

Palliative Care Workgroup

January 4th, 2019



Agenda



- Welcome and Introductions
- Bree Collaborative Overview
 - Background
 - Past Work
 - Implementation
 - Open Public Meetings Act
- Preliminary Scope of Work
 - Previous Bree Collaborative Recommendations
 - End-of-Life Care
 - Alzheimer's Disease and Other Dementias
 - Oncology Care
 - Draft Charter and Roster
- Public Comments/Good of the Order

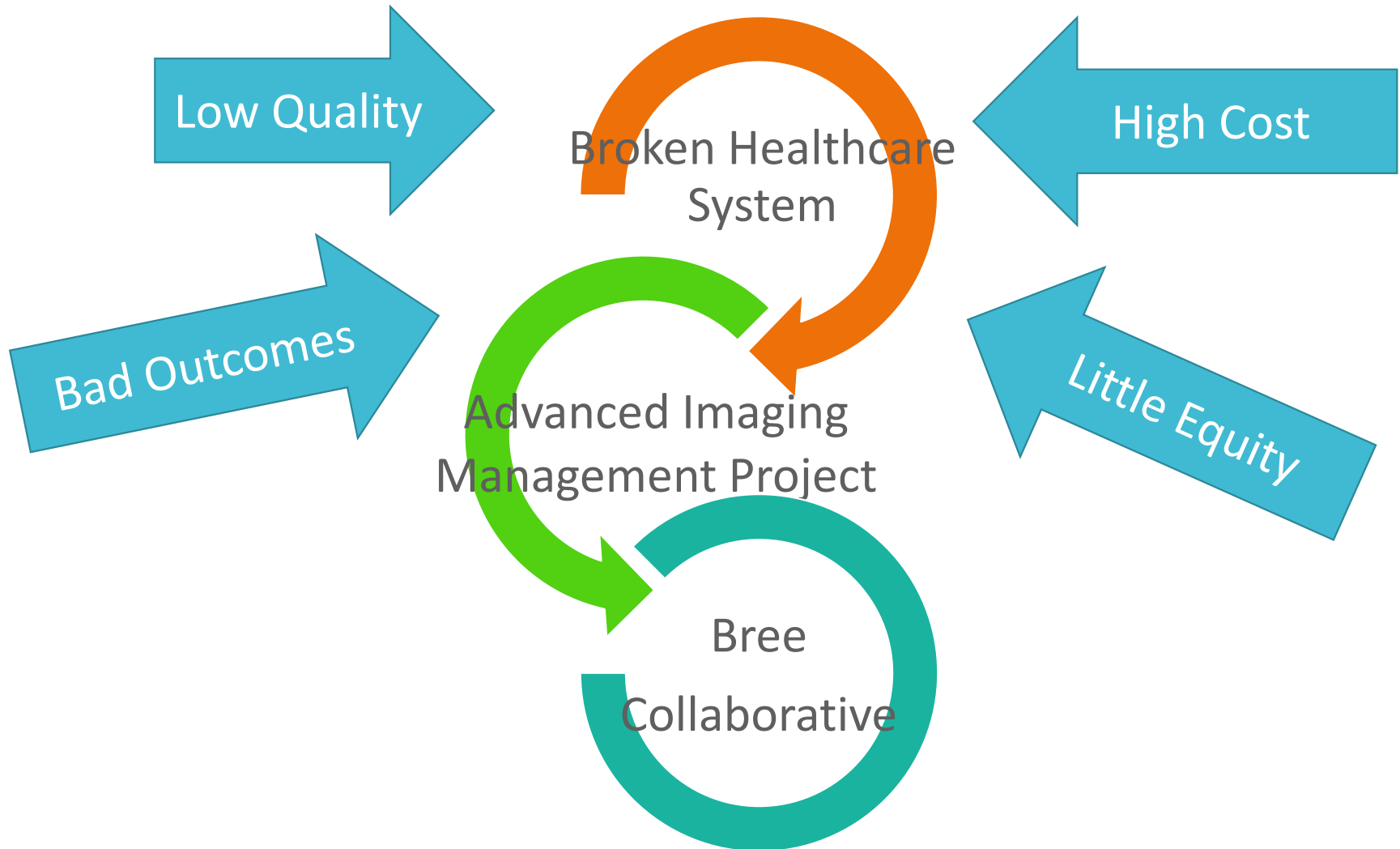
Roberts Rules of Order



- Quorum is 50%+1
 - Need quorum to make decisions
- Decisions made through motions
 - Making a motion
 - Seconding the motion
 - Debate (if needed)
 - Vote
 - Announcing results
- One person: one vote
- Voting limited to members present

