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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.

   a. Physicians focus on the illness trajectory, prognosis, and medical treatments, making patient visits or providing supervision in collaboration with advanced practice registered nurses or physician assistants (see Domain 2: Physical Aspects of Care).

   b. Nurses provide direct patient care, serving as patient advocate, care coordinator, and educator. Nurses are at the center of the immediate assessment and reassessment of patient needs (see Domain 2: Physical Aspects of Care).

   c. Advanced practice providers (physician assistants and advanced practice registered nurses) expand the capacity to deliver complex care and provide direct care (see Domain 2: Physical Aspects of Care).

   d. Social workers attend to family dynamics, assess and support coping mechanisms and social determinants of health, identify and facilitate access to resources, and mediate conflicts (see Domain 3: Psychological and Psychiatric Aspects of Care and Domain 4: Social Aspects of Care).

   e. Chaplains, as the spiritual care specialists, assess and address spiritual issues and help to facilitate continuity with the patient’s faith community as requested (see Domain 5: Spiritual, Religious, and Existential Aspects of Care).

Note: Words bolded in red are defined in the Glossary.
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f. Clinical pharmacists optimize medication management through a thorough review of the patient’s medications to identify therapies to further palliate symptoms, resolve or prevent potential drug-related toxicities, and recommend dose adjustment and deprescribing where appropriate.

1.1.3 The IDT may also include other professionals with credentials, experience, and skills to meet the needs of the patient and family, including: mental health professionals, child life specialists, nursing assistants, nutritionists, respiratory therapists, occupational therapists, physical therapists, speech and language pathologists, massage, art, and music therapists, community health workers, paramedics, emergency medical technicians, psychologists, psychiatric-mental health advanced practice registered nurses, case managers, traditional medicine practitioners, and volunteers.

1.1.4 The IDT facilitates the implementation and ongoing refinement of the palliative care plan in communication with all care providers to support patient and family goals.

1.1.5 The IDT provides developmentally appropriate and culturally sensitive care to patients and families.

1.1.6 The team meets regularly to discuss patient care, IDT functioning, and operational details essential to the provision of quality palliative care. The frequency of IDT meetings is based on the needs of the population served, the care setting(s), and service model.

1.1.7 The patient and family have access to palliative care staff 24 hours a day, seven days a week by phone or telehealth applications.

1.1.8 The IDT accesses and ensures continuity with community services for families caring for neonates, children, or adults with a serious illness.

1.1.9 Policies and procedures are in place for prioritizing and promptly responding to referrals and ongoing patient and family care needs.

1.1.10 For programs with volunteers, policies and procedures are in place to guide volunteer services including recruitment, screening, training, role clarification, support, supervision, and performance evaluation.

1.1.11 A palliative care specialty team includes a certified palliative care specialist. The setting of care or reimbursement may further dictate which clinician must be certified.

Guideline 1.2 Comprehensive Palliative Care Assessment

An interdisciplinary comprehensive assessment of the patient and family forms the basis for the development of an individualized patient and family palliative care plan.

Criteria:

1.2.1 An initial comprehensive assessment is completed as soon after the referral as is reasonably possible.

1.2.2 Each member of the IDT contributes to a comprehensive assessment as soon as reasonably possible, depending on the urgency of patient needs.
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1.2.3 The initial assessment includes conversations with the patient, family caregivers, clinicians, and others according to the patient’s preferences.

1.2.4 The initial assessment is conducted in person by one or more IDT members, depending on the needs and concerns of the patient, is documented, and includes:
   a. Patient and family understanding of the serious illness, goals of care, treatment preferences, and a review of signed advance directives, if available
   b. A determination of decision-making capacity or identification of the person with legal decision-making authority
   c. A physical examination including identification of current symptoms and functional status
   d. A thorough review of medical records and relevant laboratory and diagnostic test results
   e. A review of the medical history, therapies, recommended treatments, and prognosis
   f. The identification of comorbid medical, cognitive, and psychiatric disorders
   g. A medication reconciliation, including over-the-counter medications
   h. Social determinants of health, including financial vulnerability, housing, nutrition, and safety
   i. Social and cultural factors and caregiving support, including caregiver willingness and capacity to meet patient needs
   j. Patient and family emotional and spiritual concerns, including previous exposure to trauma
   k. The ability of the patient, family, and care providers to communicate with one another effectively, including considerations of language, literacy, hearing, and cultural norms
   l. Patient and family needs related to anticipatory grief, loss, and bereavement, including assessment of family risk for prolonged grief disorder

1.2.5 The team identifies and documents if the adult patient or a family member served in the military and whether the patient or family member may be eligible for VA benefits.

