

PALLIATIVE CARE CONSULT TEAMS (PCCT) AND VISN LEADS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive maintains and refines the role of Palliative Care Consult Teams (PCCT) at each VHA facility and Palliative Care leadership in each VISN.

2. SUMMARY OF MAJOR CHANGES:

a. Paragraph 3.b. and 4.c.(6): Emphasizes the need for collaboration among VA and non-VA health care systems.

b. Paragraph 3.e.: Outlines the transition of these teams and associated leaders from special purpose funding to enduring resources within existing budgets, provides for ongoing reporting to the Deputy Under Secretary for Health for Operations and Management on meaningful measures.

c. Paragraphs 4.d.(1), (2), and (3): Ensure electronic capture of workload using appropriate Stop Codes, call for facilities to determine needed adjustments in team staffing based on Veterans' needs and promotes labor mapping for palliative care physicians according to policy.

d. Paragraph 5.(3): Recommends (does not require) board certification in palliative care for all palliative care providers within 2 years of the release of this directive.

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: Geriatrics and Extended Care in the Office of Patient Care Services (10P4G) is responsible for the contents of this directive. Questions may be addressed at 202-461-6750.

5. RESCISSIONS: VHA Directive 2008-066, dated October 23, 2008 is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of June 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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DISTRIBUTION: Emailed to the VHA Publications Distribution List on June 21, 2017.

CONTENTS

PALLIATIVE CARE CONSULT TEAMS (PCCT) AND VISN LEADS

1. PURPOSE..... 1

2. BACKGROUND..... 1

3. DEFINITIONS..... 2

4. POLICY 3

5. RESPONSIBILITIES..... 3

6. REFERENCES..... 7

PALLIATIVE CARE CONSULT TEAMS (PCCT) AND VISN LEADS

1. PURPOSE

This Veterans Health Administration (VHA) Directive maintains and refines the role of Palliative Care Consult Teams (PCCT) at each VHA facility and Palliative Care leadership in each VISN. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. Approximately one-fourth of all Americans who die each year are Veterans, and 21,000 Veterans die in Department of Veterans Affairs (VA) inpatient care each year. Many of these Veteran deaths will be attributed to long-term chronic illnesses. There is a substantial need for hospice and palliative care (HPC) and the need is projected to increase for the next several years.

b. HPC is a covered service on equal priority with any other medical care service as authorized in the Medical Benefits Package. HPC is to be provided in any inpatient, outpatient, VA Community Living Center or home care setting. These services include, but are not limited to, advanced care planning, symptom management, inpatient HPC services, collaboration with community hospice providers, and access to home hospice care.

c. The mission of the VA HPC program is to honor Veterans' preferences for care at the end of life. Facilities are required to have in place a mechanism to identify Veterans who may be appropriate for HPC and determine their specific preferences for care. VHA staff should strive to meet the Veterans' needs in the setting that best accommodates their needs and preferences, including reasonable geographic proximity that limits hardship on the Veteran and family.

d. VA must offer to provide or purchase hospice care that VA determines an enrolled Veteran needs; this includes inpatient, CLC, and home hospice care (see title 38 Code of Federal Regulations (CFR) 17.36 and 17.38). Veterans who need hospice care may choose to receive such care through a non-VA payment source such as Medicare. However, if an enrolled Veteran in need of hospice care chooses to receive care from VA, needed hospice care services are to be provided or purchased by VA. VA medical facility staff will assist Veterans in obtaining needed hospice services through referral or purchase as appropriate.

e. Palliative Care Consult Teams have been required by policy since 2003. As part of the Comprehensive End of Life Care Initiative, targeted funding was directed from VA Central Office to VISNs for fiscal years 2009 to 2012 to build an enduring infrastructure of medical center palliative care consult teams and VISN palliative care leadership. Medical centers and VISNs are now expected to maintain and fund these teams and leadership positions using their own budgetary resources with anticipated reporting to the Deputy Under Secretary for Health, Operations and Management on meaningful measures and metrics to ensure continued delivery of quality palliative care for Veterans with serious illness.

