

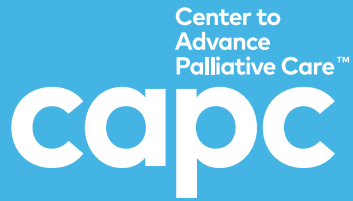


SERIOUS ILLNESS STRATEGIES

for Health Plans and Accountable
Care Organizations

Driving Better Value and Quality of Life
for High-Risk Populations

Center to
Advance
Palliative Care™
capc



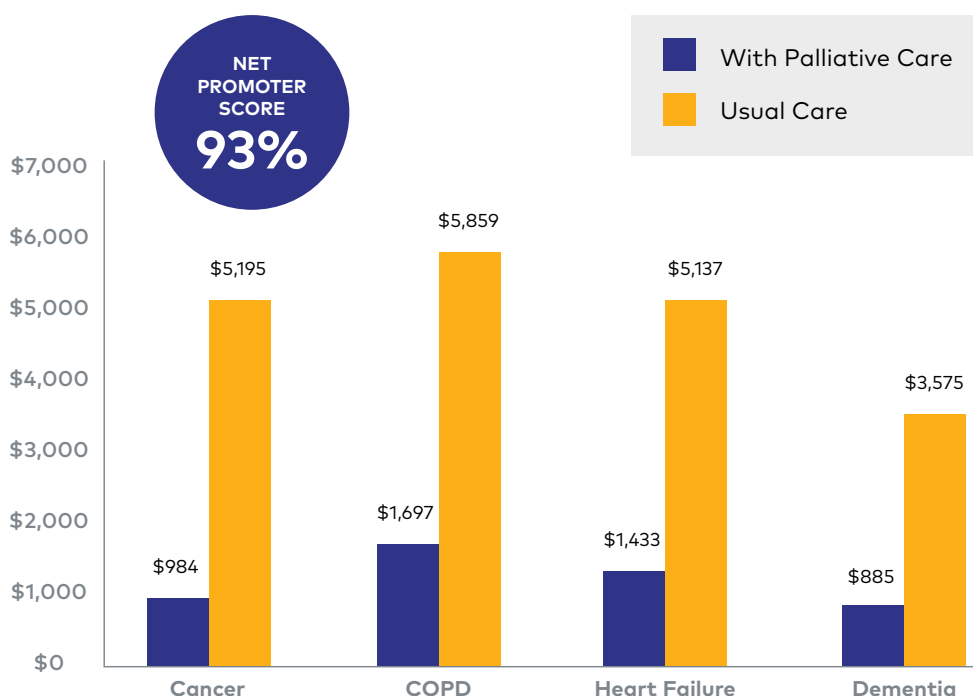
ABOUT CAPC

The Center to Advance Palliative Care is the nation's leading resource for palliative care development and growth. We are a national, member-based organization dedicated to increasing access to quality palliative care services for people facing serious illness. We provide hospitals, health systems, hospices, payers, and other health care organizations with the tools, training, technical assistance, and metrics needed to support the successful implementation and integration of palliative care. Learn more at [capc.org](https://www.capc.org).

Foreword

While it seems that every day someone is touting their approach to the triple aim—higher quality and satisfaction at lower cost—we know that many solutions are not succeeding.¹ What does work—and has for a long time—is attending to patient and family quality of life. When health care organizations have the necessary skills and services to assist with decision-making and appropriately manage pain and other symptoms, success follows.

Palliative Care Program Hospital Costs per Month and Satisfaction Score



Sources: Cassell, JB, et al. "Effect of a Home-based Palliative Care Program on Healthcare Use and Costs." *J Am Geriatr Soc*, (2016).
Boehler, A. NICHM Foundation Webinar, "Prioritizing Super-Spenders: Coverage and Care for High-Need Patients." (May 19, 2017).

The Center to Advance Palliative Care is pleased to offer this resource for health plans and accountable care organizations. Part 1 makes the case for advancing access to quality palliative care, and Part 2 provides practical guidance for implementation. More information can be found at capc.org.

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PART 1

THE IMPERATIVE: A COMMON PROBLEM WITH AN EFFECTIVE SOLUTION

“ The continued demonstration that strong results can be achieved creates an imperative for a new standard of care for serious illness. ”

