

Requesting Support for Inpatient Palliative Care in Public Hospitals: Topics and Tactics

Your organization likely has established practices for seeking support from administrative and clinical leadership for specific programs. Some organizations have a specific form that must be used; others may just specify required elements for written requests. Most organizations will also have specific settings in which verbal requests for support are to be made for the coming fiscal year. If you are unsure about the practices at your hospital, ask other clinical service leaders about the preferred process, format, and setting for making a request.

The following information covers approaches and topics commonly included in support requests. The goal in presenting this information is to orient you to what might be expected, and to give ideas for what to cover in written or verbal support requests. A companion [Support Request Template](#) slide deck is also available.

1. Introductions and description of request. For example, “I’m _____, representing a multidisciplinary committee that has explored ways to improve care for our patients. We are here today to make the case [to initiate or expand] a specialist palliative care consultation team that will also promote best practices for serious illness care throughout the hospital.”

2. Case vignettes. Describe a real patient or several patients with serious, advanced illness who have (or would have) benefited from specialist palliative care (PC) during inpatient hospitalization in your hospital. Focus not on faulting the attending clinical teams but rather on the opportunities for maximizing quality and safety of care had palliative specialists been engaged. How did (or would) the care differ when palliative care was involved?

- Inevitably, some stakeholders may be confused about hospice versus palliative care, so these case vignettes also give you a good opportunity to point out ways that your palliative consultations are not hospice care (e.g., for patients who are upstream of a six-month prognosis, or for palliative medicine that is concurrent with ongoing disease-focused care).
- This is also a good opportunity to describe cases that speak to your hospital’s most urgent needs or high-priority goals. For example, if your hospital leaders are hyper-focused on readmission rates, describe how PC involvement (could have) helped to avoid the readmission that occurred for one of your vignette cases.
- The slide deck [Meeting the Need: Understanding the Impact of Palliative Care in California’s Public Hospitals](#) includes several case vignettes that highlight how an inpatient palliative care (IPPC) service benefits patients, other hospital providers, and the health system. Feel free to use or adapt slides from that deck in your presentation.

3. Quantify actual or anticipated outcomes. If you already have a program, use data to quantify some outcomes mentioned in your case vignettes. For example, aggregate data on patient and family

This document is part of a set of CHCF resources on [Making the Case for Inpatient Palliative Care](#).

experience (satisfaction, etc.), number of patients with symptom burden or symptom management challenges, impact of PC on specific symptoms (e.g., Edmonton Symptom Assessment System [ESAS] scores at first consultation and three days later), number of discharges to hospice.

If you don't have a program, or if you do not have data describing care processes and outcomes, support the assertions made in your case vignettes with published studies where hospital care was improved with specialist palliative care consultations. For example:

Outcome	How Does PC Help?	Source
Greater family satisfaction with quality of care	More communication, greater comfort, preferences met	David Casarett et al., " The Optimal Delivery of Palliative Care: A National Comparison of the Outcomes of Consultation Teams vs. Inpatient Units ," <i>Archives of Internal Medicine</i> 171, no. 7 (Apr. 11, 2011): 649–55.
Shorter intensive care unit length of stay	Goals of care changed	Sally A. Norton et al., " Proactive Palliative Care in the Medical Intensive Care Unit: Effects on Length of Stay for Selected High-Risk Patients ," <i>Critical Care Medicine</i> 35, no. 6 (June 2007): 1530–35.
No increase in hospital mortality	Reduce symptoms, discharge to home care or hospice	Ahmed Elsayem et al., " Impact of a Palliative Care Service on In-Hospital Mortality in a Comprehensive Cancer Center ," <i>Journal of Palliative Medicine</i> 9, no. 4 (Aug. 15, 2006): 894–902; and J. Brian Cassel et al., " Hospital Mortality Rates: How Is Palliative Care Taken into Account? " <i>Journal of Pain and Symptom Management</i> 40, no. 6 (Dec. 1, 2010): 914–25.
Reduced costs per hospital stay	Reduce symptoms, expedite safe discharge	Peter May et al., " Economics of Palliative Care for Hospitalized Adults with Serious Illness: A Meta-Analysis ," <i>JAMA Internal Medicine</i> 178, no. 6 (June 1, 2018): 820–29.
Reduce readmissions	Better coordination with postacute care including hospice	Kerin Adelson et al., " Standardized Criteria for Palliative Care Consultation on a Solid Tumor Oncology Service Reduces Downstream Health Care Use ,"

Outcome	How Does PC Help?	Source
		<i>Journal of Oncology Practice</i> 13, no. 5 (May 2017): e431–40; and Peter May et al., " Evaluating Hospital Readmissions for Persons with Serious and Complex Illness: A Competing Risks Approach ," <i>Medical Care Research and Review</i> 77, no. 6 (Dec. 1, 2020): 574–83.
Reduce cost of those readmissions that do occur	Better coordination with postacute care including hospice	Glenn Gade et al., " Impact of an Inpatient Palliative Care Team: A Randomized Controlled Trial ," <i>Journal of Palliative Medicine</i> 11, no. 2 (Mar. 11, 2008): 180–90.

4. California context. Note that as of 2020, 88% of California’s public hospitals have IPPC services (see slide 8 of the *Meeting the Need* slide deck referenced above). Having a robust IPPC service is in fact the standard of care in public hospitals.