1.2.6 For pediatric patients, the team ascertains the developmental status and children or teens’ understanding of their disease, as well as parental preferences for their child’s care at the time of initial consultation. This is revisited throughout the trajectory of care.

1.2.7 The IDT performs subsequent assessments at regularly defined intervals and whenever the patient’s status significantly changes, new problems are identified, or the patient experiences a transition in health care setting or provider.

Guideline 1.3 Palliative Care Plan

In collaboration with the patient and family, the IDT develops, implements, and updates the care plan to anticipate, prevent, and treat physical, psychological, social, and spiritual needs.
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Criteria:

1.3.1 The patient’s preferences, needs, values, expectations, and goals, as well as the family’s concerns, provide the foundation and framework for the plan of care.

1.3.2 The IDT collaboratively discusses and documents patient status, patient and family needs, treatment options, and symptom management.

1.3.3 The IDT develops, implements, and coordinates the care plan in collaboration with the patient and family, other clinicians, and community providers, when indicated and possible.

1.3.4 The care plan is always accessible to the patient, IDT, and other involved clinicians and, with the patient’s consent, is shared with family, caregivers, and community providers.

1.3.5 The care plan is updated and reviewed at regular intervals and when the patient experiences a significant change in status; changes are based on the evolving needs of the patient and family, with recognition of complex, competing, and shifting priorities in goals of care.

1.3.6 When appropriate, the patient is referred to hospice.

1.3.7 The IDT facilitates the implementation of the plan of care to ensure:
   a. The patient and family have access to medications and treatments
   b. New medications, medical equipment, tests, and therapies are authorized by payers
   c. The patient and family can safely and effectively manage and administer medications

1.3.8 The IDT provides patient and family with anticipatory guidance regarding disease progression and management strategies to maximize quality of life for both the patient and family.

1.3.9 Treatment and care setting alternatives are documented and communicated to the patient and family to promote informed shared decision-making.

1.3.10 Treatment recommendations are based on goals of care, assessment of risk and benefit, and best evidence. Re-evaluation of treatment efficacy, patient-family goals, and choices are documented.

1.3.11 The IDT makes referrals and assists in the integration of the additional providers to support the plan of care.

1.3.12 When serving as consultants, palliative care specialists contribute to the care plan developed by the referring provider and overtly clarify their ongoing role in care.

1.3.13 When working with patients with cognitive and/or communication impairment or incapacity, the IDT:
   a. Identifies the availability and willingness of a surrogate decision-maker
   b. Supports the surrogate with education related to signs and symptoms of psychological and psychiatric distress, and techniques to help alleviate distress
   c. Supports health care decision-making in a manner that is patient-focused and goal-concordant using principles of substituted judgment and best interest
**Guideline 1.4  Continuity of Palliative Care**

The IDT has defined processes to ensure access, quality, and continuity of care, especially during transitions of care.

**Criteria:**

1.4.1 The IDT has defined processes for identifying patients with palliative care needs specific to the population(s) served.

1.4.2 Patients and families receive an explanation of the palliative care services and, depending upon the setting of care, a written consent for services is signed by the patient and/or health care surrogate.

1.4.3 When specialist palliative care is discontinued:
   a. The IDT documents their assessment and recommendations for ongoing care and shares them with the patient and family, as well as involved clinicians
   b. If a patient and family transitions to a care setting where palliative care is unavailable, the IDT reviews the ongoing care plan with the patient and family, as well as the clinicians who will continue or assume care oversight

1.4.4 Upon the death of the patient, the IDT provides grief support to the family and ensures access to long-term bereavement support for family members (see Domain 7: Care of the Patient Nearing the End of Life).

1.4.5 The IDT ensures that care providers are informed of the patient’s death and plans for bereavement support, as indicated.

**Guideline 1.5  Care Settings**

Palliative care is provided in any care setting, including private residences, assisted living facilities, rehabilitation, skilled and intermediate care facilities, acute and long-term care hospitals, clinics, hospice residences, correctional facilities, and homeless shelters.