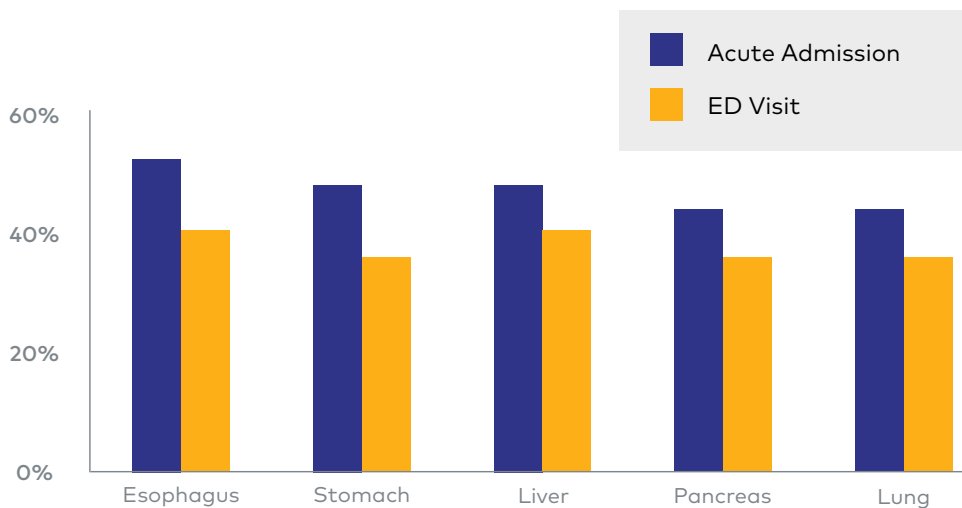
Randall Krakauer, MD

Former Chief Medical Officer for Medicare, Aetna

A Very Common Problem

Individuals with serious illness—such as cancer, advanced heart disease, and dementia—face heightened risk of crisis hospitalization and preventable spending. For example, recent analysis by Avalere Health shows that people diagnosed with cancers of the brain, esophagus, liver, or lung have more than a one-in-three chance of at least one hospital admission every six months, and as much as a 40% chance of at least one Emergency Department (ED) visit in that same time period (see Figure 1, below).²

FIGURE 1: Percent of Six-Month Oncology Episodes with at Least One Admission or ED Visit



Source: Price, K and A Dahl. "Data-Driven Success Under the Oncology Care Model." *Am J Manag Care*, (June 2016).

Nearly 80% of crisis ED visits and hospitalizations (excluding pneumonia) are due to exacerbations of pre-existing and chronic symptoms—such as shortness of breath in COPD or chest pain in cardiac illnesses.³ Although the movement towards value-based payment helps to align incentives towards crisis prevention, much of America's current health care system remains poorly-equipped to appropriately care for the seriously ill. A recent study of physicians found that a full two-thirds of medical practices lack systems to assess patients' wishes or adequately assess symptom burden.^{4,5} **These gaps leave patients and families with few viable options for the relief of symptoms and stresses, except for calling 911 or visiting the ED.** Once there, the severity of their underlying illness and their distress often result in admission, where too many of these patients decompensate.

CONSIDER JOHN

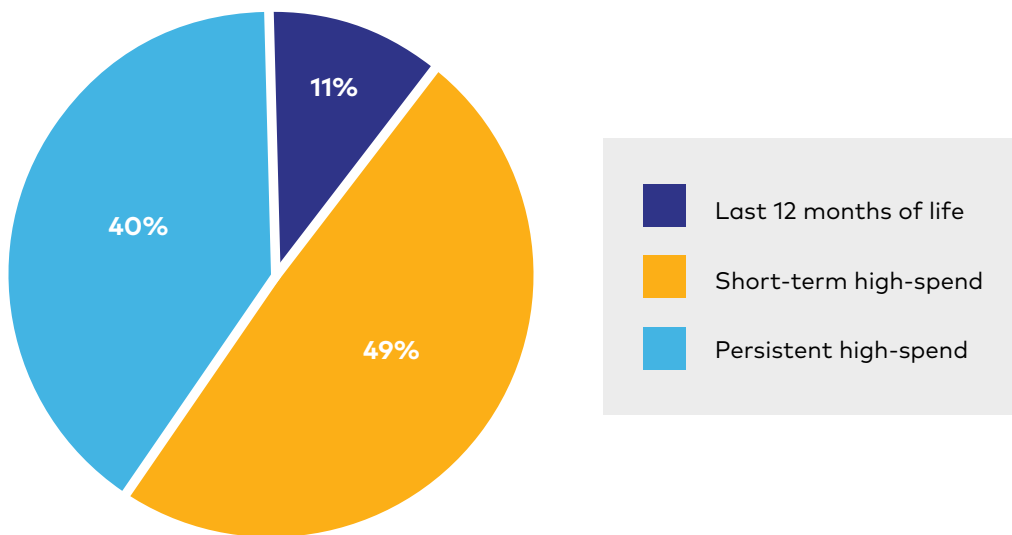


John was diagnosed with esophageal cancer several months ago and is undergoing second-line therapy. The pain is “terrible,” and during another sleepless night, his overwhelmed and exhausted wife calls his doctor. She hears a taped voice telling her to hang up and call 911 if it is an emergency. This results in their fourth trip to the ED in three months.

- After the last ED visit, John was admitted to the hospital for five days, followed by twenty-one days of post-acute rehabilitation, with little change to his treatment plan or his symptom burden.
- On this fourth visit to the ED, his pain is an eight on a scale of one to ten, for which he is taking a dangerously toxic dose of 5,000 mg of acetaminophen every day without relief.
- At this point, the family is labeled a “frequent flier” and considered to be “abusing” the ED, despite their appropriate use of the only solution available to them.

John illustrates the high costs to the health care system of failing to meet the needs of the seriously ill population. This high spending is not limited to those who have a terminal diagnosis. Of the top 5% of health care utilizers in the United States, only 11% are in their last year of life, with **a full 40% facing year after year of high utilization**, a finding highlighted in a recent National Academy of Medicine report and illustrated in Figure 2, below:⁶

