

## Interviews of Coalition Members' Leading Adult Acute Care Palliative Care Programs

| Domains of Care   | NCP Guidelines   | Interview Questions  | Characteristics of Leading SCC Programs  |
|---|--|--|--|
| <p><b>Domain 1:<br/>Structure and<br/>Processes of<br/>Care</b></p> | <p><b>Guideline 1.1</b><br/><b>The timely plan of care is based on a comprehensive interdisciplinary assessment of the patient and family.</b></p> | <p>How has your team been successful in increasing timely and appropriate palliative care referrals (e.g., providing consult &lt; 24 hours of request)?</p> <p>What steps have you taken to proactively identify patients (e.g. use of screening tool) and avoid late consult requests (e.g. requests for a consult &lt; 48 hours of death) or avoid missed consults?</p> <p>Do you have 24 hour coverage?</p> <p>How many days a week do you have coverage?</p> | <p>Timely referrals and communication with patient/family members are achieved through:</p> <ul style="list-style-type: none"> <li>• Excellent communication among members of interdisciplinary team</li> <li>• Orders entered in electronic medical record that provide automatic print out or other notification to palliative care team members who initiate timely assessments.</li> <li>• Daily interdisciplinary patient rounds</li> <li>• Hospital offers community-based palliative care fellowship</li> </ul> <p>Palliative care teams proactively identify patients and avoid late or missed consults through the use of:</p> <ul style="list-style-type: none"> <li>• Screening tools including numerical scoring and in some cases upon admission for all patients</li> <li>• Palliative care ER screening</li> <li>• Educating physicians and staff as to indicators for palliative care referrals; use of pocket cards with criteria</li> <li>• Daily team rounding on nursing units</li> <li>• Maintaining consistent open communication with attending physicians and collaborating closely with hospitalists</li> <li>• Quality improvement initiatives to increase % referrals within 48 hours of admission with documented outcomes</li> <li>• Targeting patients with end-stage illness</li> <li>• Having inpatient hospice services</li> <li>• Demonstration projects for earlier “upstream” palliative care interventions that lead to better outcomes for patients and families especially in critical care units</li> </ul> <p>Many programs have palliative care physician on-call coverage after hours and new non-emergent consults are scheduled Monday through Friday during regularly scheduled hours.</p> |

| Domains of Care | NCP Guidelines   | Interview Questions  | Characteristics of Leading SCC Programs  |
|-----------------|--|--|--|
|                 |  | <p>What is your ratio of palliative care consults to dedicated FTE's?<br/>           How many FTE's are designated to your team and what roles do they represent?</p>  | <p>Many respondents were unable to provide a ratio of consults to dedicated FTEs. With one exception, these palliative care programs have one or more dedicated palliative care FTEs, most often including MD, APN or RN with other key disciplines assigned to the palliative care team from home departments. Programs are challenged by increasing referrals with limited FTEs. Many are impacted by the shortage of available board certified palliative care clinicians.</p>  |
|                 | <p><b>Guideline 1.2</b><br/> <b>The care plan is based on the identified and expressed preferences, values, goals, and needs of the patient and family and is developed with professional guidance and support for decision making.</b></p>  | <p>How does your palliative care service consistently address the patients' goals of care and treatment plan?</p>  | <p>Programs consistently address patients' goals of care as a primary focus of palliative care consultation by:</p> <ul style="list-style-type: none"> <li>• Identifying patient preferences and health care agents</li> <li>• Holding family meetings within the first 48 hours of the consult and at regular intervals</li> <li>• Using templates to facilitate goals of care and treatment plan discussions</li> <li>• Team communicating/documenting patient preferences</li> <li>• MD dictated consults addressing various domains of care</li> </ul>   |
|                 | <p><b>Guideline 1.3</b><br/> <b>An interdisciplinary team provides services to the patient and family consistent with the care plan. In addition to nursing, medicine, and social work, other therapeutic disciplines with important assessment of patients and families include physical therapists, occupational therapists, speech and language pathologists, nutritionists, psychologists, chaplains, and nursing assistants. For pediatrics, this should include child-life specialists. Complementary and alternative therapies may be included.</b></p> | <p>How has your palliative care program successfully integrated each of the disciplines addressed in the eight domains of care?</p> <p>How have you used physician champions to promote/educate regarding palliative care?</p> | <p>Programs address the eight domains of care through a coordinated interdisciplinary team approach that frequently includes medicine, nursing, spiritual care, social work, pharmacy, dietary, case managers, therapists, hospice and other disciplines with</p> <ul style="list-style-type: none"> <li>• Regular team meetings to address goals of care/treatment plan.</li> <li>• Team coordinated assessments, interventions and communications with patient, family, physician and staff, engaging in care-planning across the continuum</li> <li>• Quality improvement initiatives focused on NCP Guidelines</li> <li>• Teams educate each other regarding their discipline's goals and provide "transdisciplinary care"</li> </ul> <p>Physician champions are very significant in gaining acceptance of palliative care by key physician stakeholders: Successful initiatives include:</p> <ul style="list-style-type: none"> <li>• Promoting "upstream" consults for chronically ill patients</li> <li>• Differentiating between palliative care and hospice care</li> <li>• Surgeon champion offering annual surgical conference with national palliative care experts; regular CME programs</li> <li>• Integrating palliative care into residents' training</li> <li>• Palliative care medical directors promoting the work with administration and medical staff</li> </ul> |

