Outpatient Palliative Care in a Community Clinic Setting:

An Innovative Approach to Care

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Objectives

- Identify the organizational models for a hospice supported palliative care program
- Describe examples of consultative and treatment services provided in an outpatient palliative care clinic
- Identify regulatory issues related to the development and operation of an outpatient palliative care clinic

What does Siri think?

PALLIATIVE CARE: Evolved from Hospice

HOSPICE ⇨ **PALLIATIVE CARE**

Open and Honest Communication

Dedication to Whole Person Care
within family framework

Interdisciplinary Coordination
Develop/coordinate the "Plan of Care"

Optimizes Clinically Relevant Outcomes

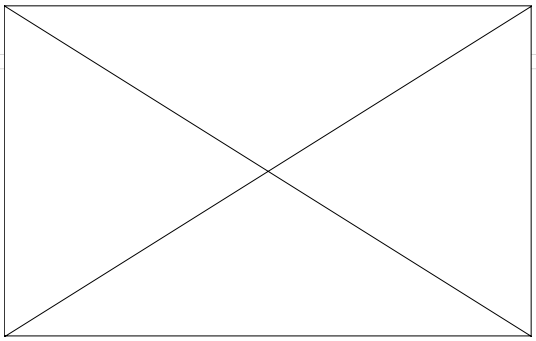
Why is Palliative Care Important?

The sickest and most vulnerable 5% of patients account for 50% of all healthcare spending

Medicare Payment Policy: Report to Congress. Medpac 2009 www.medpac.gov
Health Affairs 2005;24:903-14.
CBO May 2009 High Cost Medicare Beneficiaries www.cbo.gov
nchc.org/facts/cost.shtml

Need for Out-Patient Palliative Care in Advanced Illness

- Inadequate symptom management
- Need to decrease hospital re-admissions
  - 50% not seen by clinician within 30 days
  - Uncontrolled symptoms often lead to hospitalization
  - Need for medication re-conciliation, compliance
- Fragmentation of care, need for care coordination
- Psycho-social support for families
- Need for a continuing dialogue on expectations and goals of care



Need for Out-Patient Palliative Care

- Inadequate symptom management
  - There just wasn't a lot of attention paid to the symptoms, and for any cancer patient that's the reality for them, that's what they're suffering from the most
  - "He wanted to make the most of each day and there was something missing that wouldn't allow him to do that"
  - The challenge of the disease and the symptoms was overwhelming … "and there just wasn't anyplace to turn"

Why Palliative Care is Important to Improving Value in Health Care

- Improves patient quality *and* length of life
- Improves family satisfaction and long-term well-being
- Reduces resource utilization and costs

Palliative Care Gaps In Current System

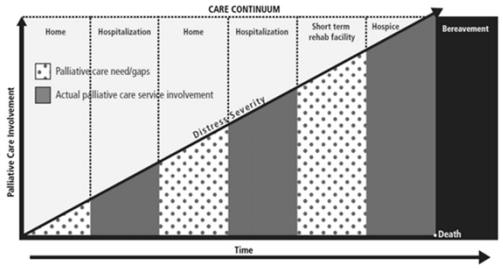
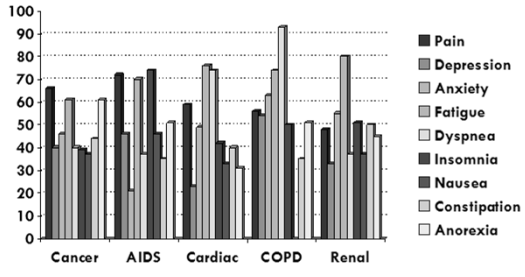


Fig. 1. Care gaps in current palliative care delivery models.

