



A Public Entity

Inland Empire Health Plan



MyPath

PROGRAM
GUIDELINES
(A Palliative Care Approach)

A BETTER QUALITY OF LIFE

Overview¹

The Centers for Medicare and Medicaid Services (CMS) defines palliative care as: “patient and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.” Many Physicians and Practitioners note that palliative care is an overall approach to the practice of medicine that is broader than end-of-life care and is for “any age and any stage” of illness.

Inland Empire Health Plan (IEHP), in accordance with Senate Bill (SB) 1004, created a palliative care program called “**MyPath**” for its Medi-Cal and IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) Members. Defined clinical criteria was established in order to meet the requirements of SB 1004. However, the mission of IEHP’s **MyPath** program is consistent with the broader definition presented by CMS above.

MyPath Program Services

Palliative care must include, at a minimum, the following services when medically necessary and reasonable to the palliation or management of a qualifying serious illness:

1. **Advance Care Planning (ACP)** – Documents discussions between a Physician or other qualified health care professional and a Member, family member, or legally recognized decision-maker. Counseling should address, but is not limited to, advance directives. For appropriate Members, POLST forms should include family conflict resolution over issues surrounding the Member’s decisions. Family members who may wish to supersede the Member’s goals of care should be identified, supported and reconciled.
2. **Palliative Care Assessment and Consultation** – Collects routine medical data and personal information not regularly included in a medical history. Topics may include, but are not limited to:
 - a. Treatment plan, including palliative care and chronic disease management
 - b. Pain and symptom management
 - c. Medication side effects
 - d. Emotional and social challenges
 - e. Spiritual concerns
 - f. Patient goals
 - g. Advance directive and/or POLST forms
 - h. Legally recognized decision maker
3. **Individualized Written Plan of Care** – Engages the Member and/or his or her representative(s) in its development. If the Member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative consultation or ACP discussion. The Member’s plan of care must include all authorized palliative care, including but not limited to, pain and symptom management and chronic disease management. The plan of care must not include services already provided through another Medi-Cal-funded program.
4. **Pain and Symptom Management** – Provides prescription medications, physical therapy, and other medically necessary services to address the Member’s pain and other symptoms.

¹Department of Health Care Services, SB 1004 Medi-Cal Palliative Care Policy, September 1, 2016 - Update

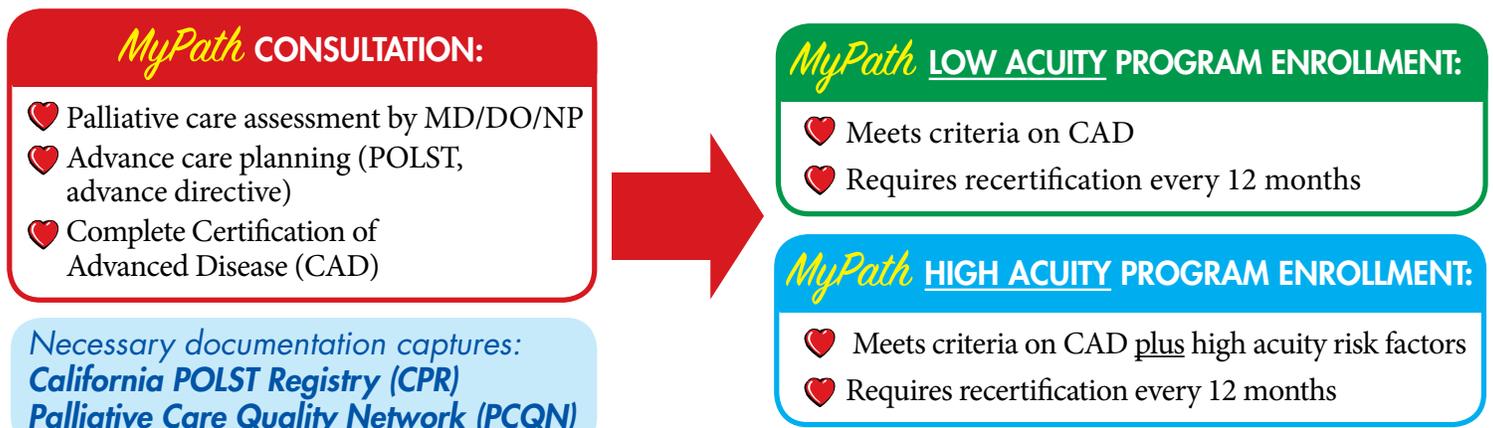
5. **Mental Health and Medical Social Services** – Offers counseling and social services to assist in minimizing the Member’s stress and psychological problems that arise from a serious illness. Services include, but are not limited to, psychotherapy, bereavement counseling, medical social services, and discharge planning. Particular attention and education are given to the primary caregiver to prevent both unnecessary hospitalizations of the Member and unnecessary health harms to the caregiver due to the role of caregiving. Medical social services should not duplicate specialty mental health services provided by the county. The Palliative Care Team works with the Member, county and IEHP to coordinate care as needed.
6. **Care Coordination** – Ensures continuous assessment of the Member’s needs and implementation of the plan of care. The Palliative Care Team regularly communicates plan of care with the Member’s Primary Care Physician (PCP). This communication occurs at a minimum of weekly intervals. The Palliative Care Team is willing to address the Member’s immediate needs (e.g., pain and symptom management, DME needs) in the event that the PCP is unavailable to avoid a delay in care.
7. **Palliative Care Team** – Coordinates care in order to meet the physical, medical, psychosocial, emotional, and spiritual needs of Members and their families. Palliative Care Team Members must provide all authorized palliative care. The Team is to consist of:
 - a. Doctor of medicine or osteopathy
 - b. Registered nurse, licensed vocational nurse, and/or Nurse Practitioner
 - c. Social worker
 - d. Chaplain
8. **Chaplain Services** – Offers support as needed.
9. **24/7 telephonic palliative care** – Offers support as needed.

