

Requesting Support for Outpatient 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 form that must be used; others may just specify required elements for written requests. Most organizations will also have particular 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] an outpatient palliative care clinic that will also promote best practices for serious illness care throughout the system.”

2. Case vignettes. Describe a real patient or several patients with serious, advanced illness who have benefited from outpatient palliative care (OPPC). If you do not yet have an outpatient service, select cases that highlight gaps, such as frequent admissions for symptom crises, patients presenting to the hospital who do not have a clear understanding of their condition or prognosis, or how lack of clarity regarding goals of care created difficulties when a patient was admitted. Do not imply or state that colleagues in other services are at fault; rather, focus on how palliative care can help.

- Some stakeholders may be confused about hospice versus palliative care, so these case vignettes also give you a good opportunity to point out the difference between the two (e.g., for patients 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 hyperfocused on readmission rates, describe how OPPC involvement (could have) helped to avoid the readmission that occurred for one of your vignette cases. If clinic wait times are an issue, describe how OPPC can save time for other treating providers, like oncologists, by assuming responsibility for time-consuming tasks like assessing and managing symptoms, or clarifying and documenting care goals.
- The [Additional Slides That Might Be Useful](#) deck includes a case vignette describing how a palliative care (PC) clinic can build on the work started by an inpatient PC consultation service. Pointing out how the inpatient and outpatient services complement each other is also a good idea.

As you present vignettes, or after, describe what an OPPC service does, as it is likely not everyone in your audience will know. A recent [paper](#) by Rabow et al. that studied safety-net OPPC programs describes seven core PC services offered by 10 California safety-net palliative care services: pain/symptom management, comprehensive assessment, care coordination, advance care planning, PC plan of care, emotional support, and social service referrals. Describing these core services will also help your audience understand why you need an interdisciplinary team.

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 experience/satisfaction scores
- Number of patients with high symptom burden that the PC team manages
- Impact of PC on specific symptoms (e.g., Edmonton Symptom Assessment System scores at initial visit compared to subsequent visits)
- Number of advance directives completed or surrogate decisionmakers identified
- Number of referrals to home-based palliative care or 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 (about how palliative care can help) with published studies describing positive contributions of OPPC. For example:

Outcomes	Source
Palliative care associated consistently with improvements in advance care planning, quality of life, reduced symptom burden, and better patient and caregiver satisfaction.	Dio Kavalieratos et al., " Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-Analysis ," <i>JAMA</i> 316, no. 20 (Nov. 22/29, 2016): 2104–14.
Palliative care associated with less emergency department (ED) use, less hospitalization, and lower symptom burden for patients with chronic noncancer illnesses.	Kieran L. Quinn et al., " Association of Receipt of Palliative Care Interventions with Health Care Use, Quality of Life, and Symptom Burden Among Adults with Chronic Noncancer Illness: A Systematic Review and Meta-Analysis ," <i>JAMA</i> 324, no. 14 (Oct. 13, 2020): 1439–50.
Cancer patients receiving earlier palliative care from a PC clinic had lower rates of ED, hospital, and intensive care unit use.	Colin Scibetta et al., " The Costs of Waiting: Implications of the Timing of Palliative Care Consultation Among a Cohort of Decedents at a Comprehensive Cancer Center ," <i>Journal of Palliative Medicine</i> 19, no. 1 (Jan. 2016): 69–75.
Randomized controlled trial in which patients receiving early PC along with standard oncologic care had better quality of life, fewer depressive symptoms, less aggressive end-of-life care, and longer lives than similar patients receiving only standard oncologic care.	Jennifer S. Temel et al., " Early Palliative Care for Patients with Metastatic Non-small-cell Lung Cancer ," <i>New England Journal of Medicine</i> 363, no. 8 (Aug. 19, 2010): 733–42.

4. California context. Note that as of 2017, most of [California's public hospitals have outpatient palliative care services](#). Having such services in public hospitals is now the standard in our state.

5. Describe capacity and demand. Whether you are looking to start a new OPPC program or increase the number of clinic sessions you offer, you need to make the case that there is demand for your services, and that you need resources to meet that demand.

