How to Integrate Palliative Care into a Range of Settings and Specialties

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Objectives

- Plan and implement palliative care improvement projects
  - In partnerships with other service lines that care for people experiencing serious illness
  - Using free tools available from the California Health Care Foundation (CHCF)
- Tailor project design and implementation to specific settings and care processes, using two examples:
  - Pain management in radiation oncology
  - Advance care planning in primary care

Palliative Care Integration: Rationale

- People who are experiencing serious illness need to receive palliative care in all settings in which they receive care

Palliative Care in California's Safety Net

Collaboratives 2008-2023

Inpatient Palliative Care

- 2008-2013

Community-Based Palliative Care

- 2015-2019

Generalist Palliative Care

- 2018-2023

California Health Care Foundation

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Generalist Palliative Care: Presenting Sites

Contra Costa Regional Medical Center

LAC+USC Medical Center

California Health Care Foundation

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Mentored Implementation Program

Public health care systems applied with palliative care and partner service line, to implement improvement project

- Palliative care specialists as coaches and project directors, to expand their impact on patient care

Program elements:

Structured approach	Monthly coaching	Learning community	$65K for 18 months

Li et al. Acad Med. 2015;90:303-10

Partnering to Leverage Strengths

Partner Service Lines

- Aware of patient needs
- Motivated to improve patient care
- Familiar with systems change in service line

Palliative Care Specialists

- Aware of training resources
- Experts in serious illness care
- Familiar with palliative care implementation

Needs Assessment & Planning Process

Identify Quality Gap +
Target Audience & Behavior

Predisposing, Enabling, and
Reinforcing (PER) Factors Worksheet

Plan Interventions & Evaluation

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Anderson et al Am J Hosp Palliat Care. 2021;38:4-11

PER Worksheet: Primary Care | ACP

AUDIENCE TO TARGET	Primary care providers	
BEHAVIOR TO TARGET	Discuss advance care planning with seriously ill and older adults	
PREDISPOSING: Stages of Precontemplation & Contemplation	**ENABLING: Stages of Preparation & Action**	**REINFORCING: Stages of Maintenance of Behavior**
KNOW • Conceptual model for advance care planning	BE ABLE TO (skills) • Identify patients who need a discussion	REMINDED • Electronic health record prompts
BELIEVE / VALUE • I have time to address advance care planning	ACCESS TO • Coaching from palliative care team to navigate challenges	POSITIVE REINFORCEMENT • Provider feels they know patient better as a person
INTENTION • Multiple conversations over time	BARRIERS REMOVED • Time to have the discussion	NEGATIVE REINFORCEMENT • Patients react negatively
		SOCIAL SUPPORT • Discussions with colleagues

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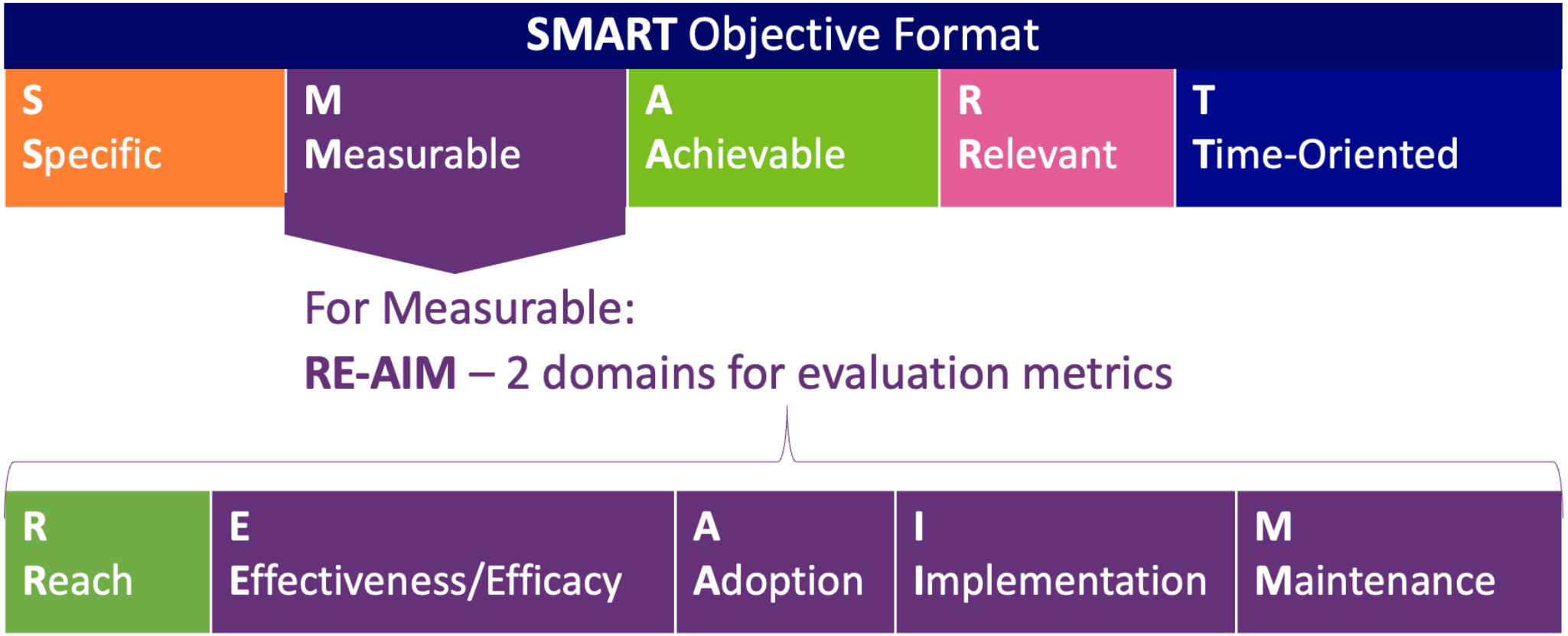
Langlois & Hallam. Health Promot Pract. 2010 11:282-8

