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Integration of palliative care in the management of multiple chronic conditions: An expert consensus paper with policy implications

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ABSTRACT

Background: This paper was jointly developed from members of the American Academy of Nursing Expert Panels on Palliative and End of Life Care, Primary Care, Aging, Acute and Critical Care, and two expert physicians.
Purpose: The overarching goal is to promote the integration of palliative care as symptom management into the primary care setting to transform care for patients living with multiple chronic conditions.
Methods: Embracing the recommendations made by the World Health Organization, the U.S. Department of Health and Human Services, and the National Academies of Science Engineering and Medicine to initiate palliative care or symptom management at the onset of nonreversible or serious chronic conditions.
Discussion: Earlier palliative interventions reduce disease exacerbation, prevent hospitalization, maintain physical functioning, and support health-related quality of life.
Conclusion: This is a needed paradigm shift as the nation's aging population escalates, Americans are living longer, and the healthcare costs for the nation are unprecedented.
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Background

The United States has the highest cost of healthcare worldwide (American Medical Association [AMA], 2023; Commonwealth Fund [CWF], 2023). Healthcare spending reached $4.3 trillion in 2021 averaging close to $12,900 per person (AMA, 2023; Peter G. Peterson Foundation [PGPF], 2023). The average cost of healthcare per person in other countries is half this amount. Putting this into perspective, healthcare costs have increased over the past decades, from 5% of the gross domestic product (GDP) in 1960 to 18% in 2021 (CWF, 2023; PGPF, 2023). In 2008, out of 159 nations studied, one-half spent less than 6% of their GDPs on health. The United States spent 15.2% (Gregorio & Gregorio, 2013).

Every day, 10,000 Americans turn 65 and become eligible for Medicare (CWF, 2023; Hoyt, 2023). In 2022, there were over 60 million Medicare enrollees representing 18.2% of the U.S. population and accounting for $901 billion or 22.3% of the overall health consumption expenditure (Congressional Budget Office [CBO], 2022; CWF, 2023). The CBO predicts that Medicare spending will double over the next 30 years (CBO, 2022).

More than two-thirds of Medicare beneficiaries have multiple chronic conditions (MCC). MCC is defined as having two or more

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concomitant conditions such as heart disease, diabetes, kidney disease, lung disease, dementia, and so on (Centers for Disease Control and Prevention [CDC], 2022; Centers for Medicare and Medicaid [CMS], 2021). Consistent with 80% of all adults being younger than 65, more than 60% of these adults with MCC report asthma, cognitive impairment, depression, smoking, obesity, poorer access to healthcare, disability, and worse quality of life in both unadjusted and adjusted analysis (Adams, 2017).

The economic burden for the management of MCC is substantial. Adults with five or more MCC spend 14-times more on healthcare services than with adults who have no chronic conditions (CDC, 2020). These financial costs are particularly high in MCC populations with Alzheimer's disease and related dementias, chronic obstructive pulmonary disease (COPD), and cardiovascular disease (CVD) (Gaugler et al., 2022). Currently, one in three or 33% of U.S. adults have MCC. In persons aged 65 and older, 80% of Medicare beneficiaries are living with MCC (Agency for Healthcare Research and Quality [AHRQ], 2023, 2024). This is the largest patient population and users of healthcare resources accounting for 64% of all clinician visits, 70% of all inpatient stays, 83% of all prescriptions, 71% of all healthcare spending, and 93% of Medicare spending (AHRQ, 2023).

According to a recent report from Blue Cross and Blue Shield (BCBS, 2023) and the Congressional Research Service (CRS, 2023), the costs of managing chronic conditions account for 86% of U.S. healthcare costs. When considering mental health issues together with chronic conditions, the total United States costs exceed 90% of the nation's healthcare resources (CDC, 2022).

As the U.S. population ages, the number of patients with MCC will continue to escalate. By the year 2030, the 72 million baby boomers (born between 1946 and 1964) will have all reached the age of 65 and will comprise 21% of the U.S. population (America's Health Rankings [AHR], 2022). By 2035, there will be more older adults than children, and in 2060, approximately one in four Americans will be 65 years and older, the number of 85 and older will triple, and the nation can expect a half-million centenarians (Administration for Community Living [ACL], 2021; AHRQ, 2023). This mounting challenge of aging Americans with MCCs is a major public health issue and often linked to suboptimal health outcomes and rising healthcare costs (AHRQ, 2020; Bierman, 2021; Hoffman, 2022).

The purpose of this paper is to highlight the need to integrate and implement palliative interventions or symptom management in primary care settings for patients living with symptomatic MCC. A discussion on the role of nursing in the implementation strategy and process is outlined. Furthermore, the authors provide an overview on MCCs, describe federal initiatives, promote a paradigm shift, and set-forth an urgent call to integrate palliative interventions in the primary care setting for patients with MCCs.

