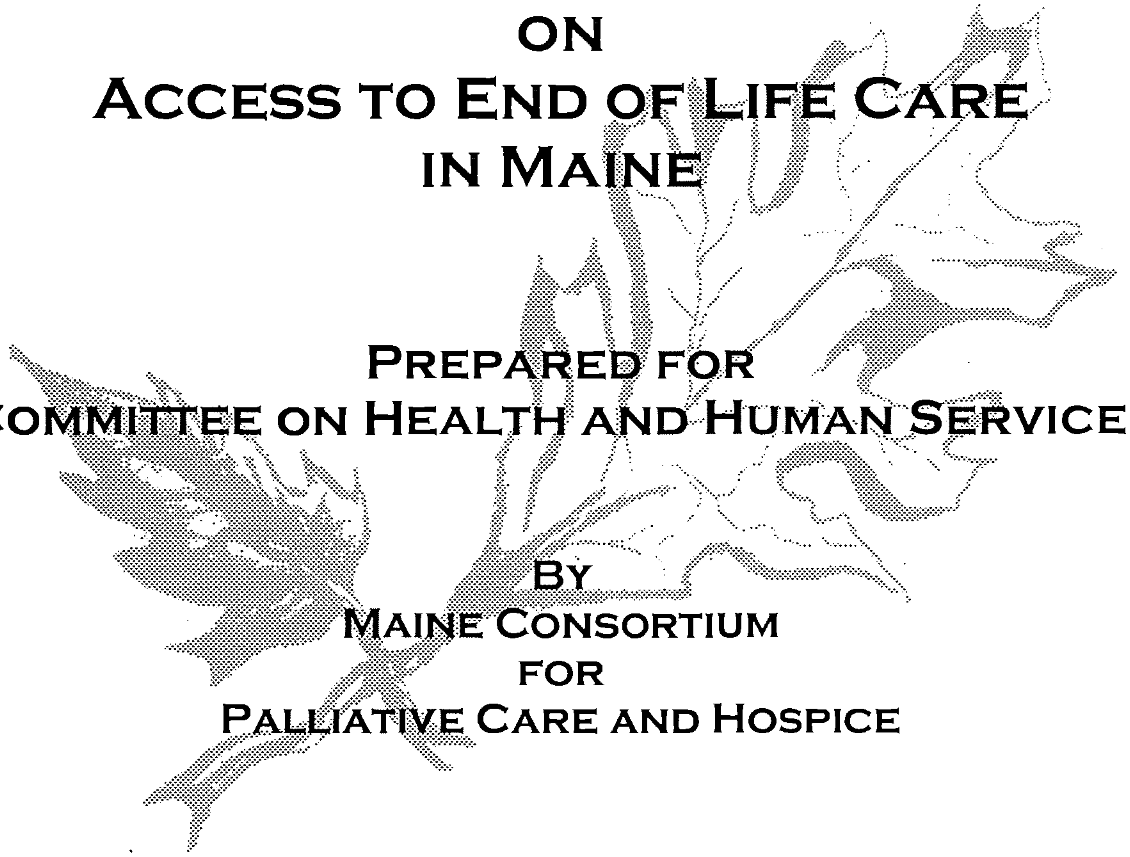
INTERIM REPORT ON ACCESS TO END OF LIFE CARE IN MAINE



PREPARED FOR
COMMITTEE ON HEALTH AND HUMAN SERVICES

BY
MAINE CONSORTIUM
FOR
PALLIATIVE CARE AND HOSPICE

MAY 1999

MCPCH

Maine Consortium for Palliative Care and Hospice

Table of Contents

Charge from the Legislature

Introduction 1

Barriers to Access Quality End-of-Life Care 2

Recommendations and Suggestions 4

Executive Summary RWJ Grant 5

Community-State Partnerships to Improve End-of-Life Care Data Sheet 8

MCPCH Vision 10

MCPCH Membership 11

Ongoing and Future Programs and Projects Regarding End of Life Issues in Maine 13

The Maine Compact for Palliative Care and Hospice 14

The Maine Consortium for Palliative Care and Hospice
Individuals or organizations interested in receiving further information may contact
Kandyce Powell at 207-626-0651 or Larry Harcourt at 207-885-0361
or email to: mcpch@blazenetme.net

