



Palliative Care

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for Palliative Care. The CPG discusses behavioral health implications and outlines the organizations that WellCare aligns with regarding palliative care and relevant Measureable Health Outcomes.

OVERVIEW

Palliative care is patient and family-centered health care that focuses on effective management of pain and other distressing symptoms, while incorporating psychosocial and spiritual care according to patient / family needs, values, beliefs, and cultures. The goal of palliative care is to anticipate, prevent and reduce suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care begins at diagnosis and should be delivered concurrently with disease-specific, life-prolonging therapies and should facilitate patient autonomy, access to information and choice. Palliative Care becomes the main focus of care when disease-directed, life prolonging therapies are no longer effective, appropriate or desired. Palliative Care applies to pediatric and adult patients. Palliative Care treats people suffering from serious and chronic illnesses such as cancer, cardiac disease such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), kidney failure, Alzheimer's disease, Parkinson's disease, Amyotrophic Lateral Sclerosis (ALS). Palliative Care focuses on symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and depression.¹

Over the last decade, Palliative Care has been one of the fastest growing trends in health care. In fact, the number of Palliative Care teams within U.S. hospitals has increase 148%, from more than 600 in the year 2000 to more than 1,600 today.² Growth has occurred primarily in response to the increasing number of Americans living with serious and chronic illnesses and to the caregiving realities faced by their families. It has also been embraced for the simple reason that it gives patients and families control and choice over their own care. The strong partnership of patient, family and the Palliative Care team ensures that treatment goals are established and coordinated, and that full communication is maintained in what is often a long, complex course of serious illness. Additional highlights of palliative care include:³

- Provides relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten nor postpone death.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Offers a support system to help the family cope during the patient's illness and in their own bereavement.
- A team approach to address the needs of patients / families, including bereavement counseling, if indicated.
- Enhances quality of life, and may also positively influence the course of illness.
- Can be applied early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative Care also improves their ability to tolerate medical treatments and helps the individual to have more control over their care by improving their understanding of their choices for treatment. All patients with pain, including children, should be treated, irrespective of whether or not the underlying cause can be identified. Inability to establish an underlying cause should not be a reason to conclude that the pain is fabricated. Palliative Care can be helpful to all patients with serious illness and at any stage of their disease. This is particularly the case in children, because they are resilient to illness in ways that adults are not. Palliative Care can start at the beginning of an illness and be given along with treatment meant to cure. Palliative Care aims to improve quality of life by relieving distressing symptoms. The health care team helps with decision making and determining care goals. The approach involves different disciplines and includes physicians, nurses, case / care managers, social workers and chaplains.² Refer to the addendum for additional information, including the difference between palliative and hospice care.

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the National Coalition for Hospice and Palliative Care (NCHPC), Institute for Clinical Systems Improvement (ICSI), and the American Society of Clinical Oncology (ASCO). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to palliative care, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with NCHPC, ICSI, and ASCO on the topic of palliative care. Highlights from their respective publications are noted below.

NATIONAL COALITION FOR HOSPICE AND PALLIATIVE CARE (NCHPC)

The NCHPC recommends that care be considered for the following populations:⁴

- Individuals living with chronic and life - threatening injuries from accidents or other forms of trauma
- Neonates, children, adolescents, and adults with congenital injuries or conditions leading to dependence on life - sustaining treatments and/or long - term care, supported by others to perform their activities of daily living
- Neonates, children, adolescents, and adults with developmental and intellectual disabilities who develop serious or life threatening illness
- Individuals, of any age, with acute, serious, and life - threatening illnesses (e.g. severe trauma, acute stroke, and leukemia), where cure or reversibility is a realistic goal, but the conditions themselves and/or their treatments pose significant burdens and result in poor quality of life
- People living with progressive chronic conditions (e.g. peripheral vascular disease, malignancies, renal or liver failure, stroke with significant functional impairment, advanced heart or lung disease, frailty, neurodegenerative disorders, and the various forms of dementia)
- Seriously and terminally ill patients (e.g. people living with end - stage dementia, terminal cancer, or severe disabling stroke) who are unlikely to recover or stabilize; and for whom intensive palliative care is the predominant focus and goal of care for the remainder of their lives
- Vulnerable, underserved, and under - resourced populations who develop serious or life threatening illness (e.g. homeless individuals, immigrants, individuals with low income, oppressed racial and ethnic groups, veterans, prisoners, older adults, and individuals with mental illness)

The underlying tenets of palliative care in the guideline include: ⁴

- Patient and family centered palliative care;
- Comprehensive palliative care with continuity across health settings;
- Early introduction of palliative care at diagnosis of a serious disease or life threatening condition;
- Interdisciplinary collaborative palliative care;
- Clinical and communication expertise within palliative care team members;
- Relief of physical, psychological, emotional, and spiritual suffering and distress of patients and families;
- A focus on quality; and
- Equitable access to palliative care services.

