Realizing the **Full Benefit** of Palliative Care

Service Optimization and Strategic Growth

- The Case for Palliative Care
- Starting a Palliative Care Program
- Growing the Inpatient Consult Service
- Expanding Palliative Care Capacity Across the Medical Staff
Physician Executive Council

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**Palliative Care Program Development Toolkit**

- Contains additional tools and content to expedite palliative care program development
- “Plug and play” tools include:
  - Palliative care cost savings estimator
  - Key metric dashboards for each phase of growth
  - Ready-to-use PowerPoint template for making the case for program growth
  - Sample documents from successful palliative care programs, such as screening tools, service standards, progress note templates, and physician-patient talking points
- Available online at advisory.com/pec/pctoolkit

Available Online
Available Within Your Physician Executive Council Membership

The Physician Executive Council is continuously developing resources to assist members in transforming clinical care delivery. The most relevant resources are outlined here. In addition, we have compiled additional resources, including a series of six on-demand webconferences, to support clinical executives and palliative care program leaders in developing and growing a robust palliative care service.

All of the resources listed here are available in unlimited quantities through your Physician Executive Council membership.

**Resources on Transforming Clinical Care Delivery**

- **Building the Evidence-Based Organization**  
  *(Coming Spring 2014)*

- **Engaging Physicians in Patient Experience**  
  *(Coming Spring 2014)*

- **Improving Provider Communication and Patient Transitions**  
  Hospital-Based Best Practices

- **Delivering on Value**  
  Positioning Quality for Success in an Evolving Performance-Based Environment

- **New Quality Compact**  
  Partnering with Physicians to Advance a New Performance Standard

**On-Demand Palliative Care Webconference Series**

- **Encouraging Physician Referrals to Palliative Care**  
  A Conversation with the Center to Advance Palliative Care

- **The Case for Palliative Care**  
  Cost and Quality Benefits of Expanding Services

- **Introducing the Palliative Care Toolkit**  
  Tools for Developing and Growing the Program

- **Starting a Palliative Care Program**  
  Tactics for Planning and Building a Sustainable Service

- **Growing Your Palliative Care Consult Service**  
  Best Practices to Increase Utilization While Maintaining Service Quality

- **The Future of Palliative Care**  
  Inpatient and Outpatient Models for Increasing Your Program’s Value
Executive Summary

Palliative Care Investments Can Dramatically Improve Hospital Care Quality and Reduce Costs
To reduce costs and improve care quality, hospital executives must do more than cut costs and hit quality metrics. They must find opportunities for substantive inpatient care delivery transformations using principles such as patient-centeredness and top-of-license staffing. Palliative care has emerged as a winning transformation opportunity whose benefits accrue under both traditional fee for service paradigms and emerging risk contracts.

Implementing a Palliative Care Culture Change
To capture full benefits, palliative care programs must bring about a fundamental shift in physicians’ understanding of this aspect of patient care. Growing the model will require cultivating a palliative care dialog with clinicians, establishing a service that meets the needs of physicians and their patients, and building upon this foundation of mutual trust as the program grows.

Looking Beyond the Palliative Care Team for Program Growth
Growing palliative care requires looking beyond the palliative care team for two key reasons. First, palliative care programs need informed physicians to increase referrals. And second, there will never be enough palliative care specialists to meet the needs of all patients. Instead, hospitals must work to enlist and equip the entire medical staff as partners in providing palliative care. This enables palliative care specialists to work at top-of-license with the most complex cases, while also raising the standard of “usual care” by helping other providers better meet their patients’ basic palliative care needs.

Overcoming Roadblocks to Maximize and Sustain Palliative Care’s Benefits
When all patients who would benefit from palliative care services receive them, improved outcomes and reduced costs will result. This study, along with its accompanying online resources, lays out a comprehensive guide for hospital executives and clinical leaders seeking to work toward this vision. As you work toward this goal, we invite you to call upon us to facilitate discussions with your team, offer further guidance, or provide any other needed support. As always, we close with appreciation for the opportunity to serve you.
Advisors to Our Work

The Physician Executive Council is grateful to those who shared their insights, analysis, and time with us.

We would especially like to recognize the following people for being particularly generous with their time and expertise.

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With Sincere Appreciation
The Palliative Care Imperative
Agreeing on a Common Definition of Palliative Care

Characteristics of Palliative Care

- Prevents and relieves suffering and symptoms
- Enhances quality of life for patient and family
- Emphasizes goals of care and aids in decisionmaking
- Plans for end-of-life care
- Provides psychosocial and spiritual care
- Is appropriate at any stage of a serious illness, including alongside curative treatments

Continuum of Care

First Things First

Many definitions of palliative care exist, often resulting in confusion. This study uses the following definition: “Palliative care is specialized medical care for patients with serious illness designed to improve quality of life. It emphasizes pain and symptom management, counseling for patients and families, support for patients making decisions about their treatment and goals of care, and care coordination.”

Unlike hospice, palliative care is suitable for patients at any stage of their disease, and it can be offered alongside curative therapies.

Unfortunately, though some of the biggest benefits come when palliative care is introduced early on in treatment, many physicians still mistakenly believe that palliative care is the same as hospice and thus do not refer patients to palliative care service until they are no longer seeking curative treatment.

29% of primary care physicians mistakenly believe that palliative care and hospice are virtually the same.

In many ways, the palliative care mind-set constitutes a fundamental shift in the approach to patient care.

Usually when a patient is sick, the treatment plan is clear—combat the disease at all costs. But sometimes this approach leads to treatments that are low-yield and burdensome for the patient.

Palliative care’s approach is different. It bases treatment on what the patient wants—their personal goals for their care. With palliative care, treatment planning may take longer as providers develop a deep understanding of the patient’s goals and then make treatment decisions accordingly. This often results in combining curative and symptom-focused treatments.

**A Fundamental Shift**

Palliative Care Constitutes a Change in Focus from Usual Care

<table>
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<tr>
<th>Goals of Care:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
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<tbody>
<tr>
<td>Delayed until end of life is near</td>
<td>Established early in disease trajectory</td>
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<tr>
<th>Treatment Strategy:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
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<tr>
<td>Includes primarily curative treatments</td>
<td>Includes a combination of curative and symptom-focused treatments</td>
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<th>Service Utilization:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
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<tr>
<td>Pursues curative treatments even when low-yield, high-cost, and burdensome for patient</td>
<td>Pursues treatments that align with patient goals</td>
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“[Shifting] the usual hospital care pathway is neither a simple nor straightforward process, given the highly patterned treatment culture of the US hospital, which is structured to prolong life and avert death at all costs.”

R. Sean Morrison, MD, et al. for the Palliative Care Leadership Center’s Outcomes Group

When delivered effectively, palliative care yields substantial quality and cost benefits.

At a very high level, the case for palliative care is threefold: improved care quality, reduced inpatient cost per case, lower total costs of care.

From an return-on-investment perspective, the quality and inpatient cost savings provide universal benefits no matter the payment environment. Additional total-cost of care reductions (e.g., avoided hospitalizations) are most compelling for providers operating in a risk-based environment.

The next few pages will review data supporting each benefit in turn, starting with improved quality.

### Benefits in Every Payment Scenario

<table>
<thead>
<tr>
<th>Improved Care Quality</th>
<th>Reduced Inpatient Costs</th>
<th>Lower Total Cost of Care</th>
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<tr>
<td>• Reduces patient symptom burden and aggressive EOL(^1) care</td>
<td>• Saves hospitals thousands of dollars per inpatient case(^2)</td>
<td>• Reduces unnecessary hospitalizations and ED visits</td>
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<tr>
<td>• Lengthens EOL survival time</td>
<td>• Reduces ICU LOS,(^3) contributing to cost savings and freeing up capacity</td>
<td>• Lowers readmission rates</td>
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<tr>
<td>• Improves patient experience of care</td>
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<th>Benefit Under Fee for Service</th>
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The best evidence of palliative care’s quality benefits comes from a study conducted at Massachusetts General Hospital, which evaluated the benefits of palliative care in late-stage lung cancer patients.

Researchers assigned patients randomly to receive either early palliative care integrated with usual oncologic care or usual care alone. The differences in outcomes between the two groups were striking and significant.

Palliative care patients had fewer symptoms and less than half the rate of depression after only 12 weeks in the study. At the end of their lives, only one-third of the palliative care patients received aggressive end-of-life care, contrasted with more than half of patients in the usual care group.

Perhaps most compelling, in addition to having a higher quality of life, palliative care patients also lived longer—more than 2.5 months longer than the usual care patients, on average.

Study in Brief: Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

• Studied the effect of introducing palliative care soon after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease
• Randomly assigned 151 qualifying patients to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone; 107 patients completed the study
• Quality of life and mood were assessed at baseline and at 12 weeks; end-of-life data were collected from electronic medical records
• Results showed that patients assigned to early palliative care had better outcomes than patients assigned to standard care
Palliative care also improves patients’ satisfaction with their care experience. This conclusion is supported by data from a study that randomly assigned more than 500 patients, across several hospitals, to receive an inpatient palliative care consult. Palliative care patients reported significantly greater satisfaction with their care. Specifically, they reported experiencing a greater sense of caring, respect, and understanding from their providers.

