



Home on the Range: Plans and Providers Team Up to Bring Palliative Care to Rural Californians

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About the Authors

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About the Foundation

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Introduction

The well-documented benefits of palliative care for people with serious illness have led to a proliferation of specialty palliative care programs operating in acute care hospitals in California and nationally.¹ In recent years, there has been increasing focus on providing access to palliative care in patient homes, clinics, and physician offices — referred to as community-based palliative care (CBPC). In addition to improving alignment between patient goals/preferences and the care they receive, CBPC has been shown to improve symptom control and to reduce unnecessary hospitalizations and total costs of care.²

Many health insurance plans in California have incorporated coverage for CBPC into their products, including some commercial and Medicare Advantage plans and all Medi-Cal (Medicaid) managed care plans, which have been required to ensure access to palliative care for eligible, seriously ill Medi-Cal enrollees since January 2018.³

As the demand for palliative care has expanded into California's immense and disparate rural areas, health plans and providers have faced a fundamental challenge unique to sparsely populated spaces: designing and sustaining programs that will serve relatively few people who have intensive and complex needs, who are spread across huge geographies that tend to lack health care resources generally, and where there is a shortage of palliative care providers specifically.

Seeking strategies for providing palliative care (particularly CBPC) in rural areas, the California Health Care Foundation (CHCF) sponsored a two-year initiative in 2017. Five partnerships — each including at least one organization providing palliative care and one health plan — developed or expanded contracts to deliver palliative care in a rural community. (See the appendix for information on the participants.) These partnerships received small grants and technical assistance delivered through in-person meetings, webinars, clinical and programmatic coaching support, and participation in a yearlong [Center to Advance Palliative Care Payment Accelerator Program](#).

This report describes key lessons from the CHCF rural palliative care initiative, which are intended to help health plans and providers understand the challenges and consider possible solutions to support delivery of palliative care in rural areas.

What Is Palliative Care?

Palliative care is focused on improving the quality of life for seriously ill patients and their families by reducing suffering and stress. It is ideally provided by a team of palliative care doctors, nurses, social workers, chaplains, and others who work together with a patient's other doctors to offer an additional layer of support. It is appropriate at any age, regardless of diagnosis or prognosis, and is provided alongside all other appropriate treatments.

Many insurance plans incorporate coverage for palliative care in products such as Medicare Advantage or group coverage, and all Medi-Cal (Medicaid) managed care plans must ensure access to palliative care for eligible, seriously ill enrollees. CBPC coverage, however, is often limited to those with very advanced or complex conditions.

As the demand for palliative care has expanded into California's immense and disparate rural areas, health plans and providers have faced a fundamental challenge unique to sparsely populated spaces: designing and sustaining programs that will serve relatively few people who have intensive and complex needs, who are spread across huge geographies that tend to lack health care resources generally, and where there is a shortage of palliative care providers specifically.

Barriers and Potential Solutions in Rural Areas

Rural communities face a multitude of challenges in delivering all types of health care, including specialty palliative care. Rural populations are generally older, sicker, and poorer than their urban and suburban counterparts.⁴ Many residents struggle with psychosocial challenges ranging from housing insecurity and mental health needs, to high rates of substance use disorders and addiction.⁵ There are also complications related to social isolation, such as loneliness and fewer neighbors or family members to serve as caregivers.

At the same time, most rural communities are medically and socially underserved; on average they have fewer health care, mental health, and social service supports than urban and suburban areas. Long distances between people's homes and health care settings, as well as transportation difficulties, further complicate efficient access to services.

While a range of issues can make delivering CBPC complicated and difficult in any environment, this report focuses on issues that are unique to or intensified in rural communities. The most important challenges of delivering palliative care in rural areas can be grouped into four areas:

- ▶ Identifying and enrolling patients
- ▶ Staffing services
- ▶ Sustaining services
- ▶ Attending to the full spectrum of patient needs

These problems and some strategies to address them are described below.

