Efficient Delivery of Palliative Care Across a Safety Net System

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Problem Statement

Patients with serious illness have complex psychosocial needs; however, patients and providers are often unaware of many supportive services available to them. My goal was to enhance access to these services by developing a palliative care resource directory.

Initial Discovery

PALLIATIVE CARE RESOURCE DIRECTORY PROJECT

I thought that a resource directory would add value:

- Connecting patients and caregivers with the resources and services needed to avoid unnecessary hospitalizations and ED visits
- Prompt providers to anticipate patients' needs before they become critical

I conducted **15 interviews** with a range of frontline providers and system leaders. I found mostly moderate enthusiasm from frontline providers, and learned that system leaders were exploring technology platforms that could improve care coordination and address the social determinants of health. Rather than compete with a new platform (which would take time to develop), **I pivoted** to address the more pressing need for increased access to specialty palliative care services, which was evident in these initial interviews.

Discovery

Stakeholder Group	Expand access to specialty palliative care	Education for Frontline Providers	Reduce unnecessary end-of-life costs
Frontline providers • RN (4), MD/NP (21) • BHT (7), Navigators (1) • Respite + Home Health Teams (2)	MUST HAVE: 94%	MUST HAVE: 89%	Not tested
Patient Groups (2)	NICE TO HAVE: 100%	Not tested	Not tested
Program Directors (12)	MUST HAVE: 67% NICE TO HAVE: 33%	MUST HAVE: 75% NICE TO HAVE: 25%	Not tested
System Leaders (7)	MUST HAVE: 42% NICE TO HAVE: 42%	MUST HAVE: 29% NICE TO HAVE: 14%	MUST HAVE: 42%
External (2)	MUST HAVE: 100%	MUST HAVE: 100%	MUST HAVE: 100%

I conducted **59 interviews** with key stakeholders. Interview themes included:

- **Need for specialty palliative care beyond current services**
  - ESLD, COPD, CHF; Homeless
- **Need for new models of care delivery, to meet patients' needs**
  - Enhanced home health services, televisits
- **Desire for brief specialist input, to conserve specialist resources and reduce patient appointment burden**
  - Patient Care Conferences
- **Desire for education and training, from frontline providers**
  - Self-care, Communication, Symptom Management, Prognosis

Mission Model Canvas

Key Partners
- External funders (Stupski Foundation, CHCF)
- IT department
- Quality management department

Key Activities
- Develop referral processes
- Attend case review conferences
- Outreach to community and specialty clinics

Key Resources
- Interdisciplinary palliative care team
- IT system for referrals (eReferal)
- Physical space for patient visits

Value Propositions

EXPAND access to specialty palliative care for patients with CHF, COPD, ESLD

SUPPORT frontline providers through education and training in palliative care

REDUCE unnecessary hospitalizations and ED visits for patients with serious illness by 40%

Buy-in & Support

Mandate (SB 1004)

Network of champions

Stakeholder feedback

Deployment
- eReferral
- Patient care conferences
- Televisits
- Clinic visits
- In-person and online education sessions

Beneficiaries

FRONTLINE PROVIDERS (clinicians, behavioral health, homeless outreach)

PATIENTS with serious illness (cancer, COPD, CHF, ESLD)

Mission Budget/Cost

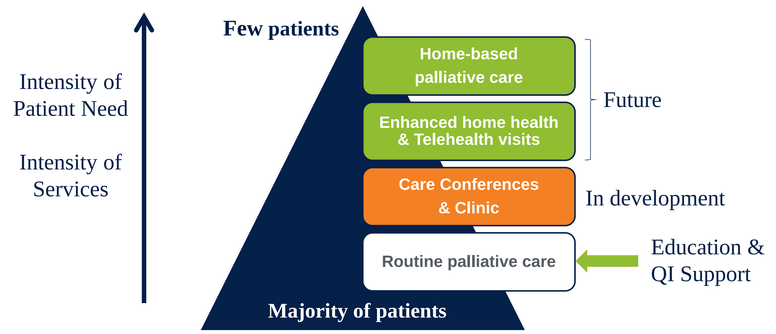
Staff salaries (1.5 MD, 1.0 SW, 1.0 Program Coordinator)

Mission Achievement/Impact Factors
- Reduce both end-of-life ED visits and hospitalizations by 40%, for patients who receive "early" palliative care (>90 days before death)
- Improve self-rated confidence in delivering "primary palliative care," by 20%
- Specialty palliative care offered to 80% of patients eligible for SB 1004 Palliative Care

Lessons Learned

Based on the themes from stakeholder interviews, I developed a conceptual model for palliative care delivery.

Conceptual Model for Palliative Care Delivery



KEY LESSONS

- The majority of palliative care will be delivered by frontline providers. Specialty palliative care providers will play a key role in equipping frontline providers through education and assistance with quality improvement activities.
- Alternative care delivery models (e.g. facilitated care conferences) may be needed to meet the needs of vulnerable patients.

Next Steps

- To support new initiatives shown in the conceptual model, we applied for and were awarded **$500,000 IN EXTERNAL GRANT FUNDING**
- New staff will start September 2017 → (Some additional discovery and adjustment to model) → Pilot clinical and educational initiatives
- New staff to champion individual innovation projects:
  - Operationalizing new care delivery models (sub-CHIP projects)
    - Televisits
    - Home visits
    - Patient care conferences
  - Educational needs assessment & strategic planning
- Will develop strategy, outreach, and implementation plan for expanding services to patients with COPD, CHF, ESLD
- Will complete end-of-life care utilization analysis and develop business plan for service sustainability, based on expected cost savings
- Will evaluate pilot initiatives, report on progress, engage in ongoing quality improvement