

## Hospital Palliative Care Advisory Group

July 20, 2015

### Meeting Summary

**Attendance (by phone):** Michelle Brazil; Alane Capen; Mary Rossi-Coajou; Joan Daugherty; Sydney Morss Dy; Peggy Funk; Cathy Hamel; Tara Holicky; Susan Lyons; Rachel Pierre-Mathieu; Marion Parrott; Angela Poppe Ries; Anthony Riley; Sheena Siddiqui; Nicole Stallings; Jaya Vijayan; Steven Wilks; Julie Wright

**MHCC Staff:** Linda Cole; Rebecca Goldman; Paul Parker

#### Meeting Objectives:

Linda Cole stated that the meeting materials had been sent in advance for the group to review. MHCC staff will be reviewing each of the 38 National Quality Forum (NQF) preferred practices in terms of staff recommendations for those that: (a) should be recommended as best practices; (b) should be required for hospital palliative care programs; (c) are not recommended.

Rebecca Goldman reviewed the legislation to remind the group of the requirements of this report. The legislation states that MHCC is to report on best practices and data outcomes found during the pilot period. Additionally, the report is to include recommendations to be used to develop minimum standards for palliative care programs to be used to expand programs statewide. She believes the report should include best practices and data outcomes, as stipulated in the legislation. In order to be useful to aid in establishing minimum standards, MHCC staff feels that the report should include recommendations for both best practices and a list of minimum requirements.

#### Review of Recommendations on NQF Preferred Practices:

The outcome of discussion on the NQF preferred practices is shown in the table attached. Group discussion took place on the following practices

**NQF Preferred Practice #16:** “Assess and manage psychological reactions of patients and families to address emotional and functional impairment and loss, including stress, anticipatory grief and coping, in a regular ongoing fashion. “

Dr. Steven Wilks, Suburban Hospital, asked what is meant by the word “manage.” His program uses chaplains, social workers, and/or doctors as needed. His program does not have all the disciplines that could be necessary for the assessment and management of psychological reactions available full time, and he is interested in whether there will be specific requirements for this. He believes his program staff makes a concerted effort to provide these types of services to patients when they can; however, there are instances when patients’ need for psychological services are not fully or immediately met due to limited resources.

Alane Capen, Coastal Hospice, added that integration of hospital staff, not just palliative care staff, is important when addressing patient needs of this nature.

Rebecca Goldman pointed out that this report covers hospital-based palliative care programs that have been in existence for a while. Materials produced can be a tool for hospitals developing such programs.

Dr. Sydney Dy agreed that adherence to this practice is heavily influenced by the level of available resources. She believes that social workers do not have enough time to fully address these issues, even at Johns Hopkins. It is a good goal, but, in reality, may not be fully met.

Alane Capen responded that the word “ongoing” part is problematic for her. Palliative care patients are only in the hospital for a short period of time. They do an initial assessment of the psychological reaction, but they may not have more time for regular or ongoing treatment. Dr. Jaya Vijayan, Holy Cross, added that “manage” should be removed. Several other pilot representatives agreed.

*Rewording: “Assess and address psychological reactions of patients and families, including emotional and functional impairment and loss, stress, anticipatory grief, and coping, to the extent possible and practical during the time available during the hospital stay, and make appropriate referrals for ongoing management of psychological reactions.”*

**NQF Preferred Practice #20:** “Develop and document a plan based on assessment of religious, spiritual, and existential concerns using a structured instrument and integrate the information obtained from the assessment into the palliative care plan.”

Dr. Vijayan said that they use a tool at Holy Cross developed by Trinity Health. This tool is used by chaplains, not physicians. She agreed to share the tool so that it can be incorporated into the Appendix of the report.

Susan Lyons, nurse practitioner at Meritus Health, said that she uses the FICA tool and finds that it is critical to determining the extent to which the patient identifies as part of a spiritual community. This tool can also be included in an Appendix.

**NQF Preferred Practice #22:** “Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care.”

Dr. Vijayan said that they have a spiritual care department at the hospital, but these staff members are not all certified in palliative care. The team has a relationship with spiritual care advisors. Certification in palliative care goes beyond being a board certified chaplain. Specialty training and certification should not be required.

*Rewording: “Specialized palliative and hospice care teams should include spiritual care professionals.”*

**NQF #34:** “Convert the patient treatment goals into medical orders and ensure that the information is transferrable and applicable across care settings, including long-term care, emergency medical services and hospital care, through a program such as the Physician Orders for Life-Sustaining Treatment (POLST) program.”

This would translate into MOLST, or a similar program. Ms. Lyons stated that she is a MOLST trainer and this is already required for all hospitals in Maryland. Ms. Capen responded that, in practice, she sees

some hospitals using only the Do Not Resuscitate Order, while the rest of the form remains blank. Ms. Lyons offered to help them with training resources.

**NQF #36:** “Develop healthcare and community collaborations to promote advance care planning and the completion of advance directives for all individuals, for example the Respecting Choices and Community Conversations on Compassionate Care programs.”

There are many types of community collaborations so the specific examples do not need to be included.

Dr. Vijayan asked if this is recommended for the palliative care team or for the hospital. The palliative care team does not have the resources to do it and it needs to be done in collaboration with the hospital.

Julie Wright said that Carroll Hospital is not doing this. Alane Capen said that they do training sessions for the community.

**NQF #38:** “For minors with decision making capacity, document the child’s views and preferences for medical care, including assent for treatment, and give appropriate weight in decision making. Make appropriate professional staff members available to both the child and the adult decision maker for consultation and intervention when the child’s wishes differ from the adult decision maker.”

Julie Wright said that her program could never meet this as a required standard.

#### Review of Use of Codes “1” and “3”:

Rebecca Goldman reported that five pilot hospitals responded to her request for information about the use of these codes. It appears that they were consistent in using “3” for patients who turned down all palliative care services, while they used “1” for patients who accept palliative care team recommendations at differing levels, including comfort care. In the case of one pilot, MedStar Union Memorial, patients who accepted only comfort care were coded “3”. They appear likely to be coded “1” at other pilots, based on the responses received to the request.

#### Satisfaction Surveys:

Linda Cole requested that for those programs who had reported implementing patient satisfaction surveys, staff needs the results now in order to incorporate them into the report.

Ms. Wright asked if MHCC staff would like the results of any other data collected. For examples, she is tracking utilization and it seems to be that a palliative care consult reduces admissions and length of stay. Staff said that although we have access to the HSCRC data, they would like to see any results that might help in the report.

#### Next Steps:

Staff will summarize the discussion held today and will share the results with the members of the Advisory Group.