Q&A Summary
Clinical and Behavioral Management of the Complex and Critically Ill— When to Consult for Palliative Care Services

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I have a Russian-speaking member who has thyroid cancer, metastasized to his lungs, just recently sent home alone with polyethylene glycols (PEG) for feedings, who is having difficulty with instilling enteral feeding and remembering to take his meds. Would he be a good candidate for palliative care? He is only getting home health aide assistance four days per week, and they are not able to help with PEG.

Absolutely. This member meets primary criteria (requires complex care) as well as secondary criteria (metastatic cancer and lack of family support).

When a member has palliative care where does that fall under the benefits? There is a benefit outline specific to hospice, but I have not seen one specific to palliative care.

You are correct, there is no specific benefit for palliative care. Where it falls under benefits will depend on who is the provider and place of service. If the member is receiving the care by a physician or midlevel provider or receiving inpatient or at outpatient center, it will likely fall under medical benefit. If receiving it through home health care (HHC), it may be under the home health care benefit, and therefore you will need to watch utilization. If he/she is receiving hospice care, of course it will be covered through the hospice benefit. When receiving through HHC, I recommend getting social work support and looking for as many community resources as possible to help preserve the benefit if it is limited.

Is palliative care a covered benefit and if so, what benefit is it covered under?

See above.

Do most of our members have a palliative care benefit?

See Above.

Who pays for palliative care?

See Above.

I have a member with HIV exhibiting some mental and emotional symptoms and would really appreciate more info on how HIV affects the brain.

The best reference for this is the “Guide for HIV/AIDS Clinical Care” published by the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. Jan 2011. Section 8: Neuropsychiatric Disorders. Pages 523–578.

Is there any suggested scripting for assessing social/cultural values around approaching the subject of palliative care?

I don’t have any specific scripting for this, but I would recommend asking open-ended questions like, *“Tell me about your family. How do they support one another through chronic and severe illness? Do you have any family traditions surrounding this? Who is your main support?”*
Please also see the Serious Illness Conversation Guide in the Appendix of the presentation.

Where can I find that talking point for palliative care?

See the Appendix for Serious Illness Conversation Guide.

Question #6 on the pretest read “All individuals should be informed about the status/nature of their illness prognosis”....true/false. I chose True, and it was wrong. Please explain why you would not make the individual aware.

When performing a palliative care assessment, a social/spiritual/cultural assessment should be done as well as an assessment of understanding. During this assessment, one should ask the patient how he/she would like information about his/her illness communicated and to whom. There are cultures that do not allow a clinician to discuss life-threatening/terminal prognoses with patients directly; that information should instead be communicated to the main caregiver or other family designee.

The care you described for Mr. G, in my opinion, describes the care that any patient going home receives (or should receive). How is palliative care different in this particular case?

The difference is that a palliative care program pulls all this care together and coordinates as well as putting the patient in the center of the care team. Also you have hit on the point that palliative care is really appropriate for ANYONE with complex illness, not just the dying.

Does the patient make the decision if he/she is aware of the prognosis?

Your question is unclear, but the patient is the center of the care team. If he/she is not aware due to incapacitation or prefers not to be aware from his/her own choice or cultural preference, then usually a family member is designated to make decisions. This is best accomplished through advanced directives.

How do we start an actual referral to palliative care? Find a palliative care provider and refer that way? Or start with primary care provider or primary specialist?

I would recommend that you encourage the member to speak with his/her own primary provider about referral to palliative care; however, we can directly refer members to an in network provider who should collaborate with their primary providers. Please also consider a medical director referral when you believe a patient should be receiving palliative or hospice care when he/she is not.

As a RN case manager, am I able to refer the member to palliative care? Or is there a special team of nurses that handle that? Or would the member's doctor have to refer them?

See previous question.