MEMORANDUM

DATE: December 11, 2014

TO: Dr. Edward Chow, Health Commission President, and Members of the Health Commission

THROUGH: Barbara A. Garcia, MPA, Director of Health

FROM: Colleen Chawla, Deputy Director of Health and Director of Policy & Planning

RE: San Francisco Palliative Care Task Force Final Report and Recommendations

From May 2014 through August 2014, a diverse group of representatives from San Francisco’s health care and community organizations, advocacy and professional associations, and consumers, convened to discuss San Francisco’s palliative care needs. The Palliative Care Task Force was co-sponsored by Department of Adult and Aging Services and San Francisco Department of Public Health in response to the growing need for palliative care, the identification of gaps in the delivery of palliative care, and the lack of knowledge of the range of palliative care services in the city. Co-chaired by Anne Hinton, Director of the 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, the Palliative Care Task Force developed a series of short and long-term recommendations focusing on Quality, Systems, Finance, and Community Engagement of palliative care.

Palliative Care Task Force co-chairs Anne Hinton and Christine Ritchie will present the body’s report and recommendations to the Health Commission at its meeting on December 16, 2014.

Attachments

- Palliative Care Task Force Final Report
- San Francisco Palliative Care and Supportive Care Resources Directory
- Draft Health Commission Resolution
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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**San Francisco Department of Public Health**  
Barbara A. Garcia, MPA  
Director of Health

**San Francisco Department of Aging and Adult Services**  
Anne Hinton  
Executive Director
Acknowledgements

We would like to express our deepest gratitude to the following organizations for funding the Task Force: the California HealthCare Foundation; the University of California, San Francisco; the San Francisco Department of Aging and Adult Services; California Pacific Medical Center; and, Saint Francis Memorial Hospital.

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.

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.

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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. Everyone.*

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.\textsuperscript{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.\textsuperscript{1} 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.\textsuperscript{10} The program allows eligible children (under the age of 21) and their families to receive palliative care

\textsuperscript{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

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<td>California Department of Social Services</td>
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<td>San Francisco Department of Public Health</td>
<td>DPH</td>
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<td>California Hospital Association</td>
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<td>JFCS</td>
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<td>Institute on Aging</td>
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<td>Kaiser Permanente San Francisco</td>
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<td>LCS</td>
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<td>The Marchese Company</td>
<td>Marchese Co</td>
<td>San Francisco VA Medical Center</td>
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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).¹ 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.

¹ 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

<table>
<thead>
<tr>
<th>Quality Short-Term Recommendations</th>
<th>Quality Long-Term Recommendations</th>
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<tbody>
<tr>
<td><strong>1.</strong> Promote measurement of palliative care service quality in acute care hospitals.</td>
<td><strong>1.</strong> A. Require that all acute care hospitals in San Francisco secure Advanced Certification in Palliative Care through the Joint Commission.</td>
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<tr>
<td><em>Tasks:</em> a) inventory how palliative care quality is currently being measured in San Francisco area healthcare systems and hospitals.</td>
<td><em>Tasks:</em> a) develop an advocacy group to champion this effort and work with hospitals and health system payers <em>(see Finance Short-Term Recommendation #5)</em>; b) identify payers to champion certification as an indicator of palliative care 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.</td>
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<td><em>Proposed Champion(s):</em> TBD</td>
<td><em>Proposed Champions:</em> DPH; All San Francisco Hospitals, BSC, SFHP; HPMG; CHA</td>
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<td><strong>2.</strong> Promote palliative care quality measurement in San Francisco Health Plan clinics and in the Plan itself.</td>
<td><strong>2.</strong> B. Encourage payers to require providers to measure quality around palliative care and end-of-life care.</td>
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<td><em>Tasks:</em> 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.</td>
<td><em>Tasks:</em> 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 <em>Measuring What Matters</em> portfolio developed by the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.</td>
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<td><em>Proposed Champion:</em> Dr. Scott Endsley-SFHP</td>
<td><em>Proposed Champions:</em> Dr. Scott Endsley-SHFP, Dr. Gary Herzberg- BSC, Dr. Terry Hill-HPMG</td>
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<td><strong>3.</strong> Promote adoption of palliative care processes in long-term care facilities (LTC).</td>
<td><strong>3.</strong> 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.</td>
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<td><em>Tasks:</em> 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.</td>
<td><em>Proposed Champions:</em> Dr. Scott Endsley-SFHP Note: HEDIS—Healthcare Effectiveness Data and Information Set—is a tool used by health plans to measure performance on dimensions of care/service.</td>
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<td>Note: 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</td>
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<td>Quality Short-Term Recommendations</td>
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| 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.  
*Proposed Champion: Anne Hughes-LHH* | strategies for use in every day practice in long-term care facilities. |
| **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).  
*Tasks:* 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.  
*Proposed Champions: IOA, DAAS, JFCS, Margy Baran-IHSS Consortium, Steve Decker (IHSS Educational Trainer)* | **4.** Advocate for a state requirement for certification and continuing education hospice and palliative care for direct care and front line workers.  
*Proposed Champion: CDPH, CDSS, IHSS* |
| **5.** Promote advance care planning by physicians and advanced practice providers in San Francisco.  
*Tasks:* a) coordinate this recommendation with the Task Force Systems and Community Engagement Workgroups.  
*Proposed Champions: Dr. Jeff Newman-UCSF, Dr. BJ Miller-Zen Hospice, SFMS, Palliative Care and Geriatrics Specialists* | **5.** Require advance care planning as a component of all health care involving Task Force palliative care target population.  
*Proposed Champion(s): SFMS* |
| **6.** Promote palliative care training for physicians, nurses, and social workers.  
*Proposed Champions: Connie Borden-St. Mary’s; Sharon Ezekiel and Dr. Eric Widera-SF VA Medical Center, Dr. Anne Kinderman-SFGH; Dr. Tom Reid-UCSF* | **6.** Advocate for a state requirement mandating hospice and palliative care training for ongoing licensing requirements for MDs, RNs, LCSWs.  
*Tasks:* a) work with appropriate state agencies governing licensing and continuing education for MDs, RNs, LCSWs.  
*Proposed Champions: Dr. Lael Duncan-CCCC, Anne Hughes-LHH; Monique Parrish-LCS* |
| **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.  
*Proposed Champion(s): TBD* | **7.** Require the question. “Who is your health care agent for decision-making?” along with emergency contact on state social service uniform assessment.  
*Proposed Champion(s): TBD* |
| **8.** Promote use of the Partners for Children Program, as a means of improving access to pediatric palliative care | |
Quality Short-Term Recommendations | Quality Long-Term Recommendations
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in San Francisco. Proposed Champions: 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) | Encourage payers to require providers to measure quality around palliative care and end-of-life care. Tasks: a) advocate for state policy and programs that advance palliative and end-of-life care, e.g., State Health Care Innovation Plan, etc. Proposed Champion: Judy Thomas-CCCC

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**

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<tr>
<th><strong>Finance Short-Term Recommendations</strong></th>
<th><strong>Finance Long-Term Recommendation</strong></th>
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| **1. Promote broader understanding of the business case for palliative care among stakeholders who are in a position to fund palliative care services.**  
*Tasks:* 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.  
*Proposed Champions:* Kathleen Kerr-Consultant, Dr. BJ Miller-Zen Hospice | |
| **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.**  
*Tasks:* 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. | |
### Finance Short-Term Recommendations

**Proposed Champions:** Kathleen Kerr-Consultant, Monique Parrish-LCS

| 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. **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. **Proposed Champions:** Dr. Heather Harris-SFGH; Dr. Anne Kinderman-SFGH, Administration Champion TBD |

| 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. **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. **Proposed Champion(s):** TBD |

| 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. **Tasks:** a) develop a brief proposal describing the Advisory Board composition, purpose, and proposed functions (see Appendix D.). |

### Finance Long-Term Recommendation

| 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. **Proposed Champion(s):** 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. 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.*

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<tr>
<th>Systems Goal 1. Short-Term Recommendations</th>
<th>Systems Goal 1. Long-Term Recommendations</th>
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<tr>
<td>1. Create a new (or incorporate into existing) database of palliative care resources, accessible to providers across systems and locations. <em>Tasks:</em> 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. <em>Proposed Champions:</em> Abbie Yant-St. Francis, Anne Hinton-</td>
<td>1. Once created, ensure sustainability and routine updating of palliative care resource database. <em>Tasks:</em> 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</td>
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### 2. Develop common San Francisco hospice intake form to streamline referral process for inpatient hospice.

**Tasks:**
- a) 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.

**Proposed Champions:**
- Jane Hawgood-Zen Hospice;
- Michael Smithwick-Maitri;
- David Zwicky-Hospice by the Bay

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### 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

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).**

**Tasks:**
- 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.

**Proposed Champion(s):** TBD

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]**

**Proposed Champions:**
- Dr. Anne Kinderman-SFPH,
- Dr. Catherine Seeley-CPMC,
- Kaushik Roy-Shanti,
- Traci Dobronravova-JFCS;
- DPH Transitions, San Francisco Cancer and Care Navigation Programs

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#### Systems Goal 2. Long-Term Recommendations

1. **Expand access to community-based program(s) for high-quality, serious illness care navigation and advance care planning services.**

**Tasks:**
- 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 information accuracy.

**Proposed Champions:**
- Sharon Ezekiel-SF VA,
- Health Profession Schools (e.g., UCB; SFSU),
- Norma del Rio,
- LHH, San Francisco Technology Firms (e.g. Zendesk, Salesforce)
### Systems Goal 2. Short-Term Recommendations

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.**
   
   *Tasks:* 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.
   
   *Proposed Champion:* Community Engagement Workgroup

### Systems Goal 2. Long-Term Recommendations

4. **Develop community-based symptom management services, to address critical gaps in access to expert symptom management for ambulatory patients.**
   
   *Tasks:* 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.
   
   *Proposed Champions:* TBD, Plus Payers (e.g. Blue Cross, SFHP, Brown & Toland, etc.), Hospital Readmission Committees and Quality Management Departments; Inpatient Palliative Care Programs

### 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

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.**

   *Tasks:* 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.

#### Systems Goal 3. Long-Term Recommendations

1. **Develop citywide standards for advance care plan (ACP) content and processes, across health systems and social service agencies.**

   *Tasks:* 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.

   *Proposed Champions:* SFMS, SF EMS, DPH, DAAS, Hospital Council, Clinic Consortium, LTCCC, Quality/Community Engagement Workgroups
### Systems Goal 3: Short-Term Recommendations

**Proposed Champions:** Quality/Community Engagement Workgroups, Task Force

#### 2. Survey payers, social service agencies regarding current practices and bi-directional ACP “communication standards” between: client-provider; provider-provider; payer-provider.

*Tasks:* 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.

*Proposed Champions:* Quality/Community Engagement Workgroups, Task Force

#### 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.

*Tasks:* 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.

*Proposed Champions:* SFMS, SF EMS, DPH, DAAS, Hospital Council, Clinic Consortium, LTCCC

### Systems Goal 3: Long-Term Recommendations

#### 2. Identify medical and social service providers who care for socially vulnerable patients, and assess need for education regarding advance care planning.

*Tasks:* 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.

*Proposed Champions:* Case Management Programs, DPH, DPH Transitions

#### 2. Integrate palliative care services into complex care management programs for patients with high utilization of emergency services.

*Proposed Champions:* Dr. Anne Kinderman-SFGH, Dr. Deborah Borne-DPH, SFHP, Blue Cross, DPH Transitions

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

#### 1. Identify medical and social service providers who care for socially vulnerable patients, and assess need for education regarding advance care planning.

*Tasks:* 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.

*Proposed Champions:* Case Management Programs, DPH, DPH Transitions

#### 1. Integrate core advance care planning into standard assessment and care planning for identified high-risk patient populations.

*Proposed Champions:* Dr. Anne Kinderman-SFGH, Dr. Deborah Borne-DPH, SFHP, Blue Cross; DPH Transitions

#### 2. Explore advance care planning programs and feasibility of adapting and implementing program.

*Proposed Champion:* CCC

#### 2. Define standards for ongoing advance care planning education and for providers caring for high-risk socially vulnerable patients.
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**

