Palliative Care Task Force Final Report.

From May 2014 through August 2014, a diverse group of representatives from San Francisco's leading health care and community organizations, advocacy and professional associations, and consumers, convened to discuss San Francisco's palliative care needs.

In addition to producing this summary report, which provides short- and long-term recommendations on how to move San Francisco closer to meeting the palliative care needs of its residents—critical in light of the city's aging demographics and the need for culturally responsive long-term care options—Task Force members and members of the public demonstrated tremendous passion, creativity, and commitment to ensuring equitable access to palliative care for all San Franciscans.

With a defined Task Force goal “to develop strategic recommendations to meet San Francisco's current and future palliative care needs,” the Task Force developed recommendations in four key areas: Quality, Finance, Systems, and Community Engagement. Individually and collectively, the recommendations provide a valuable framework for achieving collaborative and integrated palliative care in all settings and across the care continuum.

We are deeply grateful to the members of the Task Force, members of the public, and members of the Task Force planning group. The success of this endeavor is attributable to all of their outstanding contributions and dedication to this project.

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Special thanks to the University of California, San Francisco for hosting the Task Force kickoff meeting and to the Jewish Home for generously hosting the remaining four Task Force meetings.

We also extend our appreciation to the San Francisco Department of Public Health, the San Francisco Department of Aging and Adult Services, and Ground Floor Public Affairs for generously providing Task Force staff support and resources.

Last, we are profoundly grateful to the consumers who served on the consumer panel at the final Task Force meeting. Their stories moved us greatly, reminding us that behind each piece of data and every report are people who deserve our compassion and support.

Executive Summary

In May 2014, members of the San Francisco Palliative Care Task Force embarked on a three-month effort “to develop strategic recommendations to meet San Francisco’s current and future palliative care needs”—the Task Force framing goal. Palliative care is specialized team-based care for patients that focuses on the relief of symptoms associated with serious illness to improve quality of life for both the patient and family.¹

Co-sponsored by the San Francisco Department of Public Health and the San Francisco Department of Aging and Adult Services (DAAS), and co-chaired by DAAS Executive Director, Anne Hinton, and Dr. Christine Ritchie of the University of California, San Francisco, the Task Force brought together a diverse group of representatives from San Francisco’s leading health care and community organizations, advocacy and professional associations, and consumers.

Task Force members, in conjunction with a group of engaged members of the public, identified three deliverables to support the Task Force framing goal: 1) definitions for palliative care and a palliative care target population; 2) an inventory of dedicated palliative care services currently available in San Francisco; and 3) priority short- and long-term palliative care recommendations aimed at improving access to quality palliative care.

To facilitate development of short- and long-term recommendations, four Task Force workgroups were formed: Quality, Finance, Systems, and Community Education. To inform and guide the workgroup process, experts gave presentations on a variety of relevant topics at the five Task Force meetings (e.g., palliative care systems integration, advance care planning, state policy advancing palliative care). In addition, a series of Issue Briefs addressing critical palliative care issues were provided to members.

If implemented, the Task Force’s short- and long-term recommendations, which are summarized here and presented in detail in this report, promise to move San Francisco closer to meeting its current and future palliative care needs.

Quality Workgroup recommendations adhere to the National Consensus Project (NCP) framework for quality palliative care and NCP guidelines for developing and measuring the structures, processes, and outcomes of palliative care. Key recommendations include:

- Promote measurement of palliative care service quality in acute care hospitals.
- Encourage payers to require providers to measure quality.
- Promote palliative care training for direct care and front line workers employed by social service, home health and home care organizations.

Finance Workgroup recommendations provide a stepwise approach to building the business case necessary to fund and support the delivery of palliative care. Key recommendations include:

- Promote broader understanding of the business case for palliative care among stakeholders who are in a position to fund palliative care services.
- Develop a data-driven understanding of current utilization patterns in the final 12-24 months of life for a defined population of patients, to promote understanding of the opportunities for optimizing utilization and fiscal outcomes that would likely occur if San Franciscans had broader access to palliative care across the continuum.
- Assemble an Advisory Board, to be affiliated with the Long Term Care Coordinating Council that can offer support related to palliative care (information about palliative care contribution to value—quality and costs, sufficiency of current services, etc.).

Systems Workgroup recommendations actively support collaboration across systems to minimize barriers and disparities in access to hospice and palliative care services. Key recommendations include:

- Create a new (or incorporate into an existing) database of palliative care resources accessible to providers across systems and locations.
- Develop standards for advance care planning (ACP) documentation and information sharing across locations and systems of care.
- Integrate palliative care services into complex care management programs for patients with high utilization of emergency services.

Community Engagement Workgroup recommendations addressed three priorities:

- Create a public campaign to increase awareness about the “conversation” (i.e., identifying care preferences for serious illness, designating a health care agent).
- Create “Wellness/Conversation Campaigns” events in the organizations represented by the Task Force.
- Strive to make San Francisco a conversation-competent community that honors and respects diversity.

The next phase of this project will focus on finding an appropriate home to continue the important work of the Task Force, including implementing Task Force recommendations.

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I. Introduction

In 2013, Dr. BJ Miller, Director of the Zen Hospice Project, Assistant Professor, University of California, San Francisco and palliative care expert, conducted a series of meetings with key San Francisco health and social service leaders to introduce Zen Hospice and discuss opportunities to improve palliative care service coordination in San Francisco.^a

The meetings revealed gaps in the availability and delivery of palliative care in San Francisco, but also revealed that a significant number of San Francisco organizations are providing palliative care services and supports, although few are collaborating. In addition, many of the health and social service leaders participating in the meetings reported being unaware of the range of palliative care services offered in the city. In response to these findings, the San Francisco Department of Public Health agreed to lead the development of a San Francisco Palliative Care Task Force.

On May 29, 2014, the San Francisco Palliative Care Task Force convened for the first of five meetings. Co-sponsored by the San Francisco Department of Public Health and the San Francisco Department of Aging and Adult Services, the Task Force was charged with exploring options for developing a more coordinated system of palliative care to meet San Francisco's current and future palliative care needs across the care continuum.

The Task Force included representatives from San Francisco's leading health care and community organizations and advocacy and professional associations, together with several consumers. The Task Force was additionally enhanced by an active and committed group of individuals representing members of the public.

Task Force Co-Chairs Anne Hinton, Executive Director of the San Francisco Department of Aging and Adult Services, and Christine Ritchie, MD, MSPH, University of California, San Francisco Department of Medicine, Division of Geriatrics, Center for Research on Aging, Jewish Home, facilitated the meetings. This report is the summary of the Task Force work, and presents the Task Force short- and long-term strategic recommendations to move San Francisco closer to meeting its current and future palliative care needs.

^a The Zen Hospice Project is a six-bed residential facility in San Francisco for terminally ill patients who can no longer remain at home, due to progressive illness, limited finances, or lack of adequate social support.

II. Palliative Care Consumers: Task Force Inspiration

Palliative care consumers were the inspiration for the San Francisco Palliative Care Task Force. In light of this special role, the Task Force invited four San Francisco palliative care consumers, patients and caregivers, to participate on a panel at the final Task Force meeting. The purpose of the panel was to inform workgroup recommendations: the consumers shared their palliative care stories—what had gone well, what had not, and their personal suggestions for improving access to palliative care in San Francisco. Their suggestions were subsequently integrated into the final Task Force recommendations.

The following selected quotes from the consumer panelists give prominence to their experiences and hopes for improving the care and support of individuals managing serious illness, as well as for those caring for someone seriously ill. In addition, they bring to life the importance of the Task Force and this report by underscoring the value of palliative care's response to human need, and the paramountcy of community and networking for palliative care patients and caregivers.

