

The State of Palliative Care in California's Catholic Hospitals*

September 2008

***"You matter because you are you.
You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but
to live until you die."
-- Dame Cicely Saunders***

Providing appropriate, high quality care is a challenging priority for healthcare providers; particularly given the shifting demographics, limited financial resources, expensive curative treatments, and the interplay between these issues. In order to adequately address this priority, health professionals must have access to more than just advanced life-saving techniques, but also to state-of-the-art care designed to manage the complex symptoms of people with serious, life-threatening, and terminal illnesses. Hospice care is the most widely recognized type of such care. However, in recent years health care leaders have been paying growing attention to palliative care, which "expands traditional disease-model medical treatments to include the goals of enhancing quality of life for patient and family, optimizing function, helping with decision-making, and providing opportunities for personal growth. Palliative care can be delivered concurrently with life-prolonging care or as the main focus of care." (National Consensus Project for Quality Palliative Care 2004)

During the first quarter of 2008, the California HealthCare Foundation sponsored a review of California hospital-based palliative care programs by the National Health Foundation and University of California, San Francisco, Palliative Care Team. The web-based survey was designed to identify existing adult and pediatric palliative care programs, how they are structured and what they are doing.

In its ongoing efforts to address and promote positive end of life health care policies, the Alliance worked with the California Health Care Foundation and the University of California, San Francisco, on their survey instrument. This collaboration ensured that the survey would meet the needs of Catholic hospitals while not duplicating efforts on the statewide level.

Appendix C provides a summary report of the survey results for all hospitals in California that participated in the survey. The survey was released to 353 California hospitals and had an astounding 92% response rate and 85.5% completion rate.

The following report provides a snapshot of survey results for California Catholic hospitals (see Appendix B for a list of participating Catholic hospitals). Some highlights:

- Catholic hospitals had a 98 percent response and completion rate (49 of 51 hospitals).
- Of the 49 responding Catholic hospitals, 86 percent have a palliative care program (as compared to 43 percent of all responding California hospitals), most having only adult palliative care services.
- Following the trend of all California hospitals, the majority (97 percent) of palliative care programs in Catholic hospitals have been launched since 2000.

- Relative to hospital systems, Providence Health & Services and Catholic Healthcare West report the highest proportion of palliative care programs within their hospitals followed by St. Joseph Health System and Daughters of Charity Health System.
- Of the remaining Catholic hospitals in California, Saint Agnes Medical Center, St. John's Health Care Center and Scripps Mercy all report having palliative care programs.
- More than 74 percent of Catholic hospitals reported collecting patient utilization data, patient demographics and discharge disposition, and 95 percent reporting having established outcome goals.

In order to identify and promote the development and sustainability of palliative care programs, the survey was also designed to capture information on the barriers to establishing such programs, how new programs can be implemented, and how to increase the quality of existing programs. Appendix A is a summary of this qualitative data.

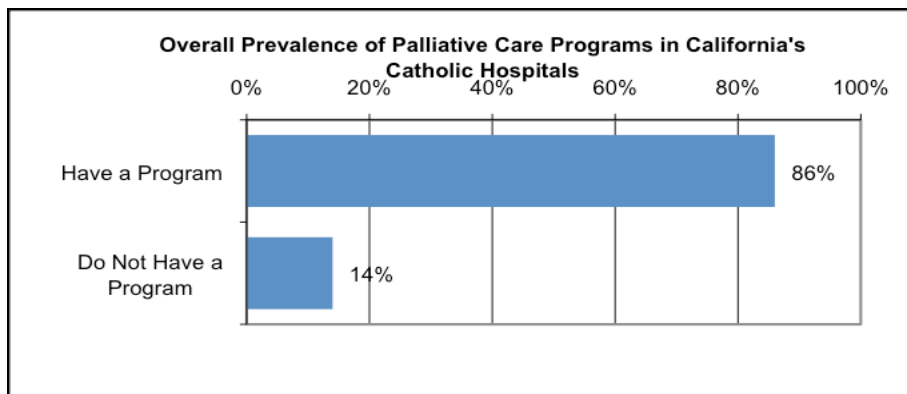
It is anticipated that the results from this survey will provide baseline data against which the success of future efforts could be assessed. The Alliance will continue discussions with CHCF on additional data analysis, and work with its member health systems and hospitals on future efforts. The survey results will also be shared with other Catholic partners, such as the Supportive Care of the Dying Coalition, led by Sister Karin DuFault.

* Adapted from the report to the California Healthcare Foundation prepared by Danielle Cameron, National Health Foundation - June 2008

The State of Palliative Care in California's Catholic Hospitals: A Summary

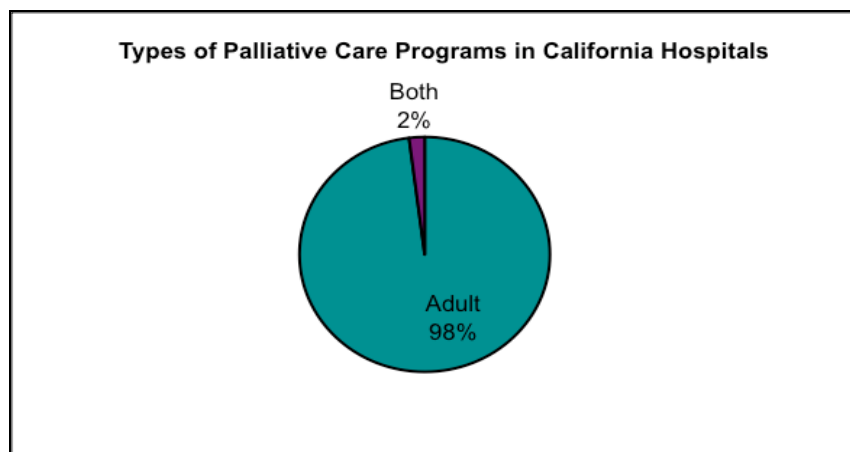
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Overall Prevalence of Palliative Care Programs in California's Catholic Hospitals