<table>
<thead>
<tr>
<th>Community Engagement Short-Term Recommendations</th>
<th>Community Engagement Long-Term Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Create a public campaign to increase awareness about the “conversation” (i.e., identifying care preferences for serious illness, designating a health care agent).</td>
<td><strong>1.</strong> San Francisco will become a conversation-competent community that honors and respects the diverse communities, which are its very fabric.</td>
</tr>
<tr>
<td>Tasks: 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.</td>
<td>Tasks: 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/s 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</td>
</tr>
<tr>
<td><strong>2.</strong> Create “Wellness/Conversation Campaigns” events in the organizations represented by the Task Force.</td>
<td><strong>Tasks:</strong> a) survey employees within organizations to</td>
</tr>
<tr>
<td>Community Engagement Short-Term Recommendations</td>
<td>Community Engagement Long-Term Recommendation</td>
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<tr>
<td>---------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Proposed Champions: Anne Hughes-LHH, Task Force (Members representing UCSF, DPH, IHSS, KPSF, etc.), Planning Group</td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Affiliation</th>
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</thead>
<tbody>
<tr>
<td>Co-Chair</td>
<td>Anne Hinton</td>
<td>Executive Director, San Francisco Department of Aging and Adult Services</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Christine Ritchie</td>
<td>MD, MD MSPH, UCSF Department of Medicine, Division of Geriatrics, Center for Research on Aging, Jewish Home San Francisco</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Margaret Baran</td>
<td>MPH, Executive Director, In-Home Supportive Services Consortium</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Deborah Borne</td>
<td>MSW, MD, Consulting Medical Director, Transitions Division, San Francisco Department of Public Health</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Monique Booth</td>
<td>RN, BSN, Assistant Nurse Manager, Kaiser San Francisco, and Consumer</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Edward Chow</td>
<td>MD, President, San Francisco Health Commission</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Anni Chung</td>
<td>President and CEO, Self-Help for the Elderly</td>
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<tr>
<td>Co-Chair</td>
<td>Kelly Dearman</td>
<td>JD, Executive Director, IHSS Public Authority</td>
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<tr>
<td>Co-Chair</td>
<td>Norma del Rio</td>
<td>MSW, MA, Social Services Department, Laguna Honda Hospital</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Traci Dobronravova</td>
<td>MSW, Associate Director, Seniors At Home; Co-Chair, Long Term Care Coordinating Council</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Scott Endsley</td>
<td>MD, Interim Chief Medical Officer, San Francisco Health Plan</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Sharon Ezekiel</td>
<td>LCSW, Palliative Care Coordinator, San Francisco VA Medical Center</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Gary Herzberg</td>
<td>MD, Medicare Medical Director, Blue Shield of California</td>
</tr>
<tr>
<td>Co-Chair</td>
<td>Terry Hill</td>
<td>MD, Vice President, Hill Physicians Medical Group (shared with Carvel Teft, MD, Vice President, Medical Services, Hill Physicians Medical Group)</td>
</tr>
<tr>
<td>Member</td>
<td>Anne Hughes</td>
<td>RN, PhD, FAAN, Advance Practice Nurse, Palliative Care, Laguna Honda Hospital</td>
</tr>
<tr>
<td>Member</td>
<td>Pamela Johnson</td>
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<tr>
<td>Member</td>
<td>Redwing Keyssar</td>
<td>RN, Director, Palliative Care Program, Jewish Family and Children's Services</td>
</tr>
<tr>
<td>Member</td>
<td>Anne Kinderman</td>
<td>MD, Director, Supportive &amp; Palliative Care, San Francisco General Hospital</td>
</tr>
<tr>
<td>Member</td>
<td>Perry Lang</td>
<td>Executive Director, Black Coalition on AIDS</td>
</tr>
<tr>
<td>Member</td>
<td>Mary Lanier</td>
<td>Chief Admin. Officer, Davies Campus California Pacific Medical Center</td>
</tr>
<tr>
<td>Member</td>
<td>Grace Li</td>
<td>Chief Operating Officer, On Lok Lifeways</td>
</tr>
<tr>
<td>Member</td>
<td>Ralph Marchese</td>
<td>Principal, The Marchese Company</td>
</tr>
<tr>
<td>Member</td>
<td>Rabbi Sheldon Marder</td>
<td>Chaplain/Director, Department of Jewish Life, Jewish Home</td>
</tr>
<tr>
<td>Member</td>
<td>BJ Miller</td>
<td>MD, Director Zen Hospice; Assistant Professor, UCSF</td>
</tr>
<tr>
<td>Member</td>
<td>Kaushik Roy</td>
<td>Executive Director, The Shanti Project</td>
</tr>
<tr>
<td>Member</td>
<td>Michael Smithwick</td>
<td>MBA, Executive Director, Maitri, Residential Care for People Living with AIDS</td>
</tr>
<tr>
<td>Member</td>
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<td>MPH, Family Consultant, Family Caregiver Alliance</td>
</tr>
<tr>
<td>Member</td>
<td>Rabbi Eric Weiss</td>
<td>Executive Director, Bay Area Jewish Healing Center</td>
</tr>
<tr>
<td>Member</td>
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<td>RN, MA, Vice President Mission, Advocacy and Community Health, Saint Francis Memorial Hospital</td>
</tr>
<tr>
<td>Member</td>
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<td>FACHE, Director of Business Strategy, Hospice by the Bay</td>
</tr>
</tbody>
</table>
C. Task Force Members of the Public and Planning Group

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**Betty Fung**, Director of Programs, Self-Help for the Elderly

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**Jeff Newman**, MD MPH, Adjunct Professor, Institute for Health & Aging, UCSF

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**Angela Sun**, PhD, MPH, Executive Director, Chinese Community Health Resource Center

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**Co-Chair Christine Ritchie**, MD, MD MSPH, UCSF Department of Medicine, Division of Geriatrics, Center for Research on Aging, Jewish Home San Francisco

**Kelly Boylan**, Account Executive Ground Floor Public Affairs

**Colleen Chawla**, Deputy Director of Health, Director of Policy & Planning, San Francisco Department of Public Health

**Linda Edelstein**, San Francisco Department of Aging and Adult Services

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**Monique Parrish**, DrPH, MPH, LCSW Task Force Project Manager/Report Writer LifeCourse Strategies

**Sneha Patil**, MPH, Health Program Planner, Office of Policy and Planning, San Francisco Department of Public Health

**Alex Tourk**, Principal Ground Floor Public Affairs

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**Melissa McGee**, Long Term Care Principal Investigator, Facilitator, Long Term Care Coordinating Council, San Francisco Department of Aging and Adult Services

**Carrie Wong**, MSW, MPH, LCSW Director of Long Term Care Operations, San Francisco Department of Aging and Adult Services
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.
E. References

9. Meier DE. Health Care Reform and Palliative Care: Matching Care to Patient’s Needs, in Center to Advance Palliative Care [Audio Conference]: Center to Advance Palliative Care.; 2011.
12. Morrison R.S., Meier D.E. America’s Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation’s Hospitals New York: Center to Advance Palliative Care, National Palliative Care Research Center; 2011.
F. State and National Palliative Care Resources

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


**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](http://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/](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/#](http://coalitionccc.org/#)

**Institute of Medicine**

**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](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/](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](http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Palliative_and_End-of-Life_Care_Measures.aspx)
San Francisco Palliative & Supportive Care Resource Directory

This resource directory is a project of the San Francisco Palliative Care Task Force—a diverse group of representatives from San Francisco’s leading health care and community organizations, advocacy and professional associations, and consumers—committed to meeting San Francisco’s current and future palliative care needs. The directory was created to offer health and social service providers with a summary of currently available dedicated palliative care services and supports in San Francisco.

The organizations listed in this directory are primarily public and non-profit, and many, although not all, were represented on the San Francisco Palliative Care Task Force. This directory should not be considered an exhaustive list of all palliative and supportive care resources in San Francisco.

Resources are first presented in an at-a-glance matrix; individual organizational profiles follow. In both, resources are grouped into the following categories: Hospital and Outpatient Services; Skilled Nursing Facilities; Hospice Services; Community Medical Services; Community Services; Community Services—Caregiver Support; and Community Services—In-Home Support.

Two service directories providing additional resource information that may be needed by palliative care patients and families are listed below:

2-1-1 is an easy-to-remember toll-free number that connects callers with local community services, such as food, shelter, counseling, employment assistance, transportation, quality childcare, etc. 211 is confidential and available 24 hours a day in more than 150 languages. Phone 2-1-1 or go to http://211bayarea.org/san-francisco/.

2014 Guide to Services for Seniors and Adults with Disabilities (prepared by the City and County of San Francisco Department of Aging and Adult Services Intake Program) provides a cross-section of resources for older adults and adults with disabilities, from assistive devices to housing related services, legal services to counseling, and immigration to Lesbian, Gay, Bisexual, Transgender (LGBT) services. The guide can be accessed at http://www.sfdaas.org/135.htm.

Note: the San Francisco Department of Public Health, which publishes this directory, does not recommend or endorse any of the agencies or service providers listed. Please contact Sneha Patil (sneha.patil@sfdph.org) with any complaints or changes related to any agency or service provider listed. Comments and suggestions are welcome.

We thank the following organizations for funding the San Francisco Palliative Care Task Force: the California HealthCare Foundation; the University of California, San Francisco; the San Francisco Department of Aging and Adult Services; California Pacific Medical Center; and, Saint Francis Memorial Hospital. We additionally 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.
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<th>Complementary Therapies Provided</th>
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<tr>
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| California Pacific Medical Center | 3700 California St., SF 94118. | Dr. Catherine Seeley, Medical Director Palliative Care Services, SeeleyCA@sutterhealth.org; Department Offices and Administrative Secretary, 415-600-3190. | Monday-Friday 8:30AM – 5:00PM. | Professional interpreter services available, in person for most common languages and/or remotely for less common languages or after business hours. | • Hospital Medical Services  
• Long-term care  
• Skilled nursing care  
• Rehabilitation services  
• In-Home Medical Services through Seniors at Home and AIM (Advanced Illness Management—a care management and palliative care model)  
• Residential Care through Coming Home Hospice and Irene Swindells Alzheimer’s Residential Program w/acceptance of hospice care as resident’s age in place  
• Social Work Support  
• Chaplain/Spiritual Support  
• Pharmacy Support  
• Psychologist/Psychiatrist  
• Bereavement Services  
• Advance Care Planning  
• Financial Coverage for Palliative Care (Insurance) | CPMC’s Institute for Health and Healing (IHH) clinic offers specialty and preventive integrated medicine, combining contemporary biotechnical approaches and personalized holistic health. Services include:  
• Chinese Medicine  
• Guided Imagery  
• Nutrition consultations and Health Information on topics as requested | Frail, elderly, and memory-impaired patients and their families; organ transplant and end stage organ failure patients, as well as those with complex gastrointestinal disorders; and patients with serious life-threatening illnesses or conditions in their last year or two of life. |
| **Chinese Hospital** | 845 Jackson Street, San Francisco, 94133. | Peggy Cmiel, CNO, 415-677-2478, peggyc@chasf.org. | Monday-Saturday, 8:30AM-5PM. | English, Cantonese, Mandarin, Toisanese. Interpreter phone services available. | • Health and disease education and management  
• Facilitating communication among patient, families, and providers  
• Pain and symptoms management  
• Thorough psychosocial assessment to identify patient needs  
• Disposition planning including appropriate referrals to home care, hospice care, and convalescent homes, arrangement of durable medical equipment  
• Spiritual care and emotional support for patients and families  
• Discussion of Advance Directive  
• Culturally-sensitive discussion | Discussion and practice of relaxation/mind-fullness skills such as deep breathing exercises  
• Massage therapy at hospital  
• Referrals to Chinese Hospital East West Health Services for acupuncture and traditional Chinese Medicine  
• Psychotherapy referrals  
• Referrals to caregiver support groups or cancer support groups | Elderly Chinese immigrants  
Malignancies (all forms of cancer, leukemia)  
Congestive Heart Failure/ cardiovascular disease  
Chronic Obstructive Pulmonary Disease  
Alzheimer’s disease/dementia  
Neurological disease (e.g. stroke, Lou Gehrig’s disease), and Parkinson’s disease |
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<th>Complementary Therapies Provided</th>
<th>Special Populations Served</th>
</tr>
</thead>
</table>
| Kaiser Permanente    | 2425 Geary Blvd., SF     | Leslie McGee, Continuum of Care Services Director, 415-833-3317, Leslie.J.McGee@kp.org; Pamela JD Johnson, Continuum of Care Administration, Pamela.jd.johnson@kp.org. | Most services available seven days a week. | Most languages through personnel on staff or use of language line. | - Hospital Medical Services  
- Outpatient Medical Services  
- Hospice Care  
- Social Work Support  
- Chaplain/Spiritual Support  
- Pharmacy Support  
- Bereavement Services  
- Advance Care Planning  
- Volunteer Caregiver Support  
- Financial Coverage for Palliative Care (Insurance)  
- Health Care Interpreter  
- Caregiver/Family Support  
- Therapy/Counseling/Support Groups  
- Community Medical Providers  
- In-Home Medical Services |                              | Patients with serious, life-threatening illnesses or conditions in their last year or two of life.  
**Hospice Services:** Kaiser Hospice is a service provided in the home with special arrangements made for inpatient care as needed. Patients are admitted to hospice upon order of a Kaiser physician. Contact for Services Indicated: Windi Heaton, 415-833-3655. |                                                                                             |
| Laguna Honda Hospital| 375 Laguna Honda Blvd., SF | Phone: 415-682-1230; Rowena Patel, Nurse Manager, rowena.patel@sfdph.org; Anne Hughes, Adv. Practice Nurse, Anne.hughes@sfdph.org, 415-759-4569. | 24 hour care provided for inpatients. Weekday consultation for new referrals 8AM–5PM. | Mandarin, Spanish, Cantonese, Vietnamese, Punjabi, Tagalog. Audio telephone interpreter 24 hours a day. | - Long-term Care  
- Skilled Nursing Care  
- Rehabilitation Services  
- Outpatient Medical Services  
- Residential Care  
- Hospice Care  
- Social Work Support  
- Chaplain/Spiritual Support  
- Pharmacy Support  
- Psychologist/Psychiatrist  
- Caregiver/Family Support  
- Bereavement Services  
- Therapy/Counseling/Support Groups  
- Direct Care Worker Support  
- Volunteer Caregiver Support  
- Artist Support (see complementary therapies)  
- Health Care Interpreter  
- Special Population Support |                              | Urban poor  
- Substance abusers  
- Mentally ill  
- Non-English speaking patients, in particular Chinese-speaking |
<table>
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<th>Palliative Care Services Provided</th>
<th>Complementary Therapies Provided</th>
<th>Special Populations Served</th>
</tr>
</thead>
</table>
| San Francisco General Hospital | 1001 Potrero Avenue, SF 94110. | Supportive & Palliative Care Service Pager, 415-443-5063; Director, Supportive & Palliative Care Service, 415-206-3303. | On-site: Monday-Friday, 8AM-5PM. Off-site phone consultation with physician available nights, weekends, and holidays. | Professional interpreter services available. | • Hospital Medical Services  
• Social Work Support  
• Chaplain/Spiritual Support  
• Advance Care Planning  
• Health Care Interpreter/Language Capabilities  
• Special Population Support | Assistance with returning patients to country of origin for end-of-life care. | • Trauma victims  
• Immigrants (documented and undocumented)  
• Limited English proficient  
• Homeless  
• LGBT  
• Substance depended  
• Severe and persistent mental illness  
• Incarcerated  
• Unbefriended persons (without any surrogates)  
• Conserved persons (i.e. have court-appointed decision maker) |
| San Francisco Veterans Affairs (VA) Medical Center | 4150 Clement St., SF 94121. | Sharon Ezekiel, LCSW, Palliative Care Coordinator, 415-221-4810 x3224, Sharon.Ezekiel@va.gov; Anne Kelly, LCSW, CLC Hospice Unit Social Worker, 415-221-4810 x4979. Website: www.sanfranciscova.gov/services/Geriatric_Services.asp. | Monday-Friday, 8AM-4:30 PM. | English. | • Hospital Medical Services  
• Hospice Care  
• Skilled Nursing Care (in-contracted)  
• Outpatient Medical Services  
• Hospice Care  
• Social Work Support  
• Chaplain/Spiritual Support  
• Psychologist/Psychiatrist  
• Caregiver/Family Support  
• Bereavement Services  
• Therapy/Counseling/Support Groups  
• Advance Care Planning  
• Direct Care Worker support through referral of the VA’s Homemaker/Home  
• Health Aide program  
• Volunteer Caregiver Support  
• Transportation if the veteran is eligible for VA transportation services  
• Financial Coverage provided by the VA  
• Health Care Interpreter  
• Special Population Support | In the Community Living Center (CLC) hospice unit, services provided through Recreational Therapy are available such as music, art, pet therapy, etc. | Veterans. |
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| St. Francis Memorial Hospital                | 900 Hyde St., SF 94109         | W. Donnie Nelson, Palliative Care Coordinator, 415-353-6859, william.nelson@dignityhealth.org; Dr. Patricia Galamba, Medical Director, 415-928-4920. | Monday-Friday, 8AM-4PM   | Face-to-face interpreters available in Chinese, Spanish, French, Japanese, Russian. Telephone and video interpreters available in numerous languages. | • Hospital Medical Services  
• Social Work Support  
• Chaplain/Spiritual Support  
• Caregiver/Family Support  
• Advance Care Planning  
• Health Care Interpreter/Language Capabilities | • Music therapy  
• Pet support therapy | Chinese, Russian, and LGBT communities, as well as homeless, marginally housed, or underrepresented individuals. |
| St. Mary's Medical Center                    | 450 Stanyan St., SF 94117      | Constance L. Borden, RN, MSN, AN, 415-750-5907, connie.borden@dignityhealth.org. | Monday-Friday, 8AM-5PM   | English, Cantonese, Mandarin.                             | Inpatient palliative consultations.                                                                                                           |                                 | • Frail elderly  
• Asian                                                                                   |
| University of California, San Francisco (UCSF) Moffitt/Long | 505 Parnassus Ave. SF 94143 | 415-476-4838                                                                 | 24/7                     | English.                                                 | • Hospital Medical Services  
• Outpatient Medical Services (Affiliated with Symptom Management Service, Memory and Aging Center, Neurology Outpatient Clinic)  
• Home Medical Services (See House Calls, Bridges)  
• Social Work Support  
• Chaplain/Spiritual Support  
• Pharmacy Support  
• Advance Care Planning  
• Health Care Interpreter | Legacy Project: a free video-recording service for people facing life-threatening illness. We help people record their stories, favorite memories, and messages for loved ones to inherit. | Patients with serious life threatening illnesses or conditions in their last year or two of life. |
| UCSF Helen Diller Family Comprehensive Cancer Center | 1600 Divisadero St., SF, 94115 | 415-885-7671.                                                               | Monday-Friday, 8AM-5PM   | English.                                                 | • Outpatient Medical Services  
• Social Work Support  
• Limited Chaplain/Spiritual  
• Advance Care Planning  
• Health Care Interpreter | Legacy Project: a free video-recording service for people facing life-threatening illness. We help people record their stories, favorite memories, and messages for loved ones to inherit. | Cancer Patients with localized or metastatic disease. |
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<tbody>
<tr>
<td>UCSF Memory and Aging Center</td>
<td>1500 Owens St., Suite 320, SF 94158.</td>
<td>Phone, 415-353-2057; Fax, 415-353-8292.</td>
<td>Monday-Friday, 9AM-5PM.</td>
<td>English, Spanish, French, Cantonese, Mandarin, Arabic, and Tagalog. Translator also available.</td>
<td>• Multidisciplinary evaluations provided by Neurologist, Neuropsychologist, Nurse, Social Worker, Physical Therapist, Genetic Counselor and Pharmacist • Symptom management to maximize patient comfort • Clear communication about goals of care and treatment decisions • Advanced long term care planning • Referrals as needed to community resources • Support and education to family caregivers • Grief counseling</td>
<td>Support groups and supportive counseling for patients and family caregivers; Care Consult Clinic.</td>
<td>Individuals with Alzheimer’s Disease, Vascular Dementia, Frontotemporal Dementia, Lewy Body Disease, Progressive Supranuclear Palsy, Corticobasal Degeneration, Huntington’s Disease, Creutzfeldt-Jakob Disease.</td>
</tr>
<tr>
<td>UCSF Mount Zion</td>
<td>1600 Divisadero St., SF 94115.</td>
<td>415-885-7671.</td>
<td>Monday-Friday, 8AM-5PM.</td>
<td>English.</td>
<td>• Hospital Medical Services • Outpatient Medical Services (Affiliated with Symptom Management Services) • Home Medical Services (Affiliated with UCSF Bridges) • Social Work Support • Chaplain/Spiritual: Limited, as needed • Advance Care Planning Health Care Interpreter</td>
<td>Legacy Project: a free video-recording service for people facing life-threatening illness. We help people record their stories, favorite memories, and messages for loved ones to inherit.</td>
<td>Patients with serious life threatening illnesses or conditions in their last year or two of life.</td>
</tr>
<tr>
<td>UCSF Outpatient Movement Disorder Supportive Care Clinic</td>
<td>1635 Divisadero St., Ste., 520, SF 94115.</td>
<td>Patients need a referral from a physician. Call 415-353-2311 to schedule an appointment.</td>
<td>Fourth Thursday morning of every month, 9AM-12PM.</td>
<td>English, Russian (conversational).</td>
<td>Each patient is evaluated by a multidisciplinary team that includes a nurse practitioner specializing in the management of advanced movement disorders, a neurologist who is fellowship trained in movement disorders, and a social worker with experience working with individuals with advanced movement disorders.</td>
<td>We currently work closely with several physical therapists and speech therapists at UCSF who are specialists in treating patients with advanced movement disorders. We also work closely with the UCSF pain management service, given the prevalence of pain in Parkinson’s disease and atypical parkinsonian syndromes.</td>
<td>Advanced movement disorders include patients with Parkinson’s disease, atypical Parkinsonian syndromes, Huntington’s disease, as well as progressive ataxia, choreiform and dystonia syndromes.</td>
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</table>

