HEALTH PLAN ACCELERATOR FOR PALLIATIVE CARE:

A TOOLKIT FOR INTERNAL CHAMPIONS

TRANSFORMING CARE PARTNERS

This toolkit was developed with the generous support of the California Health Care Foundation

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INTRODUCTION

The field of palliative care has made tremendous strides over the past decade, with expanded access to services across settings and expanded payment mechanisms through Medicaid managed care plans and other commercial or Medicare plans. Health care leaders are realizing that palliative care improves health outcomes and quality of life while reducing the overall cost of care.

This toolkit provides essential information and resources to assist health plan champions in creating or advancing a palliative care program.

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WHAT'S INSIDE

The toolkit is divided into three sections:

BE ENCOURAGED

This section includes words of wisdom and encouragement from other health plan leaders who have been instrumental in building palliative care programs.

MAKE THE CASE

This section offers suggestions and resources to help make a compelling argument for investing in palliative care. It also includes a video featuring health plan leaders describing the benefits of offering palliative care.

DEVELOP A PLAN

This section outlines actions that a health plan can take to improve access to and increase the quality of palliative care. It also includes resources to support the implementation of these actions.

BACKGROUND

"The Health Plan Accelerator for Palliative Care" (The Accelerator) is part of a broader initiative, funded by the California Health Care Foundation (CHCF), to identify and disseminate **actionable opportunities for advancing palliative care over the next 5-10 years**. In discussions that informed this initiative, many members of the palliative care movement emphasized that the field of palliative care is at an inflection point in its growth. While specialty palliative care is available in most acute care hospitals, there remains a significant gap in the availability and use of outpatient and home-based palliative care. Acknowledging the vital role that health plans play in expanding equitable and high-quality palliative care, The Health Plan Accelerator was developed by Transforming Care Partners to assist internal champions at health plans in advocating for, developing the business case for, and formulating a plan to further advance palliative care.

The Accelerator serves as a companion to another CHCF resource, "California's Palliative Care Evolution: Celebrating Progress and Shaping the Future", also developed by Transforming Care Partners. In contrast to the Accelerator, which is tailored specifically for health plans, that resource is designed for leaders representing multiple sectors. These leaders, including those from health systems, providers, community-based organizations, policy makers, government agencies, and membership organizations, all play a role in advancing palliative care. In addition to identifying the drivers of progress in California, that resource highlights eight opportunities and potential actions to further advance palliative care over the next 5-10 years.

ABOUT THE AUTHORS

At Transforming Care Partners, we partner with pathbreaking organizations and entrepreneurial leaders who are passionate about maximizing their impact. Our services include strategy development and implementation; program implementation and evaluation; and organization financial sustainability and scaling. Our team combines leadership experience in business, nonprofits, health care, and philanthropy with a strong drive to action. Together, we work to overhaul the aging experience in the United States.

Loren Pogir,

Founder and Managing Partner

Loren founded Transforming Care Partners to help organizations and leaders build sustainable business models and implementation plans to transform the experience of aging and serious illness care at scale.

Kathleen Kerr,

Partner

Kathleen has more than 25 years of experience in supporting the design, implementation, and evaluation of sustainable, high-quality serious illness programs across settings.

Erich Bagen,

Partner

Erich brings over 25 years of experience in both the philanthropy field and private sector, and a passion for transforming serious illness care heightened from his own involvement as a caregiver and advocate for a parent with Lewy Body Dementia and Alzheimer's Disease.

ACKNOWLEDGMENTS

Transforming Care Partners would like to extend gratitude and appreciation to the people (listed below) interviewed for this resource, as well as those who provided valuable reviews of early drafts. In generously sharing their time, experiences, and insights, they helped identify feasible and meaningful opportunities for health plans to improve the quality of care delivered to seriously ill members.

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BE ENCOURAGED

You are not alone in your journey to advance palliative care. In this section of the toolkit, hear from experienced health plan palliative care champions who have successfully developed palliative care programs in their organizations.

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Skip to the Next Section: **Make the Case** →

LEARN FROM PEERS

Take a moment to watch this video featuring experienced health plan palliative care champions who have successfully developed palliative care in their organizations. Some common themes highlighted in the video include:

1

FIND ALLIES

Seek support from within your health plan or collaborate with people from other health plans or organizations. These additional voices will enhance your ability to communicate the opportunities that palliative care provides. Organizations like the Center to Advance Palliative Care, the Coalition to Transform Advanced Care, and state coalitions such as the Coalition for Compassionate Care of California are excellent platforms for connecting with like-minded people.

2

CONNECT TO PERSONAL STORIES

Humanize the need for palliative care by linking it to personal narratives. Most people have encountered serious illness in their personal or professional lives. Internal champions can tap into these stories to help health plan leaders understand how palliative care can alleviate unnecessary suffering experienced by people with a serious illness.

3

CREATE A SENSE OF URGENCY

Recognize the increasing interest among health plans to address the needs of the highest-cost, highest-need members. Health plans stand to benefit significantly from offering palliative care to a subset of this population, which will continue to grow as the overall population ages.

Watch the video here →

MAKE
THE CASE

This section provides suggestions and resources to assist you in crafting a compelling argument for investing in palliative care.

← Skip to Previous Section: **Be Encouraged**

Skip to the Next Section: **Develop a Plan** →

CRAFT THE ARGUMENT

Description of Palliative Care

Palliative care is a relatively new specialty. Educating patients, families, clinicians, and health plan leaders on what exactly palliative care is and is not can be an important component to making the case. Often palliative care is confused with hospice care. The two are related but not the same.

Learn More →

The Value Case:

How Palliative Care Supports the Quintuple Aim

A substantial body of evidence demonstrates that palliative care improves clinical outcomes, patient and caregiver quality of life, and patient experience, while also mitigating the cost of care. There is also emerging evidence that palliative care contributes to an enhanced provider experience and advances health equity.

Learn More →

Policy Imperatives and Trends

Regulatory mandates are in place or are being considered in several states. Even where not mandated, health plans can seek a competitive advantage by adopting palliative care now, before it becomes a requirement.

Learn More →

Talking Points to Generate Interest

As you work towards aligning stakeholders and presenting the case for palliative care to plan decision makers, it's essential to have talking points that succinctly and clearly communicate the benefits of palliative care.

Learn More →

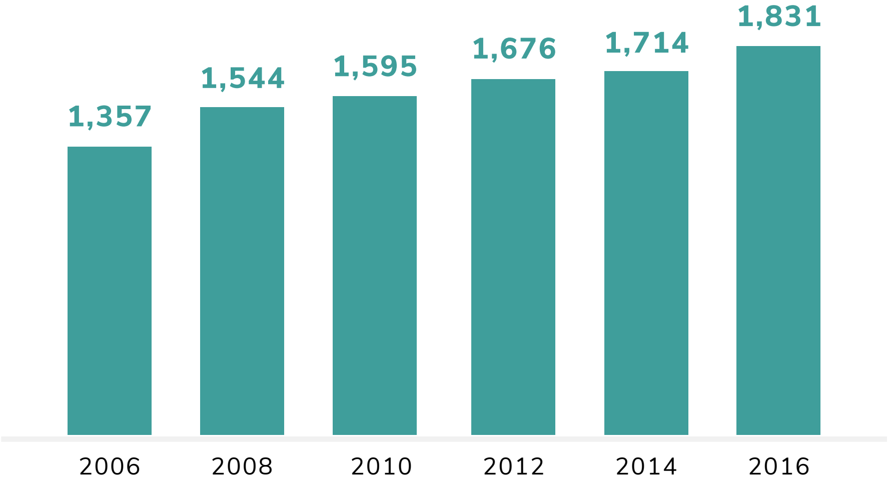
CRAFT THE ARGUMENT

DESCRIPTION OF PALLIATIVE CARE

Palliative care is a relatively new specialty, first recognized in 2006 by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education. Despite remarkable growth in recent years, accurate understanding of palliative care is still not widespread among patients or clinicians. Misperceptions, such as confusing palliative care with hospice, and gaps in knowledge about how palliative care adds value persist. Therefore, even if someone has heard of palliative care, it is best not to assume that they know what it is and how it supports people with serious illness and their caregivers.

