



IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	My Path (A Palliative Care Approach)	Guideline #	UM OTH 09
		Original Effective Date	11/8/2017
Section	Other	Revision Date	02/24/2025

COVERAGE POLICY

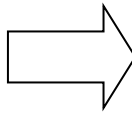
Inland Empire Health Plan (IEHP), in accordance with Senate Bill (SB) 1004, is dedicated to creating a community/home-based palliative care program for its Medi-Cal and non-delegated Medicare Members without regard to age.

The My Path Program consists of a consultation visit that will include an assessment of eligibility for program enrollment when criteria are met as documented on the Certification of Advanced Disease (CAD) (**Appendix A and B**). The consultation visit does require prior authorization. Program enrollment also requires prior authorization.

Adult Members:

My Path Consultation:

- Palliative care assessment by MD/DO/NP
- Advance care planning (POLST, Advance directive)
- Complete Certification of Advanced Disease (CAD)



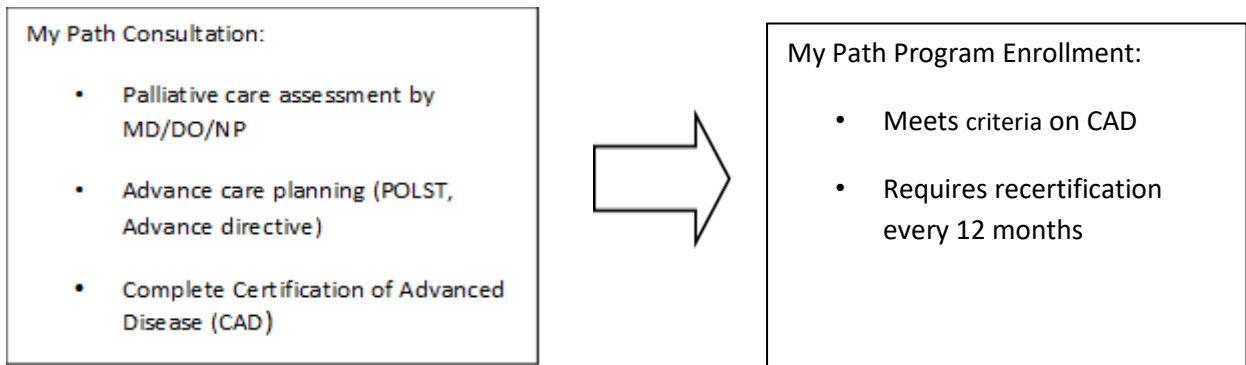
My Path Low Acuity Program Enrollment:

- Meets criteria on CAD
- Requires recertification every 12 months

My Path High Acuity Program Enrollment:

- Meets criteria on CAD plus high acuity risk factors
- Requires recertification every 12 months

Pediatric Members:



A Member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.

A. The Certification for Advanced Disease (CAD) will assess if the adult Member meets all the General Criteria (section B) and at least one of the Disease-Specific Criteria (section C) for enrollment in the program. Providers will recommend Program Acuity Tier based on the criteria outlined (section D). The CAD must be submitted with the authorization request for My Path program enrollment.

1. Members under the age of 21 years who do not qualify for services based on General Criteria may become eligible for palliative care services according to the broader criteria outlined in the Pediatric Palliative Care Eligibility Criteria (Section C) for enrollment in the program. The CAD must be submitted with the authorization request for My Path program enrollment.

B. General Criteria (all needed):

1. Patient who is likely to or has started to use the hospital and/or emergency room as a means to manage their advanced stage disease; and
2. Patient is in the advanced stage of illness with continued decline in health, and is not eligible or declines hospice; and
3. Patient may be receiving appropriate patient-desired medical therapy, OR for whom patient-desired medical therapy is no longer curative, OR is intolerant/ declines further medical therapy, OR decompensates due to severe non-compliance; and
4. Patient's death within two (2) years would not be unexpected based on clinical status; and
5. Patient 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.

