

PALLIATIVE CARE REFERRAL & SCREENING TOOL

Created by the Coalition for Compassionate Care of California in collaboration with health plan partners:



Referral Date

PATIENT INFORMATION

Patient Name: _____ Diagnosis: _____ ICD-10 code: _____

Phone: _____ Address (include Zip): _____

ID/CIN Number: _____ Male Female Date of Birth: _____ Age: _____

Language: _____ PCP/Specialist Name & Phone: _____

Health Plan: _____ LOB: Medicare Medi-Cal Commercial PPO

Location: Hospital SNF Home Other: _____

If Hospital or SNF, Anticipated Discharge Date: _____

Anticipated Disposition: Home with Caregiver Support Home without Caregiver Support Home with Home Health
 Home with Home Infusion Therapy Board & Care Shelter Other community living situation

REFERRAL SOURCE INFORMATION

- Internal Referral (circle one): UM, CM, BH, Member Services, Other
 External Referral (circle one): Hospital, SNF, Outpatient Provider, Other

Name: _____ Organization: _____ Specialty or Role: _____

Address (include Zip): _____ Phone: _____

Fax: _____ Email: _____ Alt Contact Name & Phone: _____

- Patient meets basic eligibility/screening guidelines or other health plan specific diagnostic criteria for a full Palliative Care Service Evaluation (see reverse side).
 Current referral prompted by: Patient is using the hospital or ED to manage symptoms
 Uncontrolled symptoms related to underlying disease (e.g., pain, shortness of breath, vomiting)
 Inadequate home, social, family support
 Pertinent history, medical records, test results, x-rays, etc. attached.

Was member or authorized representative informed of this referral? Yes No

Signature: _____ Date: _____

REFERRING PATIENT FOR PALLIATIVE CARE SERVICE EVALUATION

Please mark faxes CONFIDENTIAL. Please send from secure email.

- | | | |
|--|--------------------|---|
| <input type="checkbox"/> Blue Shield Promise | fax # 323.889.2109 | email: BSCPHP_PalliativeCare@blueshieldca.com |
| <input type="checkbox"/> Health Net/CHW | fax # 844.907.0436 | email: CareConnections@HealthNet.com |
| <input type="checkbox"/> LA Care | fax # 213.438.4866 | email: MLTSS@LACare.org |
| <input type="checkbox"/> Molina | fax # 800.811.4804 | |

PLEASE TURN THE PAGE FOR ELIGIBILITY/SCREENING GUIDELINES

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association

PALLIATIVE CARE SCREENING CRITERIA

Disclaimer: The criteria noted below are the Medi-Cal minimal criteria. Medi-Cal members may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. Exceptions to these criteria are optional based on specific health plan policy and line of business (Medi-Cal, Medicare, PPO, HMO, etc.). Health Plan will review referrals for most appropriate care or program.

Section 1: Adults

A. General Eligibility Criteria (*Must meet ALL*)

- Using/expected to use the hospital and/or ED to manage their illness
- Advanced illness with decline
- Death within one year is not unexpected
- Member will try in home or outpatient management prior to using the ED
- Member will participate in advance care planning

B. Disease Specific Criteria (*Must meet ONE*)

- CHF**
 - ✓ NYHA class III or IV or hospitalized for CHF with no further invasive interventions planned, and
 - ✓ Ejection fraction < 30% or significant co-morbidities
- COPD**
 - ✓ FEV1 < 35 % predicted or
 - ✓ Oxygen requirement ≥ 3 L / min
- Advanced cancer**
 - ✓ Stage III or IV solid organ cancer, lymphoma, or leukemia and
 - ✓ Karnofsky Performance Scale ≤ 70% or has failed two lines of standard therapy.
- End stage liver disease**
 - ✓ Irreversible liver damage, Albumin < 3.0 and INR 1.3 and
 - ✓ Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, or
 - ✓ Evidence of irreversible liver damage and MELD score of > 19
- Other:** _____

Section 2: Pediatrics

A. General Eligibility Criteria (*Must meet ALL*)

- The member is under age 21
- The family and/or legal guardian agrees to the provision of pediatric palliative care services
- Member has a life-threatening illness

B. Disease Specific Criteria (*Must meet ONE*)

- 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.**
- Conditions requiring intensive long-term treatment aimed at maintaining quality of life, e.g. Human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy.**
- Progressive conditions for which treatment is exclusively palliative after diagnosis, e.g. Progressive metabolic disorders or severe forms of osteogenesis imperfecta.**
- Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications, e.g. Advanced or progressive cancer or complex and severe congenital or acquired heart disease.**
- Other:** _____

SUBMIT PERTINENT HISTORY, MEDICAL RECORDS, TEST RESULTS