Kamal AH, Currow DC, Ritchie CS, et al., JPSM 2012 Nov 15. in press

Symptom Burden in Advanced Illness

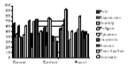


JP Solano, B Gomes, Higginson,J Pain Symptom Manage 2006; 58--69

Opportunities for Cost Avoidance

HIGH MEDICAL COMPLEXITY

+

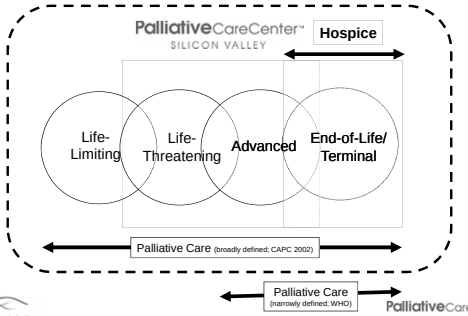


HIGH SYMPTOM BURDENS

=

HIGH RISK FOR ADMISSION

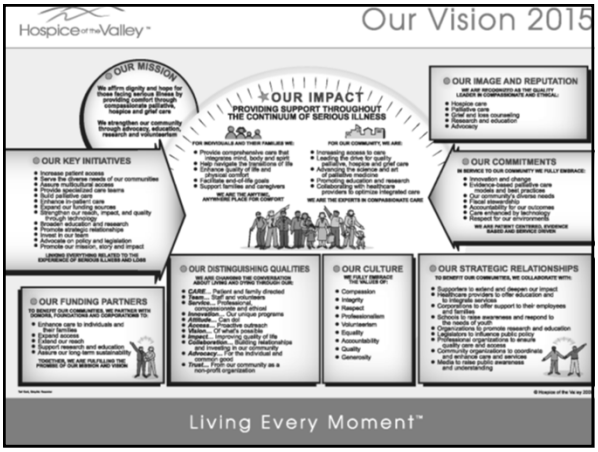
Target Population: Chronic Serious Illness



First Steps

Key Initiative: "Build Palliative Care"

- Strategic planning process
  - Multi-dimensional scan
  - Emerging landscape: economic; healthcare; socio-demographic; technological; political and environmental
  - Local, state and national perspectives
  - Key stakeholder and focus groups
  - Site visits
  - Futures and Vision Conference
  - Key initiative: **"Build Palliative Care"**



Potential Business Models for Palliative Care

- **Managed or Integrated Care Systems Models**
  - With the expectation that projected savings will offset costs of palliative care service
    - Re-admissions
    - ICU stays
    - In hospital mortality
- **Academic Models**
  - Clinical service, education, research
- **Community Based Models**
  - Sponsoring Organizations
    - Hospitals
    - Multi-specialty Clinics
    - Other Entities, e.g. home care
    - Hospice

Deterrents to Out-Patient Palliative Care

- Few organizational models outside of academic, managed/integrated care systems
  - Results from these are difficult to extrapolate to other settings
- No reimbursement mechanism specific to palliative care professionals
  - Code for symptoms
  - Family meetings, GoC discussions not reimbursed
  - Fees similar to IM/FP but for greater time investment
- Paucity of established business models

Clinic Model

- **Advantages**
  - Opportunity to see patients at earlier stages of disease for advanced care planning and symptom management
  - More efficient use of professional resources
  - Broader array of treatments and diagnostic opportunities
  - Advantages of a unique community offering
- **Disadvantages**
  - Money, time and risk
  - **Largely uncharted waters for a community based organization**
  - Available models uncertain

California Hospices are Often Expert in Palliative Care and Provide these Services to the Dying: Why not also to those living with serious illnesses?

The Corporate Practice of Medicine Law

California law prohibits the corporate practice of medicine. Laypersons or lay entities may not own any part of a medical practice. (Business & Professions Code Section 2400) Physicians must either own the practice, or must be employed or contracted by a physician-owned practice or a medical corporation. (The majority of stock in a medical corporation must be owned by California licensed physicians, with no more than 49% owned by other licensed health care professionals, such as nurses, physician assistants, nurse practitioners, etc. No stock in a medical corporation may be owned by a lay-person. (Corporation Code Section 13401.5(a))

How Can California Hospices Partner with Physicians to Provide Palliative Care?

