AMGA

The Dr. Barney Newman Collective for Quality and Innovation in Ambulatory Palliative Care

Phase 2 Meeting Summary

March 10–12, 2026

AMGA Quality and Innovation Collective (QuIC)

Ambulatory Palliative Care

Welcome and Opening Remarks

John W. Kennedy, MD*, President, AMGA Foundation and Chief Medical Officer, AMGA, and*
Barney Newman, MD*, Emeritus Medical Director, Summit Health*

Dr. John Kennedy welcomed Quality and Innovation Collective (QuIC) participants to their first in-person meeting, introducing the meeting goals and framing them within the QuIC's broader objective: understanding the current landscape of palliative care in an ambulatory setting and developing processes and methods to improve access for all people with serious illness, regardless of setting, diagnosis, prognosis, or age.

The QuIC's founding donor Dr. Barney Newman further emphasized the importance of this work, noting that palliative care is a critical component of serious illness management—and one that is too often introduced late in the course of a progressive illness, if at all.

Newman shared a personal experience with a close family member who had a large tumor and for whom palliative care should have been an automatic referral. Misperceptions—including concerns that the patient would feel her family was giving up on her—delayed the transition to palliative care by months, significantly shortening the duration of that experience. During that time, the primary nurse led the patient and family through difficult decisions with dedication, but because palliative care was introduced so late, the patient was unable to participate in decision making, the family was unable to have meaningful conversations about values and goals of care, and the outcome was not what the family had hoped for.

Newman reflected that his personal experience has only deepened his conviction about the importance of palliative care in patient treatment.

Palliative Care QuIC Participants

The Palliative Care QuIC brings together healthcare organizations from across the country, serving diverse patient populations in urban, suburban, and rural settings. Participants represent various stages of ambulatory palliative care implementation and include providers, administrators, and quality leaders from:

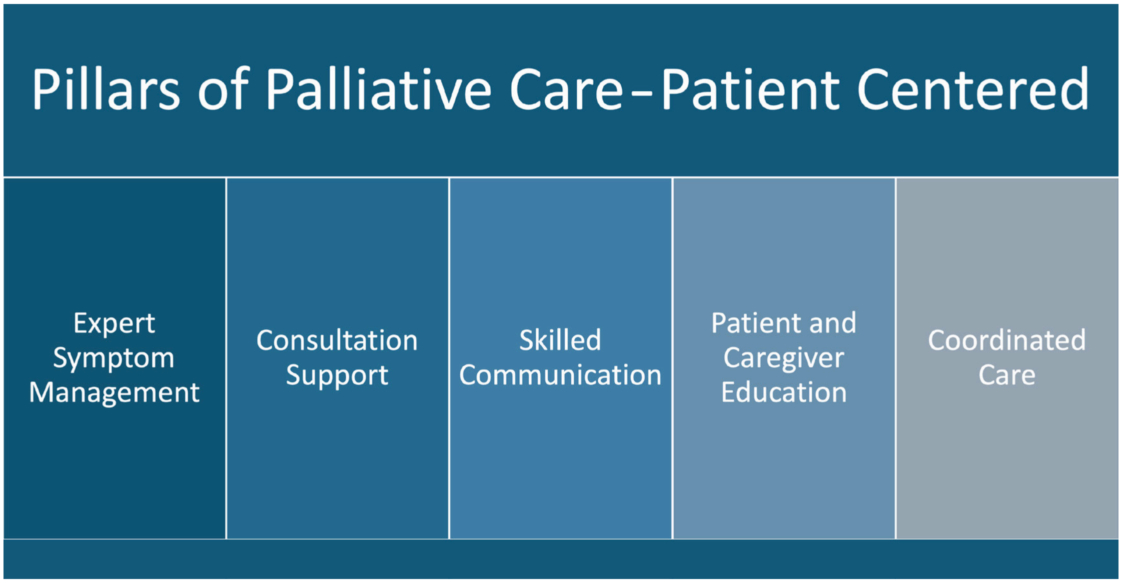
- **HealthPartners** (Minneapolis-St. Paul, MN, and western Wisconsin)
- **Lehigh Valley Health Network** (Allentown, PA)
- **MaineHealth Medical Group** (Portland, ME, and network sites)
- **Ochsner Health** (Louisiana, Mississippi, Alabama, Florida)
- **SSM Health** (four-state integrated health network across the Midwest)
- **Stormont Vail Health** (Topeka, KS)
- **Summit Health/VillageMD/CityMD** (New Jersey and New York regions)

Ambulatory Palliative Care: Why It Matters and Where We're Going

Katherine Aragon, MD*, Inpatient Adult Palliative Care, Outpatient Palliative Care Clinic, Inpatient Hospice, University of North Carolina-Chapel Hill*

Dr. Katherine Aragon opened the keynote by asking why palliative care deserves focus—and why now. Her answer: The number of people with serious chronic illness is rising, the population is aging, and despite innovations enabling people to live longer, those later years are often marked by chronic illness,

stress, and emotional distress. Care for these conditions is frequently fragmented, incompletely coordinated, and poorly communicated. Aragon noted that the medical system is not designed for this reality—but palliative care is. Professionals in the field are equipped across the full continuum of patient needs, from communication to symptom management to care coordination.