C. Disease-Specific Criteria for Adult Members (at least one):

1. Congestive Heart Failure (CHF)
 - a. Any patient who is hospitalized due to CHF as the primary diagnosis, **OR**
 - b. 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:
 - i. Ejection Fraction < 30 for systolic failure
 - ii. Significant co-morbidities: 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):
 - a. Severe airflow obstruction: FEV1<35% predicted **AND** 24-hour oxygen requirement, **OR**
 - b. 24-hour oxygen requirement of greater than or equal to three liters/minute

3. Advanced Cancer:
 - a. Any Stage III or IV cancer, or locally advanced or metastatic cancer, leukemia or lymphoma **AND** one of the following:
 - i. Palliative Performance Scale (PPS) score < or equal to 70% (PPS 70%= Cares for self; unable to carry on normal activity or do active work) **(Appendix C)**
 - ii. Failing two lines of standard of care therapy (chemotherapy or radiation therapy).
 - iii. 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:

 - a. Ascites; and/or
 - b. Subacute (spontaneous) bacterial peritonitis; and/or
 - c. Hepatic encephalopathy; and/or
 - d. Hepatorenal syndrome; and/or
 - e. Recurrent esophageal bleed; and/or
 - f. 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/>))

5. End Stage Renal Disease:
 - a. GFR < 15 **AND one of the following:**
 - i. Patient refusing dialysis, has poor compliance, **OR**
 - ii. Declining status with multiple other advanced co-morbidities, such as CHF, ESLD, COPD.

6. Dementia:
Any one of the following:
 - a. 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 (**Appendix D**) **OR**
 - b. FASS 6 to 7 **OR**
 - c. Any patient with diagnosis of dementia who has been institutionalized or required hospitalization primarily due to their dementia, plus completed an appropriate metabolic workup (CMP, Thyroid Function Tests, B12) and neuro-imaging (or documented refusal).

7. Neurodegenerative Disease (e.g. Parkinson's, ALS, Multiple Sclerosis):
 - a. Impaired breathing capacity requiring oxygen **OR**
 - b. 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:**
 - c. Nutritional impairment associated with weight loss **OR**
 - d. Life threatening complication event in past 12 months such as aspiration pneumonia, sepsis, and stage 3 or 4 pressure ulcers.

8. AIDS:
 - a. Palliative Performance Scale (PPS) \leq 50% **AND**
 - b. 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:
 - i. Opportunistic infections (e.g. multidrug-resistant M. tuberculosis, MAC, CMV, Cryptosporidium, Toxoplasmosis, Progressive Multifocal Leukoencephalopathy), and/or
 - ii. AIDS related malignancy (e.g. Non-Hodgkin's or CNS lymphoma, visceral Kaposi's sarcoma), and/or
 - iii. HIV-associated dementia, and/or
 - iv. HIV wasting syndrome ($>$ 10% unintentional weight loss over 12 months, 33% loss of lean body mass or BMI $<$ 20), and/or
 - v. Declining status with presence of multiple co-morbidities (e.g. advanced liver disease, CHF, ESRD)

9. Sickle Cell Disease:
Any one of the following:
 - a. High risk of using the hospital to manage their disease with documentation of reason for high-risk status **OR**
 - b. 3 or more admissions in 2 consecutive months in the last 6 months **OR**
 - c. 4 or more Emergency Department Visits in the past 60 days **OR**
 - d. Documented irreversible end organ damage.

10. Documentation of other advanced illness (psychiatric or substance abuse related diagnoses are excluded as *primary* qualifying diagnoses for program).

D. Providers will recommend program acuity tier (Low vs. High) for adult members based on the following criteria:

1. Low- meets criteria in C and D
2. High – meets criteria in C and D, and requires clinical justification – clinical justification criteria includes (at least one):
 - a. ACG score = CCM level and PHU > 50%
 - b. More than 2 inpatient admissions in the past 3 months
 - c. More than 3 ER visits in the past 3 months
 - d. Palliative Performance Scale (PPSv2) 60% or less
 - e. Presence of co-morbid uncontrolled significant mental health disorder (e.g. Bipolar, Schizophrenia) and marked with poor functionality (Global Assessment of Functioning scale (GAF) <= 50)
 - f. Homeless or poor social support
 - g. Co-morbid active alcohol and/or drug abuse
 - h. Clinical justification.

