

# Essential Elements of Medi-Cal Palliative Care Services: Palliative Care Provider Team Roles Descriptions

This resource is part of “Section B: Ensure readiness (and evolution) of provider organization” of the California Health Care Foundation publication *Essential Elements of Medi-Cal Palliative Care Services: Tips and Tools for Medi-Cal Managed Care Plans and Palliative Care Providers*.

Medi-Cal managed care plans and their palliative care provider partners shared information from their programs for this guide, including internal policies and procedures. CHCF is grateful for this leadership and willingness to contribute for the benefit of more people whose health and lives can be improved with high-quality palliative care.

The California Department of Health Care Services recommends that a palliative care (PC) provider team in the Medi-Cal palliative care program have the following staff roles on its PC team (summarized from “[Palliative Care \[PDF\]](#),” All-Plan Letter 18-020, DHCS, December 7, 2018):

- Doctor of medicine or osteopathy
- Registered nurse
- Licensed vocational nurse or nurse practitioner
- Social worker
- “DHCS also recommends that MCPs provide access to chaplain services as part of the palliative care team. Chaplain services . . . are not reimbursable through the Medi-Cal program.”

In addition to this core team, PC providers add supervisors and administrative support roles. Listed below are select “essential functions” for the full mix of staff team roles, extracted from job descriptions shared by PC providers. Responsibilities that are less specific to palliative care (such as chart documentation and departmental meetings) are not listed. Because these role descriptions are compilations from multiple palliative care provider teams, they represent a mix of staffing models. Specific roles and responsibilities might be distributed differently, depending on the combination of clinical disciplines used by the organization.

## Team Manager (RN required)

Serves as a supervisor, advisor, and resource for the palliative care team. This position functions as a collaborative member of the interdisciplinary team and provides consultation concerning difficult cases. The team manager directly supervises all palliative care clinical team members.

- Acts as a resource and role model to the palliative care team.
- Directly supervises all palliative care clinical team members.
- Oversees schedules, ensuring patient needs are covered.
- Depending on census, may carry a small case load and make patient visits.
- Delivers orientation and training for new palliative care staff.
- Conducts educational needs assessments and incorporates research findings into training workshops, meetings, classes, and discussions with new hires and current staff.
- Provide assistance in assessment planning, implementation, and evaluation of patient and family/caregiver care to nurses and palliative care aides.
- Conducts annual staff field visits.
- Demonstrates knowledge and awareness of community resources available to patients and their families, and assists with referrals and linkages.

## Palliative Care Physician

Under the supervision of the medical director and with administrative guidance from the chief operating officer or designee, physicians work in collaboration with other team members to provide palliative care for our patients.

- Provides palliative care for patients via phone, videoconferencing, and home visits, per the patient's care plan. Care is delivered primarily via videoconferencing and home visits.
- Functions independently to perform age-appropriate history and physical for complex acute, critical, and chronically ill palliative care patients.
- Orders and interprets diagnostic tests and therapeutic procedures consistent with patient's clinical needs in collaboration with primary care and specialty providers.
- Prescribes appropriate pharmacologic and nonpharmacologic treatment for the optimal management of symptoms and support of best possible quality of life.
- Implements interventions to support the patient to regain or maintain physiologic stability, in collaboration with primary care and specialty providers, as well as other agencies (e.g., Home Health, Hospital Palliative Care, Care Transitions).
- Monitors the effectiveness of interventions with the interdisciplinary team.
- Educates patients, family members, and caregivers regarding medical problems, shared decision-making, and medication adherence.
- Facilitates the patient's transition within and between health care settings.
- Ensures appropriate follow-up, including consultation and referrals.
- Ensures timely referrals to hospice when a patient meets hospice eligibility criteria, in the context of the interdisciplinary team that prepares patients and families for such a transition through counsel and guidance.
- Demonstrates expertise in person-centered shared decision-making that guides care.
- Provides leadership to the interdisciplinary team in its core work: complex and holistic care assessments and care plans, and implementation and evaluation of care plans.
- Uses advanced communication skills as a leader in the interdisciplinary team.
- Understands Medicare and Medicaid reimbursement and coding for all levels of service, as well as related regulatory requirements. Submits accurate coding and billing information for each patient interaction.
- Maintains up-to-date patient records so that problems, plans, actions, and goals are accurately and clearly stated, and changes are reflected as they occur, including new information obtained during meetings with the interdisciplinary team and primary care and specialty providers.
- Collaborates regularly with the interdisciplinary team for ongoing care coordination, to include admissions and discharges of palliative care patients.
- Participates in peer review, chart review, and quality assurance activities, medical staff meetings, case reviews, and clinical training sessions.
- Collaborates with the medical director to devise a professional/personal development plan in line with objectives of [OUR ORGANIZATION] and personal needs.

