

Policy Name:	Palliative Care Policy
Policy Number:	None
Department:	Palliative Care Collaborative Team
Functional Area:	
Contributing Department	Medical Staff, Nursing, Population Health, Regulatory, Quality, Ethics, Spiritual Care
Approved by:	Palliative Collaborative
Effective Date:	12/23/2024
Version:	2.0
Status:	Approved
Manual	Care Giving
Section	General Practice

I. Mission, Vision and Values

This organization aims to ensure its Mission, vision, and values are reflected in all organizational-wide policies, procedures, and guidelines. It is in accordance with the Mission of Bon Secours Mercy Health “improving the health and well-being of our communities and bring good help to those in need, especially people who are poor, dying and underserved.

II. Policy

It is the policy of Bon Secours Mercy Health that through application of palliative care competencies and access to specialty palliative care, all persons living with or affected by a serious illness receive compassionate, holistic, coordinated care, which includes the relief of symptoms and other stresses of a serious illness from the time of diagnosis through the disease process.

III. Purpose

As part of wholistic patient-centered care for patients and loved ones facing serious illness, BSMH strives to carry out through

- A. health care team members with palliative care competencies;
- B. specialty palliative care services; and/or
- C. other designated health system and community serious illness resources.

IV. Scope

This is a system-wide policy and applies to all patient care areas within the Bon Secours Mercy Health (BSMH) System.

V. Policy Details

A. Interventions:

Assess spirituality	For patients facing advanced serious illness, a spiritual assessment identifies meaning and purpose. Seeing the whole person with dignity allows the multidisciplinary team to embrace physical, psychosocial, and spiritual dimensions. Spiritual care professionals will provide the assessment and communicate the spiritual needs as part of the holistic care plan.
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<p>Assess social needs including social determinants of health (SDOH)</p>	<p>A health care team member will engage in compassionate conversation with patients and loved ones facing serious illness, in their preferred setting, to assess social needs and social determinants of health (SDOH). This includes recognition of psychosocial barriers that contribute to unnecessary suffering and arranging for needed services (e.g. food, housing, transportation), as available, to alleviate burdens and assist in improving quality of life.</p>
<p>Assess the needs of caregivers</p>	<p>The patient's caregivers are an essential part of the patient's holistic support, advocating for their personal health care goals when facing serious illness. The strain on caregivers of overwhelming emotional and physical responsibilities leads to changes in social relationships, financial hardship, fatigue, depression, and grief. A health care team member will assess caregivers for perceived level of burden and provide support as part of a holistic approach to caring for the patient.</p>
<p>Assess behavioral health</p>	<p>In serious illness, anxiety, depression, trauma, grief, and other psychological responses are real and common. If not addressed, these lead to negative outcomes including the onset or worsening of physical illness, mental illness, substance use disorders, existential suffering, and complicated grief. A health care team member will provide early behavioral health screening, assessment and preventive, supportive measures for patients and loved ones.</p>
<p>Offer Advance Care Planning</p>	<p>Patients are empowered by conversations related to how they wish to be cared for when approaching end of life. All adults should designate a healthcare decision maker for a situation in which they cannot express their wishes themselves. Similarly, healthcare decision makers for pediatric patients should be given the opportunity to discuss wishes for care of the child as he/she approaches end of life. It is desirable for a health care team member to broach advance care planning, understand state laws pertaining to surrogate decision maker hierarchies, and properly complete advance directive and portable Do Not Resuscitate orders. As patient advocates, the health care team will elicit, seek to understand, and properly document patient preferences.</p>
<p>Ensure health awareness and share prognosis</p>	<p>For every patient with serious illness, determining patient understanding of their condition ensures alignment with shared health information. To avoid confusion, this is to be done in concert with clinicians who are also managing the patient's care. The physician and/or advanced practice clinician will assess a patient's prognosis and readiness to receive the information. Once assessed, the clinician will deliver the information as part of goal-aligned care.</p>
<p>Discuss benefit burden of medical interventions based on goals and values</p>	<p>Benefits and burdens of medical interventions (including tests, procedures, and treatments) should be described through the following: scientific evidence, disease severity and prognosis, social determinants of health, and patient perception. The treating or consulting physician and/or advanced practice clinician will facilitate information as part of the informed consent process based on the consideration of these factors. This is vital in providing medical interventions that are beneficial while avoiding those that may cause burden or even harm. These benefit burden conversations serve as a foundation for providing goal aligned care.</p>