This section of the toolkit offers a definition and outlines the core components of specialty palliative care. It also provides insights into how to differentiate specialty palliative care from hospice or primary/generalist palliative care.

Palliative Care Programs in U.S. Hospitals with 50 or more beds, 2000-2016*



Source: Internal CAPC analysis based on data from the American Hospital Association Annual Survey Database™ 2000-2016, https://www.capc.org/documents/download/487/

1

Definition of Specialty Palliative Care

Specialty palliative care is medical care focusing on relieving the stress and suffering of serious illness, with the goal of improving quality of life for both the patient and the family. This specialized care is delivered by a team of trained palliative care professionals, including doctors, nurses, social workers, and chaplains, who are often supported by other disciplines. These specialists collaborate with a member's existing medical team to provide an additional layer of support. This is usually done in a co-management model where the palliative care team is not the primary provider.[1]

Specialty palliative care can be delivered in various settings, including hospitals, clinics/physician offices, nursing facilities, and patients' homes. Importantly, palliative care is distinct from hospice care, as it is appropriate for individuals at any stage of a serious illness and can be provided along with curative treatment. Members receiving palliative care are not subject to a six-month prognosis requirement, retain all their health plan benefits, and can continue with disease-focused treatments.

2

Specialty Palliative Care Core Components

While there may be variation in how specialty palliative care is delivered based on the setting, team staffing, and payment models, its core components include:[2]

- Comprehensive physical, emotional, spiritual, and social assessment
- Expert management of pain and other distressing symptoms
- 24/7 telephone or telehealth access
- Medication management
- Referrals to community resources
- Assessment of family caregiver capabilities and directly supporting family caregivers with training, coaching, and emotional support
- Expert communication addressing the priorities of patients and families, including advance care planning, goals of care, and shared decision making
- If provided in the home, environmental assessment of the living conditions

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[1] Palliative Care Definition | What is Palliative Care | Center to Advance Palliative Care (capc.org)

[2] National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www.nationalcoalitionhpc.org/ncp.

3

Difference Between Specialty and Generalist/Primary Palliative Care

Specialty palliative care is a more intense, specialized form of support provided by a dedicated team of palliative care specialists, while generalist (also known as "primary") palliative care is a more integrated, basic form of palliative care incorporated into primary care or other medical specialties. Both aim to improve the quality of life for individuals facing serious illness, but they differ in their levels of specialization and scope of practice. Representative skill sets for generalist and specialty palliative care can be seen in Table One below.

Generalist palliative care has been gaining momentum as a complement to specialty palliative care. Widely available generalist palliative care can ensure a minimum level of palliative care is available to anyone who would benefit and allow specialty palliative care services to focus on more complex situations.

Table One: Representative Skill Sets for Primary and Specialty Palliative Care

GENERALIST/ PRIMARY PALLIATIVE CARE	SPECIALTY PALLIATIVE CARE
Basic case management and caregiver support	**Management** of refractory pain and other symptoms
Basic management of pain and other symptoms	**Management** of more complex depression, anxiety, grief, and existential distress
Basic management of depression and anxiety	**Assistance** with conflict resolution regarding goals or methods of treatment within families, between staff and families, and among treatment teams
Basic discussions around prognosis, goals of treatment, suffering, and code status	**Assistance** in addressing cases where further disease-directed treatment may be unsuccessful
	Care coordination and case management support to address health and/or social needs

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[3] Generalist plus Specialist Palliative Care–Creating a More Sustainable Model, NEJM, Quil and Abernethy, 2013

4 Video Resources

These two videos produced by the California Health Care Foundation can help you describe specialty palliative care to key stakeholders.

California's Palliative Care Evolution: What is Palliative Care?

This video features palliative care leaders and providers who work in health plans, health systems, and the home, describing palliative care and its value.

Watch the video here →

Extra Supports for People with Serious Illness

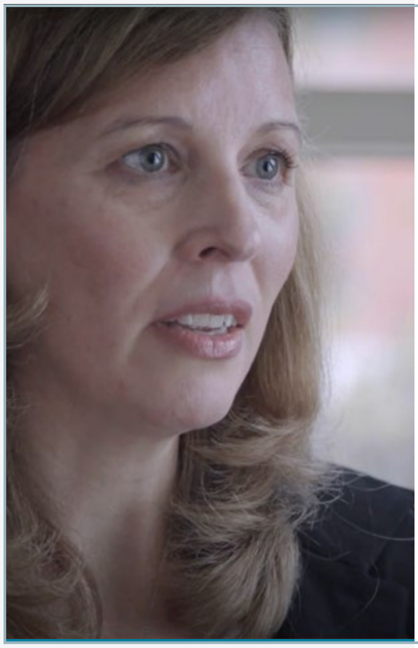
This video features palliative care providers working in different settings, describing how they support patients and families with serious illnesses.

Watch the video here →

CRAFT THE ARGUMENT

THE VALUE CASE: HOW PALLIATIVE CARE SUPPORTS THE QUINTUPLE AIM

A robust body of evidence demonstrates that palliative care enhances clinical outcomes, quality of life, and patient experience, while also mitigating the cost of care by anticipating and averting crises and reducing unnecessary or unwanted interventions. Additionally, an emerging body of evidence suggests that palliative care enhances the provider experience, by mitigating provider burnout and alleviating moral distress, and can improve equity through whole-person care. In this section of the toolkit, you will find evidence and testimonials from other health plan leaders that you can use to build your business case, as well as a video (below) you can share directly with health plan decision makers to help them understand the value case for palliative care.



Lessons Learned from California's Palliative Care Evolution: The Value Case for Palliative Care

In this video, health plan leaders describe palliative care's value to their organizations: enhancing clinical outcomes, equity, quality of life, and member experience, while mitigating unnecessary costs of care. This video can complement your business case, supporting the argument for health plan leaders to invest in palliative care.

Watch the video here →

1

Palliative Care Improves Health Outcomes, Patient Experience, and Cost of Care

Highlights of selected literature describing palliative care's impacts on health outcomes, patient experience, and cost of care across settings are presented in Table Two. A more comprehensive list of these studies can be found in Appendix One. Selected literature includes randomized control trials, well-designed observational studies, systematic reviews, and multi-site studies. Many of the featured studies looked at impact across domains (e.g., assessing both patient experience and costs of care for the same population). The evidence shows that palliative care simultaneously improves health, patient experience, and economic outcomes—the gold standard for quality in health care.

