Opportunities to Further Advance Palliative Care in California

California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

About the Author

Transforming Care Partners is a consulting firm focused on improving the experience of aging and serious illness care by partnering with leading and growing organizations on strategy development, implementation, and evaluation/learning. For additional information about the authors, contributors, and other acknowledgments, please visit www.chcf.org/resource-center/californias-palliative-care-evolution.

About the Project

As the California Health Care Foundation (CHCF) winds down its work in palliative care after 15 years, this project examines and celebrates the collective successes achieved by the many stakeholders responsible for the growth of palliative care in California, and considers opportunities to build on and accelerate this growth to meet future needs.

For this project, Transforming Care Partners engaged with and synthesized insights from in-depth interviews with over 30 leaders across five segments of the field (i.e., health plans, health systems/providers, community-based organizations, policymakers / government agencies, and membership organizations). The authors also facilitated a cross-discipline working session with over 200 participants at the Coalition for Compassionate Care of California Annual Summit in May 2023 to solicit more input.

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. For more information, visit www.chcf.org.

Introduction

Although tremendous progress has been made in palliative care (PC), not all Californians have access to quality palliative care in 2023. Even without the precise data to comprehensively assess PC capacity, utilization, quality, or equitable access to and use of services, California's palliative care field leaders and organizations are among the first to acknowledge there is significant work left to be done. For example, clinical capacity is insufficient in settings like nursing homes and outpatient clinics, as well as in certain geographies (e.g., rural areas). Moreover, nearly a third of California public hospitals lack access to at least a half-day outpatient palliative care clinic.[1] Even where PC capacity exists, it does not reach all who could benefit from it.

Throughout the conversations undertaken for this project, many members of the palliative care movement remarked that the field of palliative care is at an inflection point in its growth. It is no longer in start-up mode, but not yet mature enough to be a universally accepted and integrated standard of care. Stakeholders stressed the importance of maintaining momentum at this critical point in the field's development.

To this end, contributors highlighted eight opportunities to advance the field and even accelerate the field's momentum (see "Opportunities to Advance Palliative Care in California" on page 5). Specific actions were also identified for stakeholders to help advance these opportunities. Although many common themes emerged, the opportunities and actions highlighted in this report are not meant to be definitive or exhaustive, but rather serve as a starter for ongoing discussions about priorities, goals, and collaborative efforts toward common objectives.

The palliative care movement remains strong in California. By working together on these opportunities, stakeholders can maintain momentum, sustain hard-won gains, accelerate palliative care's growth, and ensure that all Californians have access to quality PC.

Opportunities to Advance Palliative Care in California

	1. Equity	▶ Analyze data to identify areas of disparity and listen to community needs. ▶ Tailor programming and communication to respond to community needs. ▶ Expand the specialty palliative care workforce to include more clinicians of color.
	2. Uptake	▶ Engage with community members to improve understanding of palliative care. ▶ Educate providers and case managers who care for people with serious illness about palliative care benefits. ▶ Implement processes to identify people who would benefit from palliative care and connect them to services. ▶ Integrate palliative care into existing medical and social programs that serve seriously ill populations.
	3. Advocacy	▶ Keep palliative care visible to policymakers and government organizations. ▶ Highlight the value of palliative care in meeting other key health care priorities. ▶ Increase partnerships with disease-focused and other aligned organizations that can incorporate palliative care advocacy into their own agenda.
	4. Workforce Capacity	▶ Expand and strengthen the workforce by increasing educational opportunities for specialty palliative care clinicians, particularly for clinicians of color. ▶ Increase generalist palliative care training and skills for non-palliative care clinicians.
	5. Standards and Measures	▶ Refine, endorse, and adopt minimum standards and measures until federal or state mandates are put in place. ▶ Monitor adherence to minimum standards and the use of specified measures.
	6. Payments	▶ Use bundled payments that align with optimal care delivery models. ▶ Build the evidence base related to payment model and amount.
	7. Data	▶ Strengthen efforts to enhance data quality for seriously ill patients. ▶ Develop an ICD-10 code for specialty palliative care. ▶ Develop and maintain a statewide database of palliative care providers.
	8. Integration	▶ Embed palliative care within other inpatient and outpatient services and settings. ▶ Integrate palliative care with Medi-Cal's Enhanced Care Management (ECM) services. ▶ Integrate palliative care with home-based medical services.

Opportunity 1: Equity

> **OPPORTUNITY: Ensure palliative care reaches and meets the needs and preferences of communities of color and other underserved populations.**
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> Potential stakeholder actions:
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> ➤ Analyze data to identify areas of inequity and listen to community needs.
> ➤ Tailor programming and communication to respond to community needs.
> ➤ Expand the specialty palliative care workforce to include more clinicians of color.

California stands as not only the largest state, but also one of the most diverse. Among its 39.5 million residents, 65% are people of color, 27% are foreign-born, and 9% identify as LGBTQ.[2] Regrettably, considerable inequities in health and health care persist for these diverse populations, including those with serious illnesses. A 2019 California statewide survey, commissioned by the California Health Care Foundation (CHCF), highlighted disparities across people of color and those with low incomes concerning important conversations about medical preferences, instances of discrimination while seeking health care, and the degree of trust in health care providers (see "Health Disparities Experienced by People of Color and Those with Low Incomes").

Health Disparities Experienced by People of Color and Those with Low Incomes

	White	Black	Asian / Pacific Islander	Latino/x	<150 FPL
Have not talked with a decisionmaker about the kind of medical care they would want at the end of life	44%	62%	70%	NA	62%
Have not documented wishes for medical treatment at the end of life	58%	68%	NA	76%	74%
Have felt judgment or discrimination from providers	14%	37%	15%	22%	32%
Have a lot of trust in providers	49%	39%	33%	32%	34%

Note: *FPL* is federal poverty level. *NA* is not available.
Source: *Help Wanted: Californians' Views and Experiences of Serious Illness and End-of-Life Care*, California Health Care Foundation, October 2019.

High-quality palliative care (PC) has the potential to mitigate many of these disparities. Unfortunately, data on equitable access to and use of palliative care in California are lacking. It is likely that California has made strides in narrowing the gap for people with low incomes by mandating that Medi-Cal managed care plans offer palliative care. Still, findings on whether people of color and other historically marginalized communities experience inequities in access to or use of PC are inconclusive.[3] If there are gaps in PC usage, it cannot be explained by differences in care preferences because 9 in 10 Californians, regardless of race or ethnicity, say they would want the support offered by palliative care if they had a serious illness.[4]

The field of palliative care is still in the early stages of learning how to ensure it reaches and meets the needs and preferences of communities of color and other underserved populations. Meanwhile, three actions can be taken today.

Action: Analyze data to identify areas of disparity and listen to community needs.

Health plans and palliative care programs can use analytics, including community assessments, to identify potential areas of inequity in access, acceptance, and quality of PC services. They can also conduct listening tours with community members to learn about the communities' priorities and about the barriers to access and acceptance of palliative care services within that context. Participatory processes, such as patient and advisory councils or focus groups, should be integrated into an ongoing practice to listen to community needs, with special attention to communities typically underrepresented (e.g., limited English proficiency, experiencing homelessness or marginally housed, undocumented). PC teams should consider adding some measures of equity to their PC quality dashboards.

Action: Tailor programming and communication to respond to community needs.

Although there is still more to learn about how to adapt palliative care programs to meet the needs of people of color and other underserved communities, some known strategies could be implemented more widely today.

▶ **Launch or sponsor community engagement programs.** Community engagement and education programs can build awareness and acceptance of palliative care services in the community. See Opportunity 2, "Uptake," for more information about this cross-cutting strategy.

▶ **Partner with or support the creation of Serious Illness Care (SIC) Navigation Programs led by community health workers.** SIC Navigation Programs provide nonmedical services to

seriously ill patients and caregivers, often in their homes. One example of such a program is the Advanced Illness Care Program developed by the AC Care Alliance. The AC Care Alliance delivers comprehensive nonmedical care to people with serious illness, encompassing social, emotional, spiritual, and caregiver support.[5] Community health workers are trained as serious illness care navigators, with oversight by a nurse trained in palliative care. Among other social, emotional, and spiritual support services, care navigators can explain the benefits of PC and how it differs from hospice. They can also empower participants to ask for a PC consultation if they qualify and help them navigate that conversation with their primary care provider or specialist. These competencies can be built in stand-alone organizations focused on serious illness or can be incorporated into aligned community health worker and lay navigation programs (e.g., complex care management) tailored to the needs of specific populations.[6]

➤ **Integrate language capabilities and cultural knowledge.** Ensure palliative care programs have the necessary language capabilities and cultural fluency to effectively serve their respective populations. For example, the Chinese American Coalition for Compassionate Care partnered with Kaiser Permanente to develop a culturally attuned, Mandarin-language dictionary of serious illness care terms for use by clinicians, staff, and interpreters.

➤ **Leverage telemedicine (e.g., video visits) to provide palliative care to people who have difficulty attending traditional office visits.** Telemedicine can provide access to a more robust and diverse specialty palliative care workforce. If telemedicine is the primary mode of care delivery, local teams should consider employing local community health workers who can conduct in-person visits, integrate services within local primary or specialty care teams, or both. This approach would be especially useful in rural settings, tribal settings, urban settings with poor public transportation, or other palliative care "deserts." Some providers recognize that broadband and device access is a barrier and provide solutions (e.g., tablets, training) to bridge this technology gap.

➤ **Disseminate care models or programs that promote equitable outcomes or reduce known disparities.** Programs tailored to community needs might already exist in specific areas, and any new initiatives focused on reducing disparities should be widely disseminated. Given limited capital and organizational capacity, the field should maximize efforts to build on existing programs.

> *"We need to understand voices and respect preferences, not push people into something. We also likely need to adapt the intervention to meet the needs of communities of color. For example, PC integration in religious organizations or with community health workers."*
>
> —Kim Bower, MD, Medical Director, Blue Shield of California

Action: Expand the specialty palliative care workforce to include more clinicians of color.

