Making the Case for Palliative Care: An Opportunity for Health Care Reform

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I. Introduction

Approximately ninety million Americans are living with at least one chronic illness, and this number is expected to more than double over the next twenty-five years with the aging of the baby boomers.1 Yet, studies show that most people living with a serious illness experience inadequately treated symptoms, fragmented care, poor communication with their doctors, and significant strains on their family caregivers.2

Palliative care is the interdisciplinary medical sub-specialty that focuses on relieving suffering and improving quality of life for patients with serious illness and their families. It is offered simultaneously with other medical treatments.3 In this article, we

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2 STATE-BY-STATE REPORT CARD, supra note 1, at 1; see Joan M. Teno et al., Family Perspectives on End-of-Life Care at the Last Place of Care, 291 JAMA 88, 89, 91-92 (2004); SUPPORT Principal Investigators, A Controlled Trial To Improve Care for Seriously Ill Hospitalized Patients: The Study To Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), 274 JAMA 1591, 1592 (1995); KARL LORENZ ET AL., EVIDENCE REPORT/TECHNOLOGY ASSESSMENT: END OF LIFE CARE AND OUTCOMES: SUMMARY 2-3 (2004), available at http://www.ahrq.gov/clinic/epcsums/eolsum.pdf.

3 Amy S. Kelley & Diane E. Meier, Editorial, Palliative Care — A Shifting Paradigm, 363 NEW ENG.
will review in detail the differences between nonhospice palliative care and hospice palliative care, as well as the policy implications for these differences. We will review how palliative care and hospice are provided. In addition, we will review the evidence base regarding the benefits of palliative care for patients and their families on quality of care in various settings of care. Next, we will examine the data demonstrating the cost savings of palliative care for both Medicare and Medicaid recipients. Finally, we will discuss the opportunities for palliative care to provide a solution to the problems facing the health care system in the United States.

II. Palliative Care versus Hospice: What are the differences?

The primary focus of palliative care is to improve the quality of life for patients and their families, with an emphasis on the needs and goals of the patient and family, independent of prognosis. Interdisciplinary palliative care teams accomplish this goal by improving pain and other symptom control, clarifying goals of care, and guiding treatment decisions to meet those goals. In addition, palliative care teams are knowledgeable about community services to assist patients and their families outside of the hospital, and the teams collaborate with other providers across settings of care,

![Diagram](image)

**FIGURE 1.** National Consensus Project for Quality Palliative Care, 2004.

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J. MED. 781, 781-82 (2010), available at http://www.nejm.org/doi/pdf/10.1056/NEJMe1004139. "Nonhospice palliative care is offered simultaneously with life-prolonging and curative therapies for persons living with serious, complex, and life-threatening illness." Id. at 781. Study results "show that palliative care is appropriate and potentially beneficial when it is introduced at the time of diagnosis of a serious or life-limiting illness — at the same time as all other appropriate and beneficial medical therapies are initiated." Id. at 782.

In the United States, palliative care is broadly offered either as a Medicare hospice benefit, which is known as hospice palliative care, or alternatively as a medical service outside of hospice, known nonhospice palliative care. Whereas hospice delivery is dependent on prognosis, palliative care is available to patients with serious, complex, and life-threatening illness independent of their prognosis and is offered simultaneously with life-prolonging and curative therapies (see Figure 1). Experts advocate that when a patient is diagnosed with a serious illness, palliative care should be started and continue simultaneously with curative or disease-modifying treatments. Patients and families are vulnerable at the time of diagnosis of serious illness and the introduction of palliative care at this time allows for providers with expertise in communication to ensure that the goals of the patient and family are at the forefront of the medical care.

In the United States, there is a firm distinction between palliative care and hospice, based on prognosis. Hospice was initially established under Medicare with the goal to provide comprehensive, interdisciplinary, team-based palliative care for patients with an easily identifiable short prognosis.\footnote{Id. at 345-46.} In contrast to palliative care, the Medicare Hospice Benefit is primarily available to patients with a prognosis of living for six months or less, if the disease follows its natural course, as determined by two physicians.\footnote{John J. Mahoney, The Medicare Hospice Benefit—15 Years of Success, 1 J. Palliative Med. 139, 141 (1998).} Furthermore, in order to become eligible for hospice, patients must agree to relinquish insurance coverage for curative or life-prolonging therapies.\footnote{R. Sean Morrison & Diane E. Meier, Palliative Care, 350 New Eng. J. Med. 2582, 2586 (2004) (explaining that this applies to those individuals who receive Hospice services under the Medicare benefit).} The optimal time for enrollment in hospice is when curative treatments become more harmful than beneficial, or when patients are in the last weeks or months of life.\footnote{See id. at 2583 (explaining that when dealing with advanced diseases, a burden versus beneficial analysis regarding treatment choices may be necessary); National Consensus Project for Quality Palliative Care: Clinical Practice Guidelines for Quality Palliative Care, Executive Summary, 7 J. Palliative Med. 611, 616 (2004) (acknowledging that the plan for palliative care may change with time, as the benefit to burden ratio is constantly reevaluated); NATIONAL QUALITY FORUM, A NATIONAL FRAMEWORK AND PREFERRED PRACTICES FOR PALLIATIVE AND HOSPICE CARE QUALITY: A CONSENSUS REPORT VII (2006), http://www.rwjf.org/files/research/txPHreportPUBLIC01-29-07.pdf (outlining standards for physicians to follow with palliative care, including a recurring...} Unlike many other
models of care delivery, hospice focuses its care on both the patient and their family, such that the hospice care team continues to care for the family caregivers after the death of their loved one with bereavement services.9

Eligibility to receive palliative care, on the other hand, is based on need without a prognostic restriction. Because patients with serious illness but without a prognosis of living six months or less still face considerable unmet needs, hospital-based non-hospice palliative care in the United States has grown rapidly. As of 2009, sixty-three percent of U.S. hospitals and eighty-five percent of hospitals with more than 300 beds reported the presence of a palliative care program – an increase of 140 percent from 2000.10

III. How Does Palliative Care Meet the Needs of Seriously Ill Patients and Families?

Multiple reports have shown that patients with a serious illness and their families do not receive the quality of care that they deserve. Studies have demonstrated that these patients and their families receive poor quality medical care, and report untreated symptoms and unmet psychosocial and personal care needs, resulting in a tremendous burden for the caregiver, and low patient and family satisfaction.11 In contrast, multiple studies have demonstrated the benefits of palliative care for patients with serious illness in addressing these unmet needs. More specifically, palliative care

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9 See Morrison & Meier, supra note 7, at 2584 (explaining that an important aspect of palliative care is providing bereavement services to both patients and caregivers). It is not uncommon that some family members receive bereavement services for fourteen months after their loved one's death. Id.