> If you invest in providing palliative care—staffing and services—the cost of care goes down more than the cost of a palliative care program. We do an analysis each month and each quarter to look at the financial return on investment and still find that the amount of dollars saved from hospitalizations is greater than the expense.
>
> **Robert Moore, MD, MPH**, Chief Medical Officer
> *Partnership HealthPlan of California*

> Within a health plan, generally what people will focus on is the cost. There is definitely cost savings when implementing or offering palliative care to the members. But let's look at other things. Let's look at the existential value. Let's look at the social or emotional or psychosocial value. Let's look at the quality-of-life aspect. All of that can be achieved when offering palliative care. There's the value right there. Human life.
>
> **Kim Beverly, MSW, MSG**, Palliative Care Clinical Program Manager
> *Blue Shield of California*

Table Two: Examples of Evidence Demonstrating Palliative Care Benefits

SETTING		HEALTH AND QUALITY OF LIFE OUTCOMES	PATIENT EXPERIENCE	COST
Inpatient	Results	Improved pain, nausea, dyspnea, and anxiety	Better experience of care and patient-reported quality of communication with providers, and satisfied family caregivers	Lower hospital costs, fewer readmissions, greater use of hospice and longer hospice length of service
	Sample Finding	87% of palliative care recipients had improvement in pain or other symptoms (O'Mahoney 2005)	95% of family caregivers surveyed by phone said they would recommend the palliative care service to others (O'Mahoney 2005)	Direct costs of hospital care were 28% lower among palliative care recipients (May 2018)
Outpatient/Clinic	Results	Improved quality of life and reduced symptom burden	Improved patient and family satisfaction	Lower costs in the final six months of life driven by fewer hospitalizations, less Intensive Care Unit use, and fewer emergency department visits
	Sample Finding	Compared to usual care, fewer palliative care recipients had depressive symptoms (16% vs. 38%) (Temel 2010)	At four months post clinic enrollment, patients who were randomized to palliative care had greater improvement in satisfaction compared to usual care patients (Zimmerman 2014)	Costs for inpatient care in the last month of life were 26% lower when patients received earlier palliative care through outpatient clinics (Scibetta 2016)
Home	Results	Improved symptoms	High satisfaction among patients, caregivers, and referring providers	Lower total costs of care driven by fewer hospital admissions, fewer outpatient emergency department visits, and greater use of hospice
	Sample Finding	Post-enrollment improvements seen in anxiety, appetite, dyspnea, well-being, depression, and nausea (Kerr 2014)	Patients, caregivers, and physicians reported high satisfaction (93%-96%) with the palliative care program (Kerr 2014)	Overall costs were 33% lower for home-based palliative care patients (Brumley 2007)

A more comprehensive list of these studies can be found in Appendix One.

2 Palliative Care Improves Provider Well-Being

Anecdotal evidence from palliative care leaders suggests that specialty palliative care teams improve the well-being of other treating providers by saving them time, and by managing complex symptoms and situations that they may not have the expertise to address independently. Palliative care services contributing to provider well-being include:

- Expert assistance with complex symptom management.
- Facilitation of challenging (and time-consuming) patient and family discussions regarding prognosis, goals of care, and treatment decisions.
- Instruction in self-care and wellness techniques to handle grief and loss.
- Assistance in navigating other services related to serious illness, such as home health, hospice, and services offered by community-based organizations.

> *'They [the family] have given him this beautiful, lovely life. And I think that right now his body's too tired. And this is the time to say goodbye.'*
>
> Sometimes the palliative care doctor being able to take that difficult moment and say those words is a little bit of a relief to the other doctors who may be struggling with delivering the heart breaking information.
>
> **Kimberly Bower, MD**, Medical Director
> *Blue Shield of California*

Case example

A 66-year-old female, suffering from out-of-control pain from calcinosis due to long-term dialysis, presented a challenging situation. The patient's screams and resistance to care were not only frightening other patients, but also posed a source of frustration for the nurses. The expert pain control provided by the palliative care team played a pivotal role. It allowed the patient to cooperate with the care plan and agree to treatment, as she could now imagine a tolerable quality of life, which eased the frustration the nursing staff was experiencing. For the patient's family, the prospect of taking her home became significantly more comfortable as they witnessed that effective pain management was achievable through oral medications.

— Case example from a California public health care system, featured in Meeting the Need: Understanding the Impact of Palliative Care in California's Public Hospitals (see "Useful Resources" for link)

3 Palliative Care Addresses Equity

By providing individualized whole-person care, palliative care can contribute to addressing health equity for people of color and other historically marginalized groups. While additional research is necessary to demonstrate that palliative care improves equity, the following rationale and testimonial can be used to help make the case.

Rationale of how palliative care addresses equity

Through its core tenets and practices, palliative care aims to comprehensively address an individual's medical, psychological, social, and spiritual needs. Additionally, palliative care plays a crucial role in alleviating various forms of suffering resulting from racial inequities among Americans with serious illness. These include disparities in pain assessment and pain management, challenges related to communication and trust between clinicians and patients, and an outsized burden on family caregivers from communities of color.

The interdisciplinary palliative care team—comprising physician, nurse, social worker, and chaplain—is also often better equipped than other parts of the health care system to address these needs once identified. For example, palliative care teams have expertise in addressing social determinants of health, connecting people with other medical and non-medical services, and operating within a patient's community norms and value system to explain the benefits of various services, even when a patient may lack trust in the healthcare system due to experiences of racism and discrimination. Addressing the multifaceted nature of serious illness on an individual level can improve the experience of care and increase the likelihood of more equitable care.

> Palliative care really helps us address health equity because it helps us meet patients where they are within their community and within whatever life circumstance that they're in. And it lets us take care of them with an interdisciplinary team. So, a doctor, nurse, social worker, spiritual counselor can address all of those things that people need when they're vulnerable and may be disenfranchised from our healthcare system or lack trust in the healthcare system.
>
> **Kimberly Bower, MD**, Medical Director,
> *Blue Shield of California*

CRAFT THE ARGUMENT

POLICY IMPERATIVES AND TRENDS

In some cases, health plans are required to offer palliative care to their members. Nationally, Medicare Advantage Organizations (MAOs) participating in the Value-based Insurance Design (VBID) Hospice Benefit component are mandated to ensure access to palliative care for eligible enrollees, regardless of whether those enrollees choose hospice services.

In California, Medi-Cal managed care plans and Dual Eligible Special Needs Plans (D-SNPs) are mandated to offer palliative care. Since 2018, Medi-Cal managed care plans in California have been required to ensure access to palliative care for seriously ill adult members who meet specific eligibility criteria. In 2019, this requirement was extended to include pediatric members. As of January 2024, D-SNPs in California are required to ensure access to palliative care for their seriously ill members. Several other states are currently pursuing or exploring similar requirements.[4]

Even if not mandated to provide palliative care, health plans can seek a competitive advantage by adopting palliative care now, and by developing a strong palliative care provider network and sound referral and care management practices, before it becomes universal practice.

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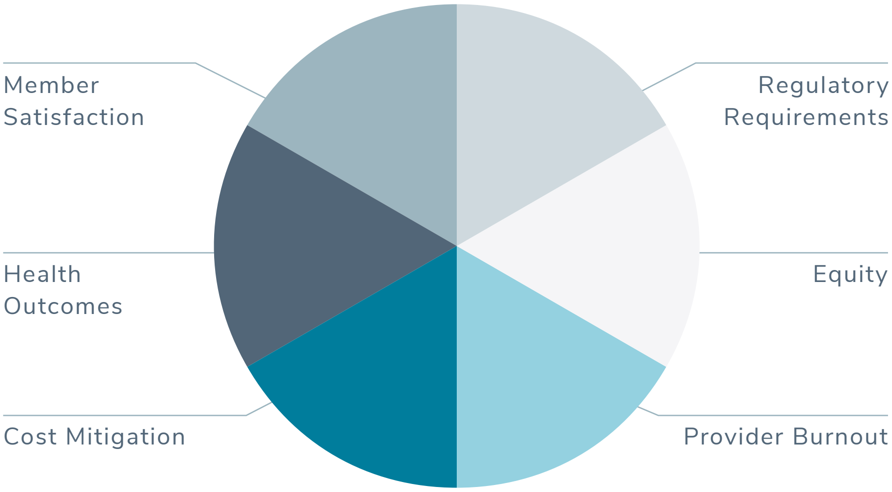
[4] States Make Progress on Palliative Care - NASHP

CRAFT THE ARGUMENT

TALKING POINTS TO BUILD INTEREST

As you work towards aligning stakeholders and presenting the case for palliative care to plan decision makers, it's essential to have talking points that succinctly and clearly communicate the benefits of palliative care. You should take the time to learn about priorities at your plan, and then tailor these sound bites to your audience and what they are likely to care about most. Priorities in your organization could include member satisfaction, health outcomes, cost mitigation, regulatory requirements, equity, and/or provider burnout.

