VHA-PROVIDED PALLIATIVE AND HOSPICE CARE WORKLOAD CAPTURE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes policy and references for coding and workload capture of Palliative and Hospice Care (PHC) to ensure that they meet Veterans with complex care needs in Department of Veterans Affairs (VA) medical facilities.

2. SUMMARY OF MAJOR CHANGES: This directive:

a. Requires referral to the VHA Managerial Cost Accounting Office (MCAO) website, Program Documents, National Programs and Implementation Guide, Cost & Workload for GEC, available at: http://vaww.dss.med.va.gov/programdocs/pd_clinictop.asp, to ensure staff are using the most recent version of workload capture instructions. ***NOTE:*** *This is an internal VA website that is not available to the public.*

b. Relocates the Key Workload Capture Elements for Frontline Workers to Appendix A.

3. RELATED ISSUES: VHA Directive 1139, Palliative Care Consult Teams (PCCT) and VISN Leads, dated June 14, 2017.

4. RESPONSIBLE OFFICE: The Office of Geriatrics and Extended Care (GEC) (12GEC) is responsible for the contents of this directive. Questions may be addressed to the Palliative and Hospice Care program office in GEC at 202-461-6750 or emailed to VHACO12GECAction@va.gov.

5. RESCISSIONS: VHA Directive 2008-041, Hospice and Palliative Care Workload Capture, dated August 4, 2008 is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of February 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

BY THE DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Beth Taylor, DHA
Assistant Under Secretary for Health
for Patient Care Services

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publication Distribution List on February 25, 2021.

CONTENTS

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1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy concerning VHA responsibility for documentation and coding of workload for palliative and hospice care (PHC) in addition to outlining key related processes for frontline staff and leadership to promote accurate capture of workload. **AUTHORITY:** Title 38 United States Code (U.S.C.) § 7301(b); Title 38 Code of Federal Regulations (C.F.R.) 17.38.

2. BACKGROUND

a. 38 C.F.R. 17.38(a)(1)(xi)(A) outlines VHA's authority and obligation to offer to purchase or provide PHC to enrolled Veterans who need these services. PHC are covered services, on equal priority with other medical care authorized in the medical benefits package, and are to be appropriately provided in authorized inpatient, outpatient or home care settings.

b. VHA PHC's program mission is to honor Veterans' preferences for care. Department of Veterans Affairs (VA) medical facilities are required to identify Veterans who may be appropriate for PHC and determine their specific preferences for care. VHA staff strive to meet these Veterans' needs in the setting that best accommodates the Veterans' needs and preferences, including reasonable geographic proximity that limits hardship on Veterans and their families.

c. PHC 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. PHC 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. These programs emphasize the comprehensive management of the physical, psychological, emotional, social and spiritual needs of the Veteran.

d. The PHC Teams are available to serve as a resource and are central to the provision or purchase of PHC. These PHC Teams represent an enduring infrastructure of VA medical facilities and for accurate documentation of workload. Data integrity is a critical component in VHA as these data are used for workload capture, cost reporting, resource allocation and strategic planning.

e. Veterans with serious chronic illness often require both VHA and community-based services, VHA has a responsibility to promote efficient transitioning of Veterans to and from these community-based services through such programs as We Honor Veterans (www.WeHonorVeterans.org) which promotes enhanced collaboration among VA medical facilities and community hospices to improve the care of Veterans at end of life.

f. Pursuant to 38 U.S.C § 1710 (f) (1), Veterans receiving hospice care provided or purchased by VA (e.g. outpatient, contract nursing home or in a VA medical facility) are exempt from first-party medical copays.

g. Dually eligible Veterans (e.g., for both VA care and Medicare) choose the payer of their choice. Veterans who choose the Medicare hospice benefit or other non-VA payer retain their eligibility for full VA care and benefits. ***NOTE:*** *It is the responsibility of VHA to notify Veterans who opt to use the Medicare Hospice Benefit that VA has no authority to pay for any balances or copayments that may be due after Medicare or any other non-VA source makes payment for hospice care.*

3. DEFINITIONS

a. **Electronic Health Record.** Electronic health record (EHR) is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA) and Cerner platforms. ***NOTE:*** *The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.*

b. **Hospice.** Hospice is a subset of palliative care, intended for individuals choosing a comfort oriented approach to care (though disease modifying interventions are permitted) and includes a life-limiting illness with a prognosis of six months or less if the disease runs its normal course, as determined by a VA physician, even for Veterans receiving community care under the MISSION Act. Hospice care is delivered by an interdisciplinary team with experience and expertise in this specialty. See paragraph 6 for more information on Hospice care.

c. **Life-limiting Illness.** A life-limiting illness is a disease or condition that is expected to significantly shorten life span.

d. **Palliative Care.** 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. These palliative care interdisciplinary teams assist the Veteran and family in achieving 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.