My one recommendation is that the value of listening is both taught and held as a valuable and essential part of palliative care; actually, of all care. Knowing how to listen and be empathetic, I think, would save money. And, it would benefit everyone—young, old, homeless, those whose primary language is not English.
Palliative Care Patient

South 3 [Laguna Honda Hospital] became my home. Staff took care of me while I took care of my Mom. They looked at me and at my pain. Placing my Mom at Laguna Honda was not easy; it was not an easy decision. Before my family transferred her there, I struggled. I realized I could not be a one-person skilled nursing facility.
Caregiver of Palliative Care Patient

Everyone should know about palliative care. Educating our health care colleagues is critical. Having now been in the system [as patient] and seen the lack of knowledge about palliative care, I know this is something we need to address. I also wish there were more openness in the medical field to other modalities of treatment. Without my acupuncture, Chinese herbs—that eased my suffering—I believe I would not have done as well as I have. For me, they were a bridge.
Palliative Care Patient

For a long time I worked nights so I could help my Mom [with Alzheimer's disease], but I am older now too and that doesn't work well for me anymore, so I changed to evenings. My siblings help out and sometimes I can get the grandkids to help, but mostly I am the only one caring for my Mom. I don't have a break. And accessing resources with my mother's health insurance has been much harder.
Caregiver of Palliative Care Patient

III. Background, Palliative Care Settings, San Francisco Palliative Care Early Adopters

A. Background

Why palliative care? Why now? Palliative care is a dynamic person-and family-centered practice of care that focuses on improving quality of life during serious or life-threatening illness. Unlike hospice, palliative care can be provided at any age and any stage of an illness, alongside all appropriate curative treatments.

Palliative care is provided by interdisciplinary teams and can be delivered in multiple settings: acute care hospitals, skilled nursing and other long-term care facilities, clinics, assisted living facilities, and private residences.²

Key elements of palliative care include the following:³

- Relieves symptoms, pain, and stress of a serious illness—whatever the diagnosis;
- Facilitates communication with patients about patient care goals and provides support for complex medical decision-making;
- Improves quality of life for both the patient and the family;
- Is provided by a team of doctors, nurses, social workers, chaplains, and other specialists (e.g., Psychologists, Pharmacists, etc.) —who provide an extra layer of support— in conjunction with all other appropriate medical treatments, including curative and life-prolonging therapies; and
- Is appropriate at any age and at any stage in a serious illness.

Palliative care programs have grown exponentially over the last decade, supported by research and analysis that consistently show palliative care’s positive role in improving patient quality of life while allowing for the more efficient use of health care resources.⁴⁻⁷ The increased demand for palliative care is associated with the increased number of adults living with serious illness, the result of advances in disease prevention, disease-modifying therapies, medical technology, and the aging of the population.⁸

To promote the availability of palliative care and increase access, a number of national health care organizations and associations have developed major palliative care quality and policy initiatives, e.g., The Joint Commission, Centers for Medicare & Medicaid Services (CMS), National Quality Forum, and American Cancer Society. These developments, along

with others, have brought palliative care directly into health care reform discussions as a targeted service for promoting health care quality and reducing health care costs.⁹

CMS recently announced a demonstration project (Medicare Care Choices Model) that will provide an option for Medicare beneficiaries to receive palliative care services from certain hospice providers, while concurrently receiving disease-modifying treatments. CMS's Center for Medicare and Medicaid Innovation (CMMI) has also funded a number of projects featuring palliative care as a critical component of health care transformation, consistent with delivering better health, improving care and lowering costs—CMS's Three-Part Aim. Palliative care is likely to continue evolving and expanding as a field, and is rapidly becoming a significant component of national, state, and local health care delivery systems.

In California, palliative care has been featured in several statewide programs. In 2012, *The Let's Get Healthy California* Task Force, created by an executive order, identified six goals to make California the healthiest state in the nation.⁸ One of the six specifically focuses on end-of-life care. Building on this goal—which includes palliative care as both a priority and an indicator—California included palliative care as a central focus in its CMMI State Health Care Innovation Plan application.

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 links with community-based organizations. The Plan, 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.

The goals of the *Let's Get Healthy California* Task Force and California's State Health Care Innovation Plan reflect state policy leaders' acknowledgement that palliative care is a critical success factor in promoting health care delivery system transformation in the state.

California has also taken the lead in several other palliative care efforts. In 2011, California initiated a Medi-Cal Pediatric Palliative Care Benefit, Partners for Children.¹⁰ The program allows eligible children (under the age of 21) and their families to receive palliative care

⁸ In 2012, Governor Jerry Brown issued an executive order 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.”

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.

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, introduced in 2014. The bill required the California Department of Health Care Services to develop a similar palliative care benefit for beneficiaries who are 21 years of age or older. On September 25, 2014, Governor Brown signed SB 1004. As of January 1, 2015, the new law will require Medi-Cal to establish standards and provide technical assistance to Medi-Cal managed care plans to ensure the delivery of palliative care services to Medi-Cal beneficiaries.¹¹

With increased national and state attention on palliative care across the health care continuum, the time was right for San Francisco to launch the [San Francisco Palliative Care Task Force](#) and begin exploring opportunities to make palliative care available to more San Francisco residents.

B. Palliative Care Settings

To educate Task Force members and assist them with achieving the Task Force goal of developing strategic palliative care recommendations, experts presented a variety of relevant topics at Task Force meetings (e.g., palliative care systems integration, advance care planning, state policy advancing palliative care). The presentations were complemented by a series of Issue Briefs profiling a number of critical palliative care issues. One issue that proved germane to the development of Task Force recommendations was the diversity of settings in which palliative care has been successfully implemented. Understanding that palliative care is not relegated to one setting, helped members identify opportunities for greater collaboration across systems to increase palliative care access.

Palliative care is currently provided in hospital-based, outpatient and community-based, and hospice-based settings.

Hospital-Based Palliative Care

The most well established palliative care delivery model is the hospital-based palliative care consultation service. Nationally, it is estimated that some 80% of hospitals with 300 or more beds have such services.¹² A palliative care consultation team typically includes some combination of a Board certified palliative care physician, nurse specialist, nurse, social worker, and chaplain. Referrals for hospital palliative care consultation are typically initiated at the request of the primary treating physician. Once a referral is received, the

team meets with patients, and their families, usually in a series of consultations. Initial assessments address physical, psychosocial, social, cultural, and spiritual issues—the full spectrum of areas that may contribute to suffering for the patient or the family.

Working closely with patients' treating physicians, the team helps patients select treatments and discharge options that meet their goals and preferences. Once the assessment is completed, a patient-centered care plan is developed that covers a range of issues, from symptom and side effect management, to preferred religious and cultural practices and rituals, to goals for medical care. Meetings are customarily held with the patient, family, members of the consultation team, and non-palliative care medical providers, such as the attending oncologist or cardiologist. Meetings focus on reviewing and discussing patient goals of care, prognosis, treatment options, and, as appropriate, plans for post-discharge care.^{13, 14}

Outpatient/Community-Based Palliative Care Services

The success of hospital-based palliative care has inspired a growing interest among health care organizations, policy makers, and funders throughout the country to finance, operationalize, and deliver community-based palliative care—non-hospice palliative care delivered outside of the acute care hospital. Community-based palliative care is available through clinic-based, home-based, and technology-based services (i.e., phone support, videoconferencing, etc.). It is also provided in nursing homes, assisted living facilities, and private residences—wherever patients are residing. These programs are being sponsored by a wide range of health care organizations, including health systems and hospitals, medical groups, home health agencies, hospices, post-acute care organizations, and payers.

Because people live in the community, the need for palliative care after or between hospital stays is becoming more acute; however, the availability of palliative care outside the acute care setting remains limited.¹ The chief barrier to providing palliative care in community settings is financial. With its emphasis on understanding, discussing, and honoring patient preferences and goals of care, the time required to provide this care is not sufficiently reimbursed under the current fee-for-service billing structure.

To address this challenge, a growing number of commercial and public payers are working to develop new reimbursement models that allow their beneficiaries to access early palliative care.¹⁵ A toolkit developed by the National Business Group on Health and the Center to Advance Palliative Care, “Improving Care for People with Serious Illness through Innovative Payer-Provider Partnerships,” provides information and resources for payers and providers interested in collaborating to deliver care to medically complex individuals.¹⁶

Building on the toolkit findings, the California HealthCare Foundation is sponsoring a payer-provider initiative that partners health plans with palliative care organizations, to deliver community-based palliative care to beneficiaries with serious illness.

