

MAINE STATE LEGISLATURE

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Prevalence of Palliative Care in Maine

Brief Study by Hospice Analytics for

The Maine Hospice Council

v. 11/4/16

SUMMARY

In 2016, the Maine Hospice Council contracted with Hospice Analytics, Inc. to complete a phone survey of all Maine hospitals and hospices regarding the provision of palliative care programs. Twenty-six (26) hospices and thirty-four (34) hospitals across the state of Maine were contacted. Seventeen (17/60, 28%) of those 60 providers reported having a palliative care program currently. Additionally, one respondent was contacted who represented the multitude of Federally Qualified Health Centers (FQHC) throughout Maine. FQHCs are clinics which provide primary health care and qualified preventive health services to the underserved. This respondent reported that none of the FQHCs in Maine have a palliative care program. Key findings from the phone surveys of the hospitals and hospices are presented below.

KEY FINDINGS

Hospital-Based Palliative Care Programs

1. Thirty-four (34) hospitals across the state of Maine were contacted. Ten (10/34) or 29% reported having a palliative care program.
2. The total number of patients in Maine receiving hospital-based palliative care services in 2015 was 4,554, with a mean of 455 and a range of 20-1,483.
3. Eighty percent (8/10, 80%) of hospitals bill for palliative services.
4. One hundred percent (10/10, 100%) of hospital-based palliative care programs utilize at least 1 physician. Seventy percent (7/10, 70%) utilize at least one Nurse Practitioner.
5. One hundred percent (10/10, 100%) of hospital-based palliative care programs utilize the skills of a Social Worker.

Hospice-Based Palliative Care Programs

6. Twenty-six (26) hospices across the state of Maine were contacted. Seven (7/26) or 26% reported having a palliative care program.
7. The total number of patients in Maine receiving hospice-based palliative care services in 2015 was 410, with a mean of 58.5, and a range of 0-150. (One program started in 2016 and had no patients in 2015).
8. Fifty-seven percent (4/7, 57%) of hospices bill for palliative services and do so utilizing Home Health billing mechanisms. Their palliative care programs are managed within their Home Health program, not their hospice program.
9. Seventy-one percent (5/7, 71%) of hospice-based palliative care programs utilize at least 1 physician. Forty-two percent (3/7, 42%) utilize at least one Nurse Practitioner.
10. One hundred percent (7/7, 100%) of hospice-based palliative care programs utilize the skills of a Social Worker.

Table 1: Key Comparisons of Hospital and Hospice-Based Palliative Care Programs in Maine

KEY COMPARISONS	HOSPITAL-BASED	HOSPICE-BASED
# of palliative care programs currently	10/34, 29%	7/26, 26%
Total # of patients that received palliative services in 2015	4,554	410
# of programs that bill for palliative care	8/10, 80%	4/7, 57%
# of programs that utilize at least 1 physician	10/10, 100%	5/7, 71%
# of programs that utilize at least 1 Nurse Practitioner	7/10, 70%	3/7, 42%
# of programs that utilize at least 1 Social Worker	10/10, 100%	7/7, 100%

BACKGROUND

In 2015, the Maine legislature passed a bill statutorily creating the Palliative Care and Quality of Life Advisory Council, PL 2016, chapter 203. The legislature appointed members to the council and The Maine Hospice Council was named the “convening authority.” The Maine Hospice Council received a grant from the Maine Health Access Foundation to collect baseline data about palliative care in the state of Maine. The data will be used to identify gaps, create a workplan, and initiate policy recommendations to the legislature regarding provision of palliative care services throughout the state. The Maine Hospice Council contracted with Hospice Analytics, Inc., a Colorado-based research and consulting company, to design and administer phone surveys about palliative care with all the hospitals and hospices in Maine.

METHODS

From August through October of 2016, Cathy Wagner, RN, MSN, MBA, CHPN, a Special Projects Researcher for Hospice Analytics, contacted all Maine hospitals and hospices to conduct an extensive palliative care phone survey (Appendix 1). The vast majority of responses were collected via live telephone conversation. A few respondents preferred completing the survey via email. The majority of respondents stated that they were responding with estimates as they did not have the data available to look at or the data was not collected in their organization. The Maine Hospice Council provided the following definition of palliative care which was used for this project.