What is the ranking of priorities in your organization?



Talking Points

Some examples of where to start are below:

→ Palliative care is instrumental in helping members and families cope with the symptoms and stressors of disease, enabling better anticipation and avoidance of crises, and reducing unnecessary or unwanted care.

→ Implementing palliative care could significantly improve outcomes and quality of life for our members with serious illness. Palliative care could fill important gaps in caring for this high-need and high-cost population. Ample evidence indicates that providing this care is financially feasible for health plans. In fact, it might help us reduce our costs.

→ Palliative care improves the well-being of providers by saving them time and alleviating moral distress. Palliative care specialists help other providers manage difficult-to-control patient symptoms, challenging goals of care conversations, and complex family dynamics.

→ Palliative care teams have expertise in addressing social determinants of health, connecting individuals with other medical and non-medical services, and operating within a patient's community norms and value system to explain services and build trust. All of these help make care more patient-centered and more equitable.

→ Numerous studies have demonstrated that palliative care consistently improves quality of life, the experience of care, and clinical outcomes—all while effectively moderating the cost of care.

→ All Medi-Cal managed care plans and D-SNPs in California are required to offer palliative care to seriously ill members. Several other states are in the process of creating similar requirements. This trend is intensifying, and palliative care will eventually be universal. We could create a competitive advantage by offering robust palliative care now.

→ Government stakeholders like policymakers and regulators are specifically looking for health plans to demonstrate they are investing in caring for members with serious illness; palliative care is an essential part of meeting these expectations.

→ Palliative care services are particularly beneficial for our highest-risk members: those frequently admitted to the hospital and emergency department.

DEVELOP A PLAN

Once organizational buy-in for investing in palliative care is secured, the next step involves assessing your current state and then developing a comprehensive strategy and implementation plan that leverages your existing position. This section outlines seven essential elements to consider when constructing a robust palliative care strategy. These elements draw from insights gained through palliative care projects supported by the California Health Care Foundation over the past decade, including in-depth interviews with leaders as part of the resource titled "California's Palliative Care Evolution: Celebrating Progress and Shaping the Future".

← Skip to Previous Section: **Make the Case**

Skip to the Next Section: **Appendix One** →

CRAFT THE STRATEGY

Within this section of the toolkit, specific action items for each of the seven elements are detailed based on your plan's current state: “**The Essentials**” for those starting out, “**Progressing Further**” for those that have the basics covered, and “**Setting the Standard**” for those who are ready to build cutting-edge programs and contribute to strengthening the broader field of palliative care. These actions are cumulative. Following the actions, you’ll find links to resources designed to accelerate learning and implementation efforts.

The information is specifically tailored for internal champions at health plans seeking to expand or optimize their palliative care program. For plans without an existing palliative care program, additional resources can be found in Appendix Two.

1

Payment

Adopt a bundled payment model for home-based and outpatient palliative care.

Learn More →

2

Quality

Adopt policies and practices that adhere to minimum standards and improve quality of care.

Learn More →

CRAFT THE STRATEGY

3

Integration

Integrate palliative care across all lines of business, in all settings, and with other medical and social services frequently used by people with serious illness.

Learn More →

4

Uptake

Increase utilization of palliative care.

Learn More →

5

Equity

Ensure palliative care reaches and meets the needs of communities of color and other historically marginalized populations.

Learn More →

6

Workforce Capacity

Increase the number of clinicians with generalist palliative care skills and encourage use of generalist palliative care when specialty palliative care is not needed.

Learn More →

7

Family Caregiver Support

Assess the needs of family caregivers and provide them with training and resources to support the care needs of seriously ill members.

Learn More →

1

PAYMENT

Adopt a bundled payment model for home-based and outpatient palliative care.

Payers should adopt a bundled payment model for home-based and outpatient palliative care. In a bundled payment model, a single payment covers the delivery of a specified set of services, by a multidisciplinary team, over a defined period of time. Bundled payments create incentives for delivering the optimal palliative care model, making it feasible and sustainable for providers to offer high-quality palliative care. In contrast, fee-for-service payment models do not cover the cost of the full interdisciplinary team, including nurses, chaplains, care navigators, social workers, or the extensive coordination activities required to deliver services.

A 2023 survey of Medi-Cal managed care plans conducted by the Coalition for Compassionate Care of California found that 67% of the 14 responding plans reported using a bundled payment model for home-based palliative care.[5] Furthermore, the Consensus Standards for Community-Based Palliative Care in California (including home and outpatient palliative care), which were developed by a collaborative of health plans, provider organizations and health services researchers, also endorse bundled payments as the preferred payment model.[6]

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

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[5] State of Medi-Cal Palliative Care: Findings from the Annual Plan and Provider Surveys.

[6] Consensus Standards for Community-Based Palliative Care in California

1

PAYMENT

THE ESSENTIALS

☐ **Adopt a bundled payment model** that covers the effort of the entire interdisciplinary team needed to deliver all specified outpatient and home-based palliative care services across lines of business and markets.

☐ **Compensate palliative care providers for initial assessments,** irrespective of whether patients ultimately enroll.

PROGRESSING FURTHER

☐ **Use program design tools** such as tiers of service (i.e., higher payment for more complex cases) and guidance on use of telehealth (e.g., allow telephone or video visits in some circumstances) to ensure intervention intensity matches member needs while remaining sustainable for the plan and palliative care provider.

☐ **Offer performance-based incentives** related to data collection, important care processes (e.g., surrogate decision maker identified) or outcomes (e.g., member experience or decreased unplanned hospitalizations).

SETTING THE STANDARD

☐ **Participate in evaluations** of the economic impact of using a bundled payment for outpatient and home-based palliative care services to increase awareness among plans and policymakers that this is economically sustainable.

1 PAYMENT

Table 1: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Report	Palliative Care in Medicaid Costing Out the Benefit: Actuarial Analysis of Medicaid Experience (National Academy for State Health Policy)	Guidance on how to price a bundled payment.
Report	Home-Based Palliative Care Payment and Delivery Models for Short-Term Interventions (Center to Advance Palliative Care)	Guidance on payment approaches for short-term palliative care needs, such as during a transition to home after hospital, hospice, or to another care team.
Survey	2023 survey of MCPs and palliative care providers (Coalition for Compassionate Care of California)	Survey of 14 Medi-Cal managed care plans (MCPs); includes a question regarding payment mechanisms used for home-based palliative care.

2

QUALITY

Adopt policies and practices that adhere to minimum standards and improve quality of care.

Palliative care has the potential to yield improved clinical outcomes, better member experience of care, and lower cost of care. However, health plans can only attain these outcomes if they offer high-quality palliative care to their members. Palliative care is still a relatively new field compared to other medical specialties, with wide variations in services offered and quality achieved by palliative care providers. Health plans can enhance the likelihood of achieving improved outcomes by adopting policies and practices that adhere to minimum standards and encourage continuous improvement.

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

2 QUALITY

THE ESSENTIALS

A Monitor program performance and implement improvements

☐ **Monitor program performance** across all aspects of the quintuple aim (patient experience, patient outcomes, reducing costs, care team well-being, health equity) and disseminate the findings to provider partners to support quality improvement and promote appropriate referrals.

B Adopt policies and practices that reduce variation in staffing models and scope of services delivered

☐ **Develop internal minimum standards** based on the National Consensus Project Clinical Practice Guidelines and the Consensus Standards for Community-Based Palliative Care in California (see "Resources" below). Ensure that minimum standards specify capabilities that drive health, and experience and economic outcomes, such as a requirement that the clinical care team be available by phone, have access to health records, and can make visits when necessary on a 24/7 basis.

☐ **Define qualifications and training prerequisites** for the palliative care team and establish certification/ accreditation prerequisites for palliative care provider organizations.

