Community-Based Palliative Care:
The Natural Evolution for Palliative Care Delivery in the U.S.

Arif H. Kamal, MD, David C. Currow, BMed, MPH, Christine S. Ritchie, MD, Janet Bull, MD, and Amy P. Abernethy, MD
Division of Medical Oncology (A.H.K., A.P.A.), Department of Medicine; Duke Cancer Institute (A.H.K., A.P.A.), Duke University Medical Center, Durham, North Carolina, USA; Department of Palliative and Supportive Services (D.C.C., A.P.A.), Division of Medicine (D.C.C), Flinders University, Bedford Park, South Australia; Southern Adelaide Palliative Services (D.C.C.), Repatriation General Hospital, Daw Park, South Australia, Australia; Division of Geriatrics (C.S.R.), Department of Medicine, University of California at San Francisco, San Francisco, California; Jewish Home of San Francisco Center for Research on Aging (C.S.R.), San Francisco, California; Four Seasons (J.B.), Flat Rock, North Carolina, USA

Abstract
Palliative care in the U.S. has evolved from a system primarily reliant on community-based hospices to a combined model that includes inpatient services at most large hospitals. However, these two dominant approaches leave most patients needing palliative care—those at home (including nursing homes) but not yet ready for hospice—unable to access the positive impacts of the palliative care approach. We propose a community-based palliative care (CPC) model that spans the array of inpatient and outpatient settings in which palliative care is provided and links seamlessly to inpatient care; likewise, it would span the full trajectory of advanced illness rather than focusing on the period just before death. Examples of CPC programs are developing organically across the U.S. As our understanding of CPC expands, standardization is needed to ensure replicability, consistency, and the ability to relate intervention models to outcomes. A growing body of literature examining outpatient palliative care supports the role of CPC in improving outcomes, including reduction in symptom burden, improved quality of life, increased survival, better satisfaction with care, and reduced health care resource utilization. Furthermore the examination of how to operationalize CPC is needed before widespread implementation can be realized. This article describes the key characteristics of CPC, highlighting its role in longitudinal care across patient transitions. Distinguishing features include consistent care across the disease trajectory independent of diagnosis and prognosis; inclusion of inpatient, outpatient, long-term care, and at-home care delivery; collaboration with other medical disciplines, nursing, and allied health; and full integration into the health care system (rather than parallel delivery). J Pain Symptom Manage 2013;46:254–264. © 2013 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.
**Key Words**
Palliative care, health care delivery, community-based distribution

**Introduction**

The evolution of palliative care in the U.S. has resulted largely from the incremental addition of delivery models as new needs arose, local solutions could be found, demand grew, and reimbursement mechanisms permitted. Conversely, growth has largely not occurred from systematic health services planning. Originally delivered as community-based hospice care, palliative care in the U.S. has expanded with the addition of acute inpatient hospice units and facilities early on, and more recently, inpatient consultative and unit-based palliative care. Increasing recognition of the need for patient-centered approaches across the continuum of care, as more patients are living with chronic serious illness, has supported the expansion and growth of these evolving delivery models.

Limitations of the current delivery methods for palliative care necessitate that novel innovative strategies increase the scope and depth of palliative care in the U.S. New models are developing organically (e.g., palliative care bridging programs), but more formalized description allows the full consideration of the components of the model; standardization to ensure replicability and consistency; has the ability to define requirements and objectives; and relate intervention models to outcomes. Toward this aim, we describe here the predominant components of an emerging model of integrated palliative care delivery for the U.S.—community-based palliative care (CPC). CPC’s primary goal is to ensure that the administrative and funding models for palliative care are harmonious to the objective of minimizing disruptions to patients and their families and optimizing quality of life in every setting.

This article discusses the current delivery models for palliative care in the U.S., reviews the hallmark components of effective CPC, examines successful demonstrations of CPC, discusses the broader impact of CPC on the entire health care system, and highlights its expected future role in palliative care delivery.

**Contemporary Approaches to Palliative Care in the U.S.—Supporting Evidence and Limitations**

In the U.S., palliative care was first predominately delivered through hospice (a largely community-based service), with the incremental addition of inpatient palliative care (hospital-based) over the past decade. Outpatient palliative care offered through clinics is a new and growing addition.

