

# MAKE THE CASE

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



# 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.

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## 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.

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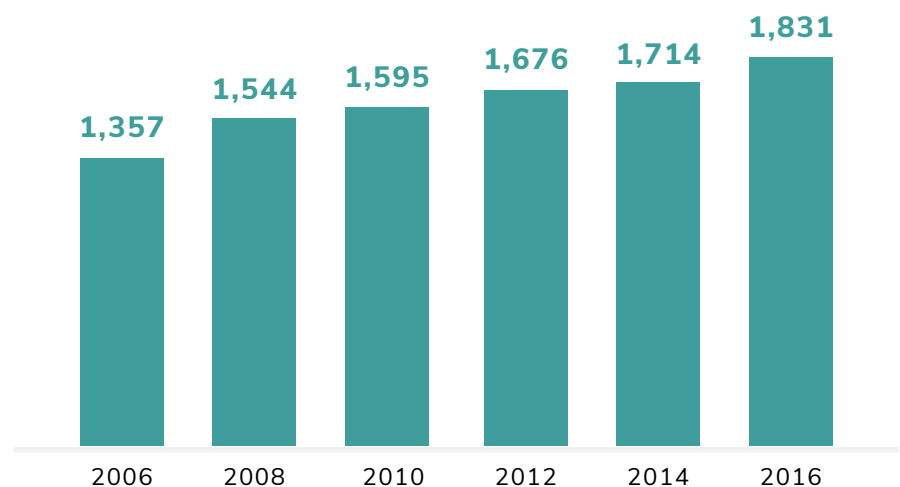
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# DESCRIPTION OF PALLIATIVE CARE

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/>



## 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.<sup>1</sup>

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.



## 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:<sup>2</sup>



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

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/npc>.














## 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

 <b>GENERALIST/ PRIMARY PALLIATIVE CARE</b>	 <b>SPECIALTY PALLIATIVE CARE</b>
<ul style="list-style-type: none"> <li> <b>Basic case management</b> and caregiver support</li> <li> <b>Basic management</b> of pain and other symptoms</li> <li> <b>Basic management</b> of depression and anxiety</li> <li> <b>Basic discussions</b> around prognosis, goals of treatment, suffering, and code status</li> </ul>	<ul style="list-style-type: none"> <li> <b>Management</b> of refractory pain and other symptoms</li> <li> <b>Management</b> of more complex depression, anxiety, grief, and existential distress</li> <li> <b>Assistance</b> with conflict resolution regarding goals or methods of treatment within families, between staff and families, and among treatment teams</li> <li> <b>Assistance</b> in addressing cases where further disease-directed treatment may be unsuccessful</li> <li> <b>Care coordination and case management</b> support to address health and/or social needs</li> </ul>

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 →

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# 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 



## 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.

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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*

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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 ( <a href="#">O'Mahoney 2005</a> )	95% of family caregivers surveyed by phone said they would recommend the palliative care service to others ( <a href="#">O'Mahoney 2005</a> )	Direct costs of hospital care were 28% lower among palliative care recipients ( <a href="#">May 2018</a> )
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%) ( <a href="#">Temel 2010</a> )	At four months post clinic enrollment, patients who were randomized to palliative care had greater improvement in satisfaction compared to usual care patients ( <a href="#">Zimmerman 2014</a> )	Costs for inpatient care in the last month of life were 26% lower when patients received earlier palliative care through outpatient clinics ( <a href="#">Scibetta 2016</a> )
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 ( <a href="#">Kerr 2014</a> )	Patients, caregivers, and physicians reported high satisfaction (93%-96%) with the palliative care program ( <a href="#">Kerr 2014</a> )	Overall costs were 33% lower for home-based palliative care patients ( <a href="#">Brumley 2007</a> )

A more comprehensive list of these studies can be found in [Appendix One](#).



## 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)



## 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*

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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.

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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*



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# 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.<sup>4</sup>

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.

4 [States Make Progress on Palliative Care - NASHP](#)

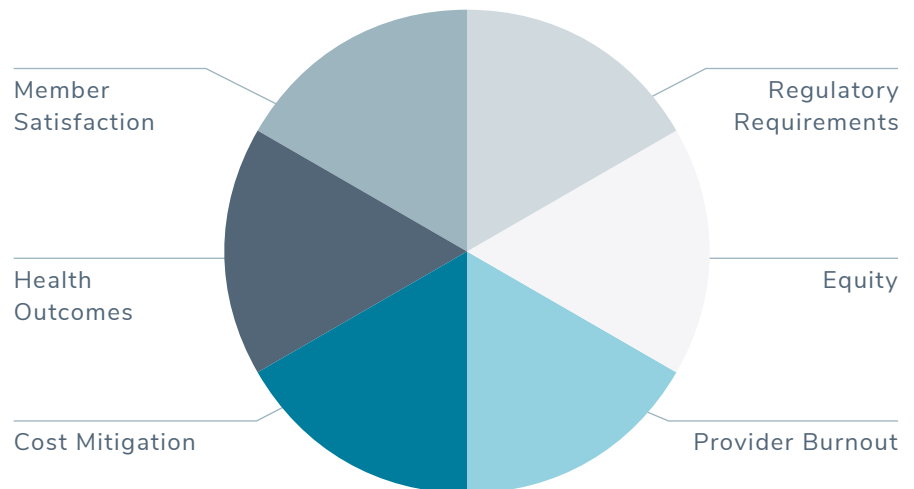


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# TALKING POINTS TO BUILD INTEREST

