OUTPATIENT PALLIATIVE CARE AND SUPPORT SERVICES
The Palo Alto Medical Foundation is coordinating care in the last year of life

Five years after creating a palliative care program at Dominican Hospital in Santa Cruz, CA, Sharon Tapper, MD, endeavored to take the best parts of that model – a multidisciplinary approach, a focus on patient preferences, patient and family engagement in decision-making and, above all, coordination of services – and apply them throughout the care experience of individuals in the last year of life. As the creator and Medical Director of the Palo Alto Medical Foundation’s (PAMF) Outpatient Palliative Care and Support Services, Tapper is seeing that vision come to life.

The program has grown to cover three regions, and when it goes live in a fourth, it will serve as many as 1,000 patients per day. Tapper sat down with AAHPM to discuss how the program is faring nearly four years after she first conceived it and thirty months after its launch.

What's innovative about PAMF's outpatient palliative care program?

ST: In one of our regions, there are eight unaffiliated hospices, ten unaffiliated home health agencies, ten unaffiliated nursing homes and three unaffiliated hospitals. Typically, as patients get sicker and go between these silos of care, they experience breakdowns in medication management, symptom management, advance care planning and goals of care. Our program puts systems in place to coordinate with all of these silos, which I call “stakeholders”. We act as an extra layer of support for the family and medical care system in taking care of a seriously ill patient. I describe us as the glue that helps keep that all together for these patients.

How is that “glue” applied, in practical terms?

We’re part of a multi-specialty physician group, and anyone we see has to have an electronic record in our system. Along with the patient and family, that’s our center of coordination. Anyone receiving inpatient palliative care or hospice services within PAMF is an automatic referral to our program. Beyond that, it’s physician referral only, which is important for two reasons. First, we bill for our services, and Medicare requires a referring physician to bill for a consultation. Second, it helps affect the way the physicians think about our service. The way you educate them about what we’re doing is to have them opt-in, have them discuss it with their patients.

We use our billings and philanthropic grants to supplement the cost of running the program. Despite this, we still run at a loss and are supported by our organization. The majority of our cost is labor. We try to be efficient and utilize existing clinic space. We believe the program creates savings in the total cost of care for our patients, given the drop in admissions and high length of stay on hospice. But because we are not part of a fully integrated health system, we have not yet been able to capture comprehensive cost data.

What was the motivation behind the program’s creation?

ST: With innovation – and not just in health care – people look at a situation and see a gap. I saw patients at Dominican leave and not have adequate follow up. I could see that gap.
How was support for the program generated and maintained, both with your administration and among your stakeholders?

ST: The number one thing was getting buy-in from leadership. There was actually one leader here who was quoted as saying, “If we don’t do this, we’ve lost our way.” My organization really helped me. I was given a project manager. I had someone help me develop the business case for the program.

In pitching my idea, I focused on developing an “ask” that consisted of the “why” of what I wanted to do, the “who” would be affected, and the “how” it would increase demands for human and material resources. (Access slide presentation.) I showed the old paradigm for a seriously ill patient and what it would look like if we had the system that I was proposing in place. I tried to focus on how the future state I was trying to create through the program would look better from the patient’s perspective.

Among the stakeholders, the hospices were initially unsure about the impact we would have. But our program here in Santa Cruz has been up and running for two years, and our local hospices love it. We’ve dramatically increased their length of stay and conversion rate – it’s pretty much 100 percent in our population. Also, the percentage of patients in our Santa Cruz population that die with hospice support is very high – 69 percent this year – much, much higher than the state of California.

What metrics are you using to evaluate the program? What has the data shown?

ST: We have what I call “surrogate markers.” One looked at the number of calls to the primary care provider 10 patients made pre- and post-program intervention. They dropped dramatically. Another looked at the absolute number of hospital admissions from 90 days prior to referral into our program and 30 and 90 days after referral. We’ve reduced admissions by 76 percent at 30 days and by 67 percent at 90 days in our Medicare population. Also, I’m very proud that 100 percent of our referring physicians would use us again and that our patient satisfaction is in the 90th percentile, which reflects how the great work our team does is felt by patients and families.

What lessons have you learned as you’ve engaged in this work?

ST: I’ve learned the importance of project development and implementation, and I’ve learned how to incorporate the “three part aim” as a component of process and outcomes measures. Those competencies really complement my experience in the Center for Medicare & Medicaid Innovation Advisors Program.

In a broader sense, though, I’ve come to feel like there’s an almost overwhelming rush toward care coordination right now. To do what’s best for the patient, we need to get coordination right, and that isn’t always the case. In my area, a hospital might have a care transitions team, a home health agency will have a team, and you could have a family that’s receiving calls from three or four different social workers. It can be overwhelming.

We make an effort to coordinate all of those points of interaction, and we assess if another agency is trying to do this and make sure that the family doesn’t reject our program because there’s so much coordination. It always comes back to considering the experience from the point of view of the patients. This all distills down to the quality of their experience, not your organizational needs.