**Hospice**

Since the opening of the first hospice in the U.S. in 1974 and creation of the Medicare Hospice Benefit in 1982, community-based hospice care has been an integral component of end-of-life care in the U.S. health care landscape. There are now more than 3600 hospices in the U.S., representing a remarkable 110-fold increase in service provision in only three decades. These organizations serve more than one million patients annually, representing around 40% of all decedents in the U.S. annually. Hospice, by Medicare definition, is interdisciplinary; recent mandates for face-to-face visits have increased medical involvement in the community setting. Increasingly, research on hospice care has demonstrated improved survival compared with usual care, improved patient and family satisfaction with appropriate timing of referral, and decreased use of other inappropriate health system resources.

Despite its remarkable uptake, there stand two significant roadblocks impeding hospice expansion into a more longitudinal model; one is benefit-related and the other is financial. The most obvious restriction is related to its core mission: hospice eligibility is defined by the Medicare Hospice Benefit to be reserved for terminally ill patients with life expectancies of six months or less “if the disease runs its normal course.” This defines hospice’s charge to provide end-of-life (EOL) care and establishes, through federal mandate, clear financial and regulatory boundaries within which hospice reimbursed by Medicare...
must operate. Hospice is known in the medical and lay communities to be synonymous with “near death” care, having formalized a workforce and skill set around supporting tasks very specific to EOL planning.

The second major barrier involves the feasibility of financing hospice “upstream,” i.e., earlier in the illness trajectory than the EOL setting tied to current reimbursement models. For example, Taylor et al. recently highlighted that cost savings to a health system with hospice use are not linear over extended hospice enrollment time; in fact, utilization past 233 days for patients with cancer and 154 days for patients with other conditions increases the overall expenditures even when accounting for early cost savings. Recent efforts to overhaul the Medicare Hospice Benefit as part of the overall health care reform in the U.S. have brought further attention to the idea of a maximized cost to length of stay ratio, making expansion of hospice upstream to EOL care untenable and likely not supported by payers and policy makers. Furthermore, with nonprofit hospices operating at a 1.8% margin and currently having to foot costs of bereavement services (which are not reimbur sased by Medicare),3 asking organizations to provide expanded palliative care without a dramatic overhaul of the hospice benefit would be financially and logistically unviable.

Recognizing that EOL care is one component of CPC, and cannot be the dominant model of its delivery, stems from the increasing understanding that palliative care as a profession requires care across all components of the life-limiting and chronic illness trajectory. Clearly, although hospice has thrived in the U.S. over the last 30 years as the dominant medical delivery system for EOL care, it cannot be the full solution for CPC because there will always be a meaningful cohort of patients for whom hospice is not an option because of benefit criteria or patient/caregiver preference.

**Inpatient Consultative Palliative Care**

At present, almost two-thirds of all hospitals in the U.S. provide some palliative care services;9 63% of hospitals with greater than 50 beds have a consultative palliative care service, a 138% increase from 2000. These efforts have been fruitful; studies have demonstrated improved patient outcomes and family satisfaction,10 cost savings,11 and decreased resource utilization12 with the addition of inpatient palliative care. Despite its remarkable benefits, inpatient palliative care has several limitations.

First, most palliative care contact that begins with inpatient teams eventually falls short in addressing longitudinal needs across all subsequent settings of care. For example, in a study of 20 inpatient palliative care programs in a palliative care quality network that included both academic and safety net hospitals, 60% of providers had no mechanism for the follow-up of consultative patients after discharge; only 20% of those that did provide follow-up reported that patients received this care in an outpatient clinic; and 5% had made home visits.13 In this example, and likely in other health care systems, most discharged patients have no mechanism for the continued evaluation and adjustment of care plans and only receive further palliative care when their condition becomes severe enough to require rehospitalization or referral to hospice.

Second, the hospital environment makes it difficult to comprehensively assess the needs of palliative care. Multiple factors, woven into the patient’s natural environment, may compound or exacerbate symptoms or psychosocial distress. Without exposure to the patient’s home and community, hospital-based clinicians may not be able to fully grasp the “milieu” of physical, emotional, social, mental, occupational, logistical, and existential stressors impacting the patient and family. Moreover, without observing the relationships between patients and their caregivers, family, and social support structures, a depth of understanding of how a patient best copes and interacts is unavailable. Community-based assessment provides a more realistic depiction of caregiver roles and associated stressors, which may be invisible when the patient is hospitalized.