E. Pediatric Palliative Care Eligibility Criteria (all needed):

1. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
2. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
 - a. 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); or
 - b. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis or muscular dystrophy); or
 - c. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
 - d. 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).

COVERAGE LIMITATIONS AND EXCLUSIONS

- A. My Path is a plan benefit for Medi-Cal (Direct and delegated) and non-delegated Medicare Members (Dual Choice Members whose Medicare is assigned to IEHP Direct).
- B. The provision of My Path shall not result in the elimination or reduction of any covered benefits or services and shall not affect a beneficiary's eligibility to receive any services, including home health services, for which the beneficiary would have been eligible in the absence of receiving My Path (DHCS, 2018).
- C. An adult Member with a serious illness who is receiving palliative care may choose to transition to hospice care if they meet hospice eligibility criteria. A Member may not be concurrently enrolled in hospice care and palliative care.
- D. A Member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
- E. My Path program enrollment requires re-certification every 12 months.
- F. If the Member under 21 years of age 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.

- G. For children who have an approved California Children’s Services (CCS)-eligible condition, CCS remains responsible for medical treatment for the CCS-eligible condition. The My Path program is responsible for the provision of palliative care services related to the CCS-eligible condition.
- H. Refer to Appendix E for a table comparing coverage criteria for adult vs. pediatric members
- I. Examples of adult Members eligible for My Path are:
 - 1. A patient with lymphoma who is receiving palliative chemotherapy, has a PPS 50%, and is willing to attempt in-home or outpatient disease management instead of using the emergency room, when appropriate.
 - 2. A delegated Medi-Cal Member with end-stage liver disease complicated by recurrent upper GI bleeding from esophageal varices, who is hospice appropriate but declines participation, and is willing to attempt in-home or outpatient disease management instead of using the emergency room, when appropriate.
- J. Examples of adult Members not eligible for My Path are:
 - 1. A patient with end-stage renal disease on hemodialysis who is compliant with dialysis and has stable co-morbid conditions.
 - 2. A delegated Medicare Member (e.g. a Dual Choice Member whose Medicare is not assigned to IEHP Direct).

ADDITIONAL INFORMATION

None

CLINICAL/REGULATORY RESOURCE

- A. 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 facilitating patient autonomy, access to information, and choice.” (CMS, 2017).

As described in Department of Health Care Services (DHCS) All Plan Letter 18-020, *Palliative Care*, released 12/7/18, palliative care must include, at a minimum, the following services, without regard to age, when medically necessary and reasonable for the palliation or management of a qualifying serious illness: (DHCS, 2018).

- 1. **Advanced Care Planning (ACP):** To include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling should address, but is not limited to, advance directives and, for appropriate Members, POLST forms and should include family conflict resolution over issues surrounding the patient’s decisions. Family members who may wish to supersede the patient’s goals of care should be identified, supported, and reconciled.
- 2. **Palliative Care Assessment and Consultation:** Aimed at collecting 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. Advanced directive and/or POLST forms
 - h. Legally recognized decision maker
3. **Individualized Written Plan of Care:** Developed with the engagement of the Member and/or his or her representative(s) in its design. 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.
 4. **Pain and Symptom Management:** To include prescription medications, physical therapy, and other medically necessary services to address Member's pain and other symptoms.
 5. **Mental Health and Medical Social Services:** 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. Services to include, but not limited to, psychotherapy, bereavement counseling, medical social services, and discharge planning. Particular attention and education will be given to the primary caregiver to both prevent unnecessary hospitalizations of the Member and unnecessary health harms to the caregiver from the role of care-giving. Provision of medical social services shall not duplicate specialty mental health services provided by the county and the palliative team shall work the Member, county, and IEHP in assisting with coordinating care as needed.
 6. **Care Coordination** provided by a member of the palliative team ensuring continuous assessment of the Member's needs and implements the plan of care. The palliative team will regularly communicate plan of care with the Member's PCP. This communication should occur at a minimum of weekly intervals. The palliative team must be willing to address Member's immediate needs (e.g. pain and symptom management, DME needs) if the PCP is unavailable to avoid a delay in care.
 7. **Palliative Care Team** who will work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of Members and their families. The 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

MCPs may authorize additional palliative care not described above, at the MCPs discretion and cost. An example of an additional service is telephonic palliative care support that is available 24 hours a day, 7 days a week.

