Objectives

1. Define palliative care.

2. Explain how the 4th edition of the National Consensus Project’s *Clinical Practice Guidelines for Quality Palliative Care* (NCP Guidelines) was developed.


4. Identify strategies to implement the NCP Guidelines within your health care team and organization.
What is Palliative Care?

Palliative Care Definition

• Interdisciplinary care delivery system designed for patients, their families and caregivers
• Beneficial at any stage of a serious illness
• Anticipates, prevents, and manages physical, psychological, social, and spiritual suffering to optimize quality of life
• Delivered in any care setting through the collaboration of many types of care providers
• Improves quality of life for both the patient and the family through early integration into the care plan

- National Consensus Project for Quality Palliative Care
Key Concepts

• Person-and family-centered approach to care
• Inclusive of all people living with serious illness, regardless of setting, diagnosis, age or prognosis
• A responsibility of all clinicians and disciplines caring for people living with serious illness

Serious Illness

A health condition that carries a high risk of mortality and either negatively impacts a person’s daily function or quality of life or excessively strains their caregiver.*

Community is Person-Centric

“Community” is defined:
- by the person living with serious illness
- as a lens through which their needs are assessed

Guidelines Background & Process
Why Clinical Practice Guidelines?

✓ Guidelines improve care and safety for patients and families:
  • Defines structures and processes of care
  • Sets expectations for providers
  • Guides clinical decision making
  • Promotes standardization
  • Creates a foundation for accountability

✓ Guidelines provide the essential elements for standards, policies and best practices

National Consensus Project for Quality Palliative Care (NCP)

• Began in 2001 to define and improve the delivery of palliative care
• Stakeholder involvement expanded over the last decade
• National Coalition for Hospice and Palliative Care serves as organization home of NCP
The 4th edition

• For all people with serious illness, regardless of setting, diagnosis, prognosis, or age
• Funded by the Gordon and Betty Moore Foundation
• Published by the National Coalition for Hospice and Palliative Care
• NCP leadership consisted of 16 national organizations
National Consensus Project Process (2017-18)

• **Development:**
  - Steering Committee and Writing Workgroup formed
  - NCP Strategic Directions Stakeholder Summit held
  - Writing > reviews > revisions > approvals
  - consensus achieved

• **Systematic review of research evidence:**
  - Completed by the RAND Evidence-based Practice Center

• **Endorsements:**
  - Received from more than 80 national organizations

• **Publication:** October 31, 2018

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Endorsing Organizations

- Academy of Integrative Pain Management
- Academy of Neonatal Nursing
- Accountable Care Learning Collaborative
- Accreditation Commission for Health Care
- Aging Life Care Association
- American Academy of Home Care Medicine
- American Academy of Hospice and Palliative Medicine
- American Academy of Nursing
- American Academy of Pediatrics
- American Association of Critical Care Nurses
- American Association of Critical Care Nurses
- American Association of Nurse Practitioners
- American Board of Internal Medicine
- American Cancer Society
- American College of Surgeons
- American HealthCare Association
- American Heart Association/American Stroke Association
- American Hospital Association
- American Nurses Association
- American Psychiatric Nurses Association
- American Society of Anesthesiologists
- Argentum
- Association for Clinical Pastoral Education
- Association of Professional Chaplains
- Association of Rehabilitation Nurses
- Blue Shield of California
- California State University Institute for Palliative Care
- Cambia Health Solutions
- Catholic Health Association of the United States
- Center for Practical Bioethics
- Center to Advance Palliative Care
- Coalition for Compassionate Care of California
- Coalition to Transform Advanced Care
- College of Natural Supervision and Psychotherapy
- Community Health Accreditation Partner
- Diverse Health
- ElevatingHOME & Visiting Nurse Associations of America
- Emergency Nurses Association
- End of Life Nursing Education Consortium
- EnvisioBlueCross BlueShield
- Family Caregiver Alliance
- Gerontological Advanced Practice Nurses Association
- Healthcare Chaplaincy Network
- Horizon Healthcare Services, Inc.
- Hospice and Palliative Nurses Association
- Infusion Nurses Society
- Institute for Healthcare Improvement
- International Transplant Nurses Society
- LeadingHealth
- Long-Term Quality Alliance
- National Alliance for Caregiving
- National Association of Catholic Chaplains
- National Association of Clinical Nurse Specialists
- National Association of Home Care and Hospice
- National Association of Pediatric Nurse Practitioners
- National Association of Social Workers
- National Consumer Voice for Quality Long Term Care
- National Hospice and Palliative Care Organization
- National PALCE Association
- National Palliative Care Research Center
- National Partnership for Women and Families
- National Patient Advocate Foundation
- National Pediatric Hospice and Palliative Care Collaborative
- National POLST Paradigm
- Neshama: Association of Jewish Chaplains
- Northwell Health
- Nurses Organization of Veterans Affairs
- Oncology Nurses Society
- Physician Assistants in Hospice and Palliative Medicine
- Respecting Choices
- Sigma Theta Tau International Nursing Honor Society
- Social Work Hospice and Palliative Care Network
- Society of Palliative Care Pharmacists
- Society of Pediatric Nurses
- Society for Social Work Leadership in Health Care
- Supportive Care Coalition
- The Conversation Project
- The National Association of Directors of Nursing Administration in Long Term Care
- The National Hospice and Palliative Care Organization
4th edition: Domains & Content