Third, even in hospitals that have palliative care programs, the timing and reach of palliative care may be insufficient. A review of palliative care consultations at one academic center over five years14 revealed that, despite a dramatic increase in consultations—from 600 in 2004 to 2000 in 2009—the median time from consultation to discharge remained steady at 2.5 days. Palliative care providers were asked
to assess, treat, and re-evaluate symptom interventions, participate in discussions of the goals of care, conduct family meetings, and help resolve difficult issues in less than three days. Even in Australia, considered at the forefront of advancing palliative care delivery into mainstream medicine, a study found that although one-third of all hospitalized patients had a goal of care consistent with a palliative approach, only 20% of that group had received a palliative care consultation.¹⁵

Fourth, when palliative care is exclusively delivered in the inpatient setting, often during the course of decompensated illness, opportunities to involve palliative care early in the continuum of illness are often missed. Palliative care has historically gained favor because of demonstration to administrators and payers what it can save (e.g., emergency room visits, intensive care unit days, and hospital length of stay) hospitals and health care systems for patients often near the end of life. Thus, as preventing inappropriate or unwanted resource utilization has become a crux for its value and a significant reason for its growth in the U.S., continued efforts must be made by palliative care upstream of hospitalization for the discipline to evolve and deliver the full spectrum of benefits expected by patients, caregivers, families, health administrators, and payers. These may include outcomes such as reduced hospital admissions, further upstream hospice initiation, and decreased use of unnecessary outpatient interventions (e.g., laboratory, imaging, and office visits) that will not change the course of clinical care.

**Outpatient Palliative Care Clinics**

Outpatient palliative care clinics recently have been heralded as the missing component of care models that facilitate care across settings. In 2008, Meier and Beresford¹⁶ described these clinics as “a new frontier” in the U.S.; they expected clinics to function as “a key link in the chain of continuity of palliative care.” However, widespread implementation of palliative care clinics in the U.S. remains nascent. Berger et al.¹⁷ reported that only 8% of hospitals in California have an outpatient palliative care program.

Outpatient palliative care has been linked to positive patient outcomes; probably the most widely cited study of palliative care, that by Temel et al.,¹⁸ was of an outpatient palliative care model. Patients with newly diagnosed metastatic lung cancer were randomized to standardized palliative care delivered predominantly in an outpatient setting vs. usual care; intervention patients had better quality of life, better symptom control, reduced resource utilization, and no decrease in survival over a median of four outpatient visits with subspecialty palliative care professionals.¹⁸

In a landmark study published in 2004 by Rabow et al.,¹⁹ outcomes were compared when patients received care through a palliative comprehensive care team with that when patients received care through usual primary care; participants were outpatients with advanced heart failure, chronic obstructive pulmonary disease, or cancer. In addition to significant symptom improvement, patients also reported high satisfaction with services. Another Phase II study of outpatient palliative care in patients with metastatic cancer²⁰ also demonstrated similar improvement in symptoms with increases in satisfaction with care. Other reported benefits of outpatient palliative care include greater comfort in the last two weeks of life,²¹ maintenance of performance status,²² more EOL discussions,²³ and better long-term outcomes for caregivers.²⁴

But outpatient palliative care, even when available, is not the comprehensive solution to seamless, patient-centric palliative care. Similar to inpatient palliative care models, clinic-based outpatient models have limitations. They are challenged to ensure continuity of the palliative care plan across all patient settings, including home, hospital, clinic, rehabilitation center, and long-term care facility. They rely on patients’ ability to travel to clinic facilities, are limited by the clinics’ hours of operation (often only one half day to one full day per week), and depend on other providers’ referrals. Furthermore, many components of outpatient palliative care (such as mental health, social work, and nutrition support services) are inconsistently reimbursed in traditional fee-for-service practices. Consequently, outpatient clinics alone cannot be the solution for an evolution in palliative care delivery to meet all the demands required but must be an integral part of a comprehensive approach.
Integration Is Needed

Most striking is that hospice, inpatient palliative care, and outpatient palliative care are not inherently linked solutions. In a truly patient-centric system, these elements would be organized around the patient and family, focused on meeting their needs, regardless of the location of care. As a result, gaps in palliative care delivery would be filled. As Fig. 1 depicts, the currently available components leave people “uncovered” by palliative care during critical periods of worsening illness and deterioration. In particular, as people decline beyond the point of being able to attend outpatient clinics but do not need hospitalization, CPC services are not routinely available unless the person meets U.S. hospice criteria or has access to medical home care. In essence, we have been progressively studying CPC in pieces—assessing the component parts that are available without deliberately assembling these pieces into a continuum.