- B. As specified in SB 1004, beneficiaries who meet the eligibility criteria may access both palliative and traditional chronic disease management services that are medically necessary. Essential to care coordination, the palliative care team and a plan of care will ensure coordination between care services, particularly including the beneficiary's PCP. For those whose illness is sufficiently far advanced, there will remain the option of electing hospice care.
- C. Centers for Medicare and Medicaid Services (CMS) letter #10-018 and DHCS Policy letter 11-004, provide guidance or implementation of the Affordable Care Act Section 2302 entitled "Concurrent Care for Children". Section 2302 removes the prohibition of receiving curative treatment upon election of the hospice benefit by a Medicaid or Children's Health Insurance Program (CHIP) eligible child.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provision requires Medicaid and CHIP programs operating as Medicaid expansions to provide all medically necessary services, including hospice services, to individuals under age 21. Hospice services are to be made available to Medicaid and Medicaid-expansion CHIP-eligible children without forgoing any other service to which the child is entitled under Medicaid for the treatment of the terminal condition.

- D. According to APL 18-020, Managed Care Health Plans are required to provide EPSDT-eligible Members with any other health care, diagnostic services, treatment and other measures to correct or ameliorate defects, physical and mental illnesses and conditions uncovered by the screening services. Services must also be provided when medically necessary to prevent disease or disability or their progressing, to prolong life and promote physical and mental health and efficiency. This is because hospice care options for children do not fit the traditional adult hospice model. Children can live longer with a life-threatening condition because of aggressive treatment and their natural resilience.

DEFINITION OF TERMS

Palliative Care - “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 facilitating patient autonomy, access to information, and choice.” (DHCS, 2018).

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DISCLAIMER

IEHP Clinical Authorization Guidelines (CAG) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Authorization Guidelines (CAG) express IEHP's determination of whether certain services or supplies are medically necessary, experimental and investigational, or cosmetic. IEHP has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). IEHP makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in the Clinical Authorization Guidelines (CAG). IEHP expressly and solely reserves the right to revise the Clinical Authorization Guidelines (CAG), as clinical information changes.



APPENDIX A

Certification of Advanced Disease: Adult

Name: _____ DOB: _____

Member ID: _____

Name of Palliative Care Program: _____

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

- Patient who 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 the 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 is intolerant/ declines further medical therapy, OR decompensates due to severe non-compliance.
- Patient's death within two (2) years would not be unexpected based on clinical status.
- Patients and, if applicable, family/patient-designated support person agree to both of the following:
 1. 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
 2. 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 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, hs-CRP, 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

- Patient refusing dialysis, has poor compliance

OR



- Declining status with multiple other advanced co-morbidities, such as CHF, ESLD, COPD

6. Dementia:

- 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:

OR

- FASS 6 to 7

OR

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. Neurodegenerative 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

- Nutritional impairment associated with weight loss

OR

- 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:
 - Opportunistic infections (e.g. multidrug-resistant M. tuberculosis, MAC, CMV, Cryptosporidium, Toxoplasmosis, Progressive Multifocal Leukoencephalopathy)
 - AIDs related malignancy (e.g. Non-Hodgkin's or CNS lymphoma, visceral Kaposi's sarcoma)
 - HIV-associated dementia
 - HIV wasting syndrome ($>$ 10% unintentional weight loss over 12 months, 33% loss of lean body mass or BMI $<$ 20)
 - 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: _____

Clinical documentation supporting the patient is late stage of disease:



C. Program acuity type:

- Low
- High - requires clinical justification – criteria includes:
 - ACG score = CCM level and PHU > 50%
 - More than 2 inpatient admissions in the past 3 months
 - More than 3 ER visits in the past 3 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) <= 50)
 - Homeless or poor social support
 - Co-morbid active alcohol and/or drug abuse

