



A Better Benefit:

Health Plans Try New Approaches to End-of-Life Care

Introduction

In the event of serious illness, Californians strongly indicate that they would want to have care that adequately addresses pain and discomfort as well as providing spiritual, social, and cultural support — all of which are hallmarks of palliative care.¹ Unfortunately, although a growing number of people with advanced illness access this type of support through hospices or hospital-based palliative care programs, most patients at the end of life do not receive these services, or only receive them much later in the course of care than is considered optimal.^{2,3}

Among the factors affecting access to palliative care is health insurer reimbursement. Most benefits for these services are patterned on the Medicare Hospice Benefit (MHB), which is limited to patients with an expected prognosis of six months or less and prohibits reimbursement for curative care once patients chose palliative-focused care. Some of California's health plans, however, are opting to craft innovative palliative care services and hospice benefits that allow access to these services earlier in the course of illness.

This report describes the findings of a scan conducted from August through October of 2012. The study was designed to:

- Investigate and describe the spectrum of palliative care and hospice benefits and services that California's largest health plans are currently offering or plan to offer soon.

- Explore the attitudes of health plans and palliative care stakeholders toward coverage of concurrent care (access to hospice or palliative care concurrently with curative or disease-modifying care).

Information for this report was gathered through review of published reports and academic literature, interviews with key stakeholders (Appendix A), and interviews with physician leaders of six of the largest health plans (in terms of enrollment) in California (Appendix B).

Palliative Care and Hospice Care

Palliative care is most often delivered by an interdisciplinary team of professionals including physicians or nurse practitioners, nurses, social workers, and counselors such as spiritual care providers. Although palliative care is often provided in the latter stages of illness or disease, it can be provided at any stage of illness and in both inpatient and outpatient settings.

Hospice care is a form of palliative care specifically designed for patients who are terminally ill. It is most often provided in the patient's home by an interdisciplinary team focused on maximizing comfort and quality of life for the patient and the family.

Palliative care professionals practice in hospitals, hospices, and outpatient clinics. Several boards of the American Board of Medical Specialties cosponsor certification in hospice and palliative medicine. The National Board for Certification of Hospice and Palliative Nurses (NBCHPN) offers specialty certification for nurses and administrators.

The Medicare Reimbursement Model

Since 1983, when Congress established the Medicare Hospice Benefit, the majority of patients receiving palliative care have done so through a hospice agency. Even with the rapid growth of hospital-based, inpatient palliative care services, palliative care is primarily delivered by hospices, and the majority of hospice patients are over 65 and insured by Medicare. It is not surprising, therefore, that the Medicare benefit has, until recently, been the model for palliative care reimbursement, even for commercial health plans. In fact, in 2001, the California Department of Managed Health Care required all health maintenance organizations to offer hospice care at levels at least equivalent to those of Medicare, and most plans wrote benefit language that mirrored the MHB exactly. The Medi-Cal hospice benefit also mirrors the MHB, as is typical for Medicaid programs.

For at least 10 years, hospice and palliative care proponents have pointed out that the MHB model tends to limit access to palliative care in two ways:

1. The benefit explicitly limits access to hospice care to patients with an expected prognosis of six months or less (as attested to by two physicians). Thus, many patients who might benefit from palliative services cannot receive it or receive it only when they are close to death.
2. Medicare beneficiaries who choose hospice care must agree to forgo Medicare payment for disease-modifying treatment for the “terminal condition.” Medicare will not provide reimbursement for both concurrently. The indirect effect of what has come to be called “the terrible choice” is that physicians refer to hospice care only after all curative options are exhausted, often without even discussing the option for hospice or palliative care with patients and their families until that point. Similarly, patients (and their families) equate hospice care with “giving up” and postpone enrollment until very late in the course of the illness.

For patients who do not meet criteria for hospice care, or who choose not to enroll in hospice, palliative care is often provided in the inpatient setting by a multidisciplinary team of palliative care professionals.⁴ A small but growing number of palliative care teams are available to outpatients as well, often as part of a large physician practice.

