



Improving Communication about Serious Illness-Implementation Guide



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Overview

This Resource is the product of a two-year collaboration between the Society of Hospital Medicine's (SHM's) Center for Quality Improvement and The Hastings Center. This collaboration created a new task-based pathway to improve care for seriously ill patients, focused on prognosis and goals of care communication by hospitalists in collaboration with nurses and teams.

SHM hopes that this implementation guide will be helpful to:

1. Individual clinicians hoping to improve their communication skills,
2. Clinical champions positioned to lead projects to improve serious illness communication, service and hospital leadership, to understand how to best support hospitalists and their teams in providing the highest quality of care to their seriously ill patients.

Key terms

Advance directive: A document in which a person with decision-making capacity gives directions about future medical decisions and care (treatment directive) and/or designates who should make these decisions if the person loses decision-making capacity (proxy directive). Advance directives should be reflected in medical records. Portable medical orders for seriously ill patients that are authorized for use in some states (often known as POLST or MOLST) may be used to consolidate a patient's advance directives.

Palliative care: An interdisciplinary, evidence-based specialty and care focus that aims to improve quality of life for people with serious illness and for their families by relieving symptoms and the stress of serious illness and by aligning treatments with patient preferences. Specialty palliative care is usually accessed via consultation or referral.

Primary palliative care: Domains of palliative care that can be met by appropriately trained clinicians as part of normal care, with specialist consultation or referral if needed. Primary palliative care needs typical of seriously ill patients include discussion of prognosis and goals of care; symptom management; and psycho-social support.

Serious illness: The presence of one or more life-limiting conditions, e.g. advanced cancer, congestive heart failure, chronic obstructive pulmonary disease, end stage renal disease, dementia or other degenerative neurological illnesses, in a hospitalized patient. The presence of serious illness indicates a need for palliative care assessment and the integration of palliative care into treatment and care plans.

Surrogate: An individual or process whose role is to make health care decisions for a person who lacks decision-making capacity. A surrogate appointed through a Durable Power of Attorney for Healthcare may be known as a "proxy" or "agent."

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Case for Change

Key points

- Most Americans diagnosed with serious illness will be hospitalized in the last months of their lives, due to acute episodes of illness.
- Interdisciplinary palliative care is a proven approach to the management of serious illness. Palliative care is consistent with all treatment plans and responsive to what patients and caregivers want and need.
- Hospitalization often marks turning points in a serious illness trajectory. Seriously ill patients need consistent access to high quality palliative care both during hospitalization and post-discharge.
- Primary palliative care has emerged as a new strategy for meeting palliative care needs that do not require specialist consultation. This strategy responds to the reality that the nation's palliative care specialist workforce is too small to effectively address the needs of all seriously ill patients through a consultation model.
- Primary palliative care needs typical of seriously ill patients include discussion of prognosis and goals of care; symptom management; and psycho-social support.
- Hospitalist physicians direct most care for seriously ill adults in the hospital. They are the linchpin for clinical information for each of their patients, and often drive the process of clinical consensus around prognosis and treatment goals among specialty medicine and surgical colleagues.
- Hospitalists are optimally situated to serve as primary palliative care providers because of their direct responsibility for the care of seriously ill patients and their collaborative, consensus-building role with other physicians and with clinician colleagues.
- For hospitalists and their teams to be effective primary palliative care providers, they need educational support to help them integrate key palliative care processes into their workflow, backed up by operational support from leadership and work systems.

Primary Palliative Care in Hospital Medicine

Serious illness: a common experience across an aging society

As our nation ages, the management of serious, often age-associated illness and comorbidities is integral to the health of older Americans, and to family caregivers, as a population. The reality of population aging and the experience of serious illness as a common experience, shared by millions of Americans as patients, family caregivers, and consumers of health care, calls for improvements to care systems.

Research and analysis have clarified a set of problems in how care in the last stage of life is financed, organized, and delivered. Some improvements can and should be accomplished through changes in clinical and organizational thinking, behavior, and processes in hospitals and other care settings. This Resource Room aims to support clinical and organizational changes in hospital medical wards.

Some problems will also require advocacy for policy reforms to shift entrenched reimbursement patterns from high-intensity interventions to a broader range of services reflecting what people in the last stage of life want and need.

Palliative care: a proven approach for seriously ill patients

Palliative care is an interdisciplinary, evidence-based specialty and care focus that aims to improve quality of life for people with serious illness and for their families by relieving symptoms and the stress of serious illness and by aligning treatments with patient preferences.¹

Through focused attention to communication about prognosis and goals of care, palliative care helps patients and families to select treatment and care plans that best align with their values and preferences. Patients who are expected to recover from illness or injury also need and benefit from palliative interventions such as pain relief. Research shows that palliative care consultation services increase health care value by helping to ensure that patients do not receive treatments that are unwanted or unduly burdensome.^{2,3,4}

The relief of suffering is fundamental to medicine and other health care professions. Palliative care is a practical expression of this professional value.

Primary palliative care: a new care delivery model to expand access

In the hospital, palliative care is typically organized as an interdisciplinary consultation service and delivered by clinicians with training and/or certification in palliative care. The limited size of the palliative care specialist workforce relative to the needs of an aging population hampers basic access for seriously ill patients.⁵ Some hospitals, especially small community hospitals, still lack palliative care consultation services.⁶ Also, the consultation model is not the best fit for meeting a routine health care need of a patient population.

In response to these structural problems, palliative care specialists have articulated principles of “generalist” or “primary” palliative care.⁷ These principles include discussion of prognosis and goals of care; symptom management; and psychosocial support. They reflect core components that can be delivered by professionals who are not palliative care specialists and who have appropriate training, tools, and institutional support. Key specialties such as clinical oncology and critical care have translated these principles for use in their settings.^{8,9}

All seriously ill patients need some form of palliative care; therefore, all professionals who care for seriously ill patients are part of palliative care and end-of-life care systems. Hospitalists routinely care for seriously ill patients and are a key specialty in the effective delivery of primary palliative care to their patient population.¹⁰

Improving hospital care through primary palliative care: the role of hospital leadership

Hospitals are key venues for improving care for seriously ill people. Hospitalizations often occur at turning points in a serious illness trajectory, when palliative care needs are high.¹¹ Most Americans experience hospitalization in the last year of life for the treatment of acute episodes of serious illness.¹² Seriously ill patients need continuity of palliative care after hospitalization. Improvements to palliative care in the hospital also complement local efforts to expand access to community palliative care through outpatient clinics, home care agencies, hospice programs, and other venues.

Hospital medicine is the fastest growing medical specialty in the U.S.¹³ These generalist physicians direct the care of most hospitalized patients in the U.S. and are recognized as leaders in quality and safety.¹⁴

The integration of primary palliative care into hospital medicine is the next step forward in hospital-based efforts to improve serious illness care. Support from hospital leadership for efforts to integrate primary palliative care into this specialty will significantly close the palliative care specialty workforce gap and boost the value of the care hospitalists and hospitals provide.

