



Palliative Care in California: Narrowing the Gap

Palliative care (PC) is specialized medical care that provides patients with relief from the symptoms, pain, and stress that often occur with serious illness. As evidence of the benefits of palliative care has grown in recent years, services have expanded from hospital- to community-based settings and have grown in number. In 2014 the California Health Care Foundation sponsored an environmental scan of palliative care services across the state, and assessed the supply of such services relative to the estimated need among patients in the final year of life. The analysis found that services available in acute care hospitals were sufficient to meet 33% to 50% of estimated need, and that programs in community settings (clinics and/or patient homes) could meet 24% to 37% of need. Services were unevenly distributed across the state, with many counties not having access to inpatient palliative care (IPPC), community-based palliative care (CBPC), or either type of service. The 2017 update of this effort found dramatic increases in the number of programs, the number of patients being served, and broader availability across the state.

Methods

This analysis examines the prevalence, capacity, and sufficiency of inpatient and community-based palliative care programs in California in 2017 — that is, the number of programs (prevalence), the number of people typically served by those programs (capacity), and how the number served compares to the need for palliative care in that region (sufficiency). While palliative care can help people at any stage of serious illness, this analysis focused on the need for palliative care among those in the last year of life. A description of the methods used to identify programs and estimate need is available as an appendix to the [full issue brief](#).

Findings

In 2017 inpatient palliative care capacity for the entire state is estimated to be sufficient to meet between 43% and 66% of need (mid-point estimate = 52%), and current community-based capacity is estimated to be sufficient to meet between 33% and 51% of need (mid-point estimate = 40%).

Need, Capacity, and Sufficiency of Palliative Care (PC) Services, 2014 vs. 2017

	2014	2017	CHANGE	TREND
People needing PC in final year of life*	183,937	191,343	7,406	Stable
Inpatient PC (IPPC) capacity	72,394	99,013	26,619	Increase
Community-based PC (CBPC) capacity	53,570	76,730	23,160	Increase
IPPC sufficiency†	39%	52%	33%	Increase
CBPC sufficiency†	29%	40%	38%	Increase
Counties with no IPPC	19	18	-1	Reduction
Counties with no CBPC‡	22	6	-16	Reduction
Counties with no specialty PC	15	4	-11	Reduction
Counties with ≥50% sufficiency IPPC	8	21	13	Increase
Counties with ≥50% sufficiency CBPC	5	14	9	Increase
Counties with ≥50% sufficiency IPPC and CBPC	1	6	5	Increase

* Mean of high and low estimates of need for PC among individuals in final year of life.

† Reflects capacity divided by the mean of high estimate of need and low estimate of need for PC.

‡ In 2018, after data collection for this project ended, the number of counties with no CBPC shrank to zero.

Source: Analysis conducted by Kathleen Kerr, 2018.

While need for PC has remained relatively stable, capacity has grown significantly for both inpatient and community-based services. Increased capacity in the inpatient setting reflects a modest (9%) increase in the number of programs but a more significant increase in the number of individuals being cared for by programs (up 37.5%). Significant gaps still exist among small hospitals and (especially) for-profit hospitals, only 11% of which have services. Prevalence of community-based services more than doubled, with the most significant growth seen among hospice organizations that are now offering PC in addition to hospice care.

Factors That Have Promoted Growth

While this analysis does not formally examine the factors that promoted increased capacity, it is highly likely that SB 1004, the California law that requires the state's Medi-Cal managed care plans to offer palliative care to qualifying beneficiaries, has played a key role in increasing access, particularly in rural communities. Similarly, a growing body of literature that demonstrates the positive impact CBPC can have on patient, family, and utilization/cost outcomes has led several payers, notably Health Net and Blue Shield of California, to offer PC across many or all business lines. As a result, these organizations have been active in developing statewide networks to deliver such care, contracting with organizations that were already offering PC and supporting creation of new programs in areas where no vendors were available.

Remaining Questions

This research did not endeavor to examine what exactly the palliative care programs do for patients (scope of services), the nature of their staffing/clinical models, or how prepared staff are to deliver quality care. Given the absence of regulations and state or federal standards addressing palliative care, an analysis of program characteristics with an eye to assessing indicators associated with care quality (staff training, use of standardized protocols, etc.) would be a critical complement to this examination of prevalence. Further, while it is possible to estimate the number of people who might need palliative care in the final year of life, this analysis did not assess the types of insurance they have. Currently, many patients with Medi-Cal managed care, Medicare Advantage, and some types of commercial insurance have a good chance of having CBPC services covered by insurance. Others, notably those with traditional Medicare fee-for-service coverage, would likely be able to access home-based palliative care only if they had the resources to pay for it out of pocket.

Remaining Challenges

While much progress has been made, many challenges remain. Not every program identified in 2014 survived into 2017, testimony to how programs offering a new type of care are especially vulnerable to closure. In community settings, many PC programs have found that having capacity does not necessarily translate into immediate referrals. Much work

still needs to be done to educate referring providers, patients, and families about the benefits of PC, with an emphasis on distinguishing PC from hospice. Absence of standardization in the scope of care, clinical models, training requirements, and processes for billing and authorizations creates enormous burdens on both providers and the entities that pay for care, leading to inefficiencies that inhibit scaling, increase the cost of administering programs, and hamper efforts to evaluate outcomes.

While capacity has increased significantly, it's still not sufficient to meet the needs of those in the final year of life, much less the larger seriously ill population (those with chronic progressive conditions who may need support for several years, and those who need support for a brief time and then recover). Specialty PC is unlikely to ever fill that gap, as financial and workforce issues will ultimately cap the number of specialty services. It is thus important to supplement efforts aimed at increasing specialty PC capacity with efforts aimed at increasing the efficiency of such services, efforts that promote palliative care skills among primary care providers and other health care professionals serving seriously ill populations, and efforts that incorporate palliative care focus areas and principles into a wide range of programs that serve seriously ill patients, such as home-based primary care, Program for All-Inclusive Care of the Elderly (PACE) programs, and complex case management programs.

About the Author

Kathleen Kerr is a health care consultant. Her work is focused on promoting the development of sustainable, quality palliative care programs.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.