Provide symptom management for quality of life	Symptoms of serious illness may include pain, shortness of breath, constipation, fatigue, delirium, and others. Proactive and ongoing assessment and management allows the patient to experience an optimal quality of life. Referral to clinicians with expertise, such as palliative care, will be made for management of intractable symptoms negatively impacting quality of life.
Engage Palliative Care and Hospice services.	Palliative care offers an extra layer of support for the seriously ill patient's mental, physical, and spiritual needs. The provision of palliative care services is based on need rather than prognosis. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment. Palliative care should be accessible to all patients negatively impacted by their illness.

B. Palliative Care Staff Competency and Education

1. Staff Competency: All clinical staff may demonstrate core competencies in care decisions, overwhelming symptoms, psychosocial/spiritual support, end stage disease.
2. Staff Education: BSMH will provide access to palliative care education for clinical staff to enhance palliative care competencies. Education may include (but not limited to) the following topics:
 - a) Care Decisions (prognosis, treatment preferences, advance care planning, and resuscitation)
 - b) Overwhelming Symptoms (pain, shortness of breath, fatigue, nausea, loss of appetite, and difficulty sleeping)
 - c) Psychosocial / Spiritual Support (anxiety, depression, fears, and spiritual tension)
 - d) End Stage Disease (End of life transition; comfort care, Hospice)

C. Procedure and Referral Process

1. Identify the Need for Palliative Care
 - a) Palliative care needs identified; request by health care team member, request by patient and/or loved ones.
 - b) Identification Tools in the literature and/or the Electronic Health Record (ESAS and/or Pain Score; Epic End of Life Care Index and/or other Prognostic Scores)
 - i. See data analytics and/or literature for updated evidence base approaches to identifying palliative care need.
2. Procedure for Palliative Care intervention
 - a) Assess identified patients for unmet palliative care needs using clinical assessment and other available assessment tools.
 - b) Deliver palliative care by 1) health care team member with palliative care competencies; 2) specialty palliative care team members (by referral); and/ or 3) other health system and community serious illness resources.
 - c) Referral to Specialty Palliative Care
 - i. If needs cannot be met through health care team members with palliative care competencies, refer to specialty palliative care.

D. Specialty Palliative Care

1. Population
 - a) Adults with palliative care needs that are identified and/or referred to specialty palliative care services.
 - b) Pediatric patients with palliative care needs that require specialty palliative care services, where available.

- c) Neonatal patients with palliative care needs that are identified follow Neonatology / Pediatrician / Palliative care services where available.
 - ii. Referral Process: Inpatient/Outpatient
 - a) Place consult order in an electronic medical record, email, phone, or fax.
 - b) Specialty Palliative Care team responds to all consultations based on Internal Palliative Care Team guidelines.
 - c) When the consultation is placed, the reason for consult should be specified.
- E. Resources
 - 1. American Academy of Hospice and Palliative Medicine, <http://www.aahpm.org/>
 - 2. American Hospital Association, www.aha.org
 - 3. CAPC Clinical Training Recommendations <https://www.capc.org/clinical-training-recommendations-for-all-clinicians-caring-for-patients-with-serious-illness/>
 - 4. Center to Advance Palliative Care www.capc.org
 - 5. Ethical and Religious Directives for Catholic Health Care Services. Washington, D.C: United Conference of Catholic Bishops (6th ed.) <https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf>
 - 6. Get Palliative Care <http://www.getpalliativecare.org/>
 - 7. Joint Commission Standards for Palliative Care <https://www.jointcommission.org/measurement/measurements/palliative-care/>