As in many other health care fields, clinicians of color are underrepresented in palliative care. Health plans and health systems should prioritize contracting with or hiring clinicians who share race/ethnicity and language characteristics with their patient populations. Doing so will help to ensure that patients have access to clinicians with greater understanding of their cultural perspectives and linguistic needs. The field should also address equity gaps in the broader composition of the PC workforce by exploring financial and nonfinancial incentives for people of color entering education programs and seeking to work in California (see Opportunity 4, "Workforce Capacity").

> *"Clinically, I see the negative outcomes of the lack of community awareness of palliative care among traditionally underserved communities. I think it will take special dedicated attention to improve this that will include attending to equity, increasing workforce representative of the communities we serve, and driving demand from these communities."*
>
> —Coalition for Compassionate Care of California 2023 Annual Summit participant and health system worker

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RESOURCES FROM THE FIELD

▶ Equitable Access to Quality Palliative Care for Black Patients: A National Scan of Challenges and Opportunities (Center to Advance Palliative Care [CAPC])[7]

▶ Health Equity in Palliative Care Toolkit (CAPC)[8]

▶ Improving Health Care Quality for Black Patients Living with Serious Illness: A Catalog of Interventions (PDF) (CAPC)[9]

▶ Improving Access to and Equity of Care for People with Serious Illness (National Academies Press)[10]

▶ AC Care Alliance[11]

▶ English/Chinese Glossary of End-of-Life Care Terms (PDF) (Chinese American Coalition for Compassionate Care)[12]

▶ Improving and Expanding Programs to Support a Diverse Health Care Workforce (PDF) (Urban Institute)[13]

Learn more about each action, including how all stakeholders can commit to this opportunity. Specific actions for different stakeholder groups are listed in the table below.

Opportunity 1: Equity — Potential Actions by Stakeholder

Ensure palliative care reaches and meets the needs and preferences of communities of color and other underserved populations.

Action: Analyze data to identify areas of disparity and listen to community needs.	Action: Tailor programming and communication to respond to community needs.	Action: Expand the specialty palliative care workforce to include more clinicians of color.
Health Plans		
▶ Regularly evaluate enrollment and service outcomes to identify disparities across member characteristics (e.g., race/ethnicity, gender, gender identity, sexual orientation, age, income, geography, diseases, disabilities, social needs such as housing status, etc.).	▶ Contract with community-based organizations that offer nonmedical, culturally responsive, supportive care programs (e.g., lay navigation, emotional and spiritual support, etc.) to ensure responsiveness to the needs of specific populations.	▶ Prioritize contracting with or hiring clinicians who share the characteristics of your members.
Health Systems and Community-Based Providers		
▶ Regularly evaluate enrollment and service outcomes to identify disparities across patient characteristics (e.g., race/ethnicity, gender, gender identity, sexual orientation, age, income, geography, diseases, disabilities, social needs such as housing status, etc.). ▶ Create community advisory boards or other ongoing participatory processes to gain regular insight into community needs.	▶ Support the creation of or forge stronger ties and referral mechanisms with community-based organizations that offer nonmedical, culturally responsive, supportive care programs (e.g., lay navigation, emotional and spiritual support, etc.) to ensure responsiveness to the needs of specific populations. ▶ Integrate language capabilities and culturally appropriate practices into programs. ▶ Leverage telemedicine to provide palliative care (PC) to people who have difficulty attending traditional office visits.	▶ Prioritize hiring PC clinicians of color for full-time PC positions, offer mentorship programs, and offer financial incentives in the early years of practice (e.g., housing stipends).
Clinicians Who Care for People with Serious Illness		
	▶ Participate in equity-focused communications training.	▶ PC clinicians should directly support new or potential PC providers of color by offering mentorship or similar peer supports. ▶ PC clinicians should consider opportunities to work in underserved areas.

Action: Analyze data to identify areas of disparity and listen to community needs.	Action: Tailor programming and communication to respond to community needs.	Action: Expand the specialty palliative care workforce to include more clinicians of color.
State and Local Government Agencies		
➤ Require PC programs that offer services to Medi-Cal enrollees to regularly evaluate enrollment and service outcomes to identify disparities across patient characteristics (e.g., race/ethnicity, gender, gender identity, sexual orientation, age, income, geography, diseases, disabilities, social needs such as housing status, etc.) and report their findings.		➤ Offer incentives for PC programs that receive state funding to employ or contract with clinicians that have shared characteristics with the local community. ➤ Offer incentives to encourage clinicians of color to become certified in palliative care. ➤ Offer incentives (e.g., cash bonuses, housing stipends, loan forgiveness) for PC clinicians to take positions in safety-net hospitals and in rural or other underserved areas.
Philanthropy		
➤ Fund research to learn how to reduce disparities in access, acceptance, and quality of PC.	➤ Fund pilots and early demonstration of interventions that meet the needs of underserved communities and are complementary to PC (e.g., serious illness navigation, caregiver support). ➤ Create materials that explain palliative care with culturally appropriate framing and in needed languages. ➤ Fund the scaling of care models that promote equitable outcomes.	➤ Provide funding to encourage clinicians of color to become certified in palliative care and to remain in California. ➤ Provide funding for incentives (e.g., cash bonuses, housing stipends, loan forgiveness) for PC clinicians to take positions in safety-net hospitals and in rural or other underserved areas.

Note: These potential actions serve as examples of how various stakeholders can contribute to the ongoing advancement of palliative care. They are intended to stimulate thought and strategic planning, and the list should not be considered exhaustive. To learn more, visit www.chcf.org/resource-center/californias-palliative-care-evolution.

Opportunity 2: Uptake

OPPORTUNITY: Increase utilization of existing palliative care capacity.

Potential stakeholder actions:

➤ Engage with community to improve understanding of palliative care.

➤ Educate providers and case managers who care for people with serious illness about palliative care benefits.

➤ Implement processes to identify people who would benefit from palliative care and connect them to services.

➤ Integrate palliative care into existing medical and social programs that serve seriously ill populations.

Clinical capacity to offer palliative care (PC) is just one side of the equation. To ensure appropriate "demand" for palliative care, people with serious illness need to understand what palliative care is, how it can support them in complementary but different ways than their other medical services, and how to access PC services once they are desired. Organizations can contribute to generating and maintaining demand by establishing systems to identify people who could benefit from palliative care, communicating the benefits of these services to those who could benefit, initiating referrals, and following up on referrals to increase uptake.

Action: Engage with community to improve understanding of palliative care.

An estimated 71% of adults reported having never heard of palliative care, and communities of color are often even less aware.[14]

Also, even when people say they know what palliative care is, their understanding can be inaccurate or incomplete, often conflating palliative care with hospice — including false beliefs that palliative care cannot be provided alongside other treatments.[15] For some patients and caregivers from communities of color, these widespread misperceptions can be compounded by broader issues of mistrust caused by institutional racism and other forms of discrimination from health care systems, including a resulting concern that opting for PC might result in the withholding of curative care.

There is a significant opportunity to overcome these challenges and bolster the acceptance of palliative care by educating patients and families about what PC is and what benefits it brings. According to a 2019 survey commissioned by CHCF, when the services that palliative care offers were described, 9 in 10 Californians expressed their desire for this care in the event of a serious illness, regardless of their race or ethnicity.[16]

> *"My responsibility, whether it's a plan, whether it's in a community agency, or even just as a social worker or a friend or a neighbor, is to empower people with the knowledge so that they can speak for themselves. We need to be in the community and educate the community members about what is palliative care, what is advance care planning and empower them with that knowledge so that they can go forward and discuss it with their primary care physicians. When I offered this education in the core of the community, people were thirsty for this knowledge."*
>
> —Kim Beverly, MSW, MSG, Palliative Care Clinical Program Manager, Blue Shield of California

Ongoing community engagement activities can foster awareness and build trust in palliative care, leading to higher referral acceptance. Organizations responsible for the well-being of people facing serious illnesses could collaborate with community and faith-based organizations that already maintain trusted relationships within their community. Engagement activities should be codesigned with these trusted partners, and codesigners should pay special attention to language, the role of community champions as messengers, location of engagement activities, and a commitment to ongoing programming (see "Guiding Principles for Community Engagement").

GUIDING PRINCIPLES FOR COMMUNITY ENGAGEMENT

Language and framing matter. Once people engage in a substantive discussion in straightforward language about palliative care and understand the services they would receive, enthusiasm for these supports become clear, as the 2019 CHCF survey underscored. The Serious Illness Messaging Toolkit (see "Resources from the Field" at the end of this section) can be a foundational resource for crafting messages. This toolkit, rooted in market research and testing, devised five strategies applicable to community engagement.

Messengers matter. Community engagement activities should encompass genuine interactions involving community members, palliative care clinicians, and peer ambassadors willing to share their personal experiences with palliative care as either patients or caregivers. It is crucial that patient and caregiver ambassadors are regarded as trusted figures within their communities (for instance, Black

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patients or caregivers engaging in predominantly Black communities). When possible, the palliative care clinician involved in outreach should also be a trusted member of the community. However, given the lack of racial and ethnic diversity within the palliative care clinician community (see Opportunity 1, "Equity"), this goal will not always be achievable.

Location and commitment matter. Community engagement activities should be conducted in collaboration with trusted community partners and advocates. These activities should take place in settings where people naturally gather and feel comfortable, such as senior centers, senior housing, places of worship, restaurants, or online environments. Activities must happen regularly (e.g., at least two to four times per year), rather than as isolated, one-off events. This approach helps establish the necessary trust, relationships, and knowledge within the community.

Action: Educate providers and case managers who care for people with serious illness about palliative care benefits.