10 See STATE-BY-STATE REPORT CARD, supra note 1, at 9. Compare R. Sean Morrison et al., Cost Savings Associated with US Hospital Palliative Care Consultation Programs, 168 ARCHIVES OF INTERNAL MED. 1783, 1783 (2008) [hereinafter Morrison et al., Cost Savings] (explaining that as of 2005, seventy percent of U.S. hospitals with more than 250 beds offered palliative care programs, which was a ninety-six percent increase from the year 2000), with R. Sean Morrison et al., America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals, 14 J. PALLIATIVE MED. 1094, 1095 (2011) [hereinafter Morrison et al., America's Care] (showing that as of 2011, eighty-five percent of hospitals with 300 or more beds offered palliative care programs).

11 See Teno et al., supra note 2, at 91-92 (explaining family perceptions of quality of end of life care); Kenneth E. Thorpe & David H. Howard, The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity, 25 HEALTH AFFAIRS 378, 385-86 (2006) (suggesting the type of clinical care patients received contributing to increased Medicare spending); SUPPORT, supra note 2, at 1596-97 (concluding that the scenario described by study of care for seriously ill and dying was not an “attractive” one).
teams improve physical and psychological symptoms, caregiver well being, and family satisfaction. The teams also prolong survival and reduce health care utilization and costs. Additionally, studies have demonstrated the ability of palliative care teams to reduce costs by addressing goals of care and assisting patients and families to choose treatments that meet these goals. This is achieved through care provided by interdisciplinary teams of physicians, nurses, social workers, spiritual counselors, pharmacists, aides, as well as physical therapists, psychologists, and others.

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12 See David Casarett et al., Do Palliative Consultations Improve Patient Outcomes? 56 J. AM. GERIATRIC SOC'Y 593, 597-98 (2008) (discussing results indicating palliative care can improve quality of end of life care); Laura P. Gelfman et al., Does Palliative Care Improve Quality? A Survey of Bereaved Family Members, 36 J. PAIN & SYMPTOM MGMT. 22, 25 (2008) (explaining that results show palliative care consultation services improve family-centered outcomes); Marit S. Jordehy et al., Quality of Life in Palliative Cancer Care: Results From a Cluster Randomized Trial, 19 J. CLINICAL ONCOLOGY 3884, 3891 (2001) (finding palliative cancer care increased family satisfaction among other benefits); Teno et al., supra note 2, at 92 (reporting satisfaction increased when palliative-care services provided).


14 See Morrison et al., Cost Savings, supra note 10, at 1785 (stating “patients receiving palliative care consultation had significantly lower costs” than usual patients who did not); Joan D. Penrod et al., Hospital-Based Palliative Care Consultation: Effects on Hospital Cost, 13 J. PALLIATIVE MED. 973, 976 (2010) (finding “palliative care during hospitalizations was associated with significantly lower direct hospital costs.”); R. Sean Morrison et al., Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries, 30 HEALTH AFF. 454, 457 (2011) [hereinafter Morrison et al., Palliative Care Consultation Teams] (finding overall results show “patients who received palliative care had significantly lower costs than patients who” did not).

15 Thomas J. Smith & J. Brian Cassel, Cost and Non-Clinical Outcomes of Palliative Care, 38 J. OF PAIN & SYMPTOM MGMT. 32, 33 (2009) (finding palliative care services can generate substantial savings through cost avoidance); Anthony L. Back et al., Impact of Palliative Care Case Management on Resource Use By Patients Dying of Cancer at a Veterans Affairs Medical Center, 8 J. PALLIATIVE MED. 26, 30 (2005) (finding palliative care patients received case management desired in original plan); Morrison et al., Palliative Care Consultation Teams, supra note 14, at 460; Joan D. Penrod et al., Cost and Utilization Outcomes of Patients Receiving Hospital-Based Palliative Care Consultation, 9 J. PALLIATIVE MED. 855, 857 (2006) (finding “[p]alliative care patients were more likely to be on medical services and less likely” admitted to intensive care); Ahmed Elsayem et al., Palliative Care Inpatient Service In A Comprehensive Cancer Center: Clinical and Financial Outcomes, 22 J. CLINICAL ONCOLOGY 2008, 2011 (2004) (discussing how nurses are overwhelmed by expectations and demands of palliative care patients’ families).

16 Others team members might include massage or yoga therapists, art therapists, occupational therapists, dieticians, speech pathologists and volunteers. See, e.g., Elsayem et al., supra note 15, at 2009.
This unique model of interdisciplinary care allows for a more holistic approach to patients and their families built on a foundation of expert communication skills. Specifically, palliative care or hospice teams have frequent open discussions with patients and their families to clarify goals of the medical care and coordinate care between the hospital setting and other settings of care, including home with or without hospice, nursing home with or without hospice, or inpatient hospice care. This frequent communication and coordination of care allows the palliative care or hospice teams to identify and rapidly treat distressing symptoms and this, in turn, helps reduce the risk for medical complications and frequent hospitalizations. Discussions with patients and families about the patient's prognosis and care, led by expert skilled communicators, result in lower costs of care, decreased family burden, as well as improved family satisfaction and bereavement outcomes.

In addition to these improvements in quality of care and reduction in cost, several recent studies have shown that both palliative care and hospice care improves survival in specific patient populations, as compared to patients who do not receive hospice or palliative care. A randomized controlled trial of early palliative care for