Palliative Care means interdisciplinary, evidence-based, person-centered, family-focused medical care that optimizes quality of life by anticipating, preventing and treating suffering caused by a serious illness. This extra layer of support includes, but is not limited to, addressing physical, emotional, cultural, intellectual, and spiritual needs; facilitating and empowering individual autonomy and choice of care; honoring an individual’s wishes; providing access to information; discussing the individual’s goals of treatment and treatment options, including, when appropriate, Hospice Care; and managing pain and symptoms comprehensively. This care is provided and supported across the entire age spectrum.

RESULTS

Thirty-four (34) hospitals and 26 hospices in Maine were contacted and completed the palliative care phone survey. Telephone surveys took 5-10 minutes on average for organizations where the respondent reported NOT having a palliative care program. For those who reported that they DO HAVE a palliative care program, the phone survey took 30 minutes on average to complete. The most challenging aspect of this project was identifying and setting an appointment with the correct person to complete the survey, which often took longer than survey administration.

HOSPITAL-BASED PALLIATIVE CARE PROGRAMS

Hospital-based Palliative Care Programs

Thirty-four (34) hospitals across the state of Maine participated in the survey, including one “prison hospice” and one Veterans Administration Hospital. Five additional hospitals were contacted multiple times but did not respond to the invitation to participate in the survey. Psychiatric and strictly Rehabilitation hospitals were excluded from this project. Based on phone or email surveys, ten (10/34) or 29% reported having a palliative care program.

Table 2: Hospital-based Palliative Care Programs

Number of hospitals surveyed	34
Number (%) of hospitals providing palliative care services	10 (29%)
Number of patients receiving palliative care services in 2015:	
Sum	4,554
Mean	455
Range	20-1,483

Table 3: Hospital-based Palliative Care Team Composition

Discipline	Dedicated, Non-dedicated, Volunteer and Contractual Staff
Physician, Intern, Resident, and/or Fellow	10/10, 100 %
Advanced Practice Nurse / Nurse Practitioner	7/10, 70%
Registered Nurse	3/10, 30%
Social Worker	10/10, 100%
Chaplain	9/10, 90%
Pharmacist	2/10, 20%
Psychologist	1/10, 10%
Volunteers (in a non-professional role)	0
Certified Nurse Assistant	1/10, 10%
Office Manager / Administrative Assistant	1/10, 10%
Dietician	1/10, 10%
Physician Assistant	1/10 10%

Hospital-based Palliative Care Program descriptions

- **Established:** The first hospital-based palliative care program In Maine was established in 2001. The most recent was established in 2015.
- **Branding:** Three (3/10, 30%) of the hospital-based palliative care programs had a unique brand name for their program, a name different from, for example, “Maine Hospital Palliative Care Program”. The majority simply referred to their program as, “The Palliative Care Program” or something similar.
- **Certification:** Seven (7/10, 70%) of hospital-based palliative care programs have at least one physician who is certified in Hospice and Palliative Medicine. Four (4/10, 40%) have at least one certified Nurse Practitioner and two (2/10, 20%) have at least one Registered Nurse certified in Hospice and Palliative Care. Additionally, one program has a certified Social Worker.
- **Operating hours:** Four (4/10, 40%) programs offer palliative care services 24/7/365.

- **Services:** All palliative care teams reported providing predominantly symptom management and discussions around goals of care. Other respondents added that their programs also provide: advance care planning, POLST discussions, family meetings, discussions about the ethical considerations of treatment options, emotional and spiritual support, care coordination and research.
- **POLST:** POLST (Physician Orders for Life Sustaining Treatment) is being used in 100% of the palliative care programs, often initiated by the palliative care team. Two respondents stated that POLST would be more effective if a central database/repository existed.
- **Diagnoses:** The most commonly treated illnesses encountered by the palliative care team are cancer, cardiac and respiratory diseases. Less frequently encountered illnesses are neurodegenerative disorders, renal and/or liver disorders, and dementia. One program also serves patients with complex prenatal, neonatal and pediatric disease(s).
- **Location:** The most common location for palliative care services among hospital-based programs is the in-patient hospital setting (10/10, 100% of programs). Nine (9/10, 90%) programs also provide services in out-patient clinics. Four (4/10, 40%) programs additionally provide palliative care in nursing homes, residential homes and in assisted living facilities.
- **Management:** Six (6/10, 60%) of the hospital-based palliative care teams have a dyad management structure, where one manager is a clinician, usually a physician, and the other manager coordinates the programmatic aspects. The majority of these managers report to a Chief Medical Officer or similar in the hospital.