Evaluation: SMART Objectives & RE-AIM



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Glasgow et al. Am J Public Health. 1999 89:1322-7 [11]

Target Behaviors & Partners

Pain Management

- Radiation Oncology: LAC+USC
- Medical Oncology: Olive View-UC Los Angeles

Advance Care Planning

- Primary Care Providers: Contra Costa County
- Heart Failure NPs & SWs: Harbor-UC Los Angeles
- Nephrology: Santa Clara Valley Medical Center

Goals of Care Conversations

- Emergency Medicine: Alameda Health System
- Emergency Medicine: UC Irvine
- Trauma Team: Zuckerberg San Francisco General

End of Life Care

- Neurology Residents: UC San Diego

LAC+USC = Los Angeles County - University of Southern California Medical Center

UC = University of California

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Sample Project Outcomes

Confidence & Comfort	Decreased discomfort with code status discussions: 40% to 0% Emergency medicine residents, Alameda Health System
Knowledge & Skills	Improved pain assessment 12/16 areas Radiation Oncology Residents, LAC+USC
Efficiency & Uptake	Advance Care Planning (ACP) into EHR care gap, 6-fold increase in ACP Primary Care Providers, Contra Costa Health Services
Patient Care	Identified 329 oncology outpatients with significant pain; 76% received intervention and had improved pain on subsequent visits Olive View UCLA, Medical Oncology Fellows (10 month project)

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Key Ingredients for Project Success

IDENTIFY A PARTNER CHAMPION MOTIVATED AND COMMITTED TO ADDRESSING KEY GAPS IN CARE

ALIGN PROJECT OBJECTIVES WITH LARGER ADMINISTRATIVE GOALS

ENSURE PROPOSED ACTIVITY WILL MEANINGFULLY BENEFIT PARTNER SERVICE LINE

EMBED PROJECT TOOLS, PROCESSES, AND METRICS INTO EHR AND WORKFLOWS

START SMALL AND BUILD

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Profile: LAC+USC Medical Center
Pain Management in Radiation Oncology

Carin van Zyl, MD

Service Chief, Palliative Medicine

Audience: Radiation oncology residents

Patients: Presenting for radiation therapy

Behaviors at each visit:

- Screen for pain using PEG tool (pain, enjoyment of life, general activity)
- Comprehensive assessment
- Adjust medications & document

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Los Angeles County - University of Southern California
Krebs et al. J Gen Intern Med. 2009;24:733-8.

