

Special Article

Optimizing the Success of a Palliative Care Consult Service: How to Average Over 110 Consults Per Month

Steven Radwany, MD, Hallie Mason, MSN, CRNP, John Stephen Clarke, PhD, MD, Lynn Clough, MA, Linda Sims, PhD, and Teresa Albanese, PhD
Summa Health System, Akron, Ohio, USA

Abstract

The widespread need for palliative care has prompted the development of hospital-based palliative care consult services to provide a more interdisciplinary approach to managing advanced illness and end-of-life concerns. Establishing a successful consult service is a challenging task. This is a descriptive study of the development of a palliative care consult service (PCCS) within a non-profit, multi-hospital health system, and the five successful strategies used to optimize growth over the first five years. The PCCS is a mobile interdisciplinary team established to provide accessible, comprehensive end-of-life care and symptom management to patients with advanced illness within the health care system. Critical to its success, the team developed and maintained a database to document growth and ensure continuous quality improvement. A description of this database is provided, along with current performance outcomes. The program has prospered since its inception in 2002, with a 47% average annual growth over the first five years. The PCCS now averages 110 consults per month and has treated more than 3500 patients. This growth can be directly attributed to the five key strategies that have been used to plan, develop, and expand the program. J Pain Symptom Manage 2009;37:873–883. © 2009 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

Key Words

Palliative medicine, palliative care consult service, end of life, symptom management programs

Introduction

Palliative medicine is gaining acceptance as a means to provide a more interdisciplinary

approach to the health care of chronically and terminally ill patients. Formally recognized in the United States as a medical subspecialty in 2006,¹ the field is thriving with the development of hospital and community programs, physician and nurse certifications, and accreditation of fellowship programs by the Accreditation Council of Graduate Medical Education.^{2,3}

The advancing age of the population and rapid advancement in medical technology have led to increasing numbers of people

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Address correspondence to: Steven Radwany, MD, 55 Arch Street, Suite 1A, Akron, OH 44304-1698, USA. E-mail: radwanys@summa-health.org

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with serious, chronic illnesses who experience multiple hospitalizations. This has piqued interest in how chronic life-threatening illness is managed in the acute care setting. In the United States, about 70% of people die in a hospital, nursing home, or outpatient medical setting,⁴ and one in five Americans die in an intensive care unit (ICU).⁵ Examination of the issues and concerns surrounding the management of serious illness and end-of-life care has inspired the desire for more integrated approaches to assist patients and their families face the realities and decisions that accompany advanced illness.

The number of hospital-based palliative care programs throughout the world has grown dramatically in recent years. This growth suggests that these programs are effective in improving quality of life, pain and symptom management, patient understanding of the disease process and its prognosis, discharge planning, and resource utilization,⁶⁻⁹ at the same time as demonstrating positive impact on the cost of health care in this population.¹⁰

The establishment and growth of a palliative care consult service (PCCS) within a hospital system presents many challenges, both economic and cultural, to new palliative care providers. This article describes the development of a PCCS in a multi-hospital health system and the five key strategies used to optimize its success during the first five years.

Program Development

Summa Health System is a non-profit, multi-hospital health care system serving more than a half million patients each year in northeastern Ohio. It encompasses three teaching hospitals and 1235 licensed beds, logging over 38,000 inpatient admissions and 113,000 emergency room visits per year. The health care system also includes community health centers, a health plan, a physician-hospital organization, research programs, a philanthropic foundation, and other supporting organizations. Hospice of Summa was established and accepted its first patient in 1999 as part of senior services within this integrated delivery system. Beginning in 2002, five key strategies were used to develop and implement a new PCCS

for hospital inpatients within this service structure.

Planning

The initial planning phase utilized at Summa Health System included an Appreciative Inquiry Summit,¹¹⁻¹³ which allowed the organization to develop the consult service around the core values and vision of the health system and the needs of the community. In 2002, the Hospice of Summa hosted this planning session with the general purpose of developing an innovative program to address the end-of-life needs of hospitalized patients.