17 Paolo L. Mandredi et al., Palliative Care Consultations: How Do They Impact the Care of Hospitalized Patients?, 20 J. PAIN & SYMPTOM MGMT. 166, 170-173 (2000).
18 See id.; Marit S. Jordhøy et al., A Palliative-Care Intervention and Death at Home: A Cluster Randomised Trial, 356 LANCET 888, 888 (2000); R. Sean Morrison et al., A Novel Interdisciplinary Analgesic Program Reduces Pain and Improves Function in Older Adults Following Orthopedic Surgery, 57 J. AM. GERIATRIATRICS SOC'Y 1, 1 (2009) [hereinafter Morrison et al., Novel Program].
19 Alexi A. Wright et al., Place of Death: Correlations With Quality of Life of Patients With Cancer and Predictors of Bereaved Caregivers' Mental Health, 28 J. CLINICAL ONCOLOGY 4457, 4457 (2010) [hereinafter Wright et al., Place of Death]; Alexi A. Wright et al., Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment, 300 JAMA 1665, 1666 (2008) [hereinafter Wright et al., Associations Between].
20 See Wright et al., Place of Death, supra note 19, at 4457; Wright et al., Associations Between, supra note 19, at 1666; see also Baohui Zhang et al., Health Care Costs in the Last Week of Life: Associations With End-of-Life Conversations, 169 ARCHIVES INTERNAL MED. 480 (2009); Jan C. Hofmann et al., Patient Preferences for Communication With Physicians about End-of-Life Decisions, 127 ANNALS OF INTERNAL MED. 1 (1997); Holly G. Phiperson, Socialization to Dying: Social Determinants of Death Acknowledgement and Treatment Among Terminally Ill Geriatric Patients, 33 J. HEALTH SOC. BEHAV. 378 (1992); Jane C. Weeks et al., Relationship Between Cancer Patients' Predictions of Prognosis and Their Treatment Preferences, 279 JAMA 1709, 1714 (1998).
21 Temel et al., supra note 13, at 739; Marie Bakitas et al., Effects of a Palliative Care Intervention on Clinical Outcomes in Patients with Advanced Cancer: The Project ENABLE II Randomized Controlled Trial, 302 JAMA 741, 746-47 (2009); Stephen R. Connor et al., Comparing Hospice and Nonhospice Patient Survival Among Patients Who Die Within a Three-Year Window, 33 J. PAIN SYMPTOM MGMT. 238, 242 (2007); Bruce Pyenson et al., Medicare Cost in Matched Hospice and Non-Hospice Cohorts, 28 J. PAIN SYMPTOM MGMT. 200, 207 (2004).
patients with advanced lung cancer demonstrated the benefits of a model for concurrent oncologic care with palliative care.\textsuperscript{22} In this study, patients newly diagnosed with advanced non-small cell lung cancer who received palliative care simultaneous with standard oncologic care reported a better quality of life, had fewer depressive symptoms and survived 2.7 months longer than those who received oncologic care alone.\textsuperscript{23}

It is not clear which aspects of hospice or palliative medicine, or which benefits of these services result in this improved survival rate. Experts have considered multiple explanations for the prolongation of life, including a decrease in depression symptoms; the avoidance of being hospitalized and potentially harmful medical interventions associated with hospitalization; an improvement in symptom burden; and an enhanced family support, without which it would be difficult for patients to remain safely at home.\textsuperscript{24}

In an effort to develop standards and guidelines for palliative care, the National Quality Forum,\textsuperscript{25} the National Consensus Project for Quality Palliative Care,\textsuperscript{26} and the Joint Commission,\textsuperscript{27} have mandated that palliative care be provided by an interdisciplinary team of clinical staff, which includes members from disciplines of medicine, nursing, social work, spiritual counseling, pharmacy, and volunteers with training, credentialing, and certification in palliative care. It is also critical that the palliative care team be reachable twenty-four hours per day, seven days per week.

IV. How Do Palliative Care and Hospice Improve Health Care Value?

Although patients with serious illness and those with complex illness including multiple chronic conditions and functional impairment only represent about ten percent of all patients in the United States, these are the very patients who account for more than half of the nation's health care costs.\textsuperscript{28} Palliative care programs that focus on providing care for the seriously hospitalized patients are developing rapidly\textsuperscript{29} with more

\textsuperscript{22} Temel et al., \textit{supra} note 13, at 739.
\textsuperscript{23} Casarett et al., \textit{supra} note 12, at 596.
\textsuperscript{24} Meier, \textit{supra} note 4, at 349. A decrease in depression symptoms has been shown to be an independent predictor of mortality in multiple disease types. \textit{Id}.
\textsuperscript{25} NATIONAL QUALITY FORUM, \textit{supra} note 8, at VII.
\textsuperscript{26} National Consensus Project for Quality Palliative Care: Clinical Practice Guidelines for Quality Palliative Care, Executive Summary, \textit{supra} note 8, at 612-14.
\textsuperscript{27} Advanced Certification for Palliative Care, THE JOINT COMM'N, \url{http://www.jointcommission.org/assets/1/18/Palliative_Care_brochure_final_8-17-11.pdf} (last visited Apr. 18, 2012).
\textsuperscript{28} Meier, \textit{supra} note 4, at 348.
\textsuperscript{29} Benjamin Goldsmith, et al., \textit{Variability in Access to Hospital Palliative Care in the United States}, 11 J.
broadly mounting evidence of improvement in quality of care and reduction of costs of care for the sickest and most complex patients. Similarly, the Medicare-certified hospices, which deliver care to more than 1.5 million dying Americans every year (about forty-one percent of all Medicare deaths in 2009), are also associated with quality improvements and reductions in total health care spending.

Because our country is facing continually rising health care costs, it is vital to explore programs that can both improve quality of care and reduce costs of care. Palliative care and hospice programs are important approaches to improving health care value in our health care system. Multiple studies have demonstrated that palliative care program and hospice program offer this critical combination.
V. How Can Palliative Care and Hospice Reduce Health Care Spending?

In addition to the improvements in quality of care for these patients, palliative care consultation teams have also been shown to reduce costs by providing high quality patient-centered and family-focused care to the sickest and, therefore, costliest patients. The costliest Medicare beneficiaries are those patients with multiple chronic conditions or functional dependencies, those who are frequently hospitalized, those with dual eligibility for Medicare and Medicaid, and those in their last year of life.\(^{35}\) Data shows that ten percent of the sickest Medicare beneficiaries accounted for about fifty-seven percent of total program Medicare spending, calculated at about $44,220 per capita per year.\(^{36}\) Palliative care is most capable of caring for these patients and, when eligible, hospice services would continue to care for them. This system would both ensure these patients receive high quality care and reduce unnecessary utilization of health care services.

Palliative care and hospice programs are able to successfully ensure high quality care and appropriate health care utilization through aggressive symptom management and frequent discussions with patients and their families to clarify their goals of care. In turn, the programs can focus treatment and discharge plans to meet those delineated goals. These interventions can reduce costly and preventable hospitalizations, readmissions, and emergency department visits.\(^{37}\) Furthermore, with the improved care coordination and initiation of appropriate home care services, patients are able to remain in their homes and when these patients do return to the hospital, they are most likely to be admitted to the palliative care service or hospice program instead of a high-cost intensive care unit, where non-beneficial, potentially harmful and costly tests are avoided.\(^{38}\) There is compelling evidence that palliative care and hospice programs can reduce the likelihood of hospitalization for patients in the United States.\(^{39}\)

\(^{35}\) See Meier, supra note 4, at 346-47 (describing the high costs of care for patients who are eligible for palliative or hospice care who instead receive care in hospital settings).

\(^{36}\) Id. at 346.