Medicare and most commercial health plans will cover palliative care consultation by a physician or nurse practitioner, and some also reimburse for the services of licensed clinical social workers. The reimbursement mechanism is essentially the same as for any other specialty consult service. Few health plans, if any, offer reimbursement for other key members of a palliative care team such as the nurse or spiritual care provider. Typically, the costs of these other professional services are paid by the hospital or the physician practice that employs the palliative care team members.

Why More and Earlier Palliative Care Is Better

In California, more than 14 million people have a chronic illness, and 7 million have multiple chronic conditions. Many of these illnesses have a high symptom burden, threaten length and quality of life, and generate high health care costs. Research has shown that providing palliative care earlier, rather than later, in the course of these illnesses leads to better health outcomes, higher satisfaction with care, and reductions in health care costs.⁵⁻⁷

Research has also shown that there is considerable value in the concurrent delivery of palliative and curative care, particularly for patients with advanced chronic or serious illness.⁸ When patients are not forced to make the choice between the two, patients accept palliative care earlier in the disease trajectory, and experience better symptom management and quality of life. In addition, patients benefit from more in-depth discussions of the disease process in the context of their own preferences

and goals of care.⁹ As a result of increased knowledge and confidence that their symptoms will be managed, many patients choose treatment that is less cure-directed and less aggressive, which leads to fewer side-effects and lower costs of care.^{10,11}

In light of the data supporting the value of concurrent palliative and disease-modifying care, the American Society of Clinical Oncologists (ASCO) issued a recommendation that all patients with metastatic non-small-cell lung cancer (NSCLC) be offered palliative care along with standard cancer therapy, beginning at the time of diagnosis.¹²

Health Plan Interest in Palliative Care

Earlier and more extensive access to palliative care falls into a health care sweet spot, where doing the right thing also improves outcomes, consumer experience, and cost-effectiveness.¹³ All payers have a financial interest in the cost savings that well-designed palliative care represents. Although Medicare covers the largest population of individuals with advanced chronic disease and serious illness, Congress is not likely to enact changes to Medicare expanding access to palliative care in the near future.¹⁴

Instead, private health plans are currently leading the way. Between 2004 and 2007, Aetna, led by then-CEO Jack Rowe, MD, conducted a pioneering pilot study of concurrent delivery of palliative and curative care.¹⁵ Working with one large employer/purchaser, Aetna crafted a comprehensive case management program patterned on key elements of palliative care. Its Compassionate Care Program employed trained nurse case managers to talk with patients and families about the disease process, engage in discussions about goals of care and preferences, and offer assistance with advance directives. The case managers also provided referrals to community resources for social and emotional support, pain and symptom management, and home or respite care.

Aetna also piloted a liberalized hospice benefit that expanded access to commercial members with prognoses of up to 12 months (rather than six months), and that allowed those who chose hospice care to continue to access reimbursement for curative care at the same time. Both of these advantages were made available to the commercial population, but because of the MHB restrictions, Medicare Advantage members were still limited to the six months prognosis requirement for hospice services.

By analyzing medical claims, Aetna found that, compared to matched historical controls, hospice use increased for all groups, and inpatient stays were lower for all groups receiving comprehensive case management. The result was an estimated net medical cost decrease of at least 22%.¹⁶

Health Plan Interview Methodology

To understand what California's health plans are doing to increase access to palliative care, several key stakeholders were contacted to help shape the research questions and determine who would be the best informants at the health plans. They included leaders of national and statewide palliative care and end-of-life care coalitions, physician directors of hospital-based palliative care programs, hospice directors, health benefits experts and activists, and health plan industry association executives. (See Appendix A.)

Based on these discussions, the researchers contacted the seven largest health plans (by number of enrollees), and requested telephone interviews with the medical director or person most familiar with palliative care benefits/services provided by the health plan. Six agreed to an interview: Aetna, Anthem Blue Cross of California/Wellpoint, Blue Shield of California, Health Net, Kaiser Permanente – Southern California, and United Healthcare. Kaiser Permanente – Northern California declined to participate. (See Appendix B.)

