

# Palliative Care and Community Benefit Can Work Together

**C**atholic health care has cause to celebrate in terms of leadership and quality in two seemingly different areas of health care: palliative care and community benefit.

At first glance, palliative care and community benefit appear to be polar opposites. Palliative care focuses on serious illness and care at the end of life while most community benefit programs are designed to keep people well, help them manage a chronic illness, and improve the health in our communities.

Both palliative care and community benefit are provided in response to human need, but palliative care looks at the needs of individuals and community benefit looks at the needs of populations. In the case of palliative care, the need is for physical, emotional and spiritual support of those facing life-threatening illness. In the case of community benefit, the need is the lack of access to health care services and for health improvement through health promotion and disease prevention.

Palliative care, aside from hospice care, is primarily delivered by hospitals to inpatients. Community benefit, by definition, is practiced in the community.

This final distinction, however, is fading, and increasingly palliative care is being brought into the community.

To explain why this distinction of *where* palliative care is practiced will fade, permit us to digress.

## FINDING COMMON GROUND

The authors have been thinking a great deal about Lewis and Clark lately. Both Sisters of Mercy Health System and CHA are headquartered in St. Louis, where the famous explorers and their team started and ended their historic two-year expedition.

Historians have focused on the trip from the perspective of the men in the boat. The men

thought they were exploring uncharted territory along the way. Lewis and Clark's mission was to take detailed notes on the largely unknown wilderness.

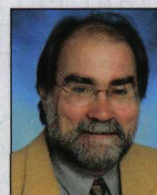
Uncharted? Unknown? Maybe to Lewis and Clark, but not to the American Indians. They lived along the shore and after many generations, thought their territories were well-charted already.

In many respects, hospital services, including palliative care, have a Lewis and Clark perspective of their communities. They view them from the boat. Conversely, community programs, at their best, view communities from the shore with the people who live there.

And what might palliative care leaders find if they were to go to the shore, to venture out to where people live? If palliative care were to focus attention on communities as well as their patients in their hospital beds, this is what they might find:

- There are more people dying and in pain living in the community than are within hospital walls.
- Many community members who are facing serious, life-threatening conditions are uninsured for palliative care.
- Many community members need, but cannot access, compassionate and coordinated care for their serious illness or end of their life.
- Many community members are unaware of their options for making advance decisions about their care at the end of their lives.
- Communities contain under-appreciated assets for assisting patients and families.

These community problems and opportunities related to palliative care seek collaboration between community benefit and hospital palliative care leaders. Where will these two groups of smart, creative and dedicated people be able to find a common place to meet?



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Here are six questions they could explore:

- What are the palliative care related needs in this community?
- How could we work together to address these needs?
- What programs have worked elsewhere? (Can any evidence-based program be replicated?)

- What barriers might we face?
- What community resources and assets could we build upon?
- How can we partner with faith-based programs and groups?

At the recent Supportive Care Coalition Conference titled, "Recovering Our Traditions," we

### WHAT PALLIATIVE CARE SERVICES COUNT AS COMMUNITY BENEFIT ?

#### A. COMMUNITY HEALTH SERVICES

##### Count

- Community health education (lectures on palliative care, advance directives)
- Palliative care provided in free clinics
- Support groups and bereavement groups
- Palliative care case management of persons uninsured for palliative care

##### Don't Count

- Presentations made for marketing purposes
- Referral programs to organizations' medical staffs
- Case management that is part of basic care

#### B. HEALTH PROFESSIONAL EDUCATION

##### Count

- Internships and fellowships in palliative care
- Professional education offered to physicians and staff in the community

##### Don't Count

- CMA/professional education for employees and medical staff
- Orientation programs to new staff and physicians on palliative care

#### C. SUBSIDIZED HEALTH SERVICES

##### Count

- Palliative care that is part of subsidized services (burn units, trauma units)
- Outpatient palliative care

##### Don't Count

- Organization's inpatient palliative care program

#### D. RESEARCH AND INNOVATION

##### Count

- Unpaid costs of research, including clinical trials, related to palliative care when findings are made public
- Publishing/delivering papers on palliative care (but not travel costs)

##### Don't Count

- Internal quality studies
- Environmental improvement
- Coalition building

#### E. FINANCIAL AND IN-KIND

##### Count

- Contributions to community-based palliative care organizations or to others to do palliative care
- Staff time consulting to community-based programs
- Grants to others to study palliative care

##### Don't Count

- Value of volunteers' time
- Staff work on their time
- Fundraising by staff members

#### F. COMMUNITY BUILDING ACTIVITIES

##### Count

- Advocacy for improved palliative care
- Coalition building for palliative care

##### Don't Count

- Advocacy for improved reimbursement for palliative care programs

#### OTHER ACTIVITIES THAT SHOULD NOT BE COUNTED

- Opportunity costs: financial losses due to reducing need for ER visits and admissions
- Program costs counted as a community benefit by another organization
- Efforts to market the organization as having a palliative care program



heard inspiring examples of community-based palliative care programs: working with homeless persons in Kansas City, Mo., reaching out to low-income Hispanics in Hood River, Ore., and developing a community benefit program for persons uninsured for palliative care in Sioux City, Iowa.

Barriers exist to developing community-based palliative care — often funding and workforce shortages — but there are also community resources that can help address those barriers. Community-based palliative care programs can enjoy significant community support in terms of both philanthropic contributions and volunteers. Grant funds may be also available.

The biggest barrier to community-based palliative care is that traditionally community benefit and palliative care professionals have not worked together. But shouldn't that be easy to fix? Like the Gateway Arch, couldn't these two treasures of Catholic health care meet in the middle and find common ground?

We suggest that palliative care programs

should (and many are) get out of the boat and partner with community benefit programs on the shore. We suggest that community benefit programs look to the expertise in the boat and bring it ashore. ■



**Comment on this column  
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## RESOURCES

1. Susan Shampaine Hopper, *Moving Palliative Care into the Community: New Services, New Strategies*, United Hospital Fund, 2004, [www.uhfnyc.org/pubs-stories3220/pubs-stories\\_show.htm?doc\\_id=204825](http://www.uhfnyc.org/pubs-stories3220/pubs-stories_show.htm?doc_id=204825).
2. Harlem Palliative Care Network: An Interview with Richard Payne and Terri Reid Payne, [www.2.edc.org/lastacts/archives/archivesSept01/featureinn.asp](http://www.2.edc.org/lastacts/archives/archivesSept01/featureinn.asp).
3. The Harlem Palliative Care Network: An interview with Richard Payne and Terrie Reid Payne. *Innovations in End-of-Life Care*, 2001: 3(5), [www.edc.org/lastacts](http://www.edc.org/lastacts).



**If your family was separated during an emergency, would you know how to get back together?**

Make sure your family has an emergency plan that includes meeting places and ways to communicate with each other. To learn more about making an emergency plan, go to [ready.gov](http://ready.gov)