2 QUALITY

PROGRESSING FURTHER

A Monitor program performance and implement improvements

☐ **Require providers to participate** in the [Palliative Care Quality Collaborative (PCQC)](), which collects data on quality and provides feedback to help providers improve performance.

☐ **Regularly engage** with palliative care providers to identify areas for improvement.

B Adopt policies and practices that reduce variation in staffing models and scope of services delivered

☐ **Ensure consistent implementation** of minimum standards across lines of business and markets.

SETTING THE STANDARD

A Monitor program performance and implement improvements

☐ At regular intervals, **re-assess monitoring activities** and update approaches to reflect current opportunities.

B Adopt policies and practices that reduce variation in staffing models and scope of services delivered

☐ **Participate in national efforts** to establish minimum standards and associated measures for palliative care.

2 QUALITY

Table 2: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Consensus Standards	CAIC Consensus Standards for Community-based Palliative Care in California (Coalition for Compassionate Care of California)	Outlines minimum requirements for eligibility, scope of services, provider qualifications, measures, and payment models. It can be used as a starting point for developing minimum standards.
Consensus Guidelines	National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 4th Edition (National Coalition for Hospice and Palliative Care)	Detailed description of recommended practices for palliative care to inform benefit design.
Database	Palliative Care Quality Collaborative	Monitor and benchmark quality of care delivered by palliative care providers.
Report	Recommendations for Cross-cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness (PDF) (National Coalition for Hospice and Palliative Care)	Measures a plan might use to assess quality of palliative care program.

3

INTEGRATION

Integrate palliative care across all lines of business, in all settings, and with other medical and social services frequently used by people with serious illness.

Health plans can enhance access to high-quality serious illness care and optimize the appropriate utilization of existing services by providing palliative care across lines of business. This integration should also span a care continuum that includes home-based primary care, care management, disease management, as well as incorporating outpatient clinics where individuals with serious illness, like those in oncology clinics, already receive care.

Facilitating collaboration among these services enables patients to transition seamlessly to the support that aligns with their evolving needs, reducing the risk of both over- and under-serving patients. This approach also fosters improved coordination among treating providers and establishes palliative care as the standard of care for people with serious illness.

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

3 INTEGRATION

THE ESSENTIALS

A Within the plan: Offer palliative care across all lines of business and foster connections between palliative care and aligned plan programs.

☐ **Offer palliative care** across all lines of business.

☐ **Share palliative care infrastructure, staff, and educational programs** across lines of business to promote consistency and efficiency.

B Across the provider network: Promote integration of palliative care into aligned medical services and support collaboration between palliative care providers and the network of medical and social services used by seriously ill members.

☐ **Ensure network capacity** to offer palliative care in all settings where seriously ill members seek care, leveraging both in-person and telephone or video visits.

☐ When necessary, **mentor and support** organizations that are newer to delivering palliative care and encourage collaboration between newer and more experienced providers in the network.

☐ **Use contracting requirements and incentives** to encourage the integration of palliative care into other inpatient, outpatient, and home-based services that are used by seriously ill members. For example, offer a bundled payment for outpatient oncology visits if the care model includes palliative providers.

3 INTEGRATION

PROGRESSING FURTHER

A Within the plan: Offer palliative care across all lines of business and foster connections between palliative care and aligned plan programs.

☐ **Establish connections** between palliative care and other plan programs and services available to members with serious illness, such as Complex Care and Long-Term Services and Supports.

B Across the provider network: Promote integration of palliative care into aligned medical services and support collaboration between palliative care providers and the network of medical and social services used by seriously ill members.

☐ **Promote connections and collaboration** between palliative care providers and other medical and social services commonly used by members with serious illness, such as home-based primary care, complex care management, care navigation, and behavioral health.

☐ **Ensure that palliative care providers deliver services** to eligible members residing in assisted living facilities and nursing homes, including those who are receiving post-acute short term skilled care and those with longer stays. Require intensified attention (i.e., mandatory home visit within 48 hours) during a resident's transition back to home.

3

INTEGRATION

SETTING THE STANDARD

A Within the plan: Offer palliative care across all lines of business and foster connections between palliative care and aligned plan programs.

☐ **Evaluate outcomes** for the entire seriously ill population, rather than solely at the service level, to gain insight into care gaps and the combined impacts of all services.

B Across the provider network: Promote integration of palliative care into aligned medical services and support collaboration between palliative care providers and the network of medical and social services used by seriously ill members.

☐ **Undertake or participate in a study** of the effects of integration, and disseminate the findings to guide the development and adoption of the most promising models.

3 INTEGRATION

Table 3: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Report	Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models (Center to Advance Palliative Care)	Example actions for building palliative care capabilities at the payer level and among network providers.
Case Study	Embedded RN-Led Clinics in Primary Care Practices (Center to Advance Palliative Care)	Example of embedding palliative care with another clinic service.
Webinar	The Intersection of CalAIM and Palliative Care (MCP Palliative Care Learning Community Webinar)	Review of how palliative care intersects with Medi-Cal transformation.
Report	Medical Care at Home Comes of Age (California Health Care Foundation)	Description of various home-based care models.

4

UPTAKE

Increase utilization of palliative care.

Uptake of palliative care, along with its associated benefits, only happens when people with serious illness understand what palliative care is, how it can complement their other medical services, and the ways to access it.

Health plans can play a pivotal role in generating and sustaining this demand through community engagement efforts that raise awareness and establish trust in palliative care. They can also educate case managers and health care providers about the benefits of palliative care and implement systems for identifying people who could benefit from these services.

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

4 UPTAKE

THE ESSENTIALS

☐ **Use inclusive eligibility criteria.** For example, expand the eligible population for home-based palliative care services beyond the minimums specified in Medi-Cal policy guidance.

☐ **Provide training to clinical and non-clinical plan staff** regarding the benefits of palliative care, and how to effectively communicate its value.

☐ **Implement a four-part approach** to identify appropriate members:

- ○ **Utilize claims and administrative data** to proactively identify individuals with serious diagnoses and unmet symptom burden or insufficient social supports.
- ○ **Collaborate with hospital-based clinicians and staff**, including discharge planners.
- ○ **Integrate member identification** into the workflows of plan care managers.
- ○ **Promote referrals from healthcare providers** who care for a substantial number of seriously ill members, such as oncologists or cardiologists.

☐ **Offer resources that describe palliative care using culturally appropriate phrasing** and, when necessary, in multiple languages.

4 UPTAKE

PROGRESSING FURTHER

☐ **Incorporate community engagement activities** into the palliative care strategy, such as regular talks at senior centers, faith-based organizations, adult day programs, and similar settings.

☐ **Assist palliative care providers in marketing their services** to non-palliative care providers within the network.

☐ **Inform other essential groups** responsible for the care of seriously ill members (e.g., hospital discharge teams, oncology practices) about the value of palliative care, the specifics of the plan's program, the referral process, and effective methods for introducing palliative care to patients.

SETTING THE STANDARD

☐ **Partner with other plans** to conduct community and provider education related to palliative care to maximize reach within markets that have multiple plans.

4 UPTAKE

Table 4: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Toolkit	Care Managers: Addressing the Unique Needs of Patients with Serious Illness (Center to Advance Palliative Care)	Online courses and resources to help care managers meet the needs of members with serious illness.
Online Course	Essential Care Management Training for Health Plans (Care Excellence)	Foundational, advanced, and leadership training for care managers working at health plans. Online and in-person offerings.
Video Series	Introducing Palliative Care Video Series (Coalition for Compassionate Care of California)	Video series and supporting materials to help case managers and clinicians become more comfortable with describing palliative care or responding to common questions or concerns about palliative care when offering it to their members or patients.
Memo	Recommendations for Identifying the Population with Serious Illness (Center to Advance Palliative Care)	Brief description of strategy for a data-based approach to identifying members who might benefit from palliative care.
Online Course	Palliative Care for Care Managers (California State University Shiley Haynes Institution for Palliative Care)	Online course for care managers that introduces palliative care, evidence-based therapeutic approaches, determining who qualifies, and effectively communicating options with members.

