

Dying in America

IOM Committee's Proposed Core Components of Quality End-of-Life Care

COMPONENT	RATIONALE
Frequent assessment of the patient's physical, emotional, social, and spiritual well-being	Interventions and assistance must be based on accurately identified needs.
Management of emotional distress	All clinicians should be able to identify distress and direct its initial and basic management. This is part of the definition of palliative care, a basic component of hospice, and clearly of fundamental importance.
Offer referral to expert-level palliative care	People with palliative needs beyond those that can be provided by non-specialist-level clinicians deserve access to appropriate expert-level care.
Offer referral to hospice if the patient has a prognosis of 6 months or less	People who meet the hospice eligibility criteria deserve access to services designed to meet their end-of-life needs.
Management of care and direct contact with patient and family for complex situations by a specialist-level palliative care physician	Care of people with serious illness may require specialist-level palliative care physician management, and effective physician management requires direct examination, contact, and communication.
Round-the-clock access to coordinated care and services	Patients in advanced stages of serious illness often require assistance, such as with activities of daily living, medication management, wound care, physical comfort, and psychosocial needs. Round-the-clock access to a consistent point of contact that can coordinate care obviates the need to dial 911 and engage emergency medical services.
Management of pain and other symptoms	All clinicians should be able to identify and direct the initial and basic management of pain and other symptoms. This is part of the definition of palliative care, a basic component of hospice, and clearly of fundamental importance.
Counseling of patient and family	Even patients who are not emotionally distressed face problems in areas such as loss of functioning, prognosis, coping with diverse symptoms, finances, and family dynamics, and family members experience these problems as well, both directly and indirectly.
Family caregiver support	A focus on the family is part of the definition of palliative care; family members and caregivers both participate in the patient's care and require assistance themselves.
Attention to the patient's social and cultural context and social needs	Person-centered care requires awareness of patients' perspectives on their social environment and of their needs for social support, including at the time of death. Companionship at the bedside at time of death may be an important part of the psychological, social, and spiritual aspects of end-of-life care for some individuals.
Attention to the patient's spiritual and religious needs	The final phase of life often has a spiritual and religious component, and research shows that spiritual assistance is associated with quality of care.
Regular personalized revision of the care plan and access to services based on the changing needs of the patient and family	Care must be person-centered and fit current circumstances, which may mean that not all of the above components will be important or desirable in all cases.



**Committee on Approaching Death:
Addressing Key End-of-Life Issues**

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NOTE: The proposed core components of quality end-of-life care listed in this table were developed by the IOM Committee on Approaching Death: Addressing Key End-of-Life Issues. Most of the components relate to one of the domains in the Clinical Practice Guidelines for Quality Palliative Care set forth by the National Consensus Project for Quality Palliative Care (http://www.hpna.org/multimedia/NCP_Clinical_Practice_Guidelines_3rd_Edition.pdf).

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