**Criteria:**

1.5.1 Care is provided in the setting preferred by the patient and family, if feasible, or the IDT helps the patient and family select an alternative setting.

1.5.2 The IDT consults and collaborates with the clinicians and other professionals involved in patient care to maximize the patient’s safety and sense of control.

1.5.3 Providers in all settings address the unique needs of children, whether they are patients, family members, or visitors.

1.5.4 Palliative care facilitates visits with family, friends, and pets in accordance with patient and family preferences and policies within the care setting.
1.5.5 The IDT shares information and resources regarding palliative care with clinicians and other professionals involved in the patient’s plan of care.

Guideline 1.6 Interdisciplinary Team Education

Education, training, and professional development are available to the IDT.

Criteria:

1.6.1 All members of the IDT have appropriate levels of education, including training in palliative care.
   a. Advanced practice registered nurses, physicians, physician assistants, pharmacists, and physical, occupational or speech therapists have relevant graduate degrees and are licensed in their respective disciplines.
   b. Nurses have appropriate educational preparation to their license and scope of practice.
   c. Social workers have relevant bachelor’s and/or graduate degrees and meet state licensing requirements.
   d. Spiritual care providers have relevant master’s degrees and are ideally board certified as a professional chaplain.
   e. Nursing assistants and personal care attendants meet state licensing requirements.
   f. Volunteers, when utilized, must have training relevant to their role.

1.6.2 The IDT encourages discipline-specific credentialing and certification, or other recognition of competence including specialized training.

1.6.3 Education, resources, and support are available to enhance IDT communication and collaboration.

1.6.4 Palliative care staff participate in initial orientation and continuing education focused on the NCP Guidelines and document their participation accordingly.

1.6.5 All palliative care clinicians receive training regarding the use of opioids, including:
   a. Safe and appropriate use of opioids
   b. Risk assessment for opioid substance use disorder
   c. Monitoring for signs of opioid abuse and diversion
   d. Managing pain for patients at risk for substance abuse
   e. Safe disposal of opioids in home and community settings
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Guideline 1.7  Coordination of Care and Care Transitions

Care is coordinated and characterized as the right care at the right time throughout the course of an individual’s disease(s) or condition. The IDT recognizes that transitions of care occur within care settings, between care settings, and between care providers. Care transitions are anticipated, planned, and coordinated to ensure patient goals are achieved.

Criteria:

1.7.1 IDT members understand how to effectively facilitate communication, care coordination, and transitions of care, sharing information including procedures that safeguard patient and family privacy.

1.7.2 The IDT establishes policies for optimal communication, including the sharing of documentation with everyone involved in the plan of care.

1.7.3 Before, during, and after transitions of care, the IDT coordinates with the patient and family and other providers to ensure continuity of care.

1.7.4 A timely assessment is completed after each care transition.

Guideline 1.8  Emotional Support to the Interdisciplinary Team

Providing palliative care to patients with a serious illness and their families has an emotional impact, therefore the IDT creates an environment of resilience, self-care, and mutual support.

Criteria:

1.8.1 The program assesses staff for distress and grief.

1.8.2 Administrative staff, IDT, and volunteers receive emotional support provided free from blame or stigma to alleviate the stress of caring for patients and families.

1.8.3 The IDT implements interventions to promote staff support and sustainability, such as opportunities to discuss the impact of providing palliative care.

1.8.4 Workload and workflow are structured to foster professional engagement and maximize time spent on activities that improve patient and family outcomes and staff wellness.

Guideline 1.9  Continuous Quality Improvement

In its commitment to continuous quality improvement (CQI), the IDT develops, implements, and maintains a data-driven process focused on patient- and family-centered outcomes using established quality improvement methodologies.
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Criteria:

1.9.1 The program measures and improves quality by systematically collecting and analyzing data on care processes and outcomes specific to the patient population and organization’s capacity, setting improvement targets, and planning and implementing change. This cycle is repeated in an iterative and ongoing fashion until it achieves sustained improvement.

1.9.2 The IDT considers the six domains of health care quality as defined in 2001 by the Institute of Medicine (safe, effective, patient-centered, timely, efficient and equitable)\(^1\) in the design of its CQI program.

1.9.3 The IDT identifies care coordination measures and integrates these into CQI initiatives.

1.9.4 To the extent possible, the IDT uses assessment instruments, quality measures, and experience of care surveys that are validated, clinically relevant, and cross-cutting across settings or populations.