Health systems and health plans should offer ongoing education on the value of palliative care to non-PC clinicians and health plan case managers. Clinicians and health plan staff do not always understand the benefits of palliative care and may even confuse it with hospice care.[17] Misperceptions persist among some clinicians that referring patients to palliative care could cause a loss of control over treatment decisions or is a sign of giving up on the patient. Continued education is a critical tool to drive demand and use of palliative care, notably:

➤ **Educate non-PC clinicians.** Health systems should provide education about the benefits of PC to all clinicians responsible for the care of people facing serious illness. This education explains the value of PC and teaches clinicians when and why to refer patients to PC. This education can be provided separately from generalist palliative care skills training.

➤ **Educate case managers.** Health plans should provide palliative care education to plan case managers to help them understand the value of PC and to become comfortable discussing PC as an option when reviewing services with seriously ill members or their caregivers. Case manager education could include shadowing opportunities to promote practical understanding of serious illness programs, as well as training videos, scripts, and practice sessions for describing palliative care to members.

"I've had several providers that initially did not understand the value of palliative care. But with education, advocacy, and patience, these providers changed their minds and now integrate palliative care into their care."

—Cyndie Holzworth, RN, Director of Nursing — Outpatient Services,
Hoffman Hospice & Palliative Care

Action: Implement processes to identify people who would benefit from palliative care and connect them to services.

Education alone is not enough. Purpose-built systems are beneficial to actively identify and refer patients into palliative care. Systems should encompass routine screening for palliative care needs, clear referral criteria, and a mechanism to start referrals when patients meet criteria. Although algorithm-based approaches can aid in patient identification, clinicians remain essential for recognizing people who may elude algorithmic detection. Additionally, clinicians play a crucial role in educating patients about the value of palliative care and helping them through the referral process. Over several years of collaborative efforts, Medi-Cal managed care plans have identified four promising practices. When used in combination, these practices optimize the identification of members who would benefit from palliative care:

▶ **Data-driven strategies.** Use of claims and other plan data to identify members with evidence of advanced serious illness, unaddressed symptoms, and other unmet needs.

▶ **Plan care manager identification.** Identification by health plan care managers, often from the panel of patients they are already managing under other complex case management programs or similar.

▶ **Hospital-based staff engagement.** Promotion of palliative care within hospital-based staff including hospitalists, hospital-based palliative care services, and discharge planners.

▶ **Clinician referrals.** Referrals from clinicians who care for large numbers of seriously ill people such as cardiologists, oncologists, and pulmonologists.

Action: Integrate palliative care into existing medical and social programs that serve seriously ill populations.

Even when people make the decision to accept a palliative care referral, they can still encounter challenges. These challenges can be rooted in practical matters such as cost of care, demands of transportation, or the physical challenges of getting to more appointments. Challenges can also be caused by emotional strain such as being overwhelmed by multiple teams managing or delivering care in the home.

Integrating palliative care into other existing medical and social programs that serve seriously ill populations not only simplifies the process of accepting services for patients, but also reduces the burden of accessing care. Further elaboration on this opportunity is provided in Opportunity 8, "Integration."

RESOURCES FROM THE FIELD

➤ Help Wanted: Californians' Views and Experiences of Serious Illness and End-of-Life Care (CHCF)[18]

➤ The Serious Illness Messaging Toolkit[19]

➤ Introduction to Palliative Care for Health Professionals (Center to Advance Palliative Care [CAPC])[20]

➤ Conversation Skills for Introducing Palliative Care: New Video Tools (Coalition for Compassionate Care of California)[21]

➤ Care Managers: Addressing the Unique Needs of Patients with Serious Illness (CAPC)[22]

➤ Essential Care Management Training for Health Plans (California State University Shiley Haynes Institute for Palliative Care)[23]

➤ Community House Calls Program (Harborview Medical Center)[24]

Learn more about each action, including how all stakeholders can commit to this opportunity. Specific actions for different stakeholder groups are listed in the table below. Please be aware that actions for stakeholders to support "Action: Integrate palliative care into existing medical and social programs that serve seriously ill populations" are included under Opportunity 8.

Opportunity 2: Uptake — Potential Actions by Stakeholder

Increase utilization of existing palliative care capacity.

Action: Engage with community members to improve understanding of palliative care.	**Action: Educate providers and case managers who care for people with serious illness about palliative care benefits.**	**Action: Implement processes to identify people who would benefit from palliative care and connect them to services.**
Health Plans		

➤ Integrate community engagement into palliative care strategy (e.g., regular talks or workshops at senior centers, faith-based organizations, adult day programs, etc.).
 	
➤ Provide materials that explain palliative care in culturally appropriate terms and in multiple languages (as needed).
	➤ Train plan staff (case managers, provider relations, member services, medical directors) about the value of palliative care (PC), how members can access it, and how to communicate its value.
	
	➤ Educate other key groups that care for seriously ill members (e.g., hospital discharge, oncology practices) about the value of palliative care, the plan's specific palliative care program, the process to make a referral, and best practices for introducing palliative care to patients.
		➤ Implement a four-part approach to identifying palliative-appropriate members:
		
		  ➤ Leverage claims and administrative data that indicate serious diagnosis plus unmet symptom burden or inadequate social supports.
		
		  ➤ Incorporate identification into workflows used by plan care managers.
		
		  ➤ Partner with hospital-based clinicians and staff, such as discharge planners.
		
		  ➤ Offer training and processes that encourage referrals from providers that care for large numbers of seriously ill members, such as oncologists and cardiologists.

Health Systems and Community-Based Providers		

➤ Incentivize PC providers to educate community members about palliative care (e.g., regular talks or workshops at senior centers, faith-based organizations, adult day programs).
 	
➤ Provide materials that explain palliative care in culturally appropriate terms and in multiple languages (as needed).
	➤ Create opportunities for clinicians and staff to access information about palliative care, including case studies, that focuses on the value of PC to patients, clinicians, and the organization.
	
	➤ Offer training to doctors and other staff in how to effectively communicate with patients about palliative care.
		➤ Implement a layered approach to identifying palliative-appropriate patients:
		
		  ➤ Leverage clinical and administrative data that indicate serious diagnosis plus unmet symptom burden or inadequate social supports.
		
		  ➤ Incorporate identification into workflows used by hospital-based clinicians and staff that have regular contact with seriously ill patients, such as hospitalists, social workers, and discharge planners.
		
		  ➤ Incorporate identification into workflows used by providers that care for large numbers of seriously ill patients, such as oncologists and cardiologists.

Action: Engage with community members to improve understanding of palliative care.	**Action: Educate providers and case managers who care for people with serious illness about palliative care benefits.**	**Action: Implement processes to identify people who would benefit from palliative care and connect them to services.**
Clinicians Who Care for People with Serious Illness		
▶ PC clinicians can partner with at least one community partner (e.g., senior center, senior housing, religious institution) and participate in ongoing engagement activities (e.g., agree to sit on a panel around the benefits of PC).	▶ Non-PC clinicians can partake in an education program to learn about the value of PC and eventually become ambassadors by recommending PC to peers.	▶ Non-PC clinicians can establish relationships with the PC team for warm handoffs and integrated care.
State and Local Government Agencies		
▶ Sponsor and fund community engagement activities and help spread them through Area Agencies on Aging or other local aging / supportive services departments.	▶ Require PC education in medical schools and in training programs for other specialties. ▶ Be champions for and explain the value of PC in related public health programs and priorities (e.g., aging, equity).	▶ Include reporting and performance measures that address access to or screening for PC.
Serious Illness Advocates and Educators		
▶ Coordinate community engagement activities with other public-facing entities and institutions (e.g., disease-specific advocacy organizations).	▶ Work with disease-specific and other professional organizations (e.g., American Cancer Society) to explain the value of palliative care to their constituents, providing the content for these organizations to customize and incorporate into their own educational materials.	▶ Identify and share best practices.
Philanthropy		
▶ Lead efforts to bring stakeholders together to fund or implement a community engagement initiative.	▶ Provide funding for education programs.	▶ Identify and share best practices.

Note: These potential actions serve as examples of how various stakeholders can contribute to the ongoing advancement of palliative care. They are intended to stimulate thought and strategic planning, and the list should not be considered exhaustive. To learn more, visit www.chcf.org/resource-center/californias-palliative-care-evolution.

Opportunity 3: Advocacy

> **OPPORTUNITY: Ensure that palliative care is a priority for policymakers, health care system leaders, and allied organizations.**
>
> Potential stakeholder actions:
>
> ➤ Keep palliative care visible to policymakers and government organizations.
>
> ➤ Highlight the value of palliative care in meeting other key health care priorities.
>
> ➤ Increase partnerships with disease-focused and other aligned organizations that can incorporate palliative care advocacy into their own agenda.

Although tremendous strides have been made in the visibility and value recognition of palliative care (PC), it is still far from being the standard of care for everyone with a serious illness. Ongoing, strong voices advocating for PC are still needed to ensure it is understood and prioritized by policymakers and health care leaders.

> *"And I have not yet met anyone — a policymaker, patient, provider — who, when they learn about and understand palliative care, they think, 'Oh, we don't need to do that.' No, of course we do. But like everything else at the state level, there are so many interests and so many priorities. We need to just keep up the dialogue, keep up the awareness so that we can just keep palliative care on the table for the discussions around important health care policies."*
>
> —Anastasia Dodson, MPP, Deputy Director, California Department of Health Care Services

Action: Keep palliative care visible to policymakers and government agencies.

As PC initiatives compete with many other health care priorities, leaders in the PC field should strategically focus on specific policy and implementation goals, ensuring these priorities remain prominently emphasized when engaging with policymakers and government agencies. Sustained efforts such as making regular phone calls, sending emails, and participating in meetings, as well as documenting and publishing stories that underscore demand for PC, are indispensable. Advocates within government need this continual presence to help justify the allocation of resources to PC amid the array of competing interests and demands. The turnover of policy

staff also requires ongoing education about the essence and value of PC and its alignment with broader health care priorities.