5 EQUITY

Ensure palliative care reaches and meets the needs of communities of color and other historically marginalized populations. This includes considerations based on race/ethnicity, language, gender identity, sexual orientation, age, income, geographic location, diseases, disabilities, and social needs such as housing status.

Considerable inequities in health and health care persist for diverse populations, including those with serious illnesses. A 2019 statewide survey in California revealed disparities among people of color and low-income individuals regarding the absence of crucial conversations about medical preferences, experiences of discrimination when seeking healthcare, and levels of trust in healthcare providers.[7]

The field of palliative care is still in the early stages of learning how to ensure it reaches and meets the needs of communities of color and other under-served populations. Even as new knowledge is being developed, health plans can take steps to identify and address inequities, such as analyzing data to identify areas of disparity, listening to community needs, and tailoring programs to meet those requirements. Additionally, health plans can hire or contract with more clinicians who reflect the diversity of the community being supported.

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

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[7] Help Wanted: Californians' Views and Experiences of Serious Illness and End-of-Life Care. California Health Care Foundation, October 2019.

5 EQUITY

THE ESSENTIALS

☐ **Prioritize contracting with providers and hiring plan staff** who have characteristics in common with your members.

☐ **Initiate or expand internal diversity, equity, and inclusion (DEI) activities** to address how internal and external work cultures and practices contribute to inequities, and explore ways to bring about positive change.

☐ **Regularly evaluate enrollment and service outcomes** to identify disparities associated with member characteristics, including race/ethnicity, language, gender identity, sexual orientation, age, income, geographic location, diseases, disabilities, and social needs, such as housing status.

PROGRESSING FURTHER

☐ **Engage with diverse communities** to learn more about their needs and preferences for palliative care using methods like focus groups and interviews.

☐ **Utilize incentives to motivate providers** to pursue DEI goals, such as favoring network providers who share characteristics with member populations.

☐ **Contract with community-based organizations** that provide non-medical, culturally responsive, supportive care programs (e.g. lay navigation, emotional and spiritual support) to ensure responsiveness to the needs of specific populations.

SETTING THE STANDARD

☐ **Develop, evaluate, and disseminate additional strategies** to reduce disparities in access to and outcomes of care.

☐ **Consider requirements or incentives** to improve care quality for the most-studied domains of inequities (pain management, communication about goals of care, etc.).

5 EQUITY

Table 5: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Blog	How Medicare Advantage Could Address Pain Inequities For Black Patients Living With Serious Illness (Health Affairs)	Health Affairs blog with actionable steps for Medicare Advantage plans to address disparities in pain management for Black members.
Toolkit	Health Equity in Palliative Care Toolkit (Center to Advance Palliative Care)	Curated tools and resources to improve the quality of serious illness care provided to historically marginalized and under-served patient groups.
Report	Equitable Access to Quality Palliative Care for Black Patients: A National Scan of Challenges and Opportunities (Center to Advance Palliative Care)	Report summarizing challenges, opportunities, and possible interventions to improve equity.
Report	Improving Access to and Equity of Care for People with Serious Illness (The National Academies Science, Engineering, and Medicine)	Summary of workshop proceedings providers can use to deepen understanding of challenges, opportunities, and possible interventions to improve equity.
Toolkit	English/Chinese Glossary of End-of-Life Care Terms (Chinese American Coalition for Compassionate Care)	Tool plan providers can use when communicating with Chinese-speaking individuals about palliative and end-of-life care.

6 WORKFORCE CAPACITY

Increase the number of clinicians with generalist palliative care skills and encourage use of generalist palliative care when specialty palliative care is not needed.

Despite an increase in the number of specialty palliative care clinicians and the emergence of more pathways for pursuing a career or training in specialty palliative care, a workforce shortage of specialty palliative care clinicians is likely to persist over the next 20 years.[8] Additionally, some seriously ill patients' needs can be met by basic palliative care interventions which do not require a palliative care specialist or a full interdisciplinary team. Given these considerations, generalist palliative care (also known as "primary palliative care") has been gaining momentum as a complement to specialty palliative care. Generalist palliative care skills used in communication and symptom management enable front-line clinicians to administer basic palliative care comfortably and competently. If made widely available, generalist palliative care would ensure that a minimum level of palliative care is accessible to anyone who would benefit—and allow specialty palliative care services to focus on more complex situations.

ACTION ITEMS

THE ESSENTIALS

At the very least, start here →

PROGRESSING FURTHER

Take the next steps →

SETTING THE STANDARD

Strive for excellence →

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[8] Lupu D, Quigley L, Mehfoud N, Salsberg ES. The Growing Demand for Hospice and Palliative Medicine Physicians: Will the Supply Keep Up? J Pain Symptom Manage. 2018 Apr;55(4):1216-1223. doi: 10.1016/j.jpainsymman.2018.01.011. Epub 2018 Feb 2. PMID: 29410071.

6 WORKFORCE CAPACITY

THE ESSENTIALS

☐ **Disseminate information on available generalist palliative care educational programs** to non-palliative care physicians who care for people with serious illness (cancer, heart failure, renal failure, chronic obstructive pulmonary disease, etc.) and geriatricians.

PROGRESSING FURTHER

☐ **Pay for generalist palliative care training** for nurses and other clinicians who care for people with serious illness.

SETTING THE STANDARD

☐ **Incentivize process improvements** to support generalist palliative care (e.g., creating easy access to documentation of goals of care conversations within the electronic health record).

6 WORKFORCE CAPACITY

Table 6: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Report	The Case for Improving Symptom Management and Communication Skills (Center to Advance Palliative Care)	Succinct outline of rationale for improving symptom management and communication skills for all providers who care for seriously ill patients.
Report	Clinical Training Recommendations for All Clinicians Caring for Patients with Serious Illness (Center to Advance Palliative Care)	Recommendations and links to courses to build generalist palliative care skills.
Toolkit	Essential Skills and Supports for All Clinicians Treating Serious Illness: Building Generalist Palliative Care Capabilities Across Services and Settings (California Health Care Foundation)	Cases studies and resources that can inform design of a generalist palliative care initiative.
Report	Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models (National Coalition for Hospice and Palliative Care)	Example of incorporating generalist palliative care capabilities into population-based strategy/policy.
Training Program	End-of-Life Nursing Education Consortium (End-of-Life Nursing Education Consortium)	Nurse education program that uses a train-the-trainer model to scale palliative and end-of-life care clinical skills.
Training Program	VitalTalk	Serious illness communication skills training appropriate for all clinicians who care for seriously ill patients.

7

FAMILY CAREGIVER SUPPORT

Assess the needs of family caregivers and provide them with training and resources to support the care needs of seriously ill members.

Caregivers of people with serious illness are often overwhelmed and experience significant levels of stress and burden, which can directly impact their ability to provide quality support to the people in their care. Currently, most specialty palliative care teams address some caregiver needs through the team's social worker, but often these supports are not comprehensive and/or are highly dependent on individual social worker knowledge, skills, and competing priorities.

Whether administered by a health plan itself or through requirements for contracted palliative care teams and other providers, offering a more comprehensive and consistent additional layer of support to family caregivers has the potential to improve member outcomes. These outcomes may include reducing emergency room visits and hospitalizations, addressing medication-related issues, and ultimately, improving member satisfaction. Supported caregivers also contribute to helping members stay at home, thereby reducing the need for skilled nursing facility placement.

Additionally, caregiver support programs provide the added benefit of improving outcomes for the caregiver, who might also be a member. This includes a decrease in caregiver depression and anxiety, prevention of injuries, and better management of the caregiver’s own chronic conditions.