Palliative Care Yields Enhanced Patient Satisfaction Over Usual Care

Patient Care Experience Scale

Higher scores indicate patients were more satisfied with care, felt greater sense of control, and felt that their wishes were taken seriously

Doctors, Nurses/Other Care Providers Communication Scale

Higher scores represent greater caring, respect, understanding between patients and providers

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<tr>
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<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
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<tr>
<td>Patient Care Experience Scale</td>
<td>6.6</td>
<td>6.9</td>
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<td>p=0.04; n=275, n=237</td>
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<th>Usual Care Patients</th>
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<td>Doctors, Nurses/Other Care Providers Communication Scale</td>
<td>7.5</td>
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<td>p=0.0004; n=275, n=237</td>
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Many studies have found cost savings for patients receiving palliative care compared to those receiving usual care. Data from two of the most rigorous studies is presented here. Both found cost savings across multiple hospitals.

For patients discharged alive, the savings averaged more than $1,600 per patient, depending on the payer. Savings were even greater for patients who died in the hospital.

The accompanying table contains data illustrating the impact of these cost savings over the course of a year. Three separate hospitals each calculated the average costs avoided per day for patients who received a palliative care consult. When multiplied by the number of patients seen in a year, the total savings ranged from $700,000 to more than $1.5 million annually.

The majority of these savings typically comes from decreased intensive care unit (ICU) costs; ICU length of stay is often shorter for palliative care patients. Thus, in addition to reducing direct costs of lengthy ICU stays, palliative care can increase ICU capacity, enabling the hospital to meet more patients’ needs.

1) Post-palliative care consult.
2) Palliative care.

Lower Total Cost of Care

A Powerful Case Outside the Hospital

Outpatient palliative care can have a significant impact on total cost of care, both by avoiding an initial ED or hospital admission, and by helping patients transition home and stay there comfortably after discharge.

One study from Kaiser Permanente found that reductions in both ED utilization and hospitalizations for terminally ill patients led to significant cost savings. Total costs of care per patient were nearly $8,000 lower for those in the palliative care group.

Another study compared readmission rates for patients who received an inpatient palliative care consult and were then discharged to various levels of home care. The data from these studies shows that patients who received post-discharge, in-home palliative care had readmission rates that were substantially lower than those for patients who were discharged with no home care or to a nursing facility.

Even more striking: the readmission rate among palliative care patients was almost half of that for the medical center as a whole, which is no small detail since patients receiving a palliative care consult are typically very ill.

---

1) Study conducted at Kaiser Permanente Colorado and Kaiser Permanente Hawaii from 2002 and 2004. Study included 207 homebound, terminally ill patients with a prognosis of approximately one year or less who were randomly assigned to usual care or usual care plus an in-home palliative care program.

2) Data collected for patients from 2007-2009.
Hospitals and Insurers Increasing Service Offerings

Palliative Care in US Hospitals Growing

Number of Palliative Care Teams in US Hospitals

- 66% of hospitals over 50 beds have palliative care teams
- 658 teams in 2000
- 1,265 teams in 2005
- 1,635 teams in 2010

Insurers Investing in Palliative Care

“Six health plans are expanding access to palliative care in two primary ways: provision of specialized case management, and the liberalization of the hospice benefit (for commercial beneficiaries only).”

Inpatient Programs Still Underutilized

Despite the overall trend of expansion in palliative care infrastructure, widespread underutilization persists.

One benchmark for gauging palliative care utilization is the percentage of hospital admissions receiving a specialist consult. Palliative care experts tend to believe that about 5% to 10% of all admissions should receive an inpatient consult. The vast majority of organizations, however, fall short of this mark. Instead, consult rates cluster in the range of 2% to 4% of admissions.

It is important to note that determining the utilization target for a given organization is not as simple as looking to a national benchmark. None exist, because appropriate utilization is so dependent on variables like a hospital’s patient population and available palliative care resources in the community.

Rightsized Utilization Depends on Institution-Specific Factors

Defining Appropriate Utilization

“Appropriate utilization depends on a hospital’s patient population, such as age, disease, and severity of illness. Leading performers are in the 10% to 15% range. For programs clustered at 2% to 4% of total admissions, utilization is often a function of capacity constraints versus optimal design. A growing cluster of programs serve 5% to 10% of total admissions and have achieved a critical mass of awareness and integration into practices. As programs approach 10%, they must start to balance inpatient specialty consult service growth with improvement in generalist skills for palliative care and with development of services in the outpatient continuum of care.”

Lynn Spragens
CEO Spragens & Associates, Advisor to the Center to Advance Palliative Care

1) Estimated, based on qualitative feedback from interviews.

Distribution of Hospitals by Percentage of Admissions Receiving Palliative Care Consults

Source: Center to Advance Palliative Care; Physician Executive Council interviews and analysis.
Industry Has a Long Way to Go

Benchmarks aside, another perspective on the underdeveloped state of palliative care adoption compares the service models currently in use to the kinds of models the industry will need in the future.

Today, most hospitals have either recently formalized an inpatient consult service or have programs that serve only a small portion of potential patients due to capacity constraints. While certainly beneficial for their patients, these programs have a limited ability to meet patients’ needs.

Leading organizations are building next-generation service models, shown on the right side of the graphic. These new models show great promise for meeting patients’ needs in two ways.

• First, by optimizing the inpatient palliative care service, reserving specialists’ time for the most complex cases while the broader medical team uses palliative care principles to better address patients’ basic care needs.

• Second, by expanding across the continuum of care, palliative care services can reach patients earlier in disease progression and also help manage care post-discharge.

1) Qualitative assessment of prevalence of each model.

Source: Physician Executive Council interviews and analysis.
To build an effective palliative care model, organizations must prepare to address a core set of challenges common across the stages of palliative care program growth, from initial program establishment through cross-continuum expansion. The challenges include:

• Making the financial case to secure funding and buy-in for program development
• Finding clinicians to provide specialized services, which can also be a challenge
• Cultivating relationships with patients and physicians, educating them about the benefits of palliative care, and overcoming resistance to changes in practice patterns
• Keeping up with rapidly increasing demand once resistance is overcome—a testament to palliative care’s value

Source: Physician Executive Council interviews and analysis.
Pathway to a Sustainable Palliative Care Strategy

This study provides guidance on overcoming challenges to program development, illustrating the pathway to a sustainable palliative care strategy.

The Physician Executive Council has identified 12 imperatives for growing and optimizing the palliative care service to realize its full benefit.

• Chapter one provides guidance on getting a program up and running—focusing specifically on the inpatient consult service, where most hospitals begin offering palliative care.

• Chapter two focuses on how to grow an existing palliative care service to maximize its value.

• Chapter three showcases an emerging strategy that hospitals and health systems are using to better utilize limited palliative care resources while meeting the needs of all patients—developing and supporting palliative care skills across the medical staff.

12 Imperatives for Growing and Optimizing the Palliative Care Service

I
Starting a Palliative Care Program

1. Conduct a Needs Assessment
2. Establish a Foundation of Trust Among Referrers
3. Assemble the Right Team
4. Grow Service Scope in Phases
5. Measure Performance to Demonstrate Impact

II
Growing the Inpatient Consult Service

6. Create Inpatient Palliative Care Growth Plan
7. Comprehensively Address Referrer Concerns
8. Raise Visibility Among Patients
9. Reduce the Referral Burden on Physicians
10. Evolve the Palliative Care Dashboard

III
Expanding Capacity Across the Medical Staff

11. Promote Generalist Palliative Care Skills
12. Implement Team-Based Palliative Care Supports

Additional Resources: Palliative Care Program Development Toolkit

• Contains additional tools and content to expedite palliative care program development
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  – Palliative care cost savings estimator
  – Sample metric dashboards for each phase of growth
  – Ready-to-use PowerPoint template for making the case for program growth
  – Sample documents from successful palliative care programs, such as screening tools, service standards, progress note templates, and physician-patient talking points
  – On-demand webconferences highlighting key topics and resources
• Available online at: advisory.com/pec/pctoolkit

Source: Physician Executive Council insights and analysis
Starting a Palliative Care Program

Imperative #1: Conduct a Needs Assessment
Imperative #2: Establish a Foundation of Trust Among Referrers
Imperative #3: Assemble the Right Team
Imperative #4: Grow Service Scope in Phases
Imperative #5: Measure Performance to Demonstrate Impact
Physician Relationships Underlie Programmatic Success

Whether a palliative care program is highly developed or just starting out, the key determinant of program success is physician engagement.

Physicians write the orders, thereby shaping demand for palliative care. In that sense, physicians are the primary customers of palliative care programs.

Consequently, establishing a successful palliative care program depends not only on having the right infrastructure, but also on ensuring clinicians trust the palliative care team to share responsibility for their patients’ care.

Without a foundation of trust, even an otherwise optimally run palliative care program in terms of finances, staffing, care coordination, and training will not deliver full benefits to patients or the organization.

A successful palliative care program must pair a strong foundation of trust with a well-constructed program to drive higher-value care.

Source: Physician Executive Council interviews and analysis.
Palliative Care Requires Measured, Stepwise Development

Because of the cultural complexities and sensitive issues in palliative care, building a culture of trust requires a slower buildup than traditional business planning would dictate for other clinical initiatives.

As one palliative care director said, “It’s the same as pain management. ‘Start low. Go slow.’”

Whether building a new program or adding a new service, a stepwise approach allows for time to build this foundation of trust while ensuring that the new initiative is reaching its goals. This stepwise approach to palliative care program development is seen here in the form of five imperatives.

Conventional ‘Business Planning’ Approaches Insufficient

Five Imperatives for Palliative Care Program Development

- Conduct a Needs Assessment
- Establish a Foundation of Trust
- Assemble the Right Team
- Use a Phased Approach
- Measure Performance to Demonstrate Impact

Source: Physician Executive Council interviews and analysis.
Identifying the Need for Palliative Care

At Umbridge Hospital, palliative care program development began with the efforts of one hospice nurse liaison. She facilitated referrals to hospice, advocated for patients at the end of life, and provided case management for admitted hospice patients.

