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Palliative Care Services: Solutions for Better Patient Care and Today's Health Care Delivery Challenges

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CENTER TO ADVANCE PALLIATIVE CARE

Palliative Care Services: Solutions for Better Patient Care and Today's Health Care Delivery Challenges

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Executive Summary

Palliative care specializes in taking care of patients with serious illness and focuses on providing relief from symptoms, pain and stress in order to improve the quality of life for patients and their families. The care is provided by an interdisciplinary team whose focus is:

- Assessment and treatment of a patient's physical and emotional/spiritual distress
- Communication and decision making with patients and their families to establish achievable patient-centered goals of care
- Coordination of transitions of care and support for practical needs of patients and families

Palliative Care Services: Solutions for Better Patient Care and Today's Health Care Delivery Challenges is designed to provide hospital and health care system leaders with the knowledge and resources necessary to understand the benefits and opportunities of providing high-quality palliative care services. Based on 20 years of clinical service development and research to understand the impact of hospital palliative care services, effective palliative care services can:

- Improve patient- and family-centered care and optimize quality of life
- Reduce avoidable patient suffering and distress from physical and psychological symptoms
- Reduce intensive care unit (ICU) length of stay for complex, seriously ill patients
- Improve discharge planning efficiency by rapid establishment of achievable patient-centered goals and care plans that meet these goals
- Reduce readmissions for patients with serious illness or multiple chronic conditions
- Improve both survival and quality of life in cancer patients co-managed with oncologists in the outpatient setting
- Prevent adverse events and lead to better outcomes, fewer readmissions and shorter hospital stays

Many hospitals and health care systems have recognized these benefits and are moving in a coordinated fashion to integrate palliative care principles and services. These services help meet national priorities of providing high-quality, patient-centered care and reducing readmissions and health care costs.

Important steps to ensure that hospitals are maximizing the potential of palliative care programs include:

- Convene a planning committee comprised of key hospital and health care system clinicians and administrative leaders
- Complete a needs assessment and align palliative care services with hospital and health care system priorities
- Review current priorities and identify those areas where palliative care services have been shown to improve outcomes
- Collect data to demonstrate the need for palliative care services and to use as baseline measures for performance improvement.
- Learn from peer institutions that are successfully integrating palliative care services into ICUs, emergency departments (EDs), hospitalist programs and outpatient services
- Develop a strategic plan and budget including new services, staffing and metrics to document program value

By viewing palliative care services as an essential component for co-management of the sickest and most complex patients served by U.S. hospitals—rather than only an "end-of-life" service line—leaders can improve the quality of care and quality of life for seriously ill patients and their families.

Palliative Care: Definition and Impact

Palliative care is the medical and nursing specialty focused on improving quality of life for seriously ll patients and their families. The following definition highlights how palliative care provides an added layer of support at the same time the patient is receiving all appropriate curative or disease-modifying treatments:

> *Palliative care is specialized medical care for people with serious illness. This type of care is focused on providing patients relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis. The goal of palliative care is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.*[5]

Palliative care should be delivered by a patient's primary clinician(s) as a routine component of care, such as assessment and treatment of pain and other symptoms. These primary palliative care services should be expected from all clinicians caring for seriously ill patients.

