

A New Vision for California's Healthcare System

# Honoring Patients' Wishes

EXPANDING PALLIATIVE CARE IN CALIFORNIA



School of  
Public Health

UNIVERSITY OF CALIFORNIA, BERKELEY



Berkeley Forum

for Improving California's Healthcare Delivery System

# CONTENTS

Berkeley Forum Leadership .....	1
Executive Summary .....	2
Introduction .....	4
The Case for Community-Based Palliative Care.....	5
Selecting Patients for Palliative Care Interventions	
Bringing Care to the Patient	
Financing Community-Based Palliative Care .....	7
Estimating Expenditures from Scaling Up Community-Based Palliative Care	
Model Community-Based Palliative Care Programs .....	8
Sharp HealthCare Transitions Program	
Sutter Advanced Illness Management (AIM) Program	
Aetna Case Management	
Scaling Up Model and Results .....	9
Healthcare Workforce Capacity and Needs .....	10
Building on Strengths to Develop More Options for Care	
National and Statewide Efforts to Expand Access to Quality Community-Based Palliative Care .....	12
Let's Get Healthy California	
The California State Innovation Model	
California Legislative Efforts	
The Institute of Medicine	
Quality and Performance Measurement	
The Coalition for Compassionate Care of California (The CCCC)	
The Center to Advance Palliative Care (CAPC)	
The California State University Institute for Palliative Care	
The California HealthCare Foundation Field Guide	
Moving Forward .....	14
Workforce Development	
Quality and Measurement	
Care Integration	
Engagement	
References.....	14
Acknowledgements .....	16



# Berkeley Forum Leadership

The Berkeley Forum, established in January 2012, includes select CEOs of California's health systems, health insurers and physician organizations, along with state regulators and policymakers, that are collaborating to improve the affordability and quality of healthcare for all Californians. The University of California, Berkeley's School of Public Health serves as a neutral facilitator for discussions and provides the analytic staff for this effort.

## PARTICIPANT LIST

### Anthem Blue Cross

Pam Kehaly, West Region President

### Cedars-Sinai Healthcare System

Tom Priselac, President and CEO  
Rick Jacobs, Senior Vice President,  
System Development and  
Chief Strategy Officer

### California Health and Human Services Agency

Diana Dooley, Secretary

### Healthcare Partners

Robert J. Margolis, Co-Chairman and  
Chief Executive Officer Emeritus

### Kaiser Permanente

Bernard Tyson,  
Chief Executive Officer  
Anthony A. Barrueta, Senior Vice  
President, Government Relations

### Sutter Health System

Patrick E. Fry, President and  
Chief Executive Officer

### USC Health

Thomas Jackiewicz,  
Senior Vice President and  
Chief Executive Officer

### UC Medical Centers

David Feinberg,  
Chief Executive Officer,  
UCLA Health System

## LEADERSHIP TEAM

### Stephen M. Shortell, PhD, MPH, MBA

Chair of the Berkeley Forum,  
Blue Cross of California  
Distinguished Professor and  
Director of the Center for Healthcare  
Organizational Innovation Research,  
University of California, Berkeley

### Richard M. Scheffler, PhD

Co-Chair of the Berkeley Forum,  
Distinguished Professor of Health  
Economics and Public Policy  
and Director of the Nicholas C. Petris  
Center on Health Care Markets  
and Consumer Welfare,  
School of Public Health,  
University of California, Berkeley

### Eric Kessell, PhD, MPH

Director of Health Policy and Practice,  
Nicholas C. Petris Center  
on Health Care Markets and  
Consumer Welfare,  
School of Public Health,  
University of California, Berkeley

### Brent D. Fulton, PhD, MBA

Assistant Adjunct Professor  
of Health Economics and Policy,  
Associate Director, Nicholas C. Petris  
Center on Health Care Markets  
and Consumer Welfare,  
School of Public Health,  
University of California, Berkeley

## LEAD AUTHOR

### Eric Kessell

### CO-AUTHORS\*

Richard M. Scheffler  
Stephen M. Shortell

*\*With assistance from the  
following at the Petris Center,  
School of Public Health,  
University of California,  
Berkeley:*

Brent D. Fulton  
Kati Phillips  
Forum Coordinator and  
Project Manager

Vishaal Pegany  
MPH, MPP Candidate  
Beth Keolanui  
MPH Candidate  
Evan Williams  
Student Assistant



# Executive Summary

Palliative care combines pain and symptom management, goal setting, family caregiver support, and practical and social support (CAPC, 2014). Current evidence suggests that palliative care is associated with improved patient outcomes, patient and family satisfaction, and prolongs life (Meier, 2011). Palliative care delivery operates on a continuum over which the proportion of curative-intent to palliative services varies over the course of illness. Community-based palliative care (CBPC) is a component of newer models of healthcare delivery that emphasize the importance of assessing preferences and providing greater choice in the location where care is delivered. The Berkeley Forum report of 2013 issued a Vision calling for increased use of concurrent curative-intent and community-based palliative care for seriously ill patients, to include a focus on advance care planning and physical, emotional and social support. In the Forum's Vision, by 2022, over 100,000 Californians per year would receive CBPC.

This brief has three purposes: 1) to describe the challenges of implementing more choices to honor patient preferences for community-based palliative care (CBCP) programs, based on the experience of several mature programs in California and nationwide; 2) to examine the value of reducing the expense of high-cost, undesired hospital spending, if CBCP were implemented on a scale consistent with the Forum Vision and 3) to predict the changes to the size and composition of the healthcare workforce that would need to take place in order for the Vision to be realized.

To estimate the potential value derived from CBPC, we conducted a review of mature programs from California and nationwide that were described in peer-reviewed literature. The report highlights three major programs in California that gave patients greater choice of care outside the hospital. In these programs, interdisciplinary teams incorporated patient goals and wishes into treatment planning, which provided patient-centered care that tended to move people out of intensive hospital settings and into care in the community. We estimate that if Californians participate in CBPC at the numbers envisioned, in 2014 there would be a \$72 million reduction in intensive hospital-based care, while still respecting patients' wishes, and nearly \$1.1 billion in 2022.

We estimate that the Forum Vision will require tripling the number of hospice- and palliative medicine certified physicians by 2022. The healthcare system will also benefit by having more generalist providers and other health care professionals trained in aspects of palliative medicine. With the physician hospice and palliative medicine (HPM) certified workforce already strained, and the nature of CBPC inherently interdisciplinary, it will be necessary for healthcare systems to be creative using existing resources to achieve the desired goals.