The Appreciative Inquiry Summit involved all program stakeholders, including hospital administrators, representatives from various departments and disciplines within the health system, leaders from affiliated and allied organizations, and members of the community. The inclusion of the stakeholders during this initial phase of development was crucial for generating strong, broadly based support for the program during the early stages. Involving multiple disciplines and system vice presidents, the chair of the system board and key physician leaders generated formidable authority and visibility for the program. This process ultimately served to enmesh the identity of the PCCS with senior services and with the core mission, vision, and values of Summa's integrated delivery system.

The planning phase also included site visits to organizations that offered palliative care services. Palliative care team members visited several programs, including The University of Pittsburgh Medical Center (UPMC), The McGaw Medical Center of Northwestern University, Mount Carmel Health System, the Midwest Hospice and Palliative Care Center, and the University of Toronto to evaluate their programs and "borrow" successful practices. The information gained from these visits was then incorporated into the planning of the PCCS at Summa.

The cost of establishing and maintaining a PCCS was studied, and funding opportunities were explored in order to assure the financial viability of the program. The palliative care team was able to develop a financial justification to support the program solely on the basis of shortening prolonged hospital and ICU stays. This was manifested as an initial focus

on critical care bed occupancy and length of stay (LOS) by the system, with a later focus on financial performance as the program grew.

A final step in the planning process included the establishment of the PCCS multidisciplinary advisory board to assist in ongoing strategic planning and program evaluation. Members meet twice annually and include physicians, nurses, social workers, chaplains, administrators, and a pharmacist.

The palliative care team was initially composed of a physician, nurse practitioner (NP), social worker, chaplain, pharmacist, and a dietitian. Of note, the physician was a credible leader in the organization, in medical education, and chair of the system ethics committee. The goal established for the PCCS was to provide accessible, comprehensive end-of-life care for patients with advanced illness. This care includes: symptom management, enhanced communication and care coordination, patient and family support, assistance with prebereavement concerns, discharge planning, and improved palliative care education. The PCCS team accepted its first consult in December 2002.

Education

Summa's Palliative Care and Hospice Services continues to develop and present educational programs to every major medical and nursing department in the system in order to increase knowledge of palliative care in general and deliver particular services offered by the PCCS. Annually, these include two grand rounds and one nursing grand rounds provided by the physician and NP members of the PCCS and visiting professors. This strategy not only benefits the organization and patients but also establishes recognition for the program and its team members, ultimately promoting referral to the service. The physician and nursing faculty has also implemented both didactic and clinical education programs in palliative care for medical and nursing students, residents, and fellows to promote improved end-of-life care while raising the profile of team-based palliative interventions. Annually, these include two conferences with surgical residents, two with internal medicine residents, and six with medical students. Since 2006, weekly conferences are held for palliative medicine fellows and often include geriatric fellows, doctoral level pharmacy students,

student NPs, residents, and medical students. Finally, community education through news media, invitations to community organizations, public presentations, and word of mouth, has prompted some families to directly request PCCS intervention.

Communication

The PCCS works to optimize communication with referring physicians, patient-care coordinators, staff nurses, care managers, support personnel, patients and families, as well as within the multidisciplinary team. This is a third key strategy that is essential for providing excellent palliative care to patients. It is the foundation for a smooth coordination of services and the effective use of resources, both of which lead to a successful consult service.

Initially, daily meetings were held with nurse leaders, ICU staff, discharge planners, and the PCCS team to discuss patients to promote the coordinated and cost-effective care of the critically ill. Patients were chosen for intervention based on a retrospective analysis of ICU deaths and included patients who were in ICU beds for more than two weeks, were from extended-care facilities, or had returned to the ICU within a short time after being transferred or discharged. The meetings helped the ICU staff to identify intensive care patients who could benefit from the consult service and allowed for more effective resource utilization at the appropriate level of care.

The strategies implemented to promote effective ongoing communication within the multidisciplinary team include weekly meetings with staff and care managers with emphasis on continual feedback to and from the referring health care providers. Team meetings promote a camaraderie, shared responsibility, and opportunity for the exchange of information, suggestions, and concerns. Communication is also promoted by allowing and encouraging primary nurses and social workers to participate in team meetings and family meetings.