Domains of Palliative Care

Domain 1: Structure and Processes of Care
Domain 2: Physical Aspects of Care
Domain 3: Psychological and Psychiatric Aspects of Care
Domain 4: Social Aspects of Care
Domain 5: Spiritual, Religious, and Existential Aspects of Care
Domain 6: Cultural Aspects of Care
Domain 7: Care of the Patient Nearing the End of Life
Domain 8: Ethical and Legal Aspects of Care
Key Themes: the 6 C’s

Each domain addresses:
- Comprehensive assessment
- Care coordination
- Care transitions
- Caregiver needs
- Cultural inclusion
- Communication

Domain 1: Structure and Processes of Care

- Principles and practices can be integrated into any health care setting
- Delivered by all clinicians and supported by palliative care specialists who are part of an interdisciplinary team (IDT)
- Begins with a comprehensive assessment and emphasizes:
  - Patient and family engagement
  - Communication
  - Care coordination
  - Continuity of care across health care settings
Domain 2: Physical Aspects of Care

• Begins with understanding patient goals in the context of physical, functional, emotional, and spiritual
• Focuses on relieving symptoms and improving or maintaining functional status and quality of life
• Emphasizes symptom management that encompasses pharmacological, non-pharmacological, interventional, behavioral, and complementary treatments
• Is accomplished through collaboration between all professionals involved in the patients’ care across all care settings

Domain 3: Psychological and Psychiatric Aspects of Care

• IDT addresses psychological and psychiatric aspects of care in the context of serious illness
• IDT conducts comprehensive developmentally and culturally sensitive mental status screenings
• Social worker facilitates mental health assessment and treatment in all care settings
• IDT communicates to the patient and family the implications of psychological and psychiatric aspects of care
Domain 4: Social Aspects of Care

- Addresses environmental and social factors that affect patients and their families
- Social determinants of health have a strong influence on care outcomes
- IDT partners with the patient and family to identify strengths and address needs
- Social worker is essential to the IDT

Domain 5: Spiritual, Religious, and Existential Aspects of Care

- Spirituality is recognized as a fundamental aspect of palliative care
- Dynamic aspect through which individuals seek meaning, purpose, and transcendence, and experience relationships
- Expressed through beliefs, values, traditions, and practices
- IDT serves in a manner that respects
  - all spiritual beliefs and practices, and
  - when patients and families decline to discuss their beliefs or accept support
Domain 6: Cultural Aspects of Care

- First step is assessing and respecting values, beliefs and traditions
- Care plans incorporate culturally sensitive resources and strategies
- Respectful acknowledgment and culturally sensitive support for grieving practices is provided
- IDT members continually expand awareness of their own biases and perceptions

Domain 7: Care of the Patient Nearing the End of Life

- Highlights care provided to patients and their families near the end of life,
- Particular emphasis on the days leading up to and just after the death of the patient.
- Comprehensive assessment and management of physical, social, spiritual, psychological, and cultural aspects of care are critically important near death
- IDT provides developmentally appropriate education to patient, family and others
Domain 7: Care of the Patient Nearing the End of Life (continued)

- Interdisciplinary model of hospice care is recognized as the best care for patients nearing the end of life
- Early access to hospice support should be facilitated whenever possible to optimize care outcomes
- Palliative care teams, hospice providers and other healthcare organizations must work together to find solutions for all patients and families in their final months of life

Domain 8: Ethical and Legal Aspects of Care

- IDT applies ethical principles to the care of patients with serious illness, including honoring patient preferences, and decisions made by surrogates
- Surrogates’ obligations are to represent the patient’s preferences or best interests
- Familiarity with local and state laws is needed relating to:
  - Advance care planning
  - Decisions regarding life-sustaining treatments
  - Evolving treatments with legal ramifications (e.g., medical marijuana)
4th edition: Publication

Anatomy of a Domain: Example 1

Domain 1: Structure and Processes of Care

Palliative care principles and practices can be integrated into any health care setting, delivered by all clinicians and supported by palliative care specialists who are part of an interdisciplinary team (IDT) with the professional qualifications, education, training, and support needed to deliver optimal patient- and family-centered care. Palliative care begins with a comprehensive assessment and emphasizes patient and family engagement, communication, care coordination, and continuity of care across health care settings.