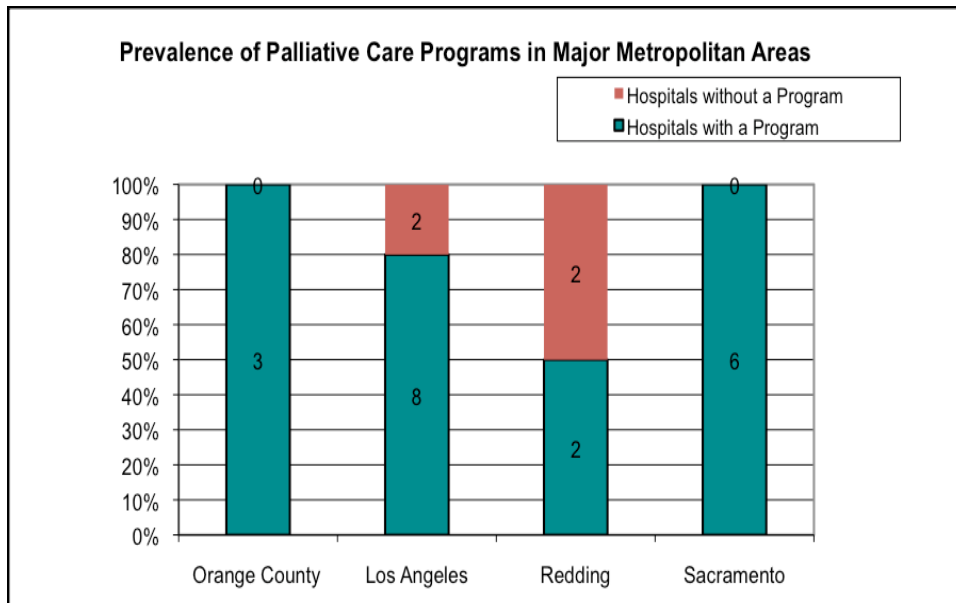
86% (42/49) of responding hospitals reported having existing palliative care programs. Two hospitals did not respond to the survey.

Types of Palliative Care Programs in California's Catholic Hospitals



Of 42 hospitals with palliative care programs, the majority (98%) report having only adult services. One hospital reported having both adult and pediatric services. No hospitals reporting having only pediatric services.

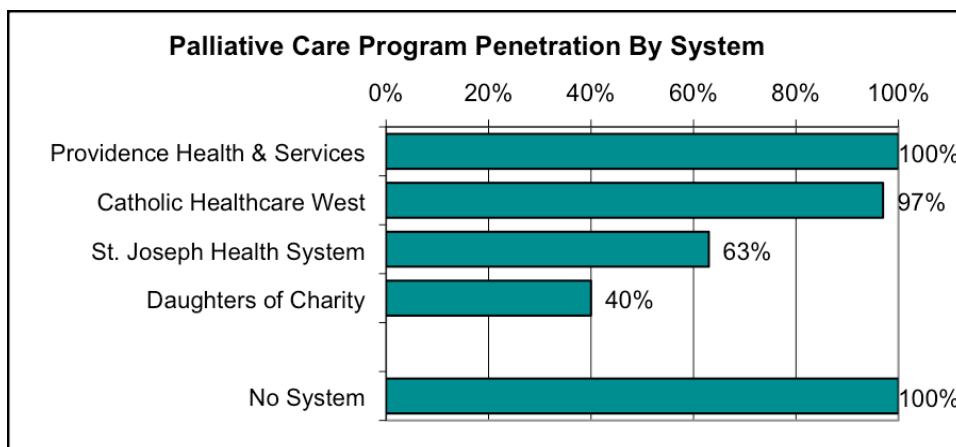
Regional Differences in Existence of Programs



Comparing hospital referral regions where there exist more than two alliance hospitals, Los Angeles reports the largest number of programs (8), but Sacramento (100%, 6/6) and Orange County (100%, 3/3) report the highest rate of hospital-based palliative care programs.

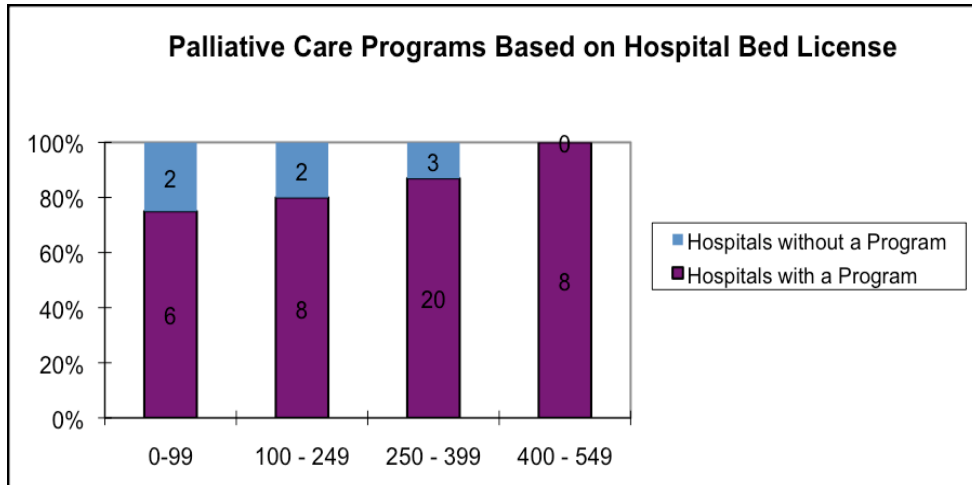
Note: Hospital referral regions were assigned to hospitals based on zip codes from the Dartmouth Atlas *Geographic Query Finder* (2007).