Largest, Fastest-Growing, and Costliest U.S. Patient Population

Adults with MCC represent one of the highest-need segments of the U.S. primary care patient population (CDC, 2020; Hoffman, 2022). There is growing evidence that one chronic condition has a negative impact on the risk for developing others, particularly in older adults (Hoffman, 2022). The nation's aging population combined with associated risk factors (e.g., obesity, tobacco use, poor nutrition, and lack of physical activity) will escalate in the American population of aging adults with MCC (Bierman, 2021; Hoffman, 2022). MCC lead to additional problems such as physical, social, and cognitive debilities; morbidity; disease exacerbation; hospitalization; adverse effects from medications; multiple providers with conflicting information; isolation; depression and mortality (AHRQ, 2023; CDC, 2020). The following discussion highlights the burden of MCC for our nation's ambulatory and hospitalized primary care patient population.

According to the CDC (2021), *Behavioral Risk Factor Surveillance System*, the primary percentage (9.6%) of adults with three or more chronic health conditions had comorbidities of arthritis, asthma, chronic kidney disease, COPD, CVD, cancer, depression, and diabetes. In a cross-sectional analysis of the *National Ambulatory and Hospital Ambulatory Medical Care Survey (2009–2011),* Dudley and colleagues found most primary care visits were for COPD, heart failure (HF), and dementia (American Heart Association [AHA], 2023; Dudley et al., 2017). These three nonreversible disease states will be used throughout this paper to demonstrate the clinical need for integration of palliative care in the primary care setting.

The 2019 *Healthcare Cost and Utilization Project* revealed that 84.1% of inpatient stays were for patients diagnosed with one or more chronic conditions (Owens et al., 2019). The most common reported conditions associated with adult inpatient stays were hypertension, diabetes, and chronic respiratory disease (Owens et al., 2019). Of all inpatient stays, 12.8% or 3.9 million Americans met diagnostic criteria for depression and 5.2% included substance use disorder (Owens et al., 2019). Over 50% of inpatient stays were for patients with three or more conditions and this number increased with age (72.7% in patients 85 years or older) (Owens et al., 2019). Patients with three or more comorbidities had a higher death rate (Owens et al., 2019). This is the ideal patient population who can benefit from skilled palliative symptom management used to prevent disease exacerbation and worsening of disease.

History of Federal Initiatives in MCC

March of 2024 marked the fourteenth anniversary of the *Patient Protection and Affordable Care Act (ACA),* signed into legislation by former President Obama. *Title IV—Prevention of Chronic Disease and Improving Public Health* was included among the many titles or key directives of this legislation (2010). A series of legislative initiatives championed by the U.S. Department of Health & Human Services (HHS) focused on MCC. In the same year, HHS established an interagency work group of subject experts and released the *Multiple Chronic Conditions: A Strategic Framework* (HHS, 2010). HHS called for collaboration between government agencies, policymakers, and the public sector to develop robust change to address the growing challenge of Americans living with MCC (AHRQ, 2010). See Table 1 to review the brief history of federal initiatives in MCC.

Current Federal Initiatives in MCC

In November 2020, the AHRQ convened the *Summit on Transforming Care for People Living with Multiple Chronic Conditions.* A premise of the summit concurred that the current U.S. healthcare system is best suited for addressing single diagnoses and acute conditions, suggesting change must occur to better match the needs of the MCC population. During this 2-day summit, participants assisted AHRQ to identify and prioritize key areas for investigation and innovation.

These efforts led to an October 2021, special issue of *Health Services Research (HSR)*, focused on the current trends in *The Science of Care for People with Multiple Chronic Conditions* (Bierman & Werner, 2021). Dr. Arlene Bierman, director of the AHRQ's Center for Evidence and Practice Improvement, in November 2021, highlighted the agencies' research agenda for persons with MCC in an AHRQ blog. Dr. Bierman reported *"AHRQ's research agenda provides a roadmap to guide future research investments to help address the wicked problem of MCC"* (Bierman, 2021).

Recently, AHRQ established a learning collaborative (LC) of interdisciplinary professionals to the *Patient-Centered Care for Persons (PCCP) with MCC*. The purpose for the LC is to discuss models of PCCP that have real-world implementation with frontline providers. The LC will include bidirectional learning about barriers and feasible solutions to common implementation barriers. Best practices will be included in the PCCP roadmap for use by AHRQ and other federal partners (AHRQ, 2024).

