

# LEADERSHIP & PROFESSIONAL DEVELOPMENT

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## Bringing an Inpatient Palliative Care Program to a Teaching Hospital: Lessons in Leadership

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Most people in the United States die in hospitals. In 2004, more than 50% of critically ill patients died in acute care settings (National Center for Health Statistics, Centers for Disease Control and Prevention, 2005). Patients in intensive care units (ICUs) have a mortality rate of 5%–40%, depending on type of critical care unit and severity of illness (Knaus, Wagner, Zimmerman, & Draper, 1993). Studies suggest that patients still die in hospitals with poor quality of life. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) documented in detail that many critically ill hospitalized people undergo prolonged deaths characterized by use of invasive life-sustaining medical technologies and that physician-patient-family communication is inadequate (SUPPORT principal investigators, 1995). Other studies have reported similar findings, including poor symptom control at the end of life for patients in ICUs (Desbiens, Wu, Broste, Wenger, & Connors, 1996; Hawryluck, Harvey, Lemieux-Charles, & Singer, 2002; Lynn et al., 1997) and family dissatisfaction with care that includes a lack of communication between families

and medical teams (Abbott, Sago, Breen, Abernethy, & Tulskey, 2001; Azoulay et al., 2000; Malacrida et al., 1998).

Kaufman (2005) stated that palliative care is a pragmatic attempt to introduce an alternative pathway for end-of-life care. Palliative care is an interdisciplinary team approach that improves the quality of life of patients and families living with life-threatening illness through early identification, assessment, and treatment of pain and other physical, psychological, and spiritual problems (World Health Organization, 2002). A study reported that palliative care programs are increasing in U.S. hospitals (Morrison, Maroney-Galin, Kralovec, & Meier, 2005). The authors cited a survey by the American Hospital Association (2003) that reported that palliative care programs increased from 632 (15% of hospitals) in 2000 to 1,027 (25% of hospitals). The increase may be explained by more hospital demand for better quality of care and mounting evidence that supports the benefits of palliative care programs.

Studies have demonstrated substantial reductions in direct and indirect costs associated with hospital palliative care compared with

conventional care (Campbell & Guzman, 2003; Gilmer et al., 2005; Schneiderman et al., 2003; Smith et al., 2003). Researchers have shown that proactive consultation with the palliative care team improves decision making, conflict resolution, and patient-family-physician communication, which, in turn, improves patients' quality of care and reduces lengths of stay in the ICU (Aulisio, Chaitin, & Arnold, 2004; Campbell & Frank, 1997; Campbell & Guzman; Carlson, Devich, & Frank, 1988; Dowdy, Robertson, & Bander, 1998; Field, Devich, & Carlson, 1989; Schneiderman, Gilmer, & Teetzel, 2000; White & Luce, 2004).

This article describes the process of developing an inpatient palliative care proposal, using a leadership model combined with business planning. The project was done as part of the lead author's participation in the Oncology Nursing Society's (ONS's) Leadership Development Institute. The project team, led by two advanced practice nurses, completed a pilot project in the ICU and then presented a proposal to hospital administration for an inpatient consultative palliative

### Leadership & Professional Development

This feature provides a platform for oncology nurses to illustrate the many ways that leadership may be realized and professional practice may transform cancer care. Possible submissions include but are not limited to overviews of projects, interviews with nurse leaders, and accounts of the application of leadership principles or theories to practice. Descriptions of activities, projects, or action plans that are ongoing or completed are

welcome. Manuscripts should clearly link the content to the impact on cancer care. Manuscripts should be six to eight double-spaced pages, exclusive of references and tables, and accompanied by a cover letter requesting consideration for this feature. For more information, contact Associate Editor Paula Klemm, PhD, RN, OCN®, at klemmpa@udel.edu or Associate Editor Judith K. Payne, PhD, RN, AOCN®, at payne031@mc.duke.edu

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care program that would function in collaboration with an existing outpatient palliative care program. One goal of this article is to demonstrate that the leadership model and business plan are replicable and appropriate for use in inpatient settings.

