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

Phase 1 Meeting Summary

Virtual Discussion Forum – December 16, 2025

Ambulatory palliative care represents a critical evolution in how healthcare systems support patients living with serious illness. Unlike traditional inpatient palliative care or hospice services, ambulatory programs aim to meet patients where they are—in clinics, at home, and embedded within specialty practices—providing comprehensive symptom management, psychosocial support, and advance care planning before crisis points emerge.

On December 16, 2025, eight healthcare organizations gathered virtually for Phase 1 of The Dr. Barney Newman Collective for Quality & Innovation in Ambulatory Palliative Care (Palliative Care QuIC). This collective brings together systems at varying stages of ambulatory palliative care development, from organizations with robust multisite programs to those rebuilding services following staffing changes and organizational transitions, and organizations starting on this journey of development.

Dr. Puneeta Sharma, chief medical officer at Valley Medical Group and a palliative care physician with over 15 years of experience, moderated the 90-minute discussion focused on organization priorities, barriers to progress, and possible solutions. This Phase 1 session is part of a three-part series, utilizing AMGA's Quality and Innovation Collective (QuIC) format, which enables participants to listen to high-level discussions, share current care practices through virtual collaboration, and ultimately create new models and care paths through interactive workshops.

Current State: Ambulatory Palliative Care Across Participating Organizations

Advanced Programs

HealthPartners operates two distinct ambulatory practice models. HealthPartners representatives described their community-based palliative care program, which provides in-home and virtual visits to patients who are increasingly homebound. Their clinic-based practice is embedded in specialty clinics across the system, with full-time palliative care providers in three oncology clinics (Monday through Friday) and part-time presence (approximately two days per month) in pulmonary, cardiology, gastroenterology, nephrology, and neurology clinics. The interdisciplinary team includes physicians, advanced practice clinicians (APCs), registered nurses (90% telehealth, 10% in-person), medical social workers, and chaplains. In 2025, HealthPartners focused on integrating previously siloed programs into one unified palliative care department across all sites.

Lehigh Valley Health Network serves more than 1,000 ambulatory palliative care patients through two practice models. Their home-based practice and two office clinic locations provide comprehensive care through an interdisciplinary team that includes nurse practitioners, social workers, and physician oversight. The team conducts weekly interdisciplinary meetings, utilizes communication platforms like TigerText and Epic staff messaging, and maintains close alignment with subspecialty services. The ambulatory census is primarily nurse practitioner-driven with physician backup.

MaineHealth Medical Group recently achieved a significant milestone: establishing specialty palliative care presence at all eight local health system sites across the network. The frequency of services varies by location, with co-located palliative care in most oncology clinics and a freestanding clinic in Scarborough serving patients with any serious illness diagnosis. Home-based palliative care operates in select areas within the network. A MaineHealth Medical Group team member noted that approximately 50% of their patients have oncology diagnoses, with the other 50% representing non-oncology serious illnesses—a deliberately broad approach maintained since the program's inception. MaineHealth also provides 24/7 access to specialty palliative care physicians for ambulatory patients.

Intermediate Programs

Ochsner Health maintains a robust outpatient clinic structure at their main New Orleans campus. The clinic employs three full-time physicians and two full-time APCs, with two providers embedded full-time in the cancer center. Approximately half of visits occur virtually, accommodating patients who may live three to four hours away in Louisiana or throughout the Gulf South region. Satellite ambulatory clinics in other cities provide closer-to-home access. The interdisciplinary team includes social workers, a chaplain, and a mental health counselor. Ochsner has implemented systemwide advanced care planning initiatives and offers specialized support including monthly grief support meetings and 13-month bereavement follow-up for families of deceased patients.

Participating Organizations

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)
- **Skagit Regional Health** (Mount Vernon, WA)
- **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)

Program advisory support was provided by Amy Scheu, Associate Vice President for Midwest Hospice and Enterprise Palliative Care at Advocate Health; Narayana Murali, MD, DNP, FACP, System CMO, Medicine Services & Professor of Medicine, Geisinger College Health Science; and Puneeta Sharma, MD, CPE, MHCM, Chief Medical Officer, Valley Medical Group. Dr. Barney Newman, the program sponsor, also participated in the discussion.