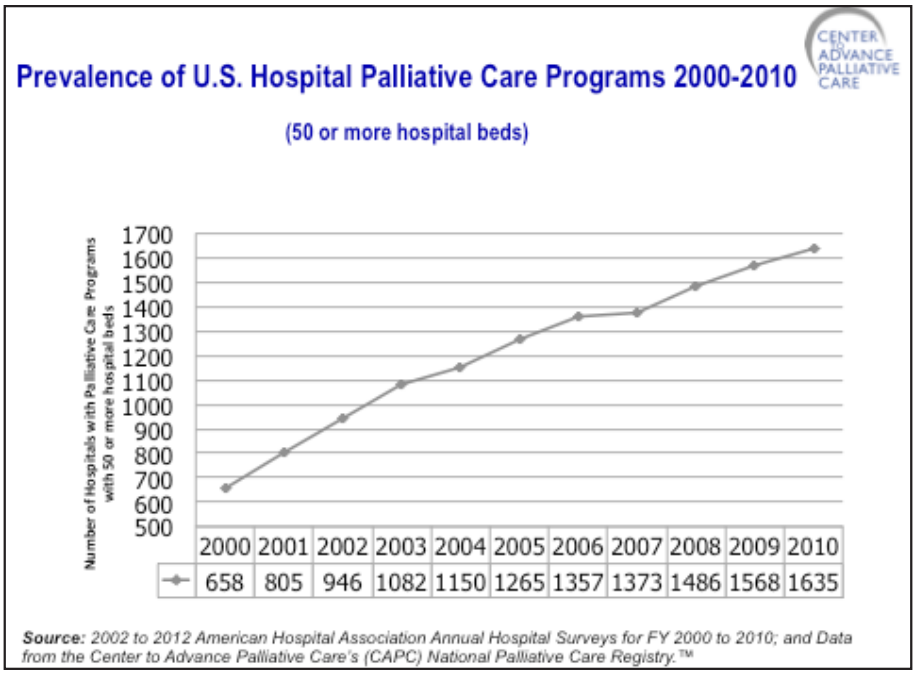
Specialist palliative care services should be delivered by an interdisciplinary team that includes clinicians, social workers, spiritual counselors and others with special training and, if possible, with certification (see Appendix A). Services provided by a specialist palliative care team focus on:

- Assessment and treatment of a patient's physical and emotional/spiritual distress, including pain, depression and shortness of breath, and of family burnout and exhaustion
- Communication and decision making with patients and their families to establish and then pursue medically achievable, patient-centered goals of care
- Coordination of transitions of care and support for practical needs of patients and families across care settings

In addition, palliative care teams provide expert clinical consultation to colleagues, educate hospital staff and trainees and collect, measure and report program outcome data. Palliative care teams strive to integrate palliative care principles throughout the institution, seeking to align with mission and improve key quality outcomes.

Growth in Hospital Palliative Care

Availability of hospital-based palliative care services has increased rapidly in the United States during the last 10 years. More than 1,600 hospitals, 66 percent of those with 50 or more beds, reported on the 2010 American Hospital Association Annual Hospital Survey that they had a palliative care team.[6] Nearly all of America's larger hospitals with more than 250 beds reported having a palliative care team, an important resource given the concentration of serious and complex illnesses in these settings. See the graph "Prevalence of U.S. Hospital Palliative Care Programs 2000–2010" on page 5.



Recent opinion polling revealed that palliative care is relatively unknown to the public and poorly understood by many health care providers.[5,7] Many physicians misunderstand palliative care and wrongly conflate it with hospice or end-of-life care, a finding that calls for better training at all levels from medical school students to mid-career practitioners. And although consumers know relatively little about palliative care, once informed they become extremely positive about this type of care and want access to it.

The public opinion research showed that:

- 95 percent of consumers agree that it is important for patients with serious illness and their families to know about palliative care
- 92 percent of consumers say it is important that palliative care services be made available at all hospitals for patients with serious illness and their families[5]

Impact of Palliative Care

Palliative care programs consistently demonstrate improvement in patients' physical and psychosocial symptoms; in family caregiver well-being; and in patient, family and physician satisfaction.[1,3,9-20] Palliative care teams identify and effectively treat distressing symptoms that have been shown to increase medical complications and hospitalization.[1,21] Teams meet with patients to establish realistic care and treatment goals, support families in crisis and plan for safe transitions from the hospital to other care sites. These teams possess expertise in effectively communicating prognostic information and eliciting patient and family values and goals.

Recent studies have demonstrated that palliative care is associated with prolonged survival for some patient populations.[9,22-24] Investigators suggest that palliative care helps decrease depression in patients, reduces hospitalizations and high-risk interventions and provides expert treatment of multiple, complex symptoms. It also helps enhance support for family caregivers, as patients are able to remain safely at home or in a setting of their choice.[1,9]

National Guidelines and Certification

The National Consensus Project's *Clinical Practice Guidelines for Quality Palliative Care*, developed by a coalition of all major palliative care organizations in the United States, outlines the essential structural elements of palliative care.[25]

These elements include:

- An interdisciplinary team with a physician, nurse, social worker, spiritual counselor, pharmacist, aide and volunteers
- Staffing ratios determined by the nature and size of the population to be served
- Staff who are trained, credentialed and/or certified in palliative care
- Access for patients and team responsiveness 24 hours a day, seven days a week

Formal guidelines and best practices for palliative care have been established through professional consensus and adapted by both the National Quality Forum (NQF) and The Joint Commission (TJC).