## Background

The Joan Karnell Cancer Center is affiliated with Pennsylvania Hospital, the nation's first hospital, founded in 1751. Pennsylvania Hospital is a 481-bed acute care facility in Philadelphia that is part of the University of Pennsylvania Health System. At Pennsylvania Hospital, approximately 1,200 new cases of cancer are diagnosed annually. Other services include cardiology, orthopedics, general surgery, and neuroscience.

An outpatient palliative care program was developed in 2003, and the outpatient team had noted multiple issues in the inpatient setting when patients were admitted, such as lack of advance directives, communication problems, inadequate symptom management, and extended stays in the ICU. The outpatient palliative care team developed a proposal to start an inpatient consultative palliative care program at its affiliated hospital, which included hiring a full-time palliative care nurse practitioner. The goals of developing a new inpatient consultative palliative care program were to link the outpatient and inpatient settings more closely, facilitate a smoother transition for patients and of information, improve symptom management, ensure patient safety, improve patient and family satisfaction, and expedite appropriate treatment and end-of-life decisions in critically ill patients. The addition of one full-time nurse practitioner as an inpatient program coordinator would allow for the development of a coordinated approach to inpatient care and communication among members of interdisciplinary teams. The foci of the proposal were the ICU and the oncology unit because those were the areas where most of the issues were identified.

Another key part of the proposal was to show that implementation of an inpatient palliative care consultation team would result in cost avoidance for the hospital, that the full-time nurse practitioner position would "pay for itself" over time through decreases in costs realized by shorter lengths of stay and fewer futile medical procedures.

## Theoretical Model

The five practices that comprise the Practices of Exemplary Leadership Model (Kouzes & Posner, 2002) (see Table 1) were combined with business planning to develop a pilot project and a proposal for senior hospital administrators.

**1. Model the way:** Making a case for a palliative care program required two initial steps: to establish a project team and to create a mission statement to clarify the team's values.

*Establish a project team:* The project team was responsible for the development of the

project. The team invested time and energy to collect and analyze the information necessary to demonstrate how improved palliative care would contribute to the hospital's goals and priorities. Careful thought was given to who should be involved in the task force to ensure appropriate expertise, authority, and inclusion of stakeholders.

- **Nurse leader:** The palliative care coordinator was the nurse leader. She was an advanced practice nurse with expertise in palliative care and credibility among her peers.
- **Cancer center leader:** The cancer center administrator was the cancer center leader. She was an advanced practice nurse with expertise in oncology and administration. She served as a liaison between the cancer center and hospital leaders and was a strong advocate for palliative care.
- **Physician leader:** The chief of hematology/oncology and medical director of the palliative care program at the cancer center was the physician leader. He was board certified in palliative care, had a strong commitment to palliative care, and was respected among his peers. He promoted the program to the medical community of the hospital.
- **Cancer center social workers:** The social workers participated actively in an ICU palliative care pilot project developed as part of the proposal to support the clinical case.
- **Hospital information representative:** The clinical director of quality and patient safety was the hospital information representative. She played a key role in the development of the financial case.
- **Internal medicine resident:** This physician participated in the ICU palliative care pilot project. He was a strong supporter of a palliative care program in critical care units and a representative for the inpatient staff who validated the need that the outpatient team had identified.
- **Oncology clinical nurse specialist:** She participated in the ICU palliative care pilot project by conducting a satisfaction survey, used to support the proposal.
- **Chaplain:** She participated in the ICU palliative care pilot project by providing spiritual care to patients and families. She also represented the inpatient staff, garnering more support for the proposal from the inpatient setting.
- **Palliative care administrative assistant:** She was actively involved with the logistics of the proposal.

*Create a mission statement:* An agreed-upon mission statement is the cornerstone of any project. Effective palliative care proponents understand the importance of validating two mission statements—that of the palliative care team and that of the hospital. Palliative care team members needed to build a mission statement that reflected their own personal values, general direction, and organizational

purpose. At the same time, the palliative care proponents had to understand the priorities of hospital leaders to ensure that the program's mission statement was congruent with the hospital's mission.