| Domains of Care | NCP Guidelines | Interview Questions  | Characteristics of Leading SCC Programs   |
|-----------------|----------------|--|---|
|                 |                | <p>Are physicians viewed as a primary customer of your service?</p> <p>How has support from key administrative leaders in your organization assisted in achieving your strategic goals?</p> <p>What is the reporting relationship for palliative care in your facility? How has this reporting relationship benefitted your program?</p> <p>Do you have administrative assistant support? How many FTEs?</p> <p>What steps have you taken to create culture change in your organization regarding palliative care?</p> | <ul style="list-style-type: none"> <li>• Palliative care reporting to Chief Medical Officer</li> </ul> <p>There is no consensus as to whether physicians or patient/family are the primary customers of palliative care services. All agree that cultivating collaborative physician relationships is essential.</p> <p>Local and system-level administrative support is essential to initiating, expanding and sustaining a high quality palliative care service. Successful programs are closely aligned with the mission/vision/values of the organization and the goals of the program are well understood by executive leaders, particularly the CEO, VP Mission, CNO and CFO. Executive leadership's participation in the Center to Advance Palliative Care (CAPC) initial training facilitated greater support and understanding of program needs. System-wide palliative care initiatives are seen as an integral part of clinical transformation. Financial incentives for executive leadership are another successful strategy.</p> <p>Reporting relationships vary with recognition that mission leaders are strong advocates for palliative care's alignment with mission and values while nursing executives or chief medical officers are the best champions for the clinical component of care. In some cases there is a dual reporting relationship to Mission and Nursing.</p> <p>Program responses vary from no administrative assistant support to a full time FTE who handled data, billing and collections, budget and financials. Several programs identified the Decision Support Team as a significant program resource.</p> <p>All of the programs report culture change in the years since palliative care was formally initiated. This includes</p> <ul style="list-style-type: none"> <li>• Less resistance from MD's regarding consults and an openness to engage palliative care earlier in the patient's admission</li> <li>• Differentiation between palliative care and hospice care</li> <li>• Welcoming palliative care in ICU and ER settings of care</li> <li>• Comprehensive staff and MD education, transforming care of the chronically and terminally ill patients and families.</li> <li>• Physicians and hospital staff, mentored in the art and science of palliative care, are empowered to integrate palliative care into their own clinical practice.</li> </ul> |