Hospice-Based Palliative Care

Although palliative care is not the same as end-of-life care, palliative care encompasses the hospice model of care, which provides care to terminally ill patients who have six months or less to live, and are no longer receiving curative treatment for their underlying disease. As with palliative care provided in other settings, the hospice model is an interdisciplinary team approach to providing medical care, pain management, and emotional, and spiritual support, tailored to the patient's needs and wishes. Hospice care provides access to compassionate care twenty-four hours a day, seven days a week—in the patient's home, or in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities. Hospice also offers respite services to caregivers and extends bereavement support to families after their loved one's death.

C. San Francisco Palliative Care Early Adopters

A second issue highlighted in the issue briefs that proved equally pertinent to the development of Task Force recommendations was San Francisco's strong foundation in palliative care. San Francisco is widely recognized as the home of some of the earliest innovative hospital, health 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.

[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 in San Francisco for terminally ill patients who can no longer remain at home, due to progressive illness, limited finances, or lack of adequate social support.

[Kaiser Permanente](#) is the largest nonprofit health plan in the United States, and one of the largest health plans in California. Kaiser Permanente San Francisco 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.

Sutter Health in California 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, facilitates patient transitions from hospital to home, and provides nurse-led home-based patient services including palliative care in several California regions. California Pacific Medical Center, a Sutter Health affiliate in San Francisco, has an established inpatient palliative care program and a palliative care training program for medical residents.

Dignity Health is another significant hospital and health care system in California dedicated to providing comprehensive palliative care. 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 inpatient palliative care services.

San Francisco VA Medical Center (SFVAMC) operates a longstanding palliative care service. The Palliative Care team of doctors, nurses, chaplains, psychologists, pharmacists, and social workers— most of whom are certified or credentialed in hospice and palliative 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.

Laguna Honda Hospital and Rehabilitation Center (LHH) is a skilled nursing and rehabilitation center owned and operated by DPH. 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. Note: San Francisco General Hospital, the main public hospital in San Francisco (also owned and operated by DPH) launched its palliative care service in 2008.

On Lok Lifeways has been providing comprehensive services to frail, nursing-home-eligible elderly living at home for many decades. 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.

IV. Task Force Deliverables, Workgroup Process

During the initial Task Force meeting, members reviewed the Task Force goal “to develop strategic recommendations to meet San Francisco’s current and future palliative care needs,” and discussed their ideas and suggestions regarding what the Task Force could realistically accomplish. To achieve the Task Force goal, members identified three supporting deliverables and a process for completing this work.

A. Task Force Deliverables

The three selected Task Force deliverables include: 1) definitions for palliative care and a palliative care target population; 2) an inventory (directory) of dedicated palliative care services currently available in San Francisco; and 3) priority short- and long-term palliative care recommendations aimed at improving access to quality palliative care.

Task Force Definitions

Over the course of several Task Force meetings, members discussed various definitions for palliative care and the palliative care target population—the first Task Force deliverable. At the conclusion of this process, members approved a definition for palliative care that is a composite of definitions used by the following organizations: United States Department of Health and Human Services, Centers for Medicare & Medicaid Services, National Quality Forum, and Center to Advance Palliative Care, plus member edits.

The Task Force palliative care target population definition was developed through member responses to various definitions presented via an online survey tool, and edits submitted during Task Force meeting discussions. The final palliative care target population includes all individuals diagnosed with a serious illness (an aspirational target population), and two sub-population targets to address in the near-term.

Task Force Definition of Palliative Care

Guiding Principles of Palliative Care: Palliative care means person- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.* Palliative care throughout the continuum of care facilitates patient autonomy, access to information, and choice, and may involve attending to physical, intellectual, emotional, and social needs and supporting patients in their spiritual journey.

* “Suffering” in this context means the physical, emotional, and social distress associated with serious illness. Suffering may or may not be a part of one’s experiences or spiritual journey at the end of life. Patients, their loved ones and caregivers, and health care providers can experience suffering.

Practical Principles of Palliative Care: The aim of palliative care is to relieve suffering and provide the best possible quality of life for both the patient and their loved ones. Palliative care treats people who are facing serious and chronic illnesses including (but not limited to) cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, Alzheimer's, HIV/AIDS, devastating neurologic conditions, debility, and multi-morbidity. Palliative care focuses on: 1) relieving the symptoms of these diseases, such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and difficulty sleeping; 2) helping patients gain the strength to carry on with daily life; and 3) improving patients' ability to tolerate medical treatments and have more control over their care, by better understanding their choices and treatment options.

The following features further characterize the Task Force's palliative care philosophy:

- Care is provided and services are coordinated by an interdisciplinary team that includes community providers, families, and key members of a patient's community;
- Patients, families, key members of a patient's community, palliative experts, and primary health care and community providers collaborate and communicate about care needs;
- Services are available concurrently with or independent of curative or life-prolonging care; and
- Patient and family desires for peace and dignity—on their own terms—are supported throughout the course of illness, during the dying process, and after death.

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 individuals and their families have access to palliative care starting at the moment they are diagnosed with a serious illness. Recognizing the importance of addressing greater needs more urgently, the Task Force endorses focusing in the near-term on the following two sub-population targets:

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

Task Force Directory

Members identified an urgent need for a directory of dedicated San Francisco palliative care services and supports (predominantly nonprofit) that could be shared with Task Force members and other interested stakeholders. Task Force members and members of the public created the directory's organizational profile structure (specific fields of information) and design format (a combination at-a-glance matrix and detailed organizational profiles). Members representing dedicated palliative care services and supports completed organizational profiles for the directory. Organizations and services providing similar services and supports but not represented on the Task Force, were also included. The final directory is scheduled for release in October 2014.

Task Force Priority Short- and Long-Term Strategic Recommendations

The Task Force identified four issue areas for development of short- and long-term recommendations: Quality, Finance, Systems, and Community Engagement. The four were selected because they are critical to the development and delivery of an integrated and collaborative palliative care service system. Task Force members and members of the public joined the workgroup that best fit their interests and expertise.

B. Task Force Workgroup Process

To maximize Task Force members and members of the public participation in the development of workgroup recommendations, time was set aside during three of the five Task Force meetings for the workgroups to meet. Workgroups were supplied with instructions for selecting a leader or leaders, deciding on priorities and focus areas, and established a working structure that suited the needs and availability of workgroup members. All the workgroups used a common dashboard template for developing and reporting their draft recommendations during Task Force meetings.

V. Workgroup Recommendations

The following Quality, Finance, Systems, and Community Engagement workgroup tables of short- and long-term recommendations reflect prioritized, implementable, and bold recommendations to move San Francisco closer to meeting its current and future palliative care needs. Tasks necessary to achieve each recommendation, when identified, are included, as are potential champions for the recommendation—i.e., point persons or organizations knowledgeable about and possibly invested in implementing the recommendation should it be selected for advancement in the next phase of the Task Force.

In the legend below, the primary organizations listed as *Proposed Champion(s)* in the workgroup tables are listed with their corresponding acronym or abbreviation.