**SKILLED NURSING FACILITIES**

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</tr>
</thead>
<tbody>
<tr>
<td>Jewish Home</td>
<td>302 Silver St., SF 94112.</td>
<td>Edwin Cabigao, Head of Nursing Department, 415-334-2500, <a href="mailto:ecabigao@jhsf.org">ecabigao@jhsf.org</a>.</td>
<td>Monday-Friday.</td>
<td>English, Russian, Tagalog, Spanish,</td>
<td>• Long-term Care • Skilled Nursing Care • Rehabilitation Services • Comfort Care/End-of-Life Care</td>
<td>The Jewish Home offers two supportive programs: No One Dies Alone aims to ensure that residents and patients have</td>
<td>The Jewish Home is a geriatric facility, serving people over the age of 65. In some</td>
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<tr>
<td>Palliative Care</td>
<td>Hebrew, Yiddish. The</td>
<td>Richard Nasca, Director, 415-861-1110,</td>
<td>Staff is available 24 hours a day.</td>
<td>Cantonese, Spanish, plus hospital-based interpretive services.</td>
<td>with opportunities to collaborate with outside hospice services care</td>
<td>someone at their side during their final hours, and Kol Haneshamah, which offers volunteer Spiritual Care Partners to those in their final weeks, months, or even years of life. Both programs are grounded in Jewish spiritual values.</td>
<td>special cases, the Home serves younger adults with cognitive illness, physical illness, and/or emotional/mental health illness that require a skilled level of care to promote their highest well-being and greatest level of functioning.</td>
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<tr>
<td>Services</td>
<td>Jewish Home also has access to translation services via CyraCom.</td>
<td><a href="mailto:nascar@sutterhealth.org">nascar@sutterhealth.org</a>; Fax, 415-861-5763.</td>
<td></td>
<td></td>
<td>• Social Work Support • Chaplain/Spiritual Support • Pharmacy Support • Psychologist/Psychiatrist • Caregiver/Family Support • Direct Care Worker Support • Volunteer Caregiver Support • Transportation • Recreation/Activities Support including, but not limited to, arts/crafts, music, poetry, literature, movement/exercise, pets, sensory, creative writing • Special Population Support</td>
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<td>115 Diamond St., SF 94114.</td>
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<td>Also see Laguna Honda Hospital - p. 5.</td>
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<td>Richard Nasca, Director, 415-861-1110,</td>
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<td><a href="mailto:nascar@sutterhealth.org">nascar@sutterhealth.org</a>; Fax, 415-861-5763.</td>
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<tr>
<td>HOSPICE SERVICES</td>
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<tr>
<td>Coming Home Hospice (Sutter Health, California Pacific Medical Center)</td>
<td>115 Diamond St., SF 94114.</td>
<td>Richard Nasca, Director, 415-861-1110, <a href="mailto:nascar@sutterhealth.org">nascar@sutterhealth.org</a>; Fax, 415-861-5763.</td>
<td>Staff is available 24 hours a day.</td>
<td>Cantonese, Tagalog, Spanish, plus hospital-based interpretive services.</td>
<td>Residential Hospice Care • 24-hour Skilled Nursing Care • 24-hour Certified Aide Care • On-going Family Education and Support • Social work Support and Counseling • Spiritual Support and Counseling • Volunteer Services • Dietary Services • Personal Needs Care</td>
<td>Massage • Personal grooming care • Chorale signing groups • Ancillary services as requested</td>
<td>Underserved • Complex medical management • LGBT • Frail</td>
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<td>Hospice by the Bay</td>
<td>1902 Van Ness Ave., #2, SF 94109.</td>
<td>415-626-5900.</td>
<td>24/7, year round.</td>
<td>Chinese and Spanish speaking staff, interpreters for other languages available via language line.</td>
<td>Hospice Care • Therapy/Counseling/Support Group • Advance Care Planning • Hospital Medical Services • Long-term Care • Skilled Nursing Care • Rehabilitation Services • Caregiver/Family Support • Bereavement Services • Volunteer Caregiver Support</td>
<td>As needed.</td>
<td>Patients with serious, life-threatening illnesses or conditions in their last year or two of life.</td>
</tr>
<tr>
<td>Maitri AIDS Hospice</td>
<td>401 Duboce Ave., SF 94117.</td>
<td>Mary Schroeder, Program Director/Intake, 415-558-3006, <a href="mailto:mschroeder@maitrisf.org">mschroeder@maitrisf.org</a>.</td>
<td>24/7.</td>
<td>Tagalog, Spanish.</td>
<td>Residential Care • Hospice Care • Social Work Support • Chaplain/Spiritual Support</td>
<td>Reiki • Massage Therapy • Music therapy</td>
<td>LGBT • People Living with HIV/AIDS</td>
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| Pathways Home Health and Hospice | 395 Oyster Point Blvd. Ste. 128, South SF, 94080. | For all services call 888.755.7855; Visit pathwayshealth.org; Email info@pathwayshealth.org. | 8:30AM - 5PM, 7 days a week, including holidays. Afterhours telephone assistance is available 24 hours a day, as are urgent nursing visits. | American Sign Language, Arabic, Cantonese, Creole, Farsi, Fijian, French, German, Hebrew, Hindi, Ilocano, Italian, Japanese, Korean, Mandarin, Punjabi, Russian, Spanish, Tagalog, Vietnamese. | • Palliative care-certified physician on staff.  
• Nursing visits.  
• Volunteer, social work, and spiritual care visits.  
• Pharmacist  
• Respiratory Therapist  
• Dietician  
• Telemonitoring for remote daily monitoring of vital signs  
• Nurse on-call 24 hours a day for telephone consultation | • Aromatherapy  
• Comfort touch  
• Music sessions  
• Pet therapy (as available) | Pathways sees all populations and does not discriminate based on race, religion, sex, sexual orientation, or any other culture with which our patients may identify. |
| Sutter Care at Home           | 1625 Van Ness Ave, #4, SF 94109. | Home Health Agency, 415-600-0410; AIM/Hospice, 415-749-4201. | Office 8AM-5:30PM (Clinical Services provided 24/7). | Tagalog, Spanish, Indonesian, Malay, Cantonese, Mandarin, Russian. Select patient engagement materials also translated into 15-20 languages. Interpreters for other languages available via language line. | • AIM (Advanced Illness Management) is a care management and palliative care model serving persons with advancing illness in the last 12-18 months of life.  
• AIM Home Health (home based skilled clinical services, patient must meet skilled criteria per Medicare Guidelines. Care provided by nurses, physical therapist, occupational therapists, social workers, speech therapist, home health aide, and other ancillary services e.g. Dietician)  
• AIM Transitions Care (home based skilled care provided by nurses (RN, LVN) & Social Workers (MSW)) | • Private home  
• Residential Care Facilities for the Elderly (RCFE)  
• Skilled nursing  
• Single Room Occupancy (SROs)  
• Acute care Hospital  
• Hospice facility  
• All diseases, though most commonly are chronic illnesses  
• All payers |
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</table>
| Zen Hospice Project| 273 Page St., SF 94102 | General: 415-913-7682; Nurse Director Mary Knopf, [mary@zenhospice.org](mailto:mary@zenhospice.org); Education Director Shelley Adler, [shelley@zenhospice.org](mailto:shelley@zenhospice.org); Volunteer Director Roy Remer, [roy@zenhospice.org](mailto:roy@zenhospice.org). | We staff the Guest House twenty-four hours a day, seven days a week. | Spanish and Korean spoken by staff. For all other languages, we employ a telephone-based interpreter service. | • AIM Telesupport (telephonic support provided by nurses (RN))  
• Hospice Care (patient must meet hospice eligibility criteria to qualify) | • Psychotherapy  
• Massage  
• Music thanatology  
• Reiki  
• Acupuncture, etc. | • Homeless and underserved  
• Complex illness  
• LGBT  
• Families  
• Caregivers |
| On Lok Lifeways    | 1333 Bush St., SF 94109 | Grace Li, 415-292-888, [graceli@onlok.org](mailto:graceli@onlok.org). | Mon.-Fri. 8AM-4:30PM for PACE Centers, Clinic on Saturdays, and after-hours on-call medical provider. | English, Spanish, Mandarin, Cantonese, Toishanese, Tagalog, and Korean. | • Long-term care  
• Skilled nursing care  
• Rehabilitation services  
• Outpatient Medical Service  
• Community Medical Providers  
• In-Home Medical Services  
• Social Work Support  
• Chaplain/Spiritual Support  
• Pharmacy Support  
• Psychologist/Psychiatrist  
• Caregiver/Family Support  
• Bereavement Services  
• Therapy/Counseling/Support Group  
• Advance Care Planning  
• Direct Care Worker Support  
• Transportation  
• Home/Building Modifications-Architecture  
• Health Care Interpreter  
• Special Population Support | • Nutrition services & home delivered meals  
• Home care  
• Adult day health services (nursing, recreation and rehabilitation therapies, social work, personal care)  
• Primary medical care  
• Prescription medications  
• Transportation  
• Diagnostics  
• Dental  
• Optical  
• Hearing  
• Podiatry care  
• Acute hospital care  
• Nursing home care | Patients with serious, life-threatening illnesses or conditions in their last year or two of life, and frail elders who require a nursing facility level of care. |
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| UCSF Bridges Program                                 | 3333 California St., #380, SF 94118.                                     | 415-514-3577.                      | Mon.-Fri. 8AM-5PM.       | In-person translation offered for all languages. | • MD assessment, counseling and treatment for the physical and emotional effects of serious illness
• Assistance with medical decision-making and advance care planning
• Linkage to community resources
• Close collaboration with the patients’ primary care physician, specialists, family members, caregivers, etc. |                                |                                                                                                                  |
| COMMUNITY SERVICES                                   |                                                                          |                                    |                          |                                       | |                                                                                                                |                                | Primarily Jewish and Jewishly connected patients who are ill, at end of life, or living with grief.                |
| Bay Area Jewish Healing Center                       | 2530 Taraval St., Ste. 202, SF 94116.                                   | Gail Kolthoff, Executive Assistant, 415-750-4197, jewishhealing@bajhc.org. | Weekdays. Other hours by pre-arrangement. | English, Hebrew. | • Chaplain/Spiritual Support
• Caregiver/Family Support
• Bereavement Services
• Counseling/Support Groups
• Advance Care Planning
• Direct Care Worker Support
• Volunteer Caregiver Support
• Special Population Support |                                |                                                                                                                  |
| CARE                                                 | 1001 Potrero Ave., SF 94110.                                            | Sylvia Romero-Pagan, 415-206-5912, romero-pagans@hemeonc.ucsf.edu. | English group: Tues., 5:30 - 7:30PM; Spanish group: Thurs., 5:30 - 7:30PM; Chinese group: Mon., 1:30 – 3:30PM. | English, Spanish, Cantonese. | We periodically offer sessions on advance care planning. We consider the program itself a form of complementary medicine. We regularly offer sessions on topics such as acupuncture, massage, qi gong, etc. |                                | Medically underserved cancer patients who receive their care and treatment at San Francisco General Hospital. |
| San Francisco Bay Area Network for End-of-Life Care  | 50 Cole St. SF 94117                                                    | Nate Hinerman, Ph.D., Dean, Undergraduate Programs, Golden Gate University 415 422-2314 http://www.sfeol.org/ | Weekdays                 |                                       | • Offer free Physician Orders for Life Sustaining Treatment Support
• Community-building and networking for hospice workers, healthcare professionals, grief counselors, clergy, volunteers and others who provide end-of-life care in the Bay Area.
• Continuing education to ensure excellence and cultural competence in end-of-life services.
• Educational programs and |                                |                                                                                                                  |
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<tr>
<td>Shanti Project – HIV Services Programs</td>
<td>730 Polk St., #3, SF 94109.</td>
<td>For information on how to enroll in general HIV Services, please contact Eric Sutter, 415-674-4754. For information on Shanti LIFE Program® activities, please contact Jackson Bowman, 415-674-4755.</td>
<td>Various services hold different hours. See organization profile for detail.</td>
<td>English, Spanish.</td>
<td>Shanti’s HIV Services Programs include Care Navigation, Peer Advocacy, Integrated Case Management (in collaboration with Westside Community Services), Educational Workshops and other HIV Self-Management Programming (Shanti LIFE Program®), and Volunteer Peer Support. All HIV Services staff and volunteers provide palliative care for people confronting end-of-life issues through on-going practical and emotional support that helps to reduce pain and social isolation, and assist clients in securing end-of-life resources from community partners.</td>
<td>Free canine-therapy, weekly yoga, weekend retreats for long-term survivors, and free tickets to local social and cultural events (theatre, sports and music events, etc…)</td>
<td>Clients in Shanti’s HIV Services Program come from San Francisco’s most disenfranchised and at-risk populations. See organization profile for more information.</td>
</tr>
<tr>
<td>Shanti Project – Margot Murphy Breast Cancer Program</td>
<td>730 Polk St., #3, SF 94109.</td>
<td>Please contact 415-674-4780 for more information on how to enroll or refer in our program.</td>
<td>Mon.-Fri., 9AM-5PM – by appointment only.</td>
<td>Cantonese, English, Mandarin, Spanish.</td>
<td>Shanti’s Margot Murphy Breast Cancer Program serves clients from initial diagnosis of breast cancer through active treatment, and for a period following the end of active treatment. In Care Navigation, we provide intensive case management services and emotional support, including assistance for women and men who are receiving palliative care and confronting end-of-life issues.</td>
<td>We offer free massage, yoga, Qi Gong, and Reiki sessions at our office for all breast cancer clients.</td>
<td>Low-income women of color comprise a majority of Shanti’s breast cancer client population: 72% are Asian (primarily Cantonese speakers), Latina, or African American. The majority of our clients are over the age of 55 and face significant medical and day-to-day challenges.</td>
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**COMMUNITY SERVICES – CAREGIVER**