| Domains of Care | NCP Guidelines  | Interview Questions   | Characteristics of Leading SCC Programs   |
|-----------------|---|---|---|
|                 |   | <p>How do you use customer satisfaction data (patients, families, staff, and physicians) to improve your palliative care services?</p>  | <ul style="list-style-type: none"> <li>Palliative care provides a strong healthcare community model comprised of inspiring, compassionate, caregivers who consistently consider and tend to patients' and families' physical, emotional, and spiritual needs. Through model behavior, vital presence, empowering knowledge, and trusted partnerships they are gradually impacting the approach and delivery of care to all patients.</li> </ul> <p>Most programs report customer satisfaction data regarding pain and symptom management, advance care planning and patient/family support, utilizing hospital wide surveys and other tools specifically designed for palliative care patients and their families. Physician and staff satisfaction data is less frequently obtained.</p> |
|                 | <p><b>Guideline 1.4</b><br/>The use of appropriately trained and supervised volunteers within the interdisciplinary team is strongly encouraged.</p>  | <p>Do volunteers have a significant role in your palliative care program?</p>   | <p>Approximately ½ of the programs utilize volunteers in innovative ways including bread baking on the unit for “aroma therapy,” hand-made lap blankets and quilts, pet therapy, memory boxes, NICU volunteers and No One Dies Alone programs.</p>  |
|                 | <p><b>Guideline 1.5</b><br/>Support for education and training is available to the interdisciplinary team.</p>  | <p>What educational models have you effectively used?</p>   | <p>Many programs use ELNEC and EPEC curriculum and train-the-trainer models in addition to grand rounds, on-line interactive learning and using each patient care intervention as an opportunity for teaching. Some partner with hospice programs for MD, resident, staff, nursing student and community education. One health system designed a nursing CEU program that highlights Catholic mission and values.</p>   |
|                 | <p><b>Guideline 1.6</b><br/>In its commitment to quality assessment and performance improvement, the palliative care program develops, implements, and maintains an ongoing data driven process that reflects the complexity of the organization and focuses on palliative care outcomes.</p> | <p>What process and quality measures does your team use to ensure high quality services?</p> <p>What three or four metrics would you consider to be essential for new programs? Additional metrics for mature programs?</p> | <p>Programs use the NCP guidelines, NQF preferred practices and CAPC recommended metrics as a guide. There is wide variation in the use of process and quality measures recognizing the field of palliative care has not yet established evidence-based quality outcomes. Most programs report process measures such as pain and symptom scores, timeliness of consults and family conferences, use of palliative care bundles and screening criteria, hospital length of stay, admission, consult and discharge data, palliative care involvement with inpatient deaths, spiritual assessments and satisfaction data. System-wide dashboards link palliative care initiatives to other quality indicators such as readmission rates.</p>   |