Task Force Workgroup Proposed Champions Acronyms and Abbreviations

Proposed Champion Organization	Acronym/Abbreviation	Proposed Champion Organization	Acronym/Abbreviation
Anthem Blue Cross	Blue Cross	On Lok Lifeways	On Lok
Blue Shield of California	BSC	Saint Francis Memorial Hospital	St. Francis
Brown & Toland Physicians	Brown & Toland	Saint Mary’s Medical Center	St. Mary’s
California Association of Health Facilities	CAHF	San Francisco Clinic Consortium	Clinic Consortium
California Advocates for Nursing Home Reform	CANHR	San Francisco Department of Aging and Adult Services	DAAS
California Department of Public Health Licensing & Certification	CDPH	San Francisco Department of Emergency Management	SF EMS
California Department of Social Services	CDSS	San Francisco Department of Public Health	DPH
California Hospital Association	CHA	San Francisco Department of Public Health Transitions Program	DPH Transitions
California Pacific Medical Center	CPMC	San Francisco General Hospital	SFGH
Coalition for Compassionate Care of California	CCCC	San Francisco Health Plan	SFHP
Family Caregiver Alliance	FCA	San Francisco Medical Society	SFMS
Hill Physicians Medical Group	HPMG	San Francisco State University	SFSU
Hospice by the Bay	Hospice by the Bay	San Francisco Transitional Care Program	SFTCP
In-Home Supportive Services Consortium	IHSS Consortium	San Francisco VA Medical Center	SF VA
In-Home Supportive Services Public Authority	IHSS Public Authority	Self-Help for the Elderly	Self-Help
Jewish Family and Children’s Services	JFCS	The Shanti Project	Shanti
Institute on Aging	IOA	Task Force Members	Task Force
Kaiser Permanente San Francisco	KPSF	<i>To Be Determined</i>	TBD
Laguna Honda Hospital	LHH	Saint Francis Memorial Hospital	St. Francis
LifeCourse Strategies	LCS	University of California, Berkeley	UCB
Long Term Care Coordinating Council	LTCCC	University of California, San Francisco	UCSF
Maitri	Maitri	Zen Hospice Project	Zen Hospice
The Marchese Company	Marchese Co	San Francisco VA Medical Center	SF VA

Note: Quality, Finance, Systems, and Community Engagement Workgroups are represented as such in the recommendations.

A. Quality

Understanding what quality in health care means—its definition, application, and interpretation—is critical to comprehending, measuring, and improving health care. The Institute of Medicine (IOM) defines quality of care as: *The extent to which health services provided to individuals and patient populations improve desired health outcomes. The care should be based on the strongest clinical evidence and provided in a technically and culturally*

*competent manner with good communication and shared decision-making. Quality care is safe, effective, patient-centered, timely, efficient, and equitable.*¹⁷

The National Consensus Project (NCP) Clinical Practice Guidelines for Palliative Care, the Joint Commission Advanced Certification Program for Palliative Care, and the Centers for Medicare & Medicaid Services (CMS), affirm that measuring quality should be an essential component of all palliative care programs. As such, palliative care quality measurements are continually being refined to further improve quality of life for patients and families.

The Quality Workgroup endorsed the NCP's framework for quality and domains of palliative care in their goals and recommendations. The NCP Framework identifies three primary categories for collecting information related to quality: **structure** (the stable elements of the health care system in which care is delivered, e.g., hospital buildings, staff), **processes** (what health care services are provided, the transactions between patients and providers throughout the delivery of health care), and **outcomes** (the effects of health care for the patient and family).[†] NCP's core domains of palliative care include the following:

- Structure and process of care (i.e., accessibility, training/certification)
- Physical aspects of care;
- Psychological and psychiatric aspects of care;
- Social aspects of care;
- Spiritual, religious, and existential aspects of care;
- Cultural aspects of care;
- Care of the patient at end-of-life; and
- Ethical and legal aspects of care (includes attention to advance care planning processes and documentation).

Quality Workgroup Goals

1. Promoting development of palliative care services that feature structures and processes of care that adhere to NCP guidelines and criteria; and
2. Promoting measurement of structures, processes, and care outcomes that demonstrate adherence to the NCP guidelines.

[†] Kathleen Kerr, a consultant with expertise in palliative care finance and quality, assisted the Finance and Quality Workgroups with developing their recommendations.

Table 1. Quality Short-Term and Long-Term Recommendations

Quality Short-Term Recommendations	Quality Long-Term Recommendations
<p>1. Promote measurement of palliative care service quality in acute care hospitals. <i>Tasks:</i> a) inventory how palliative care quality is currently being measured in San Francisco area healthcare systems and hospitals. <i>Proposed Champion(s):</i> TBD</p>	<p>1. A. Require that all acute care hospitals in San Francisco secure Advanced Certification in Palliative Care through the Joint Commission. <i>Tasks:</i> a) develop an advocacy group to champion this effort and work with hospitals and health system payers (<i>see Finance Short-Term Recommendation #5</i>); b) identify payers to champion certification as an indicator or palliative care service quality (for example, adopt as a criterion for inclusion in a preferred provider network); c) work with the California Hospital Association and the Hospital Council to advocate for a state-wide requirement. <i>Proposed Champions:</i> DPH; All San Francisco Hospitals, BSC, SFHP; HPMG; CHA</p> <p>B. Encourage payers to require providers to measure quality around palliative care and end-of-life care. <i>Tasks:</i> a) provide education and outreach on quality measures, e.g., use Center to Advance Palliative Care and California HealthCare Foundation tools and mechanisms for engaging payers; orient to validated measure sets designed for broad use, such as the <i>Measuring What Matters</i> portfolio developed by the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association <i>Proposed Champions:</i> Dr. Scott Endsley-SHFP, Dr. Gary Herzberg-BSC, Dr. Terry Hill-HPMG</p>
<p>2. Promote palliative care quality measurement in San Francisco Health Plan clinics and in the Plan itself. <i>Tasks:</i> a) understand how quality is measured currently within the San Francisco Health Plan; b) clarify how these measures are reported and to whom; c) identify the accountability structure and current benchmarks; d) identify key contacts for measurement of palliative care quality in the San Francisco Health Plan. <i>Proposed Champion:</i> Dr. Scott Endsley-SFHP</p>	<p>2. Require that community-based and outpatient programs, at minimum, monitor and report performance on the HEDIS Care of the Older Adult measures, which features an item that assesses advance care planning discussion or documentation of surrogate decision maker. <i>Proposed Champions:</i> Dr. Scott Endsley-SFHP <i>Note:</i> HEDIS—Healthcare Effectiveness Data and Information Set—is a tool used by health plans to measure performance on dimensions of care/service.</p>
<p>3. Promote adoption of palliative care processes in long-term care facilities (LTC). <i>Tasks:</i> a) request that the state insert into their annual survey of LTC facilities, a question addressing the number of LTC staff who are certified in hospice and palliative care; b) in collaboration with the San Francisco Long Term Care Coordinating Council, form a committee of LTC providers</p>	<p>3. Require adoption of palliative care processes and programs in long-term care (e.g., INTERACT, etc.). <i>Proposed Champions:</i> CAHF, CANHR <i>Note:</i> INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and</p>

