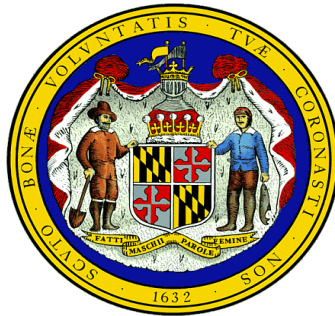




Maryland Hospital Palliative Care Programs: Analysis and Recommendations



Required under HB 581: *Hospitals-Establishment of
Palliative Care Pilot Programs*

December 1, 2015

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Table of Contents

Executive Summary	1
Introduction	1
Pilot Study Process	1
Results of the Data Collection.....	2
Research Findings	2
Evaluation of Best Practices and Minimum Standards	4
Recommendations	4
Purpose of Report	8
Legislative History	8
Process for Implementation of the Legislative Mandate	8
Selection of Pilot Hospitals	9
Hospital Palliative Care Advisory Group.....	9
Other Resources	10
Palliative Care.....	11
Definition and History of Palliative Care.....	11
Delivery Models for Palliative Care.....	12
Issues in the Palliative Care Specialty.....	12
Evidence of Benefits and Cost Savings to Patients and Health Systems	15
Movements Toward Standardization and Expansion.....	17
Characteristics of Maryland Hospital Palliative Care Programs	19
Availability of Palliative Care Programs at Maryland Hospitals	19
Joint Commission Certification.....	20
Services Provided by Hospital Palliative Care Programs	21
Identification of Patients	21
Staffing Composition	21
Palliative Care Program Policies and Plans	22
Relationship with Hospice Service Providers	22
Integration with Other Hospital Units.....	23
Funding Sources	24
Summary of Pilot Hospital Palliative Care Program Characteristics.....	25
Pilot Study Data Outcomes for Maryland Hospital Palliative Care Programs	25
Defining Palliative Care for Pilot Study	26

Pilot Project Flagging Protocol	28
Discharge Abstract Observations	29
Assessment of Data Outcomes and Measures on Access and Utilization of Maryland Hospital Palliative Care	44
Recommendations for Standardization and Expansion of Hospital Palliative Care Programs	46
Summary of Advisory Group Evaluation of National Quality Forum-Endorsed Practices	46
Recommendations for Best Practices and Minimum Standards for Maryland Hospital Palliative Care	47
Conclusion	64

List of Tables and Figures

Table 1. Pilot Hospital Palliative Care Programs, Jurisdiction, and Number of Licensed Acute Care Beds	9
Table 2. Hospitals that Reported Palliative Care Programs and Jurisdiction	19
Table 3. Pilot Hospital Palliative Care Programs’ Relationship to Hospice	23
Table 4. Pilot Hospitals’ Description of Palliative Care Integration with Other Hospital Units or Departments	23
Table 5. Funding Source as a Percentage of Total Service Cost for Pilot Hospital Palliative Care Programs	24
Table 6. Total Medical/Surgical Discharges and Use of Palliative Care Procedure Code at All Maryland Hospitals, FY 2015	26
Table 7. Number and Percent of Flagged Palliative Care Consultations at Pilot Hospitals by Consultation Outcome, FY 2015	29
Table 8. Number and Ratio of Palliative Care Consultations to Medical/Surgical Discharges, FY 2015	30
Table 9. Percent of Selected Age Groups for Medical/Surgical Discharges and Pilot Hospital Palliative Care Consultations, FY 2015	31
Table 10. Reported Racial and Ethnic Characteristics of Medical/Surgical Discharges and Palliative Care Consultations at Pilot Hospitals, FY 2015	32
Table 11. Percent of Flagged Palliative Care Consultations and Medical/Surgical Discharges in All Major Diagnostic Categories of Diseases and Disorders (DDs), FY 2015	34
Table 12. Most Frequent Disposition at Discharge for Palliative Care Consultation Groups and Medical/Surgical Discharges at Pilot Hospitals, FY 2015	35
Table 13. Percent of Flagged Palliative Care Consultations Who Accepted Palliative Care Plan of Care and Died in the Hospital, by Pilot, FY 2015	36

Table 14. Percent of Flagged Palliative Care Consultations and Medical/Surgical Inpatients Who Were Admitted Within 31 Days before This Admission.....	37
Table 15. Primary Payer Sources for Hospital Stays by Selected Age Groups for Flagged Palliative Care Consultation Groups and All Medical/Surgical Discharges, FY 2015.....	38
Table 16. Unadjusted Average Length of Stay for Selected Flagged Palliative Care Consultations and Unflagged Medical/Surgical Discharges, Excluding In-Hospital Deaths, FY 2015	39
Table 17. Unadjusted Average Charges Per Stay for Selected Flagged Palliative Care Consultations and Unflagged Medical/Surgical Discharges, Excluding In-Hospital Deaths, FY 2015	40
Table 18. Unadjusted Average Charges Per Day for Selected Flagged Palliative Care Consultations and Unflagged Medical/Surgical Discharges, Excluding In-Hospital Deaths, FY 2015.....	41
Table 19. Percent of Variance of the Unadjusted Average Length of Stay to the Case Mix Adjusted Average Length of Stay for Pilot Hospitals.....	42
Table 20. Case Mix Adjusted Average Length of Stay for Selected Palliative Care Consultations, FY 2015	43
Table 21. Case Mix Adjusted Average Charges Per Stay for Selected Palliative Care Consultations, FY 2015.....	43
Table 22. Case Mix Adjusted Average Charges Per Day for Selected Palliative Care Consultations, FY 2015.....	44
Figure 1. Palliative Care Continuum of Care.....	13

List of Appendices

Appendix A: Chapter 379 (House Bill 581)
Appendix B: Hospital Palliative Care Advisory Group Membership
Appendix C: Request for Application: Application to Participate in the Hospital Palliative Care Pilot
Appendix D: Hospital Palliative Care Advisory Group: Background and Charge
Appendix E: Journal of Pain and Symptom Management Article: “An Assessment of Hospital-Based Palliative Care in Maryland: Infrastructure, Barriers, and Opportunities
Appendix F: St. Paul Group Case Mix Adjustment Analysis
Appendix G: National Quality Forum Preferred Practices with Maryland Pilot Hospital Review
Appendix H: Comparison of Requirements: National Quality Forum, the Joint Commission, and CMS Conditions of Participation
Appendix I: Spiritual Assessment Tools: FACIT and FICA
Appendix J: MOLST: Maryland Medical Orders for Life-Sustaining Treatment

Executive Summary

Introduction

Palliative care is specialized medical care for individuals with life-threatening conditions that provides patients with relief from symptoms, pain, and stress in order to improve their quality of life. Palliative care can be provided at any stage in a serious illness or condition and may be provided along with curative treatment. This is in contrast to hospice care which is provided when the patient has a life of six months or less, and agrees to forego any curative treatment. Demand for palliative care services is projected to grow as population demographics continue to skew older and medical advances increase life expectancy. Nationally, the number of palliative care programs in hospitals more than doubled between 2000 and 2010. At least 30 Maryland hospitals developed palliative care specialty services within that same time frame. With the growth of this specialty, steps toward promoting expansion and standardization have recently gained momentum in other states including New York, Rhode Island, Connecticut, Massachusetts, and California.

During the 2013 legislative session, the Maryland General Assembly passed House Bill 581 (HB 581) which directed the Maryland Health Care Commission (the Commission) to collaborate with the Department of Health and Mental Hygiene (DHMH) Office of Health Care Quality (OHCQ) and the Maryland Hospital Association (MHA) on a pilot study of geographically diverse hospital palliative care programs in order to gather data on costs, savings, access, and patient choice, and to report on best practices to be used in the development of statewide standards. With 11 pilot hospitals representing services in nine Maryland jurisdictions and with guidance from the Hospital Palliative Care Advisory Group, the Commission embarked on designing a data collection process, reviewing existing resources and initiatives, and developing recommendations for best practices and minimum standards.

Pilot Study Process

The Commission selected 11 established hospital palliative care programs to participate in the pilot project through a Request for Applications process. A review of academic studies and other publications provided additional insight. Two entities in particular, which are leaders in palliative care and health care research and advocacy, the Center to Advance Palliative Care and the National Quality Forum (NQF), provided materials that were key in the development of both the research design and findings. Responses to surveys were used to develop profiles and compare pilot program structures, staffing, and practices. In order to develop a set of best practices and minimum standards, this project used the NQF's endorsed list of 38 preferred practices for palliative and hospice care programs as a guide for discussion. These practices also serve as the foundation for the Joint Commission on Accreditation for Healthcare Organization's (Joint Commission) certification requirements for palliative care programs. Additionally, pilot hospitals provided detailed data on their patient populations over the course of one fiscal year by flagging consultations in the Health Services Cost Review Commission's (HSCRC) discharge abstract.

Results of the Data Collection

Primary and secondary data provided the basis for a summary of palliative care services across Maryland, a profile of the pilot programs, and a representation of the patient populations at pilot programs during the designated study period. Common program characteristics include: inpatient consultation models; interdisciplinary teams; at least one credentialed staff member; existence of certain policies and plans; and challenges with limited resources, staffing shortages, lack of awareness, and late referrals. The report also includes descriptions of screening processes and services provided at hospitals with palliative care programs in Maryland, as well as each pilot's description of its relationship to hospice services, integration with emergency services, and integration with intensive care services. Only one program in Maryland is currently certified by the Joint Commission, while others reported that they did not believe the benefits outweigh the costs associated with the certification process at this time. Six out of 11 pilots offered outpatient palliative care services. After consultation with the Advisory Group, the Commission determined that this pilot project should focus on the inpatient experience.

The palliative care inpatients flagged during the pilot period had serious, life-threatening diseases and were often near the end of life. Four in 10 patients were referred to hospice as a result of a palliative care consultation. Compared to unflagged medical/surgical inpatient populations at pilots, patients who received palliative care consultations had longer lengths of stays and costly health care stays. Alternatively, average charges per day for patients who received palliative care consultations were lower than average charges per day for unflagged medical/surgical inpatients who did not receive a palliative care consultation. Unfortunately, the impact of the palliative care intervention cannot be fully assessed during a particular hospital stay because it is unknown at what point during the hospital stay the patient received a consultation or accepted palliative care. Additionally, pilots advised that some dying patients stayed in the hospital for an extended period of time, which increased the length of stay while making them prime candidates for palliative care. In order to truly measure the impact of this intervention, which is intended to benefit patients who are likely to need continued medical care throughout the progression of a serious life-threatening disease, total health care system use must be considered. Such research was beyond the scope of this project. More nuanced studies which group pilot hospitals or more detailed patient characteristics could offer additional insight. Both tracking patient utilization across different health care settings and subgrouping the pilot hospitals by common characteristics was beyond the scope of this study, which was to recommend best practices and minimum standards for these programs.

Research Findings

Costs, savings, and benefits of palliative care services

This report provides information on inpatient experience and charges for a single hospital stay. However, it does not include conclusions regarding a direct relationship between a palliative care consultation and patient experience as a result of that consultation or service provision for a number of reasons. It is unknown at what point during the stay a palliative care consultation took place, and, consequently, when a palliative plan of care may have been

accepted which may decelerate a patient's aggressive and costly treatment. There are also significant differences in the in-hospital mortality rate of patients who accepted palliative care at the pilot hospitals, pointing to potential differences in hospital practices for patients near the end of life that also affect this comparison.

While analysis of the primary data collected during the pilot period did not offer a definitive conclusion regarding the comprehensive costs or savings related to palliative care, there are other published studies that reported cost savings. The American Medical Association published a study in 2008 which indicated that palliative care team consultations resulted in savings of nearly \$1,700 in direct costs per admission and \$279 on savings per day for patients discharged alive. For patients who died in the hospital, cost savings were higher – more than \$4,900 per admission and \$347 per patient day. Indeed, the pilot data allows for comparison of flagged palliative care groups who accepted and declined palliative care. The differences in charges per stay between these two groups were in the hundreds and thousands of dollars in some cases. However, due to the reasons listed above, this data cannot be used to conclude a direct relationship between receiving a consultation or accepting palliative care and the outcome of a hospital stay. Further, these comparisons were not consistent across all pilot hospitals.

Other published studies also report reduced readmissions and reduced costs for emergency services as a result of palliative care. Two pilots conducted independent research that indicated patients who accept a palliative care plan of care had lower readmission rates and lower charges during subsequent hospital visits at their hospitals. Additionally, Advisory Group members provided research that indicated patients and caregivers reported a higher level of satisfaction with their hospital experience after a consultation with a trained palliative care team member.

Access to palliative care services and patient choice

Hospitals in Maryland and across the country are increasingly investing in specialized palliative care programs, credentialed staff, and staff training as they begin to recognize the value of this service. At the time of this study, at least 32 hospitals in Maryland had what they consider a palliative care program. Additionally, every general acute care hospital had personnel who delivered some type of palliative care services at that hospital during the study period, based on a specific procedure code for palliative care. Based on surveys of Maryland hospital administrators, at least half of Maryland hospitals will expand their palliative care program and awareness in the near future.

Pilot hospital data suggests that Hispanics receive consultations at a rate that is less than the rate of all medical/surgical admissions. African Americans, though similarly represented in palliative care consultations and general medical/surgical populations, were overrepresented in the proportion of patients who declined palliative care after a consultation. This latter finding is in line with the existing data regarding the lower use of hospice services among African Americans compared to Whites. Recommendations include an emphasis on cultural sensitivity and interpretation services in order to address these concerns.

Evaluation of Best Practices and Minimum Standards

In addition to data collection and analysis to gain further insight into costs, savings, benefits, access, and patient choice, HB 581 directs the Commission to provide recommendations to be used to develop minimum standards for palliative care programs with the goal of expanding access to palliative care services statewide at hospitals with 50 beds or more by July 1, 2016, in a manner that ensures geographic balance and promotes racial and ethnic diversity. In order to develop a list of recommendations that meets this directive, staff consulted with national and local advocates and determined that an existing list of 38 recommended practices, endorsed by the NQF, should serve as a guide for discussion. The Advisory Group reviewed the 38 “preferred practices” in depth. Of those practices, 37 were retained or modified for a list of recommended best practices, and 30 of those were recommended as minimum standards for a hospital palliative care program. The Commission recommends that statewide minimum standards first focus on practices that will ensure an acceptable level of patient care, consistent across hospitals. Then as resources allow, programs should implement best practices to the extent possible.

Recommendations

The Commission, in consultation with OHCQ, MHA, and the Hospital Palliative Care Advisory Group, recommends the following 37 best practices under eight domains, of which 30 are recommended as minimum standards, which are based on the NQF-endorsed 38 preferred practices for hospice and palliative care programs.

Structures of Care: Four best practices, also recommended as minimum standards

- Hospitals should provide palliative care by an interdisciplinary team, trained in palliative care, to consult on palliative care services in collaboration with primary health care professionals.
- Hospitals should provide education to all health professionals on the domains of palliative care.
- Palliative care programs should provide adequate training and clinical support to ensure that professional staff are confident in their ability to provide palliative care for patients.
- Palliative care programs should ensure the palliative care team is appropriately trained, credentialed, and/or certified in their area of expertise.

Processes of Care: Five best practices, also recommended as minimum standards, and one best practice only

- Palliative care programs should record the patient’s palliative care goals, needs, and care plans in medical orders.
- Palliative care programs should ensure timely and thorough transfer of the patient’s goals, needs, and care plans upon transfer to a different care setting.
- Palliative care programs should present hospice as an option to patients and families when appropriate, based on an assessment of the patient’s and family’s goals, needs, and plan of care.

- Palliative care programs should enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.
- Palliative care programs should provide education and support to families and unlicensed caregivers to ensure safe and appropriate patient care with educational materials that are age-, language-, and educationally appropriate.

Best practice only Palliative care programs should ask patients and caregivers to assess the physicians'/health care professionals' ability to discuss hospice as an option.

Physical Aspects of Care: One best practice, also recommended as a minimum standard, and one best practice only

- Palliative care programs should measure and document pain, dyspnea, constipation and other symptoms using available standardized scales.

Best Practice Only Palliative care programs should ask patients and caregivers whether pain, dyspnea, constipation and other symptoms and side effects were managed in a timely, safe, and effective manner to a level acceptable to the patient and family.

Psychological and Psychiatric Aspects of Care: Two best practices, also recommended as a minimum standards, and two best practices only

- Palliative care programs should assess the psychological reactions of patients and families to address emotional and functional impairment and loss, including stress, anticipatory grief and coping. Programs should develop a plan to address the needs of the patient and family and make appropriate referrals for the ongoing management of needs.
- Hospitals should identify resources to address the grief and bereavement care needs for patients and families, within the hospital or through referral to a hospice provider.

Best practice only Palliative care programs should measure and document anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms using available standardized scales.

Best practice only Palliative care programs should ask patients and caregivers whether the patient's anxiety, depression, delirium, behavioral disturbances and other psychological symptoms were managed in a timely, safe, and effective manner to a level acceptable to the patient and family.

Social Aspects of Care: Two best practices, also recommended as minimum standards

- Palliative care programs should conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, discuss goals of care, disease prognosis and advance care planning, and offer support.
- Palliative care programs should develop and implement a comprehensive social care plan that addresses social, practical, and legal needs of the patient and caregivers.

Spiritual, Religious, and Existential Aspects of Care: Two best practices, also recommended as minimum standards, and two best practices only.

- Palliative care programs should provide information about the availability of spiritual care services, and make spiritual care available either through organizational spiritual care counseling or through the patient's own clergy relationships.
- Palliative care programs should develop an ongoing relationship with spiritual care professionals in order to educate spiritual care professionals about palliative care issues and concerns.

Best practice only Palliative care programs should develop and document a plan based on assessment of religious, spiritual, and existential concerns using a structured instrument and integrate the information into the palliative care plan.

Best practice only Palliative care programs should build partnerships with community clergy and provide education and counseling related to end-of-life care.

Cultural Aspects of Care: Two best practices, also recommended as minimum standards

- Palliative care programs should conduct a cultural assessment of the patient's needs as a component of that patient's plan of care.
- Hospitals should have interpreter services available at the hospital, and palliative care programs should utilize these services as needed.

Care of Imminently Dying Patient: Six best practices, also recommended as minimum standards

- Palliative care programs should recognize and document the transition to the active dying phase and communicate to the patient, family and staff the expectation of imminent death.
- Palliative care programs should educate the family on a timely basis regarding the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate and culturally appropriate manner.
- Palliative care programs should routinely ascertain and document patient and family wishes about the care setting for site of death, and fulfill patient and family preferences when possible.
- Palliative care programs should provide adequate dosage of analgesics and sedatives to achieve patient comfort and address concerns about narcotics and analgesics hastening death.
- Hospitals should have a plan or policy to treat the body after death with respect according to the cultural and religious practices of the family and in accordance with local law.
- Hospitals should facilitate effective grieving by implementing a bereavement care plan in a timely manner after the patient's death through services provided at the hospital or develop a relationship with another provider, such as a hospice, for these services.

Ethical and Legal Aspects of Care: Six best practices, also recommended as minimum standards, and one best practice only

- Hospitals should document the designated surrogate/decision maker in accordance with state law for every patient in primary, acute, and long-term care and in palliative and hospice care.
- Palliative care programs should document the patient/surrogate preferences for goals of care, treatment options and setting of care at first assessment and at frequent intervals as conditions change.
- Hospitals should convert the patient's treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services and hospital care, by using the MOLST program to the fullest extent possible and ensuring that staff is trained and knowledgeable of the benefits.
- Hospitals should make advance directives and surrogacy designations available in electronic personal health records.
- Hospitals should develop healthcare and community collaborations to promote advance care planning and the completion of advance directives for all individuals.
- Palliative care programs should have access to or establish ethics committees or ethics consultation across care settings to address ethical conflicts at the end of life.

*Best
practice
only*

Palliative care programs should develop a relationship with a provider who specializes in pediatric palliative care.

Purpose of Report

This report is produced by the Commission, in consultation with OHCQ and MHA, as well as other interested groups and pilot hospitals. It addresses the requirements of HB 581 (incorporated into Chapter 379) introduced during the 2013 legislative session, which can be found here: http://mgaleg.maryland.gov/2013RS/Chapters_noln/CH_379_hb0581t.pdf

Legislative History

During the 2013 legislative session Delegate James Hubbard, District 23A, Prince George's County, introduced *HB 581 Hospitals- Establishment of Palliative Care Programs- Required*. The legislation, as introduced, would have required DHMH to adopt regulations to create standards for hospital palliative care programs not accredited by a national accreditation body. The legislation also required every general hospital with more than 50 beds to establish a palliative care program that is either accredited by an accreditation agency or approved by DHMH. All programs were to be operational by July 1, 2016.

After discussions with various stakeholders (including MHA, the Commission, and other interested groups) the proposed legislation was amended. HB 581 created a voluntary pilot program to study quality and cost outcomes of palliative care programs. (See Appendix A.) HB 581 also signifies the General Assembly's interest in developing standards for hospital palliative care.

This project requires that the Commission work cooperatively with MHA and OHCQ. The legislation directs the Commission to select at least five hospital pilots in a manner that ensures geographic balance. As required by the legislation, pilot programs must collaborate with community providers; gather data on costs, savings, access, and patient choice; and report to the Commission on best practices to be used in the development of statewide standards. The Commission is further directed, in consultation with the pilot programs established, and stakeholders identified by the Commission, to identify core measures for the data collected under this legislation and to develop standards for the reporting requirements. OHCQ is directed to develop regulations based on the results of this study. The report is due to the General Assembly by December 1, 2015.

Process for Implementation of the Legislative Mandate

In July 2013, Commission staff convened a steering committee that included representatives from MHA and OHCQ, prior to the October 1, 2013 effective date of the legislation. The committee identified candidates for the Hospital Palliative Care Advisory Group (Advisory Group), including MHA, OHCQ, yet-to-be-selected pilot hospitals, and other industry experts including representatives from the Hospice & Palliative Care Network of Maryland, the Maryland State Medical Society (MedChi), the Centers for Medicare and Medicaid Services (CMS), the Maryland Cancer Collaborative, and researchers in the field of palliative care. (See Appendix B.)

Selection of Pilot Hospitals

In order to develop appropriate criteria to aid in the selection of pilot hospitals, staff conducted interviews with existing hospital palliative care programs. Staff then developed a Request for Applications (see Appendix C), which was sent to all Maryland hospitals with more than 50 beds. The requirements for pilot hospitals included: a minimum of 50 beds (legislative mandate), collaboration with community partners (legislative mandate), certified staff, minimum volume of 200 cases annually, and resources for data collection. The Commission received 14 applications; three applicants did not meet minimum criteria. Eleven hospitals were ultimately selected from nine different jurisdictions.¹ Table 1 provides details about the pilot hospitals.

Table 1. Pilot Hospital Palliative Care Programs, Jurisdiction, and Number of Licensed Acute Care Beds

Pilot Hospital	Jurisdiction	Number of Licensed Acute Care Beds
Carroll Hospital Center (Carroll)	Carroll County	140
Doctors Community Hospital (Doctors Community)	Prince George's County	163
Greater Baltimore Medical Center (Greater Baltimore)	Baltimore County	231
Holy Cross Hospital of Silver Spring (Holy Cross)	Montgomery County	423
Howard County General Hospital (Howard County)	Howard County	266
The Johns Hopkins Hospital (Johns Hopkins)	Baltimore City	1,129
MedStar Union Memorial Hospital (MedStar Union Memorial)	Baltimore City	211
Meritus Medical Center (Meritus)	Washington County	223
Peninsula Regional Medical Center (Peninsula Regional)	Wicomico County	292
Suburban Hospital (Suburban)	Montgomery County	236
University of Maryland Upper Chesapeake Medical Center (Upper Chesapeake)	Harford County	180

Source: MHCC's Interim Update: Licensed Acute Care Hospital Beds, Fiscal Year 2016

Hospital Palliative Care Advisory Group

After the selection of pilot hospitals, the Commission convened the first meeting of the Advisory Group on December 17, 2013. The charge to this group was to assist Commission staff in developing pilot study questions and a standard set of core measures to answer those

¹ Union Hospital of Cecil County applied and was selected as a pilot hospital, but discontinued its voluntary participation. Greater Baltimore Medical Center was selected as a pilot hospital and, upon selection, explained that the same staff directs the program at Howard County General Hospital, and requested its inclusion. Howard County General Hospital was approved for inclusion as a pilot hospital. The net outcome was 11 pilot hospitals.

questions, interpreting a variety of information in order to make conclusions, and assisting with the development of recommendations. (See Appendix D for Background and Charge). The Advisory Group met seven times over a two year period during the course of this study. In addition, several subcommittees were formed to address the topics of definitions, standards and best practices, out-of-hospital data, and satisfaction. Subcommittee recommendations were reviewed by the full Advisory Group.

Other Resources

Commission staff also relied on an extensive body of existing work, using both published documents and discussions with staff from the following sources:

- The Center to Advance Palliative Care (CAPC) is a national member-based organization dedicated to increasing the availability of quality palliative care services for people facing serious illness through training and advocacy. CAPC conducts an annual survey of palliative care programs across the country. The Commission obtained CAPC data for all pilot hospitals reporting for years 2012 and 2013 and used this data in the profile of Maryland hospital palliative care programs.
- The National Quality Forum (NQF) is a non-profit, nonpartisan, membership-based organization that works to promote improvements in healthcare. NQF facilitates national collaboration and endorses consensus reports by convening working groups in both the public and private sectors. NQF published a national framework and endorsed a list of 38 preferred practices for palliative and hospice care quality in 2006. Staff used this list of practices to facilitate the discussion on best practices and minimum standards.
- The Health Services Cost Review Commission (HSCRC), an independent state agency operating within DHMH, sets hospital rates for all payers in the State of Maryland, including Medicare and Medicaid. Among other responsibilities related to this charge, HSCRC collects medical abstracts and billing data for all inpatient admissions, outpatient surgeries, clinic visits, and referred outpatient ancillary utilization at all Maryland hospitals. The Commission worked with HSCRC to add a variable to the inpatient discharge abstract in fiscal year 2015 to identify selected palliative care patients. This data set provided information on access to and utilization of palliative care services, as well as charges for palliative care services at Maryland hospitals.
- Within DHMH, the Maryland Cancer Collaborative has worked to support palliative care services as a component of the Comprehensive Cancer Control Plan. Recently, it conducted surveys of Maryland hospital administrators regarding palliative care programs. This work resulted in a published article in the *Journal of Pain and Symptom Management* titled “An Assessment of Hospital-Based Palliative Care in Maryland: Infrastructure, Barriers, and Opportunities” (see Appendix E), which was also used in the profile of Maryland hospital palliative care programs.

Palliative Care

Definition and History of Palliative Care

In HB 581, palliative care is defined as, “specialized medical care for individuals with serious illnesses or conditions that: (1) is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness or condition, whatever the diagnosis; (2) has the goal of improving quality of life for the patient, the patient’s family, and other caregivers; (3) is provided at any age and at any stage in a serious illness or condition; and (4) may be provided along with curative treatment.” Essentially, palliative care – from the Latin “palliare” or “to cloak”² – focuses on relieving or preventing suffering related to serious, complex, life-limiting, or life-threatening diseases that affect quality of life or functional ability. While palliative care patients could have any range of illnesses or disease, common illnesses include cancers, respiratory diseases, organ failure, or HIV/AIDS – illnesses that often have symptoms including pain, shortness of breath, fatigue, and nausea.

Palliative care was one of the first services that medical practitioners could provide, prior to the discovery and development of cures for many life-threatening illnesses. Over time, new medicines and technology led to a medical focus on curative treatment.³ The palliative care movement grew from the hospice movement in the 1970s as practitioners recognized that even if the death of a patient is not imminent, the patient could benefit from the symptom management that had been traditionally associated with treatment of diseases in the dying stage.⁴

Palliative care was first declared a medical specialty in 2007.⁵ According to the NQF, the number of palliative care programs in hospitals more than doubled between 2000 and 2010.⁶ During staff interviews with Maryland hospitals, administrators reported significant development of palliative care specialty services since 2000. Of the 19 programs interviewed during the Request for Applications development process, the University of Maryland Medical Center reported the oldest program, established in 1994 and supported by grant funding. All other programs interviewed during this initial research phase reported establishment in 2002 or later.

Demand for palliative care services is projected to grow. Patients die at an older age and more slowly due to advanced medical interventions, and demographic changes have led to fewer

² Andrews M. Demand Grows for Palliative Care. *Kaiser Health News*. March 29, 2011. Available at: <http://khn.org/news/michelle-andrews-on-palliative-care/>

³ California Healthcare Foundation. Palliative Care in California: Fundamentals of Hospital-Based Programs. Oakland, CA: May 2007. Available at: <http://www.chcf.org/publications/2007/11/palliative-care-in-california-the-state-of-hospitalbased-programs>

⁴ Andrews M. Demand Grows for Palliative Care. *Kaiser Health News*. March 29, 2011. Available at: <http://khn.org/news/michelle-andrews-on-palliative-care/>

⁵ Brody, Jane. Palliative Care, the Treatment That Respect Pain. New York: The New York Times Company. December 2, 2013. Available at: http://well.blogs.nytimes.com/2013/12/02/palliative-care-the-treatment-that-respects-pain/?_r=0

⁶ National Quality Forum. Endorsement Summary: Palliative Care and End-of-Life Care Measures. February 2012. Available at: http://www.qualityforum.org/Projects/Palliative_Care_and_End-of-Life_Care.aspx

family caregivers for many patients. In the future, providers of end-of-life services like palliative care will fill a growing need for people with terminal and life-limiting diseases.⁷

Delivery Models for Palliative Care

According to the palliative care model, an interdisciplinary approach is critical to address the needs of patients with life-threatening illnesses. Palliative care teams include medical practitioners, social workers, pharmacists, and spiritual care providers. Patients may still receive curative treatment from primary care practitioners or other specialists, and also could typically use services like advance care planning, comfort measures, assistance with daily activities, and family support. These other services stay with the patient until the end of life, whether death comes within a week or within a few years.⁸

According to CAPC, the most prevalent model of palliative care service delivery in acute care hospitals is the consultation service model, where an interdisciplinary team is brought in at the request of a primary care practitioner to assist with complex issues including symptom management, family needs, or challenges regarding end-of-life discussions. This is the predominant model in Maryland hospitals. Palliative care is also provided in hospitals on inpatient palliative care units, in nursing homes, assisted living facilities, community home-based programs, or outpatient clinics. Many hospices provide palliative care separate from hospice care. Primary care practitioners also provide palliative care or implement the long-term management of palliative care team recommendations.

Issues in the Palliative Care Specialty

Changes in Health Care Financing & Organization, a national program of the Robert Wood Johnson Foundation, reported that two major hurdles prevent palliative care from being utilized more often: the misperception by both patients and providers that palliative care is the same as hospice care, and the shortage of doctors trained in palliative care.⁹ Additionally, CAPC reports that hospital programs face barriers including workforce shortages, late referrals, and limited resources. The Maryland pilot hospitals echoed all of these concerns during the pilot period.

