

PALLIATIVE CARE CONSULT TEAMS AND VETERANS INTEGRATED SERVICE NETWORK LEADS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive states policy regarding the role of Palliative Care Consult Teams (PCCT) at each Department of Veterans Affairs (VA) medical facility and palliative care leadership in each Veteran Integrated Service Network (VISN) for the Palliative and Hospice Care (PHC) program.

2. SUMMARY OF MAJOR CHANGES: Major changes include:

a. Replaces and updates the definitions of hospice and palliative care within the context of the PHC continuum in paragraph 3.

b. Defines VHA's provision of concurrent palliative care in paragraph 2 to address the myth that terminally ill Veterans electing the Medicare Hospice Benefit are no longer eligible to access their VHA benefits.

c. Updates responsibilities in paragraph 5 for the Executive Director, Office of Geriatrics and Extended Care (GEC) and VA medical facility PHC Team Coordinator and adds responsibilities for VISN Rehabilitation and Extended Care Integrated Clinical Community Leaders.

d. Includes recommended minimum staffing levels for the VA medical facility PCCT to address the dramatic growth in workload and demand for palliative care consult services (see Appendix A).

3. RELATED ISSUES: VHA Directive 1440, VHA-Provided Palliative and Hospice Care Workload Capture, dated February 19, 2021; VHA Handbook 1004.03(2), Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017.

4. RESPONSIBLE OFFICE: The Office of Geriatrics and Extended Care in the Office of Patient Care Services (12GEC) is responsible for the contents of this directive. Questions may be addressed to GEC by phone at 202-461-6750 or by email to the VHA 12 GEC Action inbox (VHA12GECAction@va.gov).

5. RESCISSIONS: VHA Directive 1139, Palliative Care Consult Teams (PCCT) and Veterans Integrated Service Network (VISN) Leads, dated June 14, 2017, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of September 2027. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

September 9, 2022

VHA DIRECTIVE 1139

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

/s/ M. Christopher Saslo
DNS, APRN-BC, FAANP
Acting Assistant Under Secretary for Health
for Patient Care Services/CNO

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 Publications Distribution List on September 12, 2022.

CONTENTS

PALLIATIVE CARE CONSULT TEAMS AND VETERANS INTEGRATED SERVICE NETWORK LEADS

1. PURPOSE..... 1

2. BACKGROUND..... 1

3. DEFINITIONS 2

4. POLICY 3

5. RESPONSIBILITIES..... 3

6. TRAINING 8

7. RECORDS MANAGEMENT 8

8. REFERENCES 8

APPENDIX A

VA MEDICAL FACILITY PALLIATIVE CARE CONSULT TEAM STAFFING A-1

PALLIATIVE CARE CONSULT TEAMS AND VETERANS INTEGRATED SERVICE NETWORK LEADS

1. PURPOSE

This Veterans Health Administration (VHA) directive states policy regarding the role of Palliative Care Consult Teams (PCCT) at each Department of Veterans Affairs (VA) medical facility and palliative care leadership in each Veterans Integrated Service Network (VISN) for the Palliative and Hospice Care (PHC) program. **AUTHORITY:** 38 U.S.C. § 7301(b).

2. BACKGROUND

a. Approximately one-fifth of all Americans who die each year are Veterans and approximately 18,000 Veterans die in VA inpatient care each year. Many of these Veteran deaths are attributed to long-term chronic illnesses. There is a substantial need for VA's PHC program, which is projected to increase over the next several years.

b. PHC is a covered service on equal priority with any other medical care service as authorized in VA's medical benefits package. PHC services are delivered in inpatient, outpatient, VA Community Living Centers (CLCs) or home care settings. These services include but are not limited to, advance care planning, symptom management, inpatient PHC consultation or management, goals of care conversations and collaboration with home and community hospice providers.