The guidelines are categorized into eight (8) domains – the entire published guideline is available [here](#): ⁴

- | | |
|--|---|
| 1. Structure and Processes of Care | 5. Spiritual, Religious and Existential Aspects of Care |
| 2. Physical Aspects of Care | 6. Cultural Aspects of Care |
| 3. Psychological and Psychiatric Aspects of Care | 7. Care of the Patient at the End of Life |
| 4. Social Aspects of Care | 8. Ethical and Legal Aspects of Care |

INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT (ICS)

The Institute for Clinical Systems Improvement (ICS) guideline assists primary and specialty care providers in identifying and caring for adult patients with a serious (potentially life-limiting, life-threatening or chronic, progressive) illness who may benefit from palliative care. In addition, the guideline is appropriate for patients who still desire curative or life-prolonging treatments, or patients who are best served by active end-of-life management. It outlines key considerations for creating a plan of care to meet patient, family and other caregivers' needs throughout the continuum of care. Aims include: ⁵

1. Increase the identification of patients who are in the early stages of a serious illness who would benefit from palliative care.
2. Improve the effectiveness and comfort level of primary care clinicians in communicating the necessity and benefits of palliative care with those patients with a serious illness.
3. Improve the assessment of the identified patient's palliative care needs, utilizing the domains of palliative care.
4. Increase the percentage of patients in the early stages of a serious illness who have a care plan identified and/or documented.
5. Improve the ongoing reassessment and adjustment of the patient's plan of care as the condition warrants, utilizing the domains of palliative care.
6. Increase the completion, documentation and ongoing utilization of advance directives for patients with a serious illness.

The guideline does not provide information regarding the identification or care for pediatric patients with life-threatening or chronic progressive illness. Additional clinical highlights include: ⁵

- Planning for palliative care should begin early in the patient's journey of a serious illness. Referrals should be considered early on in the patient's care if there are complex needs. Primary care providers should begin planning early through palliative care conversations with their patients.
- Providers should complete a systematic review of patients' palliative care needs and document patients' goals for care and advance directives.
- Suffering is common and typically presents itself in physical symptoms; controlling symptoms to maximize patient comfort is a cornerstone function of palliative care. Also important are the recognition, assessment and management of non-physical areas of suffering that are important to the patient (e.g., cultural, psychological, social, spiritual, financial, ethical and legal issues). Where available, consultation with palliative care specialists should be considered for all of these symptoms.
- The ability to address these issues depends on the quality of communication with patients and families. Setting realistic goals of care and providing realistic hope are essential. Engaging patients in decisions about their care increases their involvement and satisfaction. Shared Decision-Making (SDM) is one method to engage patients.
- Palliative care is compatible with all other medical treatments.

- Health care providers play an important role in the grief and bereavement processes by supporting the patient and family throughout the course of illness and following the patient's death.

To access the entire published guideline, click [here](#).

AMERICAN SOCIETY OF CLINICAL ONCOLOGY (ASCO)

The American Society of Clinical Oncology (ASCO) published a statement regarding individualized care for patients with advanced cancer. Patients with advanced incurable cancer face complex physical, psychological, social, and spiritual consequences of disease and its treatment. Care for these patients should include an individualized assessment of the patient's needs, goals, and preferences throughout the course of illness. Consideration of disease-directed therapy, symptom management, and attention to quality of life are important aspects of quality cancer care. However, emerging evidence suggests that, too often, realistic conversations about prognosis, the potential benefits and limitations of disease-directed therapy, and the potential role of palliative care, either in conjunction with or as an alternative to disease-directed therapy, occur late in the course of illness or not at all.⁶

The ASCO's statement provides a vision for improved communication with and decision making for patients with advanced cancer. The statement advocates an individualized approach to discussing and providing disease-directed and supportive care options for patients with advanced cancer throughout the continuum of care. In addition, the statement expands on previously published statements on end-of-life care (1998) and palliative care (2009). Finally, the ASCO outlines the goals for individualized care, barriers that currently limit realization of this vision, and possible strategies to overcome these barriers that can improve care consistent with the goals of our patients and evidence-based medical practice. To access the entire published statement, click [here](#).⁶

Evidence Based Practice

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement*.