Cover illustration by Heidi Powell

SENATE

JUDY PARADIS, DISTRICT 1, CHAIR
SUSAN W. LONGLEY, DISTRICT 11
BETTY LOU MITCHELL, DISTRICT 10

JANE ORBETON, LEGISLATIVE ANALYST
BETSY REINHEIMER, COMMITTEE CLERK

HOUSE

J. ELIZABETH MITCHELL, PORTLAND, CHAIR
JOSEPH E. BROOKS, WINTERPORT
ELAINE FULLER, MANCHESTER
THOMAS J. KANE, SACO
WENDY PIEH, BREMEN
MICHAEL W. QUINT, PORTLAND
GLENYS P. LOVETT, SCARBOROUGH
JEFFERY G. JOYNER, HOLLIS
TARREN R. BRAGDON, BANGOR
LOIS A. SNOWE-MELLO, POLAND

STATE OF MAINE

ONE HUNDRED AND EIGHTEENTH LEGISLATURE

COMMITTEE ON HEALTH AND HUMAN SERVICES

April 28, 1998

Dr. Larry Harcourt, Acting Chair
Maine Consortium for Education on Palliative Care and Hospice
P.O. Box 521
Portland, ME 04112

Dear Dr. Harcourt,

We are writing on behalf of the Health and Human Services Committee of the Legislature to ask for your assistance with the issues of hospice and palliative care.

During the 118th Legislature, the committee heard a bill, LD 2268, to create a task force on hospice coverage and palliative care. We thank you for participating in the public hearing on the bill and for providing information on work of the Maine Consortium for Education on Palliative Care and Hospice. The members were impressed with the experience, interest and expertise of the members of the consortium.

The committee has asked us to request that the consortium expand its membership to include other interested parties, professionals in the field and representatives of interested groups. In addition, the committee asked that notice be provided of the meetings and all meetings be open to the public.

The committee is particularly interested in whether terminally ill persons have access to hospice coverage and palliative care and whether the consortium recommends any legislation or rule making by agencies to improve the care and coverage given to the terminally ill.

The committee would appreciate any report and recommendations that the consortium could provide. January 1 is a timeframe that would work well for the committee's work next year. Please let us know if the consortium has any questions or requires any further guidance. We appreciate this assistance and thank you and the consortium in advance.

Sincerely,

Judy A. Paradis

Judy A. Paradis jo
Senate Chair

J. Elizabeth Mitchell

J. Elizabeth Mitchell JO
House Chair

G:\OPLALHS\COMMTTEE\HUM\CORRESP\4-22HUM2.DOC

Barriers to Access Quality End-of-Life Care

Education

- Curriculum deficiencies and poorly organized continuing education opportunities impede access to needed professional training in hospice and palliative care for physicians, nurses, psychologists, ministers and others in the health care profession.
- Educational opportunities for the lay public concerning end-of-life care are inconsistent and not promoted by community, church, school, or business in any formal manner.
- A lack of effective communication exists among the various stakeholders in end-of-life care (providers, health care institutions, consumers, insurers, regulators, and policy makers) with regard to the various specialized informations available to each group.
- Ever-changing federal and state rules and regulations regarding assessment, level of care, and reimbursement criteria create constant deterrents to quality continuity of care.

Clinical Improvement

- Non-existent baseline data and a lack of consistent assessment tools for pain and symptom management impede the development of practice standards and outcome assessment.
- A medical culture that is biased against the prescribing of adequate opioids for pain management (fear of license revocation for excessive prescribing practices; social conditioning against "addiction" or "drug diversion"' poorly developed standards at primary care level for pain and symptom management.
- No compulsory organized educational training on palliative care and hospice in medical schools, or residency programs.
- No continuing medical education requirements or licensure requirements for physicians with regard to palliative care and hospice.
- Few nursing schools that offer training or clinical practicums on palliative care and hospice.
- Efficiency models for medical practice decrease patient contact with physicians, limiting opportunity to address the complex issues surrounding chronic and terminal illness.
- Reimbursement structures that favor procedures and testing and less direct patient communication.
- No designated regional palliative care and pain management centers impede the referral of patients needing special care or evaluation.
- Poorly understood and under-utilized interdisciplinary team approach to care.
- No DRG code for palliative care.

Economics

- Fragmented reimbursement system.
- No Medicaid palliative care or hospice benefit.
- No minimal benefit standard from insurers regarding palliative care and hospice.