c. The mission of VA's PHC program is to honor Veterans' preferences for care. VA medical facilities are required to identify Veterans who may be appropriate for PHC and determine their specific preferences for care. VA medical facility staff must 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. PHC is delivered by a specialized VA medical facility PCCT whose goal 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. PHC programs and VA medical facility PCCTs emphasize the comprehensive management of the physical, psychological, emotional, social and spiritual needs of Veterans with life-limiting or serious illness.

e. If an enrolled Veteran needs palliative or hospice care and chooses to receive care from VA, VA must offer to provide or purchase PHC services. If an enrolled Veteran needs palliative or hospice care and chooses to receive care outside VA, VA must offer to purchase PHC services. VA medical facility staff will assist Veterans in obtaining these services through referral or purchase as appropriate while seeking to obtain these services in the Veteran's community. Veterans may also choose to receive PHC through a non-VA payment source such as Medicare.

f. VISNs and VA medical facilities maintain and fund PCCTs and associated leadership positions (e.g., Rehabilitation and Extended Care Integrated Care Community (REC ICC) Leaders) using their own budgetary resources. VISNs and VA medical facilities also report to the Assistant Under Secretary for Health for Patient Care Services on meaningful measures and metrics as established by Office of Geriatrics and Extended Care (GEC) leadership to ensure continued delivery of quality palliative care for Veterans with serious illness.

g. Concurrent palliative care is VA's provision of specialized palliative care that supplements the care Veterans receive as part of their community hospice care plan, whether the hospice care is provided through the Medicare Hospice Benefit, VA-paid hospice or other medical insurance or resource. Enrolled Veterans have full access to their VA medical benefits (e.g., specialized palliative care services) whether they are receiving hospice care or not. While VA must not duplicate services provided by community hospices, VA will offer to provide or purchase specialized concurrent palliative care treatments that align with the Veteran's goals of care when the need for these services is identified by a VA PCCT or VA health care provider.

3. DEFINITIONS

a. **Hospice.** Hospice is a part of the PHC continuum that focuses on the Veteran's comfort and quality of life, with input on goals of care from the Veteran or surrogate and family and includes bereavement support for families. Hospice is for individuals with a prognosis of 6 months or less if the disease runs its normal course, as determined by a VA physician. The Veteran or surrogate makes an informed decision to receive hospice care and this care is delivered by VA medical facility staff with expertise in this area or by a community hospice. **NOTE:** *A supportive bereavement phone call from VA medical facility staff (not necessarily a member of the PCCT) to the family of a Veteran that died in a VA medical facility is one of the most meaningful quality interventions reported by bereaved family members.*

b. **Palliative Care.** For the purpose of this directive, palliative care is a broader part of the PHC continuum than hospice care, as it does not require the presence of an imminently terminal condition (prognosis of 6 months or less). Similar to hospice, palliative care focuses on comfort and quality of life, with input from the Veteran or surrogate and family on goals of care. However, palliative care also supports a balance of comfort measures and life-prolonging measures as provided by a specialized VA medical facility PCCT in the home, community, outpatient, CLC or inpatient settings for Veterans with life-limiting or serious illness.

c. **Palliative Care Consult.** A palliative care consult is a request to the VA medical facility PCCT by physicians or other health care providers or care teams for assistance in treating Veterans who have a life-limiting or serious illness and their families. Palliative care consult requests can be for inpatient, 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.

4. POLICY

It is VHA policy that each VA medical facility must have a fully functioning PCCT with sufficient dedicated full-time equivalent (FTE) VA medical facility staff to meet the needs of Veterans with serious illness and their families. **NOTE:** See specific staffing guidance in Appendix A.

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 Patient Care Services is responsible for supporting GEC 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 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, Office of Geriatrics and Extended Care.** The Executive Director, GEC is responsible for:

(1) Developing PHC policy and promoting reliable access to quality VISN PHC programs in all settings.

(2) Providing and promoting the dissemination of educational resources developed by the national PHC program within GEC and community partners to enhance the expertise of end-of-life care delivered by VA medical facility PCCTs and other staff.