The NQF *National Framework and Preferred Practices for Palliative and Hospice Care Quality*[26] includes 38 preferred structural and quality practices and has been used to develop quality metrics for hospital palliative care services in the United States.[27-30] An example of an NQF preferred practice is routine determination and documentation of patient and family goals of care using an advance care planning process that has been demonstrated to increase the likelihood that the care delivered matches patient- and family-centered goals and values. The Center to Advance Palliative Care (CAPC) reviewed the NCP's clinical practice guidelines and the NQF preferred practices and derived, through a national consensus process, a list of 12 program features essential for hospital palliative care programs (see Appendix B).[27]

Building on these publications, in 2011 TJC began a new Advanced Certification Program for Palliative Care.[31] Palliative care certification by TJC signifies that hospitals are committed to patient- and family-centered care that optimizes the quality of life for patients with serious illness and their families. Certification is based on clinical practice guidelines and national standards for delivering high-quality palliative care that emphasizes:

- A formal, organized palliative care program led by an interdisciplinary team whose members possess the requisite training and expertise
- Use of evidence-based guidelines or expert consensus to guide patient care
- Leadership endorsement and support of the program's goals for providing care, treatment and services
- A special focus on patient and family engagement
- Rigorous and continuous quality improvement efforts
- Processes that support the coordination of care and communication among all care settings and providers

Program Funding

Palliative care programs are funded through a diverse portfolio of resources including 1) fee-for-service billing for physician and advance practice nurse services, 2) direct hospital support and 3) philanthropy. Since the clinical work is largely cognitive and time intensive, it is poorly reimbursed relative to time invested and the billing for clinical services does not cover many of the program costs. The remaining funds are usually provided by the hospital in recognition of the ability of palliative care teams to "pay for themselves" by reducing high-cost, long-stay, inadequately reimbursed care that does not meet patient goals and values.[32-34]

Health Care Reform: The Role of Palliative Care in the Hospital

Providing high-quality palliative care can create opportunities and have a positive impact on key priority areas of health care reform and address some of the most important challenges that hospitals face such as:

- Improving quality
- Reducing variation in care
- Reducing avoidable readmissions
- Ensuring patient safety and satisfaction
- Addressing ICU overcrowding
- Planning for bundled payment systems[8]

Several leading U.S. health care systems have created palliative care programs that are achieving successful outcomes and improving quality of care by reducing readmissions, using resources wisely and integrating systems.

Improving Quality of Care and Reducing Readmissions

Patients with one or more serious or chronic conditions represent approximately 5 percent of the total patient population but account for more than half of health care costs. These patients are at the highest risk for adverse clinical outcomes, prolonged hospital stays, frequent care transitions and readmissions, and lower quality of care. Routine screening for unmet palliative care needs using checklists upon admission leads to timely and appropriately targeted involvement of palliative care teams. These teams can help prevent complications from hospitalization, symptom distress, miscommunication and fragmentation, and prolonged stays and also can reduce readmissions.[35]

Inova Health System

At the largest hospital in the Inova Health System in Northern Virginia, patients receiving palliative care had lower readmission rates.[36] Using a palliative care screening tool (see Appendix D) and the V66.7 billing code for palliative care encounter as a tracking mechanism, analysis revealed a 30-day readmission rate of 5 percent to 8 percent for palliative care patients, compared to the benchmark of 20 percent among all Medicare fee-for-service patients.[36-37]

Inova Health System's approach demonstrated earlier "upstream" palliative care integration and reduction in avoidable hospitalization, achieved by assuring that care and treatment plans respected patient- and family-determined goals of care.

This example demonstrates the benefit of targeted and early palliative care team involvement as an effective strategy for reducing readmissions. The recommendations for leaders are:

- Ensure that palliative care specialists are part of any planning process to reduce readmissions
- Screen all hospitalized patients upon admission to identify those at highest risk for unmet palliative care needs, a population that is also at high risk for readmission[38]
- Anticipate the growth in demand for both generalist and specialist palliative care services as a result of universal screening for palliative care needs
- Improve generalist palliative care knowledge and skills among all clinicians (e.g., physicians, nurses, social workers) with special attention to pain and symptom management and routine and timely communication with patients and families about achievable goals for medical care

Improving Quality of Care and Using Resources Wisely

Integration of palliative care services can help shift the physician and hospital culture toward achieving patient- and family-centered care goals. Well-articulated and broadly communicated goals improve care quality and, as a result, can reduce length of stay in the ICU or hospital. The shift comes about through expertly assessing and managing symptoms, establishing timely treatment goals, revising treatments to establish concordance with these goals and assuring full communication with all involved clinicians so that they are "on the same page" about the plan for care.