## Action Steps to Advance Care

**Informed by the Forum Vision, a review of state and national efforts to increase access to CBPC, interviews with palliative care providers and our analyses of existing programs and workforce supply suggest four priority areas for advancing community-based palliative care in California.**

### QUALITY AND MEASUREMENT

- Expand electronic health records to include patient preference information and social factors along with the clinical data to identify appropriate timing and intensity of interventions along the disease continuum. Better predictive models are needed to optimize the value of the care delivered.

- Adapt and expand the National Quality Forum (NQF) measures that address end-of-life care to address the needs of patients with serious illness earlier in the disease course, when CBPC programs are often engaged.
- Expand the use of patient-reported outcome measures (PROs) to assess the quality and effectiveness of community-based palliative care programs.

### CARE INTEGRATION

- Expand patient-centered medical homes (PCMHs), which focus care management on patients with chronic illness and can be natural settings to incorporate community-based palliative care.
- Consider offering additional financial incentives to provider teams for engaging in community-based palliative care that promotes care integration.



- Integrate advance care planning (ACP) across the continuum of care so that patients get more value from their care during the course of the disease process.
- Align incentives for insurers and providers to develop reimbursement models that prevent unwanted care at the end of life in order to improve patient and caregiver satisfaction while reducing expenditures.

## PATIENT AND FAMILY ENGAGEMENT

- Better inform consumers to make them aware of their options in healthcare to drive the system towards delivering higher quality and greater choice.
- Implement local public engagement efforts to help patients and their families engage in advance care planning conversations with their healthcare providers and to raise CBPC as an option earlier in the disease process.

## WORKFORCE DEVELOPMENT

- Train more providers in motivational interviewing and goal-setting conversations for patients with chronic illness.
- Expand the scope of practice for Nurse Practitioners (consistent with the Forum Vision) to deliver CBPC services independently.
- Build the supply of currently licensed nurses, social workers and other professionals through accredited distance-learning certification programs such as the California State University Institute for Palliative Care.
- Train patients' caregivers in conjunction with home-based care to improve patient experience as well as improve quality of life for the family.



# Introduction

**Aligning treatment with patient and family preferences is recognized as a key component of high-quality healthcare. Newer models of healthcare delivery, such as the patient-centered medical home, emphasize the importance of assessing preferences and providing greater choice in the location where care is delivered. Greater access to information on treatment options from online sources results in consumers demanding more options for care, while measures of provider quality and external reviews of consumer satisfaction encourage systems in competition to meet consumer demand. Greater choice and patient-centered care are particularly salient for consumers with chronic illness and those approaching end of life.**

In recent years, healthcare providers and organizations have undertaken major efforts to better align the needs and wishes of seriously ill patients with the care they actually receive. A majority of Californians say they want lower-intensity sites of care during the last stage of life; they also want that care to emphasize pain and symptom management, spiritual support and shared-decision making (CHCF, 2011). Additionally, spending on seriously ill patients — often for low-value services or care that does not align with patient wishes — comprises a large proportion of healthcare expenditures. Medicare spends approximately 25% of its budget on the 5% of beneficiaries who die during a given year. Failing to provide care that is concordant with patient preferences thus reduces quality of care while unnecessarily generating high costs. Fortunately, opportunities for better end-of-life care exist both in the hospital as well as in community settings, such as the patient's home and outpatient clinics.

In 2013, The Berkeley Forum for Improving California's Healthcare Delivery System issued its Vision for the state's delivery and payment system (Scheffler, et al., 2013). Private and public sector leaders joined with researchers at the University of California, Berkeley School of Public Health to devise an approach that would create a more affordable, cost-effective healthcare system that also improves Californians' health and well-being.

The Berkeley Forum identified several initiatives for reducing the growth of healthcare expenditures. These initiatives describe a system that produces high-quality, integrated, patient-centered care, in which the healthcare workforce is deployed efficiently and to each profession's scale of practice. This system encourages Californians to be physically active and to avoid pre-term births and healthcare-associated infections.

The Vision also called for an increase in the use of concurrent curative-intent and community-based palliative care for seriously ill patients, to include a focus on advance care planning and physical, emotional and social support. The Forum estimated that the proposed

palliative care model would generate over \$6 billion in savings by the year 2022.

Despite their promise for improving healthcare quality while reducing costs, some aspects of palliative care programs have at times been misconstrued as a means of saving money by denying care. This incorrect assumption was particularly true for Medicare payment for advance care planning. This mischaracterization of advance care planning is addressed head-on in a recent report from The Institute of Medicine: "Without understanding the likely course of illness and the risks and benefits of treatment choices, patients (and families) cannot make informed decisions about their care." (IOM, 2014). The report issued strong recommendations for government and private insurers to cover seamless, integrated and accessible care, and to reorient delivery programs to ensure quality and address the needs of all people near the end of life and their families. A review of four well-designed palliative care service programs found improved patient satisfaction, symptom control and quality of life, reduced health care utilization and lengthened survival in patients with lung cancer. (Rabow, et al., 2013)

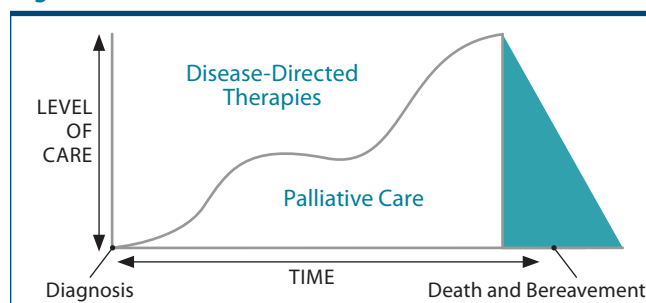
In spite of endorsement of CBPC from state and federal sources, well-designed programs are not yet prevalent in most regions of the country. This brief has three purposes: 1) to describe the challenges of implementing more choices to honor patient preferences for community-based palliative care (CBCP) programs, based on the experience of several mature programs in California and nationwide; 2) to examine the value of reducing the expense of high-cost, undesired hospital spending, if CBCP were implemented on a scale consistent with the Forum Vision and 3) to predict the changes to the size and composition of the healthcare workforce that would need to take place in order for the Vision to be realized. For this brief, Berkeley Forum staff interviewed key staff-members of several organizations that either provide CBPC directly or purchase it through provider contracts. Comments given during interviews are not attributed to any organization except by permission.

