



CLINICAL POLICY

Palliative Medicine & Supportive Care

A. EFFECTIVE DATE :

September 19, 2023

B. PURPOSE :

To outline the components of the Palliative Medicine & Supportive Care consultation services at John Dempsey Hospital. This includes the John Dempsey Hospital (JDH) Inpatient Palliative Medicine & Supportive Care Consultation Service and the Outpatient Oncology Supportive Care Clinic in the NEAG Comprehensive Cancer Center.

C. POLICY :

- All patients with a serious illness are eligible for a palliative care consultation and continuous management at point of entry and upon admission at John Dempsey Hospital.
- All patients being treated in the NEAG Comprehensive Cancer Center are eligible for a palliative care consultation and continuous management.
- All specialty palliative care clinicians must be certified in palliative care (or have equivalent training with the goal of working towards certification) and be credentialed with the JDH Medical Staff Office to provide palliative care services.
- Palliative care education (includes but is not limited to palliative care definition, benefits, advance care planning, pain & symptom management, end-of-life care) is provided ANNUALLY to all hospital clinical staff using the SABA E-learning platform.
- All patients managed by the Oncology Palliative & Supportive Care Service in the NEAG Comprehensive Cancer Center are required to complete the Opioid Therapy Agreement for Cancer Associated Pain upon initiation of opioid therapy and yearly if continued on opioid therapy.

D. SCOPE :

This policy applies to all John Dempsey Hospital inpatient units, Emergency Department, and NEAG Comprehensive Cancer Center.

1. Primary Palliative Care:

Palliative Care is provided by the healthcare team responsible for the routine day-to-day care and basic palliative care services of the seriously ill patient. This care is provided by physicians, nursing staff, social workers, chaplains, and other professionals involved with routine patient care and understands the basic principles of palliative care.

- Basic palliative care assessment and treatment skills
- Basic management of pain, symptoms, functional status and quality of life
- Basic management of depression and anxiety

- Basic discussions about prognosis, goals of care, suffering & code status
- Able to identify patients at high risk for unmet palliative care needs which require the expertise of specialty level palliative care.

2. **Specialty Palliative Care:**

Palliative Care is provided by appropriately trained and credentialed health care providers. Specialty Palliative staff applies advanced knowledge in palliative care and utilizes their experience and skill to manage the complex needs of a seriously ill patient.

- Management of refractory pain or other symptoms
- Explore complex goals of care with patients/families
- Management of complex depression, anxiety, grief and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment, within families, between staff and families, and among treatment teams
- Help families navigate discharge options, etc.

“Palliative care clinicians” may include some or all of the following—physicians or physician assistants, nurses or advance practice nurses, social workers, chaplains, psychologists, pharmacists and other professionals.

The Palliative Medicine & Supportive Care Services will work to:

- Optimize symptom control
- Optimize functional status when appropriate
- Promote the highest quality of life for patient and family
- Educate patients and family to promote understanding of the underlying disease process and expected future course of the illness
- Establish an environment that is comforting and healing
- Coordinate discharge to the appropriate level of care in a timely manner
- Assist actively dying patients and their family in preparing for and managing life closure
- Serve as educators for staff
- Promote a system of care that fosters timely access to supportive care services

E. DEFINITIONS :

1. **Palliative Care:** Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve the quality of life for both the patient and the family. Palliative care is the comprehensive care and management of the physical, psychological, emotional and spiritual needs of patients (of all ages) with serious and/or life-threatening illness and their families. Palliative care may be complementary to curative or life-prolonging therapies that are being used to meet patient-defined goals of care.

2. **Serious Illness:** A condition that carries a high risk of mortality, negatively impacts quality of life and daily function, and/or is burdensome in symptoms, treatments, or caregiver stress. Serious illness can also be referred to as severe illness.

F. MATERIAL(S) NEEDED :

None

G. PROCEDURE :

PROCEDURE 1: Assessments

Palliative Medicine & Supportive Care Services are available to the following populations of patients:

1. JDH Palliative Medicine & Supportive Care Consultation Service: Any hospitalized patient at point of entry or upon admission
 - Adult patients and their families with serious and/or life-threatening illness.
 - Inpatient