Studies have demonstrated when palliative care teams are involved, patients receive significantly better care due to medical treatments that are best tailored to the patients' needs. This care may eliminate treatments that provide little benefit or that conflict with patients' treatment wishes.

A study of eight hospitals in diverse regions and health care markets and with mature, adequately staffed and well-integrated palliative care programs demonstrated significant savings.[32] The cost for palliative care patients was dramatically lower both for decedents (average of $4,908 per admission) and for patients who survived (average of $1,696 per admission) to hospital discharge compared to their nonpalliative care counterparts, driven in part by reduced ICU utilization. These findings have been replicated and are consistent across hospital types nationwide.

A similar study evaluated the impact of palliative care consultation on Medicaid patients at four New York state hospitals.[33] Palliative care consultation that clarified goals of care and relieved symptoms was associated with an average reduction of between $4,000 to $7,500 per hospitalization, compared to similar patients who did not receive palliative care consultation.[33] This study also revealed significant reduction in ICU and pharmacy costs when palliative care was provided.

Palliative care consultation promotes care that is well communicated to all involved clinicians both inside the hospital and out, is responsive to patient- and family-centered goals and priorities, and focuses on expert identification and treatment of patient and family symptoms.[8]

Improving Quality of Care and Integrating Systems

Accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) will increase the demand for expertise in managing the sickest and costliest patients. Recognizing the enormous benefits of palliative care services to patients, families and the entire health care system, forward-looking health care organizations are integrating palliative care principles into the fabric of their institutions. See case examples from three health care systems on pages 9–10.

Banner Health

Banner Health started a palliative care program in 2010 at the system's flagship hospital, Banner Good Samaritan Medical Center (BGS), a 650-bed level-one trauma hospital. Within two years of implementation, palliative care became one of four focus areas for Banner Health's annual development Initiatives.

Key development steps include:

- Forming a palliative care advisory board charged with developing a systemwide palliative care clinical and business model to standardize and ensure access to high-quality palliative care across settings
- Formulating a systemwide definition and mission for palliative care services that focus on seriously ill patients of any age, diagnosis and illness stage
- Adopting a patient screening tool, developed through a national consensus process, to identify patients with unmet palliative care needs upon admission and daily during hospitalization[38]
- Improving the continuity and quality of care by collaborating with clinical partners in outpatient clinics, long-term care facilities, home care and rural areas
- Integrating with the Banner Health Pioneer Accountable Care Organization program: This ACO has 50,000 members and is focusing efforts on improving care for the general population and for chronically ill, seriously ill and high-risk patients. Palliative care providers work closely with the ACO's leadership to identify and serve palliative care patients as a targeted high-risk group.

OSF HealthCare

OSF HealthCare consists of seven Midwest hospitals and medical centers, one long-term care facility, the OSF Medical Group, OSF Home Care Services and OSF Saint Francis, Inc., and two colleges of nursing. OSF HealthCare is a designated Pioneer Accountable Care Organization focusing on a patient-centered medical home model.

Palliative care and OSF's Advance Care Planning Model are linked to provide high-quality patient- and family-centered care. From their inception, these services received high-level support at the local and corporate levels. Palliative care and advance care planning team leaders are part of an executive strategy to ensure the best possible system integration. Variations in hospital size, services and population needs across the system guide specific characteristics and capacities for each facility's palliative care team. An operations council of clinical and nonclinical staff from all facilities works to promote systemwide palliative care and advance care planning services.[39]

Palliative care is integral to the OSFHealthcare'e ACO-PCMH demonstration project. Medical home case management staff identify high-risk patients using CMS risk-stratification methodology. The goal for the medical homes is to have at least 50 percent of all patients 65 years or older complete an advance directive and to have 100 percent of high-risk patients receive palliative care management.

