Realizing the **Full Benefit** of Palliative Care

Service Optimization and Strategic Growth

Questions?
Contact Megan Grant
Member Services
(202) 266-5806
grantm@advisory.com
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.
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.

Palliative Care Constitutes a Change in Focus from Usual Care

<table>
<thead>
<tr>
<th>Goals of Care:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Delayed until end of life is near</td>
<td>Established early in disease trajectory</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment Strategy:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Includes primarily curative treatments</td>
<td>Includes a combination of curative and symptom-focused treatments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Utilization:</th>
<th>Usual Care</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pursues curative treatments even when low-yield, high-cost, and burdensome for patient</td>
<td>Pursues treatments that align with patient goals</td>
</tr>
</tbody>
</table>

“[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

The Case for Palliative Care

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>Benefit Under Fee for Service</th>
<th>Benefit Under Risk Contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Care Quality</td>
<td>$</td>
</tr>
<tr>
<td>- Reduces patient symptom burden and aggressive EOL(^1) care</td>
<td>- Reduces hospitals thousands of dollars per inpatient case(^2)</td>
</tr>
<tr>
<td>- Lengthens EOL survival time</td>
<td>- Reduces ICU LOS,(^3) contributing to cost savings and freeing up capacity</td>
</tr>
<tr>
<td>- Improves patient experience of care</td>
<td></td>
</tr>
</tbody>
</table>

1) End-of-life.
2) Savings compared with usual care.
3) Length of stay.

Source: Physician Executive Council interviews and analysis.
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.

### Palliative Care Improving Quality of Life and Survival

#### Patients Have Lower Symptom Burden, Less Depression

**FACT-L Symptom Management Scores**

- Higher scores indicate fewer symptoms, better quality of life

<table>
<thead>
<tr>
<th></th>
<th>Patients Receiving Aggressive Care</th>
<th>Patients Assigned to Early Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Patients with Symptoms of Depression</td>
<td>38% (n=47)</td>
<td>16% (n=60)</td>
</tr>
<tr>
<td>p-value</td>
<td>0.01; n=47, n=57</td>
<td>0.03; n=47, n=60</td>
</tr>
</tbody>
</table>

#### Patients Live Longer Despite Less Aggressive Care

**Patients’ Median Survival (Months)**

<table>
<thead>
<tr>
<th></th>
<th>Patients Receiving Aggressive Care</th>
<th>Patients Assigned to Early Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual Care Patients</td>
<td>8.9 (n=56)</td>
<td>11.6 (n=49)</td>
</tr>
<tr>
<td>Palliative Care Patients</td>
<td>54% (n=47)</td>
<td>33% (n=57)</td>
</tr>
</tbody>
</table>

### 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

---

1) Functional Assessment of Cancer Therapy – Lung measures symptoms on a scale from 0-136, where higher score means better quality of life.
2) Patients classified as receiving “aggressive care” if met one of the following: chemotherapy within 14 days of death, no hospice care, or admission to hospice 3 or fewer days prior to death.

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**

<table>
<thead>
<tr>
<th></th>
<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>p=0.04; n=275, n=237</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher scores indicate patients were more satisfied with care, felt greater sense of control, and felt that their wishes were taken seriously</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.6</td>
<td>6.9</td>
<td></td>
</tr>
</tbody>
</table>

**Doctors, Nurses/Other Care Providers Communication Scale**

<table>
<thead>
<tr>
<th></th>
<th>Usual Care Patients</th>
<th>Palliative Care Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>p=0.0004; n=275, n=237</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher scores represent greater caring, respect, understanding between patients and providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.5</td>
<td>8.3</td>
<td></td>
</tr>
</tbody>
</table>

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.

Reduced Inpatient Costs

Sizeable Reduction in Hospital Costs

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.

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.

Reduced Inpatient Costs

Sizeable Reduction in Hospital Costs

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.

Reduced Inpatient Costs

Sizeable Reduction in Hospital Costs

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.
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.

### In-Home Palliative Care Lowers Utilization, Reduces Readmission Rates

#### Results from Kaiser Permanente’s In-Home Palliative Care Intervention Pilot

<table>
<thead>
<tr>
<th></th>
<th>ED Utilization</th>
<th>Hospitalizations</th>
<th>Mean Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual Care Patients</td>
<td>33%</td>
<td>59%</td>
<td>$20,222</td>
</tr>
<tr>
<td>Palliative Care Patients</td>
<td>22%</td>
<td>36%</td>
<td>$12,670</td>
</tr>
</tbody>
</table>

#### p-values
- ED Utilization: 0.01
- Hospitalizations: <0.001
- Mean Cost of Care: 0.03

#### Readmission Rates of Patients Who Received Inpatient Palliative Care Consults, Subsequently Discharged to Various Levels of Home Care

<table>
<thead>
<tr>
<th>Discharged to</th>
<th>n=408 managed care patients &gt;65 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Home Care</td>
<td>25.7%</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>24.1%</td>
</tr>
<tr>
<td>Home-Based Palliative Care</td>
<td>8.3%</td>
</tr>
<tr>
<td>Hospice</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Overall medical center readmission rate for older adults was 15%.