As specified in SB 1004, Members who meet the eligibility criteria may access both palliative care and traditional chronic disease management services that are medically necessary. The Palliative Care Team and a plan of care ensure coordination between care services, particularly including the Member’s PCP. For those whose illness is sufficiently far advanced, the option of electing hospice care remains.

MyPath Program Workflow

The **MyPath** program workflow consists of a consultation visit that includes an assessment of eligibility for program enrollment when criteria are met as documented on the Certification of Advanced Disease (CAD). The consultation visit does not require prior authorization. Program enrollment requires prior authorization.

Consultation visits must occur according to IEHP timeliness access standards.



MyPath Program Details

Eligibility Requirements

MyPath is a Medi-Cal benefit. All Medi-Cal beneficiaries are eligible. Also, IEHP provides the benefit for IEHP DualChoice Cal Medi-Connect Plan (Medicare-Medicaid Plan) Members (only Direct).

During a program consultation visit, a Physician will assess the patient, looking to see if he or she meets program criteria listed on the IEHP website. Visit www.iehp.org and search under “Utilization Management Criteria,” subtopic “Other” and click on “**MyPath**.”

Certification Process

Members must meet criteria to be eligible for this ongoing in-home program. They will need to be recertified every 12 months.

Program Length

There is no time limit. The program targets Members with a prognosis of two years or fewer.

Referral Process

Submit a referral request to IEHP for a **MyPath** Palliative Care consultation.

Certification of Advanced Disease

Sample of Certification of Advanced Disease (CAD) form. To access the form, visit the IEHP website at <https://www.iehp.org/en/providers/special-programs?target=mypath>

Name: _____

DOB: _____

Member ID: _____

Name of Palliative Care Program: _____

A. General criteria: Check each of the following that apply (**All** are needed for eligibility).

- Patient is likely to or has started to use the hospital and/or emergency room as a means to manage their advanced stage disease.
- Patient is in an advanced stage of illness with continued decline in health, and is not eligible or declines hospice.
- Patient may be receiving appropriate patient-desired medical therapy, OR for whom patient-desired medical therapy is no longer curative, OR in intolerant/declines further medical therapy, OR decompensates due to severe non-compliance.
- Patient's death within two years or less would not be unexpected based on clinical status.
- Patients and, if applicable, family/patient-designated support person agree to both of the following:
 - a. Willing to attempt, as medically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department AND
 - b. May be willing to participate in Advance Care Planning discussions.

B. In addition, one of the following diagnoses must be selected, and associated severity criteria met:

1. Congestive Heart Failure (CHF):

- Any patient who is hospitalized due to Congestive Heart Failure (CHF) as the primary diagnosis; OR
- NYHA III classification or higher (definition of NYHA III: Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.)