4. POLICY

It is VHA policy that workload and cost related to PHC are correctly captured through accurate labor mapping of staff involved in providing PHC, as well as by the appropriate clinic and encounter coding, to ensure that they meet the needs of Veterans with complex care needs in VA medical facilities.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patience Care Services is responsible for supporting the program office with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations.is responsible for:

(1) Communicating the contents of this directive to each of the e. Veterans Integrated Service Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **Executive Director, Geriatrics and Extended Care.** The Executive Director, GEC, as the leader of PHC program office is responsible for:

(1) Developing policy for palliative care and hospice care.

(2) Ensuring compliance with this directive through appropriate monitoring activities and promoting accurate documentation of PHC workload.

(3) Promoting collaborative relationships with community hospice programs to enhance Veterans' access to these services and promote smooth transitions to and from VA medical facilities and care programs (e.g., Veteran Community Partnerships and the We Honor Veterans program, see link in references).

(4) Collecting, analyzing and collaborating with VISN Palliative Care Program Managers, VA medical facility PHC Teams and their leadership on the data elements (e.g., resource allocations and quality measures) that support improved care of seriously ill Veterans.

e. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Designating the VISN PHC Program Manager and ensuring that this individual has dedicated time commensurate to meeting their responsibilities as described in paragraph 5.f.

(2) Quarterly monitoring of selected workload and performance measures for proper utilization of health care resources to meet the needs of seriously ill Veterans, to include appropriate VA medical facility PHC Team staffing and accurate workload capture.

(3) Ensuring that all VA medical facilities within the VISN comply with this directive and informing GEC leadership when barriers to compliance are identified.

(4) Reviewing the workload capture variances, findings and recommendations submitted by the VISN PHC Program Manager.

f. **VISN Palliative and Hospice Care Program Manager.** The VISN PHC Program Manager is preferably a clinician with significant palliative care and hospice expertise whose responsibilities include but are not limited to:

(1) Developing, managing and coordinating the VISN-wide PHC program in accordance with VHA GEC guidelines, directives and program initiatives.

(2) Supporting the VISN and VA medical facility Directors in ensuring appropriate interdisciplinary staffing of VA medical facility PHC Teams.

(3) Supporting the development of and implementation of activities to promote collaborative relationships with community hospice providers and others to improve the care of Veterans with serious illness (e.g., Veteran Community Partnerships www.va.gov/healthpartnerships/vcp.asp).

(4) Providing education to PHC Teams on the importance of accurate PHC workload capture, according to VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015; VHA Managerial Cost Accounting Office National Programs and Implementation Guide; VHA Coding Guidelines; and GEC.

(5) Reporting to the VISN Director on variances in workload capture across the VISN to include validating the workload capture findings and offering recommendations for efficient and effective use of resources (e.g., increased use of telehealth).

(6) Serving as the VISN point of contact for liaison activities with the PHC program office and GEC in Central Office.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Supporting the VISN Director, the VISN PHC Program Manager and the VA medical facility PHC Teams as described in paragraphs 5.e., 5.f. and 5.k. to ensure accurate workload capture.

(2) Monitoring for proper utilization of health care resources to meet the needs of seriously ill Veterans, to include appropriate VA medical facility PHC Team staffing and accurate workload capture.

(3) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if non-compliance is identified.

