

Promoting health equity in palliative care: strategies for hospital and health system leaders

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One of the most pressing goals in palliative care is promoting greater health equity as “the absence of unfair, avoidable or remediable differences among groups of people” defined socially, economically, demographically, geographically or by other dimensions (1). Palliative care’s model of whole person care is uniquely poised to promote health equity by tailoring care in multiple dimensions including medical, psychosocial, and spiritual, to the unique needs of an individual (2).

Historically underserved populations face disproportionate barriers to accessing palliative care services, reflecting broader structural and social inequities. A review of sociodemographic disparities in access to palliative care and hospice services found differences in outcomes based on participants’ race or ethnicity, sociodemographic and/or insurance status (3). For example, opioid analgesic dispensing varies by racial composition of communities across all socioeconomic levels, raising concerns about inequitable access to effective pain medication and disproportionate impacts of policies governing opioid analgesic availability on certain groups (4). Moreover, critically ill patients from lower socioeconomic or racially and ethnically minoritized groups can experience higher mortality rates despite receiving more high-intensity life-sustaining treatments near the end of life (5,6). These and other disparities undermine the ability for palliative care to improve outcomes across populations.

To promote greater health equity, hospital and health

system leaders should reimagine how palliative care is delivered and integrated within other health care services. In this article, we offer three potential strategies that leaders can consider for driving progress: building greater skills and capabilities among non-palliative care clinicians, more tightly integrating palliative and other ambulatory services, and redesigning care delivery and payment models.

Skills and capabilities among non-palliative care clinicians

The substantial nationwide shortage of palliative care clinicians will likely persist for the foreseeable future (7). One consequence of this shortage is that palliative care specialists cannot manage all patients’ palliative care needs. To meet patient needs, it is therefore a pragmatic imperative to equip non-palliative care clinicians (e.g., internal medicine subspecialists, surgeons, and clinicians from other specialties) with foundational palliative care skills and capabilities (8).

Foundational skills begin with communication. Communication that is empathetic, clear, and patient-centered is critical because it ensures that patients’ values and preferences are understood and helps to align care plans with their goals. Resources and frameworks, such as VitalTalk, Relationship-Centered Communication, and the Serious Illness Care Program, can serve as starting points (9,10).

Serious illness conversations are a critical component

of palliative care, but their success cannot be measured by a single outcome. Focusing on decisions made—such as transitioning to comfort measures or completing advance directives—does not capture the full scope of these conversations (11). There should also be emphasis on addressing patients' and families' needs and helping them cope with illness and its meaning (12). These emphases must be paired with assessment of patient understanding and experience through development and scaling up of patient-reported outcomes, shared decision-making, and other assessment tools, as well as pragmatic studies of patient understanding (13).

Other key skills include foundational skills in symptom assessment and management; care coordination for individuals with serious illness; and prognostication. Routine assessment and management of pain and other symptoms should be key skills among all clinicians who care for patients with serious illness. Clinicians should also have an understanding about indications for referral to palliative care specialists, such as complex or refractory symptoms. Additionally, given that about half of all Medicare decedents were enrolled in hospice at the time of death, it is important that all clinicians be able to prognosticate and identify hospice-eligible individuals and assist individuals with this transition of care (14). It is not feasible to require the involvement of a palliative care specialist to facilitate this transition for all patients initiating hospice services.

Such efforts should be implemented with recognition about the risk of clinician burnout. Potential strategies for minimizing clinician burden could emphasize existing trainings and forums and involve (I) leveraging time points such as onboarding, continuing medical education and recertification, to require education and demonstration of core palliative care knowledge and skills; (II) using forums such as morbidity and mortality conferences to systematically highlight palliative care competencies and tools (e.g., by regularly selecting cases that highlight such competencies and tools and the harms that can occur when they are absent); and (III) creating delivery models that pair palliative care and other clinicians together in a co-management or joint delivery approach to equip the latter with knowledge and skills.

In these steps, leaders should also work to reduce unwarranted inconsistencies in palliative care access and delivery. Currently, variation across hospitals and systems can lead to unequal care experiences for patients with palliative care needs (15). One fundamental problem with this variation is that different patients receive different levels

and degrees of palliative care in ways that could entrench or worsen disparities. Leaders can build off prior work to define, use, and track measures of potentially avoidable emergency department visits or hospitalization to create analogous measures of potentially unwarranted or avoidable measures of palliative care use. While imperfect, such measures would represent a pragmatic way to illuminate the issue an increase dialogue about unwarranted variation, which could be further assessed via quality improvement and other strategies.