Furthermore, numerous health care policies and initiatives targeting older adults or people grappling with complex or severe illnesses could benefit from incorporating palliative care. Leaders in the field should continue to proactively advocate for the integration and implementation of palliative care within complementary initiatives, as they have started to do as part of California's Master Plan for Aging and CalAIM (California Advancing and Innovating Medi-Cal).

The Coalition for Compassionate Care of California is actively involved in state-level advocacy, and stakeholders in California should participate in and engage with those efforts.

Action: Highlight the value of palliative care in advancing other health care system priorities.

Along with PC's stand-alone value, the field should emphasize how PC contributes to other key health care industry priorities including whole-person care, equity, home-based medical services, reducing clinician burnout, dementia care, home-based medical services, and financial value. (See "Examples of How Palliative Care Contributes to Other Key Health Care Priorities.")

Examples of How Palliative Care Contributes to Other Key Health Care Priorities

Example Priority	How Palliative Care Supports the Priority
Achieve Whole-Person Care	Palliative care, with its focus on understanding a patient's values and wishes and helping meet their broader physical, spiritual, and social service needs, is a critical part of whole-person care for people with serious illness.
Foster Equity	By centering the unique needs of the individual, palliative care can help bridge gaps in care for people of color and other underserved groups.
Provide Comprehensive Home-Based Medical Services	Only 11% of homebound Medicare enrollees are currently receiving home-based medical services. As health systems and health plans are beginning to realize the value of home-based medical services to improve quality and reduce unnecessary health care utilization, home-based palliative care has one of the strongest evidence bases for quality improvement and cost savings.
Reduce Clinician Burnout	Among US doctors, 63% in 2021 and 44% in 2017 (pre-COVID-19 pandemic) reported symptoms of burnout. Palliative care (PC) can help reduce burnout of non-palliative care clinicians. PC teams can save non-PC clinicians time by conducting complex goals-of-care conversations and reduce moral distress of non-PC clinicians by teaching them generalist PC skills such as how to have difficult conversations on prognosis.

Continued next page

Example Priority	How Palliative Care Supports the Priority
Improve Advanced Dementia Care	In 2025, 840,000 Californians are expected to be living with Alzheimer's disease, an increase of 22% from 2020. PC has the potential to enhance any dementia care strategy, providing quality-of-life improvements for patients and support for family caregivers.
Increase Value	Significant evidence shows that in addition to improving clinical and patient experience outcomes, palliative care also mitigates health care costs through reducing avoidable or unwanted hospitalizations and emergency department visits.

Sources: Jennifer M. Reckrey et al., "*Receipt of Home-Based Medical Care Among Older Beneficiaries Enrolled in Fee-For-Service Medicare*," *Health Affairs* 39, no. 8 (Aug. 2020): 1289–96; Tait D. Shanafelt et al., "Changes in Burnout and Satisfaction with Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic," *Mayo Clinic Proceedings* 97, no. 12 (Dec. 2022): P2248–58; and "2023 Alzheimer's Disease Facts and Figures," *Alzheimer's & Dementia* 19, no. 4 (Apr. 2023): 1598–1695.

Action: Increase partnerships with disease-focused and other aligned organizations that can incorporate palliative care advocacy into their own agenda.

Many disease-focused organizations (e.g., American Cancer Society, Alzheimer's Association, American Heart Association, American Lung Association), professional organizations (e.g., California Medical Association, California Hospital Association, California Primary Care Association), and other aligned entities (e.g., AARP) have a strong history of advocacy and well-established infrastructure that lets them maintain a prominent presence among policy leaders and government agencies. Additionally, these organizations have developed trusted brands and garnered recognition among patients and caregivers.

Palliative care can be a critical part of quality health care for constituencies of these organizations. The PC field should seek to intensify its collaboration with these aligned entities as vital advocates. These organizations could endorse and champion PC on behalf of their members, fostering connections with policy leaders and government agencies. Moreover, they could enhance understanding and acceptance of PC directly among patients and caregivers through their existing networks.

Learn more about each action, including how all stakeholders can commit to this opportunity. Specific actions for different stakeholder groups are listed in the table below.

Opportunity 3: Advocacy — Potential Actions by Stakeholder

Ensure that palliative care is a priority for policymakers, health care system leaders, and allied organizations.

Action: Keep palliative care visible to policymakers and government organizations.	Action: Highlight the value of palliative care in meeting other key health care priorities.	Action: Increase partnerships with disease-focused and other aligned organizations that can incorporate palliative care advocacy into their own agenda.
Health Plans		
▶ Share stories and encourage patients and families to share stories with policymakers and government agencies on the need for and benefits of palliative care (PC).	▶ Help senior management see the link between PC and other top strategic priorities (e.g., whole-person care, equity, cost mitigation and value optimization, provider burnout).	
Health Systems and Community-Based Providers		
▶ Share stories and encourage patients and families to share stories with policymakers and government agencies on the need for and the benefits of PC.	▶ Help senior management see the link between PC and other top strategic priorities (e.g., whole-person care, equity, cost mitigation and value optimization, provider burnout).	
Clinicians Who Care for People with Serious Illness		
▶ Share stories and encourage patients and families to share stories with policymakers and government agencies on the need for and the benefits of PC.	▶ Help senior management see the link between PC and other top strategic priorities (e.g., whole-person care, equity).	▶ Give feedback to disease-focused organizations on the value of PC.
State and Local Government Agencies		
▶ Share stories and encourage patients and families to share stories with policymakers and government agencies on the need for and the benefits of PC.	▶ Help make the link between PC and other government initiatives (e.g., aging, dementia care, equity, population management, cost mitigation and value optimization, provider burnout).	

Action: Keep palliative care visible to policymakers and government organizations.

Action: Highlight the value of palliative care in meeting other key health care priorities.

Action: Increase partnerships with disease-focused and other aligned organizations that can incorporate palliative care advocacy into their own agenda.

Serious Illness Advocates and Educators

➤ Set prioritized policy and implementation goals to present a unified and clear voice to policymakers and government agencies.

➤ Organize a coalition of advocates and a regular cadence for ongoing communication with policymakers and government agencies to keep PC top of mind.

➤ Collect and work to get stories published in key media outlets on the benefits of PC and the rising demand from patients and families.

➤ Sponsor, publish, and promote research on the benefits of PC for other key health care priorities.

➤ Advocate for PC inclusion in aligned policies and initiatives.

➤ Work to elevate PC's profile with disease-focused and other aligned organizations so they are motivated to use existing advocacy programs to promote PC.

Philanthropy

➤ Fund PC advocacy coalitions.

➤ Fund research linking PC with other top health care priorities, or look to include PC elements into research being conducted on other priorities.

➤ Include PC when funding disease-focused and other aligned advocacy.

Note: These potential actions serve as examples of how various stakeholders can contribute to the ongoing advancement of palliative care. They are intended to stimulate thought and strategic planning, and the list should not be considered exhaustive. To learn more, visit www.chcf.org/resource-center/californias-palliative-care-evolution

Opportunity 4: Workforce Capacity

> **OPPORTUNITY: Increase the number of clinicians with specialist and generalist palliative care training and credentials.**
>
> Potential stakeholder actions:
>
> ▶ Expand and strengthen the workforce by increasing educational opportunities for specialty palliative care clinicians, particularly for clinicians of color.
>
> ▶ Increase generalist palliative care training and skills for non-palliative care clinicians.

Despite an increase in specialty palliative care clinicians and the emergence of more pathways for pursuing a career or training in palliative care (PC), a pressing need remains for an ongoing commitment to workforce development to keep up with the growing need for PC.

The current gap in the supply of US doctors trained in specialty palliative care is only expected to widen over the next 20 years. By some estimates, the gap could be as large as 9,000 to 16,000 physicians by 2040.[25] Even with favorable policy changes to encourage significant fellowship program growth, physician-to-patient ratios are not anticipated to significantly improve due to retirements from an aging workforce, burnout exits, and growth in the patient population.[26] While it is unlikely that there will ever be enough specialty PC clinicians to meet the needs of all people with serious illness, efforts should be undertaken to minimize the gap.

Although data are not as accessible for nonphysicians, insights from qualitative lessons in the field suggest gaps in the workforce for other members of the interdisciplinary team such as nurses, social workers, and chaplains. Organizations also face challenges recruiting team members of color or with relevant language skills.

Increasing generalist palliative care (also known as "primary palliative care") is another way to bridge the gap and ensure a minimum level of palliative care is available to anyone who would benefit. The National Consensus Project's *Clinical Practice Guidelines for Quality Palliative Care* recommends that clinicians caring for people with serious illness should have "sufficient training and experience to complete palliative assessments and address common sources of suffering."[27] Generalist palliative care skills enable non-palliative care specialists and service lines (e.g., cardiology, emergency medicine, oncology) to administer basic palliative care comfortably and competently. As such, generalist palliative care has been gaining momentum as a supplemental approach to specialty palliative care.

Action: Expand and strengthen the workforce by increasing educational opportunities for specialty palliative care clinicians, particularly for clinicians of color.

Support policy measures that address the workforce shortage.

The Balanced Budget Act of 1997 placed a limit on the number of Medicare-supported residency slots[28] at a time when hospice and palliative medicine was not yet formally recognized as a sub-specialty by the American Board of Subspecialties. As a result, specialty training in hospice and palliative medicine has relatively few training slots per year, as these slots are funded through private philanthropy or institutional support, despite serving a considerable number of Medicare patients. California health policy and health care leaders can help address this issue by supporting national policy solutions to the workforce shortage. An example is the Palliative Care and Hospice Education and Training Act (PCHETA). PCHETA has the potential to increase funding for PC teaching staff and fellowships in medical schools, as well as provide career awards and incentives for clinicians practicing PC.[29]

Additional policy solutions that provide federal funding for specialty-level graduate education could also be pursued. The American Academy of Hospice and Palliative Medicine advocates for policy revisions aimed at reshaping the nation's financing system for graduate medical education to better align with workforce requirements.[30] For example, they advocate for lifting the cap on fellowship position funding for high-need specialties such as hospice and palliative medicine. California health policy and health care leaders can play an important role in supporting relevant federal policies and implementing those policies at the state level.