| Domains of Care | NCP Guidelines   | Interview Questions  | Characteristics of Leading SCC Programs  |
|-----------------|--|--|--|
|                 |  | <p>What are the critical factors that must be included for program sustainability and growth?</p> <p>Have you demonstrated cost avoidance/ savings in your program? If yes, have the results been beneficial in strengthening the business case for palliative care? If not, what resources do you need to successfully make the case?</p> | <p>Hospitals identify the following critical factors to successfully grow and sustain a viable palliative care program:</p> <ul style="list-style-type: none"> <li>• Strong interdisciplinary team approach across the continuum of care</li> <li>• A solid infrastructure that fits the culture of the hospital</li> <li>• Creatively thinking “outside the box”</li> <li>• Recruiting/ retaining highly skilled board certified staff</li> <li>• Building strong relationships with physicians, hospital administration, finance and foundation</li> <li>• Using data to demonstrate quality patient care and building a business case for palliative care</li> <li>• Continuously educating staff</li> </ul> <p>Most programs report demonstrated cost avoidance/savings in their program using a variety of models. In some cases these results have been beneficial in strengthening the business case and expanding staff. Others report a “distrust” of cost avoidance data. Several note the importance of collaborating with finance leaders, involving them in the initial planning of palliative care services and utilizing their expertise in developing credible models to measure cost savings.</p> |
|                 | <p><b>Guideline 1.7</b><br/> <b>The palliative care program recognizes the emotional impact on the palliative care team of providing care to patients with life threatening illnesses and their families.</b></p>                              | <p>How does your team effectively address compassion fatigue/moral distress among team members?</p>  | <p>Compassion fatigue and moral distress is a common concern, particularly with growing program demands and limited palliative care staff. Strong interpersonal team relationships and mutual support are important factors in retaining staff and creating a balance between work and personal life. Chaplains play a key role in providing opportunities for team reflection, renewal and debriefing. One hospital utilizes the employee assistance program following difficult patient deaths.</p>  |
|                 | <p><b>Guideline 1.8</b><br/> <b>Palliative care programs should have a relationship with one or more hospices and other community resources to ensure continuity of the highest-quality palliative care across the illness trajectory.</b></p> | <p>What steps have you taken to address continuity of care across the continuum?</p>   | <p>Palliative care programs have well-developed relationships with medical providers, home care agencies, hospice organizations, and nursing homes to ensure timely transitions into appropriate care settings. In some cases, hospice liaison representatives attend palliative care rounds to discuss common patients and the two programs are under one reporting structure with staff members crossing over, providing continuity for patients and families,</p>   |

| Domains of Care   | NCP Guidelines   | Interview Questions  | Characteristics of Leading SCC Programs  |
|---|--|--|--|
|   | <p><b>Guideline 1.9</b><br/> <b>The physical environment in which care is provided should meet the preferences, needs, and circumstances of the patient and family to the extent possible.</b></p>   | <p>In what ways has palliative care positively contributed to the environment of care? (E.g. special rooms, gardens, music etc.)</p> | <p>Palliative care programs utilize music, massage therapy, healing gardens, soft lighting, prayer shawls, pet therapy, meditation rooms, comfort care carts and suites, and hospitality food carts, to enhance the environment of care for palliative care patients and families. Use of spiritual rituals creates sacred space. Visiting hours are extended to accommodate family needs.</p>   |
| <p><b>Domain 2:</b><br/> <b>Physical Aspects of Care</b></p>                      | <p><b>Guideline 2.1</b><br/> <b>Pain, other symptoms, and side effects are managed based upon the best available evidence, with attention to disease-specific pain and symptoms, which is skillfully and systematically applied.</b></p>   | <p>How does the interdisciplinary team ensure excellent pain and symptom management?</p>   | <p>Controlling pain and symptoms is a primary focus for palliative care services. Typically pain and symptom scales are used to assess and treat patients and order sets are useful in providing a consistent standard of care. Pharmacists are a key resource for palliative care teams. All members of the interdisciplinary team have a role in assessing pain and symptoms and providing therapeutic interventions.</p>  |
| <p><b>Domain 3:</b><br/> <b>Psychological and Psychiatric Aspects of Care</b></p> | <p><b>Guideline 3.1</b><br/> <b>Psychological status is assessed and managed based upon the best available evidence, which is skillfully and systematically applied. When necessary, psychiatric issues are addressed and treated.</b></p> | <p>How are the psychological and psychiatric aspects of care effectively addressed by your team?</p>                                 | <p>Palliative care teams utilize an interdisciplinary approach to addressing psychological and psychiatric aspects of care. A thorough psychosocial history helps the team develop an understanding of the patient and family's past experiences with illness, death and loss. Chaplains are identified as a valuable resource in addition to social workers. Psychiatry consults are available for serious mental health issues. Programs report increasing referrals for dementia care patients.</p>                   |
|   | <p><b>Guideline 3.2</b><br/> <b>A grief and bereavement program is available to patients and families, based on the assessed need for services.</b></p>  | <p>What do you offer in terms of bereavement services that you feel is most beneficial to patients and families?</p>                 | <p>Bereavement support is provided through:</p> <ul style="list-style-type: none"> <li>• Spiritual care at the time of death, providing rituals and allowing loved ones adequate time with the deceased</li> <li>• Memorial services</li> <li>• Grief/support groups, literature and memory packets</li> <li>• Sympathy cards and follow up phone calls</li> <li>• Collaboration with hospice services to provide more extended bereavement services</li> <li>• Debriefing for staff following patient deaths</li> </ul> |
| <p><b>Domain 4:</b><br/> <b>Social Aspects of Care</b></p>                        | <p><b>Guideline 4.1</b><br/> <b>Comprehensive interdisciplinary assessment identifies the social needs of</b></p>  | <p>How does your team respond effectively to the social needs of patients and families?</p>  | <p>Social workers routinely engage with patients and families from admission to discharge and are key members of the palliative care team. Some programs have a dedicated MSW and all report successful working relationships with hospital social workers,</p>  |