FIGURE 2: Costliest 5% of Patients in the United States

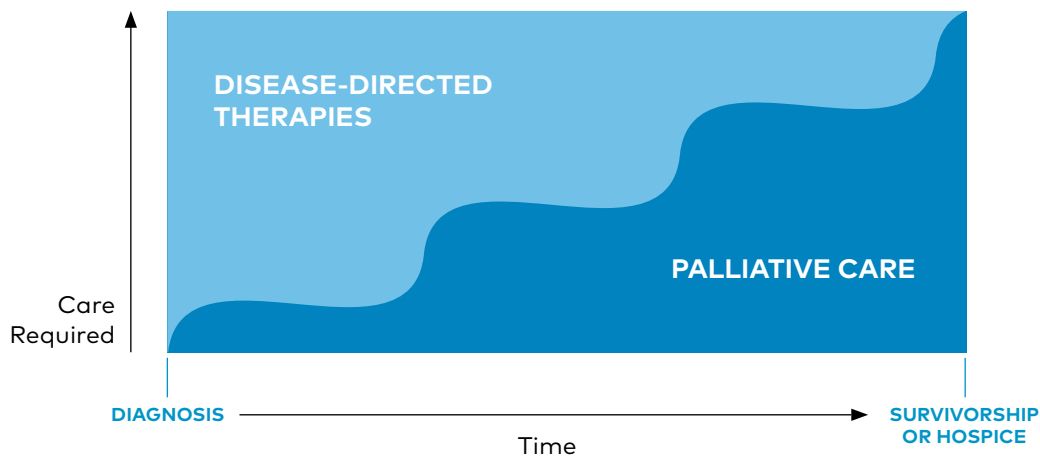


Fortunately, a growing number of health plans and health systems are adopting new serious illness strategies in partnership with both their network providers and their members. **Thanks to successful organizations leading the way—such as Aetna, Cambia-Regence, Blue Shield of California, Trinity Health System, OptumCare, and Sharp Healthcare—we’ve learned that it’s both better medicine and better economics to change our approach to serious illness care.**

An Effective Solution

Palliative care—specialized care that focuses on addressing the pain, symptoms, and stresses of serious illness—improves quality, improves satisfaction, and reduces spending when delivered concurrent with treatment (see Figure 3, below).

FIGURE 3: Palliative Care Should Be Delivered Concurrent with Treatment



The best serious illness care includes these five key characteristics associated with effective palliative care:

- 1 Identifies the right population in need of palliative care, and adjusts services as needs change
- 2 Provides 24/7 meaningful (i.e., timely and competent) clinical response as a means to prevent and avert crises and middle-of-the-night 911 calls and ED visits
- 3 Ensures expert pain and symptom management
- 4 Assists with decision making, clarifying patient and family care priorities, and helping to match treatment and services to those goals
- 5 Supports family caregivers with education, counseling, and/or respite



Consider 11-year-old Gwen and her family. Before her second birthday, Gwen was diagnosed with a rare disorder. After years of excruciating pain, repeat hospitalizations, and family distress, the pediatric palliative care team became involved. That team, led by a physician board-certified in both pediatrics and palliative care, was able to manage her pain and help her family through difficult decisions to plan ahead for future events. As a result, Gwen's use of the hospital declined significantly, while her parents' stress levels and job absenteeism plummeted.⁷

" At Cambia Health Solutions, we believe that palliative care is deeply personal and fundamentally rooted in respect for human life. It is an important catalyst for honoring patient choices and understanding personal definitions of quality, rather than merely focusing on the clinical aspects of serious illness. "

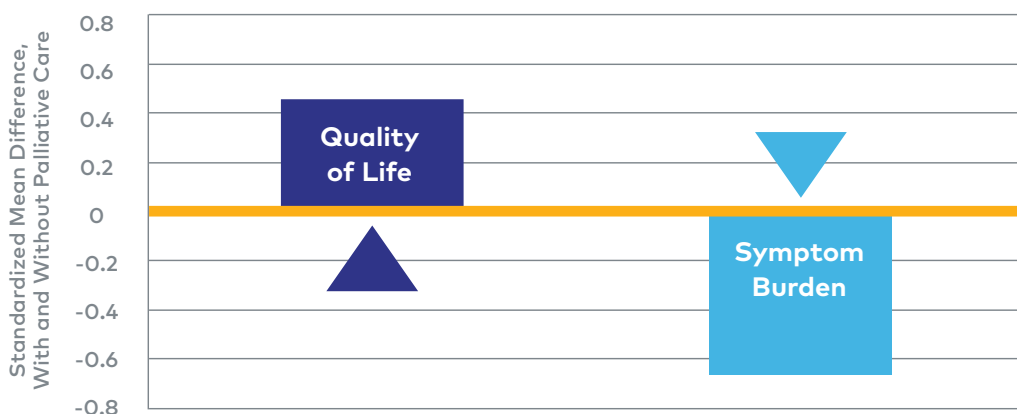
Mark Ganz

Chief Executive Officer and President, Cambia Health Solutions, parent company to Regence BlueCross BlueShield

Proven Improvements in Quality and Satisfaction

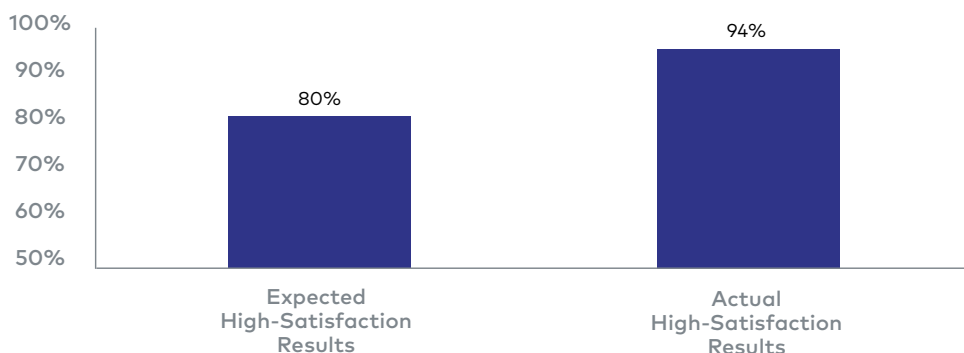
Studies consistently show improvements in quality outcomes and resource utilization once palliative care is introduced. A recently published systematic review, highlighted in Figure 4, below, found **improvements in quality of life, symptom burden, and satisfaction with care, with no differences in mortality.**⁸