Finally, the PCCS team takes responsibility and great pains to assure smooth transitions from hospital to home or nursing facility by providing physician to physician and/or NP to staff handoffs for critical patient information, including, but not limited to, goals of care, advance directives, and specific palliative

measures undertaken. These efforts promote early requests for palliative care consults if and when patients return to the hospital. Of the 2579 consults in the first five years of the PCCS, 375 were reconsults, pertaining to 294 individuals. It should be noted that 116 of the 375 reconsults were the result of admissions of Hospice of Summa patients for pain and symptom management.

Accessibility

From its inception, the PCCS was available to medical staff, nurses, patients, and families 24 hours a day, seven days a week. Additionally, daily follow-up of patients was provided with verbal, written, or electronic communication to nurses and to the referring service as needed. The PCCS assured access to the service by pager, 24-hour message line, and through the hospital electronic order-entry system.

System-wide changes increased accessibility to the service. The PCCS worked with large multidisciplinary teams to develop and implement order sets for palliative care and terminal ventilator weaning, promoting improved symptom management and end-of-life care according to established guidelines. These order sets could be used by physicians of varied disciplines to manage the care of their patients, with or without the assistance of the palliative care consult team. During this time, the hospital system initiated a computer order-entry program incorporating these order sets and adding the PCCS to the consult services menu, along with a selection of reasons for consult. Furthermore, the PCCS intentionally tailored its service to provide the level of assistance desired by the particular physician, ranging from minimal guidance and suggestions to full management of patient care. This titration is based on physician, NP, and registered nurse (RN) interactions and feedback in addition to the experience gained from sequential referrals over time from individual physicians. In addition, support for nursing and other staff in crisis is often provided by the PCCS through its NPs without requiring formal consultation. This specific important service has solidified relationships and built trust throughout the system.

Finally, the opening of a new hospital-based acute palliative care unit (APCU) in 2006 increased accessibility to palliative care services by offering an immediately available alternative

to the ICU for appropriate patients presenting to the Emergency Department. The original proforma for the APCU budgeted for an average LOS of four days and split expected admission sources among new hospice admissions and transfers from med-surgical, critical care, and other units. The APCU provides an environment suited to the delivery of optimal palliative care with increased coordination and continuity of care for patients as they transitioned in their needs and goals of care. The unit has accepted even the occasional patient on mechanical ventilation expected to be weaned and discontinued after transfer to the APCU.

Evaluation

A database was created and is maintained to record patient demographics and conditions, consult services provided, and the referral base dynamics. Considerable planning is necessary to identify data points to be gathered, balancing the need for information with the time needed to gather and enter data. Continuously gathering, updating, and analyzing this data allowed practice patterns and needs to be identified while assuaging a budget-conscious hospital leadership. The documentation of rapid growth in requests for the PCCS and the impact of the PCCS on the quality and cost of care for terminally ill patients provided clear justification for adding another palliative medicine specialist and NP to the team.

Members of the health care team, patients, and families are encouraged to provide the PCCS with suggestions to improve services by means of survey through the Professional Advisory Committee and the family-centered interviews. These efforts produced evidence that the goals and objectives of the PCCS were being met while identifying directions for future growth in meeting community needs.

Information gained from these performance evaluations, along with the parallel growth experienced by the hospice home care program, provided the hospice leadership with justification for the development of the APCU. The magnitude of growth in the PCCS made it clear that a dedicated unit for hospice and palliative care patients was feasible and necessary to provide optimal end-of-life care. The comfort-oriented approach to care required a more inviting, private, home-like environment to attend to the needs of

terminally ill patients and their families. The APCU has 12 private rooms, family rooms, a spa room, a communal kitchen for families, and a community room for family meetings and support groups. The addition of this unit promoted the efficient coordination of palliative care services and resources within the system while further identifying the demand for palliative care consultations.