Pillars of Palliative Care–Patient Centered

Expert Symptom Management

Consultation Support

Skilled Communication

Patient and Caregiver Education

Coordinated Care

Aragon shared research supporting palliative care's benefits: Patients spend more time in hospice, experience less intensive treatment such as chemotherapy, and report improved mood; healthcare organizations see decreased hospital and emergency department (ED) utilization and lower overall costs of care.[1–3]

Such data help leaders understand the ROI of palliative care, Aragon noted, but making the business case for program growth—hiring and training integrated teams, sustaining patients across the continuum—remains difficult. Value-based care and alternative payment models will eventually support palliative care more fully, but the field is currently navigating a challenging environment, particularly around billing for roles like social workers and registered nurses (RNs).

Aragon then described what she has seen work operationally. She highlighted palliative care programs comanaged with and embedded in specialties such as pulmonary care, neurology, and oncology—a model that is more convenient for seriously ill patients and helps normalize earlier palliative care involvement. At the University of North Carolina (UNC), a colocated independent clinic takes referrals from across the system, enabling growth and expanded patient volume. Aragon cautioned that palliative care capacity must scale alongside specialty growth—programs should not expand one side without expanding the other.

Telehealth was identified as a force multiplier, especially for rural patients and routine goal check-ins. Familiarity with community resources outside the organization's own walls was also encouraged, even for programs with robust internal teams.

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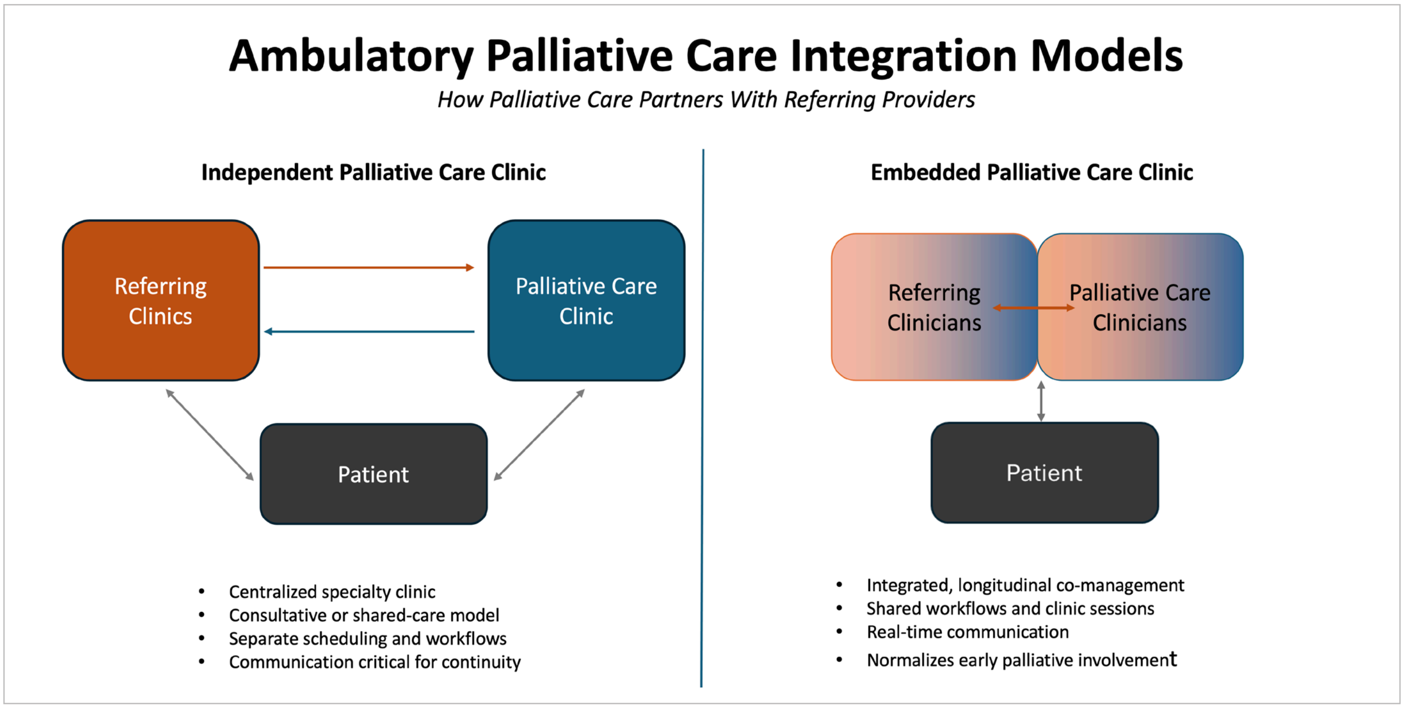
1. https://www.nejm.org/doi/full/10.1056/NEJMoa1000678
2. https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.2007.01234.x
3. https://pubmed.ncbi.nlm.nih.gov/38227034/



Ambulatory Palliative Care Integration Models

How Palliative Care Partners With Referring Providers

Independent Palliative Care Clinic

- Centralized specialty clinic
- Consultative or shared-care model
- Separate scheduling and workflows
- Communication critical for continuity

Embedded Palliative Care Clinic

- Integrated, longitudinal co-management
- Shared workflows and clinic sessions
- Real-time communication
- Normalizes early palliative involvement

Aragon concluded by emphasizing cultural humility—acknowledging that patients want different things at end of life and with chronic conditions—and health equity, specifically the need to address persistent disparities in serious illness care and expand access to all populations.

