

# San Francisco Palliative Care Task Force Meeting #1 Highlights

The San Francisco Palliative Care Task Force, co-convened by the San Francisco Department of Public Health (DPH) and San Francisco Department of Aging and Adult Services (DAAS), assembled for the first of five Task Force meetings on Thursday, May 29, 2014. The purpose of the Task Force is to review and discuss San Francisco palliative care resources and make recommendations to meet current and future needs that are responsive to the city's socioeconomic, cultural, and population diversity.

Anne Hinton, Executive Director of DAAS and Co-Chair of the Task Force, opened the meeting and offered welcoming remarks. San Francisco Supervisor Mark Farrell; Steve Pantilat, MD, Director, Palliative Care Program and the Palliative Care Leadership Center at the University of California, San Francisco (UCSF); and, Kate O'Malley, Senior Program Officer, California HealthCare Foundation, provided additional opening remarks.

Co-Chairs Anne Hinton and Christine Ritchie MD MSPH, UCSF Department of Medicine, Division of Geriatrics, Center for Research on Aging, Jewish Home San Francisco, facilitated member introductions, reviewed the meeting objectives, and presented the Task Force draft guiding principles. In reviewing the guiding principles, one member suggested expanding the cultural competency/cultural responsiveness principle to include responsive bidirectional learning of culture between palliative care providers and consumers.

## Task Force Draft 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.

### **Framing Presentation: *Palliative Care Today***

BJ Miller, MD, Director Zen Hospice and Assistant Professor, UCSF, provided an overview of palliative care, highlighting the field’s growth and integration across medical, social, institutional, and community-based organizations. Underscoring palliative care’s role in addressing both suffering and quality of life, Dr. Miller reported that palliative care is associated with a number of evidence-based outcomes, including increased patient (and family) satisfaction and quality of life, and increased survival. It is also associated with improved staff satisfaction and retention, improved appropriate use of health care resources, and reduction in total health care costs. Dr. Miller further noted that palliative care is becoming more accepted and integrated throughout the continuum of care, the interdisciplinary palliative care team (doctors, nurses, social workers, chaplains, and others) is a key feature of palliative care. Some teams now include administrators, home health aides, informal caregivers, volunteers, psychologists, artists, etc.

In conclusion, Dr. Miller articulated “the problem,” — the gap between the care people want and the care they receive. The solution he suggested is threefold: grow and incorporate palliative care capacity within health systems across the full continuum (medical + social, institutional + community-based); seek and implement new benefit and payment mechanisms for palliative care; and, utilize community agency skills and assets. Activation of this solution however will require responding to the challenges of limited knowledge regarding the magnitude of need for palliative care, limited awareness of palliative care among providers and the public, a limited palliative care workforce, and misaligned policy and payment mechanisms.

### **Task Force Discussion**

For the remainder of the Task Force meeting, members engaged in two discussions. The first solicited member ideas and suggestions regarding a preferred outcome for the Task Force. Members responded to the prompt, “What do you want to come out of the Task Force?” The second discussion addressed work process and concluded with several suggested Task Force deliverables. Below is a summary of member contributions to each discussion (note: contributions to the outcomes discussion are organized by theme).

### ***Ideas/Suggestions Regarding the Task Force Outcome***

#### **Delivery of Quality Palliative Care Services**

- Address the palliative care needs of the “direct care” workforce
- Recognize that the shortage of trained palliative care specialists is a barrier to the expansion of palliative care services.
- Ensure collaboration and quality through an adequate workforce of palliative care professionals and caregivers educated about palliative care.

- Recognize that spiritual care, as a component of palliative care, is not the same as psychological care or cultural competence, it is its own bonafide component of palliative and end-of-life care.