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

(4) Collecting, analyzing and communicating the results of the data elements that support improved care of Veterans with serious illness to REC ICC Leaders, VISN PHC Program Managers, VA medical facility PHC Team Coordinators and VA medical facility leadership at least quarterly and as indicated.

(5) Providing oversight for the VISN and VA medical facility compliance with this

directive (e.g., quarterly review of workload and performance indicators) and ensuring corrective action is taken when non-compliance is identified.

(6) Ensuring that quality improvement collaboratives (virtual meetings for VA medical facility PCCTs from all VA medical facilities within a VISN) occur twice a year.

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

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

(2) Designating a VISN PHC Program Manager to ensure oversight of the VISN's PHC programs and serve as the contact person for liaison activities with the national PHC program within GEC.

(3) Reviewing quarterly PHC program performance review and programmatic issues reported by the VISN REC ICC Leader.

(4) Ensuring the VISN PHC Program Manager has dedicated time appropriate to adequately fulfill the responsibilities as outlined in paragraph 5.g.

f. **Veterans Integrated Service Network Rehabilitation and Extended Care Integrated Clinical Community Leader.** The VISN REC ICC Leader is responsible for:

(1) Serving as an advisor for all programmatic, clinical or other issues in the care of Veterans with serious illness who could benefit from the PHC program.

(2) Reporting to the VISN Director on a quarterly basis regarding VISN PHC program performance (e.g., bereaved family survey results), workload and programmatic issues as provided by the national PHC program within GEC and the VISN PHC Program Manager.

(3) Collaborating with the VISN PHC Program Manager in implementing quality improvement initiatives, monitoring performance of VA medical facility PCCTs and ensuring adequate staffing of VA medical facility PCCTs to meet the needs of Veterans with serious illness.

(4) Promoting active participation in quality improvement collaboratives (virtual meetings for VA medical facility PCCTs from all VA medical facilities in the VISN) provided by the national PHC program within GEC twice a year for all VA medical facility PCCTs in the VISN.

(5) Promoting collaboration among VA medical facility PCCTs and non-PCCTs to assist Veterans with serious illness in identifying and implementing their goals of care (e.g., ensuring compliance with VHA Handbook 1004.03(2), Life Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017, as well as proactively identifying Veterans in

need of specialized palliative care services (e.g., utilizing the Care Assessment Need score tool to assess Veterans for possible benefit of palliative care consultation).

(6) Promoting Hospice-Veteran Partnerships and Veteran Community Partnerships across the VISN to ensure effective collaboration with and transitioning to and from community resources in the care of Veterans with serious illness.

g. Veterans Integrated Service Network Palliative and Hospice Care Program Manager. The VISN PHC Program Manager is responsible for:

(1) Providing oversight of the VISN's PHC programs and serving as the contact person for liaison activities with GEC.

(2) Ensuring that collaboration and communication among VA medical facility PCCTs in the VISN achieves measurable improvement in VISN PHC programs (e.g., develop and implement action plans to address opportunities for improvement in bereaved family survey scores).

(3) Developing, managing and coordinating the VISN-wide PHC programs in accordance with VHA policies (e.g., VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers (CLC), dated August 13, 2008; VHA Directive 1440, VHA-Provided Palliative and Hospice Care Workload Capture, dated February 19, 2021; and VHA Handbook 1004.03(2)); and program initiatives (e.g., to identify and address opportunities for improvement on bereaved family survey scores) while incorporating nationally recognized guidelines and practices to guide care (e.g., Clinical Practice Guidelines for Quality Palliative Care and Improving Quality and Honoring Individual Preferences Near the End of Life, available at https://www.nationalcoalitionhpc.org/wp-content/uploads/2018/10/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf. **NOTE:** This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.).

(4) Monitoring and sharing palliative care best practices in both VHA and the private sector.

(5) Facilitating opportunities for local and regional staff development and education in palliative care through face-to-face or virtual training, to include trainings provided by the PHC program office at a minimum.