- No reimbursement for hospice care until a determination of six months or less to live is given. Life expectancy in non-cancer patients with severe chronic or terminal illness is difficult to determine and results in late referral to hospice for fear that patient will outlive coverage.
- Not all health-care in Maine have a provision for palliative and hospice care.
- Crisis in home health is seriously affecting Medicare Certified Hospice programming.
- No cost related date available to assess the impact of untreated pain (workplace absence and decreased productivity, increased emergency room treatment and hospitalizations, alcohol and drug abuse).
- Decreased physician referrals to hospice for fear that patients may outlive six month Medicare benefit and be seen as inappropriate referrals.
- Cost of medical care is one of the leading causes of personal bankruptcy in the U.S., and accounts for at least 10% of the personal bankruptcy filings in Maine.
- Accelerating costs of pharmaceutical management often compromises patient ability to receive adequate treatment.
- Rising number of uninsured individuals (14.9% in Maine residents in 1997) have limited access to palliative care and hospice resources, enter into the treatment phase much later if at all, and are disproportionately impacted by the cost of care.
- Balanced Budget Act of 1997 markedly reduced payments to home health agencies that have traditional supported Medicare certified hospice organizations.
- Triangulated payment systems for hospice patients in long term care facilities create decreased utilization of hospice services and competition for reimbursement as well as raised red flags for fraud and abuse investigation.
- Transportation issues and lack of proximity to medical facilities pose special problems to rural Maine residents. This is especially relevant in Aroostock County with only one certified home health agency that has recently undergone dramatic cuts in staffing.
- Inappropriate referrals to hospice care for patients with chronic and terminal illness and more than six months life expectancy, because of lack of reimbursement for home care and medications by Medicare.

Community

- Family dynamic changes have lead to greater number of elderly patients without spouses living alone, many of whom due to illness are "shut in" their homes, abandoned by their families, and must rely on social services for transportation, meals, and assistance.
- Poor awareness of hospice availability (only about 50% of Maine citizens were aware that hospice services existed in Maine in a recent market survey conducted for the Maine Hospice Council).
- Poor understanding of grief and bereavement issues in the workplace, churches, and schools provide little emotional support for those dealing with death and dying.
- No statistical data available to assess the impact on productivity of employees that also serve as primary caregivers in their homes.

- Increasing elderly population (over age 65 population expected to quadruple in the next 20 years) with proportionate rise in chronic diseases will require more available community involvement to meet the needs for care.
- A culture that tends to be unfamiliar, uncomfortable, and resistant to issues concerning death and dying.

Social Policy Recommendations

a. Develop a strategic plan for end-of-life care in Maine.
b. Require insurers to develop a hospice and palliative care benefit.
c. Develop and support a statewide ethics committee for end-of-life care.
d. Develop a Medicaid Hospice Benefit.
e. Address regulations that will promote the development of hospice and palliative care residences in Maine.

Further suggestions for improving care at the end-of-life

a. Promote systemic collaboration within health care that will support and sustain continuity of high quality end-of-life care.
b. Follow national trends and extract relevant information from the "Last Acts" Reports for state legislators.
c. Support research on all aspects of end-of-life care in Maine.

M C P C H

Maine Consortium for Palliative Care and Hospice

Care at the End of Life: A Public / Private Partnership

Executive Summary

In January 1999, the Maine Consortium for Palliative Care and Hospice (MCPCH) received a three-year grant of $450,000 from Robert Wood Johnson for a project entitled, "Care at the End-of-Life: A Public / Private Partnership". The Consortium was one of four implementation grants to receive funding under a new program encouraging state and community groups to reshape public policy affecting end-of-life care.

The Maine Consortium includes agencies, groups and individuals from throughout the state. The group believes Maine residents have begun to identify end-of-life issues unique to the state's culture, but that progress needs to be made in a number of key areas such as access, education, economics, clinical improvement and grassroots education. The goal is for death to be treated as more than a medical event by infusing the philosophy of hospice care into all end-of-life care.