> **WORKFORCE DEFINITIONS**
>
> **Specialty palliative care.** Specific area of medical practice that focuses on providing specialized care and support to people with serious illness. Specialty palliative care clinicians have specialized training and certification. Specialty palliative care is optimally delivered through a multidisciplinary team of trained doctors, nurses, social workers, and chaplains.
>
> **Generalist palliative care.** Basic level of palliative care provided by health professionals who may not have specialized training or expertise in palliative care but have general skills in managing pain and symptoms, discussing prognosis and goals of care, and identifying unmet social needs of patients with serious illness. When necessary, generalist palliative care providers refer patients to specialty palliative care for more complex interventions. Generalist palliative care is also called primary palliative care or basic palliative care.

Develop mid-career pathways.

Field leaders should establish flexible mid-career pathways in California, making it easier for clinicians to receive specialty training in palliative care. Some blueprints for innovation already exist. For example, a part-time, competency-based mid-career fellowship in palliative care is available at the University of Pennsylvania's Perelman School of Medicine. Traditional fellowships are full-time and span 12 months, thus requiring clinicians to step away from current responsibilities. In contrast, the competency-based (not traditional time-based) Perelman model enables participants to maintain their faculty positions, salary, and benefits while engaging in part-time training leading to specialty certification.[31] This type of flexible model could drive greater PC adoption among mid-career professionals. In addition, training on foundational palliative care to help prepare advanced practice nurses to subsequently pursue specialty certification in palliative care is available through the California State University Shiley Haynes Institute for Palliative Care (see "Resources from the Field" at the end of this section).

Provide support to diversify the palliative care physician workforce.

Supplementary financial incentives, beyond existing loan forgiveness programs, might make the first five years of practice more financially feasible to a more racially and socioeconomically diverse pool of doctors. These mechanisms could include additional housing stipends or unrestricted cash payments that could be tied to staying in California or in specific high-need areas, such as rural areas or safety-net hospitals. Furthermore, nonfinancial incentives should also be explored, including structured mentorship and protected time for research and practice innovation. Similarly, incentives should be offered to other types of clinicians (e.g., nurses, social workers) from communities of color to obtain training and certification in palliative care.

Action: Increase generalist palliative care skills for non-palliative care clinicians.

Increase implementation and uptake of generalist palliative care training and integration.

More avenues are available to pursue training in generalist palliative care than ever before. Various delivery mechanisms have been developed to include in-person, online synchronous, and online asynchronous training. Many programs also offer assistance in integrating generalist palliative care into clinical workflows. Although individual-level generalist palliative care training is valuable, implementation at an institutional level would have even greater leverage. As such, field leaders should advocate for more structural support of palliative care at health care delivery organizations, where training, workflow changes, and measurement can be integrated into one cohesive program. Building up institutional programs can also insulate the knowledge base and processes from individual staff turnover.

Build an evidence base for generalist palliative care.

The evidence base for generalist palliative care is still developing. California field leaders should find ways to contribute to this evidence base by building standards and measurement into generalist palliative care implementation. Strategic measurement that leverages data capture and reporting capabilities in an electronic health record can achieve this goal without unduly burdening busy providers.

Develop standards for generalist palliative care.

Field leaders should set minimum standards for generalist palliative care credentialing and identify and implement best practices in integrating generalist palliative care. The Center to Advance Palliative Care (CAPC) led an interdisciplinary expert consensus process to define the skill set for generalist palliative care by discipline, providing a strong foundation for advancing this work (see "Clinical Training Recommendations for All Clinicians Caring for Patients with Serious Illness" in "Resources from the Field" at the end of this section). The National Coalition for Hospice and Palliative Care offers recommendations that could serve as a basis for developing standards for integrating generalist palliative care capabilities into population-based models (see "Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models" in the "Resources from the Field" section).

RESOURCES FROM THE FIELD

- ▶ Serious Illness Care: Tools for Clinicians and Health Systems (Ariadne Labs)[32]
- ▶ California State University Shiley Haynes Institute for Palliative Care[33]
- ▶ National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 4th ed. (National Coalition for Hospice and Palliative Care [NCHPC])[34]
- ▶ Clinical Training Recommendations for All Clinicians Caring for Patients with Serious Illness (Center to Advance Palliative Care)[35]
- ▶ End-of-Life Nursing Education Consortium[36]
- ▶ Essential Skills and Supports for All Clinicians Treating Serious Illness: Building Generalist Palliative Care Capabilities Across Services and Settings (CHCF)[37]
- ▶ Pediatric Palliative Care Nursing Education, Training, and Employment Initiative (George Mark Children's House)[38]
- ▶ Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models (NCHPC)[39]
- ▶ Essentials of Palliative Care (Stanford School of Medicine)[40]
- ▶ Evidence-Based Communications Training (VitalTalk)[41]

Learn more about each action, including how all stakeholders can commit to this opportunity. Specific actions for different stakeholder groups are listed in the table below.

Opportunity 4: Workforce — Potential Actions by Stakeholder

Increase the number of clinicians with specialist and generalist palliative care training and credentials.

Action: Expand and strengthen the workforce by increasing educational opportunities for specialty palliative care clinicians, particularly for clinicians of color.	Action: Increase generalist palliative care training and skills for non-palliative care clinicians.
Health Plans	
	▸ Pay for generalist palliative care (PC) training for non-PC clinicians who care for people with serious illness (oncology, heart failure, renal failure, COPD). ▸ Incentivize process improvements to support generalist palliative care and integrate with workflow (e.g., electronic health record fields for goals of care).
Health Systems and Community-Based Providers	
▸ Increase fellowship programs for specialty PC. ▸ Develop financial and nonfinancial incentives for PC fellows, particularly PC doctors of color, to practice in California (e.g., housing stipends, mentorship programs). ▸ Develop flexible mid-career pathways into PC. ▸ Build relationships with local teaching programs to increase visibility of PC as a career option.	▸ Implement generalist PC programs that involve service line / specialty PC partnership and include training, workflow changes, and ongoing measurement.
Clinicians Who Care for People with Serious Illness	
▸ Help recruit new clinicians into the field. ▸ Mentor clinicians of color starting their careers in PC.	▸ Non-PC specialists can seek out or participate in generalist PC training and/or colead workflow and integration in their service line with a specialty PC partner.
State and Local Government Agencies	
▸ Provide support for and supplemental funding to implement legislation such as the proposed Palliative Care and Hospice Education and Training Act (PCHETA).	▸ Support policies to adopt standards for generalist PC training and credentialing.
Serious Illness Advocates and Educators	
▸ Encourage stakeholders to contact legislators to support relevant workforce legislation such as PCHETA.	▸ Advocate for and organize coalitions around a more robust evidence base for generalist PC. ▸ Advocate for and organize coalitions around minimum standards for generalist PC training and certification.

Action: Expand and strengthen the workforce by increasing educational opportunities for specialty palliative care clinicians, particularly for clinicians of color.	Action: Increase generalist palliative care training and skills for non-palliative care clinicians.
Philanthropy	
▶ Support policy to reform graduate medical education to better support more palliative care clinicians (e.g., PCHETA, changes to Medicare financing).	▶ Fund a more robust evidence base for generalist PC, minimum standards for certification, and implementation that includes training, workflow changes, and measurement.

Note: These potential actions serve as examples of how various stakeholders can contribute to the ongoing advancement of palliative care. They are intended to stimulate thought and strategic planning, and the list should not be considered exhaustive. To learn more, visit www.chcf.org/resource-center/californias-palliative-care-evolution.

Opportunity 5: Standards and Measures

> **OPPORTUNITY: Improve the quality of care by reducing variation in care models and methods for assessing quality.**
>
> Potential stakeholder actions:
>
> ➤ Refine, endorse, and adopt minimum standards and measures until federal or state mandates are put in place.
>
> ➤ Monitor adherence to minimum standards and the use of specified measures.

In contrast to home health or hospice, there are no universally adopted minimum standards or measures for home-based palliative care (HBPC) across payer types. As HBPC has become more prevalent, the absence of universal and enforced minimum standards has led to significant variation in nearly every aspect of HBPC delivery. Variations include differences in eligibility criteria, care team composition, required services, payment models, and provider qualifications. Given the variation in the type of care being delivered, it is not surprising that there is also wide variation in measures used to assess key care processes and outcomes.

Although allowing for flexibility and innovation is important in a new clinical area like HBPC, stakeholders report that the current degree of variation is impeding scaling efforts and threatening quality of care. The absence of minimum standards and measures and the resulting variation has created these challenges:

➤ **Payer reluctance.** Variations in HBPC models can lead to variations in costs and outcomes, which can create uncertainty for payers and can make HBPC seem like a risky investment.

> **DEFINITIONS**
>
> **Standards.** Detailed requirements and expectations for delivering a benefit or clinical service. Here, standards are the blueprint for a palliative care program, including the types of patients that should receive palliative care, the qualifications of providers who would deliver it, and the services that must be available to all patients. Standards may also specify the preferred payment model and the measures used to assess quality and adherence to requirements.
>
> **Minimum standards.** Standards that serve as the minimum or "floor" for the field.
>
> **Measures.** Quantitative or qualitative assessments that track adherence to standards or evaluate essential processes or outcomes.

► **Risk of scaling ineffective models.** Absent minimum standards, payers may contract for and providers may offer palliative care services that lack core elements of interdisciplinary, comprehensive PC or that include providers with little to no training in the field. Although these services may be less costly to deliver, they are also less likely to generate good outcomes. Poor outcomes resulting from substandard care models can create the misconception that palliative care is ineffective.

► **Inefficient operations.** HBPC providers often manage multiple contracts with varying eligibility criteria, service models, reimbursement mechanisms, payment amounts, and measures used to assess performance. This variation creates enormous operational challenges and makes it difficult to sustain HBPC as a viable line of business.

