



Compassion in Action: A Population Health Approach to Palliative Care

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The good news is that we are living longer than ever. The average lifespan in the U.S. is 80 years compared to just 50 in the year 1900. In 2010, there were 5.5 million Americans over age 85. By 2050, that number is expected to nearly quadruple to 19 million.¹ The bad news is that despite these gains in longevity, the death rate hasn't budged—it remains stuck at 100 percent. Yet within this sobering statistic lurks another stark reality. While we are likely to live longer, we are also likely to spend part of that time, years or decades, with a serious illness like cancer, Parkinson's disease, or heart failure. In fact, two-thirds of Americans over age 65 have a serious illness. Unfortunately, in the current healthcare system, people with serious illness often receive care they do not want and from which they will not benefit (e.g., ICU care for someone dying of leukemia) and fail to receive care they do want from which they will benefit (e.g., good pain control for someone with pancreatic cancer). The last months of life are too often characterized by repeated hospitalizations, high healthcare utilization, and poor quality of care.² The results are unnecessary suffering and stress for patients and their loved ones. As healthcare leaders, we can and must do better. Palliative care offers an effective, proven approach to do just that.

Benefits Reach beyond End-of-Life Care

Put simply, palliative care is medical care focused on improving quality of life for people with serious illness. Misperceptions persist among patients and healthcare professionals that palliative care is just for end of life. While palliative care teams certainly have expertise in easing suffering at the end of life, palliative care also provides many benefits for people with cancer, heart failure, and Parkinson's disease,

1 AARP, "The Next Four Decades 2010–2050," May 2010.

2 Institute of Medicine, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, Washington, DC: The National Academies Press, 2015.

among others, throughout the course of illness. By providing expert symptom management, communication about treatment preferences and goals, and psycho-social-spiritual support, palliative care teams do everything good we want for patients—relieve pain and shortness of breath, improve quality of life, increase satisfaction with care, and reduce unnecessary healthcare utilization.³ In some studies patients receiving palliative care even live longer. By applying a population-based approach to palliative care for people with serious illness, healthcare leaders can ensure these benefits for their patients, families, and institutions. It is easiest to implement a population-based approach to palliative care by setting (inpatient,

→ Key Board Takeaways

Boards play a key role in defining the vision and strategy for the organization. Asking a few key questions and advocating for a larger role for palliative care services can help board members promote high-quality care for the most seriously ill patients:

- What palliative care services do we offer? In which settings and for which patients?
- How do we know that patients who can benefit from palliative care or are in need of such care are receiving it when and where they need it?
- What palliative care quality measures do our palliative care teams monitor and what is our performance compared to similar organizations?
- Where are there opportunities to engage our palliative care services in other important initiative and strategic goals like access and value?
- How can we integrate palliative care with our population health strategy?
- How can a population health approach involving palliative care help us achieve better health equity?

3 Marie Bakitas, et al., “Effects of a Palliative Care Intervention on Clinical Outcomes in Patients with Advanced Cancer,” *JAMA*, August 19, 2009; Jennifer Temel, et al., “Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer,” *New England Journal of Medicine*, August 19, 2010; Joseph Rogers, et al., “The Palliative Care in Heart Failure (PAL-HF) Randomized, Controlled Clinical Trial,” *Journal of the American College of Cardiology*, July 18, 2017; Steven Pantilat, et al., “Comparison of Integrated Outpatient Palliative Care With Standard Care in Patients With Parkinson Disease and Related Disorders,” *JAMA Neurology*, May 1, 2020.

outpatient, home) and to target the limited resource of specialty palliative care to the neediest patients.

A Population-Based Approach to Palliative Care

Most people with serious illness will spend time in the hospital for treatments, management of complications due to those treatments, and exacerbations of illness. As with many healthcare services, the current approach to palliative care in the inpatient setting is reactive—palliative care teams see the patients they are asked to see. Unfortunately, this approach leaves out many patients with significant palliative care needs and allows for unconscious bias in referrals.

A novel, proactive, population-based approach is to use the electronic medical record (EMR) to find patients who would benefit from specialty palliative care.⁴ At the University of California, San Francisco (UCSF), we have been piloting such an approach. We developed an algorithm to identify inpatients with serious illness as a first step to finding those with palliative care needs where we:

- Designated some services, such as malignant hematology and advanced heart failure, as “serious illness teams” and assumed all their patients have some palliative care needs.
- Indicated that patients in the ICU for more than 48 hours are likely to have palliative care needs.
- Adapted a list of “serious illness” ICD-10 codes⁵ to identify patients not captured with the first two criteria and added a search in the EMR for the word “metastatic” because we found in chart review that many people with metastatic cancer did not have those ICD-10 codes.
- Included people over age 75 with a prior admission in the past year who were not captured by these other criteria.