Identifying and Enrolling Patients

While plans and palliative care providers across geographic settings have reported difficulty identifying and enrolling appropriate patients,⁶ failing to do so in a rural area can make sustaining a program especially difficult. For example, identifying and enrolling only 2% of 10,000 potential palliative care patients, as could happen in a suburban market, would result in a service volume sufficient to support a small home-based palliative care program, but identifying and enrolling 2% of 100 potential patients, as could happen in a rural area, would not.

CHALLENGE

Small number of potential patients due to narrow eligibility criteria. Most health plans have fairly specific eligibility criteria for their palliative care programs. Access may be limited to patients with specific diagnoses, such as cancer or heart failure, and eligibility may be further limited to patients with especially advanced disease, such as heart failure patients who have an ejection fraction of <30%. While such requirements can ensure CBPC is only offered to those who need it most, narrow criteria can keep the pool of potential enrollees below the number needed to support a service.

Lack of accurate contact information. Some rural CBPC programs report difficulty reaching potential patients even after they have been identified, often because CBPC programs don't have easy access to contact data, or the data they have are inaccurate.

Few resources for a robust patient outreach program. Many rural CBPC organizations, which tend to be small, find it hard to absorb the cost of implementing patient outreach programs that are likely to yield only a small number of enrollees.

Patient reluctance to accept services. Some patients are isolated, and not everyone has phone service. Establishing trust with potential patients can be difficult, especially with those who are wary of allowing providers into their homes and those who do not understand what palliative care is or how it can help them.

POTENTIAL SOLUTION

Loosen eligibility criteria. Plans can expand eligibility criteria, creating a larger pool of potential patients by eliminating requirements related to disease severity or by expanding eligibility to more diagnoses. This is a reasonable solution since — even with an expanded patient pool — the total number of people receiving services will still be fairly small, minimizing risk to plans.

Share data. Plans can give palliative care providers restricted access to elements of their health information systems, which may house the most accurate patient contact information. Palliative care providers can also work with local health systems and primary or specialty providers to access patient contact information. While patient privacy and data security concerns can prevent data sharing in some situations, if these barriers can be addressed, data sharing can allow for increased access to potential patients, as well as enhanced communication and better care coordination after enrollment.

Piggyback on other patient health care encounters. Palliative care provider organizations and health plan program leaders can collaborate with community providers, hospital palliative care teams, and health plan concurrent review nurses to identify potentially eligible patients.

ONE PLAN REPORTED:

To find patients for our in-home palliative care program, we use our partnerships with our local hospital-based inpatient palliative care units, the hospital palliative clinic, our behavioral health partner, and our utilization management nurses assigned to every hospital and SNF in both counties wherever our members are admitted.

Build on existing relationships with other health care providers. Palliative care providers can build on patients' existing trusted relationships, asking primary care providers and specialists in hospital and ambulatory settings to recommend palliative care to their patients. Conducting the initial palliative care visit while the patient is still in the hospital or during a joint clinic/office visit can be especially effective.

Be flexible, patient, and persistent. Providers who make a practice of "meeting the patient where they are" often see success in overcoming patient reluctance to accept services. This includes being willing to discuss what palliative care is multiple times, doing initial outreach in person rather than by phone, having a nurse or social worker do "drive-by" unscheduled outreach visits, and connecting with family or neighbors to locate difficult-to-find patients. One program reported that using a community health worker (CHW), a layperson from the community, helped in establishing trust and increasing acceptance of services.

Staffing Services

Palliative care organizations in rural areas often face significant difficulties hiring and retaining staff. Further, because these small organizations tend to have relatively few employees, they are particularly vulnerable if a key clinical staff member leaves. Such departures can leave the program in the unfortunate position of being unable to meet the demand for services they may have invested significant time and energy to create.

CHALLENGE

Shortage of trained providers. The widespread shortage of trained specialist palliative care clinicians is especially acute in rural areas, where the labor pool is smaller and provider organizations often cannot compete with urban and suburban programs on compensation and benefit packages.