How Payers Are Increasing Access

Building on Aetna’s experience with palliative care, the six health plans interviewed for this research are expanding access to palliative care in two primary ways: provision of specialized case management; and liberalization of the hospice benefit (for commercial beneficiaries only). One health plan, Kaiser Permanente – Southern California, also offers home-based palliative care to both commercial and Medicare Advantage members. In addition, some of the six insurers are piloting or planning other initiatives, including home-based palliative care, outpatient palliative care consultation, enhanced advance care planning services, and a defined palliative care benefit.

All of the health plans use different models of reimbursement and care delivery, including one staff model (Kaiser Permanente – Southern California) and several variations on delegated and fee-for-service models. Whether the plans provide services themselves, encourage or require contracted provider groups to offer services, or simply offer reimbursement for palliative care services, the reported drivers are usually the same. They want to provide more and earlier palliative care because it offers cost-effective, high-quality outcomes for members.

In some cases, initiatives are led by one department, and in others by a cross-departmental or cross-functional

Table 1. Summary of Palliative Care Programs or Benefits from California Insurers

	INSURERS INTERVIEWED (enrollment, in millions)					
	ANTHEM BLUE CROSS (8.3)	KAISER PERMANENTE – SOUTHERN CA (3.5)	BLUE SHIELD OF CA (2.9)	HEALTH NET (2.3)	AETNA (1.5)	UNITED HEALTHCARE (<1.0)
Enhanced Case Management (CM): Includes discussions of goals, options, pain/symptom management, advanced care planning, connections to community resources via telephone			Case managers can flex benefits and/or refer patients to PC providers	Initial home visit included	“Compassionate Care Program” Implementing CM program in ACOs	Telephonic program (with in-home RN support at one site)
Liberalized Hospice Benefit: Allows for concurrent illness-directed care	Limited to palliative chemo, radiation, and TPN			Includes but not limited to palliative chemo, radiation, and TPN	12-month prognosis	“Terminal” or 12-month prognosis
Home-based PC: Interdisciplinary team, concurrent with curative care		Patients ineligible or do not want hospice	Considering for certain conditions	Considering, pending results of a pilot in another state		Medicare Advantage (one county only)
Other PC Efforts		Interdisciplinary PC team consultation in specialist offices and at clinics SW or case manager support for physician-initiated ACP	Considering a defined PC benefit (Phase II, after CM rollout)			

Source for enrollment numbers: California Association of Health Plans, Annual Report, 2011.

team. Almost always, they rely in part on physician champions. Key initiatives are summarized in Table 1 and described below.

Enhanced Case Management

OFFERED BY: Aetna, Heath Net, United Healthcare

PILOT IN PROGRESS: Aetna (piloting in ACOs), Blue Shield of California

CONSIDERING/PLANNING: None at this time

Enhanced case management programs provide intensive contact between specially trained case managers and health plan members with complex and/or advanced illnesses. The health plan leaders interviewed cited three reasons for developing these programs. First, they noted that members did not have the information they needed to make informed health care decisions. Second, their members with advanced, chronic, and serious illness needed more support to help them manage their care. And lastly, initial endeavors into enhanced case management improved quality without unduly increasing costs.

The specialized case management programs take different forms in each health plan. Some specifics:

- Much of the case management is done telephonically, but may include an initial home visit, and perhaps one or more follow-up home visits.
- Support services include discussions of care goals, preferences, options, pain and symptom management, coordination of care, psychosocial support, spiritual support, assistance with advance care planning, and connection to community resources.
- Some plans allow case managers to flex benefits within specific parameters.
- Some plans aim to refer patients to community-based palliative care providers. (Blue Shield of California is developing a registry of palliative care providers.)

- Aetna is piloting enhanced case management within the structure of accountable care organizations (ACOs).

The four plans providing or piloting enhanced case management services typically offer services to both Medicare Advantage and commercial members. (One insurer highlighted caution about flexing benefits for Medicare Advantage members.) Members likely to benefit from enhanced case management are identified in several ways: predictive modeling/algorithms based on diagnosis and utilization, and confirmed through discussion with case managers or the member's physician; direct referral by hospital-based case managers or plan providers; member self-referral; and health risk assessments completed by members.