Audience Q&A

How can palliative care programs manage handoffs?

At UNC, providers and staff receive education on staying connected with the palliative care team and receive credit for work done outside of clinic visits, an approach Aragon's predecessor advocated. She noted the value of having all programs under one umbrella, while acknowledging that long-term care remains the weakest link due to the complexity of community providers, varied services, and contractual arrangements. Her team is working to strengthen these connections through a robust geriatrics program.

How is UNC building palliative care knowledge across its healthcare ecosystem?

Education has been a primary tactic, with social workers, advanced practice providers, and a chaplain leading sessions for a wide range of learners, including anesthesiologists, psychology staff, and intensive care providers. Direct exposure is another approach: Nurse practitioners, medical students, residents, fellows, and interested physicians have been welcomed to shadow the team. The program is also deeply involved with the institution's residency program, particularly internal medicine, and with departments such as neurology and transplants, with the goal of making those programs feel supported.

How can palliative care programs justify the upfront investment?

Aragon suggested framing palliative care as population management—focusing on services with strong cost-saving potential, such as symptom management for high-utilization patients with multiple comorbidities. Programs should also define and refine their scope of practice and referral criteria, as overly broad categories like pain management can overload resources and create unacceptably long wait times. Identifying an influential clinical champion was also recommended. Finally, Aragon advised demonstrating how palliative care supports the Quintuple Aim and value-based care through metrics around ED visits, avoidable hospitalizations, accountable care organization (ACO) performance, patient satisfaction, and quality of life.

QuIC Overview and Quality Improvement Report

Earlean Chambers, RN, MS, CPHQ, *Senior Director of Clinical and Quality, Population Health Initiatives, AMGA Foundation*

QuIC participants submitted assessments and initial plans before the Phase 2 gathering. After reviewing these data and meeting with participants, AMGA Foundation Senior Director Earlean Chambers shared her analysis of the groups, beginning with identified strengths. All programs demonstrated a commitment to the interdisciplinary team approach, even where staffing was not yet complete. Participants represent diverse operating models—community-based, clinic-based, telehealth, and hybrid—and have secured meaningful leadership and operational support. She also noted that participants across all maturity levels have recognized certification as a standard for their palliative care programs.

The presentation then turned to shared challenges. Workforce issues, including recruiting and retaining the right mix of staff, are a persistent barrier. On data and measurement, participants cited electronic health record (EHR) limitations, data and measurement gaps, and financial sustainability challenges—particularly the difficulty of demonstrating hard ROI for a program requiring ongoing investment. Another challenge is evaluating how well palliative care treatments align with a patient's expressed goals, values, and preferences; no organization has yet solved for the co-concordant care measurement, making it a shared priority across the QuIC.

An overview of the QuIC's Motivating Needs followed—elements AMGA and the Advisory Committee identified as essential to a successful ambulatory palliative care program.

Motivating Needs

AMGA

1. Interdisciplinary Team
2. Clinical Care and Symptom Management
3. Advance Care Planning
4. Patient and Family-Centered Care
5. Community and Outpatient Integration
6. Quality Improvement and Data Tracking
7. Education and Public Awareness
8. Sustainable Funding and Policy Support

Chambers noted that some participants are pursuing multiple Motivating Needs in their plans, while others are focusing on one, and that some Motivating Needs (Interdisciplinary Teams) are central to upcoming interventions, while others (Patient- and Family-Centered Care) are less prominent despite high rankings. Additional obstacles identified in the analysis included the need to remove barriers to patient-provider conversations and to establish clear structures and processes.

Chambers observed that self-diagnosis was accurate across all seven organizations—each understands its own problem regardless of program maturity level. With a progress report due in early May, the goal now is identifying what each organization can realistically execute.

Sustainability Funding & Policy Support + Clinical Care & Symptom Management Panel

Advisor/Moderator: ***Narayana Murali, MD, DNP, FACP****, System CMO, Medicine Services & Prof of Medicine, Geisinger College Health Science*

HealthPartners offers palliative care services across Minnesota and Western Wisconsin through hospitals, home-based care, and ambulatory specialty clinics. The department manager shared that palliative care has become central to the organization's end-of-life strategy: Quality initiatives seek the palliative care department input, other departments refer patients to it, and the team has developed the ability to estimate cost savings to the system.

Pressing challenges now include staffing and capacity. Value-based care constraints have limited referral bandwidth, leading the program to accept hospice discharges only from within its own system of care. The team has been adapting through using RNs for preoperative care and educating providers on advance care planning. The department manager noted that perceived staffing shortages are sometimes actually a tools and infrastructure problem. Looking ahead, the organization seeks an appropriate staffing model for community-based palliative care—particularly following recent mergers and the reassignment of community-based physicians into clinic settings—and improved measurement approaches. The organization currently uses the Quick Questions tool to assess palliative care outcomes, but its limitation to scheduled appointments means telephone encounters have been underreported.

