family education strategies specific to the mental health diagnosis in the context of serious illness. In addition, clinicians benefit from an understanding of the psychological reactions to serious illness, grief, and loss.

When the symptoms are beyond the clinician’s capacity to treat, palliative care specialists and/or mental health specialists are integrated into the plan of care. Clinicians need expertise in care coordination between providers when patients have a cognitive and/or communication impairment or incapacity or are experiencing extreme mental distress.

Key Research Evidence

The systematic review addressed the following key question: KQ3) What is the impact of palliative care interventions on psychological and psychiatric assessment and management of patients? Twenty-six systematic reviews were identified pertaining to KQ3. The evidence table in the systematic review describes the key findings of each included review. The summary of findings table summarizes the research evidence across identified reviews and describes the quality of evidence. The complete findings are published online in the Journal of Pain and Symptom Management (doi: 10.1016/j.jpainsymman.2018.09.008).

Practice Examples

Practice Example D3-A

A long-term care facility in a suburban area is concerned with the high hospitalization rate of its residents, especially near the end of life. The leadership of the facility commits to incorporating palliative care into routine care of their seriously ill patients and structuring their program around the NCP Guidelines. They meet with the case management group at the local hospital, along with leadership of two area hospices, and strategize how they can work together to improve the outcomes of their patients. They identify shared metrics and outcomes and implement shared palliative care education for all staff. The long-term care facility invests in further training for the social workers and supports one individual as she works towards certification in palliative care. The facility enhances the psychological assessment for all residents and improves the distress screening for new admissions to long-term care. It standardizes training in facilitating goals of care discussions and documenting advance care plans with patients and families. Furthermore, it offers access to grief support for patients and their families, along with bereavement services for families and staff in collaboration with its hospice partners.

Practice Example D3-B

A community geriatric practice serves a continuing care retirement community (CCRC) by providing consultations and ongoing co-management, with a particular focus on patients with Alzheimer’s and other dementias. The geriatric advanced practice registered nurses provide regular home-based follow-up and see patients in the CCRC’s skilled care section, communicating and collaborating with the facility medical director and/or the patient’s primary physician. An interdisciplinary team meeting occurs weekly with the geriatric advanced practice registered nurses, physicians, the medical director, the director of nursing, the CCRC spiritual care director, and the nursing home social worker and rehabilitation therapists. Team members express concern regarding caregiver stress and capacity for couples living in the assisted living community or independent living when one member of the couple has dementia. As a result, the practice hires an advanced practice registered nurse certified in both geriatrics and hospice and palliative care nursing; he facilitates the development of an expanded assessment of patient and family caregiver needs and distress. Procedures are developed to guide symptom assessment and management.
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with an emphasis on the psychological needs of both patients and family caregivers, including validated screening for depression. The practice and CCRC form collaborative relationships with the local hospital palliative care service for help with patients with concurrent medical illnesses and complex symptom needs along with a psychiatric practice that includes psychologists and grief counselors. This growing collaboration between the CCRC and the hospital palliative care service calls itself the Advance Illness Steering Committee (AISC) and selects a well-respected community hospice program as a preferred provider, setting up agreements to share data. The AISC evaluates ongoing needs for its shared patients, including how to further share education and resources across the entities to reach quality outcomes and ways to identify patients as soon as they are eligible for hospice. The hospice provides additional spiritual care resources and grief and bereavement support for all families served.

**Practice Example D3-C**

A large inner-city homeless shelter clinic delivers primary care to seriously ill homeless people. The homeless shelter clinic collaborates with the hospital palliative care service, including palliative care training for all the homeless shelter staff, clinic social workers and psychologists, and volunteer chaplains. The clinic establishes procedures for screening and managing depression and other emotional responses to illness, as well as screening for physical illnesses and symptoms. The homeless shelter clinic forms collaborative relationships with hospices that offer inpatient care in long-term care facilities or inpatient units when needed for end-of-life care.

**Practice Example D3-D**

A pediatric palliative care team at a tertiary children’s hospital developed a collaborative practice with the pediatric oncology program to optimize well-being of children throughout their cancer care trajectory. When a young girl with newly diagnosed metastatic cancer developed severe anxiety in the presence of clinicians, the palliative care team worked with the child and her parents to gain trust and assess the causes of her distress. The palliative team collaborated with child life specialists and the pediatric clinical psychologist to address the child’s anxiety, using a combination of play therapy, art therapy, relaxation techniques, and medication. The child’s mother played an integral role in helping the team to adjust strategies based on the child’s needs in the hospital, clinic, and home settings. Co-therapy sessions were facilitated to help the child and her identical twin process their feelings and anxiety as the disease advanced, providing opportunities for the child to identify and communicate what was most important to her at end of life.

**Practice Example D3-E**

A hospice agency has established a relationship with a Department of Veterans Affairs Medical Center (VAMC) as one of their community partners. The hospice agency recognizes the opportunity to improve their care of Veterans with dual diagnoses of advanced medical conditions along with psychiatric illnesses. The VAMC identifies palliative care-trained staff members to collaborate with the hospice interdisciplinary team and give specialty input. Along with a psychiatrist, one of the VAMC’s pharmacists voluntarily collaborates with the team. This leads to shared educational sessions for both entities and improvement in medication and symptom management for the patients.