---

1) Study conducted at Kaiser Permanente Colorado and Kaiser Permanente Hawaii from 2002 and 2004. Study included 297 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

Given the strong ROI case, combined with the market’s increasing focus on value and total costs, it comes as no surprise that payers and providers are beginning to pay more attention to palliative care.

Over the past 10 years, palliative care programs have grown rapidly. Since 2000, the number of hospitals with inpatient palliative care teams has increased by nearly 148%. Currently, around 66% of all hospitals with more than 50 beds have a palliative care team.

In addition, payers are also expanding services to their enrollees. To take only one example, the California Healthcare Foundation recently published a report examining the spectrum of palliative care and hospice services supported by California’s health plans. The report found that the six largest health plans are rapidly expanding access to palliative care through specialized case management and liberalization of the hospice benefit.

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.
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.

Expanding Capacity Essential to Meet Total Patient Need

Spectrum of Palliative Care Models

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

Key Challenges Span All Stages of Growth

Stages of Palliative Care Program Growth

- Complex Financial Justification
- Shortage of Specialists
- Resistance, Lack of Awareness (Patients, Physicians)
- Keeping Pace with Growing Demand

Source: Physician Executive Council interviews and analysis.
The 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. These imperatives are divided into three categories:

**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

Excerpted in this document

Source: Physician Executive Council insights and analysis.
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.
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

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.
**Increased Utilization Projected to Yield ROI**

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**

1. **Calculate Historical Direct Cost Savings**
   - Measure mean daily direct cost differential before and after consult
   - Determine mean LOS (days) after consult
   - Calculate average cost savings per case (direct cost differential multiplied by LOS)

2. **Project Annual Direct Cost Savings**
   - Use CAPC recommendations for number of consults by program maturity
   - Project annual consults
   - 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 |

---

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.
**Cannot Flip a Switch to Increase Utilization**

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

---

1) Performance varies by facility. Attained current performance range earlier than tiered program anticipated.

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

### Array of Barriers to Palliative Care Referrals

#### Common Physician Concerns About Palliative Care

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

### 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

---

1) Illustrative quotes.  
Source: Physician Executive Council interviews and analysis.
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

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.

**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.

### Fairview’s Progress Note Allows Access to Patient’s Palliative Care Information

- Progress note embedded into EHR so any Fairview clinician can easily access
- Only palliative care specialists are able to input information into the note
- Captures advance directives and surrogate decision maker information
- Includes patient symptom scores
- Documents patient’s family situation and support network

#### Palliative Care Progress Note

<table>
<thead>
<tr>
<th>Palliative Care Progress Note</th>
<th>Full version available online at: advisory.com/pec/pctoolkit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
<tr>
<td>Symptom Assessment</td>
<td></td>
</tr>
<tr>
<td>Goals of care:</td>
<td></td>
</tr>
<tr>
<td>Advance Directive and Surrogate Decision Maker:</td>
<td></td>
</tr>
<tr>
<td>Family Support Network:</td>
<td></td>
</tr>
<tr>
<td>Spiritual Concerns:</td>
<td></td>
</tr>
<tr>
<td>Financial Concerns:</td>
<td></td>
</tr>
</tbody>
</table>

### 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

Source: Fairview Health Services, Minneapolis, MN; Physician Executive Council interviews and analysis.
Facilitating Ongoing Discussions About Palliative Care

Enable Productive Ongoing Dialogue

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.

Creating a Forum to Address Physician Concerns

Broaching the Topic of Palliative Care

Potential Venues for Forum

- Targeted department meetings
- Brown bag lunches with palliative team
- Palliative care consult sit-ins
- Ongoing palliative care training sessions

Conversation Starters

- What are the most challenging aspects of symptom management?
- How do you approach discussions with patients about goals of care?
- What do you find difficult about caring for patients at the end of life?

Common Physician Concerns

- Controlling pain
- Discussing prognoses and goals of care
- Coordinating with palliative care team
- Managing family conflict

Source: Physician Executive Council interviews and analysis.
The Physician Executive Council has developed a full suite of 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.

### On-Demand Palliative Care Webconference Series

- **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

- **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

### The 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
  - 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](http://advisory.com/pec/pctoolkit)
Questions or Comments?

Contact Us With Your Feedback

If you have questions about the content of this briefing or would like more information on the Physician Executive Council, our membership designed to support the chief medical officer and team, please contact our member services manager.

Member Services Contact

Megan Grant
Member Services Manager
202-266-5806
grantm@advisory.com