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

Care Management

The goals for Care Management is to support the member and member's family to establish with a Palliative Care provider and remove barriers preventing the member from achieving those goals. Thorough assessment is the cornerstone to identifying uncontrolled symptoms and need to Palliative Care referral. Members should receive education and coaching regarding the elements of pain to recognize and be prepared to describe to the practitioner to help with appropriate diagnosis and treatment. The main focuses of Care Management at WellCare in regards to Palliative Care is to accomplish the following:³

- Ensure that members understand the difference between Palliative Care and end-of-life (Hospice) care.
- Recognize members that are appropriate for Palliative Care, including triggers for Palliative Care.
- Educate the member and their family/designated representative on the benefits of Palliative Care: symptom management; psychosocial support.
- If member does not have referral, assist through outreach to PCP.

Integrated Care Management: Since pain is highly subjective, the Palliative Care team's assessment of the pain sufferer as a whole person, including all relevant biological, social, psychological, and spiritual dimensions pertaining to etiology and impact of pain, is essential. Integrated care management for pain requires the interdisciplinary care team to work collaboratively to overcome obstacles and alleviate the Member's pain through:⁷

- Member access to Pain Medicine services
- prioritizing routine and event-related pain assessment and management
- treatment of underlying conditions that contribute to pain
- care team awareness of pain treatment-related substance misuse, abuse, addiction, and diversion, including

risk assessment and management

- assessing for appropriateness of including a pain specialist on the Member's care team (if not already included)

The use of Mindfulness Based Stress Reduction (MBSR) and other cognitive behavioral therapies continues to expand as contemporary neuroimaging techniques broaden the industry's knowledge of the neural mechanisms of pain perception. Techniques should be considered as potential components of care for the Member experiencing pain.⁸ The care team should also assess risk of depression and poor coping skills, and share with provider(s) if risks are identified.

MEASURABLE HEALTH OUTCOMES

Targeted Health Outcomes (Extended Program Goals) result from successful member self-management (see Case Management Objectives).

1. The Member experiences no symptoms requiring acute medical care and intervention. The case manager compares the recent utilization frequency for (Condition for which member is receiving palliative care) to the frequency prior to CM engagement. CM monitors for ED and inpatient authorization/utilization related to the primary diagnosis. In absence of ED and inpatient utilization, authorizations and claims data, or to otherwise demonstrate less frequent need for acute medical intervention, CM may use Provider and/or Member narrative.
2. The Member reports fewer or lessening symptoms over a specific period of time after the start of Case Management engagement. Member-specific goals should reference member's individual symptoms. Compare member's responses to pain assessment questions on initial and subsequent assessments.

CASE MANAGEMENT GOALS

Case Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which will lead to the targeted health outcomes above. Examples:

1. The Member attends initial and follow up appointments with Palliative Care team per treatment team recommendations over last 90 days. (verified by claims or member/provider narrative)
2. Specific for Members requiring hospitalization: The Member participates in provider follow-up visit within 7 days of hospital discharge.
3. Member's description of pharmacologic and non-pharmacologic techniques (such as meditation) over the last 30 days matches the Palliative Care provider's prescribed pain management plan.
4. Member reports satisfaction with pain management regime over last 14 days.
5. The results of the Member's pain interview portion of the assessment score shows Member is receiving good pain control within 30 days of case management engagement.

Other measurable health outcomes may apply based on complications and comorbidities in the individual. Refer to those other CPGs for additional options for health outcomes.

CASE MANAGEMENT OBJECTIVES

Case Management Objectives should focus on improving the member's self-management skills including:

- Learn ways to control pain
- Take medications as prescribed
- Food tolerance
- Advance Directives and HIPAA release
- Balance physical activity and getting enough rest
- Increased socialization
- Recognizing/reporting worsening symptoms timely or getting immediate care for emergent symptoms
- Assess spiritual needs
- Utilize safety precautions with DME

The care team should also conduct risk screening and treat anxiety and depression, if applicable.