2. Oncology Supportive Care Clinic: Established patients in the NEAG Comprehensive Cancer Center
 - Adults diagnosed with cancer, where cure is a realistic goal, but the disease and its treatment pose significant physical and/or psychosocial-spiritual burdens.
 - Adults living with advanced cancer at any point in the disease process, and especially those faced with significant physical and/or psychosocial-spiritual burdens.
 - Outpatient
3. The procedure for providing supportive care services includes:
 1. Initial and subsequent assessments that are developed through patient and family interviews, review of medical records, discussion with other providers, physical examination, and review of laboratory, diagnostic tests, and procedures.
 2. Assessment includes documentation of:
 - Disease status and treatment history
 - Functional status and expected prognosis
 - Comorbid medical and psychiatric disorders
 - Physical, psychological, and spiritual symptoms and concerns
 - Advance care planning preferences and surrogate decision maker(s)
 3. All initial and ongoing assessment data are reviewed on a regular basis. Assessment findings are the basis for the care planning process.
 4. Reassessment is performed as needed by the clinical situation.
 5. To ensure access to Oncology Palliative & Supportive Care services, an on-call schedule is created for coverage through the Department of Hematology/Oncology.
 6. To ensure access to JDH Palliative & Supportive Care Consultation services, an on-call schedule is created for coverage through the consultation team.
 7. Hospital discharge issues, follow up concerns or medication problems for non-oncology palliative care patients will be directed to the primary medical team and/or the JDH Palliative Medicine & Supportive Care Consultation Service, not to the Cancer Center.

PROCEDURE 2: Referral Process

1. Referral Criteria
 - General Referral Criteria:
 - Presence of a serious illness and one or more of the following:
 - New diagnosis of life-limiting illness and need for symptom control and/or patient/family support
 - Declining ability to complete activities of daily living
 - Weight loss
 - Progressive metastatic cancer
 - Admission from long-term care facility
 - Two or more hospitalizations for the same illness within three months
 - Difficult-to-control physical or emotional symptoms
 - Patient, family or physician uncertainty regarding prognosis
 - Patient, family or physician uncertainty regarding appropriateness of treatment options
 - Patient or family requests for futile care in the presence of a DNR order, uncertainty, or conflicts
 - Uncertainty or conflicts regarding the use of non-oral feeding/hydration in cognitively impaired, seriously ill or dying patients
 - Limited social support in setting of a serious illness (e.g., no family support system, lives alone, homeless, chronic mental illness)
 - Patient, family or physician request for information regarding hospice appropriateness
 - Patient or family psychological or spiritual distress
 - Intensive Care Unit Criteria:

- Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., advanced dementia)
 - Two or more ICU admissions within the same hospitalization
 - Prolonged or failed attempt to wean from ventilator
 - Multiorgan failure
 - Consideration of ventilator withdrawal with expected death
 - Metastatic cancer
 - Anoxic encephalopathy
 - Consideration of patient transfer to a long-term ventilator facility
 - Family distress impairing surrogate decision making
 - Coma or PVS lasting more than two weeks
 - Cancer Criteria:
 - Metastatic or locally advanced cancer progressing despite systemic treatments
 - Karnofsky < 50 or ECOG > 3
 - Brain metastases, spinal cord compression or neoplastic meningitis
 - Malignant hypercalcemia
 - Progressive pleural/peritoneal or pericardial effusions
 - New advanced cancer diagnosis opting to forgo cancer directed therapies to focus on comfort
 - Neurological Criteria:
 - Folstein Mini Mental Score < 20
 - Feeding tube being considered for any neurological condition
 - Status epilepticus > 24 hours
 - ALS or other neuromuscular disease considering mechanical ventilation
 - Any recurrent brain neoplasm
 - Parkinson’s disease with poor functional status or dementia
 - Advanced Alzheimer’s or other dementia with poor functional status and one or more hospitalizations for infection in the last six months
 - Coma or PVS lasting more than two weeks
2. Making a referral:
- A referral can come from providers, nurses, family members, patients, social workers, and clergy.
 - If the referral comes from anyone other than a provider, a member of the consultation service notifies the primary team and discusses the appropriateness of consultation.
 - Inpatient: A referral order to “Supportive Care (Palliative) consult team” will be entered in EpicEMR and routed to the Supportive Care (Palliative) Consult List.
 - Outpatient: A referral order “Ambulatory Referral to Supportive Care (Cancer Center)” will be entered in EPIC EMR and routed to the Supportive Care work queue for scheduling.
3. Process for identifying patients with serious illness:
- Inpatient:
 - i. Daily Rounds: Consultation team members will have the option to join unit specific/specialty rounds or medical team meetings to identify patients
 - Outpatient Oncology Palliative & Supportive Care Clinic:
 - i. Bi-monthly Interdisciplinary Team meetings
 - ii. Weekly tumor boards & specialty team meetings
 - iii. EPIC EMR Best Practice Advisory: All Stage IV Cancer patients + no referral to Oncology Palliative & Supportive care within 1 year.
4. Responding to a consult request:
- The consultation services respond to all requests for referrals/consultations.