Stormont Vail Health operates a clinic-based program (without home visits) with three full-time physicians and three nurse practitioners, each assigned to designated teams with three care managers. They described how their program serves approximately 220 patients in the Topeka area and surrounding rural Kansas communities. The team includes social work support and chaplaincy services, with care extending across both outpatient and inpatient settings. Most team members rotate between hospital and clinic. The program offers both in-person and virtual visits, though new consultations are preferentially scheduled in person. In 2025, a physician expanded the program's scope to include pediatric populations, with a dedicated neurosensory room for developmental screenings.

SSM Health has approximately 45 FTE dedicated to palliative care across four states, with teams operating as integrated units for inpatient, outpatient, and virtual care. Their team described their workforce composition: about 9 FTE physicians, 18 nurse practitioners, with the majority being nurses, plus 1-2 FTE in chaplaincy and 3-4 FTE in social work (including one Licensed Clinical Social Worker, or LCSW). The St. Louis region acquired a wholly home-based agency and integrated it into their medical group, adding a growing virtual component. In Wisconsin, SSM is shifting from strong home-based care to a stronger virtual presence with minimal home visits, while expanding from oncology embedding into cardiology clinics (with one nurse practioner spending half-time in cardiology) and stretching into renal clinics for chronic kidney disease. SSM recently partnered with their managed care pharmacy team to support medication management for palliative patients, particularly valuable for complex oncology treatments.

Emerging Programs

Skagit Regional Health is working to reintroduce ambulatory palliative care after previous services were shifted to inpatient-only coverage due to volume demands. Their team described their public health system, serving a 2,600-square-mile catchment area (600 square miles being ferry-dependent islands) with 65% Medicare/Medicaid patients. Previously, 0.4 FTE palliative care was available in their oncology clinic for oncology and cardiology patients. Currently, two full-time FTE providers and one nurse practitioner (departing within months) serve only inpatient needs. The organization faces unique challenges: Neighboring larger health systems recently eliminated their entire outpatient palliative care programs within the last six to eight months, complicating efforts to demonstrate value to executive leadership.

Summit Health/VillageMD/CityMD is essentially starting from the ground up in their New York region (Westchester County). The organization previously had robust outpatient palliative care and home-visiting APCs, but staffing changes, COVID-19, organizational acquisitions, and transitions eliminated these services. Without a dedicated palliative care provider for inpatient or outpatient referrals, hospitalists are bridging gaps through advance care planning conversations, symptom management, and hospice referrals. The team has been addressing high readmission rates by utilizing hospitalists for post-discharge virtual visits and transitional care management (TCM), identifying these complex patients as candidates for eventual palliative care services. All hospitalists have completed Center to Advance Palliative Care (CAPC) training modules as a requirement.

In contrast, Summit Health's New Jersey region employs a sole palliative care physician aligned to three oncology cancer centers in northern New Jersey, where she rotates Monday through Friday. Her patient population is approximately 50% oncology and 50% primary care referrals. While not formally structured as a full interdisciplinary team, the physician partners closely with behavioral health providers (offering services to patients and caregivers),

pharmacists at the cancer centers, and a care manager who serves both palliative and hospice patients.

Dr. Newman, who founded the original New York program, inquired about plans for ambulatory provider recruitment. The Summit Health team acknowledged challenges with primary care and specialty staffing across 2025 but confirmed conversations about hiring APCs with palliative care experience for 2026. However, they emphasized the need to establish systematic referral processes and provider education to optimize utilization, noting that even in New Jersey with the sole physician's excellent work, "we don't seem to be able to feed her enough of the right patients."

Essential Aspects of Ambulatory Palliative Care: Motivating Needs

Prior to the Phase 1 meeting, participants completed a needs assessment ranking the most important or essential aspects of developing and implementing ambulatory palliative care initiatives. These "motivating needs" represent fundamental building blocks for program success.

The collective rankings identified eight priority areas:

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

Participants also identified additional motivating needs, including education for physician trainees and new-to-palliative care clinicians; removing barriers to conversations; clear structure and processes; organizational support for staffing resources and funding; increasing access in rural areas; reducing costs; demonstrating value in high-value care models; and supporting home-to-hospice transitions.

The Phase 1 discussion focused on the top three ranked needs, exploring current implementation status, successful strategies, barriers, and opportunities for collaboration.

