

# Palliative Care

Health Net Care Connections™

CalViva Health Care Connections

California Health & Wellness Care Connections

**Presented by:**

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*Coverage for  
every stage of life™*

# Agenda

Housekeeping

What Is Palliative Care?

How Is Palliative Care Different From Hospice?

How to Make a Referral

Contact Information for Questions

Referral Criteria

Q&A

# Palliative Care

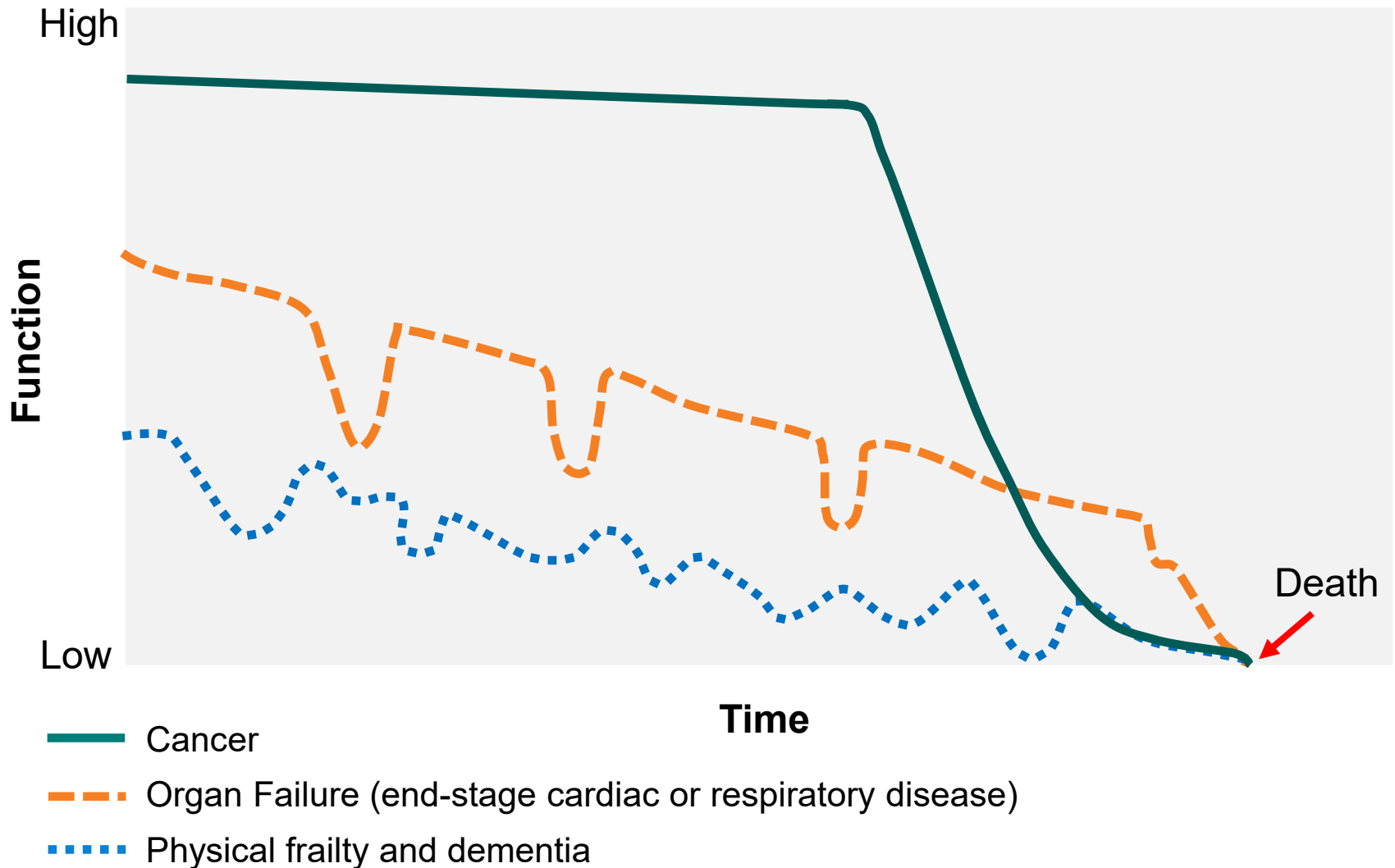
- Specialized care for those with serious progressive illness in need of extra help
- Focus on managing:
  - Symptoms
  - Advanced care planning needs
  - Care coordination with existing providers
  - Pain
  - Psychosocial support
- Goal is to:
  - Improve quality of life for patient and family
  - Provide an extra layer of support for the member
  - Support: caregivers, family, and friends
- Palliative Care provides a special team of doctors, nurses, and specialists
- Palliative Care can be provided together with curative treatment