\(^{37}\) See Abraham A. Brody et al., The Effects of an Inpatient Palliative Care Team on Discharge Disposition, 13 J. PALLIATIVE MED. 541, 543 (2010); Morrison, et al., Palliative Care Consultation Teams, supra note 14, at 459; Morrison, Cost Savings, supra note 10, at 1785, 1789; Albert L. Siu et al., The Ironic Business Case for Chronic Care in the Acute Care Setting, 28 HEALTH AFF. 113, 122 (2009); Alexander K. Smith et al., Emergency Department Experiences of Acutely Symptomatic Patients with Terminal Illness and Their Family Caregivers, 39 J. PAIN & SYMPTOM MGMT. 972, 975 (2010); Temel et al., supra note 13, at 738.

\(^{38}\) Meier, supra note 4, at 350 (discussing the average costs per patient).

\(^{39}\) See Brumley et al., supra note 30, at 998; Elsayem et al., supra note 15, at 2010; Morrison et al., Cost Savings, supra note 10, at 1786; Penrod et al., supra note 15, at 857; Smith & Cassel, supra note...
When specifically evaluating cost for hospitalized patients, palliative care consultation programs can save hospitals thousands of dollars per admission of adults with serious illness. A study examining data from eight geographically and structurally diverse hospitals serving low, medium, and high-cost markets, including 49,973 patients discharged alive and 4,726 patients who died in the hospital, demonstrates that palliative care consultation significantly reduces costs.\(^4\) Direct hospital costs could be reduced by nearly $1,700 per admission ($174 per day) for live discharges and $5,000 per admission ($374 per day) for patients who died.\(^4\) The average 400-bed hospital providing palliative care consultation to 500 patients during the year could see an annual net savings of $1.3 million.\(^4\) Perhaps most notable, decreases in costs consistently occurred forty-eight hours after the initial consultation, suggesting a shift in the intensity of care that occurs following palliative care consultation. This study provides evidence that, in addition to improving the quality of care, palliative care consultation can reduce costs of hospitalization.

In addition, the cost savings of palliative care, specifically in the Medicaid population, has been demonstrated.\(^4\) With Medicaid spending ballooning to $366 billion in 2009,\(^4\) states face a growing need to improve value by strengthening quality and reducing Medicaid costs. Unlike many of the other suggested initiatives, which include reducing payments to providers, reducing or eliminating services not mandated by the federal law, and narrowing Medicaid eligibility criteria, this study suggests that

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15, at 37; Smith et al., supra note 30, at 703; Taylor et al., supra note 32, at 1475-76; Temel et al., supra note 13, at 740; Wright et al., Associations Between, supra note 19, at 1668; Zhang et al., supra note 20, at 482, 484-85. But see Back et al., supra note 15, at 33 (among 265 terminally ill patients studied, palliative care patients had more frequent acute care hospitalizations, but shorter stays); Bakitas et al., supra note 21, at 744 (similarly sized study finding no statistically significant reduction in hospital or intensive care stays, or emergency room visits).

\(^4\) Morrison et al., Cost Savings, supra note 10 at 1784-85 (describing the study’s sample and results).

\(^4\) Id. at 1785.

\(^4\) Id. at 1789.

\(^4\) See generally Morrison et al., Palliative Care Consultation Teams, supra note 14, at 457 (discussing results of study that explored “the effect of hospital palliative care consultation teams on hospital costs for a group of Medicaid patients in New York State); see also infra notes 46-54 and accompanying text (detailing the study).

Hospital palliative care programs increase services to Medicaid beneficiaries while still reducing Medicaid spending.\textsuperscript{45}

More specifically, this study evaluated whether hospital palliative care consultation teams reduced hospital costs for Medicaid patients in New York State.\textsuperscript{46} The authors used hospital administrative data from four urban-based New York state hospitals to compare hospital costs of Medicaid patients receiving palliative care consultations to propensity score matched patients who received usual care.\textsuperscript{47} The hospitals included a community hospital, two academic medical centers, and a safety-net hospital.\textsuperscript{48} The initial sample included 1,717 patients discharged alive and 495 patients who died in the hospital.\textsuperscript{49} Patients receiving palliative care consultations had an average $6,900 reduction in hospital costs per admission.\textsuperscript{50} Those Medicaid patients who were discharged alive and received palliative care had an average decrease in hospital costs of $4,098 per admission whereas Medicaid patients who died in the hospital and received palliative care had an average decrease in hospital costs of $7,563.\textsuperscript{51} Moreover, patients who received palliative care also had lower costs for intensive care and higher rates of referral to outpatient hospice programs.\textsuperscript{52} Patients who received palliative care and died in the hospital spent less time, and were less likely to die, in an intensive care unit.\textsuperscript{53} This study further demonstrates that palliative care teams can reduce Medicaid costs while ensuring that a patient received high quality medical care that is consistent with their goals. Comparable cost savings have been associated with palliative care consultation in the Veterans' Affairs ("VA") hospital setting.\textsuperscript{54}

\textsuperscript{45} See Morrison et al., \textit{Palliative Care Consultation Teams}, \textit{supra} note 14, at 457-58.
\textsuperscript{46} See id., at 454-55.
\textsuperscript{47} Id. at 455-56. Rosenbaum and Rubin developed propensity scores as a means of controlling for confounding in observational studies and of blinding investigators to outcomes. See Paul Rosenbaum & Donald B. Rubin, \textit{The Central Role of the Propensity Score in Observational Studies for Causal Effects}, 70 \textit{Biometrika} 41, 41-43 (1983). In well-designed studies using propensity scores, the trial is constructed akin to a randomized control trial with clearly defined inclusion criteria and a carefully structured intervention. See id.
\textsuperscript{48} Id. at 455.
\textsuperscript{49} Id. at 456.
\textsuperscript{50} Id. at 459.
\textsuperscript{51} Morrison, et al., \textit{Palliative Care Consultation Teams}, \textit{supra} note 14, at 457.
\textsuperscript{52} Id. at 457-58.
\textsuperscript{53} Id.
\textsuperscript{54} See Joan D. Penrod, et al., \textit{Cost and Utilization Outcomes of Patients Receiving Hospital-based Palliative Care Consultation}, 9 \textit{J. Palliative Med.} 855, 857-58 (2006). Compared to patients receiving usual care, palliative care patients were forty-two percent less likely to be admitted to the intensive care unit ("ICU"). Id. at 857. Once admitted to the ICU, however, palliative care patients had a "significantly shorter stay." Id. Additionally, compared to usual care patients, palliative care
With the rapid expansion of palliative care programs now serving more than sixty percent of U.S. hospitals with more than fifty beds, hospital palliative care consultation programs affect approximately 1.5 percent of all discharges with an average net cost savings per-patient per-admission of $2,659 or approximately $1.2 billion per year in savings. Experts aim for continued penetration of palliative care services to reach 6 percent of hospital discharges at ninety percent of all U.S. hospital with more than fifty beds, to achieve a savings of approximately $4 billion per year. Similarly, hospice care has been shown to reduce total health care costs for the majority of Medicare beneficiaries receiving it. The estimated average cost savings of $2,300 per hospice beneficiary on average, compared with similar patients not receiving hospice services would yield an overall savings of more than $3.5 billion a year for the 1.6 million patients served. Furthermore, the cost savings for both cancer and non-cancer patients persisted for those patients with longer enrollments in hospice. Of note, in contrast to the patients who remained enrolled in hospice, those with cancer who disenrolled from hospice had costs of care that were nearly five times higher, and those patients are more likely to have emergency department visits and hospitalizations. These data demonstrate how hospice reduces health care utilization and costs.