Table 1
Federal Initiatives in MCCs

Agency	Initative	Year	Overview
National Quality Forum (NQF)	Multi-stakeholder steering committee to develop measurement framework for patients with MCCs	2011 to 2012	Align federal initiatives targeting MCCs. Identify measure gaps. Guide selection of measures for public reporting and payment. Roadmap for new delivery models.
Centers for Medicare and Medicaid Services (CMS)	Chronic Conditions among Medicare Beneficiaries	2010 to 2012	CMS produced two chartbooks highlighting the prevalence of MCCs among Medicare beneficiaries and the impact on Medicare utilization and spending.
Centers for Disease and Prevention (CDC)	Chronic Disease Indicators	2012 to 2013	Chronic disease indicators (CDI) were generated from a consensus among CDC, the Council of State and Territorial Epidemiologists (CSTE), and the National Association of Chronic Disease Directors (NACDD). Updated in 2012 to 2013 with a total of 201 individual measures for 124 indicators, which include MCC topic areas.
Rand Organization	Multiple Chronic Conditions in the United States	2017	Methodological analysis to update MCC's chartbook—data taken from 2014 adult population.
National Institute of Nursing Research (NINR)	Centers for Excellence in Research initiatives in MCCs in adults	2017	2.0 million in funding by HHS to support sustainability and enhance interprofessional biobehavioral research in adult patients with MCCs.
Agency for Healthcare Research and Quality (AHRQ)	SHARE Approach	2016	The SHARE Approach is a five-step process for shared decision-making between the patient and provider. Evaluating benefits, harms, and risks of each option focusing on what matters most to the patient.
Administration of Community Living (ACL) formally known as the Agency on Aging	Empowering Older Adults with Disabilities through Chronic Disease Self-Management Education	2012	Agency on Aging initiated the program on Self-Management Education Program in chronic disease initiative, financed through the Affordable Care Act's Prevention and Public Health Fund. Since 2015, cohorts are awarded annually.
American Geriatric Society (AGS)	Guiding Principles for the Care of Older Adults with Multimorbidity: An Approach for Clinicians	2012	The American Geriatrics Society convened an expert panel with expertise in the clinical management of older adults with multimorbidity. The goal of the panel was to develop a clinical approach for clinicians to provide optimal care for this patient population.

Note. MCC, multiplechronic conditions.
ACL (2017), AGS (2012), AHRQ (2014, 2016), Buttorff et al. (2017), CDC (2013), CMS (2010), National Institutes of Nursing Research (NINR) (2018), National Quality Forum (NQF) (2012).

Transformative Potential of Integrating Palliative Care in Primary Care Settings

Implementing palliative care in primary care settings is pivotal for enhancing the overall quality of life in MCC populations. By addressing the diverse trajectories of disease, palliative care provides a holistic approach to managing symptoms, which can significantly alleviate patient suffering and improve overall well-being. This proactive and patient-centered care model not only optimizes symptom management but also plays a central role in reducing hospital admissions. Through early and continuous intervention, palliative care in primary settings ensures that patients receive comprehensive support, which can lead to better health outcomes and address the quintuple aim of healthcare.

Trajectory of Disease

Addressing MCC requires an understanding of the disease trajectory and where the patient is along that trajectory. This is a dynamic process involving interaction between care teams to ensure care plans meet the unique needs of each patient. Unfortunately, it is often the chronic condition with the worst prognosis or trajectory with the highest likelihood of rapid decline that takes priority.

In 2003, the Rand Corporation illustrated three distinct disease trajectories for persons living with chronic illness (see Figure 1). These disease trajectories depict a short period of progressive decline (cancer), gradual and slow progression (HF, COPD), and prolonged gradual decline (AD/ADRD). Cancer was initially described as having a trajectory with a steady progressive and a predictable sudden decline in physical function (Lynn & Adamson, 2003). In recent years, treatment progress has resulted in a much less uniform and predictable trajectory for noncurable cancer (Geijteman et al., 2024).

HF and COPD have a slower disease progression, a long duration with an uncertain prognosis. This trajectory is punctuated by episodes of acute exacerbations and hospitalizations followed by recovery and unexpected death (ElMokhallalati et al., 2020; Lynn & Adamson, 2003; Murray et al., 2024). Many older adults with AD/ADRD experience a prolonged insidious decline with an unpredictable death (Lynn & Adamson, 2003; Murray et al., 2024).

A study by Zhu et al. (2018) evaluated a lifetime disease progression trajectory simulation model demonstrating how a person starts healthy, becomes at risk, and then progresses to one or more chronic conditions with life years lost. The researchers found the risk of disease occurred in the late 30's; developing a first chronic condition occurred at 50 to 60 years of age with the progression of disease complications in the 70's. This trajectory progresses to death in the 80's (Zhu et al., 2018). This study suggests that life expectancy is equivalent to disease trajectory.

Prognosis can help determine a disease trajectory and can be used by healthcare professionals, patient, and family to plan, develop, and integrate appropriate palliative interventions (Murray et al., 2024). The American Geriatrics Society (AGS), *Guiding Principles on the Care of Older Adults with MCC* (Boyd et al., 2019), use prognosis and disease trajectory synonymously. Prognosis in this guideline, refers to the projected likely course of disease, while disease trajectory refers to changes in physical functioning, overall health status, and quality of life over a defined timeframe (Boyd et al., 2019):

Understanding the disease trajectory helps to guide the development of the best plan of care and includes three key actions.

- Identify and communicate the patient's health priorities based on the disease trajectory;
- Determine when to stop, start, or continue care based on patient-centered priorities and evaluating benefit verses harm and associated burden of care;
- Aligning care decisions between the patient, caregivers, and healthcare team should be based on patient priorities (Boyd et al., 2019).