It is critical to differentiate between palliative care and hospice care services. While both focus on patients with life-threatening illnesses, patient- and family-centered care, and comprehensive care, palliative care can be offered *along with* curative care. In contrast, hospice care describes a particular service and system of care in the United States, during which curative

⁷ National Institutes of Health. State of the Science Conference Statement: Improving End-of-Life Care. December 8, 2004. Available at: <https://consensus.nih.gov/2004/2004EndOfLifeCareSOS024html.htm>

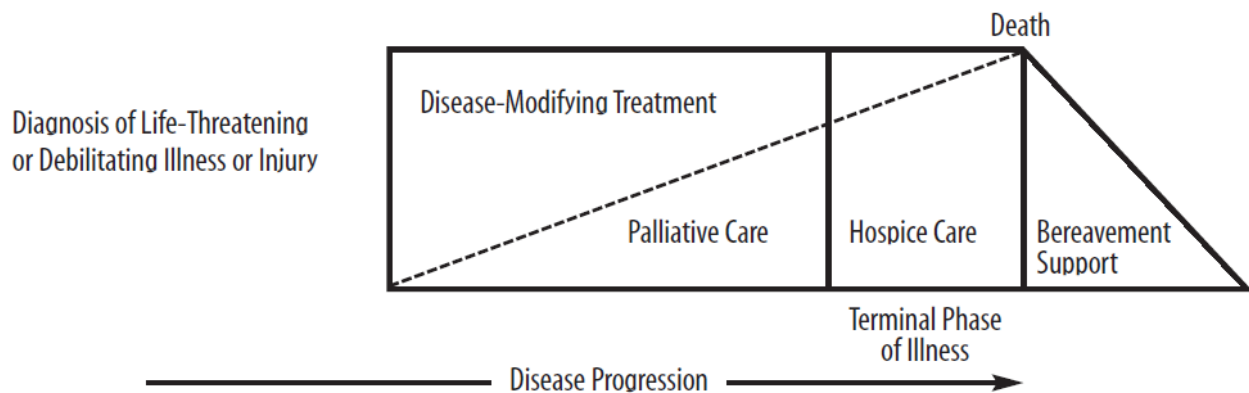
⁸ Lynn J. Living Long in Fragile Health: The New Demographics Shape End-of-Life Care. Hastings Center Report. November-December 2005;Spec No:S14-8

⁹ Understanding the Effects of Palliative Care on Patient Functioning. Washington, DC: Health Care Financing & Organization, an initiative of the Robert Wood Johnson Foundation, managed by AcademyHealth. Accessed March 24, 2014. Available at: <http://www.hcfo.org/publications/understanding-effects-palliative-care-patient-functioning-0>

treatment is no longer pursued and palliative care is offered toward the end of life.¹⁰ Medicare Conditions of Participation for hospice care require that a physician certify that the patient has a terminal diagnosis and the likely course of the illness is such that the patient has a life expectancy of six months or less. In other words, all hospice care is palliative care, but not all palliative care is hospice care.

As stated in the Maryland Comprehensive Cancer Control Plan, “palliative care ideally begins at the time of diagnosis with a life-threatening illness and continues throughout the course of illness until the death of the patient and into the bereavement period.”¹¹ Figure 1 displays the optimal palliative care continuum of care.

Figure 1. Palliative Care Continuum of Care



Source: National Quality Forum. A National Framework and Preferred Practices for Palliative and Hospital Care Quality: A Consensus Report. Washington, DC; 2006.

The close association and resulting confusion between palliative care and hospice care can be problematic for establishing patient goals of care. Too often, primary care practitioners question the value of palliative care consultations and recommendations in a patient’s plan of care.¹² Advisory Group members cited reluctance by primary care providers to address palliative care because of the close association with end-of-life discussions, and also noted that these providers are sometimes hesitant to even request a consultation by trained palliative care staff for these services. This reluctance fuels continued misperception among patients and families without education about the differences in these services.

Differentiating between palliative care and hospice care is especially important for patients with long-term illnesses with uncertain life expectancies. A report on palliative care in California described the difficulties of receiving hospice-based palliative care at home for patients with illnesses that do not have predictable trajectories. Palliative care can be introduced

¹⁰ California Healthcare Foundation. Palliative Care in California: Fundamentals of Hospital-Based Programs. Oakland, CA: May 2007. Available at: <http://www.chcf.org/publications/2007/11/palliative-care-in-california-the-state-of-hospitalbased-programs>

¹¹ Maryland Department of Health and Mental Hygiene. Maryland Comprehensive Cancer Control Plan. Available at: <http://phpa.dhmh.maryland.gov/cancer/cancerplan/SitePages/Home.aspx>

¹² Weissman D, Meier D. Identifying Patients in Need of a Palliative Care Assessment in the Hospital Setting. Journal of Palliative Medicine. Volume 14, Number 1, 2011.

sooner and offer relief from suffering.¹³ In another assessment, Parikh et al. stress the potential benefits of introducing specialty palliative care alongside standard medical care, outside of hospital and emergency settings. Changing the misperception of palliative care requires outreach to primary and community doctors who provide ongoing treatment to patients, as well as developing public education campaigns to directly target patients and families.¹⁴

Misperceptions about palliative care influence public policy decisions as well. An initial provision in a draft of the Affordable Care Act included reimbursement to doctors for advance care planning, including discussions of living wills and end-of-life treatment options. Palliative care providers believe that reimbursement for sometimes-lengthy conversations about the range of options for patients who qualify for palliative care would increase access to these services. However, drafters dropped that provision due to accusations of support for “death panels.”¹⁵

CMS may address several of these issues in the near future. In July, 2015, it announced a policy proposal under which it would reimburse physicians and other health care professionals for talking to patients with advanced stage diseases about their goals and wishes, and the likely results of their treatment options. Public comments are being accepted and CMS will make a decision whether to fund and how much to reimburse for these conversations by fall, 2015.¹⁶ CMS also recently announced a “Medicare Care Choices Model”, which provides Medicare beneficiaries who qualify for coverage under the Medicare hospice benefit (as well as dual eligibles) the option to elect to receive supportive care services typically provided by hospice while continuing to receive curative services. CMS invited more than 140 Medicare-certified hospices, including three hospices in Maryland, to participate in the model for up to five years. If the results show outcomes such as increased satisfaction and lower costs, Medicare and other insurers may provide coverage in the future.¹⁷

In Maryland, the leading barriers to providing palliative care include lack of awareness among the general public and lack of physician “buy-in.” Maryland hospital administrators also report funding constraints and poor reimbursement policies as hindrances to expanding palliative care at Maryland hospitals.¹⁸ There are fewer traditional funding sources for research for palliative care, compared to the extent available for similar work in other specialties. Parikh et al. attribute the lack of grant and funding sources to policymakers’ reluctance to devote resources to

¹³ California Healthcare Foundation. *Palliative Care in California: Fundamentals of Hospital-Based Programs*. Oakland, CA: May 2007. Available at: <http://www.chcf.org/publications/2007/11/palliative-care-in-california-the-state-of-hospitalbased-programs>

¹⁴ Parikh R, Kirch R, Smith T, Temel J. Early Specialty Palliative Care – Translating Data in Oncology into Practice. *The New England Journal of Medicine*. December 12, 2013. 369:24.

¹⁵ Ollove M. Doctors may get paid for end-of-life planning. *Stateline*. June 2, 2014.

¹⁶ Ollove M. Medicare reconsiders rule that leaves dying patients facing a stark choice. *Washington Post*. August 24, 2015.

¹⁷ CMS Fact Sheet. 2015-07-20. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-20.html>

¹⁸ Gibbs K, Mahon M, Truss M, Eyring K. An Assessment of Hospital-Based Palliative Care in Maryland: Infrastructure, Barriers, and Opportunities. *Journal of Pain and Symptom Management*. June 2015. Vol. 49 No. 6

initiatives linked to “death and dying”¹⁹ – further perpetuating the need to distinguish between palliative care and hospice.

Evidence of Benefits and Cost Savings to Patients and Health Systems

The American Medical Association described the difficulty in measuring a nuanced health care system intervention like palliative care, compared to, e.g., a pharmacological intervention given at a specific point in a patient’s care,²⁰ especially with limited program resources and fewer funding opportunities. Advisory Group members also reported challenges related to collecting data post-discharge on a particular hospital service, even more so if the hospital visit ended with a patient’s death.

Still, there is published evidence regarding the effectiveness of palliative care – with studies suggesting more work needs to be done to better substantiate the effectiveness of palliative care across all care settings. Several literature reviews were published in the early 2000s assessing studies that reported improved patient care. Franke found reported positive effects on patients’ physical symptoms, such as pain, related to palliative care.²¹ Finlay et al. found all but one study indicated positive impacts of a hospital palliative care team on a patient’s care.²² More recently, a Health Care Financing & Organization study of patients in North Carolina reported that the number of palliative care visits was positively related to higher functioning, although the patient’s initial level of functioning is also an important consideration.²³

Among Advisory Group members, Johns Hopkins clinician and researcher Dr. Sydney Morss Dy, found moderate strength of evidence for interventions targeting continuity, coordination, and transitions of care in patients with advanced and serious illness tied to outcomes of patient and family satisfaction.²⁴ In a study conducted at MedStar Union Memorial, Walker, Fabie, and Kearney measured family satisfaction and perception as a result of a palliative team family meeting. Families reported higher levels of satisfaction after a family meeting with the palliative care team compared to previous communication with the medical teams, despite the nature of the topics discussed. The greatest impact was demonstrated in the areas of families’ needs, trust, and courtesy and respect.²⁵

¹⁹ Parikh R, Kirch R, Smith T, Temel J. Early Specialty Palliative Care – Translating Data in Oncology into Practice. *The New England Journal of Medicine*. December 12, 2013. 369;24.

²⁰ Zimmerman C, et al. Effectiveness of Specialized Palliative Care. American Medical Association. 2008.

²¹ Franke, AL. Evaluative research on palliative support teams: a literature review. *Patient Education and Counseling*. August 2000;41(1):83-91.

²² Finlay I, et al. Is There Evidence That Palliative Care Teams Alter End-of-Life Experiences of Patients and Their Caregivers? *Journal of Pain and Symptom Management*. March 2003. DOI: 10.1016/S0885-3924(02)00599-7

²³ Taylor D, et al. (2013). The effect of palliative care on patient functioning. *Journal of Palliative Medicine*, 16, 1227-1231.

²⁴ Dy S, Apostol C, Martinex K, Aslakson R. Continuity, Coordination, and Transitions of Care for Patients with Serious and Advanced Illness: A Systemic Review of Interventions. *Journal of Palliative Medicine*, Volume 16, Number 4, 2013.

²⁵ Fabie J, Walker K, Kearney C. Can families report satisfaction after receiving “bad news”? The impact of inpatient palliative care meetings on family satisfaction. MedStar Health Research Institute.

Practitioners working with hospitals and within health systems are required to provide data that proves cost savings to health systems and hospitals. Two often-cited studies convey that offering palliative care services to hospital inpatients leads to cost savings. The American Medical Association published a study in 2008 that indicated palliative care team consultations resulted in savings of nearly \$1,700 in direct costs per admission and \$279 in savings per day for patients discharged alive. For patients who died in the hospital, cost savings were higher – more than \$4,900 per admission and \$374 per day. Cost reductions were seen in laboratory and intensive care costs.²⁶ Another study published in 2011 in *Health Affairs* concluded that Medicaid patients who receive palliative care incurred \$6,900 less in hospital costs – \$4,100 per admission for patients discharged alive and more than \$7,500 for patients who died in the hospital – compared to groups of patients who did not receive palliative care. Cost savings resulted from less intensive care usage and more hospice referrals.²⁷

Other sources suggest that adding palliative care to a patient’s plan of care can curb future hospital use. Among older people, 90 percent of visits to emergency rooms are for symptoms like pain, shortness of breath, and fatigue that can accompany chronic illness – symptoms that could likely be prevented or managed by palliative care specialists prior to an emergency hospital visit.²⁸ A study in California found that palliative care following hospital discharge helped to reduce readmissions within 30 days.²⁹ Less emergency and inpatient hospital usage was reported for patients who receive palliative care at outpatient clinics, according to a study in the journal *Cancer*.³⁰

In Maryland, a study of patients discharged from three MedStar Health hospitals in Baltimore (MedStar Union Memorial, Good Samaritan, and Harbor) reported a lower rate of readmissions for patients who received a palliative plan of care, adjusting for patients who died. MedStar Health also found lower charges per readmission for patients who received palliative care at 30 days and at 60 days. Readmission charges for palliative patients who accepted a palliative plan of care were \$8,744 for 30-day readmissions and \$8,467 for 60-day readmissions, compared to readmission charges for non-palliative care patients that did not accept a palliative plan of care, which were \$18,391 for 30-day readmissions and \$22,464 for 60-day readmissions. The study also reported a higher rate of acceptance of a palliative plan of care following a palliative consultation when the consult is performed within three days of admission.³¹ Another pilot hospital, Carroll Hospital Center, conducted an evaluation of its patients between July 2014

²⁶ Morrison R, et al. Cost Savings Associated With US Hospital Palliative Care Consultation Programs. American Medical Association. September 2008;168(16):1783-90. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/18779466>

²⁷ Morrison, R, et al. Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries. *Health Affairs*. March 2011. 30, no. 3 (2011):454-63. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21383364>

²⁸ Brody J. Palliative Care, the Treatment That Respects Pain. New York: The New York Times Company. December 2, 2013. Available at: <http://well.blogs.nytimes.com/2013/12/02/palliative-care-the-treatment-that-respects-pain/>

²⁹ Euguidanos S, Vesper E, Lorenz K. 30-day readmissions among seriously ill older adults. *Journal of Palliative Medicine* December 2012; 15(12): 1356-61. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/23045990>

³⁰ Better end-of-life care. Wall Street Journal. July 15, 2014.

³¹ Fabie J, Walker K. The power of a plan: The impact of palliative care decisions at hospital discharge on readmission rates. MedStar Health Research Institute.

and June 2015 and reported a cost savings of \$2,300 per admission and reductions in inpatient, observation, and emergency use after a palliative care consultation.³²

Movements Toward Standardization and Expansion

Policymakers and health care leaders have recently placed emphasis on expanding access to a standard of palliative care. Two legislative initiatives to increase access to palliative care in New York went into effect in 2011. The New York Palliative Care Information Act requires physicians and nurse practitioners treating patients diagnosed with a terminal illness or condition to offer counseling on the available options for palliative care and end-of-life care. The Palliative Care Access Act is intended to ensure that patients are fully informed of the options available to them when they are faced with a serious illness or condition.³³ Also, Mount Sinai Medical Center in New York City recently implemented a pilot study to standardize criteria for initiating palliative care and hospice care among its cancer patients. After standardization, palliative care consultations increased from 41 percent to 82 percent and the 30-day readmission rate decreased from 36 percent to 17 percent.³⁴

In Rhode Island, the Quality of Life/Palliative Care Legislation established a Palliative Care Advisory Council and Palliative Care Consumer and Professional Information Education Program in 2013 with the overarching goals to require palliative care access in Rhode Island health facilities, establish a system for identifying patients or residents who could benefit from palliative care, and provide information about and facilitate access to appropriate palliative care services for patients or residents with serious illness.³⁵ In 2015, Massachusetts passed an act that developed an interdisciplinary advisory council.³⁶ Connecticut has a similar Palliative Care Advisory Council within the Department of Health to report on the state of palliative care and advise on matters related to improving palliative care and the quality of life for people with serious or chronic illnesses.³⁷ Other legislation to increase access to palliative care has been introduced in New Jersey, California, and New Hampshire.

A 2007 report by the California Healthcare Foundation includes four arguments for increasing hospital-based palliative care: (1) Epidemiological – nearly half of deaths occur in the hospital, and hospitals need to provide this service to dying patients; (2) Clinical – to treat the suffering of these patients; (3) Legal/regulatory – to adhere to appropriate symptom control and

³² Carroll Hospital Center. Palliative Care State Pilot Statistics: July 2014-June 2015. Presented by Julie Wright, RN BSN CHPN.

³³ Hospice and Palliative Care Association of New York State. Legislative and Regulatory News. Available at: <http://www.hpcanys.org/about/palliative-care/legislation-regulatory-news/>

³⁴ Bankhead C. Meeting Coverage: Initiative Raises Palliative Care Use in Cancer. MedPage Today. October 2013. Available at: <http://www.medpagetoday.com/MeetingCoverage/AdditionalMeetings/42603>

³⁵ American Cancer Society Cancer Action Network. Rhode Island Paving the Way for Palliative Care. Available at: <http://www.acscan.org/action/ri/updates/2689/>

³⁶ The 189th General Court of the Commonwealth of Massachusetts. Available at: <https://malegislature.gov/Bills/188/House/H4520/History>

³⁷ Connecticut Department of Public Health. Available at: <http://www.ct.gov/dph/cwp/view.asp?a=3117&q=537876>

patients' goals of care; and (4) Financial – due to the reported cost savings to health care systems.³⁸

Related to the publication of their work in the *Journal of Pain and Symptom Management* (JPSM), the Maryland Cancer Collaborative surveyed Maryland hospital administrators in 2014 and asked whether the hospital planned to add or increase palliative care services in the coming three years. Sixty four percent of reporting hospitals planned to increase the number of palliative care physicians, nurses, and/or physician assistants; 56 percent planned to add or expand educational opportunities, training, or professional development for employees, but fewer than half planned to increase their budget for palliative care (48 percent) or add or increase the number of non-medical palliative care team members such as social workers or chaplains (44 percent), and none reported an intention to add or increase the number of palliative care acute beds. Three hospitals planned to establish a palliative care program within the next three years.³⁹

The Maryland Comprehensive Cancer Control Plan included a blueprint for expansion of palliative care across Maryland with recommendations for patients, families, and communities; healthcare professionals and staff; institutions; and healthcare legislators, policymakers, and payers. This blueprint describes “4 A’s” to serve as a guide for expansion: *Awareness* of the benefits of palliative care; *Acknowledgement* of its value; *Access* to resources; and *Action* to develop, implement, and evaluate initiatives.⁴⁰ It should be noted that CAPC’s recent report card on state hospital palliative care programs awarded Maryland an A with a grade of 87.5 in its most recent report, which can be found at <https://reportcard.capc.org/>. The ranking is based on the percentage of hospitals in the state reporting palliative care programs.

In summary, palliative care is both among the oldest of medical practices as well as one of its newest credentialed specialties. The majority of Maryland general acute care hospitals have a palliative care program. Most of these programs, both nationally and in Maryland, follow the consultation model. One of the difficulties encountered in the development of palliative care is the need to differentiate these programs from hospice programs, for both the public and providers. Some research on costs and benefits of palliative care have been done, but more research is needed. This report builds upon previous work and provides a list of best practices and recommendations for minimum standards for hospital palliative care programs. At this point in time, Maryland health care consumers and health care providers may all benefit from a consistent definition and statewide standardization of palliative care programs at Maryland hospitals.

³⁸ California Healthcare Foundation. Palliative Care in California: The State of Hospital-Based Programs. May 2007. Available at: <http://www.chcf.org/publications/2007/11/palliative-care-in-california-the-state-of-hospitalbased-programs>

³⁹ Gibbs K, Mahon M, Truss M, Eyring K. An Assessment of Hospital-Based Palliative Care in Maryland: Infrastructure, Barriers, and Opportunities. *Journal of Pain and Symptom Management*. Vol. 49 No. 6 June 2015.

⁴⁰ Maryland Department of Health and Mental Hygiene. Maryland Comprehensive Cancer Control Plan. Available at: <http://phpa.dhmh.maryland.gov/cancer/cancerplan/SitePages/Home.aspx>.

Characteristics of Maryland Hospital Palliative Care Programs

Commission staff obtained information about Maryland hospital palliative care programs from a variety of sources. Staff interviewed hospital administrators early in the research process regarding the presence of a palliative care program and, if present, its history and growth. Staff surveyed pilot hospitals extensively on various aspects of their programs related to core data elements and best practices throughout the pilot period. The Commission obtained data provided to CAPC on its annual national survey of palliative care programs for 2012 and 2013. Finally, staff used the JPSM article, “An Assessment of Hospital-Based Palliative Care in Maryland: Infrastructure, Barriers, and Opportunities.”⁴¹

Availability of Palliative Care Programs at Maryland Hospitals

The following table lists 32 hospital palliative care programs, and their jurisdictions, that are known to the Commission at this time. Because there are currently no requirements to report on these programs, there is no official list documenting the existence of all hospital palliative care programs in Maryland. Commission staff compiled the following list during the pilot period based on the best available information.

Table 2. Hospitals that Reported Palliative Care Programs and Jurisdiction

Hospital	Jurisdiction
Anne Arundel Medical Center	Anne Arundel County
Atlantic General Hospital*	Worcester County
Bon Secours Baltimore Health System	Baltimore City
Calvert Memorial Hospital	Calvert County
Carroll Hospital Center	Carroll County
Doctors Community Hospital	Prince George’s County
Frederick Memorial Healthcare System	Frederick County
Greater Baltimore Medical Center	Baltimore County
Holy Cross Hospital of Silver Spring	Montgomery County
Howard County General Hospital	Howard County
The Johns Hopkins Hospital	Baltimore City
MedStar Good Samaritan Hospital	Baltimore City
MedStar Harbor Hospital	Baltimore City
MedStar Union Memorial Hospital	Baltimore City
Mercy Medical Center	Baltimore City
Meritus Medical Center	Washington County
Peninsula Regional Medical Center	Wicomico County
Shady Grove Medical Center	Montgomery County
Suburban Hospital*	Montgomery County
Union Memorial Hospital of Cecil County	Cecil County
University of Maryland Baltimore Washington Medical Center	Anne Arundel County

⁴¹ Gibbs K, Mahon M, Truss M, Eyring K. An Assessment of Hospital-Based Palliative Care in Maryland: Infrastructure, Barriers, and Opportunities. *Journal of Pain and Symptom Management*. Vol. 49 No. 6 June 2015.

Hospital	Jurisdiction
University of Maryland Harford Memorial Hospital*	Harford County
University of Maryland Medical Center	Baltimore City
University of Maryland Medical Center Midtown Campus	Baltimore City
University of Maryland Shore Medical Center at Chestertown	Kent County
University of Maryland Shore Medical Center at Dorchester	Dorchester County
University of Maryland Shore Medical Center at Easton	Talbot County
University of Maryland St. Joseph Medical Center	Baltimore County
University of Maryland Upper Chesapeake Medical Center	Harford County
VA Maryland Health Care System	Multiple Jurisdictions
Washington Adventist Hospital	Montgomery County
Western Maryland Regional Medical Center*	Allegany County

Source: Research by Commission staff and Maryland Cancer Collaborative staff

* Included in Commission research, but not listed as a hospital that reported a palliative care program for the JPSM article research.

All of these hospitals deliver inpatient palliative care services using a consultation service model whereby a primary care provider requests a palliative care consultation and the patient remains in the current nursing unit. Additionally, two pilot hospitals, Johns Hopkins and Meritus also have an inpatient palliative care unit with dedicated beds for palliative care patients. All pilot hospitals serve an adult population, aged 18 or older; Johns Hopkins also serves pediatric patients.

More than one-third of hospitals (9 out of 25) surveyed for the JPSM article that have palliative care programs reported offering outpatient palliative care services.⁴² Commission pilot hospital responses to CAPC’s annual survey indicated that seven of the 11 pilot hospitals offer some form of outpatient palliative care services. Four operate a hospital clinic, one offers home visits through a community practice, one offers services through an independent physician practice, and one offers collaborative care over the phone or with a skilled nursing facility. One pilot hospital, MedStar Union Memorial, also recently implemented a telemedicine program for further access to patients after discharge.

Joint Commission Certification

Currently, only one hospital palliative care program in Maryland is certified by the Joint Commission, MedStar Union Memorial. Among the pilot hospitals, four reported intentions to apply in the near future: Johns Hopkins, Howard County, Greater Baltimore, and Suburban. Three other pilot hospitals reported that they would like to apply, but do not have required elements: Meritus, Carroll, and Doctors Community. The remaining three pilot hospitals do not plan to apply at this time: Peninsula Regional, Holy Cross, and Upper Chesapeake.

The JPSM article reported that five hospitals with palliative care programs indicated they were in the process of applying for Joint Commission certification or planned to do so within the next 24 months. Noted barriers to applying for certification include: staffing issues like the need for 24/7 coverage, difficulty finding qualified personnel, and the need for additional full-time

⁴² Ibid.

staff. Other common barriers to pursuing certification included the newness of the program, the high costs associated with certification, and the lack of clear benefits.⁴³

Services Provided by Hospital Palliative Care Programs

Palliative care services are similar across hospitals, regardless of size or geography, according to the JPSM article. Based on survey responses, all hospitals with palliative care programs include bridging patients to hospice care and more than 90 percent include pain and/or symptom assessment and management, discussion of advance directives with patients, psychosocial support, and preparation of a comfort care plan. Eighty six percent of hospital palliative care programs offer pastoral care/spiritual consultation and bridging to community resources, and 81 percent provide caregiver and family support.⁴⁴ According to CAPC annual survey responses, six of the 11 pilot hospitals provide inpatient hospice care.

Nearly 40 percent of hospitals reported a lack of discussion of financial planning or referral to financial counselors, as well as a lack of psychiatric and mental health assessment and management. The JPSM article also reported a statistical difference in geographic availability of financial planning services, which were present in only 40 percent of programs in Central Maryland, but in 90 percent of palliative programs in other regions.⁴⁵

Identification of Patients

Most hospital palliative care programs rely on the primary health care provider, the patient, or the family to initiate a request for palliative care. Most institutions require a referral by a medical practitioner, and most (86 percent) allow mid-level providers like physician's assistants and advanced practice registered nurses to order a consultation. Social workers and nurses are able to initiate referrals for palliative care consultation at a minority of institutions (36 percent and 32 percent, respectively).⁴⁶

Nearly 60% of palliative care programs systematically initiate early introduction of palliative care during the course of treatment. In contrast, nearly 20 percent of hospitals do not have a formal process to initiate a discussion about palliative care.⁴⁷ Based on CAPC data, six out of 11 pilot hospitals utilize screening criteria to identify palliative care consultations. The CAPC survey asks respondents to identify the top referral sources to palliative care. Three pilot hospitals were unable to report this. Among pilot hospitals that did report, the most frequently reported referral sources by specialty include hospitalists, pulmonary specialists, and oncologists.

Staffing Composition

All pilot hospital programs have at least one clinical staff member certified in palliative care. The total number of palliative care team members ranges from a single staff member each at Carroll (certified registered nurse) and Doctors Community (certified physician) to 13 team

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Ibid.

members at the Johns Hopkins program, consisting of an administrator, medical director, physician, advanced practice nurses, registered nurse, chaplains, social worker, psychologist, physician fellows, pharmacist, and clerical staff, not all of whom are certified in palliative care or a specialty field.

Nine out of 11 pilot hospital teams include a physician; six of those pilots have physicians certified in palliative care or a related specialty. Of the two pilot hospitals that do not have a physician as a member of the team: Meritus has a certified advanced practice nurse and Carroll is led by a registered nurse with palliative care certifications. All but two teams (Carroll and Doctors Community) include a social worker. Four teams have a non-clinical medical director, seven teams include clerical support staff, and three teams have a dedicated hospice liaison. MedStar Union Memorial and Johns Hopkins also have clinical pharmacists who are residency trained in palliative care as core team members, which is standard for palliative care teams at all MedStar Health and University of Maryland system hospitals in Maryland. Pilots also report access to additional hospital staff members as needed or available, including chaplains, for example.

Palliative Care Program Policies and Plans

House Bill 581 required that pilot hospitals include policies and procedures established by the hospitals that (1) provide access to information and counseling regarding palliative care services appropriate to a patient with a serious illness or condition; (2) identify the authorized decision maker for an individual who lacks capacity to make health care decisions in order to provide the decision maker access to information and counseling regarding options for palliative care for the patient; (3) require providers to engage in a discussion of the benefits and risks of treatment options in a manner that can be understood easily by the patient or authorized decision maker; (4) encourage the patient or authorized decision maker to include the patient's relatives and friends in counseling regarding palliative care; and (5) facilitate access to appropriate palliative care consultations and services, including associated pain management consultations and service consistent with the patient's needs and preferences. All pilots verified that these policies or procedures were in place at their hospital as part of the requirements to become a pilot hospital for this project.

The CAPC survey requests information regarding plans in place at palliative care programs that help guide programmatic decisions. All pilot hospitals report the use of a quality improvement plan and education plan. Generally, the education plan is a tool used to educate hospital staff regarding the benefits and availability of palliative care. All but two pilot hospitals report using a marketing plan for outreach to the public and other audiences. Eight out of 11 pilot hospitals report having a bereavement plan in place in their program. Several pilots rely on a relationship with hospice programs to deliver bereavement services.

Relationship with Hospice Service Providers

All pilot hospitals report close ties with at least one, and in most cases several, local hospice providers. Table 3 includes descriptions of the relationship, as reported to CAPC and to Commission staff.

Table 3. Pilot Hospital Palliative Care Programs’ Relationship to Hospice

Hospice Relationship Description	# of Responses	Pilot Hospitals
Functions as one program with hospice	2	Howard County Peninsula Regional
Hospital owns hospice but is separate from palliative care program	3	Carroll Greater Baltimore Holy Cross*
Contract(s) with community hospice agencies	2	Doctors Community Meritus
Informal collaboration with hospice	4	Johns Hopkins MedStar Union Memorial Suburban Upper Chesapeake



*Hospice owned by Trinity Health, parent of Holy Cross



Source: Commission staff analysis of CAPC annual survey responses for 2012 and 2013

Integration with Other Hospital Units

The CAPC annual survey includes questions about the integration of palliative care into intensive care and emergency medicine at the hospital. The pilot hospitals’ responses to the survey indicate relatively more integration with intensive care than emergency medicine. As shown in Table 4 below, six of the pilot hospitals reported working collaboratively with intensive care and three of those six reported that the intensive care unit developed plans to improve access to palliative care in that unit. Only three pilot hospitals reported working collaboratively with emergency medicine; one of those reported that an emergency medical team developed plans to improve access to palliative care.