(6) Supporting the development and activities of Hospice-Veteran Partnerships and Veteran Community Partnerships.

(7) Supporting the development and maintenance of VISN PHC program units or households located in CLCs and in acute care settings.

(8) Developing and implementing a quality improvement plan for the VISN and reporting findings quarterly to the VISN REC ICC Leader with recommended action plans (e.g., sharing bereaved family survey scores with leadership and front-line staff).

(9) Ensuring that VA medical facilities employ case-finding mechanisms to identify Veterans in need of palliative care.

(10) Meeting with PHC Team Coordinators and VA medical facility PCCTs at VA medical facilities throughout the VISN at least once a year, in order to provide guidance on staffing, quality, workload, access and strategic planning elements.

(11) Collaborating with the VISN REC ICC Leader in implementing quality improvement initiatives.

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

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

(2) Ensuring that palliative care is available to Veterans in all VA medical facility settings.

(3) Ensuring the VA medical facility's PHC program includes a fully functioning PCCT with designated staff and administrative support sufficient to meet the needs of Veterans and their families. **NOTE:** *Guidance on recommended staffing is provided in Appendix A.*

(4) Ensuring that a clinician with PHC expertise, preferably recognized by a professional board, is named as the VA medical facility PHC Team Coordinator and has dedicated time to fulfill the responsibilities outlined in paragraph 5.i.

(5) Ensuring that the VA medical facility PCCT has the clinical expertise including evidence of Veteran-specific palliative care training and the administrative support to conduct its principal responsibilities. **NOTE:** *Board certification in palliative care is preferred for all palliative care providers (physicians, physician assistants and nurse practitioners) or documentation of palliative care expertise and experience when certification is not possible.*

(6) Ensuring access to primary (or basic) PHC services is available 24 hours a day, 7 days a week for VA medical facilities offering inpatient services. These services may be provided by VA medical facility PCCT members or by other staff who have received training in palliative care.

(7) Ensuring the PCCT has access to Veteran-specific palliative care training as provided by the PHC program office.

i. **VA Medical Facility Palliative and Hospice Care Team Coordinator.** The VA medical facility PHC Team Coordinator is responsible for:

(1) Collaborating with the VISN PHC Program Manager and the VA medical facility PCCT to identify and solve clinical and administrative challenges in the care of Veterans with serious illness determined to potentially benefit from palliative care.

(2) Serving as the facilitator for engaging VA health care providers in Veteran-centric palliative care training programs as provided by the PHC program office.

(3) Encouraging and stimulating improvement in the care of Veterans with serious illness by implementing best practices as identified by the VISN PHC Program Manager, peers in the field and in the medical literature (see Clinical Practice Guidelines for Quality Palliative Care in paragraph 8.e.).

(4) Reporting at least quarterly on performance (e.g., bereaved family survey results), workload and programmatic issues as provided by the national PHC program within GEC and the VISN PHC Program Manager to the VA medical facility Director in addition to leading VA medical facility quality improvement initiatives as directed by the VA medical facility Director to support VA, VISN and VA medical facility initiatives.

(5) Promoting appropriate use of Service Agreements between the VA medical facility's PHC program and inpatient and outpatient clinical services.

(6) Promoting and providing integration of palliative care expertise beyond the VA medical facility PCCT.

(7) Ensuring effective communications with community hospice agencies for transitioning seriously ill Veterans to and from VA medical facilities.

(8) Leading a PCCT meeting at least once per week to plan, review and evaluate patient care plans of Veterans receiving palliative care, with input from both the Veterans and their families. **NOTE:** *Team meetings that include discussion of medication treatment plans must 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.*

(9) Meeting regularly as a VA medical facility PCCT to discuss ongoing programmatic issues including quality improvement (e.g., quarterly review of bereaved family survey results to include the sharing of results with front-line staff), staffing, VHA policies and clinical practices.

j. **VA Medical Facility Palliative Care Consult Team.** The VA medical facility PCCT is a specialized interdisciplinary group of professionals from medicine (e.g., physicians, physician assistants), nursing (e.g., nurse practitioners, advance practice nurses), 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 PCCT is responsible for:

(1) 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, CLC hospice and palliative care units or households and Veterans receiving community hospice care requires additional PCCT staff or is to be performed by staff other than the PCCT.