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I Best Practices

Establishing best practices in prognosis and goals of care communication

This effort to establish a set of best practices that can be mentored and evaluated is grounded in evidence-based palliative care specialty standards and in interdisciplinary evidence and consensus concerning decision-making communication with seriously ill patients. It builds on the principles of primary palliative care that are reflected in focused work already undertaken in clinical oncology and critical-care medicine and nursing. It translates these principles, and the extensive evidence base supporting them, in terms of the tasks and workflow of hospitalists. It explains how hospitalists and hospital systems can make changes to improve quality of care in a crucial area of practice.

This initiative responds to calls from the National Academy of Medicine and a wide range of national efforts to improve care for seriously ill people.¹ It also responds to the Joint Commission's call to frame end-of-life care as a patient safety issue, with explicit attention to communication supporting informed decision-making.²

This collaboration draws on The Hastings Center's decades of leadership in interdisciplinary consensus guidance, reflected in the 1987 and 2013 editions of *The Hastings Center Guidelines*, a landmark work for clinicians and institutions on treatment decision-making and care for seriously ill and dying patients.³ Concurrent work by an SHM education task force to revise palliative care competencies for hospitalists has also informed this collaboration.⁴ An affiliated collaboration between The Hastings Center and the American Association of Critical-Care Nurses (AACN) informed the pathway development process at all stages through insights from nursing and from interprofessional research.^{5,6}

The SHM/Hastings Center collaboration was launched in July 2015 through a national stakeholder meeting that included hospitalists, acute-care nurses, and other hospital clinicians, many of whom were dually certified as palliative care specialists, and also patient and family advocates; health care ethicists, social scientists, and other experts. Meeting participants also included the members of an Expert Panel convened by SHM whose members, together with Hastings Center investigators, AACN representatives, and SHM leadership and staff, served as the work group that developed and reviewed this document.

Meeting participants explored the specific challenges of discussing prognosis and goals of care with patients and families whom hospital clinicians are meeting for the first time under stressful conditions. This facilitated discussion clarified that hospitalists need skills training, clinical mentoring, leadership recognition, and structural support, from information technology and other work systems, to integrate primary palliative care into normal workflow from admission through discharge, successfully and consistently. The stakeholder meeting produced a working paper summarizing major themes relevant to the translation of evidence-based findings from specialty palliative care into the primary care context, and specifically to the task-based work environment of the frontline hospital clinicians.

I Key Learnings From This Meeting Included:

Value

Best practice for hospitalist-initiated goals of care discussions should show how discussing prognosis, clarifying patient preferences, aligning treatment with preferences, documenting goals of care so this information can guide care, and managing symptoms and distress improve value in hospital medicine. Standards and initial and future metrics should support high-value care delivery in the context of serious illness so clinicians and administrators share an accurate picture of what high-value health care looks like.

Leadership

Best practice for hospitalist-initiated goals of care discussions relies on the explicit support of hospital leadership. The safety and quality improvement research literature demonstrates that social change in complex systems proceeds from leadership buy-in and endorsement. Supporting the integration of primary palliative care into normal hospital care with the goal of greater value for seriously ill patients also supports organizational progress toward value-based payment and other systemic reforms.

Role clarity

Best practice for hospitalist-initiated goals of care discussions should be supported by unit-level and organizational recognition of how primary palliative care is integrated into normal hospital care. Hospitalists collaborate with other physicians as co-managers of a patient's care, or may assume responsibility for a patient's medical care during a care transition from a surgical or intensive care setting. Explaining how hospitalists collaborate with medical and surgical specialties, including palliative care specialists, and with nurses and other team members, prevents confusion and conflicts about roles and scope of practice in delivering primary palliative care.

Tasks:

Best practice for hospitalist-initiated goals of care discussions should realistically reflect the task-based work environment of hospitalists and bedside nurses, with close attention to how primary palliative care needs are identified and responded to from admission through discharge, and the skills needed for these tasks. How information about patient preferences is documented, shared during hospitalist-to-hospitalist handoffs and with nurses and other team members, and conveyed to outpatient providers are key operational aspects of primary palliative care that support practice.

Resilience:

The implementation of best practice for hospitalist-initiated goals of care discussions and other core components of primary palliative care should include attention to the emotional aspects of discussing prognosis, serious illness, and the end of life. In addition to learning how to communicate effectively with patients and families under stressful conditions, hospitalists and bedside nurses also need opportunities to reflect on and discuss challenging cases and to develop resilience.

Based on these themes, project leaders selected prognosis and goals of care discussions as a key palliative care process for hospitalists and initiated work to develop a practical model – a pathway – that reflects these learnings, and the reality of the hospitalist work environment.

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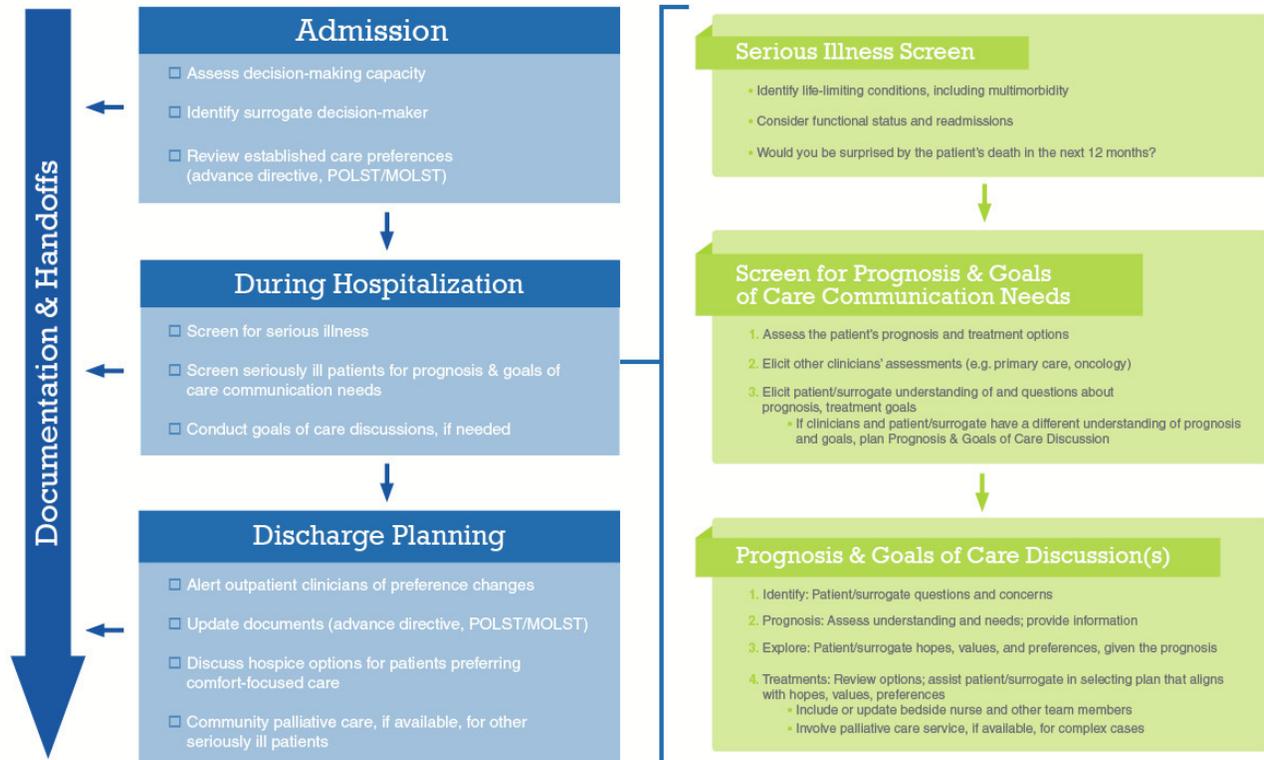
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Goals of Care Pathway