Referrals

- The large majority of respondents reported that their main source of referrals for the palliative care program are the hospitalists and intensivists. Others referral sources include oncology, ER, cardiology, and varied nurses. Out-patient referrals generally come from the community Primary Care Providers.
- Fifty percent (5/10, 50%) of programs utilize automatic triggers which serve to initiate a palliative care consult. Those triggers include: terminal ventilator wean, palliative sedation, stage IV cancer diagnosis, ICU stay greater than 7 days, very complex cases, and multiple hospitalizations. Additionally, three (3/10, 30%) respondents stated that they use an affirmative answer to the “Surprise Question” (“Would you be surprised if this patient died within the next year?”) as an automatic trigger for a palliative care consult.

Financial Aspects and Billing

- All ten hospital-based programs (10/10, 100%) reported that their palliative care programs have some level of administrative and financial support. Many respondents stated that they need more clerical support. Several also stated that they need more money in order to expand programs and serve more patients.
- Eight (8/10, 80%) of the hospitals bill for palliative services. Respondents reported that they bill for palliative care services in a variety of ways: by physician, v codes, time, E/M (evaluation and management) codes, ICD-9/10, symptom codes, diagnosis codes, and fee for service. One program respondent stated that they do not bill as they contract with a local hospice for a Nurse Practitioner, therefore the hospice bills for palliative services. One respondent was uncertain if or how they bill for palliative services.
- Five (5/10, 50%) hospitals use V66.7 (encounter for palliative care) codes in their palliative care programs. Three respondents were uncertain about the use of v codes. Several respondents noted that v codes are no longer used now that they are incorporated into ICD-10.

- When asked what percentage of program expenses are paid for by direct billing, seven (7/10, 70%) of hospital respondents were uncertain. Other estimates included 40%, 70%, and 90%.
- Two (2/10, 20%) of the programs collect and track statistics about how their palliative care program saves the hospital money or avoids costs. One program estimated the savings at \$1,000,000 in 2015. The other program estimated a savings to the hospital in 2015 of \$1,600,000 or an estimated 75% reduction in the costs of labs, imaging, and pharmacy mainly.

Outcome Measures

- All ten (100%) hospital-based palliative care programs collect statistics and outcome measures. Those measures include: symptom scores, length of stay, length of stay pre-and-post consult, patient satisfaction, costs, completion of advance directives and POLST, time to referral and to consult, referral source, location of care, patient disposition, number of consults, reason for referral, type of intervention, satisfaction survey from hospitalists, and hospital readmissions.
- Seven (7/10, 70%) programs engage in an annual review of their palliative care program.
- Seven (7/10, 70%) programs conduct quality projects for their palliative care program.
- Respondents estimated that as few as 10% of patients do NOT have an advance directive before the palliative care consult and that as many as 90% have one after the consult. Several respondents stated that this data is unknown at their hospital.
- Hospital-based respondents were asked, “Where has your program had the greatest impact?” The most frequently stated impact was reduced length of stay and increased hospice referrals. Other comments by respondents include: improved quality of life for patients, cost savings, reduced readmissions, increased provider satisfaction, POLST completion, improved transitions of care across settings, expanding the definition of palliative care to include the community, helping patients clarify goals, modeling best practices for comfort care, and creating a culture where patients’ wishes are honored.
- None of the programs (zero) have Joint Commission Advanced Certification in Palliative Care. Several respondents stated they have considered it but none are seriously planning for it.

Community Relationships and Activities

- Three (3/10, 30%) hospital-based programs stated that they have a unique relationship with a local hospice. They share staff on a contractual basis, either sharing a hospital Physician to serve as the hospice Medical Director or sharing a Nurse Practitioner for palliative care services.
- Eight (8/10, 80%) hospital-based respondents stated that they are involved in palliative care activities that included: undergraduate, graduate and fellowship program and curriculum development; pediatric palliative care program development; ACO collaborations; hospital palliative care committees; The Palliative Care and Quality of Life Advisory Council; community-wide palliative care collaborations; and the statewide POLST coalition.

Patient Disposition in Hospital-Based Palliative Care Programs

Data was collected about the patient’s discharge status or disposition in hospital-based palliative care programs. Several respondents did not have this data but gave estimates. The category “Self-Care” included those patients that may have been discharged with additional services in place, such as Home Health. The ranges are reported here and the mode, where applicable.

