



National Hospice and Palliative Care Organization
Palliative Care Resource Series

**CREATING SUPPORT FOR YOUR
COMMUNITY-BASED PALLIATIVE
CARE PROGRAM**

Daniel Maison, MD FAAHPM

INTRODUCTION

Hospice organizations are completely dependent on referrals from their caregiving partners. Hospice staff are invited guests each and every time they are asked to participate in the care of a patient.

Developing buy in from referral sources is essential to the ongoing success of hospice work. Referring partners must understand and embrace the importance and benefit of the services hospices offer to their patients. This fact is especially important when hospice organizations are considering launching a new program, such as palliative care. If a perfect program is created but unused, precious resources (time, talent, and finances) will have been wasted.

This article will focus on understanding what motivates referral sources to make decisions. Suggestions will be presented for collecting practical information to help serve referral sources' spoken and unspoken needs for facilitating an understanding of the benefits of the hospice organization's new palliative care program.

TAKE A STEP BACK

Let's ask some big questions that are often left unasked. Why are patients referred to a particular program? What do referral sources see as the benefit for their patients? What do they see as the benefit to themselves? Common motivators for making any decision include the following:

1. It is the right thing to do.
2. It benefits me in some way.
3. It benefits someone I care about (patients) in some way.
4. We have always done it that way.

Would referring a patient to the palliative care program satisfy any of these four motivators in decision making? If a hospice organization is well established and has good relationships with referring partners, picking up the phone and referring a patient may satisfy all four of these motivators for a particular physician. What about the non-referring sources in the community? There may be additional patients a palliative program could be serving.

ASSESSMENT

The simple way to get answers to the complex question, “Why don’t they refer?” is to go to the source and ask. The how, what, and who to ask is more challenging. There are a variety of ways to get your questions answered.

1. Determine the type of information you wish to gather and the questions that will follow:

- What are your thoughts about our hospice starting a palliative care program?
- Do you have patients we could help by offering such a program?

2. Decide how to ask the questions. Here is a partial list of ways to query referring partners:

Ask them one-on-one

Getting 15 minutes with a referring physician can be invaluable. However, going door to door to door is labor intensive, time consuming, and not always successful. Often the referral sources who are least likely to sit and speak with a hospice organization are the ones the hospice wants to reach!

Conduct a survey

Conducting a survey tends to be much more economical. A mass mailing is much more time efficient than meeting each and every person on the mailing list. The question is how many people will actually take the time to respond? Experience has shown that people who answer surveys tend to be at two extremes—those who are happy with services and those who are unhappy with them. The ones in the middle do not tend to respond as much and they are often the ones with whom connection is needed the most.

Hold a focus group

Gathering a focus group consisting of key community partners may yield beneficial information to help build a new palliative care program. However, focus groups require a fair amount of staff time and preparation and can result in minimal participation. Continuing to reach out to potential referral sources over time can assist the hospice in obtaining helpful data.

Form an advisory board

Invite a variety of individuals from your community to join your advisory board. The group might include representatives of potential referral sources, a few members of your Board of Directors and 2-3 consumers.

Invite key physicians to join the board

There is an old administrative trick of inviting the biggest critic of an organization to chair the program committee. This can transform critics into supporters and strengthen the program and community relationships.

Understand that there is no “best way” to go about gathering information. Each strategy has its pros and cons. Trial and error should be expected and is okay.

Now that data has been mined and some questions have been answered, what else has been accomplished? Every referral source that has been talked to has felt heard. Buy-in has been generated by asking them to help the palliative care program meet their needs.

LESSONS LEARNED FROM A PALLIATIVE CARE PROGRAM

A. I was asked to see a physician who had concerns about our services. He said whenever he referred a patient to us, he never heard about the patient again until he/she had died. After meeting with him for an hour or so, we developed a plan that he personally reviewed with us. Per his request, the next time he sent us a patient, we called him for all orders, consulted with him at every change in the patient's condition, and sent him the death certificate when the patient died.

The physician did not return our calls for orders, did not respond when we tried to report any changes, and did not return repeated calls from the funeral home. He also called us a day after his patient died and asked why we were bothering him with so many phone calls.

The physician asked for very specific things and when we provided them, he complained. The next time he referred a patient to our hospice, we took care of everything and we let him know when his patient had died. In other words, we did exactly what we had done prior to our meeting to discuss his concerns. He now sends us one to two patients per month (up from one or two per year) and is "very pleased" with our services.

Sometimes, as in this case, what was really being requested was to be heard and validated. Often, concerns and criticisms evaporate when those expressing them feel that their issues have been understood. We focused on results and it worked. B. We met with local physicians. The physicians said that their biggest barrier to referral was our inability to provide certain palliative treatments (e.g. blood transfusions). We came up with a comprehensive plan, did extensive training with our staff, and greatly broadened the scope of the palliative treatments we provided. After six months of hard work, we rolled our new services out to these physicians. Referrals were flat and length of stay did not budge.

Things stayed the same until one of their patients ended up in the emergency room at 2:00 am (the family called 911 without calling us). The emergency room contacted one of the group's physicians who was furious and blamed us for the patient going to the emergency room. The physician demanded meeting with us to tell us they would not refer a patient to our hospice again. Of course, referrals decreased.

We invited the head of the physician group to join an advisory board. He agreed immediately. We made him feel heard and validated. Since then, we have enjoyed an increasingly positive relationship with that physician group and referrals have increased. The next time there was an issue with one of their patients, they gave us the benefit of the doubt and we were able to address the issue the following day without any repercussions to our relationship or referrals.

CONCLUSION

The first step in getting the community on board is to figure out what motivates them and what they want from a palliative care provider. There are many ways to gather this information and trial and error is inevitable. The process of gathering information is often as helpful as the actual data collected.