Prognosis and Goals of Care Communication Pathway

Figure 1: Hospital Prognosis and Goals of Care Communication Pathway

This primary palliative care pathway synthesizes best practices in hospital-based prognosis and goals of care communication identified by the work group. This Figure shows how key processes map onto time points of the typical workflow of hospitalists and their teams. Pathway implementation can be tailored by hospitals to reflect state and local law concerning advance directives, portable medical orders, and other relevant policy. Each step in this pathway must be documented in the patient's medical record, so that clinicians can view information about previous screening, care, and communication over the course of a hospitalization.



Pathway Development Process and Implementation Notes

Defining best practices for hospital medicine

The collaborative interdisciplinary work group managed by the SHM Center for Hospital Innovation and Improvement, augmented by a national stakeholder meeting that produced a working paper, identified prognosis and goals of care communication as the most productive focus for a primary palliative care pathway for hospital medicine.

The work group was informed by clinical insights from the practice of interdisciplinary hospital palliative care, hospital medicine, and acute-care nursing. Perspectives from dually certified professionals provided expert comparisons of palliative care specialist consultations and hospitalist workflow. This helped ensure that a best practice standard for prognosis and goals of care discussions led by hospitalists and their teams would be realistic and substantive.

Translating aims into hospitalization phases

The work group defined the aims of prognosis and goals of care communication in the hospital as:

1. ensuring that hospitalists and their teams are aware of patients' established care preferences and incorporate these preferences into hospital care,
2. offering all seriously ill hospitalized patients the opportunity to discuss prognosis, goals, and any concerns about their treatment with hospital clinicians responsible for their care,
3. aligning hospital and post-hospital care plans with patients' values and preferences, including preferences that may have changed or been articulated during hospitalization, and
4. maximizing community support for seriously ill patients and their families through discharge referrals to community palliative care and hospice when available and appropriate.

The work group then mapped these aims onto phases of a seriously ill patient's hospitalization and the daily workflow of hospitalists and their teams. We identified key activities and described them in terms of processes for three phases: Admission, During Hospitalization, and Discharge Planning. See Figure 1

Reflecting hospitalist workflow and time constraints in a quality improvement strategy

The pathway shows how to integrate recommended processes into available time and existing tasks. It reflects the structure of hospital care as it unfolds across shifts, with attention to clinician-to-clinician handoffs of responsibility and information, and variations in the roles and availability of clinicians such as social workers, case managers, and palliative care consultation services across institutions.

- The pathway focuses on prognosis and goals of care communication with seriously ill patients as a key domain of palliative care that hospitalists caring for seriously ill patients should be prepared to meet as part of routine care (primary palliative care), consulting with palliative care specialists, if available, for complex cases.
 - This pathway can be integrated into existing screening processes or adapted institutionally in other ways as appropriate.
 - It highlights quick screening processes for serious illness and for prognosis and goals of care discussion needs. These help clinicians easily identify seriously ill patients whose palliative care needs are related to communication, and those who may have other primary palliative care needs, including pain and symptom management and psychosocial support of patients and families.
- The pathway highlights processes that take only a few moments to complete.
 - Taking a few moments at admission to identify a care preference or decision and to refer to community palliative care at discharge can have a profound effect on safety, quality, and patient experience, by aligning hospital and post-hospital care with patient preferences and ensuring that patients and families get the support they need.
- The pathway shows how responsibility for communication about prognosis and goals of care starts at admission, and aims to support communication from shift to shift.
 - It realistically reflects typical workflow in the care of seriously ill patients, breaking communication about prognosis and goals of care into discrete processes that correspond to other tasks at hand during admission, hospitalization, and discharge planning.
 - It anticipates that hand-offs between hospitalists, bedside nurses, and other clinicians will include status updates on prognosis and goals of care communication over the course of hospitalization.
 - It can be used by different team members, including bedside nurses, social workers, chaplains, and case managers, who collaborate with hospitalist physicians.
 - It emphasizes close coordination between hospital and outpatient clinicians to support continuity of primary palliative care across care settings.

■ The clinical utility of the pathway depends on clear and consistent documentation of each step of the pathway in the patient's medical record, so clinicians can view information about previous screening, care, and communication.

- Efforts to improve goals of care communication should include concurrent improvements to medical record systems if a hospital's current systems and documentation practices cannot adequately support pathway use.
- This Resource Room offers proposed metrics for quality improvement work corresponding to the pathway, including examples of where steps can be documented. **See: Proposed Metrics**

■ Clinician training and mentoring supports pathway use

- Discussing serious illness, prognosis, and goals of care in a clear, compassionate, and patient-centered way calls for skills that some hospitalists, nurses, and other team members may not yet have acquired through training and mentoring.
- Institutions that care for seriously ill patients and employ hospitalists to manage their care have an obligation to provide these clinicians with training and mentorship opportunities. **See: Training**

■ Hospital operations support pathway use and quality improvement in serious illness care

- Leadership investment in the design or adaptation of medical records systems is a key aspect of hospital operations integral to pathway implementation.

Leadership support for hospitalist staffing levels appropriate to serious illness care will give hospitalists more time for prognosis and goals of care discussions and other typical primary palliative care needs.

Overview of Pathway

Admission: key communication processes

Hospitalized patients often have preferences for life-sustaining treatments and/or end-of-life care that are unknown to hospital clinicians, putting patients at risk for receiving treatment that is not in accord with their preferences. The admission assessment of every patient, whether or not the patient is seriously ill, should aim to procure the information needed to ensure that decisions about a patient's medical care are made appropriately during their hospital stay, and within the context of any previously established preferences.

The admission assessment can be quick for most patients, as the goal is to clarify existing information. Unless a treatment decision must be made imminently, the discussion of prognosis and goals of care can take place later in the patient's hospitalization.

The following processes should be completed for every patient at hospital admission, by the admitting hospitalist or by another clinician (e.g., nurse, social worker) who is collaborating with the admitting hospitalist. **See: Tools**

1. Assess decision-making capacity as part of clinical evaluation

At admission, the responsible physician should evaluate the patient's capacity to understand the patient's current diagnosis, prognosis, treatment options, and treatment recommendations, if any.