Table 4: Disposition of Hospital-based Palliative Patients

Disposition	Range	Mode
Died while in palliative care program	5-30%	25%
Discharged to hospice	15-58%	30%
Discharged to nursing home	22-33%	25%
Discharged to self-care	4-35%	None

HOSPICE-BASED PALLIATIVE CARE PROGRAMS

Prevalence of Hospice-based Palliative Care Programs

Twenty-six (26) hospices across the state of Maine were contacted. Based on phone or email surveys, seven (7/26) or 26% reported having a palliative care program currently. One program started in 2016 and therefore had zero (0) patient consults in 2015. It is noteworthy that seven (7/26, 26%) of all hospices that were contacted operate as volunteer-only hospices.

Table 5: Hospice-based Palliative Care Programs

Number of hospices completing the survey	26
Number (%) of hospices providing palliative care services	7/26, 26%
Number of patients receiving palliative care services in 2015	
Sum	410
Mean	58.5
Range	0-150

Team Composition of Hospice-based Palliative Care Programs

The composition of teams varied among Hospice-based palliative care programs. It is noteworthy that 100% (7/7) programs utilize the services of a social worker on their palliative team. Seventy-one percent (5/7, 71%) of the Hospice-based programs utilize at least one physician, but none utilize physician interns, residents or fellows as compared to a few hospital-based teams.

Table 6: Hospice-based Palliative Care Team Composition

Discipline	Dedicated, Non-dedicated, Volunteer and Contractual Staff
Physician	5/7, 71%
Advanced Practice Nurse / Nurse Practitioner	3/7, 42%
Registered Nurse	6/7, 85%
Social Worker	7/7, 100%
Chaplain	5/7, 71%
Pharmacist	0
Psychologist	0
Volunteers (in a non-professional role)	3/7, 42%
Certified Nurse Assistant	3/7, 42%
Office Manager / Administrative Assistant	0
Dietician	0
Physician Assistant	0

Hospice-based Palliative Care Program Descriptions

- **Establishment:** Establishment of the first hospice-based palliative care program was reported as being in 2010. The most recent was established in 2016.
- **Branding:** Two (2/7, 28%) Hospice-based palliative care programs had a unique brand name for their program, a name different than, for example, “Maine County Palliative Care Program”. The majority simply referred to their program as “The Palliative Care Program” or something similar.
- **Certification:** Five (5/7, 71%) hospices have at least one physician and/or nurse certified in Hospice and Palliative Medicine. One hospice has an Administrator Certified in Hospice and Palliative Care. It is unknown what the discipline is of that administrator.
- **Operational hours:** Five (5/7, 71%) hospices offer palliative care services 24/7/365.
- **Services:** One hundred percent (100%) of hospices reported that their palliative care team provides predominantly symptom management, advance care planning and discussions surrounding goals of care.
- **POLST:** Many respondents stated that they do not see many patients entering the program with a completed POLST. The majority of respondents stated that they do initiate the POLST in their palliative care programs. One program does not use POLST at all. One respondent commented that increased training about POLST is needed.
- **Diagnoses:** The most commonly seen illnesses encountered by the palliative care team are cancer and cardiac disease. Less frequently encountered illnesses are neurodegenerative disorders, respiratory disease and dementia.
- **Location:** One hundred percent (7/7, 100%) of hospice-based programs provide palliative care services in the patient’s home. Eighty-five percent (6/7, 85%) provide services in assisted living facilities. One hospice (1/7, 14%) provides services in out-patient clinics. Three hospices (3/7, 42%) provide services in hospitals. And seventy-one percent (5/7, 71%) provide services in nursing homes.
- **Management:** Five (5/7, 71%) hospice-based palliative care teams have a manager that is a registered nurse. The reporting structure varied but the majority report to an upper management professional within the hospice program (VP of Clinical Services or Hospice CEO).

Referrals

- One hundred percent (100%) of the hospices reported that the majority of their palliative care referrals come from hospitalists and community primary care providers. Other referral sources include discharge-planners, oncologists and home health care personnel.
- Two (2/7, 28%) hospices utilize automatic triggers which serve to initiate a palliative care consult. Those triggers include a patient discharged from the hospital and admitted to hospice with a cancer diagnosis, and frequent hospitalizations and/or frequent ER visits.