VI. In Which Settings of Care has Palliative Care Demonstrated Improvements?

A significant amount of research has focused on the quality improvements and cost savings benefits of palliative care in the hospital setting, which has caused a significant expansion of palliative care in the hospital setting. In spite of this expansion of palliative care in the hospital setting, there is still limited availability of outpatient or home-delivered palliative care programs. Nevertheless, studies have demonstrated that palliative care services improve quality of care for patients outside of the inpatient hospital setting. We will describe how, in using innovative models of care, palliative care patients had significantly lower total direct costs per day, on average saving of $239.00 daily. Similarly, palliative care patients spent, on average, $98.00 less on ancillary cost per day compared to usual care patients.

55 See Benjamin Goldsmith, et al., Variability in Access to Hospital Palliative Care in the United States, 11 J. PALLIATIVE MED. 1094, 1096-98 (2008); STATE-BY-STATE REPORT CARD, supra note 1, at 9.
56 Meier, supra note 4, at 351.
57 Id. at 350-51.
58 Taylor Jr. et al., supra note 32, at 1471.
59 Meier, supra note 4, at 351.
60 Taylor Jr. et al., supra note 32, at 1473-74.
61 See Melissa D.A. Carlson et al., Impact of Hospice Disenrollment on Health Care Use and Medicare Expenditures for Patients With Cancer, 28 J. CLINICAL ONCOLOGY 4371, 4374 (2010).
62 See Meier, supra note 4, at 354-56.
has been shown to be beneficial in multiple other settings, including the outpatient setting, home care, care management, long-term care settings, and through telemedicine.

**A. Outpatient Palliative Care**

The outpatient service offers specialist-level palliative care services either as a brief consultation or as a concurrent care model, in collaboration with the patient’s primary treating physician. In addition, outpatient palliative care programs offer the following services: (1) immediate follow-up after discharge, (2) ensure that the care plans developed in the hospital are continued outside the hospital, (3) verify medications to be continued in the outpatient setting, and (4) remain available to respond to the questions and concerns of patients and families after they are discharged from the hospital. Outpatient palliative care services can provide improved continuity of care, reduce unnecessary re-hospitalizations, and address the needs of patients and caregivers.

In one controlled trial of an intervention, an interdisciplinary team offered palliative medicine consultation and direct services to outpatients, their families, and their primary care physicians, in addition to usual primary care. Over the course of one year, the trial found that patients who received the intervention had fewer physical, psychological, and spiritual symptoms, as well as improvements in their advance care planning. Furthermore, the patients who received the intervention had reduced health care utilization with fewer primary care and urgent care visits, without an associated increase in specialty clinic visits, emergency department visits, number of hospitalizations, or number of days hospitalized.

Many opportunities exist in integrating palliative care into outpatient specialty practices. In the previously discussed study, patients newly diagnosed with metastatic non-small cell lung cancer were randomly assigned to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone in the outpatient setting. As compared with patients receiving standard care, those who received palliative care reported significant improvements in quality of life and mood as

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63 Diane E. Meier & Larry Beresford, *Outpatient Clinics are a New Frontier for Palliative Care*, 11 J. PALLIATIVE MED. 823, 823 (2008).
64 Id.
65 Id.
67 Id.
68 Id. at 88-89.
well as less aggressive care and longer survival. Another study examined the impact of outpatient oncology palliative care services on patients with metastatic cancer and found improvement in both symptom control and patient satisfaction. Furthermore, the authors found that the integration of palliative care consultation into the oncology services was feasible.

Unfortunately, outpatient palliative care services are relatively less common. A study, which examined the characteristics of outpatient palliative care services associated with California hospitals, found that outpatient palliative care services are rare compared with inpatient services and most were only very recently established. Outpatient palliative care services are typically interdisciplinary, with nurses acting as core care providers. Although the existence of hospital palliative care teams may lead to the launching of outpatient palliative care programs, more efforts are needed to expand outpatient and community-based palliative care services. These outpatient and community-based services will offer better continuity between the inpatient settings and avoidance of unnecessary re-hospitalizations and emergency department visits. In addition, further research must be conducted to better understand the clinical impact of outpatient palliative care practices, as well as health care utilization and cost outcomes.

B. Care Management Models Employing Home-Based Palliative Care

Care management programs are increasingly being designed to improve medical care for patients with complex and chronic illness in an effort to achieve high quality, cost effective care and to improve coordination of care. With the development of these programs, specialized care management programs are focusing on the care of the chronically ill with advanced illness. A Kaiser Permanente home-based palliative care

69 Temel et al., supra note 13, at 733; see supra notes 21-22 and accompanying text. The median survival for such patients improved from 8.9 months to 11.6 months. Temel et al., supra note 13, at 733.
71 Id. at 211.
73 Id. at 2058.
74 Meier & Beresford, supra note 63, at 823.
75 Michael W. Rabow et al., Outpatient Palliative Care Practices, 170 ARCHIVES INTERNAL MED. 654, 655 (2010).
76 Richard D. Brumley et al., Effectiveness of a Home-Based Palliative Care Program for End-of-Life, 6 J. PALLIATIVE MED. 715, 716 (2003).
management program enrolled patients with life-threatening illness and a prognosis of approximately one year or less to live, to evaluate the efficacy of a palliative care program for end-of-life care at home. The authors found that patients who received the palliative care intervention had improved satisfaction with care, a decrease in acute care service use (including hospital days and emergency department visits), a reduction in medical costs of care by forty-five percent, and were most likely to die at home.

Similarly, the Advanced Illness Coordinated Care Program was designed as a care coordination and support program to improve care for patients coping with advanced illness and preparation for end-of-life care. As a pilot program for patients with advanced illness, the investigators enrolled patients with advanced cancer, chronic obstructive pulmonary disease, or chronic heart failure and found increased patient and family satisfaction and improved advance care planning.