Evaluating Performance

The PCCS database continues to be used to evaluate the success of the program and to ensure continuous quality improvement. All referred patients are entered into the database along with a unique identifier that allows linkages to the hospital's administrative data repository. This ensures that additional studies can be developed that incorporate clinical and financial data at the patient level. Within the PCCS database, the following elements of the consult are included for each patient: dates, follow-up dates, reasons for consultation, diagnoses, resuscitation status, referring physician, referring specialty, referring department, outcomes, and services provided (Table 1). The database software is Excel and is often imported into SPSS for additional analyses.

Provider satisfaction with program services was initially assessed through surveys distributed to nurse patient care coordinators and to physicians who had consulted the service on 20 or more patients. These two groups had sufficient experience with the service to provide valid and practical feedback. The physicians accounted for half of consult requests

during the five years since the program inception (1680 of 3341 consult requests). Two of those physicians included the directors of the palliative care and hospice services and were excluded. Of the 42 surveys that were distributed, 31 providers returned the surveys, with a total response rate of 74%. The physician response rate was 59% and the nurse response rate was 90%.

A cover letter, survey, and self-addressed stamped envelope were mailed to physician offices and hand delivered to patient care coordinators. The provider survey consists of seven questions regarding the practitioner's experience with the service, each rated on a 5-point scale. It asks providers to rate the availability, communication, helpfulness, benefit, and support of the PCCS. In open-ended questions, the respondents also are asked which of the PCCS services are most helpful and to list suggestions for improvement to the PCCS service. The survey questionnaire is provided in Appendix A. Respondents had the option of remaining anonymous. Survey responses were entered into an SPSS database for analysis.

Patient/family satisfaction is assessed through an ongoing qualitative study of families whose loved ones had died at some time after a PCCS consult in the ICU was performed.¹⁴ This research involved focus group and personal interview methods to elicit family members' satisfaction with care provided by the PCCS team and end-of-life decision making. Contact was attempted with the next of kin listed for 156 patients between August 2005 and August 2007. Family members were first contacted by a letter briefly describing the study, and later by phone. Of the 93 family members with whom we were able to make contact, 50 agreed to participate in the study, resulting in a 53.8% response rate.

Finally, program evaluation also includes studies of the financial impact of the PCCS and the palliative care unit. This is accomplished by linking cost-of-care data with the PCCS database information.¹⁵⁻¹⁷

Performance Results

Growth in Services

At the time of this report, the PCCS had treated a total of 3579 patients since program

Table 1

Palliative Care Consult Service Database

Database Content
Patient identification
Primary diagnosis
Patient demographics
Next of kin contact info
Consult outcome
Discharge disposition
Patient LOS in the service
Patient total LOS
Dates of consult and discharge
Referral source/source of consult
Referral source medical specialty
Unit source of consult
Reason for consult

inception. These patients represent 22,672 patient days in the service over the last five years. The annual consults increased from 289 in 2003 to over 1300 in 2007, with the average monthly palliative care consults growing from 15 to 110. The increased growth is represented in Fig. 1, and indicates an average annual growth rate of 47% during the first five years of the program.

Patient Population

The average age of patients referred to the service is 72 years, with a median of 75 years. The total PCCS population of 3579 patients represents 283 primary diagnoses, with more than half attributed to the following 10 diagnostic groupings, depicted in Table 2: lung cancer 10.7% ($n=323$), respiratory failure 11.6% ($n=351$), end-stage heart disease 10.0% ($n=302$), cerebral vascular accident 6.3% ($n=191$), debility 3.4% ($n=104$), end-stage chronic obstructive pulmonary disease 3.5% ($n=107$), end-stage renal disease 3.8% ($n=115$), end-stage lung disease 2.3% ($n=71$), breast cancer 2.5% ($n=76$), and colon cancer 2.5% ($n=76$).