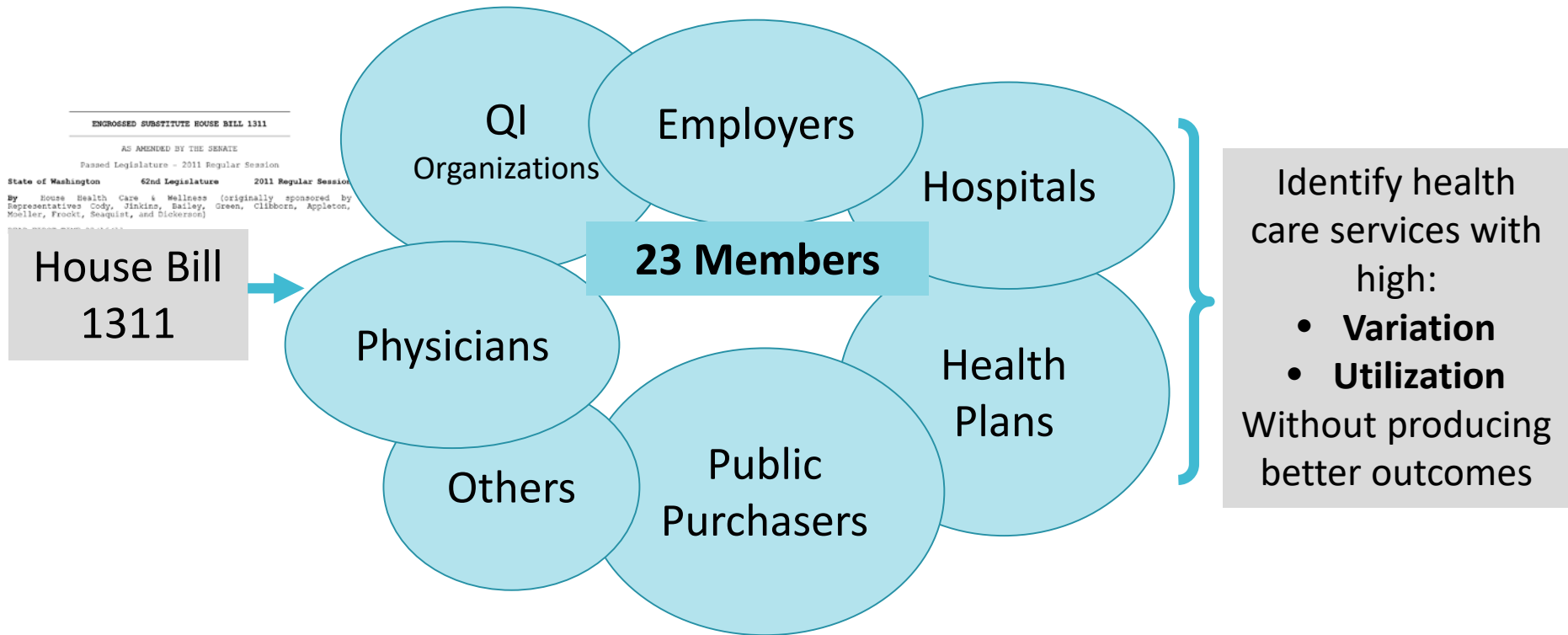
Background

2011 Health Care Environment



Background

Members and Topic Selection



Recommendations Formed in Clinical Committee



Financial Incentives

Provider Feedback Reports

Shared Decision Aids

Evidence-Based Guidelines

Data Transparency

Centers of Excellence

Public Reporting

Clinical Committee

Meeting Monthly
for 9-12 Months

Public Comment

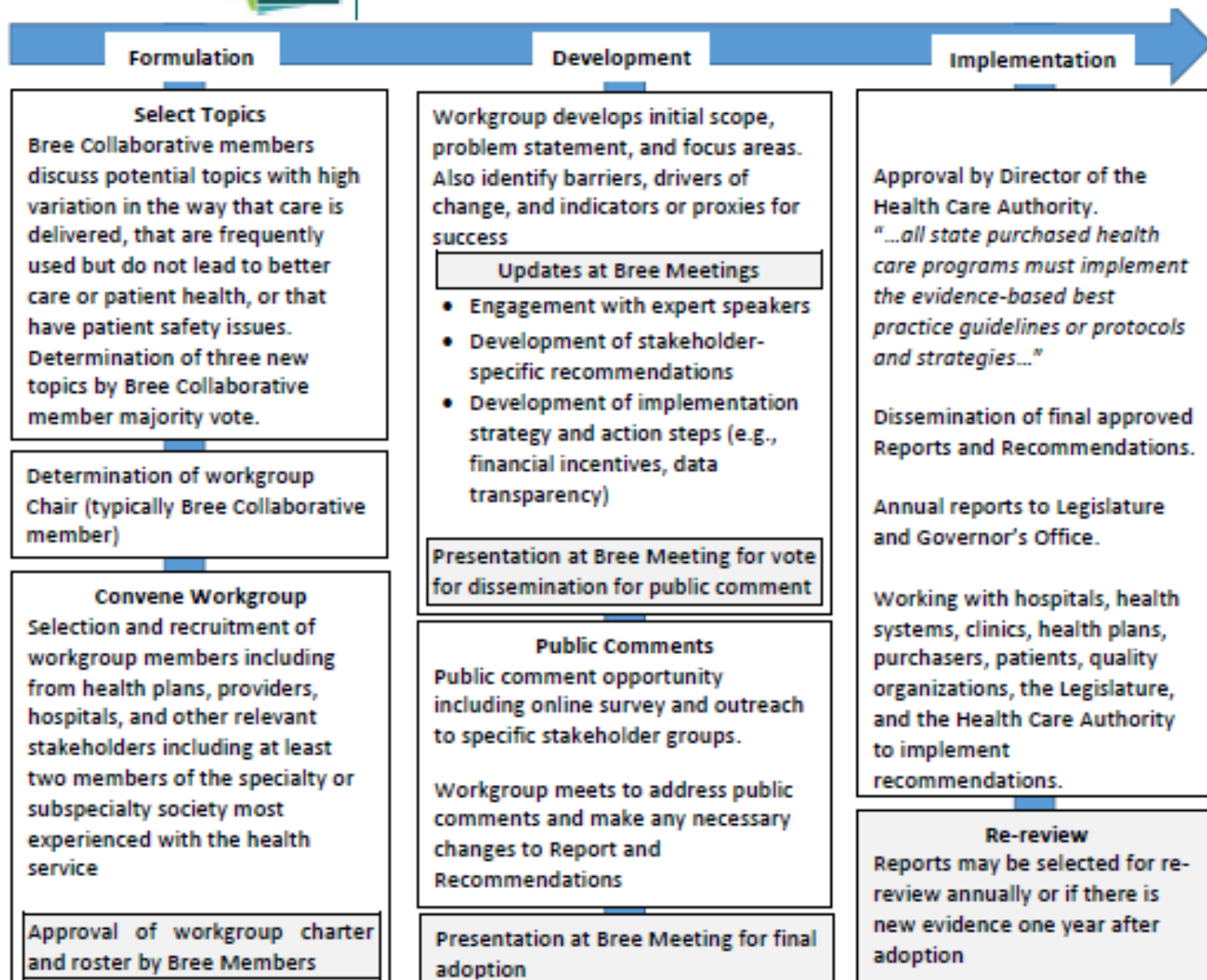
Recommendations
to improve health
care quality,
outcomes, and
affordability in
Washington State

The Health Care Authority

Broader Health Care Community



Report and Recommendation Process



Topic Areas



Obstetrics (2012)



Cardiology (2012)



Elective Total Knee and Total Hip Replacement Bundle and Warranty (2013 and 2017)



Elective Lumbar Fusion Bundle and Warranty (2014 and 2018)



Elective Coronary Artery Bypass Surgery Bundle and Warranty (2015)



Bariatric Surgical Bundled Payment Model and Warranty (2016)



Low Back Pain (2013)



Spine SCOAP (2013)



Hospital Readmissions (2014)



End-of-Life Care (2014)



Addiction and Dependence Treatment (2015)



Prostate Cancer Screening (2016)



Pediatric Psychotropic Drug Use (2016)



Behavioral Health Integration (2017)



Guidelines for Prescribing Opioids for Pain (2015-Present)



Opioid Use Disorder Treatment (2017)



Alzheimer's Disease and Other Dementias (2017)



Hysterectomy (2017)



LGBTQ Health Care (2018)



Collaborative Care for Chronic Pain (2018)



Suicide Care (2018)

Areas for 2019



Guidelines for Prescribing Opioids for Pain
Ongoing



Maternity Bundled Payment Model



Palliative Care



Shared Decision Making



Harm to Self and Others

Reports



- What is the problem?
 - Is variation unwarranted?
 - Does it contribute to patient harm?
- What does it look like in Washington State?
- What are solutions within the medical system?
 - Focus areas
 - Stakeholder-specific recommendations
- How do we get there?