Difficulty retaining staff. The nature of the work and the rural setting can lead to staffing challenges. Long drive times to remote locations can be isolating for staff and hard on staff vehicles. Efforts to support staff well-being and create feelings of connection and community can be difficult with little face-to-face time among staff; the absence of such programs leaves rural staff at risk for burnout.

Mismatch between care model and available workforce. The desired care model may not fit the conditions on the ground in terms of professional staff availability and revenue requirements.

POTENTIAL SOLUTION

Be flexible in employment models. Some programs may find it easier to create and maintain clinical capacity by recruiting and training per diem providers to supplement salaried staff. Another strategy is to cross-train existing staff from other business lines (such as home health and hospice) who express interest in palliative care. Training can be done through online courses, such as those offered by the [Center to Advance Palliative Care](#) or the [California State University Shiley Institute for Palliative Care](#).

Make staff satisfaction a priority. Strategies to improve staff satisfaction and retention include conducting regular team meetings (virtual or in person) with specific time for team wellness activities, offering educational and training programs, providing more generous mileage reimbursements for work-related travel and, where possible, promoting use of telemedicine to reduce travel for clinical staff and allowing administrative staff to work from home.

Adjust the staffing/care model. Programs can adjust their care model to match the available workforce, such as moving from a physician-led model to a nurse-led one, or vice versa. Such changes can also help organizations expand their revenue sources and the number of patients they serve — for example, by enabling a nurse practitioner or physician (who can bill for visits under Medicare) to see patients in a clinic in addition to providing in-home services.

ONE PROVIDER REPORTED:

We transitioned from a nurse-led program to a care model that has a nurse practitioner and a physician as the lead staff. This allowed us to open a clinic so patients can see the palliative care physician directly, which is a patient satisfier and helps us respond to symptom management issues.

Sustaining Services

Sustaining a palliative care program — aligning the scope of services delivered with available payment and the cost of care delivery — can be particularly challenging in a rural area. Uncertainty about revenues, the high cost of care delivery, and the payer mix in rural areas all make it difficult to achieve the balance needed to sustain a program.

CHALLENGE

Uncertainty that revenues will cover costs.

Aligning the scope of services with available payment and the cost of care delivery can be particularly difficult in a rural area. For rural provider organizations with more established business lines like home health and hospice — which have more reliable revenue sources and tend to have higher volumes than palliative care — it can be difficult to justify the ongoing costs of staffing and administering a palliative care program.

High costs of care delivery. The complex needs of many rural palliative care patients, the scarcity of other medical or social service organizations that can help address those needs, and the long driving distances for home-based services make rural palliative care expensive to deliver, compared to similar programs in urban or suburban settings.

Plans and providers having different expectations and knowledge of costs.

Plans may not be aware of the difference in cost between care delivery in urban versus rural areas. Plans may be reluctant to adjust payment rates to align with rural providers' actual care delivery costs.

Coverage misalignment. Many people who need palliative care in rural areas have fee-for-service (FFS) Medicare, which doesn't pay for most in-home services provided by nurse- or social-worker-led palliative care teams. Contracts with Medi-Cal or commercial plans typically cover only a small proportion of the seriously ill population.

POTENTIAL SOLUTION

Share staffing costs. CBPC programs can adjust processes to reduce staffing costs, including cross-training staff from other business lines, and allowing staff to flex to another service (e.g., hospice) when the palliative care census is low. Also, a health plan may cover the cost of some CBPC team disciplines on a temporary basis while a referral base is built.

ONE PROVIDER REPORTED:

Our interdisciplinary team is comprised of a physician, two nurses, a care coordinator, two community health workers (CHWs), a social worker, and a chaplain. The nurses and CHWs see the patients in person in addition to video-conferencing, while the rest of the team provides care via telemedicine and telephone. The CHWs are employed by the plan and support our care team on an as-needed basis. They are available to go to patient homes to check on them, in particular if our team is having difficulty contacting the patient, and facilitate videoconferences for members of the care team.