5. Actual or estimated volumes. Present data on the number of patients hospitalized with serious/advanced conditions, to provide some insight into the scope of the relevant population — are you talking about 100 patients per year, or 500, or 2,500? This is critical for determining how large a specialist palliative care team needs to be — whether you currently have a team (what is the gap between current and needed staffing) or are initiating or reinitiating development of a team. There are several ways to quantify this, above and beyond what volume of referrals an existing or prior program has experienced:

- A one-day or one-week assessment of all patients in the hospital (or on relevant units) who received palliative care referrals or could have met palliative care referral criteria. This would require visits to each unit, talking with staff, looking at charts, etc.
- Hospital statistics on the annual number of patients whose care included specialist palliative care or whose discharge disposition was hospice or death. This could include the number of unique people, the total number of their hospitalizations, the number of hospital bed days, etc.
- The number of hospitalizations for a relevant clinical population over the course of a year (regardless of their disposition at discharge), which could also include a tally of 30-day readmissions. For example:
 - All hospitalizations for cancer patients that were not for active treatment or urgent response (sepsis, bone fracture, etc.)

- All hospitalizations for cancer patients who had poor-prognosis cancers (stage 4 or specific high-mortality cancers such as esophagus, liver, pancreas, brain, etc.)
- All hospitalizations for end-stage heart failure, liver failure, kidney failure, etc.

Of these, how many did receive palliative care, and how many did not?

- Talk to others working on quality and safety in your hospital and ask if they have done similar assessments. Perhaps they have already done chart reviews or other in-depth evaluations of care that could be repurposed for your proposal, such as readmissions for cirrhosis, cancer, congestive heart failure, or chronic obstructive pulmonary disease.

6. Specific requests. Be very clear and concrete about what you are asking for. This usually includes staffing from various disciplines; protected time for quality improvement projects hospital-wide; annual memberships to palliative care organizations such as the Center to Advance Palliative Care (CAPC) and the Palliative Care Quality Collaborative; permission and resources to initiate specific projects; resources for trainings and education; permission and resources to collaborate with community organizations; etc.

Describe how many full-time equivalents (FTEs) for each discipline you are requesting and why. These figures relate to the size of the patient population but also to your goals and processes of care delivery. Why do you need social workers for patient care and family meetings? Why do you need a clinical pharmacist available for interdisciplinary team meetings? How would a chaplain support your patients and families as well as your team?

- If you already have such members on the team, it should be relatively easy to describe in detail how they play a critical role, and why you need to sustain or expand their availability.
- Be ready to point to the National Consensus Project's [Clinical Practice Guidelines for Quality Palliative Care](#), or [Joint Commission's advanced certification](#) as evidence for the need for a full multidisciplinary team.
- Make it clear that these team members not only have direct encounters with patients and families but also support one another and other clinical staff caring for patients with serious illness, and the full team enables each member to practice at the top of their training and expertise.
- Emphasize that talking with patients and family members about prognosis and the benefits and burdens of possible treatments takes time, patience, and trust. Be prepared for some administrators to underestimate how long it takes to have multiple family meetings about goals of care for a loved one in a way that does not seem to be pushing patients and families hurriedly to an outcome they do not want.
- Slide 18 of the *Meeting the Need* slide deck referenced above includes a brief vignette and text describing the role played by each IPPC team member, highlighting specific contributions to quality care.

7. Support from referring providers. Describing support from other clinicians is absolutely critical. Present testimony from key clinical leaders that they support your plan and will ask for consultations for their patients (or already do, if you have a service). This may include specialists in cardiology, oncology, pulmonology, critical care, hospitalists, and others. Ideally, they would describe their support in person with you at any high-stakes presentations to senior leaders. They should be prepared to describe the value your team brings as an extra layer of support for their patients, and how specialist palliative care helps them.

8. Nonclinical responsibilities. Some palliative care teams take responsibility for more than just consultations. If a major focus for your palliative care team will be (or is) education and training of other teams, be sure to include sufficient details about that in your proposal. Or if your team will play a critical role in changing processes of care such as opioid safety or advance care planning, describe how it will be done. In any such scenario make it clear that the relevant team members will need significant nonclinical time in education or quality improvement projects.

9. Describe outcomes and tie them to the resources requested. Describe the outcomes that will be (or have been) achieved, and how they are measured or evaluated. This is where you should mention the full range of impacts on patients, families, referring providers, and the hospital as a whole. For example, if your palliative care consultations (will) have a big impact on symptom management, then you would point out that you (will) measure symptom burden before and after your consultation for patients, and if you have such data already, present before-and-after symptom measures to demonstrate your impact. It is critical that you describe such clinical impacts before moving on to financial impacts.

Most if not all palliative care programs make the case for the costs of their teams at least partially through a description of cost-avoidance. A [recent meta-analysis](#) of six studies representing a mix of academic, community, and Department of Veterans Affairs hospitals found that palliative care involvement early in a hospital stay reduced hospitals' direct costs by \$3,237 per case on average, about 28% less than usual care. A [multisite study of IPPC for Medicaid beneficiaries](#) found similarly impressive results. You can reference these findings in support of the economic case for IPPC.

- If your organization has not assessed economic outcomes for your palliative care service, use the [CAPC Impact Calculator](#), which is available to all for free and can be used to estimate fiscal impact at your institution.
- Slides summarizing findings from studies of the economic impact of IPPC are available in the *Meeting the Need* deck referenced above. If you do not have local data, referring to outcomes generated by other IPPC services can be a useful substitute.

While the primary goals and purpose of the palliative care program are to improve quality and outcomes for patients and families, it does help to make your case to note that palliative care can also help referring providers and can reduce costs for your hospital as well.