- If the team member determines that an initial assessment or continued follow-up is not appropriate, the team will work with the attending physician/oncology team to facilitate patient access to the appropriate resource(s).
 - Goal: Consultation completed within 24 hours of referral orders entered Sunday - Friday. Referrals entered Saturday will be completed by Monday.
5. Role of the palliative medicine & supportive care team after the initial consultation:
Based on the specific needs of the patient, there is a discussion between the palliative medicine and supportive care team and the primary team to determine the role of the consultation team.
- The role may involve:
- Providing advice to patient, family or staff
 - Consulting and making recommendations
 - Placing orders only if agreed upon with the inpatient primary team during hospitalization
 - Co-management of palliative medicine and supportive care needs in the Oncology Palliative & Supportive Care Clinic

PROCEDURE 3: John Dempsey Hospital Palliative & Supportive Care Committee

1. The committee will report to the chief medical and nursing officers and consist of the following members:
 - Two representatives from the palliative care program—one from each consultation team
 - One representative from nursing administration
 - One representative from the ethics committee
 - One representative from each of the following services or administrative committees: critical care committee, cardiovascular medicine service, the neurology services, surgical services, consult/liaison psychiatry service, medicine service, nursing.
 - One representative each from the hospital departments of social services, care coordination, chaplaincy services, pharmacy.
2. The palliative care subcommittee will meet quarterly.
 - To oversee the Palliative and Supportive Care program.
 - To meet the CMS Condition of Participation for a quality assessment and performance improvement program.
 - To meet or exceed Joint Commission/NQF palliative care/hospice standards.
 - Monitoring palliative care clinical care practices through evaluation of data concerning pain and symptom control, advance directives, utilization of hospital resources, hospice referrals and patient/family satisfaction.
 - Developing and implementing palliative care education initiatives for all staff health professionals, to include competency-based metrics for relevant clinical staff.
 - Making recommendations to the medical executive committee regarding appropriate changes in patient care policies and procedures.

PROCEDURE 4: Care Planning

1. The care plan is based upon an ongoing assessment, determined by goals set with patient and family, and with consideration of the changing benefit/burden assessment at critical decision points during the course of illness.
2. The care plan is developed through the input of patient, family, caregivers, involved health care providers, and the supportive care team, with additional input, when indicated of other specialists and caregivers.
3. The care plan process includes structured assessment and documentation to include:
 - Physical and psychological assessment, which addresses the current disease status, treatment options, functional status, expected prognosis, symptom burden, and psychological coping.
 - Social and spiritual assessment, which addresses the social, practical, religious, spiritual, and existential concerns of the patient and caregivers, including but not limited to relationships,

communication, existing social and cultural networks, decision making, work settings, finances, sexuality/intimacy, caregiver availability and stress, access to medicines and equipment.

- Cultural assessment, including, but not limited to, locus of decision making, preferences regarding disclosure of information, dietary preferences, language, family communication, desire for complementary and alternative medicine, perspectives on death, suffering and grieving, and funeral/burial rituals.

4. Care planning conferences with a patient and family will occur regularly to determine the most appropriate goals of care as indicated by the clinical conditions and are coordinated by the Oncology Palliative & Supportive Care team in conjunction with the attending physician/primary oncology team and other hospital staff.
5. Care plan changes are based on the evolving needs and preferences of the patient and family over time, recognizing the complex and shifting priorities in goals of care.
6. The consultation team provides support for decision making, develops and carries out the care plan and communicates the plan to patient, family, involved health professionals and to the providers involved with patient transfer to different internal or external care settings.

PROCEDURE 5: Continuity of Care

1. A consultation team member is responsible for working with other health care staff for coordinating the discharge plan.
2. A team member synthesizes the plan of care and works to convert the patient's treatment goals into medical orders that are transferable across care settings.
3. A consultation team member confirms access to services that can assist following discharge:
 - Physician specialists
 - Nursing home/intermediate care facilities
 - Hospice
 - Home health care
 - Outpatient palliative care
 - Durable medical equipment services
 - Rehabilitation services
 - Counseling services
 - Transportation
 - Pharmacy benefits

PROCEDURE 6: End-of-Life Care

1. Patients are treated with respect to their individual wishes for care and treatment. A request to discontinue treatment will be honored with the same support and respect as the decision to continue treatment.
2. The consultation service is available to assist with symptom management, prognosis determination, patient and family support, disposition planning and other issues related to end-of-life decisions.
3. Hospice services are recognized as an integral part of the continuum of care. Patients who have an expected prognosis of six months or less, assuming the disease follows its usual course, should be offered hospice services.
4. Chaplaincy services are available to patients and their family members.
5. Social services are available to provide resources to patients and their family members.