Look for value added to other service lines. Providing palliative care can increase revenues in other business lines, such as home health and hospice, by increasing enrollment or length of service in other programs. Providers can factor in these increased revenues from other service lines when assessing fiscal outcomes for the palliative care program.

Focus on efficiencies. To increase service efficiencies, plan-provider teams can experiment with ways to reduce the cost of delivering CBPC services. Strategies include using per diem rather than full-time staff, especially where volumes are low; using telemedicine to reduce travel time for scarce and high-cost providers like palliative care physicians; and modifying staffing models to incorporate lower-cost disciplines. For example, a community health worker might be used instead of a social worker or nurse for some tasks.

Communicate early and often. Plan-provider teams that regularly meet prior to and during program implementation are able to develop a clear, shared understanding of the expected scope of service, and how expectations align with what actual patients need once the program is implemented. Carefully tracking the amount of service delivered to address specific patient needs allows plans and providers to engage in data-based rate reviews and adjust scope or payment as needed.

Consider a provider-led model. CBPC providers wanting to offer services to FFS Medicare patients can do so by using a provider-led model. This typically involves using a single-discipline model — a physician or nurse practitioner — where the provider makes, and bills for, home or tele-visits. While this care model is not as robust or effective as the interdisciplinary team model that is seen as best practice in palliative care, it does allow provider organizations to partially address a community need while generating some revenue. Such services may increase referrals generally, especially among primary or specialty care providers who are uncomfortable offering palliative care services to only a subset of their patients based on insurance type.

Attending to the Full Spectrum of Patient Needs

Optimal palliative care requires ensuring patients are supported by a wide spectrum of medical and social services. To support people with serious illness, CBPC programs need to connect and collaborate with the larger health care and social services delivery systems, but this can be especially challenging in underresourced rural areas. Common gaps include too few primary care and specialty care providers, lack of supportive services (like case managers), and long physical distances between many rural patients and their providers and acute care hospitals. As a result, rural palliative care programs typically have fewer potential partners to help them provide or coordinate comprehensive support for patients.

CASE EXAMPLE A young woman with end-stage lung disease who was separated from her husband and was the primary caretaker of two biological children and three foster care children was referred to home-based palliative care. Due to the severity of her illness and multiple psychosocial issues, the palliative care team worked closely with the referring health plan to approve a suite of services to meet the patient's needs. The patient was supported by a physician, social worker, chaplain, community health worker, and several nurses. Key services provided to the patient included pain and symptom management, clarification of goals of care including advance care planning and completion of a POLST (Physician Orders for Life-Sustaining Treatment) form, planning for the care and custody of the patient's minor children (which included working with the foster care agency), and identifying and obtaining needed durable medical equipment. The palliative care team provided in-person home visits and support over the phone and via videoconference.

CHALLENGE

Complex needs and lack of resources. Many patients have complex psychosocial needs, exacerbated by poverty. There may be a lack of mental health and substance use disorder treatment services, or culturally and linguistically concordant care. County services are often underresourced, and coverage can be fragmented in ways that limit access (e.g., different entities accountable for treating mental health issues and substance use disorders).

Underutilization of available supports. Patients may be unaware of or have difficulty accessing existing programs that may help them.

Difficulty engaging with primary and specialty providers. Already burdened providers may not make timely referrals to palliative care if the process is at all cumbersome. Some are reluctant to refer if they suspect that the referral will create additional work, such as the need to prescribe and manage medications recommended by a palliative care nurse.

No local hospice exists.

POTENTIAL SOLUTION

Adopt care processes and staffing models that will meet a broad spectrum of needs. CBPC teams can use innovative approaches to address complex needs — for example, trained community health workers (CHWs) can initiate advance care planning discussions and provide links to community resources. Plan-provider teams can establish standing meetings to review enrolled patients, resolve any challenges to meeting their care needs, and ensure referrals to services that would benefit the patient and lighten the load on the palliative care team.