► **Underuse of services.** Clinicians' uncertainty about eligibility criteria, types of services, and quality of services can create reluctance to refer patients to HBPC.

"The one thing that we still need to do . . . is reduce the variability of palliative care. I wish I could say that palliative care consults or that interactions with palliative care teams were standardized and that everybody got the best care possible."

—Matthew Gonzales, MD, FAAHPM, Associate Vice President,
Chief Medical and Operations Officer, Providence Institute for Human Caring

"Too many service groups offer PC, but there are no rules, policies, standards, and measures to clarify the benefit to the patient and insurer/payer."

—Coalition for Compassionate Care of California 2023
Annual Summit participant, health plan worker

Action: Refine, endorse, and adopt minimum standards and measures until federal or state mandates are put in place.

Federal and state regulations applicable to all payers and providers would be the most certain means of achieving universal adoption of minimum standards and measures. However, the prospect of this scenario occurring in the near future seems unlikely. Instead, payers and providers, who stand to benefit from minimum standards and measures, can collaborate with policymakers and researchers to set these standards and measures.

Stakeholders can build on the minimum standards previously developed by the California Department of Health Care Services (DHCS) and the California Advanced Illness Collaborative (CAIC). DHCS has already defined a minimum set of Medi-Cal standards for eligibility criteria, services, and provider qualifications.[42] In a related but distinct endeavor, CAIC has released voluntary standards that go beyond the DHCS standards by including guidance across payer type and addressing quality measurement and payment model selection.[43]

DHCS and CAIC's minimum standards provide a beneficial starting point in creating universal minimum standards for all payer types. These standards can be further refined based on current practices and new insights gained since their inception, including:

➤ Recent descriptions of the minimum essential elements of palliative care and quality measures presented by the National Coalition for Hospice and Palliative Care.[44]

➤ Insights from plans and providers engaging in the delivery of home-based palliative care since DHCS set its minimum standards.

➤ Lessons learned from an evaluation of the CAIC standards.[45]

The refined minimum standards could incorporate:

➤ Expanded eligibility criteria, required services, and minimum provider qualifications.

➤ Guidance about the best payment models, including the role of bundled payment.

➤ Specific measures.

Action: Monitor adherence to minimum standards and the use of specified measures.

Once refined minimum standards have been developed, users should actively track adherence to the standards and measures. Addressing compliance with standards that deal with the composition of the interdisciplinary team, team member competencies, or similar care structures can be done through the service design, benefit design, and contracting processes. Assessing the adequacy of care plans, the proper involvement of different team members, and similar processes can be achieved through record reviews and audits.

Absent state or federal regulations mandating reporting to a central regulatory body, plans and providers must enforce the use of measures specified in the standards within their specific organizations and areas of influence. The evaluation of the CAIC standards found that variation in measurement persisted, even among sites adhering to other aspects of the standards. Reducing

this variation in measurement practices and promoting minimal measurement can be achieved more effectively by limiting the number of measures and discouraging customization by payers and providers.

Using the Palliative Care Quality Collaborative (PCQC), a national palliative care quality registry, is one way to ensure consistent tracking in a benchmarking environment that promotes quality palliative care. Several managed care plans require contracted providers to participate in the PCQC, providing plans with easy access to a common set of measures that can be compared at the provider, regional, and plan levels.

RESOURCES FROM THE FIELD

▶ California Advanced Illness Collaborative Consensus Standards for Community-Based Palliative Care in California (Coalition for Compassionate Care of California)[46]

▶ Medi-Cal Palliative Care Policies (California Department of Health Care Services)[47]

▶ Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models (National Coalition for Hospice and Palliative Care [NCHPC])[48]

▶ Recommendations for Cross-Cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness (PDF) (NCHPC)[49]

▶ Palliative Care Quality Collaborative[50]

Learn more about each action, including how all stakeholders can commit to this opportunity. Specific actions for different stakeholder groups are listed in the table below.

Opportunity 5: Standards and Measures — Potential Actions by Stakeholder

Improve the quality of care by reducing variation in care models and methods for assessing quality.

Action: Refine, endorse, and adopt minimum standards and measures until federal or state mandates are put in place.	Action: Monitor adherence to minimum standards and the use of specified measures.
Health Plans	
► Participate in national and regional efforts to develop or endorse minimum standards that include minimum measures. ► Adopt voluntary standards and measures across lines of business and markets, in the absence of regulatory requirements.	► Audit adherence to minimum standards; develop infrastructure to receive and analyze data; act on findings. ► Adjust palliative care provider payment to account for effort and costs associated with collecting and reporting data.
Health Systems and Community-Based Providers	
► Participate in national and regional efforts to develop or endorse minimum standards that include minimum measures. ► Adopt minimum standards and measures across sites and markets, in the absence of regulatory requirements.	► Develop infrastructure needed to track adherence to standards. ► Track performance using endorsed measures, even when not required by regulators or payer partners.
Clinicians Who Care for People with Serious Illness	
► Adopt minimum standards and measures.	► Provide necessary data to help with monitoring.
State and Local Government Agencies	
► Participate in national and regional efforts to develop and/or endorse minimum standards that include minimum measures. ► Create regulations that require adherence to minimum standards for as many patients as possible.	► Require plans, licensed providers, or both to report on adherence to standards and performance on minimum measures. ► Share performance information to promote improvement and recognition of better performers.
Serious Illness Advocates and Educators	
► Participate in national and regional efforts to develop or endorse minimum standards that include minimum measures. ► Distribute information on minimum standards to all stakeholders. ► Recognize entities that adopt voluntary standards.	► Recognize high performers.

Action: Refine, endorse, and adopt minimum standards and measures until federal or state mandates are put in place.

Action: Monitor adherence to minimum standards and the use of specified measures.

Philanthropy

▶ Fund national and regional efforts to develop or endorse minimum standards that include minimum measures.

▶ Fund demonstration projects and research that will reveal implementation best practices.

▶ Fund demonstration projects and other research that assesses adherence to standards and investigates links between adherence to standards and clinical, patient experience, and financial outcomes.

Note: These potential actions serve as examples of how various stakeholders can contribute to the ongoing advancement of palliative care. They are intended to stimulate thought and strategic planning, and the list should not be considered exhaustive. To learn more, visit www.chcf.org/resource-center/californias-palliative-care-evolution.

Opportunity 6: Payment

> **OPPORTUNITY: Adjust payment practices and policies to align with optimal care models.**
>
> Potential stakeholder actions:
>
> ➤ Use bundled payment models that align with optimal care delivery models.
> ➤ Build the evidence base related to payment model and amount.

State and federal regulations do not specifically mandate payment models or amounts for specialty palliative care. This has led to health plans and health systems offering home-based and outpatient palliative care with varying combinations of services, using multiple payment mechanisms, and providing different levels of compensation to providers.[51] The absence of payment-related requirements has contributed to variation in practice and outcomes and threatens provider sustainability. In a 2023 Coalition for Compassionate Care of California survey of Medi-Cal managed care plans and their contracted PC providers, 86% of responding plans believed their palliative care program was sustainable, but only 50% of providers shared this perspective.[52] In this same survey, 50% of providers also said the compensation they received was inadequate to cover the scope of services they were asked to provide. Underfunding the palliative care team due to a mismatch between the expected scope of services PC providers should deliver and the actual cost of delivering these services can compromise the sustainability of services, clinical outcomes, patient experience, and impact on health care costs.[53]

"The way in which payment is structured drives the way in which care is provided. Until payment models change, the care will not change. Paying for interdisciplinary care will not only support the development of palliative care but also serve as a model for the rest of the health care system in a time when workforce . . . is becoming more and more of an issue."

—Coalition for Compassionate Care of California 2023 Annual Summit
participant, health plan worker

Action: Use a bundled payment model.

Two primary payment models support home-based and outpatient palliative care: bundled payments and fee-for-service (FFS). In a bundled payment model, a single payment covers the delivery of a specified set of services, typically by a multidisciplinary team, over a defined period. Under FFS, a provider bills and receives payment for each encounter or service delivery instance. Between these two models, only bundled payments provide incentives for delivering the best palliative care model, which includes a team consisting of disciplines that can rarely bill for services under FFS (e.g., nurses, chaplains, care navigators, social workers) and extensive coordination activities between face-to-face visits, which usually go uncompensated.

Payers offering palliative care benefits, whether voluntary or due to regulatory mandates, should adopt a bundled payment model for home-based and outpatient palliative care. The adoption of bundled payments seems to have substantial support from those who pay for palliative care. In a 2023 Coalition for Compassionate Care of California survey of Medi-Cal managed care plans, 67% of the responding plans reported using a bundled payment model.[54] Furthermore, the California Advanced Illness Collaborative, involving four health plans and 10 provider organizations, also endorsed bundled payments as the preferred payment model.[55]

Payment amounts can be informed by data describing economic outcomes of palliative care and incorporate provider input regarding the time required to deliver specified services. Plans and providers should also consider using bonus payments or similar structures to align incentives, like offering supplemental payments when enrolled members avoid emergency department visits or unplanned admissions.

> ### OPTIMAL MODEL OF PALLIATIVE CARE
>
> The National Coalition for Hospice and Palliative Care outlined recommendations for integrating palliative care capabilities and specialists into population-based models:
>
> ► Comprehensive assessment of symptoms and stressors affecting quality of life
>
> ► Expert management of symptoms and stressors by an interdisciplinary care team
>
> ► Patient and caregiver education and support, explaining what to expect, clarifying goals and values, supporting shared decisionmaking, and advance care planning
>
> ► Aide services to meet personal care needs
>
> ► Care plan coordination across all providers and community services, including formal relationships with community organizations
>
> ► Ongoing support of patients and families including telehealth with round-the-clock access
>
> Source: National Coalition for Hospice and Palliative Care (NCHPC) to Chris Ritter (Acting Deputy Director, Patient Care Models Group Director, Center for Medicare and Medicaid Innovation), "NCHPC Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models," May 16, 2022.