If the physician remains uncertain about the patient's capacity to make medical decisions, the physician should conduct a clinical assessment of the patient's decision-making capacity. A hospitalist is qualified to conduct this assessment; some cases, e.g., patients with psychiatric conditions or brain injuries, may require consultation with specialists. A patient is presumed to have decision-making capacity unless an assessment determines that the patient lacks this capacity.

2. Identify the patient's surrogate decision-maker

When a patient has been determined to lack decision-making capacity, the physician should confirm whether this patient has designated a surrogate decision-maker, or has a court-appointed surrogate. A patient may have appointed a surrogate through a durable power of attorney (DPOA) for health care: a surrogate appointed through a DPOA is often referred to as a "health care proxy." Or, a patient may have designated a surrogate in an advance care planning document such as POLST/MOLST.

When a patient has decision-making capacity, clarifying the identity of that patient's surrogate is also important, in the event that this patient loses decision-making capacity during hospitalization.

- The name of the patient's surrogate, and copies of documents that appoint or designate a patient's surrogate, should be placed in the patient's medical record. Physicians and other clinicians should take care not to presume that a patient's family caregiver or contact person is, in fact, the patient's surrogate decision-maker. Clarifying the identity of the surrogate and sharing this information via the medical record and with team members and family members prevents confusion during subsequent discussions.
- Hospitalists, nurses, and other team members involved in prognosis and goals of care communication should know the legal processes of the state in which they practice concerning how surrogate decision-makers can be identified for patients who lack surrogates. For example, some states have laws stating a priority order, e.g., spouse, then adult child, for designating a surrogate for a patient who lacks a surrogate. Some states have laws to allow a patient to verbally designate a surrogate decision-maker at admission for the period of hospitalization. A hospital can provide clinicians, patients, and families with information about relevant state laws through existing services such as social work and clinical ethics, as well as through services focused on advance care planning with hospitalized patients.
- When a patient lacks decision-making capacity and also lacks a ready surrogate, e.g., "patient alone" or "unbefriended" patient, the physician responsible for this patient's care at admission should follow the institution's process for ensuring that a surrogacy arrangement for this patient is put into place so treatment and care decisions can be made should they arise.

3. Review established care preferences

At admission the responsible physician should ask a patient (or surrogate or caregiver, as appropriate) whether the patient has completed any documentation of the patient's preferences for life-sustaining treatments, chronic illness care, and/or end-of-life care. These documents may include a treatment directive (also known as a living will); a Physician Orders for Life-Sustaining Treatment (POLST) or Medical Orders for Life-Sustaining Treatment (MOLST) form, and/or a portable medical order, such as a Do Not Resuscitate (DNR) order, covering out of hospital care.

The physician should also confirm whether any previously documented preferences represent the patient's current care preferences, or if the patient's preferences for future care have changed.

- Asking about all care preferences that are actionable and relevant during a hospitalization is vastly preferable to asking only about preferences for resuscitation (code status). Research indicates that the quality of code status discussions at admission is often low and unlikely to support an informed decision. Also, a patient's preference concerning a discrete intervention such as resuscitation does not determine their other care preferences; for example, a patient with a DNR order may find some forms of ventilation acceptable for symptom relief.

If a patient has not previously documented treatment and care preferences, the admitting physician should ask the patient about any clear preferences; oral statements concerning preferences can be of great value and should be documented in the medical record.

- Patients who have not completed advance care planning should be encouraged to do so and should be referred to a clinician, such a social worker, who can assist them during hospitalization or discharge.

The physician should preserve all information about care preferences, including updates to previously documented preferences, in a dedicated location in the hospital's medical record, so this information is readily viewable by all clinicians involved in a patient's care

Many hospitals do not yet have consistent ways of documenting information relevant to goals of care and care preferences; this is a key area for hospital improvement work. **See: Proposed Metrics**

I During Hospitalization: Key Communication Processes

The processes recommended during hospitalization aim to ensure that all seriously ill patients have the opportunity to ask questions and discuss concerns about their prognosis and treatment, and to make informed decisions about hospital and post-hospital care plans so that the care they receive aligns with their preferences.

Planning and leading prognosis and goals of care discussions has been identified by SHM as a core competency for hospitalists in addition to being a key domain of primary palliative care. It is important for clinical educators and mentors to help hospitalists acquire and practice the skills needed for this aspect of hospital medicine.

Hospital clinicians often question their roles in discussions of prognosis and goals of care and worry that addressing these sensitive topics will offend patients. However, patients facing treatment decisions report that they appreciate the support they receive from hospital clinicians through discussion. Opportunities for discussion are also important informational and psychosocial supports for surrogate decision-makers.

These processes should begin on the first or second hospital day, so that discussions can unfold during a hospitalization, rather than all at once. The exception is for patients who are clinically unstable and facing imminent treatment decisions, such as intubation. In these cases, the following steps should occur at admission. **See: Tools**

1. Screen for serious illness

The goal of this routine formal process is to identify patients early in the course of a serious illness, as both primary and specialty palliative care is more effective when introduced early in the course of an illness. Once these patients are identified, the hospital team can have a significant impact on their care and their family's ability to cope by referring to community palliative care on discharge, in addition to meeting any hospital palliative care needs.

For a serious illness screening process to become routine, hospitalists may need some additional education in prognostication and identifying seriously ill patients, using the tools of routine medical record review and assessments during admission and early in hospitalization. We recommend the following subprocesses for identifying seriously ill patients:

- Identify life-limiting conditions, e.g. advanced cancer, congestive heart failure, chronic obstructive pulmonary disease, end stage renal disease, dementia or other degenerative neurological illnesses. Consider multimorbidity, as the effect of additional illnesses on prognosis is cumulative, especially in older adults.
 - Disease specific prognosis calculators and hospice eligibility guidelines can be helpful in confirming that a patient's condition is life-limiting and therefore constitutes serious illness.
 - Consider functional status and readmissions. Especially in older adults, prognosis is dependent on functional status. (Hospital admission should include an assessment of activities of daily living [ADLs], so this information should be available to the hospitalist.) When a patient has a life-limiting condition, frequent hospital readmissions usually indicate a worsening prognosis.
- Ask yourself the "surprise question": "Would I be surprised by this patient's death in the next 12 months?" Clinicians often overestimate patients' prognosis. Given this tendency toward prognostic optimism, and the inherent uncertainty of prognostication, asking yourself whether you would be surprised by a patient's death within a year, rather than whether you are certain it will occur, is an effective way to identify patients who would benefit from palliative care, including prognosis and goals of care discussions.
 - Consult with outpatient clinicians if uncertainty about a patient's prognosis persists.

Patients identified as having a serious illness should next be screened for palliative care needs. This pathway focuses on one need: for prognosis and goals of care communication. Screening for other key palliative care needs, including pain and symptom management, and psychosocial support of patients and families, should also be performed for seriously ill patients.

