

October 23, 2008

PALLIATIVE CARE CONSULT TEAMS (PCCT)

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes Palliative Care Consult Teams (PCCT) and their roles at each VHA facility.

2. BACKGROUND:

a. Approximately one-fourth of all Americans who died in 2006 were veterans, and 23,000 veterans died in Department of Veterans Affairs (VA) inpatient care. 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 and on equal priority with any other medical care service as authorized in the Medical Benefits Package. HPC is to be appropriately provided in any inpatient, outpatient, 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 the veteran's 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. Facility staff should strive to meet the veterans' needs in the setting that best accommodates their needs and preferences, including reasonable geographic proximity.

d. VA must offer to provide or purchase hospice care that VA determines an enrolled veteran needs; this includes inpatient 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 facility staff will assist veterans in obtaining needed hospice services through referral or purchase as appropriate.

e. Definitions

(1) Hospice and Palliative Care (HPC). Hospice and palliative care collectively represent a continuum of comfort-oriented and supportive services provided in the home, community, outpatient, or inpatient settings for persons with advanced life-limiting disease.

(a) HPC adds focus on quality of life and comfort to the treatment plan in a person with advanced disease that is life-limiting and refractory to disease-modifying treatment. HPC supports a balance of comfort measures and curative interventions to achieve the goals of care as well as support and provide bereavement care to the veteran's family.

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(b) Hospice is a mode of palliative care, often associated with specific characteristics of the individual receiving the care, diagnosed with a known terminal condition with a prognosis less than 6 months, and desiring therapies with a palliative intent for the terminal condition.

(c) Palliative care is a broader term that includes hospice care as well as other care that emphasizes symptom control, but does not necessarily require the presence of an imminently terminal condition or a time-limited prognosis. Palliative care may include a balance of comfort measures and curative interventions that varies across a wide spectrum.

(d) The goal of HPC is to achieve the best possible quality of life 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 patient.

(2) Palliative Care Consult. Palliative care consults are requests by physicians or other health care professionals to the Palliative Care team for assistance in treating patients who have a life-limiting or serious illness and their families. Consult requests can be for either inpatient 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. One or more members of the palliative care consult team may respond and involve other team members as indicated by the nature of the consult and the needs of the patient and family.

(3) Palliative Care Consult Team. A Palliative Care Consult Team (PCCT) is a core interdisciplinary group of professionals from medicine, nursing, social work, psychology or other mental health provider and chaplaincy and may include other professionals such as pharmacists, dietitians, physical therapist, occupational and recreation therapist, creative art 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 appropriate education, credentialing, experience, and ability to meet the physical, psychological, emotional, social and spiritual needs of both patient and family. The PCCT is responsible for promoting and disseminating educational expertise among staff providing end of life care to ensure access to core palliative care services is available 24 hours a day, seven days a week. These services may be provided by core PCCT members or by other staff with evidence of training in palliative care adequate to address veterans' needs. The PCCT meets at least weekly as a team, to plan, review and evaluate patient care plans, with input from both the veteran and his family. The team also meets regularly to discuss provision of quality care, including staffing, policies and clinical practices.

3. POLICY: It is VHA policy that each Network Director is responsible for ensuring that its Palliative Care Program is coordinated at the VISN level and that each facility's Palliative Care

Program has a fully functioning Palliative Care Consult Team with dedicated Full-time Equivalent Employee (FTEE) staff using available budgetary resources.

4. ACTIONS

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

(1) A Palliative Care Program Manager/Coordinator is named as the contact person to assure oversight of the VISN's Palliative Care Program.

(a) The commitment of the VISN Palliative Care Program Manager/Coordinator's time is sufficient to adequately fulfill the responsibilities as outlined below. Note that in select VISNs these responsibilities have been shown to require a FTEE equivalent but this may vary depending on VISN size and end of life care needs.

(b) The VISN Palliative Care Program Manager/Coordinator's responsibilities include but are not necessarily limited to ensuring that collaboration and communication among palliative care teams in the VISN will lead to measurable improvement in palliative care as well as developing, managing and coordinating the VISN-wide Palliative Care program in accordance with VHA Guidelines, Directives and Program initiatives. The VISN Palliative Care Program Manager/Coordinator monitors and shares best palliative care practices from both within VHA and in the private sector; supports development and activities of statewide Hospice-Veteran Partnerships (HVPs); facilitates local and regional staff development and education in palliative care; develops and implements a quality improvement plan for the VISN annually and reports findings regularly to VISN leadership; monitors proper utilization of palliative care resources and facilitates appropriate palliative care workload capture.