Liberalized Hospice Benefit

OFFERED BY: Aetna, Anthem Blue Cross, Health Net, United Healthcare

PILOT IN PROGRESS: None at this time

CONSIDERING/PLANNING: None at this time

Health plans reported offering a liberalized hospice benefit because of the restrictions of the MHB and because earlier hospice referral appears to lead to better quality without raising costs. The liberalized hospice benefits include:

- Expansion of the prognosis criteria for hospice admission beyond the MHB requirement of six months or less so that members can be enrolled in hospice earlier in the disease trajectory; and/or
- Concurrent reimbursement for the hospice per diem and for illness-directed treatment for the “terminal condition.”¹⁷

Medicare Advantage patients who opt for hospice care are carved out of the insured population; Medicare pays the hospice directly, and Medicare will not reimburse for other care related to the terminal illness.

Home-Based Palliative Care

OFFERED BY: Kaiser Permanente – Southern California

PILOT IN PROGRESS: United Healthcare

CONSIDERING/PLANNING: Blue Shield of California,
Health Net

One health plan is offering, one is piloting, and two are considering reimbursement for home-based palliative care services for members with advanced illness and prognoses in the 6- to 18-month range. These initiatives, which one insurer called “hospice light,” were developed as a result of the significant spending increases that occur in the last year for members who do not receive hospice services — including higher use of the hospital and ICU. Home-based care is also more consistent with member preference.

Kaiser Permanente – Southern California offers home-based palliative care to all members. In most cases, it is viewed as a precursor to hospice care. Services are provided by a multidisciplinary team including a physician or nurse practitioner, a nurse, a social worker, and a chaplain, all of whom are Kaiser Permanente employees.

United Healthcare provides outpatient (including home-based) palliative care services for Medicare Advantage members. In the Orange County-based pilot, services by a multidisciplinary team including physician/nurse practitioner, social worker, and chaplain are provided through a contract with EverCare Hospice and Palliative Care. Patients who would benefit are identified by primary care physicians, treating physicians, and case managers. Identification of potential patients based on clinical criteria is planned.

Blue Shield of California is considering various models that would integrate community-based symptom management resources to provide home-based palliative care for patients with certain conditions. The models include collaboration with hospice providers, oncology practices, and home health agencies.

Other PC Efforts in Development or Under Consideration

Kaiser Permanente – Southern California is piloting the provision of outpatient palliative care by an interdisciplinary team in specialist offices and in stand-alone clinics. The goals are to make palliative care available where members more often receive care — in the outpatient setting — and to support community-based providers caring for members with advanced illness. In some pilot areas, services are available to any member who may benefit as determined by the referring physician.

In other areas, the palliative care team comes on certain days to offices with high-risk populations such as oncology or pulmonology. In addition to physician referral, nursing staff or social workers may help identify patients who could benefit, and then see if the patient’s physician concurs. Services are similar to those offered by inpatient palliative care teams and hospice teams. The palliative care practitioners discuss disease progression and goals of care, assess the need for improved symptom management, and address coordination of care. The number of visits with the palliative care team varies according to patient needs.

Kaiser Permanente – Southern California is also piloting Advanced Illness Coordinated Care (developed in collaboration with Dr. Dan Tobin of Care Support of America) in which trained social workers or case managers support physician-initiated advance care planning discussions with members facing serious progressive illness.¹⁸ The intervention consists of a six-part structured conversation between a social worker and a patient diagnosed with a life-threatening illness that is carried out over the last 12 to 24 months of life. The goal is to elicit patient preferences and make sure they are communicated to the treating physician.

Blue Shield of California is considering the development of a defined palliative care benefit where payment would most likely cover a prescribed set of services by specified

providers. As with most changes to benefit structure, it may take several years to develop a palliative care benefit.