Deep Dive: Top Three Motivating Needs

#1: Patient and Family-Centered Care

When Dr. Sharma asked why patient and family-centered care ranked first across all organizations, participants affirmed this as the foundational purpose of palliative care itself.

“That is palliative care, right?” said a participant. “It is totally focused. It is what matters most to our patients from a quality perspective. That is the driving force behind palliative care.”

Another participant emphasized that patient and family-centered care serves as the “why” for all other aspects of program development: “When we think about how do we make the case for additional FTE in palliative care, it’s to provide high-quality patient and family-centered care.”

An attendee framed it as a hierarchy of needs: “The basis of it is providing patient and family-centered care to people living with serious illness. That kind of has to come first. It doesn’t matter what you’re doing with numbers and C-suite and anything else. You’re not doing palliative care if you’re not doing that.”

Current Implementation Approaches

Participating organizations employ diverse strategies to deliver patient and family-centered care:

Psychosocial and Emotional Support: HealthPartners provides comprehensive psychosocial support through their full interdisciplinary team, including clinical social work and spiritual counseling, with response times of one business day or less for most inquiries. They refer patients to support groups and grief consortiums as appropriate.

Lehigh Valley Health Network offers interprofessional team support encompassing emotional and psychosocial assistance, practical and caregiving help, communication and decision-making support, spiritual and cultural care, and grief support.

Ochsner Health encourages family attendance at visits (with patient consent) and provides emotional/psychosocial support during provider visits. Family members can schedule counseling/therapy services with Ochsner’s mental health provider, who independently treats caregivers and provides ongoing support. Ochsner also staffs a chaplain available for patient families, leads monthly grief support meetings, and maintains 13-month bereavement support for families of all deceased patients (inpatient or outpatient).

Stormont Vail sends bereavement cards and letters at 1, 3, 6, 9, and 12 months, with plans to expand bereavement services. They provide chaplain support, social work services, and community resource connections.

Accessibility and Responsiveness: Multiple organizations emphasized making palliative care easily accessible. Ochsner has a direct phone line answered by medical assistants—no operator navigation required—with RNs and LPNs calling back to assess needs and directing patients to appropriate resources. Stormont Vail described their team as wanting to be “this patient’s Grand Central Station”: a single go-to contact person for all healthcare needs, coordinating across multiple providers and appointments.

HealthPartners embeds providers in specialty clinics where patients already receive care, increasing accessibility and enabling specialized support. MaineHealth established palliative care presence at all eight network sites, with varying frequencies based on local needs, bringing specialty care closer to patients across the geographically large Maine network.

Embedded Specialty Care: Several organizations co-locate palliative care providers within high-need specialty settings. HealthPartners has full-time presence in three oncology clinics and regular sessions in pulmonary, cardiology, gastroenterology, nephrology, and neurology clinics. SSM Health is expanding from oncology into cardiology clinics (with growing cardiologist interest) and renal clinics for chronic kidney disease patients. Stormont Vail collaborates closely with their cancer center's survivorship program.

Navigating Value-Based Care Tensions

HealthPartners raised an emerging challenge: maintaining patient and family-centered care focus while participating in high-value care models. "How does that align, or how do we continue to focus on that in the midst of sort of the new value-based care models?" asked one attendee. "Recognizing that there can be win-win-win, it can be great for the patient, it can be great for the care team, and it can be great for the system. But recognizing that it's not always like that."

Another attendee agreed that palliative care naturally aligns with high-value care or value-based care principles: "Palliative care in general is really at the forefront of value-based care. It's definitely important work that we do." However, HealthPartners noted that not all ambulatory palliative care patients fall under value-based contracts, creating difficult navigation questions: "We know we can't be all things to all people. Do we need any limitations in place for who we're serving?"

Dr. Sharma acknowledged that when serious illnesses affect patients and families, the goal is to provide the best possible clinical outcomes while respecting patient autonomy, maintaining dignity, and ensuring families don't feel isolated in the journey. The unintended consequence—improved utilization metrics—results from "doing the right thing for the patient and the family."