Disease prognostication through biological markers, appropriate diagnostics (e.g., ejection fraction, pulmonary function, radiographic

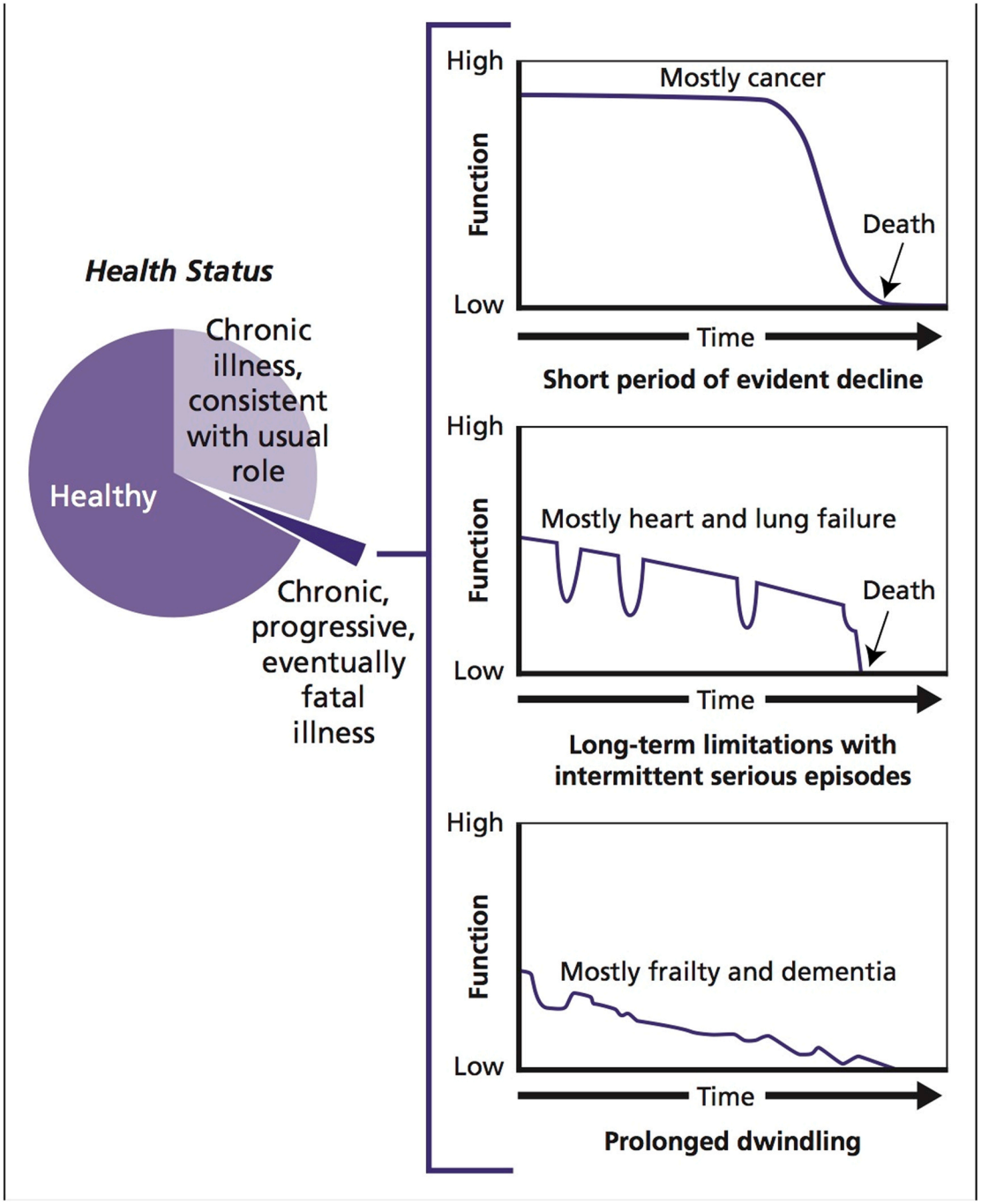


Figure 1. Disease trajectories. Used with permission from Lynn, J., & Adamson D. (2003). *Living Well at the End of Life: Adapting Health. Care to Serious Chronic Illness in Old Age*, RAND Corporation, WP-137. https://www.rand.org/pubs/white_papers/WP-137.htm.

findings, etc.), and disease-directed medication management can assist the healthcare team, patient, and family in determining the best plan of care. These are important determinants when considering individualized patient-centered care with high-quality outcomes (AHRQ, 2024; Kuebler, 2023). Patient care plans require ongoing updates to harmonize with evolving therapeutic developments.

Effective Symptom Management

Despite the advances in disease-specific therapies, patients living with MCC have significant symptom burden (Dudley et al., 2017; Graney et al., 2019). While most conditions have pathophysiological differences, patients often experience similar symptoms such as dyspnea, fatigue, pain, insomnia, depression, anxiety, and a decline in physical functioning (Dudley et al., 2017; Graney et al., 2019). Poorly managed symptoms reduce patient perceived quality of life and can increase the underlying disease severity (Dudley et al., 2017; ElMokhallalati et al., 2020; Graney et al., 2019). The *Integrated Model of Multimorbidity and Symptom Science* highlights the multilevel factors and the reciprocal interactions among health conditions, symptoms, disease-directed therapies, and outcomes (Tripp-Reimer et al., 2020).