# The Case for Community-Based Palliative Care

Generally, palliative care combines pain and symptom management, goal setting, family caregiver support, and practical and social support. It operates on a continuum of care in which the proportion of curative to palliative services varies over the course of illness (Figure 1). The IOM proposes twelve core components of quality end-of-life care (IOM 2014).

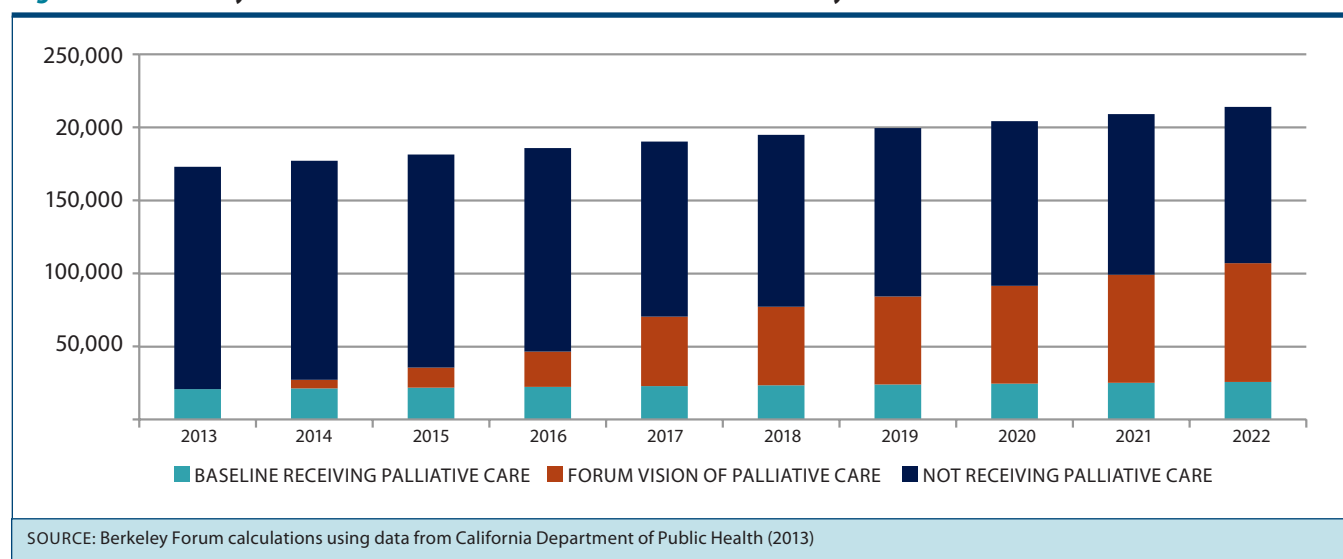
- Frequent assessment of patient's physical, emotional, social and spiritual well-being
- Management of emotional distress
- Offer referral to expert-level palliative care
- Offer referral to hospice if the patient has a prognosis of 6 months or less
- Management of care and direct contact with patient and family for complex situations by a specialist-level palliative care physician
- Round-the-clock access to coordinated care and services
- Management of pain and other symptoms
- Counseling of patient and family
- Family caregiver support
- Attention to the patient's social context and social needs
- Attention to the patient's spiritual and religious needs
- Regular personalized revision of the care plan and access to services based on the changing needs of the patient and the family

**Figure 1: Continuum of Palliative Care**



In 2012, over 19 million Californians were covered by one of seven insurance plans that had either implemented or were planning programs that increase access to palliative care (CHCF, 2013). In September 2014, California Senate Bill 1004 required Managed Medi-Cal plans to establish standards to ensure delivery of palliative care services (Welfare and Institutions Code, 2014), potentially expanding access to a broad swath of the population. As would be expected in a new and developing field, the programs vary in terms of the location of care (e.g., ambulatory clinics, at home, via telephone), the type of providers delivering care (physicians, nurses,

**Figure 2: Berkeley Forum Vision of Increased Use of Community-Based Palliative Care in California**



nurse practitioners, social workers), and the type of care provided (concurrent treatment for illness-directed care, enhanced case management, goal-setting, pain/symptom management, advance care planning). Without standardized methods, it is difficult to assess CBPC programs staffing, benchmarks for outcomes and best practices (CHCF, 2012b).

The Berkeley Forum Vision of a palliative care intervention would provide patients with access to interdisciplinary, patient-centered CBCP. For our model, we include those who have a prognosis of approximately one year or less due to certain conditions. Conditions that would be covered include cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, ALS, cirrhosis and HIV. The Forum modeled the number of potentially eligible patients from estimates of deaths from the considered medical conditions and the increasing provision of palliative care to potentially appropriate patients over time. By 2022, half of all Californians meeting the disease conditions would be receiving CBCP (see Figure 2 on the previous page). This large number of potential patients with varying preferences gives providers the opportunity to design and customize systems that increase the range of choices that California consumers have in selecting care.<sup>1</sup>

## Selecting Patients for Palliative Care Interventions

For providers and plans to offer CBPC interventions that produce high-value, high-quality care, they must accurately target the patients who will benefit most. For example, early palliative care provided to patients with non-small-cell lung cancer has been shown to improve quality of life, reduce depressive symptoms, reduce provision of aggressive end-of-life care, and has been associated with longer survival time (Temel et al., 2010). The American Society of Clinical Oncology issued a provisional opinion in 2011 recommending patients with metastatic cancer and/or high symptom burden receive concurrent palliative care and standard oncologic care (Smith et al., 2012). The uncertain course of many illnesses makes it challenging to define populations strictly on the bases of prognosis (life-expectancy), so eligibility criteria for CBPC need to incorporate multiple variables (CHCF, 2013). In addition, patients with chronic non-progressive problems could overwhelm system capacity: one provider interviewed found that chronic pain patients were best served by the pain clinic rather than through a palliative care service. Tools such as the Payer Provider toolkit, developed by the Center to Advance Palliative Care (CAPC) and the National Business Group on Health offer some guidance.<sup>2</sup>

In interviews with plans and providers, we found that although programs emphasize serving high-risk populations, participation in palliative care can be viewed along a continuum that includes different population groups. From the provider perspective, palliative-care appropriate patients can be broadly organized into three groups: 1) the healthy/well; 2) the chronically ill; and 3) the critical/extremely ill. Embedding palliative care into primary care medical homes in a tailored way would involve providing care planning to the healthy/well, defining care priorities for the chronically ill, and end-of-life care planning for the critically/extremely ill.