Existence of Palliative Care Programs in Relation to Hospital System



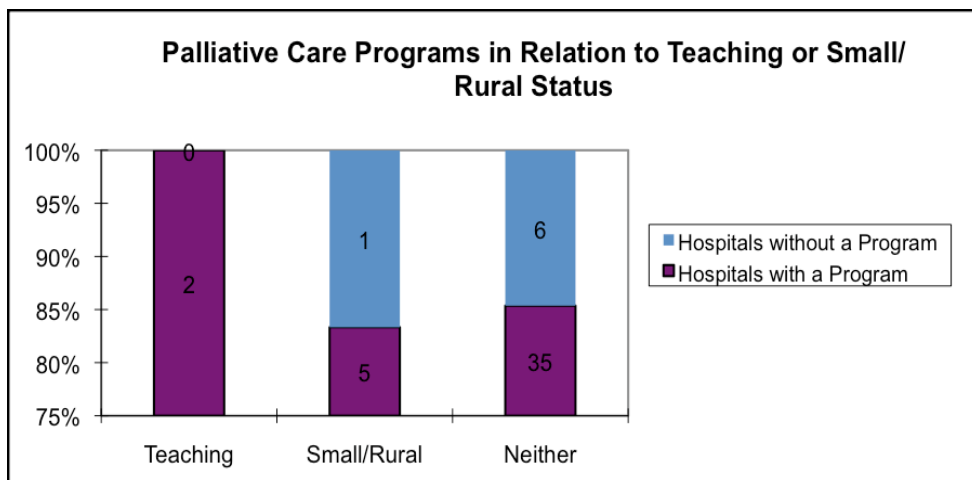
Providence Health & Services (100%, 4/4) and Catholic Healthcare West (97%, 28/29) report the highest proportion of palliative care programs within their hospitals. They are followed by St. Joseph Health System (63%, 5/8) and Daughters of Charity (40%, 2/5). All three non-system hospitals report having palliative care programs.

Existence of Palliative Care Programs in Relation to Licensed Bed Size



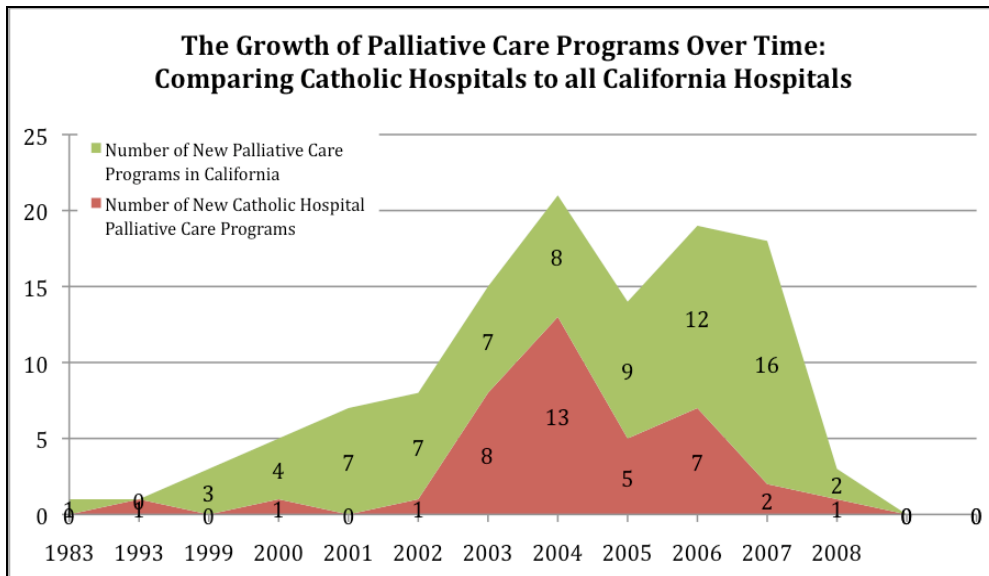
As licensed bed size increases, so does the proportion of hospitals with palliative care programs. The largest proportion of hospitals (23/42) have a licensed bed size between 250-399; 87% of them report having a palliative care program.

Existence of Palliative Care Programs in Relation to Teaching or Small/Rural Status

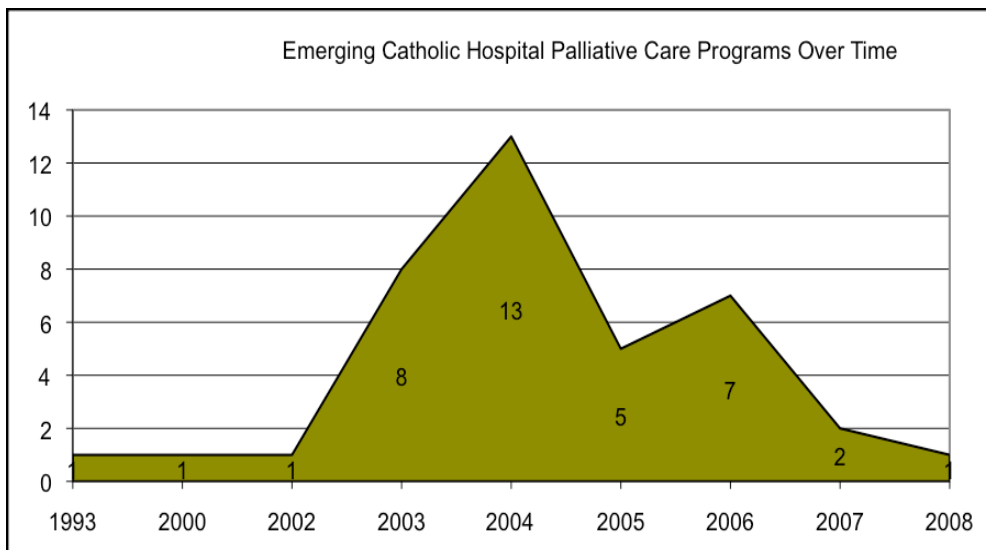


Alliance of Catholic Health Care hospitals tend to be neither teaching nor small/rural. With that said, 100% (2/2) teaching hospitals have palliative care programs and (73%, 5/6) small/rural hospitals report having palliative care programs.