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</table>
| Family Caregiver Alliance | 785 Market St., #750, SF 94103. | 415-434-3388 or 800-445-8106, www.caregiver.org. | Mon.–Fri., 9AM-5PM. | English, Spanish. FCA subcontracts with other organizations to facilitate our services in other languages. | • Caregiver/Family Support  
• Therapy/Counseling/Support Groups  
• Social Work Support  
• Advance Care Planning  
• Special Population Support  
• Legal/Advocacy Support | Activities at respite retreats for family caregivers may include art therapy, drumming circles, and other holistic activities to help caregivers with stress management and self-care. | FCA serves family and unpaid caregivers of older adults and those with cognitive or neurological impairments. Support group offered specifically for Spanish-speaking caregivers and an |
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<th>Program Name</th>
<th>Address</th>
<th>Contact/Phone</th>
<th>Hours of Operation</th>
<th>Languages Spoken</th>
<th>Palliative Care Services Provided</th>
<th>Complementary Therapies Provided</th>
<th>Special Populations Served</th>
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<td><strong>COMMUNITY SERVICES – IN-HOME SUPPORT</strong></td>
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<td>online support group for LGBT caregivers.</td>
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<tr>
<td><strong>In-Home Supportive Services Consortium</strong></td>
<td>1035 Market St, Ste. L-1, SF 94103.</td>
<td>Margaret Baran, Executive Director In-Home Supportive Services Consortium, 415-255-2079, <a href="mailto:mbaran@ihssco.org">mbaran@ihssco.org</a>; In-Home Supportive Services Consortium: <a href="http://www.ihssco.org">www.ihssco.org</a> Training Academy for Personal Care Assistants (TAPCA): <a href="http://www.tapca.org">www.tapca.org</a> TAPcare online registry: <a href="http://www.tap-care.org">www.tap-care.org</a>.</td>
<td>6AM–9PM.</td>
<td>Cantonese, English, French, German, Mandarin, Russian, Samoan, Spanish, Swedish, Tagalog, Taishanese, Tigrinya, Tongan, Ukrainian, Vietnamese.</td>
<td>IHSS assists consumers who have chronic and acute behavioral health and medical health issues to live safely and independently in their homes. Provide assistance with domestic and personal care services, accompaniment to medical appointments, assistance with medication, etc., based on the consumer’s specialized care plans and delivered by compassionate, well-trained personal care assistants (home care workers).</td>
<td>Elderly and people with disabilities.</td>
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</tr>
<tr>
<td><strong>Jewish Family and Children’s Services</strong></td>
<td>2150 Post St, SF 94115.</td>
<td>Seniors at Home/JFCS Intake line: 415-449-3700; Redwing Keyssar, 415-449-3749, <a href="mailto:redwing@jfcs.org">redwing@jfcs.org</a>; <a href="http://www.seniorsathome.org">www.seniorsathome.org</a> <a href="http://www.jfcs.org">www.jfcs.org</a>.</td>
<td>Mon.-Fri. 8:30AM-5PM. Intake open on Saturdays.</td>
<td>English, Hebrew, Russian, Spanish.</td>
<td>• Patient Consultation/support • Social Work Support • Chaplain/Spiritual Support • Caregiver/Family Support • Bereavement Services • Therapy/Counseling/Support Groups • Advance Care Planning • Direct Care Worker Support • Volunteer Caregiver Training/Support • Limited Transportation Services • Legal/Advocacy Support • Special Population Support</td>
<td>Homecare and care management services, as well as subsidies for consultations and homecare services.</td>
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<tr>
<td><strong>San Francisco In-Home Supportive Services Public Authority</strong></td>
<td>832 Folsom St, 9th Fl., SF 94107.</td>
<td></td>
<td>Weekdays.</td>
<td>English, Russian, Spanish, Mandarin, Cantonese.</td>
<td>• In-Home Care • Caregiver/Family Support</td>
<td>In-home support, including meal preparation, cleaning, and personal needs care.</td>
<td>Low-income adults with disabilities and seniors who would prefer staying home compared to an institutionalized care.</td>
</tr>
<tr>
<td><strong>Self-Help for the Elderly</strong></td>
<td>731 Sansome St., Ste. 100, SF 94111.</td>
<td>Phone: 415-677-7628; Fax: 415-398-5903; Email: <a href="mailto:info@selfhelpelderly.org">info@selfhelpelderly.org</a>; Website: <a href="http://www.selfhelpelderly.org">www.selfhelpelderly.org</a>.</td>
<td>24/7.</td>
<td>English, Cantonese, Mandarin, Toishanese.</td>
<td>• Home Medical Services • Hospice Care • Chaplain/Spiritual Support • Caregiver/Family Support • Bereavement Services • Therapy/Counseling/Support Groups</td>
<td>Monolingual Chinese patients who speak only Cantonese or Mandarin.</td>
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<td>Program Name</td>
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Program Overview: With generous support from our philanthropic partners, the palliative care team at California Pacific Medical Center (CPMC) started in 2004. Since that time, our Palliative Care Service has been considered integral to the fabric of patient care and physician education at CPMC. On average the palliative care team works with upwards of 1,100 new patients each year. Roughly a third of the consults are from the Intensive Care Unit (ICU), and a third from oncology teams. Geriatric frailty and end-stage organ disease account for many of the consultations. The team includes fellowship trained and boarded (hospice and palliative medicine) physicians and nurse practitioners.

In addition to inpatient clinical services, the team provides:

- Resident education during a two-week core elective, and weekly psycho-oncology support group
- Assistance with complex care planning and coordinated efforts with Case Management, Social Work, and Spiritual Care staff
- Integrated services with a dedicated supportive volunteer team, bereavement services, Institute for Health and Healing (IHH), and AIM (Advanced Illness Management) and Hospice liaison via weekly meetings, in addition to daily coordination—as needed
- A continuum of care from the Emergency Department, through the ICU and medical-surgical specialties to post acute Skilled Nursing Facility (SNF) care, residential hospice and dementia care, as well as continuing care through Sutter Care at Home
- Staff education via Noon Conferences, Grand Rounds, End-of-Life Nursing Education Consortium (ELNEC) conferences, and didactics to departments such as social work, case management, rehabilitation and the community
- Participation in philanthropy, research, and quality improvement projects

Palliative Care Services Provided:
- Hospital Medical Services
- Long-term Care
- Skilled Nursing Care
- Rehabilitation Services
- In-Home Medical Services through Seniors at Home and AIM
- Residential Care through Coming Home Hospice and Irene Swindells Alzheimer’s Residential Program w/acceptance of hospice care as resident’s age in place.
- Social Work Support
- Chaplain/Spiritual Support
- Pharmacy Support
- Psychologist/Psychiatrist
- Bereavement Services
- Advance Care Planning
- Financial Coverage for Palliative Care (Insurance)

Palliative Care Services Planned:
- Outpatient Medical Services
- Increased integration with Home care Services Sutter Care at Home (SCAH) and AIM
- On call system for 24/7 coverage
Complementary Therapies Provided: CPMC’s IHH clinic offers specialty and preventive integrated medicine, combining contemporary biotechnical approaches and personalized holistic health. A few of the services include: Chinese medicine; guided imagery; nutrition consultations and health information on topics as requested.

Special Populations Served: Frail, elderly, and memory-impaired patients and their families; organ transplant and end stage organ failure patients, as well as those with complex Gastrointestinal Disorders; and, patients with serious life-threatening illnesses or conditions in their last year or two of life.

Language(s) Spoken: Professional interpreter services available, in person for most common languages and/or remotely for less common languages or after business hours.

Organizational Liaisons:
- Sutter Care at Home and AIM
- Swindell’s Residential and Day Treatment Services
- Family Health Center (CPMC/ Sutter Pacific Medical Foundation-SPMF)
- Institute for Health and Healing (CPMC)
- Brian Hemming Cancer Center (CPMC)
- Brown & Toland Medical Group
- Sutter Pacific Medical Foundation (SPMF)
- Hospice by the Bay
- Maitri
- Zen Hospice

Hours: Monday-Friday, 8:30AM – 5:00PM on site. All other hours - emergency phone consultations only.

Contact for Services Indicated: Medical Director Palliative Care Services: Dr. Catherine Seeley (SeeleyCA@sutterhealth.org); Department Offices and Administrative Secretary: 415-600-3190.
Program Overview: The main focus of our Palliative Care Services program is improving patient quality of life: we help patients and their families better understand serious illness, experience less physical and emotional discomfort, and adjust their expectations and decision-making—within the framework of their disease. The Palliative Care Team is chaired by the Chief Nursing Officer, along with a physician champion, and three core providers: a clinical nurse specialist, social worker, and chaplain, all of whom work with the patient’s primary care physician, consultants, pharmacist, dietitian, and floor nurses.