Over half of patients in our 516-bed hospital were identified as having a serious illness on any given day. We are now working on processes to determine what their palliative care needs are and how best to address those needs, including through palliative

- 4 Robert Wachter, Timothy Judson, and Michelle Mourad, “Reimagining Specialty Consultation in the Digital Age: The Potential Role of Targeted Automatic Electronic Consultations,” *JAMA*, August 6, 2019.
- 5 Amy Kelley, et al., “Identifying Older Adults with Serious Illness: Transitioning from ICD-9 to ICD-10,” *Journal of Pain and Symptom Management*, June 2019.

care consultation. This approach will undoubtedly find many more patients who need palliative care than are currently receiving it or than our teams can see. Nonetheless, this systematic, population-based, proactive approach will allow us to allocate our resources to those patients that need them most and decide whether to expand our palliative care capacity.

Short of this EMR-based screening approach, a hospital can focus the work of a palliative care team to have the greatest impact. Analysis of the Palliative Care Quality Network (PCQN), a large, national database with patient-level outcomes collected by palliative care teams, found that one quarter of patients referred for palliative care consultation have moderate to severe pain, and 40 percent of those patients were not referred for pain.⁶ Overall, the PCQN data shows that palliative care teams are able to improve pain in 80 percent of patients with moderate to severe pain and reduce their hospital length of stay by two days. Furthermore, when the palliative care team sees the patient on hospital day one, pain is more likely to improve and length of stay is shorter by an average of 1.5 days. Taken together, these findings show that seeing patients on hospital day one is associated with better quality (improved pain) and reduced utilization (shorter length of stay). Instituting protocols to identify patients with serious illness and pain in the emergency department and embedding palliative care teams with teams that care for many sick patients—like the ICU or advanced lung service—can help get palliative care teams engaged sooner and achieve better outcomes.

The best data for the benefits of specialty palliative care are in the outpatient setting. The potential need for specialty palliative care in the outpatient setting is huge and identifying the neediest patients is critical to maximize impact. Palliative care teams can apply a population-based approach by targeting clinics enriched for people with serious illness. For example, at UCSF we have close collaborations with the ALS clinic, interstitial lung disease clinic,⁷ hepatology clinic, and Parkinson’s disease clinic. These practices care for patients that, by definition, have a life-limiting serious illness. Working with the clinicians in those practices has fostered a close partnership leading to more and earlier referrals to palliative care. This collaboration also supports mutual

6 Steven Pantilat, et al., “Identifying Opportunities to Improve Pain Among Patients with Serious Illness,” *Journal of Pain and Symptom Management*, 2018.

7 Steven Pantilat, et al., “Better Together: A Mixed-Methods Study of Palliative Care Co-Management for Patients with Interstitial Lung Disease,” *Journal of Palliative Medicine*, June 11, 2021.

education that improves the care of patients. In our palliative care clinic, we follow patients for a median of seven months and up to three years. We found reductions in hospitalizations and hospital days in the six months after referral compared to the six months before. We also refer 62 percent of patients to hospice, compared to 45 percent of Americans that die overall, and they have a longer median length of stay—30 days compared to a national median of 18 days. Interestingly, the EMR-based screening algorithm for serious illness that we implemented in a primary care practice has not proven to be very effective.

Home-based palliative care is another important service in a comprehensive approach to providing high-quality care for people with serious illness. Typically, these services are led by nurses and target people with advanced serious illness like heart failure, COPD, cancer, and dementia. For these services, EMR- and claims-based algorithms are effective in identifying patients likely to benefit. Key features include 24/7 availability, home visits at least monthly, and support for the patient and family. These programs are associated with high satisfaction, lower utilization, and longer hospice use.⁸

At a lecture, the famous anthropologist Margaret Mead mused about the earliest sign of civilization. She reflected that many people say it's a shard of pottery, a tool, or an idol. To her, the earliest sign of civilization is a 15,000-year-old healed human femur. She explained that a healed femur required someone to take care of you—to provide food and shelter and keep you safe for many weeks. No one can survive such a devastating injury on their own. Only in a group where individuals look after each other and show caring and compassion can the injured individual survive to heal the femur fracture. The caring and compassion that makes that healing possible is the earliest sign of civilization.

In the face of suffering and illness, we in healthcare are among the torchbearers of caring and compassion. Over the next 25 years, the number of people in the U.S. with serious illness will more than double. This growth is good news for all of us who will benefit from this increased longevity. At the same time, this change will pose a challenge to our healthcare system charged with caring for this growing population of people with high healthcare needs. As a nation and as leaders in healthcare

8 Dana Lustbader, et al., [“The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization,”](#) *Journal of Palliative Medicine*, January 2017.

we must embrace this challenge and opportunity. Taking a population approach to implementing palliative care is one way to demonstrate that compassion while improving care for our patients and creating the system of care we will want for our families, friends, communities, and ourselves.

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