Barriers

Participants identified capacity constraints as the primary barrier to delivering comprehensive patient and family-centered care. With limited FTE, organizations struggle to serve everyone who needs palliative care. HealthPartners is working to understand what percentage of their ambulatory census receives social work and spiritual care involvement—using benchmarks of 20% to 30% for social work and 10% to 20% for spiritual care for FTE justification—but acknowledged the challenge of determining which patients most need these services when "every patient needs social work support, but we are not staffed to provide every patient with social work support."

#2: Clinical Care and Symptom Management

Clinical expertise in managing complex symptoms represents the core clinical competency distinguishing specialty palliative care from primary or hospice care.

Current Approaches and Innovations

Medication Management and Protocols: HealthPartners' community-based palliative care team has full prescribing capabilities with RN phone triage, though without 24/7 availability, after-hours urgent needs are still directed to 911 or the emergency department. Their clinic-based team manages triage, RN basket message monitoring, full prescribing, refill management, and palliative care coverage to support the broader team.

Lehigh Valley has developed opioid contracts, requires CAPC education modules, provides ongoing pain and symptom management education to the interdisciplinary team (IDT), uses the Edmonton Symptom Assessment System (ESAS), implemented a Lehigh Valley Pain Management protocol, and collaborates with interventional radiology.

MaineHealth clinicians prescribe the full range of pain and symptom management medications at all sites, with developed opioid and controlled substance practice guidelines plus controlled substance agreements. Ochsner requires in-person visits prior to opioid prescriptions and annually thereafter (per Louisiana Board of Pharmacy requirements), with follow-up every three months. They utilize pain contracts, check the Prescription Monitoring Program (PMP), with each controlled prescription (with PMP integration into Epic), and can order urine drug screens (UDS) with specific metabolite testing in their clinical lab.

SSM Health maintains triage RNs and administrative support with provider backup during traditional business hours (not 24/7/365), accepting referrals via phone and electronically through MyChart.

Expanding to New Populations and Challenges: Lehigh Valley described their continuous growth in clinical protocols and policies, recently finishing an extubation order set for palliative extubation/liberation. They're increasingly involved with sickle cell populations in collaboration with hematology colleagues, strategizing approaches to care and considering ketamine use in that population. "A lot of it is continuing to grow, to find out where are the pain points in the system, and how can we be helpful. That keeps us relevant. It keeps us supported. In the beginning, we were doing a lot more goals of care, and as we've gotten better and improved our symptom management skills, we're really becoming more of an asset to the institution, which is helpful for sustainability."

Stormont Vail's team follows CAPC modules extensively for onboarding and continuing education, with providers utilizing UpToDate resources and collaborating with each other on complex cases. Their physician offers acupuncture in clinic as an additional layer of supportive care beyond pharmaceutical interventions.

Pharmacy Partnerships: SSM Health's recent partnership with their managed care pharmacy team supports medication management not only for ACO patients, but also for the entire palliative panel—"a great add," especially for "physicians and nurse practitioners who are working outside of the hospital realm, who can really use that support as they manage complex treatments, especially in the oncology realm."

Education and Training

Education emerged as both a strength and challenge. Organizations rely heavily on CAPC modules for nursing education and onboarding. MaineHealth provides particularly intensive training: All physicians practicing palliative care are board-certified in specialty palliative care with the vast majority having completed fellowship training. Most APCs have advanced certification in palliative care. New APCs attend all fellowship didactics for the first year and receive intensive Vital Talk and serious illness conversation training. They "really try to give them the same kind of intensive education that physician fellows get."

MaineHealth also offers a communication skills training program with standardized patients using both Serious Illness Conversation and Vital Talk approaches, available to anyone across the health system interested in advanced training. They previously ran a palliative care ECHO (Extension for Community Healthcare Outcomes) program for several years to provide education to non-palliative care clinicians, particularly in symptom management, though engagement from outside palliative care was limited, leading to the program's sunsetting.

Stormont Vail described requiring new team members to complete the entire CAPC module set and extensive shadowing with each team member: "Everybody does symptom management in a little bit of a different way. All effective, but there are always different ways to do it."

Dr. Sharma inquired about educating non-palliative specialists in primary palliative care skills. An attendee noted that time and bandwidth represent huge barriers for participation, and measuring impact remains "really challenging" beyond anecdotal local feedback. Some organizations use patient satisfaction as a proxy metric.