*"The monthly case rate enables provider flexibility with care delivery. Incentive
payments align the provider care to the health plan's needs."*

—James Cotter, MD, MPH, Associate Medical Director, Health Services Department,
Partnership HealthPlan of California

Action: Build the evidence base related to payment for palliative care.

Investing in the evidence base is needed to bolster the confidence of payers who have not yet
transitioned from FFS to bundled payments. The analyses should generate information cus-
tomized to meet the needs of health plan actuarial staff, who are responsible for modeling the
economic outcomes of payment models and policies. Specific data points of interest to actuarial
staff would include:

▶ Provider effort required to deliver a specified set of services, including number, duration, fre-
quency, and location of visits/activities, by discipline

▶ Characteristics of the enrolled population

▶ Cost of delivering palliative care

▶ Impact on total costs of care

In addition to bolstering the confidence of payers, strengthening the evidence base also holds the
potential to influence state and federal policies and requirements.

RESOURCES FROM THE FIELD

▶ Palliative Care in Medicaid Costing Out the Benefit: Actuarial Analysis of Medicaid Experience
(National Academy for State Health Policy)[56]

▶ Studies of Economic Outcomes of Home-based Palliative Care (PDF) (Coalition for Compassionate
Care of California [CCCC])[57]

▶ Home-Based Palliative Care: Payment and Delivery Models for Short-Term Interventions (PDF)
(Center to Advance Palliative Care)[58]

▶ State of Medi-Cal Palliative Care: Findings from the Annual Plan and Provider Surveys (PDF)
(CCCC)[59]

Learn more about each action, including how all stakeholders can commit to this opportunity.
Specific actions for different stakeholder groups are listed in the table below.

Opportunity 6: Payment — Potential Actions by Stakeholder

Adjust payment practices and policies to align with optimal care models.

Action: Use bundled payments that align with optimal care delivery models.	Action: Build the evidence base related to payment model and amount.
Health Plans	
▶ Adopt a bundled payment model that covers the effort of the entire interdisciplinary team (IDT) needed to deliver all specified outpatient and home-based palliative care (PC) services, across lines of business and markets.	▶ Participate in evaluations of the economic impact of using a bundled payment, for outpatient and home-based PC, to increase confidence among payers that it is economically acceptable.
Health Systems and Community-Based Providers	
▶ Participate in studies to develop a reasonable estimate of time needed by the entire IDT to deliver palliative care, to inform calculation of a fair bundled payment amount.	▶ Participate in evaluations of the economic impact of using a bundled payment for outpatient and home-based PC, to increase confidence among payers that it is economically acceptable.
Clinicians Who Care for People with Serious Illness	
▶ Participate in time-limited studies of effort required to deliver outpatient and home-based palliative care, to increase payer understanding of the time required to deliver comprehensive, guideline-concordant palliative care.	
State and Local Government Agencies	
▶ Seek input and data from payers currently using a bundled payment model and their contracted home-based palliative care providers, to inform policy development. ▶ Recommend or require a bundled payment model in policies that seeks to increase access to palliative care.	
Philanthropy	
▶ Fund learning communities to develop and share best practices, including experiences related to payment model. ▶ Support projects that estimate the full cost of delivering outpatient and home-based palliative care to the Medicare Advantage population, as was done for Medicaid, to support plans that wish to use a bundled payment but lack the internal data needed to estimate a bundled payment amount.	▶ Fund evaluations of the economic impact of using a bundled payment, for outpatient and home-based PC, to increase confidence among payers that it is economically acceptable.

Note: These potential actions serve as examples of how various stakeholders can contribute to the ongoing advancement of palliative care. They are intended to stimulate thought and strategic planning, and the list should not be considered exhaustive. To learn more, visit www.chcf.org/resource-center/californias-palliative-care-evolution.

Opportunity 7: Data

> **OPPORTUNITY: Improve the quality and availability of data to enhance understanding of palliative care providers, patients receiving care, and resulting outcomes.**
>
> Potential stakeholder actions:
>
> ➤ Strengthen efforts to enhance data quality for seriously ill patients.
>
> ➤ Develop an ICD-10 code for specialty palliative care.
>
> ➤ Develop and maintain a statewide database of palliative care providers.

To effectively track and improve access and quality, stakeholders — such as payers, providers, policymakers, and researchers — need to know the organizations and providers who do or who could deliver palliative care, the patients who have received or should receive it, and the resulting outcomes. However, incomplete and sometimes inaccurate data have led to:

➤ **Limited insight into regional palliative care capacity.** A lack of comprehensive knowledge about organizations delivering palliative care and overall capacity in specific regions inhibits referrals, impedes the development of payer networks, and hinders readiness assessments.

➤ **Inadequate understanding of palliative care access, uptake, and impacts.** A lack of consistent and reliable methods for identifying patients who have received palliative care prevents a comprehensive assessment of gaps in access, uptake, and outcomes.

➤ **Inability to easily identify palliative-appropriate patients.** Difficulties in identifying patients who likely would have benefited from palliative care make it difficult to assess outcomes and measure unmet needs.

➤ **Inability to assess equity issues.** Limited information regarding the racial and ethnic characteristics of seriously ill patients curtails the ability to evaluate inequities in access and outcomes.

Action: Strengthen efforts to enhance data quality for seriously ill patients.

Accurate and complete data within health care claims and electronic health care records would make it easier to identify people who would benefit from palliative care and to assess disparities in access and outcomes. For example:

➤ Accurate information about race, ethnicity, and linguistic preferences/capabilities would help stakeholders determine if palliative care is equitably available and used. It will also help with assessments of differences in outcomes across populations.

➤ Functional status, assessment of caregiver burden, and other information that signals need for palliative care would make it easier to define the palliative-relevant population and evaluate how many eligible patients actually receive palliative care.

Health systems, health plans, medical groups, and palliative care providers can all act within their respective spheres of influence to promote the accuracy, completeness, and accessibility of data needed to optimize the delivery and evaluation of palliative care.

Action: Develop an ICD-10 code for specialty palliative care.

Introducing a dedicated ICD-10 code (see "Definitions") for specialty palliative care would help track palliative care encounters across settings. This would yield valuable insights for quality assessments, research, and policy decisions.

> **DEFINITIONS**
>
> **ICD Codes.** International Classification of Diseases and Related Health Problems (ICD) codes are used by providers and payers to flag diseases, symptoms, social circumstances, and external causes of injury or diseases, as well as services delivered by health professionals.[60] The current version of the ICD, the 10th revision, is called ICD-10.

An ICD-10 code for "palliative care encounters" (code Z51.5) is available. However, this code does not necessarily indicate the involvement of palliative care specialists. Z51.5 is used to categorize admissions or encounters in any setting related to comfort care, end-of-life care, and hospice care for terminally ill patients. Its current use may indicate a range of interventions; for example, that a hospital medicine doctor oversaw the delivery of comfort care to a dying patient or that a patient was seen by a specialty palliative care team in a palliative care clinic.

The absence of a dedicated ICD-10 code for specialty palliative care poses challenges in identifying patients who have received specialty palliative care across different settings and payers. Consequently, assessing outcomes for palliative care at the population level, including understanding care gaps, becomes quite challenging. Once an ICD-10 code is established, palliative care stakeholders at all levels must promote its use.

Action: Develop and maintain a statewide database of palliative care providers.

Limited data exist regarding the providers delivering palliative care services and the extent to which those provider organizations have the infrastructure, policies, and practices aligned with expert consensus best practice recommendations, minimum standards, and associated measures.

In other areas of health care, such as hospice or home health, providers must obtain certification or licensure, resulting in publicly accessible provider registries and information about which organizations offer specific services. However, no such information is available for palliative care, regardless of the setting. Although palliative care organizations can voluntarily pursue certification for their inpatient or home-based services through entities like The Joint Commission or the Community Health Accreditation Partner, only a fraction of active palliative care providers do so.

Establishing a statewide palliative care provider database would offer substantial benefits by enhancing knowledge of provider capacity and providing deeper insights into the characteristics, competencies, and performance of palliative care providers.

RESOURCES FROM THE FIELD

▶ Data Blind Spots: Identifying Palliative Care (webinar) (Center to Advance Palliative Care)[61]

▶ Addressing Serious Illness Care in Medicare Advantage (*New England Journal of Medicine*)[62]

Learn more about each action, including how all stakeholders can commit to this opportunity. Specific actions for different stakeholder groups are listed in the table below.

Opportunity 7: Data — Potential Actions by Stakeholder

Improve the quality and availability of data to enhance understanding of palliative care providers, patients receiving care, and resulting outcomes.

Action: Strengthen efforts to enhance data quality for seriously ill patients.	Action: Develop an ICD-10 code for specialty palliative care.	Action: Develop and maintain a statewide database of palliative care providers.
Health Plans		
► Assess the completeness and accuracy of data describing patient characteristics, and undertake local improvement efforts as needed; partnership with information technology, data analytics, or both departments will likely be needed. ► Use incentives or penalties to encourage accurate and complete data capture by contracted providers.	► Collaborate with national entities like the National Coalition for Hospice and Palliative Care and California-based providers, health plans, and/or advocacy groups to draft a request for a new ICD-10 code through the Centers for Medicare & Medicaid Services' standard application and review process. ► Operationalize the ICD-10 code once approved.	► Require providers to participate in the palliative care (PC) provider database.
Health Systems and Community-Based Providers		
► Assess the completeness and accuracy of data describing patient characteristics, and undertake local improvement efforts as needed; partnership with information technology, data analytics, or both departments will likely be needed. ► Use incentives or penalties to encourage accurate and complete data capture.	► Collaborate with national entities like the National Coalition for Hospice and Palliative Care and California-based providers, health plans, and/or advocacy groups to draft a request for a new ICD-10 code through the Center for Medicare & Medicaid Services' standard application and review process. ► Operationalize the ICD-10 code once approved.	► Participate in the PC provider database.
Clinicians Who Care for People with Serious Illness		
► Participate in projects that seek to improve the accuracy and completeness of data describing patient characteristics, helping informatics professionals and administrators appreciate the workflows, prompts, and data capture capabilities needed to improve performance.	► Operationalize the ICD-10 code once approved.	