Factors Impeding Development of Innovative Programs and Benefits

Many of the health plan leaders who were interviewed expressed frustration at impediments to broader development and implementation of innovative programs to increase access to palliative care. The following barriers were identified:

Policy. Perhaps the biggest issue is the way that the MHB dominates the “mindset” about palliative care. Both health plan leaders and hospice agency representatives noted that the commercial population needing palliative care is much smaller than the Medicare population needing it, so less attention has been paid to palliative care benefits for the former. Instead, by default, all members face the limitations of the MHB. While health plans and hospice providers are now taking steps to increase access to palliative care for non-Medicare patients, the MHB remains as a barrier to expansion of many innovations to the Medicare population.

Culture. Another impediment, faced by hospices since their inception, is the death-denying culture in the US. Health care providers and patients see advancing illness and death as failures of medicine, rather than facts of the human condition. More recently, acceptance of natural mortality has become a political hot button, tied to the concept of health care rationing.

Understanding of palliative care. Compounding the cultural obstacle is the fact that neither consumers nor health care professionals have a clear understanding of palliative care. In 2011, the Center to Advance Palliative Care (CAPC) commissioned a public opinion survey to explore awareness and understanding of palliative care.¹⁹ Seventy percent of consumers indicated they were not knowledgeable at all about palliative care. Physicians

tended to equate palliative care with hospice and see it as appropriate at the end of life.

Supply. The limited supply of board-certified palliative care professionals practicing in community settings is an impediment to access. While the number of physicians and nurses with certification in palliative care has been growing steadily since 2008, most practice either in hospitals or hospices.

Payment mechanism. There is no defined palliative care benefit offered by Medicare or health plans. This type of benefit is complicated to develop and implement because the value of palliative care depends on delivery of multifaceted services by an interdisciplinary team of professionals, but few reimbursement models include non-licensed professionals. In addition, there are difficulties defining the eligible population. Much of the value of the palliative care innovations described above depends on accurately targeting the patients who will benefit most, and the uncertain course of many illnesses makes it difficult to define a population based on prognosis.

Expanding Earlier Access to Palliative Care

While discussions with insurers, as well as hospice and palliative care providers and advocates, revealed obstacles to expansion of palliative care, they also revealed a number of ways to facilitate more access to palliative care earlier in the health care continuum.

Increase awareness and understanding of palliative care. Once informed about the definition of palliative care, over 80% of consumers in CAPC’s public opinion study indicated they would consider using palliative care if they or a loved one had a serious illness. Dissemination of accurate information about palliative care is essential to increasing consumer use of palliative care.

Disseminate evidence of the value of earlier palliative care. It is critical to publicize the data showing how early palliative care, particularly when offered concurrently with disease-modifying treatment, meets the goals articulated in the Institute for Healthcare Improvement (IHI) Triple Aim framework. It calls for better health outcomes, improved patient experience, and lower costs of care — among all health care stakeholders including clinicians, consumers, and payers.

Gather outcome data on new innovations. The stakeholders pointed to the importance of gathering more outcomes data and more standardized data. The use of standard outcomes measures would allow comparison of different innovations and identification of best practices across health plans.

Call for policy change. Funding the Medicare concurrent care demonstration project is the first step toward expanding access to full-service palliative care for seniors. Change to the MHB will also facilitate efforts to change both consumer and provider attitudes about palliative care.

Develop and test new reimbursement models. New reimbursement streams that support interdisciplinary palliative care teams in both inpatient and outpatient settings are needed. Team-based care leads to the best outcomes, and current limitations on reimbursement are a disincentive to inclusion of non-revenue-generating providers on the team. Development of new reimbursement streams may also encourage more practitioners to seek training and certification in palliative care, which will help alleviate current shortages.

Capitalize on health care reform incentives. Palliative care is a natural fit for health reform initiatives such as capitation and pay for performance. In settings where reimbursement is capitated (IPAs and newly designated ACOs), providers need to generate the best possible outcomes at the lowest possible cost. Data show that

palliative care teams facilitate both, even for the most complex and costly patients. Palliative care teams also offer the services needed to reduce hospital readmissions (for which hospitals are now penalized via reduction in Medicare payments), especially for patients with advanced chronic illness who are most at risk for readmission within 30 days of discharge.