FIGURE 4: Meta-Analysis Highlights Improvements in Quality of Life and Reduced Symptom Burden through Palliative Care



When health care delivery aligns with patient needs and preferences, high satisfaction results. See Figure 5, below, for what happened when one health plan expanded its palliative care benefits.⁹

FIGURE 5: Regence BlueCross BlueShield Personalized Care Support Program's Satisfaction Results

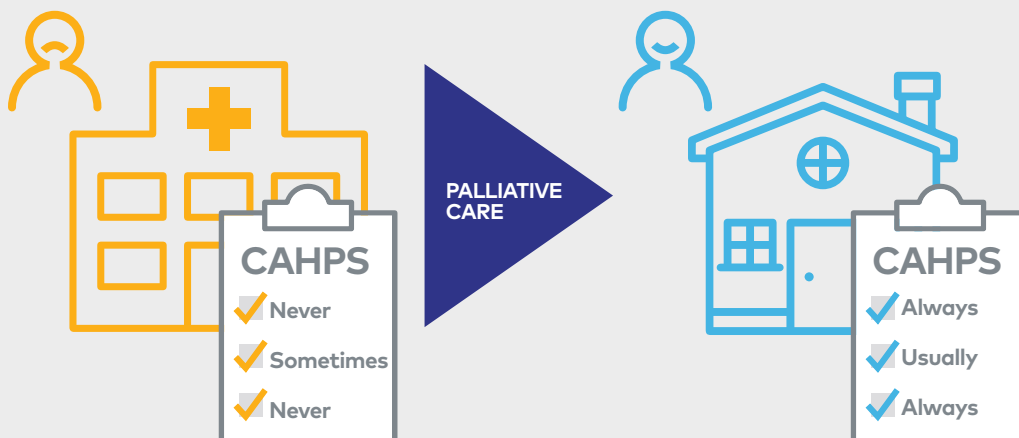


IN THE CASE OF JOHN,

suffering from esophageal cancer and revolving in and out of the ED, a board-certified palliative medicine physician finally consulted with the couple on their fourth ED visit, and prescribed an effective pain management regimen that his wife could administer at home. This was the first time John's pain from the esophageal cancer was safely and effectively addressed. The family also received a series of home visits by a palliative care nurse and access to a 24/7 response line for any urgent issues. With these interventions, John avoided the ED and hospital for the next eighteen months, transitioning directly to home hospice care once his cancer progressed.

John's case reflects a growing body of evidence that palliative care, when delivered concurrent with treatment, improves quality of life and, by preventing crises, reduces unnecessary health services utilization.

FIGURE 6: Before and After Palliative Care



Proven Improvements in Utilization and Spending

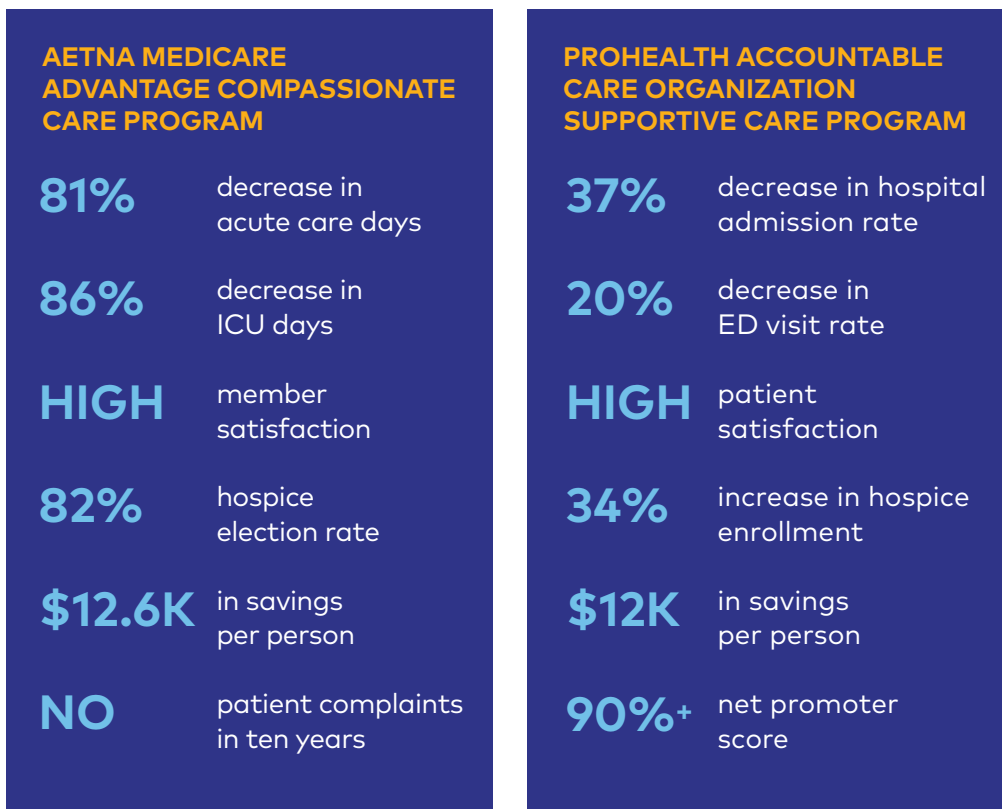
Palliative care enhances value because it produces the improvements in quality that lead to lower total health care costs.* Health care costs are reduced by decreasing the need for 911 calls, ED visits, hospitalizations, and intensive care. In addition, reduction in health care costs comes from reducing or eliminating burdensome and costly treatments that are not likely to provide much benefit, often carry risk of harm, and instead steal time from patients that could be better spent at home and with family, which is what the great majority of people want.