Both plans and providers can identify patients through automated selection processes, including automatic referral of patients with end stage malignancies to a palliative care physician for symptom management. While some providers object to automatic triggers as impinging on their clinical judgment and control of patient care, plans have found that, with time and careful implementation, their teams have begun embracing this approach more than in the past.

## Bringing Care to the Patient

Palliative care cannot be solely delivered in the hospital setting, but needs to be available in the community. Having care delivered in the home or a clinic can also help dispel the harmful misperceptions of palliative care, for example the failure to appreciate the differences between palliative care and hospice care. For this reason, some plans support an ongoing discussion with communities to discuss patients care preferences, understanding advance planning and to present palliative care as an additional option for those with serious illness, regardless of current or planned use of curative-intent treatment.

In-home palliative care provided to homebound, terminally ill patients with less than one year of life can improve patient satisfaction, increase likelihood of dying at home (versus the hospital), and reduce visits to the emergency department and admissions to the hospital (Brumley et al., 2007). Ambulatory (office-based) CBPC programs have extended their outreach into the homes. Focused attention at the home can permit providers to identify risks that might not otherwise be uncovered in an ambulatory setting or through telephone calls. Some providers interviewed have reported an increase in the completion of Physician Order for Life-Sustaining Treatment (POLST) forms when elicited in the home. However, home visits are time-consuming — providers traveling to homes may be able to make 4-6 visits per day, and do not always produce adequate reimbursement to maintain.

<sup>1</sup>For details, see Scheffler, et al. (2013), Appendix VII: <http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/Appendix-VII.-Palliative-Care-Initiative-Memorandum.pdf>

<sup>2</sup><http://www.capc.org/payertoolkit/>



# Financing Community-Based Palliative Care

Palliative care programs can be resource intensive, and their net cost or savings to the provider and plan depends on a number of factors, including who is at risk for health care expenditures, how the target population is defined, the care delivery model utilized, base-line practice patterns, and payer mix (for providers). Some plans and providers report offering community-based palliative care premised on population health management rather than driven solely on cost savings, although some large-scale programs have seen cost savings as a result of CBPC programs.

Medicare hospice benefit rules can limit providers who want to structure palliative care programs flexibly and to offer concurrent curative-intent and palliative care. One health plan self-financed its palliative care program but based payment to providers on the same fee schedule as Medicare (per diem rate).

California's extensive managed care penetration provides many opportunities to explore payment mechanisms (CHCF, 2012b). California Senate Bill 1004 requires standards to be set to ensure that Medi-Cal Managed Care plans deliver of palliative care services through licensed hospice agencies and home health agencies. CHCF has called for developing and testing new reimbursement models, and in October of 2014 issued ten grants to "pair payers and providers to develop operational and financial plans for delivering palliative care projects in the community setting."<sup>3</sup> Additionally the California State Innovations Model (CalSIM) proposal calls for "new benefit and payment approaches to better meet patient preferences for palliative and hospice care" (California Department of Human Services, 2014).

One approach to expanding CPBC programs focuses on patients with advanced illnesses to show the benefit of palliative care not only to patients and providers, but also to the health plan. For example, one plan piloted a program where hospices assumed responsibility for managing care for some patients with chronic illness but who were not enrolled in their hospice services; fees were paid by the global budget. Once the model demonstrates value, the plan can begin to incorporate more palliative services upstream by opening up the criteria for hospice care to allow for increased participation in palliative care. Through this process, the plan supports the development of community-based palliative care models for patients

that may need less intensive services. The plan could then expand its training and education to its primary care physicians and other health workers. Eventually, palliative care services would be delivered from the time of a patient's diagnosis to the time he or she requires more treatment in hospitals, clinics, etc. This way palliative care services are available to everyone along the continuum of illness.

## Estimating Expenditures from Scaling Up Community-Based Palliative Care

To estimate potential value from community-based palliative care (CBPC), we conducted a review of mature programs from California and nationwide that were described in peer-reviewed literature. We limited our review to studies that estimated net savings/cost-reductions, which already accounted for the direct costs of providing the intervention. We selected three programs that gave patients greater choice of care outside the hospital and projected their shift in value over a six-month period. We then modeled the number of potentially appropriate patients who would enroll in community-based palliative care and assumed that 25% of those patients joined each of the three programs and experienced outcomes and savings at the average rate reported. We also assumed that 25% of enrolling patients enrolled in community-based palliative care that used different models than the more established programs. To model improvements in efficiency in smaller programs over time we increased the performance relative to the larger plans from 50% in 2014 to 82% in 2022.

<sup>3</sup><http://www.chcf.org/rfps/2014/rfp-palliative-care-access>. Accessed September 2014

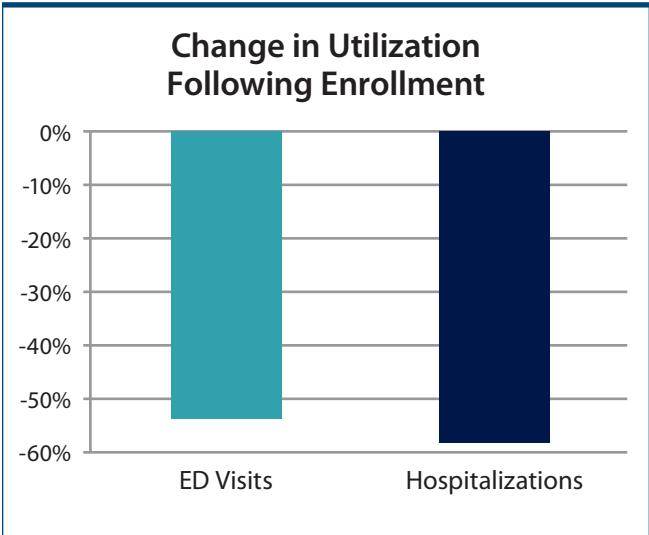
# Model Community-Based Palliative Care Programs

## SHARP HEALTHCARE TRANSITIONS PROGRAM

This model provides home-based, ambulatory and telephone-based follow-up to those with advanced heart failure (Hoefer et al., 2013). Patient and caregiver choice is enhanced through an evidence-based prognostication model, which provides practical information about the disease process in advance of milestones. This patient-centered approach encourages decision-making away from the emergency room, ICU or hospital, where choices are more likely to be reactive. The intervention simultaneously offers curative services and multidisciplinary palliative care services, which increase over the course of illness. Services include in-home medical consultation, caregiver support, and advance health care planning.