The Maine Hospice Council will administer the program. The leadership team will be comprised of Kandyce Powell, MSN, RN; Larry Harcourt, M.D.; and Michael Murphy, Ph.D., and carried out by the 14 grant partners listed below:

Bingham Program
Blue Cross / Blue Shield of Maine and Affiliates
Council of Churches
Coalition for Dialogue on Death and Dying
E.S. Muskie School of Public Service
Maine Medical Association
Maine Osteopathic Association
Maine Hospice Council
Maine Hospital Association
Maine Medical Assessment Foundation
Maine Health Care Association
Home Care Alliance
Organization of Maine Nurse Executives
University of New England

Each partner has carved out a piece of this project which is compatible with its mission, compatible with the mission of MCPCH, and realistic within the context of this proposal. Several of the partners have agreed to collaborate on objectives in order to more comprehensively address a specific barrier. With the understanding that, in order for change to occur, responsibility for that change needs to be shared. Following is a brief description of each partner's goals and objectives.

Coalition for Dialogue on Death and Dying

Goal: Engage the local community to assume responsibility towards end-of-life care by replicating existing coalition model in five regions of the state.

Objectives: 1) Understand each of the areas diverse cultures of dying and bereavement. 2) Identify and assess the current system of care. 3) Evaluate end-of-life care delivery system by end of year two. 4) Adopt an action plan addressing end-of-life care systems change in each area. 5) Increase knowledge about end-of-life issues and resources available.

Council of Churches

Goal: To engage the local faith communities to assume responsibility for improving end-of-life care.

Objectives: 1) Establish 18 multi-faith congregational dialogues over a three-year period. 2) Develop an anthology/manual. 3) Prepare report for congregations in Maine.

Maine Hospice Council

Goal: Increase awareness and education regarding Hospice and Palliative Care in Maine.

Objectives: 1) Develop a central repository for information regarding end-of-life care working in collaboration with the Maine Hospital Association. 2) Develop and publish a statewide resource directory in collaboration with the Coalition for Dialogue on Death and Dying and Council of Churches. 3) Design and implement a Hospice and Palliative Care curriculum for medical students at the University of New England in collaboration with UNE and the Maine Osteopathic Association. 4) Produce interim reports to the legislature. 5) Engage, print, and broadcast media in the partnership effort. 6) Schedule public hearings on end-of-life care throughout the state. 7) Increase Medicare Hospice referrals from 6% to 10% over a three-year period in collaboration with the Home Care Alliance and other appropriate organizations.

Maine Medical Association

Goal: To provide more physician education regarding end-of-life care.

Objective: 1) Send five to ten physicians to train with the AMA's EPEC project. 2) Establish forums to implement the EPEC Program statewide.

Maine Osteopathic Association

Goal: To provide more physician education regarding end-of-life care.

Objectives: 1) Work collaboratively with UNE to develop curriculum for medical students.

Maine Health Care Association

Goal: Develop baseline data in long-term care settings.

Objective: 1) Design an assessment tool. 2) Collect information on LTC residents who are transferred to acute care facilities to die, the existence of pain management protocols in the LTC facilities, and the percent of patients with advance directives.

Maine Medical Assessment Foundation

Goal: Collect epidemiological data on pain and symptom management across several practice settings in two communities in Maine.

Objectives: 1) Design a program for data collection. 2) Identify two communities in Maine willing to participate (one has been identified). 3) Seek outside funding for implementation of program. 4) Establish benchmarks related to end-of-life which may be established and tracked over time.

Maine Hospital Association

Goal: Examine the role of healthcare institutions regarding end-of-life care.

Objectives: 1) Provide information and education on advanced care planning, pain and symptom management resources for spiritual and emotional support. 2) Host conference for hospital and affiliated staff in year one with a follow-up conference in year two. 3) Initiate palliative care compact with member institutions.

E.S. Muskie School of Public Service

Goal: Perform ad hoc policy analyses regarding Medicare/Medicaid policy and other reimbursement for Hospice.

Objectives: 1) Analyze relationships between managed care organizations and Hospice. 2) Analyze relationships between Long Term Care and Hospice.

Blue Cross/Blue Shield and Affiliates

Goal: Develop a "model" Hospice benefit that is interdisciplinary, community centered, and evidenced based.

Objectives: 1) Collaborate with other partners in assessing current reimbursement practices for Hospice and palliative care. 2) Challenge the state's other managed care organizations to participate in the project. 3) Evaluate adequacy of reimbursement. 4) Collect qualitative data from nurse case managers regarding strengths/weaknesses of present system. 5) Extrapolate relevant financial/utilization statistics from existing database. 6) Identify any changes necessary in public policy re reimbursement and make recommendations for change.