2. Screen for prognosis & goals of care communication needs

Each time a patient with serious illness is hospitalized, there is an opportunity to identify unaddressed prognosis and goals of care communication needs. Not every seriously ill patient will need to discuss these issues every time they are hospitalized.

A seriously ill patient does have a need to discuss prognosis and goals of care if there are differences in understanding between the patient (or their surrogate, if the patient lacks decision-making capacity) and the patients' clinicians. We recommend the three-step process to identify which patients have prognosis and goals of care communication needs calling for further discussion:

Step 1: Perform your own assessment of the patient's prognosis and treatment options. Confer with primary care providers, inpatient and outpatient specialists such as oncologists or cardiologists, and other disciplines, such as bedside nurses, to supplement your assessment.

- Hospitalists and other clinicians may have different assessments of a patient's prognosis. For example, a hospitalist sees a patient for the first time when the patient is acutely ill. This patient's other physicians may be more aware of how this patient copes with serious illness most of the time. Hospitalists should share their concerns related to prognosis and treatment with other team members, with the aim of reaching consensus among the care team about the patient's prognosis.
- Even if consensus cannot be reached, it is important to clarify the perspectives of different care team members, to facilitate communication about prognosis if needed.
- The hospitalist responsible for this patient's care right now has a direct obligation to the patient to ensure that this patient does not receive treatments that are not aligned with the patient's preferences relative to prognosis.

Step 2: Elicit the patient's (or surrogate's, as appropriate) understanding of their prognosis and what they hope their treatment will accomplish. Ask the patient, and also family members involved in the patient's care, what questions they have about what to expect from the patient's illness.

- Patients who have serious illness, and families of these patients, often have misunderstandings about prognosis and also about what a treatment can and cannot accomplish.
- When asked, patients often voice concerns about the future.

Step 3: Consider whether the patient's (or surrogate's) understanding of prognosis and treatment goals is similar to or significantly different from the understanding of clinicians involved in this patient's care.

- If the patient's (or surrogate's) understanding of the prognosis and treatment goals are similar to those of the hospitalist and other clinicians, and the patient's care preferences are reflected in their hospital care, *your record of the brief screening discussions you have just conducted is likely to be sufficient to clarify goals of care during this hospitalization and to inform communication with outpatient clinicians and referrals to community palliative care at discharge.*

If the patient's (or surrogate's) understanding of the prognosis and treatment goals *significantly differ* from those of the hospitalist and other clinicians, a *fuller discussion is warranted* to ensure that hospital care reflects patient preferences relative to prognosis, and also to support informed decision-making should treatment decisions arise during hospitalization. **See "Fuller Discussion" Process**

Fuller Discussion of Prognosis & Goals of Care: Process for the Medical Ward

Hospital discussions of prognosis and goals of care for seriously ill patients whose understanding of prognosis and treatment goals *significantly differ* from those of the hospitalist and other clinicians resemble family conferences in the Intensive Care Unit (ICU), with a few differences:

- On the medical ward discussions are likely to involve the patient rather than a surrogate decision-maker for a critically ill patient who is unable to participate, though many patients will also want to involve their families in these discussions.
- These discussions may take place at a patient's bedside, rather than in a conference room or other space.

Holding discussions about prognosis and goals of care over successive days when possible gives patients and families more time to digest information and consider options, reducing their distress. Because the membership of the care team is likely to change from day to day, using handoff processes and the medical record to brief incoming team members about any ongoing discussions is crucially important.

Including a patient's primary care provider or specialist in a discussion of prognosis and goals of care is recommended when this clinician has a strong relationship with the patient and/or can provide key information about prognosis and treatment.

Including bedside nurses whenever possible, is highly recommended, as is including other disciplines, e.g., social work, spiritual care, case management, capable of supporting communication. Patients and families often look to these team members for psycho-social support during and after discussions with physicians, and to clarify facts after a discussion. At minimum, the hospitalist should update the bedside nurse and other involved clinicians following a discussion.

After the hospitalist determines which other members of the care team will be involved in a discussion, the basic steps in this discussion are as follows:

- Identify the patient's (or surrogate's) questions and concerns, including the patient's sense of how things had been going leading up to the hospitalization, and the patient's concerns or worries about what to expect in the future.

Discuss prognosis.

- Begin by asking the patient (or surrogate) what they have been told about prognosis by other clinicians, and asking what additional information they would find helpful.
 - If there are gaps in the patient's information or understanding concerning prognosis, ask permission to share your assessment or the assessment of other clinicians, e.g., the patient's oncologist. It is helpful to conceive of prognosis not only as how long the patient may live, but also what the time they have remaining may look like, e.g., how their functional status may change.
 - Ask patient and families what questions they have about what to expect in the future, given the patient's illness, and to offer information about functional status as well as mortality.
 - Ask the patient to summarize what they have understood, to make sure you were clear.
 - As described above, the hospitalist's assessment of the patient's prognosis may differ from other members of the care team, even after discussion among the team. Patients may want to hear the hospitalist's own assessment of prognosis. If the hospitalist's assessment differs from that of others, the hospitalist should be prepared to explain why, e.g., the patient's condition has progressed.
- Once the prognosis has been established, explore the patient's and family's hopes, values, and preferences in the context of this prognosis. This creates a framework for considering potential decisions about treatment and care.
 - Discuss specific treatment and care options, and assist the patient (or surrogate) in selecting plan that aligns with their hopes, values, and preferences in the context of the patient's prognosis.
 - It is always appropriate for the hospitalist to identify which treatment options (including the option to forgo an intervention) appear to best aligned with the hospitalist's understanding of the patient's hopes, values, preferences. Similarly, it is always appropriate for the hospitalist to express concern about choices that do not seem to match what the patient wants.
 - Some patients may welcome a clinician's recommendations about whether to try or forgo an intervention, while others may not.

On occasion, a prognosis and goals of care discussion must address complex issues. For example, a clinician may be concerned that a patient's voice and preferences are not being heard due to factors such as fluctuating capacity, family dynamics, cultural norms, or difficulty in communication. In such cases, a hospitalist may need to collaborate with a hospital's specialist palliative care consultation service and/or clinical ethics consultation service.

■ Discharge Planning: Key Communication Processes

Discharge planning processes for seriously ill patients should ensure a patient's care preferences, including any ongoing need for discussion of prognosis and goals of care, are documented and communicated to outpatient clinicians. Because seriously ill patients can be presumed to have ongoing palliative care needs that should be addressed in their post-hospital care, hospitalists and hospital leaders should also seek to maximize community services available to seriously ill people.