For example, symptom burden in patients living with HF has been linked to those living with advanced cancer or acquired immune deficiency syndrome (AIDS) (Koshy et al., 2020; Mechler & Liantonio, 2019). Yet, the use of palliative consults occurs more frequently in patients living with cancer compared to those living with HF (Koshy et al., 2020;

Mechler & Liantonio, 2019). Dyspnea, fatigue, edema, pain, depression, exercise intolerance, and cough are commonly reported by patients living with HF (Koshy et al., 2020; Mechler & Liantonio, 2019). Shifting care priorities to focus on symptom management and targeted care can improve patient quality-of-life years, reduce hospitalization, slow disease progression, and promote cost-effective care (Koshy et al., 2020; Mechler & Liantonio, 2019).

A recent study that evaluated symptom prevalence, severity, distress, and management in patients living with HF, COPD, and end-stage renal disease (ESRD) identified patient-reported prevalent symptoms and compared them with previously reported studies (AlHosni et al., 2023; Mechler & Liantonio, 2019). Investigators found that each disease had a unique set of highly prevalent symptoms. For example, COPD patients reported symptoms of dyspnea, fatigue, pain, cough, and insomnia. Patients with HF reported fatigue, numbness, insomnia, and edema. Common symptoms for patients living with ESRD were pain, fatigue, numbness, pruritus, and insomnia (AlHosni et al., 2023).

The National Institute on Aging, the Alzheimer's Association, and the National Institutes of Health 2018 guidelines report a cognitive behavioral syndrome (Brooks, 2018). This syndrome of AD/ADRD can lead to changes in mood, anxiety, sleep, and personality that affect personal and social relationships. These symptoms are often noticeable long before memory and thinking symptoms appear (Brooks, 2018). Patients living with early dementia experience agitation, pain, and dyspnea (Hendriks et al., 2014; Monroe et al., 2012, 2013). Studies consistently reveal that dementia is a risk factor for inadequate pain and symptom management (Monroe & Carter, 2010; Monroe et al., 2014). This is a prevalent problem among patients living with dementia and residing in the community, where one-third to one-half of patients experience pain according to self-report or caregiver account. Often, pain is described as moderate to severe (Hunt et al., 2015, 2018; Wei et al., 2021). With earlier introduction of palliative care in dementia management, pain and other symptoms can be identified, assessed, and optimally managed while the patient is communicative and cognitively aware. Earlier assessment of the patients' self-reported pain at baseline can improve palliative pain management as dementia progresses.

Understanding the patient's symptom experience is essential when developing and implementing palliative symptom management (AlHosni et al., 2023). Proactively managing symptoms associated with MCC empowers the patient and family through self-management to ward off disease exacerbations (ACL, 2017). The optimal management of symptoms prevents worsening of the underlying condition that can lead to increased frailty and disability by maintaining physical functioning, and reducing hospital admission (Global Initiative for Chronic Obstructive Pulmonary Disease [GOLD], 2023; Kuebler, 2023).

Reducing Hospital Readmission

The mandatory federal pay-for-performance *Hospital Readmissions Reduction Program (HRRP)* was created through the ACA in 2010 with the goal to decrease 30-day hospital readmission rates (Psotka et al., 2020). Initially, penalties for earlier than 30-day readmission were assigned to diagnosis of HF, acute myocardial infarction, and pneumonia (Psotka et al., 2020). This has since expanded to include COPD, total hip or knee arthroplasty, and coronary artery bypass graft. Approximately 79% of Medicare-participating hospitals have been penalized, saving Medicare millions of dollars (Boccuti & Casillas, 2017).

Hospital readmission following discharge within 30 days is a frequent, burdensome, and costly event for older patients with MCC (Facchinetti et al., 2020). Older patients living with MCC often require frequent hospitalization to manage disease exacerbation (Facchinetti et al., 2020). Hospital admission shifts the focus of care from chronic to acute disease management in the short-term follow-up, but factors such as patient self-management, outpatient care, socioeconomic issues, and community resources rather than the underlying chronic condition contribute to long-term readmission rates (Facchinetti et al., 2020).

Data evaluating disease exacerbation are found primarily in the COPD patient population and used here to highlight the value of palliative symptom management. A recent systematic review and meta-analysis evaluating risk factors for all-cause readmission following an exacerbation of COPD determined the combination of MCCs, previous exacerbations and hospitalization, and increased length of stay as significant risk factors for readmission rates at 30- and 90 days following discharge (Alqahtani et al., 2021).

Additionally, 14 studies representing almost 4 million patients with similar risk factors for hospital readmission were reported (Alqahtani et al., 2021). HF, depression, alcohol use, and renal failure were consistent risk factors. An important risk factor in the COPD patient was the chronic use of systemic corticosteroids (Alqahtani et al., 2021).

