Essential Elements of Medi-Cal Palliative Care Services: Clinical Interdisciplinary Team Meetings Agendas and Protocols

This resource is part of "Section E: Strengthen the partnership, improve quality, and monitor operations" 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.

A successful partnership between a Medi-Cal managed care plan (MCP) and a contracted palliative care (PC) provider includes regular meetings to address the different levels of collaboration, including:

- Program operations and logistics
- Clinical consultation and care coordination for specific MCP members in interdisciplinary teams
- Quality improvement and program growth, using improvement measures data and goal targets

In practice, many MCP-PC provider partnerships cover two or all three of these areas in one recurring meeting.

This resource addresses the second category: Interdisciplinary team meetings.

AGENDA: MONTHLY CLINICAL INTERDISCIPLINARY TEAM MEETING

- Review of new referrals
- Presentation and discussion of enrolled members (see outline and example)
    - Newly enrolled members
    - Members on their way to discharge from palliative care
    - Members not making progress despite interventions

INFORMATION REVIEWED FOR NEW REFERRALS (not yet enrolled)

- Member name
- Date of birth
- Referral date
- Diagnosis
- Status of referral

CASE PRESENTATION OUTLINE FOR ENROLLED MEMBERS

- Name of member
- Age
- Date of enrollment in PC program
- Diagnosis (highlighting the qualifying condition)

- Brief history including psychosocial issues, support network, level of engagement in PC, advance care plans
- Visit history: dates, discipline(s), visit form (home, virtual)
- ER and inpatient utilization trend before PC enrollment compared to utilization while enrolled (highlighting successes with any utilization appropriately avoided)
- POLST and advance directive status
- Major issues and care plans, including level of engagement with PC team
- Any additional issues/problems that need to be discussed

EXAMPLE: CASE PRESENTATION

Date of review: *2/28/2020*
Name: *Example Patient*
DOB: *01/01/1941*
Enroll date: *12/12/2019 (two months)*
Palliative care RN/CM: *Maria M.*
PCP: *Susan G.*
Engagement: *Engaged (other options: Not engaged, Unable to reach)*

Brief history: *80-year-old Spanish-speaking female with Dx of CHF EF 20%, HTN DMII. Lives at home with her twin sister. Her sister is legally blind and on hemodialysis. Children and husband have passed away.*

Recent visits:
2/5/2020 — Nurse LVN (phone)
2/11/2020 — SW (in person)
2/18/2020 — Nurse RN & chaplain (in person)
2/26/2020 — SW (phone)

Next visit: *3/3/2020 Nurse RN*

POLST/date: *DNR 12/26/2019*
Advance directive/date: DPOA: *Sister Annie 1/26/2020*

ED/hospitalizations prior to enrollment:
3/9/2020 — SOB
2/22/2020 — Heart failure

ED/hospitalizations during enrollment: *0*

Avoided ED/hospitalizations during enrollment: *None documented. However, patient is now compliant with medications and all MD appts, which is why no ED or hospitalizations.*

Current issues:
- *Medication compliance*
- *Continue to assist with MD appts*