Lehigh Valley Health Network's OACIS (Optimizing Advanced Complex Illness Support) program serves Pennsylvania and New Jersey, with telemedicine and home-based care supplementing inpatient and office-based services. The OACIS/Palliative Medicine director noted that benchmarking and tracking savings via tools like the Center to Advance Palliative Care (CAPC) calculator have supported the program's growth. The program is now involved in a wide range of system priorities—decreasing interhospital transfers, reducing length of stay—and is working to manage this expanding scope.

The division chief of palliative medicine and hospice described a focus on workforce development in response to recent Medicare and Medicaid funding cuts, including provider education integrated into department goals, the addition of an electronic medical record (EMR) tab for advance care planning modeled after the serious illness conversation, and the engagement of high-performing nurse practitioners in triage. The OACIS director added that these nurses have increasingly taken on complex symptom and medication management, including opioid prescribing, and the team is preparing a business case for a dedicated palliative care pharmacist.

Ochsner Health, serving Louisiana, Alabama, and Mississippi, built support for an expanded outpatient clinic by demonstrating $2,000 per-member savings through EMR alerts, documentation tools, and physician training that increased advance care planning completion. The organization's physician vice-chair of palliative medicine noted that current reporting metrics do not capture the full scope of what the team does—particularly the non-face-to-face care coordination work that effective palliative care requires. A palliative medicine physician walked through Ochsner's broader palliative care services, including an embedded cancer clinic, a palliative care mental health clinic, and multidisciplinary clinics focused on specific diseases such as ALS and Parkinson's. Moving forward in the QuIC, the team aims to evaluate how ambulatory palliative care impacts care utilization and patient value in the last six months of life, with an eye toward presenting compelling findings to organizational leadership.

> *Ochsner Health physician vice-chair of palliative medicine raised the central tension facing palliative care programs: demonstrating value while maintaining a patient-centered model that prioritizes goals of care and symptom management alongside cost reduction.*

Group Discussion: Funding and Sustainability

Participants recommended identifying services already covered under existing billing (e.g., e-consults, nurse services during wellness visits) and exploring opportunities to backfill costs through adjacent revenue sources such as hospice margins. Framing palliative care's contribution to cost avoidance—through outcomes like reduced hospital stays—was suggested as an important component of the business case within value-based care arrangements.

Several participants noted the value of quantifying individual staff roles. One participant shared that documented savings in the hundreds of thousands can directly justify the addition of one or two clinicians. The group also discussed the potential of predictive analytics tools to help financial decision-makers visualize future outcomes.

Quality Improvement & Data Tracking + Interdisciplinary Team Panel

Advisor/Moderator: ***Amy Scheu, MSH, CHPCA****, Associate Vice President of Midwest Hospice & Enterprise Palliative Care, Advocate Health*

MaineHealth Medical Group had no ambulatory palliative care team as recently as 2020. Today, ambulatory care is the program's biggest growth area. The senior medical director of palliative care noted that the program is increasingly seen across the organization as a solution to multiple challenges—but has reached capacity and needs additional staff.

The program has been optimizing available resources through a centralized nursing team, drawing on the senior medical director's strong conviction that nurses trained in the specialty are essential to palliative care. These nurses are supported with standardized documentation for patient calls and flow charts for triage decisions.

Patient satisfaction has consistently ranked in the 95% to 99% range, and the team is working to replicate this success in job satisfaction, which the recently joined practice manager identified as an ongoing issue. Upcoming priorities include involving nurses more meaningfully in patient goal conversations and providing better support for medication

management—the practice manager and senior medical director both noted that time-consuming and unrewarding tasks like tracking down medications can drain nursing staff.

SSM Health is working toward integrating palliative care services across 20 hospitals with distinct leadership structures spanning Illinois, Wisconsin, Missouri, and Oklahoma. The organization's palliative medicine clinical programs manager described the QuIC assessment as revealing significant fragmentation—a barrier to meeting complex patient needs across physical, emotional, and spiritual dimensions.

The manager and a system administrator are building teams under a new leadership structure, standardizing job profiles, and enabling staff to practice at the top of their licenses. The overarching goals are transparency, consistency, and stability. SSM Health anticipates that this alignment will result in more consistent, timely care for patients.

Stormont Vail Health, based in Kansas, has grown its palliative care program from 30 patients in 2017 to 289 today and recently moved into a dedicated space. A multifaceted approach—including telehealth, automated consult triggers, and a survivorship education series—helped demonstrate program value by improving patient engagement, including reducing no-show rates to 2%.

To increase advance care directive (ACD) completion from a 10% baseline, Stormont Vail implemented a structured three-visit patient education process, automatic Epic triggers, and a real-time dashboard. Completion rates have reached 64%. A Stormont Vail APRN noted that these efforts are building toward a longer-term vision of a dedicated advance care planning clinic.