Caregiver support can manifest in various forms tailored to the specific needs of caregivers. This may include resource navigation and problem solving, emotional support and counseling, social-emotional skills training, medical skills training, respite, financial aid opportunities, and bereavement support.

7 FAMILY CAREGIVER SUPPORT

ACTION ITEMS

THE ESSENTIALS	PROGRESSING FURTHER	SETTING THE STANDARD
At the very least, start here →	Take the next steps →	Strive for excellence →

THE ESSENTIALS

☐ **Ensure the health plan adopts a structured approach** to supporting family caregivers of seriously ill members. Family caregiver support can be delivered by palliative care providers, community organizations, or with health plan internal resources. This support could include assessment, navigation, medical and non-medical skills training, and respite.

☐ **Require contracted palliative care providers** to have a structured and comprehensive approach to supporting family caregivers. Consider the effort required to do this work when calculating payment amount for palliative care providers.

☐ **Ensure that family caregiver support resources**, whether delivered by the palliative care team or other partners, **are cataloged** and easily accessible to caregivers and all relevant contracted providers.

7 FAMILY CAREGIVER SUPPORT

PROGRESSING FURTHER

☐ **Require contracted palliative care providers** to reassess caregiver needs on a regular basis (e.g., Zeit Burden survey administered every 60-90 days).

☐ **Develop a comprehensive suite of caregiver programming**, either administered through the health plan or through a provider network (beyond palliative care providers), to fill gaps in existing programs.

☐ **Ensure that programs incorporate culturally and linguistically tailored support**, preferably through partnerships with trusted community-based organizations.

☐ **Develop and implement a mechanism to collect feedback** on caregiver support interventions to facilitate quality assessment and improvement.

SETTING THE STANDARD

☐ **Offer a respite benefit** for family caregivers of seriously ill members.

☐ **Ensure that the suite of caregiver programs incorporates flexibility and variety** to address the full spectrum of caregiver abilities and needs at different points along the caregiver journey.

7

FAMILY CAREGIVER SUPPORT

Table 7: Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Assessment Tools	Caregiver Assessment Tools (Family Caregiver Alliance)	Examples of caregiver assessment tools used by state agencies.
	Zarit Burden Interview	Widely used assessment tool. 22- or 12-question caregiver burden assessment that can be self-administered or administered by trained staff as an interview.
	Caring for the Caregiver (Center to Advance Palliative Care)	List of six caregiver assessment tools.
Database of Programs	Best Practice Caregiving Database (Benjamin Rose Institute on Aging and Family Caregiver Alliance)	Over 40 evidence-based dementia-focused Caregiver Support interventions, some with extensive implementation support and many that also support caregivers of people with other conditions.
Program Example	Veterans Affairs (VA) Caregiver Support Program	The VA provides an example of more comprehensive offerings to caregivers through their Program of General Caregiver Support Services and Program of Comprehensive Assistance for Family Caregivers.
Payment Model	Guiding an Improved Dementia Experience (GUIDE) Model	Medicare dementia-focused care model that includes care coordination and care management, caregiver education and support, and respite services.

APPENDIX ONE

Selected References Describing Palliative Care Impacts

This annotated reference list summarizes key findings from a handful of the hundreds of peer-reviewed studies of the impacts of palliative care. Studies were selected because of the strength of design (randomized trial, well-designed observational study, or systematic review, for example.) Studies that looked at impact across domains—for example, assessing both patient experience and costs of care for the same population—and multi-site studies were also featured. As a body of evidence, these studies demonstrate that palliative care simultaneously improves health, experience, and economic outcomes—the gold standard for quality in health care.

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Selected References Describing Palliative Care Impacts

Inpatient Palliative Care: Impacts Across Multiple Domains

Study Characteristics	Patient Experience	Health & Quality of Life Outcomes	Utilization and Cost Outcomes
Glenn Gade et al., "Impact of an Inpatient Palliative Care Team: A Randomized Controlled Trial," *Journal of Palliative Medicine* 11, no. 2 (Mar. 11, 2008): 180-190.			
Randomized, controlled, multi-site trial of inpatient palliative care. Financial outcomes focused on post-acute care, including occurrence and cost of hospitalizations.	Palliative care patients reported better experience of care and better communication with care providers.	Not assessed in this study.	Inpatient palliative care associated with reduced costs over six months, and longer hospice stays (24 days versus 12).
Sean O'Mahony et al., "The benefits of a hospital-based inpatient palliative care consultation service: preliminary outcome data," *Journal of Palliative Medicine* 2005;8(5):1033-1039.			
Retrospective evaluation of 592 consecutive patients seen by a hospital-based inpatient palliative care consultation service.	95% of family caregivers surveyed by phone said they would recommend the palliative care service to others.	87% of palliative care recipients had improvement in pain or other symptoms.	Not assessed in this study.
Peter May et al., "Economics of Palliative Care for Hospitalized Adults with Serious Illness: A Meta-Analysis," *JAMA Internal Medicine* 178, no. 6 (June 1, 2018): 820–29.			
Re-analysis of data from six prominent studies with more than 133,000 patients using rigorous matching methods.	Not assessed in this study.	Not assessed in this study.	Direct costs of hospital care were 28% lower among palliative care recipients, compared to matched patients that did not receive palliative care.

Study Characteristics	Patient Experience	Health & Quality of Life Outcomes	Utilization and Cost Outcomes
Peter May et al., "Evaluating Hospital Readmissions for Persons with Serious and Complex Illness: A Competing Risks Approach," *Medical Care Research and Review* 77, no. 6 (Dec. 1, 2020): 574–83.			
Retrospective study of impact of inpatient palliative care consults on subsequent hospital admissions.	Not assessed in this study.	Not assessed in this study.	30-, 60-, and 90-day readmission rates were lower for palliative care patients, compared to matched patients who did not receive palliative care.
R. Sean Morrison et al., "Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries," *Health Affairs* (Millwood) 30, no. 3 (Mar. 2011): 454–63.			
Retrospective analysis of inpatient palliative care delivered to Medicaid enrollees at four hospitals.	Not assessed in this study.	Not assessed in this study.	Costs reduced by 11% per case. Patients dying in intensive care units (ICUs) decreased from 58% to 34%. Patients discharged to hospice increased from 1% to 30%.
Carin van Zyl et al., "Doing More with the Same: Comparing Public and Private Hospital Palliative Care within California," *Journal of Palliative Medicine*. 2022 Jul;25(7):1064-1071			
Retrospective analysis of Palliative Care Quality Network data from six public and 40 private California hospitals reporting on consultations to 4,244 and 38,354 adults, respectively.	Not assessed in this study.	Palliative care teams in both types of hospitals achieved improvements in pain, nausea, dyspnea, and anxiety.	Not assessed in this study.

Outpatient/Clinic-Palliative Care: Impacts Across Multiple Domains

Study Characteristics	Patient Experience	Health & Quality of Life Outcomes	Utilization and Cost Outcomes
Brian Cassel et al., "Early palliative care for patients with solid tumors and hematological malignancies: Impact on quality metrics and costs of care," *Supportive Care in Cancer* 25, suppl. 2 (Apr 22, 2017): 185-185.			
Retrospective analysis of cancer decedents' hospital and clinic utilization, comparing 433 early-palliative care recipients (first contact with palliative care >90 days before death) matched 1:1 to 433 late-palliative care recipients.	Not assessed in this study.	Not assessed in this study.	Late-palliative care patients were 4.8 times more likely to be admitted to the hospital in the final 30 days of life, and 4.2 times more likely to die in the hospital. Direct costs of care in the final 30 days of life for the late-palliative care patients were double the costs for early-palliative care patients.
David Hui et al., "Impact of timing and setting of palliative care referral on quality of end-of-life care in cancer patients," *Cancer*120, no. 11 (June 2014): 1743-1749.			
Retrospective analysis of health care use by cancer decedents who were referred to specialty palliative care; 1/3 were referred more than 90 days prior to death.	Not assessed in this study.	Not assessed in this study.	Earlier palliative care was associated with lower rates of hospitalization, ICU use, and emergency department visits.
Dio Kavalieratos et al., "Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis," *JAMA.2016* Nov 22;316(20): 2104-2114.			
Systematic review and meta-analysis.	Palliative care was associated consistently with improvements in patient and caregiver satisfaction.	Palliative care was associated consistently with improvements in advance care planning, quality of life, and symptom burden.	Palliative care was associated consistently with lower health care utilization.