Employ existing resources. Palliative care team members, especially CHWs and social workers, can encourage and help connect patients with existing services and supports such as housing, transportation, and meals. Some supports may be available through the health plan itself.

Assume some primary care responsibilities if helpful. Some rural CBPC teams wind up providing some aspects of a typical primary care role as a strategy for overcoming fragmentation. For example, in some settings a palliative care physician makes referrals to needed specialist and other services directly, rather than waiting for a primary provider to act on a recommendation. Palliative care teams that include providers who can manage medications may be more valued and utilized by referring providers.

Meet the need but adjust the contract. A palliative care organization could offer a more intensive intervention to meet the needs of hospice-eligible patients, if the contract scope of services and payment amount can be adjusted.

ONE PROVIDER REPORTED:

Our contract is based on a per-member-per-month payment structure, including three tiers of service. The most intensive tier, called "virtual hospice," is used if the patient has no access to on-the-ground hospice services or is unwilling to enroll in hospice services.

Essential Success Strategies

Two overarching strategies helped plan-provider teams in rural areas address multiple challenges and promote the success of their palliative care programs: cultivating strong relationships between organizations and individuals, and being creative and flexible with staffing and service models. These are discussed below.

Cultivate Strong Relationships Between Organizations and Individuals

Successful rural palliative care programs leverage relationships with a broad set of organizations and individuals in their communities, spanning health systems, medical groups, social service organizations, health departments, emergency medical technicians, and more. These cross-organizational relationships are especially useful for identifying potentially eligible patients, educating providers and patients about palliative care, and promoting appropriate referrals.

These connections are also important for ensuring best use of community resources — an important strategy for preventing “scope creep,” where palliative care providers are burdened with addressing a complex and broad range of issues that require a time investment that exceeds payment for palliative care services.

Though developing and sustaining relationships takes time and energy, the relatively small number of players in rural areas can make collaboration easier. For example, in a rural area with only one or two palliative care providers, plans that want to ensure access to palliative care for their members have an incentive to assure the sustainability of the local palliative care provider organizations. This creates a rationale for multiple plans — even when they are technically competitors — to pool their resources and influence to promote appropriate referrals from their shared contracted medical groups or health systems.

Cross-Organizational Collaboration

One participating plan developed a partnership approach to delivering palliative care to its members. The plan hosts standing meetings and facilitates regular communications among its many partners. These include two hospice organizations providing home-based palliative care, local hospital-based inpatient palliative care services, a hospital-based palliative clinic, and a regional behavioral health provider. Health plan nurses are assigned to hospital and skilled nursing facilities across the counties served. The plan’s chief medical officer makes periodic visits to network specialists such as oncologists, pulmonologists, and cardiologists to reinforce the importance of referring appropriate patients to palliative care.

Be Creative and Flexible with Staffing and Service Models

Staffing and service models that work well in urban and suburban environments may not have the same success in sparsely populated areas. Developing the right model can be difficult, and needing to adjust in response to external or internal events is to be expected. In fact, several participants in the CHCF rural palliative care initiative changed staffing and service models during the course of the two-year project. The experiences of the plan-provider teams point to a number of effective strategies related to staffing and service models.

- ▶ *Include community health workers on the palliative care team.* Recruiting and training community health workers — who are viewed as trusted members of the community — provides a bridge between patients and CBPC providers, enhancing acceptance of palliative care services and extending the capacity of clinical teams.
- ▶ *Develop standardized processes to maximize quality, efficiency, and revenues.* Guidelines for initial response time, criteria to triage patients to service levels based on their needs, and use of advanced practice providers helps to maximize service capacity, efficiency, and quality.