Provider Signature

Date

Certification of Advanced Disease: Pediatric

APPENDIX B

Name: _____

DOB: _____

Member ID: _____

Name of Palliative Care Program: _____

A. General Criteria: Check each of the following that apply

1. Patient who is likely to or has started to use the hospital and/or emergency room as a means to manage their advanced stage disease; and
2. Patient is in the advanced stage of illness with appropriate documentation of continued decline in health, and is not eligible or declines hospice; and
3. Patient may be receiving appropriate patient-desired medical therapy, OR patient-desired medical therapy is no longer curative, OR the patient is intolerant/ declines further medical therapy, OR decompensates due to severe non-compliance; and
4. Patient's death within two (2) years would not be unexpected based on clinical status; and
5. Patient 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. Pediatric Palliative Care Eligibility Criteria: Check each of the following that apply (ALL needed for eligibility)

1. The family and/or legal guardian agree to the provision of pediatric palliative care services; and
2. There is documentation of a life-threatening diagnosis. This can include but is not limited to:
 - a. 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); or
 - b. Conditions requiring intensive long-term treatment aimed at maintaining quality of life
 - c. (e.g., human immunodeficiency virus infection, cystic fibrosis or muscular dystrophy); or Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
 - d. 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).

ICD-10 codes: _____

Clinical documentation supporting the above criteria:

C. Program acuity type:

- Low
- High - requires clinical justification – criteria may include:
 - ACG score = CCM level and PHU > 50%
 - More than 2 inpatient admissions in the past 3 months
 - More than 3 ER visits in the past 3 months
 - Presence of co-morbid uncontrolled significant mental health disorder (e.g. Bipolar, Schizophrenia) and marked with not meeting milestones
 - Homeless or poor social support

Provider Name

Date

Provider Signature



APPENDIX C

Palliative Performance Scale

%Rate	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 <i>Effort</i> , Evidence of Disease	Full	Normal or Reduced	Full
70	Reduced	Unable to do normal work	Full	Normal or Reduced	Full
60	Reduced	Unable for most activities, Significant	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



APPENDIX D

Functional Assessment Staging Scale

Score	Description
1	No difficulty either subjectively or objectively.
2	Complains of forgetting location of objects. Subjective work difficulties
3	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organization capacity.
4	Decreased ability to perform complex tasks such as: <ul style="list-style-type: none"> • Planning dinner for guests • Handling personal finances (e.g. forgetting to pay bills) • Difficulty shopping, etc.
5	Requires assistance in choosing proper clothing to wear for the day, season, or occasion. Repeatedly, observed wearing the same clothing, unless supervised.
6	*Improperly putting on clothes without assistance or cueing (e.g. shoes on wrong feet, day clothes 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 properly dispose of toilet tissue) *Urinary incontinence – intermittent or constant *Fecal incontinence – intermittent or constant
7	*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

My Path: Adult vs Pediatric:

Appendix E

Criteria	Adult	Pediatric
Acuity	Low and high. See Appendix A	Low and High can also be determined by documented medical necessity. See Appendix B.
Certification of Advanced Disease	Must meet all General Criteria and at least 1 Disease-Specific Criteria	May still be eligible even if don't qualify based on general criteria
General Criteria		Same as for adults
Disease-specific Criteria	Criteria for CHF, chronic pulmonary disease, advanced cancer, liver disease, end stage renal disease, dementia, AIDS	None
Pediatric Palliative Care Criteria	N/A	Life-threatening diagnosis: curative treatment may fail, long-term treatment for quality of life, exclusively palliative, extreme vulnerability to complications
Coverage	Medi-Cal (direct and delegated), non-delegated Medicare (DualChoice whose Medicare is assigned to IEHP Direct)	Medi-Cal (direct and delegated) and non-delegated Medicare. If member has a CCS-eligible condition, CCS remains responsible for medical treatment of that condition. My Path is responsible for palliative care services related to CCS-eligible condition.
Hospice Care	May not be concurrently enrolled in hospice care and palliative care.	May be eligible for concurrent palliative care and hospice services.