Dear House Committee on Health Care,

I have been a palliative care physician for a decade. I have worked in the full range of clinical settings from bricks and mortar clinics, to home visits, to inpatient palliative care. I've worked in academic teaching healthcare systems and community hospital systems. I have seen first hand the dramatic positive impact that home based community palliative care programs have on patients and their families living with serious illness, as well as the impact on the clinicians caring for them and the costs savings to the health care system.

Let me share with you one story to highlight this impact and then I will share some concrete data. I took care of Mrs. KT for over 3 years. When I first met KT she was hospitalized (for the third time in 6 months) for an aspiration pneumonia, intractable seizures and a urinary tract infection related to her end stage multiple sclerosis. I met KT, her husband and her children to understand their unique family, values and goals of care. They are a deeply spiritual and religious family who valued longevity at all cost and felt that despite KT's physical limitations (she was bed bound and had trouble with speech), she still had deep meaning through time with family and seeing her children grow up, marry and have grandchildren. Given their goals, we arranged for home palliative care visits. I became their primary provider, seeing them at home and coordinating with her home health nurse, her neurologist, pulmonologist and primary care provider. In the following 3 years, Kim only had 1 other hospital stay that was brief, and otherwise we were able to keep her home, treat infections coordinating with home health, and provide interprofessional support for their spiritual distress and social needs (connecting family with care giver resources, advance care planning, community resources for grief/bereavement counseling etc.). Eventually KT's condition worsened, she had no communication ability and her family worried her suffering was too severe. We eventually moved to a focus on comfort when her next infection occurred and we were able to anticipate and coordinate with our local hospice agency. All this happened because of an interprofessional team that could provide continuity and follow KT across health settings. We were able to avoid numerous burdensome and costly ER visits and hospital admissions AND provide personalized, high quality care that matched their values.

All this occurred in Seattle WA, at our safety net hospital, Harborview Medical Center (affiliated with UW), which started a home based palliative care program through a grant from the Cambia Health Foundation and then was supported after the grant by the hospital because of the significant positive impacts on patients, families, clinicians and the system. I've been at the UW for a decade and moved to Portland ~2 years ago to join Providence's palliative care team. I have been shocked by the limited availability of palliative care services in our community. Primary care and specialists are tirelessly trying to serve patients and families in a completely fragmented system, They do not have the bandwidth or expertise to coordinate home based care for patients who can no longer get to clinics and patients and families as they get sicker feel abandoned and lost. What palliative care resources are available are so poorly funded and in high demand, they can only offer one & done consults that do not solve the underlying problems of fragmentation and interprofessional teams are not funded to provide care that address the range of social determinants of health we know contribute to poor outcomes.

This new funding model, would be transformational. Studies show this model can decrease hospitalizations by 81%, ER visits by 53% and a savings of $12,000 per participating member, while increasing satisfaction by 13%. A similar bill in CA saved $3 for every $1 dollar spent. Please support!