(2) All facilities within the network have fully functioning Palliative Care Consult Teams with dedicated staff sufficient to meet veterans' needs and to meet the responsibilities as defined in the Background Section 2e, (2) and (3). The VISN Director will:

(a) Ensure that the PCCT has the clinical expertise and the administrative support to conduct its principal responsibilities. These responsibilities include responding to inpatient consultations for HPC, active case-finding for HPC, assisting in the development and maintenance of a HPC program for the facility, promoting educational activities in HPC for all facility staff, participating in quality improvement activities in HPC for the facility, and ensuring that the facility has an identified VA liaison with community hospice programs. Lists of sample competencies for each PCCT discipline are available on the Geriatrics and Extended Care Web site.

(b) Have a mechanism in place for PCCTs to receive consults and document results electronically. This will be accomplished by having a standard title for the consult request or service of "Palliative Care" and a standard title that includes the word "Palliative" or "Hospice" to provide for consistency in the process of national reporting.

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(c) Encourage the use of Service Agreements between the Palliative Care Program and inpatient and outpatient clinical services in each facility, such as Intensive Care Units, Primary Care, Home Based Primary Care and Oncology/Hematology. A sample Service Agreement can be found on the Geriatrics and Extended Care Website. Key elements of the Palliative Care Service Agreement include:

1. A statement that authorized representatives of the facility's Palliative Care Program and the associated Clinical Service indicate by their signatures their acceptance of the terms and conditions of the Agreement.

2. Characteristics of patients who should receive consideration for referral to the Palliative Care Program.

3. The mechanism through which referrals will be made, including a tracking mechanism for consultation requests, and the time frame by which a response will be received by the referring service.

4. The scope of Palliative Care Program services available to veterans and their families.

5. The interface between the referring service and the Palliative Care Program.

6. Annual review of the Agreement.

(e) Submit a report to the Office of Geriatrics and Extended Care (114), VA Central Office, by the last day of October each year on the total number of PCCT consults, the number of PCCT consults performed in the outpatient setting, the number of inpatient deaths, the percent of inpatient deaths in which the PCCT was consulted, and for those deaths, the average number of days between initial PCCT consultation and the death of the veteran during the prior fiscal year. Submit data on VA Form 10-0405, Format for Annual Reporting Requirement (see Att. A). Alternatively and recommended if possible, consolidated data from VISNs listing each facility's data can be submitted in an Excel spreadsheet which includes the following variables: Fiscal Year; VISN; facility names and numbers; name of contact; telephone number of contact; number of PCCT consults; number of PCCT consults performed in the outpatient setting; total number of inpatient deaths in the facility; and percent of inpatient deaths in which the PCCT was consulted (for those deaths, the average number of days between initial PCCT consultation and the death of the veteran). *NOTE: An Excel spreadsheet template is posted on the GEC Web site and may be used by the VISN to submit data.*

b. Facility Director. The 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 defined in the Background Section 2e, (2) and (3).

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

(a) One member of the PCCT is designated as the coordinator, whose responsibilities include: 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, and promoting competency in palliative care for all members of the PCCT through current certification or by attendance at continuing education programs annually.

(b) At least 0.25 dedicated time Full-time Equivalent (FTE) employee in each of these disciplines: physician, nurse, social worker, psychologist or other mental health provider and chaplain. These disciplines have been in place by policy since 2003 and are now expanded to include a psychologist to assist in addressing mental health issues. *NOTE: The minimum dedicated FTE employee is 0.25 FTE for each discipline. Facility directors are 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 both inpatient and outpatient settings and support the maintenance of an effective PCCT with dedicated staff as defined in the Background Section 2e.*

(c) At least a dedicated 0.25 FTE administrative support staff to assist with coordinating educational programs, monitoring and reporting of quality measures, and disseminating best practices.

c. 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 (eg Hospice-Veteran Partnerships, and

(4) collecting, analyzing and communicating to the PCCTs and their leadership each year the results of the data elements required to be reported in this Directive.

5. REFERENCES

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

b. *Clinical Practice Guidelines for Quality Palliative Care*. National Consensus Project for Quality Palliative Care 2004.

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

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6. FOLLOW-UP RESPONSIBILITIES: The Office of Patient Care Services (114) is responsible for the contents of this directive. Questions may be addressed to 202-461-6750.

7. RESCISSION: This VHA Directive expires October 31, 2013.

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Under Secretary for Health

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ATTACHMENT A

**VA FORM 10-0405, ANNUAL PALLIATIVE CARE CONSULT REPORTING
REQUIREMENT**

Below is an imbedded copy of Department of Veterans Affairs (VA) Form 10-0405, Annual Palliative Care Consult Reporting Requirement. This form can also be found on the VA Forms web site at: <http://vaww.va.gov/vaforms>



10-0405-fill.pdf