Spanning health care settings, palliative care has been shown to reduce cost for its target population:¹⁰

Setting	Results	Studies
Inpatient Hospital	→ \$1,696 costs saved per admission for live discharges; \$4,908 for death	Morrison, 2008
	→ 43% fewer ICU admissions	Gade, 2008
	→ 1.1 day length of stay reduction (oncology)	May, 2017
	→ Automatic palliative care consultation reduced re-admissions by 48%	Adelson, 2017
Outpatient	→ In Primary Care: 20% fewer hospital admissions	RTI International, 2006
	→ In Cancer Center: 50% reduction in hospitalization, with 35% reduction in ED visits	Scibetta, 2015
Skilled Nursing Facility	→ 43% reduction in care transitions (to ED or hospital)	Miller, 2016
Home-Based	→ 36% lower costs (\$12,000 saved per patient)	Lustbader, 2016
	→ 48% to 56% reduction in hospital admissions	Cassel, 2016
Pediatric (Cross-Setting)	→ \$3,331 saved PMPM, including a 45% reduction in average inpatient days	Gans, 2016

* A good resource for cost and utilization results that has been used successfully by actuaries: Smith, Susan, et al. "Evidence on the Cost and Cost-Effectiveness of Palliative Care: a Literature Review." *J Palliat Med*, (2014).

Health plans and accountable care organizations that pursue strategies to ensure access to palliative care services for the right individuals find consistently strong results. Consider these two published examples achieving similar results in very different settings:^{11,12}



" We have found that palliative care teams, when working with the right population, are consistently effective in improving outcomes and care appropriateness across a variety of programs and different parts of the country. "

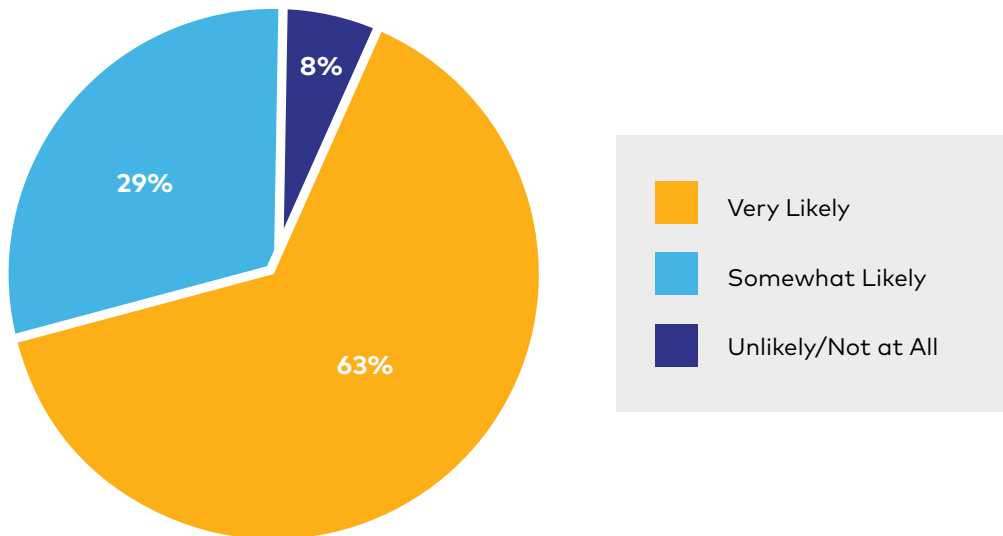
James Mittelberger, MD, MPH

Director and Chief Medical Officer, Optum Center for Palliative and Supportive Care

Patients and Families Want Palliative Care

A national public opinion survey conducted by Public Opinion Strategies in 2011 revealed that, once consumers are informed about palliative care, 63% say they would be “very likely” to consider using palliative care if they or a loved one had a serious illness, with an additional 29% saying they would be “somewhat likely”—**a full 92% of consumers expressing a desire to access palliative care.**¹³ See Figure 7, below.

FIGURE 7: How Likely Would You Be to Consider Palliative Care for a Loved One?



This public opinion survey also found that **more than two-thirds of respondents believe it is “very important” that palliative care services be available at all hospitals.**

Helping Caregivers Improves Employee Productivity

Vital components of high-quality serious illness care are education and support for family caregivers. Studies show that early palliative care significantly improves the mental and physical functioning of the *caregiver*, including a sizable reduction in depressive symptoms.¹⁴ **Such benefits for family caregivers translate into financial benefits for employers.** *The MetLife Study of Working Caregivers and Employer Health Care Costs* (2011) notes that employers pay 8% more in health expenses for employees with caregiving responsibilities, when compared to non-caregiving employees.

" Palliative care could expand the reach of population health interventions beyond prevention of illness by developing strategies to improve well-being after an illness has occurred. "

Joan Teno, MD and David Casarett, MD

Journal of the American Medical Association, May 12, 2016

In sum, while care for individuals living with serious illness in the United States is often of poor quality and high cost, we now have an unprecedented opportunity to deploy proven strategies to improve the patient and family experience, the quality of care, and the value of health delivery for these high-need patients. Improved quality of life for those with serious illness leads directly to reductions in avoidable spending, and more time at home due to a decreased reliance on crisis care in EDs and hospitals.