3. DEFINITIONS

a. **Hospice and Palliative Care.** Hospice and palliative care (HPC) collectively represent a continuum of comfort-oriented and supportive services provided by an interdisciplinary team in the home, community, outpatient, community living centers (CLC), or inpatient settings for persons with serious illness.

(1) HPC includes a focus on quality of life and comfort as a significant aspect of the treatment plan for a person with serious illness. While palliative care supports a balance of comfort measures and life-prolonging measures, both hospice and palliative care seek to achieve the goals of care as well as support and provide bereavement care to the Veteran's family.

(2) The goal of HPC is to achieve the best possible quality of life and highest practicable level of well-being through relief of suffering, control of symptoms, and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs, and practices. Programs emphasize the comprehensive management of the physical, psychological, emotional, social and spiritual needs of the Veteran.

(3) Palliative care is a broader term that includes hospice care but does not require the presence of an imminently terminal condition (prognosis of 6 months or less). Palliative care may include a balance of comfort measures and life-prolonging interventions that vary across a wide spectrum.

(4) Hospice is a part of the continuum of palliative care, intended for individuals diagnosed with a known terminal condition with a prognosis of 6 months or less if the disease runs its normal course. The Veteran or surrogate makes an informed decision to receive hospice care and this care is delivered by an interdisciplinary team with expertise in this area.

b. **Palliative Care Consult.** Palliative care consults are requests by physicians or other health care professionals to the Palliative Care team for assistance in treating Veterans who have a life-limiting or serious illness and their families. Consult requests can be for inpatient, Community Living Centers (CLC), or outpatient settings and may include, but are not limited to, performing assessments and making recommendations related to prognosis, pain and symptom management, goals of care and associated treatment decisions, advance care planning, psychosocial, spiritual and other issues, family meetings, and referrals to hospice and other VA and community services. The PCCT reviews the initial inpatient consult request for Veteran needs and speaks with the referring physician/provider for any additional information. When the request requires a consult of complexity Level 3 or higher (CPT code 99243-99245 for inpatient consults, or 99253-99255 for outpatient consults), the physician or appropriate non-physician practitioner with physician collaborator responds and completes the initial consult in collaboration with the inter-disciplinary team. In accordance with the Veteran and family goals, the team then determines the plan for follow-up and on-going assessment and evaluation. Consults and follow-up visits are documented in

computerized patient record system (CPRS) using CPT coding to ensure electronic capture of palliative care workload.

c. **Palliative Care Consult Team.** A Palliative Care Consult Team (PCCT) is a core interdisciplinary group of professionals from medicine, nursing, social work, mental health and chaplaincy and may include other professionals such as clinical pharmacists, dietitians, physical, occupational, creative art, recreational and music therapists, and community health nurse coordinators. The team also includes administrative support to ensure it can conduct its principal responsibilities. The palliative care team members have demonstrated core competencies and evidence of sufficient Veteran-specific training in hospice and palliative care to meet the physical, psychological, emotional, social and spiritual needs of both Veteran and family. Board certification in palliative care is preferred for all palliative care providers (physicians and nurse practitioners) within two years of the release of this directive and when certification is not possible, documentation of palliative care expertise and experience is strongly encouraged.

4. POLICY

It is VHA policy that each VA medical center has a fully functioning Palliative Care Consult Team with sufficient dedicated Full-time Equivalent (FTE) staff to meet the needs of Veterans with serious illness and their families.

5. RESPONSIBILITIES

a. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for ensuring that:

(1) A Palliative Care Program Manager is designated to ensure oversight of the VISN's Palliative Care Programs and be the contact person for liaison activities with the HPC program office.

(2) The VISN Palliative Care Program Manager has dedicated time commensurate to meeting the following roles and responsibilities for the VISN.

(3) A clinician with palliative care expertise, preferably recognized by a professional board, is named as the VISN Palliative Care Clinical Champion.

