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Professional Services Memorandum

Clement J. Zablocki
VA Medical Center
Milwaukee, Wisconsin

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Palliative Care Program

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1. PURPOSE

A. To establish policies and procedures for providing Palliative/Hospice Care for veterans within the Community Living Center (CLC) and define responsibilities of the Palliative Care Consultation Team (PCCT) and the Palliative Care Program in improving end-of-life care within Clement J. Zablocki VA Medical Center.

B. Definitions of Palliative Care and Hospice

1. Palliative Care is active total medical care that focuses on relieving and preventing suffering. As such it can be appropriate for patients in all disease categories, including those seeking curative treatments. Control of pain, other symptoms, and psychological, social, and spiritual problems are paramount. The goal of palliative care is achievement of the best possible quality of life for residents and their families.

2. Hospice care under the VHA definition is all care provided to veterans meeting the following four criteria:
   a) Diagnosed with a life-limiting illness;
   b) Treatment goals focus on comfort rather than cure;
   c) Life expectancy is determined to be six (6) months or less if the disease runs its normal course, consistent with the prognosis component of the Medicare Hospice Criteria;
   d) Veteran accepts hospice care.

3. The term hospice, as differentiated from palliative care, is used in VHA to denote care in the terminal phase of illness to a veteran meeting these four criteria, in order to distinguish end-of-life care that is exempt from extended care co-payment (i.e. hospice care provided within a nursing home setting).

4. Coding for Hospice and Palliative Care Services:
    a) All palliative care services, including but not limited to hospice must be documented as such and coded with the secondary ICD-9-CM Code V 66.7.
    b) A primary ICD-9-CM code must still be used to reflect the reason for the encounter.
    c) When hospice care as defined is provided, an additional point of visit code (POV) must be used. For the VA Community Living Center (CLC), the POV is 96 (also called Treating Specialty 96). All residents in the hospice beds of the VA CLC are admitted under Treating Specialty 96.
    d) Additionally any resident in the VA nursing home whose plan of care meets the VHA hospice criteria can be admitted under or re-coded as Treating Specialty 96 regardless of his/her location in the building. As a hospice resident, they would then become exempt from the extended care co-payment.

C. The components of the Palliative Care Program are:

1. Palliative Care Consultation Team (PCCT) comprised of the Palliative Care Program Medical Director, Registered Nurse, Social Worker, Psychologist, and Chaplain is coordinated by the Palliative Care Program Coordinator.

2. Palliative Care Inpatient Unit designated for veterans with a limited life expectancy and/or those receiving courses of palliative radiation or chemotherapy with the intent to either cure, prolong life or comfort.

3. The Palliative Care Outpatient Clinic (PCOC) is staffed by palliative care physician, registered nurse, social worker, and psychologist.

4. Palliative Care provided through VA Home Based Primary Care (HBPC) or referral to Community Home Hospice Programs.

5. Palliative Care Education Program which includes:

    - VA Interprofessional Fellowship in Palliative Care
    - Clinical experiences for medical students and trainees from the Medical College of Wisconsin
    - Hospital-wide staff education (Grand Rounds, Journal Club, inservices, and networking throughout various divisions) to improve quality of end-of-life care.

6. Grief and bereavement support as needed provided by VA staff psychologists, chaplains, and social workers.

7. Volunteer Program including training and supervision of volunteers to assist hospitalized veterans on the palliative care unit.

8. Hospice Veteran Partnership program.

9. Palliative Care Research Program.

D. The Palliative Care program organizationally is located within the Acute Care Nursing Division and Rehabilitation, Extended, and Community Care Division (RECC). The program crosses divisional and professional lines, and all Divisions work together to support the program.

2. POLICY

A. Veterans are determined eligible for admission to the Palliative Care Unit by meeting criteria for admission, as reviewed by the Palliative Care Consultation Team, in conjunction with Social Worker and Nurse Case Manager. All admissions must be assessed and approved by the Palliative Care Medical Director or covering physician.

B. Admission to the Palliative Care Unit will be accepted Monday through Friday (excluding holidays) from 8:00 AM to 3:30 PM. There are no emergent admissions to Palliative Care. Veterans not appropriate for admission include, but are not limited to, those who are ventilator or Bipap dependent (although patient's who are on scheduled CPAP or BiPap at night for sleep apnea for example are able to be admitted on 8AS), on heparin drips, therapeutic TPN, or have a dementia or psychiatric diagnosis that require a restricted environment. Exceptions to these admission criteria must be approved by the palliative care team on 8AS. No other services have admission privileges to the Palliative Care Inpatient Unit.

C. Palliative Care staff attend orientation, in-service education, and continuing education programs appropriate to their care responsibilities. Written policies, protocols, and standards approved by the Palliative Care Interdisciplinary Team and the Palliative Care Program Medical Director will govern patient care.

D. The Palliative Care Program will meet applicable internal and external care standards.

3 RESPONSIBILITIES

A. The Medical Director works in collaboration with the palliative care interdisciplinary team in regard to all aspects of the program.