MEDICAL BEHAVIORAL INTEGRATION

At times, people think depression is "normal" when receiving palliative care, but in actuality, treating the depression could be considered an enhancement to the quality of life. It is important to evaluate and treat depression. Adding an

anti-depressant or starting a person in counseling should be strongly considered if mood begins to dip. The major behavioral issues associated with Palliative Care are depression, anxiety and cognitive impairment/delirium. Both the patient and their family may also experience emotional strain from:³

- Threatened loss of physical integrity
- Possible decline in mental/ functional capacity
- Change in family/ social role
- Increased dependence on medical system
- Ultimate prospect of death

Emotional distress is common following a life-threatening illness diagnosis. Research indicates that those with a history of depressive disorders may be at particular risk when they learn they have a life-threatening illness. The chart below compares normal reactions to those of an individual with a depressive disorder:³

Normal Adjustment

- Anxiety
- Sadness
- Fatalism
- Grief

Depressive Disorder – Interference with Function

- Severe Reactions
- Pervasive Reactions
- Prolonged Reactions

Actively facing a diagnosis head on is the best way to cope with a life-threatening illness. A study of women with breast cancer found that those who sought social support and used active coping strategies reported more inner peace and satisfaction with life compared to women who tended to deny or avoid their diagnosis. Those who are actively facing their diagnosis are more likely to seek social support, actively participate in problem solving and focus on the positives. Those who deny or avoid their diagnosis are more likely to have passive or avoidant behaviors such as social withdrawal and rumination.³

Depressive Disorders Seen in Palliative Care³

Depression in seriously ill patients can be associated with increased physical symptoms, suicidal thoughts, worsened quality of life, and emotional distress. Depressive disorders highly prevalent in Hospice and Palliative Care settings:

- Adjustment disorders
- Mood disorder due to disease or other medical condition
- Major depression
- Bipolar disease
- Dysthymia
- Minor depression

Risk Factors

- Prior History
- Gender
- Age
- Psychosocial Support
- Performance Status
- Pain

Depression – Emotional Concerns

- Unfulfilled Ambitions
- Meaning
- Control
- Past Regrets
- Dignity
- Family Welfare

Depression Treatment

- Empathic Caregiver
- Psychotherapy
- Medication – antidepressants, psychostimulants

The following items outline risk factors, primary types of disorders, and treatments for anxiety associated with life-threatening illness.³

Risk Factors – Medical

- Uncontrolled Pain
- Metabolic Disturbances
- Endocrine Disorders
- Medications
- Withdrawal Syndromes

Risk Factors – Psychiatric

- Delirium
- Depression

Primary Anxiety Disorders

- Post-Traumatic Stress Disorder
- Generalized Anxiety Disorder
- Panic Disorder
- Phobias
- Obsessive Compulsive Disorder

Anxiety Treatment

- Psychotherapy (Group and/or Individual; Pharmacotherapy)

Addressing Fear³

Fear of Abandonment. It is important to identify and alleviate the fears that patients who are dying commonly experience, because these fears can precipitate or exacerbate depression. Fear of abandonment may be common:

- When patients face multiple changes, like becoming more debilitated and dependent, they often worry that

caring for them may become too burdensome for their families.

- Family members might experience tremendous stress while acting as caregivers and may not understand what the person who is dying is experiencing. Alienation and abandonment of the patient can result.

Addressing the above issues during a family meeting and identifying coping strategies can help alleviate fear and minimize the potential for alienation and abandonment.

Fear of the Unknown. Death is often violently portrayed by the media. Depression can be related to intense fears that death will be very painful or horrific. Educating patients and families about the dying process and what can be done to alleviate suffering can help to address these fears. Alternative therapies involving massage, art, relaxation, music and guided imagery can help mitigate anxiety and stress.

Fear for Loved Ones. Persons who are dying often worry about how their families will survive after their death. Helping the patients and families make plans for the future might enable them to cope better with future potential losses.

Fear of the Afterlife and the Future. Patients' spiritual needs should be assessed, when indicated, to allow for better understanding of each patient and to facilitate referral to a spiritual caregiver.