Conclusion

Efforts to integrate palliative care earlier in the health care continuum are gathering momentum. Health plan leaders are supportive because, in their words, “it is the right thing to do,” and because it makes sense from both quality and financial perspectives. The initiatives described in this report are likely to confirm results of earlier pilots — improved health care quality, reduced utilization, and cost savings — but only if health plans define specific endpoints and outcomes and then collect reliable data. As additional data emerge, it is reasonable to expect that other insurers and health plans will also increase access to earlier palliative care.

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ABOUT THE FOUNDATION

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Appendix A: Stakeholder Interviewees

ORGANIZATION	INDIVIDUAL INTERVIEWED
California Coalition for Compassionate Care	Judy Citko, JD Executive Director
Children's Hospice and Palliative Care Coalition	Devon Dabbs Executive Director and Cofounder
University of California, San Francisco Division of Hospital Medicine	Steve Pantilat, MD, FACP Professor of Clinical Medicine, Department of Medicine Alan M. Kates and John M. Burnard Endowed Chair in Palliative Care Director, Palliative Care Leadership Center
Integrated Healthcare Association	Tom Williams, DrPh President and CEO
Center to Advance Palliative Care	Lynn Spragens, MBA President and CEO, Spragens & Associates Center to Advance Palliative Care Advisor
California Health Benefits Review Program	Garen Corbett, MS Director
California Association of Health Plans	Patrick Johnston President and CEO
Hospice of the Valley	Sally Adelus President and CEO
VITAS Healthcare Cooperation of California	Kristina Runnels Director, Patient Financial Services
Office of Congresswoman Jackie Speier	Alana Paull, Esq. Senior Legislative Assistant
University of California, Berkeley, School of Public Health Petris Center on Health Care Markets and Consumer Welfare	Liora Bowers, MBA, MPH Director, Health Policy and Practice Manager, Berkeley Forum for Improving California's Healthcare Delivery System

Appendix B: Health Plan Interviewees

HEALTH PLAN	INTERVIEWEE
Aetna	Randall Krakauer, MD, FACP, FACR National Medicare Medical Director
Anthem Blue Cross of California / Wellpoint	Sylvia Carlisle, MD, MBA Managing Medical Director
Blue Shield of California	Marcus Thygeson, MD Vice President, Medical Services
Health Net	Jonathan Scheff, MD, MBA Chief Medical Officer
Kaiser Permanente – Southern California	Nancy Gibbs, MD Regional Geriatric Coordinating Physician Kaiser Permanente, Baldwin Park Medical Center
United Healthcare	James Mittelberger, MD, MPH National Chief Medical Officer Evercare Hospice and Palliative Care Ovations/United Healthcare

ENDNOTES

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7. Temel, J.S., et al. “Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer.” *N Engl J Med.* 363:733–42. 2010.
8. Ibid.
9. See note 6.
10. See note 5.
11. See note 7.
12. Smith, T.J., S. Temin, E.R. Alesi, et al. “American Society of Clinical Oncology provisional clinical opinion: the integration of palliative care into standard oncology care.” *J Clin Oncol.* 30:880–887, 2012.
13. Berwick, D.M., T.W. Nolan, J. Whittington. “The Triple Aim: Care, Health, And Cost.” *Health Aff.* 27(3):759–769, 2008.
14. Although the Affordable Care Act (ACA) includes a provision for a Medicare demonstration project addressing the feasibility and impact of concurrent hospice care and disease-modifying care, this was one of only two demonstrations (out of a total of 43) that were not funded.
15. See note 6.
16. Ibid.
17. Anthem Blue Cross limits disease-modifying treatments to palliative chemotherapy, radiation, and total parenteral nutrition for people with cancer.
18. Engelhardt, J.B., V.M. Rizzo, R.D. Della Penna, et al. “Effectiveness of care coordination and health counseling in advancing illness.” *Am J Manag Care.* 15(11):817–25, November 2009.
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