Action: Strengthen efforts to enhance data quality for seriously ill patients.	Action: Develop an ICD-10 code for specialty palliative care.	Action: Develop and maintain a statewide database of palliative care providers.
State and Local Government Agencies		
		➤ Require Medi-Cal palliative care providers to participate in the PC provider database.
Serious Illness Advocates and Educators		
➤ Lobby for the uniform use of tools for assessing characteristics and circumstances that point to a need for palliative care, such as patient function and caregiver burden. ➤ Distribute information to raise awareness of the importance of data accuracy and completeness and share best practices for collection and effective use of improved data.	➤ Lead efforts that include national and California-based providers, health plans, and/or advocacy groups to draft a request for a new ICD-10 code through the Centers for Medicare & Medicaid Services' standard application and review process.	➤ Encourage participation in the PC provider database and develop use cases to highlight the value of such a tool.
Philanthropy		
➤ Fund efforts to improve the effective use of correct and complete data.	➤ Fund efforts to assemble national and California-based providers, health plans, and/or advocacy groups to draft a request for a new ICD-10 code through the Centers for Medicare & Medicaid Services' standard application and review process.	➤ Support development and maintenance of the provider database.

Note: These potential actions serve as examples of how various stakeholders can contribute to the ongoing advancement of palliative care. They are intended to stimulate thought and strategic planning, and the list should not be considered exhaustive. To learn more, visit www.chcf.org/resource-center/californias-palliative-care-evolution.

Opportunity 8: Integration

> **OPPORTUNITY: Integrate palliative care into existing medical and social programs that serve seriously ill populations.**
>
> Potential stakeholder actions:
>
> ➤ Embed palliative care within other inpatient and outpatient services and settings.
>
> ➤ Integrate palliative care with Medi-Cal's Enhanced Care Management (ECM) services.
>
> ➤ Integrate palliative care with home-based medical services.

Palliative care should be integrated with other medical and social programs that serve people with serious illness, to streamline care for patients and to ensure people who would benefit from palliative care can access it at the right time. Integration can occur at varying levels, from intentional cross-organizational collaboration aimed at promoting identification of people who would benefit from palliative care to formal colocation and partnership, such as embedding a palliative care team within a specialty oncology practice. Integration can support the impact and sustainability of palliative care through:

➤ **Increased uptake.** Providers can facilitate patients' use of PC services by integrating palliative care into settings where people are already receiving care, such as specialty outpatient clinics and primary or acute care in the home. See more information under Opportunity 2, "Uptake."

➤ **Care customized to patient needs.** Positioning PC as one of several tools available to improve care of seriously ill people enables providers to customize services to align with patient needs more effectively. If PC services operate in close collaboration with home-based primary care, care management programs, disease management programs, and similar services, patients can more easily transition to the type of support that best meets their needs at a given time. Such versatility anchors service delivery in patient and family needs and likely helps avoid over- and underserving patients.

➤ **Increased awareness of PC as the standard of care.** Normalization of PC occurs for both other treating providers and for patients by establishing access to PC as the standard of practice within a given setting. Patients can be instructed to expect consultations with PC as a common procedure in the clinic, thus eliminating the potential for patients to misconstrue a PC referral as indicative of a limited prognosis. Similarly, other treating clinicians can reliably expect engaging with PC as a part of their routine, mitigating the risk of providers incorrectly assessing the best timing for referring to PC, which can result in late or no referral.

"Integration makes palliative care more effective for the patient, rather than being just one more fragment in a fragmented system."

—Coalition for Compassionate Care 2023 Annual Summit participant

"It has been really important to build a continuum of services in all places for a patient and follow a person throughout their care experience. We know that people facing serious illness have more transitions and are more likely to go back and forth to different specialists. I think that one of our biggest successes is creating serious illness care and specialty palliative services across all settings, so that we have the ability to meet the patient where they are in their life journey."

—Susan Elizabeth Wang, MD, National Medical Director, Dignified Journeys & Palliative Care;
Southern California Chief, Geriatrics & Palliative Medicine, Kaiser Permanente

Action: Embed palliative care within other inpatient and outpatient services and settings.

Positioning palliative care teams to deliver care alongside other treating clinicians carries many potential benefits. This strategy has been tested in primary care practices, specialty disease clinics like oncology, and in hospital areas with high concentrations of seriously ill people such as emergency departments and intensive care units. The goal is to make it easier for people to access palliative care and to reduce the barriers to identifying and referring patients. PC programs that have tried embedded palliative care report that non-palliative care providers are accepting of the services and can see improvements in patient care. Some studies have documented clinical, operational, and economic benefits for health systems related to embedded PC services.[63]

Action: Integrate palliative care with Medi-Cal's Enhanced Care Management services.

The CalAIM (California Advancing and Innovating Medi-Cal) policy guidance for Enhanced Care Management (ECM) explicitly states that the comprehensive health assessment conducted as part of ECM should include a screening process for assessing the need for palliative care. Some populations eligible for ECM, particularly frequent users of health services, likely qualify (or will qualify) for palliative care. To facilitate optimal coordination between ECM and palliative care providers, health plans and palliative care provider organizations can undertake the following steps:

1. Train ECM providers to educate members on the value of palliative care, and how and when to communicate with plan partners that a member might benefit from palliative care. This training should include the health plan's palliative care provider partners to help organizations get to know each other.

2. Train palliative care providers on ECM, and similarly involve ECM providers in the training.

3. Enable the exchange of data and care plans between ECM providers and palliative care providers.

4. Document integration efforts to ensure consistency going forward, given inevitable staff turnover.

Also, intentionally linking palliative care with ECM and other CalAIM programs will help maintain visibility and relevance as new programs, policies, and requirements are introduced. Looking ahead, palliative care champions, both within and outside health plans, should work toward establishing connections between palliative care and other plan programs. They should also show how these linkages bring mutual benefits.

Action: Integrate palliative care with home-based medical services.

Providers of palliative care services should consider ways to integrate with other home-based medical services such as home-based primary care and hospital-to-home transitional care programs. People who are homebound and already receiving primary or transitional care in their homes likely would also benefit from specialty palliative care.

RESOURCES FROM THE FIELD

▶ Embedded RN-Led Clinics in Primary Care Practices (Center to Advance Palliative Care)[64]

▶ How States Can Embed Palliative Care in Health Care Reform Initiatives (National Academy for State Health Policy)[65]

▶ The Intersection of CalAIM and Palliative Care (Coalition for Compassionate Care of California [CCCC])[66]

▶ Social Needs in Palliative Care: Learning from Enhanced Care Management (ECM) (CCCC)[67]

▶ Medical Care at Home Comes of Age (CHCF)[68]

Learn more about each action, including how all stakeholders can commit to this opportunity. Specific actions for different stakeholder groups are listed in the table below.

Opportunity 8: Integration — Potential Actions by Stakeholder

Integrate palliative care into existing medical and social programs that serve seriously ill populations.

Action: Embed palliative care within other inpatient and outpatient services and settings.	Action: Integrate palliative care with Medi-Cal's Enhanced Care Management (ECM) services.	Action: Integrate palliative care with home-based medical services.
Health Plans		
▶ Encourage integration by including palliative care (PC) in contracting requirements and incentives programs. ▶ Study impacts and share findings to inform design and uptake or the most promising models.	▶ Train ECM providers to educate members on the value of PC and how to refer into PC. ▶ Orient palliative care providers to the components of ECM. ▶ Foster collaborative relationships, including data sharing, between ECM providers and palliative care providers.	▶ Integrate palliative care into contracting requirements and incentives programs for other home-based medical services. ▶ Study impacts and share findings to inform design and uptake or the most promising models.
Health Systems and Community-Based Providers		
▶ Participate in the design, piloting, and evaluation of embedded palliative care services.	▶ Train palliative care providers about the benefit of ECM for their patients. ▶ Seek and nurture collaborative relationships with ECM providers.	▶ Participate in the design, piloting, and evaluation of programs that integrate palliative care with other home-based medical services.
Clinicians Who Care for People with Serious Illness		
▶ Participate in the design, piloting, and evaluation of embedded palliative care services.	▶ Participate in projects that educate ECM providers about palliative care and those that educate palliative care providers about ECM. ▶ Collaborate with ECM providers to optimize care for shared patients.	▶ Participate in the design, piloting, and evaluation of programs that integrate palliative care with other home-based medical services.
State and Local Government Agencies		
	▶ Include training about the value of PC and how to refer into PC as part of ECM providers' training.	

Continued next page

Action: Embed palliative care within other inpatient and outpatient services and settings.	Action: Integrate palliative care with Medi-Cal's Enhanced Care Management (ECM) services.	Action: Integrate palliative care with home-based medical services.
Serious Illness Advocates and Educators		
▶ Help distribute information about best practices and outcomes related to embedded palliative care.	▶ Help distribute information about best practices and outcomes related to ECM-palliative care collaborations.	▶ Help in distributing information about best practices and outcomes related to integrating palliative care with other home-based medical services. ▶ Collaborate with advocacy organizations representing other home-based medicals services, such as home-based primary care, to align goals and messaging.
Philanthropy		
▶ Support distributing information about best practices and outcomes related to embedded palliative care.	▶ Support distributing information about best practices and outcomes related to ECM-palliative care collaborations.	▶ Support distributing information about best practices and outcomes related to integrating palliative care with other home-based medical services. ▶ Collaborate with philanthropies supporting other home-based medical services, such as home-based primary care, to align goals and activities.

Note: These potential actions serve as examples of how various stakeholders can contribute to the ongoing advancement of palliative care. They are intended to stimulate thought and strategic planning, and the list should not be considered exhaustive. To learn more, visit www.chcf.org/resource-center/californias-palliative-care-evolution.

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