Palliative Care Services Provided:
- Health and disease education and management
- Facilitating communication among patient, families, and providers
- Pain and symptoms management
- Thorough psychosocial assessment to identify patient needs
- Disposition planning including appropriate referrals to home care, hospice care, and convalescent homes, arrangement of durable medical equipment
- Spiritual care and emotional support for patients and families
- Discussion of Advance Directive
- Culturally-sensitive discussion about end-of-life care

Palliative Care Services Planned:
- Individualized plan of care according to patient and family needs
- Referrals from physicians, palliative care team members, patients and families, or any hospital staff members
- Ongoing follow up for patients with multiple needs and concerns to ensure smooth transitions to home with arranged services or to nursing home facilities

Complementary Therapies Provided:
- Discussion and practice of relaxation/mindfulness skills such as deep breathing exercises
- Massage therapy at hospital
- Referrals to Chinese Hospital East West Health Services for acupuncture and traditional Chinese Medicine
- Psychotherapy referrals
- Referrals to caregiver support groups or cancer support groups

Special Populations Served: The majority of patients at Chinese Hospital are first generation, elderly Chinese immigrants. Many are on Medicare and Medi-Cal. The Palliative Care Team primarily focuses on patients with the following serious illnesses:
- Malignancies (all forms of cancer, leukemia)
- Congestive Heart Failure/ cardiovascular disease
- Chronic Obstructive Pulmonary Disease
- Alzheimer’s disease/dementia
- Neurological disease (e.g. stroke, Lou Gehrig’s disease), and Parkinson’s disease
- Chronic debilitating infections
- Multisystem failure / Malnutrition/ Failure to thrive

Language(s) Spoken: The Palliative Care Clinical Nursing Specialist, social workers, and chaplain speak other languages including Cantonese, Mandarin, and Toisanese (a common Chinese dialect in San
Francisco). Interpreter phone services are used for patients and family speaking other languages other than Chinese and English.

**Organizational Liaisons:**
- Local Hospice and Home Health agencies
- Nursing home facilities and convalescent homes
- Adult Day Care Centers
- Chinese Community Health Resources Center (CCHRC)
- Outpatient Specialty Clinics
- San Francisco Transitional Care Program (SFTCP)

**Hours:** Monday- Saturday, 8:30AM – 5PM, for hospital patients only.

**Contact for Services Indicated:** Peggy Cmiel, CNO, 415-677-2478, peggyc@chasf.org.
KAISER

Program Overview: Kaiser Permanente is recognized as one of America’s leading health care providers and not-for-profit health plans. Kaiser currently serves approximately 9.3 million members in eight states and the District of Columbia. Founded in 1945, Kaiser’s mission is to provide high-quality, affordable health care services and to improve the health of Kaiser members and the communities we serve. Care for members and patients is focused on member total health and is guided by members’ personal physicians, specialists, and teams of caregivers. Industry-leading technology advances and tools for health promotion, disease prevention, care delivery, and chronic disease management, support Kaiser’s expert medical teams. Kaiser’s vision is to be the leader in Total Health by making lives better.

Palliative Care Services Provided:
- Hospital Medical Service
- Outpatient Medical Services
- Social Work Support
- Chaplain/Spiritual Support
- Pharmacy Support
- Bereavement Services
- Advance Care Planning
- Volunteer Caregiver Support
- Financial Coverage (Insurance)
- Health Care Interpreter: Current
- Caregiver/Family Support: Current
- Therapy/Counseling/Support Groups
- Community Medical Providers
- Home-Based Services
- Hospice Care*

Palliative Care Services Planned:
- Long-Term care
- Rehabilitation care
- Skilled nursing care
- Direct Care Workers

Special Populations Served: Patients with serious life threatening illnesses or conditions in their last year or two of life.

Language(s) Spoken: Most languages through personnel on staff or use of language line.

Hours: Most services are available seven days per week.

Contact for Services Indicated: Pamela JD Johnson, Continuum of Care Administration, pamela.jd.johnson@kp.org.

*Hospice Services: Kaiser Hospice is a service provided in the home with special arrangements made for inpatient care as needed. Patients are admitted to hospice upon order of a Kaiser physician.

Contact for Services Indicated: Windi Heaton, 415-833-3655.
LAGUNA HONDA HOSPITAL

Program Overview: Laguna Honda operates a sixty-bed inpatient Palliative Care Program that cares for adults with progressive and terminal illnesses in a large publicly owned and operated long-term care facility. The Palliative Care Program has been in existence for twenty-five years and has transitioned from a pure hospice identity to a palliative program. Admission criteria include the following: the patient must be a San Francisco resident, need for skilled nursing care, and accept a palliative plan of care. In addition, palliative care consultation is available in outpatient clinic and on inpatient units.

Palliative Care Services Provided:

- Long-term Care
- Skilled Nursing Care
- Rehabilitation Services
- Outpatient Medical Services
- Residential Care
- Hospice Care
- Social Work Support
- Chaplain/Spiritual Support
- Pharmacy Support
- Psychologist/Psychiatrist
- Caregiver/Family Support
- Bereavement Services
- Therapy/Counseling/Support Groups
- Direct Care Worker Support
- Volunteer Caregiver Support
- Artist Support (see below for complementary therapies)
- Health Care Interpreter
- Special Population Support

Complementary Therapies Provided: Acupuncture, massage therapy, medical Qi Gong, music therapy, art therapy, and hypnotherapy available.

Special Populations Served: Urban poor, substance abusers, mentally ill, and non-English speaking patients, in particular Chinese-speaking.

Language(s) Spoken: Bilingual staff and volunteers speak Mandarin, Spanish, Cantonese, Vietnamese, Punjabi, and Tagalog. Audio telephone interpreter is available twenty-four hours a day.

Organizational Liaisons:

- Part of San Francisco Health Network
- Zen Hospice Project partner
- Chinese American Coalition for Compassionate Care partner

Hours: Twenty-four hour care provided for inpatients on sixty-bed unit. Weekday consultation for new referrals is available Monday-Friday, 8AM-5PM.

Contact for Services Indicated: South 3 tel. 415-682-1230; Nurse Manager: Rowena.patel@sfdph.org; Advanced Practice Nurse: Anne.hughes@sfdph.org, 415-759-4569; http://lagunahonda.org/Palliative%20and%20Hospice%20Care.
SAN FRANCISCO GENERAL HOSPITAL

Program Overview: The Supportive & Palliative Care Service at San Francisco General Hospital provides interdisciplinary palliative care services for hospitalized patients and their families. Services are obtained through physician-ordered consultation, although non-physician staff, patients, and family members are encouraged to advocate for consultation when palliative care services are desired. The interdisciplinary team provides expert symptom management, values/goals clarification, education regarding hospice and community support services, advance care planning, and staff support.

Palliative Care Services Provided:
- Hospital Medical Services
- Social Work Support
- Chaplain/Spiritual Support
- Advance Care Planning
- Health Care Interpreter/Language Capabilities
- Special Population Support

Palliative Care Services Planned: Outpatient Medical Services.

Complementary Therapies Provided: Assistance with returning patients to country of origin for end-of-life care.

Special Populations Served: Trauma victims, immigrants (documented and undocumented), limited English proficient, homeless, LGBT, substance dependent, severe and persistent mental illness, incarcerated, unbefriended persons (without any surrogates), and conserved persons (i.e. have court-appointed decision maker).

Language(s) Spoken: Professional interpreter services available, in-person (for most common languages, during business hours), and/or remotely (for less common languages, or after business hours).

Organizational Liaisons:
- Part of San Francisco Health Network
- Laguna Honda Hospital (Hospice/Palliative Care Unit)
- Department of Public Health “Health at Home” Program
- Medical Respite & Sobering Center
- Palliative Care Quality Network
- UCSF School of Medicine

Hours: Services provided on-site Monday-Friday, 8AM-5PM (excluding holidays). Off-site phone consultation with physician available nights, weekends, and holidays.

Contact for Services Indicated: Supportive & Palliative Care Service Pager 415-443-5063; Director, Supportive & Palliative Care Service 415-206-3303; http://hospital-sfgh.medicine.ucsf.edu/services/palliative.html.
Program Overview: The San Francisco Veterans Affairs Medical Center’s (SFVAMC) Palliative Care Program consists of a Palliative Care clinic where visits occur in-person, by telephone, or via video teleconferencing with our Community Based Outpatient Clinics. The clinic is held on Tuesdays, Wednesdays, and Thursdays. The program also has an inpatient Hospice and Palliative Care Consult Team that serves the SFVAMC’s acute care hospital and onsite Community Living Center (CLC), and a 10-bed hospice unit within the CLC. The Hospice and Palliative Care team is interdisciplinary and consists of physicians, nurse practitioners, nurses, social workers, chaplains, psychologists, other disciplines most of whom have certification and/or advanced training in Palliative Care and end-of-life care. All veterans are eligible for hospice care services, at home or in an inpatient setting.

Palliative Care Services Provided:
- Hospital Medical Services
- Hospice Care
- Skilled Nursing Care (in-contracted)
- Outpatient Medical Services
- Hospice Care
- Social Work Support
- Chaplain/Spiritual Support
- Psychologist/Psychiatrist
- Caregiver/Family Support
- Bereavement Services
- Therapy/Counseling/Support Groups
- Advance Care Planning
- Direct Care Worker support through referral of the VA’s Homemaker/Home Health Aide program
- Volunteer Caregiver Support
- Transportation if the veteran is eligible for VA transportation services
- Financial Coverage provided by the VA
- Health Care Interpreter
- Special Population Support

Complementary Therapies Provided: In the CLC hospice unit, services provided through Recreational Therapy are available such as music, art, pet therapy, etc.

Special Populations Served: Veterans.

Language(s) Spoken: English.

Organizational Liaisons: We work with community agencies for contracted support, such as community/home hospice agencies, home health agencies, etc.

Hours: Monday-Friday, 8:00AM – 4:30PM.

Contact for Services Indicated: Sharon Ezekiel, LCSW, Palliative Care Coordinator: 415-221-4810 x3224, Sharon.Ezekiel@va.gov; for Referral to the CLC hospice unit: Anne Kelly, LCSW, CLC Hospice Unit Social Worker, 415-221-4810 x4979; www.sanfrancisco.va.gov/services/Geriatric_Services.asp.
ST. FRANCIS MEMORIAL HOSPITAL

Program Overview: Saint Francis Memorial Hospital has developed a Palliative Care Program to address the needs of patients suffering from chronic or terminal illness when control of symptoms interferes with the achievement of the best quality of life for patients and their families. The Palliative Care team strives to address symptom management problems including pain and other stressful physical symptoms as well as any psychological, social, or spiritual needs.

The interdisciplinary Palliative Care team consists of a medical director, a nurse practitioner, staff nurses, physicians, chaplains, social workers, and case managers. From diagnosis to discharge, or end of life, the team works with patients and their loved ones to help them understand their prognoses and options. Through advanced care planning—including completion of Advance Directives—the patient and family are assisted in determining which interventions and medical care they desire. The patient and family are also educated about the disease process and options for care after hospitalization.

In collaboration with the attending physician, the Palliative Care team focuses on developing a trusting relationship with the patient and family, providing information to both throughout the course of treatment and the dying process.

Palliative Care Services Provided:
- Hospital Medical Services
- Social Work Support
- Chaplain/Spiritual Support
- Caregiver/Family Support
- Advance Care Planning
- Health Care Interpreter/Language Capabilities

Palliative Care Services Planned:
- Early intervention through emergency room evaluation
- Enhancement of interventional palliative care in critical care units

Complementary Therapies Provided: Music therapy and pet support therapy.

Special Populations Served: Chinese, Russian, and LGBT communities, as well as homeless, marginally housed, or underrepresented individuals.

Language(s) Spoken: Face to Face interpreters available in Chinese, Spanish, French, Japanese, and Russian. Telephone and video interpreters available in numerous languages.

Organizational Liaisons:
- San Francisco Bay Area Jewish Healing Center: 415-750-4197
- Catholic Charities/ Grief Care: 415-564-7882
- Coming Home Hospice: 415-861-1110
- Family Caregiver Alliance: 415-434-3388
- Hospice by the Bay: 415-626-5900
- Jewish Family & Children's Services: 415-449-1200
- Laguna Honda Hospice: 415-759-3375
- Latina Breast Cancer Agency Support Services: 415-584-3444
- Pastoral Care Department Institute for Health and Healing: 414-600-3939
• Pathways Hospice: 415- 567-3973
• HAND-Support after Neonatal Death: 415-282-7330
• Self Help for the Elderly: 415-982-9171
• Visiting Nurses and Hospice of San Francisco: 415-600-0400
• Zen Hospice Project: 415-863-2910
• Asian Network Hospice 415-345-9797
• Sutter VNA & Hospice 415-600-0444

**Hours:** Monday-Friday, 8AM-4PM.

**Contact for Services Indicated:** W. Donnie Nelson – Palliative Care Coordinator, 415-353-6859, william.nelson@dignityhealth.org; Dr. Patricia Galamba – Medical Director, 415-928-4920.
**ST. MARY’S MEDICAL CENTER**

**Program Overview:** St. Mary’s Palliative Care Consult Service is in its eleventh year of operation. We provide consultations to persons with serious illnesses and their families and loved ones. We work in partnership with the primary physician and team.

**Palliative Care Services Provided:**
- Inpatient palliative consultations
- Reducing or controlling pain or debilitating symptoms
- Counseling patients and families/loved ones when making difficult decisions
- Listening and providing support through all stages of illness
- Discussion of treatment choices, including hospice referrals and coordination of in-patient comfort care

**Special Populations Served:**
- Frail elderly
- Asian

**Language(s) Spoken:** Hospital provides a translator for Cantonese and Mandarin.

**Hours:** Monday-Friday, 8AM-5PM. Pager coverage weeknights and weekends.

**Contact for Services Indicated:** Constance L. Borden, RN, MSN, ANP; 415-750-5907; Connie.borden@dignityhealth.org.
Program Overview: The Palliative Care Service at UCSF Medical Center (Moffit/Long Hospital) is dedicated to the care and comfort of seriously ill patients and their families. The goal of the service is to maximize a patient's comfort, while providing appropriate medical treatment in the advanced stage of illness. In addition, the Palliative Care Service includes a two-bed hospital unit, the Comfort Care Suites that provides a more home-like setting for patients and their families.

Palliative Care Services Provided:
- Hospital Medical Services
- Outpatient Medical Services (Affiliated with Symptom Management Service, Memory and Aging Center, Neurology Outpatient Clinic)
- Home Medical Services (See House Calls, Bridges)
- Social Work Support
- Chaplain/Spiritual Support
- Pharmacy Support
- Advance Care Planning
- Health Care Interpreter

Palliative Care Services Planned:
- Outpatient non-cancer palliative care services.
- Expansion of the Palliative Care Service (inpatient)

Complementary Therapies Provided: Legacy Project: a free video-recording service for people facing life-threatening illness. We help people record their stories, favorite memories, and messages for loved ones to inherit.