North Shore-Long Island Jewish Health System

North Shore-Long Island Jewish (NSLIJ) Health System is a 15-hospital system serving the New York metropolitan area. Its initial palliative care program began in 2004 at North Shore University Hospital with two funded staff members. By 2012, the program grew to include three full-time physicians, two nurse practitioners, a 10-bed palliative care unit and four palliative medicine fellows. In March of 2012, North Shore University Hospital received The Joint Commission's Advanced Certification for Palliative Care.

Integration of palliative care services across the continuum aligns with NSLIJ Health System's strategic plan to improve care for patients with advanced and serious illness. In the system, 10 of 15 hospitals have palliative care services, and these services are also available in outpatient settings, nursing homes and home care. The health care system's Advanced Illness Coordinating Committee emphasizes patient- and family-centered care, highlighting the need for early and regular reassessment of goals and values. Ongoing educational initiatives include efforts aimed at improving cross-specialty generalist palliative care skills. NSLIJ is partnering with the Institute for Healthcare Improvement to develop new models of palliative care delivery across the health care continuum. These models have a stronger focus on home-based palliative care for seriously ill patients who continue to benefit from curative or life-prolonging treatments and who are not eligible for hospice.

Common features of successful palliative care systems integration include:

- System-level senior management and administrative support and strong commitment to palliative care as a key solution to pressing health system needs
- Recognition that palliative care outcomes are well aligned with current hospital priorities of quality improvement, risk and harm reduction, and patient- and family-centered care
- Recognition that palliative care is a simultaneous care co-management model, delivered at the same time as all other appropriate and beneficial medical therapies—and not limited to care at the end of life
- Commitment to data-driven guidance on quality and how to improve it, focusing on measurement of palliative care quality outcomes (e.g., symptom burden, concordance of care delivered with patient-determined goals, adverse events and costs)
- Emphasis on early and routine integration of palliative care into new health care models—bundled payments, ACOs, PCMHs—requiring high levels of care coordination
- Strong commitment to educational efforts to improve generalist palliative care skills for all staff
- Inclusion of palliative care program leaders in key strategic committees, helping to disseminate clear messaging on palliative care scope and service benefits
- Palliative care program growth based on evidence of quality and cost impact reflective of program value

Palliative Care Service Delivery

Consultation Service

Most hospitals begin providing palliative care services with a consultation service, either in selected units or across the entire hospital setting. A hospitalwide consultation service maximizes the potential for spread of palliative care principles and practices. The core members of the palliative care team include an advanced practice nurse, physician, social worker and chaplain. Other team members may include physician assistants, nurses and nurse assistants, massage/art/music therapists, case managers, psychologists, pharmacists and dieticians. Depending on hospital size and patient need, team members may be assigned to the palliative care service on a full-time or part-time basis. There is significant variation across sites in staffing models, reporting structures and staffing ratios.

The palliative care team manages referrals, triages additional services and coordinates discharge planning, while working in tandem with other hospital staff. In some hospitals, specially trained individuals work as "counselors" on the team, specifically for the purpose of facilitating and leading "family goal of care" meetings.[40] Because of the high level of medical complexity, assessment and decision making, an advanced practice nurse—clinical nurse specialist or nurse practitioner—is the preferred professional nursing position on a consultation team. Specialist palliative care certification is available for physicians, nurses (advanced practice nurse, RN and LPN/LVN/nursing assistants), social workers and chaplains (see Appendix A).

All teams determine which patient populations the consultation service will see and which populations are outside the team's scope of expertise or program goals. For most teams, the core service population includes patients who have one or more serious or life-threatening illnesses and need specialist-level help with:

- pain and/or symptoms management;
- major medical decisions, requiring clarification of achievable medical care goals and personal goals of care;
- counseling and support for complex family dynamics; and/or
- disposition and management to meet intensive and demanding care needs.

A physician consultation order is required for billing. However, at many hospitals, any staff or family member may request a palliative care consultation. At some hospitals, consultations are suggested or initiated by preestablished criteria (e.g., pre-LVAD placement, pre-tracheotomy or PEG tube placement, prolonged ICU length of stay).[41]

Palliative care team members may be called upon to continue management of patients in the post-acute care setting, including serving as the attending physician for patients discharged with hospice services, providing outpatient follow-up or making palliative care home visits. Providing services across the continuum requires additional staff capacity to meet the demand for palliative care.