Another similar model of care, the Patient-Centered Management ("PCM") model of care, is a "comprehensive patient-focused collaboration that includes end-of-life and pain management, education, provider coordination, and patient advocacy." One patient-centered management model enrolled patients who had a life-limiting diagnosis with multiple co-morbid conditions from a large not-for-profit health maintenance organization in California. The patients who received the PCM model had a reduction in hospital admissions by thirty-eight percent, hospital days by thirty-six percent, and emergency department visits by thirty percent. In addition, the PCM patients had a total cost savings of more than twice the cost of the PCM program. Furthermore, the PCM patients had a reduction in poorly controlled symptoms, improvement in care coordination, and a high level of patient satisfaction, all without any change in survival.

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77 Id. at 716-17.
78 Id. at 720-21.
80 Id. at 96.
82 Id.
83 Id. at 84, 89. These reductions in utilization were as compared to the control group that received usual case management. Id. at 85.
84 Id. at 88-89.
85 Id. at 90-91.
Another example of using the PCM was an integration of case management with formal palliative care assessment, conducted as a collaboration between the palliative care team at Mount Sinai Medical Center and Franklin Health (now Paradigm Health) – an independent for-profit complex care management program. The Franklin Health PCM project integrated palliative care assessment, intervention, and goals of care discussions into an existing home-based care management model. This PCM program with integrated palliative care resulted in both an enhanced quality of patient care that was feasible and an effective approach to improving the care of seriously ill patients in the community.

Each of these care home-based management programs is an example of care management program that has successfully integrated palliative care services as a component of disease management in the home setting. These programs demonstrate that it is not only feasible to integrate palliative care into disease specific management in the home setting, but also show the benefits of improved satisfaction and reduction in costs. The combination of feasibility, improved satisfaction, and cost reduction make the case for continued integration of palliative care services into the management of disease in the home.

C. Palliative Care in the Long-Term Care Setting

When patients are ready to leave the hospital, but cannot go home, they are forced to consider the limited options for post-acute care. These options include nursing homes with or without hospice, inpatient hospice, or residential care with or without hospice. Most post-acute care is provided in nursing homes. Although most people would prefer to die at home, a quarter of all deaths in the United States occur in long-term care facilities. Unfortunately, studies have shown that family caregivers are least satisfied

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86 Diane E. Meier et al., Integrating Case Management and Palliative Care, 7 J. PALLIATIVE MED. 119, 121 (2004).
87 See id. at 127-29 (discussing the structure of the program). The collaboration “was a vehicle to export palliative care out of the hospital or office, and into the home setting where the majority of seriously ill patients reside.” Id. at 127.
88 See id. at 130-32 (evaluating the program created by the collaboration). An evaluation of the preliminary results of the collaboration found that the collaboration’s model “increase[d] the level of patient and family satisfaction with care.” Id. at 131. Clinicians were also happy with the training the model provided them. Id. In addition, the model is “flexible and can be applied to a range of patient populations in a variety of plan arrangements.” Meier et al., supra note 86, at 131.
89 See Laura C. Hanson & Mary Ersek, Meeting Palliative Care Needs in Post-Acute Care Settings, 295 JAMA 681, 682 (2006) (noting that twenty-three percent of deaths occurred in nursing homes in 2001).
with conventional nursing home care. Furthermore, patients who die in the nursing home setting report unrelieved pain and emotional distress, as well as unmet personal care needs and unmet communication needs about treatment decision making.

Many palliative care leaders have called for improved palliative care in long-term care settings, including nursing homes and residential care facilities, with a specific focus on advance care planning, staff training, and changes in clinical care practices. Different innovative projects to improve quality of care in the nursing home setting have included integrating palliative care. These interventions include successful integration of advance care planning into the nursing home setting, training of nursing staff in palliative care, and increase in quality improvement measures such as symptom management, documented advance care planning discussions, and hospice enrollment. More specifically, many interventions have shown benefits from successful

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90 See Teno et al., supra note 2, at 91 (noting that the highest levels of dissatisfaction with end of life care came from family members of patients who ended their lives in nursing homes).
91 See Kimberly Reynolds et al., Needs of the Dying in Nursing Homes, 5 J. PALLIATIVE MED. 895, 898-99 (2002) (describing unmet needs of nursing home residents); Jennifer R. Levin et al., Life-Sustaining Treatment Decisions for Nursing Home Residents: Who Discusses, Who Decides and What is Decided? 47 J. AM. GERIATRICS SOC'Y 82, 82 (1994) (noting “the majority of nursing home residents have not executed an advance directive, and . . . most nursing home residents have not discussed life-sustaining care with their family members or physicians”); Bruce A. Ferrell, Pain Evaluation and Management in the Nursing Home, 123 ANNALS INTERNAL MED. 681, 681 (1995) (discussing general lack of research and education about appropriate pain management in nursing homes); Elizabeth H. Bradley et al., Discussions About End-Of-Life Care in Nursing Homes, 46 J. AM. GERIATRICS SOC'Y 1235, 1235 (1998) (measuring frequency of discussions about end-of-life care and finding such discussions relatively infrequent in nursing homes).
92 Hanson & Ersek, supra note 89, at 681 (introducing the topics and findings of this article).
93 See generally id. There has been an increase in training nursing home staff so that they have the requisite knowledge and resources in palliative care. Id. at 685.
94 See Muriel Gillick et al., A Patient Centered Approach to Advance Medical Planning in the Nursing Home, 47 J. AM. GERIATRICS SOC'Y 227, 229-30 (1999). This is critical in nursing homes especially, due to the elderly having an increased chance of being diagnosed with serious illnesses. Id; see generally Muriel Gillick, Adapting Advance Medical Planning for the Nursing Home, 7 J. PALLIATIVE MED. 357, 357 (2004) (discussing need of this intervention due to needs of those who populate nursing homes).
95 See Mary Ersek et al., Enhancing End-of-Life Care in Nursing Homes: Palliative Care Educational Resource Team (PERT) Program, 8 J. PALLIATIVE MED. 556, 556-57 (2005). As nursing homes are becoming increasingly populated with a growing elderly population, a decrease in trained nursing home staff is becoming apparent. Id. at 556. Educating nursing home staff has shown to increase the requisite skills in order to improve nursing home patients' quality of life. Id. at 557.
96 See generally Laura C. Hanson et al., A Quality Improvement Intervention to Increase Palliative Care in Nursing Homes, 8 J. PALLIATIVE MED. 576 (2005) (discussing various interventions and the quality of care each provides).
collaborations between hospice organization and nursing homes. These benefits include better pain management, fewer hospitalizations, and improved family satisfaction with end-of-life care.