Guideline 1.1 Interdisciplinary Team

Since palliative care is holistic in nature, it is provided by a team of physicians, advanced practice registered nurses, physician assistants, nurses, social workers, chaplains, and others based on need. The palliative care team works with other clinicians and community service providers supporting continuity of care throughout the illness trajectory and across all settings, especially during transitions of care. Depending on care setting and patient population, IDT members may be certified palliative care specialists in their discipline and/or have additional training in palliative care. Primary care and other clinicians work with interdisciplinary colleagues to integrate palliative care into routine practice.

Criteria:

1.1.1 The IDT provides care focused on individual physical, functional, psychological, social, spiritual, and cultural needs.
1.1.2 The IDT encourages all team members to maximize their professional skills for the benefit of patients and families.

Bleed tabs for easy access

Words bolded in red are defined in the Glossary
Anatomy of a Domain: Example 2

Clinical and Operational Implications

Clinical Implications
In all care settings, palliative care seeks to improve physical comfort and optimal functional status. Physical concerns, including ongoing access to medications, can be exacerbated as patients transfer across settings of care. Changes align with the goals, needs, culture, ages, and developmental status of the patient and family. Expert symptom management focuses not only on physical factors but also emotional, spiritual, religious, and cultural factors, which set the foundation of palliative care and promote comfort and quality of life.

Operational Implications
Clinicians develop and follow policies and protocols related to the assessment and treatment of physical symptoms, including controlled substances. Systems are in place to facilitate communication and coordination of care, especially during care transitions, to ensure the patient’s plan of care continues to be implemented.

Essential Palliative Care Skills Needed by All Clinicians
All clinicians need expertise in the assessment of patient symptom burden, functional status, and quality of life, and in the development of a palliative treatment plan that is consistent with patient and family needs and preferences. Clinicians need the skills to identify and treat symptoms associated with various illness and related treatments, including pain, nausea, constipation, dyspnea, fatigue, and delirium.

Palliative care specialists can assist other clinicians as consultants or care coordinators based on the specific needs of the patient, particularly in instances of complex and intractable symptoms. Consultation with specialist-level palliative care can assist when patients have complex pain and symptom management needs.

Key Research Evidence
The systematic review addressed the following key questions: KQ20. What is the impact of palliative care interventions on physical symptoms (screening, assessment, and management of patients)? Forty-eight systematic reviews were identified in training to KQ20. The evidence table in the systematic review describes the key findings of each included review. The summary of findings table summarizes the research evidence across identified reviews and describes the quality of evidence. The complete findings are published online in the Journal of Palliative Medicine (DOI: 10.1089/jpam.2019.09.650).

Anatomy of a Domain: Example 3

Practice Example D1-A

A Federally Qualified Health Center recognizes that its aging population will benefit from the integration of palliative care into its care model. The leadership of the organization accesses training in palliative care for the nurse care navigators and two express interest in pursuing advanced certification in hospice and palliative care to serve as “champions” within the health center. The navigators traditionally assist patients with coordinating services and ensuring appointments with specialty providers, as well as primary care follow-up. Each navigator is the primary contact and liaison between patient and providers, thus ensuring that the patients’ needs are met. With enhanced palliative care skills, navigators learn to screen for unmet needs in all the domains of care in the NCP Guidelines and then facilitate assessments and access to support as indicated. The navigators serve as contacts for hospital-based palliative care programs to enhance coordination of care post-discharge. They also have relationships with community home health and hospice programs to facilitate referrals and care coordination to traditional home health and hospice services, as well as home-based palliative care.
Additional Content

Appendix I: Glossary

- Acculturation: “...the process of cultural and psychological change that results following meeting between cultures.”

- Activities of daily living (ADLs; also see “Instrumental activities of daily living”): “...are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.”

- Advanced practice providers: Defined in the NCP Guidelines as physician assistants and advanced practice registered nurses utilized to expand the capacity of palliative care interdisciplinary teams to deliver complex care and provide direct care.

Appendix II: Tools and Resources

Domain 1: Structure and Processes of Care


- California Health Care Foundation – Community-based Palliative Care Resource Center: This online resource center provides strategies and support for organizations that are planning, implementing, or enhancing a community-based palliative care (CBPC) program. http://www.chcf.org/projects/2015/cbpc-resource-center

Systematic Review of Research Evidence

- Conducted by Rand Evidence-based Practice Center with Technical Expert Panel (TEP)

- Complete findings published: Journal of Pain and Symptom Management
  - https://www.jpsmjournal.com/article/S0885-3924(18)30468-8/fulltext

- Funded by:
  - Gordon and Betty Moore Foundation
  - Gary and Mary West Foundation
  - The John A. Hartford Foundation
  - Stupski Foundation
Practice Examples