Discharge planning processes involving hospitalists, nurses, social workers, and other team members should:

- Alert outpatient clinicians to any changes in a patient's care preferences that reflect prognosis and goals of care discussion(s) during hospitalization and/or changes to care preferences documented at admission.
 - Letting outpatient clinicians know that a prognosis and goals of care discussion has taken place during hospitalization is important. Research shows that primary care providers may be unsure how to initiate this discussion.
 - Whether or not outpatient clinicians were involved in discussions that took place during a patient's hospitalization, it is important to clarify and document that these preferences should continue to shape care going forward unless the patient's preferences change, or the deterioration of the patient's condition requires that goals of care be reviewed.
 - In addition to documenting care preferences in a dedicated section of the discharge summary, hospitalists should use medical record notes, email, and/or telephone calls to alert outpatient clinicians to key changes in patient preferences that will affect care going forward.
- Review and update advance directives and POLST/MOLST forms or other portable medical orders to ensure that these reflect a patient's current preferences.
 - The completion of POLST/MOLST at discharge (in states where this form is authorized) is recommended as a consolidating document for all patients with explicit preferences concerning resuscitation, intubation, and/or ventilation, e.g., DNR, DNI, to help ensure that their care preferences are known and respected across care settings and by first responders.
- Discuss local options for hospice care with patients who prefer comfort-focused care at hospital discharge. Hospice is the most widely available and effective form of comfort-focused care available to patients and families, and also prevents unwanted re-hospitalizations. Coverage for hospice services is nearly universally available to eligible patients through the Medicare hospice benefit as well as private insurance.
 - It is highly recommended that hospitalists become familiar with local hospice programs and that hospital social workers and case managers who collaborate with hospitalists in discharge planning maintain detailed information about these programs and the services they provide to patients at home and in other settings.
 - Referring interested patients and families at discharge to a local hospice program for more information about hospice is also recommended.
- Discuss local options for community palliative care.
 - Community palliative care is growing nationally in response to recognition that appropriate care for seriously ill patients is grounded in continuity of palliative care, on its own or concurrent with disease-specific interventions.
 - Hospitalists and their teams are integral in ensuring that patients who have serious illness are referred to available programs at discharge.

It is highly recommended that hospitalists become familiar with local community palliative care options available through hospital outpatient clinics, home care agencies, and/or hospice programs.

Pathway Implementation Framework and Strategies

The clinical practice changes described in and supported by this pathway call for educational steps by hospitalist mentors and clinician educators and structural steps by hospital leaders and administrators. The involvement of the Chief of the Hospitalist Service is crucial to successful implementation, as this position provides needed interface between hospitalists and other services and systems within an institution. Hospitalists who are board-certified in palliative medicine should play a role in pathway implementation and support the development of primary palliative care in their institutions, as this is consistent with recommendations from both of their medical specialties.

Educational steps for hospitalist mentors and clinician educators

SHM recommends that clinical mentors and educators, including hospitalists who are also palliative medicine specialists, take the following steps in their own institutions to help hospitalists in practice learn about primary palliative care, acquire needed skills, and integrate this pathway into normal workflow:

- Use grand rounds and other educational opportunities to introduce hospitalists, nurses, other team members, and palliative care specialists to primary palliative care principles and to this pathway as a practical application of these principles, with attention to how to use the pathway effectively given time constraints and in relation to other tasks.
 - In institutions where some hospitalists are already leading discussions about prognosis and goals of care, use case studies to demonstrate how patients and families benefit from hospitalist-led discussions and to engage clinicians who are not yet involved in these discussions.
 - Help hospitalists to prioritize prognosis and goals of care communication as crucial tasks in the care of seriously ill patients. Case-based example can demonstrate how initiating interventions prior to communication may result in low-value care that is inconsistent with a seriously ill patient's preferences, and how communication to clarify preferences may prevent harms that could result from lack of information.
 - Consider how an institution's practice of reporting cases for QI or peer review may provide an opportunity for identifying cases in which lack of communication in the care of a seriously ill patient led to delays in responding to suffering, to poorly informed decision-making, or to other preventable problems.
- Encourage hospitalists, nurses, and other team members to share their questions and concerns about care pathway implementation with clinical mentors and educators. Key areas of concern may include time management; comfort with discussing prognosis and goals of care; documenting and sharing information; resolving disagreements; and ensuring continuity of primary palliative care post-discharge. Identify opportunities for improvement projects that allow hospitalists and teams to adapt the care pathway to their local setting.
 - Use the pathway diagram Figure 1 as a discussion aid to help clinicians pinpoint their concerns, and also where barriers to pathway implementation could occur in their institution. Strategize about how to reduce those barriers through skills training, operational improvements, or both.
- Describe the skills that hospitalists should acquire and practice to support pathway use. Dedicate time to skills training for hospitalists, nurses, and teams. Share information about training opportunities available through SHM and other professional organizations.
 - In institutions with access to a simulation center, consider developing or adapting simulation training to help hospitalists practice skills for discussing prognosis and goals of care with patients, families, and clinical colleagues.
 - Use cases that hospitalists and colleagues will readily recognize as frequently arising in their setting so that time spent on improving communication skills is clearly relevant to practice.

See: Tools; Training

Operational steps for hospital leaders and administrators

SHM recommends that hospital leaders and administrators take the following operational steps in their own institutions and communities to support hospital improvement work on prognosis and goals of care communication in hospital medicine:

- Structurally support the documentation of goals of care information in a dedicated location through technological adaptation of the electronic medical record systems using model templates, and through clinician training, so that clinicians do not have to rely on admit or progress notes or informal communication to convey this crucial information.
- Ensure that institutional policy covering handoffs and care transitions provides practical guidance on hospitalist-to-hospitalist and hospitalist-to-community-provider handoffs of goals of care information.
- Invest in training opportunities for hospitalists to develop primary palliative care knowledge and skills and for clinical mentors and educators to develop primary palliative care improvement projects in collaboration with colleagues, in nursing, clinical social work, specialty palliative care, and other disciplines.
- Support the development of community palliative care in the area served by a hospital, to ensure post-hospitalization continuity of care for seriously ill patients and to strengthen local care systems for this population.
- Ensure that hospitalists and their teams have adequate time for prognosis and goals of care discussions with their patient population so that the aims of primary palliative care, distilled in this pathway, are attainable.
 - Expecting hospitalists to care for a very high census of patients should be recognized as a structural barrier to primary palliative care access for seriously ill patients, because a hospitalist in this situation will not be able to fit even brief discussions into their clinical workload despite patient need.

Based on prior studies of specialty palliative care, it is likely that investment by institutions in ensuring that hospitalists have sufficient time for prognosis and goals of care discussions will have a favorable return on investment, due to lower length of hospital and ICU stays, reduced readmissions, lower costs to insurers, and improved net margin for hospitals.

Proposed Metrics for Hospital Improvement Work on Prognosis And Goals Of Care Communication

Process measures

Each step in the prognosis and goals of care communication pathway was designed as a process that should be documented in a patient's medical record. Therefore, a program to improve prognosis and goals of care communication in a service, unit, and/or hospital can draw on these data as process measures.

Many hospitals do not yet have adequate systems to document goals of care preferences, screening information, and discussions. Improvement projects to develop these documentation systems and/or adapt existing systems to accommodate information to guide care for seriously ill patients are therefore a priority.