During the process of building the case for a hospital-based palliative care program, proponents needed to consider the perspective of hospital administrators. Although quality of care and clinical outcomes are common goals for palliative care advocates and administrators, financial stability is an additional concern for administrators. Therefore, proponents needed to focus their proposal on the financial impact of the proposed changes in addition to the clinical results. The process of aligning the palliative care program's goals with the hospital's mission and priorities is called "mission alignment" (Center to Advance Palliative Care, 2004).

The cancer center's mission and the hospital's mission shared a common goal: to improve patients' quality of life. The introduction of the proposal included a paragraph acknowledging the values of both mission statements.

**2. Inspire a shared vision:** Imagining the future of the palliative care program with exciting opportunities for the cancer center, the hospital, and the team was part of creating a vision. The palliative care coordinator developed a three-year strategic plan for the palliative care program. The plan included the mission that already had been agreed upon by the team, along with the vision. The vision included a number of goals; one of them was to start a palliative care consultative inpatient program at the hospital. In 2003, a proposal to start a palliative care program at the hospital was submitted to the hospital administrators by the outpatient palliative care team. The proposal was rejected because the information supporting it was based on data from other hospitals in the country and was not specific to the hospital. Because all shared the vision and because the desire to achieve the goal of starting a program remained, the palliative care team decided to work on a second proposal that would use a new plan (see Figure 1).

**3. Challenge the process.** The strategic plan to develop a stronger proposal using the hospital's own data included four major steps, as proposed by the Center to Advance Palliative Care (2004): (a) conducting a system assessment, (b) developing the clinical case, (c) developing the financial case, and (d) describing the proposed palliative care program. The task force was challenged to accomplish the steps in a three-month period for the revised proposal to be considered for the next fiscal year.

- Conducting a system assessment included identifying patients who would benefit from the palliative care program as well as determining key people in the hospital who would support it. Patients in the ICU,

**Table 1. The Practices of Exemplary Leadership Model**

Practice	Definition	Examples From This Project
Model the way.	To earn the right and the respect to lead through direct individual involvement and action	<ul style="list-style-type: none"> <li>Establish a project team.</li> <li>Create a mission statement for a palliative care program.</li> <li>Validate the hospital's mission statement.</li> </ul>
Inspire a shared vision.	To envision the future by imagining exciting and ennobling possibilities; to enlist others in a common vision by appealing to shared aspirations	<ul style="list-style-type: none"> <li>Envision the future of a palliative care program, including an inpatient palliative care consultation service through the development of a strategic plan for palliative care at the hospital.</li> <li>Obtain consensus of the goal by the entire team.</li> </ul>
Challenge the process.	The recognition of good ideas, the support of those ideas, and the willingness to challenge the system to get new products, processes, and services	<ul style="list-style-type: none"> <li>Identify the challenges.</li> <li>Create a proposal for an inpatient palliative care consultation service by developing a business plan.                             <ul style="list-style-type: none"> <li>Conduct a system assessment.</li> <li>Develop the clinical case.</li> <li>Develop the financial case.</li> <li>Describe the proposed palliative care program.</li> </ul> </li> <li>Complete the project in a three-month time frame to propose the addition of a new full-time employee for an inpatient palliative care coordinator for consideration in the budget process for the next fiscal year.</li> <li>Present the proposal to the hospital administration, customized to the hospital by using its own inpatient data.</li> </ul>
Enable others to act.	To foster collaboration by promoting cooperative goals and building trust; to strengthen others by sharing power and discretion; a team effort	<ul style="list-style-type: none"> <li>Strong, cooperative teamwork is required among team members, including additional work hours.</li> <li>Cooperative teamwork was essential when implementing a palliative care pilot project and developing the financial case.</li> </ul>
Encourage the heart.	To recognize contributions by showing appreciation for individual excellence	<ul style="list-style-type: none"> <li>A personalized thank-you card was given to each team member in appreciation for the excellent work accomplished.</li> </ul>

*Note.* Based on information from Kouzes & Posner, 2002.

the oncology service, and patients with sickle cell anemia were identified as those who would benefit the most. Clinical nurse specialists, nurse managers, nursing staff, some physicians, and a hospital leader involved with those services were identified as palliative care supporters.

