2

National Guidelines and Recommendations

High-quality palliative care delivery in any setting should adhere to the field's quality standards, the National Consensus Project *Clinical Practice Guidelines for Quality Palliative Care* (NCP Guidelines), currently in the fourth edition.

The NCP Guidelines cover eight domains of care, including the structure and processes of the palliative care program as well as the physical, psychological/psychiatric, social, spiritual, cultural, end-of-life, ethical, and legal aspects of patient care. The guidance in each domain forms the basis of certification programs for palliative care programs, such as those offered by The Joint Commission and Community Health Accreditation Partner (CHAP).

In 2019, the CAPC-led Serious Illness Quality Alignment Hub convened leaders from across multiple health care sectors. The goal was to coordinate serious illness strategies and standards and to synthesize the NCP Guidelines into a summary that payers and policymakers might use to credential home-based palliative care providers. The list of recommendations includes the following:

- → **An interdisciplinary team should have at least three of the following disciplines, including at least one prescriber:**
    - *Physician (MD or DO)*
    - *Advanced Practice Provider*
    - *Nurse (Registered Nurse or Licensed Practical Nurse)*
    - *Social Worker (Note: Medicaid-serving programs should* ***require*** *a social worker on the team)*
    - *Chaplain or Spiritual Care Professional*

- **Team members must have either specialty certification in palliative care or documentation of specific competencies in palliative care**, preferably with a goal of working toward certification. At least one prescriber on the team should have specialty certification in palliative care. Specific pain and symptom management competencies gained through education programs such as CAPC Designation may be used while working toward specialty certification.
- **Reliable access to other health professionals and services should be provided**, such as to pharmacists, community health workers, physical therapists, or personal care services; linkage agreements are acceptable documentation.
- **24/7 access to a clinician with proven competencies in pain and symptom management and access to the patient's medical record** must be provided, using telehealth as warranted.
- **Team members should have demonstrated capability to conduct a comprehensive patient assessment** to include, at a minimum:
    - *Pain and symptom distress*
    - *Functional status*
    - *Cognitive status*
    - *Caregiver burden*
    - *Spiritual needs*
    - *Social needs, including but not limited to financial vulnerability, housing, transportation, nutrition, and safety*
- **Team members should have demonstrated capability to create a care plan** through shared decision-making and to coordinate that plan across all of the patient's providers and services, including treating providers. Assessment and care-planning capabilities can be demonstrated by the submission of de-identified initial assessment and care plan documents for past patients.
- **Quality measures, including patient-reported outcomes, must be collected to support continuous quality improvement**. Membership in PCQC with clinical reporting meets this requirement.