PROCEDURE 7: Care of the Imminently Dying Patient

Care will include:

1. Documentation in the medical record that a patient is "imminently" or "actively" dying
2. Communication with the patient, family and surrogate decision makers that death is imminent
3. Preparing patient and family for what to expect during the normal dying process

4. Managing pain and other physical/psychological symptoms effectively
5. Educating/counseling patients and families concerning the appropriate use of pain and symptom management
6. Providing treatment of symptoms according to the wishes of the patient or family
7. Providing options for general inpatient hospice services
8. Providing options for out-of-hospital care, including home or residential hospice services
9. Respecting the patient's privacy, values, religion, and culture
10. Involving the patient and family in all aspects of care
11. Responding to the psychological, social, emotional, spiritual and cultural concerns of the patient and family
12. Addressing issues of body or organ donation, autopsy and funeral planning with sensitivity

PROCEDURE 8: Patient/Family/Caregiver/Staff Education

1. During the assessment process, patient/family/caregiver educational needs are assessed and documented.
2. Staff educational needs are identified and incorporated into the plan of care.
3. Educational/counseling needs are routinely assessed and reassessed throughout care and treatment.

PROCEDURE 9: Assessment and Treatment of Physical/Emotional Symptoms

1. The consultation service completes a comprehensive assessment. The assessment considers:
 - Diagnosis
 - Presenting problems
 - Current treatments, medication profile, and side effects
 - Current pain/symptom management regimen
 - Patient concerns
 - Patient/family preferences
 - Spiritual and cultural beliefs and values that influence treatments
2. The patient is asked to characterize their symptoms at the time of initial assessment and at regular intervals following the assessment, and after initiation of therapy.
3. The team proposes a comprehensive treatment plan; the team confers with the patient and family and confirms plan elements.
4. Unless there is agreement from the inpatient primary team, orders and their implementation need to go through the primary team.
5. The consultation service works with the primary team to ensure the implementation and monitoring of the treatment plan.
6. The treatment plan is modified based on ongoing assessment.
7. Timely referrals are made to specialists when treatments fail to improve physical or psychological symptoms.
8. The team ensures that all assessments, recommendations, and responses to therapy are documented in the medical record, and that changes in the plan of care are communicated to the team and the nursing staff at the time they occur.
9. Prior to discharge, a plan is established for continuing care requirements.

PROCEDURE 10: Pain Management and Opioid Prescribing

Standards for assessment:

1. The assessment and treatment of pain will be consistent with the patient's cultural and age-specific needs. All patients will be assessed for pain. The Clinical Protocol *Pain: Care of the Patient* located in the Nursing Practice Manual will be utilized as a guide for the pain assessment.
2. Pain will be assessed upon admission, with vital signs, upon self-reports of pain, and if pain of the non-verbal patient is presumed. Pain will be assessed after each intervention and documented per the Clinical Protocol *Pain: Care of the Patient*.

3. A plan of care will be established to deal with pain; the plan should involve both pharmacological and non-pharmacological interventions.

Standards for opioid therapy:

1. The *Palliative Care Pain Management* order set is to be used as a guide for all scheduled and PRN opioid orders for inpatients. The Palliative Care Pain Management order set is not required in the following situations:
 - Ambulatory patients in clinics and treatment/diagnostic areas
 - One-time doses
 - PCA/IV infusions of opioids
2. Patients requiring continuous opioid therapy should be on only one continuous or long-acting opioid at a single time. This includes the following:
 - Opioid via PCA with basal rate
 - Opioid via continuous infusion
 - Extended-release morphine
 - Extended-release oxycodone
 - Transdermal fentanyl patch
3. Patients requiring a short-acting or rapid-onset opioid or opioid-combination product should be prescribed only a single product at any time. These include:
 - Morphine
 - Hydromorphone
 - Oxycodone
 - Oxycodone/acetaminophen (Percocet)
 - Hydrocodone/acetaminophen (Vicodin)
4. The Oncology Palliative & Supportive Care service will assist in the assessment and management of patients with cancer-associated pain. Patients with non-malignant pain syndromes will not be routinely followed or managed by the service.
5. Resources for pain management assistance
 - Pain resource professionals and pharmacists with focused pain education
 - Palliative care service pain management for patients with serious and/or life-threatening illness and cancer
 - Hospitalist/Internal Medicine/Primary care provider for non-emergent inpatient and outpatient consultation for assessment and triage of chronic pain
 - UConn Health Chronic Opioid Therapy Toolkit https://health.uconn.edu/pain-center/wp-content/uploads/sites/235/2019/11/Chronic-Opioid-Therapy-Toolkit_2019.10.10.pdf