#### Systems: Healthcare/Social Service

- Establish a navigation system to help patients access palliative care across the health and social service continuum.
- Identify the nexus between two parallel streams in healthcare: complex case management under a medical model and palliative care.
- Get ahead of the curve; provide palliative care “to scale” without sacrificing quality.
- Identify opportunities for support and collaboration between the medical model of palliative care and social supports.
- Identify ways to decrease logistical suffering

#### Community Education/Engagement/Awareness

- Educate and engage people about palliative care early, “up stream,” before they need palliative care, in language they understand.
- Promote advance care planning as a means of helping people understand palliative care.
- Be a community that has an open conversation about treatment preferences.
- Focus on educating the provider community, especially primary care providers, about palliative care. Assist primary care providers in their ability to communicate the relationship between palliative care and hospice to patients—all hospice is palliative care but not all palliative care is hospice, i.e., hospice focuses on end-of-life care, while palliative care extends beyond to include chronic and complex illness; both focus on living well for as long as possible.
- Recognize that the suffering experienced by some segments of the population receiving palliative care may have roots in trauma and inequities experienced earlier in their lives.

#### San Francisco Palliative Care Inventory/Network

- Clarify the existing service structure for palliative care across the continuum – who provides what, where, how much, etc.
- Create a document that describes the spectrum of current palliative care services in San Francisco.
- Clarify terminology of palliative care that articulates services offered; differentiate between bricks and mortar institutions such as hospitals, nursing facilities, hospice residences, and the wider array of community-based services.
- Identify the challenges to getting patients the palliative care services they need and the gaps that need to be overcome through planning and execution of a new service framework.

#### Policy

- Promote policies that expand home-based caregiver support services (i.e., in-home supportive services) for palliative care patients.

### Financing

- Propose a seamless system of palliative care that is coordinated and supported by insurance (e.g., pays for inpatient and outpatient palliative care, and then when needed, hospice) to reduce the financial burden on patients.
- Consider capitation to finance comprehensive and seamless array of palliative care services—share risk (insurers and providers) on value-based contracting strategies.
- Explore the economic viability of reimbursing for integrated palliative care across health care settings; ensure that payers and providers are more in sync on payment issues.
- Verify how many people who were formally uninsured in San Francisco are currently insured under Covered California.
- Recognize the financial impact of current insurance policies that do not reimburse certain palliative care disciplines and activities, i.e., MSWs, chaplains, home visits, TeleMed.

### Need for New and Innovative Services

- Establish a broad-based San Francisco palliative care consultation service.
- Create a daycare for people with palliative care needs.
- Provide transportation services to people with palliative care needs (e.g., cab vouchers).

### Serving Marginalized/Disenfranchised Communities

- Identify opportunities to provide palliative care services to people who are disenfranchised, e.g., homeless, poor, undocumented, uninsured.
- Research the palliative care needs of vulnerable populations.

### ***Discussion: Member Ideas/Suggestions Regarding the Task Force Work Process***

1. Identify major themes from each Task Force meeting and send out surveys to members requesting their input and feedback.
2. Focus each Task Force meeting on specific themes identified in previous meeting or via surveys.
3. Bring in subject matter experts at each meeting to present on relevant themes.
4. Work in small workgroups during Task Force full meetings to develop strategic recommendations.
5. Use DPH Task Force webpage for a Task Force blog.
6. Consider bringing in a design expert if the Task Force elects to create a master blueprint of palliative care.
7. Examine other city initiatives for possible synergies with Task Force.

### Suggested Task Force Deliverables

1. Create an inventory of current palliative care services across the continuum (note: survey Task Force members and other health care and social service partners about the palliative care services they provide or know others provide, include bricks and mortar services as well as service infrastructures).
2. Clarify target population for palliative care services.
3. Develop priority short- and long-term strategic recommendations to respond to current and future palliative care needs (note: recommendations may include a Phase II for the Task Force and development of a comprehensive palliative care service system design/blueprint for San Francisco, development of a pilot project, etc.).

\*The San Francisco Palliative Care Task Force is co-sponsored by the San Francisco Department of Health and the San Francisco Department of Aging and Adult Services with additional support from the California Health Care Foundation and the University of California, San Francisco.

## Task Force Members in Attendance

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