Activities to Have in Place Before Making the Case: What to Do Before Asking for Resources for Your Outpatient Palliative Care Program . . . and After You Get Them

These steps will ensure you are fully prepared to make the case for your new, sustained, or expanded outpatient palliative care (OPPC) service.

Prepare Brief Case Vignettes

Before a program exists. Capture and prepare case vignettes that describe a variety of patient and family needs, referring provider needs, and care that could have been better (safer, higher-quality, better patient experience). Highlight number of nonelective admissions and emergency department (ED) visits.

After a program exists. Capture and prepare case vignettes that describe a variety of patient and family needs, types of referring providers, palliative care interventions (e.g., specific symptom management, goals-of-care conversations, family meetings, referrals to social services), and outcomes. Use this variety to highlight contributions of various disciplines involved — physician, pharmacist, advanced practice nurse / nurse practitioner, registered nurse, social worker, chaplain, and others as appropriate for your service. Include quotes from patients and families and referring providers if possible. Anticipate possible misperceptions and proactively use case vignettes to counter them — for example, if stakeholders think other treating clinicians already deliver these services (and thus no need for palliative care), then present a case describing how the palliative care team identified and addressed unrecognized or unaddressed symptoms, and how doing so helped reduce nonelective admissions or ED visits.

Conduct Data Analyses and Prepare Summaries of Key Points

Before a program exists. If possible, prepare data to describe the number of patients with serious illness that use your health system's inpatient and outpatient services who would likely benefit from outpatient palliative care. It may be easiest to gather such data for a specific clinical service — for example, oncology or cardiology. Establish that there are more than enough of such patients to justify creating "X" number of outpatient palliative care clinics. The Clinic Capacity Calculator can help with this task. Gather information about number of nonelective admissions, ED visits, and the costs of those services. Look at the proportion of patients that have surrogate decisionmaker identified, documented goals of care, or completed advance directives.

After a program exists. Describe the who, what, when, where, how, and why of your outpatient palliative care program. This might include patient demographics (including information on race/ethnicity), referral sources, predominant reason for referral, average months followed and average number of visits, work done between visits to support care coordination and referrals to social services, and reasons for discharge including referrals to home-based palliative care or hospice. If possible, compare palliative care recipients to usual care recipients to document differences in rates of nonelective hospitalizations, ED visits, or use of home-based palliative care and hospice (services that offer specialty serious illness care that are also associated with reductions in preventable admissions and ED visits).

Evaluate Opportunities to Improve Generalist Palliative Care

Using a combination of case vignettes and data (where possible), identify opportunities for palliative care specialists to help other staff, treating clinicians, and residents to improve their skills in areas such as serious illness conversations with patients, advance care planning and honoring choices, family meetings, assessment of symptoms, evidence-based symptom management, opioid and other medication safety, prognostication, use of debriefing after difficult cases, bereavement support, engaging with angry families, etc. To the extent the specialist palliative care team has time and resources available, design and deliver trainings to improve generalist palliative care in such domains when and where audiences would be receptive.

Evaluate Systems of Care

Using your specialist palliative care expertise, evaluate health system (clinics, ED, inpatient units, postacute care) processes of care for patients with serious illness. For example, evaluate the whole process of advance care planning among patients with serious illness, including processes for engaging patients and identifying proxies, documenting conversations, uploading documents to the electronic health record, and subsequently accessing and honoring those choices. Share your observations with the appropriate clinical and administrative leaders and explore opportunities for the OPPC team (with appropriate support) to facilitate improvements.

Keep Your Data and Stakeholders Up to Date

Continue to cultivate positive relationships with your stakeholders. Find venues and opportunities to give them updates regularly, including:

- Progress reports on trainings, systems enhancements, etc.
- Data on program volumes, ability to engage with patients earlier in the disease course, etc.
- Positive feedback from appreciative families whenever you receive it
- Leadership or support of quality improvement initiatives
- Inroads with various referring physicians or teams
- Contributions to high-priority goals for your hospital or health system
- Challenges and opportunities you discover along the way