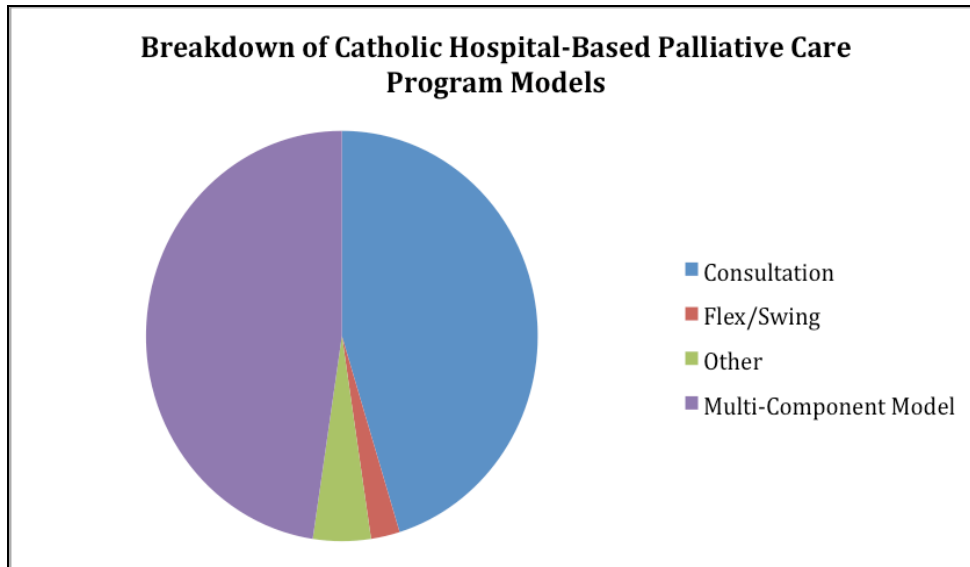
The Growth of Palliative Care Programs Over Time: Comparing Catholic Hospitals to all California Hospitals



Following the trend of all California hospitals, the majority 97% (38/39) of palliative care programs in Catholic hospitals have been launched since 2000.

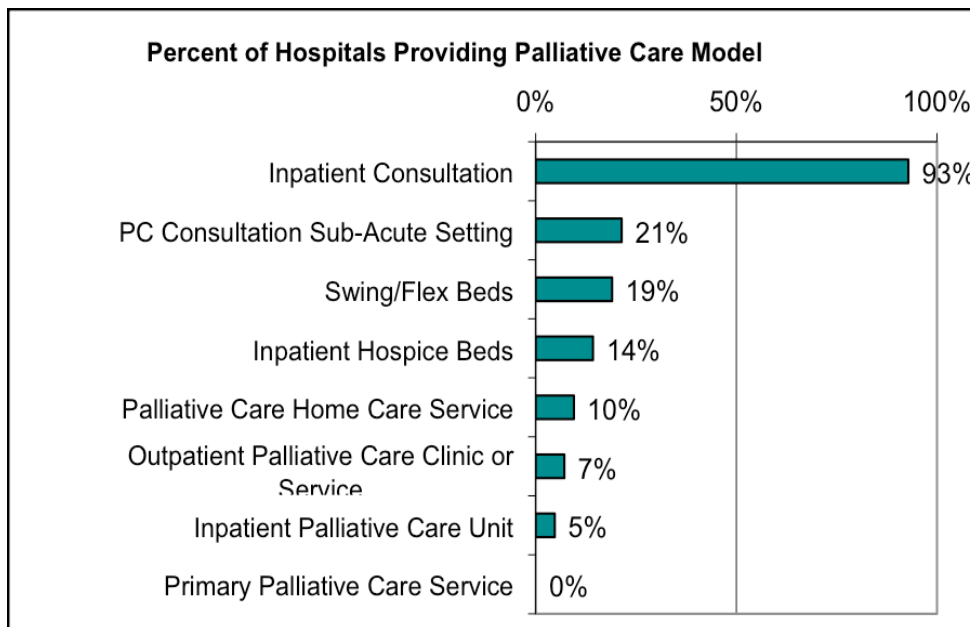


Prevalence of Types of Adult Palliative Care Models



93% (39/42) of Catholic hospitals with palliative care programs provide inpatient consultative services. 45% (19/42) provide ONLY inpatient consultative services. Another 48% (20/42) have multiple components in addition to consultative services.