PROCEDURE 11: Advance Care Planning Documentation

1. Patients may appoint a Healthcare Representative and complete a Living Will through the State of Connecticut Advance Directives documentation, which may be found at: <https://www.ct.gov/agingservices/lib/agingservices/pdf/advancedirectivesenglish.pdf>
2. Completed documentation will be scanned into the electronic medical record and may be found on the Media tab under the title Advance Directives or accessed through the code status link in Epic.
3. EPIC Advanced Care Planning Note will be utilized for documentation of ACP conversations, goals of care or code status conversations.

Hospital Clinical Staff Core Competencies in Palliative Care

Palliative care is provided at two levels:

1. **The Primary Palliative Care Level:**
 - Palliative care is provided by the healthcare team responsible for the routine day-to-day care and basic palliative care services of the seriously ill patient. This care is provided by physicians, nursing staff, social workers, chaplains, and other professionals involved with routine patient care and understands the basic principles of palliative care.

- Primary Palliative Care service includes such things as basic palliative care assessment and treatment skills.
- Primary Palliative care clinicians have expertise in the assessment patient symptom, functional status, and quality of life, and are able to identify patients at high risk for unmet palliative care needs which require the expertise of specialty-level palliative care.

Core Competencies for Primary Palliative Care:

- Clinicians know the basic principles and aims for caring for patients with complex needs and possess the skills to identify symptoms associated with serious illness and related treatments including pain, nausea, constipation, dyspnea, fatigue, etc.
- Clinicians have a basic understanding and comfort level talking to the patient about basic decisions around the care they want to receive, how to talk about advanced directive, and other basic question/concern the patient may have on advanced management of their care.

2. The Specialty Palliative Care Level:

- Palliative Care is provided by appropriately trained and credentialed health care providers.
- Specialty Palliative staff applies advanced knowledge in palliative care and utilizes their experience and skill to manage the complex needs of a seriously ill patient such as persistent uncontrolled symptoms not manageable by primary treating team, explore complex goals of care with patients/families, and help families and patients navigate discharge options, etc.

Core Competencies for Specialty Palliative Care:

- Clinicians have advanced knowledge from specialty training or specialty certification in palliative care and utilize their expertise and skills to manage the complex needs of patients with serious illness.
- General Medicine: Has broad understanding of and experience in the care of serious or life-threatening diseases/ conditions, including course of illness, prognostic factors, common complications/syndromes and symptoms. In particular: cancer, chronic lung/heart/kidney/liver/endocrine/rheumatologic/ vascular/infectious diseases; progressive neurological disorders; and serious trauma.
- Pain and Symptom Management: Appropriately manages pain and other distressing physical symptoms of disease, illness or treatment in a timely manner and achieves outcomes and side effects acceptable to the patient/family. Management may include referrals to appropriate specialists and/or acceptance and support of the patient's decision to include complementary therapies in treatment.
- Emotional: Supports patient and family expression of emotional needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and/or professionals with expertise in this area.
- Psychosocial: Provides an environment to support patient and family expression of psychosocial needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and/or professionals with expertise in this area. Integrates this area with each interaction.
- Spiritual/Cultural: Manages interactions to support patient and family expression of spiritual needs, strengths and cultural practices. Creates an environment that allows integration of dialogue about spiritual issues within care experience. Refers to spiritual care staff and community resources as congruent with patient/family values. Communicates cultural care preferences of patients/families to others.
- Relationship: Family and Community Addresses desires and needs for support from family and friends. Determines if there has been a change in family communication. Facilitates family communication of specific issues by structure of interactions. Provides anticipatory guidance for

family members as they focus on their relationships. This may include reconciliation of relationships. Provides helpful tools and/or resources for assistance with family communication.