## Palliative Care Registered Nurse

Provides palliative care to clients and their family/caregiver according to the primary clinician's orders and agency's standards and policies.

- Performs appropriate physical and emotional assessments of client status/needs and the needs of the family/caregiver.
- Communicates with client's physician regarding the client's needs and reports changes in condition; obtains and receives physician's orders as required.
- Provides professional nursing advice by utilizing all elements of nursing process.
- Provides health care education to the client and family/caregiver as appropriate and at their level of understanding.
- Demonstrates an adequate knowledge of clinical disease entities.
- Demonstrates adequate knowledge of specialized diets and medications commonly prescribed to clients.
- Demonstrates knowledge and awareness of rehabilitative and preventive care, ensures client safety and protection, providing ongoing education as client's condition changes.
- Demonstrates the ability to facilitate client/family/caregiver decision-making and to solve problems.
- Coordinates palliative care with primary care physician and other agency staff, and refers to community resources as appropriate.
- Documents each client visit reflecting nursing intervention, client instruction, and client/family/caregiver response, and specific plan for subsequent visit(s).
- Documents changes in physician orders, communication and coordination with physician and other team members, and submits written physician orders in a timely fashion.
- Submits discharge summary and reviews chart for completion.

## Palliative Care Social Worker

A multifaceted position that requires professional MSW skills in conjunction with exceptional communication and clinical palliative care knowledge. This position provides services to clients and their families that include counseling services and coordination of resources and other community services. Also coordinates educational activities to develop awareness and generate referrals with physicians, discharge planners, social workers, admission directors, skilled nursing facilities, residential care facilities, Department of Veterans Affairs, and other related health care providers.

- Uses appropriate assessment skills for evaluation of the social and emotional responses of the client/family/caregiver to chronic illness and caregiving.
- Demonstrates knowledge and awareness of community resources available to clients/families/caregivers, and assists with referrals and linkages.
- Provides appropriate counseling services to the client/family/caregiver, including counseling, coping, anticipatory grief, and long-term care planning.
- Communicates with client's primary care physician regarding the client's needs and reports changes in condition.
- Communicates effectively with social and community agencies regarding supportive care cases and the psychosocial needs of the client/family/caregiver, especially for those with high-risk indicators — abuse, neglect, inadequate food / medical supplies, and high suicide potential.
- Collaborates and communicates with the palliative care teams.

- Using educational and outreach approaches, implements activities with physicians, discharge planners, health care providers, and the public to generate referrals to palliative care and [OUR ORGANIZATION'S] other supportive services.
- Builds sustainable relationships with targeted referral sources by maintaining regular contact with appropriate personnel and ensuring good rapport.
- Completes and submits psychosocial evaluation in accordance with agency standards.
- Documents notes of each client visit reflecting client evaluation, intervention, client/family/caregiver response.
- Assists interdisciplinary team members in understanding significant social and emotional factors related to health problems and issues.

### Community Health Worker / Community Outreach Specialist

#### Example 1:

Part of the interdisciplinary team under the supervision of a nurse case manager. Assists the nurse case manager (CM) and the team in developing and implementing an effective plan of care for patients, and adds an additional layer of support for patients' physical, psychological, and spiritual needs.

- Per care plan, communicates with patients and families via phone, video technology, and home visits. Facilitates video conferencing with other team members during home visits. Provides active listening, support, and follow-up, in collaboration with the team.
- Helps patients with personal needs, errands, and chores, such as light housekeeping and meal or snack preparation in accordance with the care plan.
- Provides companionship for patients, short respite breaks for family members, and engages in quality-of-life projects as directed by the care plan.
- Facilitates advance care planning in collaboration with the team.
- Participates in team meetings and collaborates on patient care plans.
- Assists the patient in obtaining vital signs for blood pressure, pulse, temperature, and oximetry readings, at the request of clinicians.
- Assists with the coordination of social services and community resources, under the direction of social work and nursing.
- Investigates community resources available for our patients.
- Coordinates durable medical equipment for patients, and assists in the delivery of equipment, meals, and other resources from outside agencies.
- Helps patients navigate healthcare services by assisting with calling providers, and scheduling and tracking appointments.
- Provides simple wound care by applying a dry dressing such as gauze or adhesive bandage, or reinforcing an existing dressing under the direction of the nurse or provider.
- Provides reminder calls to patients and/or caregivers in advance of scheduled visits, and for medication management.
- May provide help with personal hygiene and/or support family members, per the care plan.
- Notifies care team or Clinical Director of any unsafe home environments or signs of abuse.
- Assesses patients' spiritual needs and connects patients to spiritual care based on patient preferences.