The patients with advanced dementia living in nursing home are faced with particular barriers to receiving palliative care. For example, there are enrollment barriers for patients who want to be enrolled in hospice as a Medicare benefit and receive simultaneous care in a skilled nursing facility. In addition, it can be particularly challenging to determine a six-month prognosis for patients with advanced dementia that can, therefore, create another barrier to hospice enrollment. Nevertheless, there are clear benefits for patients with advanced dementia to receive hospice care. One study demonstrated that patients with advanced dementia who are nursing home residents and enrolled in hospice are less likely to die in the hospital and more likely to report a higher quality of life, as compared to patients who are not enrolled in hospice. More research needs to be conducted to determine the quality of care benefits and cost savings of further integrating palliative care into long-term care settings.

D. Palliative Care Integrated into Telemedicine

"Telemedicine is the use of telecommunications and information technologies ... to provide clinical care and health education to patients and professionals when distance separates the patients." Telephone-based palliative care is another innovative

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100 Susan C. Miller et al., Dying in U.S. Nursing Homes with Advanced Dementia: How Does Health Care Use Differ for Residents with, Versus without, End-Of-Life Medicare Skilled Nursing Facility Care?, 15 J. PALLIATIVE MED. 43, 49 (2012).
102 See Miller et al., supra note 100, at 49.
103 Froukje Duursma et al., Study Protocol: Optimization of Complex Palliative Care at Home Via Telemedicine, A Cluster Randomized Controlled Trial, BMC PALLIATIVE CARE, no. 13, 2011, at 1, 2.
way to deliver quality of care for patients with serious illness at home who have no other palliative care services available to them. A randomized controlled trial of advanced-practice nurse-administered, telephone-based, intensive palliative care intervention for patients newly diagnosed with advanced cancer found that, compared with participants receiving usual oncology care, patients who received the nurse-led, palliative-care intervention had improved quality of life and mood, without differences in resource utilization.\textsuperscript{104} There is limited data available on telemedicine for patients in need of palliative care and more research needs to be conducted to explore its potential benefits.

VII. Opportunities for Palliative Care to Promote Health Care Reform

By efficiently and effectively improving quality of care for the most seriously ill patients, palliative care offers a critical opportunity for health reform. The data has demonstrated how palliative care and hospice care improves both the quality of care for seriously ill patients and their families and reduces cost.\textsuperscript{105} Furthermore, recent public opinion research has shown that, once informed about palliative care, ninety-two percent of the American public is highly likely to consider palliative care for themselves or their families if they have a serious illness.\textsuperscript{106} Ninety-two percent also said that it is important that palliative care services be made available at all hospitals for patients with serious illness and their families throughout the United States.\textsuperscript{107} In spite of this recent public opinion poll and the data demonstrating the potential for palliative care and hospice care to improve quality and reduce cost, the Affordable Care Act does not call for a mandate to integrate palliative care and hospice into new health care delivery and payment models.\textsuperscript{108}

\textsuperscript{104} Bakitas et al., supra note 21, at 747.
\textsuperscript{105} See supra notes 11-61 and accompanying text.
\textsuperscript{107} Id. at 13. "Ninety-two percent of respondents say they would be likely to consider palliative care for a loved one if they had a serious illness." Id. "Ninety-two percent of respondents say it is important that palliative care services be made available at all hospitals for patients with serious illness and their families." Id.
\textsuperscript{108} Meier, supra note 4, at 366 (emphasizing integration of palliative care and hospice program could be integrated into the new delivery model, but it is not mandated).

Although not mandated in the ACA, the new law does enable the integration and participation of palliative care and hospice programs as a component of the new delivery and payment models, such as accountable care organizations (ACOs), patient-centered medical homes (\ldots also known as Health Homes),
The rapid growth of palliative care programs in the last decade demonstrates the increasing demand for care tailored to patients with serious illness who do not have a predictable prognosis and are, therefore, not eligible for hospice. With the expansion of palliative care programs, there is a need for a national workforce trained and experienced in caring for this patient population, such that most mid- to large-size hospitals in the U.S. already have palliative care teams with relevant skills.\textsuperscript{10}

In light of the growing demand of creating innovative, cost-effective health care delivery models, palliative care and hospice teams could be integrated into these delivery models to provide effective communication with patients and their families to clarify goals of care consistent with patient's wishes. These new delivery models, such as accountable care organizations ("ACOs"), patient-centered medical homes (also known as "Health Homes"), and the bundling of payments for a single episode of health care,\textsuperscript{11} focus on improving the quality of care and reducing costs of care for seriously ill patients with complex care needs.\textsuperscript{11}

VIII. What Is Necessary for Palliative Care's Success?

Despite the considerable growth in the number of palliative care programs across the United States, limitations in the workforce, research funding, and access to services prevent full availability of palliative care for all patients facing serious illness and their families.\textsuperscript{12} Policy experts advocate for: (1) an investment in a trained workforce to both care for these patients and teach the principles of palliative care, (2) an investment in research to build the palliative care and improve quality of care, and (3) an investment in the growth of palliative care access in various settings of care through improvement in payment, regulatory, and accreditation standards.\textsuperscript{13}

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\textsuperscript{10} Id. (contrasting the general need for professional skills to carry out the ACA's goals against palliative care and hospice programs that have a well trained staff).

\textsuperscript{11} Id. ("Each of these models aims to improve quality and control cost for high-need patient populations . . .").

\textsuperscript{12} Id. at 354.

\textsuperscript{13} Meier, supra note 4, at 357-63 (discussing assorted policy suggestions).
A. Train Workforce in Palliative Care

A major challenge to creating effective new delivery and payment models is that health care providers in the United States are not currently trained in the professional skills necessary to care for patient populations with serious and advanced illness, and complicated care needs. Experts call for mandatory training in pain and symptom management, communication about goals for medical care, and management of serious and complex illness both in and outside hospitals at all levels of training, including undergraduate, graduate training, and midcareer levels.

In spite of the growing demand, there is a dramatic shortage of palliative medicine physicians. Where there is approximately one cardiologist for every seventy-one persons experiencing a heart attack and one oncologist for every 141 newly diagnosed cancer patients, there is only one palliative medicine physician for every 1,200 persons living with a serious or life-threatening illness.

There are many factors driving this shortage, including limited training spots for graduate-level training and a lack of Medicare funding for graduate-level training. Palliative medicine became a formal sub-specialty in 2007, yet as of 2012, there were only eighty-three accredited subspecialty training fellowship programs in the United States, producing about 210 new palliative medicine physicians per year. Although Medicare funding currently supports the majority of residency training for physician specialties in the United States, it does not support palliative medicine specialty training. Therefore, palliative medicine fellowship training programs are dependent on philanthropy for funding support.