- ☐ Foundation Model HSC 1206i (> 40 MDs; 10 Specialties etc.)
- ☐ Contracting with a Medical Corporation
- ☐ As a Management Services Organization (MSO)
- ☐ Through a Primary Care Community Clinic

Considerations

- Tax-exempt status
- Medicare-certified hospice
- Corporate Practice of Medicine
- Model

Business Model

- Direct Revenue
  - Professional services
  - Assumption of risk (managed care)
  - Philanthropic support
  - Grants
  - Directorships (Hospitals)
- Favorable impact on hospice census
  - Increase in referrals (direct and indirect)
  - Increase in LOS

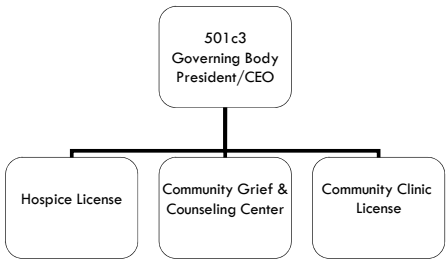
Risks of Business Model

- Referral of chronic non-cancer pain
- Inundation with patient requests
- Problems recruiting staff
- Parasitizing hospice referrals though prolonged palliative care services
- Limited referrals
- Change in Medicare reimbursement for hospice
- Medi-Cal eliminates hospice coverage

Start Up Phase

- Due diligence
  - Counsel
  - Consultants (hospice regulatory and community clinic)
  - Dept of Public Health
- Governing Board approval of project and budget
- Corporate structure

Corporate Structure



Governing Body Actions

- Resolutions:
  - Amend and restate Articles of Incorporation
  - Direct staff to establish a Palliative Care Center licensed as a community clinic
  - Designate the Board as the Center's Governing Body
  - Amend the Bylaws: Palliative Care Center and Hospice Committees
  - Appoint Administrator

Next Steps

- Organization engagement
- Community engagement
  - Independent; free-standing, community-based
  - Facility location
  - Comprehensive integrated model incorporating Transitions
  - Strategic partners

Regulatory Requirements

Palliative Care Center License

- Licensed as a Community Clinic, defined as an outpatient health facility for patients who remain less than 24 hour and provide direct medical, surgical, dental, optometric or podiatric advice and services, as well as counseling
- Community Clinics are regulated under Title 22, Division 5, Chapter 7
- Two types of Community Clinics:
  - Primary Care, which includes community and free clinics
  - Specialty, which includes surgical, chronic dialysis and rehabilitation clinics

Community Clinic Licensure Eligibility

- Community Clinic operator must be a non-profit corporation
- Charges to patients for services must be based on the patient's ability to pay, utilizing a sliding fee scale.

Community Clinic Services

- Community Clinics must provide or arrange for the diagnostic, therapeutic, radiological, laboratory and other services for care and treatment of patients admitted for care to the clinic.
- Community Clinics must:
  - Offer supervision of each service provided by a person licensed, certified or registered to provide the service
  - Maintain written patient care policies
  - Maintain the equipment and supplies required to provide the services

Community Clinic Staffing

- Staffing regulations require:
  - Designation of a licensed MD as professional director
  - Appointment by the Governing Body of an administrator
  - The presence of an MD, PA or RN whenever medical services are provided
  - That at least 1 MD has admitting privileges at an area hospital
  - That the number of nursing staff be based on the number and types of patients seen in the clinic

Community Clinic Organizational Requirements

- Operates under a governing body with legal authority and responsibility for clinic's operation
- Recruits, hires and orients employees according to job descriptions & provides continuing training
- Maintains current & accurate personnel records and patient health records
- Reports unusual occurrences (epidemic outbreaks, poisonings, fires, major accidents
- Maintains disaster and QAPI programs

Community Clinic Facility Requirements

- Building permit issued by and building inspection conducted by the city or county as applicable
- Clinic facility must comply with OSHPD 3 requirements