Special Populations Served: Patients with serious life threatening illnesses or conditions in their last year or two of life.

Language(s) Spoken: English only by palliative care team members.

Hours: 24 hours a day/7 days a week.

Contact for Services Indicated: 415-476-4838.
UCSF HELEN DILLER FAMILY COMPREHENSIVE CANCER CENTER—SYMPTOM MANAGEMENT SERVICE

Program Overview: The Symptom Management Service offers outpatient Palliative Care Co-Management Service consultations to improve the quality of life and care for patients at UCSF’s Helen Diller Family Comprehensive Cancer Center. The Service works collaboratively with Mt. Zion’s Symptom Management and Palliative Care Consultation Service and the outpatient Bridges Program.

Palliative Care Services Provided:
- Outpatient Medical Services
- Social Work Support
- Limited Chaplain/Spiritual Support
- Advance Care Planning
- Health Care Interpreter

Palliative Care Services Planned:
- “Pre-Habilitation Program” (preparing frail elderly for high-risk surgery)
- Home-based PC service as a collaboration with palliative care services at Jewish Family and Children’s Services and UCSF Bridges (Community Bridges)

Complementary Therapies Provided: The Symptom Management Service Notes Project which aims to help people with serious illness to record their thoughts, to share their stories, and to reflect on their memories and relationships, and the Legacy Project, a free video-recording service for people facing life-threatening illness. We help people record their stories, favorite memories, and messages for loved ones to inherit.

Special Populations Served: Cancer patients with localized or metastatic disease.

Language(s) Spoken: English.

Organizational Liaisons: Helen Diller Family Comprehensive Cancer Center.

Hours: Monday-Friday, 8AM-5PM.

Contact for Services Indicated: 415-885-7671.
UCSF MEMORY & AGING CENTER

Program Overview: UCSF Memory & Aging Center (MAC) provides diagnosis and care for people with neurodegenerative illnesses in clinic and research settings.

Palliative Care Services Provided:
- Multidisciplinary evaluations provided by Neurologist, Neuropsychologist, Nurse, Social Worker, Physical Therapist, Genetic Counselor and Pharmacist
- Symptom management to maximize patient comfort
- Clear communication about goals of care and treatment decisions
- Advanced long term care planning
- Referrals as needed to community resources
- Support and education to family caregivers
- Grief counseling

Palliative Care Services Planned: Care Ecosystem- http://www.ucsf.edu/news/2014/06/115476/dementia-care-%E2%80%9Cecosystem%E2%80%9D-bring-online-respite-caregivers.

Complementary Therapies Provided: Support groups and supportive counseling for patients and family caregivers; Care Consult Clinic.

Special Populations Served: Individuals with Alzheimer’s Disease, Vascular Dementia, Frontotemporal Dementia, Lewy Body Disease, Progressive Supranuclear Palsy, Corticobasal Degeneration, Huntington’s Disease, Creutzfeldt-Jakob Disease.

Language(s) Spoken: All languages available with UCSF translator services. In-house languages include English, Spanish, French, Cantonese, Mandarin, Arabic, and Tagalog.

Organizational Liaisons: UCSF Palliative Care Program.

Hours: Monday-Friday, 9AM-5PM.

Contact for Services Indicated:
UCSF Memory and Aging Center
1500 Owens Street, Suite 320
San Francisco, CA 94158
Phone: 415-353-2057
Fax: 415-353-8292.
UCSF/MOUNT ZION–SYMPTOM MANAGEMENT AND PALLIATIVE CARE CONSULTATION SERVICE

Program Overview: The Symptom Management and Palliative Care Consultation Service at Mount Zion provides comprehensive palliative care team support for patients with advanced illness.

Palliative Care Services Provided:
- Hospital Medical Services
- Outpatient Medical Services (Affiliated with Symptom Management Services)
- Home Medical Services (Affiliated with UCSF Bridges)
- Social Work Support
- Limited Chaplain/Spiritual Support
- Advance Care Planning
- Health Care Interpreter

Palliative Care Services Planned: “Pre-Habilitation Program” (preparing frail elderly for high-risk surgery).

Complementary Therapies Provided: Legacy Project: a free video-recording service for people facing life-threatening illness. We help people record their stories, favorite memories, and messages for loved ones to inherit.

Special Populations Served: Patients with serious life threatening illnesses or conditions in their last year or two of life.

Language(s) Spoken: English.

Organizational Liaisons: Helen Diller Family Comprehensive Cancer Center.

Hours: Monday-Friday, 8AM-5PM.

Contact for Services Indicated: 415-885-7671.
UCSF OUTPATIENT MOVEMENT DISORDERS SUPPORTIVE CARE CLINIC

Program Overview: The Outpatient Movement Disorders Clinic is for patients with advanced movement disorders—with significant motor or non-motor symptoms, as well as psychosocial issues. Patient quality of life concerns, caregiver stress, and establishing/understanding goals of care are primary focal areas for the Clinic team.

Palliative Care Services Provided: Each patient is evaluated by a multidisciplinary team that includes a nurse practitioner specializing in the management of advanced movement disorders, a neurologist who is fellowship-trained in movement disorders, and a social worker with experience working with individuals with advanced movement disorders.

Palliative Care Services Planned: A physical therapist from the Clinic is planning to see all patients in the palliative care clinic in the next few months to evaluate mobility and reduce falls. In addition, the Clinic is applying for a large grant to further fund and study the role of palliative care in advanced movement disorder patients compared with standard care. This grant would allow for a dedicated occupational therapist, speech therapist, nutritionist, and psychiatrist in the clinic. This project is planned for 7/1/2015, pending grant approval.

Complementary Therapies Provided: The Clinic currently works closely with several physical therapists and speech therapists at UCSF who are specialists in treating patients with advanced movement disorders, and with the UCSF pain management service, given the prevalence of pain in Parkinson’s disease and atypical Parkinsonian syndromes.

Special Populations Served: Advanced movement disorders include patients with Parkinson’s disease, atypical Parkinsonian syndromes, Huntington’s disease, as well as progressive ataxia, choreiform, and dystonia syndromes.

Language(s) Spoken: English, Russian (conversational).

Organizational Liaisons: UCSF Memory and Aging Center.

Hours: Fourth Thursday morning of every month, 9AM-12PM.

Contact for Services Indicated: Patients need a referral from a physician. Please call 415-353-2311 to schedule an appointment.
SKILLED NURSING FACILITIES

IRENE SWINDELLS ALZHEIMER’S RESIDENTIAL CARE PROGRAM

Program Overview: The Irene Swindells Alzheimer's Residential Care Program is licensed by the Department of Social Services as a Residential Care Facility for the Elderly (RCFE). It is a medical center-based assisted living program specializing in expert dementia care. The program provides long-term residential care for elderly individuals with Alzheimer’s disease or other related types of dementia who do not require skilled nursing, and who would benefit from a communal living environment. The focus of the program is to enhance quality of life through an integrative, psychosocial approach to care. The program team features a manager who is a licensed family therapist, a registered expressive arts therapist, a medical director who is a board certified geriatrician, a licensed vocational nurse program coordinator, and a nursing supervisor available 24/7. To gain entrance into the program, residents must not be bed-bound. The facility has 25 beds available on a first come first serve basis. Financial assistance may be available to qualified residents through the CPMC Foundation. A waiting list is maintained when all beds are full. The facility has a hospice waiver and every effort is made to maintain residents in the facility through end-of-life.

Palliative Care Services Provided: Hospice care for up to five residents.

Palliative Care Services Planned: Provide hospice care-plan through a licensed hospice provider, such as Sutter Visiting Nurses Association (VNA), Pathways, Hospice by the Bay.

Complementary Therapies Provided: Creative arts therapy-based activity therapy program.

Special Populations Served: Dementia.

Language(s) Spoken: English, Tagalog, Spanish, Chinese.

Hours: 24 hours a day/7 days a week.

Contact for Services Indicated: Rob Sarison, LMFT, 415 600-6392.
JEWHISH HOME

Program Overview: As a U.S. Centers for Medicare & Medicaid Services five-star rated facility and with a complement of more than 650 compassionate, experienced clinical and allied health personnel, the Jewish Home provides seniors with a variety of life-enriching healthcare programs and services in a welcoming, stimulating environment. Operated by a 501(c)(3) nonprofit corporation, the Jewish Home serves approximately 1,200 patients and residents each year on its nine-acre campus. Non-residential care is offered through the Home’s short-term and rehabilitation services unit for patients who require geriatric-specialized, interdisciplinary rehabilitation to recover from surgery or an acute illness, and through its acute geriatric psychiatry hospital. The Home is affiliated with the University of California, San Francisco for teaching and research. Admission to the Jewish Home is not limited by religious or cultural affiliation.

Palliative Care Services Provided:

- Long-term Care
- Skilled Nursing Care
- Rehabilitation Services
- Comfort Care/End-of-Life Care includes collaboration with outside hospice services
- Social Work Support
- Chaplain/Spiritual Support
- Pharmacy Support
- Psychologist/Psychiatrist
- Caregiver/Family Support
- Direct Care Worker Support
- Volunteer Caregiver Support
- Transportation
- Recreation/Activities Support (i.e., arts/crafts, music, poetry, literature, movement/exercise, pets)
- Special Population Support

Palliative Care Services Planned: The Jewish Home’s Palliative Care Committee plans to continue meeting to promote the highest quality of care for residents. In addition, the Jewish Home plans to continue collaborating with outside Hospice providers to ensure residents, and their families, choice and options for end-of-life support.

Complementary Therapies Provided: The Jewish Home offers two supportive programs: No One Dies Alone aims to ensure that residents and patients have someone at their side during their final hours, and Kol Haneshamah, which offers volunteer Spiritual Care Partners to those in their final weeks, months, or even years of life. Both programs are grounded in Jewish spiritual values.

1. The Jewish Home’s No One Dies Alone Program provides trained companions to be at the bedside during the time that residents and patients are actively dying.

2. Kol Haneshamah (the name is based on the verse “Let every breath sing praise to God” – Psalm 150) is a collaboration of the Jewish Home and the Bay Area Jewish Healing Center. The program matches volunteer Spiritual Care Partners with long-term care residents in order to create new friendships at the end of life—friendships that are unique because of their spiritual nature, and because they are an opportunity to start fresh in a relationship.
**Special Populations Served:** The Jewish Home is a geriatric facility, serving people over the age of 65. In some special cases, the Home serves younger adults with cognitive illness, physical illness, and/or emotional/mental health illness that require a skilled level of care to promote their highest well-being and greatest level of functioning.

**Language(s) Spoken:** English, Russian, Tagalog, Spanish, Hebrew, Yiddish. The Jewish Home also has access to translation services via CyraCom.

**Hours:** Weekdays.

**Contact for Services Indicated:** Edwin Cabigao, Head of Nursing Department, 415-334-2500, ecabigao@jhsf.org.
HOSPICE SERVICES

COMING HOME HOSPICE

Program Overview: Coming Home Hospice has operated in San Francisco’s Castro neighborhood for the past 27 years, licensed as a Residential Care Facility for the Chronically Ill (RCFCI). Coming Home is a 15-bed residence providing 24-hour skilled nursing care and Certified Aide care with an exceptionally rich staffing ratio in order to provide excellence in patient care. All patients admitted to Coming Home are also under the care and medical supervision of one of the Medicare Certified Hospice Agencies in San Francisco. Marsha Nunley, MD, an Internist and Palliative Care Specialist with many years of hospice experience, is our Medical Director.

Coming Home Hospice provides a warm, welcoming, home-like atmosphere, where family members, friends, children, and animal companions are welcome to visit daily. The facility offers well-appointed comfortable private rooms with telephones and televisions in each room.

Palliative Care Services Provided:
• Residential Hospice Care
• 24-hour Skilled Nursing Care
• 24-hour Certified Aide Care
• On-going Family Education and Support
• Social Work Support and Counseling
• Spiritual Support and Counseling
• Volunteer Services
• Dietary Service
• Personal Care Needs

Complementary Therapies Provided: The following services are offered through our community partners:
• Massage
• Personal grooming care
• Chorale Signing groups
• Ancillary services as requested

Special Populations Served: Underserved, complex medical management, LGBT, and frail patients.

Languages Spoken: Cantonese, Tagalog, Spanish, plus hospital based interpretive services.

Hours: Staff is available 24 hours/day.

Contact for Services: Rich Nasca, Director, 415-861-1110, nasca@sutterhealth.org; Fax, 415-861-5763. Coming Home Hospice is affiliated with Sutter Health, California Pacific Medical Center.
HOSPICE BY THE BAY

**Program Overview:** Hospice by the Bay is a 501(c)3 non-profit organization licensed by the State of California as both a home health and a hospice provider. We are also a designated Pediatric Waiver provider for the State of California, a licensed Medicare and Medi-Cal provider, and we are accredited by the Community Health Accreditation Program (CHAP).

The mission of Hospice by the Bay is to alleviate a patient’s pain, to prevent and treat conditions that might otherwise threaten the quality of life, and to provide support to the patient’s family and loved ones through the provision of hospice and palliative care services.

**Palliative Care Services Provided:**
- Hospice Care
- Therapy/Counseling/Support Groups
- Advance Care Planning
- Hospital Medical Services
- Long-term Care
- Skilled Nursing Care
- Rehabilitation Services
- Caregiver/Family Support
- Bereavement Services
- Volunteer Caregiver Support

**Complementary Therapies Provided:** As needed.

**Special Populations Served:** Patients with serious, life-threatening illnesses or conditions in their last year or two of life.

**Language(s) Spoken:** Chinese and Spanish speaking staff, interpreters for other languages available via language line.

**Hours:** Twenty-four hours a day, seven days a week, year round.

**Contact for Services Indicated:** 415-626-5900.
MAITRI AIDS HOSPICE

Program Overview: Since 1987, Maitri has served over 1,100 San Franciscans with advanced AIDS and in need of 24-hour nursing care, in our 15-bed residential care facility located in the Castro/Duboce area. Originally opened as a hospice, Maitri still serves residents who are at the end of life (a core part of Maitri’s charitable mission). Increasingly, Maitri is helping very medically fragile individuals—those with advanced AIDS who are low income—stabilize and discharge back to independent living.