# Transition of Focus

COMPLEX CASE MANAGEMENT	PALLIATIVE CARE	HOSPICE BENEFITS
Chronic / complex disease- not contemplating death	End of life 1-2 years and/or chronic / complex disease	End of life 6 months
Concurrent with curative	Symptom relief concurrent with curative	Symptom relief NO curative (for terminal illness)
Primary care physician (PCP) and specialist	PCP, specialist, and palliative consultant	Hospice team including physician
Complex Case Management (CCM) RN/social worker (SW)	Integrated team approach MD/NP/RN/SW	Integrated team plus aides, chaplain, and respite benefit
Focus: Curative treatment by usual medical team with support for psycho-social issues	Focus: Transition from curative only to symptom management and goals of care	Focus: Symptom relief by the hospice team with NO curative treatment of the terminal illness
Advance directive +/- Physician Orders for Life-Sustaining Treatment (POLST)	Advance directive POLST discussion	Advance directive POLST

# Trajectory of Functional Decline



# Services Included in Palliative Care

- Advance Care Planning
- Palliative Care Assessment and Consultation
- Plan of Care
- Pain and Symptom Management
- Mental Health and Medical Social Services
- Care Coordination (existing benefits)
- Chaplain Services
- 24/7 Telephonic Palliative Care Support



# The Palliative Care Model



- Place of Service
  - Hospital-based
  - Clinic-based
  - Home-Based Palliative Care



- Telehealth



- Health Net Contracted Home-Based Palliative Care Vendors



- Referral Source
  - Real time direct referral from providers
  - Claims data mining
  - Health Plan
  - Case Manager (CM)
  - Concurrent Review (CCR)
  - Transition Care Management (TCM)

# Home-Based Primary Care (HBPC) Program Outpatient (OP) Team

## Health Plan Team

- Tao Le, MD
- Marv Gordon, MD
- Rubylynne Manas, MBA
- Cindy Tatu, RN
- Julie Perryman RN
- Gabriele Pierce, RN
- Jessica Meza, LVN
- Gurwinder Gill, LVN
- Ines Bravo