Table 4. Pilot Hospitals’ Description of Palliative Care Integration with Other Hospital Units or Departments

Description of Integration with Intensive Care:	Pilot Hospital	
There has been no work to develop a system of care coordination between intensive care and palliative care	Carroll Holy Cross Howard County Peninsula Regional Suburban	 Less Integration
Teams have worked collaboratively to develop a system to enhance palliative care in the unit or department (e.g., screening criteria, automatic consults)	Doctors Community Greater Baltimore Upper Chesapeake	More Integration
The unit or department has developed and/or implemented plans to improve delivery of palliative care (e.g., palliative care training for staff, patient/family support materials, hired a hospice and palliative medicine trained physician, routine family meetings)	Johns Hopkins MedStar Union Memorial Meritus	

Description of Integration with Emergency Medicine:	Pilot Hospital	
There has been no work to develop a system of care coordination between emergency medicine and palliative care	Carroll Greater Baltimore Holy Cross Howard County MedStar Union Memorial Peninsula Regional Suburban Upper Chesapeake	 Less Integration
Teams have worked collaboratively to develop a system to enhance palliative care in the unit or department (e.g., screening criteria, automatic consults)	Doctors Community Meritus	More Integration
The unit or department has developed and/or implemented plans to improve delivery of palliative care (e.g., palliative care training for staff, patient/family support materials, hired a hospice and palliative medicine (HPM) trained physician, routine family meetings)	Johns Hopkins	

Source: Commission staff analysis of CAPC annual survey responses for 2012 and 2013

Funding Sources

The majority of funding for most pilot hospital palliative care programs comes from programmatic hospital support, described as either hospital support or billing in the CAPC survey. Two exceptions are Greater Baltimore and Howard County (managed by the same palliative care team), which reported more than half of their funding from philanthropy and/or grants. Peninsula Regional's palliative care program was also supported by hospice program funds, and Johns Hopkins had funding for a stipend for the medical director. Table 5 reflects the responses to CAPC.

Table 5. Funding Source as a Percentage of Total Service Cost for Pilot Hospital Palliative Care Programs

Pilot Hospital	Hospital Support or Billing	Philanthropy/ Grants	Hospice	Medical Director Stipend
Carroll	100%			
Doctors Community	100%			
Greater Baltimore	35%	65%		
Holy Cross	99%	1%		
Howard County	60% in 2012 46% in 2013	40% in 2012 54% in 2013		
Johns Hopkins	85%	10%		5%
MedStar Union Memorial	100%			
Meritus	100%			
Peninsula Regional	60%		40%	
Suburban	100%			
Upper Chesapeake	100%			

Source: Commission staff analysis of CAPC annual survey responses for 2012 and 2013

Summary of Pilot Hospital Palliative Care Program Characteristics

Commission staff obtained information about Maryland palliative care programs from various sources. Based on data from these sources, a list of 32 hospitals that have palliative care programs were presented; 11 of these hospitals are pilot hospitals in this report. Currently, only one Maryland program is Joint Commission certified, but some others plan to seek certification. Most palliative care programs rely on the primary care provider, the patient, or the family to initiate a request for palliative care. All pilot hospital programs have established relationships with hospice programs. All pilot hospital programs report having policies and plans in place as required by HB 581.

Pilot Study Data Outcomes for Maryland Hospital Palliative Care Programs

House Bill 581 required this report to include analysis regarding costs and savings to hospitals and providers, access to care, and patient choice for palliative care services in Maryland. Advisory Group members helped to identify core data measures and sources for this information, including patient-level data collected by HSCRC on every inpatient admission to a Maryland hospital.

Commission staff worked with HSCRC to develop a process to identify inpatients who received consultations from palliative care teams at pilot hospitals during the pilot period. HSCRC is legislatively mandated to collect certain information on all inpatient discharges from Maryland hospitals. Using HSCRC's established data collection process for this study, pilot hospital palliative care teams flagged patients who received palliative care consultations during fiscal year 2015 (July 1, 2014 to June 30, 2015). The HSCRC discharge abstract provides demographic information including age, race and Hispanic origin, disease categories, diagnoses, disposition at discharge, readmission rates, and lengths of stays and charges for health care services. In this section, the data set is referred to as the *discharge abstract* and patients are referred to as *discharges*. By utilizing this existing resource, the Commission avoided duplication of data collection and obtained access to the same level of detail on each palliative care patient consultation as the rest of the hospital patient population. It greatly expanded staff's ability to analyze variables of interest to the General Assembly and provided a broader perspective for comparisons of patient experience and costs. Staff used the HSCRC discharge abstract to answer the following questions:

- What was the general use of palliative care consultation services at pilot hospitals?
- What were the characteristics of the patient population assessed by palliative care team staff? What were the characteristics of the patient population that accepted palliative care program services, compared to the population that chose not to use these services? Were there differences between the group who accepted palliative care after a consult and those who did not?
- What was the disposition of the patient population using hospital palliative care program services at the end of the hospital stay? What was the disposition of those who did not accept palliative care at the end of the hospital stay?

- What were the readmission rates and payer sources of the patient population groups assessed by palliative care team staff compared to medical/surgical inpatients?
- What was the general acute care hospital utilization and cost experience of the patient population using hospital palliative care program services? What was the hospital utilization and cost experience of those patients who did not accept palliative care? What was the experience for unflagged medical/surgical discharges?

Defining Palliative Care for Pilot Study

First, the discharge abstract includes a variable to track procedure codes, including palliative care (ICD-9 code V66.7). This variable helps the HSCRC estimate case levels to measure performance linked to hospital payments. The HSCRC excludes cases with a V66.7 procedure code from eligibility to acquire a potentially preventable complication and when measuring inpatient mortality for the Quality Based Reimbursement program. HSCRC audits this data by comparing it to patient records.

According to Advisory Group members, a primary care provider may categorize his or her services as palliative care, but this does not necessarily indicate that the patient received any defined level of palliative care or that these services meet the definition of palliative care used by this pilot project. For this reason, Advisory Group members recommended that Commission staff seek an alternative way to track palliative care patients for this pilot project (see flagging protocol below). Still, this information may be valuable to better understand the location of discharges who were coded as receiving palliative care, in any form, in the last fiscal year. As shown in Table 6, more than 19,000 inpatients were coded for palliative care in FY 2015 at nearly every acute general care hospital in Maryland.

Table 6. Total Medical/Surgical Discharges and Use of Palliative Care Procedure Code at All Maryland Hospitals, FY 2015

Hospital	Medical/Surgical Discharges	Discharges with Palliative Care Procedure Code	Ratio of Discharges who Received Palliative Care to Medical/Surgical Discharges
Anne Arundel Medical Center	18,638	1,357	7.3%
Atlantic General Hospital	3,317	266	8.0%
Bon Secours Hospital	2,606	23	0.9%
Calvert Memorial Hospital	3,824	89	2.3%
Carroll Hospital Center	8,193	467	5.7%
Doctors Community Hospital	8,624	336	3.9%
Edward W. McCready Memorial Hospital	294	-	-
Frederick Memorial Hospital	11,982	873	7.3%
Fort Washington Medical Center	2,224	5	0.2%
Garrett County Memorial Hospital	1,495	39	2.6%
Greater Baltimore Medical Center	11,488	387	3.4%
Holy Cross Germantown Hospital	1,893	60	3.2%
Holy Cross Hospital of Silver Spring	17,915	1,122	6.3%
Howard County General Hospital	11,136	661	5.9%

Hospital	Medical/ Surgical Discharges	Discharges with Palliative Care Procedure Code	Ratio of Discharges who Received Palliative Care to Medical/Surgical Discharges
Johns Hopkins Bayview Medical Center	17,371	1,001	5.8%
The Johns Hopkins Hospital	31,058	1,170	3.8%
Laurel Regional Hospital	2,895	107	3.7%
Mercy Medical Center	9,328	164	1.8%
Meritus Medical Center	12,928	547	4.2%
MedStar Franklin Square Hospital	15,089	606	4.0%
MedStar Good Samaritan Hospital	9,201	449	4.9%
MedStar Harbor Hospital	5,476	190	3.5%
MedStar Montgomery Medical Center	5,806	308	5.3%
MedStar Southern Maryland Hospital Center	9,863	331	3.4%
MedStar St. Mary's Hospital	4,887	141	2.9%
MedStar Union Memorial Hospital	15,082	368	2.4%
Northwest Hospital Center	9,173	303	3.3%
Peninsula Regional Medical Center	14,265	642	4.5%
Prince George's Hospital Center	7,922	152	1.9%
Shady Grove Adventist Hospital	12,095	470	3.9%
Sinai Hospital of Baltimore	15,820	464	2.9%
St. Agnes Hospital	13,355	588	4.4%
Suburban Hospital	11,943	668	5.6%
Union Hospital of Cecil County	4,114	177	4.3%
University of Maryland Baltimore Washington Medical Center	15,651	908	5.8%
University of Maryland Charles Regional Medical Center	5,630	125	2.2%
University of Maryland Harford Memorial Hospital	2,907	172	5.9%
University of Maryland Medical Center	23,341	1,084	4.6%
University of Maryland Medical Center Midtown Campus	3,412	20	0.6%
University of Maryland Shore Medical Center at Chestertown	1,805	52	2.9%
University of Maryland Shore Medical Center at Dorchester	1,867	70	3.7%
University of Maryland Shore Medical Center at Easton	6,188	285	4.6%
University of Maryland St. Joseph Medical Center	12,614	416	3.3%
University of Maryland Upper Chesapeake Medical Center	9,565	607	6.3%
Washington Adventist Hospital	7,474	300	4.0%
Western Maryland Regional Medical Center	9,432	502	5.3%
Total	431,186	19,072	4.4%

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Pilot Project Flagging Protocol

The guideline for flagging pilot hospital palliative care consultations in the HSCRC discharge abstract was to flag all patients who were referred to each hospital palliative care program and obtained a palliative care consultation to address serious, complex, and potentially life-limiting or life-threatening conditions. This included any patient who was seen by a member of the palliative care team, no matter what the outcome of the consultation. The flagging protocol included tracking the outcome of the consultation, using the following categories.⁴⁸

- Patient visits coded 1 received a palliative care consultation and accepted a palliative plan of care and were not referred to hospice care.
- Patients coded 2 received a palliative care consultation and accepted a plan of care specifying hospice care, and were referred to hospice care.
- Patients coded 3 received a palliative care consultation but did not accept a palliative plan of care, including referral to hospice.
- Patients coded 8 received a palliative care consultation and this code was used as an alternative to the preceding 1, 2, and 3 options. This option was available if pilots chose to code all patients “8” without further detail. Each pilot reported a preference to utilize the 1, 2, and 3 coding options. However, a number of patients (overall, less than five percent) were coded 8 in the data from four pilot hospitals. These patients are included in analysis of the total consults where indicated, and excluded when an analysis regarding the outcome of the consultation is important.

Commission staff attempted to standardize the categorization of the outcomes of the consultations as much as possible using the definitions above. However, the process also required hospital pilot staff to use discretion when interpreting whether patients “accepted palliative care recommendations” to a degree that would be useful for this pilot project. Based on a review and discussion about the data, those determinations were made differently at MedStar Union Memorial. At this pilot hospital, code 1 was used when patients accepted palliative care *and* changed the trajectory of care to de-escalate other treatment in favor of a palliative care plan; code 3 was used in cases when patients chose to continue aggressive curative treatment while palliative care staff continued to manage palliative care treatment at the same time. All other pilot hospitals coded patients who accepted palliative care, at any stage in the disease process, as code 1.

The following data provides a comparison of patients who received a palliative care consultation and total medical/surgical patients during the pilot period. However, the discharge abstract does not provide the ability to determine at what point during a hospital stay a patient received a palliative care consultation – whether it took place early toward the beginning of a hospital stay, or toward the end when it was clear a patient was close to death. Thus, limited conclusions can be drawn regarding the direct impact of palliative care on the length of one hospital stay and costs to the health care system across pilot settings based on this flagged data.

⁴⁸ The variable added the HSCRC inpatient discharge abstract from July 1, 2014 to June 30, 2015 was data item 57, variable PALLCARE, record position 243.

However, this data provides a description of the palliative care patient and utilization for one hospital stay, and allows a comparison to the medical/surgical patient population, which are valuable to demonstrate the population that would be served by standardized hospital palliative care programs.

Discharge Abstract Observations

Question: What was the general use of palliative care consultation services at pilot hospitals?

During fiscal year 2015, 11 pilot hospitals' palliative care teams flagged nearly 7,000 patient consultations. The number of discharges flagged at each pilot hospital ranged from 300 at Howard County to 1,453 at Johns Hopkins, as shown in Table 7. Overall, the data indicates that staff consulted with patients for whom palliative care recommendations were accepted nearly 80 percent of the time. MedStar Union Memorial's data is not reflective of the same coding decisions used at other pilot hospitals. Staff at this pilot reported that they generally flagged patients who chose to continue aggressive curative treatment as code 3, indicating that they declined palliative care at the time, even though the palliative care team managed symptoms.

As Table 7 shows, overall, nearly 40 percent of palliative care consultations accepted a referral to hospice. This illustrates the overlap in the patient population between hospice and palliative care and emphasizes the challenge at hospitals to introduce palliative care early enough to impact a patient's care over a longer term. Some of these patients were likely suitable for palliative care much earlier than in the final stages before dying. A closer relationship with hospice, as described in the CAPC survey responses shown in Table 3, did not correspond to a greater percentage of referrals to hospice.

Table 7. Number and Percent of Flagged Palliative Care Consultations at Pilot Hospitals by Consultation Outcome, FY 2015

Pilot Hospital		Accepted Palliative Care Plan of Care	Declined Palliative Care Recommendations	Referred to Hospice	Outcome Unknown	Total
Carroll	Frequency	249	119	267	-	635
	Percent	39.2%	18.7%	42.1%		
Doctors Community	Frequency	75	102	250	47	474
	Percent	15.8%	21.5%	52.7%	9.9%	
Greater Baltimore	Frequency	211	45	238	-	494
	Percent	42.7%	9.1%	48.2%		
Holy Cross	Frequency	312	247	398	-	957
	Percent	32.6%	25.8%	41.6%		
Howard County	Frequency	99	61	136	4	300
	Percent	33.0%	20.3%	45.3%	1.3%	
Johns Hopkins	Frequency	660	37	501	255	1,453
	Percent	45.4%	2.6%	34.5%	17.6%	
MedStar Union Memorial	Frequency	58	333	129	-	520
	Percent	11.1%	64.1%	24.8%		
Meritus	Frequency	195	106	254	-	555

Pilot Hospital		Accepted Palliative Care Plan of Care	Declined Palliative Care Recommendations	Referred to Hospice	Outcome Unknown	Total
	Percent	35.1%	19.1%	45.8%		
Peninsula Regional	Frequency	330	23	176	-	529
	Percent	62.4%	4.4%	33.3%		
Suburban	Frequency	208	81	172	20	481
	Percent	43.2%	16.8%	35.8%	4.2%	
Upper Chesapeake	Frequency	328	32	232	-	592
	Percent	55.4%	5.4%	39.2%		
Total	Frequency	2,725	1,186	2,753	326	6,990
	Percent	39.0%	17.0%	39.4%	4.7%	

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Ninety-eight percent of palliative care consultations fit the definition of medical/surgical patients based on major diagnostic codes (that is, they were not newborn, obstetric, pediatric, psychiatric, or rehabilitation inpatients). Table 8 displays the ratio of palliative care consultations to total medical/surgical discharges. Overall, the ratio of palliative care consultations to medical/surgical discharges was 5 percent. Nine of the pilots' ratios fell between one standard deviation of the mean, between 3.5 and 6.2 percent – with Howard County (nearly three percent) and Carroll (nearly eight percent) outliers outside of that distribution.

Table 8. Number and Ratio of Palliative Care Consultations to Medical/Surgical Discharges, FY 2015

Pilot Hospital	Flagged Palliative Care Consultations	Medical/Surgical Discharges	Ratio of Consults to Medical/Surgical Discharges
Carroll	635	8,193	7.8%
Doctors Community	474	8,624	5.5%
Greater Baltimore	494	11,488	4.3%
Holy Cross	957	17,915	5.3%
Howard County	300	11,136	2.7%
Johns Hopkins	1,453	34,909	4.2%
MedStar Union Memorial	520	15,082	5.1%
Meritus	555	12,928	4.3%
Peninsula Regional	529	14,265	3.7%
Suburban	481	11,943	4.0%
Upper Chesapeake	592	9,565	6.2%
Total	6,990	156,048	4.5%

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Question: What were the characteristics of the patient population assessed by palliative care team staff? What are the characteristics of the patient population that accepted palliative care program services, compared to the population that chose not to use these services? Were there differences between the group who accepted palliative care after a consult and those who did not?

Table 9 displays selected age groups for the medical/surgical discharge population at all hospitals, at pilot hospitals, and for flagged palliative care consultations. The percentage of discharges under 65 years of age, between the ages of 65 and 84, and 85 years of age or older are very similar at all Maryland hospitals and pilot hospitals, suggesting that medical/surgical admissions to the pilot hospital group are representative of hospitals statewide. For palliative care consultations at pilot hospitals, compared to the overall medical/surgical discharge population, patients who received palliative care consultations skewed older. One quarter of patients who received a palliative care consultation were 85 year of age or older, compared to a little more than 11 percent of all medical/surgical discharges.

Table 9. Percent of Selected Age Groups for Medical/Surgical Discharges and Pilot Hospital Palliative Care Consultations, FY 2015

Patient Group	Under 65 Years of Age	65-84 Years of Age	85 Years of Age or Older
Medical/surgical discharges at all Maryland hospitals	50.8%	37.6%	11.6%
Medical/surgical discharges at pilot hospitals	50.8%	37.8%	11.4%
Flagged palliative care consultations at pilot hospitals	29.8%	45.2%	25.0%

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Table 10 displays a collapsed racial breakdown and Hispanic origin of discharges from pilot hospitals in FY 2015, as available in the HSCRC discharge abstract. This shows the varying diversity of the populations served at each pilot. Among races, based on the composition of medical/surgical discharges, there was no apparent pattern of disparity in the provision of palliative care consultations – though African Americans made up a larger proportion of consultations at Holy Cross, Howard County, Peninsula Regional, and Union Memorial than the total medical/surgical discharge population. This data also shows that African Americans made up a higher proportion of patients who declined palliative care recommendations, overall and at nearly all pilots. The National Hospice and Palliative Care Organization acknowledges that African Americans are less likely to use hospice and receive other routine medical procedures than white counterparts, and provides outreach material to address this concern. Data displayed in Table 10 aligns with that assessment, but regarding the acceptance of palliative care.⁴⁹ In total, and at eight out of 11 pilots (except Carroll, Johns Hopkins, and Suburban), the proportion of Hispanic medical/surgical discharges was larger than that of the patients who received a palliative care consultation. The percent of Hispanic medical/surgical discharges was double the percent who received a palliative care consultation at seven pilots, suggesting a disparity in access to these services for this population across Maryland.

⁴⁹ National Hospice and Palliative Care Organization. African American Outreach Guide – Abbreviated Version. Found at http://www.nhpco.org/sites/default/files/public/Access/African_American_Outreach_Guide.pdf.

Table 10. Reported Racial and Ethnic Characteristics of Medical/Surgical Discharges and Palliative Care Consultations at Pilot Hospitals, FY 2015

Pilot Hospital	Patient Group	Race					Ethnicity
		White	Black	Asian	Other	Unknown	Hispanic Origin
Carroll	Medical/Surgical Discharges	93.9%	4.5%	0.1%	0.2%	1.2%	0.9%
	Flagged Consultations	95.3%	3.6%	0.0%	0.0%	1.1%	0.9%
	Accepted Palliative Plan of Care	95.7%	2.9%	0.0%	0.0%	1.4%	0.8%
	Declined Recommendations	95.2%	4.8%	0.0%	0.0%	0.0%	0.0%
	Referred to Hospice	94.8%	3.8%	0.0%	0.0%	1.4%	1.5%
Doctors Community	Medical/Surgical Discharges	20.0%	71.5%	1.0%	7.2%	0.3%	4.3%
	Flagged Consultations	22.3%	69.7%	1.7%	6.3%	0.0%	1.7%
	Accepted Palliative Plan of Care	28.9%	66.7%	0.0%	4.4%	0.0%	1.3%
	Declined Recommendations	27.1%	64.4%	3.4%	5.1%	0.0%	0.0%
	Referred to Hospice	20.1%	70.7%	1.7%	7.5%	0.0%	2.8%
Greater Baltimore	Medical/Surgical Discharges	74.2%	22.6%	1.0%	2.0%	0.1%	1.3%
	Flagged Consultations	76.7%	21.4%	0.5%	1.4%	0.0%	0.6%
	Accepted Palliative Plan of Care	77.3%	22.2%	0.5%	0.0%	0.0%	0.5%
	Declined Recommendations	60.0%	40.0%	0.0%	0.0%	0.0%	0.0%
	Referred to Hospice	79.5%	17.1%	0.5%	2.9%	0.0%	0.8%
Holy Cross	Medical/Surgical Discharges	39.8%	42.2%	4.9%	9.8%	3.3%	12.8%
	Flagged Consultations	34.8%	46.8%	7.4%	6.5%	4.5%	6.2%
	Accepted Palliative Plan of Care	37.7%	44.9%	8.5%	15.3%	2.1%	5.5%
	Declined Recommendations	22.3%	58.6%	8.3%	7.3%	3.6%	8.5%
	Referred to Hospice	40.3%	41.0%	6.1%	5.8%	6.8%	5.3%
Howard County	Medical/Surgical Discharges	64.0%	24.7%	6.2%	4.9%	0.2%	2.5%
	Flagged Consultations	57.5%	32.6%	6.3%	3.6%	0.0%	1.3%
	Accepted Palliative Plan of Care	64.6%	25.3%	10.1%	0.0%	0.0%	1.0%
	Declined Recommendations	40.4%	42.6%	4.3%	12.8%	0.0%	1.6%
	Referred to Hospice	60.0%	33.7%	4.2%	2.1%	0.0%	1.5%
Johns Hopkins	Medical/Surgical Discharges	53.8%	35.8%	2.3%	6.1%	2.0%	2.8%
	Flagged Consultations	54.1%	33.4%	2.4%	6.6%	3.5%	3.2%
	Accepted Palliative Plan of Care	53.2%	33.7%	1.8%	8.6%	4.6%	2.7%
	Declined Recommendations	37.5%	40.6%	6.3%	15.6%	0.0%	0.0%
	Referred to Hospice	58.6%	29.8%	2.9%	5.8%	2.9%	4.8%
MedStar Union Memorial	Medical/Surgical Discharges	19.0%	20.1%	0.1%	1.3%	59.5%	0.5%
	Flagged Consultations	11.9%	25.5%	0.0%	0.7%	61.8%	0.2%
	Accepted Palliative Plan of Care	0.0%	8.6%	0.0%	0.0%	91.4%	0.0%
	Declined Recommendations	12.9%	28.5%	0.0%	1.0%	57.6%	0.0%
	Referred to Hospice	13.5%	23.1%	0.0%	0.0%	63.5%	0.8%
Meritus	Medical/Surgical Discharges	91.3%	6.5%	0.4%	1.8%	0.0%	1.1%
	Flagged Consultations	93.2%	5.9%	0.5%	0.5%	0.0%	0.0%
	Accepted Palliative Plan of Care	93.6%	5.2%	0.7%	0.0%	0.0%	0.0%
	Declined Recommendations	85.5%	14.5%	0.0%	0.0%	0.0%	0.0%
	Referred to Hospice	96.1%	3.0%	0.5%	0.0%	0.0%	0.0%
Peninsula Regional	Medical/Surgical Discharges	73.9%	23.1%	0.2%	2.6%	0.2%	4.3%
	Flagged Consultations	69.3%	27.7%	0.0%	2.8%	0.2%	2.8%
	Accepted Palliative Plan of Care	66.8%	30.2%	0.0%	2.6%	0.4%	3.0%
	Declined Recommendations	63.2%	31.6%	0.0%	5.3%	0.0%	4.4%
	Referred to Hospice	74.8%	22.3%	0.0%	2.9%	0.0%	2.3%
Suburban	Medical/Surgical Discharges	66.7%	16.5%	4.8%	10.6%	1.4%	6.0%
	Flagged Consultations	68.4%	14.7%	4.6%	12.1%	0.3%	6.9%
	Accepted Palliative Plan of Care	67.3%	14.8%	3.1%	17.3%	0.6%	7.2%
	Declined Recommendations	75.0%	16.7%	4.2%	4.2%	0.0%	6.2%
	Referred to Hospice	68.1%	14.3%	6.7%	10.9%	0.0%	7.0%
Upper Chesapeake	Medical/Surgical Discharges	88.3%	9.3%	0.9%	1.5%	0.1%	1.1%
	Flagged Consultations	90.4%	7.4%	0.9%	1.1%	0.2%	0.5%
	Accepted Palliative Plan of Care	90.1%	8.0%	0.4%	1.9%	0.0%	0.9%
	Declined Recommendations	93.3%	0.0%	6.7%	0.0%	0.0%	0.0%
	Referred to Hospice	90.6%	7.2%	1.1%	0.6%	0.6%	0.0%
Total	Medical/Surgical Discharges	59.0%	26.7%	2.1%	4.8%	7.4%	3.7%
	Flagged Consultations	60.7%	26.7%	2.3%	4.0%	6.4%	2.5%
	Accepted Palliative Plan of Care	66.7%	24.0%	2.1%	6.2%	3.1%	2.5%
	Declined Recommendations	40.4%	34.2%	2.7%	3.6%	19.1%	2.4%
	Referred to Hospice	64.2%	25.0%	2.3%	3.8%	4.8%	2.8%

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

More than half of flagged palliative care discharges fell within three major diagnostic categories (MDCs). In order, these were: infectious and parasitic diseases and disorders, diseases and disorders of the respiratory system, and diseases and disorders of the circulatory system. By comparison, the majority of medical/surgical inpatients fell under the following MDCs: diseases and disorders of the circulatory system, diseases and disorders of the musculoskeletal system/connective tissue, diseases and disorders of the respiratory system, diseases and disorders of the digestive system, and diseases and disorders of the nervous system. Common diagnoses that fall under the most frequent five MDCs listed in Table 11, in order by MDC number include:

- Diseases and disorders of the nervous system: nervous system or cranial tumors, cerebrovascular disorders, and traumatic stupor and coma;
- Diseases and disorders of the respiratory system: pulmonary edema and respiratory failure, pneumonia, respiratory tumors, and respiratory infections and inflammations;
- Diseases and disorders of the circulatory system: heart failure, myocardial infarction, and cardiac arrhythmia;
- Diseases and disorders of the digestive system: digestive malignancy, esophagitis, gastroenteritis, and gastrointestinal hemorrhage;
- Diseases and disorders of the musculoskeletal system and connective tissue: pathological fractures and musculoskeletal and connective malignancies;
- Infectious and parasitic diseases and disorders: septicemia.

Table 11. Percent of Flagged Palliative Care Consultations and Medical/Surgical Discharges in All Major Diagnostic Categories of Diseases and Disorders (DDs), FY 2015

All Flagged Palliative Care Consultations		Medical/Surgical Discharges	
<u>Major Diagnostic Categories</u>	<u>Percent</u>	<u>Major Diagnostic Categories</u>	<u>Percent</u>
Infectious and Parasitic DDs	19.6%	DDs of the Circulatory System	16.2%
DDs of the Respiratory System	18.3%	DDs of the Musculoskeletal System And Connective Tissue	13.7%
DDs of the Circulatory System	12.9%	DDs of the Respiratory System	11.9%
DDs of the Nervous System	9.2%	DDs of the Digestive System	11.6%
DDs of the Digestive System	9.0%	DDs of the Nervous System	9.0%
DDs of the Kidney/Urinary Tract	5.7%	Infectious and Parasitic DDs	7.9%
DDs of the Hepatobiliary System/Pancreas	4.8%	DDs of the Kidney And Urinary Tract	6.2%
DDs of the Musculoskeletal System And Connective Tissue	4.1%	DDs of the Endocrine, Nutritional And Metabolic System	4.4%
DDs of the Endocrine, Nutritional And Metabolic System	3.4%	DDs of the Hepatobiliary System/Pancreas	4.1%
Myeloproliferative DDs	2.8%	DDs of the Skin, Subcutaneous Tissue And Breast	3.0%
Factors Influencing Health Status/ Other Contacts with Health Services	2.1%	DDs of the Blood and Blood Forming Organs and Immunological Disorders	2.3%
DDs of the Blood and Blood Forming Organs and Immunological Disorders	1.9%	Injuries, Poison And Toxic Effect of Drugs	2.1%
DDs of the Skin, Subcutaneous Tissue And Breast	1.3%	DDs of the Female Reproductive System	2.0%
HIV Infection; Mental DDs; Injuries, Poison And Toxic Effect of Drugs; DDs of the Ear, Nose, Mouth And Throat; DDs of the Female Reproductive System; DDs of the Male Reproductive System; Newborn And Other Neonates; Alcohol/Drug Use or Induced Mental Disorders; Multiple Significant Trauma; Pregnancy, Childbirth And Puerperium; DDs of the Eye; Burns	All < 1%	Myeloproliferative DDs	1.5%
		DDs of the Ear, Nose, Mouth And Throat	1.3%
		Factors Influencing Health Status and Other Contacts with Health Services	1.0%
		DDs of the Male Reproductive System	1.0%
		HIV Infection; Multiple Significant Trauma; Eye; Burns	All < 1%
		<u>Not Included in Medical/Surgical:</u>	
		Pregnancy, Childbirth And Puerperium; Newborn And Other Neonates; Mental DDs; Alcohol/Drug Use or Induced Mental Disorders	

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Question: What was the disposition of the patient population using hospital palliative care program services at the end of the hospital stay? What was the disposition of the patient population who did not accept palliative care at the end of the hospital stay?

Table 12 displays the disposition at discharge for flagged palliative care consultation groups and medical/surgical discharges at pilot hospitals. The comparison highlights differences in the outcomes of hospital stays within each patient group. Namely, 41 percent of patients who accepted a palliative care plan of care expired in the hospital, compared to less than three percent of all medical/surgical patients and less than nine percent of patients who declined palliative care recommendations. This corresponds to reports that palliative consultations are often requested very late in a disease progression, past a point at which interventions could provide long-term benefit to a patient or mitigate future health care system use. Also of note, 52 percent of patients who declined recommendations were discharged directly to another health care facility including hospital units, long-term facilities, and skilled nursing facilities, compared to 20 percent of the medical/surgical population. This highlights a dilemma with assessing health care facility use and costs for this project: one hospital admission does not tell a complete story about hospital use or health care system use.