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Quality Short-Term Recommendations	Quality Long-Term Recommendations
<p>and administrators to develop a comprehensive plan for palliative care in LTC that includes a palliative care training plan; c) create a San Francisco LTC interest group, for LTC providers/administrators, medical directors/directors of nursing; d) leverage lessons learned from prior efforts to improve quality of palliative care in LTC settings by seeking input from key organizations and individuals (Coalition for Compassionate Care of California, Mary Ersek, University of PA); e) engage with the CSU Institute for Palliative Care and Zen Hospice for training and certification of aides and direct care workers.</p> <p><i>Proposed Champion: Anne Hughes-LHH</i></p>	<p>strategies for use in every day practice in long-term care facilities.</p>
<p>4. Promote palliative care training for direct care and front line workers employed by social service, home health, and home care organizations and In-Home Support Services (IHSS).</p> <p><i>Tasks:</i> a) request that the state collect as part of the annual survey process of home health agencies and hospices, information about the proportion of staff certified in palliative and palliative care; b) identify and promote adoption of existing training and educational programs to train front line staff for these organizations.</p> <p><i>Proposed Champions:</i> IOA, DAAS, JFCS, Margy Baran-IHSS Consortium, Steve Decker (IHSS Educational Trainer)</p>	<p>4. Advocate for a state requirement for certification and continuing education hospice and palliative care for direct care and front line workers.</p> <p><i>Proposed Champion:</i> CDPH, CDSS, IHSS</p>
<p>5. Promote advance care planning by physicians and advanced practice providers in San Francisco.</p> <p><i>Tasks:</i> a) coordinate this recommendation with the Task Force Systems and Community Engagement Workgroups.</p> <p><i>Proposed Champions:</i> Dr. Jeff Newman-UCSF, Dr. BJ Miller-Zen Hospice, SFMS, Palliative Care and Geriatrics Specialists</p>	<p>5. Require advance care planning as a component of all health care involving Task Force palliative care target population.</p> <p><i>Proposed Champion(s):</i> SFMS</p>
<p>6. Promote palliative care training for physicians, nurses, and social workers.</p> <p><i>Proposed Champions:</i> Connie Borden-St. Mary's; Sharon Ezekiel and Dr. Eric Widera-SF VA Medical Center, Dr. Anne Kinderman-SFGH; Dr. Tom Reid-UCSF</p>	<p>6. Advocate for a state requirement mandating hospice and palliative care training for ongoing licensing requirements for MDs, RNs, LCSWs.</p> <p><i>Tasks:</i> a) work with appropriate state agencies governing licensing and continuing education for MDs, RNs, LCSWs.</p> <p><i>Proposed Champions:</i> Dr. Lael Duncan-CCCC, Anne Hughes-LHH; Monique Parrish-LCS</p>
<p>7. Promote inclusion of the question. "Who is your health care agent for decision-making?" along with emergency contact information on state social service uniform assessment.</p> <p><i>Proposed Champion(s):</i> TBD</p>	<p>7. Require the question. "Who is your health care agent for decision-making?" along with emergency contact on state social service uniform assessment.</p> <p><i>Proposed Champion(s):</i> TBD</p>
<p>8. Promote use of the Partners for Children Program, as a means of improving access to pediatric palliative care</p>	

Quality Short-Term Recommendations	Quality Long-Term Recommendations
<p>in San Francisco. <i>Proposed Champions:</i> Pediatric Palliative Care Leaders (e.g., Devon Dabbs, Children’s Hospice & Palliative Care Coalition; Dr. Jill Abramson, Partners for Children; Dr. Robert Dimand, California Children’s Services)</p>	
	<p>Encourage payers to require providers to measure quality around palliative care and end-of-life care. <i>Tasks:</i> a) advocate for state policy and programs that advance palliative and end-of-life care, e.g., State Health Care Innovation Plan, etc. <i>Proposed Champion:</i> Judy Thomas-CCCC</p>

B. Finance

Palliative care offered in a variety of settings has been shown to improve outcomes for people with serious illness and their families. These outcomes (i.e., better symptom control, greater clarity with goals of care) often manifest as avoided health crises, increased capacity to receive care safely in the home, and improved planning, with the secondary effects of reduced use of some health services (hospital admissions, emergency department visits), and increased use of other types of services (home-based care and hospice care.) These changes in type and setting of care result in lower health care costs.

The challenge of funding palliative care in the inpatient setting and even more so in the community, is that in most cases current reimbursement structures (mostly fee-for-service) do not cover the cost of the time-intensive, inter-disciplinary interventions that are the hallmark of quality palliative care. Hence, the business case for palliative care depends on cost reduction or cost avoidance – for example, using some of the dollars that would have been spent on avoidable inpatient care to fund a palliative care service, with the expectation that the amount of avoided costs will exceed the cost of staffing the service.

The Finance Workgroup elected to promote the following fiscal strategy—to develop a business case to expand access to palliative care services—in their recommendations:

1. Gather and disseminate evidence showing that palliative care improves patient and family outcomes while reducing utilization of some typically expensive types of health services (hospital stays, emergency visits), thereby reducing overall health care costs;
2. For any given setting or patient population, identify the entity that stands to benefit from those reduced costs (health system? medical group? payer?);
3. Gather information that describes current patterns of health care use toward the end of life for a specific population, and use these data to estimate the dollar-value of the

expected change in utilization that a palliative care intervention would likely produce, for the entity at risk for costs;

4. Contrast the expected savings to the expected cost of staffing and running the palliative care service; and
5. Promote use of this kind of return-on-investment information to support creating, expanding or sustaining palliative care services. Such efforts might highlight opportunities within systems, where those who provide care and those who bear fiscal risk are organizationally integrated (i.e., within integrated health systems or the safety-net system). Alternatively, promotion might occur by facilitating partnerships between entities that bear risk for health care costs and provider organizations that do offer or wish to offer palliative care.

Table 2. Finance Short- and Long-Term Recommendations

Finance Short-Term Recommendations	Finance Long-Term Recommendation
<p>1. Promote broader understanding of the business case for palliative care among stakeholders who are in a position to fund palliative care services. <i>Tasks:</i> a) develop a summary of evidence from the peer-reviewed literature and other sources that describes palliative care impact on utilization and fiscal outcomes. Include in this document references to existing tools, such as the Payer-Provider Partnership Toolkit, developed by the Center to Advance Palliative Care; b) work with organizations (i.e., Coalition for Compassionate Care of California, California HealthCare Foundation) and individuals (e.g., Task Force members affiliated with health systems, payers, health insurance purchasers) that could help disseminate the summary. <i>Proposed Champions:</i> Kathleen Kerr-Consultant, Dr. BJ Miller-Zen Hospice</p>	
<p>2. Promote broader understanding of the possible impact of increasing access to palliative care across the continuum of care by appreciating outcomes being achieved by palliative care services that are currently active in San Francisco. <i>Tasks:</i> a) ask Task Force members affiliated with provider organizations with active palliative care services to share data describing the utilization, fiscal and other quality impacts of their services; b) aggregate and organize this information to demonstrate how palliative care is already improving the value of care across settings and patient populations.</p>	

Finance Short-Term Recommendations	Finance Long-Term Recommendation
<p><i>Proposed Champions:</i> Kathleen Kerr-Consultant, Monique Parrish-LCS</p>	
<p>3. Develop a data-driven understanding of current utilization patterns in the final 12-24 months of life for a defined population of patients, to promote understanding of the opportunities for optimizing utilization and fiscal outcomes that would likely occur if San Franciscans had broader access to PC across the continuum.</p> <p>Tasks: a) craft a proposal to develop data describing current use of health care services in the final 12-24 months of life for some subset of the Task Force’s target population; b) conduct the analysis; c) use data from the literature and the summary of local outcomes described above to estimate probable impact that enhancing access to palliative care would have on health care utilization and health care costs; d) provide this information to stakeholders who have responsibility for developing and funding services for the defined population, and more broadly.</p> <p><i>Proposed Champions:</i> Dr. Heather Harris-SFGH; Dr. Anne Kinderman-SFGH, Administration Champion TBD</p>	
<p>4. Identify pilot projects that provide proof of concept that increasing access to palliative care in the San Francisco yields improvements in the quality of care and reductions in the cost of care.</p> <p>Tasks: a) develop a compendium of possible projects that could promote delivery of palliative care to San Francisco residents, through developing new services or by incorporating palliative care delivery into existing programs, such as the Community Care Transitions Program operated by DAAS; b) identify funding sources to support the implementation of one or more of these pilot projects.</p> <p><i>Proposed Champion(s):</i> TBD</p>	
<p>5. Assemble an Advisory Board, to be affiliated with the Long Term Care Coordinating Council, that can offer support related to palliative care: information about palliative care contribution to value (quality and costs), information about sufficiency of current services, and opportunities/strategies to extend the reach of such services to better meet the needs of more San Franciscans.</p> <p><i>Tasks:</i> a) develop a brief proposal describing the Advisory Board composition, purpose, and proposed functions (see Appendix D.).</p>	<p>5. Provide on-going support to offices and organizations that have an interest in ensuring access to quality palliative care, by highlighting innovations and advances in service delivery that appear in the literature and other sources, promoting collaborations between payers and providers, and highlighting potential palliative care projects that hold promise for increasing the value of health care in the San Francisco.</p> <p><i>Proposed Champion(s):</i> Dr. Heather Harris-SFGH, Ralph Marchese-Marchese Co., Dr. BJ Miller-Zen Hospice</p>

Finance Short-Term Recommendations	Finance Long-Term Recommendation
<i>Proposed Champions:</i> Dr. Heather Harris-SFGH, Ralph Marchese-Marchese Co., Dr. BJ Miller-Zen Hospice	

C. Systems

Health systems integration has long been recognized as essential for delivering quality effective health care.¹⁸ But the concept is no longer relegated to a single system or a single integration approach, e.g., vertical or horizontal. Two primary reasons account for this shift: today, patients, funding, and resources move more fluidly between various health care systems, challenging the unilateral concept of integration; and, the community-based service system is no longer considered separate and “outside” of health care; rather, it is a system highly interdependent with the health care system. Because of these factors, increasing integration and collaboration within and across multiple systems is no longer an ideal, but an imperative to meeting patient and family health care and support needs.