AND one of the following:

- Ejection Fraction < 30 for systolic failure
- Significant comorbidities: e.g., renal disease, diabetes, dementia, or poor biomarkers including rising BNP, pro-BNP, hsCRP, BUN/ Creatinine (patient is in their best compensated state), and CAD.

2. Chronic Pulmonary Disease (e.g., COPD, Cystic Fibrosis, Pulmonary Fibrosis):

- Severe airflow obstruction: FEV1 < 35% predicted AND 24-hour oxygen requirement; OR

- 24-hour oxygen requirement of greater than or equal to three liters/minute

3. Advanced Cancer:

- Any Stage III or IV cancer, or locally advanced or metastatic cancer, leukemia or lymphoma

AND one of the following:

- Palliative Performance Scale (PPS) score < or equal to 70% (PPS 70% = Cares for self; unable to carry on normal activity or do active work)
- Failing two lines of standard of care therapy (chemotherapy or radiation therapy)
- Patient is not a candidate for or declines further disease-directed therapy

4. Liver Disease:

Irreversible Liver Damage as evidenced by one of the following:

- Ascites
- Subacute (spontaneous) bacterial peritonitis
- Hepatic encephalopathy
- Hepatorenal syndrome
- Recurrent esophageal bleeds
- Model for End-Stage Liver Disease (MELD) score of greater than 19

To calculate MELD Score:

<https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld-calculator/>

MELD Score: _____

5. End Stage Renal Disease:

- GFR < 15

AND one of the following:

- Patient refusing dialysis, has poor compliance
- Declining status with multiple other co-morbidities (e.g., CHF, ESLD, COPD)

6. Dementia:

Any one of the following:

- Functional Assessment Staging Scale (FASS) score of 5 with high risk of using the hospital to manage their disease with documentation of reason for high risk status:

-
- FASS 6 to 7

- Any patient with diagnosis of dementia who has been institutionalized or required hospitalization primarily due to their dementia, PLUS had an appropriate metabolic workup (CMP, Thyroid Function Tests, B12) and neuro imaging (or documented refusal)

7. Neurologic Disease (e.g., Parkinson's, ALS, Multiple Sclerosis):

- Impaired breathing capacity requiring oxygen; OR
- Rapid disease progression as evidenced by decline in ambulation status from independent to wheelchair/bed bound, or decline in speech to unintelligible, or decline in oral intake to pureed foods, or decline in ADLs to requiring mod/max assistance

AND one of the following:

- Nutritional impairment associated with weight loss
- Life threatening complication event in past 12 months, such as aspiration pneumonia, sepsis, stage 3 or 4 pressure ulcers

8. AIDS:

- Palliative Performance Scale (PPS) \leq 50%

AND

- CD4 cell count $<$ 25 or viral load $>$ 100,000 WITH either non-compliance, refusal, intolerance, failure, or resistance to antiretroviral therapy

AND

- Presence of ANY of the following:
 1. Opportunistic infections (e.g., multidrug-resistant *M. tuberculosis*, MAC, CMV, Cryptosporidium, Toxoplasmosis, Progressive Multifocal Leukoencephalopathy)
 2. AIDs-related malignancy (e.g., Non-Hodgkin's or CNS lymphoma, visceral Kaposi's sarcoma)
 3. HIV-associated dementia
 4. HIV wasting syndrome ($>$ 10% unintentional weight loss over 12 months, 33% loss of lean body mass or BMI $<$ 20)
 5. Declining status with presence of multiple co-morbidities (e.g., advanced liver disease, CHF, ESRD)

9. Other advanced illness (psychiatric or substance abuse-related diagnoses are excluded as *primary* qualifying diagnoses for program):

ICD-10: _____

Provide clinical documentation supporting the patient is in late stage of disease:

C. Program acuity type:

- Low
- High - requires clinical justification – criteria includes:
 - More than two inpatient admissions in the past three months
 - More than three ER visits in the past three months
 - Palliative Performance Scale (PPSv2) 60% or less
 - Presence of co-morbid uncontrolled significant mental health disorder (e.g., Bipolar, Schizophrenia) and marked with poor functionality (Global Assessment of Functioning scale (GAF) \leq 50)
 - Homeless or poor social support
 - Co-morbid active alcohol and/or drug abuse