The nurse observed that one out of every three patients she assisted was ineligible for hospice, yet many were “frequent fliers” to the hospital, with clear unmet palliative care needs. This observation led to the creation of an interdisciplinary committee or “design team” charged with exploring the possibility of a palliative care service to address these patients’ needs.

The team conducted chart reviews, interviewed clinicians, and researched palliative care programs at other hospitals. Ultimately, they determined that an inpatient palliative care consult service would best achieve their goals, and that engaging their physician leaders through the design team would ensure widespread support.

Multidisciplinary Team Can Best Assess Need

Hospice Nurse Liaison Identified an Unmet Need

- Nurse found approximately one-third of patients she served were not eligible for hospice, yet were frequently readmitted for complex needs
- In response, hospital created a palliative care design team to assess the need and explore the potential for palliative care

Palliative Care Design Team Conducted a Comprehensive Assessment

- Team included social workers, chaplains, nurses, case managers, dietitians, and hospice nurse liaison
- Conducted chart reviews for patients admitted multiple times over a 60-day period and for patients who died in the ICU
- Researched palliative care models, decided to work toward establishing an inpatient consult service

Case in Brief: Umbridge Hospital

- 500-bed community hospital located in the Northeast
- Hospice nurse liaison identified many patients with potentially unmet palliative care needs
- A multidisciplinary design team was created to explore the need for palliative care through patient chart reviews and to assess various palliative care models
- Later launched an inpatient palliative care consult service to meet needs of patients not eligible for hospice
- Offerings now include: inpatient consult service, inpatient palliative care unit, and outpatient palliative care clinic

Source: Physician Executive Council interviews and analysis.
Engage Physicians in Program Development

Umbridge Hospital’s palliative care design team took three critical steps to engage referring physicians in shaping the emerging palliative care program.

First, they conducted a five-question survey at a mandatory medical staff meeting to understand physicians’ attitudes toward palliative care and their interest in receiving more information.

Second, they assembled a physician advisory group to oversee the consult service during its first year. An influential physician volunteered to lead the group and issued personal invitations to members of each medical specialty to join the committee.

Third, the design team developed a marketing presentation to increase clinician awareness of the service. Team members presented it to their own departments, with presentations delivered in 43 sites across the hospital.

Due to these efforts, referrals to the palliative care service increased steadily, and the program grew to include both an inpatient palliative care unit and outpatient services.

Physician Leadership Critical for Gaining Widespread Support

Umbridge Hospital’s¹ Steps to Cultivate Physician Support

- **Physician Survey**
  - Five-question survey conducted during medical staff meeting; questions included:
    - What do you know about palliative care?
    - Would you like to use palliative care?
    - Would you like to attend a CME session on palliative care?

- **Physician Advisory Group**
  - Led by highly respected physician champion
  - Champion personally invited 23 physicians representing different specialties to join
  - Group met quarterly to discuss needs, explore palliative care models, and develop marketing plan
  - Physicians from the Advisory Group became palliative care champions

- **Design Team-Led Marketing**
  - Design team developed flip chart presentation to market program
  - Interdisciplinary pairs from the design team presented to 43 different areas in the hospital
  - Referrals to palliative care service grew steadily over time

¹ Pseudonym.

Source: Physician Executive Council interviews and analysis.
Once stakeholders are engaged in developing a new palliative care program, an institution must identify a program leader. Many chief medical officers attribute their palliative care program’s success to a strong leader who cultivated the foundation of trust with clinicians. While ideal attributes for a palliative care leader will vary, they include being highly committed to palliative care and well respected among the medical staff. Many organizations struggle to decide whether a physician must lead their palliative care programs. There is no clear answer, both physician- and nurse-led models exist and are successful. The choice often becomes a question of an organization’s openness to non-physician leaders.

Selection of Physician or Nurse Leader Depends on Experience, Culture

Ideal Attributes of a Palliative Care Leader

- Committed to palliative care
- Experienced with symptom management
- High-scoring on patient satisfaction measures
- Respected among medical staff
- Articulate and firm when advocating for needs or beliefs

Key Questions to Guide Selection

- Who has earned respect within the medical community?
- Who is experienced in symptom management?
- Who is a skilled communicator and can ensure that patient and family concerns are heard and understood?

“You have to evaluate the culture of your institution. We hired a palliative care physician specialist to begin with because we knew our organization would be less receptive of a nurse leader. When we gradually brought in palliative care nurses, the old guard began to change.”

Director of Palliative Care, Health Care System in the Northeast

Source: Physician Executive Council interviews and analysis.
Appropriate Staffing Depends on Hospital Size, Program Characteristics

In addition to a dedicated leader, palliative care programs must be supported by a diverse team of providers. Palliative care is, at its core, an interdisciplinary practice, and each staff role brings unique patient benefits.

A Physician Executive Council survey of palliative care programs found that 93% of respondents had a physician on their palliative care team, and 75% had an advanced practice provider. In addition, over half of respondents reported having a social worker on staff.

However, hospital size, available resources, and program characteristics all influence program staffing. There is no one-size-fits-all staffing model for palliative care. Additionally, bed size is not an ideal way to size the team; the team at a given organization will need to grow as program utilization grows.

### Appropriate Staffing Depends on Hospital Size, Program Characteristics

#### Palliative Care Staffing Snapshot

**Average Number of FTEs by Staff Type**

<table>
<thead>
<tr>
<th>Bed Size¹</th>
<th>Physician</th>
<th>APP²</th>
<th>Nurse</th>
<th>Social Worker</th>
<th>Chaplain</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 beds</td>
<td>1.0</td>
<td>0.6</td>
<td>0.7</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>300 beds</td>
<td>0.9</td>
<td>0.8</td>
<td>0.5</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td>400 beds</td>
<td>1.3</td>
<td>0.9</td>
<td>0.8</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>500 beds</td>
<td>1.7</td>
<td>1.8</td>
<td>1.1</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>600+</td>
<td>1.7</td>
<td>2.7</td>
<td>0.6</td>
<td>0.6</td>
<td>0.3</td>
</tr>
</tbody>
</table>

1) Full-time equivalent employees.
2) Rounded to nearest 100 beds.
3) Advanced practice provider.

These organizations represent a wide range of utilization levels. The group average could be characterized as approximately 2-4% of inpatient admissions.

#### Percentage of Respondents with Staff Role on Palliative Care Team

<table>
<thead>
<tr>
<th>Percentage of Respondents</th>
<th>Staff Role In Palliative Care Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>93%</td>
<td>Teams with Physician</td>
</tr>
<tr>
<td>75%</td>
<td>Teams with APP</td>
</tr>
<tr>
<td>55%</td>
<td>Teams with nurse</td>
</tr>
<tr>
<td>58%</td>
<td>Teams with social worker</td>
</tr>
<tr>
<td>43%</td>
<td>Teams with chaplain</td>
</tr>
</tbody>
</table>

1) Full-time equivalent employees.
2) Rounded to nearest 100 beds.
3) Advanced practice provider.

Source: 2013 Physician Executive Council Palliative Care Staffing Survey; Physician Executive Council interviews and analysis.
Keeping in mind the principle that physicians are the true customers of a palliative care program, palliative care programs should start with a small, well-defined pilot that addresses a specific physician need.

Then, teams should measure the impact of the pilot. If the program meets physicians’ needs, then the program will have earned their support for the next phase of development. If a pilot does not adequately serve physicians, it must be redesigned.

This is not a situation where, “if you build it, they will come.” Rather, programs must make palliative care attractive to physicians to ensure organic growth throughout each phase of development.
Choose a Strategic Starting Point

When the cancer center leaders at UC San Diego Medical Center (UCSD) explored the creation of a palliative care program, they decided to pilot the service with their bone marrow transplant (BMT) patients. They chose BMT because of low oncologist satisfaction coupled with strong support for the palliative care service.

Additionally, though BMT patients have significant needs that can be addressed through palliative care, they are all pursuing curative therapies, so the program was able to demonstrate that palliative care can be provided concurrent with active treatment.

The BMT pilot’s success supported organic program expansion. Oncologists requested palliative care for their patients in the cancer center as well. Word then spread, generating demand for an inpatient service available to patients throughout all specialties.

Provide Proof of Concept with a Targeted Patient Pool

UC San Diego Medical Center Palliative Care Pilot

- Started palliative care pilot program in BMT\(^1\) unit
- Success of program led cancer center physicians to later request palliative care services for all patients
- Eventually service expanded to inpatient setting and non-cancer patients

Patient Populations Suited to Pilot

- Congestive heart failure
- End-stage renal disease
- ICU
- Lung cancer
- Pancreatic cancer
- Bone marrow transplant

Criteria for Selecting Pilot Site

- Physicians receptive to palliative care
- Small, well-defined patient population
- Patients have significant palliative care needs
- Patients pursuing curative treatment

Case in Brief: UCSD Medical Center

- 552-bed academic medical center located in San Diego, California
- Piloted program on BMT unit in 2005; demonstrated value of service and led cancer center’s physicians to request service for their patients; service expanded to inpatient setting and to non-cancer patients
- Current staff include palliative care physicians (1.2 FTE), physician fellow, nurse practitioners (2.0 FTE), pharmacist, and social worker; conduct approximately 500 consults per year
- Billing covers approximately 30% of costs; budget supplemented with philanthropy and operating funds
- Cancer center director credits palliative care program with improving oncologist satisfaction, reducing turnover, and improving the cancer center’s ability to recruit new physicians

\(^1\) Bone marrow transplant.