1.9.5 Patients, families, clinicians, and other partners participate in the evaluation of the IDT.

1.9.6 The IDT participates in quality reporting and accountability programs, as required or necessary to maintain licensure or accreditation.

Guideline 1.10 Stability, Sustainability, and Growth

Recognizing limitations in reimbursement for interdisciplinary palliative care, the IDT endeavors to secure funding for long-term sustainability and growth.

Criteria:

1.10.1 A community needs assessment is conducted to identify populations in need of palliative care, determine if demand and resources are sufficient to support a sustainable palliative care program model, design services specific to the target population(s), and identify partners.

1.10.2 Based on the needs assessment, a business plan with anticipated revenue and expenses is developed to ensure continuity of service to patients and families.

1.10.3 When launching a new program, key performance metrics are agreed on in advance to define when a program is meeting its goals.

1.10.4 The IDT develops strategic plans to prepare for changes in the target population and market forces, as well as other opportunities or threats that may affect the sustainability and growth of the program.

Clinical and Operational Implications

Clinical Implications

Across patient populations and care settings from diagnosis to end of life, palliative care is shown to prevent and relieve suffering and optimize quality of life for patients and families. Its foundation is a well-trained and well-supported IDT that performs comprehensive assessments and develops and implements
palliative care plans in coordination with the patient, family, and other health care and community providers. Palliative care is delivered in a safe environment with respect for patient and family values, culture, preferences, and goals.

**Operational Implications**

The IDT provides consistent patient- and family-centered services, collaborates with partner organizations to facilitate care coordination, fosters a positive organizational culture, strives for continuous quality improvement and financial sustainability, and grows to address the needs of the populations it serves.

**Essential Palliative Care Skills Needed by All Clinicians**

Clinicians and staff working in all care settings benefit from an understanding of the value of palliative care, as well as an overview of palliative care principles and practices. Clinicians caring for the seriously ill have sufficient training and experience to complete palliative assessments and address common sources of suffering. The palliative assessment addresses the essential elements of the domains of palliative care yet may not be as in-depth as the assessment a palliative care team would provide.

**Key Research Evidence**

The systematic review addressed two key questions: KQ1a) What is the effect of interdisciplinary team care on patient and family/caregiver outcomes; and KQ1b) What is the impact of palliative care interventions to improve continuity and coordination of care on patient and family/caregiver outcomes? Thirteen systematic reviews were identified pertaining to KQ1a and 18 pertaining to KQ1b. The evidence tables in the systematic review describe 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 Pain and Symptom Management* (doi: 10.1016/j.jpainsymman.2018.09.008).

**Practice Examples**

*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.
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Practice Example D1-B

Staff at a community hospital identify a trend in after hours and weekend utilization of the emergency department (ED). A significant proportion of patients they see are seriously ill children with symptom issues following a hospitalization at the pediatric hospital, which is 30 miles away. The local hospice has a large home-based pediatric palliative and hospice program, with just one board-certified hospice and palliative medicine pediatrician. The hospital’s pediatric service partners with a large community pediatric practice and the hospice pediatric physician, to implement a collaborative quality improvement initiative. Outcomes include staff education for hospital ED personnel, the development of decision-support tools for symptom management, processes to clarify after-hours access to specialty palliative care, and a community resources guide specifically for families with seriously ill children.

Practice Example D1-C

A small rural hospital with limited resources and no formal palliative care services has an increasingly aging population. It has a long relationship with a community hospice partner, providing home-based palliative care, and two local skilled nursing facilities that provide rehabilitation. These three entities collaborate to improve post-acute care for their community by providing staff education, which includes formal training in communication skills and goals of care discussions for their staff. They evaluate, refine, and formalize their communication and referral processes between the entities. This collaboration leads to the formation of a Palliative Care Steering Committee with representatives from all the entities, including the hospital’s home health department. Together, they identify and codify all the community resources available that would benefit their seriously ill patient population and compile a resource guide. The hospice hires an advanced practice registered nurse with advanced training in palliative care and the entities collaborate to form an interdisciplinary team (IDT) for palliative care which includes: the social worker from the nursing home, the hospital chaplain, and a hospitalist/emergency department physician. As a result of this collaboration and regular discussions by the palliative care IDT, they demonstrate improvement in their net promoter scores (which indicates the likelihood to recommend the program as a measure of patient satisfaction with care), increased community volunteerism, and decreased hospital re-admissions and non-beneficial emergency department visits for their sickest patients. The hospitalist also becomes a hospice medical director, furthering collaboration and continuity.