- Developing the clinical case involved gathering information regarding how the palliative care program would improve quality of care, patient satisfaction, and staff satisfaction. The clinical case for the proposal included data mostly from the ICU palliative care pilot project. Data from other research studies also were incorporated.
- Developing the financial case involved demonstrating how the palliative care program could decrease hospital expenses. The major goal of the financial case was to estimate the volume of patients who would benefit from the palliative care program. Although many patients could benefit from the program, efforts focused on patients suffering from chronic or life-threatening diseases. Two methods were used to predict patient volume for the program: national mortality data used to calculate a percentage of the hospital's total admissions and documentation of numbers of diagnosis-related groups (DRGs) with high inpatient death rates. To calculate the potential financial benefit from

a palliative care program, the proposal used a combination of high-potential DRGs and the advanced impact calculator designed by the Center to Advance Palliative Care (visit [www.capc.org](http://www.capc.org)). Patient volume was predicted by using available hospital statistics. Patient admissions data were filtered by selection of DRGs with different variables, including patients with unmet palliative care needs, high mortality rates, highest costs, specific units in the hospital (obstetric and psychiatric services were excluded), and lengths of stay. After the data were run and filtered several times, approximately 20 DRGs were included. The advanced impact calculator estimated potential financial savings for the hospital from a palliative care program. The calculator used the following hospital data: average length of stay in days, average total cost per day, number of staffed beds, average hospital occupancy rate, total number of discharges per year, and estimated deaths per year. The estimated total annual savings was almost \$250,000 if 20% of potential patients were referred to a proposed palliative care program (see Figure 2).

- Describing the proposed palliative care program included a clear statement explaining the specific request, how the palliative care program would be configured

using current hospital resources, objectives of the palliative care program, description of the nurse practitioner palliative care role (see Figure 3), estimated costs for the program, and alternate sources of funding (see Figure 4). Finally, the conclusions pinpointed specific benefits of the proposed palliative care program.

**4. Enable others to act:** The entire proposal required strong cooperative work among the team members. However, the areas where teamwork was needed most included implementation of the ICU palliative care pilot project at the hospital and development of the financial case.

As part of a two-month pilot project, the outpatient palliative care team from the cancer center agreed to provide services to ICU patients and families in the hospital. The purpose of the pilot project was to assess the effect of a palliative care program in the ICU and to gather data for the main proposal. The ICU staff was surveyed at the completion of the project to evaluate the level of satisfaction with the palliative care interventions. A strong commitment from the team was needed to complete the pilot project, especially because it demanded additional hours of work.

The clinical director of quality and patient safety was the primary team member working on the financial part of the proposal. She

**May 2002:** funding obtained for outpatient palliative care program

**January 2003:** outpatient palliative care program developed; patients enrolled in the program

**July 2003:** proposal for inpatient palliative care program submitted

**October 2003:** proposal denied

**July 2004:** new coordinator hired for outpatient program; strategic plan for program developed, which included new proposal for inpatient program

**November 2005:** pilot project started in intensive care unit (ICU)

**January 2006:** ICU pilot project completed

**March 2006:** inpatient palliative care proposal presented to senior administration

**April 2006:** inpatient palliative care proposal approved

**July 2006:** funding identified; new program started in January 2007

**January 2007:** nurse practitioner position budgeted for July 2007

## Figure 1. Timeline

agreed to research the hospital data to calculate the potential cost savings of an inpatient palliative care program.

**5. Encourage the heart:** After two months of hard work, the palliative care proposal was completed. Because the project required many staff members to work above and beyond their job duties, the project leaders recognized their dedication and their contributions to the success of the project during the two-month process and at the completion of their work. The work also was emotionally draining because the team was working with many families facing end-of-life decisions; therefore, providing support and encouragement along the way was especially significant.