PART 2

THE STRATEGIES

“ Palliative care is about delivering comprehensive support centered on what matters most to patients and their families. This whole-person care—whether aimed at relieving physical distress, or providing emotional, spiritual, or practical support—allows individuals to live each day more fully despite serious illness. ”

Daniel Johnson, MD

Medical Director, Supportive Care Solutions, Kaiser Permanente Colorado

Serious Illness Framework

The Center to Advance Palliative Care has convened health plan and accountable care organization leaders, learned from their successful transformations of serious illness care, and then synthesized their approaches to create this **Serious Illness Framework**.

FIGURE 8: **Serious Illness Framework: Six Essential Strategies**



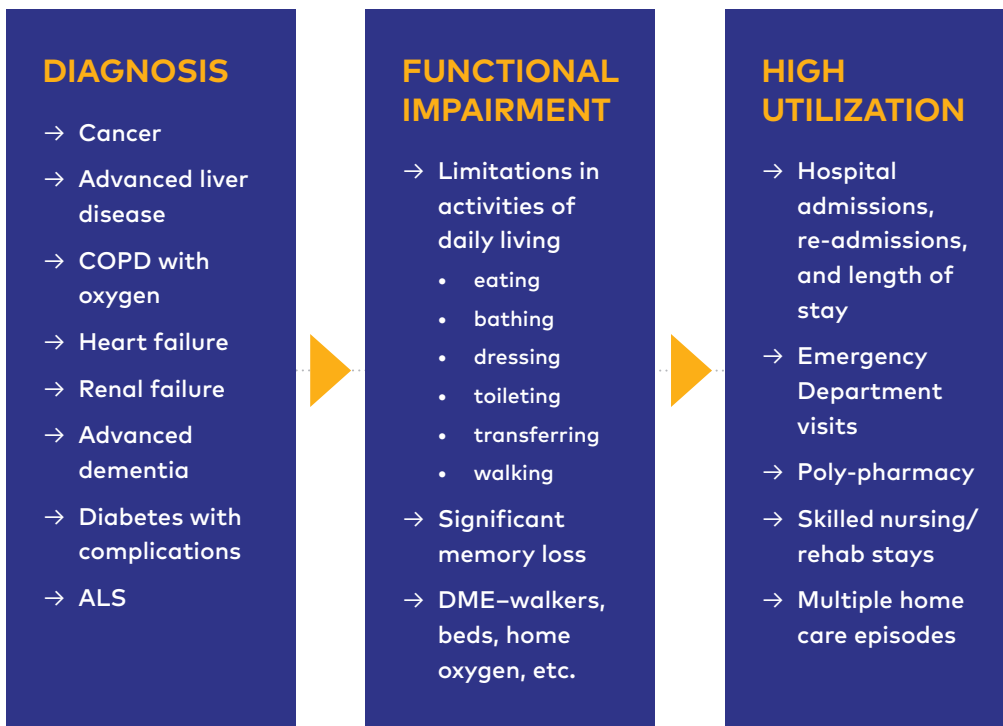
Figure 8, above, illustrates the comprehensive approach that is needed to transform care and achieve results. A summary of each key strategy follows.

STRATEGY 1

Proactive Identification

With limited resources, health plans and health systems must target resources to the appropriate sub-population, but there is not yet a clear consensus of how to define the “seriously ill population.” However, there is general agreement that the population at risk of unnecessary suffering can be identified through a **combination of three key types of variables: diagnosis, functional impairment, and past health services utilization** as depicted in Figure 9, below.¹⁵

FIGURE 9: Three Key Variables to Identify the Population in Need



Key Best Practices in Identification Include:

- Seek creative indicators of functional impairment, since current claim and EHR data systems typically do not capture this information. Some payers use durable medical equipment (DME) authorizations, such as for walkers and home oxygen, as a marker for functional impairment.
- Combine data-driven algorithms with clinical opinion. The best practice combines both, such as reviewing data-generated lists with the treating providers, and/or confirmatory screening phone interviews with patients/members and caregivers.
- Use timely patient identification methodology. Methods that have long delays may be too late for some of the highest-risk patients. Using authorization systems or EHR data may improve timeliness.

The need to identify the right individuals cannot be overemphasized. Efforts to improve serious illness care that fail to prospectively identify the majority of patients in need will have little overall impact, clinically or economically.

STRATEGY 2

Engagement And Assessment

While there is a science to identifying the individuals most in need, there is an art to matching services to needs. Payers must ensure that people with serious illness are interacting with **carefully hired and well-trained care managers with certain essential assessment skills:**

- These essential skills include the ability to hold meaningful conversations with people with serious illness, along with their family caregivers, so that service delivery aligns with what is most important to the patient and family.

The ability to address and communicate about patient priorities for care is a fundamentally different skill set. Aetna's Compassionate Care Program puts significant resources into the selection, hiring, and training of its serious illness care managers, and believes that it is this investment that leads to the returns described in Section I.

- Equally important is the ability to conduct comprehensive assessments to identify the issues that directly impact a patient's functioning and well-being, as shown in Figure 10, on the next page. This type of assessment requires skilled appreciative inquiry, which differs considerably from the usual practice of firing off a list of questions, a practice that does not generate the root causes of recurrent crises.



What's important to you?

What do you need to do?

