Definitions

(1) "Assessment" means procedures by which a practitioner of the healing arts identifies strengths, weaknesses, problems, and needs to determine a member's need for palliative care services.
(2) "Interdisciplinary Team" means a team of individuals working together in a coordinated manner to provide palliative care services. An interdisciplinary team is directed by the individual and composed of the following individuals who are trained or certified in palliative care:
(a) A registered nurse;
(b) A social worker; and
(c) A physician or primary care provider, or specialty care provider;
(d) In addition to (a-c) above, the interdisciplinary team may include the client-family unit; and
(e) One or more of the following palliative care program personnel:
(A) Licensed Practical Nurse;
(B) Certified nurse's aide;
(C) Home health aide;
(D) Hospice aide;
(E) Community health worker;
(F) Occupational therapist;
(G) Physical therapist,
(H) Trained volunteer (faith or community based),
(I) Spiritual care professional,
(J) Advanced practice clinicians, and
(K) Licensed or credentialed mental health professional including:
(i) Licensed psychiatrist;
(ii) Licensed psychologist;
(iii) Psychiatric nurse; and
(iv) Qualified Mental Health Professional.
(3) "Palliative care services" means comfort services that focus primarily on reduction or abatement of physical, psychosocial, and spiritual symptoms of serious illness.
(4) "Primary caregiver" means the person designated by the patient or representative to assume responsibility for care of the patient as needed. If the patient has no designated primary caregiver and is unable to designate one, the interdisciplinary team shall designate a primary caregiver.
(5) "Portable Orders for Life-Sustaining Treatment (POLST)" means the formal written medical orders signed by a physician, nurse practitioner, physician assistant or naturopathic physician that helps identify the types of medical treatment an individual will receive during their palliative care.
(6) "Prognosis" means the amount of time set for the prediction of a probable outcome of a disease.
(7) "Residential care facility" has the meaning given that term in ORS 443.400.
(8) "Seriously Ill" means an accident, injury, illness, disease, physical, or mental condition that negatively impacts the patient's quality of life.
(9) "Skilled nursing facility" has the meaning given that term in ORS 442.015.
(10) "Symptom management" means assessing and responding to the physical, emotional, social, and spiritual needs of the client and their family.

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System of Care

(1) A Coordinated Care Organization (CCO) shall maintain a network to provide a community or home-based Palliative care benefit for its members.
(2) A residential care facility or a skilled nursing facility is not subject to the provision or arrangement of palliative care services for residents of the facilities.
(3) A provider of palliative care services under the program and a CCO shall determine the reimbursement paid for services by mutual agreement.

Eligibility for the Palliative Care Service

(1) An individual shall be determined eligible for the Oregon Health Plan (OHP) on the date the services are rendered;
(2) Palliative care services shall be provided by
(3) An individual qualifies for palliative care services under the program if they:
(a) Have been diagnosed with a serious illness that negatively impacts the individual's quality of life or the quality of life of their primary caregiver; and
(b) Palliative care is ordered by the individual's physician or other specialty care provider
(c) Meets the criteria outlined in the Palliative Care Guidance Tool;
(4) Providers must bill Medicare or other insurances prior to billing Medicaid for services rendered

Plan of Care

(1) A written plan of care shall be developed and updated yearly or when there is a change in health status for each individual eligible for palliative care services, and the care provided to an individual must be provided in accordance with the plan.
(2) The plan of care is developed and updated as directed by the individual accessing palliative care services, in collaboration with the members of the interdisciplinary team (IDT).
(3) Assessment
(a) The plan must include a comprehensive palliative care assessment to include physical, psychological, social, spiritual needs, and functional status. This must include on-going assessment of need for community-based palliative care services.
(b) Assessment of caregiver needs, making appropriate referrals to community-based services such as support groups, caregiver respite, and grief or bereavement services.
(c) Develop an individual plan to identify and document symptom management, goals of care, and care coordination;
(d) Include ongoing assessment of pain, other physical symptoms, functional status, and psychological symptoms using standardized tools as available.
(e) signature of the individual receiving the services or their legal representatives authorizing services written in the plan of care and the date.

Provider Qualifications for Palliative Care Program

(1) Providers must be credentialed per CCO requirements.
(2) Members of the Interdisciplinary team (IDT) must be trained or certified in palliative care with documentation of a minimum of 16 hours of palliative care training for those who are not certified
(3) Training topics include, but are not limited to:
(a) Advance Care Planning conversations including discussion of POLST and/or Advance Directive.
(b) Palliative Care Assessment, including Patient assessment; Social needs screening; Home safety assessment; Caregiver assessment; Spiritual assessment; Functional assessment.
(c) Basic pain and symptom management; Expected disease trajectory or Physicians, Nurse Practitioners, Physician Assistants and Registered Nurses:

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(d) Additional recommended training: Trauma informed care; Social determinant issues; Boundaries; Motivational interviewing.

Palliative Care Services

(1) The Palliative Care program must designate an Interdisciplinary team or groups composed of individuals who provide or supervise the care and services offered to the patient.
(2) Members of the Interdisciplinary team interact on a regular basis and have a working knowledge of the assessment and care of the patient/family unit by each member of the group. The interdisciplinary team is responsible for:
(a) Development of the plan of care;
(b) Provision or supervision of palliative care and services;
(c) Review and updating of the plan of care for each individual receiving palliative care; and
(d) Establishment of policies governing the day-to-day provision of palliative care and services.
(2) Palliative care services shall include:
(a) Palliative care assessment;
(b) Advance care planning including a discussion regarding completing a POLST and/ or Advance Directive;
(c) Case management and care coordination provided by a registered nurse or other qualified member of the interdisciplinary team;
(d) Symptom assessment and management;
(e) Transitional care management;
(f) Behavioral health and social work services;
(g) Twenty-four hour clinical telephone support;
(h) Spiritual care services;
(i) Education with individual and their caregivers, including:
    (i) Aspects of in-home care, including the safe use of medications, and storage and disposal of medications in home setting
    (ii) Goal of patient being more self-reliant or when to seek higher level of care
    (iii) When to contact EMS
    (iv) Hospice services availability and eligibility
    (v) Bereavement support and services availability
(3) The palliative care services, as determined and provided by an interdisciplinary team, must be provided through the individual's direction and in the individual's choice of residence.

Requirements for Coverage

(1)To be covered, Palliative care services must meet the following requirements:
(a) Receive a referral from a client's physician or other specialty care provider.
(b) The individual must elect Palliative care services.
(c) The services provided must be consistent with the plan of care.

Disenrollment Criteria

(1) Individuals are no longer eligible for community-based palliative care services if the individual:
(a) Enrolls in hospice;
(b) Death;
(c) Is no longer is enrolled in Medicaid;
(d) Experiences improvement of condition or functional status extended outside eligibility criteria;
(e) Individuals living conditions that are found to be unsafe for staff contact, and no alternative can be found;
(f) Chooses to disenroll;

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(g) The individual moves out of palliative care provider's service area;
(h) The individual (or other persons in the individual's home) engage in behavior that is disruptive, abusive, or is considered a health and safety concern to the individual or a member of the IDT, to the extent that delivery of care to the patient, or the ability of the agency to operate effectively, is seriously impaired.

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