OSHPD 3 Requirements

- Minimum size requirements for exam and treatment rooms
- Lockable medication storage, including a medication refrigerator
- Utility room with separate clean and dirty work areas & janitor's closet with mop sink
- Air circulation/filtration that meets Heating, Ventilation & Air Conditioning specifications
- Provision for medical waste holding or disposal

Strategic Partners

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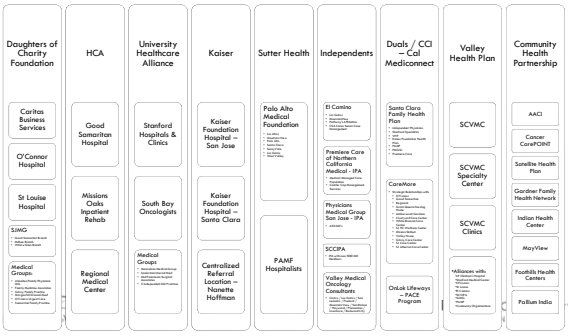
Our Local Landscape



PalliativeCareCenter™ SILICON VALLEY

Beneficiaries	☐ Patients and their families having chronic, life threatening illnesses
Services	☐ Medical consultation and care Symptom and "illness" Management Communication, Guidance GoC
	☐ Nursing support
	☐ Counseling and case management
	☐ Volunteer support
	☐ Family caregiver program

Referral/Recommendation Sources

- ☐ Independent practitioners and medical groups
- ☐ Patient self-referral
- ☐ Hospitals (e.g. discharge planners)
  - ◘ In-patient, ER
- ☐ SNF/ALF
- ☐ Insurance plans
- ☐ Case management organizations
- ☐ Home health agencies
- ☐ Community organizations

Consultation Referral Screen

Life-threatening Illness

< 3 Year Life Expectancy

- ◘ Symptoms poorly controlled
- ◘ Poor understanding of illness
- ◘ Goals of Care require clarification

- ◘ Recent Hospitalization, e.g. CHF, COPD
- ◘ Hospital discharge to SNF
- ◘ CARS score; Charlson Comorbidity Score
- ◘ Physiologic Score, e.g. BOLD, Child-Pugh; Seattle Heart Score
- ◘ Dx Advanced Cancer; Starting Hemodialysis

Out-Patient Palliative Care

- ☐ **Intake**
  - ◘ **Assessment of Need**
  - ◘ **Risk Stratification**
- ☐ **Evaluation**
  - ◘ **IDT**
- ☐ **Care Plan**
- ☐ **Follow-up management**
- ☐ **Communication**

→ **Interdisciplinary Team**

→ **Case Management**

→ **Bioethics, Other Committees**

Clinic Operation

- **Co-management model preferred**
  - Consultative
  - Assume care
- **Staffing**
  - 1 -1.5 FTE MD
  - NP
  - LCSW
  - MSW Intern
  - Administrator
  - Office Coordinator
  - Volunteers

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- Freestanding (Independent)
- Outpatient
  - Inpatient and home services
- Licensed
- Interdisciplinary
  - *Nursing (NP)*
  - *Medical*
  - *LCSW, MSW Intern*
  - *Transitions; Volunteer services*
  - *Integrative therapies*
- Research oriented and evidence based

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The First Six Months

- Challenges and Opportunities
- Lessons Learned

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Screening Tools

Hospice of the Valley

Palliative Care Center SILICON VALLEY

Palliative Care Center
Transitions Screening Tool

TOTAL SCORE: ______

CRITERIA				SCORING
Basic Disease Process: Score 2 points for each disease. ☐ Cancer (Metastatic/Recurrent) ☐ Advanced COPD ☐ End stage renal disease ☐ Alzheimer's, other dementia, Parkinson's ☐ General Debility		☐ Stroke (with decreased function of at least 50%) ☐ ALS ☐ Advanced heart disease (e.g. severe CHF, CAD) ☐ Other life-threatening illness ______		______
Palliative Performance Scale (PPS)				
0	1	2	3	
☐ PPS 70-100%	☐ PPS 60%	☐ PPS 50% ☐ PPS 40%	☐ PPS 30% ☐ PPS 20% ☐ PPS 10%	______
Illness onset or progression over the past years NO (0) ____ YES (2) ____				
Unrelieved Physical Symptoms (e.g. pain, dyspnea) NO (0) ____ YES (2) ____				