Before developing recommendations, the Systems Workgroup identified a host of systems problems and issues impacting the delivery of palliative care in San Francisco:

- Providers working in different systems are unaware of resources available to patients outside of their own systems and facilities.
- Current delivery system is fragmented.
- Lack of information and data sharing across systems, particularly in regard to advance care planning documents and patient preferences regarding their care.
- Dissonance between the “medical model” and “social model” of care delivery (e.g. different incentives and funding).
- Limited integration of services and inter-agency care coordination; we need better coordination between hospital/ home and community—especially for homeless and underserved populations.
- Access to community-based palliative care services and end-of-life caregiving services is very limited, particularly for vulnerable populations.
- Traditional reimbursement structures have limited the development of clinic- and home-based palliative care services.
- Patients and providers are unable to access caregiving services such as In-Home Supportive Services as quickly as would be necessary to allow them to remain at home for end-of-life care.

- When patients lack access to consistent, capable caregivers and/or safe living environments, there are very few options available to them, other than acute hospitalization.
- Logistical barriers often create a mismatch between available resources and the patients who would benefit from them, e.g. application and admission to inpatient hospice facilities.

Reflecting on these challenges, the workgroup identified several potential solutions:

- Minimize barriers to accessing existing hospice and palliative care services and related community resources, regardless of where patients reside or receive primary care.
- Work toward narrowing disparities in access to community-based palliative care services.
- Establish citywide standards for advance care planning, including core components and information sharing across sites and systems.
- Improve communication of Advance Directives for complex needs and disenfranchised individuals without surrogate decision makers.
- Promote the development of systems that enable rapid access to documentation of patients’ care preferences across settings and systems.

Framing each potential solution as a goal, the Systems Workgroup developed a comprehensive set of responsive short- and long-term recommendations.

Table 3. Systems Short- and Long-Term Recommendations

Systems Goal 1: Minimize barriers to accessing existing hospice and palliative services and related community resources, regardless of where patients reside or receive primary care.

Systems Goal 1. Short-Term Recommendations	Systems Goal 1. Long-Term Recommendations
<p>1. Create a new (or incorporate into existing) database of palliative care resources, accessible to providers across systems and locations. <i>Tasks:</i> a) investigate platform options, information technology options; b) explore grant funding opportunities to enable initial development and launch; c) transfer compiled resources from Palliative Care Task Force info into central database; d) notify hospital-based and community providers regarding availability. <i>Proposed Champions:</i> Abbie Yant-St. Francis, Anne Hinton-</p>	<p>1. Once created, ensure sustainability and routine updating of palliative care resource database. Tasks: a) investigate potential funding mechanisms for routine database maintenance and upkeep; b) enable functionality to allow users to suggest changes or corrections, and provide education to encourage feedback from users; c) explore potential for yearly internship positions for health professions students (social work, public health, nursing leadership) that would include routine verification of database</p>

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<p>DAAS, San Francisco Technology Firms (e.g. Zendesk, Salesforce)</p>	<p>information accuracy. <i>Proposed Champions:</i> Sharon Ezekiel-SF VA, Health Profession Schools (e.g., UCB; SFSU), Norma del Rio-LHH, San Francisco Technology Firms (e.g. Zendesk, Salesforce)</p>
<p>2. Develop common San Francisco hospice intake form to streamline referral process for inpatient hospice. <i>Tasks:</i>) identify eligible facilities, obtain contacts for each; b) determine interest and support for common intake form c) review existing intake forms and draft common intake form; d) send draft to stakeholders; e) work with facilities to educate hospital- and community-based providers regarding new form. <i>Proposed Champions:</i> Jane Hawgood-Zen Hospice; Michael Smithwick-Maitri; David Zwicky-Hospice by the Bay</p>	

Systems Goal 2: Work toward narrowing disparities in access to community-based palliative care services, particularly for underinsured or uninsured residents of SF.

Systems Goal 2. Short-Term Recommendations	Systems Goal 2. Long-Term Recommendations
<p>1. Create a report identifying significant gaps in access to palliative care services, which could be presented to various audiences (health care systems, payers, social service agencies, Long-Term Care Coordinating Council). <i>Tasks:</i> a) combine information regarding available palliative care services in San Francisco collected by the Task Force, and identify significant gaps in service (inpatient, community-based, social services); b) write report and present to multiple stakeholders: DPH, DAAS, LTCCC, BSC, SFHP, etc. <i>Proposed Champion(s):</i> TBD</p>	
<p>2. Create an advisory group that can inform payers and systems regarding the development and implementation of community-based care navigation and/or symptom management service for patients with serious illness, in systems or for patient populations where disparities in access exist). [See Finance Workgroup Short-Term Recommendation #5] <i>Proposed Champions:</i> Dr. Anne Kinderman-SFGH, Dr. Catherine Seeley-CPMC, Kaushik Roy-Shanti, Traci Dobronravova-JFCS; DPH Transitions, San Francisco Cancer and Care Navigation Programs</p>	<p>3. Expand access to community-based program(s) for high-quality, serious illness care navigation and advance care planning services. <i>Tasks:</i> a) define scope of navigation services; identify participating hospital system(s) and community partners; b) determine appropriate staffing model for navigation services; c) explore grant- and system-based resources to create a pilot navigation program; d) determine appropriate metrics to assess the impact of navigation services; e) define criteria and mechanisms for referral, initial target population(s) for pilot program; f) identify physical space for work with (non-home-bound) referred clients; g) hire necessary staff based on length and scope of pilot program; h) initiate services, with ongoing assessment of services and</p>

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Systems Goal 2. Short-Term Recommendations	Systems Goal 2. Long-Term Recommendations
	<p>outcomes reporting; i) identify funding sources (payers, health systems, philanthropy) to maintain and expand on pilot services. <i>Proposed Champions:</i> Shanti, DPH Transitions, LTCCC, TBD</p>
<p>3. Work with social service agencies, health systems, and payers to develop patient educational materials to facilitate access to palliative care and hospice services, when appropriate. <i>Tasks:</i> a) develop brief survey of San Francisco Task Force member organizations and major health plans to determine how they inform patients/clients regarding available palliative care and hospice services; b) identify best practices in patient and family education and request permission for disseminating example educational materials to partner organizations. <i>Proposed Champion:</i> Community Engagement Workgroup</p>	<p>4. Develop community-based symptom management services, to address critical gaps in access to expert symptom management for ambulatory patients. <i>Tasks:</i> a) define scope of medical services; identify participating hospital system(s) and community partners; b) determine appropriate staffing model for medical services; c) explore grant- and system-based resources to create a pilot symptom management services; d) determine appropriate metrics to assess the impact of symptom management services; e) define criteria and mechanisms for referral, initial target population(s) for pilot program; f) identify physical space for work with referred patients; g) hire necessary staff based on length and scope of pilot program; h) initiate services, with ongoing assessment of services and outcomes reporting; i) identify funding sources (payers, health systems, philanthropy) to maintain and expand on pilot services. <i>Proposed Champions:</i> TBD, Plus Payers (e.g. Blue Cross, SFHP, Brown & Toland, etc.), Hospital Readmission Committees and Quality Management Departments; Inpatient Palliative Care Programs</p>

Systems Goal 3: Establish citywide standards for advance care planning, including core components and information sharing across sites/systems.