- ▶ *Plan for inevitable personnel changes.* Weathering personnel changes is easier if programs are ready with a range of possible interventions, such as sharing staff from home care and hospice, leveraging telephone calls and telemedicine, and cross-training members of the interdisciplinary palliative care team to cover essential tasks.
- ▶ *Embrace telemedicine / video visits.* Strategic use of phone and video visits with patients and between staff is crucial to creating sustainable rural programs. All the palliative care provider organizations participating in the CHCF initiative were already using these technologies or planned to, as a means of expanding access and maintaining or improving efficiencies. Providers looking to use telemedicine should note that not all team members will be immediately comfortable giving up in-person visits, so adoption will take time. It will be necessary for each organization to determine the best mix of in-person and virtual care, and to collaborate with plan partners to ensure appropriate reimbursement for video-based care.

“We are most excited about having proven that we can build and sustain our patients’ trust while providing a large proportion of care via telemedicine. With teamwork and the support of the care coordinator and community health workers, we have been able to use videoconferencing effectively to build a relationship with each patient and provide consistent, high-quality care to them. We feel we have been most successful when a nurse makes the initial home visit in person. This visit, which is usually two to three hours in length, allows for trust to be built and rapid integration into care to occur.”

Conclusion

While many of the challenges described in this report can affect the provision of palliative care in all types of geographic settings, the severity and impact of those challenges can be especially daunting for rural palliative care programs. The CHCF rural palliative care initiative highlighted the possibilities that exist when providers and plans work creatively to find their way around obstacles. As in all palliative care work, the strategies depend on relationships of trust between plans, palliative care provider organizations, and their broader medical communities, and especially between patients and the people who care for them.

Appendix. Rural California Plan-Provider Partnerships

Most of the rural counties participating in the initiative contain significant geographic regions designated as Medically Underserved Areas, Rural Health Areas, and Health Professional Shortage Areas by the Health Resources and Services Administration of the US Department of Health and Human Services.

HEALTH PLANS	DESCRIPTION	COUNTIES	POPULATION (2018)	NUMBER OF MEMBERS (2018)
Health Net / California Health & Wellness (HN/CHW)	Health Net and California Health & Wellness are subsidiaries of Centene Corporation, a publicly traded company that offers a range of health insurance products nationally. Health Net / California Health & Wellness have over 1.3 million Medi-Cal members in 30 California counties	Imperial	63,926	12,200
		Nevada	182,830	62,800
		Tehama	99,814	8,400
Health Plan of San Joaquin (HPSJ)	Regional Medi-Cal managed care plan with over 335,000 members in 2 counties	San Joaquin	745,424	210,000
		Stanislaus	547,899	115,000
Partnership HealthPlan (PHC)	Regional Medi-Cal managed care plan with over 560,000 members in 14 Northern California counties	Lake	703,520	8,000

PROVIDERS	DESCRIPTION	COUNTIES	PLAN PARTNER
Community Care Choices / Community Hospice	Independent nonprofit organization providing hospice and home-based palliative care (Community Care Choices) in 10 counties.	San Joaquin Stanislaus	HPSJ
Foothills Palliative Care Consultants / Hospice of the Foothills	Independent nonprofit organization providing hospice, home-based palliative care, and clinic-based palliative care.	Nevada	HN/CHW
Hospice Services of Lake County	Independent nonprofit organization providing hospice and home-based palliative care.	Lake	PHC
Outreach Care Network	Independent for-profit organization providing hospice, palliative care, and home health services in 3 states, including 5 California counties.	Imperial	HN/CHW
Pacific Palliative Care / Hospice of San Joaquin	Independent nonprofit organization providing hospice and home-based palliative care (Pacific Palliative Care).	San Joaquin	HPSJ
ResolutionCare	Nonprofit, rural-based palliative care organization providing home-based palliative care services using a mix of in-person and video visits. Services are provided throughout California with a primary focus on rural Northern California.	Tehama, expanded to anywhere in California	HN/CHW
San Joaquin General Hospital	Safety-net health system with a full range of inpatient and outpatient services, including inpatient and clinic-based specialty palliative care. Approximately 70% of patients seen at SJGH are HPSJ members.	San Joaquin	HPSJ
Sierra Nevada Memorial Hospital	A Dignity Health network hospital serving Nevada County.	Nevada	HN/CHW

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