Patient's Overall Level of Psychosocial & Spiritual Distress

Scoring
- 0 ☐ **Not at all distressed**
- 1 ☐ **Mild** chronic distress or infrequent moderate distress (≤ 1/wk) & brief duration (≤ 24 hrs)
- 2 ☐ **Moderate** continuous or moderate episodic distress (at least once a week)
- 3 ☐ **Severe** ongoing or severe episodic distress at lease several times a week

______

Family's/Caregivers Overall Level of Distress

Scoring
- 0 ☐ **Not all distressed**
- 1 ☐ **Mild** chronic distress or infrequent moderate distress (≤ 1/wk) & brief duration (≤ 24 hrs)
- 2 ☐ **Moderate** continuous or moderate episodic distress (at least once a week)
- 3 ☐ **Severe** ongoing or severe episodic distress at lease several times a week

______

Unmet Needs

Scoring
- 0 ☐ Patients & families needs are being adequately addressed in all areas of care
- 1 ☐ Mild concern that patient &/or families needs are not being adequately addressed
- 2 ☐ Moderate concern that patients &/or families needs are not being adequately addressed
- 3 ☐ Major concern that patients &/or families needs are not being adequately addressed

______

Decision Making Conflict and/or Distress

Scoring
- 0 ☐ **No distress &/or conflict** with decision making
- 1 ☐ **Mild**, intermittent distress &/or conflict with decision making
- 2 ☐ **Moderate** episodic or continuous distress &/or conflict with decision making
- 3 ☐ **Severe** episodic or continuous distress &/or conflict with decision making

______

Advanced Care Planning

Scoring
- 0 ☐ Written designation of surrogate & discussion with surrogate
- 1 ☐ Written designation of surrogate, but no detailed discussion of advanced care preferences
- 2 ☐ Witnessed verbal statement of advanced care preferences & goals of care
- 3 ☐ None or vague communication about advanced care preferences

______

Client Name: ______

Adapted from Centre Baptist Hospital Palliative Care Screening Tool & Palliative Acuity Scale

Hospice of the Valley

Palliative Care Center SILICON VALLEY

Palliative Care Center
Transitions Screening Tool

Eligibility Guidelines for Transitions:

1 Patients must have one or more of the diseases listed in **Basic Disease Process** (≥ 2 points); **and**

2 **PPS** of ≤ 60% or less (≥ 1 points); **and**

3. **Illness Onset or Progression Within the Past 2 Years**: Yes (2 points)

4 **Patient and Family's Overall Level of Psychosocial & Spiritual Distress** (0-15)

1 + 2 + 3 MUST all be present for someone to be considered eligible for Transitions

Total Score:

- 0 – 4 Points: Not appropriate for Transitions, but may be appropriate for other Palliative Care services
- 5 - 10 Points: May be appropriate for Transitions, additional information required
- ≥ 11 Points: Appropriate for Transitions, schedule admission home visit

Eligibility Guidelines for PCC:

1 Patients must have one or more of the diseases listed in **Basic Disease Process** (≥ 2 points); **and**

2. **Illness Onset or Progression**: Yes (2 points)

______ Nurse Practitioner Signature ______ Date

______ LCSW Signature ______ Date

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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Client Name: ______

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Marketing and Communications

Hospice of the Valley

Palliative Care Center SILICON VALLEY

Media Coverage

BayAreaNewsGroup

The Mercury News

California's first outpatient palliative care center opens in San Jose

By Lisa M. Krieger
September 13, 2013

Striving to treat not just a disease, but the entire person, a new medical facility for the seriously ill has opened in San Jose.