Table 12. Most Frequent Disposition at Discharge for Palliative Care Consultation Groups and Medical/Surgical Discharges at Pilot Hospitals, FY 2015

Patient Disposition	Flagged Palliative Care Consultations			Medical/Surgical Discharges at Pilots
	Accepted Palliative Care Plan of Care	Declined Recommendations	Referred to Hospice	
<u>Transfer/discharge within hospital:</u>				
From rehab, chronic, or psych unit to acute care or from acute care to these units	0.3	0.7	0.1	1.1
To on-site subacute unit or hospice	0.7	0.1	5.8	0.4
Subtotal	1.0	0.8	5.9	1.5
<u>To other health care facility:</u>				
Other acute care, rehab, chronic, or psych hospital or unit at another hospital	4.2	7.9	1.0	5.5
Long-term facility	8.0	16.1	4.0	4.5
Subacute facility	6.5	5.3	0.8	2.4
Other	1.2	1.2	17.5	0.7
Skilled nursing facility	7.6	19.1	3.5	6.0
Hospice facility	2.0	2.5	15.9	1.2
Subtotal	29.5	52.1	42.7	20.3
Home or self-care	13.2	22.4	5.0	58.7
Home under care of home health agency	13.6	14.2	39.6	15.0
Expired in the hospital	41.0	8.8	5.9	2.6
Other	1.8	1.7	0.7	2.0

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Table 13 further illustrates the range in the rate of patients who accepted a palliative care plan of care and died in the hospital across pilots. One example: at Greater Baltimore less than five percent of patients who were flagged as accepting a palliative care plan of care died in the hospital. Data also revealed that another one-third of patients who were flagged as accepting a palliative care plan of care were discharged to home under the care of a home health agency, which may include a hospice agency, and nine percent were discharged to a hospice facility. Looking further, at least five pilots had some proportion of patients who were flagged as accepting a palliative plan of care who were ultimately discharged to hospice. This does not necessarily suggest a data coding issue among pilots; hospice referrals can be provided by other physicians. However, the degree of variance among pilots shown in Table 13 suggests that the 11 pilots implemented different practices to treat patients who are close to death. It also characterizes both the challenge of making broad assessments regarding patient utilization using certain single variables and the limited ability to track whether the palliative care consultation impacted the patient’s medical care, based on how and when that decision took place. Seven out of 11 pilots fell between one standard deviation of the mean, between 20% and 63%. Four outliers included Greater Baltimore (much lower than the mean at nearly 5 percent) and Peninsula Regional (18 percent), Meritus (65 percent), and Doctors Community (much higher, at nearly 80 percent). Further study grouping these pilots by common characteristics may provide additional insights, but is beyond the scope of this initial assessment used to inform the recommendations for best practices and standards for hospital palliative care programs.

Table 13. Percent of Flagged Palliative Care Consultations Who Accepted Palliative Care Plan of Care and Died in the Hospital, by Pilot, FY 2015

Pilot Hospital	Percent of Flagged Consultations Who Accepted Palliative Care Plan of Care and Died in the Hospital	Percent of Medical/Surgical Patients Who Died in the Hospital
Carroll	20.1%	2.1%
Doctors Community	78.7%	2.6%
Greater Baltimore	4.7%	1.2%
Holy Cross	47.1%	3.8%
Howard County	28.3%	2.5%
Johns Hopkins	61.5%	2.4%
MedStar Union Memorial	56.9%	2.1%
Meritus	65.1%	2.8%
Peninsula Regional	17.6%	2.4%
Suburban	41.4%	3.7%
Upper Chesapeake	34.2%	3.0%
Total	41.0%	2.6%
Average	41.4%	2.6%

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Question: What were the readmission rates and payer sources of the patient population groups assessed by palliative care team staff compared to medical/surgical inpatients?

As stated previously in reference to Table 12, one hospital admission does not provide a full illustration of hospital use, partially demonstrated by the additional data displayed in Table 14. Patients who received palliative care consultations were more than twice as likely to have been admitted to the hospital previously in the last 31 days compared to the general medical/surgical discharge population, overall at pilot hospitals. It would be interesting to investigate future hospital utilization and details for other settings beyond the hospital, like nursing homes and hospice facilities. For the former, the HSCRC recently began tracking patients across hospitals using one identification number for one patient. That level of investigation was beyond the scope of this study, but would provide insight into a question for which there is interest, based on the literature review and Advisory Group feedback. For the latter, a dataset is not readily available to tie patient stays across different care settings at this time.

Table 14. Percent of Flagged Palliative Care Consultations and Medical/Surgical Inpatients Who Were Admitted Within 31 Days before This Admission

Pilot Hospital	Flagged Palliative Care Consultations	Medical/Surgical Discharges At Pilot Hospitals
Carroll	26.9%	11.7%
Doctors Community	32.5%	15.0%
Greater Baltimore	23.7%	13.7%
Holy Cross	24.9%	12.2%
Howard County	27.0%	11.9%
Johns Hopkins	26.9%	16.9%
MedStar Union Memorial	13.1%	6.1%
Meritus	33.7%	14.3%
Peninsula Regional	31.8%	13.0%
Suburban	20.4%	9.2%
Upper Chesapeake	35.8%	15.5%
Total	27.0%	13.1%
Average	27.0%	12.7%

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Table 15 shows primary payer source information for flagged discharges and all medical/surgical discharges, by selected age groups. Patients who received a palliative care consultation who were under the age of 65 had a higher proportion of Medicare and Medicaid benefits. Patients who declined the palliative care team’s recommendations were less likely to be insured by commercial insurance than any other group.

Table 15. Primary Payer Sources for Hospital Stays by Selected Age Groups for Flagged Palliative Care Consultation Groups and All Medical/Surgical Discharges, FY 2015

Payer Source	Flagged Palliative Care Consultations						Medical/Surgical Discharges at Pilot Hospitals	
	Accepted Palliative Care Plan of Care		Declined Palliative Care Recommendations		Referred to Hospice			
	Age Groups							
	Under 65	65 +	Under 65	65 +	Under 65	65 +	Under 65	65 +
Medicare	22.4%	88.0%	27.6%	85.9%	20.6%	87.3%	16.7%	85.2%
Medicare HMO	1.8%	4.6%	1.6%	7.2%	1.2%	5.0%	0.8%	4.3%
Medicaid	7.5%	0.4%	10.3%	1.7%	8.9%	0.9%	6.5%	0.8%
Medicaid HMO	17.3%	0.2%	26.8%	0.6%	19.4%	0.3%	18.5%	0.2%
Blue Cross	19.4%	1.6%	7.4%	0.6%	20.3%	1.2%	19.6%	2.8%
Other Commercial	9.4%	2.2%	7.7%	1.4%	9.8%	2.6%	12.8%	2.5%
HMO	17.4%	1.8%	15.4%	2.0%	16.7%	1.8%	18.9%	2.7%
Self pay	1.3%	0.2%	1.3%	0.2	1.0%	0.2%	2.2%	0.3%
Charity	0.2%	0.1%	0%	0%	0.1%	0%	0.3%	0%
Other	3.2%	0.9%	1.9%	0.4%	1.9%	0.8%	3.6%	1.1%

Source: Commission staff analysis of HSCRC Maryland Inpatient Discharge Abstract

Question: What was the general acute care hospital utilization and cost experience of the patient population using hospital palliative care program services? What was the experience for those patients who did not accept palliative care? What was the experience for unflagged medical/surgical discharges?

In order to comparatively assess patient utilization of hospital services at different locations and among different patient groups using the HSCRC’s discharge abstract, accounting for differences in case mix is important. Case mix refers to the characteristics of a patient population. The patient populations served by two different health care facilities may be receiving the same broad category of service, such as acute medical/surgical services, but the two populations may have different disease conditions and levels of disease severity and the proportion of patients in each population at given levels of risk for complications and divergent outcomes may vary considerably. Adjusting for differences in case mix allows evaluation of the relative performance of a group of hospitals or other health care facilities. It is intended to allow for a comparison of how health care facilities perform or how patients utilize a facility that is more of an “apples to apples” comparison, so that the differences seen among facilities are not just a factor of the differences in disease severity or other risk factors of the patient populations.

Reasonably comparing the experience of flagged palliative care patients in this project across the pilot hospitals is a unique challenge that cannot be fully addressed by case mix adjustment. Patients with the same diagnosis who do not have a palliative care plan of care could have expensive medical procedures toward the end of life that a patient who has accepted palliative care options as part of his or her plan of care would not receive. Additionally, a patient may have been admitted to the hospital with a serious illness and undergone an expensive test or

treatment, only to later accept a palliative plan of care that leads them away from aggressive curative treatment to more symptom management. There are also significant differences in the in-hospital mortality rate of patients who accepted palliative care at the pilot hospitals, pointing to potential differences in hospital practices for patients near the end of life that also affect this comparison. While this project attempted to identify all inpatients who receive a palliative care consult during the study period, it did not capture the point in time during the patient’s hospitalization when the consult occurred. It could have been very early in the patient’s hospital stay, in which case acceptance or rejection of palliative care options would be likely to strongly influence the length of stay and charges. Or, the consult may have occurred after the patient had already been in the hospital for some time, perhaps receiving expensive treatments that were not found to be effective in addressing the patient’s needs, which could have become more acute during the patient’s hospital stay. In this latter case, acceptance or rejection of a palliative care plan might be expected to make less difference in the patient’s overall hospital experience of care, as the patient might be close to death at the time of the consult.

The analysis for this project compares different patient groups in order to determine if there were any patterns in the differences of lengths of stay or charges across the group of 11 pilot hospitals. Patients who died in the hospital were excluded from these analyses because of the significant variance in this outcome among the pilot hospitals. The St. Paul Group provided case mix adjusted average length of stay and charge data for the flagged palliative care consultation groups and for medical/surgical discharges, including Medicare and non-Medicare categories. (See Appendix F for a summary of the full analysis provided by the St. Paul Group.) In total, 5,445 of 6,990 flagged patients are included in this analysis.

First, the following three tables show unadjusted results for selected patients who received palliative care consultations and medical/surgical inpatients who were discharged alive without case mix adjustments in order to illustrate a comparison of actual utilization for these groups. Table 16 shows the unadjusted average length of stay for patients who received a palliative care consultation and were discharged alive, and unflagged medical/surgical inpatients who were discharged alive, without case mix adjustments. This data shows that patients who received a palliative care consultation had longer average lengths of stays than unflagged medical/surgical discharges at all pilot hospitals, ranging from 2.5 days longer at Carroll to 8.2 days longer at Holy Cross.

Table 16. Unadjusted Average Length of Stay for Selected Flagged Palliative Care Consultations and Unflagged Medical/Surgical Discharges, Excluding In-Hospital Deaths, FY 2015

Pilot Hospital	Flagged Palliative Care Consultations	Unflagged Medical/Surgical Discharges	Difference in Length of Stay
Carroll	5.8	3.3	2.5
Doctors Community	9.5	4.7	4.7
Greater Baltimore	7.9	3.9	4.0
Holy Cross	12.4	4.2	8.2
Howard County	10.2	4.5	5.8

Pilot Hospital	Flagged Palliative Care Consultations	Unflagged Medical/Surgical Discharges	Difference in Length of Stay
Johns Hopkins	13.0	5.8	7.1
MedStar Union Memorial	11.9	4.3	7.7
Meritus	7.5	3.6	3.9
Peninsula Regional	9.5	4.4	5.1
Suburban	9.1	4.2	4.9
Upper Chesapeake	8.9	4.2	4.7
All Pilot Hospitals	10.0	4.5	5.4

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract, with additional Commission staff analysis

The HSCRC discharge abstract also provides information regarding the total charges during these stays. Table 17 shows unadjusted charges per stay for the same patients who received palliative care consultations compared to unflagged medical/surgical discharges at the same hospital. Charges reflect the total stay, but do not include details regarding when the palliative care consultation took place during the stay. Unadjusted average charges per hospital stay were higher for patients who received a palliative care consultation than those who did not at all pilots. Average charges per stay were correlated with the average length of stay, more so for flagged palliative care consultations than unflagged medical/surgical discharges.

Table 17. Unadjusted Average Charges Per Stay for Selected Flagged Palliative Care Consultations and Unflagged Medical/Surgical Discharges, Excluding In-Hospital Deaths, FY 2015

Pilot Hospital	Flagged Palliative Care Consultations	Unflagged Medical/Surgical Discharges
Carroll	\$18,879	\$13,652
Doctors Community	\$25,463	\$14,044
Greater Baltimore	\$21,079	\$13,757
Holy Cross	\$33,183	\$12,312
Howard County	\$26,970	\$10,736
Johns Hopkins	\$52,220	\$28,677
MedStar Union Memorial	\$39,627	\$21,044
Meritus	\$19,586	\$11,863
Peninsula Regional	\$25,055	\$14,759
Suburban	\$21,169	\$14,641
Upper Chesapeake	\$19,347	\$12,173
All Pilot Hospitals	\$30,052	\$17,252
<i>Pearson correlation co-efficient</i>	<i>0.96</i>	<i>0.70</i>

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract, with additional Commission staff analysis

A calculation of unadjusted average charges per day using this data provides another perspective. Patients who received a palliative care consultation had lower average charges per day than unflagged medical/surgical discharges at all pilots except for one (Howard County). This may suggest that patients who received palliative care consultations may have foregone more costly medical procedures, compared to the population who did not receive a palliative care consultation. Again, concrete conclusions cannot be drawn using this data.

Table 18. Unadjusted Average Charges Per Day for Selected Flagged Palliative Care Consultations and Unflagged Medical/Surgical Discharges, Excluding In-Hospital Deaths, FY 2015

Pilot Hospital	Flagged Palliative Care Consultations	Unflagged Medical/Surgical Discharges
Carroll	\$3,261	\$4,100
Doctors Community	\$2,689	\$2,969
Greater Baltimore	\$2,668	\$3,518
Holy Cross	\$2,685	\$2,967
Howard County	\$2,634	\$2,407
Johns Hopkins	\$4,026	\$4,910
MedStar Union Memorial	\$3,322	\$4,928
Meritus	\$2,629	\$3,304
Peninsula Regional	\$2,640	\$3,370
Suburban	\$2,337	\$3,528
Upper Chesapeake	\$2,186	\$2,926
All Pilot Hospitals	\$3,020	\$3,817

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract

Next, the following four tables provide additional insight into comparisons across palliative care consultation groups. Case mix adjustments offer a more equivalent comparison between groups of patients with similar diagnoses, who may have had different treatments or procedures based on their plan of care. Still, it is unknown whether patients converted to a more typical palliative care plan before, during, or toward the end of their stay and what other procedures were provided that may impact a case mix assignment. Table 19 lists the percent of variance of the unadjusted average length of stay to the more comparable case mix adjusted length of stay for the total flagged palliative care population group. This adjustment factored in differences for case mix in patients across the pilot hospitals. Hospitals with a positive percent of variance had a lower unadjusted average length of stay than would have been predicted based on their case mix. Thus, case mix adjustment was made to increase the unadjusted length of stay that reflects the percent listed. Hospitals with a negative percent of variance had a higher unadjusted average length of stay than have been predicted based on their case mix, so the case mix adjustment lowered the comparable average length of stay at this pilot. The closer to 0, the less adjustment was required to adjust for case mix.

Table 19. Percent of Variance of the Unadjusted Average Length of Stay to the Case Mix Adjusted Average Length of Stay for Pilot Hospitals

Pilot Hospital	Percent Variance for Average Length of Stay Case Mix Adjustment
Carroll	38.5%
Doctors Community	3.2%
Greater Baltimore	9.6%
Holy Cross	-4.4%
Howard County	2.4%
Johns Hopkins	-12.4%
MedStar Union Memorial	-3.9%
Meritus	20.1%
Peninsula Regional	-5.9%
Suburban	0.2%
Upper Chesapeake	0.1%

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract, with additional Commission staff analysis

Tables 20 through 22 present case mix adjusted comparisons for each flagged palliative care patient group, by outcome, across pilot hospitals. Table 20 shows the case mix adjusted average length of stay for flagged palliative care consultation groups. Among the groups of palliative care consultations, those who were referred to hospice had the shortest case mix adjusted average length of stay at all pilot hospitals except for two (MedStar Union Memorial and Suburban). Referral to hospice is an important aspect in the field of palliative care, and is associated with reductions in high-intensity care, particularly intensive care admissions, hospital admissions, and emergency department visits.⁵⁰ When comparing patients who accepted a palliative care plan of care and patients who declined recommendations, patients who accepted a palliative care plan of care were discharged sooner than those who declined at eight of 11 pilots. Conversely, at three pilots (Johns Hopkins, Suburban, and Upper Chesapeake), patients who declined recommendations following a consult had a shorter average length of stay than those who accepted a palliative care plan of care. One other statistic that helps to illustrate the disparate narratives across pilots: four pilots' case mix adjusted average length of stay for the total flagged group falls outside of one standard deviation of the mean for the pilot group. Carroll's case mix adjusted average length of stay was below one standard deviation, and Holy Cross, Johns Hopkins, and MedStar Union Memorial had case mix adjusted average lengths of stay above one standard deviation.

⁵⁰ Bergman J, et al. Hospice use and high-intensity care in men dying of prostate cancer. *Archives of internal medicine*. 2011; 171(3): 204-10.

Table 20. Case Mix Adjusted Average Length of Stay for Selected Palliative Care Consultations, FY 2015

Pilot Hospital	Accepted Palliative Care Plan of Care	Declined Palliative Care Recommendations	Referred to Hospice	Total Flagged Palliative Care Consultations
Carroll	7.7	10.3	7.3	8.0
Doctors Community	9.0	12.9	8.3	9.8
Greater Baltimore	9.3	10.8	7.7	8.7
Holy Cross	11.9	16.5	8.8	11.8
Howard County	11.3	13.8	8.5	10.5
Johns Hopkins	12.0	11.6	10.0	11.4
MedStar Union Memorial	9.0	12.4	10.0	11.5
Meritus	8.8	10.3	8.4	9.0
Peninsula Regional	9.0	14.1	8.3	8.9
Suburban	11.0	7.2	8.3	9.1
Upper Chesapeake	10.2	9.9	7.5	8.9

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract

Table 21 shows the case mix adjusted average charges per stay for flagged palliative care consultations. Among the groups of patients who received palliative care consultations, patients who were referred to hospice had the lowest case mix adjusted charges per stay at all but two hospitals (MedStar Union Memorial and Meritus). The data shows that patients who accepted a palliative care plan of care had lower case mix adjusted average charges per stay than patients who declined services at seven pilots and higher charges at four pilots, with a wide range in the difference in charges – ranging from \$14,000 less at Doctors Community for those who accepted a palliative care plan of care than those who declined to \$7,000 more at Suburban for patients who accepted a palliative care plan of care.

Table 21. Case Mix Adjusted Average Charges Per Stay for Selected Palliative Care Consultations, FY 2015

Pilot Hospital	Accepted Palliative Care Plan of Care	Declined Palliative Care Recommendations	Referred to Hospice	Total Flagged Palliative Care Consultations
Carroll	\$20,321	\$28,820	\$19,655	\$21,741
Doctors Community	\$23,958	\$37,978	\$23,350	\$28,280
Greater Baltimore	\$26,046	\$28,115	\$21,253	\$23,912
Holy Cross	\$34,464	\$53,825	\$24,751	\$35,649
Howard County	\$49,146	\$36,480	\$23,709	\$33,981
Johns Hopkins	\$43,432	\$40,642	\$31,755	\$40,552
MedStar Union Memorial	\$24,573	\$38,231	\$30,123	\$35,097
Meritus	\$22,182	\$28,285	\$23,903	\$24,708
Peninsula Regional	\$24,396	\$40,191	\$23,191	\$24,586

Pilot Hospital	Accepted Palliative Care Plan of Care	Declined Palliative Care Recommendations	Referred to Hospice	Total Flagged Palliative Care Consultations
Suburban	\$29,912	\$22,862	\$22,350	\$25,781
Upper Chesapeake	\$28,624	\$24,271	\$20,203	\$24,280

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract

Table 22 shows the case mix adjusted average charges per day for flagged palliative care consultation groups. Patients who accepted a palliative care plan of care had the lowest case mix adjusted average charges per day at five pilots; patients referred to hospice as a result of their consultation had the lowest case mix adjusted average charges per day at three pilots; and patients who declined palliative care recommendations had the lowest case mix adjusted average charges per day at three pilots. Additionally, the data shows that patients who accepted a palliative care plan of care had lower case mix adjusted average charges per day than patients who declined services at seven pilots and higher charges at four pilots.

Table 22. Case Mix Adjusted Average Charges Per Day for Selected Palliative Care Consultations, FY 2015

Pilot Hospital	Accepted Palliative Care Plan of Care	Declined Palliative Care Recommendations	Referred to Hospice	Total Flagged Palliative Care Consultations
Carroll	\$2,632	\$2,812	\$2,707	\$2,711
Doctors Community	\$2,662	\$2,939	\$2,830	\$2,895
Greater Baltimore	\$2,789	\$2,603	\$2,775	\$2,761
Holy Cross	\$2,899	\$3,254	\$2,813	\$3,016
Howard County	\$4,361	\$2,643	\$2,799	\$3,239
Johns Hopkins	\$3,610	\$3,507	\$3,166	\$3,570
MedStar Union Memorial	\$2,721	\$3,091	\$3,027	\$3,060
Meritus	\$2,529	\$2,757	\$2,835	\$2,761
Peninsula Regional	\$2,717	\$2,861	\$2,794	\$2,753
Suburban	\$2,722	\$3,171	\$2,703	\$2,839
Upper Chesapeake	\$2,820	\$2,464	\$2,687	\$2,740

Source: St. Paul Group analysis of HSCRC Maryland Inpatient Discharge Abstract

Assessment of Data Outcomes and Measures on Access and Utilization of Maryland Hospital Palliative Care

This pilot data revealed that the 11 pilot hospital palliative care teams conducted nearly 7,000 consultations for patients during FY 2015. More than 2,700 inpatients with life-limiting diseases accepted palliative care plans of care. An additional 2,700 were referred to hospice care as a result of the palliative care team consultation. Pilot programs consulted with five percent of medical/surgical inpatients, and treated a patient population that was older, more likely to expire in the hospital and more likely to have been an admitted inpatient within the last month.

The unadjusted average length of stay and average charges per stay for each pilot hospital further demonstrate through quantifiable metrics that patients who received a palliative care consultation have characteristics, such as higher acuity, that led to longer hospital stays, compared to medical/surgical discharges who did not receive a palliative care consultation. In turn, patients who received a palliative care consultation also had higher average charges per stay. However, patients who received a palliative care consultation had lower unadjusted average charges per day than the unflagged medical/surgical patients, suggesting that, while they stayed longer in the hospital, they may have shifted to less aggressive and less costly care.

Case mix adjusted average length of stay and average charges per stay among the palliative care consultation groups provide evidence that consultations which resulted in hospice referrals shortened patients' lengths of stays and charges per stays at the pilot hospitals, likely redirecting patients to the most appropriate setting for end-of-life care. However, the data outcomes do not provide consistent evidence regarding whether patients who accept a palliative care plan of care tended to use fewer or more hospital resources than patients who declined palliative care recommendations during a single hospital stay flagged for this analysis. Additionally, even if more consistency was identified, it could be erroneous to make an assumption about the impact of a palliative care consultation on the length of stay and charges without knowing at what point during the stay the consultation took place, the details of the recommendations, and any other treatment or interventions provided during the stay, all of which were not included in the research design due to either unavailability of the information or scope outside of this pilot project. The data on length of stay and overall charges for one hospital stay do not address the impact of palliative care across the entire health care utilization experience of palliative care patients. A more comprehensive assessment of costs for total patient care and utilization of services throughout the health care system is challenging to measure and was beyond the data collection capabilities for this project.

Still, other published studies suggest that a palliative care plan helps to avoid future hospitalization. Hospitals continue to increasingly invest more in specialized palliative care staff and training, as they begin to recognize the value of this service. This conclusion highlights a predicament faced by this research at this time: If programs were more similar, conclusions may be easier to draw about costs, savings, and impacts of palliative care. However, it would likely require a set of standards first to ensure more similarity for evaluation.

Recommendations for Standardization and Expansion of Hospital Palliative Care Programs

Much work has already been done to organize leadership and advocate for the growth and improvement of palliative care services. Staff used an NQF consensus report published in 2006, which endorses a list of 38 preferred practices for palliative and hospice care quality,⁵¹ as a template for recommendations. CAPC produced a crosswalk of NQF-endorsed practices and recommended tools, resources, and examples of policies to illustrate how to implement these practices at hospital palliative care programs.⁵² Both documents are referenced in the following discussion.

In HB 581, the Commission was asked to gather data from pilot hospitals to “report to the Maryland Health Care Commission on best practices that can be used in the development of statewide palliative care standards.” The Advisory Group reviewed 38 preferred practices. Of those practices, 37 were retained in the list of recommendations, though some of the wording was modified.⁵³ Of the 37 recommended best practices for Maryland hospitals, 30 were also considered minimum standards for a hospital palliative care program.

The Commission recommends that, as an initial matter, statewide minimum standards first focus on practices that will ensure an acceptable level of patient care, consistent across hospitals. Subsequently, as resources allow, programs should implement best practices to the extent possible. Best practices would be ideal for all hospital palliative care programs, but are not necessary to provide quality palliative care for patients, at a program that may still be developing.

Summary of Advisory Group Evaluation of National Quality Forum-Endorsed Practices

The advisory group used the NQF-endorsed list of 38 practices to facilitate a detailed discussion about each practice with Advisory Group members. This resulted in four categories: 1) practices that could be used almost verbatim as a program requirement; 2) practices in which the intent should be incorporated into requirements, but wording should be revised; 3) practices that are best practices and would improve programs, if resources are available; and 4) practices that are not necessary to deliver quality palliative care at Maryland hospitals, according to the Advisory Group (see Appendix G). Additionally, staff at OHCQ provided an assessment detailing which NQF-endorsed practices are similar to existing regulatory requirements for hospitals. OHCQ reported that 25 of the 38 NQF-endorsed practices somewhat align with either the Joint Commission accreditation standards or CMS’ Conditions of Participation for hospitals (see Appendix H). While many of these align with the intent of the practices listed below, they often stress end-of-life concerns rather than palliative care, and do not address the preferences for structured documentation and assessments specified below.

⁵¹ National Quality Forum, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report* (Washington, DC: National Quality Forum, 2006), www.qualityforum.org.

⁵² Center to Advance Palliative Care, *Policies and Tools for Hospital Palliative Care Programs: A Crosswalk of National Quality Forum Preferred Practices*, CAPC crosswalk source (New York: Center to Advance Palliative Care), www.capc.org.

⁵³ NQF Preferred Practice #2 requires 24/7 access to palliative care consultation services, which the Advisory Group does not recommend as a best practice for Maryland hospital palliative care programs.

In the following section, each NQF-endorsed practice is listed in bold and italics, followed by a brief description of the Advisory Group discussion and the Joint Commission standards and CMS Conditions of Participation, if applicable. The discussion provides additional information about how an entity could implement the recommendation based on the reported experiences at pilot hospitals or other published research. Immediately following the discussion, the Commission’s recommendation is highlighted. Commission staff assigns ownership for recommended minimum standards and best practices to either palliative care programs within hospitals or to hospitals, as a whole.

Recommendations for Best Practices and Minimum Standards for Maryland Hospital Palliative Care

Structures of Care: NQF-endorsed Practices 1-5

The first five NQF-endorsed practices cover structures of care such as program administration, availability, staffing, and staff training and credentials. CAPC recommends that hospitals institutionalize the following five practices by developing an interdisciplinary Palliative Care Committee. Subcommittees of the Palliative Care Committee then address staffing needs related to education, training, and specific issues at the hospital. CAPC also provides a template for a staff needs assessment and a list of training resources.⁵⁴

NQF-endorsed Practice #1: Provide palliative and hospice care by an interdisciplinary team of skilled palliative care professionals, including, for example, physicians, nurses, social workers, pharmacists, spiritual care counselors and others who collaborate with primary health care professional(s).

Palliative care, by definition, requires an interdisciplinary team and collaboration with primary health care professionals. The Advisory Group consensus recommended this practice as a best practice and minimum standard for hospitals.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Hospitals should provide palliative care by an interdisciplinary team, trained in palliative care, to consult on palliative care services in collaboration with primary health care professionals.

NQF-endorsed Practice #2: Provide access to palliative and hospice care that is responsive to the patient and family 24 hours a day, 7 days a week.

The Advisory Group consensus recommendation was to not include this practice as a minimum standard or best practice. Advisory group members reported that palliative care teams may not need to be accessible on a 24/7 schedule at all Maryland hospitals. Generally, work day

⁵⁴ Center to Advance Palliative Care. Policies and Tools for Hospital Palliative Care Programs: A Crosswalk of National Quality Forum Preferred Practices. New York: Center to Advance Palliative Care

availability is sufficient for this consultation-based specialty service and requiring that a staff member be available at all hospitals at all times may lead to inefficiency.

NQF-endorsed Practice #3: Provide continuing education to all health professionals on the domains of palliative care and hospice care.

All pilot hospitals reported this practice. Pilots reported that palliative care teams educate practitioners using Grand Rounds, Schwartz Rounds, and at other meetings with non-palliative care team members. In the CAPC annual survey data presented in the preceding section, pilots reported different levels of integration with intensive care and emergency care. Additional studies could help determine the most effective targeted outreach or strategies. The Advisory Group consensus recommended that this practice as a best practice and minimum standard for hospitals.

While the Joint Commission requires that hospitals provide staff with education about the unique needs of dying patients and their families, end-of-life care is not the same as palliative care which can be provided at any stage of the disease process. The following standard is recommended.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Hospitals should provide education to all health professionals on the domains of palliative care.

NQF-endorsed Practice #4: Provide adequate training and clinical support to ensure that professional staff are confident in their ability to provide palliative care for patients.

All pilot hospitals reported this practice. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs. For training and clinical support, pilots use several common training tools. A majority of pilots use the following: Medical Order for Life-Sustaining Treatment (MOLST), CAPC Resources, End-of-Life Nursing Education Consortium (ELNEC) Training, End-of-Life/Palliative Education Resource Center (EPEC) Materials, and Schwartz Rounds. Additionally, several pilots use the following: Grand Rounds, AAPHM meetings, UNIPACs, Virginia Commonwealth University (VCU) Resources, and fellowships.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should provide adequate training and clinical support to ensure that professional staff are confident in their ability to provide palliative care for patients.

NQF-endorsed Practice #5: Hospice care and specialized palliative care professionals should be appropriately trained, credentialed and/or certified in their area of expertise.

All pilot hospitals reported this practice; all have at least one clinical staff member certified in the palliative care specialty. A list of training tools is included in the discussion of NQF-endorsed Practice #4 above. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should ensure the palliative care team is appropriately trained, credentialed, and/or certified in their area of expertise.

Processes of Care: NQF-endorsed Practices 6-11

NQF-endorsed Practice #6: Formulate, utilize and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.

Advisory Group Feedback: All pilot hospitals reported this practice. CAPC suggests that this practice can best be implemented by documenting the patient's goals, needs, and care plans in medical orders. The Advisory Group consensus recommended dissemination via medical orders as a best practice and minimum standard for palliative care programs.

While CMS Conditions of Participation stipulate that the patient has the right to participate in the development and implementation of his or her plan of care, staff recommends the following standard because it addresses documentation in medical orders.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should record the patient's palliative care goals, needs, and care plans in medical orders.

