Original Article

An Assessment of Hospital-Based Palliative Care in Maryland: Infrastructure, Barriers, and Opportunities

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Abstract

Context. Maryland recently passed legislation mandating that hospitals with more than 50 beds have palliative care (PC) programs. Although the state's health agency can play a key role in ensuring successful implementation of this measure, there is little actionable information from which it can guide resource allocation for enhancing PC delivery statewide.

Objectives. To assess the PC infrastructure at Maryland's 46 community-based nonspecialty hospitals and to describe providers' perspectives on barriers to PC and supports that could enhance PC delivery.

Methods. Data on PC programs were collected using two mechanisms. First, a survey was sent to all 46 community-based hospital chief executive officers by the Maryland Cancer Collaborative. The Maryland Health Care Commission provided supplementary survey and semistructured interview data.

Results. Twenty-eight hospitals (60.9%) provided information on their PC services. Eighty-nine percent of these hospitals reported the presence of a structured PC program. The profile of services provided by PC programs was largely conserved across hospital geography and size. The most common barriers reported to PC delivery were lack of knowledge among patients and/or families and lack of physician buy-in; most hospitals reported that networks and/or conferences to promote best practice sharing in PC would be useful supports.

Conclusion. Systematic collection of state-level PC infrastructure data can be used to guide state health agencies' understanding of extant resources and challenges, using those data to determine resource allocation to promote the timely receipt of PC for patients and families. J Pain Symptom Manage 2015;49:1102–1108. *Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

Key Words
Palliative care, infrastructure, state-level data, barriers and supports, departments of health

Introduction

In 2013, the Maryland legislature passed, and the governor signed into law, House Bill 581.[1] This law requires that by 2016, Maryland hospitals with 50 or more beds have an accredited palliative care (PC) program, and all hospitals provide access to information and counseling regarding PC services appropriate to a patient with a serious illness or condition. Research has identified multiple benefits of timely integration of PC for patients, caregivers, and health care systems.[2] Randomized trials have shown that for patients facing serious illnesses, early integration of PC (concurrent with standard and disease-focused care) is associated with equivalent or improved survival, decreased symptom burden, enhanced satisfaction with treatment experience, better symptom management, and improved quality of life for caregivers.[3–8] Furthermore, for patients with life-threatening

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illnesses (e.g., cancer, chronic obstructive pulmonary disease, stroke), early receipt of PC resulted in fewer hospital days and average health care costs roughly $4800–$7500 less than patients receiving standard care alone.[9,10]

Despite the benefits of timely receipt of PC, evidence suggests that it remains underused.[11–13] Potential clinical barriers include physician attitudes,[14] avoidance of palliative and end-of-life discussions until all treatment options have been exhausted,[15] and a lack of knowledge by providers about the types of services available through PC, patient eligibility, and best time to initiate referrals.[16] Organizational barriers also can present hurdles to broader integration of PC as facilities that serve chronically ill patients sometimes lack sufficient numbers of appropriately trained staff, adequate resources, and protocols to optimize the chances of timely receipt of PC.[17,18]

In addition to ensuring compliance with House Bill 581, Maryland's state health department (i.e., the Department of Health and Mental Hygiene [DHMH]) is well positioned to coordinate resources and catalyze systemic changes that can ultimately enhance access to PC statewide. The ability for DHMH to do this depends on the availability of timely actionable information. Previous work has examined the availability of PC services nationwide at cancer centers,[19] but there remains a gap in understanding PC availability and barriers at the state and local levels. This study aims to address some of these gaps at the state level and is centered on the following questions:

1. What is the hospital-based PC infrastructure in the state of Maryland? That is, how widely available is PC, and what types of services do PC programs offer?
2. What PC services do hospitals plan to enhance over the next five years?
3. From the provider perspective, what are barriers to enhanced delivery of PC, and what are useful supports that would enhance PC delivery?
4. To what extent do the infrastructure, barriers, and supports differ based on hospital size or region?

Methods

Survey Design

A review of existing PC surveys[19,20] was conducted by the Palliative Care Workgroup of the Maryland Cancer Collaborative, a statewide coalition supported by the Maryland DHMH, which works to implement the Maryland Comprehensive Cancer Control Plan. Questions were developed by the workgroup with the input of external experts, including members of the Maryland Cancer Collaborative Evaluation Workgroup, the Maryland State Council on Cancer Control, the Maryland State Advisory Council on Quality Care at the End of Life, and the Hospice and Palliative Care Network of Maryland. Questions were developed to collect data around several focus areas: PC processes, PC program characteristics, PC program staff, temporal trends in PC, and challenges and needs.

During the survey revision process, the Maryland Cancer Collaborative became aware of a survey and semistructured interviews that were conducted during the fall of 2013 by the Maryland Health Care Commission (MHCC), another division of the DHMH. The collaborative partnered with the MHCC and adapted the wording of several survey questions to match questions asked by the MHCC to collect comparable data.

Data Collection

Surveys were distributed to all nonspecialty community-based hospitals in Maryland. Given the assumption that PC services may be coordinated by various hospital departments, rather than attempting to identify and send to the appropriate contact within each hospital, surveys were sent to hospital chief executive officers (CEOs). An introductory letter was mailed to each CEO with a request for the CEO to designate the appropriate PC contact at the institution to complete the survey instrument online. A fact sheet about PC also was mailed with the letter to raise awareness of the benefits of providing hospital-based PC among CEOs. Copies of the surveys and other materials are provided in the Appendix (available at jpsmjournal.com). Responses were compared with data collected by the MHCC; responses of hospitals that had already reported data through the MHCC survey data were merged for matched questions.

Within three weeks after the initial mailing, CEO assistants were contacted by phone and/or electronic mail to collect contact information of the designated responder. Third and fourth contacts were attempted for more than eight weeks to remind nonresponders and encourage survey completion. Hospitals were considered nonresponders if they did not complete the survey after four attempted contacts.

Statistical Analysis

Fisher's exact test was performed to compare all survey responses based on hospital size (i.e., 250 beds or fewer vs. more than 250 beds) and region (i.e., Central Maryland vs. Western Maryland, Southern Maryland, and the Eastern Shore). All analyses were performed using GraphPad Prism (GraphPad Software, Inc., La Jolla, CA), and figures were made using Adobe Illustrator (Adobe Systems Inc., San Jose, CA).