Capacity. Describe the approximate number of unique patients you can care for in a typical half-day clinic annually, and if you believe that number will be the same if you add more clinics. If you do not have an OPPC program, you have several choices for estimating the number of patients your proposed clinic can care for:

- The Rabow paper referenced above includes average values that you can use.
- Ask a peer public hospital palliative care leader that has an OPPC service about their clinic volumes.
- A simple [Clinic Capacity Calculator](#) is available to help you estimate the number of patients that can be cared for in a half-day clinic.

Demand. Estimate the number of seriously ill patients who would use your new or expanded PC clinics. There are several methods for making this estimate.

- Consider the number of patients cared for by your inpatient palliative care service (IPPC) that could have been referred to a PC clinic at discharge.
- Ask leaders of clinical services that care for large numbers of seriously ill patients — oncology, cardiology/heart failure, pulmonology, liver clinic, nephrology — about the number of patients they see who would benefit from comanagement by an OPPC service.
- If you have access to analytic support or medical center data, consider the number of patients who die in the hospital each year. How many were being seen in your health system's clinics? Patients seeking outpatient treatment in your system for progressive, serious illnesses are good candidates for comanagement by a PC clinic.
- You could conduct a sophisticated analysis that quantifies all deaths — inpatient and outpatient — for patients who use your health system. The PC team at Zuckerberg San Francisco General Hospital did this in 2015 and developed two summaries of their findings: [Estimating the Need for Community-Based Palliative Care in a Public Health System \(PDF\)](#) and [Making the Case: Is Outpatient Palliative Care for Oncology Patients Feasible Within the Safety Net?](#) They found that of the approximately 1,000 patients who died each year, only about a third were ever seen by the IPPC. Even for patients who were seen by the IPPC, the median number of days between first contact with the IPPC and death was only 13 days — meaning that most patients who died had just a few weeks of specialty palliative care support. While an analysis like this is useful for understanding the big picture, you will probably launch only one to two half-day clinics to start, no matter how big the demand — and you are likely to launch only a few additional clinics each year thereafter. Remember that you need to verify enough demand only for the new clinic sessions you are proposing. If your health system has limited analytic resources, such an analysis may not be feasible (or needed) to justify creating or expanding an OPPC program.

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

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

memberships to palliative care organizations such as the [Center to Advance Palliative Care](#) and the [Palliative Care Quality Collaborative](#), permission and resources to initiate specific projects, resources for training and education, permission and resources to collaborate with community organizations, etc.

Describe how many full-time equivalents 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](#) 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 about 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 family meetings about goals of care for a loved one in a way that does not seem to be hurriedly pushing patients and families to an outcome they do not want.

7. Support from other treating clinicians. Describing support from other clinicians is absolutely critical. If your service has collected data describing referring provider satisfaction with your OPPC, you will want to share those data. Additionally, present testimony from key clinical leaders that they support your plan and will refer their patients (or already do, if you have a service). This may include specialists in cardiology, oncology, pulmonology, 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. If you have a program, consider doing a simple study that quantifies the time per patient your team spends assessing and managing symptoms — time other treating providers can devote to other patient care issues. Being able to state — or having other treating providers state — that your service saves oncologists 30 minutes per patient (for example) while improving quality is a powerful argument for your program.

8. Nonclinical responsibilities. Some palliative care teams take responsibility for more than just direct patient care. 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 health system 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 at each clinic visit, and if you have such data already, present data to demonstrate your impact (i.e., percentage of patients with reduction in symptom scores at third clinic visit compared to initial clinic visit). It is critical that you describe such clinical impacts before moving on to financial impacts.

Some, but not all, health systems expect OPPC programs to describe the actual or expected financial impacts of the program. This is usually done by comparing hospitalization, readmission, and ED visit rates for patients seen by the OPPC to rates for similar patients who were not seen by the service. Be sure to verify that such information is needed to secure support for your service *before* you endeavor to develop this information. Data from studies that demonstrated OPPC impact on use of health care services are featured in the [Additional Slides That Could Be Useful](#) deck available for download. Reference these studies in your presentation. In some instances, data from published studies are enough to convince administrators that an OPPC service will deliver value and should be supported.