Policy experts have suggested specific policy initiatives to address the lack of a specialty trained physician workforce. These initiatives include initiating Medicare funding for palliative medicine fellowship training, loan forgiveness for palliative care physicians and nurses, development of federally funding palliative care career

114 See id. at 356.
116 Meier, supra note 4, at 356.
117 STATE-BY-STATE REPORT CARD, supra note 1, at 6.
118 See Meier, supra note 4, at 356-64.
120 See Meier, supra note 4, at 363.
121 Id.
development awards, and a mandate to integrate core palliative care training as a criteria for state licensure.\textsuperscript{122}

\textbf{B. Research Funding for Palliative Care}

Increased funding for palliative care research is needed to strengthen clinical practice and improve health care delivery that will maximize quality of life for patients facing serious and chronic illnesses and their families. The National Institutes of Health ("NIH") and the Institute of Medicine have repeatedly called for substantial investments in palliative care research.\textsuperscript{123} In spite of calls for investments in palliative care, one study found that more than twenty-five percent of published palliative medicine research was performed without any acknowledged extramural funding and less than one-third of published studies were supported by NIH funding.\textsuperscript{124} Furthermore, although the leading causes of death in the United States are cancer, dementia, and diseases of the heart, lung, and kidney, fewer than one percent of all funded grants by the National Cancer Institute, National Heart, Lung and Blood Institute, National Institute on Diabetes, Digestive and Kidney Diseases, and the National Institute on Aging were awarded to investigators performing palliative medicine research.\textsuperscript{125} While the growth of the palliative care field has been remarkable, a strong evidence base is required to support the clinical practice of its core domains, including symptom management, communication skills and care coordination. To address the need for investment in palliative care, policy experts advocate for specific focus areas and funding mechanisms for palliative care research in all NIH institutes, the Agency for Health care Research and Quality ("AHRQ"), and the Veterans Affairs.\textsuperscript{126}

\textbf{C. Securing Access to Palliative Care}

As of 2009, sixty-three percent of U.S. hospitals with at least fifty beds and eighty-five percent of hospitals with more than 300 beds reported the presence of a palliative care team.\textsuperscript{127} About 1,568 hospitals out of a total of 2,489 hospitals nationwide offer some type of palliative care service.\textsuperscript{128} While this represents an increase of 138

\begin{itemize}
\item \textsuperscript{122} \textit{Id.} at 360-65.
\item \textsuperscript{123} Laura P. Gelfman & R. Sean Morrison, \textit{Research Funding for Palliative Medicine}, 11 J. PALLIATIVE MED. 36, 37-38 (2008).
\item \textsuperscript{124} \textit{Id.} at 38.
\item \textsuperscript{125} \textit{Id.}
\item \textsuperscript{126} Meier, \textit{supra} note 4, at 360-61.
\item \textsuperscript{127} \textit{STATE-BY-STATE REPORT CARD}, \textit{supra} note 1, at 9.
\item \textsuperscript{128} \textit{Id.}
\end{itemize}
percent from 2000, there are significant opportunities for growth in multiple settings of care, including the hospital, home-based care-management, and long-term care, because palliative care has been demonstrated to improve quality and decreases costs in each of these settings.\textsuperscript{129}

Aside from physician and nurse practitioner fee-for-service reimbursement by most private insurance, Medicare, and Medicaid, hospital palliative care programs are funded by a business model of cost avoidance rather than on revenue generation.\textsuperscript{130} By reducing unwanted and unnecessary utilization, palliative care programs have advocated successfully for hospital support. There is still a need for policy solutions to increase access to quality palliative care, such as enhancing the reimbursement structure for palliative care in multiple settings of care with a billing structure that reflects the complexity of the patients for whom palliative care clinicians provide care.\textsuperscript{131} In addition, new models of health care delivery should ensure access to palliative care as a core component of available services to reduce the high costs and improve the poor quality of care received by patients with serious illnesses. Finally, all U.S. hospitals, nursing homes, and home care agencies should be required to have palliative care teams with meeting quality standards in order to receive accreditation.

IX. Conclusion

The growth of palliative care and hospice in the United States reflects a response to the expanding population of seriously ill patients and their families. There is a growing body of evidence supporting the quality improvement benefits of palliative care, as well as cost reduction for patients with Medicare, Medicaid, and VA coverage across care settings. In spite of this mounting evidence, the further expansion of palliative care services is limited by a deficient workforce, lack of funding for palliative medicine research, and restricted access to palliative care services in inpatient, outpatient, and community settings. The goal to ensure access to high-quality palliative care for all Americans who might benefit requires the expansion of training of providers in palliative care, the development of an evidence base to ensure quality and the expansion of capacity of health care organizations to provide palliative care.\textsuperscript{132}

\textsuperscript{129} Id.
\textsuperscript{130} R. SEAN MORRISON ET AL., Palliative Care, Access, Quality, and Costs, in THE HEALTH CARE IMPERATIVE: LOWERING COSTS AND IMPROVING OUTCOMES: WORKSHOP SERIES SUMMARY 498, 503 (Pierre L. Yong et al., eds., 2010).
\textsuperscript{131} See Meier, supra note 4, at 356.
\textsuperscript{132} See id.
Specific initiatives have supported the expansion of access to palliative care to date. These include the American Medical Association’s nationally disseminated physician education initiative Education for Physicians in End-of-Life Care, the American Hospital Association’s annual Circle of Life awards,133 and the Joint Commission’s new Advanced Certification Program for Palliative Care,134 which is designed to recognize hospital inpatient programs that demonstrate exceptional patient and family-centered care in order to optimize the quality of life for patients with serious illnesses. The national efforts, which are primarily driven by health care reform, that ensure that all palliative care programs deliver high quality care135 must continue to expand with an emphasis on patient-centered quality care, that avoids preventable and potentially dangerous hospitalizations across the system.136 With continued support from the private sector and growing support from the government, palliative care will continue to grow, such that high quality cost-effective palliative care can be offered to all seriously ill patients and families in the United States.

133 Id. at 369-70.
135 Id.
136 See Richard Brumley et. al., Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care, 55 J. AM. GERIATRICS SOC’Y 993, 993-94 (2007); Randall Krakauer et. al., Opportunities to Improve the Quality of Care for Advanced Illness, 28 HEALTH AFF. 1357, 1357 (2009); Claire M. Spettell et. al., A Comprehensive Case Management Program to Improve Palliative Care, 12 J. PALLIATIVE MED. 827, 827 (2009).