Summit Health serves a large population of middle-aged and older adults in Westchester County, NY, and Fairfield County, CT. High rates of chronic disease led the palliative care team to prioritize transitions of care, implementing a seven-day post-discharge follow-up process tracked through 30-day readmission rates. A Summit Health internal medicine physician noted that early post-discharge contact consistently reduces readmissions.

Summit Health currently delivers palliative care solely through a hospitalist service with no outpatient referral options—an area the organization is actively working to expand. A Summit Health hospitalist noted that primary care providers will need to take on a central coordinating role as palliative care grows. A post-hospitalization telehealth clinic, built on existing infrastructure, supports this through virtual review of goals of care, patient illness understanding, and medical orders for life-sustaining treatment.

Summit Health is also using EMR documentation to combat fragmentation from staff turnover and multiple acquisitions. The hospitalist noted that documenting quality-of-life discussions within the patient chart creates a shared record visible to all specialists.

Group Discussion: Care Transitions and Technology

Participants requested additional strategies for primary care coordination and communication during care transitions. Technology was identified as a key enabler—specifically secure messaging and visit templates in Epic and Athena. For patients with limited technology access or comfort, reverting to audio-only or scheduling calls when another care team member is already present at home were suggested as practical alternatives.

For securing buy-in for new staff roles, participants advised using documentation and billing data to build the financial case. Throughout the discussion, participants emphasized the importance of a culture of transparency, engagement, and collective problem-solving.

Patient & Family-Centered Care + Community & Outpatient Integration Activity

Participants divided into two groups to discuss goals-of-care conversations and care coordination models.

How does your organization facilitate goals-of-care conversations?

The first challenge discussed was team resistance—ranging from staff who view these conversations as someone else's responsibility to providers who are protective of longstanding patient relationships. Participants emphasized the importance of respecting those relationships and framing palliative care involvement as collaborative rather than intrusive. Normalizing the process through advance care planning outreach and patient portal communication was suggested, along with simply building the habit of having these conversations.

Training and incentives were identified as essential tools. One organization mandates educational modules for hospitalists; another has incorporated goals-of-care training into annual learning requirements and aligned physician compensation with completion. A participant noted that beginning this training at the medical student and residency level results in more natural integration later in a clinician's career.

For the conversations themselves, participants recommended having a social worker present and gathering input from other care team members in advance. Useful tools cited included ambient listening software, Epic dot-phrase shortcuts, and sticky-note features. One organization developed a customized, hyperlinked note that allows any provider to view the most recent goals-of-care conversation when hovering over a patient's code status.

What models are you using to deliver palliative care, and why?

QuIC organizations described embedding palliative care in specialty settings such as oncology and trauma, using telehealth for scalability and access, and applying predictive tools to target interventions toward the highest-need patients. Several noted success in embedding palliative care in EDs, where initial skepticism from ED staff quickly gave way to appreciation.

For symptom management, participants described partnering with primary care and oncology on prescribing—with boundaries around chronic pain, which none of the participating organizations takes on exclusively, given resource constraints.

Participants recommended developing affiliations with home health and hospice—internal or external—as an important foundation for expanded services. Community resources were also identified as valuable supplements, given the high level of need. Minimizing fragmentation was a consistent theme: Patients receiving care across multiple settings can experience confusion about who is managing their care, and participants emphasized that patients should not bear the burden of navigating referrals on their own. Tools like End of Life Care Index scores, nursing hotlines, and hospice teams were cited as helpful for triaging and streamlining referral pathways.

Palliative Care QuIC Advisor Campfire

Moderator: ***John W. Kennedy, MD****, President, AMGA Foundation and Chief Medical Officer, AMGA*

Presenters:

Puneeta Sharma, MD, CPE, MHCM*, Chief Medical Officer, Valley Medical Group*

Amy Scheu, MSH, CHPCA*, Associate Vice President of Midwest Hospice & Enterprise Palliative Care, Advocate Health*

Narayana Murali, MD, DNP, FACP*, System CMO, Medicine Services & Prof of Medicine, Geisinger College Health Science*