Services

The documented reason for the palliative medicine consults varies, with some providing multiple reasons; over half provide "end-of-life issues" as reason for the need of palliative care services. End-of-life issues involve helping patients and families understand treatment options and prognosis, clarifying patient goals, and providing support and symptom control. The remaining specific indications for referral to the PCCS included pain and symptom

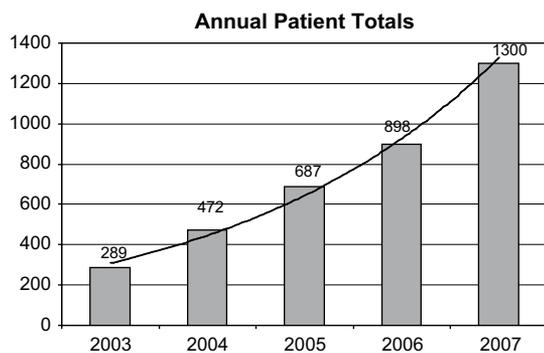


Fig. 1. Annual palliative care consults during the first five years of service (2003–2007).

Table 2
Primary Diagnoses of Palliative Care Consult Service Patients

Diagnosis	Cases n (%)
Lung cancer	378 (10.56)
Respiratory failure	363 (10.14)
End-stage heart disease	344 (9.61)
Cerebral vascular accident	219 (6.12)
Debility	143 (4.0)
End-stage chronic obstructive pulmonary disease	138 (3.86)
End-stage renal disease	133 (3.72)
End-stage lung disease	95 (2.65)
Breast cancer	94 (2.63)
Colon cancer	86 (2.40)
Miscellaneous	1671 (46.69)

management, support, decision making, discharge planning, cultural issues, and family request.

Referral Base

The consult cases originated from 309 physicians, with the majority of the cases from the following services: general internal medicine, intensive care, pulmonary and critical care medicine, hospital medicine, and oncology, as represented in Table 3. Despite the opening of a new critical care pavilion, the expected increases in consults from the intensive care and critical care areas were not realized, but referrals from the general medical-surgical floors steadily climbed. With the opening of the APCU, an increase in consults was noted, with 47% of the five-year total realized in the last 16 months of the five-year period. In particular, prior to the opening of the APCU, the emergency department (ED) was the source of only 14 consults in 44 months; the ensuing 16 months provided 113 consults from the ED. It is also interesting to note

Table 3
Service Origination of Palliative Care Consult Referrals

Referral Service	Cases
Internal medicine	1031
Intensive care and pulmonary/critical care	1111
Hospital medicine	330
Oncology	215
Family practice	159
Cardiology	126
Residents	94
Surgery	67
Hospice medical director	63

that the time to consult, defined as the number of days from hospital admission to date of consult, declined over the five years of service. Fig. 2 displays this decline based on specialty and patient location. We interpret this as a growing awareness of the service and the importance of timely referral.

The PCCS tracked the LOS and the effect of the PCCS involvement in patient care on LOS and bed availability for the system. It is difficult to find comparators to study the impact of the PCCS on LOS, because, despite the trends, continued delays for initiation of consultation still exist. As an alternative method, the number of medical-surgical and critical care hospital days saved were estimated jointly by the PCCS team, RN-patient care coordinators, and referring physicians. It was estimated that 1694 patient days in the ICU and 2451 days on the general medical-surgical floors were saved with the involvement of the PCCS (range: 0–14 days; mean 1.2 days per patient).¹⁸

Disposition

The majority of patients referred to the palliative service died in-house (46.8%, $n = 1674$) or progressed to hospice care (24.8%, $n = 889$), as seen in Fig. 3. The outcomes of the remainder of the PCCS patients included transfer to extended-care facilities, long-term acute care, rehabilitation centers, or home. A small percentage (0.4%) of patients were sent to other health care facilities or returned to the hospital. The PCCS signed off of 5% of the total patients seen, and the outcome of 3% of patients is unknown.

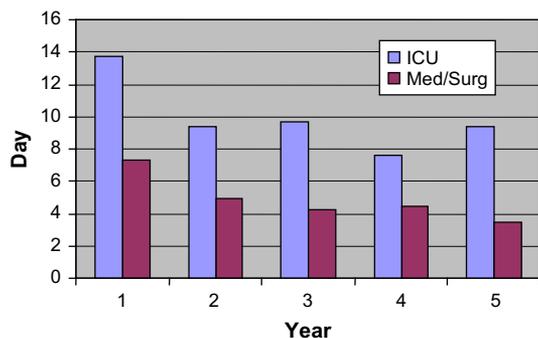


Fig. 2. Trends in time to consult during the first five years of service (2003–2007).