Financial Aspects and Billing

- All seven hospices (100%) reported that their palliative care teams enjoy strong administrative support for their program. The majority reported not having enough financial support. Comments included: “We need more nurses.” “We need more education about palliative care.” “Wish CMS would eliminate homebound status [since we bill under home health for palliative care].” “Social worker reimbursement is missing.”

- Five hospices (5/7, 71%) bill for palliative services under some mechanism. Fifty-seven percent (4/7, 57%) of those that bill for palliative services do so utilizing Home Health billing mechanisms. Their palliative care program is managed within their Home Health program, not their hospice program. One hospice bills for palliative care but is uncertain about how it is billed. Two hospice programs (2/7, 28%) provide hospice services for free; they do not bill Medicare, Medicaid or commercial insurance. Zero of the hospices billed Medicare Part B for palliative services.
- None (0) of the hospices use V66.7 (encounter for palliative care) codes in their palliative care programs.
- When asked what percentage of program expenses are paid for by direct billing, hospices had a variety of answers: “unknown”, “Zero”, “50%”, and “90%.”
- None of the hospices collected statistics about how their palliative care program had saved the hospital money or avoided costs.

Outcome Measures

- The majority of hospices collect metrics and outcome measures for their palliative care program. The most frequently collected metrics include: discipline visits, discharge status, length of stay, referral sources, hospice conversions, diagnosis, and hospitalizations.
- The majority of hospices engage in an annual review of their palliative care program.
- One hospice (1/7, 14%) conducts quality projects specific to their palliative care program.
- None of the hospice respondents were sure about the percentage of patients that come into the palliative care program with an advance directive. But the majority did mention that they see more patients in the hospice program that already have advance directives.
- Hospice respondents were asked, “Where has your program had the greatest impact?” The most frequently stated response was improved quality of life for patients. Hospice conversion was the second most frequently stated response.

Community Relationships and Activities

- Two (2/7, 28%) hospices mentioned having unique relationships with other hospices or a hospital in their area. One hospice stated their local hospital contracts for the use of the hospice’s palliative care social worker and NP who are used in the hospital’s palliative care program. Another hospice described having the only in-patient hospice facility in the area so that other hospices transfer patients to them when the need arises.
- None of the hospices were aware of any other groups providing palliative care in their area, outside of other hospices and hospitals.
- Three (3/7, 42%) hospice respondents are involved in palliative care activities, described as participation on the local hospital Palliative Care Committee.

Patient Disposition in Hospice-based Palliative Care Programs

Data was collected about the patient’s discharge status or disposition in hospice-based palliative care programs. All respondents made educated guesses as they did not have exact figures about disposition. The category “Self-Care” includes those patients who may have been discharged with additional services in place, such as Home Health. The ranges are reported here, and the mode, where applicable.

Table 7: Disposition of Hospice-based Palliative Patients

Disposition	Range	Mode
Died while in palliative care program	1-50%	None
Discharged to hospice	50-75%	50%
Discharged to hospital	None	20% (1 respondent)
Discharged to self-care	15-50%	None

ADDITIONAL INFORMATION

Hospitals and Hospices with NO Palliative Care Program

Hospitals and hospices that reported NOT having a palliative care program, were asked a few questions for data collection purposes for this project. The responses are summarized below.

- When asked why their program does not offer palliative care, the majority of respondents stated that it was due to limited resources; time, money and/or personnel. Additional responses included: initiative fatigue and other priorities, lack of education, hesitancy to use palliative care in light of new scrutiny around opioid use, shortage of Nurse Practitioners and nurses, little need in community, do not want added restrictions that come with reimbursable services, lack of infrastructure, and lack of a champion to promote palliative care.
- Among respondents for programs without a palliative care program, very few reported being engaged in palliative care initiatives or activities, although a few participate in their community hospital palliative care committees.

Non-Hospital, Non-Hospice Palliative Care Providers in Community

All respondents, whether or not their hospital or hospice has a palliative care program, were asked if they know of any other unique palliative care providers in their communities. Three respondents in total replied affirmatively. Two respondents stated that there are primary care providers and oncology practices that are providing palliative care. Another stated that residency programs in Maine now have curriculum content about palliative care and clinics where residents can deliver complex care.