(4) The VISN Palliative Care Clinical Champion has dedicated time appropriate to adequately fulfill the responsibilities as outlined in paragraph 5.c.

b. **VISN Palliative Care Program Managers.** The VISN Palliative Care Program Managers responsibilities include but are not necessarily limited to:

(1) Ensuring that collaboration and communication among palliative care teams in the VISN will lead to measurable improvement in palliative care (e.g., Bereaved Family Survey results);

(2) Developing, managing and coordinating the VISN-wide Palliative Care program in accordance with VHA Guidelines, Directives and Program initiatives (e.g. ensures inter-disciplinary staffing of Palliative Care Consult Teams at all sites);

(3) Monitoring and sharing best palliative care practices from both within VHA and in the private sector;

(4) Facilitating local and regional staff development and education in palliative care (e.g. face to face or virtual training);

(5) Supporting the development and activities of statewide Hospice-Veteran Partnerships (HVPs);

(6) Supporting the development and maintenance of hospice and palliative care units or households located in Community Living Centers and in acute care settings;

(7) Developing and implementing a quality improvement plan for the VISN, and reporting findings regularly to VISN leadership with recommended action plans; (e.g. sharing Bereaved Family Survey scores with leadership and front-line staff);

(8) Monitoring proper utilization of healthcare resources to include appropriate palliative care staffing and workload capture (e.g. ensuring proper coding and labor mapping to accurately account for palliative care workload);

(9) Ensure that medical centers employ case-finding mechanisms to identify Veterans in need of palliative care, and that palliative care is available to Veterans in all settings; and

(10) Meet with palliative care leaders and teams at sites throughout VISN at least annually, in order to provide guidance and resources and lead strategic planning.

c. **VISN Palliative Care Clinical Champion.** The VISN Palliative Care Clinical Champion's responsibilities include but are not necessarily limited to:

(1) Collaborating with the Palliative Care Program Manager and PCCTs in identifying and solving clinical and administrative challenges in the care of all Veterans with serious illness throughout the VISN;

(2) Serving as the facilitator for both palliative and non-palliative care medical staff in establishing widespread expertise through delivery of Veteran-centric palliative care training programs;

(3) Encouraging and stimulating improvement in the care of seriously ill Veterans by implementing best practices as identified by the HPC program office, peers in the field and in the medical literature; and

(4) Regular and routine reporting on quality measures and leading quality improvement initiatives to support VA and VISN initiatives.

(5) All medical facilities within the network have fully functioning interdisciplinary Palliative Care Consult Teams with dedicated staff sufficient to meet Veterans' needs and to meet the responsibilities as described in paragraph 5.b.

(6) Ensure that the PCCT has the clinical expertise that includes evidence of Veteran-specific palliative care training and the administrative support to conduct its principal responsibilities. These responsibilities include responding to inpatient and CLC consultations for HPC, active case-finding for HPC, assisting in the development and maintenance of a HPC program for the medical center, promoting educational activities in HPC for all medical center staff, participating in quality improvement activities in HPC for the medical center, and ensuring that the medical center has an identified VA liaison with community hospice programs. Lists of sample competencies for each PCCT discipline are available from the HPC program office (<https://www.vapulse.net/community/focus-areas/hospice-and-palliative-care>).

(7) Encourage the use of Service Agreements between the Palliative Care Program and inpatient and outpatient clinical services in each medical center. Sample Service Agreements can be obtained from the HPC program office.

d. **VA Medical Facility Director.** The VA medical facility Director is responsible for ensuring that:

(1) The facility's Palliative Care Program includes a fully functioning PCCT with designated staff sufficient to meet the needs of Veterans and their families and to meet the responsibilities as described in paragraphs 5.b. and 5.c.

(2) Electronic capture of palliative care workload (e.g. Palliative Care Workload Module or equivalent tool) is activated and that palliative care consults are documented using either Stop Code 351 (for hospice care related to a terminal illness) or DSS stop code 353 (for non-hospice palliative care services) and encounter coding using CPT codes 99241-99245 (for inpatient and CLC consults) or 99251-99255 (for outpatient consults).