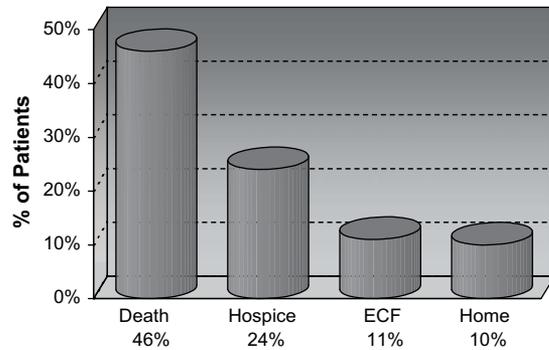


Fig. 3. PCCS discharge outcomes. The outcomes represent the advanced illnesses of the referred patients to the PCCS.

Provider Satisfaction

Results from the five-year satisfaction survey indicate that those health care providers who have used the service are highly satisfied. Ninety percent of providers rated the availability, communication, and helpfulness of the PCCS as very good or excellent. The benefit of the palliative care services to patients and their families was rated very good or excellent by 97% of the respondents. Ninety-three percent rated the support provided to the health care team as very good or excellent. Overall, physician responses were split equally between very good and excellent, whereas the majority of nurses describe the service as excellent in these areas. This probably is only indicative of the providers' different roles and expectations in the palliative care process. The comments regarding the most helpful services provided by the team indicates that the PCCS provides the information and emotional support that families need to clarify goals of care and to make end-of-life decisions.

Patient/Family Satisfaction

Semi-structured interviews were completed with 34 families who participated in a decision-making family meeting with the PCCS team.¹⁴ Families who recalled receiving support, full and understandable information, and having the appropriate amount of time for decision making expressed the least emotional burden three to six months after the death of their loved one. Additionally, subsequent care addressing patients' and families'

unique physical, emotional, and informational needs during the dying process was also associated with relief of emotional burden. Families' individual responses to the interview questions supported the need for an inpatient palliative care unit to attend to the unique care needs of terminally ill patients and their families. Results of this qualitative study will be reported separately.

Financial Impact Study

A difficulty in establishing the financial impact of PCCSs lies in the fact that they may not completely pay for themselves through billing for professional services. Instead, they benefit the hospital through cost avoidance and more appropriate use of resources: reducing un-reimbursed lengthy stays in the ICU—opening beds for those who need aggressive curative care and reducing nonbeneficial diagnostic tests and treatments. An observational study comparing palliative care patients with two controls matched for diagnosis, age, gender, and discharge outcome confirmed cost avoidance through reduced ICU stays and procedures, such as ventilation, tracheostomy, percutaneous endoscopic gastronomy (PEG), and cardioversion.¹⁵

Studies comparing pre-APCU costs on general medical floors and ICUs, and costs after transfer to the APCU show a \$500,000 annual cost avoidance attributed to the APCU.¹⁶ Much of this cost avoidance is realized by lower unit costs and the elimination of nonbeneficial diagnostic tests and services. The details of this extensive analysis are being prepared for a separate publication. An early retrospective case control study was conducted on matched samples of cancer and noncancer patients who died in the APCU, on general medical floors, and in the ICU. Patients who died in the APCU were matched by age, gender, and primary diagnosis with patients who died on general medical floors. Patients who were transferred to the APCU from the ICU served as their own controls, with only the last two days in the ICU compared to prevent bias. Results revealed significantly lower focused and direct costs on the APCU.¹⁷ The estimated savings of 4000 hospital days in the ICU and general medical-surgical floors, and cost analyses for patients' pre- and post-PCCS intervention, in addition to pre- and post-APCU

transfer, helped to strengthen support for the program.^{15,18}

Discussion

The increased recognition and need for palliative care services has led to the widespread development of programs in hospital settings. The subspecialty of palliative medicine is thriving and growing to meet the needs of a population that desires more integrated and patient-centered approaches to disease management and end-of-life care. The field has progressed to a point at which it is not only advantageous to discuss the implementation of palliative care programs in this setting, but also to examine the strategies that allow these programs to become viable and successful. Examination of the data obtained during the first five years of a hospital-based PCCS has allowed for the identification of five key strategies that have proven effective in optimizing its success. These strategies are summarized in Table 4 and include: planning, education, communication, accessibility, and performance evaluation.