Figure 2 describes process measures associated with each step in the pathway, including how to operationalize them and where to document them in a medical record.

Figure 2:

Pathway process measures, with examples of medical record sources

Construct	Positive	Negative	Denominator	Time Point	Example Sources
Presence of serious illness	Patient screens positive for serious illness	Patient does not screen positive for serious illness	All patients admitted to the medical service	Within 24 hours of admission	<ul style="list-style-type: none"> ▶ Provider admission note ▶ Nursing admission assessment
Patient/surrogate understanding of prognosis & care plan	Patient/surrogate understanding differs from that of hospitalist or care team	Patient/surrogate understanding aligns with care team	All patients with serious illness	Within 24 hours of admission	<ul style="list-style-type: none"> ▶ Provider progress notes ▶ Nursing notes
Goals of care discussion	Documentation of prognosis and goals of care discussion between patient/surrogate and provider	No documentation of prognosis and goals of care discussion between patient/surrogate and provider	Patients for whom patient/surrogate understanding of prognosis goals of care differs from care team	Within first 3 hospital days	<ul style="list-style-type: none"> ▶ Provider progress notes ▶ Advance care planning note ▶ Patient care conference note ▶ Discharge summary
Communication of patient care preferences to outpatient clinicians	Documented communication (email, e-chart, phone) to outpatient provider about patient care preferences ^a	No documentation of communication to outpatient provider about patient care preferences	All patients with serious illness	Any point in hospitalization	<ul style="list-style-type: none"> ▶ Provider progress note ▶ Discharge summary
Community-based palliative care referral ^b	Documentation of referral to community-based palliative care	No documentation referral to community-based palliative care	All patients with serious illness	Any point in hospitalization	<ul style="list-style-type: none"> ▶ Provider progress notes ▶ Case management note ▶ Social work note
Hospice referral	Documentation of referral to hospice (at any care location) was completed	No documentation that referral to hospice was completed	Seriously ill patients whose documented care preference is comfort-care	Any point in hospitalization	<ul style="list-style-type: none"> ▶ Provider progress notes ▶ Case management note ▶ Social work note ▶ Discharge summary

^a Full treatment/selective treatment/comfort-focused treatment; per POLST, <http://www.polst.org/>

^b For regions where community palliative care is available. Hospital identify services to which they track referrals, based on local resources.

Outcome measures

A hospital-based improvement project focused on prognosis and goals of care communication through implementation of this care pathway could focus on a number of outcome measures relevant to the overall goal of ensuring that all seriously ill hospitalized patients have the opportunity to receive their desired level of information about prognosis and that the medical care they receive is in accord with their goals, values, and preferences.

Based on previous work studying the impact of palliative care, implementation of a primary palliative care pathway for prognosis and goals of care communication would be expected to result in: improved alignment between care received and patient preferences; improved quality of dying for patients; improved psychological outcomes for families; an increased percentage of patients receiving comfort-focused care at the end of life and increased enrollment in hospice care; decreased re-admissions to hospitals, and decreased health care costs.

Future research to be conducted jointly by SHM and The Hastings Center will study pathway implementation to create recommendations for pathway adaptation to local settings and to refine these initial metrics to support wider use.

Resources

Hastings Center Guidelines tools for prognosis and goals of care communication

The following tools have been adapted with permission from Berlinger, N., Jennings, B., & Wolf, S.M., *The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life: Revised and Expanded Second Edition* (Oxford University Press, 2013):

Clinical resources for hospitalists

Below is an annotated list of resources about palliative care that were recommended by practicing hospitalists and palliative care clinicians and SHM members.

VitalTalk

<http://vitaltalk.org/>

VitalTalk is a nonprofit with the mission of nurturing healthier connections between patients and clinicians. VitalTalk specializes in developing and facilitating advanced communication skills courses and faculty training courses focused on balancing honesty with empathy when discussing serious illness and end of life care. Resources include:

- [website with videos demonstrating communication techniques and downloadable conversation guides](#)
- [a mobile phone App](#)
- [on-line courses](#)
- [in person individual and train the trainer courses](#)

CAPC (Center to Advance Palliative Care)

<https://www.capc.org/>

A national, member-based organization that provides hospitals, health systems, hospices, payers and other health care organizations with the tools, training, technical assistance and metrics needed to support the successful implementation and integration of palliative care.

Resources include:

- [Support for institutions in palliative care program development and quality](#)
- [On-line modules for individual training on a range of palliative care topics, available to all clinicians working at institutions with CAPC membership \(check hospital membership status here: <https://www.capc.org/accounts/register/>\)](#)
- [CAPC developed the <https://getpalliativecare.org/> website for patients and their families. It is a great resource to refer patients and families to so they can learn more about palliative care. Sections are available on what palliative care is, and well as Videos, Podcasts, and Livechats.](#)

ePrognosis

<http://eprognosis.ucsf.edu/>

A website that can be used to estimate prognosis for older adults using calculators based on published geriatric prognostic indices. Also includes links to disease-specific prognostic calculators: <http://eprognosis.ucsf.edu/links.php>

Palliative Care Fast Facts and Concepts

<http://www.mypcnow.org/fast-facts>

Fast Facts provide concise, practical, peer-reviewed and evidence-based summaries on key palliative care topics important to clinicians and trainees caring for patients facing serious illness. Brief, evidence-based and peer-reviewed summaries on a range of palliative care topics, designed to provide rapid answers to clinical questions. Available as a mobile App at: <https://itunes.apple.com/us/app/palliative-care-fast-facts/id868472172?mt=8>

Serious Illness Care Program

<https://www.ariadnelabs.org/areas-of-work/serious-illness-care/>

A program designed to support institutions in promoting serious illness communication. Including identifying patients who benefit from communication, training and conversation guides for clinicians to engage in discussions, and documentation guidance. The program provides an on-line community of practice, for those interested in adapting and implementing the Serious Illness Care Program at their home institutions.

Harvard Medical School Center for Palliative Care

<https://www.hms.harvard.edu/pallcare/index.htm>

Offers in-person courses in palliative care, including specific offerings for hospital clinicians.

■ Palliative Care for Hospitalists and Intensivists (PCFHI)

<https://www.hms.harvard.edu/pallcare/PCFHI/PCFHI.htm>

Intensive 2-1/2 -day in-person course for hospital-based specialists. Includes training in challenging communications, ethical, pain and symptom management issues in the hospital. Utilizes interactive learning formats, such as communication exercises, small-group breakout sessions, and role modeling.

Blogs

Pallimed

www.pallimed.org/

Pallimed is a website by clinicians dedicated to hospice and palliative care research, news and opinion. It was founded to track and discuss findings from journal articles relevant to palliative care for interdisciplinary health care professionals in hospice and palliative care. The scope of the blog has expanded to include reviewing media coverage of hospice and palliative care issues.