B. The Palliative Care Program Coordinator is responsible for the administrative coordination of all aspects of the Palliative Care Program. He/she coordinates the development, implementation, and ongoing support of the components of the Palliative Care Program in conjunction with the Medical Director. This assures that the Palliative Care Consultation Team decisions are communicated in a timely fashion.

C. The Palliative Care Inpatient Unit Program Manager is responsible for the administration, management, supervision, and evaluation of nursing staff in the Palliative Care Unit. Accountability is to the RECC Division Manager and to the Medical Director for program activities.

D. The Palliative Care Inpatient Nurse Practitioner provides primary care in collaboration with the attending physicians, which includes admission and readmission assessments, development of a plan of care which encompasses physical and psycho-social needs, assessment of acute changes in status, management of illness, and symptom control.

E. The Palliative Care Case Manager or designee is responsible for coordinating admissions to the Palliative Care Unit under the direction of the Palliative Care Medical Director. The Case Manager will also ensure that there is timely communication with the unit Charge Nurse, Patient Services Assistant (PSA) and Nurse Practitioner regarding admissions. The Case Manager or designee will ensure that the following documents are available on admission:

1. Patients being admitted from the inpatient areas of Zablocki VAMC will have an updated discharge summary, and orders for admission will be written and transferred to delayed status in the CPRS system by the responsible physician caring for the patient in acute care. The discharge summary must be transcribed and available prior to admission, not just dictated.

2. Veterans referred from outside facilities will need a current discharge summary detailing the course of their medical care and current medication and treatment orders.

3. Veterans admitted from home for radiation therapy will be instructed by the Radiation Oncology Medical social worker to bring a current medication list with dosages or bring medications in pharmacy labeled prescription bottles. It is preferred that a copy of the Radiation Therapy Consultation outlining the patient's medical condition and treatment goals is available in the computer chart prior to admission.

4. Patients admitted or readmitted from home for palliative care will have a completed palliative care consult outlining history of present illness, current medications, and goals of care.

F. The Social Worker assigned to the PCCT is responsible for assessment of referrals to the PCCT and assistance with utilizing appropriate VA and community resources. The PCCT Social Worker also sees patients scheduled in the PCOC as needed.

G. The Social Worker assigned to the Palliative Care Unit is responsible for psychosocial support of all inpatients including assessment, discharge planning and also grief and bereavement evaluation and assistance.

H. Chaplain Service working with PCCT is responsible for providing spiritual assessment of palliative consults and pastoral care to veterans and families on the inpatient unit as well as support to multidisciplinary unit staff as needed.

I. VA Staff Psychologist is available on a consultative basis to all veterans in whom the palliative care team is involved (either on the palliative care unit, inpatient medical ward or outpatient palliative care clinic) to provide psychological assessment and support to veterans and their families with end-of-life and bereavement issues.

4. PROCEDURES

A. Referrals for Palliative Care may be initiated by their licensed independent provider (LIP) within the Medical Center to the PC computerized package in CPRS. External referrals are directed to the palliative care social worker or case manager who will obtain pertinent information for Palliative Care Consultation Team assessment. Veterans will be seen and evaluated within 24 hours of the initial consult Monday through Friday during normal business hours.

1. Referrals for palliative care can be made for assistance in breaking bad news, assisting patients/families to set goals of care, symptom management, psychosocial, or spiritual support as well as admission to the inpatient unit.

2. The PCCT reviews the patient's medical record and initiates/completes the Palliative Care Hospital Unit Priority Score as part of the palliative consultation if admission to the palliative care unit is requested. (Appendix A)

3. If the referral was not initiated by the medical provider and the patient screens positive for palliative care needs, the attending or primary physician is consulted and outcome of the Palliative Care Screening Tool reviewed with them. A formal consult is then requested.

B. Documentation in the medical record that confirms the diagnosis, life expectancy, and goals of treatment is required on all patients referred for palliative care. It is recommended that palliative care veterans have an Advance Directive prior to admission to the Palliative Care unit.

C. Outpatient Consultations: Veterans in the emergency room or outpatient clinics who are considered possible candidates can be referred for palliative care evaluation as follows:

1. Referral to PCCT for assessment and evaluation
2. Referral to the Palliative Care Outpatient Clinic
3. Admission to appropriate acute bed during evening, weekend, or night hours and a consultation sent to Palliative Care

D. Admissions to the Palliative Care Unit

1. The Palliative Care inpatient unit is comprised of 24 skilled long-term care inpatient beds. Veterans are seen upon request through a consult to the Palliative Care Consultation Team.

2. The Palliative Care Consult Team (social worker, unit case manager, physician, and nurse program manager) review all consult requests for admissions. Veterans appropriate for admission fall into the following categories:

    a) Patients receiving radiation treatment and/or chemotherapy treatment requiring skilled care and monitoring.
    b) Patients who are actively dying, i.e. whose life expectancy is days to weeks based upon on clinical assessment using palliative care and hospice guidelines.
    c) Patients who are terminally ill, but in need of symptom management and/or further rehab in order to return to their previous living situation. The stay on the unit is expected to be no greater than 30-60 days.