Practice Example D1-D

A large academic medical center has operated an inpatient palliative care service for 10 years. In the strategic plan, the hospital leadership commits to the integration and growth of palliative care into the ambulatory specialty clinics, as well as home-based services. Phase one implementation includes embedding palliative care physicians and advanced practice providers into the oncology clinic several days a week. The cancer center and palliative care service share the expenses of an outpatient palliative care social worker. Phase two includes embedding palliative care into the pulmonary and heart failure clinics, including the integration of palliative advanced practice registered nurses, clinical nurse specialists, and physician assistants for both clinic and home-based visits. The inpatient palliative care team meeting expands to include representatives from home health, physical therapy, and the community hospice program. The entire team attends the first part of the meeting, which focuses on inpatients, and a subsection of the team continues the team meeting to discuss care planning for outpatients.
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Practice Example D1-E

A Department of Veterans Affairs (VA) Healthcare System serves an increasingly diverse and aging population of patients, many with serious illness and co-morbid psychological illnesses. The VA Healthcare System provides care to Veterans who drive hundreds of miles to receive care. The VA Healthcare System has a strong palliative care service in their hospital and regional clinics and uses triggers based on routine palliative care assessments in its electronic medical record to prompt referrals to palliative care specialty services. The local VA hospital has strong relationships with hospices and palliative care programs in the communities where Veterans live so that if a patient wants to receive care at home, the local hospice or palliative care program can continue the care plan started by the VA, coordinating care on an ongoing basis.

Practice Example D1-F

A non-profit community hospice develops a palliative care service that is well received in the community, but struggles to sustain the program financially. Advanced practice registered nurses providing palliative care work with their hospice colleagues for interdisciplinary input, but express a need for greater IDT support and expertise for non-hospice patients. Internal tensions and role confusion hurt morale. Hospice medical directors feel they are stretched too thin to oversee both palliative care and hospice teams. The hospice clinical leadership approaches the hospital-based palliative care practice regarding a possible collaboration to serve seriously ill patients. The teams organize a pilot of an advanced practice registered nurse based post-acute palliative care program for patients with advanced heart failure in an effort to improve coordination, reduce readmissions, and increase timely referral to palliative care. The pilot includes education from the cardiologists on the progression and treatment of advanced heart failure and communication skills practice for all heart failure and palliative care team members with specific attention to discussions on use of cardiac technology (eg, left ventricular assist device, automated implantable cardioverter defibrillators). The teams create procedures for identifying eligible patients, referrals, coverage and communication, and choice of quality metrics for regular review. Monthly team meetings focus on collaborative care planning and analysis of the metrics of the pilot, which demonstrate improvement in patient and family satisfaction, confidence in their care, time spent at home, and earlier hospice utilization for eligible patients. Hospitalizations, readmissions, and emergency department utilization decrease by over 50 percent. The hospital agrees to a contract with hospice to provide post-acute care for heart-failure patients and initiates a separate pilot for pulmonary disease.

Practice Example D1-G

A free-standing hospice identifies a need to provide community-based palliative care services. The hospice utilizes the NCP Guidelines to develop the program structure and processes. One of the hospice medical directors oversees the program. An advanced practice registered nurse, registered nurse, social worker, and chaplain utilize the comprehensive assessment to develop a care plan, which guides patient and family care. The team utilizes evidence-based tools that promote patient and family self-report and self-management, including the Edmonton Symptom Assessment System - revised. The electronic health record includes documentation tools to support health care team communication, trending of clinical information, and data extraction for continuous quality improvement. Clinical, operational, financial, and patient and family experience of care metrics are reviewed on a monthly, quarterly, and annual basis and shared with the board members and other stakeholders to promote program integrity and sustainability. The program demonstrates significant reductions in pain and dyspnea within 24 to 72 hours of initial consult, almost 100 percent completion of advance directives, frequent use of Physician Orders for Life Sustaining Treatment (POLST) medical orders using the Appropriate POLST Form Use Policy, significant
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reductions in utilization of the emergency room and hospitalizations, significant reductions in the total cost of care, and patient experience score ratings consistently ranked as “very satisfied.”

Endnotes