Study Characteristics	Patient Experience	Health & Quality of Life Outcomes	Utilization and Cost Outcomes
Kieran L. Quinn et al., “Association of Receipt of Palliative Care Interventions With Health Care Use, Quality of Life, and Symptom Burden Among Adults With Chronic Noncancer Illness: A Systematic Review and Meta-analysis,” *JAMA*.2020 Oct 13;324(14):1439-1450.			
Much of the evidence for outpatient palliative care is focused on cancer. This systematic review and meta-analysis reviewed non-cancer conditions.	Not assessed in this study.	Palliative care was associated with lower symptom burden.	Palliative care was associated with less emergency department use and fewer hospitalizations.
Colin Scibetta et al., “The Costs of Waiting: Implications of the Timing of Palliative Care Consultation among a Cohort of Decedents at a Comprehensive Cancer Center,” *Journal of Palliative Medicine* 19, no. 1 (Jan. 2016): 69-75.			
Retrospective observational study of 103 patients who received palliative care at least 90 days before death (mostly in a palliative care clinic), compared to 290 patients who received palliative care within 90 days of death (mostly in hospital.)	Not assessed in this study.	Not assessed in this study.	Earlier palliative care was associated with lower rates of hospitalization, ICU use, and emergency department visits in the final month of life. Inpatient costs for the hospital were 26% lower for the earlier palliative care patients.
Jennifer S. Temel et al., “Early palliative care for patients with metastatic non-small-cell lung cancer,” *New England Journal of Medicine* 363, no. 8 (Aug 19, 2010): 733-742.			
Landmark randomized controlled trial that provided outpatient palliative care visits to patients with advanced lung cancer shortly after diagnosis. Controls received standard oncology care.	Not assessed in this study.	Palliative care recipients had better quality of life and lived longer; fewer had depressive symptoms; fewer had aggressive care at the end of life.	Not assessed in this study.
Camilla Zimmerman et al., “Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial,” *Lancet* 383, no. 9930 (May 17, 2014): 1721-1730.			
Outpatient palliative care was made available at 12 medical oncology clinics with 12 other clinics used as controls.	At four months, satisfaction with care improved.	At four months, quality of life and symptom severity improved.	Not assessed in this study.

Home-Based Palliative Care: Impacts Across Multiple Domains

Study Characteristics	Patient Experience	Health & Quality of Life Outcomes	Utilization and Cost Outcomes
Richard Brumley, et al., "Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care," *J Am Geriatr Soc.* 2007 Jul;55(7):993-1000.			
Randomized controlled trial comparing home-based palliative care (HBPC) to usual care. Included 298 homebound individuals with a prognosis of approximately one year or less plus one or more hospital or emergency department visits in the previous 12 months.	HBPC patients reported greater improvement in satisfaction with care at 30 and 90 days after enrollment.	Not assessed in this study.	Overall costs were 33% lower for HBPC patients. HBPC patients were more likely to die at home, and were less likely to visit the emergency department or be admitted to the hospital.
Christopher W Kerr et al., "Cost savings and enhanced hospice enrollment with a home-based palliative care program implemented as a hospice-private payer partnership," *Journal of Palliative Medicine* 2014 Dec;17(12):1328-35			
Prospective, observational study comparing costs in the final year of life for 149 patients who received HBPC and 537 matched usual care patients.	Not assessed in this study.	Not assessed in this study.	Overall costs for HBPC patients were 36% lower in the final three months of life. HBPC patients were more likely to enroll in hospice (70% versus 25%) and had longer lengths of stay in hospice (median 34 versus nine days.)
Christopher W Kerr et al., "Clinical impact of a home-based palliative care program: a hospice-private payer partnership," *J Pain Symptom Manage.* 2014 Nov;48(5):883-92.e1.			
Prospective, observational study of 499 patients enrolled in a HBPC program who subsequently died.	Patients, caregivers, and physicians reported high satisfaction (93%-96%) with the program.	Post-enrollment improvements seen in anxiety, appetite, dyspnea, well-being, depression, and nausea.	HBPC patients had a longer hospice average length of stay of 77.9 days, compared with all other hospice referrals (average length of stay: 56.5 days).

Study Characteristics	Patient Experience	Health & Quality of Life Outcomes	Utilization and Cost Outcomes
J Brian Cassel, et al., "Effect of a Home-Based Palliative Care Program on Healthcare Use and Costs," *J Am Geriatr Soc.* 2016 Nov;64(11):2288-2295			
Observational, retrospective study using propensity-based matching comparing outcomes for 368 patients who received HBPC to 1,075 patients who received usual care. All were Medicare Advantage beneficiaries.	Not assessed in this study.	Not assessed in this study.	Overall costs were 49% - 59% lower depending on the primary disease.
Dana Lustbader et al., "The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization," *Journal of Palliative Medicine* 2017 Jan;20(1):23-28.			
Retrospective analysis of a HBPC program in a Medicare Shared Savings Program ACO, comparing outcomes for 82 individuals receiving HBPC to 569 receiving usual care.	Not assessed in this study.	Not assessed in this study.	Overall costs for HBPC patients were 37% lower across the final three months of life. HBPC patients had a higher hospice enrollment rate (57% vs 37%), and a longer median hospice length of service (34 days vs 10 days.)
Keith Kranker et al., "Evaluation of the Medicare Care Choices Model Annual Report 4." Mathematica report submitted to CMMI April 2022			
Analysis of outcomes for 4,574 Medicare FFS beneficiaries who enrolled in the Medicare Care Choices Model (MCCM) and were known to have died by March 2021. MCCM enrollee outcomes were compared to matched Medicare FFS beneficiaries.			Net Medicare expenditures were 14% lower for MCCM participants. MCCM participants had 26% fewer inpatient admissions, 14% fewer outpatient emergency department visits, 38% fewer ICU days, and were 29% more likely to enroll in hospice.

APPENDIX TWO

Resources to Help Health Plans with the Basics of Starting a Palliative Care Program

The Center to Advance Palliative Care (CAPC), the Coalition to Transform Advanced Care (C-TAC), and California Health Care Foundation (CHCF) have excellent resources to help health plans that are in the early stages of building a new palliative care program.

← Skip to Previous Section: **Appendix One**

Resources to Help Health Plans with the Basics of Starting a Palliative Care Program

Develop a Plan Resources

TYPE OF RESOURCE	RESOURCES	DESCRIPTION
Toolkit	Payer Provider Toolkit (Center to Advance Palliative Care)	Toolkit including getting-started checklists, self-assessment checklist, and case studies featuring health plan programs.
Toolkit	Serious Illness Strategies (Center to Advance Palliative Care)	Outlines three key strategies for offering palliative care including proactive identification, engagement and assessment, and home-based supports.
Toolkit	Designing and Implementing Community-Based Palliative Care: A Guide for Payers (Coalition to Transform Advanced Care)	A toolkit for health plans offering community-based palliative care (home and clinic/outpatient), including tips in designing a program, payment and finance, network-building and management, and program operationalization.
Toolkit	Essential Elements of Medi-Cal Palliative Care Services (California Health Care Foundation)	A toolkit for Medi-Cal managed care plans and palliative care providers

THANK YOU

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