1. The Palliative Care Consultation Team will evaluate consults and decide upon priority of admission based on the following criteria:

    a) External radiation consults (from home or outside the VA)
    b) Internal actively dying patients (acute care, Dom, CLC)
    c) Internal radiation patients (acute care, Dom, CLC)
    d) Internal chemotherapy patients (acute care, Dom, CLC)
    e) External actively dying patients (from inpatient hospitals or hospices)
    f) Internal palliative care patients
    g) External palliative care patients

2. Patients not appropriate for admission to the Palliative Care unit include, but are not limited to:

    a) Patients requiring ventilator or Bipap support (although patients who are on scheduled bipap or CPAP for sleep apnea or related illnesses can be admitted to the Palliative Care Unit).
    b) Patients with dementia or a psychiatric diagnosis requiring a locked unit
    c) Patients requiring clinical support such as heparin drips, vasopressors, therapeutic TPN

Exceptions to these admission criteria must be approved on a case by case basis by the 8AS palliative care staff.

3. The Palliative Care Case Manager or designee will inform the referral source or Scheduled Admissions when the veteran's admission to a

program bed is expected. The Program Coordinator will ensure that Centralized Scheduling has received consults for the Palliative Care Outpatient Clinic (PCOC) and new patient visits are scheduled in a timely fashion.

4. When Palliative Care beds are full, accepted candidates will be placed on a waiting list for admission to palliative care. Referring social workers will be notified so that community options can be explored.

E. Discharge from the Palliative Care Unit

1. The inpatient Palliative Care Interdisciplinary Team will evaluate all patients within one week of admission at the initial Interdisciplinary Care Plan (ICP) meeting. Patients and families are invited to attend in order to confirm goals of care and to discuss interventions which will control symptoms and support their psychosocial needs. All patients admitted for palliative care will be reassessed after 30 days to determine if they still meet the criteria for palliative/hospice admission.

2. After 30 days, the team will review the patient's current level of disease progression and functioning and utilize the Karnofsky Performance Status Scale. If the Karnofsky remains the same or increases and the team deems the disease process to be stable, then discharge planning from the unit would begin. If the Karnofsky decreases and the team deems that the disease is progressing, then the patient would remain on the unit for another 30 days. The patient would then be re-evaluated in 30 days.

3. If the patient's goals of care change the team would start the discharge process to an appropriate site.

F. After Hours Coverage of Patients on the Palliative Care Unit

1. The Advance Practice Nurse and/or Palliative Care Physician will provide at home phone coverage of patients on the Palliative Care Unit. The nurses and staff on the palliative care unit are expected to call the covering palliative care clinicians for needed care issues after hours.
2. If a veteran on the Palliative Care Unit needs urgent bedside evaluation by a physician after hours (including the weekend), this will be provided by the on call hospitalist. It is required that the covering Palliative Care Advance Practice Nurse or physician page the on call hospitalist to explain the medical situation and need for urgent evaluation.
3. The hospitalist or rapid response team is expected to then contact the on call Palliative Care covering clinician and communicate the recommended interventions for care, including whether the patient should be transferred to the inpatient acute hospital.

G. Home Hospice

1. Home Hospice Care will be considered and referrals made for veterans who are requesting this service and are able to function safely with supplemental family / other assistance.

2. Care and program services will be arranged either through VA Home Based Primary Care (HBPC) or other appropriate Community Hospice Programs.

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Medical Center Director

References:

VHA Directive 2008-041 "Hospice and Palliative Care Workload Capture" August 4, 2008
DVA Program Guide 1140.10 Hospice Program 9/13/96
WHO 1990 Definition of palliative care
Standards of the Hospice Program of Care recommended by the National Hospice Organization, 2001
DVA Memorandum, 6/29/92, Implementation of PCCT
DVA Memorandum, 10/20/93, hospice Advisory Team & Palliative Care Consultation
COS Memorandum, 3/31/99, Palliative Care / End-Of-Life Program

Rescission: PSM IV-7 "Palliative Care Program", dated 5/22/06

Review: Every three years

Palliative Care Hospital Unit Priority Score
for Admission to Inpatient Palliative Care Unit

1. Estimated prognosis:

   _____ Karnofsky Score

   _____ Days to weeks

   _____ Weeks to months

   _____ > 6 months life expectancy

2. Stability of caregiving system:

   _____ Currently in stable caregiving system that can be practically continued until the end of life (e.g. hospital if close to death, nursing home)

   _____ Stable caregiving system that cannot be continued but can be transferred to another reasonable caregiving system for terminal care (e.g. CNH)

   _____ Stable caregiving system that cannot be continued until death, no good alternatives for terminal care

   _____ Unstable caregiving system

3. Symptom management:

   _____ No acute palliative needs

   _____ Acute palliative needs unable to address in current setting:
   - Mild pain/symptom management
   - Moderate/severe pain/symptom management
   - Moderate/severe psycho/socio/spiritual/family needs

4. Patient/family goals:

   _____ Willing to be admitted to Palliative Care Unit

   _____ Not willing to be admitted to Palliative Care Unit

   _____ Estimated time for goal completion

5. Appropriateness to provide palliative care consultation if the patient **did not** go to the Inpatient palliative care unit

_____ Yes

_____ No