Average length of stay: 4.7 days  
Average total cost per day (hospitalwide): \$1,800  
Number of staffed beds in the hospital: 397  
Average hospital occupancy rate: 82%  
Total hospital discharges per year: 21,402  
Estimated number of potential patients needing palliative care: 1,070  
Estimated total annual savings, depending on percentage of potential patients referred

- 20%: \$469,944
- 30%: \$704,916
- 40%: \$939,888
- 50%: \$1,174,860

## Figure 2. Potential Financial Effects of a Palliative Care Program at the Hospital

## Presenting the Proposal

A two-step process was required for the proposal to be approved by hospital administrators. First, the proposal had to be approved by the hospital's chief nursing officer; second, the chief nursing officer had to present the proposal to the senior hospital administrators for approval.

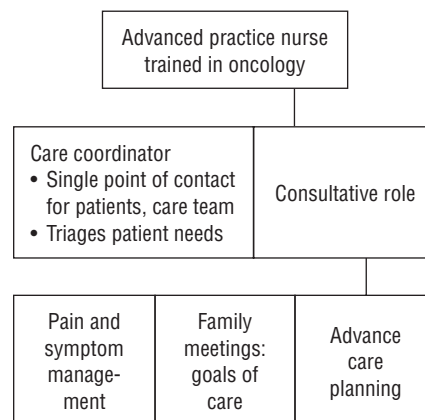
In January 2006, the representatives of the palliative care program and the cancer center met with the chief nursing officer and introduced the palliative care proposal using a slide presentation and a written, detailed proposal. The chief nursing officer approved and supported the proposal. In April 2006, the proposal was presented to senior hospital administrators, who supported and approved the initiative. The leadership team developed a creative strategy for funding the full-time nurse practitioner position, using partial funding from an existing position and partial funding from a two-year grant from a local foundation. An oncology clinical nurse specialist who was a current hospital employee with hospice and palliative care experience and who recently had completed a nurse practitioner program was identified as the ideal candidate for the position.

## Lessons in Leadership

The project illustrates how several nurse leaders backed by a supportive and dedicated interdisciplinary team were able to propose and promote an inpatient palliative care program that had the potential to affect the lives of hospitalized patients and their families. By using internal resources (inpatient and outpatient staff and physician and hospital leaders) and external resources (tools provided by professional organizations, such as the Center to Advance Palliative Care and the ONS Leadership Development Institute), as well as data from their own institution, they were able to make a compelling case to improve the care of patients. In addition, the data showed that the nurse practitioner or coordinator position could pay for itself over time through cost avoidance. An inpatient palliative care program also could be seen as a way to improve patient safety by facilitating the transfer of patients and information, improving communication between inpatient and outpatient staff, and thereby potentially improving patient and family satisfaction.

## Implications for Oncology Nurses

Palliative care programs can be used as a strategy to improve the quality of care of patients with cancer and other chronic illnesses. Palliative care programs can have a significant effect on end-of-life care, patient and family satisfaction, nursing retention, and avoidance of unnecessary costs. Using basic concepts of leadership and business management, oncology nurses and other healthcare professionals can develop palliative care projects in their institutions. The



**Figure 3. Inpatient Palliative Care Nurse Practitioner Role**

Center to Advance Palliative Care tools and support are readily available to assist in developing proposals for palliative care using hospital-specific data.

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## Proposal

To start an inpatient palliative care consultation program by hiring a full-time palliative care nurse practitioner

## Emphasis

Oncology unit and intensive care unit

## Main Objectives

- Increase the quality of life of patients by improving symptom management.
- Improve patient and family satisfaction.
- Decrease hospital costs; reduce lengths of stay.
- Improve patient safety.
- Improve job satisfaction and staff retention.
- Ensure compliance to regulatory organizations.

## Inpatient Palliative Care Team

- Palliative care nurse practitioner: one full-time-equivalent new position
- Physician coordinator: a team of existing physicians in various specialties rotating to cover the service
- Social worker: existing position
- Chaplain: volunteer from chaplaincy training program
- Psychologist: existing position; psychology interns rotating through inpatient services

## Figure 4. Palliative Care Program Proposal

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