University of New England

Goal: Design, implement, and evaluate a curriculum, for medical students regarding end-of-life care.

Home Care Alliance and OMNE

Goal: Work collaboratively with other grant partners to shape public policy.

Community-State Partnerships to Improve End-of-Life Care
Data Sheet

Project Name:	Care at the End of Life: A Public/Private Partnership
State:	Maine

	Statistics Year	Numbers	Percentage
Demographic Profile			
Total number of resident population	July 1, 1997	1,242,051	
65 years and older		173,419	
Average annual pay *	1996	$23,477	
Personal income per capita	1997	$22,078	
Median household income	1993	$28,732	
Poverty rate **		169,571	13.7%
Total number of deaths (residents)		11,700	
Within the state		11,337	
Deaths occurring in state:			
Residents	1996	11,337	
Nonresidents		345	
By sex:			
Males		5,659	
Females		6,023	
By race:			
White/European American		11,657	
Hispanic/Latin American		-	
Black/African American		17	
South Pacific/Asian American		3	
Native American ***		58	
Uninsured individuals			14.9%
By age:			
Infant deaths		65	
Deaths age 65+		9,340	

Notes:

* data collected from salaries covered by unemployment insurance

** 3 year period 1994 - 1996 10.6%

2 year period 1994 - 1995 11.2%

*** Native American/Hispanic are ethnicitys, not races

Community-State Partnerships to Improve End-of-Life Care
Data Sheet

	Statistics Year	Numbers	Percentage
Leading Causes of Death *			
Heart disease	1995	3,636	
Malignant Neoplasm		2,998	
Cardiovascular disease		744	
COPD		672	
Accidents & adverse affects		391	
Places of death:			
Home		2,702	
Long-term care facility		3,572	
Hospital (inpatient)		4,277	
Emergency room (outpatient)		702	
Hospice/Other		429	
Hospice Organizations			
Admissions		1,100	
Patients served annually		1,350	
Average length of stay			
Median length of stay		51 days	
Providers			
Palliative care certified physicians		6	
Palliative care (hospice) certified nurses		18	
Facilities/Organizations			
Number of hospitals		46	
Number of hospitals w/palliative care units		1	
Number of hospices		25	
Suicide Deaths		175	
50+ years		8	

Notes:

* 1995 data, resident deaths

M C P C H

Maine Consortium for Palliative Care and Hospice

Vision and Mission Statement

Vision: We envision communities that are responsible for dynamic social policies and practices that support high quality end of life care.

Mission: Create a socially responsive environment in the state of Maine for compassionate care at the end of life.

Goals:

1. Identify the cultures of dying and bereavement in the state of Maine.
2. Increase awareness and understanding of Hospice and Palliative Care in Maine through education at the provider, consumer, legislative and individual level.
3. Awaken communities to the need for re-defining traditional roles and responsibilities in end of life care.
   For example: The term 'communities' is used broadly to encompass the health care community, social institutions, individuals and their families, private organizations, the workplace, etc.
4. Address external and internal factors affecting end-of-life care.
   For example: Cultural attitudes, reimbursement structures, policies and regulations, and other barriers to effective end of life care
5. Provide guidelines that improve end-of-life care.
   For example: Integrative guidelines, which address the continuum of Care and incorporate a Patient Bill of Rights and Responsibilities
6. Ensure accountability within the public and private sectors for access to end of life care.
   For example: Benchmarking
7. Develop and implement a statewide Compact on Hospice and Palliative care, which will address our uniquely human essence – the physical, spiritual, intellectual and emotional dimensions, which constitute the whole person.
   For example: Patient Bill of Rights and Responsibilities, Collaborative Compact
8. Promote legislative and regulatory changes that will improve end-of-life care.
9. Empower individuals and families to take an active role in their end-of-life care including appropriate advance planning measures.
10. Evaluate the economic changes that will need to take place to improve end-of-life care.
11. Monitor and collaborate with other regional and national projects designed to study and improve end-of-life care.
    For example: Last Acts, Project on Death in America, and Foundation for Accountability.