### Example 2:

Part of the comprehensive care team alongside nurses, social workers, and behavioral health specialists. This position is responsible for outreach to clients to support them in meeting any identified unmet needs. Requires critical thinking, independent judgment, as well as comfort in community, home, hospital, and healthcare settings.

#### Direct Care Coordination and Triage

- Gather and review all available and relevant client information to identify unmet physical, behavioral, social, or medical needs.
- Address clients' barriers to care and identify potential resources while balancing cultural factors, social determinants, and member autonomy.
- Review and assess hospital admissions reports, health plan claims, pharmacy records, and other relevant clinical care information to support care planning and needs assessments.
- Assume direct care coordination for clients and provide warm handoff of clients with complex medical or behavioral health needs to appropriate resources.
- Acknowledge client's right to choose treatment or refuse treatment.
- Identify suspected abuse and neglect issues and appropriately report to mandated authorities.
- Partner closely with clients' providers and the care team to facilitate care that meets the individual's personal needs, values and preferences.
- Coach clients in navigating the health care delivery system, gaining access to appropriate community resources, negotiating transitions in their health care, and determining ways to improve self-management and satisfaction with their quality of life.
- Engage clients in advance care planning conversations.
- Establish effective relationships with community partners and maintain familiarity with key services and resources available to clients.
- Ability to synthesize multiple aspects of a client's medical or social situations especially those that pose a risk to their safety or wellness and increase likelihood of rehospitalization

#### Data Collection, Documentation and Compliance

- Identify opportunities for increased case-finding efficiencies and effectiveness.
- Collect and/or audit data and information to inform or evaluate team performance relative to our organizational metrics and our regulatory requirements.
- Contribute to continuous process improvement through participation in team huddles, trainings, and departmental, team, and organizational meetings.
- Complete initial and subsequent documentation pertinent to care coordination activities.
- Document all encounters in an accurate and timely manner in accordance with HIPAA laws, as well as internal policies and procedures.

#### Knowledge

- Understanding of the nature of client engagement and the unique needs of low-income and marginalized communities. Understanding of the impacts of trauma on health.
- Ability to be sympathetic to client, family, and caregiver needs and ability to work with people in various states of pain, trauma, and tragedy.

## Chaplain

The chaplain is responsible for the provision of spiritual care services to clients/families/caregivers of [OUR ORGANIZATION], either directly or through coordination of care with other spiritual counselors.

- Completes a spiritual assessment of clients/families/caregivers within five days of patient admission to palliative care, unless deferred by patient/family.
- Participates in the development of the interdisciplinary group (IDG) Plan of Care to meet identified spiritual needs.
- Provides direct spiritual care to patients/families/caregivers.
- Serves as liaison and support to community chaplains and spiritual counselors.
- Attends patient care conference and IDG meetings as a member of the IDG team.
- Provides consultation, education, and support to the IDG on spiritual care.
- Recruits community chaplains, spiritual counselors, and spiritual care volunteers adequate to meet client/family/caregiver needs by developing community contacts and offering education through congregations about serious illness care.
- Arranges funeral or memorial services for patients as requested.
- Participates in planning periodic memorial services to meet the needs of personnel, volunteers, and community clergy / spiritual counselors working with the IDG.
- Maintains records of spiritual care services utilization and related activities for performance improvement, program development, and policy and procedure review and revision.
- Documents direct services and ongoing communication with community chaplains and spiritual counselors.

## Team Coordinator (nonclinical)

Coordinates palliative care team schedules and provides support to the team essential functions.

- Assists with triaging phone calls from family members, caregivers, vendors, and referrals.
- Prepares and coordinates clinical work schedule, including tracking time-off requests and updating time-off calendar.
- Assists team manager with team member assignments.
- Coordinates physician scheduling.
- Assists with data collection and metrics.
- Processes changes of clinician patient assignments.
- Reviews electronic medical record tasks and notifies appropriate clinical team member of action items as needed.
- Prepares correspondence and reports, performs filing and copying as requested by director(s).
- Provides direct administrative support for clinical operations for the team: team manager, clinical director, RN case managers, social workers, spiritual care providers.
- Prepares, coordinates, and scribes for clinical meetings: interdisciplinary team, meetings of social workers, spiritual care providers, and nurses.
- Schedules/coordinates in-services with clinical staff and community members.
- Completes quarterly occupancy reports for designated skilled nursing facilities and/or residential care facilities for the elderly.
- Works closely with information technology to resolve technical issues.
- With the direction of the team manager, notifies the answering service of schedule changes.