Intervention: LAC+USC Medical Center

Training

- CAPC pain modules
- Lectures: pain assessment & documentation

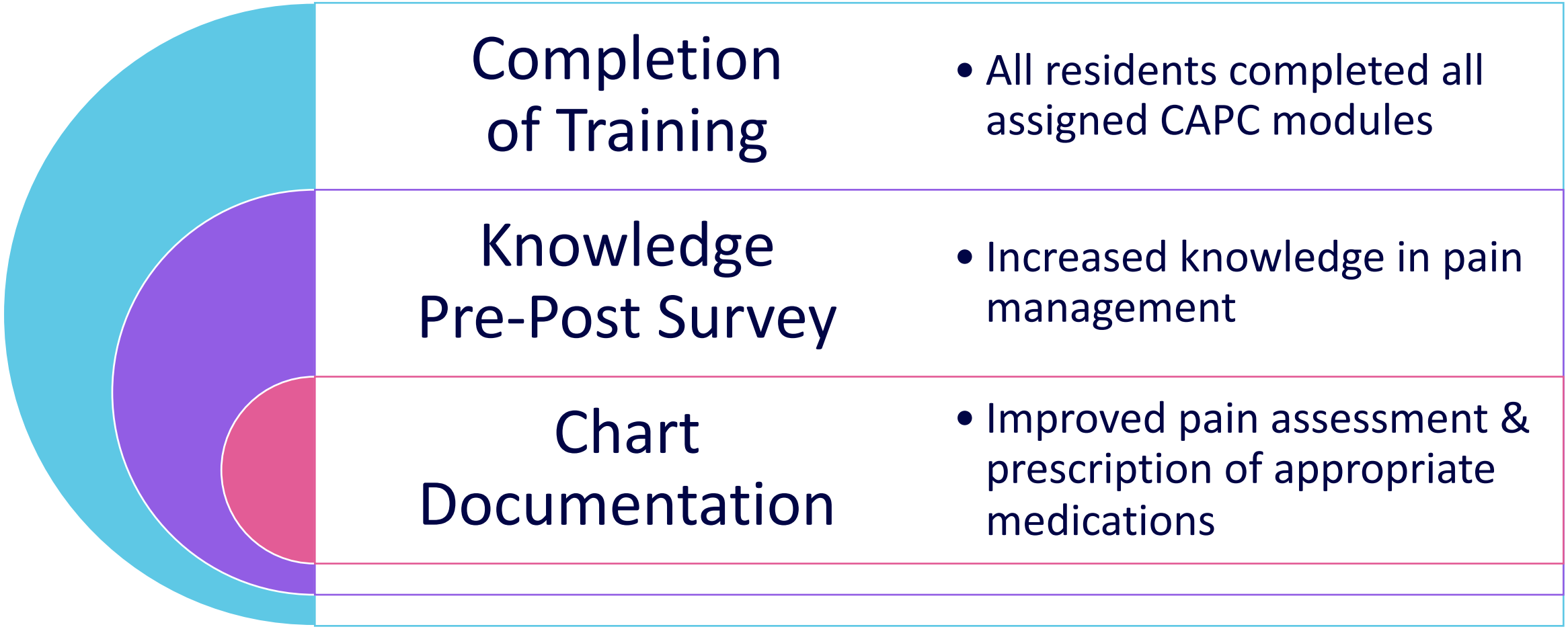
Coaching

- Chief resident
- Palliative care team shadowing in clinic

Workflow

- EHR dotphrases to integrate assessment & management into resident workflow

Metrics & Outcomes: LAC+USC



Challenge: Finding residency curriculum time for additional content

“I would recommend a hybrid approach of CAPC modules paired with a quarterly office hours or discussion seminar to discuss the learning.”

- Richard Jennelle, radiation oncology residency director, service line lead for for palliative care integration project Los Angeles County - University of Southern California Medical Center

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Profile: Contra Costa Health Services Advance Care Planning in Primary Care

Julie Freedman MD

Director, Palliative Care

Audience: Primary care providers

Patients: Older adults (60 years+)

Behaviors:

- Approach ACP over several visits
- Ask about surrogate
- Explore goals & values for selected patients
- Streamlined, standardized documentation

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Intervention: Contra Costa Health