M C P C H
Maine Consortium for Palliative Care and Hospice
Membership

Member Roster

Abby Alexander; Portland, Maine
Henry H. (Toby) Atkins II, M.D.; Bangor, Maine
Bonita Breault; Blue Cross/Blue Shield; Bar Mills, Maine
Myra Broadway; Board of Nursing; Augusta, Maine
Frank Brooks; NASW; Portland, Maine
Representative Joseph Bruno; District 38; Raymond, Maine
Gail Clinton, M.D.; South Portland, Maine
Laurel Coleman, M.D.; Augusta, Maine
Kevin W. Concannon; Commissioner, Department of Human Services; Augusta, Maine
Terry Cronin; Hospice of Maine; Portland, Maine
Marguerite DeWitt, M.D.; Rockport, Maine
Sylvia Drake Paige; Windham, Maine
Janet L Durgin; Visiting Nurses of Aroostook; Caribou, Maine
Robert W. Edson; American Cancer Society; Brunswick, Maine
Christine Gianopoulos; Director, Department of Human Services, Bureau of Adult and Elder Services; Augusta, Maine
Larry J. Harcourt; Co-Director, RWJ Grant; Maine Council of Churches; Portland, Maine
Nancy Herk-Bott; Bath-Brunswick Area Respite; Brunswick, Maine
Maureen Higgins; Maine Medical Center - Scarborough; Scarborough, Maine
Alfred L. Hipkins; RWJ Grant Administrative Assistant and Electronic Communications Services; Brunswick, Maine
Anne L. Hunter, M.D.; Scarborough, Maine
Greg Jamison; Maine Pharmacy Association; Holden, Maine
Martha Jordan; NASW; Augusta, Maine
Thomas J. Keating, M.D.; Hospice Medical Director; Brunswick, Maine
Robert Keller, M.D.; Maine Medical Assessment Foundation; Manchester, Maine
Patricia Kenney; Pharmacy Director, Techmed IV; Portland, Maine
Senator Marge L. Kilkelly; Wiscasset, Maine
Juliana L'Heureux; CHANS Home Health Care; Brunswick, Maine
Dick Legere; Maine Board of Pharmacy; Wells, Maine
Randall Manning; Board of Licensure in Medicine; Augusta, Maine
Jan Martens Staples; Portland, Maine
Lisa Harvey-McPherson; Ross Care EMHC; Bangor, Maine
Kellie P. Miller; Maine Osteopathic Association; Manchester, Maine

Dora Anne Mills; Director, Department of Human Services, Bureau of Health; Augusta, Maine
Senator Betty Lou Mitchell; Etna, Maine
Michael J. Murphy; Co-Director, RWJ Grant; Coalition for Dialogue on Death and Dying; Brunswick, Maine
Leslie Nicoll; Edmund S. Muskie School of Public Service, University of Southern Maine; Portland, Maine
Senator Judy Paradis; Frenchville, Maine
Richard Polkinghorn, M.D.; Freeport, Maine
Kandyce Powell; Co-Director, RWJ Grant; Executive Director, Maine Hospice Council; Augusta, Maine
Vicki Purgavie; Home Care Alliance; Augusta, Maine
Representative Michael W. Quint; District 33; Portland, Maine
Jim Schneid, M.D.; Augusta, Maine
Ellen Jane Schneiter; MMAF; Manchester, Maine
Sheila Seekins; Washington, Maine
David Simmons, M.D.; Calais, Maine
Edie Smith; Maine Funeral Directors' Association.; Hallowell, Maine
Gordon Smith; Maine Medical Association; Manchester, Maine
Ann E. Sossong; Maine Bioethics Network; Old Town, Maine
Dick Stephenson, , M.D.; Androscoggin Home Health Services; Lewiston, Maine
Sue Strout; Board of Osteopathic Exam / Regulation; Augusta, Maine
Kathleen Stuchiner; Maine Hospital Association; Augusta, Maine
Daniel Rissi; Blue Hill Memorial Hospital; Blue Hill, Maine
Brooke Tenney; Board President, Maine Hospice Council; Scarborough, Maine
Meredith Tipton; Blue Cross/Blue Shield of Maine; South Portland, Maine
Tom Tracy; Bates College, Department of Religion; Lewiston, Maine
Paula Valente; Maine Health Care Association; Augusta, Maine
Kathy Veilleux; Coalition of Maine Nurse Organizations, COMNO; Ellsworth, Maine
Jacob Watson; Portland, Maine
Elihu York, M.D.; Brunswick, Maine

Ongoing and Future Programs and Projects Regarding End of Life Issues in Maine

Maine Consortium for Palliative Care and Hospice
- Interim report on access to end-of-life care due Legislature submitted May 1999
- Maine Compact on End-of-Life Care initiated November 1998

Boards of Licensure in Medicine and Osteopathy
- Developed rules and regulations for the use of controlled substances in managing pain: Spring 1999

Proposed Statewide Ethics Committee on End-of-Life Care in Collaboration with the Maine Bioethics Network.