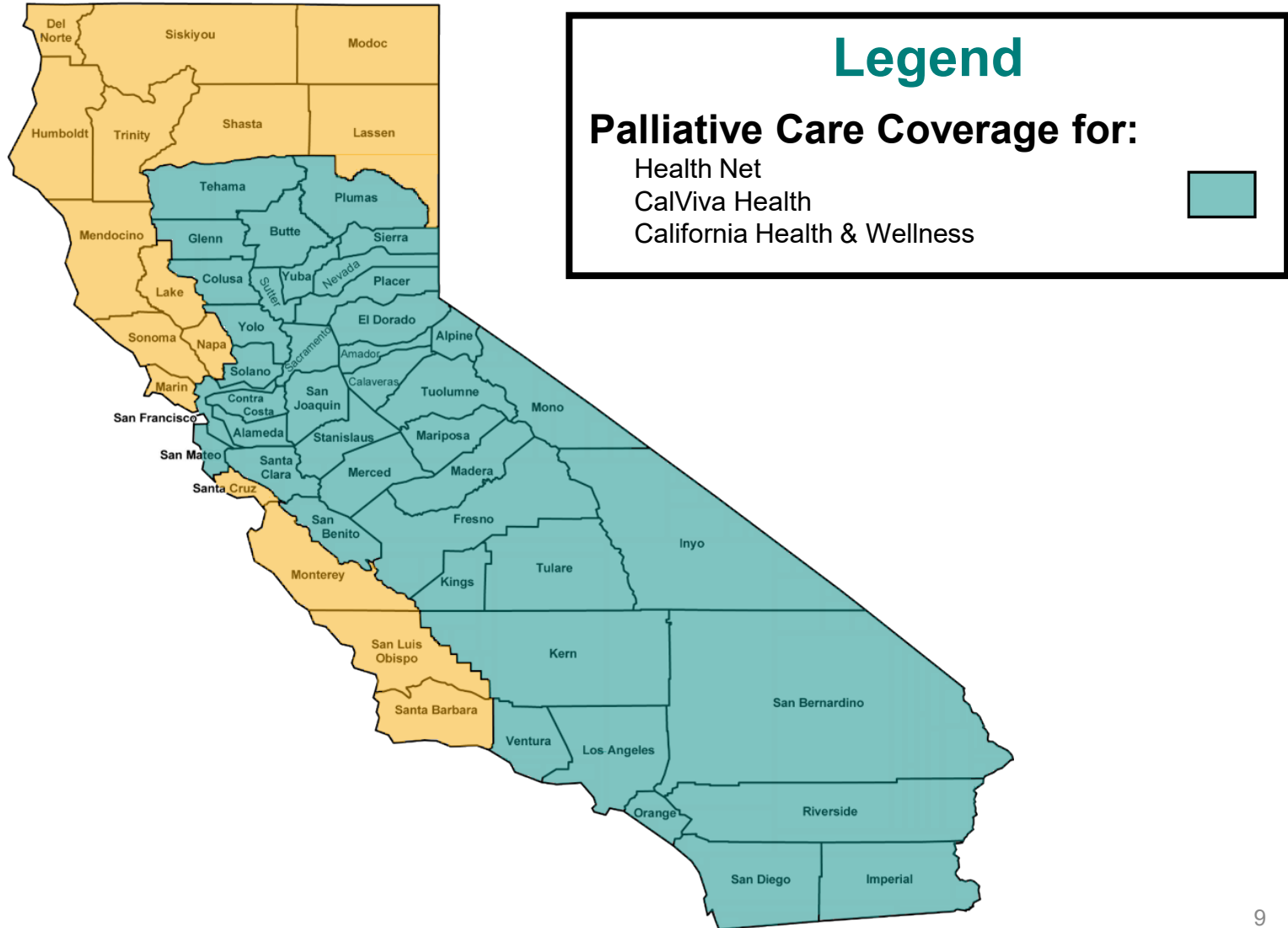
## Palliative Care Team

- MD/NP
- RN/LVN
- Social Worker
- Care Coordinators
- Chaplains
- 24/7 Telephonic Patient Care Support





# Palliative Care Coverage Map



# HBPC Program: Roles and Responsibilities

REQUIRED SERVICES	Palliative Care Provider	PPG/PCP or PPG/ Specialist	Heath Plan
Disease-Focus Management		X	X
Advance Care Planning	X		
PC Assessment and Consultation	X		
Plan of Care	X	X	
Pain and Symptom Management	X	X	
Care Coordination	X		X
Mental Health		X	X
Social Services	X		X
Chaplain	X		
24/7 Support	X		

# Case Study 1

- **Situation**
  - 64-year-old Caucasian male, commercial line of business, diagnosed with:
    - Hepatocellular cancer
    - Portal vein thrombosis
    - End stage liver disease
    - Recent stroke related to endocarditis
- **Background**
  - Diagnosed 1 year prior and now given 3-6 month prognosis
  - Goal is to watch the Super Bowl in 7 months and is “not ready” for hospice
- **Assessment**
  - Scheduled for cataract surgery
  - Intermittent right upper quadrant (RUQ) pain
  - Lactulose to prevent hepatic encephalopathy
  - International normalized ratio (INR) for anticoagulant therapy stable
  - Active in church and supportive family
- **Recommendation**
  - Address Physician Orders for Life-Sustaining Treatment (POLST)
  - Adjust lactulose to 3 bowel movements (BM) a day and pain meds
  - Assist with scheduling elective surgeries

# Referral Criteria

## Utilization (using the hospital and emergency department (ED) to manage their condition)

- Two or more hospitalizations within the last six months
- Two or more Emergency Room visits within the last six months

## Code Status

- Do Not Resuscitate (DNR)
- Artificial Nutrition, Hospitalization, Dialysis, and Ventilator

## Diagnoses (surprise question) (severe progressive)

- Prognosis of progressive 1 disease with a < 12 month life expectancy
- Would you be surprised if the member died within the next 12 months?