However, leaders should also be mindful about preserved warranted variability based on patient preferences and shared decision-making. Achieving health equity involves achieving culturally-sensitive and tailored, not mechanically uniform, approaches. Though this balance is admittedly difficult to strike, it should nonetheless be an aspirational goal. Done with this goal in mind, building skills and capabilities among non-palliative care clinicians is an important strategy for addressing the palliative care workforce shortage and supporting an integrated approach to care delivery based on core services provided by a range of clinicians, with referral to specialized palliative services for complex cases. This approach can address access concerns by increasing the likelihood that patients with serious illness receive needed support from different members of their care teams.

Expanding overall access to palliative care services is a crucial first step for promoting equity given historical access barriers among underserved populations. Additionally, however, leaders can design strategies that are poised to have disproportionately larger impacts and address unmet needs among historically underserved populations in order to reduce disparities gaps. Such strategies could include interventions involving community-based outreach, training healthcare providers in cultural humility, and integration of palliative care in rural healthcare settings. These interventions could disproportionately benefit groups such as individuals with lower socioeconomic status, who may reside in rural areas, or individuals from racial or ethnic minority groups, who have historically faced challenges in care due to lack of cultural humility training, or who may benefit more from community-based outreach due to historical mistrust of the medical system (16).

Integration of palliative and other care services

Many health system leaders appreciate the importance and need for outpatient palliative care services—recognition

that has led to growth in the number of outpatient palliative care practices around the country (17). However, the presence of different services does not equate with integration between different services. For example, patients with cancer and other serious illnesses—individuals from populations that often benefit from palliative care—often experience fragmented care that can negatively impact their outcomes and quality of life (18,19). Suboptimal communication, collaboration, and coordination between palliative care specialists and other clinicians can exacerbate this fragmentation of care (20–22).

The problem of poor integration can disproportionately affect historically marginalized communities. Individuals from these groups can face challenges such as limited access to primary care or palliative services, language barriers, and socioeconomic disadvantages such as lack of reliable transportation or lack of or under-insurance. Addressing these barriers requires targeted strategies to ensure that all patients have equitable access to both primary and palliative care services.

Fortunately, there are opportunities to better integrate palliative and other care. In particular, close coordination and integration between palliative and primary care may be especially important for addressing disparities. Primary care clinicians play a pivotal ambulatory role by forming longitudinal relationships that facilitate understanding of patients' goals and preferences. Indeed, primary care involvement is associated with improved end-of-life care outcomes (23). Similarly, close coordination with an oncologist for a patient with advanced cancer or cardiologist for a patient with end-stage heart failure can ensure that all individuals including patients have a shared understanding of their care with all clinicians understanding the patient's overall goals and priorities whether those be to pursue all life-prolonging care, to focus on comfort and symptom management, or some other goal such as maximizing function and independence.

For insight about how to capture these benefits, leaders can look to precedents from other integration approaches, such as those used to integrate primary care and behavioral health. In particular, the collaborative care model is one evidence-based approach that has been used in which psychiatrists provide consultation to primary care providers who then deliver mental health care to patients. This effort was further supported with the implementation of behavioral health integration-specific Medicare billing codes (24). Developing innovative collaborative approaches that better integrate palliative and primary care could

play a role in improving patient outcomes and decreasing disparities.

Redesign of care delivery and payment models

Few would argue the value of building skills and capabilities among non-palliative care clinicians or the importance of more tightly integrating palliative care with other ambulatory services. However, these solutions cannot scale without unifying structures and incentives in order to have sustained impact on disparities.

Care delivery and payment models provide such structures and incentives. However, to be effective, these models should be redesigned to recast the value of palliative care. Anecdotally, within many health systems, the value of palliative medicine is framed based on cost savings—particularly end-of-life cost savings—from reductions in hospitalization or other health care utilization and earlier transitions to hospice care. While these changes can be clearly beneficial for some patients in particular scenarios, it is also myopic as a singular view about the value of palliative care.