The program reports emergency department visit reductions of 58% and cost of care savings of 36%. Total cost of care per patient decreased by over \$26,000 per patient over length of stay in the program, including the approximately \$2456 cost per patient of enrollment in the program.

Figure 3: Sharp HealthCare Transitions Program, Selected Clinical Outcomes



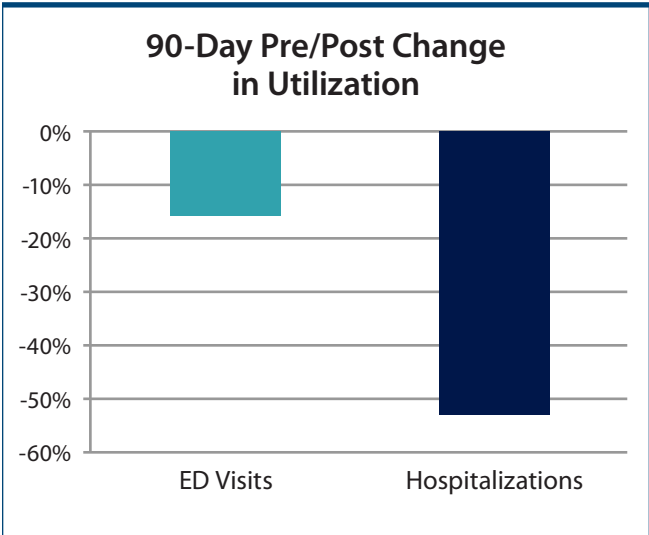
SOURCE: Hoefer et al. 2013

## SUTTER ADVANCED ILLNESS MANAGEMENT (AIM) PROGRAM

This intervention combines hospital, home care, telephone, and clinic-based interventions to ease the transition between curative and comfort care for seriously ill patients. It provides evidence-based clinical care and care management at multiple sites and has served over 4,600 patients since July 2012. The program was developed in response to uncoordinated care and acute episodes that frequently led to end-of-life care that was unwanted and unsatisfactory to patients, caregivers and providers. The AIM model provides patient-centered care that depends on patient/caregiver engagement, goal setting, and self-management (Labson et al., 2013). The care teams and patients jointly determine care plans based on personal goals and values. Through this process, the focus of care is moved from the hospital to the home/ community, where most patients choose to be. Patients are provided with hospital liaisons, care managers at physician offices, telephonic support (remotely or imbedded in physician group), and home-based services.

Early outcomes have shown a 53% reduction in hospitalizations post-enrollment and a 75% reduction in ICU days. Total cost savings in the AIM program has been estimated to be approximately \$2,000/month per patient (Labson et al., 2013), and additional evaluation is underway through a Center for Medicare and Medicaid Innovation grant.

Figure 4: Sutter Advanced Illness Management (AIM) Program, Selected Clinical Outcomes

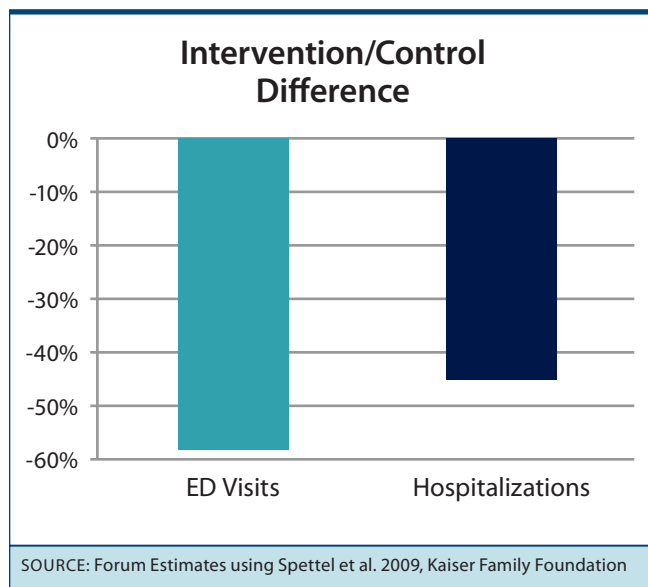


SOURCE: Sutter Health Advanced Illness Management (AIM)

## AETNA CASE MANAGEMENT

This telephone-based management program identifies patients through review of admissions, physician referral, and proprietary modeling. Few patients decline the option of specialized case management in lieu of traditional case management. The program employs a nurse case manager to provide patient education, care coordination with the patient's physician. The case manager addresses patient and caregiver needs for education on the disease process, offers assistance with advance care directives, and identifies patient preferences for care. Greater treatment options expand the length of time for in-patient hospice and dollar limits on out-patient hospice, and curative treatment is offered concurrently with hospice services. Forum staff estimated cost savings from the reported reduction in ED visits and acute inpatient days to be approximately \$7600 over six months.

**Figure 5: Aetna Case Management, Selected Clinical Outcomes**

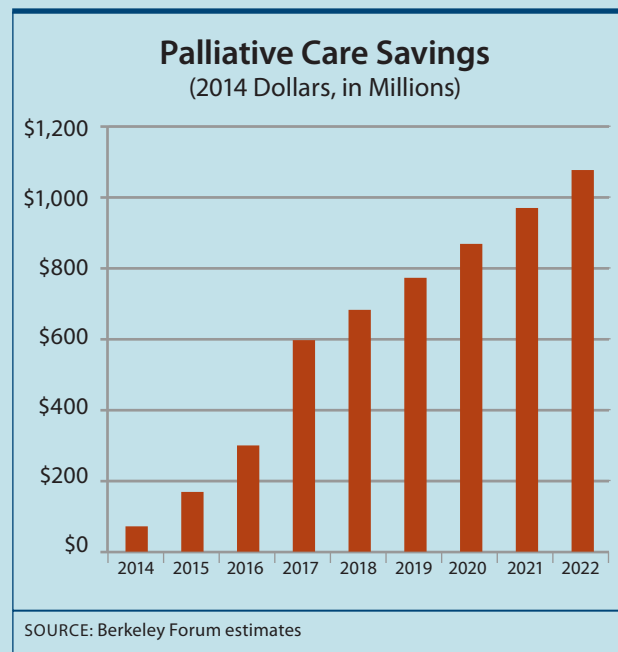


## Scaling Up Model and Results

We modeled the Forum Vision's uptake of community-based palliative care from 2014 to 2022, estimating changes in healthcare utilization and their resulting effect on health care costs in the last year of life. We assumed that the total value of each intervention would be constant over a six-month period. We assumed that the savings per month are, on average, the same regardless of the length of survival. We divided the population into four groups, and assumed that patients were enrolled in one of four options equally. Each of the three models described above received 25% of the number of patients included in the Forum Vision for that year (for example 5,895 in 2014 to 81,371 in 2022). We assumed that another 25% would be enrolled in other community-based palliative care programs, which we assumed initially would generate less savings than mature programs. We also assumed that other providers would become more efficient over the nine years and eventually achieve 80 percent of the average savings of the other three programs.