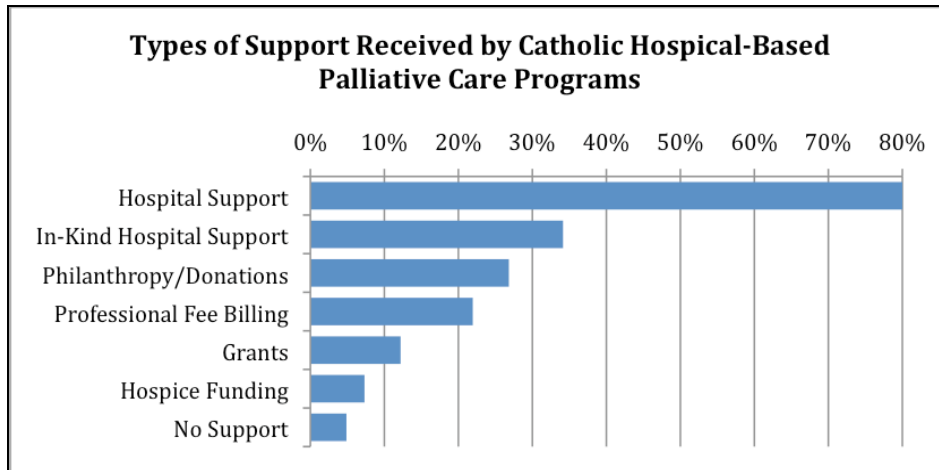
However, no hospital provides primary palliative care service and four or less provide home service, outpatient service or an inpatient unit. The majority of hospitals with multiple programs have consultation services along with either swing/flex beds, inpatient hospice beds, or consultation in a sub-acute setting.



3 hospitals reported having different types of adult palliative care service models without the consultation service component.

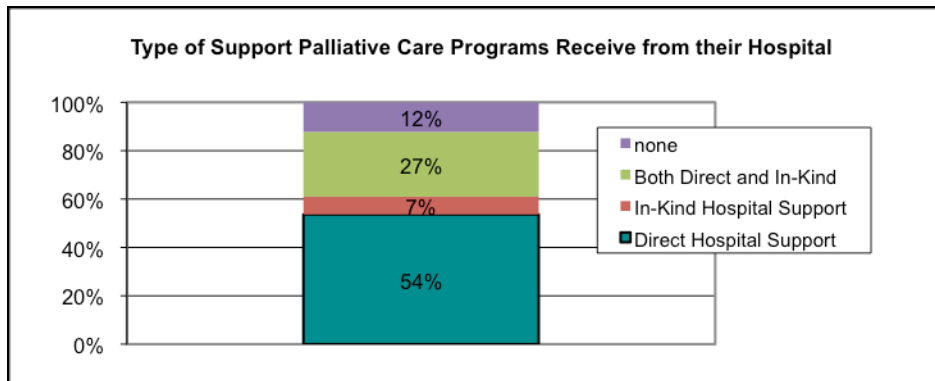
Note: "Other" model includes inpatient hospice beds, consultative services in a sub-acute care setting, and palliative home care.

Financial Resources of Adult Palliative Care Programs

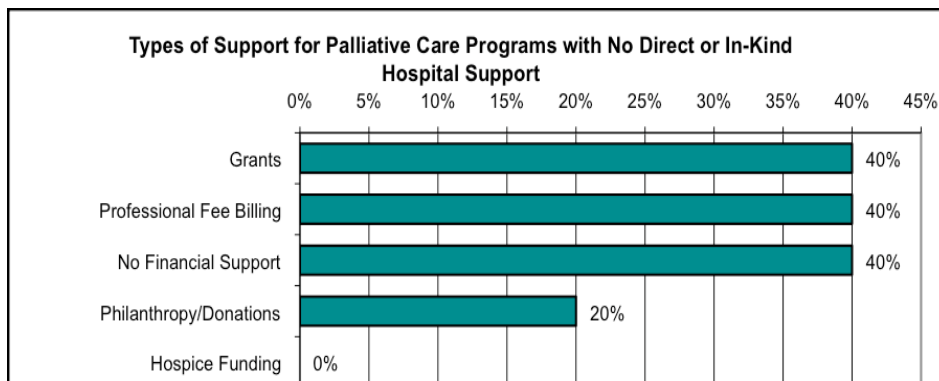


Adult palliative care programs are multi-stream funded. While only a small portion report receiving grants (12%, 5/41), or hospice funding (7%, 3/41), 80% (33/41) of programs reported receiving direct financial support from the hospitals. Two hospitals report receiving no financial support and have no staff whose job descriptions include working on the palliative care service. In these two hospitals, palliative care is provided on an ad hoc basis by individuals who have an interest in palliative care but no formal charge to deliver such services.

Type of Hospital Support Received by Palliative Care Programs

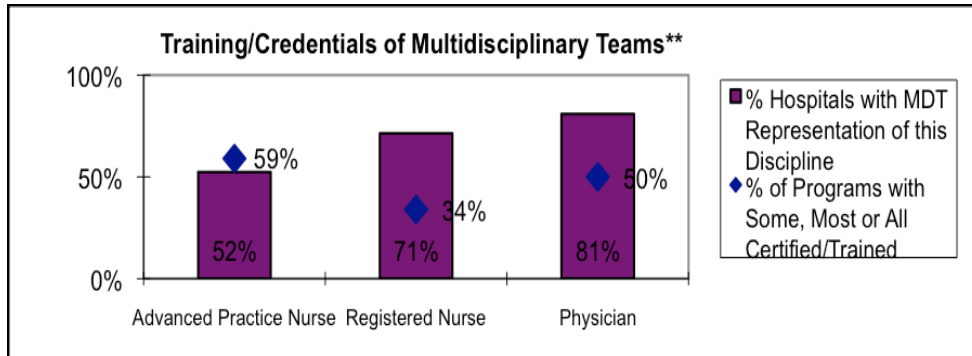


The majority of palliative care programs (88%, 35/41) receive direct, in-kind or both types of support from their hospital.