NQF-endorsed Practice #7: Ensure that on transfer between health care settings, there is timely and thorough communication of the patient's goals, preferences, values and clinical information so that continuity of care and seamless follow-up are assured.

Advisory Group Feedback: All pilot hospitals reported this practice. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

Joint Commission accreditation requires that the hospital has a process that addresses the patient's need for continuing care, treatment, and services after discharge or transfer; and when a patient is transferred or discharged, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services. CMS Conditions of Participation also require hospitals to transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

Although this standard may be addressed as a hospital requirement, staff nonetheless includes it in order to have a comprehensive set of recommendation for palliative care programs.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should ensure timely and thorough transfer of the patient’s goals, needs, and care plans upon transfer to a different care setting.

NQF-endorsed Practice #8: Health care professionals should present hospice as an option to all patients and families when death within a year would not be surprising, and reintroduce the hospice option as the patient declines.

Advisory Group Feedback: As noted previously, palliative care teams often make special efforts to differentiate palliative care from hospice. Some pilot hospitals, however, reported that this attempt to differentiate by the palliative care team does not always occur. Reasons for such failure include: if the hospital does not have access to hospice staff trained to explain the difference or with an interest in doing so; if the primary physician is not supportive of such a plan; if the palliative care team knows the patient or family would not be receptive; or if the practice within the institution is to wait until the attending physician suggests hospice as an option. Nonetheless, the Advisory Group recognized the importance of this practice and recommended a plan to address the option of hospice services when appropriate as a best practice and minimum standard for palliative care programs.

Although the Joint Commission and CMS Conditions of Participation include the rights of the patient to participate in development of a care plan, these existing requirements do not specifically address the issue of referral to hospice, which was identified as a need by the Advisory Group.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should present hospice as an option to patients and families when appropriate, based on an assessment of the patient’s and family’s goals, needs, and plan of care.

NQF-endorsed Practice #9: Patients and caregivers should be asked by palliative and hospice programs to assess physicians’/health care professionals’ ability to discuss hospice as an option.

Advisory Group Feedback: Only one pilot hospital reported using an assessment tool to measure patient satisfaction with the health care professional’s ability to discuss hospice as an option. The Advisory Group consensus recommended this practice as a best practice, while recognizing that programs likely would need both technical assistance and additional resources to implement this practice effectively. CAPC recommends using the FAMCARE Scale to measure patient and family satisfaction. More information about this tool is available at <http://www.palliative.org/NewPC/professionals/tools/famcare.html>.

BEST PRACTICE ONLY	
<i>Not Recommended as a Minimum Standard</i>	Palliative care teams should ask patients and caregivers to assess the physicians’/health care professionals’ ability to discuss hospice as an option.

NQF-endorsed Practice #10: Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.

NQF-endorsed Practice #11: Provide education and support to families and unlicensed caregivers based on the patient’s individualized care plan to ensure safe and appropriate patient care.

Advisory Group Feedback: All pilot hospitals report the ability to meet these practices during patient and family meetings. For both of these practices, CAPC recommends utilizing National Hospice and Palliative Care Organization (NHPCO) Patient/Family Education Booklets. Pilots reported a variety of existing methods to share information including verbal explanations and written materials. The Advisory Group consensus recommended these practices as a best practices and minimum standards for palliative care programs.

Although elements of these practices are addressed by existing Joint Commission and CMS requirements for hospitals, staff nonetheless includes it in order to have a comprehensive set of recommendations for palliative care programs.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.

BEST PRACTICE*Recommended as a Minimum Standard***Palliative care programs should provide education and support to families and unlicensed caregivers to ensure safe and appropriate patient care with educational materials that are age-, language-, and educationally appropriate.**Physical Aspects of Care: NQF-endorsed Practices 12-13***NQF-endorsed Practice #12: Measure and document pain, dyspnea, constipation and other symptoms using available standardized scales.***

Advisory Group Feedback: All pilot hospitals reported the use of clinical tools to measure and document these symptoms. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

Although the Joint Commission and CMS requirements address the need to assess and manage pain for all patients, the practice includes the recommendation to use specific standardized tools.

BEST PRACTICE*Recommended as a Minimum Standard***Palliative care programs should measure and document pain, dyspnea, constipation and other symptoms using available standardized scales.*****NQF-endorsed Practice #13: Assess and manage symptoms and side effects in a timely, safe and effective manner to a level acceptable to the patient and family.***

Advisory Group Feedback: No pilot hospitals reported measuring patient or family satisfaction of this aspect of care. The Advisory Group consensus recommended an assessment of the patient’s satisfaction as a best practice, while recognizing that programs likely would need both technical assistance and additional resources to implement this practice effectively.

Although CMS requirements address development of a care plan, this practice addresses the need to assess the level of satisfaction by patients and caregivers on how treatment is handled.

BEST PRACTICE ONLY*Not Recommended as a Minimum Standard***Palliative care programs should ask patients and caregivers whether pain, dyspnea, constipation and other symptoms and side effects were managed in timely, safe, and effective manner to a level acceptable to the patient and family.**

Psychological and Psychiatric Aspects of Care: NQF-endorsed Practices 14-17

NQF-endorsed Practice #14: Measure and document anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms using available standardized scales.

Advisory Group Feedback: Five out of 11 pilot hospitals reported measuring and documenting this aspect of care, with tools like the Edmonton Symptom Assessment System. The Advisory Group recognized the importance of addressing psychological symptoms using standardized scales and the availability of existing resources. The Advisory Group consensus recommended this practice as a best practice for palliative care programs.

The Joint Commission and CMS require a general patient assessment, but are not specific to measuring anxiety, depression, and delirium.

BEST PRACTICE ONLY	
<i>Not Recommended as a Minimum Standard</i>	Palliative care programs should measure and document anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms using available standardized scales.

NQF-endorsed Practice #15: Manage anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms in a timely, safe and effective manner to a level acceptable to the patient and family.

Advisory Group Feedback: No pilot hospitals reported measuring patient or family satisfaction of this aspect of care. Even though this practice is not included at pilots, the Advisory Group recognized the importance of measuring patients' satisfaction. However, programs likely would need additional resources and technical assistance to implement this effectively. The Advisory Group consensus recommended this practice as a best practice for palliative care programs.

The Joint Commission and CMS require a general patient assessment, but are not specific to measuring the level of satisfaction of patients and caregivers.

BEST PRACTICE ONLY	
<i>Not Recommended as a Minimum Standard</i>	Palliative care programs should ask patients and caregivers whether the patient's anxiety, depression, delirium, behavioral disturbances and other psychological symptoms were managed in timely, safe, and effective manner to a level acceptable to the patient and family.

NQF-endorsed 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.

Advisory Group Feedback: Nearly all pilot hospitals reported that assessing the psychological needs of patients and families was a critical part of treatment for palliative care patients. Pilots reported a limited ability or need to manage this aspect of care in a regular and ongoing fashion; they often refer patients to other hospital services and community resources when appropriate. The Advisory Group recognized the importance of incorporating an assessment of psychological needs into a plan of care, and making appropriate referrals, as a best practice and minimum standard for palliative care programs.

The Joint Commission and CMS require a general patient assessment, but are not specific to addressing psychological needs, or making appropriate referrals.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should assess the psychological reactions of patients and families to address emotional and functional impairment and loss, including stress, anticipatory grief and coping. Programs should develop a plan to address the needs of the patient and family and make appropriate referrals for the ongoing management of needs.

NQF-endorsed Practice #17: Develop and offer a grief and bereavement care plan to provide services to patients and families.

Advisory Group Feedback: Some pilot hospitals reported referring patients and families to trained hospice care providers to receive these services. Advisory Group members acknowledged that hospice care providers generally extend this service to community members, though one Advisory Group member representing a hospice provider expressed concern that an expectation to do this could put strains on hospice resources. The Advisory Group members recommended that hospital palliative care programs and hospitals develop relationships with local hospice care providers that provide this service, if the palliative care program does not provide this service itself, as a best practice and minimum standard for hospitals.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Hospitals should identify resources to address the grief and bereavement care needs for patients and families, within the hospital or through referral to a hospice provider.

Social Aspects of Care: NQF-endorsed Practices 18-19

NQF-endorsed Practice #18: Conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, discuss goals of care, disease prognosis and advance care planning, and offer support.

Advisory Group Feedback: All pilot hospitals report the ability to meet this practice. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, discuss goals of care, disease prognosis and advance care planning, and offer support.

NQF-endorsed Practice #19: Develop and implement a comprehensive social care plan that addresses the social, practical and legal needs of the patient and caregivers, including but not limited to: relationships, communication, existing social and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress, access to medicines and equipment.

Advisory Group Feedback: Pilot hospitals reported including most of the specific needs listed above when developing a social care plan. The Advisory Group consensus recommended including a general social care assessment and plan as a best practice and minimum standard for palliative care programs, without stipulating the list of specific needs listed above.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should develop and implement a comprehensive social care plan that address social, practical, and legal needs of the patient and caregivers.

Spiritual, Religious, and Existential Aspects of Care: NQF-endorsed Practices 20-23

NQF-endorsed 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.

Advisory Group Feedback: Five of 11 pilot hospitals reported using a structured tool to assess these concerns and integrate them into the palliative care plan. (See Appendix I for examples of structured tools to address spiritual care needs provided by pilots.) The Advisory Group recognized the importance of this practice, but noted that programs likely would need additional resources and technical assistance to implement this effectively. The Advisory Group consensus recommended this practice as a best practice for palliative care programs.

Although the Joint Commission addresses patients’ rights to religious and spiritual services, and CMS requires a care plan, the recommended practice includes documentation in the palliative care plan.

BEST PRACTICE ONLY

*Not Recommended
as a Minimum
Standard*

Palliative care programs should develop and document a plan based on assessment of religious, spiritual, and existential concerns using a structured instrument and integrate the information into the palliative care plan.

NQF-endorsed Practice #21: Provide information about the availability of spiritual care services, and make spiritual care available either through organizational spiritual care counseling or through the patient’s own clergy relationships.

Advisory Group Feedback: Most pilot hospitals reported that they follow this practice. The availability of spiritual care services is an important element in end-of-life discussions. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

Although the Joint Commission addresses patients’ rights to religious and spiritual services, and CMS addresses patients’ rights in general, the recommended practice includes outreach to community clergy.

BEST PRACTICE

*Recommended
as a Minimum
Standard*

Palliative care programs should provide information about the availability of spiritual care services, and make spiritual care available either through organizational spiritual care counseling or through the patient’s own clergy relationships.

NQF-endorsed Practice #22: Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care.

Advisory Group Feedback: All pilot hospitals reported access to hospital chaplains or a spiritual care department. Two pilots reported that spiritual care professionals have training in palliative care, though most pilots do not know if available spiritual care professionals have this training. The Advisory Group consensus recommended developing an ongoing relationship with the hospital’s spiritual care professionals as a best practice and minimum standard for palliative care programs, but that training and certification in palliative care for all spiritual care providers extended beyond a hospital palliative care program’s oversight.

BEST PRACTICE

*Recommended
as a Minimum
Standard*

Palliative care programs should develop an ongoing relationship with spiritual care professionals in order to educate spiritual care professionals about palliative care issues and concerns.

NQF-endorsed Practice #23: Specialized palliative and hospice spiritual care professionals should build partnerships with community clergy and provide education and counseling related to end-of-life care.

Advisory Group Feedback: Four pilot hospitals reported providing education and counseling to community clergy on palliative care issues. The Advisory Group recognized the importance of this practice, but also noted that programs would likely need additional resources and technical assistance to implement this effectively. The Advisory Group consensus recommended this practice as a best practice for palliative care programs.

BEST PRACTICE ONLY	
<i>Not Recommended as a Minimum Standard</i>	Palliative care programs should build partnerships with community clergy and provide education and counseling related to end-of-life care.

Cultural Aspects of Care: NQF-endorsed Practices 24-25

NQF-endorsed Practice #24: Incorporate cultural assessment as a component of comprehensive palliative and hospice care assessment, including, but not limited to: locus of decision making, preferences regarding disclosure of information, truth telling and decision making, dietary preferences, language, family communication, desire for support measures such as palliative therapies and complementary and alternative medicine, perspectives on death, suffering and grieving and funeral/burial rituals.

Advisory Group Feedback: Pilot hospitals reported including most of the specific elements listed above when conducting a cultural assessment. The Advisory Group consensus recommended incorporating a general cultural assessment into a comprehensive palliative care assessment as a best practice and minimum standard for palliative care programs, without stipulating the list of specific elements listed above.

Although the Joint Commission requirements address social, spiritual, and cultural variables, they do not specifically address a cultural assessment.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should conduct a cultural assessment of the patient’s needs as a component of that patient’s plan of care.

NQF-endorsed Practice #25: Provide professional interpreter services and culturally sensitive materials in the patient’s and family’s preferred language.

Advisory Group Feedback: Five out of 11 pilot hospitals have materials available in Spanish; one has advance directives in other languages. All have interpreter services available; one reports that these interpreter services are trained in palliative care issues. The Advisory

Group recognized the importance of interpreter services, which should be available throughout the hospital. The Advisory Group consensus recommended this practice as a best practice and minimum standard for hospitals.

Although hospitals are required to address this practice by both the Joint Commission and CMS, staff nonetheless includes it in order to have a comprehensive set of recommendations for palliative care programs.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Hospitals should have interpreter services available at the hospital, and palliative care programs should utilize these services as needed.

Care of Imminently Dying Patient: NQF-endorsed Practices 26-31

NQF-endorsed Practice #26: Recognize and document the transition to the active dying phase and communicate to the patient, family and staff the expectation of imminent death.

Advisory Group Feedback: All pilot hospitals recognize, document, and communicate a patient’s transition to the active dying phase, at minimum. This communication often takes place at family meetings. The Advisory Group consensus recommended this practice as a best practice and minimum standard for all palliative care programs.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should recognize and document the transition to the active dying phase and communicate to the patient, family and staff the expectation of imminent death.

NQF-endorsed Practice #27: Educate the family on a timely basis regarding the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate and culturally appropriate manner.

Advisory Group Feedback: All pilot hospitals reported this practice, though one reported that its team could use training in more age-appropriate, developmentally appropriate, and culturally appropriate approaches. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should educate the family on a timely basis regarding the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate and culturally appropriate manner.

NQF-endorsed Practice #28: As part of the ongoing care planning process, routinely ascertain and document patient and family wishes about the care setting for site of death, and fulfill patient and family preferences when possible.

Advisory Group Feedback: All pilot hospitals reported this practice. Additionally, eight pilots reported reviewing circumstances in cases when preferences are not met, which is a CAPC recommendation for implementation of this practice⁵⁵. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

Although the Joint Commission and CMS require that hospitals respect patients’ rights to participate in decisions and to develop discharge plans, they do not specifically address care settings for death or the documentation of such wishes.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should routinely ascertain and document patient and family wishes about the care setting for site of death, and fulfill patient and family preferences when possible.

NQF-endorsed Practice #29: Provide adequate dosage of analgesics and sedatives as appropriate to achieve patient comfort during the active dying phase and address concerns and fears about using narcotics and analgesics hastening death.

Advisory Group Feedback: All pilot hospitals reported this practice and described how this provision was met for patients during all disease stages. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

Although the Joint Commission requires addressing pain management, it does not specifically address adequate dosage of analgesics and sedatives and concerns about hastening death.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Palliative care programs should provide adequate dosage of analgesics and sedatives to achieve patient comfort and address concerns about narcotics and analgesics hastening death.

NQF-endorsed Practice #30: Treat the body after death with respect according to the cultural and religious practices of the family and in accordance with local law.

Advisory Group Feedback: All pilot hospitals described how this provision was met at the hospitals. At some hospitals, palliative care teams are not involved or hospitals have

⁵⁵ Ibid.

superseding protocols that are followed. The Advisory Group consensus recommended having policies or protocols and staff training as a best practice and minimum standard for hospitals.

Although this practice is often addressed at the hospital level, staff nonetheless includes it in order to have a comprehensive set of recommendations for palliative care programs.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Hospitals should have a plan or policy to treat the body after death with respect according to the cultural and religious practices of the family and in accordance with local law.

NQF-endorsed Practice #31: Facilitate effective grieving by implementing in a timely manner a bereavement care plan after the patient’s death when family remains the focus of care.

Advisory Group Feedback: Some pilot hospitals report relying on hospice care providers for this service. Advisory Group members acknowledged that hospice care providers generally extend this service to community members, though one Advisory Group member representing a hospice provider expressed concern that an expectation to do this would put strains on hospice resources. If the hospital or palliative care team does not conduct this practice, the Advisory Group consensus recommended that hospitals should, at minimum, have a plan in place to address family needs for this service, as a best practice and minimum standard for hospitals.

BEST PRACTICE	
<i>Recommended as a Minimum Standard</i>	Hospitals should facilitate effective grieving by implementing a bereavement care plan in a timely manner after the patient’s death through services provided at the hospital or develop a relationship with another provider, such as a hospice, for these services.

Ethical and Legal Aspects of Care: NQF-endorsed Practices 32-38

NQF-endorsed Practice #32: Document the designated surrogate/decision maker in accordance with state law for every patient in primary, acute and long-term care and in palliative and hospice care.

Advisory Group Feedback: Nine out of 11 pilot hospitals reported documenting a surrogate decision maker. The Advisory Group recognized the importance of this practice and the consensus recommended this practice as a minimum requirement for palliative care.

Although the Joint Commission and CMS requirements address the rights of the patient to participate in care planning or to designate a surrogate decision-maker, this practices addresses the need for documentation.

BEST PRACTICE*Recommended as a Minimum Standard***Hospitals should document the designated surrogate/decision maker in accordance with state law for every patient in primary, acute, and long-term care and in palliative and hospice care.**

NQF-endorsed Practice #33: Document the patient/surrogate preferences for goals of care, treatment options and setting of care at first assessment and at frequent intervals as conditions change.

Advisory Group Feedback: All pilot hospitals reported this practice. The Advisory Group consensus recommended this practice as a best practice and minimum standard for palliative care programs.

Although the Joint Commission and CMS requirements address the rights of the patient to participate in care planning or to designate a surrogate decision-maker, this practice addresses the need for documentation.

BEST PRACTICE*Recommended as a Minimum Standard***Palliative care programs should document the patient/surrogate preferences for goals of care, treatment options and setting of care at first assessment and at frequent intervals as conditions change.**

NQF-endorsed Practice #34: Convert the patient treatment goals into medical orders and ensure that the information is transferable 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.

Advisory Group Feedback: All pilot hospitals reported this practice. All but one reported the use of Maryland Medical Orders for Life-Sustaining Treatment (MOLST), though some reported observing less-than-full use of the documentation at the hospitals. MOLST is required by all Maryland hospitals and training can be arranged free of charge. (See Appendix J.) The Advisory Group consensus recommended using MOLST to the fullest extent possible as a best practice and minimum standard for hospitals.

Although the Joint Commission and CMS require that hospitals collaborate with patients and care providers regarding advance directives, this practice specifically addresses the full use of MOLST.

BEST PRACTICE*Recommended as a Minimum Standard***Hospitals should convert the patient’s treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services and hospital care, by using the MOLST program to the fullest extent possible and ensuring that staff is trained and knowledgeable of the benefits.**

NQF-endorsed Practice #35: Make advance directives and surrogacy designations available across care settings while protecting patient privacy and adherence to HIPAA regulations, e.g., by Internet-based registries or electronic personal health records.

Advisory Group Feedback: All pilot hospitals reported the practice of using electronic medical records, which is required for all hospitals under the Health Information Technology for Economic and Clinical Health Act (HITECH Act). The Advisory Group consensus recommended including advance directives and surrogacy designations in the patient’s electronic medical record as a best practice and minimum standard for hospitals.

BEST PRACTICE*Recommended as a Minimum Standard***Hospitals should make advance directives and surrogacy designations available in electronic personal health records.**

NQF-endorsed Practice #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.

Advisory Group Feedback: Ten out of 11 pilot hospitals reported the practice of promoting advance care planning and the completion of advance directives to patients and the general public. Pilots reported that limited time and resources prevented them from doing it as much as they would like and that other hospital staff also engaged in this practice at planned events throughout the year. Advisory Group members felt this practice was a critical component of supporting a palliative care program, but is not necessarily something that a trained palliative care team member must do. The Advisory Group consensus recommended this practice as a best practice and minimum standard for hospitals, without including the specific examples in the NQF-endorsed practice above.

BEST PRACTICE*Recommended as a Minimum Standard***Hospitals that provide palliative care should develop healthcare and community collaborations to promote advance care planning and the completion of advance directives for all individuals.**

NQF-endorsed Practice #37: Establish or have access to ethics committees or ethics consultation across care settings to address ethical conflicts at the end of life.

Advisory Group Feedback: Ten out of 11 pilot hospitals reported what they consider to be appropriate access to an ethics committee. Additionally, three pilots reported utilizing it at least monthly and seven use it less than once per month. The Advisory Group consensus recognized the importance of this practice and recommended it as a best practice and minimum standard for palliative care programs.

BEST PRACTICE*Recommended as a Minimum Standard***Palliative care programs should have access to or establish an ethics committees or ethics consultation across care settings to address ethical conflicts at the end of life.**

NQF-endorsed Practice #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 those of the adult decision maker.

Advisory Group Feedback: One pilot hospital treated minors. Three pilots reported in-system referral options; two reported they would refer minors to a children’s hospital or specialist; two reported that they do not have a process or good options for treating minors; and another two reported that they do not see minors. Even though several pilots reported that they lacked existing resources to address this practice, the Advisory Group recognized the importance of this practice. The Advisory Group consensus recommended developing a relationship with a provider who specializes in pediatric palliative care as a best practice for palliative care programs.

BEST PRACTICE ONLY*Not Recommended as a Minimum Standard***Palliative care programs should develop a relationship with a provider who specializes in pediatric palliative care.**

Conclusion

At this time, more than 30 hospitals in Maryland are delivering palliative care services in an organized fashion. Currently, there is no statewide oversight to provide a common definition or basic standard of care for these services. While it is one of the oldest forms of medicine, palliative care has only recently been recognized as a medical specialty and is a growing specialty with an increasing number of proponents. With the increase in apparently disparate programs at many hospitals, steps toward standardization should help to ensure that patients who are candidates for palliative care receive the same level of services at one hospital as they would at all others.

Only one hospital in Maryland currently has a palliative care program certified by the Joint Commission, and less than 20 percent plan to seek certification in the future. Hospitals reported a number of reasons why the full requirements for this certification are above and beyond what should be required at Maryland hospitals – including program elements which are not necessary to deliver quality patient care, particularly 24/7 access to services, certain staffing requirements, ongoing satisfaction surveys, and financial investments that outweigh the benefits of a certification process that is often perceived as overly cumbersome.

Regarding challenges to providing services, Advisory Group members reported referrals to palliative care often occur late in the progression of disease due to confusion between hospice and palliative care and lack of awareness of the benefits of palliative care. Patients would benefit from earlier referrals. Recommendations include best practices that address developing relationships with hospice service providers and interdisciplinary staff throughout the hospital and community to improve awareness, outreach, and collaboration. Earlier access to palliative care services could also be improved by implementing a more comprehensive screening process at targeted intake locations, and with increased outreach and education to primary care providers. Increased public policy support for reimbursement may encourage more doctors to have end-of-life discussions with appropriate patients, but the skills required to deliver bad news and aid in decision making are a major value demonstrated by trained and certified palliative clinicians.⁵⁶ Primary care physicians probably could not replace the services provided by interdisciplinary hospital palliative care programs with a team of trained clinicians. Communication through the use of medical records is also critical to ensure that the difficult decisions which patients and caregivers make with trained palliative care team members are conveyed across health care settings. Communication with patients and families in a language and style that is culturally appropriate is also recommended. Hispanics had relatively lower access to consultations and African Americans declined palliative care recommendations at a relatively higher rate than the medical/surgical patient population during the pilot period.

Making a conclusive assessment about the costs and savings of these services across 11 diverse pilot hospitals was difficult. Some common findings: palliative care patients with life-limiting illnesses had longer average hospital stays and higher charges per stay; however, they

⁵⁶ Griffith JC, Brosnan M, Lacey K, Keeling S, Wilkinson TJ. Family meetings—a qualitative exploration of improving care planning with older people and their families. *Age & Ageing*. 2004; 33(6):577-581.

had lower average charges per day. Supplementary research provided by Advisory Group members suggests that a palliative care plan also helps to reduce future hospitalization and use of emergency services.

Further study would be needed to analyze total costs or savings of palliative care across the health care system. This report only provides a view of palliative care for patients during the hospitalization episode at which they initially receive a consultation with a palliative care team. Still, even while lacking conclusive evidence regarding the costs and/or savings, hospitals are increasingly investing in specialized palliative care staff, as they begin to react to the perceived value of this service.

At this point in the development of the specialty and common presence at hospitals across Maryland, the State might consider establishing requirements so that patients are better informed about palliative care and a standard of care. While adding or expanding palliative care services at hospitals would require additional specialized staff and resources to support training and integration, it would not require additional capital investment because the services could likely be provided to patients in existing patient treatment spaces.

Appendix A: Chapter 379 (House Bill 581)

Chapter 379

(House Bill 581)

AN ACT concerning

Hospitals – Establishment of Palliative Care Pilot Programs – ~~Required~~

FOR the purpose of ~~requiring certain hospitals to implement a certain palliative care program on or before a certain date;~~ providing for the establishment of a certain number of palliative care pilot programs in certain hospitals in the State; requiring the Maryland Health Care Commission to select the pilot programs in a certain manner; requiring certain palliative care pilot programs to collaborate with certain providers to deliver care, gather certain data, and report certain information to the Maryland Health Care Commission; requiring the Maryland Health Care Commission to consult with certain palliative care pilot programs and certain stakeholders to develop certain core data measures and certain reporting standards; requiring ~~the palliative care program~~ certain palliative care pilot programs to include certain policies and procedures; requiring certain counseling about palliative care to include certain information regarding certain rights of patients; ~~requiring the Department of Health and Mental Hygiene to adopt certain regulations on or before a certain date; prohibiting certain regulations from requiring a palliative care program to be led by a certain physician; requiring the Department to conduct a certain survey of certain palliative care programs at certain intervals; requiring the Maryland Hospital Association to provide a certain report to the General Assembly on or before a certain date;~~ requiring the Maryland Health Care Commission, on or before a certain date, in consultation with the Office of Health Care Quality and the Maryland Hospital Association, to report certain findings to certain committees of the General Assembly; requiring the report to include certain recommendations; requiring the report to be used to develop certain standards; providing for the termination of this Act; defining certain terms; and generally relating to palliative care pilot programs in hospitals in the State.

BY adding to

Article – Health – General

Section 19–308.9

Annotated Code of Maryland

(2009 Replacement Volume and 2012 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19-308.9.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "AUTHORIZED DECISION MAKER" MEANS THE HEALTH CARE AGENT OR SURROGATE DECISION MAKER WHO IS MAKING HEALTH CARE DECISIONS ON BEHALF OF A PATIENT IN ACCORDANCE WITH §§ 5-601 THROUGH 5-618 OF THIS ARTICLE.

(3) "PALLIATIVE CARE" MEANS SPECIALIZED MEDICAL CARE FOR INDIVIDUALS WITH SERIOUS ILLNESSES OR CONDITIONS THAT:

(I) IS FOCUSED ON PROVIDING PATIENTS WITH RELIEF FROM THE SYMPTOMS, PAIN, AND STRESS OF A SERIOUS ILLNESS OR CONDITION, WHATEVER THE DIAGNOSIS;

(II) HAS THE GOAL OF IMPROVING QUALITY OF LIFE FOR THE PATIENT, THE PATIENT'S FAMILY, AND OTHER CAREGIVERS;

(III) IS PROVIDED AT ANY AGE AND AT ANY STAGE IN A SERIOUS ILLNESS OR CONDITION; AND

(IV) MAY BE PROVIDED ALONG WITH CURATIVE TREATMENT.

~~(B) ON OR BEFORE JULY 1, 2016, EACH GENERAL HOSPITAL WITH 50 OR MORE BEDS THAT DOES NOT HAVE A PALLIATIVE CARE PROGRAM ACCREDITED BY AN ACCREDITATION ORGANIZATION APPROVED BY THE DEPARTMENT SHALL IMPLEMENT A PALLIATIVE CARE PROGRAM THAT:~~

~~(1) MEETS THE REQUIREMENTS OF THIS SECTION; AND~~

~~(2) COMPLIES WITH REGULATIONS ADOPTED BY THE DEPARTMENT UNDER SUBSECTION (E) OF THIS SECTION.~~

(B) (1) (I) AT LEAST FIVE PALLIATIVE CARE PILOT PROGRAMS SHALL BE ESTABLISHED IN THE STATE IN HOSPITALS WITH 50 OR MORE BEDS.

(II) THE FIVE PILOT PROGRAMS SHALL BE SELECTED BY THE MARYLAND HEALTH CARE COMMISSION IN A MANNER THAT ENSURES GEOGRAPHIC BALANCE IN THE STATE.

(III) THE PILOT PROGRAMS ESTABLISHED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL:

1. COLLABORATE WITH PALLIATIVE CARE OR COMMUNITY PROVIDERS TO DELIVER CARE;
2. GATHER DATA ON COSTS AND SAVINGS TO HOSPITALS AND PROVIDERS, ACCESS TO CARE, AND PATIENT CHOICE; AND
3. REPORT TO THE MARYLAND HEALTH CARE COMMISSION ON BEST PRACTICES THAT CAN BE USED IN THE DEVELOPMENT OF STATEWIDE PALLIATIVE CARE STANDARDS.

(2) THE MARYLAND HEALTH CARE COMMISSION SHALL, IN CONSULTATION WITH THE PILOT PROGRAMS ESTABLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION AND STAKEHOLDERS SELECTED BY THE COMMISSION, IDENTIFY CORE DATA MEASURES FOR THE DATA COLLECTED UNDER PARAGRAPH (1)(III)2 OF THIS SUBSECTION AND DEVELOP STANDARDS FOR THE REPORTING REQUIREMENTS OF PARAGRAPH (1)(III)3 OF THIS SUBSECTION.