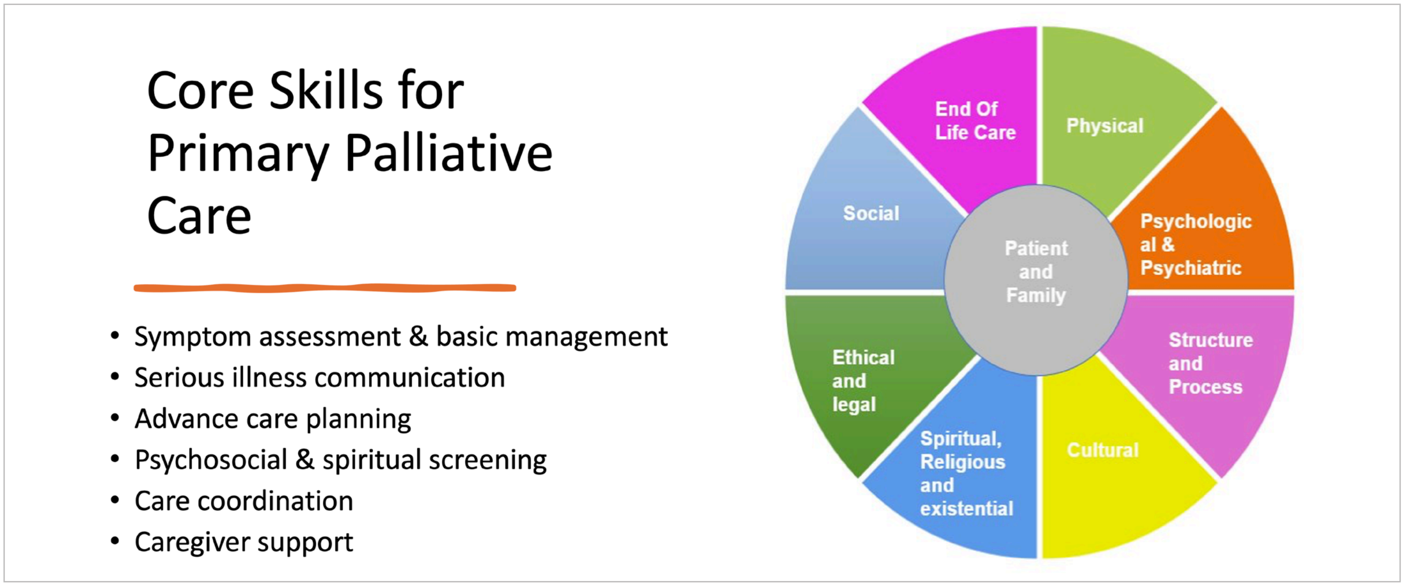
Building Primary Palliative Care Skills

Puneeta Sharma, MD, CPE, MHCM*, Chief Medical Officer, Valley Medical Group*

Dr. Puneeta Sharma opened by noting the evolution of palliative care from a field where referrals often came days before a patient's death to a system now focused on the Quintuple Aim. Achieving this multifaceted goal requires change management, organizational urgency, and a well-trained integrated team. Despite a large workforce, Valley Medical Group does not have sufficient certified palliative care clinicians to meet population needs. A single informational pamphlet, the advisor noted, is not equivalent to palliative care.

Systemwide workforce education was the first step, using communications workshops, mentorship, case-based learning, and a didactic approach to train staff on the Eight Core Domains of Quality Palliative Care.

> *Dr. Puneeta Sharma, chief medical officer, Valley Medical Group, framed the core question driving palliative care integration: What do patients want—dignity, comfort, clear communication, and control—and how can programs deliver it?*



Core Skills for Primary Palliative Care

- Symptom assessment & basic management
- Serious illness communication
- Advance care planning
- Psychosocial & spiritual screening
- Care coordination
- Caregiver support

Progress is tracked through ED and hospital utilization, advance care planning documentation rates, clinical confidence, patient and caregiver satisfaction, and symptom assessment and management outcomes—the last of which Valley Medical Group supports through standardized screening tools and templates with case-based learning.

Future plans include a fellowship program and work to address barriers including time constraints, reimbursement limitations, and clinician discomfort. Cultural resistance was identified as the most significant barrier; sharing early outcomes, including contributions to a 3% lower readmission rate, has been an effective strategy for building broader organizational support.