(3) All palliative care physicians have their time that is devoted to clinical, administration, education, and research activities accurately labor mapped according to Managerial Cost Accounting Office guidelines in VHA Directive 2011-009: Physician and Dentist Labor Mapping, or subsequent policy issue. In addition, all non-physician dedicated members of the PCCT are strongly encouraged to be labor mapped to palliative care.

e. **VA Medical Facility Palliative Care Consult Team.** The VA medical facility PCCT is responsible for:

(1) Ensuring that access to primary (or basic) palliative care services is available 24 hours a day, 7 days a week. These services may be provided by core PCCT members or by other staff with evidence of training in palliative care.

(2) Performing consults in inpatient, CLC, and outpatient settings. **NOTE:** *Care beyond consultations such as the ongoing daily clinical management of Veterans receiving care in VA acute care and CLC hospice and palliative care units or households and/or Veterans receiving community hospice care requires additional PCCT staff FTE or is to be performed by staff other than the PCCT.*

(3) Promoting and/or providing integration of palliative care expertise beyond palliative care teams.

(4) Meeting at least weekly as a team to plan, review, and evaluate patient care plans of Veterans receiving palliative care, with input from both the Veterans and their families. Team meetings which include discussion of medication treatment plans should include the clinical pharmacist when possible. This includes but is not limited to performing initial and ongoing assessment of medication therapy, medication monitoring plans (as appropriate), and identifying patient-specific medication issues, including drug interactions, adverse effects, efficacy, appropriateness, and compliance challenges for Veterans receiving ongoing palliative care.

(5) Meeting regularly to discuss ongoing programmatic issues including quality improvement (e.g. quarterly review of Bereaved Family Survey results), staffing, policies, and clinical practices.

(6) The facility's PCCT with dedicated staff includes:

(a) A member designated as the PCCT Coordinator with minimum 0.5 dedicated time for the following responsibilities: Ensuring referrals from within the facility are addressed appropriately, coordinating team meetings, ensuring effective communications with community hospice agencies for transitioning Veterans, serving as a resource for VA staff that make community hospice referrals, promoting competency in palliative care for all members of the PCCT through current certification or by attendance at continuing education programs annually, and monitoring and reporting of quality measures.

(b) At least 0.3 dedicated time Full-time Equivalent (FTE) employee in each of these disciplines: physician, nurse, social worker, psychologist or other mental health provider, and chaplain.

(c) The minimum dedicated FTE employee is 0.3 FTE for each discipline. In medical centers where more than twenty comprehensive and unique consults are performed a month, directors are strongly encouraged to increase this minimum amount as required to meet the physical, psychological, emotional, social and spiritual needs of seriously ill Veterans and their families in inpatient, CLC, and outpatient settings and support the maintenance of an effective PCCT.

f. **Chief Consultant, Geriatrics and Extended Care.** The Chief Consultant, GEC is responsible for:

(1) Developing hospice and palliative care policy,

(2) Promoting reliable access to quality hospice and palliative care in all settings,

(3) Providing and promoting dissemination of educational resources to enhance the expertise of end of life care delivered by PCCTs and other staff,

(4) Promoting collaborative relationships with community hospice programs to enhance end of life care (e.g. Hospice-Veteran Partnerships), and

(5) Collecting, analyzing and communicating to Palliative Care Program Managers and Clinical Champions, PCCTs and their leadership on a regular basis and more fully each year the results of the data elements that support improved care of seriously ill Veterans.

6. REFERENCES

a. A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report © 2006 National Quality Forum.

b. Clinical Practice Guidelines for Quality Palliative Care, 3rd ed. National Consensus Project for Quality Palliative Care 2013.
<http://www.nationalconsensusproject.org/>

c. Institute of Medicine, Dying in America, Improving Quality and Honoring Individual Preferences Near the End of Life, 2014.

d. Meier D, Beresford L. "Consultation etiquette challenges palliative care to be on its best behavior." Journal of Palliative Medicine, Vol 10 November 2007.