(C) ~~A HOSPITAL'S NONACCREDITED PALLIATIVE CARE PROGRAM~~ THE PILOT PROGRAMS ESTABLISHED UNDER SUBSECTION (B) OF THIS SECTION SHALL INCLUDE POLICIES AND PROCEDURES ESTABLISHED BY THE HOSPITAL THAT:

- (1) PROVIDE ACCESS TO INFORMATION AND COUNSELING REGARDING PALLIATIVE CARE SERVICES APPROPRIATE TO A PATIENT WITH A SERIOUS ILLNESS OR CONDITION;
- (2) IDENTIFY THE AUTHORIZED DECISION MAKER OF AN INDIVIDUAL WHO LACKS CAPACITY TO MAKE HEALTH CARE DECISIONS IN ORDER TO PROVIDE THE AUTHORIZED DECISION MAKER ACCESS TO INFORMATION AND COUNSELING REGARDING OPTIONS FOR PALLIATIVE CARE FOR THE PATIENT;
- (3) REQUIRE PROVIDERS TO ENGAGE IN A DISCUSSION OF THE BENEFITS AND RISKS OF TREATMENT OPTIONS IN A MANNER THAT CAN BE UNDERSTOOD EASILY BY THE PATIENT OR AUTHORIZED DECISION MAKER;
- (4) ENCOURAGE THE PATIENT OR AUTHORIZED DECISION MAKER TO INCLUDE THE PATIENT'S RELATIVES AND FRIENDS IN COUNSELING REGARDING PALLIATIVE CARE; AND

(5) FACILITATE ACCESS TO APPROPRIATE PALLIATIVE CARE CONSULTATIONS AND SERVICES, INCLUDING ASSOCIATED PAIN MANAGEMENT CONSULTATIONS AND SERVICES CONSISTENT WITH A PATIENT'S NEEDS AND PREFERENCES.

(D) IF A PATIENT OR AUTHORIZED DECISION MAKER DECIDES TO RECEIVE COUNSELING ABOUT PALLIATIVE CARE, THE COUNSELING SHALL INCLUDE INFORMATION REGARDING THE RIGHT OF THE PATIENT TO:

(1) CONTINUE TO PURSUE DISEASE-TARGETED TREATMENT WITH OR WITHOUT CONCURRENT PALLIATIVE CARE; AND

(2) RECEIVE COMPREHENSIVE PAIN AND SYMPTOM MANAGEMENT, INCLUDING PAIN MEDICATIONS.

~~(E) (1) THE DEPARTMENT SHALL ADOPT REGULATIONS THAT:~~

~~(I) SET THE STANDARDS FOR THE OPERATION OF A HOSPITAL'S NONACCREDITED PALLIATIVE CARE PROGRAM; AND~~

~~(II) IMPLEMENT THE PROVISIONS OF THIS SECTION.~~

~~(2) THE STANDARDS ADOPTED UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION SHALL BE COMPARABLE TO THE STANDARDS SET BY THE JOINT COMMISSION FOR PALLIATIVE CARE PROGRAMS.~~

~~(3) THE REGULATIONS ADOPTED UNDER PARAGRAPH (1) OF THIS SUBSECTION MAY NOT REQUIRE THAT A PALLIATIVE CARE PROGRAM BE LED BY A PHYSICIAN WHO IS BOARD-CERTIFIED IN PALLIATIVE CARE.~~

~~(F) (1) EACH YEAR THE DEPARTMENT SHALL SURVEY AT LEAST 25% OF THE NONACCREDITED PALLIATIVE CARE PROGRAMS IN THE STATE TO REVIEW COMPLIANCE WITH THIS SECTION AND THE REGULATIONS ADOPTED BY THE DEPARTMENT UNDER THIS SECTION.~~

~~(2) AT LEAST ONCE EVERY 4 YEARS, THE DEPARTMENT SHALL SURVEY EACH NONACCREDITED PALLIATIVE CARE PROGRAM TO REVIEW COMPLIANCE WITH THIS SECTION AND THE REGULATIONS ADOPTED BY THE DEPARTMENT UNDER THIS SECTION.~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That, on or before January 31, 2016, the Department of Health and Mental Hygiene shall adopt the regulations required under § 19-308.9(e) of the Health General Article, as enacted by Section 1 of this Act.~~

~~SECTION 3. AND BE IT FURTHER ENACTED, That, on or before January 1, 2015, the Maryland Hospital Association shall report to the General Assembly, in accordance with § 2-1246 of the State Government Article, on the palliative care programs in operation in hospitals in the State.~~

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) On or before December 1, 2015, the Maryland Health Care Commission, in consultation with the Office of Health Care Quality and the Maryland Hospital Association, shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2-1246 of the State Government Article, on the findings of the pilot programs established under Section 1 of this Act, including best practices and data outcomes experienced during the pilot period.

(b) The report required under subsection (a) of this section shall:

(1) include recommendations, based on the findings of the pilot programs established under Section 1 of this Act, to be used to develop minimum standards for palliative care programs with the goal of expanding access to palliative care services statewide at hospitals with 50 beds or more by July 1, 2016, in a manner that ensures geographic balance and promotes racial and ethnic diversity; and

(2) be used by the Department of Health and Mental Hygiene, in consultation with experts in hospital palliative care and other interested stakeholders, to assist in the development of regulations related to standards for palliative care programs.

SECTION 4 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2013. It shall remain effective for a period of 3 years and 2 months and, at the end of November 30, 2016, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Approved by the Governor, May 2, 2013.

**Appendix B: Hospital Palliative Care
Advisory Group Membership**



MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

**Maryland Health Care Commission
Hospital Palliative Care Advisory Group Membership**

Participating Pilot Hospitals:

Carroll Hospital:	Julie Wright, Palliative Care Coordinator
Doctor's Community Hospital:	Ivan Zama, MD, Director, Palliative Medicine
Greater Baltimore Medical Center:	Catherine Hamel, VP, Post Acute Services
Holy Cross Hospital of Silver Spring:	Jaya Vijayan MD, Medical Director, Palliative Care Cathy Livingston, LCSW-C, Director, Documentation Quality & Care Transitions
Howard County General Hospital:	Catherine Hamel, VP Post Acute Services
Johns Hopkins Hospital:	Thomas Smith, MD, Director of Palliative Medicine, Johns Hopkins Medical Institutions
MedStar Union Memorial Hospital:	Kathryn Walker, Ph.D., Director of Palliative Clinical Outcomes, Research and Education Rene Mayo, Senior Executive Director, Palliative Medicine
Meritus Medical Center:	Allen Twigg, Director, Behavioral Services Susan K. Lyons, Palliative Care Nurse Practitioner
Peninsula Regional Medical Center:	Joan Daugherty, Executive Director, Richard Henson Cancer Institute Alane Capen, President and CEO Coastal Hospice and Palliative Care
Suburban Hospital:	Steven Wilks, MD, Medical Director, Palliative Care Service, Suburban Hospital-Johns Hopkins Medicine
University of Maryland Upper Chesapeake Medical Center:	Angela Poppe Ries, MD, Director of Palliative Care

Members:

Michelle Brazil, Hospice Quality Reporting Program, CMS
Sydney Morss Dy, MD, Associate Professor, Departments of Health Policy and Management, Oncology, and Medicine, Johns Hopkins
Kira Eyring, American Cancer Society
Peggy Funk, Executive Director, Hospice & Palliative Care Network of Maryland
Peter Graze, MD, MedChi
Mary Rossi-Coajou, Senior Nurse Consultant, Center for Clinical Standards and Quality, Clinical Standards Group, CMS
Nicole Stallings, Vice President, Policy & Data Analytics, Maryland Hospital Association

Memorandum

Page 2

Patricia Tomsco Nay, MD, Executive Director, Office of Health Care Quality

Commission Staff:

Linda Cole

Erin Dorrien

Rebecca Goldman

Paul Parker

**Appendix C: Request for Application:
Application to Participate in the Hospital
Palliative Care Pilot**

Application to Participate in the Hospital Palliative Care Pilot Program Study

PART I- APPLICATION CRITERIA

Instructions: Please submit a complete and concise response to each of the following two criteria. For Criterion 2, if the hospital applicant has applicable policies or procedures in place, they should be provided as attached exhibits to the application. If the hospital applicant does not have applicable policies or procedures in place, attestation that it will have such policies and procedures in place prior to the beginning of the study will be sufficient.

Criterion 1: Hospital beds

Requirement: The hospital must have at least 50 licensed acute care beds in FY 2014, as per statute.

Criterion 2: Policies and procedures

Requirement: Upon initiation of the pilot study, a selected hospital palliative care program should be able to demonstrate that it has policies or procedures specific to the palliative care program which address the following areas:

- (1) access to information and counseling regarding palliative care services appropriate to a patient with a serious illness or condition;
- (2) identification of the authorized decision maker of an individual who lacks capacity to make health care decisions in order to provide the authorized decision maker access to information and counseling regarding options for palliative care for the patient;
- (3) requirement that providers engage in a discussion of the benefits and risks of treatment options in a manner that can be understood easily by the patient or authorized decision maker;
- (4) encouragement of the patient or authorized decision maker to include the patient's relatives and friends in counseling regarding palliative care; and
- (5) facilitation of access to appropriate palliative care consultations and services, including associated pain management consultations and services consistent with a patient's needs and preferences.
- (6) if a patient or authorized decision maker decides to receive counseling about palliative care, the counseling must include information about the right to: 1) continue to pursue disease-targeted treatment with or without concurrent palliative care; and 2) receive comprehensive pain and symptom management, including pain medications.

ATTESTATION:

I attest and sign that _____ *name of hospital* _____ has policies and procedures in place that comply with the above-stated requirements or will have complying policies and procedures formally adopted by the hospital prior to the beginning of this pilot study. If a program is selected it must file with the Commission a complete set of policies and procedures that address all of the above requirements.

Signature: _____ Date: _____

PART II- APPLICATION REQUIREMENTS AND MEASURES

Instructions: Please submit a complete and concise response to each of the following five Requirements and accompanying Measures. These Requirements and Measures were developed to provide applicants with a sense of what the Commission is seeking in the pilot program pool. However, we are willing to consider applications from hospitals that cannot demonstrate or document full compliance or consistency with every Requirement Measure. Please respond as directly as possible to the Requirement and Measure statement, with supplemental information as necessary, and address why your program should be included in the pilot hospital study group, even if your program does not fully adhere to the stated Requirement. Please provide a distinct response to each Requirement and Measure in the order presented.

Requirement 1: A pilot hospital should have an established operating program functioning beyond the developmental or program initiation phase.

Req. 1 Measure: The hospital should document that it had a palliative care line item in the hospital's budget *prior to July 1, 2013*.

Requirement 2: A pilot hospital should have sufficient staffing to provide needed services.

Req. 2 Measure: The hospital palliative care program should be able to demonstrate that it (1) has a designated program director who is a physician, nurse practitioner, or RN, who is certified in palliative care or another related discipline and (2) has at least one full-time equivalent employee to staff the palliative care program, which can include the designated program director. Applicants should include a list of all staff members who deliver services for the palliative care program, including titles, certifications and qualifications, and average weekly hours for each staff member.

Requirement 3: A pilot hospital should have sufficient service volume to allow for meaningful study of its patients' experience, outcomes, and program performance.

Req. 3 Measure: The hospital palliative care program should demonstrate that it served a *minimum of 200 patients* who received palliative care consultations in the most recent year or twelve month period for which data is available. Applicants should include documentation that reflects the number of total consultations and the number of patients treated with palliative care during this time period. Indicate the dates for which data is submitted.

Requirement 4: A pilot hospital should have the resources to support data collection necessary to complete the pilot study.

Req. 4 Measure: The hospital palliative care program should be able to demonstrate that it has collected a core set of data fields on palliative care patients that can be reported for *at least one full year prior to January 1, 2014*, and that the program and program staff will likely have the ability to collect data similar to the preliminary list of core data measures attached to this application, which will be finalized after pilot programs are selected. Note that this will also include data collection on patients who refuse palliative care, who will serve as a control group.

Supplemental Instructions: Applicants should consider including a copy of the order set or intake form, if available, and describe the process for data collection and record keeping. Applicants should address, in general, their ability to collect the data included in the attached list of core data measures. Applicants should include documentation reflecting general demographics and diagnoses of their patient population.

Requirement 5: A pilot hospital palliative care program should demonstrate its collaboration with community providers.

Req. 5 Measure: The hospital palliative care program should be able to demonstrate which community providers it collaborates with to deliver effective care. Applicants should include names of providers and nature of affiliation.

PART III- SUPPLEMENTAL INFORMATION

Assessments and evaluations

Applicants are encouraged to briefly discuss any assessments and evaluations conducted of their palliative care programs. Include a discussion of how those evaluations were used and what impact they had, if any, on policies, programming, or decision-making within the palliative care program. We are interested in also hearing about challenges encountered in implementing such assessments or evaluations. Assessments and evaluations could include, but are not limited to, clinical assessments, cost-benefit or effectiveness studies, or patient/family satisfaction surveys.

Unique program qualities

Applicants may include additional information about their palliative care programs that they believe uniquely qualifies them to be selected as a pilot program, based on the selection guidelines or the language in HB 581.

PART IV- DECLARATON AND AFFIRMATION

NOTE: All information provided in this application must be signed by the person(s) available for cross examination on the facts set forth in the information provided, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

"I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Signature: _____ Date: _____

**Appendix D: Hospital Palliative Care Advisory Group:
Background and Charge**

Maryland Health Care Commission

Hospital Palliative Care Advisory Group

Background:

HB 581, passed during the 2013 Legislative Session, requires the Commission to select at least five palliative care pilot programs in hospitals with 50 or more beds. The pilot programs shall: 1) collaborate with palliative care or community providers to deliver care; 2) gather data on costs and savings to hospitals and providers, access to care, and patient choice; and 3) report to the Maryland Health Care Commission on best practices that can be used in the development of statewide palliative care standards.

Charge:

The charge of the Hospital Palliative Care Advisory Group is to assist Commission staff in: 1) developing the questions to be addressed in the study and a standard set of core measures to be used in answering these questions; 2) analyzing and interpreting the study data collected in order to make recommendations regarding findings and conclusions on the study questions; and 3) assisting with the development of recommendations on best practices, from the literature, the pilot hospitals' experience, and/or the findings and conclusion of the study. The Commission will have final approval of study questions, data measures, the hospitals that will participate, and all reports and recommendations that are developed.

Membership:

The Advisory Group is composed of the pilot program hospitals, representatives of the two organizations mentioned in the legislation, the Maryland Hospital Association and the Office of Health Care Quality, DHMH; as well as other interested groups including: the Hospice and Palliative Care Network, Med Chi, the Centers for Medicare and Medicaid Services, and researchers in the field of Palliative Care.

Timeframes:

It is anticipated that the Advisory Group will convene for at least two meetings initially. The objectives of these initial meetings will be to review and discuss the study questions, the core data measures, and the process for collecting and analyzing the data in order to design the project. The Advisory Group will only convene as necessary, if problems or issues arise, during the data collection period. It is anticipated that the Group will convene one or more meetings after data collection to advise Commission staff on findings and to assist in drafting of the final report to the legislature. A Commission report to the legislature on findings from the pilot study and recommendations on best practices is due to the General Assembly by December 1, 2015. Recommendations from the pilot study are to be used by DHMH for development of minimum standards for palliative care programs with the goal of expanding access to palliative care services statewide in hospitals with more than 50 beds by July 1, 2016.

APPENDIX E: Journal of Pain and Symptom Management
Article: “An Assessment of Hospital-Based Palliative Care in
Maryland: Infrastructure, Barriers, and Opportunities”

Original Article

An Assessment of Hospital-Based Palliative Care in Maryland: Infrastructure, Barriers, and Opportunities

Kenneth D. Gibbs Jr., PhD, MPH, Margaret M. Mahon, PhD, CRNP, Meredith Truss, MPP, and Kira Eyring, BS *Cancer Prevention Fellowship Program (K.D.G.), Division of Cancer Prevention; Science of Research and Technology Branch (K.D.G.), Behavioral Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute, Bethesda, Maryland; University of Maryland Medical Center (M.M.M.), Baltimore, Maryland; Maryland Department of Health and Mental Hygiene (M.T.), Baltimore, Maryland; and American Cancer Society (K.E.), Atlanta, Georgia, USA*

Abstract

Context. Maryland recently passed legislation mandating that hospitals with more than 50 beds have palliative care (PC) programs. Although the state's health agency can play a key role in ensuring successful implementation of this measure, there is little actionable information from which it can guide resource allocation for enhancing PC delivery statewide.

Objectives. To assess the PC infrastructure at Maryland's 46 community-based nonspecialty hospitals and to describe providers' perspectives on barriers to PC and supports that could enhance PC delivery.

Methods. Data on PC programs were collected using two mechanisms. First, a survey was sent to all 46 community-based hospital chief executive officers by the Maryland Cancer Collaborative. The Maryland Health Care Commission provided supplementary survey and semistructured interview data.

Results. Twenty-eight hospitals (60.9%) provided information on their PC services. Eighty-nine percent of these hospitals reported the presence of a structured PC program. The profile of services provided by PC programs was largely conserved across hospital geography and size. The most common barriers reported to PC delivery were lack of knowledge among patients and/or families and lack of physician buy-in; most hospitals reported that networks and/or conferences to promote best practice sharing in PC would be useful supports.

Conclusion. Systematic collection of state-level PC infrastructure data can be used to guide state health agencies' understanding of extant resources and challenges, using those data to determine resource allocation to promote the timely receipt of PC for patients and families. *J Pain Symptom Manage* 2015;49:1102–1108. *Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

Key Words

Palliative care, infrastructure, state-level data, barriers and supports, departments of health

Introduction

In 2013, the Maryland legislature passed, and the governor signed into law, House Bill 581.¹ This law requires that by 2016, Maryland hospitals with 50 or more beds have an accredited palliative care (PC) program, and all hospitals provide access to information and counseling regarding PC services appropriate to a patient with a serious illness or condition. Research has identified multiple benefits of timely integration

of PC for patients, caregivers, and health care systems.² Randomized trials have shown that for patients facing serious illnesses, early integration of PC (concurrent with standard and disease-focused care) is associated with equivalent or improved survival, decreased symptom burden, enhanced satisfaction with treatment experience, better symptom management, and improved quality of life for caregivers.^{3–8} Furthermore, for patients with life-threatening

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Accepted for publication: December 20, 2014.

illnesses (e.g., cancer, chronic obstructive pulmonary disease, stroke), early receipt of PC resulted in fewer hospital days and average health care costs roughly \$4800–\$7500 less than patients receiving standard care alone.^{9,10}

Despite the benefits of timely receipt of PC, evidence suggests that it remains underused.^{11–13} Potential clinical barriers include physician attitudes,¹⁴ avoidance of palliative and end-of-life discussions until all treatment options have been exhausted,¹⁵ and a lack of knowledge by providers about the types of services available through PC, patient eligibility, and best time to initiate referrals.¹⁶ Organizational barriers also can present hurdles to broader integration of PC as facilities that serve chronically ill patients sometimes lack sufficient numbers of appropriately trained staff, adequate resources, and protocols to optimize the chances of timely receipt of PC.^{17,18}

In addition to ensuring compliance with House Bill 581, Maryland's state health department (i.e., the Department of Health and Mental Hygiene [DHMH]) is well positioned to coordinate resources and catalyze systemic changes that can ultimately enhance access to PC statewide. The ability for DHMH to do this depends on the availability of timely actionable information. Previous work has examined the availability of PC services nationwide at cancer centers,¹⁹ but there remains a gap in understanding PC availability and barriers at the state and local levels. This study aims to address some of these gaps at the state level and is centered on the following questions:

1. What is the hospital-based PC infrastructure in the state of Maryland? That is, how widely available is PC, and what types of services do PC programs offer?
2. What PC services do hospitals plan to enhance over the next five years?
3. From the provider perspective, what are barriers to enhanced delivery of PC, and what are useful supports that would enhance PC delivery?
4. To what extent do the infrastructure, barriers, and supports differ based on hospital size or region?

Methods

Survey Design

A review of existing PC surveys^{19,20} was conducted by the Palliative Care Workgroup of the Maryland Cancer Collaborative, a statewide coalition supported by the Maryland DHMH, which works to implement the Maryland Comprehensive Cancer Control Plan. Questions were developed by the workgroup with

the input of external experts, including members of the Maryland Cancer Collaborative Evaluation Workgroup, the Maryland State Council on Cancer Control, the Maryland State Advisory Council on Quality Care at the End of Life, and the Hospice and Palliative Care Network of Maryland. Questions were developed to collect data around several focus areas: PC processes, PC program characteristics, PC program staff, temporal trends in PC, and challenges and needs.

During the survey revision process, the Maryland Cancer Collaborative became aware of a survey and semistructured interviews that were conducted during the fall of 2013 by the Maryland Health Care Commission (MHCC), another division of the DHMH. The collaborative partnered with the MHCC and adapted the wording of several survey questions to match questions asked by the MHCC to collect comparable data.

Data Collection

Surveys were distributed to all nonspecialty community-based hospitals in Maryland. Given the assumption that PC services may be coordinated by various hospital departments, rather than attempting to identify and send to the appropriate contact within each hospital, surveys were sent to hospital chief executive officers (CEOs). An introductory letter was mailed to each CEO with a request for the CEO to designate the appropriate PC contact at the institution to complete the survey instrument online. A fact sheet about PC also was mailed with the letter to raise awareness of the benefits of providing hospital-based PC among CEOs. Copies of the surveys and other materials are provided in the Appendix (available at jpsmjjournal.com). Responses were compared with data collected by the MHCC; responses of hospitals that had already reported data through the MHCC survey data were merged for matched questions.

Within three weeks after the initial mailing, CEO assistants were contacted by phone and/or electronic mail to collect contact information of the designated responder. Third and fourth contacts were attempted for more than eight weeks to remind nonresponders and encourage survey completion. Hospitals were considered nonresponders if they did not complete the survey after four attempted contacts.

Statistical Analysis

Fisher's exact test was performed to compare all survey responses based on hospital size (i.e., 250 beds or fewer vs. more than 250 beds) and region (i.e., Central Maryland vs. Western Maryland, Southern Maryland, and the Eastern Shore). All analyses were performed using GraphPad Prism (GraphPad Software, Inc., La Jolla, CA), and figures were made using Adobe Illustrator (Adobe Systems Inc., San Jose, CA).

Results

Maryland Hospitals and Response Rate

Basic information on the PC infrastructure was received from 28 of 46 Maryland hospitals. This included 25 that provided extensive information by completing the full survey (survey response rate 54.3%) and three additional hospitals that provided basic information through the MHCC survey. These 28 hospitals had a total of 8263 hospital beds, representing 80% of all hospital-based and licensed acute care beds in the state. The 25 hospitals completing the full survey had a total of 7007 hospital beds, representing 67.7% of hospital beds in the state.²¹ A comparison of responding and nonresponding hospitals is shown in Table 1.

Responding hospitals were diverse with respect to size and geographic distribution. Slightly more than half of the hospitals had 250 beds or fewer ($n = 15$; 53.6%), and the remainder were larger hospitals with more than 250 beds ($n = 13$; 46.4%). Most hospitals in the sample were from Central Maryland ($n = 15$; 53.6%); the remaining were from Southern Maryland ($n = 6$; 21.4%), Western Maryland ($n = 5$; 17.9%), and the Eastern Shore ($n = 2$; 7.1%). Hospitals that provided data had an average of 295 licensed acute care beds per facility compared with 97 beds per facility for nonresponders.¹⁹ Most nonresponsive hospitals were small to medium in size; 13 of 18 nonresponders had less than 250 beds.¹⁹ Nonresponders were distributed across geographic regions, with seven located in Southern Maryland, six in Central Maryland, and five in the Eastern Shore region. There were no statistically significant differences in hospital size (dichotomized as more or less than 250 beds) or hospital geography (dichotomized as Central Maryland vs. other region) in the responding and nonresponding hospitals ($P > 0.2$).

Table 1
Characteristics of Maryland Hospitals

Characteristics	Respondents, <i>n</i> (%)	Nonrespondents, <i>n</i> (%)
Basic information		
Total number	28	18
Number (%) with PC program	25 (89)	—
Percent of hospital-based licensed acute care beds in state	80	20
Number of hospital beds		
1–50	1 (3.6)	3 (16.7)
51–100	3 (10.7)	3 (16.7)
101–200	2 (7.1)	3 (16.7)
201–250	9 (32.1)	4 (22.2)
251–300	7 (25)	1 (5.5)
301+	6 (21.4)	4 (22.2)
Hospital region		
Central Maryland	15 (53.6)	6 (33.3)
Southern Maryland	6 (21.4)	7 (38.9)
Western Maryland	5 (17.9)	0 (0)
Eastern Shore	2 (7.1)	5 (27.8)

PC = palliative care.

Hospital-Based PC Infrastructure in the State of Maryland

Of the 28 hospitals responding, 25 (86.2%) reported the presence of a PC program, that is, a structured hospital-based program that employs a multidisciplinary team that may include doctors, nurses, and other specialists who work together with a patient's other health care providers to provide PC, and three hospitals (13.8%) reported no PC program (Table 1). Overall, 54% of hospitals reported programs that provided inpatient PC only; 32% of hospitals reported programs that provided both inpatient and outpatient PC (Table 1). Thus, although most hospitals reported the presence of a PC program, less than a third of the hospitals reported having programs that provided outpatient PC.

Of the 25 PC programs, only one reported Joint Commission certification in PC, although five reported that they were in the process of applying for certification, or planned to do so within the next 24 months. Staffing issues represented the most common barrier to certification, with eight hospitals indicating this as a challenge. Specifically, these hospitals indicated the need for 24/7 coverage, difficulty finding qualified personnel, and the need for additional full-time staff among the barriers that prevent them from pursuing certification. Other common barriers to pursuing certification included the newness of the program (four programs), the high costs associated with certification (three programs), and the lack of clear benefits for pursuing certification (three programs).

Characteristics of PC Programs: Services Provided and Process for Initiating PC

The hospital-based PC programs were asked to provide information on the types of services provided and their process for initiating PC (Table 2). PC services provided were similar across hospital size and geography. More than 80% of programs reported the presence of nine of the 11 PC program characteristics assessed. These services included bridging patients to hospice care (100%), pain and/or symptom assessment and management (95%), discussion of advance directives with patients (95%), psychosocial support (91%), preparation of a comfort care plan (91%), pastoral care/spiritual consultation (86%), bridging to community resources (86%), and caregiver/family support (81%). In contrast, 59% of hospitals reported discussion of financial planning or referral to financial counselors as part of their PC programs, and 54.5% indicated that psychiatric and mental health assessment and management was a service provided by their PC program, indicating potential areas for improvement in the PC infrastructure. With the exception of financial planning services, which were present not only in 38.5% of PC programs in Central Maryland

Table 2
Characteristics of PC Programs in Maryland

Basic Information (25 Hospitals With PC Programs)	Total n (%) of 25 PC Programs
Delivery of PC	
Inpatient only	15 (60)
Inpatient and outpatient	9 (36)
Other	1 (4)
Joint Commission Certification of PC program	
Yes	1 (4)
No	24 (96)
Detailed Information (22 Hospitals With PC Programs That Responded to Survey)	Total n (%) of 22 PC Programs
Services Provided	
Bridging to hospice care	22 (100)
Symptom assessment and management	21 (95)
Pain assessment and management	21 (95)
Discussion of advance directives	21 (95)
Psychosocial support	20 (91)
Preparation of a comfort care plan	20 (91)
Bridging to community resources and services	19 (86)
Pastoral care and/or spiritual consultation	19 (86)
Caregiver/family support	18 (81)
Financial planning or referral to financial counselors	13 (59) ^a
Psychiatric and mental health assessment and management	12 (55)
Process for initiating PC	
At the request of the health care provider	20 (91)
At the request of the patient or family	18 (81)
When patient diagnosed with condition that may require PC	12 (55)
No formal process	4 (18)
When patients are admitted to the hospital	4 (18)
During the first treatment appointment (for cancer or other conditions)	4 (18)
During outpatient provider appointments as appropriate	4 (18)
When first treatment regimen fails	2 (9)
Person responsible for initiating PC consultation	
Physicians	21 (95)
Midlevel providers (including physician assistants and advanced practice registered nurses)	19 (86)
Clinical social workers	8 (36)
Nurses	7 (32)

PC = palliative care.

^aStatistically significant difference ($P < 0.05$) in the percentage of hospitals describing the provision service by region (comparing central Maryland to all other regions, Fisher's exact test). There were no differences in the PC services provided, process for initiating PC, or person responsible for initiating PC across hospital size (when comparing hospitals with more or less than 250 beds).

but also in 88.9% of PC programs in other regions ($P = 0.03$), there were no statistically significant differences in the representation of any of these 11 program characteristics by region (Central Maryland vs. Southern Maryland/Western Maryland/Eastern Shore) or hospital size (250 beds or fewer vs. greater than 250 beds).

In addition to PC services, survey respondents also provided information regarding the process and personnel responsible for initiating discussions about PC with patients—information valuable to determining

potential areas where intervention can lead to expanded PC services for patients who could benefit. Within PC programs, the most common mechanisms for initiating discussions with patients were “at the request of the health care provider” (91%) and “at the request of the patient or family” (82%) (Table 2). Fifty-five percent of hospitals reported that PC discussions are initiated when patients are diagnosed with conditions that may require PC, and 18% of hospitals indicated that the PC discussions are initiated during the first treatment appointment (for cancer or other conditions). Accounting for hospitals that used both mechanisms (appropriate diagnosis or initial treatment) for initiating PC discussions, 13 of the 22 PC (59%) programs for which there was extensive information indicated that PC discussions are systematically initiated early in the course of treatment for conditions that may require PC. In contrast, 18% of hospital PC programs indicated that their institution does not have a formal process to initiate PC discussion. When asked who can initiate a referral for a PC consultation at the institution, 95% of institutions indicated physicians, and 86% of institutions responded that midlevel providers (e.g., physician assistants and advanced practice registered nurses) could initiate these referrals (Table 2). Social workers and nurses were able to initiate referrals for PC consultation at a minority of institutions (36% and 32%, respectively).

Plans for PC Program Expansion

Hospitals also were asked about whether they planned to add or increase PC services in the coming three years (Table 3). Sixty-four percent of hospitals planned to increase the number of PC physicians, nurses, and/or physician assistants; 56% indicated that they planned to add or expand educational opportunities, training, or professional development in PC for employees. Fewer than half of institutions plan to increase their budget for PC (48%) or add or increase the number of nonmedical PC team members such as social workers or chaplains (44%), and none reported intentions to add or increase the number of PC acute beds (0%). Three hospitals (12%) planned to establish a PC program within the next three years, including one of the four hospitals surveyed that does not have a PC program currently, and two hospitals with relatively new PC programs; presumably these two hospitals will further establish their new programs.