(4) Ensuring VA medical facility Managerial Cost Accounting (MCA) staff set up the clinics for the stop codes to permit the capture of PHC workload. See Appendix A.

h. **VA Medical Facility Chief Financial Officers.** The VA medical facility CFOs are responsible for ensuring the cost and workload reporting of their VA medical facility is accurate.

i. **VA Medical Facility Service Chiefs.** The VA medical facility Service Chiefs are responsible for ensuring the cost and workload reporting of their departments is accurate.

j. **VA Medical Facility Managerial Cost Accounting Staff.** The VA medical facility MCA staff are responsible for establishing in EHR the clinics for the stop codes to permit the capture of PHC workload. See Appendix A.

k. **VA Medical Facility Palliative and Hospice Care Teams.** The VA medical facility PHC Teams include a core interdisciplinary group of professionals from medicine, nursing, social work, psychology or other mental health discipline, and chaplaincy. Further, this team may include other professional disciplines such as pharmacy, dietetics, physical, occupational and recreation therapy and community health nurse coordinators. Team members have appropriate education, credentialing, experience and ability to meet the physical, psychological, emotional, social and spiritual needs of both Veteran and family at end of life. The PHC Team is responsible for:

(1) Facilitating the accurate capture of PHC workload in support of quality care for Veterans with serious illness and their families.

(2) Supporting VA medical facility and VISN leadership in monitoring and reporting workload to ensure PHC is available to Veterans in need.

(3) Establishing and maintaining effective communications with community hospice agencies on behalf of Veterans transitioning from the community to the VA medical facilities.

(4) Serving as a resource for VA non-PHC staff that make community hospice or palliative care referrals.

(5) Collaborating with the VISN PHC Program Manager to ensure accurate workload capture practices are in place and to validate workload reporting, including collaboration with VA medical facility MCA staff, VA medical facility leadership and the PHC Program Office to resolve workload capture inaccuracies. ***NOTE:*** *PHC beyond and separate from consultations, such as the ongoing daily clinical management of Veterans receiving care in a VHA CLC hospice neighborhood or in an acute care hospice bed will only be captured if this inpatient workload is captured via the mechanisms outlined in this*

directive. This workload must be considered when determining staffing levels necessary to meet the needs of Veterans who require palliative care or hospice.

6. HOSPICE CARE ADDITIONAL INFORMATION

a. The focus of hospice care is comfort, quality of life and the honoring of Veteran preferences. The Veteran or surrogate makes an informed decision to receive hospice care and this care is delivered by an interdisciplinary hospice team with expertise in this area. Hospice Care workload reflects care provided to a Veteran meeting all the following criteria:

(1) Is diagnosed with a life-limiting illness (e.g., life expectancy of less than 6 months as determined by a VA physician, even for Veterans receiving community care under the MISSION Act).

(2) Has treatment goals focused on comfort (though disease modifying interventions are permitted).

(3) Chooses to receive hospice care, documentation of verbal consent is sufficient.

(4) The hospice care plan is managed and delivered by an interdisciplinary care team that has experience and training in hospice and is responsible for the care related to the terminal illness.

NOTE: *The prognostic component for hospice care described here is consistent with Medicare hospice criteria. While many prognostic guidelines are useful in determining eligibility for hospice, prognostication is an inherently inaccurate science. Some Veterans appropriate for hospice care will survive and require hospice services for longer than 6 months. Periodic evaluation of Veterans, their prognoses, and their expected benefit from hospice care needs to be documented in the care plan.*

b. Hospice services, whether purchased or provided by VHA, are to be processed immediately to avoid delays in accessing needed care. Note, however, Veterans currently receiving community-based hospice care that make a non-urgent request for VHA provided or purchased hospice care may require additional time to completion.

7. CODING AND WORKLOAD CAPTURE FOR PALLIATIVE AND HOSPICE CARE

Instructions for accurate coding and workload capture for VA-provided PHC, to include labor mapping and use of stop codes, are available on the VHA MCAO website, Program Documents, National Programs and Implementation Guide: http://vaww.dss.med.va.gov/programdocs/pd_clinictop.asp., and as instructed by the GEC program office. ***NOTE:*** *This is an internal VA website that is not available to the public.*

8. TRAINING

a. There are no formal training requirements associated with this directive.

b. For VA staff that provide palliative and hospice care services for Veterans, their service level orientation checklist should include on-the-job training or competency assessments to ensure effective capturing of this workload. This should occur during their service level orientation within 90 days of employment. Updates to this directive and the associated workload capture processes (e.g., including the transition to workload capture using the Cerner Electronic Medical Health Record or additional training requirements) shall be communicated by the GEC and PHC program offices to medical facility leadership after obtaining concurrence from VA central office leadership.

9. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive shall be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

10. REFERENCES

a. P.L. 101-576.

b. 38 U.S.C. § 1710 (f) (1).

c. 38 U.S.C. § 7301(b).

d. 38 C.F.R. 17.38.

e. 38 C.F.R. 17.98(a).

f. 38 C.F.R. 17.110(e)(15).

g. VHA Directive 1082, Patient Care Data Capture, dated March 24, 2015.

h. VHA Coding Guidelines, available at: https://dvagov.sharepoint.com/sites/VACOVHAHDI/HIM/vaco_HIM/subsite5/subsite3/Coding%20References/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVACOVHAHDI%2FHIM%2Fvaco%5FHIM%2Fsubsite5%2Fsubsite3%2FCoding%20References%2FCoding%20Resources%2FVHA%20Coding%20Guidelines&FolderCTID=0x012000DF24E0501B115C4EB92477CD2D2E40C3. ***NOTE:*** *This is an internal VA website that is not available to the public.*

i. VHA Managerial Cost Accounting Office website, Program Documents, National Programs and Implementation Guide, available at: http://vaww.dss.med.va.gov/programdocs/pd_clinictop.asp. ***NOTE:*** *This is an internal VA website that is not available to the public.*

j. We Honor Veterans Program, accessible at: http://www.WeHonorVeterans.org.
NOTE: *This link is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

KEY WORKLOAD CAPTURE ELEMENTS FOR FRONTLINE STAFF

To assist field staff and leadership in promoting accurate workload capture, the key elements of workload capture are summarized below to provide an outline of the action items commonly used in workload capture settings. ***NOTE:*** *Department of Veterans Affairs (VA) employees, depending on the status of the Cerner software implementation at their VA medical facility, will need to adapt to the Cerner software to effectively capture associated workload with guidance to be provided by the Geriatrics and Extended Care (GEC) program office as part of the Cerner implementation process.*

a. Palliative and Hospice Care (PHC) Teams use of stop codes 351 for hospice and 353 for palliative care. These stop codes represent care delivered by hospice or palliative specialists and their teams and are used across Veterans Health Administration (VHA) to monitor workload and resource allocation specific to PHC Teams.

b. VA medical facility Managerial Cost Accounting (MCA) staff (formerly known as Decision Support System (DSS) staff) need to set up the clinics for these stop codes to permit the capture of this specialist workload in the following areas:

(1) Outpatient (Hospice 351 and Palliative Care 353).

(2) Inpatient (Hospice 351 and Palliative Care 353).

(3) Telephone (Telephone Stop Code/351 and Telephone Stop Code/353).

(4) E-consult (Hospice 351/697 and Palliative Care 353/697).

c. Below is a chart of commonly used stop codes and the associated credit stop code:

Clinic	Stop Code	Credit Stop Code
HOSPICE Nurse Practitioner	351	185
IP HOSPICE PROF BED SVCS	351	Depends on service delivered
HOSPICE E CONSULT-X	351	697
PALLIATIVE CARE	353	Depends on service delivered
IP PALLIATIVE CARE PROF BED	353	Depends on service delivered

PALLIATIVE CARE E CONSULT-X	353	697
TELEPHONE HOSPICE CARE	324 (Geriatrics)	351
TELEPHONE PALLIATIVE CARE	324 (Geriatrics)	353
TELEHEALTH HOSPICE CARE to Veteran's home	351	179
TELEHEALTH PALLIATIVE CARE to Veteran's home	353	179

Inpatient Consultation (99251-99255). These codes are used for an initial consultation visit for an inpatient, nursing home care unit, or a partial hospital setting. These codes are only used once per inpatient stay by the reporting consultant. Follow-up Inpatient Consultation Visits are coded using the subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310). Evaluation and Management Codes are subject to change, please see the link below for updates:

https://dvagov.sharepoint.com/sites/VACOVHAHDI/HIM/vaco_HIM/subsite5/subsite3/Coding%20References/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVACOVHAHDI%2FHIM%2Fvaco%5FHIM%2Fsubsite5%2Fsubsite3%2FCoding%20References%2FCoding%20Resources%2FVHA%20Coding%20Guidelines&FolderCTID=0x012000DF24E0501B115C4EB92477CD2D2E40C3&View=%7BFB85FBD0%2D6E92%2D4B3C%2DABF8%2DB9F008CF66E9%7D. ***NOTE:*** *This is an internal VA website that is not available to the public*.