VI. Definitions

- A. Palliative Care
 - 1. Specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family (defined by CAPC).
 - 2. Palliative Care assessment and management includes:
 - a) Care decisions including discussion of prognosis, treatment preferences, advance care planning, and resuscitation.
 - b) Overwhelming symptoms associated with progression of disease.
 - c) Psychosocial distress of the patient and/or family including anxiety, depression, fears, and spiritual tension.
 - d) End of life care, including symptom management and engaging other resources to support end of life care needs such as comfort measures, Hospice care, and bereavement services.
- B. Palliative Care Delivery
 - 1. Palliative care is delivered by any member of the health care team who has palliative care competencies and/or specialty palliative care team members.
 - 2. See CAPC Training Document (reference) scope of practice recommendations for competencies in advance care planning, palliative care, hospice, and/or end-of-life training.
- C. Specialty Palliative Care
 - 1. Specialty palliative care is provided by a team of expert clinicians for patients/loved ones whose needs are greater than can be met by other health care team members. Palliative Care team members are credentialed and/or certified in palliative care or have specialty level competencies to provide palliative care.
 - 2. An interdisciplinary palliative care team (at least 2 disciplines with specialty level competencies to provide palliative care) may include but is not limited to physicians, advanced practice

nurses, physician assistants, nurses, therapists, social workers, and/or chaplains that provide inpatient and/or outpatient palliative care consultation services.

3. Other supportive services (based on market and/or community resources) that may provide specialty palliative care, fully or in part, include: Pain Management, Spiritual Care, Ethics, Community-Based Palliative Care resources, Hospice and Bereavement Services.

VII. Attachments

VIII. Related Policies

IX. Regulatory Notices

Nothing in this policy modifies the at-will status of any organizational associate or otherwise creates a contractual relationship between the organization and any associate.

The organization, in its sole discretion, reserves the right to amend, terminate or discontinue this policy at any time, with or without advance notice.

X. Version Control

Version	Effective Date	Next Review Date Starts	Description	Supersedes, if applicable	Prepared By
1.0	01/04/2022	01/04/2024	Original Document	Local Policies on this subject matter	Policy Team
2.0	12/23/2024	Starts 12/23/2026	Scheduled Review – New Template	Version 1	Policy Team

This policy/procedure/guideline is not intended to establish a standard of clinical or non-clinical care or practice. Rather, this policy/procedure/guideline creates a general tool to help guide decision-making with the understanding that different action(s) may be necessary in response to the totality of the circumstances presented.

Sites revised 01/21/2024 - Bon Secours Mercy Health adopts the above policy, procedure, policy & procedure, guideline, manual / reference guide / instructions, or principle / standard / guidance document for all Bon Secours Mercy Health entities including, but not limited to, facilities doing business as Mercy Health – St. Vincent Medical Center, St. Vincent – St. Charles Hospital, St. Vincent – St. Anne Hospital, Mercy Health – Perrysburg Medical Center, Mercy Health – Tiffin Hospital, Mercy Health – Willard Hospital, Mercy Health – Defiance Hospital, Mercy Health Allen Hospital LLC, Mercy Health - Lorain Hospital, Mercy Health St. Elizabeth Youngstown Hospital, Mercy Health St. Joseph Warren Hospital, Mercy Health - St. Elizabeth Boardman Hospital, Mercy Health - St. Rita’s Medical Center, Mercy Health – Springfield Regional Medical Center, Mercy Health - Urbana Hospital, Mercy Health - Anderson Hospital, Mercy Health - Clermont Hospital, Mercy Health – Fairfield Hospital, Mercy Health - West Hospital, The Jewish Hospital – Mercy Health, Mercy Health – Kings Mills Hospital, LLC, Mercy Health - Lourdes Hospital LLC, Mercy Health – Marcum and Wallace Hospital, Chesapeake Hospital Corporation DBA Rappahannock General, Maryview Hospital, Bon Secours Richmond Community, Bon Secours Memorial Regional Medical Center, Bon Secours – St. Mary’s Hospital, Bon Secours St. Francis Health System, Bon Secours St. Francis Medical Center, Bon Secours Mary Immaculate Hospital, Bon Secours - Southside Medical Center, Bon Secours Mercy Health Franklin, LLC, and Southern Virginia Medical Center.