Barriers to Offering PC at Institutions

Respondents were asked to identify challenges to providing PC at their institution (Table 3). The most common barriers reported were lack of knowledge about PC among patients and/or families (68%), lack of physician buy-in (56%), limited budget

Table 3
Plans for PC Program Expansion and Providers' Views on
Barriers to and Opportunities for Enhancing PC

PC Program Characteristic, Barriers, or Useful Supports	Total <i>n</i> (%) of 25 Hospitals Responding to Survey
PC services institution planning to add or expand over next three years	
No. of PC physicians, nurses, and/or physician assistants	16 (64)
Educational opportunities, training, or professional development in PC for employees	14 (56)
PC funding and/or budget	12 (48)
No. of other members of the PC team (social worker, chaplain, etc.)	11 (44)
Establish a PC program (if a program does not currently exist)	3 (12)
Number of PC acute beds	0 (0)
Challenges to providing PC at institution	
Patients and/or families are not knowledgeable about PC	17 (68)
Lack of buy-in from physicians	14 (56)
Limited budget for PC services ^a	13 (52)
Lack of adequately trained PC physicians, nurses, clinical social workers, others	11 (44)
Poor reimbursement for PC services ^a	11 (44)
Patients and/or families are knowledgeable but not interested in PC	5 (20)
Lack of buy-in from institution leadership	4 (16)
PC is available at my institution, but there are few referrals	3 (12)
PC training opportunities for existing team members are not readily available	3 (12)
Concern that PC may increase hospital mortality	2 (8)
Limited PC needs in my institution	2 (8)
Lack of evidence to suggest PC improves patient outcomes	0 (0)
Helpful PC supports for institution	
Best practice sharing from other programs/hospitals	16 (64)
Conference on PC best practices	15 (60)
Participation in a network of other PC professionals	15 (60)
Reimbursement/billing guidance	12 (48)
Mentor/consultation from other programs/hospitals	6 (24)
Training of clinical team	6 (24)
Technical assistance in the development of PC programs [†]	5 (20)

PC = palliative care.

^aStatistically significant difference ($P < 0.05$) in the percentage of hospitals describing this as a challenge or useful support by hospital size (comparing hospitals with 250 or fewer beds, to those with more, Fisher's exact test).

(52%), poor reimbursement for PC services (44%), and a lack of adequately trained PC team members (physicians, nurses, social workers, etc.; 44%). Although there were no regional differences in the distribution of these barriers, smaller hospitals (i.e., 250 beds or fewer) were more likely to indicate that limited budget for PC represented a barrier (75% of small hospitals vs. 31% of large hospitals, $P = 0.047$), whereas larger hospitals (i.e., more than 250 beds) were more likely to indicate that poor reimbursement for PC services was a challenge at their institution (75% of large hospitals vs. 21% of small hospitals; $P = 0.005$). Other less common challenges

to increasing PC included lack of interest among patients and/or families who were knowledgeable about PC (20%), lack of buy-in from institutional leadership (16%), lack of readily available training opportunities (12%), few referrals (12%), limited PC needs (8%), and concern that PC may increase hospital mortality (8%).

Useful Supports Related to PC

Responding CEOs also were asked to identify supports for PC at their institution (Table 3). Sixty-four percent identified best practice sharing from other programs and/or hospitals, whereas 60% of respondents identified participation in a network of other PC professionals and conference on PC best practices as useful. Just under half of the respondents (48%) indicated that reimbursement and/or billing guidance would be useful, and additional potentially beneficial supports included clinical team training (24%), mentor and/or consultation from other programs and/or hospitals (24%), and technical assistance in the development of PC programs (20%). There were no statistically significant regional or hospital size-based differences with respect to the supports that would be useful with one exception. Regarding technical assistance in the development of PC programs, 38% of small hospitals believed that this would be a helpful support, whereas none of the large hospitals (0%) indicated that it would be helpful ($P = 0.04$).

Discussion

Despite significant evidence that early integration of PC alongside disease-focused therapies can lead to equivalent or improved survival, enhanced quality of life for patients and caregivers, and lower costs to the health care system,^{9,10,22} PC remains underused.^{11–13} In Maryland, there is a legislative mandate for enhancing PC delivery set to take effect in 2016;¹ however, comprehensive information on the state of PC in Maryland remains lacking. This study presents data on the hospital-based PC infrastructure in the state of Maryland and provides important information for understanding how the state health agency (DHMH) can allocate resources with the goal of optimizing PC resources for patients throughout Maryland. Furthermore, it provides a model and point of comparison for other health agencies seeking to enhance PC in their jurisdictions.

The survey responses provided a number of potential areas—structurally, with health care professionals, and with the general public—where interventions could lead to enhanced receipt of PC for patients who would benefit. The vast majority of hospitals sampled (89%) had PC programs, and the service

profiles were largely similar across geography and hospital size. However, only a minority of hospitals (32%) had outpatient PC services. Outpatient PC services can save costs—with a decrease in emergency department utilization, as well as decreased hospital admissions²⁵—and improve improved end-of-life care relative to those receiving inpatient care.²⁴ Thus, enhancing the outpatient PC infrastructure represents an area that could improve the delivery and receipt of PC throughout the state.

The survey also indicated that systems to ensure timely receipt of PC are far from universal. Although most (59%) PC programs indicated that discussions about PC are initiated at time of diagnosis or at initial treatment for serious illnesses, 41% did not indicate procedures for ensuring timely PC delivery. Health care providers, specifically physicians, were the most likely to initiate discussions with patients about PC; however, lack of physician buy-in was one of the most common challenges to provision of PC at Maryland hospitals. Therefore, enhancing training opportunities to increase physician understanding of PC and/or modifying incentive structures could reverse this perceived lack of support and could enhance timely receipt of PC. Additionally, lack of knowledge about PC among patients and families represented the most common barrier to delivery at Maryland hospitals. Sixty-eight percent of hospitals identified lack of patient knowledge as a barrier, a number in line with national surveys showing 70% of American adults lacked knowledge about what PC is.²⁵ This suggests that awareness campaigns—either to the general public or targeted in health care settings—could enhance patient knowledge to mitigate this barrier.

The results also suggest that coordination by DHMH could help hospitals in their development or expansion of PC programs. Most hospitals sampled indicated that supporting mechanisms to enhance information sharing among hospitals and PC providers (e.g., conferences or formalized networks) would be helpful to them in optimizing PC delivery. Additionally, small hospitals (in contrast to larger hospitals) noted that technical assistance in the development of PC programs would be a beneficial support.

Limitations

There are a number of limitations to the study. First, we were not able to get complete information from all hospitals in Maryland. Additionally, all data relied on self-report. As there was no independent verification of the information provided, this presents the opportunity for bias. Moreover, there are no clear and uniform standards on what constitutes a PC program. Finally, although addressed to hospital CEOs, in some cases, delegates filled out the survey.

Conclusion

Although there have been calls to enhance the timely receipt of PC,^{26,27} the role that state health agencies can play has been inconsistently defined and underappreciated. With their broad reach and prominent role in health policy, health departments are well positioned to coordinate resources and catalyze systemic changes that can ultimately enhance the effectiveness of public health initiatives.²⁸ In Maryland, the DHMH will use the information gathered through this survey to guide its efforts to ensure successful implementation of the universal PC measure set to take effect in 2016. Furthermore, this information provides a baseline that can be used to evaluate the efficacy of policy interventions designed to enhance timely receipt of PC.

Disclosures and Acknowledgments

This work was supported by Centers for Disease Control and Prevention Cooperative Agreement Number 5U58DP003919–02. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention. Dr. Gibbs is supported by the Cancer Prevention Fellowship from the National Cancer Institute. This work was completed while Dr. Gibbs was a Master of Public Health candidate at the Johns Hopkins Bloomberg School of Public Health. The authors declare no conflicts of interest.

The authors thank Norma Kanarek and Marie Diener-West for critical review of the article.

Supplementary Data

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.jpainsymman.2014.12.004>.

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**Appendix F: St. Paul Group Case Mix
Adjustment Analysis**

Appendix F

M.S.G.A. - CMA LOS ANALYSIS - MHCC
 07/2014 to 06/2015
 REJECT: DEATHS
 PALLIATIVE CARE HOSPITALS
 FLAGGED CASES ONLY
 MS-DRG VER 31.0

HOSP NO.	FLAG = 1				FLAG = 2				FLAG = 3				FLAG = 8				TOTAL				HOSP NAME
	CASES	Alos	C A Alos	PCT VAR	CASES	Alos	C A Alos	PCT VAR	CASES	Alos	C A Alos	PCT VAR	CASES	Alos	C A Alos	PCT VAR	CASES	Alos	C A Alos	PCT VAR	
99	1584	10.04	0	0	2541	8.54	0	0	1055	12.44	0	0	265	13.03	0	0	5445	9.95	0	0	0 ALL HOSPITALS
09	244	14.1	12.03	17.21	465	12.24	10.03	22.03	32	11.88	11.59	2.5	222	13.42	13.38	0.3	963	12.97	11.36	14.17	JOHNS HOPKINS HOSPITAL
18	270	9.57	8.98	6.57	176	8.39	8.3	1.08	19	18.47	14.05	31.46	0	0	0	0	465	9.49	8.93	6.27	PENINSULA REGIONAL MED CTR
04	165	11.88	11.89	-0.08	349	9.43	8.8	7.16	220	17.36	16.54	4.96	0	0	0	0	734	12.36	11.82	4.57	HOLY CROSS HOSPITAL
22	24	10.83	9.03	19.93	125	10.82	9.95	8.74	279	12.53	12.37	1.29	0	0	0	0	428	11.93	11.47	4.01	UNION MEMORIAL HOSPITAL
47	214	10.36	10.15	2.07	228	7.34	7.52	-2.39	32	9.5	9.85	-3.55	0	0	0	0	474	8.85	8.86	-0.11	UPPER CHESAPEAKE MED. CTR.
20	120	10.88	10.99	-1	155	8.48	8.27	2.54	71	6.96	7.21	-3.47	16	10.44	10.82	-3.51	362	9.06	9.08	-0.22	SUBURBAN HOSPITAL
46	65	11.05	11.27	-1.95	107	7.41	8.47	-12.51	47	15.02	13.8	8.84	4	16.5	12.96	27.31	223	10.24	10.49	-2.38	HOWARD CTY. GENERAL HOSPITAL
48	17	5.88	9	-34.67	215	8.19	8.25	-0.73	96	12.75	12.92	-1.32	23	10.48	11.29	-7.17	351	9.47	9.77	-3.07	DOCTORS COMMUNITY HOSPITAL
42	200	8.81	9.34	-5.67	227	6.41	7.66	-16.32	42	11.67	10.8	8.06	0	0	0	0	469	7.9	8.66	-8.78	GREATER BALTIMORE MED. CTR.
01	68	7.15	8.77	-18.47	231	6.74	8.43	-20.05	100	9.29	10.26	-9.45	0	0	0	0	399	7.45	8.95	-16.76	MERITUS MEDICAL CENTER
31	197	5.41	7.72	-29.92	263	5.13	7.26	-29.34	117	7.94	10.25	-22.54	0	0	0	0	577	5.79	8.02	-27.81	CARROLL HOSPITAL CENTER

HOSP NO.	FLAG = 1				FLAG = 2				FLAG = 3				FLAG = 8				TOTAL				HOSP NAME
	CASES	AVG/CHG	CMA AVG/ PCT VAR	CASES	AVG/CHG	CMA AVG/ PCT VAR	CASES	AVG/CHG	CMA AVG/ PCT VAR	CASES	AVG/CHG	CMA AVG/ PCT VAR	CASES	AVG/CHG	CMA AVG/ PCT VAR	CASES	AVG/CHG	CMA AVG/ PCT VAR			
99	1584	29986	0	0	2541	24555	0	0	1055	37643	0	0	265	52935	0	0	5445	30052	0	0	0 ALL HOSPITALS
09	244	59750	43432	37.57	465	46329	31755	45.9	32	50415	40642	24.05	222	56545	55801	1.33	963	52220	40552	28.77	JOHNS HOPKINS HOSPITAL
22	24	33084	24573	34.64	125	34427	30123	14.29	279	42520	38231	11.22	0	0	0	0	428	39627	35097	12.91	UNION MEMORIAL HOSPITAL
18	270	24715	24396	1.31	176	22896	23191	-1.27	19	49870	40191	24.08	0	0	0	0	465	25055	24586	1.91	PENINSULA REGIONAL MED CTR
04	165	29759	34464	-13.65	349	22730	24751	-8.17	220	52332	53825	-2.77	0	0	0	0	734	33183	35649	-6.92	HOLY CROSS HOSPITAL
48	17	17339	23958	-27.63	215	19992	23350	-14.38	96	38106	37978	0.34	23	29835	37071	-19.52	351	25463	28280	-9.96	DOCTORS COMMUNITY HOSPITAL
42	200	23693	26046	-9.03	227	17521	21253	-17.56	42	27861	28115	-0.9	0	0	0	0	469	21079	23912	-11.85	GREATER BALTIMORE MED. CTR.
31	197	17244	20321	-15.14	263	16504	19655	-16.03	117	26969	28820	-6.42	0	0	0	0	577	18879	21741	-13.16	CARROLL HOSPITAL CENTER
20	120	24632	29912	-17.65	155	17243	22350	-22.85	71	19894	22862	-12.98	16	38882	40975	-5.11	362	21169	25781	-17.89	SUBURBAN HOSPITAL
47	214	24534	28624	-14.29	228	14571	20203	-27.88	32	18679	24271	-23.04	0	0	0	0	474	19347	24280	-20.32	UPPER CHESAPEAKE MED. CTR.
46	65	41767	49146	-15.01	107	14722	23709	-37.91	47	33139	36480	-9.16	4	41648	32943	26.42	223	26970	33981	-20.63	HOWARD CTY. GENERAL HOSPITAL
01	68	17507	22182	-21.08	231	19043	23903	-20.33	100	22255	28285	-21.32	0	0	0	0	399	19586	24708	-20.73	MERITUS MEDICAL CENTER

M.S.G.A. - CMA LOS ANALYSIS - MHCC
 07/2014 to 06/2015
 REJECT: DEATHS
 PALLIATIVE CARE HOSPITALS
 UN-FLAGGED CASES ONLY METHOD 2
 MS-DRG VER 31.0

HOSP NO.	MEDICARE				OTHER				TOTAL				HOSP NAME
	CASES	Alos	C A Alos	PCT VAR	CASES	Alos	C A Alos	PCT VAR	CASES	Alos	C A Alos	PCT VAR	
99	73072	4.77	0	0	68547	4.26	0	0	141619	4.52	0	0	0 ALL HOSPITALS
09	11447	6.57	5.68	15.67	21674	5.46	4.9	11.43	33121	5.84	5.17	12.96	JOHNS HOPKINS HOSPITAL
48	3921	5.15	4.77	7.97	4096	4.33	4.16	4.09	8017	4.73	4.46	6.05	DOCTORS COMMUNITY HOSPITAL
47	5655	4.49	4.3	4.42	3152	3.57	3.74	-4.55	8807	4.16	4.1	1.46	UPPER CHESAPEAKE MED. CTR.
46	6056	4.86	4.64	4.74	4579	3.92	4.09	-4.16	10635	4.46	4.4	1.36	HOWARD CTY. GENERAL HOSPITAL
18	8163	4.66	4.63	0.65	5289	3.95	3.92	0.77	13452	4.38	4.35	0.69	PENINSULA REGIONAL MED CTR
42	6066	4.32	4.44	-2.7	4810	3.38	3.63	-6.89	10876	3.91	4.08	-4.17	GREATER BALTIMORE MED. CTR.
04	8076	4.44	4.75	-6.53	8426	3.87	4.03	-3.97	16502	4.15	4.38	-5.25	HOLY CROSS HOSPITAL
22	5183	4.71	4.94	-4.66	4280	3.73	4.04	-7.67	9463	4.27	4.53	-5.74	UNION MEMORIAL HOSPITAL
20	6540	4.35	4.64	-6.25	4595	3.86	4.16	-7.21	11135	4.15	4.44	-6.53	SUBURBAN HOSPITAL
01	7254	3.94	4.52	-12.83	4913	3.08	3.86	-20.21	12167	3.59	4.25	-15.53	MERITUS MEDICAL CENTER
31	4711	3.52	4.34	-18.89	2733	2.99	3.86	-22.54	7444	3.33	4.17	-20.14	CARROLL HOSPITAL CENTER

HOSP NO.	MEDICARE				OTHER				TOTAL				HOSP NAME
	CASES	AVG/CHG	CMA AVG/ PCT VAR	CASES	AVG/CHG	CMA AVG/ PCT VAR	CASES	AVG/CHG	CMA AVG/ PCT VAR				
99	73072	16627	0	0	68547	17919	0	0	141619	17252	0	0	0 ALL HOSPITALS
09	11447	31345	23995	30.63	21674	27269	22588	20.72	33121	28677	23074	24.28	JOHNS HOPKINS HOSPITAL
22	5183	21833	20856	4.68	4280	20088	20079	0.04	9463	21044	20504	2.63	UNION MEMORIAL HOSPITAL
31	4711	13582	13417	1.23	2733	13773	14432	-4.57	7444	13652	13789	-0.99	CARROLL HOSPITAL CENTER
48	3921	14255	14534	-1.92	4096	13843	15417	-10.21	8017	14044	14985	-6.28	DOCTORS COMMUNITY HOSPITAL
42	6066	13901	14361	-3.2	4810	13575	15094	-10.06	10876	13757	14685	-6.32	GREATER BALTIMORE MED. CTR.
18	8163	15259	16387	-6.88	5289	13988	15785	-11.38	13452	14759	16150	-8.61	PENINSULA REGIONAL MED CTR
47	5655	11840	13761	-13.96	3152	12770	15243	-16.22	8807	12173	14291	-14.82	UPPER CHESAPEAKE MED. CTR.
04	8076	12670	14507	-12.66	8426	11968	14431	-17.07	16502	12312	14468	-14.9	HOLY CROSS HOSPITAL
01	7254	12058	14216	-15.18	4913	11574	14564	-20.53	12167	11863	14357	-17.37	MERITUS MEDICAL CENTER
20	6540	13951	16956	-17.72	4595	15624	19169	-18.49	11135	14641	17869	-18.06	SUBURBAN HOSPITAL
46	6056	10936	13557	-19.33	4579	10473	14167	-26.07	10635	10736	13819	-22.31	HOWARD CTY. GENERAL HOSPITAL

Appendix G: National Quality Forum Preferred Practices with Maryland Pilot Hospital Review

National Quality Forum Preferred Practice	MHCC pilot hospital alignment	Staff recommendation
Provide palliative and hospice care by an interdisciplinary team of skilled palliative care professionals, including, for example, physicians, nurses, social workers, pharmacists, spiritual care counselors and others who collaborate with primary health care professional(s).	All pilots have access to interdisciplinary teams of professionals at the hospital. Report will include details on the staffing structure and specific credentials, as reported in CAPC survey and to staff in interviews. Collaboration with primary health care providers is essential in the inpatient hospital care setting.	Recommended for inclusion in best practices and also as a requirement
2. Provide access to palliative and hospice care that is responsive to the patient and family 24 hours a day, seven days a week.	Not all pilots provide immediate access to care 24/7. Report will include details on the availability, as reported in CAPC survey and to staff in interviews. Report will also include opinions of the pilots regarding why immediate access at any time of day or night may not be necessary.	Not recommended
3. Provide continuing education to all health professionals on the domains of palliative care and hospice care.	<p>All pilots report providing continuing education, training, and clinical support for staff. Providing this should be a best practice. Pilots reported the use of the following resources, in order of frequency:</p> <ul style="list-style-type: none"> ● 9 use each of the following: Medical Order for Life-Sustaining Treatment (MOLST), attend conferences, use specialized in-house training coordinated by program staff and palliative care team meetings ● 8 use Center to Advance Palliative Care (CAPC) Resources and End-of-Life Nursing Education Consortium (ELNEC) Training ● 7 use End-of-Life/Palliative Education Resource Center (EPEC) Materials ● 6 use Schwartz Rounds and team meetings with non-palliative care staff members ● 5 use Grand Rounds, participate in local networking events, and listed AAPHM meetings as helpful ● 4 use UNIPACs ● 3 offer fellowships and use Virginia Commonwealth University (VCU) Resources 	Recommended for inclusion in best practices and also as a requirement
4. Provide adequate training and clinical support to assure that professional staff are confident in their ability to provide palliative care for patients.		
5. Hospice care and specialized palliative care professionals should be appropriately trained, credentialed and/or certified in their area of expertise.		

<p>6. Formulate, utilize and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.</p>	<p>All pilots report assessing the need of the patient and family. Details are below and will be assessed for similarities and differences to determine common practices.</p> <ul style="list-style-type: none"> ● Certified Nurses meet with patient/family after an order by the Attending Physician. Use template to assess the ability of the patient to participate and how much and what everyone understands, patient history, family status, spiritual values, life review, cultural and ethnic beliefs. Meetings may occur over several days or multiple admissions. ● The physician is involved in the evaluation, we do not use any standard model. ● Meeting usually consist of some combination of palliative clinician (MD or NP), palliative SW, ACE RN, attending MD, and sometimes hospital care manager. ● Standard history and exam that includes AMDs, Code status, MSAS-C, spiritual assessment ● Family meeting includes PC consultant, chaplain, and social worker/case manager ● Use Dr. Steve Levinson's Key Steps to Ethical Decision making ● Initial face to face consult conducted by palliative MD or NP usually with social worker when goals are established. Hospital care coordinator notified. Follow up planning in weekly team meeting with pastoral counselors, dietician, pharmacist. The consult team uses informal, internal tracking tool not part of the patient medical record. ● Family meetings involve physician or extender, dictated as a consult note. Social worker involved if there are discharge issues. Specialty services (speech, floor RN, PT) depending on case. For high risk cancer patients, we use a checklist (pain, adv directives, etc) ● Goals, preferences, and values are explored at sit-down family meeting, often in more than one visit. SPIKES protocol is informally used. When possible and needed, the primary attending, PC SW and/or Chaplain joins. When available, we will review a patient's living will. ● Each member of the interdisciplinary team meets with the patient/family, a family meeting is held on 90% of our patients (some have no identified family members or decision makers) and tools such as the ESAS, Folstein Mini Mental, Geriatric Depression Screen, Palliative Performance Scale and the FICA are used to formulate the assessment and plan of care. 	<p>Recommended for inclusion in best practices and also as a requirement</p>
<p>7. Ensure that on transfer between health care settings, there is timely and thorough communication of the patient's goals, preferences, values and clinical information so that continuity of care and seamless follow-up are assured.</p>	<p>All pilots report communication of some information. Details are below and will be assessed for similarities and differences to determine common practices.</p> <ul style="list-style-type: none"> ● Direct communication by phone, in person or with discharge care plans in the EMR. ● Direct communication with providers during the hospital stay. No outpatient follow up, however communicate with the various hospices for patients that do accept hospice at discharge. ● The team members call before the consultation and after the consultation. (2) ● Fax back or EPIC-send a note the same day. Include PCP and involved MDs in DC summary. ● The PC consultant contacts the referring physician and primary attending with recommendations and outcome of goals of care and documents in the patient's electronic health record. ● Phone calls and in person verbal discussions within the hospital, consultation and progress notes. Occasional phone calls to primary care in community if patient is managed by hospitalists. ● When there are notable changes, primary provider is paged and given a verbal update. All consult notes are transcribed and copied to the attending physician, community physician if known, and to facilities. ● Written notes in the chart, EMR notes generated by SW, and a secure text paging system (amion.com). For outside providers, fax and phone calls to get the info back to providers. ● MD to MD phone calls, Faxing consult/follow up notes via EMR to PMD, Hospital dc summaries include PC input 	<p>Recommended for inclusion in best practices and also as a requirement</p>

	<ul style="list-style-type: none"> • Within the hospital: formal written communication via the EMR through a dictated consultation, a formal interdisciplinary team assessment note, expanded palliative social work and chaplain assessment. Ongoing progress notes indicating updates, plan of care and goals. Meet with the bedside nurse before seeing patient, invite the nurse and treating team to family meetings and follow up via verbal communication. Outside providers receive a phone call at the time of consult and a discharge phone call and written information. Outside the hospital: telehealth program for patients with heart failure to receive an electronic tablet and videochat with the team after leaving the hospital. • 4/11 report that they follow-up with patient care after discharge in some way (some receive outpatient services at the pilot program). 	
<p>8. Health care professionals should present hospice as an option to all patients and families when death within a year would not be surprising, and reintroduce the hospice option as the patient declines.</p>	<p>While most pilots reported doing this, pilots also stressed the importance of understanding when this was appropriate. Factors that might contribute to them not doing this: 1. If they have access to hospice staff trained to do this, and an interest in differentiating palliative care from hospice; 2. If the primary physician is not supportive of that plan; 3. If they know the patient or family would not be receptive; 4. If the practice in the program is to wait until the attending physician suggests hospice as an option.</p>	<p>Not recommended, but recommend a requirement that program be able to respond to patient/family needs of this nature</p>
<p>9. Patients and caregivers should be asked by palliative and hospice programs to assess physicians'/health care professionals' ability to discuss hospice as an option.</p>	<p>1 pilot reported using an assessments tool to measure patient satisfaction of this aspect of care. While it should be a best practice, programs likely would need both technical assistance and additional resources for this to transpire successfully.</p>	<p>Recommended for inclusion in best practices</p>
<p>10. Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.</p>	<p>All pilots report this. Details are below and will be assessed for similarities and differences to determine common practices.</p> <ul style="list-style-type: none"> • Discussions held in person. Conversations patient centered, focused and goals of care drive most discussions. Additional resources added for disease knowledge or interventions. Instructional handouts available for options. Families can be teleconferenced or called independently when appropriate. Information regarding the patient is gathered from the attending, consultants, family and the pt. • During family meetings • One on one with the patient or family: usually requires multiple follow up. Social worker support essential. • Truthfully after asking permission • Discussed with the patient and/or family. Interventions and goals reviewed in the patient/ family meeting • Verbal explanations at the bedside (teaching tools may be used including Fast Facts and Dr. Joann Lynn's Handbook for Mortals). Speakerphone/conference call when indicated. • In person during family meetings generally with more than one team member • Family meetings and goals of care meetings (1-2 hours long). Includes specialist if indicated and coordinate recommendations before presenting to the family and patient. • At sit down family meetings with follow up as needed. SW and chaplain may join MD when case is complex or emotional 	<p>Recommended for inclusion in best practices and also as a requirement</p>

	<ul style="list-style-type: none"> Patients informed using a standardized approach to family meeting with formal meeting, to sit down and discuss in detail their disease process, prognosis, and options for decision making informed consent. This is done in partnership with the treating medical team, all consultants and our team. Patients are informed using an approach well documented in the palliative literature; using key phrases and pearls. For example, always asking the patient what they know/what they have been told, sitting down at the bedside, taking time for pause, firing a "warning shot" before providing bad news, asking open ended questions such as what are your fears, worries, hopes. 	
11. Provide education and support to families and unlicensed caregivers based on the patient's individualized care plan to assure-ensure safe and appropriate patient care.	<p>All pilots report this. Details are below and will be assessed for similarities and differences to determine common practices.</p> <ul style="list-style-type: none"> Education provided with verbal instruction, disease specific pieces of literature for families and patients. Caregivers must be able to verbalize understanding. Education tailored toward the patient and family's level of understanding including but not limited to pamphlets, literature etc. Social worker provides support to families in follow up meeting, providing resources and educational materials. (2) Depends - complex Nursing staff educates family/ caregiver prior to discharge if patient discharged to home. Family and caregiver concerns addressed and they are referred to appropriate community resources. If patient is transitioned to hospice or home care, the hospice/home care team will educate caregivers. Ongoing with daily rounds and phone calls. Social workers and chaplains have daily contact. Bedside nurses provide consistent support. Not a formal process, but part of routine care. In person during family meetings generally with more than one team member We use the Caregiver tool kit (derived by state). We also use materials like Gone from my sight and materials from different agencies. Regular communication in language they understand. Occasionally use handouts/pamphlets. By meeting one on one with individuals and appropriate team members. Use a folder specific to the patient/family individual needs (ex. disease education, grief and bereavement, Medicare benefits, living will and advance directive information) 	Recommended for inclusion in best practices and also as a requirement
12. Measure and document pain, dyspnea, constipation and other symptoms using available standardized scales.	Commission staff will analyze CAPC survey responses	Recommended for inclusion in best practices and also as a requirement
13. Assess and manage symptoms and side effects in a timely, safe and effective manner to a level acceptable to the patient and family	No pilots reported using an assessment tool to measure patient satisfaction of this aspect of care. While it should be a best practice, programs likely would need both technical assistance and additional resources for this to transpire successfully.	Recommended for inclusion in best practices
14. Measure and document anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms using available standardized scales.	5 pilots report this. 2 list MSAS; 2 list ESAS, 1 lists NQM guidelines	Recommended for inclusion in best practices

<p>15. Manage anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms in a timely, safe and effective manner to a level acceptable to the patient and family</p>	<p>No pilots reported using an assessment tool to measure patient satisfaction of this aspect of care. While it should be a best practice, programs likely would need both technical assistance and additional resources for this to transpire successfully.</p>	<p>Recommended for inclusion in best practices</p>
<p>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.</p>	<p>10 of 11 pilots reported this. Details are below and will be assessed for similarities and differences to determine common practices.</p> <ul style="list-style-type: none"> ● Assessment done in EMR and additional resources such as social work, psychiatry, child life, bereavement and chaplaincy brought in as needed ● Physician and social worker perform initial assessment. For the patients who accept hospice, we communicate our findings to the hospices and they follow up with the patient and families. ● Social work note documentation, and meetings, clinician documentation and meetings (2) ● Chaplain ● Assessed by the consultant and documented in the consult note in the EHR. ● Ongoing with daily rounds and phone calls. Social workers and chaplains have nearly daily contact. Bedside nurses provide consistent support. This is not a formal process, but is part of routine care. ● Multiple meetings and follow up but no standardized assessment ● Issues are listed as a "problem" in the "assessment and plan" part of the patient's chart. Assessment is made via discussion w/o a formal set of questions. The management process may include daily reassessment, SW or chaplain for psychosocial or spiritual support. The SW and chaplain may document issues too. ● Assessment by the clinical team, using formal interviewing and assessment techniques. Ongoing supportive counseling strategies are implemented accordingly. From a service perspective, we use our satisfaction survey surrounding family meetings to inform how we are doing in supporting patients and families' level of stress and coping based on their responses. 	<p>Recommended for inclusion in best practices and also as a requirement</p>
<p>17. Develop and offer a grief and bereavement care plan to provide services to patients and families prior to, and for at least 13 months after, the patient's death.</p>	<p>Pilots report that it would be appropriate to refer patients to a separate hospice for this service. Documenting the process for referrals would be a best practice.</p>	<p>Not recommended, but recommend a requirement that program be able to respond to patient/family needs of this nature</p>
<p>18. Conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, discuss goals of care, disease prognosis and advance care planning, and offer support.</p>	<p>All pilots report this and this should be an expected practice of hospital specialty palliative care teams.</p>	<p>Recommended for inclusion in best practices and also as a requirement</p>
<p>19. Develop and implement a comprehensive social care plan that includes, at a minimum,</p>	<p>All pilots report that they address certain aspects of the needs listed, though not all pilots address all of the specific needs listed in the preferred practices. It is likely in this case that the hospital has additional resources to provide services to patients.</p>	<p>Recommended for inclusion in best practices and</p>