Provider Signature

Date

Palliative Performance Scale

%	Ambulation 1	Activity & Evidence of Disease 2	Self-Care 3	Intake 4	Conscious Level 5
100	Full	Normal Activity, No Evidence of Disease	Full	Normal	Full
90	Full	Normal Activity, Some Evidence of Disease	Full	Normal	Full
80	Full	Normal Activity with Effort, Evidence of Disease	Full	Normal or Reduced	Full
70	Reduced	Unable to do Normal Work, Significant Disease	Full	Normal or Reduced	Full
60	Reduced	Unable for Most Activities, Significant Disease	Occasional Assistance	Normal or Reduced	Full
50	Mainly Chair	Minimal Activity, Extensive Disease	Considerable Assistance	Normal or Reduced	Full ± Confusion
40	Mainly Bed	As Above	Mainly Assisted	Normal or Reduced	Full or Drowsy ± Confusion
30	Bed Bound	As Above	Total Care	Reduced	Full or Drowsy ± Confusion
20	Moribund	As Above	Total Care	Sips	Full or Drowsy ± Confusion
10	Moribund	As Above	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	0	0	0	0
Rate					

Functional Assessment Staging Scale

Score	Description
1	No difficulty either subjectively or objectively.
2	<ul style="list-style-type: none"> - Complains of forgetting location of objects. - Subjective work difficulties.
3	<ul style="list-style-type: none"> - Decreased job functioning evident to co-workers. - Difficulty in traveling to new locations. - Decreased organization capacity.
4	<p>Decreased ability to perform complex tasks such as:</p> <ul style="list-style-type: none"> • Planning dinner for guests • Handling personal finances (e.g., forgetting to pay bills) • Difficulty shopping, etc.
5	<ul style="list-style-type: none"> - Requires assistance in choosing proper clothing to wear for the day, season, or occasion. - Repeatedly, observed wearing the same clothing, unless supervised.
6	<ul style="list-style-type: none"> - Improperly putting on clothes without assistance or cueing (e.g. shoes on wrong feet, day clothes vs. overnight clothes, difficulty buttoning). - Unable to bathe properly (e.g., difficulty adjusting bath water temperature). - Unable to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or does not properly dispose of toilet tissue). - Urinary incontinence (intermittent or constant). - Fecal incontinence (intermittent or constant).
7	<ul style="list-style-type: none"> - Limited ability to speak ± 6 intelligible words in an average day or interview. - Speech ability is limited to the use of a single intelligible word in a normal interaction; demonstrates repetitive actions. - Ambulatory ability is lost (cannot walk without personal assistance). - Cannot sit up without assistance. - Individual falls over if no lateral arm rests on chair. - Loss of ability to smile. - Loss of ability to hold up head independently.

Tier Description:

	LOW ACUITY	HIGH ACUITY
CRITERIA	<p>Meets <i>MyPath</i> program criteria</p> <p>Participation requires recertification/authorization every 12 months</p>	<p>Meets <i>MyPath</i> program criteria <u>AND ANY</u> of the following:</p> <ul style="list-style-type: none"> • ACG score = CCM level and PHU > 50%¹ • More than two inpatient admissions in the past three months² • More than three ER visits in the past three months • Palliative Performance Scale (PPSv2) 50% or less • Presence of co-morbid uncontrolled significant mental health disorder (e.g., Bipolar, Schizophrenia) and marked with poor functionality (GAF <=50) • Homeless • Active alcohol and/or drug abuse <p>Participation requires recertification/authorization every 12 months</p>
SERVICES	<ul style="list-style-type: none"> • Initial visit by MD/DO/NP • Follow-up visit by NP/RN as needed • Minimum two visits per month by licensed nurse (or every 14 days) • Social worker and spiritual counselor visit once a month as needed • Minimum of two outbound calls per week • Access to 24-hour nursing on call and triage services to include escalation to Provider home visit 	<ul style="list-style-type: none"> • Initial visit by MD/DO/NP • Follow-up visit by MD/DO/NP as needed • Minimum one visit per week by licensed nurse • Social worker visits at least once a month • Spiritual counselor visits at least once a month if desired by Member • Visits by HHA two times per week or as needed • Access to 24-hour nursing on call and triage services to include escalation to provider home visit • For specialty mental health needs, assist with referral and coordination of care with county mental health services

¹CCM = Complex Case Management High Risk ACG Population Health Score

²PHU = Probability of High Utilizer ACG Risk Score

Program Evaluation

The *MyPath* program is evaluated on patient outcomes, utilization, program engagement, and cost.