## Symptoms

- Has symptoms that are out of control

## Support

- Psychological, financial, social (including caregivers), or serious care planning issues related to illnesses

# Case Study 1 Follow Up



- Enrolled in palliative program
- Diagnosed with diplopia after cataract surgery; procedure to adjust focus
- Underwent transarterial radioembolization (radioactive microspheres)
- Decreased to moderate level of care then increased to high intensity after hospitalization for hepatic encephalopathy
- POLST- DNR shortly after enrollment
- Hospice several days before death
- Expired at home two years after enrollment
- Over two years had two elective and two emergent admits
- The patient lived to see two Super Bowls

# Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

(New England Journal of Medicine)

Study randomly assigned patients with metastatic lung cancer to receive either standard oncologic care or early palliative care, focused on symptom control and psychosocial support for patients and families, together with standard oncologic care.

## **Patients receiving early palliative care had:**

- lower rates of depression
- a better quality of life
- better mood scores
- fewer hospitalizations and emergency department visits
- less aggressive care at the end of life
- **significantly longer survival than did patients receiving standard care alone (11.9 months compared to 8.9 months)**

# Triple Aim - Institute Healthcare Improvement

“If a physician cannot give a patient medicine for the body, he should somehow find and give medicine for the patient’s soul.” \*



“Yes you love us teach us support and encourage us and hold our hand during this battle...You are God sent An angel God sent us in this storm” - Wife of a palliative care member

“Why do I rob banks? Because that’s where the money is.” - Willie Sutton

# Palliative Care Partnership

## Health Plan Membership for Palliative Care Services (no additional cost for the member)

- Commercial (shared risk, fee for service)
- Medicare (shared risk, fee for service)
- All Medi-Cal

### TeleHealth:

- Available for remote areas





# Referral Criteria

## Utilization (using the hospital and ED to manage their condition)

- Two or more hospitalizations within the last six months
- Two or more Emergency Room visits within the last six months

## Advanced Care Planning

- Do Not Resuscitate (DNR)
- Artificial Nutrition, Hospitalization, Dialysis, and Ventilator

## Diagnosis of Severe Progressive Illness (surprise question)

- Prognosis of progressive 1 disease with a < 12 month life expectancy
- Would you be surprised if the member died within the next 12 months?



## Symptoms

- Has symptoms that are out of control

## Support

- Psychological, financial, social (including caregivers), or serious care planning issues related to illnesses

# Palliative Care Referral Form

## Palliative Care Referral Form

Demographics	
Patient name:	Date of birth (DOB):
Address:	Alternate contact name:
City, state, ZIP:	Alternate telephone:
Telephone:	Relationship:
Language/Ethnicity:	<input type="checkbox"/> M <input type="checkbox"/> F
Primary care physician (PCP)/attending physician:	Telephone:
Insurance	
Member ID:	LOB: <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Commercial <input type="checkbox"/> PPO
Participating physician group (PPG):	PPG telephone:
Evaluate and treat as indicated	
<b>REASON FOR REFERRAL:</b> <input type="checkbox"/> Pain management <input type="checkbox"/> Disease management <input type="checkbox"/> Functional decline <input type="checkbox"/> Behavioral health <input type="checkbox"/> Emotional support <input type="checkbox"/> Socio-economic support <input type="checkbox"/> Spiritual support <input type="checkbox"/> Other _____	<b>RELATED DIAGNOSES:</b> <input type="checkbox"/> Cancer (specify): _____ <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> Heart/Congestive heart failure (CHF)(specify): _____ <input type="checkbox"/> Liver disease <input type="checkbox"/> Renal (specify): _____ <input type="checkbox"/> Gastroenterologist (GI) (specify) _____ <input type="checkbox"/> AIDS <input type="checkbox"/> Other _____
Would you be surprised if the member expired within 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member had > 2 emergency room (ER) visits in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the member had > 2 inpatient admits in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Additional history: _____	
Current location	
<input type="checkbox"/> Home OR <input type="checkbox"/> Hospital: _____ Room: _____ Estimate discharged date: _____ Skilled <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> SNF/B+C/ALF: _____ Room: _____	
Send completed form to:	
Fax to: 1-844-907-0436 A fax cover sheet must accompany all fax transmissions of protected health information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION." Email to: careconnections@healthnet.com. For questions contact (818) 676-6441.	
FOR INTERNAL USE ONLY	
Referral source: _____	Telephone: _____
<input type="checkbox"/> PCP <input type="checkbox"/> Vendor <input type="checkbox"/> PPG <input type="checkbox"/> CM <input type="checkbox"/> Other _____	
Assigned vendor: _____	

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved. 10-707

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# Exclusions: Not For Referral