Estimating the expected consult volume is necessary to determine adequate staffing. New palliative care programs that are fully staffed typically will see 1 percent to 2 percent of total hospital admissions per year, while established programs may see up to 10 percent of admissions. All programs are encouraged to provide either in-person or telephonic coverage 24 hours, seven days a week, to meet both NQF preferred practices and TJC standards. Successful programs recognize that palliative care team members need dedicated time for nonclinical duties related to hospital staff education, quality improvement and system integration activities.

Inpatient Units

An inpatient palliative care unit is designed to provide specialist palliative care to patients who meet specific criteria. An inpatient unit can be helpful meeting hospital operational needs including:

- Providing consistency in care of the sickest patients needing palliative care specialty services
- Providing a more patient- and family-centered environment
- Improving ICU bed flow by reducing ICU length of stay
- Improving ED patient flow by rapid admission to a palliative care unit
- Serving as a focal point for palliative care education, research and philanthropy

Inpatient units can be either fixed-bed units, used solely for palliative care patients, or so-called "swing-bed" or "virtual" palliative care units, designated for either palliative care or general medical-surgical patients.

Common criteria for admitting patients to palliative care units are:

- Complex pain and symptom management needs
- Death imminent during the current hospitalization, especially for ICU patients
- Prolonged hospital or ICU stays with associated family confusion, mistrust or distress about achievable goals of care

The role of specialist palliative care clinicians for inpatient units is variable. In some units, palliative care physician specialists serve as attending physicians; in other units, they serve as consultants to the primary or attending physician, albeit typically with enhanced privileges (e.g., ability to write orders). Similarly, specialist palliative care nurses and social workers may be integral members of the inpatient unit staff or serve as consultants to the unit staff. Inpatient units where the palliative care providers have control over order writing can provide high-quality and resource-efficient care.[42]

Integration into the ICU and ED

The ICU and the ED are sites that provide care for the sickest patients and where major decisions are made concerning appropriate levels of medical intervention. Increasingly, clinicians working at these sites are confronted with difficult in-the-moment decisions about using invasive high-technology measures when caring for patients with one or more chronic diseases and declining health despite the best that medical care has to offer. To help clinicians, patients and families, some ICUs and EDs are working in partnership with palliative care staff to develop collaborative practice models that seek to infuse palliative care principles and goal-setting practices into the daily care of patients and families. There are now several excellent models of collaborative care that result in measurable benefits to patients, families, clinicians and the hospital.[43] Through its Improving Palliative Care (IPAL) initiative, the Center to Advance Palliative Care has amassed tools and resources for the ICU and ED that can help spur such collaborative relationships.[44]

Outpatient Care

Outpatient palliative care services are designed to improve the continuity of care for seriously ill patients outside the hospital setting. These services include outpatient clinics, home care and care provided by palliative care clinicians to patients at assisted living, long-term acute or chronic care facilities. The most common outpatient clinic arrangement is a co-management clinic, whereby palliative care clinicians see patients on a routine schedule within a host clinic, most commonly a cancer, pulmonary or cardiac clinic.[44] A 2010 report documented increased survival and quality of life for lung cancer patients co-managed from the point of diagnosis by oncologists and palliative care clinicians at Massachusetts General Hospital. This study has led to a major interest in developing conjoint oncology-palliative care clinics.[45]

Steps to Start or Expand Palliative Care Services

Most hospitals and nearly all large and teaching hospitals in the United States report they have some type of palliative care services.[6] These services may range from a part-time nurse with a relatively small number of cases referred by nursing or social services, to a large, well-integrated program with a full complement of interdisciplinary staff that provide consultation, inpatient and outpatient services. For hospitals planning to start or expand their palliative care services, *A Guide to Establishing a Hospital-Based Palliative Care Program*[46] provides step-by-step technical assistance and highlights these key tasks:

1. Convene a planning committee comprised of key hospital clinicians and administrators, including those from the departments of finance, quality improvement, nursing, medicine, discharge planning and social services.
2. Complete a needs assessment to understand a) gaps between current and ideal clinical care and b) local hospital and community resources that can be leveraged to support improved palliative care services.
3. Review current hospital priorities and identify those areas where palliative care services have been shown to improve outcomes (e.g., improving ICU and ED throughput, improving pain management and patient communication, reducing readmissions).
4. Collect meaningful data to a) demonstrate the need for improved services (e.g., pain management patient reports), b) define baseline measures for performance improvement (e.g., ICU length of stay, readmissions) and c) understand the potential impact of palliative care services.
5. Learn from peer institutions that are integrating palliative care services; make a site visit to another facility to see how palliative care inpatient units are organized or how an ICU is integrating palliative care principles to reduce length of stay.
6. Develop a strategic plan and budget including new services, staffing and metrics to document program value. The program budget should include the expected billing and philanthropic revenue as well as the cost avoidance enabled by preventing crises and delivering higher quality care.