FIGURE 10: Serious Illness Assessment Domains

- Pain and symptom burden
- Psychological issues, including worry, stress, anxiety, and depression
- Caregiver burden and capacity
- Social, financial, and practical issues that interfere with effective care
- Spiritual concerns

Completion of advance care plans and medical orders for life-sustaining treatments (MOLST, POLST, etc.)—and then ensuring that those documents are accessible to all providers and settings—are important, but far from sufficient, aspects of this process.

Organizations should consider the pros and cons of in-person versus telephonic case management. Telephonic approaches (such as Aetna's) have been proven quite effective, but the buy-in of the treating clinicians can be enhanced through embedded on-site or home-based palliative care-trained case managers.

STRATEGY 3

Services and Benefit Design

Individuals with serious illness and their families need a whole-person approach that recognizes the functional, social, emotional, caregiver, family, practical, and spiritual contributors to suffering and recurrent crises.

Essential services should include:

24/7 and timely clinical response

for pain and symptom exacerbations

Caregiver training, support, and counseling

to equip families for the responsibilities placed on them

Assistance with activities of daily living,

such as personal care supports

Access to social and spiritual supports,

which can incorporate benefit changes and/or referral to high-quality resources in the community

It may not be necessary to create a separate “palliative care” benefit, but it is important to review coverage, member co-payment, and pre-authorization policies to ensure those with serious illness have access to these services.

Best Practices in Benefit Design

- Covering home-based primary and palliative care, such as the “Independence at Home” model or available vendor models, is a common benefit change that produces strong value.
- Expanding home health aide benefits for eligible patients who do not meet “homebound criteria” helps support exhausted family caregivers.
- Enabling concurrent hospice and curative care for commercial populations prevents symptom crises and ED/hospital utilization. Medicare Advantage populations also benefit from services that enable earlier transition to hospice.

STRATEGY 4

Provider Network – Competencies and Access

There are two critical features of the right provider network for those with serious illness:

1. All clinicians have core knowledge and skills in palliative care.
2. The network ensures sufficient access to specialty-level palliative care clinicians.

Whether an individual's palliative care needs can best be managed by his or her regular treating clinicians, by some collaboration between the treating clinicians and palliative care specialists, or by having the specialty palliative care team serve as the primary point-of-care will depend on patient need:

LOW PALLIATIVE NEED

Usual care with treating clinicians capable of effective communication and symptom management. Specialty palliative care consult(s) as needed.

MEDIUM PALLIATIVE NEED

Treating clinicians regularly collaborate with specialty palliative care team, especially for intractable symptoms or complex family communications.

HIGH PALLIATIVE NEED

Ongoing and active management by specialty palliative care team. The degree of palliative care team responsibility depends on patient need and treating clinician preference.

Provider Network Best Practice: Ensuring Core Palliative Care Competencies of Treating Providers

For payers seeking to transform the care of those with serious illness, it is important to recognize that the majority of U.S. providers have had little or no training in palliative care skills (management of pain and other symptoms, communication, mobilization of community resources). For example, a recent survey found only 29% of physicians report having any training in end-of-life conversations, with 71% reporting no such training.¹⁶

Payers can help close the skills gap by recognizing and financially rewarding providers who have successfully completed training or certification (e.g., **The Joint Commission (TJC)** advanced certification in palliative care for hospitals or for community-based programs; **CAPC Designation** for clinician training; practices with **on-site VitalTalk coaches**; practices completing the **Ariadne Labs Serious Illness Care Program**), by using bonuses, higher payment rates, inclusion in narrower networks or tiers, and/or higher annual rate increases. For example, Blue Shield of California is rewarding its hospitals for achieving TJC advanced certification, while Blue Cross Blue Shield of Massachusetts is financially supporting selected network providers' access to Ariadne Labs' training in Serious Illness Care.

The quality and financial benefits that accrue depend on fidelity to evidence-based trainings, such as those listed above. Other communication training programs may or may not result in the same outcomes.

Payers can help close the skills gap by recognizing and financially rewarding providers who have successfully completed training or certification.

Provider Network Best Practice: Ensuring Access to Palliative Care Specialists and Programs

Palliative care is a medical subspecialty recognized by the American Board of Medical Specialties (ABMS), and should be provided with an interdisciplinary team. Subspecialty palliative care is used in a manner comparable to the use of any other specialty service, as depicted in Figure 11, below.

FIGURE 11: Palliative Care Specialists are Needed When Symptoms and Strains are Intractable

We already do this...



We need to do the same with this...



Payer action is needed to ensure that those identified with serious illness have access to in-network, board-certified, and credentialed palliative care specialists. These actions include:

- **Determine whether network hospitals that have strong palliative care teams** (again, the Joint Commission Advanced Certification is a prime indicator) can extend those resources to clinic or home-based settings and, if so, expand or amend those contracts

- **Expand or amend hospice provider contracts** to enable hospice services concurrent with disease treatment and/or the provision of home-based palliative care
- **Outreach to palliative care professional societies** such as the following to identify local clinicians to add to the network:
 - American Board of Medical Specialties
(Hospice and Palliative Medicine is a medical subspecialty)
 - American Academy of Hospice and Palliative Medicine
 - Hospice and Palliative Nurses Association
 - National Hospice and Palliative Care Organization
 - Social Work Hospice and Palliative Care Network
 - American Academy of Home Care Medicine
- **Utilize [GetPalliativeCare.org](https://www.getpalliativecare.org) to find palliative care programs**

Keep in mind that, because palliative care is a medical subspecialty, board-certified palliative care physicians and advanced practice nurses are often listed only by their primary specialty (such as internal medicine or family medicine) in credentialing systems, making it sometimes difficult to identify existing in-network palliative care specialists.