- Dual risk commercial, Medicare
- Medicare primary
  - unless Health Net, CalViva Health, or California Health & Wellness as Medi-Cal secondary insurance
- Not in geographic service area
- All Health Net, CalViva Health, or California Health & Wellness Medi-Cal covered
- Currently in hospice care
- Member or agent refusal
- No home visits if there are safety or access issues (telehealth only available)
- Enrolled in California Children's Services - Partners for Children (ended Jan 1, 2019)



# Referral Form and Referral Process

- **Referral Form (see attached)**
- **Referral Process:**
  1. Receive Referral Form
  2. Review for Eligibility for the Palliative Care Program
  3. Send to Drs. Gordon/Le for Clinical Approval
  4. Forward to Palliative Care Partner/Vendor for Palliative Services



# Palliative Diagnosis

Condition	Provider 1 (157 members)	Provider 2 (153 members)
Cancer	44.6%	54.9%
Cardiology	6.4%	16.3%
Dementia / Failure to Thrive	3.8%	0.7%
Gastrointestinal	0.6%	1.9%
Hematology	0.6%	0.7%
Human Immunodeficiency Virus	0.6%	1.3%
Liver Disease	5.1%	1.3%
Metabolic	0.6%	1.9%
Neurologic	6.4%	3.9%
Pulmonary	6.4%	8.4%
Renal Failure	13.4%	3.9%
Other	11.5%	0.7%
Unknown	0.0%	3.9%

# Palliative Enrollee Disposition

Disposition	Provider 1 (157 members)	Provider 2 (153 members)
Refused	19.1%	10.5%
Unable to enroll	7.6%	0.0%
Directly to hospice	8.3%	2.0%
Disenroll to hospice	21.7%	22.9%
Deny	0.6%	0.0%
Changed insurance	10.8%	11.1%
Death (not hospice)	9.6%	6.5%
Stabilized	3.8%	5.9%
Safety issue disenroll	1.3%	0.0%
Moved	1.3%	0.0%
Non-compliant disenroll	1.9%	3.3%
Lost to follow up	0.6%	0.0%
Unknown / other	0.0%	4.6%

# Utilization and Savings

The tables below are for six months before and six months after enrollment Nov 2014 – Apr 2018 with an average length of stay of 5.5 months

Cost Reduction Per Member Per Month	
Metric	In Palliative Program
Acute in Patient (IP)	-28.7%
Emergency Room	-30.8%

Utilization Reduction	
Metric	In Palliative Program
Acute Admit	-48.1%
Acute Bed Days (BD)	-48.2%

# Case Study 2

- **Situation**
  - 54-year-old Caucasian female, Medi-Cal, history of:
    - Intracerebral bleed
    - Currently on tracheotomy, ventilator, and gastrostomy tube (G tube)
    - Long-term care facility with several acute stay admits over the past year
    - Scheduled for an elective admit for decubitus ulcer surgery
- **Background**
  - Ventriculoperitoneal (V-P) shunt, ventilator, and G tube support
  - Never regained consciousness during 30-day acute hospitalization
  - Went to subacute unit and placed on subacute long term care
  - Developed decubitus ulcer
  - Readmit for wound infection
  - Now scheduled for elective admit for plastic surgery for sacral decubitus
- **Assessment**
  - Full code
  - Divorced with two daughters, ages 18 and 22
  - Two siblings in Minnesota
- **Recommendation**
  - What would you do?



# Case Study 2

## Recommendations

- Present to medical director at rounds
- Discuss case with subacute attending
- Discuss case with subacute case manager
- Goals of care
- Start POLST discussions with family

## Outcome

- Issue raised at rounds why member is full code
- Question raised whether family is aware that member will not wake up
- First question of POLST discussion is, what does patient's family know
- Family was not aware that member will not wake up
- Family expresses wishes not to keep mother alive "like this"
- Decubitus can be painful
- Subacute attending concurs with decision to discontinue vent
- Palliative care arranges to discontinue vent with palliative case manager, social worker, and spiritual advisor present

# Palliative Care Data Points

- Suffering
- Terminally ill
- Life expectancy
- Utilization
- Decompensation
- Advanced disease
- Death within 1 year
- Patient desired treatment
- Designated support
- Advance care planning
- Try in-home therapy first
- Disease
- Treatment plan
- Pain, fatigue, bowel/bladder, dyspnea, nausea
- Depression, anxiety, insomnia
- Medication
- Med side effects
- Emotional or social challenges
- Spiritual concerns
- Goals
- Advance directives, POLST
- Decision-maker
- Team
- Care coordination
- Mental health
- Social services
- Bereavement
- Counseling
- Discharge planning