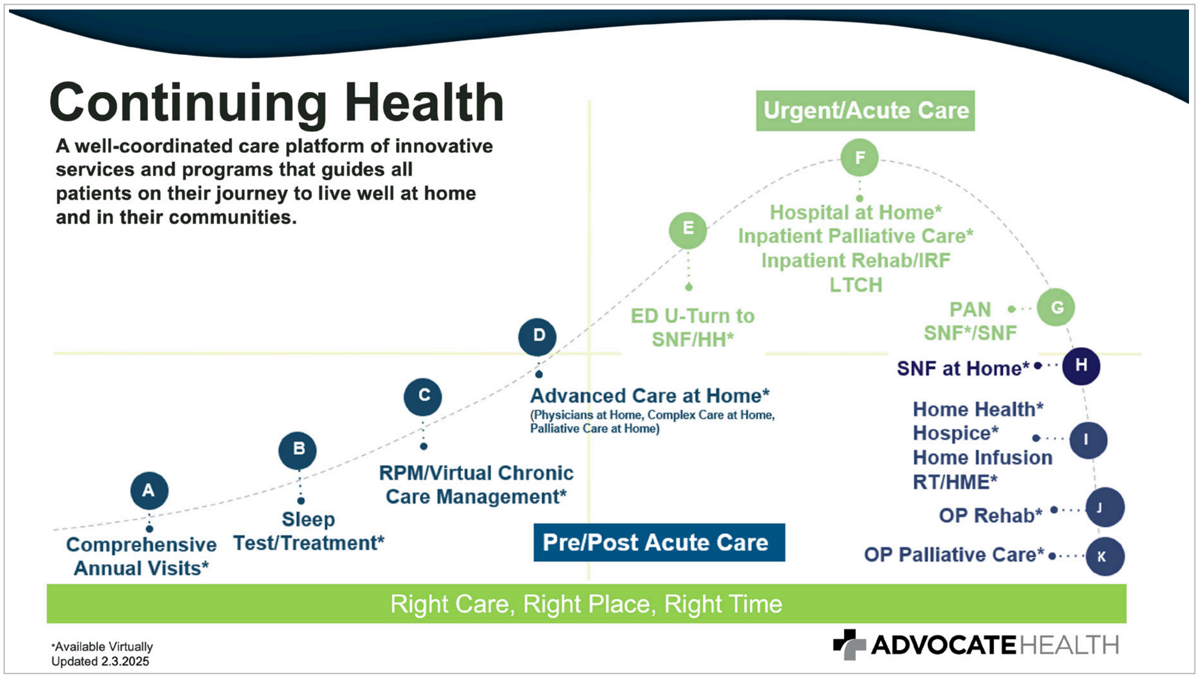
Palliative Care Ambulatory Operations

***Amy Scheu, MSH, CHPCA**, Associate Vice President of Midwest Hospice & Enterprise Palliative Care, Advocate Health*

Amy Scheu described the challenge of operating a palliative care program for nearly 5.6 million patients with nearly 167,000 team members across the Midwest and Southeast as navigating a very large ocean with strong resources. The team has built out services across the continuum of care, maximizing presence where programs and payer sources align.

Managing such a large workforce requires substantial structure. Advocate has assembled a senior steering committee to guide strategy and remove barriers, a matrixed operations leadership team, a service-line council with subcommittees for clinical operations and specialties, and an academic subgroup focused on research. Even frontline clinicians participate in working teams and planning processes.

Cross-system alignment is maintained through annual strategic planning meetings and staff surveys, quarterly results-sharing, and networking across Advocate's geographic footprint. Program performance is tracked through



Continuing Health

A well-coordinated care platform of innovative services and programs that guides all patients on their journey to live well at home and in their communities.

Urgent/Acute Care

A Comprehensive Annual Visits*

B Sleep Test/Treatment*

C RPM/Virtual Chronic Care Management*

D Advanced Care at Home* (Physicians at Home, Complex Care at Home, Palliative Care at Home)

E ED U-Turn to SNF/HH*

F Hospital at Home* Inpatient Palliative Care* Inpatient Rehab/IRF LTCH

G PAN SNF*/SNF

H SNF at Home*

I Home Health* Hospice* Home Infusion RT/HME*

J OP Rehab*

K OP Palliative Care*

Pre/Post Acute Care

Right Care, Right Place, Right Time

*Available Virtually
Updated 2.3.2025

ADVOCATEHEALTH

ED department and hospital usage, hospice length of stay, home-based care outcomes, and patient visits per FTE. A standardized note template—used across different Epic instances—makes palliative care documentation accessible systemwide. Site- and geography-level scorecards identify what each clinic needs to be successful, including staffing gaps.

Specialty and System Perspectives in Ambulatory Palliative Care

***Narayana Murali, MD, DNP, FACP**, System CMO, Medicine Services & Prof of Medicine, Geisinger College Health Science*

Geisinger serves 200–300 palliative care patients each week across central and eastern Pennsylvania. Dr. Naryana Murali described how a small team achieves this through a focus on outcomes (including length of stay and enrollment figures), tools like MyCareChoices™, and a willingness to reimagine care processes.

Murali walked through Geisinger's advance care planning workflow. In both inpatient and outpatient settings, an end-of-life score triggers an Epic Storyboard alert, prompting a provider to either conduct the conversation or delegate it to a care navigator. Reminders persist until action is taken—a deliberate design choice after static alerts proved ineffective at overcoming clinician inertia.

Conversations with patients cover the six elements of advance care planning, including illness progression and the patient's hopes and fears. When four of the six criteria are addressed, the patient is considered engaged. The advisor noted that patient engagement in this sensitive area must be cultivated iteratively, as patients often move between hope and fear—these dynamics should be revisited at every visit.

Murali emphasized that back-end tools and documentation must be simple and intuitive. Frontline providers cannot engage with processes that feel burdensome or disconnected from their workflows. The goal is to reduce the task to a single care gap, answered with a single click.

Geisinger has also adjusted its end-of-life score triggers in Epic to align patient targets with available resources—a realistic acknowledgment of capacity. Automation and consolidation in areas like referrals and documentation, along with executive support and wraparound services, have been essential. Murali cautioned that when palliative care is framed as everyone's job, accountability can erode—overall outcomes must be tracked and prioritized alongside individual metrics. Examining how long patients spend in hospice rather than the hospital, for example, reveals the true impact of palliative care on both health system costs and patient end-of-life experience.

Breakout Session: Intermediate/Emerging Programs

*Advisor Moderator: **Amy Scheu, MSH, CHPCA**, Associate Vice President of Midwest Hospice & Enterprise Palliative Care, Advocate Health*

*Participants: **Ochsner Health, SSM Health, Stormont Vail Health, Summit Health***

Staffing was the top concern among organizations at an emerging or intermediate stage of maturity. Participants described challenges covering specific areas like advance care planning as well as overall care delivery, noting that other departments frequently defer issues to palliative care, adding to an already heavy workload.