Source: UCSD Medical Center, San Diego, CA. Physician Executive Council interviews and analysis.
Establish a Foundational Service Dashboard

When building a palliative care program, evaluating early performance against key goals is critical for demonstrating impact and increasing support for the program.

The core palliative care dashboard contains three types of metrics:

- Operational metrics to quantify the work being done
- Financial metrics to support the cost case
- Clinical metrics to demonstrate the impact on patient care

Some of these metrics can be populated through the EHR, though other information must be gathered from diverse sources and tracked using a dedicated palliative care spreadsheet.

Begin with Basic Metrics to Evaluate Early Performance

Example Foundational Dashboard for Palliative Care

- **Operational Metrics**
  - Patient characteristics
  - Site of discharge
  - Advance directive status

- **Financial Metrics**
  - Length of stay (hospital and ICU)
  - Cost

- **Clinical Metrics**
  - Functional status
  - Pain and symptom assessment results
  - Palliative care intervention provided

Tool in Brief: Sample Palliative Care Dashboards

- Excel-based shell for monitoring key metrics
- Available online at: advisory.com/pec/pctoolkit
Key Takeaways: Starting a Palliative Care Program

Due to common sensitivities around palliative care, setting the stage for program success requires a different approach from the typical new service planning process. Organizations must ensure the consult service meets the needs of its primary customers, referring physicians. The following five imperatives are key to building a sustainable program:

1. Conduct a Needs Assessment
   Understand the needs of patients and physicians to determine how best to position the program to administrators and physicians.

2. Establish a Foundation of Trust Among Referrers
   Engage physicians in program development from the beginning to establish trust and collaboration.

3. Assemble the Right Team
   Select a respected and experienced leader with organizational culture in mind.

4. Grow Service Scope in Phases
   Ensure program sustainability and support cultural change by starting with a small, well-defined pilot and growing the program organically in response to physician demand.

5. Measure Performance to Demonstrate Impact
   Evaluate early performance to demonstrate impact and increase support for the program.

Source: Physician Executive Council interviews and analysis.
Growing the Inpatient Consult Service

Imperative #6: Create Inpatient Palliative Care Growth Plan
Imperative #7: Comprehensively Address Referrer Concerns
Imperative #8: Raise Visibility Among Patients
Imperative #9: Reduce the Referral Burden on Physicians
Imperative #10: Evolve the Palliative Care Dashboard
Most inpatient consult services across the country see only 2% to 4% of patients admitted to their hospitals, a number far lower than the actual percentage of patients likely in need of palliative care.

When considering only one indicator of palliative care need, inadequate treatment of pain and shortness of breath, we find that 25% of patients receive inadequate treatment of these symptoms near the end of life. Statistics like these keep palliative care at the top of the priority list for many chief medical officers around the country. Few CMOs, however, know how to address the problem. In particular, they struggle to effectively grow their inpatient consult services.

The Center to Advance Palliative Care (CAPC), a national leader in supporting palliative care services, has found that programs commonly make two mistakes related to program growth: failing to plan for growth or reacting defensively to growth by limiting access. Both undermine program success by failing ultimately to meet patients’ needs.

“Everyone knows that we need to provide more palliative care. The question is how to do that effectively.”

CMO, Health Care System in the Northeast

Source: Center to Advance Palliative Care, A Guide to Building a Hospital-Based Palliative Care Program, New York, 2004; Morrison RS, et al., “America's Care of Serious Illness,” Center to Advance Palliative Care (2011); http://reportcard.capc.org/pdf/state-by-state-report-card.pdf; Physician Executive Council interviews and analysis.
Setting Use Rate Goals in Likely Areas of Need

The first step in effective growth planning is defining which patient populations need palliative care and the extent of their need. Banner Health created a comprehensive, four-part definition for populations that need palliative care.

For each population, the CMO and clinical leaders jointly developed a utilization target that was both evidence-based and feasible. For example, they estimated that 45% of patients who died in the hospital should have received a palliative care consult. To arrive at the 45% figure, Banner’s leaders consulted externally with institutions considered to have exemplary palliative care programs, as well as internally with their own physicians.

It is important to remember that appropriate targets can vary greatly between organizations, and there are no standard national benchmarks. Appropriate utilization depends on factors such as a hospital’s case mix and the presence (or absence) of palliative care services in the broader community.

Case in Brief: Banner Health

- 23-hospital health system based in Phoenix, Arizona
- Established goal to create system-wide palliative care strategy including inpatient consult optimization and outpatient palliative care services
- Analyzed facility data over six months for four different patient population groups—patients who died in the hospital, patients discharged to hospice, patients who had level four risk of mortality, all other inpatient admissions
- Developed feasible utilization targets based on gap between need and services rendered, capacity of current palliative care staffing models
- Determined four patient population groups and rough targets based on consultations with other organizations that have exemplary palliative care programs

Four-Part Target Population Definition Focuses Growth Effort

<table>
<thead>
<tr>
<th>Defined Patient Populations for Palliative Care Consult</th>
<th>Consult Utilization Target per Patient Population¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who die in the hospital</td>
<td>45%</td>
</tr>
<tr>
<td>Patients discharged to hospice</td>
<td>40%</td>
</tr>
<tr>
<td>Patients who have a risk of mortality at level four</td>
<td>23%</td>
</tr>
<tr>
<td>All other admissions, excluding populations above</td>
<td>4%</td>
</tr>
</tbody>
</table>

¹) Targets not intended as benchmarks. Appropriate targets will vary by institution based on factors such as case mix and palliative care services offered in the broader community.

Source: Banner Health, Phoenix, AZ; Physician Executive Council interviews and analysis.
Banner incorporated ROI projections into their growth plan. Banner has a two-part method to calculate ROI. They first estimated the historical average direct cost savings per case from their own program. Using this as a baseline, they then projected their annual system cost savings by combining their historical data with anticipated growth.

The table on the right illustrates their historical average direct cost savings, roughly $3,000 per consult.

Given projected consults per year for each hospital’s bed size, they estimated the total cost savings for each facility. This was then compiled to create a projected system-wide total for all Banner Health Facilities. As their program progresses, Banner can continue to monitor these figures to assess whether the program is reaching its utilization targets as well as its projected cost savings.

### Two-Step Calculation for Projected Annual Direct Cost Savings

#### Calculate Historical Direct Cost Savings

1. Measure mean daily direct cost differential before and after consult
2. Determine mean LOS (days) after consult
3. Calculate average cost savings per case (direct cost differential multiplied by LOS)

#### Project Annual Direct Cost Savings

1. Use CAPC recommendations for number of consults by program maturity
2. Project annual consults
3. Calculate impact by historical average cost savings multiplied by projected consults

### Projected Annual Direct Cost Savings (Illustrative Example)

<table>
<thead>
<tr>
<th></th>
<th>Years 1 &amp; 2</th>
<th>Years 3 - 5</th>
<th>Mature Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Direct Cost Savings per Consult</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>CAPC Benchmarks (Consults per Bed per Year)</td>
<td>0.6</td>
<td>1.3</td>
<td>2.0</td>
</tr>
<tr>
<td>Facility A – 400 Beds (Consults per Year)</td>
<td>240</td>
<td>520</td>
<td>800</td>
</tr>
<tr>
<td>Facility A: Total Estimated Cost Savings</td>
<td>$720K</td>
<td>$1.56M</td>
<td>$2.4M</td>
</tr>
</tbody>
</table>

### Projected Total for Banner Health Facilities

- $7M
- $15M
- $23M

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1) Based on pilot palliative care program at flagship facility. Examined hard costs online including lab, room and care, pharmacy, imaging, and supply.
2) Determined by historical direct cost savings calculation. Numbers rounded.
3) Numbers rounded.

Source: Banner Health, Phoenix, AZ; Physician Executive Council interviews and analysis.
Once appropriate utilization targets have been identified, the challenge becomes breaking the larger goal into achievable milestones with strategic pathways to meet those targets. A helpful example is provided by the work of a team at OSF HealthCare.

Similar to the approach at Banner, palliative care leaders set a utilization target. At OSF HealthCare, they wanted 5% of admissions system-wide to receive a palliative care consult. However, leaders realized they could not just “flip a switch” to reach this level of consults immediately. Instead, they created incremental growth targets. For example, within the first year, all facilities needed 2.5% of admissions to receive a palliative care consult. Each subsequent year, the goal increased until it reached 5%. As a result, most facilities achieved the 5% goal, and several exceeded it.

### Characteristics of Palliative Care Consult Growth Plan

1. Used percentage of inpatient discharges as growth metric
2. Targets are general guidelines; goal is increased utilization while maintaining high-quality service
3. Measures impact via mean daily costs, cost savings projection calculator
4. Measures quality of palliative care consult service as checks-and-balances system between utilization and quality

### Utilization Growth Plan

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5%</td>
<td>3.5%</td>
<td>4.5%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

### Case in Brief: OSF HealthCare

- Seven-hospital health system based in Peoria, Illinois
- Developed growth plan to increase system-wide utilization of inpatient palliative care consult service
- Set consult service utilization targets at 5% of inpatient admissions, based on CAPC consultations and benchmarking with exemplar organizations
  - Used a tiered approach to reach overall utilization targets
  - Goal increased by 1% per year; current range across facilities is 4.5% to 10% of admissions receiving consult

Source: OSF HealthCare, Peoria, IL; Physician Executive Council interviews and analysis.

1) Performance varies by facility. Attained current performance range earlier than tiered program anticipated.
Many of the greatest barriers to garnering palliative care referrals are cultural.

Common reasons physicians do not refer range from fear of losing control over patients’ treatment plans to believing that patients don’t want palliative care.