CPC: A C + P + C Model for the Future

CPC is a potential solution for the current fragmented approach to palliative care delivery in the U.S. CPC is a comprehensive palliative care model in which the starting point is people residing in community settings; the term “community” is defined as the summation of settings in which patients and their loved ones live, work, play, and receive medical care, both statically and during transitions. CPC interdigitates seamlessly with all aspects of the palliative care continuum including hospice, inpatient consultative palliative care, and care by nonpalliative care providers. Although occasional organization-level efforts targeted at the postdischarge or prehospice population do exist, sometimes referred to by other names such as “bridging care,” “continuum programs,” or “transition care,” these have generally not yet evolved to become an inclusive longitudinal model for palliative care across the disease span and across care settings. CPC is more akin to a comprehensive palliative care approach in which care is delivered independent of setting, disease, or prognosis.

Although the exact specifications of a highly functioning, efficient, and cost-effective CPC model require ongoing discussion, further study, and refinement, there are three major tenets, designated by the acronym “CPC,” which should serve as the foundation for its development (Fig. 2). These lay a general outline for the spirit of future CPC services, reflective of the services’ mission, goals, and objectives.

The first “C” stands for “Consistent Across Transitions,” highlighting that services should be continuous across the many patient transitions expected in this population. These transitions may be:

- philosophical (e.g., a shift from exclusively disease-directed treatment to treatment, i.e., both disease-directed and palliative);
- disease-related (e.g., transition from chronic illness to life-threatening illness);

![Care gaps in current palliative care delivery models.](image-url)
CONSISTENT ACROSS TRANSITIONS

PROGNOSIS-INDEPENDENT

COLLABORATIVE AND COORDINATED

Fig. 2. Characteristics of effective community-based palliative care (C + P + C).

- locational (e.g., movement between home-based and institutional care); and
- temporally dynamic (e.g., continuously delivered or intermittently offered during apices of distress).

Patients and families must be able to rely on dependable service delivery, inclusive of similar resources, expertise, and familiarity with individual goals and wishes, regardless of movements within the health care system. This requires system-level planning to identify strengths and weaknesses of existing infrastructure for palliative care delivery, ensuring that patients touch the health system in which personnel expertise and resources are the greatest (as opposed to the closest); bring those personnel and resources to patients (e.g., in-home visits) when travel or mobility are rate-limiting factors; and appreciate that the idea of a medical home for palliative care must be agile enough to respond to the “when” and not the “if” of transitions.

Next, designated by the letter “P,” CPC must deliver care that is “Prognosis-Independent” across the continuum of serious progressive illness. Services must be tailored to heterogeneous populations with palliative needs regardless of prognosis, diagnosis, or point along the disease trajectory. In CPC, eligibility for palliative care services would not be limited by payer-established prognostic thresholds or the requirement of ongoing decline in functional status. This broader eligibility allows palliative care to reach patients 1) who have symptom-, quality-of-life-, or caregiver-related needs but a prognosis of more than six months, 2) whose providers have not yet recognized that the six-month threshold has been crossed (especially given how poorly this is recognized25), or 3) who still desire disease-directed therapies (and for whom such interventions may well be appropriate). Additionally, CPC would serve as the natural catchment for patients on the other side of hospice eligibility, including the estimated 15% of patients (163,000) who graduate from hospice annually as a result of disease stabilization or improvement.26

Last, but most important, the final “C” stands for “Collaborative and Coordinated” in which successful CPC is delivered through an interdisciplinary team of physicians, nurse practitioners, physician assistants, social workers, pharmacists, chaplains, and others who conduct regular, multidomain assessments and deploy comprehensive management plans. These teams designate a central, point clinician (known to the palliative care team but not necessarily a palliative care provider) whom the patient would interact with before, during, or between geographic transitions. The central coordinating clinician may be a palliative care specialist or another primary or secondary care provider (e.g., family doctor, cardiologist, or nurse practitioner) equipped with the appropriate level of palliative care skills matched to the needs of the patient; the model allows for primary and specialist-level palliative care to coexist and the level of specialist palliative care to be right-sized based on the patient needs. An identified range of providers also would be responsible for addressing symptom or disease exacerbations. A centralized palliative care record that warehouses critical portable documents (e.g., current medications, physician orders for resuscitation, and advance directives [ADs]) facilitates the development of a written treatment plan that would follow the patient across transitions and be updated as necessary.

Many practical issues must be considered in transitioning from the general principles outlined here to routinized development of thriving programs that deliver CPC. Key questions that require further study and discussion for solutions are outlined in Table 1. Initial experiences from local programs in delivering CPC have provided early information on what potential answers may look like.