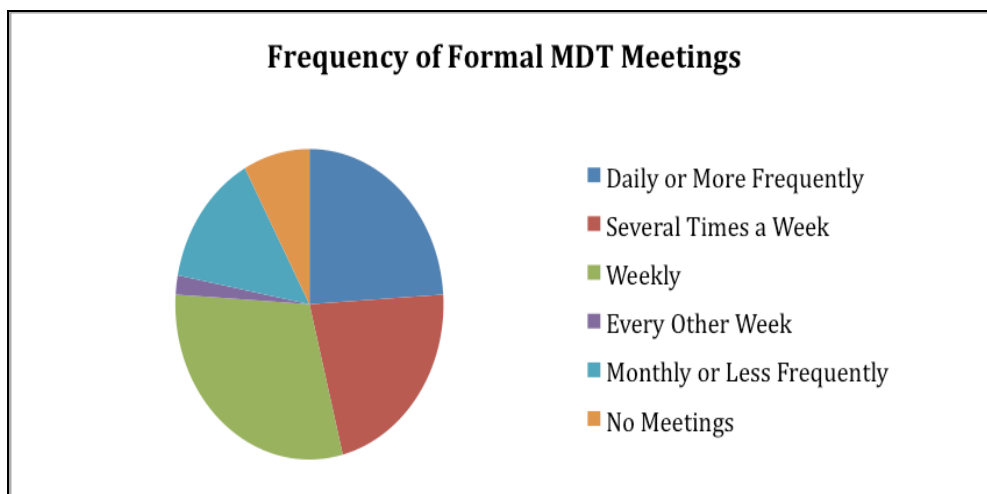


Of the five palliative care programs that receive neither direct nor in-kind support from their hospital, 40% receive grants and 40% receive professional fee billing, but 40% receive no financial support whatsoever. (Categories are not mutually exclusive.)

Adult Palliative Care Program Multidisciplinary Teams



50% (21/42) or more of surveyed adult palliative care programs have the following disciplines represented: spiritual care professional (88%), physician (81%), social worker (79%), registered nurse (71%), admin support (60%), pharmacist (55%) and advanced practice nurse (52%).



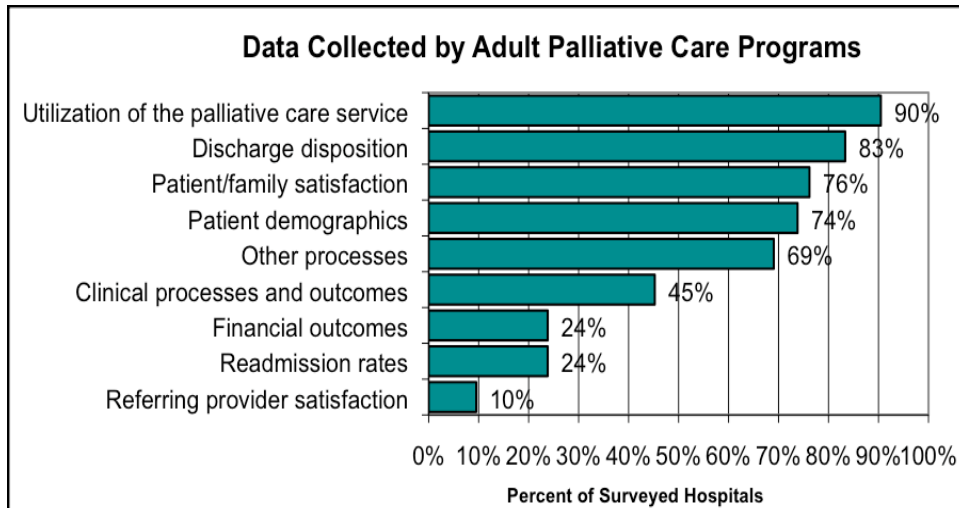
For three common disciplines represented, between 34% and 59% have actual palliative care training or credentials.**

5% (2/42) or less of surveyed hospitals had MDTs with representation for psychiatrist (5%), psychologist (2%) and physician assistant (0%).

92% (34/37) of responding hospitals with adult palliative care consultation services report their multidisciplinary teams host formal meetings, a third of which meet daily.

**Refers to those who are certified or credentialed in palliative care by the ABHPM, HPNA or have completed a one-year palliative medicine fellowship.

Adult Palliative Care Program Goals and Outcomes



Adult palliative care programs report collecting many different types of data. More than 74% (107/121) of surveyed hospitals reported collecting patient utilization data, patient demographics and discharge disposition.

The least collected data was referring provider satisfaction (only 15% of hospitals collect that data).

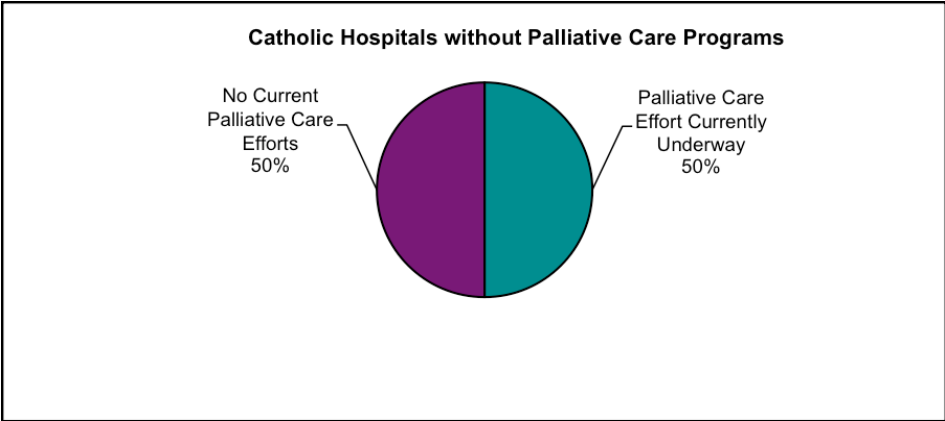
95% (40/42) hospitals reported having established outcome goals, which may be the impetus for data collection.

