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| Palliative Care | **Last Revision:** | March 2020 |
| **Last Reviewed:** | June 2020 |
| **Applies to the following THA Group of Companies:** | * Island Health Care * Island Hospice * Independent Life at Home * Palliation Choices |
|  | **Included in the following THA Manual:** | * Administrative Policy and Procedure Manual   Provision of Care, Treatment, &  Service |

#### POLICY

It is the policy of Island Health Care, Inc. to identify patients who may experience uncontrolled pain and/or other symptoms and who therefore require palliative care.

**PURPOSE**

1. Identify potential palliative care patients

2. Establish a referral process for palliative care

3. Provide continuity of care by bridging patients from IHC to hospice through palliative care program

# PROCEDURE

1. Patients who may be appropriate for palliative care are identified through the following resources:
   1. Strategic Healthcare Partners (SHP) review of the comprehensive assessment
   2. Palliation Choices/Island Healthcare criteria for referring patients for a palliative consult
   3. Attendance of an Island Hospice (IH) clinician at weekly IHC team meetings to assist in identifying potential palliative care patients.

2. Patients identified through these resources are referred by the State Director, Clinical Director or field staff to the Palliation Choices Program

1. The Palliation Choices Program contacts the patient within 1 week of receiving consult to schedule a visit; the State Director is also notified with visit details
2. After completing the patient visit, the State Director is provided with an update and ensures no order strings are needed
3. The Palliation Choices Staff Members complete the consult note and communicates Plan of Care recommendations to field staff.
4. The Palliative Care Consult note is faxed to the patient’s provider for review. The designated palliative care team member contacts the patient’s MD to discuss palliative care recommendations for pain and symptom management.
5. If spiritual and/or psychosocial issues are identified, physician’s orders may be requested for chaplain and/or social work services.
6. The patient’s palliative and/or hospice needs are discussed at the next Team Conference with both the IHC and IH nurse present
7. A list of palliative patients is added to the standard Team Conference agenda, with patient status and optimal bridging to hospice discussed weekly.
8. The IHC nurse remains as the patient’s primary care manager, implementing the recommendations specified in the Palliative Care Consult.
9. The Palliative Care team member(s) make follow-up visits every 60 days or as needed. More frequent visits will be made if medically necessary or if patient evaluation is needed.
10. Palliative Care will be provided until one or more of the following events occur:

a. The patient converts to the hospice benefit.

b. The patient/family no longer meet the palliative care criteria or do not agree with

the palliative care goals.

c. The patient’s condition stabilizes, or symptoms are under control with minimal

risk of decline.