CPC Models in Action

To date, a few CPC models have developed organically in the U.S., providing an initial snapshot of CPC in action and a roadmap for the future. One of the first reports of
A home-based nonhospice palliative care program comes from a study by Brumley et al., with patients receiving care through Kaiser Permanente in southern California. In this retrospective cohort study, a total of 558 patients who were either admitted into a multidisciplinary, home-based palliative care program or received usual care were compared for outcomes on resource utilization, costs, and satisfaction. The Kaiser Palliative Care Program uses a base team of a physician, nurse, and social worker to provide in-home visits and 24-hour telephone support; the program encourages continued patient visits to primary and subspecialty providers and allows all restorative therapies that promote relief and quality of life. Remarkably, while also showing increased satisfaction among patients surveyed at 60 days, enrollment in the palliative care program led to less care in the emergency department, fewer hospital days and fewer skilled nursing facility days compared with those patients who received usual care. Less use of medical resources led to a 45% decrease in costs; these cost savings ultimately benefit patients and society beyond just those receiving care for serious illness.

Rural CPC models also have been described. The Project ENABLE model, studied by investigators at Dartmouth, led to improvement in the quality of life and mood of patients receiving palliative care; the target population was patients from a rural cancer center and rural outreach clinic. Project ENABLE included a case management and education approach through telephone-based assessments and collaborative care between advanced practice palliative care providers and the oncology team. Other investigators internationally have demonstrated improved outcomes with rural palliative care, albeit in small studies.

Often, the primary benefit of studies involving rural health programs has been an increased understanding of capacity building and service planning for large-scale implementation. These early experiences, coupled with other innovative strategies such as telemedicine, which is increasingly being explored as a tool for communication in palliative care practice, are additional elements that support the expansion of current delivery models into a more community-based approach.

Evidence is emerging to discredit the notion that, by adding yet another provider, the integration of palliative care into the care continuum further burdens the seriously ill patient. When Dow et al. interviewed 75 hospitalized patients, 87% thought it was acceptable to discuss ADs with the admitting physician, with whom they had no prior relationship; by comparison, 23% reported that they would have liked to discuss ADs with their oncologist, and 7% already had done so. At the Mayo Clinic, the addition of a palliative medicine physician to an anesthesia-pain clinic led to improved symptom management and quality of life; pain control was equally effective. Positive results led to the continuation of this novel approach, demonstrating that palliative medicine can feasibly and effectively be integrated into the outpatient setting. These reports illustrate ways in which palliative care specialists, in regular interaction with other subspecialty providers, can improve patient outcomes.

There is now an imperative to pull services together. The component parts of evidence-based outpatient palliative care, hospice care, inpatient consultative palliative care, and the transition points in between must be integrated into a summary model of CPC (Fig. 3). This ultimately defines, refines, and studies CPC as the whole package.

### Table 1

<table>
<thead>
<tr>
<th>Key Questions for Operationalizing Community-Based Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure</strong></td>
</tr>
<tr>
<td>What workforce is needed to meet goals of consistent care across transition?</td>
</tr>
<tr>
<td>How will this workforce be trained and equipped to meet the growing need?</td>
</tr>
<tr>
<td>How can resources be distributed to meet the needs of all populations, including the rural and underserved?</td>
</tr>
<tr>
<td><strong>Process</strong></td>
</tr>
<tr>
<td>What triggers activation of CPC?</td>
</tr>
<tr>
<td>What is the unifying reimbursement model?</td>
</tr>
<tr>
<td>How does CPC stay unique to serve those with palliative needs and not just all persons with any chronic illness?</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
</tr>
<tr>
<td>How do we ensure CPC leads to more thoughtful goal-aligned care without progressive layering of bureaucracy and services?</td>
</tr>
<tr>
<td>What is the main outcome we should measure to define success?</td>
</tr>
</tbody>
</table>

CPC = Community-based palliative care.
The Expected Benefit of CPC to the U.S. Health Care System

The number of persons with chronic or serious illness who could benefit from palliative care is growing rapidly. By 2030, the number of Americans aged 65 years or older is predicted to approach 71 million, with 80% of these individuals having at least one chronic condition and 50% having two or more. These chronic conditions (e.g., cancer, heart failure, and chronic respiratory conditions) are often associated with significant symptom-related and functional morbidity—the domain of palliative care. As this patient population grows, the need for palliative care that is available outside of the hospital or home-only context will increase. Thus, a first and critical role for CPC is simply to better meet the growing need for palliative care across the general population. This is not only a timely need because of rapid changes in the population demographic but also because of increasing awareness of health care costs and reform.