Maine Cancer Pain Initiative
- National Cancer Pain Initiative meeting: June 1998
- Invited to participate in "Think Tank" to plan future of State Cancer Pain Initiatives
- Zero Acceptance of Pain Protocol implementation date June 1999

Medicaid Hospice Program pending

Public Hearings on End-of-Life Care: Six sites scheduled for June and September

Robert Wood Johnson Grant in Aroostook County for Northeast Maine Tele-medicine Network

Proposed Pediatric Hospice Program

Survey of Workplaces regarding Hospice/Palliative Care Benefits and Services in planning stage
- Initial funding has been received.

Loss and Grief Training
- Maine Youth Center
- Department of Mental Health Retardation and Substance Abuse Services
- Bureau of Child and Family Services

Nursing Ethics Network Research on Ethics and Human Rights Concerns of Maine Registered Nurses 1998

Listen to Me: Elder Ladies Seeking Input and Empowerment Regarding End-of-Life Care completed 1997

Market Research on End-of-Life Care - 1998

Public Awareness Campaign on Hospice – 1998

THE MAINE COMPACT FOR PALLIATIVE CARE AND HOSPICE

SPONSORED BY
THE MAINE CONSORTIUM FOR PALLIATIVE CARE AND HOSPICE

AND
THE MAINE HOSPICE COUNCIL

PURPOSE: To address the comprehensive management of the physical, psychological, social, spiritual and existential needs of people at the end of life.

WHEREAS The philosophy of Palliative Care and Hospice affirms life and regards dying as a natural process that is a profoundly personal experience for individuals and their families; and

WHEREAS The goal of Palliative Care and Hospice is to achieve the best possible quality of life through relief of pain and suffering while remaining sensitive to personal, cultural and religious values, and beliefs and practices; and

WHEREAS Palliative Care and Hospice guide patients and families as they make the transition through the changing goals of care and help the dying patient who wishes to address issues of life completion and life closure; and

WHEREAS Palliative Care and Hospice rely on the formulation of responsible policies and regulations by institutions and by local, state and Federal governments; and

WHEREAS Palliative Care and Hospice involve advanced care planning, including advance directives through ongoing dialogue among providers, patients and families; and

WHEREAS Palliative Care and Hospice recognize and address the economic costs of care-giving including the loss of income and non-reimbursable expenses; and

WHEREAS Palliative Care and Hospice will ensure accountability within the public and private sectors for access to end of life care; and

WHEREAS Palliative Care and Hospice increase awareness and understanding about end of life care through education of individuals, health care professionals, legislators, insurers and others.

BE IT RESOLVED that we, the undersigned, shall commit our efforts and encourage others to create a socially responsive environment in the State of Maine for compassionate care at the end of life.

ENDORSEMENT OF THE MAINE COMPACT FOR PALLIATIVE CARE AND HOSPICE

The Maine Consortium for Palliative Care and Hospice welcomes endorsement of the COMPACT. We invite you and/or your organization to join this effort to reach broader agreement on the core elements of Palliative Care and Hospice by endorsing the Compact. Should you wish to do so, please complete and return this form. Should you have any questions, please contact the Maine Hospice Council at 626-0651. Thank you.

Name of Organization or Individual: ______________________________

☐ endorses the Maine Compact for Palliative Care and Hospice.

☐ cannot endorse the Compact at this time.

Please explain (indicate if you anticipate approval at a later date).

Comments:

____

____

____

____

____

____

____

____

Name of authorized representative or individual: ______________________________

Title, if applicable: ______________________________

Address: ______________________________

____

Signature: ______________________________ Date: ______________________________

Please fax this form to the Maine Hospice Council at 622-1274 or mail to the Maine Hospice Council at P.O. Box 2239, Augusta, ME 04338-2239 or email to mcpch@blazenetme.net