(2) Assisting in the development and maintenance of a VA medical facility PHC program.

(3) Promoting educational activities in the VA medical facility PHC program for all VA medical facility staff, Veterans and their families on burial/survivorship benefits and acting as the liaison with community hospice programs.

(4) Participating in PHC quality improvement activities for the VA medical facility.

(5) Collaborating with the VISN PHC Program Manager to identify and act on opportunities for achieving desired improvement in VISN PHC programs.

(6) Collaborating with other staff who have received training in palliative care to provide access to primary (or basic) PHC services 24 hours a day, 7 days a week for VA medical facilities offering inpatient services.

6. TRAINING

There are no formal training requirements associated with this directive.

7. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must 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 must be addressed to the appropriate Records Officer.

8. REFERENCES

a. 38 U.S.C. § 7301(b).

b. VHA Directive 1440, VHA-Provided Palliative and Hospice Care Workload Capture, dated February 19, 2021.

c. VHA Handbook 1004.03(2), Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Parents' Values, Goals and Preferences, dated January 11, 2017.

d. VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers, dated August 13, 2008.

e. Clinical Practice Guidelines for Quality Palliative Care, 4th ed. National Consensus Project for Quality Palliative Care 2018. **NOTE:** For more information, please see

https://www.nationalcoalitionhpc.org/wp-content/uploads/2018/10/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf. *This linked document is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.*

VA MEDICAL FACILITY PALLIATIVE CARE CONSULT TEAM STAFFING

1. Department of Veterans Affairs (VA) medical facility Palliative Care Consult Team (PCCT) workload has increased dramatically in recent years. Since 2019, video telehealth encounters have grown from 0 to 18,521 while inpatient consults remained constant during the COVID-19 pandemic (~37,229 for fiscal year (FY) 2021). Telephonic encounters greater than 11 minutes (equivalent relative value units to an established outpatient in-person visit) increased from 21,939 in 2019 to 40,628 at the end of FY 2021. A minimum of 0.3 full-time equivalents (FTE) is required for each member of the PCCT, however, surveys of VA medical facilities have indicated most are exceeding this minimum to meet the needs of Veterans with serious illnesses. Given the growing demand for palliative care services and increased workload, the guidance below provides recommended minimum staffing levels for the PCCT.

2. The VA medical facility Director ensures a PCCT member serves as the VA medical facility Palliative and Hospice Care (PHC) Team Coordinator with a recommended 0.5 FTE minimum to support the functions of the role, realizing this role's function may be accomplished by more than one person. For each of the core disciplines of the VA medical facility PCCT, at least 0.5 FTE employee dedicated time is recommended to be provided for a health care provider, nurse, social worker, psychologist or other mental health provider and chaplain at VA medical facilities where more than 100 comprehensive in-person, telehealth or telephonic encounters are performed per year. These consults represent only the initial care management, as most require follow-up encounters or ongoing management by the PCCT. For VA medical facilities with less than 100 comprehensive encounters (level 3 or greater) per year, an interdisciplinary VA medical facility PCCT must be designated with representation from each of the core disciplines noted above, with the FTE amounts determined by the VA medical facility Director to meet the needs of Veterans with serious illness and their families.

3. While the minimum dedicated recommended FTE for each discipline is described above, VA medical facility Directors are strongly encouraged to increase FTE beyond these minimums as required to meet the physical, psychological, emotional, social and spiritual needs of seriously ill Veterans and their families in inpatient, VA Community Living Centers and outpatient settings and to support the maintenance of an effective VA medical facility PCCT.