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

# APPENDIX ONE

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## **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., " <a href="#">Impact of an Inpatient Palliative Care Team: A Randomized Controlled Trial</a> ," <i>Journal of Palliative Medicine</i> 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., " <a href="#">The benefits of a hospital-based inpatient palliative care consultation service: preliminary outcome data</a> ," <i>Journal of Palliative Medicine</i> 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., " <a href="#">Economics of Palliative Care for Hospitalized Adults with Serious Illness: A Meta-Analysis</a> ," <i>JAMA Internal Medicine</i> 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., “ <a href="#">Evaluating Hospital Readmissions for Persons with Serious and Complex Illness: A Competing Risks Approach</a> ,” <i>Medical Care Research and Review</i> 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., “ <a href="#">Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries</a> ,” <i>Health Affairs (Millwood)</i> 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., “ <a href="#">Doing More with the Same: Comparing Public and Private Hospital Palliative Care within California</a> ,” <i>Journal of Palliative Medicine</i> . 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., " <a href="#">Early palliative care for patients with solid tumors and hematological malignancies: Impact on quality metrics and costs of care</a> ," <i>Supportive Care in Cancer</i> 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., " <a href="#">Impact of timing and setting of palliative care referral on quality of end-of-life care in cancer patients</a> ," <i>Cancer</i> 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., " <a href="#">Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis</a> ," <i>JAMA</i> . 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., <a href="#">“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,”</a> <i>JAMA</i> .2020 Oct 13;324(14):1439-1450.			
<p>Much of the evidence for outpatient palliative care is focused on cancer. This systematic review and meta-analysis reviewed non-cancer conditions.</p>	<p>Not assessed in this study.</p>	<p>Palliative care was associated with lower symptom burden.</p>	<p>Palliative care was associated with less emergency department use and fewer hospitalizations.</p>
 Colin Scibetta et al., <a href="#">“The Costs of Waiting: Implications of the Timing of Palliative Care Consultation among a Cohort of Decedents at a Comprehensive Cancer Center,”</a> <i>Journal of Palliative Medicine</i> 19, no. 1 (Jan. 2016): 69-75.			
<p>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.)</p>	<p>Not assessed in this study.</p>	<p>Not assessed in this study.</p>	<p>Earlier palliative care was associated with lower rates of hospitalization, ICU use, and emergency department visits in the final month of life.</p> <p>Inpatient costs for the hospital were 26% lower for the earlier palliative care patients.</p>
 Jennifer S. Temel et al., <a href="#">“Early palliative care for patients with metastatic non-small-cell lung cancer,”</a> <i>New England Journal of Medicine</i> 363, no. 8 (Aug 19, 2010): 733-742.			
<p>Landmark randomized controlled trial that provided outpatient palliative care visits to patients with advanced lung cancer shortly after diagnosis. Controls received standard oncology care.</p>	<p>Not assessed in this study.</p>	<p>Palliative care recipients had better quality of life and lived longer; fewer had depressive symptoms; fewer had aggressive care at the end of life.</p>	<p>Not assessed in this study.</p>
 Camilla Zimmerman et al., <a href="#">“Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial,”</a> <i>Lancet</i> 383, no. 9930 (May 17, 2014): 1721-1730.			
<p>Outpatient palliative care was made available at 12 medical oncology clinics with 12 other clinics used as controls.</p>	<p>At four months, satisfaction with care improved.</p>	<p>At four months, quality of life and symptom severity improved.</p>	<p>Not assessed in this study.</p>

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., " <a href="#">Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care</a> ," <i>J Am Geriatr Soc.</i> 2007 Jul;55(7):993-1000.			
<p>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.</p>	<p>HBPC patients reported greater improvement in satisfaction with care at 30 and 90 days after enrollment.</p>	<p>Not assessed in this study.</p>	<p>Overall costs were 33% lower for HBPC patients.</p> <p>HBPC patients were more likely to die at home, and were less likely to visit the emergency department or be admitted to the hospital.</p>
 Christopher W Kerr et al., " <a href="#">Cost savings and enhanced hospice enrollment with a home-based palliative care program implemented as a hospice-private payer partnership</a> ," <i>Journal of Palliative Medicine</i> 2014 Dec;17(12):1328-35			
<p>Prospective, observational study comparing costs in the final year of life for 149 patients who received HBPC and 537 matched usual care patients.</p>	<p>Not assessed in this study.</p>	<p>Not assessed in this study.</p>	<p>Overall costs for HBPC patients were 36% lower in the final three months of life.</p> <p>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.)</p>
 Christopher W Kerr et al., " <a href="#">Clinical impact of a home-based palliative care program: a hospice-private payer partnership</a> ," <i>J Pain Symptom Manage.</i> 2014 Nov;48(5):883-92.e1.			
<p>Prospective, observational study of 499 patients enrolled in a HBPC program who subsequently died.</p>	<p>Patients, caregivers, and physicians reported high satisfaction (93%-96%) with the program.</p>	<p>Post-enrollment improvements seen in anxiety, appetite, dyspnea, well-being, depression, and nausea.</p>	<p>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).</p>

Study Characteristics	Patient Experience	Health & Quality of Life Outcomes	Utilization and Cost Outcomes
 J Brian Cassel, et al., " <a href="#">Effect of a Home-Based Palliative Care Program on Healthcare Use and Costs</a> ," <i>J Am Geriatr Soc.</i> 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., " <a href="#">The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization</a> ," <i>Journal of Palliative Medicine</i> 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., " <a href="#">Evaluation of the Medicare Care Choices Model Annual Report 4.</a> " 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.

# THANK YOU

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**For more information,  
please contact us:**



[transformingcarepartners.com](https://transformingcarepartners.com)



[loren@transformingcarepartners.com](mailto:loren@transformingcarepartners.com)

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