We estimate that if Californians participate in CBPC at the numbers envisioned, in 2014 there would be a \$72 million reduction in intensive hospital-based care, while still respecting patients' wishes, and nearly \$1.1 billion in spending could be avoided in 2022. Overall hospital spending would be reduced by over \$5.5 billion through 2022.

**Figure 6: Annual Value from Scaling Up Berkeley Forum Vision to Existing California Community-Based Palliative Care Programs**





# Healthcare Workforce Capacity and Needs

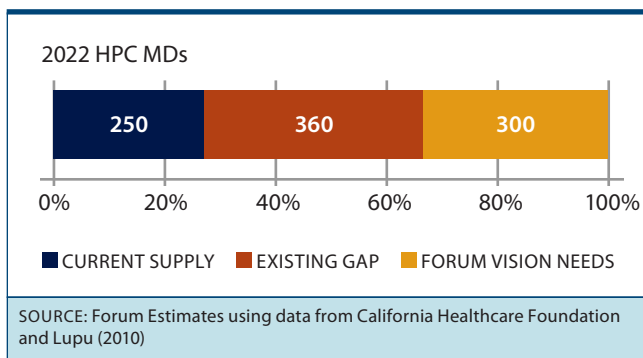
The American Academy of Hospice and Palliative Medicine estimates that, as of December 2013, there were a total of approximately 6500 certified hospice and palliative medicine physicians in the US. Lupu (2010) estimates that that there is a hospice and palliative medicine (HPM) physician shortage numbering 6,000 to 18,000.

The approximately 75 HPM fellowship programs have the capacity to train approximately 180 physicians annually (Ibid). Improving primary care physician training will ameliorate some of the gaps but will not substitute for specialized training in hospice and palliative medicine (Case et al., 2013). Neither increased fellowships nor recruiting practicing physicians alone is likely to meet demand (Maison, 2010). In California, CHCF identified the “limited supply of board-certified palliative care physicians [as] an impediment to access” (CHCF, 2013). Additionally, Medicare regulations changed in 2011 to require more frequent hospice recertification by physicians or nurse practitioners, placing more demands on an already stretched workforce (Maison, 2010). Shortages of credentialed nurses and social workers also inhibit the scaling up of palliative care to community settings (CHCF, 2012b).

However, there is great capacity to train additional palliative care professionals. Over 1,500 palliative care and 3,400 hospice programs exist nationwide, and most large-to medium-size hospital systems already have palliative care teams in place (Meier, 2011). Through coordination with training programs, these providers already in the field can potentially scale up the palliative-care workforce to meet the needs of the coming decade.

The skill set needed for quality healthcare delivery in the palliative care setting is not limited to physicians: “Clinician-patient communication, assessment and treatment of symptoms, psychosocial, spiritual and bereavement support, and coordination of care ... are embedded in the culture of nursing and NP education” (Heinle et al., 2013). Community-based palliative care services provided by nurse practitioners can be of a similar quality and cost as that provided by physicians. (Heinle, et al., 2013) Although certified hospice and palliative care nurses and nurse practitioners may also be in short supply, programs exist that permit licensed professionals to quickly develop competencies in palliative care. The California State University Institute for Palliative Care offers eight-week certificate courses for registered nurses and 8-month post-MSW certificate.

**Figure 7: Projected California Hospice and Palliative Care (HPC) Physician Workforce Needs in 2022**



Medical directors contacted by the Forum varied in their assessments of the available physician workforce. The National Hospice and Palliative Care Organization has required as of 2013 that physicians complete a fellowship before sitting for board certification exams.<sup>4</sup> The opportunity cost of participating in fellowship programs may serve as a disincentive for mid-career professionals.

Directors consistently reported that their best-performing palliative care clinicians possess a specialized set of interpersonal skills that differ somewhat from those used in hospice settings. This is in part due to their encountering patients and their families earlier in the disease process than in the end-of-life hospice setting.

Given the Forum Vision for scaling up CBCP by 2022, we wanted to assess the implications on the physician workforce. First, we estimated the ratio of patient encounters to physician using staffing ratio estimates and program size from the CHCF’s Palliative Care Action Community (PCAC)<sup>5</sup>, 20 provider organizations, consisting of hospitals, home health agencies, hospices, integrated medical groups and large health systems (Meyers, Kerr

<sup>4</sup> <http://www.nhpco.org/palliative-care/physician-certification>

<sup>5</sup> Data unpublished.

and Cassel, 2014). The programs provide a mix of inpatient clinic, telephone, and home-based services and represent a geographically broad portion of California.

Then we multiplied the Forum Vision estimates of the population eligible for community-based palliative care by the number of encounters per patient in the PCAC group, then divided by the number of encounters per physician to estimate that the Forum Vision will require approximately 300 full-time equivalent physicians by 2022. We compare this number to our estimate of the existing gap of Hospice and Palliative Care physicians, derived from approximately one-tenth of Lupu's (2010) estimate of the nationwide shortage of HPM FTEs (see Figure 7 on the previous page).

Training a family physician may take 21,700 hours, compared to the 5,350 hours required for a nurse practitioner. (AAFP, 2012). Physician training differs in scope from nurse practitioners, and the shorter duration of NP training may be an effective use of training resources if equivalent outcomes can be demonstrated in some specific circumstances in community-based palliative care (Heinle et al., 2013).

With a physician workforce already strained, and the nature of CBPC inherently interdisciplinary, it will be necessary for healthcare systems to draw creatively from existing resources. These solutions can come from partner organizations in the system and from efficient utilization of existing staff (for example, assuring that health care professionals are delivering care at full extent of their scope of practice.)



## *Building on Strengths to Develop More Options for Care*

One health plan looked in the community to see which organizations were already providing palliative care services using an interdisciplinary team. The plan decided to partner with hospice providers because they already had an interdisciplinary team in place, were available 24/7, and were doing good work in symptom management. However, the plan was aware that hospice providers were not going to have the same knowledge and competencies as a palliative care team for patients with longer prognoses and different needs. The hospice providers were thus asked to create palliative care teams separate from their hospice teams. Many hospice providers had initially thought palliative care was something they were already doing, but they learned quickly that this was a different model of care.