The first free-standing outpatient center of its kind in California, Palliative Care Center Silicon Valley aims to treat often overlooked aspects of major illness: pain, other types of discomfort, emotional distress and anxiety of families facing difficult decisions.

The opening of the nonprofit center was celebrated Friday in a ribbon-cutting ceremony with San Jose Mayor Chuck Reed, who said his wife, a nurse, is an advocate of palliative care. The center is a division of the nonprofit Hospice of the Valley.

"It is about making the lives of people more comfortable and higher quality," said Dr. Neal Slatkin, chief medical officer for Hospice of the Valley, who will treat patients at the center.

"We have tended to neglect that aspect of medicine," he said. "We have been seduced by our technologies."

Palliative is rapidly emerging as a vital resource to those struggling with serious and life-threatening illnesses. The root word for palliation in Latin, alliare, means to cloak or shield. Palliative care protects people from the ravages of illness, while reducing the stressful, expensive and often unnecessary rushes to hospital emergency rooms.

Unlike hospice care, palliative care can be provided together with curative and life-prolonging treatments.

Most palliative care is offered at hospitals. An estimated 1,600 U.S. hospitals offer inpatient programs.

For patients not sick enough to need hospitalization, a few pioneering health-care providers, such as Palo Alto Medical Foundation and Kaiser, offer home-based care. But the new San Jose

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世界日報 sf.worldjournal.com | facebook.com/sfworldjournal
2013年9月14日 星期六 SATURDAY, SEPTEMBER 14, 2013

加州首座臨終關懷中心 聖荷西 開幕

州内首座獨立設施 病人可接受體檢、商討治療計畫 市長偕夫人出席剪綵

Hospice of the Valley

Palliative Care Center SILICON VALLEY

On September 13, Mayor Chuck Reed joined Hospice VP of Medical Services and Chief Medical Officer Neal Slatkin, MD, Hospice Board Chairman Euan Thomson, PhD, Councilmember Johnny Khamis, and Hospice of the Valley President and CEO Sally Adelus, celebrating the Palliative Care Center Silicon Valley's grand opening. *(Photo Courtesy of Palliative Care Center Silicon Valley)*

Hospice of the Valley

PalliativeCareCenter SILICON VALLEY

CaliforniaHealth REPORT

California Expands Palliative Care Efforts Through Nurse Training and the State's First Outpatient Center

February 14, 2014
By Linda Childers

When Janna Woods was diagnosed with ovarian cancer last May, the Cupertino resident was unsure how she could possibly cope with the chronic back pain that had plagued her for years, combined with the onset of cancer pain.

"Chronic pain is such a debilitating condition," Woods says. "While I had been seeing a wonderful pain doctor in Santa Cruz, I knew I wouldn't be able to continue making the forty minute commute to his office while undergoing chemo."

Fortunately, a friend told Woods about the new Palliative Care Center Silicon Valley (PCCSV) in San Jose. The first independent, community-based, licensed outpatient palliative care center in California, the center, a division of Hospice of the Valley, opened its doors to the public in July 2013.

Neal Slatkin, M.D. with patient at the Palliative Care Center Silicon Valley

"Palliative medicine offers a different model of care, focusing on a patient's relief and prevention of suffering," says Sally Adelus, president and CEO of Hospice of the Valley. "Our multidisciplinary team of doctors, nurses, social workers and other staff work to support the physical and emotional needs of seriously ill patients and their families."

While most palliative care programs are offered in hospitals, PCCSV provides outpatient care for patients with serious illnesses such as congestive heart failure, chronic obstructive pulmonary disease (COPD), cancer, kidney failure, and Alzheimer's disease. PCCSV services include pain and symptom management, emotional and practical support, counseling to help adjust to life with a serious illness, and complementary therapies including Reiki and massage.

The center contracts with most insurance providers and Medicare, and patients without insurance are given the option of paying on a sliding-scale basis. As a nonprofit

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Early Outcomes

Hospice of the Valley

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Questions?