# Case Study 3

- **Situation**
  - 45-year-old Caucasian female, Medi-Cal
  - With multiple admissions for abdominal wall infection and pain
- **Background**
  - 5 months prior member underwent abdominal hernia repair with placement of a mesh into the abdominal wall
  - Now member has ED or acute admitted 1-2 times per month
  - Member has abdominal pain and infection of an open wound at the hernia repair site
  - Oxycodone has been prescribed fairly regularly and frequent antibiotics
- **Assessment**
  - Member has filled all prescriptions for antibiotics
  - Kept follow-up appointments with her surgeon and PCP
  - Following instructions on narcotics
- **Recommendation**
  - What would you do?

# Case Study 3

## Recommendations

- Present to medical director at rounds
- Obtain medical records
- Consult with surgeon as to why the mesh is not being removed
- Suggest pain management
- Recommend infectious disease consult
- Palliative care goals of care discussed

## Outcome

- Medical records confirm member is compliant
- No mention as to why mesh is not being removed
- Surgeon contacted, agrees but considers the surgery too difficult for him
- Contacted a university-associated bariatric surgeon who agrees to do surgery, which is successful, and wound heals
- Course complicated by clostridium difficile, recurrent diarrhea, intermittent nausea and vomiting, and depression but only occasional emergency department visit or admit

# Barriers



- Basic needs (food, shelter)
- Social support (community, family, caregiver, transportation)
- Behavioral health / substance abuse
- Durable Power of Attorney for Health Care (DPOAH) or lack thereof
- Lack of end-of-life wishes
- Cultural
- Medical (providers, durable medical equipment (DME), supplies, appointments, literacy)
- Activation
- Suboptimal discharge / medical planning

# Case Study 4

- **Situation**

- 65 yo WM, homeless, with severe COPD requiring intermittent O2, continues smoking, with multiple visits to the ED and hospital

- **Background**

- Formerly caretaker of a ranch but ranch sold about 6 months prior. Lives in his Lincoln Navigator SUV and he likes living there. Has portable O2. Still smokes. Goes to senior enters for warmth, food, and socialization. Keeps some PCP appointments at FQHC. Intermittent AA.

- **Assessment**

- Needs structure. Needs support. Currently not interested in housing. Needs regular PCP visits. Ideally would like to stop smoking and get permanent housing but member not currently interested.

- **Recommendation**

- Weekly visits at car, at senior center, other designated area. Phone call reminders. Reminders of PCP appointments. Reminder to take meds. Continued discussion of housing and smoking. Maintain phone contact.

## Case 4 Follow Up

No hospitalizations or ED over 10 months. Willing to talk to someone about permanent housing. Smoking less. Keeps PCP appointments. To see pulmonologist for consultation. Received flu shot and pneumonia shot.

# Resources



- Palliative care / hospice
- Hot spotting CM (community resources, faith-based support)
- At home (advanced illness home visits)
- Life plan (one-time home visit)
- Pharmacist (telephonic)
- BH specialist...facilitate appointments (Behavioral health, Case management, top one percent care consultant)
- PPG CM, prior authorization (DME, supplies), referrals
- Dialysis and specialty clinic CM/ SW
- SW- financial and insurance concerns, support
- Ambulatory CM
- Transition care management
- Concurrent review
- Complex case management
- State health plan case management
- Long-term care CM
- Disease management
- Providers (Primary care physician, specialty care physician, skilled nursing facility, high-risk clinic, medical home, pain management)
- Facilitate appointments (identify key provider)
- Assist with transportation
- Special needs program interdisciplinary care team
- 24/7 nurse call line

# Contacts

## **Rubylynne Manas, MBA**

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# Quadruple Aim



# Appendix

A decorative graphic at the bottom of the page consists of a series of overlapping, curved shapes in various shades of green, ranging from a light, pale green to a dark, forest green. The shapes create a sense of movement and depth, resembling a stylized wave or a series of hills.

# SB 1004 General Eligibility

- Member uses the hospital and/or emergency department to manage their illness
- Late stage illness with decline
- Death within a year not unexpected
- Received appropriate patient-desired medical care
- Agree to attempt home care before going to emergency department
- Agree to participate in advance care planning discussions

## **ONE OF FOUR DIAGNOSES (adult)**

Cancer, COPD, CHF, end stage liver disease