There are three common themes among these barriers: lack of physician trust; lack of awareness among patients; and process barriers, such as the time required to fill out referral paperwork. To grow the inpatient consult service, it is important to diagnose the barriers at an organizational level and implement tactics to overcome them.

When it comes to lack of trust, there are four major opportunities to address physician concerns head-on:

- Changing the service name
- Establishing service standards
- Hardwiring physician communication
- Facilitating ongoing discussions about palliative care

---

**Common Physician Concerns About Palliative Care**

- "My patient is not near the end of life."
- "I already provide good palliative care to my patients."
- "I’m not always sure if it’s appropriate to refer to palliative care."
- "My patients do not understand what palliative care is."
- "I don’t want my patients to think I have given up."
- "My patients do not want palliative care."
- "Making the referral just adds to my paperwork."
- "The palliative care team is at capacity; they often take a long time to see my patients."
- "I don’t have time to screen every patient for palliative care."

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**General Tactics to Mitigate Referral Resistance**

**Engaging Physicians**
Comprehensively address physician concerns about the mission, service offering, and value of palliative care

**Informing Patients**
Increase patient understanding of palliative care goals and services

**Overcoming Referral Burden**
Streamline the referral process to increase palliative care utilization

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1) Illustrative quotes. Source: Physician Executive Council interviews and analysis.
Overcome Resistance to Palliative Care

Addressing Perception Issues Head-On

As a starting point, one major concern hospitals can address relates to the term “palliative care.”

To understand barriers to palliative care referrals, MD Anderson Cancer Center surveyed its clinicians. The overwhelming majority reported that the name “palliative care” made it difficult for them to recommend the service to their patients. Physicians expected patients to respond negatively, maybe because they would think that they were being referred to hospice.

In response, MD Anderson changed the name of its palliative care program to “supportive care.” Following the name change, referrals to the newly titled service increased by 40%.

Further, the time from patient registration to palliative care consult decreased by four weeks, indicating that patients were referred earlier in their course of treatment.

### Study in Brief: Effect of a Name Change from ‘Palliative’ to ‘Supportive’ Care

- Clinicians at MD Anderson Cancer Center reported the name “palliative care” was a barrier preventing earlier referrals to palliative care
- In response, organization changed name of service to “supportive care”
- Name change resulted in increased and earlier referrals
- Clinicians felt more comfortable introducing service as “supportive care” to patients

Source: Dalal S, et al., “Association Between a Name Change from Palliative to Supportive Care and the Timing of Patient Referrals at a Comprehensive Cancer Center,” The Oncologist, 16, no 1 (2011):105-11; Physician Executive Council interviews and analysis.
Another key driver of physician reluctance to refer is low understanding about how to work with the palliative care service. Many physicians are concerned about loss of control, lack of timely updates, or poor handoffs. If uncertainty exists, physicians will not refer.

To clarify expectations and reassure clinicians about the quality of care their patients will receive, palliative care leaders at Froedtert and the Medical College of Wisconsin established service standards. These standards document each party’s role and responsibilities relative to consult logistics, follow-up with the referring physician, and symptom management.

As a result, physicians feel more comfortable referring patients to the palliative care service because they know what to expect for both themselves and their patients.

### Setting Expectations to Smooth Physician Referrals

**Service Standards Ease Concerns and Streamline Care**

- Palliative care team developed standards to address different expectations among the team and among referring physicians
- Service standards determine patient care logistics such as coordination between referring physician and palliative care team
- Document also outlines guidelines for symptom management and procedures for hospice referrals

---

**Palliative Care Service Standards**

**Consultation Logistics**
A minimum of two team members will assess the patient as part of the initial consultation process, one of whom must be a program nurse or physician.

**Referring Clinician**
The referring clinician is contacted at the conclusion of the consultation to report findings and suggestions.

**Symptom Management**
All opioid equianalgesic calculations (>30 mg oral morphine equivalent) should be confirmed by two team members, or one team member and one pharmacist.

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**Case in Brief: Froedtert & the Medical College of Wisconsin**

- 500-bed academic medical center located in Milwaukee, Wisconsin
- Palliative care team developed service standards to document expectations and requirements for physicians from both the palliative care team and cancer center
- Service standards address patient care logistics such as when the palliative care team will meet and how coordination between the palliative care team and referring physician will occur
- Document also outlines guidelines for symptom management and procedures for hospice referrals

---

Source: Froedtert & the Medical College of Wisconsin, Milwaukee, WI; Physician Executive Council interviews and analysis.
Poor communication between palliative care providers and referring physicians can inhibit referrals, as physicians are concerned about being out of the loop with their patients’ care. Fairview Health Services developed a palliative care progress note to address this problem.

The goal is twofold. First, the progress note template reports on the patient’s condition and on any palliative care interventions. Second, the form organizes patient data to facilitate chart reviews and collect data on the palliative care program’s performance.

Information in the progress note is embedded in Fairview’s EHR and available to other members of the patient’s care team. In addition to recommendations for the patient’s plan of care, the note includes information on the patient’s advance care plan, family structure, and religious and spiritual preferences. All clinicians at Fairview Health System can view the progress note, but only palliative care specialists can modify it.

### Case in Brief: Fairview Health Services

- 10-hospital academic health system based in Minneapolis, Minnesota
- Offers inpatient and outpatient palliative care services
- Developed palliative care progress note and embedded it into EHR; tracks 12 symptoms
- Palliative care progress note also provides information about patient’s advance care planning wishes, family structure, religious preferences, and concludes with global recommendations for patient care
- All clinicians can access patient’s palliative care information at any point from any care setting, but only palliative care specialists can modify information in the note
Physicians’ concerns about palliative care cannot be addressed without ongoing two-way conversations between referrers and the program. Dr. David Weissman, a retired oncologist turned palliative care physician, works as a consultant helping hospitals grow their palliative care programs. He is often tasked with convincing skeptical physicians to support palliative care program development.

To begin the discussion, he asks them to talk about the challenges they routinely face with end-of-life care, symptom management, and family conferences.

After physicians list their concerns, Dr. Weissman explains how a palliative care team supports their efforts and alleviates difficult responsibilities. These conversations create a “teachable moment” in which physician champions, like Dr. Weissman, can paint a compelling vision for the potential of palliative care.

There are numerous venues for these kinds of conversations. The key to success is identifying a strong facilitator to start the conversation with physicians on their own terms.
Another frequently cited reason for not referring to palliative care is physicians’ belief that patients associate palliative care with hospice and will resist a referral.

However, recent survey data suggest that physician perceptions of patient wishes are not accurate. The general public is largely unfamiliar with palliative care, but when provided with a definition, most people are in fact very supportive of the service.

Data, such as shown here, indicates the value of raising palliative care’s visibility among patients and their caregivers. Once informed, they can ask their clinicians about palliative care, potentially facilitating an earlier referral and helping to realize maximum benefit from palliative care.

Affirm Importance of “Quality of Life” Care

**Knowledge of Palliative Care**

<table>
<thead>
<tr>
<th>Knowledge of Palliative Care</th>
<th>n=800</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All Knowledgeable</td>
<td>70%</td>
</tr>
<tr>
<td>Somewhat Knowledgeable</td>
<td>14%</td>
</tr>
<tr>
<td>Very Knowledgeable</td>
<td>3%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Likelihood of Considering Palliative Care Use After Learning Its Definition**

<table>
<thead>
<tr>
<th>Very Likely</th>
<th>Somewhat Likely</th>
<th>Not Too/Not at All Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>63%</td>
<td>29%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Some palliative care programs are leveraging patient marketing strategies to increase palliative care awareness and utilization.

At pseudonymed Pomfrey Health Services, leaders specifically wanted to increase utilization of advance directives and knew low patient awareness was a critical barrier. The hospital had already invested in a patient-focused TV channel available in every room. The hospice director saw this as an opportunity. He developed television programming to educate patients about advance directives and how to complete one. This programming was then shown throughout the hospital in patient rooms.

“Infomercials” aside, many standard marketing approaches also can be used by palliative care programs seeking to increase visibility among patients and their families.

### Educating Through Patient-Room TV Programming

- Pomfrey Health found that patients had little knowledge of advance directives
- System sought to increase advance directive utilization
- Hospice director and a medical resident collaborated to create TV programming that educates patients about advance directives
- Program explained advance directives and guided patients in requesting assistance to complete a directive
- Programming distributed via existing patient TV channel, available in every patient room

### Case in Brief: Pomfrey Health Services

- Three-hospital health system based in the Northwest
- Each patient-room television has a channel dedicated to patient-directed programming
- Hospital developed programming for this channel to provide patients and families with current information on advance directives

### Additional Venues for Marketing to Patients

| ✔ Brochures | ✔ Cards left at bedside |
| ✔ Palliative care blog/website | ✔ Patient orientation |
| ✔ Videos of palliative care patient testimonials | ✔ Palliative care presence at support groups |

1) Pseudonym.

Source: Physician Executive Council interviews and analysis.
Physicians typically bear the full burden of referring patients to palliative care. However, there are others on the patient’s care team who can initiate the palliative care referral process. The two organizations presented here have implemented a team-based approach.

In this model, a member of the care team identifies a potential palliative care need and begins the referral process, completing any necessary paperwork. The team member then reviews the potential referral with the physician, who ultimately signs off on the consult request.

At Delacour Hospital, a pseudonym, hospital leaders delegated responsibility for initiating consults to floor nurses, who complete a screening tool. Any potential palliative care needs are then discussed with a palliative care nurse prior to seeking the physician’s sign-off.