Palliative Care Services Provided:
- Residential Care
- Hospice Care
- Social Work Support
- Chaplain/Spiritual Support
- Pharmacy Support
- Psychologist/Psychiatrist
- Caregiver/Family Support
- Bereavement Services
- Advance Care Planning
- Direct Care Worker Support
- Volunteer Caregiver Support
- Transportation
- Housing Support
- Special Population Support

Complementary Therapies Provided: Reiki, massage therapy, and music therapy provided.

Special Populations Served: LGBT, People Living with HIV/AIDS.

Language(s) Spoken: Tagalog, Spanish.

Organizational Liaisons: Alliance Health Project (AHP), Hospice agencies including Hospice by the Bay, Pathways Hospice, and Sutter Hospice.

Hours: 24 hours a day/7 days a week.

Contact for Services Indicated: Mary Schroeder, Program Director/Intake: 415-558-3006, mschroeder@maitrisf.org.
PATHWAYS HOME HEALTH AND HOSPICE

Program Overview: Pathways is a non-profit home health and hospice serving the Bay Area since 1977. Our hospice improves quality of life for patients with life-limiting illness by addressing distressing physical, spiritual, and emotional issues, allowing patients and their families to make the most of their time together. Services provided include:
- Personal care
- Care in assisted living and nursing homes
- Dementia program
- Grief support groups
- Volunteers
- Counseling
- Information visits by nurse liaisons
- Spiritual support

Palliative Care Services Provided: In addition to our hospice that serves San Francisco and four other counties, Pathways has a full-fledged Palliative Care program under Home Health serving patients in San Mateo, Santa Clara, and parts of Alameda Counties. Our Palliative Care provides management of troubling symptoms to make patients with serious illness more comfortable.

Patients on Palliative Care generally have advanced illness with diagnoses such as cancer, chronic lung disease, heart failure or a neurologic disease. People with life-threatening illness may be getting curative treatments like chemotherapy or radiation.
- A palliative care-certified physician oversees pathways Palliative Care.
- In addition to nursing visits, Palliative Care patients may have volunteer, social work, and spiritual care visits for holistic physical, emotional and spiritual support.
- Complex patients may also receive visits from a pharmacist, respiratory therapist, and/or Dietitian as needed for optimal care.
- Patients may also have telemonitoring for remote daily monitoring of vital signs.
- A nurse is on-call 24 hours a day for telephone consultation or visits if needed.

Complementary Therapies Provided: Aromatherapy, comfort touch, music sessions, pet therapy (as available).

Special Populations Served: We see all populations and do not discriminate based on race, religion, sex, sexual orientation, or any other culture with which our patients may identify.


Organizational Liaisons: Pathways has community liaisons and nurse liaisons that make informational visits to patients in the hospital, in a skilled nursing or assisted living facility, and at home.

Hours: 8:30AM-5PM, 7 days a week, including holidays. Afterhours telephone assistance is available 24 hours a day, as are urgent nursing visits.

Contact for Services Indicated: For all services call 888.755.7855, visit us pathwayshealth.org, email info@pathwayshealth.org.
SUTTER CARE AT HOME

Program Overview: AIM (Advanced Illness Management) is a care management and palliative care model serving persons with advancing illness in the last 12-18 months of life. It offers best practices in care coordination, care management, and palliative care focused around patient’s personal goals. AIM supports and strengthens ongoing patient/physician relationship to improve care plans aligned with each person’s preferences, values, and goals. Patients frequently receive curative treatment in addition to palliative care services. AIM is supported in the community by home health, home infusion care, and hospice care.

AIM Population: Clinical Eligibility - Patient should have a high burden of disease and at least one statement in the list below:

- Patient may be hospice appropriate and seeking active medical interventions
- Patient has had rapid/significant clinical, functional, or nutritional decline
- Patient has had recurrent, unplanned hospitalizations or ER visits.
- Provider would not be surprised if the patient died in the next 12-18 months

Palliative Care Services Provided:

- AIM Home Health (home-based skilled clinical services - patient must meet skilled criteria per Medicare Guidelines)
- Care provided by nurses, physical therapist, occupational therapists, social workers, speech therapist, home health aide, and other ancillary services (e.g. Dietician)
- AIM Transitions Care (home-based skilled care provided by nurses (RN, LVN) & Social Workers (MSW)
- AIM Telesupport (telephonic support provided by nurses (RN)
- Hospice Care (patient must meet hospice eligibility criteria to qualify)

Palliative Care Services Planned: Continued expansion of the AIM Program and collaborating on development of outpatient palliative care physician consultation services within San Francisco area.

Special Populations Served: Private home, RCFE, skilled nursing, SRO, acute care hospital, hospice facility, all diseases, though most common are chronic illnesses, and all payers.

Language(s) Spoken:
- Tagalog, Spanish, Indonesian, Malay, Cantonese, Mandarin, and Russian. Select patient engagement materials also translated into 15-20 languages.

Organizational Liaisons:
- Elaina Gunn, Home Health Administrator
- Nerice Kaufman, AIM and Hospice Administrator
- Bahar Monem, Regional Sales Manager

Hours: Office 8 AM-5:30 PM (Clinical Services provided 24 hours a day/7 days a week).

ZEN HOSPICE PROJECT

Program Overview: Zen Hospice Project (ZHP) operates across systems. Our primary service is residential hospice, which takes place at our principal organizational location—the Guest House—in the Hayes Valley neighborhood of San Francisco (license: Residential Care Facility for the Chronically Ill). Our longest continuously running program is the training and support of hospice volunteers. With over 100 active community members, our volunteers staff our Guest House as well as the hospice and palliative care unit of Laguna Honda Hospital through a long-standing partnership with the Department of Public Health. Increasingly, we are involved in inter-professional caregiver training in contemplative palliative care, with courses offered at UCSF and workshops at our Guest House. We also host myriad community engagement events, centered on the creative notion of living fully until death. Executive Director Dr. BJ Miller represents ZHP as an attending physician at the UCSF Cancer Center in the Symptom Management Service (outpatient palliative care).

Our model is broad-based and collaborative in nature. For instance, since we are not a licensed hospice agency per se, we work with agencies to deliver the medical care plan in the Guest House. Similarly, we partner with practitioners of integrative and ancillary care (e.g. psychotherapy, massage, music thanatology, Reiki, acupuncture, etc.) to deliver their services at our House. Because of our innovative collaborations, we are often the host rather than the direct service provider. ZHP nurses and certified nursing assistants staff the Guest House around the clock.

Palliative Care Services Provided:
- Residential Care
- Hospice Care
- Social Work Support
- Chaplain/Spiritual Support
- Psychologist/Psychiatrist
- Caregiver/Family Support
- Direct Care Worker Support
- Volunteer Caregiver Support
- Housing Support
- Artist Support
- Health Care Interpreter
- Special Population Support

Palliative Care Services Planned:
- Therapy/Counseling/Support Groups
- Bereavement Services
- Advance Care Planning

Complementary Therapies Provided: See program overview.

Special Populations Served: Homeless and underserved, complex illness, LGBT, families, and caregivers.

Language(s) Spoken: Spanish and Korean spoken by staff. For all other languages, we employ a telephone-based interpreter service.
**Hours:** We staff the Guest House 24 hours a day, seven days a week. Our volunteers staff the Guest House and Laguna Honda seven days per week. Other programs are generally offered during normal business hours, with some weekend workshops throughout the year.

**Contact for Services Indicated:** General Line, 415-913-7682; Nurse Director Mary Knopf, [mary@zenhospice.org](mailto:mary@zenhospice.org); Education Director Shelley Adler, [shelley@zenhospice.org](mailto:shelley@zenhospice.org); Volunteer Director Roy Remer, [roy@zenhospice.org](mailto:roy@zenhospice.org).
COMMUNITY MEDICAL SERVICES

ON LOK LIFEWAYS

Program Overview: On Lok Lifeways is a certified Program of All-inclusive Care for the Elderly (PACE). The PACE model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in their community whenever possible.

The PACE model serves individuals who are 55 years of age or older, certified by the State of California to need nursing home care, able to live safely in the community at the time of enrollment, and live in a PACE service area.

Delivering all needed medical and supportive services, a PACE program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their home for as long as possible. Services include the following:

- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical specialties, such as audiology, dentistry, optometry, podiatry and speech therapy
- Respite care
- Hospital and nursing home care when necessary

Palliative Care Services Provided:

- Long-term care
- Skilled nursing care
- Rehabilitation services
- Outpatient Medical Services
- Community Medical Providers
- In-Home Medical Services
- Social Work Support
- Chaplain/Spiritual Support
- Pharmacy Support
- Psychologist/Psychiatrist
- Caregiver/Family Support
- Bereavement Services
- Therapy/Counseling/Support Groups
- Advance Care Planning
- Direct Care Worker Support
- Transportation
- Home/Building Modifications-Architecture
- Health Care Interpreter
- Special Population Support
Complementary Therapies Provided: Nutrition services & home delivered meals, home care, adult day health services (nursing, recreation and rehabilitation therapies, social work, personal care), primary medical care, prescription medications, transportation, diagnostics, dental, optical, hearing, podiatry care, acute hospital care, and nursing home care.

Special Populations Served: Patients with serious, life-threatening illnesses or conditions in their last year or two of life, and frail elders who require a nursing facility level of care.

Language(s) Spoken: English, Spanish, Mandarin, Cantonese, Toishanese, Tagalog, and Korean.

Organizational Liaisons: Institute on Aging.

Hours: Monday-Friday, 8 AM-4:30PM for PACE Centers. Clinic on Saturdays and after-hours on-call medical provider.

Contact for Services Indicated: Grace Li, 415-292-888, graceli@onlok.org.
UCSF BRIDGES PROGRAM

Program Overview: UCSF Bridges aims to improve quality of life through home visits by physicians who specialize in symptom management, communication, and safe transitions from hospital to home.

Palliative Care Services Provided:
- MD assessment, counseling and treatment for the physical and emotional effects of serious illness
- Assistance with medical decision-making and advance care planning
- Linkage to community resources
- Close collaboration with the patients’ primary care physician, specialists, family members, caregivers, etc.

Special Populations Served: Must have UCSF primary care physician or UCSF specialist patient sees regularly.

Language(s) Spoken: In-person translation offered for all languages.

Hours: Monday-Friday, 8AM-5PM.

Contact for Services Indicated: 415-514-3577.
COMMUNITY SERVICES

BAY AREA JEWISH HEALING CENTER

Program Overview: Bay Area Jewish Healing Center is dedicated to providing Jewish spiritual care to those living with illness, to those caring for the ill, and to the bereaved through direct service, education and training, and information and referral.

Established in 1991 as the nation’s first Jewish healing center, Bay Area Jewish Healing Center provides chaplaincy and support services to anyone who wants to see a rabbi, regardless of affiliation or financial resources.

Palliative Care Services Provided:
• Chaplain/Spiritual Support
• Caregiver/Family Support
• Bereavement Services
• Counseling/Support Groups
• Advance Care Planning
• Direct Care Worker Support
• Volunteer Caregiver Support
• Special Population Support

Special Populations Served: Primarily Jewish and Jewishly connected patients who are ill, at end of life, or living with grief.

Language(s) Spoken: English, Hebrew.

Hours: Weekdays. Other hours by pre-arrangement.

Contact for Services Indicated: Gail Kolthoff, Executive Assistant, 415-750-4197, jewishhealing@bajhc.org.
CARE (CANCER, AWARENESS, RESOURCES, AND EDUCATION)

Program Overview: The CARE program is designed for people with cancer who receive their care and treatment at San Francisco General Hospital. Through the CARE program, people diagnosed with cancer receive education and support, as well as a free, healthy, and delicious meal every week.

Palliative Care Services Provided: We periodically offer sessions on advance care planning.

Complementary Therapies Provided: We consider the program itself a form of complementary medicine. We regularly offer sessions on topics such as acupuncture, massage, qi gong, etc.

Special Populations Served: Medically underserved cancer patients who receive their care and treatment at San Francisco General Hospital.

Language(s) Spoken: English, Spanish, and Cantonese spoken.

Hours:
- English group – Tues., 5:30 - 7:30PM
- Spanish group – Thurs., 5:30 - 7:30PM
- Chinese group – Mon., 1:30 – 3:30PM

Groups meet for 32 weeks annually. Participants are referred through their provider or social worker. Please see website for more info www.caresfgh.org.

Contact for Services Indicated: Sylvia Romero-Pagan, 415-206-5912, romero-pagans@hemeonc.ucsf.edu.
SAN FRANCISCO BAY AREA NETWORK FOR END-OF-LIFE CARE

Program Overview: San Francisco Bay Area Network for End-of-Life Care (SFEOL) is a membership and networking group open to organizations, individuals, and students involved in end-of-life care in the San Francisco Bay Area. SFEOL has been meeting the first Wednesday of every month (11:30 AM – 1:30 PM), without interruption, for nearly 16 years. The goal for each meeting is to work toward the improvement of all facets of hospice and palliative care by increasing public awareness of key issues through education, by identifying and filling end-of-life needs in diverse communities, and by strengthening local resources in all the inter-disciplinary dimensions required to provide good care for those with a serious or incurable illness.

SFEOL…
• Offers support and community for hospice workers, healthcare professionals, grief counselors, clergy, volunteers and others who provide end-of-life care in the Bay Area
• Promotes excellence and cultural competence in end of life services through continuing professional education
• Raises community awareness of end-of-life planning and choices
• Provides education and facilitation on advance care planning for healthcare providers and the public

Palliative Care Services Provided:
• Physician Orders for Life Sustaining Treatment (POLST)* support
• Community-building and networking for hospice workers, healthcare professionals, grief counselors, clergy, volunteers and others who provide end-of-life care in the Bay Area
• Continuing education to ensure excellence and cultural competence in end-of-life services
• Educational programs and assistance with advance care planning end-of-life care and decisions for individuals, families, groups, and healthcare facility staff

Hours: Weekdays.

Contact for Services Indicated: Nate Hinerman, PhD, Dean, Undergraduate Programs, Golden Gate University, 415-422-2314; SFEOL, http://www.sfeol.org/.