SUMMARY AND RECOMMENDATIONS

Palliative care is growing rapidly throughout the United States. This study has confirmed the number of hospital-based and hospice-based palliative care providers in the state of Maine. Among other things, it has determined the number of palliative care consults completed in Maine in 2015. A current directory of palliative care providers in Maine has been created (Appendix 2). Telephone calling each palliative care provider was an effective way capture the data. Finally, it is commendable that over twenty-six percent (7/26, 26.9%) of all hospices that were contacted operate on a volunteer-only basis. This level of commitment to the community, by members of the community, is remarkable. Based on the survey process and analysis, the following recommendations are made.

1. It would be fruitful to repeat this survey in 2-3 years to measure the expansion of current palliative care programs and the birth of new programs in the state of Maine.
2. Ongoing education continues to be needed about what palliative care is and is not, as compared to hospice care. Confusion around this issue was a common occurrence while completing the phone surveys.

3. A clearly defined distinction of what constitutes a “palliative care program” would be helpful. Occasionally respondents wanted this clarification. They were unsure if theirs was really a formal “program.” This survey focused on palliative care programs in hospitals and hospices. We should consider whether physician practices, or other health care delivery systems that provide holistic, interdisciplinary, supportive care for the seriously ill-should be surveyed as well. Do we consider these practices as providers of palliative care?
4. Education is needed about the need for, and how to, collect and analyze consistent metrics, such as cost savings/avoidance.
5. Consistent with current healthcare trends, we need to actively work to position palliative care within the acute and post-acute care environment.
6. As all of healthcare focuses on quality measures and transparency, palliative care providers must define what this means.
7. Based on comments from several respondents, there continues to be a need for expanded palliative care services in order to reach the rural areas. Examining this issue and working toward resolution would be very beneficial to the rural community.

Maine Palliative Care Providers
 Hospices

- No
- Yes



Maine Palliative Care Providers
Hospitals

- No
- Yes





Appendix 1

Prevalence of Palliative Care in Maine Telephone Survey Questions v. 4/22/16

1. **Provider name and contact information.**
2. **Palliative care service name and contact information.**
3. **Do you have a Palliative Care Program in place (separate from the Medicare Hospice Benefit)?**
 - a. If no, to whom do you refer patients to for this type of care?
4. **When was your Palliative Care Program established, and when was your first patient served?**
5. **Please describe the organization of your Palliative Care Program:**
 - a. Name and discipline of program leadership. What is the reporting structure in your organization for Palliative Care?
 - b. What disciplines participate in the program (e.g., physicians, nurses, social work, chaplain, etc.), and how many FTEs are represented by each?
 - c. How many of your physicians and nurses are Board Certified in Hospice & Palliative Medicine?
 - d. Where are services provided, and how many consultations are provided in each location – Inpatient consultation service, outpatient clinic, homecare?
 - e. To whom does your program report to within the organization?
 - f. Is your program available 24/7/365?
 - g. Does your program have Joint Commission Advanced Certification in Palliative Care? If not, are you considering it?
6. **Please describe your Palliative Care Program patient services:**
 - a. How many patients received palliative care services in 2015?
 - b. What services are provided to patients (e.g., goals of care, bereavement, symptom management, family meetings, ADs, etc.). Is POLST being used, and if so is it being brought in from the outside as well as initiated from the inside? Is the POLST form useful? Any recommended changes?
 - c. What conditions / diagnoses are eligible to receive palliative care consultation and what conditions / diagnoses are most frequently served?
 - d. What services most frequently provide referrals to your program – where are the majority of your patients from (e.g., oncology, intensive care, emergency department, etc.)?
 - e. Are there automatic triggers to consider palliative care consults (e.g., Stage IV Cancer, use of V66.7 code outside of palliative care consult team)?
 - f. What percentage of your patients are discharged deceased? To hospice? To outpatient palliative care? Other?
7. **Please describe financial aspects of your Palliative Care Program:**
 - a. Does your program have both administrative and financial support? If not, what's missing?
 - b. Do you bill for palliative care services? Who bills and who gets billed (e.g., Medicare, Medicaid, commercial payors, etc.)?
 - c. How are palliative care services billed (e.g., by physician, APN, hospital, ICD-9 symptom codes vs. billing by time)?