In another systematic review, Njoku and colleagues (2020) found that reduced lung function measured by post-bronchodilator forced expiratory volume and a forced vital capacity (FEV1/FVC) ratio of < 70% at baseline was a risk factor for readmission. Dyspnea, chronic cough, and increased sputum production were common symptoms placing the patient at risk for inpatient readmission. Hospitalization in the previous year was found to be the main predictor for readmission, followed by an asthma diagnosis, socioeconomic status, and living or discharged into the nursing home, all increasing the risk for readmission (Njoku et al., 2020).

A recent systematic review evaluating the cost analysis of COPD found the greatest increase in costs is from an acute exacerbation of COPD (Gutiérrez Villegas et al., 2021). Exacerbation occurs more frequently in moderate-to-severe COPD that is poorly symptom-controlled (American Lung Association [ALA], 2019; GOLD, 2023).

Paradigm Shift: Moving Palliative Care Into the Primary Care Setting

The origin of palliative care comes from Dr. Balfour Mount, who is recognized as the father of palliative care. In 1975 at McGill University in Montreal Canada, Mount coined the term "palliative care" after learning the etymology of the word palliative—meaning "to improve the quality of life" (Phillips, 2023). He is well-known for his famous quote:

> "*What has surprised me is how little palliative care has to do with death. The*
>
> *death part is almost irrelevant. Our focus isn't on dying. Our focus is on quality of*
>
> life."—Dr. Balfour Mount, McGill University

The growing prevalence of symptomatic MCC necessitates a paradigm shift in primary care to embrace the implementation of palliative symptom management to comprehensively meet the complex and challenging healthcare needs experienced by this patient population (Dy et al., 2021; National Academies of Science, Engineering & Medicine [NASEM], 2022; World Health Organization [WHO], 2018a). Managing MCC in primary care places the clinical focus on aggressive symptom management to reduce disease exacerbation, prevent hospitalization, and debility while promoting physical activity and improved quality of life (Evans et al., 2021; Gorman, 2016; Kuebler, 2023).

The principles of primary care are congruent with the principles of palliative care and include health promotion, disease prevention, curative care, rehabilitation, palliative care or symptom management, continuity of care, and the respect of the patient's values while including the family or caregivers (Dy et al., 2021; NASEM, 2022; WHO, 2018a). Evidence suggests that palliative care when integrated into primary care facilitates high-quality, cost-effective healthcare (NASEM, 2022; WHO, 2018b). This integration can reduce costs for healthcare systems by reducing dependency on hospital, outpatient, and inpatient services (WHO, 2018b).

The WHO suggests that specialists who provide palliative care are not always necessary to meet the palliative care needs of most patients and families in the primary care setting; and recognizes that palliative care needs can be provided by general practitioners, family physicians, and advanced practice providers within the community (WHO, 2018b). The NASEM acknowledges there are not enough palliative specialists to meet the advanced care needs of the escalating population of patients with MCCs who require aggressive symptom management (NASEM, 2022).

Both the NASEM (2022) and the WHO (2021), recommend that the integrated delivery of palliative care be embedded in the primary care setting. These reports indicate there is a vital need to address the broader determinants of health by focusing on the comprehensive and interrelatedness of the physical, mental, and social aspects of a patient's health and well-being. Primary care offers whole-person care throughout the lifespan, including quality palliative care that can support the patient living with MCC (WHO, 2021). The NASEM (2022) suggests the shared principles of person- and family-centered, continuous, comprehensive, and equitable, team-based care that is collaborative, coordinated, integrated, accessible, and high-value found in primary care are the same principles ascribed in palliative care (NASEM, 2022).

Palliative care when implemented in the primary care setting helps to maintain coordinated, comprehensive care for the patient, thereby reducing fragmentation, increasing the quality and value of the care provided, and reducing costs (Dudley et al., 2018). There is evidence that early implementation of palliative care may extend the duration of life (Hoerger et al., 2018). The Medicare Chronic Care Management reimbursement incentive for primary care providers could be better utilized and understood by patients, families, and providers. This offers an ideal model of implementing palliative care practices in patients living with symptomatic MCC (CMS, 2023).

Proposing a New Paradigm for Primary Care

In 2021, AHRQ commissioned the Johns Hopkins University Evidence-Based Practice Center to evaluate the availability, effectiveness, and implementation of palliative intervention in the ambulatory/primary care setting for patients with noncancer chronic disease and serious illness (Dy et al., 2021). This comparative effectiveness review relied on a panel of interdisciplinary experts to include nursing (Dy et al., 2021).

Key findings from this review suggest:

- There are sufficient resources available for patient, caregiver, and clinician education and training. However, few resources have been tested for effectiveness or implementation;
- Shared decision-making tools are widely used primarily in establishing advance directives;
- Palliative care models that have been tested to date have demonstrated limited beneficial effects or mixed effects on symptom burden, depression, or health-related quality of life, although these models were effective by increasing advance directive conversations and documentation;
- Patients and caregivers have their own preferences about the timing of advance care planning discussions (Dy et al., 2021).