1. Patient Outcomes

- a. Improved quality of life scores and clinical outcomes
- b. Pain and symptom distress reduction
- c. High rates of completion of advanced care planning documentation (POLST, advance directives)

2. Utilization Analysis

- a. Decrease Inpatient Admissions
- b. Decrease Emergency Room (ER) visits
- c. Decrease Urgent Care (UC) Visits
- d. Increase Primary Care Provider (PCP) Visits

3. Program Engagement

- a. Low percentage of Members enrolled in program who then disenroll due to refusing service
- b. High percentage of Members who authorized MyPath consultation and received services within 15 days
- c. Positive Provider Experience
- d. Positive Member Experience

4. Cost

- a. Overall decrease in Total cost of care of Members' pre- and post-program enrollment

References:

1. Coalition for Compassionate Care of California, California Advanced Illness Collaborative, Community-Based Palliative Care Consensus Standards for California, March 14, 2017.
2. Department of Health Care Services, Draft All Plan Letter, Palliative Care and Medi-Cal Managed Care, released 5/3/17.
3. Hoefler, D, Transitions Guidelines Chronic Illness Management, Transitions Program - Sharp HealthCare, 10/30/13.
4. University of Texas Health Science Center at San Antonio, Hospice eligibility card, accessed on 9/1/17 at http://geriatrics.uthscsa.edu/tools/Hospice_eligibility_card__Ross_and_Sanchez_Reilly_2008.pdf.
5. Vitas Healthcare, Hospice Eligibility Reference Guide & Admission Guidelines, accessed on 9/1/17 at <https://www.vitas.com/partners/hospice-eligibility-reference-guide/renal-disease>
6. AAHIVM Fundamentals of HIV Medicine, 2012 edition.
7. A Clinical Guide to Supportive and Palliative Care for HIV/AIDS Chapter 23. Medical Care in Advanced AIDS. <http://www.thebody.com/content/art34084.html>
8. Arbor Hospice, HIV Disease, Accessed on 09/22/17 at <http://www.arborhospice.org/understanding-hospice/hospice-eligibility/hiv-disease>.
9. Hospice Touch, HIV/AIDS, Accessed on 09/22/17 at <http://www.hospicetouch.com/eligibility.php#11>.

Evaluation of Potential Interested Partners for Palliative Services

Proposals are requested that address the following questions:

1. Detail of infrastructure to support the provision of palliative care services for IEHP Members.
This should include:
 - a. Number and type of Provider make-up of organization including palliative Physician support, Physician extender support, nursing support, mental health Providers, and chaplain support
 - i. Clinical staff trained in palliative care: minimum training is the Cal State San Marcos Institute for Palliative Care Training Curriculum, or equivalent, which must be completed by staff members no later than three months after beginning Home-Based Palliative Program. Medical Director must be board certified in Hospice & Palliative Medicine
 - b. Geographical coverage area
 - c. Estimation of Member capacity for palliative care services
2. Joint Commission Accreditation Status
3. Organization's experience serving the Medi-Cal population
 - a. Capacity to bill IEHP
4. Two letters of support from major expected referral sources (hospitals, health centers, at least one oncologist, at least one other specialist from this group: gastroenterology hepatology, pulmonology, cardiology)
5. If organization is not a hospice organization, a letter or memorandum of understanding with local hospice organizations who can accept patients who need hospice care.
6. Potential ability to collect and submit data using the Palliative Care Quality Network system (PCQN) which is provided to contracted Providers by IEHP. A Provider is required to enter into a Data Sharing Agreement in order to submit data through the PCQN system.
7. Access points for provision of palliative services (e.g., home-based, SNF, LTAC, CBAS, inpatient, etc.)
8. Organizational approach to meet IEHP's Core Program Elements as listed above and include details of how a palliative care Provider will collaborate with Member's PCP in overall treatment plan.
9. Organizational support to provide program-specific metrics and share with IEHP on a quarterly basis.
10. Contract proposal (e.g., fee for service with detail of service codes, case rate, shared risk model, etc.)



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IEHP Provider Relations

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Monday – Friday
8am – 5pm

www.iehp.org



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