Access to Ethics Committee

100%

100% (42/42) of responding hospitals report that their adult palliative care program has access to an ethics committee.

Hospitals with Past and Planned Palliative Care Efforts _____



7 out of 8 hospitals without palliative care programs reported that in the last 5 years there has been no palliative care service provision; but 4/8 report that palliative care efforts are underway.

Appendix A The State of Palliative Care in California's Catholic Hospitals

SUSTAINABILITY OF CATHOLIC HOSPITAL-BASED PALLIATIVE CARE PROGRAMS

What Has Promoted Sustainability? *Please describe the most significant asset/resource/circumstance that can or has promoted the sustainability and growth of your palliative care program.*

Common themes included:

- Administrative support
- Grant and other seed funding
- Physician and other champions
- Significant staff support
- Health system support
- Increased education and awareness about the program
- Value of palliative care

Actual responses included:

- Senior Leadership Administration support
- RN has been with the program since the beginning
- Administrative support for the Program and pursuing medical directorship
- Grant Funding
- Institutional support and funding from the Board of Directors, the sponsoring Sisters, and the administration
- Hospice totally supports/funds the current program
- Adequate budget and resources
- Administrative (financial) and physician support
- The need for Palliative Care
- Physicians being comfortable with team. Team able to spend more time with family than PCP to discuss options. Sometimes these conferences can take over an hour especially when multiple family members are involved with care
- Administrative support. Our Administration had the vision early on to participate in CHIPS, and gave enormous support to grow the program. It never would have been initiated if not for this support
- Several physician champions, including the Medical Director of our affiliated hospice program
- Our committed medical directors and the administrative support
- An Advanced Practice Nurse with the deep conviction that doing excellent Palliative Care work is essential to providing quality acute care
- Staff dedication
- Support of the CEO, hospitalist program that utilizes and works closely with consult, support and utilization of palliative care by intensivist group
- Hiring a Palliative Care Coordinator
- The passion of the palliative care team members
- Improved awareness by clinical nursing staff and medical staff re: palliative care
- Our biggest asset is administrative support. Our team reports through the VP who represents us well. Our corporation has also helped significantly with goal setting, expectations and teaching us to document our success with data to quantify our community's need.
- A consistent medical director

- Active association with the hospice palliative medicine fellowship
- Corporate and administrative commitment to Palliative Program; along with creative implementation of program focusing away from direct management and more towards recommendation
- With help of our foundation, funding was obtained to renovate one room for a palliative care suite that provides for families to stay with their loved one.
- I believe having a full time MD has contributed to the viability of our program. Referring MD's appreciate his willingness to get involved in time consuming discussions. This is very pertinent when a pt. has been in the ICU for a period of time and there are multiple physicians involved. There are some cheerleader units who perceive Palliative Care as an asset and actively seek referrals from MDs. It has been good to have a variety of social workers and chaplains involved in the meetings. They have expanded their skill base and comfort level on how to have difficult discussions with patients and families that center on advance care planning. The social workers and chaplains have been great with generating referrals.
- Morning rounds where cases are identified with our Hospitalists and referred to the team. It is a very valuable check on how our patients and their families are doing
- Capabilities of palliative care team has been demonstrated to be helpful to attending physicians, who now make the majority of referrals (about 2/3) to the service
- The bundle that was implemented in the CCU to get a critical care unit on board to see to the needs of their patients
- Success of previous consults and expertise of APN
- Visibility and daily informal education with staff, physicians and public along with successful outcomes of our intervention
- Starting a program, MD involvement
- Hospitalist involvement in palliative care consultation.
- Initial grant funding
- Value of service provided, not only financially but also clinically.
- Support to medical staff and families
- Staff who are interested in promoting the program
- The team approach and physician support
- Health system initiative with management incentives to meet palliative care goals
- Health system and hospital administrative support and management incentives for achieving palliative care goals
- Dedicated team members who work hard to build the program

What are Threats to Sustainability? *Please describe the most significant barrier/deficit/circumstance that could or has been a threat to the sustainability and growth of your palliative care program.*

Common themes included:

- Resistance
- Educational challenges/ continued lack of awareness and understand
- Constrained staffing and financial resources

Actual responses included:

- Nursing resistance to consult service model
- Refusal of MD's to allow involvement of the palliative care team
- Educational challenges: "Its too early for palliative care--now it's too late"
- Medical Staff Buy-in Families understanding of Program Patient use of Advance Directives
- Lack of measurable impact of the Palliative Care service. We are currently putting that in place