| Domains of Care   | NCP Guidelines   | Interview Questions  | Characteristics of Leading SCC Programs  |
|---|--|--|--|
|   | <b>patients and their families, and a care plan is developed to respond to these needs as effectively as possible.</b>   |  | participating in daily rounding, family conferences, addressing social needs and continuum of care planning.   |
| <b>Domain 5: Spiritual, Religious and Existential Aspects of Care</b> | <b>Guideline 5.1</b><br><b>Spiritual and existential dimensions are assessed and responded to based upon the best available evidence, which is skillfully and systematically applied.</b>  | Do board certified chaplains educate staff/physicians regarding the spiritual domain of care, spiritual screening and referrals?<br>Do chaplains provide spiritual assessments and develop a spiritual care plan for palliative care patients? Do they document? | Most programs have board certified chaplains and rely on their skill to educate other health professional about the spiritual needs of patients and families. Automatic referrals to chaplains are part of the palliative care consult. Skill level varies with some programs reporting stellar chaplain involvement with the palliative care team and others striving to more fully integrate chaplains into the interdisciplinary team approach. Chaplain complete spiritual assessments and document on palliative care patients. |
| <b>Domain 6: Cultural Aspects of Care</b>                             | <b>Guideline 6.1</b><br><b>The palliative care program assesses and attempts to meet the needs of the patient, family, and community in a culturally sensitive manner.</b>   | How has your program effectively met the cultural needs of patients and families?  | Staff recognizes the importance of cultural competency in caring for patients from diverse religious and ethnic backgrounds. Many report stories of how their palliative care teams respect beliefs around end of life. Palliative care offers educational programs for staff, utilizes translators ( including live video) , incorporates large extended families into care conferencing, coordinates with dietary to provide special foods and many have bi-lingual team members.  |
| <b>Domain 7: Care of the Imminently Dying Patient</b>                 | <b>Guideline 7.1</b><br><b>Signs and symptoms of impending death are recognized and communicated in developmentally appropriate language for children and patients with cognitive disabilities with respect to family preferences. Care appropriate for this phase of illness is provided to patient and family.</b> | How have you prepared staff to effectively and sensitively educate patients and families regarding the signs and symptom of impending death?   | Palliative care utilizes a variety of educational venues to help staff better prepare families for impending death. Some of these programs are mandatory for all RN's. Printed materials are prepared for families and staff is encouraged to teach families about the signs and symptoms of dying to alleviate fear and increase understanding.   |
|   | <b>Guideline 7.2</b><br><b>Postdeath care is delivered in a respectful manner. Cultural and religious practices particular to the postdeath period are</b>   | What would you consider to be the most important aspects of post death care provided in your facility?<br><br>How do you ensure that postdeath   | Some important aspects of post death care are: <ul style="list-style-type: none"> <li>• Respecting the dignity of the deceased in preparing the body</li> <li>• Providing families with privacy, time and a tranquil environment</li> <li>• Offering spiritual care</li> <li>• Using appropriate signage on the door to sensitize staff to the</li> </ul>  |