Costs for EOL care vary considerably across the U.S. and can be staggering. High health care utilization characterizes practice patterns with respect to progressive illness and EOL care, and high utilization in turn incurs high costs. Grand Junction, Colorado has been highlighted as a low-cost, high-quality example for other states; EOL care provided in its health care system entails fewer hospital days, fewer hospital deaths, and longer lengths of stay in hospice. Thus, reduced use of hospital resources—such as is achieved through outpatient palliative care—appears to help contain overall health care costs. Palliative care also appears to reduce costs associated with standard outpatient care. A trial that compared regular palliative care with usual primary care demonstrated decreased health care utilization with regular palliative care, including fewer primary care and urgent care visits; other studies have yielded similar findings. The lesson to learn here is clear: just as increased access to primary care—and not attention to emergency department-related factors—has often been the solution to preventing unnecessary visits to the emergency department, increased provision of CPC—and not necessarily changes in hospital utilization policies—may help resolve high rates of hospital readmission for patients with chronic debilitating conditions.

In the years ahead, CPC also can be expected to play a significant role in research. The demonstration of meaningful benefits achieved when palliative care is added to usual cancer care will likely lead to the use of CPC as a comparator arm in cancer clinical trials. Future clinical trials in cardiology and pulmonology may follow suit. Ongoing efforts to define “best supportive care” in oncology, so as to standardize comparator arms and improve the quality of research, could inform the development and standardization of CPC and vice versa—making it a viable comparator for interventions being studied as well as a suitable object itself for rigorous research. Standardization of CPC, using its rapidly evolving evidence base, will subsequently facilitate implementation of CPC on a widespread and consistent basis.

Finally, large professional organizations such as the American Society of Clinical Oncology and the American Thoracic Society have advocated for early palliative care. Their consensus statements cannot be realized unless and until palliative medicine specialists can work alongside subspecialist providers in diverse clinical contexts. Simply put, palliative care cannot simultaneously 1) play a complementary role to other specialties (i.e., “simultaneous deployment”) and 2) be made available to patients only during times of crisis or active dying, as is
the case with most inpatient palliative care or community hospice programs. To enable guideline-based care, clinicians need a new model of palliative care that provides patient-centered care across all clinical settings and all stages of disease. This is the mandate of CPC.

Conclusions

CPC is the natural evolution of palliative care delivery in the U.S. It presents a radically different approach by systematically planning health services, one that is specific to the care of patients with advanced or life-limiting illness. Whereas health care systems have traditionally prioritized services and planned their delivery based on the assessments of which providers, clinical environments, and reimbursement systems are most mature and developed, CPC begins with patients and their community first and then designs services to meet the identified needs in coordination with the patient’s other providers. Especially within resource-strapped settings, palliative care must learn to evolve to direct resources toward patients with the most needs through upfront assessments and continual reassessments. It also must evolve to anticipate and proactively manage issues before they evolve into crisis, establish pivotal relationships before patients become critically ill, and provide for continuous and responsive care as patients’ conditions change over time.

Currently, considerable workforce, cultural, institutional, and financial barriers prevent widespread implementation of CPC. These issues must become priorities for researchers, payers, and policy makers who share a commitment to improving continuity, quality, and outcomes of care for patients with serious, advanced, and/or life-limiting disease. As a first step toward ensuring coordinated and effective palliative care across settings, we must promote and broadly instill a new manifesto: “bringing palliative care to where patients are—mentally, physically, emotionally, spiritually, socially, sexually, and geographically.” CPC holds promise to be the model that delivers on this mantra.

Disclosures and Acknowledgments

No funding was secured to support the development of this special article. As of July 2012, Dr. Abernethy has research funding from the U.S. National Institutes of Health (NIH), U.S. Agency for Healthcare Research and Quality, Robert Wood Johnson Foundation, Biovex, DARA, Helsinn, MiCo, and Pfizer; these funds are all distributed to Duke University Medical Center to support research, including salary support for Dr. Abernethy. In the last two years, she has had nominal consulting agreements with or received honoraria from (<$5000 annually) Novartis and Pfizer. Consulting with Bristol Meyers Squibb is pending in 2012, for the role of Co-Chair of a Scientific Advisory Committee. Dr. Ritchie has research funding from the U.S. NIH and the Bechtel Foundation. Drs. Currow and Kamal do not have any competing interests to declare.

References