Emotional Triggers for Patients and Families³

It is important to identify periods of increased vulnerability for patients and families receiving Palliative Care, because these periods can trigger intense emotional reactions. Some of those period are:

- Work up/staging
- Diagnosis
- Awaiting treatment
- Change in treatment modality
- End of treatment
- Discharge from hospital following treatment
- Surviving the death of a loved one
- Medical follow-up and surveillance
- Treatment failure
- Recurrence/progression
- Advanced cancer diagnosis
- End of life

Psychosocial Health Services are those psychological and social services that enable cancer survivors, their families, and health care providers to optimize biomedical health care and to manage the psychological/behavioral and social aspects of cancer and its consequences so as to promote better health. To properly assess a member's health needs, a multidimensional, culturally informed, psychosocial health needs screening may be performed, which includes:

- *Emotional/Mental Health Needs* such as anxiety, depression, coping, sexuality
- *Practical Problems* regarding concrete needs and illness-related concerns (financial, transportation, housing)
- *Social Problems* may include a lack of social support and resources, vocational impact, and insurance
- *Support Needs* should be addressed from a personal, social, medical, and spiritual approach

SPECIAL CONSIDERATIONS: PEDIATRICS

Serious illness is not a "normal" condition for most children. This presents unique differences in caring for seriously ill children and their families, which may include:³

- Medical decisions for young children are usually made by their caregivers; whereas adult patients typically make their own decisions.
- Pediatric Palliative Care can also involve a play therapist, child life therapist, and/or child behavioral specialist.

Assessment is a fundamental part of pain management, but is difficult in children because of the child's stage of cognitive development and associated medical disease. The assessment below can be used to evaluate pain in a child:

- What words do the child and family use for pain?
- What verbal and behavioral cues does the child use to express pain?
- What do the parents and/or caregivers do when the child has pain?
- What do the parents and/or caregivers not do when the child has pain?
- What works best in relieving the pain?
- Where is the pain and what are the characteristics (site, severity, character or pain as described by the child/parent; e.g., sharp, burning, aching, stabbing shooting, throbbing)?

- How did the present pain start (was it sudden/gradual)?
- How long has the pain been present (duration since onset)?
- Where is the pain (single/multiple sites)?
- Is the pain disturbing the child's sleep/emotional state?
- Is the pain restricting the child's ability to perform normal physical activities (sit, stand, walk, run)?
- Is the pain restricting the child's ability/willingness to interact with others, and ability to play?

Correct use of analgesic medicines will relieve pain in most children with persisting pain due to medical illness and relies on the following key concepts:³

1. **Using a two-step strategy.** The World Health Organization (WHO) recommends treating pain in two steps, based on pain severity assessment:
 - Step 1 is for Mild Pain. The medicines used are non-opioid analgesics like paracetamol and ibuprofen. These substances have a fixed maximum dosage and can provide only limited analgesia.
 - Step 2 is for Moderate and Severe Pain. Strong opioids are used, e.g., morphine, using a weight-appropriate starting dose. The dosages recommended by WHO are lower than those recommended elsewhere. As long as the pain is not sufficiently addressed, the dosage needs to be increased in steps of no more than 50% per 24 hours.
2. **Dosing at regular intervals.** Opioids should be administered at regular intervals, not on an *as needed* basis.
3. **Using the appropriate route of administration.**
4. **Adapting treatment to the individual child.**

MEMBER EDUCATIONAL RESOURCES

WellCare contracts with Krames/StayWell for Member educational materials utilized by Case Managers. Items are available to review with Members to address knowledge gaps. Case Managers verbally educate Members on the topics below related to asthma. (Titles may also be sent to the member).

- | | |
|---|---|
| • Counseling for Depression | • Stress Relief – Relaxation |
| • Depression Affects Your Mind and Body | • Using Antidepressants |
| • Depression and the Brain's Chemical Balance | • Warning Signs for Suicide and What You Can Do |
| • Know the Signs and Symptoms of Depression | • What Can Cause Depression |
| • Stress Relief – Changing Your Response | |

Providers may wish to research the titles above related to asthma that Case Managers utilize with Members.

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Cancer* (HS-1034) and *Pain Management* (HS-1064).

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

References

1. NCCN clinical practice guidelines in oncology: palliative care. National Comprehensive Cancer Network Web site. <http://www.nccn.org>. Published 2017. Accessed April 18, 2018.
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*Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care 1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
5/3/2018	<ul style="list-style-type: none"> • Approved by MPC. No changes.
6/28/2017	<ul style="list-style-type: none"> • Approved by MPC. Enhanced Care Management and Measures of Compliance sections. Revised with CM, DM, QI, UM, BH and the Chief Medical Directors.
2/5/2015	<ul style="list-style-type: none"> • Approved by MPC. New.