- Lack of understanding/buy-in from staff physicians
- Utilizing the team as a resource management team rather than a vital clinical service
- Lack of physician & administrative (financial) support
- Clinical staff understanding of Palliative Care
- PCP still think Palliative Care is only for those patients considered terminal. PCP think we are part of the hospice program
- Time. All team members have "other" jobs. Sometimes this is in conflict with our meetings, consults due to the demands of our positions. In saying that, our census does not always support the need for a FTE, or sometimes even a part time position for Palliative Care. We seem to make it work as it exists at this time. We continue to assess our needs and growth.
- No financial support
- Physician resistance and clinical staff knowledge base
- Budget crisis could wipe out the FTE provided by the medical center
- No FTE
- Inability to add additional personnel due to budget although palliative care has made case both in high referral numbers and financial savings. So busy seeing patients, no time to develop other areas, lack of space in hospital to add palliative care beds. This program depends on one person and therefore is not able to grow or be sustained, especially if that person were to go. While we have other disciplines on the "team", their FTE's are still within other departments. They remain the "go-to" folks for their discipline and the ones who have had additional education for palliative care.
- An inadequate system for receiving referrals
- Insurance company/Medicare refusal to pay for palliative care--they term it as inpatient hospice which they do not cover. the family has to decide to move their family to a nursing home or be responsible for the bill
- Family members being given false hopes by physician and/or media
- One of our biggest deficits is the lack of physician involvement in the development of the program. Physicians want to call us for assistance with their individual patients, but otherwise are generally reticent to help set policy or improve the overall care of the seriously ill and dying. No one wants to talk about it until they have to. Also, many medical staff members have cultural and religious beliefs that intrude into their recommendations to patients and families.
- Burn-out due to lack of funding for support
- Case mix, and related budget concerns; high level of indigent cases
- The most significant barrier is the unchanged budget and staffing ratio that has been unchanged since 2003. Without resources, the program does not grow. The hospital needs to have palliative care in its strategic plan and dedicate funding to grow and have the program sustain itself.
- Our administration has been extremely supportive of the Palliative Care service. There is the question of manpower as representatives from the 4 core disciplines attend all the meetings. The chaplains and social workers still have their other responsibilities/tasks to attend to as well as attending the Palliative Care meetings.
- Specialists who do not refer or feel that their patients need the Palliative Care team. They will only use the service as end of life/care and comfort.
- Hospital system cap on FTE growth for the hospital has prevented any increase in staff, despite increase in number of referrals. Result has been a need to "triage" what service can realistically be provided, given limited team resources.
- Biggest barrier is the lack of human resources and lack of funding. If there were more staff then we would provide more education to other hospital staff and community about services available.
- Lack of funding for appropriate staff needs; affects current outcomes measures because of limited time for follow-up visits
- Financing the program (not reimbursable or revenue generating), trying to continue quality without enough staff to meet increasing needs
- Unfortunate financial woes of the healthcare systems nation wide
- No FTE dedicated specifically to palliative care

- Physician understanding of value of palliative care
- Lack of fulltime team, reimbursement, staffing (ratio patient to nurse/CNA)
- Lack of resources, including time
- Physician barriers to referrals for palliative care
- Physician resistance to early palliative care interventions
- Insufficient staffing time/resources to see all potential palliative care patients in the hospital

HOSPITALS WITHOUT PALLIATIVE CARE PROGRAMS _____

What are Significant Barriers or Circumstances

What are the three most significant barriers or circumstances that have prevented your hospital from creating a palliative care program?

Actual responses include:

- Small numbers of patients
- Financial
- Lack of Funding
- Cost
- Concerns regarding funding of the program
- Administrative time versus other priorities
- Top management reluctant to designate resources
- Conflicting priorities
- Lack of support from the administration
- Physician champion
- Physician buy in
- Need for education
- Operational issues that need to be addressed before starting this program
- Lack of formalized structure
- We have the various pieces but no coordination

Appendix B
The State of Palliative Care in California's Catholic Hospitals

Participating Hospitals

CATHOLIC HEALTHCARE WEST (29)

Arroyo Grande Community Hospital,
Arroyo Grande
Bakersfield Memorial Hospital, Bakersfield
California Hospital Medical Center,
Los Angeles
Community Hospital of San Bernardino,
San Bernardino
Dominican Hospital, Santa Cruz
French Hospital Medical Center,
San Luis Obispo
Glendale Memorial Hospital and Health Center,
Glendale
Marian Medical Center, Santa Maria
Mark Twain St. Joseph's Hospital, San Andreas
Mercy General Hospital, Sacramento
Mercy Hospital of Folsom, Folsom
Mercy Hospitals Bakersfield

Mercy Medical Center Merced, Merced
Mercy Medical Center, Mt. Shasta
Mercy Medical Center, Redding
Mercy San Juan Medical Center, Carmichael
Methodist Hospital, Sacramento
Northridge Hospital Medical Center, Northridge
Oak Valley Hospital District, Oakdale
Saint Francis Memorial Hospital, San Francisco
Sequoia Hospital, Redwood City
Sierra Nevada Memorial Hospital, Grass Valley
St. Bernardine Medical Center, San Bernardino
St. Elizabeth Community Hospital, Red Bluff
St. John's Pleasant Valley Hospital, Camarillo
St. John's Regional Medical Center, Oxnard
St. Joseph's Medical Center, Stockton
St. Mary's Medical Center, San Francisco
Woodland Healthcare, Woodland

DAUGHTERS OF CHARITY HEALTH SYSTEM (5)

O'Connor Hospital, San Jose
Saint Louise Regional Hospital, Gilroy
Seton Medical Center, Daly City
St. Francis Medical Center, Lynwood
St. Vincent Medical Center, Los Angeles

PROVIDENCE HEALTH & SERVICES (4)

Little Company of Mary Hospital, Torrance
Little Company of Mary San Pedro Hospital, San Pedro
Providence Saint Joseph Medical Center, Burbank
Providence Holy Cross Medical Center, Mission Hills

ST. JOSEPH HEALTH SYSTEM (8)

Mission Hospital Medical Center, Mission Viejo
Petaluma Valley Hospital, Petaluma
Queen of the Valley Hospital, Napa
Redwood Memorial Hospital, Fortuna

St. Joseph Hospital, Eureka
St. Joseph Hospital, Orange
St. Jude Medical Center, Fullerton
Santa Rosa Memorial Hospital, Santa Rosa

OTHER CATHOLIC HOSPITALS (3)

Saint Agnes Medical Center, Fresno
Saint John's Health Center, Santa Monica
Scripps Mercy Hospital, San Diego