This health plan has an advisory board comprised of hospice care providers, primary care physicians, and specialists. There were very few nurse practitioners with backgrounds in palliative care, specifically pain and symptom management. Through the work of the board, the plan was able to partner with oncologists, identify providers who could serve as champions, and conduct collaborative learning. The plan wants to increase the number of hospice nurses with certification in palliative care. While there are certification programs for chaplains and social workers, this plan is currently focusing on nurses.

# National and Statewide Efforts to Expand Access to Quality Community-Based Palliative Care

Palliative care and CBPC are being rapidly incorporated into standard care. Consensus statements from medical societies, accreditation from the Joint Commission, national standards in quality measurement, and inclusion in statewide plans to improve the healthcare delivery system all point to the movement towards improved patient choice and patient-centered care for chronic conditions and at the end of life.

## LET'S GET HEALTHY CALIFORNIA

This task force developed a set of 10-year goals to improve Californians' health and reduce disparities in health outcomes (Let's Get Healthy California Task Force, 2012). One goal focuses on maintaining dignity and independence at end of life. The task force proposed a set of indicators to measure progress in improving patient and family choice, including enrollment in hospice care prior to death and use of advance care planning.

## THE CALIFORNIA STATE INNOVATION MODEL

The California State Innovations Model (CalSIM) initiative calls to "promote the use of palliative care, when appropriate and in line with patient preferences, by educating patients, training providers, and removing any structural or informational barriers to receiving care" (California Department of Human Services, 2014). The CalSIM plan calls for the State, employers, providers and plans to include palliative care in health homes and to "identify and adopt new benefit and payment approaches to better meet patient preferences."

## CALIFORNIA LEGISLATIVE EFFORTS

California Senate Bill 1004 required Managed Medi-Cal plans to establish standards to ensure delivery of palliative care services (Welfare and Institutions Code, 2014), potentially expanding access to a broad swath of the population. Assembly Bill 1745 calls for California DHCS and Medi-Cal to partner with Centers for Medicare and Medicaid Service to develop a pediatric palliative care waiver program. Children and families can receive palliative care services simultaneously with curative-intent treatment in participating counties without electing hospice care, which requires certification by a physician that a child has less than six months to live.<sup>6</sup>

## THE INSTITUTE OF MEDICINE

The Institute of Medicine's *Dying in America* report (IOM 2014) issued a consensus statement that included strong recommendations for honoring individual preferences near the end of life. The report called for 1) Delivery of person-centered, family-oriented end-of-life care; 2) Clinician-patient communication and advance care planning; 3) Professional education and development; 4) Policies and payment systems to support high-quality end-of-life care; and 5) Public education and engagement.

---

<sup>6</sup> <http://www.dhcs.ca.gov/services/ppc/Pages/ProgramOverview.aspx>



## QUALITY AND PERFORMANCE MEASUREMENT

The National Quality Forum (NQF) has endorsed 14 measures for end-of-life care.<sup>7</sup> However, not all performance measures of healthcare quality apply in different settings, which has led to challenges in comparing performance in the diversity of places where CBPC is delivered. In response, The American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association have developed set of twelve performance measures for all hospice and palliative care programs.<sup>8</sup>

### NQF Palliative Care and End-of-Life Care Measures

- Pain Screening
- Pain Assessment
- Bowel regimen for patients treated with an opioid
- Pain assessment at outpatient visit for patients with advanced cancer
- Dyspnea treatment
- Dyspnea screening
- Preferences documented in patients admitted to the ICU
- Life-sustaining treatment preferences documented
- Spiritual/religious concerns documented for hospice patients
- Pain control for dying patients
- Implantable defibrillator deactivation prior to death
- Family evaluation of hospice care
- CARE survey administered to bereaved family members
- Bereaved Family Survey

However, advances in hospice and palliative care have tended to occur through local champions rather than through national policies (Case et al., 2013). In that vein, several organizations have developed tools for healthcare providers and others to plan and implement local palliative care programs.

## THE COALITION FOR COMPASSIONATE CARE OF CALIFORNIA (THE CCCC)

(<http://coalitionccc.org/>) is a statewide collaborative of organizations and individuals representing healthcare providers, assisted living facilities, nursing homes, hospices, consumers, state agencies and others. It provides tools for planning and evaluating programs, including a technical tool for developing a business plan for outpatient palliative care programs.

## THE CENTER TO ADVANCE PALLIATIVE CARE (CAPC)

(<http://www.capc.org>) provides tools, training and assistance to start and maintain palliative care programs in hospitals and other settings. It includes a toolkit for establishing payer-provider partnerships.

## THE CALIFORNIA STATE UNIVERSITY INSTITUTE FOR PALLIATIVE CARE

(<http://www.csupalliativecare.org/>) is an interdisciplinary program at CSU-San Marcos with a mission to enhance palliative care expertise and build palliative care awareness so that Californians will have greater access and awareness, reduced suffering, improved quality, more options and more choice. The Institute offers healthcare workforce development, through certifications in palliative care for registered nurses, social workers and chaplains and cultural competency courses. It also provides tools for making business cases for palliative care.

## THE CALIFORNIA HEALTHCARE FOUNDATION FIELD GUIDE

(<http://www.chcf.org/publications/2014/09/up-close-field-guide-palliative>) This report draws from the experience of CHCF's Palliative Care Action Committee to describe promising practices in over 20 community-based programs from across the state (Meyers, Kerr and Cassel, 2014). It provides fact sheets on innovative models for providers interested in starting new CBPC programs or improve existing ones.