Nurses practicing at their full professional scope in primary care assess, evaluate, monitor, prescribe, and coordinate the care of the nation's largest, fastest-growing, and costliest patient population—those living with and dying from symptomatic MCC (McMenamin et al., 2023). Nurses are an integral member of the interdisciplinary team meeting the primary and palliative comprehensive care needs of this challenging patient population. Nurses understand and appreciate the tenets of palliative care and can

Table 2
Examples of Palliative Care in MCC—Primary Care

Chronic Condition	Guideline Recommendations	Examples of Palliative Interventions to Control Symptoms
Heart failure	2022 AHA/ACC/HFSA Guideline for the management of heart failure 2023 Focused update of the 2021 European Society of Cardiology (ESC) Guideline for the diagnosis and treatment of acute and chronic heart failure Both guidelines address comorbidities associated with HF (e.g., iron deficiency, anemia, hypertension, sleep disorders, type-2 diabetes, atrial fibrillation, coronary artery disease, and malignancy)	Combination of angiotensin-converting enzyme (ACE) inhibitors, beta blockers (BB), mineralocorticoid receptor agonists (MRA), and sodium glucose cotransporter-2 inhibitors (SGLT2), most effective in decreasing symptoms and hospital readmission Diuretics Palliative inotropes Collaborate with cardiology and/or heart failure specialists Baseline ejection fraction and treatment based on disease stage. Reevaluate following an exacerbationCardiac rehabilitation Self-management Shared decision-making
Chronic obstructive pulmonary disease	2023 Global Initiative on Chronic Obstructive Pulmonary Disease (GOLD)	Maximize long-acting inhaled bronchodilation (anticholinergic and beta agonists) breakthrough with short-acting beta agonistsLong-term use of azithromycin and/or erythromycin Consider adding an inhaled corticosteroid in patients with $\geq$2 exacerbations in 1 yearMonitor blood eosinophils $\geq$300 cells/μL Caution on systemic corticosteroids due to long-term side effects Collaborate with a pulmonologist Pulmonary function test and baseline FEV1. Reevaluate following exacerbationPulmonary rehabilitation Self-management Shared decision-making
Alzheimers—dementia	2018 National Institutes of Aging, Alzheimer's Association, and the National Institutes of Health Guideline aimed at multiple specialties2021 American Psychological Association (APA) Guidelines for the Evaluation of Dementia and Age-related Cognitive Changes	Antiamyloid medications Earlier diagnosis and treatment Reduce comorbidities with healthy diet and physical activityBaseline biomarkers through amyloid imaging, glucose uptake under PET scan, radiotracers, and cerebrospinal fluid analysis of amyloid and tau Neurologist Mental health Shared decision-making

Note. HF, heartfailure; MCC, multiplechronic conditions.
APA (2021), Brooks (2018), GOLD (2023), Heidenreich et al. (2022), McDonagh et al. (2023), Sheinin (2023), and Youmshajekian (2023).

Table 3
Recommendations to Influence Policy on Integration of Palliative Care for MCCs in Primary Care