| Domains of Care   | NCP Guidelines  | Interview Questions  | Characteristics of Leading SCC Programs  |
|---|---|--|--|
|   | <p><b>assessed and documented. Care of the body postdeath is delivered with respect to these practices, as well as in accordance to both organizational practice and local law.</b></p>   | <p>care is managed in a culturally and religiously sensitive and appropriate way?</p>  | <p>presence of a grieving family.</p> <ul style="list-style-type: none"> <li>Honoring any cultural/religious post death requests/rituals</li> </ul> <p>One hospital collaborates with local mortuaries to pay for funeral costs for indigent patients with a small donation from family.</p>   |
|   | <p><b>Guideline 7.3</b><br/>A postdeath bereavement plan is activated. An interdisciplinary team member is assigned to the family in the postdeath period to help with religious practices, funeral arrangements, and burial planning.</p>    | <p>How do you consistently provide post death bereavement support to family and other loved ones?</p>  | <p>Palliative care utilizes hospice bereavement programs and other community resources. Chaplains often conduct memorial services. Families receive phone calls and are mailed bereavement materials.</p>  |
| <p><b>Domain 8: Ethical and Legal Aspects of Care</b></p> | <p><b>Guideline 8.1</b><br/>The patient's goals, preferences and choices are respected within the limits of applicable state and federal law, within current accepted standards of medical care, and form the basis for the plan of care.</p> | <p>How are the ethical and legal aspects of patient care effectively addressed in your facility?</p>   | <p>Palliative care services partner with their ethics committees for education and consultation and seek advice from risk management for legal aspects of patient care. Many programs have access to an ethicist for addressing ethical conflict. Several hospitals report a decrease in ethics consults as their palliative care programs mature. Palliative care enhances awareness of patient's self determination, asks questions before a crisis occurs and takes the time to learn about the patient and family's values system.</p> |
|   | <p><b>Guideline 8.2</b><br/>The palliative care program is aware of and addresses the complex ethical issues arising in the care of people with life-threatening debilitating illness.</p>  | <p>How is the palliative care program a knowledgeable resource to patients/families/staff regarding complex ethical issues in the care of people with life-threatening debilitating illness?</p> | <p>Typically palliative care is represented on the ethics committee and often addresses complex ethical issues during patient/family conferences.</p>  |
|   | <p><b>Guideline 8.3</b><br/>The palliative care program is knowledgeable about legal and regulatory aspects of palliative care.</p>   | <p>How does the palliative care team stay abreast of legal/regulatory aspects of palliative care?</p>  | <p>Palliative care programs access a variety of resources to stay abreast of legal/regulatory aspects of palliative care including CAPC, AAHPM, HPNA, ANA, NHPCO and SCC websites and publications as well as information from state board of nursing laws and updates.</p>  |

## Facilities/Organizations Interviewed:

1. St. Mary's Hospital in Amsterdam, NY
2. St. John Hospital and Medical Center in Detroit, MI
3. St. Francis Hospital (Downtown) in Greenville, SC
4. St. Joseph Hospital in Lexington, KY
5. Mercy Health Partners in Northwest Ohio  
(representing St. Vincent Mercy Medical Center  
St. Vincent Mercy Children's Hospital  
St. Charles Mercy Hospital  
St. Anne Mercy Hospital  
Mercy Hospital Tiffin  
Mercy Hospital Willard  
Mercy Hospital of Defiance)
6. CHRISTUS Health Gulf Coast Palliative Care Program in Houston, TX
7. Provena St. Mary's Hospital in Bourbonnais, IL
8. St. Edward Mercy Medical Center in Ft. Smith, AR
9. Palliative Care of North Iowa in Mason City, IA
10. Mount Carmel Palliative Care Service in Columbus, OH