Conclusion

Palliative care services are an essential tool for delivering high-quality, patient- and family-centered care. Through their demonstrated impact on improving quality and reducing readmissions and costs, palliative care teams can be aligned with and crucial to helping clinicians meet the needs of patients with the most serious and complex illnesses and their families.

Appendix A. National Palliative Care Standards and Certification

Advanced Certification—Hospitals

The Joint Commission Advanced Certification for Palliative Care Programs
http://www.jointcommission.org/certification/palliative_care.aspx

Cancer Program Accreditation

Commission on Cancer of the American College of Surgeons
http://www.facs.org/cancerprogram/index.html

National Comprehensive Cancer Network—Palliative Care Guidelines

http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

Hospital Palliative Care Standards

- National Consensus Project
  Clinical Practice Guidelines for Quality Palliative Care. 2nd ed.
  http://www.nationalconsensusproject.org/guideline.pdf

- National Quality Forum
  A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report.
  http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=22041

- Journal of Palliative Medicine
  Operational Features for Hospital Palliative Care Programs: Consensus Recommendations
  http://online.liebertpub.com/doi/abs/10.1089/jpm.2008.0149?journalCode=jpm

- Improving Palliative Care in the ICU
  Defining Standards for ICU Palliative Care: A Brief Review from The IPAL-ICU Project
  http://ipal-live.capc.stackop.com/downloads/ipal-icu-defining-standards-for-icu-palliative-care.pdf

- Improving Palliative Care in Emergency Medicine
  http://www.capc.org/ipal/ipal-em/monographs-and-publications

Clinician Board Certification

- American Academy of Hospice and Palliative Medicine
  American Board of Medical Specialties Physician Certification (MD)
  http://www.aahpm.org/certification/default/abms.html

- American Academy of Hospice and Palliative Medicine
  American Osteopathic Association Physician Certification (DO)
  http://www.aahpm.org/certification/default/do.html

- National Board for Certification of Hospice and Palliative Nurses
  Nurse Certification (Advance Practice Nurse, RN, LPN, Nursing Assistant, Program Administrator)
  http://www.nbchpn.org/

- National Association of Social Workers, Certified Hospice and Palliative Social Worker
  http://www.socialworkers.org/credentials/credentials/chpsw.asp

Appendix B. Operational Features for Hospital Palliative Care Programs: Consensus Recommendations [27]

Domain	Must Have	Should Have
1. Program Administration	Palliative care program staff integrated into the management structure of the hospital to ensure that program processes, outcomes and strategic planning are developed in consideration of hospital mission/goals.	Systems that integrate palliative care practices into the care of all seriously ill patients, not just those seen by the program.
2. Types of Services	A consultation service that is available to all hospital inpatients.	Resources for outpatient palliative care services, especially in hospitals with more than 300 beds. An inpatient palliative care geographic unit, especially in hospitals with more than 300 beds.
3. Availability	Monday–Friday inpatient consultation availability and 24/7 telephone support.	24/7 inpatient consultation availability, especially in hospitals with more than 300 beds.
4. Staffing	Specific funding for a designated palliative care physician(s). All program physicians must be board certified in Hospice and Palliative Medicine (HPM) or committed to working toward board certification. Specific funding for a designated palliative care nurse(s), with advance practice nursing preferred. All program nurses must be certified by the National Board for Certification of Hospice and Palliative Nursing (NBCHPN) or committed to working toward board certification. Appropriately trained staff to provide mental health services. Social worker(s) and chaplain(s) available to provide clinical care as part of an interdisciplinary team. Administrative support (secretary/administrative assistant position) in hospitals with either more than 150 beds or a consult service with volume > 15 consults/month.	
5. Measurement	Operational metrics for all consultations. Customer, clinical and financial metrics that are tracked either continuously or intermittently.	