At Grindelwald Hospital, a pseudonym, case managers discuss potential palliative care needs with the attending physician and then complete the referral paperwork. The physician simply states agreement with the consult request, and the palliative care order is made.

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**Imperative #9: Reduce the Referral Burden on Physicians**

**Empowering the Care Team to Initiate Services**

**Care Team Initiates Referrals, Physician Provides Sign-Off**

**Nurse-Led Referral**

- Consult initiated with a palliative care screening tool completed by an RN
- If screening identifies potential palliative care need, RN reviews results with a member of the palliative care team
- Palliative care team flags patient for potential referral through a note in the record or by contacting the physician
- Physician must sign off on referral prior to consult

**Case Manager-Led Referral**

- Physician and case manager discuss whether consult is needed
- Case manager makes the palliative care order and initiates the consult, removing the paperwork burden from the physician
- Physician must only give verbal assent for referral
- Case manager ensures the palliative care team sees the patient

---

**Case in Brief: Delacour Hospital**

- 800-bed hospital located in the Midwest
- Increased consult rate by implementing RN-led palliative care screening tool
- If palliative care needs are present, nurse contacts palliative care team
- Palliative care team notifies physician that consult is recommended

**Case in Brief: Grindelwald Hospital**

- 600-bed community hospital located in the Southeast
- Case manager decides if palliative care needs are present
- Physician provides verbal consent for palliative care team consult
- Case manager ensures patient receives consult

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1) Pseudonym.

Source: Physician Executive Council interviews and analysis.
Automating Referrals to Palliative Care

Palliative care leaders at St. John Providence Health System in Michigan developed a trigger tool to increase palliative care referrals. The tool was first used with medical ICU patients, as well as patients with congestive heart failure (CHF). CHF patients were targeted to address the significant unmet needs of this population and as an opportunity to reduce readmissions.

The tool was designed through internal pilot programs, which helped identify the appropriate triggers to use. In addition, St. John selected triggers that were appropriate for use by a nurse.

By completing the tool for each patient at admission and four days into their stay, the hospital was able to increase the consult rate for cardiology patients by 50%.

The palliative care leader at St. John’s also embedded the trigger tool into the EHR, enabling automatic physician notification to order the consult. This further simplified and streamlined the referral process.

St. John’s Trigger Tool Reduces Physician Burden, Increases Referrals

- Chose palliative care triggers that apply to patient population
- Tool completed upon admission and four days later
- Selected MICU\(^1\) and CHF\(^2\) patients as target populations for trigger tool
- Nurse designated as primary tool user on care team
- Embedded tool into EHR to automatically notify physician to order consult

50% Consult rate increase in cardiology after implementation of trigger tool

Case in Brief: St. John Providence Health System

- Five-hospital health system based in Warren, Michigan
- St. John Hospital and Medical Center partnered with Duke Institute on Care at the End of Life to develop a trigger tool to screen patients for palliative care needs
- Paper-based tool first piloted in MICU and medical floors; data from pilot used to develop current triggers
- Tool embedded into EHR and piloted again for CHF patients; program sought reduced readmissions
- Tool designed to be completed by an RN; does not rely on diagnosis to determine if consult is needed
- Completed tool entered into EHR, which automatically notifies the physician who can then order a consult
- After the initial pilot, tool implemented at system level

Source: St. John Providence Health System, Warren, MI; Duke Institute on Care at the End of Life, Durham, NC; Physician Executive Council interviews and analysis.

1) Medical intensive care unit.
2) Congestive heart failure.
St. John’s full tool included nine triggers appropriate for their target populations and utilization goals, and designed for a nurse. However, this is not a one-size-fits-all tool. Hospitals must select or create the best tool for their specific organization, based on their goals for the tool and their target populations. Some other examples of triggers to consider are listed here, and additional examples of hospital-developed checklists are available online in the Palliative Care Program Development Toolkit.

### Double-Clicking on the Palliative Care Trigger Tool

#### Preferred Tool Depends on Target Population

- **Palliative Care Screening Tool**
  - More than one hospitalization within 30 days related to chronic condition
  - Unacceptable pain level or symptoms
  - Code status changed to DNR\(^1\)
  - Marked decrease in functional status/ADLs\(^2\) in last 60 days
  - Admitted from ECF\(^3\) with ADL dependence or chronic care need
  - Patient/surrogate distressed about decision making
  - Considering PEG\(^4\) and/or trach tube placement
  - Palliative care requested by patient or family
  - No palliative care needs identified

- **Additional Examples of Triggers**
  - Patients experiencing symptoms above a certain threshold
  - Patients with two or more hospitalizations in one month
  - Patients with ICU stays of X days
  - Patients with certain diagnoses, such as pancreatic cancer or chronic heart failure

### Tool in Brief: Examples of Palliative Care Screening Tools

- Compilation of additional screening tools and checklists to identify patients needing palliative care
- Available online at: [advisory.com/pec/pctoolkit](http://advisory.com/pec/pctoolkit)

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1) Do not resuscitate.  
2) Activities of daily living.  
3) Extended care facility.  
4) Percutaneous endoscopic gastrostomy.  

Source: St. John Providence Health System, Warren, MI; Duke Institute on Care at the End of Life, Durham, NC; Physician Executive Council interviews and analysis.
Though fast utilization growth is seen as a good problem to have, serious issues can arise. When consult services grow quickly, service quality may decline, resulting in dissatisfied patients and providers, or worse. Referred patients may pass away or be discharged to hospice before their appointments, or may wait for days with uncontrolled symptoms or unclear treatment goals.

To avoid these problems, it is important to focus on service quality during periods of growth by evolving the palliative care dashboard to reflect service quality standards.

It is reasonable for new programs to track a basic set of clinical, financial, and operational metrics. However, to ensure ongoing service quality as the program grows, new dimensions such as patient and provider satisfaction must be considered.

Advanced palliative care programs should be measuring whether their services truly meet the standards of excellent care, such as the percentage of patients receiving a consult on the same day as the order was placed.

Tool in Brief: Expanded Palliative Care Dashboard

- Additional dashboard metrics for expanding palliative care programs
- Available online at: advisory.com/pec/pctoolkit

Source: Physician Executive Council interviews and analysis.
To ensure service quality at OSF, each facility tracks utilization metrics alongside corresponding quality metrics. For example, to measure utilization leaders, facilities track the percentage of admissions that receive a consult. They also measure quality as the percentage of consults that receive the “full palliative care consult experience” (see graphic for detail).

By reviewing both utilization and quality metrics, OSF leaders can identify top-performing facilities in the system that exceeded their benchmarks, such as a utilization benchmark set at 5% of inpatient admissions receiving a consult, and a quality benchmark set at 80% of consults receiving the “full experience.”

This has enabled OSF to advocate for additional investment. One facility consistently exceeded the 5% admission utilization target but plateaued at 70% on the experience measure. Upon investigation, leaders discovered that the staffing ratio for nurse practitioners was lower at this facility than others in the system. The CMO used the assessment to make the case for hiring additional staff.

### Roll-Up Measure Defines Quality Standard

#### Paired Utilization and Quality of Service Metrics

<table>
<thead>
<tr>
<th>Utilization Metrics</th>
<th>Quality Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient volume</td>
<td>—</td>
</tr>
<tr>
<td>Number of palliative care consults</td>
<td>—</td>
</tr>
<tr>
<td>Percentage of inpatient admissions that receive consult</td>
<td>Percentage of consults that meet “full palliative care consult experience”</td>
</tr>
<tr>
<td>Number of ICU patients with 5+ LOS</td>
<td>Percentage of ICU patients with 5+ LOS w/ advanced directives</td>
</tr>
<tr>
<td></td>
<td>Percentage of ICU patients with 5+ LOS w/ DNR status</td>
</tr>
</tbody>
</table>

#### “Full Experience” Metrics

1. Palliative care physician sees patient at least once during time of consult
2. Weekly (or more) Interdisciplinary Team meeting includes palliative care physician or mid-level provider and at least one other member of the palliative care team
3. Weekly (or more) formal Family Meeting where goals of care are discussed; attended by physician or mid-level provider and at least one other member of the palliative care team
4. At least two members of formal palliative care team see patient daily, Monday-Friday, one of which is physician or mid-level provider

### Case in Brief: OSF HealthCare

- Seven-hospital health system based in Peoria, Illinois
- Developed system-wide inpatient palliative care consult service standards
- Created operational definitions within each quality metric to further define consult standards
- Paired quality-of-consult service metrics with utilization goals; provides more accurate picture of consult service and distinguishes high performers

Source: OSF HealthCare, Peoria, IL; Physician Executive Council interviews and analysis.

1) Validated pain and symptom management assessment tool.
2) Nurse, social worker, chaplain, or other.
3) Future intention to develop 24/7 coverage.
Key Takeaways: Growing the Inpatient Consult Service

Most inpatient palliative care consult services fall far short of meeting all patient palliative care needs. To reap the full benefit of palliative care, the programs must grow. To that end, the following five strategies are essential for successful program growth:

1. **Create an Inpatient Palliative Care Growth Plan**
   Successful growth requires deliberate planning by defining target populations, creating utilization targets, and anticipating incremental growth.

2. **Comprehensively Address Referrer Concerns**
   Secure physician support by ensuring ongoing, open communication, establishing service standards, and codifying roles and responsibilities.

3. **Raise Visibility Among Patients**
   Informed patients are critical palliative care advocates. Educate patients and leverage their desire for palliative care services to increase program use.

4. **Reduce the Referral Burden on Physicians**
   Though physicians have typically borne the referral burden, shifting the responsibility to others on the care team helps to ensure that patient palliative care needs are identified.