GeriPal

<http://www.geripal.org/>

GeriPal (Geriatrics and Palliative care) is a blog focused on geriatrics, hospice, and palliative medicine. It is a forum for discourse, recent news and research, and freethinking commentary. Resources include blogs about recent research, as well as PodCasts and videos.

Books

Pantilat S, Anderson W, Gonzales M, and Widera E (eds): *Hospital-Based Palliative Medicine: A Practical Evidence-Based Approach*. Hoboken, New Jersey: John Wiles & Sons, Inc., 2015.

Back, Arnold, Tulsky. *Mastering Communication with Seriously Ill Patients: Balancing Honesty with Empathy and Hope*. Cambridge: Cambridge University Press, 2009.

Pediatric palliative care resources

For clinicians who care for children, we recommend the following resources that specifically address palliative care for children and their families:

- American Academy of Pediatrics Section on Hospice and Palliative Medicine. Includes information about palliative care for children aimed at both professionals as well as families, including policies, resources, curricula, and newsletters: <http://www2.aap.org/sections/palliative/default.html>
- Children's Project on Palliative/Hospice Services: ChiPPS. ChiPPS serves as The National Hospice and Palliative Care Organization's (NHPCO) pediatric advisory council. Their website includes information about palliative care and hospice for children, as well as professional resources and education, and information for families: <http://www.nhpc.org/pediatric>
- Wolfe, Hinds, Sourkes et al. *Textbook of Interdisciplinary Pediatric Palliative Care Elsevier Health Sciences* 2011
- Himmelstein B, Hilden, J et al. "Pediatric Palliative Care", *N Engl J Med* 2004; 350:1752-1762 April 22, 2004

Advance care planning resources

Prepare for Your Care

<https://www.prepareforyourcare.org/>

Prepare for Your Care is a website and tool for patients and families that provides step by step guidance through the process of advance care planning. This free resource is available in English and Spanish.

Aging With Dignity & Five Wishes

<https://www.agingwithdignity.org/>

Five Wishes is a living will that is written in everyday language and helps start and structure important conversations about care in times of serious illness. Five Wishes meets the legal requirements for an advance directive in 42 U.S. states and the

Self-care

In our task forces' survey of SHM members, hospitalists expressed low confidence to use of self-care techniques. We know this is an area in need of further exploration, and welcome your comments about how to address it. Here are some initial resources we recommend.

- Calm App: <https://itunes.apple.com/us/app/calm-meditation-techniques/id571800810?mt=8>
- Kearney MK, Weinger RB, Vachon ML, Harrison RL, Mount BM. Self-care of physicians caring for patients at the end of life: "Being connected... a key to my survival". *JAMA*. 2009 Mar 18;301(11):1155-64, E1. doi: 10.1001/JAMA.2009.352. PubMed PMID: 19293416
- Back AL, Steinhauser KE, Kamal AH, Jackson VA. Building Resilience for Palliative Care Clinicians: An Approach to Burnout Prevention Based on Individual Skills and Workplace Factors. *J Pain Symptom Manage*. 2016 Aug;52(2):284-91. doi: 10.1016/j.jpainsymman.2016.02.002. PubMed PMID: 26921494

Tools supporting key processes at admission and during hospitalization

Guidelines for the Decision-Making Process

- Evaluating the Patient
- Determining Decision-Making Capacity
- Identifying the Key Decision-Maker
- Surrogate Decision-Making Process and Standards
- Making the Decision at Hand
- Documenting the Decision
- Implementing the Decision
- Changing Treatment Decisions
- Conflicts and Challenges Related to Treatment Decision-Making

[Step-by-Step Guide to Prognosis and Goals of Care Discussion \(Family Conference\)](#)

[Discussing Routine Medications and Interventions](#)

[Supporting the Decision-Maker When Loved Ones Disagree](#)

[Hope as a Factor in Prognosis and Goals of Care Communication](#)

[Ambivalence, Denial, and Grief as Factors in Prognosis and Goals of Care Communication](#)

[Guidelines on Hand-Offs between Professionals and Transfers between Units](#)

Tools supporting key processes during discharge

[Guidelines on Continuity](#)

[Guidelines on Discharge and Transfer](#)

[Guidelines on Policy for Transitions](#)

Tools supporting educational and operational steps for pathway implementation

[Summary of Legal and Ethical Consensus](#)

[Educational Competencies for Prognosis and Goals of Care Communication](#)

[Ethical Importance of Hospital Policy](#)

[Guidelines on Palliative Care Services](#)

[Guidelines on Organizational Systems](#)

Palliative care training opportunities for hospitalists

A number of resources are now available for clinicians to gain additional training in palliative care. Below is a list of these programs, sorted by type, including continuing education programs and graduate certificate programs.

Information is also provided about certification in hospice and palliative care. Note that to be eligible for board certification in hospice and palliative medicine, physicians must complete a 1-year clinical fellowship program and pass the certification exam. Advanced practice nurses are eligible for certification after completing a required number of practice experience hours and passing a certification exam (details below).

About the SHM Palliative Care Task Force

The Palliative Care Special Interest forum and survey were part of an ongoing effort within SHM to better understand the key roles hospitalists' can play as providers of palliative care, and to find ways to support hospitalists in providing the highest quality of care to their seriously ill patients. We are pleased to announce that the SHM Board has approved a Palliative Care Task Force for another 3-years, to work on these efforts. Our main focuses are on identifying and disseminating palliative care educational resources, offering this education at annual meetings, developing programs such as mentored implementation to support hospitalists and their hospitalists in providing palliative care, and partnering with national palliative care organizations to create additional resources.

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We'd love to hear from you!

Please contact the SHM Palliative Care Task Force (nmarzano@HospitalMedicine.org) to provide feedback on these resources, to suggest others you like, or to let us know about the needs you and your colleagues have for palliative care training and support.

Acknowledgments



This care pathway is the product of a two-year collaboration between the Society of Hospital Medicine (SHM) and The Hastings Center to translate the 2013 edition of The Hastings Center's landmark Guidelines for health care professionals outside of specialty palliative care or hospice who were likely to be responsible for the care of seriously ill or dying patients. This effort aimed to identify opportunities and challenges for hospitalists to improve palliative care in hospitals, and to focus improvement on a key palliative care process: prognosis and goals of care communication.

Nancy Berlinger PhD and Howard Epstein MD served as co-principal investigators of this project. Wendy Anderson, MD, MS and Barbara Egan MD served as co-chairs of an SHM Expert Panel convened to inform the development of this pathway. Jenna Goldstein MA, Director of the SHM Center for Hospital Innovation and Improvement, served as project director. Elizabeth Dietz BA of The Hastings Center provided research and project management assistance to the authors. The authors give special thanks to Mildred Z. Solomon EdD, President and CEO of The Hastings Center and to Connie Barden RN MSN, Chief Clinical Officer of the American Association of Critical-Care Nurses (AACN) for their leadership support of this project, and to all participants in the national stakeholder meeting convened by this project in July 2015.

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