Recommendations	Specific Actions	AAN Alignment
Recommendation #1 Align with the U.S. Department of Health and Human Services, the National Academies of Science Engineering and Medicine, the Agency for Healthcare Policy and Research, and the World Health Organization to initiate earlier palliative symptom management in patients living with MCCs.	Establish consensus within nursing, medicine, insurers, and policymakers on when to initiate symptomatic palliative care within the clinical context of the patient's specific disease trajectory using prognostic indicators in the primary care setting. Collaborate on developing interdisciplinary, HHS intra-agency evidence-based clinical practice guidelines that focus on MCCs and related symptoms to prevent exacerbation, hospitalization, and debility. Partner with AHRQ to resurrect the shared decision-making training and implementation to promote patient self-management to empower patient, family, and caregivers. Prioritize clinical nursing initiatives and research agendas that align with the recent bipartisan passing of the Senate Health, Education, Labor, and Pension Committee on Primary Care to leverage whole-person care in patients with MCCs. Recommend the Centers for Disease Control and Prevention to include palliative pain management for patients with MCCs in the clinical guideline for prescribing opioids for noncancer pain.	These recommendations align with the 2023 to 2024 AAN policy priorities to advance health equity by:Increasing accessibility to earlier palliative symptom management in patients with MCCs. Promoting high-impact advances in clinical practice, innovation, and science by participating in legislative initiatives that build on and maintain the federal momentum in meeting the complex care needs of this patient population. Building capacity to support nurses and the interdisciplinary team by collaborating on clinical guidelines, collecting patient-centered outcomes that demonstrate clinical care that reduces disease exacerbation, hospitalization, cost, and promotes quality of life.
Recommendation #2 Advocate for a new clinical nursing paradigm that moves palliative care upstream in the disease trajectory with a focus on clinical evidence-based symptom management in patients with MCCs.	Strengthen nursing practice and education by disseminating evidence-based content through the Multiple Chronic Conditions Resource Center, in partnership with the official journal of the American Nurses Association—the American Nurse Journal. Resurrect the U.S. Department of Health and Human Services Multiple Chronic Conditions: A Framework for Education and Training to integrate into nursing curriculum at all levels to train, improve health, lower costs, and maximize patient quality of life. Advocate for interdisciplinary research funding and initiatives by the NIH and AHRQ that promote clinical dialog that captures improved patient outcomes, reduction in hospitalization, and debility. Recognize the clinical palliative nursing skills and education necessary to meet the comprehensive and complex care of patients with MCCs differ from those at the end-of- life. Recognize the evolution of technology, artificial intelligence in patient self-management in the primary care setting. Promote skilled evidence-based prescribing practices by advanced practice nurses to focus on disease and symptom management, maintain physical functioning.	Alignment with the AAN 2023 consensus recommendation to advance system-level change for nurse well-being by: Implement and support policy that advocates for a systematic change for a healthier workplace environment. Safe competent clinical nursing practice will ensure quality patient care with a focus on symptom management, physical functioning, and quality of life. Nurses who experience an environment of inclusivity/diversity, and freedom from discrimination are better equipped to meet the diverse needs of the nation's largest patient population. The AAN 2022 policy dialog meeting on *Optimizing the Nursing Workforce: Exploring Innovative Reform and Policy Implications.* AAN's leadership can strengthen the existing primary care model by broadening palliative symptom management through educational and research initiatives to promote safe quality care. This empowers the nurse, the patient, and family. The 2018 AAN policy on the emerging role of the baccalaureate primary care registered nurse. Focus on the impact the nurse can make by increasing access to care, health promotion, education, monitoring, and safety that meet the healthcare demands of MCCs.
Recommendation #3 Recognize that palliative care is far broader than implementation at the end-of-life and used in MCCs to reduce healthcare demands, costs, and resources in an escalating patient population.	Lead efforts that align with the World Health Organization on patient-centered care, adopted by the World Health Assembly in 2016, that asserts palliative care is an essential function of primary care. Support major initiatives that recognize primary care and palliative care share commonalities to provide coordinated, comprehensive care that respects the patient's values, responding to social determinants of health and including patient, family, and caregivers. Advocate that the patient and family be at the center of care by implementing comprehensive primary care that includes health promotion, disease prevention, curative care, rehabilitation, and palliative care that is coordinated with appropriate referrals to secondary and tertiary care. Establish forums for endorsing evidence-based palliative practices for MCCs that are separate and distinct from cancer care. Consider the context of patients' lives and living conditions as described in NINR's Research framework when considering the needs of patients with MCC.	AAN to rely on the World Health Organization's 2018 call on why palliative care is an essential function of primary healthcare when establishing a clinical paradigm of moving palliative care upstream to thwart the excessive costs of poorly managed symptoms in patients with nonreversible, symptomatic, MCCs.

Note. MCC, multiplechronic conditions.

educate the patient and family. The shift in moving palliative care further upstream in the disease trajectory within the primary care setting allows for exemplar symptom management for patients who live several years following a chronic condition diagnosis and are not terminally ill or dying. Broadening the focus of care on reducing symptom burden, preventing exacerbations, and reducing hospital admission differs from palliative care used at the end-of-life (Kuebler, 2023).

Advanced practice nurse prescribers should remain current and relevant on the implementation of evidence-based guidelines in the optimal management of symptomatic MCCs. See Table 2 for examples of palliative interventions. The use of newer medication recommendations and associated guidelines used to reduce disease exacerbation, evaluate and manage symptoms, optimize physical functioning, prevent hospitalization, and improve quality of life (Kuebler, 2023). The National Coalition for Hospice and Palliative Care 4th edition of *Clinical Practice Guidelines for Quality Palliative Care* in 2018 do not provide clinical direction on the comprehensive care needs associated with symptomatic MCC. Registered nurses assist in the assessment and evaluation of interventions and can help to communicate patient and family needs not met by the primary care team, specialists, or ancillary support.

Need for Action

Integrating palliative symptom management into the routine primary care of MCCs can reduce symptomatic exacerbations that create unnecessary confusion and stress in the lives of the patient, family, and caregivers. We believe it is possible to prevent disease exacerbation through skilled palliative interventions in the primary care setting for nonreversible conditions in patients who are not terminally ill or dying. We acknowledge that nursing leadership and engagement are key to successful implementation. Further, we advocate that palliative care be initiated at the time of diagnosis and used to reduce the healthcare demands, costs, and resources in an escalating patient population. The tools, knowledge, and guidelines are readily available. The recommended paradigm change can improve the lives of the patient, family, caregiver, provider, and nurse while positively impacting insurers, policymakers, educators, and society.

Recommendations to Influence Policy

As the premiere nursing organization, AAN can lead policy change and strengthen clinical nursing practice to ensure optimal care and outcomes for the nation's largest patient population. This document promotes consensus recommendations from leading nurse and medical experts to advocate for and promote a new paradigm through the integration of palliative practices in the primary care setting. These recommendations align with ANA policy highlighted in Table 3.

CRediT Statement

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Declaration of Competing Interest

The authors declare no conflicts of interest.

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