<p>communication, caregiver availability, and decisionmaking that addresses the social, practical and legal needs of the patient and caregivers, including but not limited to: relationships, communication, existing social and cultural networks, decision-making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress, access to medicines and equipment.</p>	<ul style="list-style-type: none"> ● 100% of pilots report addressing communication, caregiver availability, and decisionmaking ● 10/11 pilot address relationships, existing social and cultural networks, and access to medicine and equipment ● 8 address financial needs ● 7 address caregiver stress, and work and school ● 2 address sexuality 	<p>also as a requirement to include general assessment</p>
<p>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.</p>	<p>5/11 pilots reported the use of a structured tool to assess these concerns. In each case, concerns were also integrated into the palliative care plan.</p> <ul style="list-style-type: none"> ● 3 use FICA ● 1 (Holy Cross) uses a Palliative Care Spiritual Care Power Form developed by the Trinity Palliative Care Collaborative ● 1 reported the use of EMR ● Two more gave details on their non-structured tools including a checklist describing interventions provided and a "problem list" in the doctor's assessment and plan and social worker and chaplain notes ● Tools to be shared and included in Appendix. 	<p>Recommended for inclusion in best practices</p>
<p>21. Provide information about the availability of spiritual care services, and make spiritual care available either through organizational spiritual care counseling or through the patient's own clergy relationships.</p>	<p>Most pilots have access to hospital chaplain services. One pilot reported not having spiritual care services.</p>	<p>Recommended for inclusion in best practices and also as a requirement</p>
<p>22. Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care</p>	<p>All pilots have access to hospital chaplains. 2 reported that some spiritual care professionals have training in palliative care, though most do not or do not know if available spiritual care professionals have this training.</p>	<p>Recommended for inclusion in best practices and also as a requirement to have ongoing/regular relationship with spiritual care professionals</p>
<p>23. Specialized palliative and hospice spiritual care professionals should build partnerships with community clergy and provide education and counseling related to end-of-life care.</p>	<p>4 pilots report that they provide education and counseling to community clergy. This is likely very dependent on having the time and resources.</p>	<p>Recommended for inclusion in best practices</p>

<p>24. Incorporate cultural assessment as a component of comprehensive palliative and hospice care assessment, including, but not limited to: locus of decision making, preferences regarding disclosure of information, truth telling and decision making, dietary preferences, language, family communication, desire for support measures such as palliative therapies and complementary and alternative medicine, perspectives on death, suffering and grieving and funeral/burial rituals.</p>	<p>All pilots report that they incorporate a cultural assessment. 10 provided details on specific elements:</p> <ul style="list-style-type: none"> ● All respondents report that family communication is part of this assessment ● 9/10 reported including language ● 8 reported including: preferences regarding disclosure of information, suffering and grieving, perspectives on death, and funeral/burial rituals ● 7 include dietary preferences ● 6 include truth telling and decision making ● 5 include locus of decision making, and desire for support measures such as palliative therapies and complementary and alternative medicine 	<p>Recommended for inclusion in best practices and also as a requirement to include general assessment</p>
<p>25. Provide professional interpreter services and culturally sensitive materials in the patient's and family's preferred language.</p>	<p>5/11 pilots have materials available in Spanish, one of those have advance directives in other languages. All have interpreter services available; one reports that these interpreter services are trained in palliative care issues.</p>	<p>Recommended for inclusion in best practices and also as a requirement to have interpreter services available; Include communal advocacy for developing Spanish-language materials for use in hospitals</p>
<p>26. Recognize and document the transition to the active dying phase and communicate to the patient, family and staff the expectation of imminent death.</p>	<p>All pilots recognize and communicate the transition, at minimum. Additional details that were provided:</p> <ul style="list-style-type: none"> ● 4 reported discussion/verbal communication with patient and family, without additional specifics ● 1 reported: Multiple family meetings and this change in status is a time point that triggers another conversation with the patient and family to discuss expectations and strategies for management. We follow our patients every day so there is ongoing dialogue with patients and families, but when this transition is evident, it requires a more formal conversation with all stakeholders. ● 2 reported use of the pamphlet, "Gone from my sight" ● 2 pilots reported that they do, but it is rarely necessary due to close proximity of inpatient hospice unit. Most patients are transferred to inpatient hospice unless too unstable to travel or family preference. ● 2 pilots described documentation in hospital records: <ul style="list-style-type: none"> ○ Patient's status if actively dying is documented in the daily progress notes in the EHR which are accessible to all providers; Discussion with physicians, nursing and interdisciplinary team; patient's condition and expected prognosis discussed with family members as appropriate; Chaplain provides spiritual support to family ○ Document in chart and initiate a comfort care order set (which we created in our EMR) 	<p>Recommended for inclusion in best practices and also as a requirement</p>

<p>27. Educate the family on a timely basis regarding the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate and culturally appropriate manner.</p>	<p>All pilots report this, though one reports that its team could use training in more age-appropriate, developmentally appropriate, and culturally appropriate approaches.</p>	<p>Recommended for inclusion in best practices and also as a requirement</p>
<p>28. As part of the ongoing care planning process, routinely ascertain and document patient and family wishes about the care setting for site of death, and fulfill patient and family preferences when possible.</p>	<p>All pilots report this. Additionally, 8 pilots reported reviewing circumstances in cases when preferences are not met.</p>	<p>Recommended for inclusion in best practices and also as a requirement</p>
<p>29. Provide adequate dosage of analgesics and sedatives as appropriate to achieve patient comfort during the active phase and address concerns and fears about using narcotics and analgesics hastening death.</p>	<p>Pilots described how they ensure appropriate dosages and address concerns about using narcotics and analgesics. Responses will be assessed for similarities and differences to determine common practices.</p> <ul style="list-style-type: none"> ● Palliative Care algorithms and standard hospice admission orders. Attendings write the orders for all meds. ● Continuous assessment and titration to comfort. ● Order writing, monitoring and follow up with bedside clinical and nursing team (2) ● Daily assessment ● Clinical assessment of patient and adjusting dosage appropriately for adequate symptom management ● This is individualized based on history (is the patient opioid naïve or opioid tolerant?) and titrated based on patient response and assessment. ● The palliative physicians and nurse practitioner are certified in hospice and palliative care. They make recommendations to the patient's primary team and or hospice as appropriate. ● Protocols on comfort care order set and input from pharmacy. ● Direct patient observation and feedback from nursing/other team members ● Use of two standardized protocols for supporting medical staff and ensuring safety for this phase of care. Palliative care order set and protocol for withdrawal of mechanical ventilation. In addition, dedicated clinical pharmacist is residency trained in palliative care involved in all of our patients to ensure that appropriate doses are used to keep patients comfortable and safe. <p>Regarding addressing concerns and fears, pilots use:</p> <ul style="list-style-type: none"> ● Educational discussions ● Educating families that the goal is comfort and a dignified death, however if the patient or family's symptoms are not controlled we will discuss the option of escalating medications even if it leads to death. ● Education (2) ● As needed ● Encouraging patient and family to voice any concerns, educating them on current medical evidence that shows that these medications do not hasten death when dosed appropriately ● Individualized. I have found that this is a rare concern expressed by some family members and we educate on goals of care and ensuring comfort and that the disease process and medical status cause death, not the therapeutic interventions we use. ● By providing verbal education to patient, family and providers, and when appropriate there is a CAPC Fast Fact #8 on the topic of double effect. ● Open conversations with patient, family and staff 	<p>Recommended for inclusion in best practices and also as a requirement</p>

	<ul style="list-style-type: none"> • Anticipatory guidance and ongoing education via discussion • The clinical pharmacist is actively involved in educating patients, families and other clinicians about the fears involved with using medications. The clinical pharmacist helps to train the palliative care team to have similar language in educating patients and families, and they are also present during family meetings to directly address these issues. 	
30. Treat the body after death with respect according to the cultural and religious practices of the family and in accordance with local law.	<p>Pilots described how they treat and document preferences. At some pilots, palliative care teams are not involved and/or hospitals have protocols that are followed.</p> <ul style="list-style-type: none"> • Discussion with patient and/or family at the appropriate time. Cultural and Religious views are taken into consideration and followed. • Depends on place of death and religious/cultural preferences • Ask families, most often when dealing with a religion/culture less familiar to us. • Generally not involved. • This is not usually a part of our consult service. If religious rituals are known, they will be communicated to the primary team and staff of the unit. • Hospital policy and documented preferences from EMR (2) • we ask about it beforehand, especially for Muslim or Jewish patients • The hospital has standard post mortem policies. We respect cultural traditions and family can view in the patient room for a specified duration prior to transport of the body to the morgue. • The hospital has a protocol to follow after death but the team has worked with the hospital to allow the body to remain in place for several hours if needed for family visitation or rituals. Preparations are made in advance whenever possible, arrangements are made with the team in advance to account for family preferences and beliefs. • Routine post mortem care is explained and family/friends may be present if they wish. Requests based on cultural or religious practices are honored. If patient is a hospice client, hospice staff usually assist with post mortem care. 	Recommended for inclusion in best practices and also as a requirement to have policies/protocols and staff training, though probably also required by hospital
31. Facilitate effective grieving by implementing in a timely manner a bereavement care plan after the patient's death when family remains the focus of care.	<p>CMS Conditions of Participation require that hospice care providers offer this service to all community members, regardless of whether their family member was a hospice patient. Commission staff assessment of pilot program responses is that palliative care programs do not need to include this component, as long as they have a plan or policy in place to address family needs for this service, via another provider if necessary.</p>	Recommended for inclusion in best practices and also as a requirement to have a policy to address patient and family needs for bereavement services
32. Document the designated surrogate/decision maker in accordance with state law for every patient in primary, acute and long-term care and in palliative and hospice care.	<p>9/11 hospitals report documenting a surrogate decision maker. Commission staff recommends this as a best practice.</p>	Recommended for inclusion in best practices and also as a requirement
33. Document the patient/surrogate preferences for goals of care,	<p>All pilots report this documentation. Commission staff recommends this as a best practice.</p>	Recommended for inclusion in

treatment options and setting of care at first assessment and at frequent intervals as conditions change.		best practices and also as a requirement
34. Convert the patient treatment goals into medical orders and ensure that the information is transferable 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.	All pilots report this documentation. 10/11 respondents report using MOLST. Commission staff recommends this as a best practice.	Recommended for inclusion in best practices and also as a requirement to fully use MOLST or similar program
35. Make advance directives and surrogacy designations available across care settings while protecting patient privacy and adherence to HIPAA regulations, e.g., by Internet-based registries or electronic personal health records.	All pilots report making this available in EMR. Commission staff recommends this as a best practice.	Recommended for inclusion in best practices and also as a requirement
36. In conjunction with hospital staff, dDevelop 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.	<p>All pilots report this engaging in this activity. 3 pilots reported familiarity with Respecting Choices (1 uses it as a tool); 4 report familiarity with Community Conversations on Compassionate Care (1 uses it as a tool and 1 would like to see it used more). Other efforts reported include:</p> <ul style="list-style-type: none"> ● Present every year at National Decision Making Day. Present to church groups and senior centers. Included this year as a wellness educational opportunity. Presentations planned for our Long Term Care Community as well. ● Hospitalist and Nursing Home doctors. ● Family/patient meetings for goals of care, advanced care planning and MOLST completion. ● Lots of community work/lectures ● The Palliative Care physicians, Spiritual Care and Ethics Committee members participated in "Consider the Conversation" - a panel discussion at the Montgomery County Medical Society encouraging end of life care discussions (April 2014). The Palliative Care Physicians have given multiple presentations at hospital Grand Rounds, Hospitalist Noon Lecture and Department of Medicine meetings. The team will conduct activities to engage providers and the general population on Advance Directive Day (April 16) to increase awareness of advance care planning ● Public education at various venues in Washington County including senior citizen groups, health fairs, community health education programs, within the health system for National Health Care Decisions Day, health system publications, local radio show on topics like MOLST and advance directives, etc. Coastal Hospice and Peninsula Regional Medical Center are partners in the Palliative Team, and together along with the Area Agency on Aging, we brought in 2 guest speakers to present an educational offering to professionals and the community on Advance Directives. We had over 80 attendees, and we are currently planning additional community education, utilizing a local television station, and planning education to hospital staff and the hospice speakers bureau. Additionally all stage III and IV cancer patients are to receive a palliative consultation in the outpatient clinic to introduce them to palliative care and begin education on advance directives. 	Recommended for inclusion in best practices and also as a requirement

**Appendix H: Comparison of Requirements: National
Quality Forum, the Joint Commission and CMS
Conditions of Participation**

National Quality Forum		
Preferred Practice	TJC Hospital Accreditation Standard	CMS Hospital Standard
Provide palliative and hospice care by an interdisciplinary team of skilled palliative care professionals, including, for example, physicians, nurses, social workers, pharmacists, spiritual care counselors and others who collaborate with primary health care professional(s).		
2. Provide access to palliative and hospice care that is responsive to the patient and family 24 hours a day, seven days a week.		
3. Provide continuing education to all health professionals on the domains of palliative care and hospice care.	P.C. 02.02.13: The patient's comfort and dignity receive priority during end-of-life care. Element C.2: The hospital provides the staff with education about the unique needs dying patients and their families	
4. Provide adequate training and clinical support to assure that professional staff are confident in their ability to provide palliative care for patients.	P.C. 02.02.13: The patient's comfort and dignity receive priority during end-of-life care. Element C.2: The hospital provides the staff with education about the unique needs of dying patients and their families	
5. Hospice care and specialized palliative care professionals should be appropriately trained, credentialed and/or certified in their area of expertise.		

<p>6. Formulate, utilize and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.</p>	<p>P.C. 02.02.13: The patient's comfort and dignity receive priority during end-of-life care. Element C1: To the extent possible, the hospital provides care and services that accommodate the patient's and his or her family's comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs.</p>	<p>§482.13(b)(1) The patient has the right to participate in the development and implementation of his or her plan of care.</p>
<p>7. Ensure that on transfer between health care settings, there is timely and thorough communication of the patient's goals, preferences, values and clinical information so that continuity of care and seamless follow-up are assured.</p>	<p>P.C. 04.01.01 The hospital has a process that addresses the patient's need for continuing care, treatment, and services after discharge or transfer. P.C. 04.02.01: When a patient is transferred or discharged, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.</p>	<p>§482.43(d) Standard: Transfer or Referral The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.</p>
<p>8. Health care professionals should present hospice as an option to all patients and families when death within a year would not be surprising, and reintroduce the hospice option as the patient declines.</p>	<p>RI.01.02.01: The hospital respects the patient's right to participate in decisions about his or her care. Element A20: The hospital provides the patient or surrogate decision maker with the information about the outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions.</p>	<p>§482.13(b)(1) The patient has the right to participate in the development and implementation of his or her plan of care.</p>
<p>9. Patients and caregivers should be asked by palliative and hospice programs to assess physicians'/health care professionals' ability to discuss hospice as an option.</p>		

<p>10. Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.</p>	<p>RI. 01.05.01: The hospital addresses patient decisions about care, treatment, and services received at the end-of-life.</p>	<p>§482.43(b) Standard: Discharge Planning Evaluation (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. Interpretive Guidelines §482.43(b)(1), §482.43(b)(3) & §482.43(b)(4)</p>
<p>11. Provide education and support to families and unlicensed caregivers based on the patient's individualized care plan to ensure safe and appropriate patient care.</p>	<p>RI.01.01.03: The hospital respects each patient's right to receive information in a manner he or she understands.</p>	
<p>12. Measure and document pain, dyspnea, constipation and other symptoms using available standardized scales.</p>	<p>PC.01.02.01: The hospital assesses and reassesses its patients. PC.01.02.01: The hospital assesses and manages the patient's pain.</p>	<p>§482.23(b)(4) - The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.</p>

13. Assess and manage symptoms and side effects in a timely, safe and effective manner to a level acceptable to the patient and family	PC.01.02.01: The hospital assesses and reassesses its patients. Element A4: For patients who are receiving end-of-life care, the social, spiritual, and cultural variabilities that influence the patient's and family member's perception of grief are assessed.	§482.23(b)(4)
14. Measure and document anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms using available standardized scales.	PC.01.02.01: The hospital assesses and reassesses its patients.	§482.23(b)(4)
15. Manage anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms in a timely, safe and effective manner to a level acceptable to the patient and family	PC.01.02.01: The hospital assesses and reassesses its patients.	§482.23(b)(4)
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.	PC.01.02.01: The hospital assesses and reassesses its patients. Element A4: For patients who are receiving end-of-life care, the social, spiritual, and cultural variabilities that influence the patient's and family member's perception of grief are assessed.	§482.23(b)(4)
17. Develop and offer a grief and bereavement care plan to provide services to patients and families prior to, and for at least 13 months after, the patient's death.		
18. Conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, discuss goals of care, disease prognosis and advance care planning, and offer support.	RI.01.01.01 The hospital respects, protects, and promotes patient rights Element C9: The hospital accommodates the patient's right to religious and other spiritual services.	

<p>19. Develop and implement a comprehensive social care plan that includes, at a minimum, communication, caregiver availability, and decision-making.</p>		
<p>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.</p>	<p>RI.01.01.01 The hospital respects, protects, and promotes patient rights Element C9: The hospital accommodates the patient's right to religious and other spiritual services.</p>	<p>§482.23(b)(4)</p>
<p>21. Provide information about the availability of spiritual care services, and make spiritual care available either through organizational spiritual care counseling or through the patient's own clergy relationships.</p>	<p>RI.01.01.01 The hospital respects, protects, and promotes patient rights Element C9: The hospital accommodates the patient's right to religious and other spiritual services.</p>	<p>§482.13 Condition of Participation: Patient's Rights A hospital must protect and promote each patient's rights.</p>
<p>22. Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care</p>		
<p>23. Specialized palliative and hospice spiritual care professionals should build partnerships with community clergy and provide education and counseling related to end-of-life care.</p>		
<p>24. Incorporate cultural assessment as a component of comprehensive palliative and hospice care assessment, including, but not limited to: locus of decision making, preferences regarding disclosure of information, truth telling and</p>	<p>PC.01.02.01: The hospital assesses and reassesses its patients. Element A4: For patients who are receiving end-of-life care, the social, spiritual, and cultural variabilities that influence the patient's and family member's perception of grief are assessed.</p>	

<p>25. Provide professional interpreter services and culturally sensitive materials in the patient's and family's preferred language.</p>	<p>RI.01.01.03: The hospital respects each patient's right to receive information in a manner he or she understands. Element C2: The hospital provides language interpreting and translation services.</p>	<p>§482.13(a)(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. (Includes language about interpreter services).</p>
<p>26. Recognize and document the transition to the active dying phase and communicate to the patient, family and staff the expectation of imminent death.</p>		
<p>27. Educate the family on a timely basis regarding the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate and culturally appropriate manner.</p>	<p>RI.01.01.03: The hospital respects each patient's right to receive information in a manner he or she understands.</p>	
<p>28. As part of the ongoing care planning process, routinely ascertain and document patient and family wishes about the care setting for site of death, and fulfill patient and family preferences when possible.</p>	<p>R1.01.02.01: The hospital respects the patient's right to participate in decisions about his or her care, treatment, or services. RI.01.01.01 The hospital respects, protects, and promotes patient rights. Element C6: The hospital respects the the patient's cultural and personal values, beliefs, and preferences.</p>	<p>§482.43(b)(2) - A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the [discharge planning] evaluation.</p>
<p>29. Provide adequate dosage of analgesics and sedatives as appropriate to achieve patient comfort during the active phase and address concerns and fears about using narcotics and analgesics hastening death.</p>	<p>RI.01.01.01 The hospital respects, protects, and promotes patient rights. Element A8: The hospital respects the patient's right to pain a management. PC.01.02.01: The hospital assesses and reassesses its patients. PC.01.02.01: The hospital assesses and manages the patient's pain.</p>	

<p>30. Treat the body after death with respect according to the cultural and religious practices of the family and in accordance with local law.</p>	<p>RI.01.01.01 The hospital respects, protects, and promotes patient rights. Element C6: The hospital respects the patient's cultural and personal values, beliefs, and preferences.</p>	
<p>31. Facilitate effective grieving by implementing in a timely manner a bereavement care plan after the patient's death when family remains the focus of care.</p>		
<p>32. Document the designated surrogate decision maker in accordance with state law for every patient in primary, acute and long-term care and in palliative and hospice care.</p>	<p>R1.01.02.01: The hospital respects the patient's right to participate in decisions about his or her care. Element A6: When a patient is unable to make decisions about his or her care, treatment, and services, the hospital involves a surrogate decision maker in making those decisions.</p>	<p>§482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.</p>

<p>33. Document the patient/surrogate preferences for goals of care, treatment options and setting of care at first assessment and at frequent intervals as conditions change.</p>	<p>R1.01.02.01: The hospital respects the patient's right to participate in decisions about his or her care. Element A8: The hospital involves the patient's family in care, treatment, or services decisions to the extent permitted by the patient or surrogate decision-maker.</p>	<p>§482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.</p>
<p>34. Convert the patient treatment goals into medical orders and ensure that the information is transferable 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.</p>	<p>PC.02.01.11: The hospital provides interdisciplinary, collaborative care, treatment, and services.</p>	<p>§482.13(b)(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part. §482.23(b)(4) - The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.</p>

<p>35. Make advance directives and surrogacy designations available across care settings while protecting patient privacy and adherence to HIPAA regulations, e.g., by Internet-based registries or electronic personal health records.</p>	<p>RI. 01.05.01: The hospital addresses patient decisions about care, treatment, and services received at the end-of-life. Element A13: The hospital honors advance directives.</p>	<p>§482.13(b)(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part.</p>
<p>36. In conjunction with hospital staff, 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.</p>		
<p>Establish or have access to ethics committees or ethics consultation across care settings to address ethical conflicts at the end of life.</p>		
<p>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</p>		

**Appendix I: Spiritual Assessment Tools:
FACIT and FICA**

Holy Cross Hospital/ Trinity Health

Spiritual Care Palliative Care Documentation

While completion of the entire FACIT Scale (shown below) is not required, at least one of the questions must be completed in order to be able to sign and save the form – every effort should be made to answer as many questions as possible. The form can be used as often as Spiritual Care determines is needed. The recommendation is to:

- use the form at initial patient consultation in order to document baseline Spiritual needs of the Palliative Care patient
- discuss all concerns with the Palliative Care team
- develop a plan or approach to address all concerns

Is Patient Able to Answer Questions?

Yes No

FACIT Scale:

Palliative Care FACIT - SP-12

I Feel Peaceful:

Not at all A little bit Somewhat Quite a bit Very much

I Have a Reason for Living:

Not at all A little bit Somewhat Quite a bit Very much

My Life Has Been Productive:

Not at all A little bit Somewhat Quite a bit Very much

I Have Trouble Feeling Peace of Mind:

Not at all A little bit Somewhat Quite a bit Very much

I Feel a Sense of Purpose in My Life:

Not at all A little bit Somewhat Quite a bit Very much

I am able to Reach Down Deep into Myself for Comfort:

Not at all A little bit Somewhat Quite a bit Very much

I Feel a Sense of Harmony Within Myself:

Not at all A little bit Somewhat Quite a bit Very much

My Life Lacks Meaning and Purpose:

Not at all A little bit Somewhat Quite a bit Very much

I Find Comfort in My Faith or Spiritual Beliefs:

Not at all A little bit Somewhat Quite a bit Very much

I Find Strength in My Faith or Spiritual Beliefs:

Not at all A little bit Somewhat Quite a bit Very much

My Illness has Strengthened my Faith or Spiritual Beliefs:

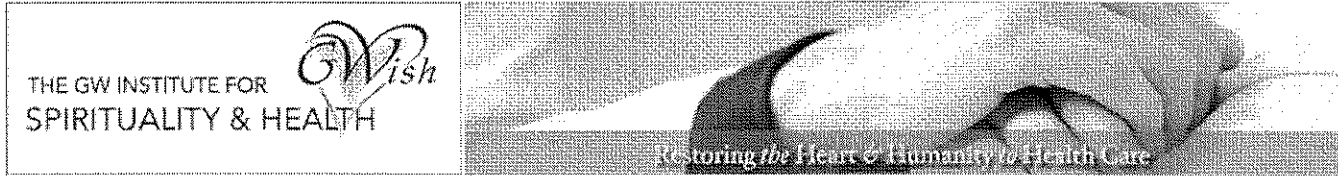
Not at all A little bit Somewhat Quite a bit Very much

I Know Whatever Happens with my Illness, Everything will be Okay:

Not at all A little bit Somewhat Quite a bit Very much



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You are here: [Home](#) / [Clinical](#) / [FICA Spiritual Assessment Tool](#) / [FICA Spiritual History Tool ©](#)

FICA Spiritual History Tool ©

The **FICA Spiritual History Tool ©** was developed by Dr. Puchalski and a group of primary care physicians to help physicians and other healthcare professionals address spiritual issues with patients. Spiritual histories are taken as part of the regular history during an annual exam or new patient visit, but can also be taken as part of follow-up visits, as appropriate. The FICA tool serves as a guide for conversations in the clinical setting.

The acronym FICA can help structure questions in taking a spiritual history by healthcare professionals.

F - Faith and Belief

"Do you consider yourself spiritual or religious?" or "Is spirituality something important to you" or "Do you have spiritual beliefs that help you cope with stress/ difficult times?" (Contextualize to reason for visit if it is not the routine history).

If the patient responds "No," the health care provider might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

(The question of meaning should also be asked even if people answer yes to spirituality)

I - Importance

"What importance does your spirituality have in our life? Has your spirituality influenced how you take care of yourself, your health? Does your spirituality influence you in your healthcare decision making? (e.g. advance directives, treatment etc.)

C - Community

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"Are you part of a spiritual community? Communities such as churches, temples, and mosques, or a group of like-minded friends, family, or yoga, can serve as strong support systems for some patients. Can explore further: Is this of support to you and how? Is there a group of people you really love or who are important to you?"

A - Address in Care

"How would you like me, your healthcare provider, to address these issues in your healthcare?" (With the newer models including diagnosis of spiritual distress A also refers to the Assessment and Plan of patient spiritual distress or issues within a treatment or care plan

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As with any other part of the patient interview, the spiritual histories should be patient-centered. Thus, the tool is meant to create an environment of trust by indicating to the patient that the physician or other healthcare professional is open to listening to the patient about his or her spiritual issues, if the patient wants to talk about those issues. There are ethical guidelines to which the physician or healthcare provider should adhere when taking a spiritual history. Healthcare professionals are encouraged not to use the FICA tool as a checklist, but rather to rely on it as a guide to aid and open the discussion to spiritual issues. See more recommendations for taking a spiritual history.

Order FICA Cards

GWish developed a small (2"x4") plastic pocket card for healthcare professionals to use when conducting spiritual assessments. The card lists the questions associated with each part of FICA and is a handy way to help implement the practice of conducting spiritual assessments. You can order plastic FICA cards using the FICA card order form (pdf).

FICA for Self Assessment

The FICA tool can also be used for looking at your own spiritual history. Learn more about using FICA for self-assessment.

The George Washington Institute for Spirituality & Health
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**Appendix J: MOLST: Maryland Orders for
Life-Sustaining Treatment**

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial

Date of Birth

 Male Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician, nurse practitioner (NP), or physician assistant (PA) must accurately and legibly complete the form and then sign and date it. The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

- the patient; or
 the patient's health care agent as named in the patient's advance directive; or
 the patient's guardian of the person as per the authority granted by a court order; or
 the patient's surrogate as per the authority granted by the Health Care Decisions Act; or
 if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

- instructions in the patient's advance directive; or
 other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

- Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

CPR (RESUSCITATION) STATUS: EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

Attempt CPR: If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.
 [If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

1 No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

Option A-1, Intubate: Comprehensive efforts may include intubation and artificial ventilation.

Option A-2, Do Not Intubate (DNI): Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

No CPR, Option B, Palliative and Supportive Care: Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

Practitioner's Signature

Print Practitioner's Name

Maryland License #

Phone Number

Date

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

2	<p>ARTIFICIAL VENTILATION</p> <p>2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.</p> <p>2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial. Time limit _____</p> <p>2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated. Time limit _____</p> <p>2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).</p>
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3	<p>BLOOD TRANSFUSION</p> <p>3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.</p> <p>3b. _____ Do not give any blood products.</p>
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4	<p>HOSPITAL TRANSFER</p> <p>4a. _____ Transfer to hospital for any situation requiring hospital-level care.</p> <p>4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.</p> <p>4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.</p>
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5	<p>MEDICAL WORKUP</p> <p>5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition.</p> <p>5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.</p> <p>5c. _____ Do not perform any medical tests for diagnosis or treatment.</p>
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6	<p>ANTIBIOTICS</p> <p>6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.</p> <p>6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.</p> <p>6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.</p> <p>6d. _____ Do not treat with antibiotics.</p>
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7	<p>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION</p> <p>7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.</p> <p>7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial. Time limit _____</p> <p>7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition. Time limit _____</p> <p>7d. _____ Do not provide artificially administered fluids or nutrition.</p>
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8	<p>DIALYSIS</p> <p>8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated.</p> <p>8b. _____ May give dialysis for a limited period. Time limit _____</p> <p>8c. _____ Do not provide acute or chronic dialysis.</p>
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9	<p>OTHER ORDERS _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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SIGNATURE OF PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

INSTRUCTIONS

Completing the Form: The physician, NP, or PA shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician, NP, or PA signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to a competent patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

Selecting CPR (Resuscitation) Status: EMS Option A-1 – Intubate, Option A-2 – Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set of interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

No-CPR Option A: Comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest / DNR if Arrest – No CPR. This choice may be made either with or without intubation as a treatment option. Prior to arrest, all interventions allowed under *The Maryland Medical Protocols for EMS Providers*. Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devices used for ventilatory assistance. In all cases, comfort measures will also be provided. No CPR if arrest occurs.

No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest. DNR if Arrest Occurs – No CPR. Prior to arrest, interventions may include opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medications by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by this original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable *Maryland Medical Protocols for EMS Providers*. Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility, and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

Location of Form: The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a copy, and a faxed MOLST form are all valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

Reviewing the Form: These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians, NPs, or PAs shall review and update, if appropriate, the MOLST orders **annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.**

Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form.

Voiding the Form: To void this medical order form, the physician, NP, or PA shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

Revoking the Form's DNR Order: In an emergency situation involving EMS providers, the DNR order in Section 1 may be revoked at any time by a competent patient's request for resuscitation made directly to responding EMS providers.

Bracelets and Necklaces: If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing. If a metal bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic Alert requires a copy of this order along with an application to process the request.

How to Obtain This Form: Call 410-706-4367 or go to marylandmolst.org



Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician, NP, or PA sign, cut off strip, fold, and insert in bracelet or necklace.

DNR A-1 Intubate DNR A-2 Do Not Intubate DNR B

Pt. Name _____ DOB _____

Practitioner Name _____ Date _____

Practitioner Signature _____ Phone _____