Practice Example: Rural Palliative Care

• A rural palliative care program provides care in patients’ homes
• Staff is often alone on visits
• Team members stressed with ethical issues (ie requests for physician aid-in-dying, family conflicts)
• Program develops an online ethics forum for staff education
• Provides educational podcasts for team members
• Leadership facilitates dual visits of the practitioners and social workers to facilitate greater support
Practice Example: Community Hospital

- Staff at a community hospital identify a trend re: after hours and weekend utilization of the ED with seriously ill children following a hospitalization
- Local hospice has a large home-based pediatric palliative and hospice program, with just one board-certified hospice and palliative medicine pediatrician.
- Hospital’s pediatric service partners with a large community pediatric practice and the hospice pediatric physician, to implement a collaborative QI initiative.

Implementation: Next Steps
1. Read the Guidelines

Available at:
www.nationalcoalitionhpc.org/ncp

2. Share with your team and organization

- Distribute NCP Clinical Practice Guidelines
  - Clinical Management Team
  - Operational Management Team
- National Consensus Project’s website
  - Press Release
  - FAQs
  - Blog
  - Social media posts
3. Assess your services

Meet with your team to assess your strengths and gaps

➢ Discuss the “why” for adopting quality palliative care guidelines
  ▪ Strengthen healthcare provider partnerships
  ▪ Contractual payor source development
  ▪ Be known as the premier provider in your service area
  ▪ Growth opportunities

➢ Review guidelines/standards originally used to develop your program

➢ Identify gaps and opportunities for providing quality palliative care

➢ Determine what your team can do differently in light of the new NCP Guidelines

➢ Adopt implementation of the Guidelines

Comparison review – Current program v. NCP Guidelines

• Policies and procedures
• Job descriptions
• IDT structure
• Staff orientation, training and education
• Clinical documentation tools / templates, i.e. comprehensive assessment, care planning
• Patient support model to support patients through care transitions
• Data collection, measurement and tracking (3 W’s)
• Mission statement
• Marketing materials
4. Develop / implement a plan to address gaps

✓ Determine **easily** attainable goals to address gaps and changes your organization can make to improve care for your patients with serious illness and their families/caregivers.

✓ Set timelines to accomplish goals.

✓ Delegate lead staff member / appoint team for each goal.

✓ Regularly meet to assess progress.

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Examples of implementation plans

- **Gap in IDT members:**
  - **Identify a partner to share resource (e.g. hospice or hospital)**
  - **Complete a Business Affiliate Agreement**
  - **Provide orientation, training, and ongoing support**

- **Gap in 24/7 coverage:**
  - **Identify potential partners to assist with coverage (Hospice RN, EMTs)**
  - **Complete a Business Affiliate Agreement**
  - **Provide orientation, training and ongoing support**
  - **Track utilization of On Call, response rate and outcomes**
  - **Update Policies and Procedures**
Examples of implementation plans

- Gap in documentation tools
  - Determine guiding principles and goals of documentation
    - Record and monitor clinical and non-clinical information pertinent to care
    - Team communication
    - Support billing and coding
    - Data extraction for metrics
    - Ease of use
  - Identify evidence-based screening tools
  - Review EMR capabilities
  - Create templates / test / review for effectiveness
  - Update Policies and Procedures
  - Train staff
  - Provide ongoing support

Practical Tips

➢ Pace yourself!

➢ Consider a phased-in approach

➢ Use Change Management Theory / Project Management to implement and sustain
5. Monitor your outcomes

- Continue to strive for quality.
- Celebrate your successes!
- Expect setbacks. Manage up!

Resources

Available at [www.nationalcoalitionhpc.org/ncp](http://www.nationalcoalitionhpc.org/ncp)

- PPT/Slide Deck for Presentations
- NCP in the News: Online articles
- Press Release
- FAQs
- Blog Post
- NCP Stakeholder Summit Report
- History / About the NCP
www.nhpco.org/palliative-care-resources

For More Information

Visit: www.nationalcoalitionhpc.org/ncp
Follow: @coalitionhpc (#NCPGuidelines)
Contact: info@nationalcoalitionhpc.org
CMS-AAHPM MACRA Quality Measure Project

- American Academy of Hospice and Palliative Medicine, in partnership with the National Coalition for Hospice and Palliative Care and the RAND Corporation, was awarded a three-year grant from Centers for Medicare and Medicaid Services (CMS) to develop two patient-reported quality measures for community-based palliative care.

- PROGRAMS THAT PROVIDE OUTPATIENT PALLIATIVE CARE SERVICES TO ADULT PATIENTS are invited to submit information to become a testing site.

- More information available at [www.nationalcoalitionhpc.org/macra](http://www.nationalcoalitionhpc.org/macra), and the Coalition information table located beside LAC Marketplace.