* For information about the San Francisco POLST Coalition, please contact Steve Heilig, San Francisco Medical Society, heilig@sfms.org, (415) 561-0850.
SHANTI

Program Overview: Shanti provides a suite of support services to approximately 2,000 individuals with breast cancer, HIV, or other life-threatening illnesses, with 1,641 from the San Francisco area and 358 from our national work presenting the L.I.F.E. Program workshops to people living with HIV.

Palliative Care Services Provided:

Shanti’s Margot Murphy Breast Cancer Program serves clients from initial diagnosis of breast cancer through active treatment, and for a period following the end of active treatment. In Care Navigation, we provide intensive case management services and emotional support, including assistance for women and men who are receiving palliative care and confronting end-of-life issues.

Shanti’s HIV Services Programs include Care Navigation, Peer Advocacy, Integrated Case Management (in collaboration with Westside Community Services), Educational Workshops and other HIV Self-Management Programming (Shanti LIFE Program®), and Volunteer Peer Support. All HIV Services staff and volunteers provide palliative care for people confronting end-of-life issues through on-going practical and emotional support that helps to reduce pain and social isolation, and assist clients in securing end-of-life resources from community partners.

Complementary Therapies Provided:

Shanti’s Margot Murphy Breast Cancer Program offers free massage, yoga, Qi Gong, and Reiki sessions at our office for all breast cancer clients.

Shanti’s HIV Services Programs offers free canine-therapy, weekly yoga, weekend retreats for long-term survivors, and free tickets to local social and cultural events (theatre, sports and music events, etc).

Special Populations Served:

Shanti’s Margot Murphy Breast Cancer Program: Low-income women of color comprise a majority of Shanti’s breast cancer client population: 72% are Asian (primarily Cantonese speakers), Latina, or African American. The majority of our clients are over the age of 55 and face significant medical and day-to-day challenges.

Shanti’s HIV Services Programs: People Living with HIV (PLWH) clients in our HIV Services Program come from San Francisco’s most disenfranchised and at-risk populations. These are people who are dually and triply diagnosed (with mental health and/or substance use issues), homeless or marginally housed, very low-income, homebound and aged, from communities of color, women (including transgender women), and individuals co-infected with hepatitis C virus (HCV) and HIV. Other subpopulations include gay, bisexual, heterosexual, transgender individuals, men, women, newly diagnosed PLWH, seniors, undocumented persons; bi/monolingual (Spanish-speaking) persons, injection drug users and other substance users, and persons recently released from prison or with a history of incarceration. A vast majority of our clients are long-term survivors of HIV (over the age of 50).

Language(s) Spoken:

Shanti’s Margot Murphy Breast Cancer Program: Staff is fluent in Cantonese, English, Mandarin and Spanish.
**Shanti’s HIV Services Programs:** Staff is fluent in English and Spanish.

**Organizational Liaisons:**

**Shanti’s Margot Murphy Breast Cancer Program:** The program has maintained a contract with the San Francisco Department of Public Health for 14 consecutive years that links Shanti to all local hospitals and clinics. In addition, Shanti holds collaborative agreements with many community partners including Project Open Hand and Breast Cancer Emergency Fund.

**Shanti’s HIV Services Programs** is funded by the San Francisco AIDS Office and works in partnership with staff from Ward 86, 360 Clinic, Project Open Hand, SROs, and other AIDS Service Organizations and community partners to provide wrap-around care for PLWH, including those with co-morbidities (HCV, Diabetes, Cancer, etc.).

**Hours:** **Shanti’s Margot Murphy Breast Cancer Program:** Monday-Friday, 9AM-5PM – by appointment only.

**Shanti’s HIV Services Programs:**
- Drop-In Services: Tues.-Thurs., 9:30AM-12:30PM
- Activities Program (free tickets to local events): Mon-Fri, 10PM-12PM
- Support Group for women with HIV: Fri, 9:30AM-11:30AM
- Movie Night: Last 2 Thursdays of the month, 5PM-7:30PM
- Volunteer Peer Support – by appointment only
- Shanti LIFE Program ® (Educational Workshops, HIV Self-Management Programming, Weekend Retreats, HIV/HCV support group, weekly yoga) – by appointment only

**Contact for Services Indicated:**

**Shanti’s Margot Murphy Breast Cancer Program:** All of our services are free of charge and confidential. We can meet clients at their home, our office, or wherever they feel most comfortable; to make sure that they get the services they need in a timely manner. Please contact 415-674-4780 for more information on how to enroll or refer in our program.

**Shanti’s HIV Services Programs:** All of our services are free of charge and confidential. We can meet a client at their home, our office, or wherever they feel most comfortable to make sure that they get the services they need in a timely manner. For information on how to enroll in our general HIV Services, please contact Eric Sutter, 415-674-4754. For information on Shanti LIFE Program® activities, please contact Jackson Bowman, 415-674-4755.
COMMUNITY SERVICES – CAREGIVER SUPPORT

FAMILY CAREGIVER ALLIANCE

Program Overview: Family Caregiver Alliance (FCA) is a non-profit organization that provides a wide range of services to families caring for a loved one with chronic or disabling health conditions. We assist caregivers with services such as information and referral, family consultation, legal/financial consultations, education, support, and counseling. Family consultants provide an in-home assessment of the individual care situation and develop a care plan addressing all the services and resources needed. Families are also offered information about our education, legal counseling, respite services and retreats; all free of charge.

Family Caregiver Alliance also provides workshops and classes throughout the Bay Area on diverse topics such as understanding dementia behaviors, stress management, care planning, and practical daily skills for caregivers. Our language capabilities are in English and Spanish, but we contract with other organizations to facilitate our services in other languages.

Palliative Care Services Provided:
- Caregiver/Family Support
- Therapy/Counseling/Support Groups
- Social Work Support
- Advance Care Planning
- Special Population Support
- Legal/Advocacy Support

Palliative Care Services Planned: FCA offers a workshop called Difficult Conversations about Difficult Decisions. No current dates scheduled but may be offered when next round of classes/workshops are scheduled.

Complementary Therapies Provided: Activities at respite retreats for family caregivers may include art therapy, drumming circles, and other holistic activities to help caregivers with stress management and self-care.

Special Populations Served: FCA serves family and unpaid caregivers of older adults and those with cognitive or neurological impairments. Support group offered specifically for Spanish-speaking caregivers and an online support group for LGBT caregivers. FCA subcontracts with Kimochi, Self-Help for the Elderly, and Openhouse to provide culturally and linguistically appropriate services to family caregivers in the Japanese, Chinese, and LGBT populations respectively.

Language(s) Spoken: English and Spanish. FCA subcontracts with other organizations to facilitate our services in other languages.

Hours: Monday-Friday, 9AM-5PM.

COMMUNITY SERVICES – IN-HOME SUPPORT

IN-HOME SUPPORTIVE SERVICES (IHSS) CONSORTIUM

Program Overview: Provide personal care assistance (home care) for seniors and people with disabilities. Operates a Training Academy for Personal Care Assistants (TAPCA) and a private-pay registry for consumers (TAPcare) looking for personal attendants.

Palliative Care Services Provided: IHSS assists consumers who have chronic and acute behavioral health and medical health issues to live safely and independently in their homes. IHSS provides assistance with domestic and personal care services, accompaniment to medical appointments, and assistance with medication, etc., based on the consumer’s specialized care plans. Services are delivered by compassionate, well-trained personal care assistants (home care workers).

Special Populations Served: Elderly and people with disabilities.

Language(s) Spoken: Cantonese, English, French, German, Mandarin, Russian, Samoan, Spanish, Swedish, Tagalog, Taishanese, Tigrinya, Tongan, Ukrainian, Vietnamese.

Organizational Liaisons: Extensive.

Hours: 6AM–9PM.

Contact for Services Indicated:
Margaret Baran, Executive Director
In-Home Supportive Services Consortium
1035 Market, L-1
San Francisco, CA 94103
Main: 415-255-2079
Direct: 415-659-5303
Fax: 415-255-0679
mbaran@ihssco.org
In-Home Supportive Services Consortium: www.ihssco.org;
Training Academy for Personal Care Assistants (TAPCA): www.tapca.org;
TAPcare online registry: www.tap-care.org.
Program Overview: The Palliative Care program at Seniors at Home/Jewish Family and Children’s Services (SAH/JFCS) was created to address the needs of clients of SAH/JFCS who have serious or chronic illness and their families. Our interdisciplinary team provides information, homecare, palliative care consultations and support, advocacy and case management to assist people in achieving the best possible quality of life, whether it is at the end of life or at any stage of a challenging illness. We also offer fee for service Palliative Care Consultations to anyone in the community.

Palliative Care Services Provided:

- Patient Consultation/support
- Social Work Support
- Chaplain/Spiritual Support
- Caregiver/Family Support
- Bereavement Services
- Therapy/Counseling/Support Groups
- Advance Care Planning
- Direct Care Worker Support
- Volunteer Caregiver Training/ Support
- Limited Transportation Services
- Legal/Advocacy Support
- Special Population Support

Palliative Care Services Planned: In 2014/2015 JFCS plans to collaborate with the UCSF Symptom Management Service on a pilot program called Community Bridges, offering palliative care support to advanced cancer patients in Mt. Zion Hospital area who are not enrolled in Hospice.

Complementary Therapies Provided: Homecare and care management services, as well as subsidies for consultations and homecare services.

Special Populations Served: Elders, Jewish Community, Russian Community, Holocaust Survivors.

Language(s) Spoken: English, Hebrew, Russian, Spanish.

Organizational Liaisons:

- UCSF Symptom Management Service
- CSU Institute for Palliative Care
- Coalition for Compassionate Care of California CCCC
- We work with all local Hospice Teams and Inpatient Palliative Care teams

Hours: Monday-Friday, 8:30AM-5PM. Intake open on Saturdays.

Contact for Services Indicated: Seniors at Home/JFCS Intake line, 415-449-3700; Redwing Keyssar, redwing@jfcs.org, 415-449-3749; www.seniorsathome.org; www.jfcs.org.
SAN FRANCISCO IN-HOME SUPPORTIVE SERVICES PUBLIC AUTHORITY

Program Overview: The San Francisco In-Home Supportive Services (IHSS) Public Authority connects low-income seniors and people with disabilities with qualified IHSS providers so they can live healthier, happier and safer lives at home and remain engaged in the community.

Palliative Care Services Provided:
- In-Home Care
- Caregiver/Family Support

Complementary Therapies Provided: In-home support, including meal preparation, cleaning, and personal needs care.

Special Populations Served: Low-income adults with disabilities and seniors who would prefer staying home compared to an institutionalized care.

Language(s) Spoken: English, Russian, Spanish, Mandarin, and Cantonese.

Hours: Weekdays.

Contact for Services Indicated: 415-243-4477.
SELF-HELP FOR THE ELDERLY

Program Overview: The mission of Self-Help for the Elderly (hereafter referred to as Self-Help) is to promote the independence, dignity, and self-esteem of older adults by providing a comprehensive range of multicultural and multilingual programs. Self-Help serves over 35,000 individuals annually in the San Francisco, San Mateo, Santa Clara, and Alameda counties. More than 90% of the agency’s clients are members of ethnic communities, and over 90% of Self-Help’s staff is bilingual and bicultural in various Chinese dialects (Cantonese, Mandarin and/or Toishanese,) Russian, Spanish, Tagalog, or Vietnamese.

Our current programs and services include licensed home health care and hospice, case management, information and assistance, emergency in-home support services, family caregiver support program, housing services, naturalization program, congregate and home delivered meals, activities at senior centers, transportation, Health Insurance Counseling and Advocacy Program (HICAP), senior housing, assisted living, adult day services and Alzheimer’s Day Care Resource Center, employment training and economic development, and the SF-Connected Program. Although the agency ensures services are available to all eligible individuals, the agency’s target clientele are limited-English-speaking, low-income and/or very low-income, and socially isolated seniors.

Palliative Care Services Provided:
- Home Medical Services
- Hospice Care
- Chaplain/Spiritual Support
- Caregiver/Family Support
- Bereavement Services
- Therapy/Counseling/Support Groups
- Advance Care Planning
- Transportation
- Health Care Interpreter
- Special Population Support

Special Populations Served: Monolingual Chinese patients who speak only Cantonese or Mandarin.

Language(s) Spoken: English, Cantonese, Mandarin, Toishanese.

Hours: 24 hours a day/7 days a week.

Contact for Services Indicated: Phone, 415-677-7628; Fax, 415-398-5903; Email, info@selfhelpelderly.org; Website, www.selfhelpelderly.org.
RESOLUTION SUPPORTING PALLIATIVE CARE AND THE RECOMMENDATIONS OF THE PALLIATIVE CARE TASK FORCE

WHEREAS, The mission of the San Francisco Department of Public Health (SFDPH) is to promote and protect the health of all San Franciscans; and

WHEREAS, SFDPH and DAAS convened the Palliative Care Task Force, a 30 – member body bringing together a diverse group of representatives from San Francisco’s leading health care and community organizations, advocacy and professional associations and consumers that engaged in five public meetings between May and August 2014 to develop strategic recommendations to address palliative care in San Francisco; and

WHEREAS, Palliative care is a dynamic person-and family-centered practice of care that focuses on improving quality of life for patients and families during serious or life-threatenng illness; and

WHEREAS, key elements of palliative care include the following:
- 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.

WHEREAS, Palliative care is currently provided in a variety of settings: hospital-based, outpatient and community-based, and hospice-based settings; and

WHEREAS, 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; and

WHEREAS, The Palliative Care Task force developed short and long-term recommendations around four critical areas necessary to the development and delivery of an integrated and collaborative palliative care service system: Quality, Finance, Systems, and Community Education; and

WHEREAS, the San Francisco Long Term Care Coordinating Council has established a Palliative Care Workgroup to continue the work of the Palliative Care Task Force; and

THEREFORE BE IT RESOLVED, That the San Francisco Health Commission commends the Palliative Care Task Force for its discussion and thoughtful work on behalf of individuals with serious or life-threatening illness and the broader City and County of San Francisco; and be it
FURTHER RESOLVED, That the San Francisco Health Commission supports the advancement of palliative care practices that serve individuals in the least restrictive setting possible; and be it

FURTHER RESOLVED, That the San Francisco Health Commission requests that SFDPH consider Palliative Care Task Force recommendations, as appropriate, when planning for future health services,

I hereby certify that the San Francisco Health Commission at its meeting of December 16th, 2014 adopted the foregoing resolution.

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Mark Morewitz
Executive Secretary to the Health Commission