6. Quality Improvement	Quality improvement activities, continuous or intermittent, for a) pain, b) nonpain symptoms, c) psychosocial/spiritual distress and d) communication between health care providers and patients/ surrogates.	
7. Marketing	Marketing materials and strategies appropriate for hospital staff, patients and families.	
8. Education	Palliative care educational resources for hospital physicians, nurses, social workers, chaplains, health professional trainees and any other staff the program feels are essential to fulfill its mission and goals.	
9. Bereavement Services	A bereavement policy and procedure that describes bereavement services provided to families of patients impacted by the palliative care program.	
10. Patient Identification		A working relationship with the appropriate departments to adopt palliative care screening criteria for patients in the emergency department, general med/surgical wards and intensive care units
11. Continuity of Care	Policies and procedures that specify the manner in which transitions across care sites (e.g., hospital to home hospice) will be handled to ensure excellent communication between facilities. _____ A working relationship with one or more community hospice providers.	
12. Staff Wellness	Policies and procedures that promote palliative care team wellness.	

Appendix C. Useful Metrics to Measure Impact and Value of Hospital Palliative Care

Operational

- New consults/month & trend
- Consult volume as % of hospital admissions
- F/u visits seen; average daily census
- Annual consults per clinical palliative care FTE
- LOS pre- and post-consultation
- Discharge status (to SNF, hospice, etc.)
- Deaths as % of consults seen
- % of hospital deaths seen by palliative care

Staff Productivity

- Consults & f/u care by provider
- Billed services by provider and for team
- Hours of clinical time by provider (vs. budget)
- Other team accomplishments for month

Processes of care

- Mean & median response time (difference between time of consult requested and consult seen)
- % time > target threshold (such as 24 hours)
- % with documented communication with referring physician pre- and post-consult
- % of consults meeting documentation standards for symptom management, goals of care discussions, transition management and family support

Financial

- Monthly costs per consult (costs/volume)
- Net billing revenue (overall and by consult)
- % of patients in ICU w/ LOS >7 days prior to consult (example of a measure that matches a quality initiative with a likely financial impact)
- % of consulted patients with readmissions
- Annual "cost avoidance" impact

Quality

- Symptom management impact
- Patient/family satisfaction with care
- Provider satisfaction with consultative services

Appendix D. Palliative Care Screening Tool (Inova)

Instructions

- Select all the triggers that apply to your patient
- Selection of two or more triggers indicates a positive screen
- Initial screen should be completed within 72 hours of admission
- Patient should be re-screened when transferred to a higher level of care unit due to declining clinical condition
- Patients in the ICUs should be re-screened on day 7
- If patient was previously enrolled in hospice, please contact the hospice provider automatically

General Palliative Care Domains

☐ Uncontrolled symptoms (dyspnea, nausea/vomiting, pain > 5/10) ≥ 24 hours
☐ Team/patient/family need help with complex decision making and determination of goals of care
☐ Patient (especially long-term care resident) with AND/DNAR orders

General Disease Category

☐ Second ED/hospital visit in the past 6 months for the same or similar diagnosis
☐ Age ≥ 70 years in the presence of two or more life-threatening comorbidities (ESRD, dementia, severe CHF) and declining functional status increasing dependence in ADLs

Specific Disease Category

☐ Advanced or end-stage organ disease (CHF, COPD, ESRD, ESLD, dementia, MS, ALS)
☐ Stage IV cancer with progression of disease despite treatment
☐ Considering PEG and/or tracheostomy placement with evidence of poor prognosis (advanced dementia)

ICU Category

☐ ICU stay of ≥ 7 days without evidence of improvement
☐ Second ICU admission during same hospital admission
☐ ICU admission from a nursing home in the setting of ≥ 2 chronic, life-limiting conditions
☐ Ventilator day # 6 or longer without evidence of improvement
☐ Glasgow score ≤ 5
☐ Multi-organ failure, involving ≥ 4 systems

Outcome of Screen and Discussion

_____ Screened but did not meet criteria for intervention
_____ Screened, met criteria for intervention.
- _____Palliative Care consult initiated
- _____Palliative Care team already involved
- _____Hospice consult initiated
- _____Primary physician/team to provide primary palliative care (family meeting, goals of care and/or code status discussion, pain and symptom management, implementation of comfort measures)
- _____Primary physician/team believes that patient is expected to improve; current plan of care to continue
- _____Primary physician/team believes patient/family does not wish to discuss palliative care options at this time
- ____Other

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