These strategies are clearly not unique to Summa; in fact, many have been borrowed and adapted with the kind and generous support of many mentors throughout the United States and abroad. Summa's PCCS program

Table 4
Strategies for Developing a Palliative Care Consult Service

Planning	Appreciative Inquiry Summit Site visits Business plan Advisory board
Education	Health system Community Professionals
Communication	Within the PCCS team With staff, patients, and families With referring physicians With primary care physicians With physicians and staffs accepting transfers
Accessibility	24/7, 365 days a year Order sets Acute palliative care inpatient unit Staff support
Evaluation	Database Staff and physician feedback Cost analysis Family interviews

was defined and tailored to meet the specific larger needs of the health care system as it evolved. At a micro level, the services were offered with the ability to titrate the level of involvement preferred by the consulting service, an important consideration in an environment with an active geriatrics department and a family practice service that preferred to manage its own palliative care needs. This further demonstrates the degree of importance of planning the consult service within the context of the organization's culture to generate optimal institutional support for the program. Sustained leadership by a physician champion within the system and the continued involvement of the stakeholders helped to maintain this program's support.¹⁹

The creation and utilization of a consult database has not previously been described in the literature. However, it is an essential component to generate positive feedback loops for continuous quality improvement of services, to guide expansion, and to maintain support for the service. The PCCS team wanted to ensure that the needs of the patients and physicians it served were met and would continue to be met as the program grew. Through this feedback and continual assessment of its services, the PCCS team was able to plan and promote growth of the program. The growth of the PCCS, its demonstrated financial impact, and the associated growth in the system's own hospice program helped to justify hiring additional staff. The PCCS as it exists today is described in Table 5. This ability to promote and manage growth has previously been

highlighted as imperative to the success of a PCCS.¹⁹ The commitment to maintaining and analyzing information from a consult database has proven to be a key effort to complement previous recommendations for establishing and growing PCCSs.

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Table 5

Summa Health System's Palliative Care Consult Service Program Description

Daily staffing	1 FTE physician 2 FTE NPs 0.25 FTE social worker 0.25 FTE chaplain 0.10 FTE pharmacist 0.10 FTE dietitian
Daily census	Mean = 22; range = 15–30
New consults per month	Mean = 110; range = 90–140
Billable visits per month	Mean = 350; range = 300–400
Follow-up visits per patient	Mean = 4; range = 0–20
Triage procedures	Days through NPs Nights to palliative care physician
Database	Excel database managed by NPs

FTE = full-time employee; NP = nurse practitioner.

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Appendix

Provider Satisfaction Survey

Summa Health System, Palliative Care Consult Services (PCCS)

	Poor 1	Fair 2	Good 3	Very good 4	Excellent 5
<i>Please circle one response per question</i>					
1. How would you rate the availability of the PCCS to you? <i>Comments:</i>	1	2	3	4	5
2. How would you rate the communication between the PCCS and you? <i>Comments:</i>	1	2	3	4	5
3. How would you rate the helpfulness of the PCCS? <i>Comments:</i>	1	2	3	4	5
4. How would you rate the benefit of the PCCS to your patients and their families? <i>Comments:</i>	1	2	3	4	5
5. How would you rate the support the PCCS provides to the health care team? <i>Comments:</i>	1	2	3	4	5
6. What is the "one service" the PCCS provides that is most helpful?					
7. Please list suggestions for the PCCS to improve services.					

Please provide us with your feedback!

Thank you for your time and feedback!

Check here if you would like the Director of the PCCS, Dr. S. Radwany, MD, to contact you. []

Signature _____
(optional)

Phone/Pager _____
(optional)