d. **Outpatient Consultation (new patient 99201-99205 and established patient 99211-215).** These codes are used in an outpatient or ambulatory care setting, including domiciliary and hospital observation stays.

e. **Telephone.** Encounters will often use the primary stop code of 324 (e.g., Geriatrics) with the PHC codes of 351 or 353 in the secondary stop code "credit" position.

f. **Telehealth.** For PHC encounters to the patient's home, the PHC stop codes of 351 or 353 should be used in the Primary Stop Code position with the stop code of 179 in the "credit" position for telehealth encounters to the Veteran's residence.

g. **Pronouncement of Death.** Use Current Procedural Terminology (CPT) codes 99238 - 99239 when a provider pronounces the death of a Veteran, completes the death summary and talks with the deceased Veteran's family.

h. **Bereavement support visits.** In accordance with 38 Code of Federal regulation (C.F.R.) 17.98(a), bereavement support visits should be entered as collateral or

historical visits in Event Capture. A common diagnosis code would be Z63.4, Bereavement, uncomplicated. The procedure code would be 90899.

i. **Psychologists/Social Workers/Chaplains.** Encounters are used by psychologists, social workers and chaplains to capture all workload, including palliative and hospice care workload. Each of these disciplines receives specific instructions from their program office on the procedures for appropriate workload capture.

j. **Use of the ICD-10 (International Classification of Diseases) Code Z51.5 Encounter for palliative care.** This code is typically used as an additional or secondary code to identify patients who receive palliative care in any health care setting, including a hospital, from any health care provider or specialty. As such, VHA does not use this code to monitor or track workload capture by palliative and hospice care specialty Teams.

k. **Provider Productivity.** Accuracy of labor mapping as well as CPT coding are essential to achieving a true reflection of providers' clinical productivity. VHA accounts for efficiency of work performed by physicians, advanced practice nurses, physicians' assistants, psychologists and others through reports developed and maintained by the Office of Productivity and Efficiency (OPES) http://opes.vssc.med.va.gov/Pages/Default.aspx. The OPES reporting is based on a Relative Value Unit (RVU) based method similar to that used by the Centers for Medicare and Medicaid Services (CMS) in the private sector. ***NOTE:*** *This is an internal VA website that is not available to the public.*

l. **Clinical Coding.** Use of clinical coding in the Veteran's EHR, including CPT and International Classification of Diseases (ICD) codes, is directed by Health Information Management Service (HIMS) in the VHA Coding Guidelines, available at: https://dvagov.sharepoint.com/sites/VACOVHAHDI/HIM/vaco_HIM/subsite5/subsite3/Coding%20References/Forms/AllItems.aspx?RootFolder=%2Fsites%2FVACOVHAHDI%2FHIM%2Fvaco%5FHIM%2Fsubsite5%2Fsubsite3%2FCoding%20References%2FCoding%20Resources%2FVHA%20Coding%20Guidelines&FolderCTID=0x012000DF24E0501B115C4EB92477CD2D2E40C3&View=%7BFB85FBD0%2D6E92%2D4B3C%2DABF8%2DB9F008CF66E9%7D#InplviewHashfb85fbd0-6e92-4b3c-abf8-. Please see VHA Managerial Cost Accounting Office (MCAO) stop code list, available at: http://vaww.mcao.va.gov/programdocs/pd_oident.asp. ***NOTE:*** *These are internal VA websites that are not available to the public.*

m. **Workload and Cost Coding and Reporting.** The Chief Financial Officers (CFO) Act of 1990 (Public Law (P.L.) 101-576) requires agency accountability and requires each agency CFO to, inter alia, develop and maintain an integrated agency accounting and financial management system, including financial reporting and internal controls. The MCA system is an example of the accounting and financial management system that assigns costs to the product level in all operations. In VHA, the MCAO, a component of the VHA Office of Finance, operates, maintains and upgrades the software system known as DSS to provide these activity-based cost accounting services.