KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Palliative Care				POLICY #: 18.15-P	
DEPARTMENT: Health Homes					
Effective Date: 05/08/2020	Review/Revised Date:	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date_____
Douglas A. Hayward
Chief Executive Officer

_____ Date_____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Director of Claims

_____ Date _____
Chief Network Administration Officer

_____ Date _____
Administrative Director of Health Homes Program

POLICY:

Kern Health Systems (KHS) will ensure that all Health Homes Program (HHP) enrolled members have access to palliative care in compliance with Department of Health Care Services (DHCS) palliative care benefit requirements.

KHS has a network of providers who provide palliative cares services to KHS members including KHS HHP enrolled members.

PROCEDURE:

Palliative care screening will be conducted during the HHP initial member assessment process. The Palliative Care Screening Outcome Tool v2 (POS v2), will be utilized in conjunction with the KHS Assessment tool to effectively capture data related to specific conditions and circumstances that indicate the need to screen for palliative care.

The POS v2 is a 10-item scale (plus an open question) that was specifically developed and validated for palliative care and covers physical symptoms, patient and family or caregiver anxiety/fears and well-being. The POS measures are specifically developed for use among people severely affected by diseases such as cancer, respiratory, heart, renal or liver failure, and neurological diseases.

A. General Eligibility and Referral Criteria:

1. Members who have advanced illness, with appropriate documentation of continued decline in health status.

B. Disease-Specific Eligibility Criteria will include but not limited to the following:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
    a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; 10 and
    b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD) Must meet (a) or (b)
    a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
    b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
    a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
    b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone
    a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and
    b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
    c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

C. Pediatric Palliative Care Eligibility Criteria:

1. Members under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care. Must meet (a) and (b) listed below.
    a. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
    b. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
        i. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease);
        ii. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
        iii. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
        iv. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to control symptoms).

D. Palliative Care Referrals

a. If the member continues to meet the above minimum eligibility criteria or pediatric palliative care eligibility criteria, the member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

b. KHS and Contracted Community Based Care Management Entities (CB-CME)s has a process to identify members who are eligible for palliative care, including a provider referral process.

c. KHS and Contracted CB-CMEs must periodically assess the member for changes in the member's condition or palliative care needs. KHS may discontinue palliative care that is no longer medically necessary or no longer reasonable.

d. For children who have an approved California Children's Service (CCS)-eligible condition, CCS remains responsible (in non-Whole Child Model counties) for medical treatment for the CCS-eligible condition, and the Managed Care Plan (MCP) is responsible for the provision of palliative care services related to the CCS-eligible condition.

E. Palliative Care Services

Palliative care must include, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

1. **Advance Care Planning**:
    a. Advance care planning includes documented discussions between a physician and/or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker.
    b. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.
    c. Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations.
        i. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment.
        ii. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
            - Treatment plans, including palliative care and curative care
            - Pain and medicine side effects
            - Emotional and social challenges
            - Spiritual concerns
            - Patient goals
            - Advance directives, including POLST forms
            - Legally-recognized decision maker

2. **Plan of Care:**
    a. A plan of care should be developed with the engagement of the member and/or the member's representative(s) in its design.
    b. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion.
    c. A member's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care.
    d. The plan of care must not include services already received through another Medi-Cal funded benefit program (e.g. CCS Program).

3. **Palliative Care Team:**
    a. The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of a member and of the member's family and are able to assist in identifying the member's sources of pain and discomfort.
        i. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc.
    b. The palliative care team will also address other issues such as medication services and allied health.
    c. The team members must provide all authorized palliative care.

d. The palliative care team should include, but is not limited to the following team members:
    i. A doctor of medicine or osteopathy (Primary Care Provider if MD or DO);
    ii. A registered nurse; a licensed vocational nurse or nurse practitioner (NP) (Primary Care Provider if NP); and a social worker.
    iii. Access to chaplain services as part of the palliative care team.

4. **Care Coordination:**
    a. A member of the palliative care team must provide coordination of care, ensure continuous assessment of the member's needs, and implement the plan of care.
    b. Pain and Symptom Management:
        i. The member's plan of care must include all services authorized for pain and symptom management.
            - Adequate pain and symptom management is an essential component of palliative care.
            - Prescription drugs, physical therapy and other medically necessary services may be needed to address a member's pain and other symptoms.

5. **Mental Health and Medical Social Services:**
    a. Counseling and social services must be available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process.
    b. Counseling services facilitated by the palliative care team may include, but are not limited to:
        - Psychotherapy,
        - Bereavement counseling,
        - Medical social services, and
        - Discharge planning as appropriate.
    c. Provision of medical social services must not duplicate specialty mental health services provided by county Mental Health Plans (MHPs).

F. Medical Necessity Process

a. CB-CME's will identify members eligible for palliative care and refer to the KHS Utilization Management (UM) department.
b. CB-CME/KHS will determine the type of palliative care that is medically necessary or reasonable for eligible members.
c. KHS will utilize its network of palliative care providers to meet the needs of eligible members.
d. KHS may authorize additional palliative care not described above, at no cost to include the following examples:
    - Additional services offered by many community-based palliative care programs include a telephonic palliative care support line that is separate from a routine advice line and is available 24 hours a day/7 days a week,

- Expressive therapies, such as creative art, music, massage and play therapy, for the pediatric population

G. Palliative Care Setting:

a. Palliative care may be provided in a variety of settings, including, but not limited to,
    i. Inpatient, skilled nursing facility, member's home, outpatient, or community-based settings.
b. Qualified providers will be utilized for palliative care based on the setting and needs of a member, and who possess current palliative care training and/or certification to conduct palliative care consultations or assessments.
c. Palliative care provided in a member's home must comply with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans.

References

ALL PLAN LETTER 18-020
ALL PLAN LETTER 17-018