Systems Goal 3. Short-Term Recommendations	Systems Goal 3. Long-Term Recommendations
<p>1. Compile list of nationally recognized, evidence-based quality metrics associated with advance care planning, and share this information across major health systems and social service agencies in San Francisco. <i>Tasks:</i> a) review Joint Commission, National Quality Forum, National Consensus Project standards for advance care planning, directed toward health systems, palliative care programs, and hospice agencies; b) identify best practices in advance care planning with local, regional, and national exemplars, from public, private, and VA systems; c) categorize recommendations and provide summary report to Task Force members, for dissemination to their organization’s quality officers and administration.</p>	<p>1. Develop citywide standards for advance care plan (ACP) content and processes, across health systems and social service agencies. <i>Tasks:</i> a) components of ACP to consider may include, for example: provider education and training; triggers for ACP discussion (e.g. patient admission/client intake); core components of ACP; prioritization of ACP conversations for most vulnerable patient populations; patient education regarding communication of their care preferences and ACP documents. <i>Proposed Champions:</i> SFMS, SF EMS, DPH, DAAS, Hospital Council, Clinic Consortium, LTCCC, Quality/Community Engagement Workgroups</p>

Systems Goal 3. Short-Term Recommendations	Systems Goal 3. Long-Term Recommendations
<p><i>Proposed Champions:</i> Quality/Community Engagement Workgroups, Task Force</p>	
<p>2. Survey payers, social service agencies regarding current practices and bi-directional ACP “communication standards” between: client-provider; provider-provider; payer-provider.</p> <p><i>Tasks:</i> a) develop limited survey of organizations regarding current protocols and standards for communication of ACP, including: ACP data elements; accessibility of ACP; sharing of ACP internally and externally; b) enlist help of Task Force members to complete or identify appropriate organization contact to complete and return survey.</p> <p><i>Proposed Champions:</i> Quality/Community Engagement Workgroups, Task Force</p>	<p>2. Develop standards for ACP documentation and information sharing across locations and systems of care. Once ACP process has been completed, the ACP documents are available internally and externally to ensure that patient/client preferences are honored.</p> <p><i>Tasks:</i> a) documentation and information sharing may include, for example: standardized location in medical record for advance directives and POLST; electronic/paper documentation methods for ACP forms, patient wishes; mechanisms to alert providers of patient care preferences; documentation and dissemination of ACP for patients receiving hospice or palliative care.</p> <p><i>Proposed Champions:</i> SFMS, SF EMS, DPH, DAAS, Hospital Council, Clinic Consortium, LTCCC</p>

Systems Goal 4: Improve communication of Advance Directives for complex needs and disenfranchised individuals without surrogate decision makers.

Systems Goal 4. Short-Term Recommendations	Systems Goal 4. Long-Term Recommendations
<p>1. Identify medical and social service providers who care for socially vulnerable patients, and assess need for education regarding advance care planning.</p> <p><i>Tasks:</i> a) meet with the Conversation Project and High Users of Multiple Systems lead agencies to assess need for ACP training, spectrum of staff that should receive training in ACP.</p> <p><i>Proposed Champions:</i> Case Management Programs, DPH, DPH Transitions</p>	<p>1. Integrate palliative care services into complex care management programs for patients with high utilization of emergency services.</p> <p><i>Proposed Champions:</i> Dr. Anne Kinderman-SFGH, Dr. Deborah Borne-DPH, SFHP, Blue Cross, DPH Transitions</p>
<p>2. Identify high-risk patient populations for ACP interventions.</p> <p><i>Tasks:</i> a) convene major stakeholders caring for socially vulnerable patient groups and agree on initial target populations, which may include, for example: homeless /marginally housed; serious mental health and/or substance use disorders; un-befriended (i.e., no surrogate decision-makers).</p> <p><i>Proposed Champions:</i> DPH Transitions, Direct Access to Housing Staff, Clinic Consortium</p>	<p>2. Integrate core advance care planning into standard assessment and care planning for identified high-risk patient populations.</p> <p><i>Proposed Champions:</i> Dr. Anne Kinderman-SFGH, Dr. Deborah Borne-DPH, SFHP, Blue Cross; DPH Transitions</p>
<p>3. Explore advance care planning programs and feasibility of adapting and implementing program.</p> <p><i>Proposed Champion:</i> CCCC</p>	<p>3. Define standards for ongoing advance care planning education and for providers caring for high-risk socially vulnerable patients.</p>

Systems Goal 4. Short-Term Recommendations	Systems Goal 4. Long-Term Recommendations
<p>4. Implement advance care planning program for defined pilot population (e.g. residents in DAH units). <i>Proposed Champion: DPH Transitions</i></p>	<p>4. Integrate lessons learned from pilot advance care planning intervention and expand to reach all identified socially vulnerable patient populations. <i>Proposed Champions: Case Management, DPH Transitions</i></p>

Systems Goal 5: Promote the development of systems that enable rapid access to documentation of patients' care preferences across settings and systems.

Systems Goal 5. Short-Term Recommendations	Systems Goal 5. Long-Term Recommendations
<p>1. Explore models used by other programs that use technology to share advance directives across communities and care settings. Tasks: a) survey Task Force organizations and all major health systems in San Francisco regarding current systems for storing advance directives, information sharing across sites b) investigate existing or possible future models for information sharing across systems, (DAAS database, California POLST Registry, Respecting Choices-LaCrosse, WI, Identification of Homeless Individuals—Atlanta, GA, MyLife Directive, social media); c) identify best practices in leveraging technology to access advance directives across sites, systems. <i>Proposed Champions: TBD, CCCC, SF EMS, SFMS</i></p>	<p>1. Based on exploration of available technology platforms and best practices, implement a system to serve as a citywide repository of individuals' treatment wishes that can be accessed by healthcare and social service providers. Tasks: a) determine feasibility of having multiple health systems support the citywide implementation of ACP storage system; b) modify existing system or create new system in order to house and share information; c) identify who will maintain system and funding required for maintenance and management of system; d) train and educate providers on use of system on an ongoing basis; e) educate the public on the purpose and benefit of sharing healthcare information. <i>Proposed Champions: CCCC, DPH, DAAS, Deborah Borne- DPH, SFHP, Blue Cross, DPH Transitions</i></p>

D. Community Engagement

The Community Engagement Workgroup members identified lack of knowledge about palliative care within the community and among health and social service professionals and organizations, as the chief barrier to fuller community engagement with and support for palliative care. To remedy this, they chose promoting advance care planning as a viable strategy for engaging the community, and health and social service professionals and organizations in end-of-life conversations. The workgroup noted that advance care planning conversations offered an opportunity to introduce palliative care. Still, workgroup members were aware of and carefully considered several challenges associated with this strategy:

- Barriers to advance care planning include payment, time, skill, and perceived value.
- Lack of advance care planning materials for diverse communities and availability of some determined not to be “user friendly.”

- Identifying an advance care planning model that could work for San Francisco’s multicultural urban community and for educating health and social service professionals.

In response to the challenges and opportunities associated with their strategy, the Community Engagement Workgroup presented the following three recommendations.