#3: Interdisciplinary Team

The IDT represents a defining characteristic of specialty palliative care, distinguishing it from symptom management alone by addressing physical, emotional, social, and spiritual dimensions of suffering.

Team Composition and Structure

Core Team Models: HealthPartners' community-based program operates with physicians providing program oversight; APCs (NPs/PAs) partnering with RNs to cover specific service areas with both in-home and telehealth visits; RNs conducting approximately 90% telehealth and 10% in-person visits (reserved for interpreter service needs or patients with communication barriers, making telehealth infeasible); medical social workers splitting approximately 50% telehealth and 50% in-person visits; and chaplains similarly splitting 50% telehealth and 50% in-person visits.

In their clinic-based settings, HealthPartners pairs clinicians with social workers for the majority of clinic days—"super helpful, just to have that dyad in the clinic where both social work and clinician is present to address not just the medical needs, but also those psychosocial needs, and that also helps a lot with the advance care planning too, and getting patients and families plugged in with those resources that they need as well."

Lehigh Valley's home-based practice is primarily nurse practitioner-driven with physician partners meeting with the team. Their ambulatory practice maintains approximately 1,000 patients overall. SSM Health distributes their 45 FTE across physicians (9), nurse practitioners (18), nurses (majority), administrative staff for scheduling and phone triage (approximately 3), chaplaincy support (1-2 FTE), and social work (3-4 FTE, including one LCSW).

Stormont Vail assigns three full-time physicians with three nurse practitioners to designated teams, each with three dedicated care managers, plus shared social work and chaplain support across outpatient and inpatient settings.

IDT Communication and Coordination

Structured Meetings: Weekly interdisciplinary team meetings represent the most common coordination approach. HealthPartners described their community-based team weekly IDT meetings, where they discuss patients who have been hospitalized, had ER visits, received initial consults, or had issues arise. Lehigh Valley's home-based team—

whose members are “out in the community throughout the week, [which] makes it sometimes very challenging for connecting”—uses weekly IDT meetings to discuss every patient, particularly critical for higher-need home-based patients. MaineHealth’s home-based service also meets weekly to review all patients, while clinic-side teams have morning huddles plus opportunities for in-depth social work and clinician conversations about patient needs.

Technology and Real-Time Communication: Beyond scheduled meetings, teams employ various communication tools. Lehigh Valley uses TigerText (now reimagined as a comprehensive care coordination platform), Microsoft Teams, Epic in-basket messaging, and phone calls for coordination between home-based teams, clinics, and referring entities. Ochsner conducts staff meetings for outpatient teams monthly, maintains a Teams Chat specific to the clinic, holds morning huddles with the Palliative Medicine Clinical Manager, and communicates with other system providers via Epic In Basket and Secure Chat.

HealthPartners recently implemented a new workflow in which schedulers not only book provider visits, but also conduct warm handoffs to the nursing team. Nurses then assess appropriateness for other disciplines’ involvement, as do providers during visits.

Co-location Benefits: Ochsner emphasized their co-location advantage: “We are co-located on the same floor with our IDT, so it’s really easy. They just walk down the hall and talk about the complex patients that we have.” They share a chaplain between inpatient and outpatient who remains very available. The proximity facilitates informal consultations and debriefing on difficult cases.

Successful Strategies

Participants highlighted several effective IDT approaches:

Benchmarking Discipline Involvement: HealthPartners shared their approach of using benchmarks for FTE justification—20% to 30% of ambulatory census for social work involvement and 10% to 20% for spiritual care—and expressed interest in learning what percentages other organizations achieve and how they identify which patients need social work support.

Systematic Assessment and Triage: HealthPartners’ new workflow includes warm handoffs from scheduling to nursing, with systematic assessment by both nurses and providers for other discipline needs. This replaces ad hoc referrals with structured screening.

Pairing Disciplines in Visits: Both HealthPartners and Lehigh Valley described pairing clinicians with social workers for clinic visits, enabling simultaneous medical and psychosocial assessment, improving care coordination, and facilitating advance care planning discussions when both disciplines are present.

Regular Touch Points Across Modalities: Successful teams maintain multiple communication channels—scheduled IDTs, morning huddles, secure messaging platforms, phone contact—recognizing that different situations require different approaches. Weekly IDTs provide comprehensive review, while real-time messaging enables immediate consultation on urgent issues.