5. **Evolve the Palliative Care Dashboard**
   As the service expands, add customer service and quality metrics to the palliative care dashboard to ensure that needs are met and quality remains high.
Chapter III

Expanding Capacity Across the Medical Staff

Imperative #11: Promote Generalist Palliative Care Skills
Imperative #12: Implement Team-Based Palliative Care Supports
Shortfall Expected to Increase with Aging U.S. Population

While a robust inpatient consult service can meet the palliative care needs of the most complex cases, these services have their limits.

Chief among these limits is the shortage of palliative care specialists. Currently, there is less than one palliative medicine specialist for every 1,000 people living with a serious or life-threatening illness.

A 2010 study quantified this gap, finding that an additional 3,781 physician FTEs would be needed to staff all hospital-based programs at moderate staffing levels.

Furthermore, the pipeline of new physicians entering the field is small—in 2013, just 237 fellowship positions for hospice and palliative care medicine existed.

The nation’s palliative care specialist workforce is not sufficient to meet the growing demand caused by an aging population and increasing prevalence of chronic diseases. As patients continue to live longer while battling the side effects and symptoms of serious illnesses, organizations need to find a way to meet the palliative care needs of even more patients.

There Will Never Be Enough Palliative Care Specialists

<table>
<thead>
<tr>
<th>Cardiologists for Patients with Heart Attack</th>
<th>Oncologists for Newly Diagnosed Patients</th>
<th>Palliative Care Physicians for Patients with Serious, Life-Threatening Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1</td>
<td>7.1</td>
<td>0.8</td>
</tr>
</tbody>
</table>

**Estimated National Shortfall**

3,781

Estimated palliative care physician FTEs still needed to staff hospital-based palliative care programs at moderate staffing levels

**Available Fellowship Positions**

237

Number of approved fellowship positions in Hospice and Palliative Care Medicine for 2013-2014

To meet the full palliative care need among patients, organizations must use their scarce specialist resources strategically, ensuring that specialists are consistently practicing at top of license. But most organizations have room to improve in this area.

In a typical palliative care program, about half of the patients actually needed a specialist consult. The rest of the patients do have palliative care needs, but their cases are routine and straightforward. Meanwhile, providers estimate that 50% of patients who should have a consult currently do not receive one. Ultimately, a palliative care model that maximizes quality gains and cost savings will need to incorporate the entire medical staff.

Generalists, by which we mean any non-palliative care physician, should be educated on palliative care to the point where referrals are more appropriately made. These non-palliative care physicians should also be better equipped to handle their patients’ basic palliative care needs. Just as primary care physicians, rather than cardiologists, handle routine cardiac problems. This will enable specialists to spend time on the most complex cases.

"Routine palliative care problems should be managed by health professionals involved in day-to-day care of patients in the same manner routine cardiac problems are handled by primary care physicians, rather than cardiologists."

Dr. David Weissman, Dr. Diane Meier
CAPC
Meeting the Full Spectrum of Patient Needs

A top-of-license palliative care model meets all palliative care needs by appropriately using providers trained to address needs at each level.

Generalists address patients’ basic needs, such as managing pain and anxiety, and offer basic discussions about prognosis and goals of treatment. These activities are already usually considered components of quality care.

Specialists provide advanced management of complex symptoms and emotional issues. They can also take on more difficult conversations with family members, especially when time-consuming discussions are needed or there is disagreement regarding goals of treatment.

It is important to remember that the divide between generalist and specialist care is based on complexity, rather than acuity. A patient can be very ill, but if the treatment path is clear, the whole family is on board with the plan, and the patients’ symptoms and side effects are well managed, there may be no need for a specialist consult. Conversely, a less-acute patient who has complex emotional side effects may still warrant a specialist’s care.

Allocating Palliative Care to Right-Level Provider

Mapping Clinician Skill Sets to Patients’ Palliative Care Needs

<table>
<thead>
<tr>
<th>Basic Needs</th>
<th>Complex Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generalist Skill Set</strong></td>
<td><strong>Specialist Skill Set</strong></td>
</tr>
<tr>
<td>• Basic management of pain and other symptoms</td>
<td>• Management of refractory pain or other symptoms</td>
</tr>
<tr>
<td>• Basic management of depression, anxiety</td>
<td>• Management of more complex depression, anxiety, grief, and existential distress</td>
</tr>
<tr>
<td>• Basic discussions about prognosis, goals of treatment, suffering, code status</td>
<td>• Assistance with conflict resolution regarding goals or methods of treatment—within families, between staff and families, treatment teams</td>
</tr>
<tr>
<td></td>
<td>• Assistance in addressing cases of near futility</td>
</tr>
</tbody>
</table>

To improve generalists’ skills in palliative care, all parties must first confront the shortfalls in “usual care.” Although many “generalists” are already managing issues such as pain and depression, there are gaps in care. For example, many cardiology patients have chronic, life-limiting diseases with heavy symptom burdens. The American College of Cardiology and American Heart Association Guidelines even recommend discussing palliative care “in the context of signs and symptoms of heart failure despite therapy.” Yet, despite these guidelines, one nationwide survey of cardiologists found that only a minority would discuss palliative care with a chronic heart failure patient, even if it were clearly indicated.

The findings are understandable, especially given the unpredictable nature of heart failure and the fact that cases are often not as simple as they seem. However, the situation underlines the existence of room to improve in generalist palliative care. Beyond cardiologists, training and support is likely needed for all specialties whose patients suffer from serious illness.

### Cardiology Snapshot Illustrates Gaps in Care, Opportunity

**Contrary to Guidelines, Few Cardiologists Discuss Palliative Care with Chronic HF Patients**

- **28%** Would discuss palliative care with a 75-year-old patient with stage IV HF and nonsustained ventricular tachycardia
- **47%** Would discuss palliative care with an 85-year-old patient with stage IV HF and an acute exacerbation

**Common Reasons Why Cardiologists Are Not Meeting Palliative Care Needs**

- Unpredictable nature of HF; no natural time when the need becomes evident
- Uncertain how to initiate palliative care conversation with patients
- Palliative care is still seen as end-of-life care, and patients often live for years after HF diagnosis

**Top Specialties to Target for Generalist Palliative Care**

- Hospitalists
- Emergency physicians
- Intensivists
- Cardiologists
- Nephrologists
- Neurologists
- Oncologists

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1) Approximate numbers, based on a national survey of cardiologists.
2) Heart failure.

Replicable Training to Reach the Whole Medical Staff

Aurora West Allis Medical Center’s Plan for Generalist Palliative Care Training

Initial Training for Physician Leaders
To support providers in meeting the new standard, hospital provided palliative care training for leaders across multiple departments

Future Training for Broader Staff
Initial training participants are asked to co-lead future training sessions targeted at their specialty cohort, e.g., hospitalists or cardiologists

New Generalist Standard
Hospital implemented requirement that admitting physicians discuss and document goals of care

Follow-Up Observations
Palliative care physician observes participants 1-2 months post-training and provides additional feedback

Case in Brief: Aurora West Allis Medical Center
- 120-bed hospital in West Allis, Wisconsin; part of Aurora Health Care
- Implemented a requirement that admitting physicians must discuss patient goals of care upon admission and discharge, and document the patient’s wishes in the EHR
- Hospital quality improvement department will conduct chart reviews to determine whether physicians are holding these discussions with their patients, meet one-on-one with physicians to inform them of their compliance compared with the broader medical staff
- To support physicians in these discussions, palliative care director has developed a 6-hour training course for physicians, to be offered in two 3-hour sessions on consecutive evenings
- The training will contain a mix of didactic training and simulated conversations with instructor feedback
- Training topics include: discussing goals of care and code status, recognizing palliative care needs, prognostication, and symptom management

Source: Aurora West Allis Medical Center, West Allis, WI; Physician Executive Council interviews and analysis.
Varied Training Targets Diverse Providers

Medical staffs are diverse and one size does not fit all when it comes to generalist palliative care training.

At Franciscan Health System, new providers are introduced to palliative care in new provider orientation, including a review of available palliative care resources as well as a four-hour education session on basic palliative care communication skills. The palliative care director specifically called out the critical role that a supportive hospital administration played in finding palliative care a place in the busy orientation schedule.

In addition to support existing providers, the system is developing a Palliative Care Academy, which will consist of two tiers:

- Tier one, for clinicians who want to improve palliative care skills within their current practice area
- Tier two, for clinicians interested in moving to a full-time palliative care practice

To ensure a standard palliative care skill set among program graduates, the program is organized around specific competency areas, such as “goals of care and conflict management.”

Education for Generalists, Specialists to Address Workforce Shortage

New Provider Orientation Session

- Reviews inpatient and outpatient palliative care resources
- Provides four-hour education on communication skills to equip medical staff to deliver basic palliative care

Tiered Palliative Care Academy for Existing Clinicians

Tier One: Generalist Training

- Builds generalist palliative care knowledge and skills among providers
- Lasts one week; 40 hours of training
- Includes competency-based didactic and observational sessions
- Accommodates six to eight participants per session, grouped by inpatient or outpatient cohorts

Tier Two: Specialist Training

- Builds advanced palliative care skills for providers planning to focus full-time in palliative care
- Spans weeks to months, depending on participant needs
- Provides one-on-one mentoring and education
- Trains one to two participants annually

Case in Brief: Franciscan Health System

- Five-hospital health system based in Tacoma, Washington
- New physician orientation program includes presentation of available palliative care services, sessions on communication techniques
- Received $250,000 grant from Cambia Foundation to develop Palliative Care Academy to provide education for existing clinicians; academy education is competency-based to equip clinicians with palliative care skills
- Consists of two tiers; tier one targeted to provide generalist palliative care education, tier two for providers interested in advanced education
- Tier one includes 20 modules including role-play sessions and development of personal action plan

Resource in Brief: Academy Objectives and Competencies

- Provides full list of modules and corresponding competencies
- Available online at advisory.com/pec/pctoolkit

1) Focusing initially on hospitalists, emergency physicians, and primary care physicians.
Collaboration between generalists and specialists can, and should, take different forms depending on the patients’ needs and the care team’s capabilities.

