

Recommendations for Palliative Care Program Standards



Access to palliative care meeting quality standards optimizes quality of life during a serious illness.

Adherence to the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care ([NCP Guidelines](#)), currently in the fourth edition, can be achieved using these standards. 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.

CAPC has gathered information on serious illness strategies and standards and synthesized the NCP Guidelines into a summary that payers and policymakers might use to credential palliative care providers across care settings or inform minimum program requirements for payment participation. Our recommendations include the following:

An interdisciplinary team should have at least three of the following disciplines, including at least one prescriber. Multiple disciplines caring for one patient ensures that physical, psychological, social, and spiritual needs are recognized and addressed.

- *Physician (MD or DO)*
- *Advanced Practice Provider (PA, APRN)*
- *Nurse (Registered Nurse or Licensed Practical Nurse)*
- *Social Worker (LCSW or MSW)*
- *Chaplain or Spiritual Care Professional (BCC or BCC-PCHAC)*
- *Certified Child Life Specialist (CCLS; should be required for programs serving children)*

At least one prescriber on the team must have specialty certification in palliative care. We recognize that hiring a certified prescriber may be difficult in certain geographic areas or types of organizations; in this case, the prescriber should demonstrate [specific competencies](#) through completion of a recognized palliative care training program, such as [CAPC Designation](#).

Other team members must have either specialty certification in palliative care or documentation of training completion, preferably with a goal of working toward certification.

Palliative care services must include, at a minimum:

- [Comprehensive assessment](#), to include: pain- and other symptom-related distress; functional status; cognitive status; medication and medication risks; caregiver burden; emotional and spiritual distress; and social risk factors. Issues identified must be documented.
- Pharmacological and non-pharmacological [management of pain and other symptoms](#), including but not limited to dyspnea, depression, anxiety, nausea, vomiting, fatigue, and constipation

- [Documented conversations](#) with the patient and caregiver(s), covering:
 - What to expect with their diagnosis(es), including prognosis (when desired) and anticipated symptoms
 - What treatment options exist, and the foreseeable impacts of each option (including financial impacts)
 - Goals of care and treatment preferences, including advance care planning. After clarifying goals and preferences, the palliative care team will coordinate with other treating teams to help align treatment with patient goals
- [Psychological, social, and spiritual support](#) for patient and caregiver(s), including counseling, education, and connection to needed community resources
- [Patient and family/caregiver education](#) to develop knowledge, skills, and protocols for self-management of illness, to reduce risk of symptom exacerbation
- Linkage and [coordination](#) with behavioral health services, long-term services and supports, certified home health care, hospice; and other Medicare, Medicaid, and CHIP services as needed
- Development of a crisis intervention plan.

The program must ensure reliable access to other health professionals and services

based on patient needs identified in the assessment. This may include, but is not limited to: pharmacists, community health workers, behavioral health professionals, rehabilitation therapists, creative arts therapists, dieticians, or personal care services; this may be done through linkage and referral.

For community-based programs, patients must have 24/7 access to a prescribing clinician with proven competencies (see above) and access to the patient's medical record.

The program should be designed in a manner that complements, rather than duplicates, existing benefits and programs that support people living with serious illness. These may include home health, behavioral health, health homes, patient-centered medical homes, comprehensive care management programs, home and community-based services, waiver programs, hospice, etc.

The program should have clear discharge criteria to identify patients who are no longer eligible or appropriate for palliative care services and provide transitional care as appropriate. Discharge is appropriate when patients are stable on the current care plan, or when eligible and interested in hospice services.

Program quality should be evaluated at least annually with a [set of measures](#) that includes patient-reported outcomes and clinical process completion rates (such as symptom assessment documentation).