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RESEARCH LETTER

Learning From Those Without: Identifying Barriers and Creating Solutions to Establishing Hospital Palliative Care Services

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Palliative care (PC) focuses on relieving distressing symptoms such as pain, dyspnea, fatigue, and depression; providing psychological, social, emotional, and spiritual support; and helping patients choose treatments consistent with their values.[1] Palliative care consultation services (PCSs) increase patient and family satisfaction,[2,3] improve quality of life,[4] reduce resource utilization,[5] and decrease hospital expenditure.[2,6] Hospitals that fund a PCS typically realize a sizable return on investment and good value, as these services provide better care at lower cost.[7] These benefits provide a strong rationale for all hospitals to establish a PCS. However, only 53% of acute care hospitals in California offer PC services, and only 37% have a hospital-based PCS.[7] To increase access for patients with serious illness, it is necessary to understand the barriers that hinder the development of PCS. In this study, we asked leaders from hospitals without a PCS to describe these barriers and identify strategies that could overcome them and promote PCSs.

METHODS

In 2011, we surveyed all acute care hospitals in California to assess the prevalence of PCSs in the state. We defined a PCS as "an interdisciplinary team that sees patients, identifies needs, makes treatment recommendations, facilitates patient and/or family decision making, and/or directly provides palliative care for patients with life-threatening illness and their families." Hospitals that did not have a PCS were asked questions regarding plans to establish one (Is there an effort underway to establish a palliative care program in your hospital?), perceived barriers to starting one (What are 3 significant barriers or circumstances that have prevented your hospital from creating a palliative care program?), and ideas for overcoming barriers (What resources, training, policy changes would be most helpful in overcoming those barriers?). Questions that allowed for open-ended responses were analyzed using a thematic approach.[8] Themes were initially reviewed by 1 researcher (C.J.B.), then refined and confirmed at each stage using an iterative process with other research team members (D.L.O., S.Z.P.) to reduce potential biases. Questions assessing hospital characteristics and status toward establishing a PCS provided a list of possible answers. Frequencies to these responses are reported accordingly.

RESULTS

Surveys were distributed to 376 acute care hospitals in California, of which 360 responded to the survey, resulting in a 96% response rate. Of the 360 hospitals surveyed, 46% (n = 166) reported not offering any PCS. Out of the 166 that did not have PCS, 7 stated they had a PCS at some point in the last 5 years, but the program was discontinued. Hospitals without a PCS were largely for profit (75%, n = 125), small with <150 beds (72%, n = 120), and not affiliated with a system (63%, n = 105). Overall, 34% (43/128) of hospitals reported that they had efforts underway to establish one, with 21% (9/43) expecting to start seeing patients within a year. Seventy-two hospitals (56%, 72/128) reported that providers from local hospices aided them in providing their patients with PC, and that this approach met the needs of their patients. A total of 93 hospitals identified multiple barriers (n = 186) to establishing a PCS, of which 162 responses could be categorized into 5 meaningful themes. Regarding strategies to overcome these barriers, 65 hospitals provided 72 responses that could be categorized into 5 meaningful themes (Table 1).

DISCUSSION

Despite citing obstacles to providing PCSs, one-third of hospitals surveyed report that they are planning to establish a program. As an alternative, many hospitals without a PCS reported that they provide their patients with PC through partnerships with local hospice services. This approach may provide some hospitals with a practical alternative to having a PCS, especially in smaller institutions where budgets and the need for PC are proportionally small. Future surveys should account for this approach to providing PCS to patients. Sharing the strong evidence of return on investment from PCS[6,7] with hospital leaders could help overcome the perceived barrier of cost and garner financial support. Training programs and technical

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TABLE 1. Barriers to Establishing a PCS and Strategies to Overcome Barriers

Barriers and Strategies	Responses, % (n)
Main barriers to establishing a PCS	93 hospitals provided 186 barriers
Insufficient funding and/or resources	31 (58)
Insufficient staff to support a PCS	20 (37)
Perceived lack of need for a PCS	14 (27)
Lack of support among non–palliative care physicians	13 (25)
Competing priorities	8 (15)
Don't know/unsure	14 (24)
Main strategies to overcome barriers to establishing a PCS	65 hospitals provided 72 strategies
Reroute funding to establish a PCS	28 (20)
Explain benefits of PCS to staff and community	24 (17)
Provide a framework for how to establish a PCS	21 (15)
Staff for a PCS	18 (13)
Physician support	10 (7)

NOTE: **Abbreviations:** PCS, palliative care consultation service.

assistance provided by the Palliative Care Leadership Center initiative and the Center to Advance Palliative Care have a proven track record in helping hospitals establish a PCS through mentored training,[9] and the End-of-Life Nursing Education Consortium has demonstrated effectiveness with nursing education.[10] These programs could provide the resources that many hospitals seek. Educating hospital leaders and clinicians about the evidence for PCSs improving care for patients with serious illness may further help to engender support for PCSs. One barrier that may be more difficult to overcome is the lack of trained PC clinicians. Efforts to educate and train generalist clinicians in primary PC may mitigate this shortfall.[1] Increasing the number of trained primary PC clinicians may also reduce fragmentation in patient care and reduce burden on specialist PC clinicians.[11] Specialty PC clinicians can also lend their expertise to hospitals seeking to start a PCS to achieve the goal of universal access to PCS.

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