Note that while vendor contracts for home-based palliative care can be effective, they are only one piece of the puzzle. Contract vendors focus on the highest-need population, leaving too many others remaining at risk for unnecessary, unwanted, and potentially dangerous interventions. Enhancing the delivery system upon which both payers and patients rely will accrue benefits on a larger scale.

STRATEGY 5

Payment and Incentives

In general, **value-based payment models align well with comprehensive serious illness care**, as both seek to address the root causes (e.g., symptom distress, exhausted family caregivers, social determinants) of predictable and preventable care crises and unnecessary ED visits, hospitalizations, and low-value interventions such as intubations for ventilator support in the ICU for end-stage dementia patients.

Best practice examples of value-based and alternative payment models for serious illness include:

- Additional “care management fees” to support psychosocial supports and/or infrastructure enhancements
- Direct salary support for palliative care specialists, including physicians, advance practice nurses, social workers, and chaplains
- Monthly case rates for a defined set of specialty palliative care services
- Shared savings, with shared risk if viable for the providers
- Enhanced fee-for-service rates for palliative care specialists or practices
- Flexibility to pilot innovative care interventions

Payment is also a powerful tool to incentivize and support core skill development in the provider network. In addition to the recognitions mentioned in Strategy 4, some payers support infrastructure and training investments and vary payment levels based on level of core palliative care trainings completed.

Using Payment to Incentivize Practice Change—Anthem, Inc.

In 2015, Anthem introduced palliative care competency as a bonus measure for their hospital quality incentive program. To earn credit for this bonus measure, network hospitals can do one of two things: a) achieve Advanced Certification for Palliative Care from The Joint Commission; or b) meet four core standards for their palliative care program. The four core standards are broad and intended to flexibly aid any size hospital in advancing access to palliative care for their patients. The core standards are:

- Existence of a formal policy on palliative care, defining, at minimum, the role of the palliative care service, the required palliative care competencies for all hospital staff, and the process by which patients receive specialty palliative care when needed
- Availability of a specialty palliative care service, comprising at least two of the following disciplines: physician, advanced practice nurse, registered nurse, social worker, chaplain
- A systematic and standardized process in place to identify patients for palliative care consultation, such as establishing referral triggers in the electronic health record
- Annual training in the areas of symptom assessment and communication skills, for all hospital staff

STRATEGY 6

Measurement and Evaluation

Health plans and ACOs need to determine whether the approaches they have implemented to improve the care of those with serious illness have actually led to the improvements expected. These might be improvements in satisfaction and consumer assessment survey results, improvements in cost appropriateness and value, and/or improvements in quality scores such as depression assessment and treatment.

Measurement should span structure, process, and outcomes, as follows:

Measurement Area	Examples
Organizational project milestones	<ul style="list-style-type: none"> → Successful implementation of a standardized screening protocol (structure) → Rates of completion of advance directives and/or advance medical orders like POLST (process)
Availability of essential services	<ul style="list-style-type: none"> → Proportion of network hospitals with a palliative care team (structure)
Network training completion	<ul style="list-style-type: none"> → Proportion of network oncology practices with demonstrated training in core palliative care skills, such as CAPC Designation (structure)
Network quality of care	<ul style="list-style-type: none"> → Rates of caregiver burden assessment (process) → Rates of referral to specialty palliative care (process) → Declines in rates of depression (outcome)
Utilization and cost	<ul style="list-style-type: none"> → Rates of all-cause ED visits within the identified population (outcome) → Re-admission rates (HEDIS) (outcome) → Reductions in Medical Expense Ratio/Medical Loss Ratio for the target population (outcome)
Experience and satisfaction	<ul style="list-style-type: none"> → CAHPS scores (outcome)

Payers should beware of unintended consequences of well-intended metrics when developing measures for a seriously ill population. For example:

- **Setting unachievable expectations for symptom relief (for example, a pain score of zero) is unsafe and unrealistic in a complex, seriously ill population, and may lead to over-medication and untoward side effects.**
- **Beware of patient survey fatigue: this population is not only going through difficult health and family strain, but is usually in contact with many organizations, all of which are also conducting surveys.**
- **While occurrence of documented discussions about advance care planning is an effective process measure, a focus on actual completion of advance directive forms creates the unintended consequence of a heavy emphasis on form completion, to the point where members feel pressured to sign health care proxy or do not resuscitate (DNR) orders whether or not they feel ready to do so.**

The Serious Illness Framework provides a comprehensive approach to care transformation to ensure that care delivered is actually matched to the needs and personal priorities of seriously ill patients and their families. Health plans and accountable care organizations that have used this comprehensive approach have achieved the high-quality care necessary to improve value. While each strategy requires focused attention and investment, all are feasible and have delivered strong returns for major U.S. health plans and their members.

More information on implementing these strategies is available through the Center to Advance Palliative Care. CAPC has compiled successful case studies across all strategies, provides a suite of practical tools and resources to integrate palliative care into population health approaches, and maintains a user-friendly online curriculum for case manager training and support.

Contact membership@capc.org for more information about how CAPC can support your organization.

Center to Advance Palliative Care's Multi-Payer Workgroup

We gratefully acknowledge the federal observers and the contributions of these past and current members of the Center to Advance Palliative Care's Multi-Payer Workgroup, coordinated by Tom Gualtieri-Reed, MBA.

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