Participants noted that recruiting is universally difficult, and that training new employees takes significant effort only to be followed by turnover. Strategies for building capacity included recruiting physicians to community-based palliative care and developing fellowship programs to grow internal talent pipelines. Participants also discussed finding billing opportunities during the training period to support program funding.

Supporting team members—particularly physicians—with flexible schedules was identified as critical. One participant noted the challenge of managing a high volume of daily consults while trying to sustain quality and personal well-being. Another emphasized that the emotionally demanding nature of palliative care work makes self-care essential; without it, burnout and turnover follow.

Early-stage programs have also been exploring growth strategies including pilot projects, virtual care, and embedding palliative care into existing programs. Securing buy-in from primary care providers was identified as important, with quality incentives—for both providers and outpatient clinics—suggested as a mechanism.

To optimize resources, organizations have been examining patient population data, including end-of-life scores and readmission patterns, to identify and prioritize highest-risk patients. Building relationships with finance teams and developing clear, data-driven narratives around cost savings, value, and ROI have been central to funding efforts. Tools like Strata, which offer predictive analytics and decision support, were cited as potentially valuable for this purpose.

One participant shared the goal of documenting productivity and service volume in order to build the case for an additional social worker. Another described using measurement analysis to develop an evidence-based rationale for program investments. Participants also noted the immediate value of peer learning at the QuIC event itself, with one healthcare organization participant sharing that their organization updated its key performance indicators (KPIs) based on a presentation at the meeting.

Breakout Session: Advanced Palliative Care Programs

Advisor Moderator: ***Narayana Murali, MD, DNP, FACP****, System CMO, Medicine Services & Prof of Medicine, Geisinger College Health Science*

Participants: ***HealthPartners, Lehigh Valley Health Network, MaineHealth Medical Group***

Advanced programs identified medication management—particularly pre-authorizations—as a significant operational pain point. Participants noted that prior authorizations are time-consuming, and while opioid authorizations require nursing-level clinical judgment, much of the administrative work in this area could potentially be handled by other staff or automated. The Hello card game of conversation starters was cited as a useful tool for supporting complex patient discussions, particularly when pharmacists are embedded with primary care physicians.

The group explored the business case for adding a palliative care pharmacist. State collaboration agreements can make pharmacist visits billable. One participant recommended broadening the analysis beyond pain medications to include the full volume of visits a pharmacist could handle and the resulting ROI—with the suggestion that once a pharmacist covers their costs, the role sustains itself.

Participants also discussed staffing ratios and roles across integrated teams. One participant described a model in which the first patient visit includes the full interdisciplinary team, with subsequent visits driven by individual patient needs.

A nonclinical administrative coordinator serves as an operational hub, keeping interdisciplinary team meetings on track. That same organization benefits from having its own population health and hospice programs, providing additional infrastructure.

Another participant noted the complexity of integrating three teams with three different care models—including telehealth, social work, spiritual care, and nursing staff—who are all RNs due to hospice care requirements. The central question facing these programs is where to focus limited resources for maximum impact.

Nursing was consistently identified as a key leverage point. One organization is building a business case for a centralized nursing pool, with triage as a core function and prior authorizations moved to other staff to free up nursing capacity—with the acknowledgment that much of this administrative work could be handled by medical technicians. Another program is embedding nurses throughout primary care, finding that RNs yield stronger results than licensed practical nurses (LPNs) due to broader licensure scope, while also beginning ambient scanning with medical assistant validation to reduce physician documentation burden. Participants noted varying perspectives on RN versus LPN interchangeability, depending on organization and setting, and flagged medical assistant turnover as a challenge in sustaining that role.

Palliative Care QuIC Advisory Committee

Narayana Murali, MD, DNP, FACP, System CMO, Medicine Services and Professor of Medicine, Geisinger College Health Science

Barney Newman, MD, Emeritus Medical Director, Summit Health

Amy Scheu, MSH, CHPCA, Associate Vice President of Midwest Hospice and Enterprise Palliative Care, Advocate Health

Puneeta Sharma, MD, CPE, MHCM, Chief Medical Officer, Valley Medical Group

The group concluded that staffing decisions must be grounded in a realistic assessment of patient capacity. One participant's hypothetical calculation—20% engagement and 20% conversion from a 10,000-patient population—yields approximately 800 patients, a practical framework for working backward from available resources rather than trying to serve everyone. The Geisinger advisor emphasized the importance of engaging the finance team to frame palliative care investments in terms of cost minimization, with tools from Strata and the CPPC recommended for demonstrating ROI.

Next Steps

***Erin Leaver-Schmidt, MPH**, Director, Population Health Initiatives, AMGA Foundation*

The meeting concluded by thanking QuIC participants and reflecting that the gathering provided an opportunity for meaningful discussion, peer learning, and actionable strategy-sharing.

Next steps include a participant survey and the third and final QuIC gathering—a virtual meeting at which representatives from all seven healthcare organizations will present updates on their work and share best practices, lessons learned, and future plans as their palliative care programs continue to develop across all maturity levels.

AMGA Ambulatory Palliative Care QuIC Team

AMGA Foundation

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