Barriers and Challenges

Insufficient FTE: Limited FTE for interdisciplinary team members, particularly social work and spiritual care, emerged as the primary barrier. An attendee noted, "We probably don't have enough FTE with some of our interdisciplinary team members. I think specifically social work and spiritual care, because I always feel like we could always use more of that." Organizations must be "judicious" about which patients receive which services, rather than providing comprehensive IDT care to all.

MaineHealth described social work FTEs that "have been open for years that have been tough to fill," particularly for more rural sites across their network, though they have "some promising action, finally, on one." Staffing specialty palliative care interdisciplinary team members across geographically dispersed locations compounds recruitment challenges.

Sustainability of Team Support: Dr. Sharma emphasized the emotional burden of palliative care work and asked about best practices for team support and preventing burnout. Lehigh Valley described their approach of biyearly retreats: fall retreats with the whole team focusing on resilience and sustainability of the work, and spring retreats separated into home-based and office-based practices to address their distinct challenges and workflows. "Really using that retreat as a time to look at workflow processes, and really hearing from the people that are doing the work every day, and understanding what are the pain points, what are things that we could improve upon, and just making sure that we're making some actionable items from that."

MaineHealth implements formalized bereavement processes for both inpatient and outpatient teams, creating dedicated time and space to process patient deaths. They've held resiliency sessions run by a psychologist organized by their fellowship program director, conducted retreats including all team members "from MAs all the way [across the team], every single type of person that's involved in palliative care patients across the system," and maintain monthly palliative care grand rounds with external speakers accessible to everyone across the system.

Ochsner described their recent strategy day as "very helpful in terms of talking about the pain points and workflow issues and how can we improve communication among inpatient and outpatient teams." Their co-location facilitates informal support: "It's easy just to walk down the hall and talk about a difficult case and debrief and get support from our teammates."

Dr. Sharma emphasized the importance of having "that ability to be able to just run something by each other, or even if you're not able to do anything, just providing that active listening—a big source of de-stressing." She noted the frequency of difficult family meetings where desired outcomes aren't achieved: "To be able to run it with somebody, and to be able to have a listening ear, I think that really helps with extending that support to your team member, and ensuring the long-term support of your team member, and ensuring resilience and preventing burnout."

Resource Allocation Across Diverse Needs: Summit Health's experience illustrates the challenge of starting IDT development when palliative care infrastructure doesn't yet exist. Without dedicated palliative providers, their hospitalists have been CAPC-trained, hold advance care planning conversations, provide symptom management, and coordinate hospice referrals—essentially performing generalist palliative care while building the case for specialty program development. They described "a lot of interdisciplinary discussions" via phone calls, messages, and conversations with primaries, oncologists, and specialists to formulate plans and align on patient goals.

Looking Forward: Next Steps

The Phase 1 discussion revealed both the substantial progress participating organizations have made in ambulatory palliative care and the significant work that remains. Common threads emerged across all three motivating needs: the challenge of capacity and FTE limitations, the necessity of systematic rather than heroic individual efforts, the power of embedded and co-located care models, and the fundamental importance of keeping patient and family needs at the center while navigating organizational and financial realities.

Dr. Sharma closed with gratitude for participants' insights: "As you heard from our members, developing high-quality ambulatory palliative care works best when you have integrated, multidisciplinary, patient-centered focus, rather than a scaled-down version of inpatient hospice. And there is so much that can be achieved, and the kind of quality of life and elevation that you can provide to the patients, as well as their family, especially when they are dealing with serious illnesses, and just being that help during their journey—that is incomparable."

Danielle Casanova, MBA, vice president, Population Health Initiatives & Health Equity, AMGA, closed the session by emphasizing the collaborative learning opportunity ahead: "We have learned so much about these organizations and their ambulatory palliative care work to date. We can also see that we have much to do and look forward to addressing these gaps in Phases 2 and 3 of the program."

Participants will receive a Phase 1 meeting summary and are developing action plans for their organizations. The collective will continue exploring implementation strategies, sharing best practices, and working together to advance ambulatory palliative care that meets patients where they are—literally and figuratively—providing comprehensive, team-based, patient-centered care throughout the serious illness journey.

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