Consider hospitalizations. For patients with serious illness and poor prognosis, hospitalizations are often viewed by payers and other stakeholders as low value or avoidable care. However, from a patient-centered perspective, there is an argument to be made that a subset of hospitalizations among these populations is necessary and beneficial. Given the nature of end-of-life care, hospitalizations can be a beneficial setting and an opportunity for care planning, expectation setting, exploration and updating of patient preferences, and ultimately, care plan changes.

Some hospitalizations exist on the critical path toward patient values-aligned decisions. Moreover, patients from racial and ethnic minority groups are more likely to receive goal-concordant care that could otherwise be considered “low-value” (services for which harms or costs outweigh benefits) at the end of life (6,25,26). Therefore, reimbursement models that penalize health systems for delivery of this care could further entrench disparities in healthcare. Different aspects of care delivery and payment models (e.g., in quality measurement, utilization benchmarking) could be redesigned to recognize this reality.

Model redesign has been shown to be helpful for advance care planning. For example, national advance care planning billing codes were introduced by the Centers for Medicare and Medicaid Services in 2016 to incentivize and reimburse clinicians having discussions with patients about their

preferences for care and complex-medical decision making. However, cost-sharing requirements can discourage patients from engaging in this type of care planning. Unfortunately, the burden of cost-sharing and financial barriers can disproportionately impact communities of color, which may engage less frequently in advance care planning (27).

Care delivery and payment models that seek to encourage processes such as advance care planning should create incentives that encourage, rather than dissuade, patients from receiving such services. More broadly, care models should reflect a broader understanding of communication, and as noted above, serious illness conversations. Doing so, and emphasizing support and communication alongside other outcomes, can align models with the fuller value proposition of palliative care and patient-centered approaches.

One implication of these dynamics is that palliative care may benefit from dedicated care delivery and value-based payment models. Compared to broad general models, targeted ones—or dedicated tracks for palliative care within broader models—could be designed around the needs of individuals who would benefit from palliative care. Medicare sought to do so in a prior model design by creating a Seriously Ill Population component of a broader population-based primary care payment model. The component had unique design features that sought to align financial incentives with processes that would promote value and quality.

Health system leaders could build on and extend this precedent by designing model components that not only focus on patients benefiting from palliative services overall, but also those disproportionately affected by disparities in access or quality. To that end, the Physician-Focused Payment Model Technical Advisory Committee—a national group with a statutory mission to make recommendations to the US Secretary of Health and Human Services on value-based payment models—has identified the unique needs of patients with complex chronic conditions and/or serious illness. Focusing on these patients as a group that accounts for the top five percent of Medicare spending nationwide, the committee noted that “seriously ill [individuals] require unique care delivery approaches” that could otherwise be inadequately met by broad encompassing models (28). Promisingly, over one-third of proposals received by the committee have included components related to addressing the needs of patients with complex chronic conditions and/or serious illness, underscoring the broader need for delivery models to address the needs of this population. Ultimately, however, payment reform alone may not be sufficient to

achieve health equity; broader societal and cultural shifts, including changes in how healthcare providers view their moral responsibilities toward underserved populations are critical (29).

Conclusions

Addressing health equity is a necessary step in palliative care. Doing so would account for the fact that historically underserved populations can face significant barriers accessing palliative care services, which can exacerbate health inequities and hinder quality of life during serious illness. To effectively tackle these challenges, health system leaders can adopt a multifaceted approach that enhances the capabilities of non-palliative care clinicians, better integrates palliative and other ambulatory services, and reimagines care delivery and payment models. Leaders must also consider the integration of community health workers, faith leaders, and culturally competent counselors to bridge the gap in palliative care delivery and engage marginalized groups.

By equipping all clinicians with foundational palliative care skills, leaders can increase the likelihood that patients receive consistent and compassionate care tailored to their individual needs. Integrating palliative care with other ambulatory services can help combat care fragmentation that can affect marginalized communities. Finally, redesigning payment models to reflect the true value of palliative care—beyond cost savings to encompass patient-centered outcomes—can underlie efforts to promote equitable access and high-quality care.

To be fair, no single solution is a panacea. The path toward greater health equity can be complex, requiring sustained commitment and innovation. Nonetheless, if implemented thoughtfully, the strategies discussed above are poised to achieve progress. Critically, these strategies underscore that achieving health equity is not just a vision for the future; it is an imperative that can be acted on without delay.

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