<sup>7</sup><http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/HIS-Fact-Sheet.pdf> Accessed August 2014

<sup>8</sup><http://aahpm.org/quality/measuring-what-matters>

# REFERENCES

- American Academy of Family Physicians. (2012). *Primary Care for the 21<sup>st</sup> Century: Ensuring a Quality, Physician-led Team for Every Patient*. [http://www.aafp.org/dam/AAFP/documents/about\\_us/initiatives/AAFP-PCMHWhitePaper.pdf](http://www.aafp.org/dam/AAFP/documents/about_us/initiatives/AAFP-PCMHWhitePaper.pdf). Accessed August 2014.
- Brumley, R., Enguidanos, S., Jamison, P., Seitz, R., Morgenstern, N., Saito, S., ... & Gonzalez, J. (2007). Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. *Journal of the American Geriatrics Society*, 55(7), 993-1000.
- California Department of Health and Human Services. (2014). *California State Health Care Innovation Plan* [http://www.chhs.ca.gov/PRI/CalSIM%20State%20Health%20Care%20Innovation%20Plan\\_Final.pdf](http://www.chhs.ca.gov/PRI/CalSIM%20State%20Health%20Care%20Innovation%20Plan_Final.pdf). Accessed October 2014.
- California Department of Public Health. (2013). Vital Statistics Query System-Death Records. Health Information and Strategic Planning: California Vital Statistics Database.
- California HealthCare Foundation. (2012a). *When Compassion is the Cure: Progress and Promise in Hospital-Based Palliative Care* <http://www.chcf.org/publications/2012/02/compassion-cure-palliative-care>. Accessed August 2014.
- California HealthCare Foundation. (2012b). *Next Generation of Palliative Care: Community Models Offer Services Outside the Hospital*. <http://www.chcf.org/publications/2012/11/next-generation-palliative-care>. Accessed August 2014.
- California HealthCare Foundation. (2013). *A Better Benefit: Health Plans Try New Approaches to End-of-Life Care*. <http://www.chcf.org/publications/2013/04/better-benefit-health-plans>. Accessed August 2014.
- Case, A. A., Orrange, S. M., & Weissman, D. E. (2013). Palliative medicine physician education in the United States: a historical review. *Journal of Palliative Medicine*, 16(3), 230-236.
- Heinle, R., McNulty, J., & Hebert, R. S. (2014). Nurse practitioners and the growth of palliative medicine. *American Journal of Hospice and Palliative Medicine*, 31(3), 287-291.
- Hoefer, D. R., Johnson, S. K., & Bender, M. (2013). Development and preliminary evaluation of an innovative advanced chronic disease care model. *Journal of Clinical Outcomes Management*, 20(9).
- Institute of Medicine (2014). *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. The National Academies Press. Washington, DC.
- Kaiser Family Foundation. (2011). *Adjusted Hospital Expenses per Inpatient Day*. <http://kff.org/other/state-indicator/expenses-per-inpatient-day/>. Accessed August 2013.
- Labson, M. C., Sacco, M. M., Weissman, D. E., Gornet, B., & Stuart, B. (2013). Innovative models of home-based palliative care. *Cleveland Clinic Journal of Medicine*, 80(e-Suppl 1), e-S30.

Let's Get Healthy California Task Force. (2012). *Final Report*. California Department of Health and Human Services. Sacramento, CA. <http://www.chhs.ca.gov/pages/LGHCTF.aspx> Accessed September 2013.

Lupu, D. (2010). Estimate of current hospice and palliative medicine physician workforce shortage. *Journal of pain and symptom management*, 40(6), 899-911.

Maison, D. (2010). Workforce shortage: a staggering need and a call to action. *Journal of Pain and Symptom Management*, 40(6), 912-913.

Meier, D. E. (2011). Increased access to palliative care and hospice services: opportunities to improve value in health care. *Milbank Quarterly*, 89(3), 343-380.

Meyers, K., Kerr, K. and Cassel, J.B. (2014). *Up Close: A Field Guide to Community-Based Palliative Care in California*. Oakland, CA: California HealthCare Foundation. <http://www.chcf.org/publications/2014/09/up-close-field-guide-palliative>. Accessed October 2014.

National Quality Forum. (2012). *Endorsement Summary: Palliative Care and End of Life Measures*. Washington, DC: National Quality Forum.

Rabow, M., Kvale, E., Barbour, L., Cassel, J. B., Cohen, S., Jackson, V., ... & Weissman, D. (2013). Moving upstream: a review of the evidence of the impact of outpatient palliative care. *Journal of Palliative Medicine*, 16(12), 1540-1549.

Scheffler, R., Bowers, L., Fulton, B., Connors, C., Shortell, M., Morrison, I. *A New Vision for California's Healthcare System: Integrated Care with Aligned Financial Incentives*. Berkeley: School of Public Health, University of California, Berkeley, 2013.

Smith, T. J., Temin, S., Alesi, E. R., Abernethy, A. P., Balboni, T. A., Basch, E. M., ... & Von Roenn, J. H. (2012). American Society of Clinical Oncology provisional clinical opinion: the integration of palliative care into standard oncology care. *Journal of Clinical Oncology*, 30(8), 880-887.

Spettell, C. M., Rawlins, W. S., Krakauer, R., Fernandes, J., Breton, M. E., Gowdy, W., ... & Brennan, T. A. (2009). A comprehensive case management program to improve palliative care. *Journal of Palliative Medicine*, 12(9), 827-832.

Temel, J. S., Greer, J. A., Muzikansky, A., Gallagher, E. R., Admane, S., Jackson, V. A., ... & Lynch, T. J. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*, 363(8), 733-742.

Warner, E. & Gualiteri-Reed, T. (2014). *A Palliative Care Toolkit and Resource Guide*. New York. Center to Advance Palliative Care.

Welfare and Institutions Code, California §§ 14132.75 (2014).



# Acknowledgments

We would like to thank the following for their contributions. We thank the numerous other individuals and organizations not listed here who provided input throughout the process of compiling this report.

Nancy Boerner

Chan Chuang

Tyler Jung

Rae Seitz

Carrie Lapham

Kyla Lee

Katherine Kerr

Judy Thomas

Nishtha Bhatt

Vishaal Pegany

Beth Keolanui

Brent Fulton

Kati Phillips

Margae Knox

## FUNDING

We acknowledge funding support by the Forum participants, provided as a gift to the University of California, Berkeley School of Public Health. The research and analyses for this report were conducted independently by faculty and staff, who take responsibility for its contents.



© 2014 The Regents of the University of California



# Berkeley Forum

*for Improving California's Healthcare Delivery System*





# Berkeley Forum

*for Improving California's Healthcare Delivery System*

<http://berkeleyhealthcareforum.berkeley.edu>



UNIVERSITY OF CALIFORNIA, BERKELEY  
SCHOOL OF PUBLIC HEALTH

<http://sph.berkeley.edu>



THE NICHOLAS C.  
PETRIS CENTER

<http://petris.org>

## CHOIR

CENTER FOR HEALTHCARE ORGANIZATIONAL  
AND INNOVATION RESEARCH

<http://choir.berkeley.edu/>

**A NEW VISION FOR CALIFORNIA'S HEALTHCARE SYSTEM**