- d. Do you use the V66.7 code (encounter for palliative care) in your billing?
 - e. What percentage of your program expenses are paid for by direct care billing?
 - f. Are statistics collected / reported on cost savings / cost avoidance to the hospital? If so, approximately how much is saved per year?
- 8. Please describe outcome measures for your Palliative Care Program:**
- a. What metrics does your program use to track success (e.g., patient satisfaction survey, etc.)?
 - b. Are there annual reviews of your program? Are there quality projects or programs monitoring the effectiveness of your program?
 - c. What percentage of patients have advance directives – both in and outside of your program?
 - d. Where has your program had the greatest impact (e.g., increasing use of advance directives, decreased critical care LOS, cost savings, increased hospice referrals, etc.)?
- 9. Please describe the relationship between your Palliative Care Program and local hospices:**
- a. How many hospices does your program work with / refer to?
 - b. If your program works collaboratively with local hospices, please describe how services are divided between your program and hospice.
- 10. If you don't currently provide homebased palliative care, do you have plans to do so in the future?**
- 11. If a program doesn't offer palliative care, why not?**
- 12. Outside of your program and local hospitals and hospices, who else in your community provides palliative care services?**

Thank you!!

Appendix 2
2016 Directory of Maine Palliative Care Providers (alphabetical)

HOSPICES	# PATIENTS SEEN IN PALLIATIVE CARE, 2015
ANDROSCOGGIN HOME CARE & HOSPICE 236 STETSON RD, AUBURN, ME 04210 207-777-7740 Contact: Karen Flynn	150
CHANS HOSPICE CARE 60 Baribeau Dr., Brunswick, ME 04011 207-729-6782 Contact: Chris Corriveau	90
HOSPICE OF SOUTHERN MAINE 180 US ROUTE 1, SCARBOROUGH, ME 04074 207-289-3640 Contact: Daryl Cady	30
MAINE HEALTHCARE AT HOME 15 Industrial Park Rd., Saco, ME 04072 207-921-4500, 207-284-4566 Contact: Heidi McCaffery	50
MAINE GENERAL HOMECARE AND HOSPICE 10 WATER STREET SUITE 307, WATERTOWN, ME 04901 207-861-6200 Contact: Michelle Vigue	75
MILES AND ST. ANDREWS HOME HEALTH & HOSPICE 40 BELVEDERE ROAD, DAMARISCOTTA, ME 04543 207-563-4592 Contact: Mickey Gehard	15
YORK HOSPITAL HOSPICE & PALLIATIVE CARE 127 LONG SANDS ROAD SUITE 12, YORK, ME 03909 207-337-7333 Contact: Tammy Crooks-Faulkingham	0 (program started in 2015)

HOSPITALS**# PATIENTS SEEN IN
PALLIATIVE CARE, 2015**

AROOSTOOK MEDICAL CENTER PO BOX 151, PRESQUE ISLE, ME 04769 207-768-4000 Contact: Roland Joy	20
CENTRAL MAINE MEDICAL CENTER 300 MAIN STREET, LEWISTON, ME 04240 207-795-0111 Contact: Dr. Bruce Condit	640
EASTERN MAINE MEDICAL CENTER PO BOX 404, BANGOR, ME 04401 207-973-7000 Contact: Dr. Jim VanKirk MD	1483
MAINE MEDICAL CENTER 22 BRAMHALL ST, PORTLAND, ME 04102 207-662-0111 Contact: Dr. Isabella Stumpf	750
MAINE GENERAL MEDICAL CENTER 35 MEDICAL CENTER PARKWAY, AUGUSTA, ME 04330 207-872-1000 Contact: Dr. Bob Dohner	452
MID COAST HOSPITAL 123 MEDICAL CENTER DRIVE, BRUNSWICK, ME 04011 207-729-0181 Contact: Jessica Vickerson	500
PENOBSCOT BAY MEDICAL CENTER 6 GLEN COVE DRIVE, ROCKPORT, ME 04856 207-596-8000 Contact: Dr. Lauren Michalakes	320
SOUTHERN MAINE HEALTH CARE 1 MEDICAL CENTER DRIVE, BIDDEFORD, ME 04005 207-283-7000 Contact: Heather DiYenno	64

ST. MARYS REGIONAL MEDICAL CENTER 100
CAMPUS AVENUE - PO BOX 291 (HOSPITAL), LEWISTON, ME 04240
207-777-8100
Contact: Elizabeth Keene

MAINE VA MEDICAL CENTER 225
1 VA Center, Augusta, ME 04330
207-623-8411
Contact: Dr. Jim Schneid

For additional information, please contact:

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