Four common models for collaboration exist, ranging from generalist palliative care, in which the admitting physician provides all palliative care to a patient, to an inpatient palliative care unit, in which the specialist team provides all needed care for referred palliative care patients. In the middle are two different cooperative models for the generalist and the palliative care team to work together.

These models are by no means mutually exclusive. In fact, all four can be used in the same hospital, with the same staff members. However, some hospitals choose to put in place a policy encouraging one model or another.

### Models of Generalist Palliative Care Collaboration

<table>
<thead>
<tr>
<th>Generalist Palliative Care</th>
<th>Consultative Palliative Care</th>
<th>Comanaged Palliative Care</th>
<th>Inpatient Palliative Care Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Greater Role for Generalist</strong></td>
<td><strong>Greater Role for Palliative Care Team</strong></td>
<td><strong>Greater Role for Generalist</strong></td>
<td><strong>Greater Role for Palliative Care Team</strong></td>
</tr>
<tr>
<td>Role of Generalist/Admitting Physician</td>
<td>Role of Palliative Care Team</td>
<td>Role of Generalist/Admitting Physician</td>
<td>Role of Palliative Care Team</td>
</tr>
<tr>
<td>- Discusses palliative care and goals of treatment</td>
<td>- Provides high-quality care, including basic pain and symptom management</td>
<td>- Not directly involved in care for these patients</td>
<td>- Provides one-time consultation with generalist</td>
</tr>
<tr>
<td>- Supports generalist with ongoing education</td>
<td>- Discusses palliative care and goals of treatment</td>
<td>- Provides one-time consultation with generalist</td>
<td>- Answers further questions as needed</td>
</tr>
<tr>
<td>- Releases patient oversight to palliative care team</td>
<td>- Provides palliative care to patient after consulting with the palliative care team</td>
<td>- Works with generalist to manage palliative care needs</td>
<td>- Takes on time-intensive, complex conversations</td>
</tr>
<tr>
<td>- Comanages patient’s palliative care needs along with the palliative care team</td>
<td>- Takes on full care of patients whose care goals are palliative in nature</td>
<td>- Receives requests to consult</td>
<td>- Releases patient oversight to palliative care team</td>
</tr>
</tbody>
</table>

Source: Physician Executive Council interviews and analysis.
Hospital Policies Emphasize Team-Based Palliative Care

Chandler Regional Medical Center in Arizona has implemented a comanagement policy for supporting hospitalists in providing palliative care.

At Chandler, when a hospitalist determines that a patient needs palliative care, the provider submits a referral to the palliative care service. While this first step is the same as with most consult services, the next step is different.

Based on the consult request, the palliative care team determines whether the patient’s case warrants specialist services or generalist services. If the case is determined to be generalist-level, the referring physician is responsible for delivering palliative care in partnership with a nurse from the palliative care service.

The CMO and palliative care lead noted several unexpected benefits from the policy. Perhaps most impressive is that 17% of their hospitalists self-selected to pursue palliative care certification since this initiative was implemented, even more impressive since their hospitalists are independent. That is beneficial for both patients and the hospital.

Providing Hands-On Learning to Referring Providers

Palliative Care Service Delivery Pathway

- **Referral**
  - Does this case warrant physician specialist services?
  - **Yes**
    - Specialist physician and palliative care team provide care
  - **No**
    - Referring provider and palliative care RN address needs together

Halo Effects

- 17% of hospitalists self-selected to pursue palliative care certification
- Increase in number of hospice referrals
- Increase in DNR code status documentation

Case in Brief: Chandler Regional Medical Center

- 243-bed hospital based in Phoenix, Arizona
- Developed palliative care service delivery policy wherein referring providers are responsible for providing primary palliative care alongside palliative care nurses; board-certified palliative care physicians consulted only for complex needs
- Resulted in generalist palliative care development, broader interest in palliative care as a medical discipline, more accurate code status documentation, increase in appropriate hospice referrals

Source: Chandler Regional Medical Center, Phoenix, AZ; Physician Executive Council interviews and analysis.
Supporting Physicians in Tough Conversations

Kent Hospital in Rhode Island has developed another strategy to support generalists in providing palliative care. They created a new staff position, the “conversation nurse,” to support conversations around goals of care and end-of-life decisions.

Physicians can directly request a consult with the conversation nurse, whose caseload is a testament to the demand for the service (70% of palliative care consults request a goals-of-care discussion). The nurse receives over 30 direct consult requests each month in addition to the other conversations she supports as a member of the palliative care team.

It’s up to the physician requesting a conversation consult to choose the level of support. The nurse frequently meets with the patient or family alone and relays information, including any key decisions, back to the physician’s team.

However, some physicians prefer to conduct the patient or family discussion themselves, with the nurse joining to provide any additional support needed to ensure a productive dialogue.

Palliative Care Nurse Devoted to Treatment Goals, End-of-Life Discussions

**Physician\(^1\) Identifies Need, Type of Support Required**

- Physician identifies need for conversation, can directly request palliative care consult from the conversation nurse
- Chooses a nurse-led conversation or a supported conversation, depending on situation, physician preference

**Conversation Nurse Provides Desired Level of Support**

**Option 1: Nurse-Led Conversation**

- Nurse meets directly with patient and/or family
- Relays information back to the medical team

**Option 2: Supported Conversation**

- Nurse joins physician in conversation with patient and/or family
- Physician leads conversation, nurse provides support as needed

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**Case in Brief: Kent Hospital**

- 275-bed teaching hospital in Warwick, Rhode Island
- “Conversation Nurse” is a member of the palliative care team who specializes in discussing goals of care and end-of-life decisions with patients and families
- Original conversation nurse was hired as a hospice liaison, but the palliative care director found that she was skilled in having conversations about goals of care and there was a large need for such conversations among patients earlier on in their disease trajectory—before hospice was an appropriate option
- The program has been so successful in its first year that the hospital has already hired a second conversation nurse for another hospital in the system
- Qualifications include strong leadership skills, previous experience with end-of-life care, and a personality that puts patients at ease

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\(^1\) Nurses and others can also request a palliative care consult.

Source: Kent Hospital, Warwick, RI; O'Reilly KB, “Hospitals Teach Being ‘Conversation-Ready’ for End-of-Life Care,” American Medical News, April 15, 2013, Physician Executive Council interviews and analysis.
To overcome capacity constraints common to inpatient consult services and ensure all patients’ palliative care needs are met, a new top-of-license palliative care service model is needed. In this model, palliative care specialists focus primarily on complex patient needs, while the broader medical staff more effectively addresses basic palliative care needs—a strategy often referred to as generalist palliative care.

The following imperatives support the medical staff in providing for patients’ basic palliative care needs:

1. **Promote Generalist Palliative Care Skills**
   Hospitals need to train their broader medical staff in basic palliative care, prioritizing training for specialties such as hospitalists and intensivists, whose patients most often have palliative care needs.

2. **Implement Team-Based Palliative Care Supports**
   Palliative care programs also should implement formalized collaboration protocols to support generalists, such as guidance for patient comanagement or resources for supporting difficult patient discussions. These supports should be designed to flex, taking on different forms depending on the patients’ needs and the care team’s capabilities.
Navigating the Path Forward
Maximizing and Sustaining Palliative Care’s Benefit

The ideal vision for the future of palliative care is that all patients who would benefit from these services will receive them, resulting in benefits across the health system in terms of improved outcomes and reduced costs.

- The foundation for this vision is a strong inpatient consult service, but hospitals cannot stop there.
- To truly maximize palliative care’s benefits, organizations must look beyond specialists. Growing palliative care capacity among all physicians is essential, and hospitals must support these physicians in providing care to their patients.
- Furthermore, sustaining palliative care’s benefits means that care does not end at the hospital’s doors. Cross-continuum services amplify palliative care’s benefits, both by reaching more patients and by creating more value in risk-based environments. See related research on outpatient palliative care models available as part of our online Palliative Care Program Development Toolkit.

A Vision for the Future of Palliative Care

- Well-Utilized Inpatient Consult Service
- Expanded Generalist Palliative Care Capabilities
- Cross-Continuum Palliative Care Services

Increasing Value Gained, Number of Patients Served Through Palliative Care Service

Resource in Brief: Preparing for Cross-Continuum Palliative Care Success

- Includes resources for determining strategic goals for outpatient expansion
- Provides an overview of five models hospitals have used to expand palliative care across the care continuum
- Available online at advisory.com/pec/pctoolkit

Source: Physician Executive Council interviews and analysis.
To move toward realizing a robust palliative care model, consider these five essential steps to growth:

- First, be strategic—identify the need and the opportunity, and make a plan for growth.
- Second, establish a relationship of trust between physicians and the palliative care program. Meet referrers’ needs and assist them in their work to earn their support for future growth.
- Third, measure performance along the way. Gathering data is essential to making the case for expansion.
- Fourth, enlist and equip the medical staff as partners in providing palliative care. Their participation is critical to sustainability and maximizing program value.
- Finally, plan for phased growth, including possible outpatient expansion toward greater total provider risk as contract and market structures adopt greater cross-continuum integration.