Addendum

The following criteria have been developed to help assess whether a Palliative Care consultation would be beneficial for a member. Presence of a serious, chronic illness should be accompanied by one or more of the following:³

- Declining ability to complete activities of daily living
- Weight loss
- Multiple hospitalizations
- Difficult to control physical or emotional symptoms related to serious medical illness
- Patient, family or physician uncertainty regarding prognosis
- Patient, family or physician uncertainty regarding goals of care
- Patient or family requests for futile care
- DNR order conflicts
- Use of tube feeding or Total Parenteral Nutrition (TPN) in cognitively impaired or seriously ill patients
- Limited social support and a serious illness (e.g., homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress

The following are two criteria for recommending a consultation with a Palliative Care Specialist.³

1. Limited treatment options; **OR**,
2. High risk of poor pain control or pain that remains resistant to conventional interventions, for example:
 - Neuropathic pain
 - Incident or breakthrough pain
 - Associated psychosocial and family distress
 - Rapid escalation of opioid dose
 - Multiple drug "allergies" or history of multiple adverse reactions to pain & symptom management interventions
 - History of drug or alcohol abuse

A Palliative Care Team consists of a partnership between a patient, specialists and the patient’s family. Palliative Care is a team approach to care. The core team may include a doctor, nurse and social worker. Palliative Care specialists can include, but are not limited to, massage therapists, pharmacists, nutritionists, and chaplains. The team spends as much time as necessary with the patient and their family. They become a partner to the patient, their family and the patient’s other doctors. They support the patient and their family every step of the way, not only by controlling symptoms, but also by helping the patient to understand their treatment options and goals.³

Questions	Palliative Care	Hospice Care
When is it appropriate?	Should begin at diagnosis and continue through treatment. Follow-up care and end of life Palliative Care is given at any stage of the disease.	Usually when patient has less than six months to live.
Who can receive it?	Anyone with a serious illness, regardless of life expectancy, can receive Palliative Care.	Someone with an illness with a life expectancy measured in months, not years.
Can the patient continue to receive treatments to cure the illness?	The patient may receive Palliative Care and curative care at the same time.	Treatments and medicines aimed at relieving symptoms are provided by hospice. As a provision of the Affordable Care Act, children under the age of 21 may receive curative treatments and co-enroll in hospice under <i>Concurrent Care</i> .
Does Medicare pay?	Some treatments and medications may be covered.	Medicare pays all charges related to hospice.
Does Medicaid pay?	Some treatments and medications may be covered.	In 47 states, Medicaid pays all charges related to hospice.
Is this a “package deal”?	There is no Palliative Care package. The services are flexible and based on the patient’s needs.	Medicare and Medicaid have packaged services.
How long can the member receive care?	This will depend on the member’s care needs and the coverage one has through Medicare or Medicaid.	As long as they meet the hospice criteria of an illness with a life expectancy of months, not years.
Where are services provided?	Home, assisted living facility (ALF), nursing facility, or Hospital (inpatient or clinic).	Hospice facility, wherever the patient resides – in a home, ALF, nursing facility or hospital. Hospice is given where the patient prefers to stay, usually at home.
Who provides services?	It varies. Usually there is a team which includes physicians, nurses, social workers and chaplains.	A Team Doctor, nurse, social worker, chaplain, volunteer, and home health aide. Hospice relies upon a family caregiver as well as on a visiting hospice nurse.

When to Screen	What to Assess	Life Expectancy
Uncontrolled symptoms	Benefits / risks of anticancer therapy. Satisfaction with response to therapy.	Years – Palliative Care
Moderate to severe distress related to cancer diagnosis	Personal goals and expectations. Reduction of patient / family distress.	Years to months – Palliative Care or Hospice Care
Seriously comorbid physical and psychosocial conditions	Adequate pain and symptom control. Optimized quality of life. Acceptable sense of control.	Months to weeks – Palliative Care or Hospice Care
Metastatic solid tumors	Psychosocial or spiritual distress. Reduction of patient/family distress. Relief of caregiver burden. Strengthened relationships.	Weeks to days (dying patient) – Hospice Care
Patient / family concerns about course of disease-decision making	Educational and informational needs. Personal growth and enhanced meaning.	Not applicable.
Patient / family requests for Palliative Care	Cultural factors affecting care.	Not applicable.