- Honoring Patient Care Wishes: Understands and communicates patient and family wishes prior to crises or impending death. Honors wishes as care goals change. Carries out interventions that make a difference for patient comfort and/or recovery. Supports patient and family when they refuse treatment. Provides a welcoming environment for family to stay with patient.
- Dying and Death: Identifies those who are approaching last days of life. Communicates honestly to patient/family about approaching death and helps make the most of the last days. Determines patient/family wishes regarding place of death and seeks to have death occur where desired. Assists family to give patient permission to die, to say good-bye and to bring reconciliation to family relationships.
- After Death: Prepares family for events that occur immediately following death, e.g., selecting funeral home and making funeral arrangements; notifying Medicare, other agencies, and attorney who handles estate; addressing financial issues; canceling appointments; etc. (This could be presented to the family in a brochure or packet of information.)
- Bereavement: Manages interactions with the bereaved that support communication of clinical concerns and questions as appropriate. Actively initiates referrals for support during bereavement. Relationship Establishes rapport with patient and family. Is viewed as “present, really listening, caring and trustworthy.” Initiates contact with bereaved family as appropriate to relationship (e.g., call and/or send a card or letter to the family expressing condolences).
- Communication: Is available physically and mentally for patient and family communication. Delivers difficult information in honest, clear manner. Maintains hope by focusing on palliative care when cure or life prolongation is no longer possible. Focuses on helping patient/family live in way meaningful to them.
- Teaching: Assesses patient and family knowledge, questions and answers. Refers to appropriate resources for additional information and support. Provides anticipatory guidance and reading materials about illness, treatments, possible outcomes and health system issues.
- Team Collaboration: Provides care with a team approach that includes patient and family as integral and essential members of the care team. Recognizes value of all team

H. **ATTACHMENTS :**

Opioid Risk Tool (ORT)

Chronic Opioid Therapy Pain Management Agreement for Patients with Chronic Pain

Pain: Care of the Patient (Adult Inpatients, Emergency Department, Procedural Areas and NEAG Comprehensive Cancer Center) https://nursing.uchc.edu/nursing_standards/docs/P/Pain%20Care%20of%20the%20Patient.pdf

I. **REFERENCES :**

- American College of Surgeons Commission on Cancer. (2021). *Optimal Resource for Cancer Care-2020 Standards. Standard 4.5 Palliative Care Services.* https://www.facs.org/media/whmfnpvx/2020_coc_standards.pdf
- Center to Advance Palliative Care. (2020). *Policies and Tools for Hospital Palliative Care Programs. A Crosswalk of National Quality Forum Preferred Practices.* www.capc.org.
- Kelley AS. Defining "serious illness". *J Palliat Med.* 2014;17(9):985. doi:10.1089/jpm.2014.0164
- National Comprehensive Cancer Network. (2022). *NCCN Clinical Practice Guidelines in Oncology: Palliative Care Version 1.2022.* www.nccn.org

J. SEARCH WORDS :

Cancer, Palliative Care, Palliative Medicine, Serious Illness, Supportive Care, Oncology

K. ENFORCEMENT:

Violations of this policy or associated procedures may result in appropriate disciplinary measures in accordance with University By-Laws, General Rules of Conduct for All University Employees, applicable collective bargaining agreements, the University of Connecticut Student Code, other applicable University Policies, or as outlined in any procedures document related to this policy.

L. STAKEHOLDER APPROVALS :

On File

M. COMMITTEE APPROVALS :

Clinical Policy Committee

N. FINAL APPROVAL :

- | | |
|---|-------------------|
| 1. <u>Bruce T. Liang, MD (Signed)</u> | <u>10/25/2023</u> |
| Bruce T. Liang, MD | Date |
| Interim Chief Executive Officer & EVP for Health Affairs | |
| Dean, School of Medicine | |
| 2. <u>Anne Horbatuck (Signed)</u> | <u>10/13/2023</u> |
| Anne D. Horbatuck, RN, BSN, MBA | Date |
| Clinical Policy Committee Co-Chair | |
| 3. <u>Scott Allen, MD (Signed)</u> | <u>10/23/2023</u> |
| Scott Allen, MD | Date |
| Clinical Policy Committee Co-Chair | |
| 4. <u>Caryl Ryan (Signed)</u> | <u>10/16/2023</u> |
| Caryl Ryan, MS, BSN, RN | Date |
| Chief Operating Officer, JDH | |
| VP Quality and Patient Services & Chief Nursing Officer | |

O. REVISION HISTORY :

Date Issued: 12/2022

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