Table 4. Community Engagement Short- and Long-Term Recommendations

Community Engagement Short-Term Recommendations	Community Engagement Long-Term Recommendation
<p>1. Create a public campaign to increase awareness about the “conversation” (i.e., identifying care preferences for serious illness, designating a health care agent). <i>Tasks:</i> a) explore free press, media, e.g. print, PSAs on TV, radio, Internet, social media; b) explore free public spaces, e.g. bulletin boards, buses, banners from light poles; c) identify short-term funding opportunities; d) enlist partners, e.g. Ad Council, community based organizations; e) identify resources and web sites; f) develop speakers bureau focusing on the conversation. <i>Proposed Champions:</i> Anne Hughes-LHH, Kelly Dearman-IHSS Public Authority, Task Force/Planning Group, Norma del Rio-LHH; Redwing Keyssar-JFCS; Anni Chung/Betty Fung-Self-Help, Hilda Uribe-Escobar-FCA</p>	<p>1. San Francisco will become a conversation-competent community that honors and respects the diverse communities, which are its very fabric. <i>Tasks:</i> a) review literature to determine the evidence base for community engagement related to advance care planning (ACP) in multicultural urban communities; b) contact counties engaging in ACP campaigns (e.g. Contra Costa) for insights about best practices and lessons learned; c) Conduct needs assessment to determine the feasibility of ACP campaign for San Francisco; d) complete analysis/ summary of various funding opportunities to initiate/ sustain ACP countywide effort; e) develop speakers bureau for ACP that includes communication skills and completion of documentation and introducing palliative care; f) identify/develop training tools for health care professionals re ACP and palliative care concepts using inter-professional models, e.g. CSU Institute for Palliative Care; g) identify metrics (measurement tools); h) promote policy changes for reimbursing ACP; i) create an ACP mobile unit and electronic ACP registry; j) create user friendly educational materials and translate materials into common languages spoken by San Francisco community members; k) Work with community pharmacies/clinics to promote ACP; l) link ACP with health care maintenance <i>Proposed Champions:</i> Anne Hughes-LHH, Dr. Jeff Newman-SFMS, Redwing Keyssar-JFCS, Anni Chung/Betty Fung-Self-Help, Hilda Uribe-Escobar-FCA, Task Force, Dr. Terry Hill/Dr. Carvel Teft-HPMG</p>
<p>2. Create “Wellness/ Conversation Campaigns” events in the organizations represented by the Task Force. <i>Tasks:</i> a) survey employees within organizations to</p>	

Community Engagement Short-Term Recommendations	Community Engagement Long-Term Recommendation
determine how many have had the conversations; b) Promote “conversations” among employees and within organizations represented on the task force, e.g. IHSS workforce, City employees and UCSF employees. <i>Proposed Champions:</i> Anne Hughes-LHH, Task Force (Members representing UCSF, DPH, IHSS, KPSF, etc.), Planning Group	

VI. Conclusion and Next Steps

Health care delivery is changing at an unprecedented pace. Central to this change is the emergence of quality, compassionate, cost effective palliative care. Supported by research that consistently shows palliative care improves care for individuals with serious illness and reduces health care costs, cities and states across the country are beginning to explore how best to provide this care now and in the future. San Francisco, with its diverse array of health care providers and community-based organizations, took a critical first step toward addressing the palliative care needs of its residents with the formation of the San Francisco Palliative Care Task Force.

Because of member expertise in a wide range of health and community-based services, the Task Force responded to the Task Force goal “to develop strategic recommendations to meet San Francisco’s current and future palliative care needs,” with three supporting deliverables: 1) definitions of palliative care and the palliative care target population; 2) an inventory of current dedicated palliative care services; and 3) priority short- and long-term recommendations by workgroup area: Quality, Finance, Systems, Community Engagement.

At the conclusion of the Task Force process, members met the Task Force goal and deliverables, making the Task Force an effective example of cross-system collaboration in the promotion of quality, compassionate, cost effective and accessible palliative care services.

With recommendations ranging from promoting measurement of the structure, processes, and outcomes of palliative care; to aggregation and analysis of existing data to promote understanding of the opportunities for altering utilization and fiscal outcomes, if San Franciscans have broader access to palliative care across the continuum; to actively supporting collaboration across systems and populations to improve palliative care access;

to ensuring all San Franciscans have the opportunity to express their end-of-life wishes, goals, and preferred health care agents, San Francisco now has a palliative care blueprint.

The next phase of this project will focus on finding an appropriate home to continue the important work of the Task Force, including implementing Task Force recommendations.

VII. Appendices

A. San Francisco Palliative Care Task Force Guiding Principles

- **Least Restrictive Setting.** Support palliative care in the least restrictive setting, according to an individual’s needs and preferences.
- **Cultural Competence and Cultural Responsiveness.** Support palliative care that is inclusive of and responsive to cultural and population diversity, including consideration of race, ethnicity, class, age, gender, sexual orientation, disability, language, religion and other indices of difference, and that supports responsive bidirectional learning of culture between palliative care providers and consumers.
- **Equity.** Support palliative care that does not vary in quality because of characteristics such as gender, race, ethnicity, geographic location, and socioeconomic status, so health disparities are reduced.
- **Accessibility.** Support palliative care that ensures that all individuals and families have equal access to palliative care services.
- **Dignity.** Support the dignity of palliative care patients and families—their choices, wishes, and desire to live well and die free of pain.

B. San Francisco Palliative Care Task Force Members

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D. Proposed Advisory Board

The Task Force proposes the formation of a Palliative Care Advisory Board for San Francisco, to be affiliated with the Long Term Care Coordinating Council. This Advisory Board will be comprised of professionals representing a wide range of entities that provide, utilize, and finance palliative care services. Representation will include a diverse group of members from the:

- Healthcare sector
- Social sector
- Payers for healthcare services in San Francisco, including the San Francisco Health Plan, and
- Healthcare consumers representing the diversity of the communities served in San Francisco

Representatives from the healthcare and social sectors will appropriately reflect the breadth of services provided throughout San Francisco from academic to community-based programs. Each representative will serve a voluntary term, of a specified duration. To support the Advisory Board, it may be necessary to provide some resource allocation for ongoing project management and administrative assistance.

The Advisory Board will address four areas essential to the development and provision of palliative care services in San Francisco: healthcare quality, finance, infrastructure and workforce issues with systems collaboration; and education and community engagement. Key functions of the Advisory Board will include the following: oversee the collection of data; evaluation and monitoring of palliative care service delivery across settings and the care continuum; and offering guidance on successful implementation of the recommendations put forth by the San Francisco Palliative Care Task Force.

Based on rigorous evaluation of local and national data, monitoring of care delivery and innovation projects, and assessment of fiscal impact due to the implementation of palliative care services, the Advisory Board will be in an optimal position to provide ongoing policy recommendations regarding the quality of care delivery and resource allocation. Last, the Advisory Board will collaborate with industry and other related entities to foster fruitful partnerships between those who are at risk for health care costs, and provider groups working to initiate and expand palliative care services.

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F. State and National Palliative Care Resources

Below is a list of major state and national palliative care resources.

American Academy of Hospice and Palliative Medicine (AAHPM) and the Hospice and Palliative Nurses Association (HPNA). AAHPM and HPNA have partnered on *Measuring What Matters*, a consensus project aimed at identifying a recommended portfolio of cross-cutting performance measures for all hospice and palliative care programs. <http://aahpm.org/uploads/education/MWM%20Top%2012%20Measure%20Information%20and%20Comments.pdf>

California HealthCare Foundation. The California HealthCare Foundation's (CHCF) Better Chronic Disease Care program supports appropriate care toward the end of life through various palliative care projects. www.chcf.org

Center to Advance Palliative Care. The Center to Advance Palliative Care (CAPC) is the leading resource for palliative care program development and growth. Access essential palliative care tools, education, resources and training for health care professionals. <http://www.capc.org/>

Coalition for Compassionate Care of California. The Coalition for Compassionate Care of California (CCCC) is a statewide collaborative of organizations and individuals representing healthcare providers, assisted living facilities, nursing homes, hospices, consumers, state agencies and others that promotes high-quality, compassionate care for all Californians who are seriously ill or approaching the end of life. <http://coalitionccc.org/#>

Institute of Medicine

The Institute of Medicine (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative health care advice to decision makers and the public. See recent publication, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* at: <http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>

Let's Get Healthy California. The Task Force is a group of government, community, and healthcare leaders working to make California the healthiest state in the nation. http://www.chhs.ca.gov/Documents/___Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf

National Consensus Project. The National Consensus Project for Quality Palliative Care (NCP) represents a groundbreaking initiative to further define and underscore the value of palliative care and to improve upon the delivery of palliative care in the United States. <http://www.nationalconsensusproject.org/>

National Quality Forum. The National Quality Forum (NQF), a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare, endorses 14 quality measures on palliative and end-of-life care. http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Palliative_and_End-of-Life_Care_Measures.aspx