Champions

- PCPs from each clinic advised team on project to ensure acceptability for PCPs

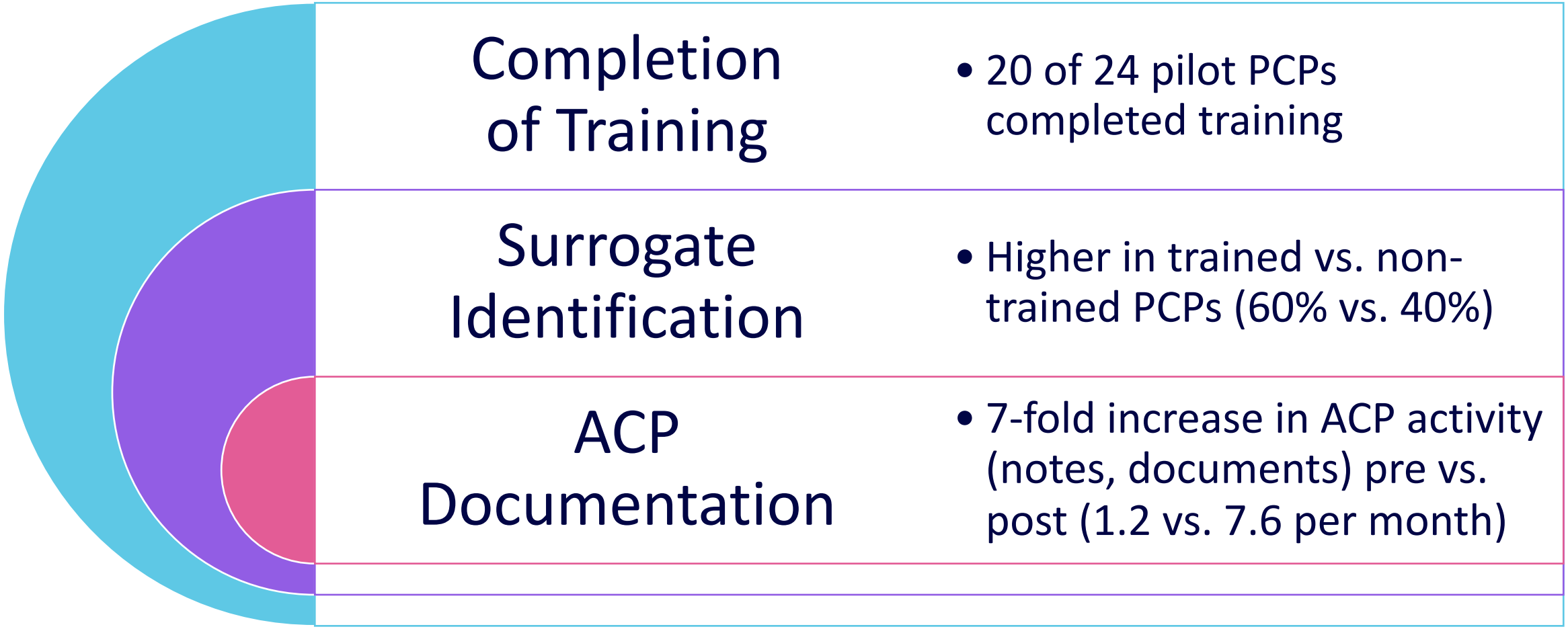
Training

- Early ACP
- GOC for seriously ill patients
- CAPC ACP modules

Workflow

- EHR speed button and care gap to remind PCPs and ease documentation

Metrics & Outcomes: Contra Costa Health



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Challenge: Asking Primary Care Providers to do yet another thing

"Before convincing PCPs to embark upon a very serious conversation, we had to focus on an integrated workflow that allows them to document in a way that isn't cumbersome."

- Haley Kirkpatrick, primary care nurse practitioner, service line lead for palliative care integration project, Contra Costa Health Services

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Summary

- Palliative care improvement projects, in partnership with other service lines, have the potential to improve care while expanding the impact of palliative care specialists
- Relatively modest investment can catalyze significant change to enhance palliative care delivered on the frontlines
- A structured approach facilitates project planning & success

Support for Project Implementation

Protected time

- For implementation team leaders (palliative + partner)

Education and training resources

- CAPC, VitalTalk, other training

Workflow changes

- Guidance and support

Evaluation

- Identifying + monitoring metrics before, during, after project

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https://www.chcf.org/resource-center/essential-skills-supports-clinicians-treating-serious-illness/

RESOURCE CENTER

Essential Skills and Supports for All Clinicians Treating Serious Illness

Building Generalist Palliative Care Capabilities Across Services and Settings

Essential Skills and Supports for All Clinicians Treating Serious Illness

Needs Assessment

Implementation of Palliative Care Capabilities Across Services and Settings

- Creating the Plan
- Key Ingredients
- Resources Required
- Measuring Impact and Making the Case

Intervention Examples: Project Profiles

Questions

Comments

What are Your Next Steps?

Which service lines have asked you about partnerships or improving care for their patients?

- Do any have champions who could lead a project?

What care gaps do you see in this service line?

What guidelines exist for integration of palliative care into this patient population?

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