Implementation



- **Agency Medical Directors Group (AMDG)** reviews and approves recommendations which are then forwarded to the Director of the Health Care Authority (HCA)
- **HCA Director** reviews and decides whether to apply to state-purchased health care programs
- Legislation does not mandate payment or coverage decisions by private health care purchasers or carriers
 - Delivery systems and providers not required to implement recommendations

Open Public Meetings Act



- Required of Bree Collaborative meetings and workgroup meetings
- Allows the public to view the “decision-making process
- Training

Roster



| OPEN GOVERNMENT/RECORDS TRAINING ROSTER | | |
|---|---------------------------|------------------------|
| Course Subject(s) (check all that apply): <input type="checkbox"/> Open Public Records Act Training (RCW 42.56) <input type="checkbox"/> Open Public Meetings Act Training (RCW 42.30) <input type="checkbox"/> Records Retention/Management Act Training (RCW 40.14) | | |
| Course Title(s): <input type="text"/> | | |
| Organization(s)/agencies providing training: <input type="text"/> | | |
| Trainer(s): <input type="text"/> | | |
| Format (in person, online, webinar, etc.): <input type="text"/> | | |
| Date: | Location: | Length of time: |
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Conflict of Interest Form



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www.breecollaborative.org

Participant Conflict Disclosure

Permanent and ad hoc members of the collaborative or any of its committees may not have personal financial conflicts of interest that could substantially influence or bias their participation. If a collaborative or committee member has a personal financial conflict of interest with respect to a particular health care service being addressed by the collaborative, he or she shall disclose such an interest. The collaborative must determine whether the member should be recused from any deliberations or decisions related to that service.

Conflict of Interest decisions must be disclosed and balanced to ensure the integrity of Bree Collaborative decisions while acknowledging the reality that interests, and sometimes even conflicting interests, do exist. Individuals that stand to gain or lose financially or professionally, or have a strong intellectual bias need to disclose such conflicts.

Example: The fact that a member is a health care provider that may provide a service under review creates a potential conflict. However, clinical and practical knowledge about a service is also useful, and may be needed in decision making.

Procedure

Members must sign a conflict of interest form. The Bree Collaborative Chair and/or Bree Collaborative Steering Committee shall make a decision as to whether a conflict of interest rises to the level that participation by the conflicted member could result in a loss of public trust or would significantly damage the integrity of the decision.

The Health Care Authority (HCA) defines conflict of interest as any situation in which a voting member has a relationship with a manufacturer of any commercial products and/or provider of services discussed or voted on during the meeting. Relationship extends to include immediate family member(s).

A relationship is considered as:

1. Receipt or potential receipt of anything of monetary value, including but not limited to, salary or other payments for services such as consulting fees or honoraria in excess of \$10,000.
2. Equi
3. Sta

Proposed Work Plan



- Monthly meetings starting in January 2019
- Present Roster and Charter January 2019
- Engage experts, talk through barriers
- Final product Fall 2019

Previous Related Recommendations



- End-of-Life Care
- Alzheimer's Disease and Other Dementias
- Oncology Care

End-of-Life Care Recommendations Adopted November 2014



Goal that all Washingtonians are informed about their end-of-life options, communicate their preferences in actionable terms, and receive end-of-life care that is aligned with their wishes, goals, and values.

- **Increase awareness of advance care planning, advance directives, and POLST in Washington State**
 - Promote community-wide discussions about how to have conversations regarding personal goals of care and the type of care desired at the end of life with family members and health care providers; the importance of having an advance directive that includes a living will (also known as a health care directive), a durable power of attorney for health care, and a written personal statement about health care goals and values; and the difference between POLST and an advance directive
- **Increase the number of people who participate in advance care planning in the clinical and community settings**
 - Educate health care professionals on how to engage individuals and their families in advance care planning and how to refer to appropriate community-based advance care planning resources
 - Encourage the use of evidence-based advance care planning tools and programs
 - Encourage people and health care providers to involve family members and friends in advance care planning and designate a legal durable power of attorney for health care
 - Encourage appropriate timing of advance care planning conversations
 - Revise reimbursement policy to pay for advance care planning counseling and discussion with patients and their surrogate decision makers
 - Promote awareness of the value of hospice and encourage appropriate hospice referrals
 - Train qualified advance care planning facilitators

End-of-Life Care Recommendations Adopted November 2014



- **Increase the accessibility of completed advance directives and POLST for health systems and providers**
 - Contract with an existing registry to store and make accessible advance directives and POLST
 - Work with the Department of Motor Vehicles to add text indicating the presence of an advance directive on the Washington State driver's license with the additional option of putting a QR code on the back of the driver's license to gain direct access to the registry
- **Increase the likelihood that a patient's end-of-life care choices are honored**
 - Implement quality improvement programs within hospitals, nursing homes, and other settings to encourage greater adherence to patients' requests as outlined in advance directives and POLST if accurate and applicable to the current situation
 - Encourage providers and facilities to measure family satisfaction with end-of-life care by widespread use of an after-death survey tool similar to that used by hospice agencies
 - Enact legislation providing legal immunity to health care providers who honor a patient's POLST, comparable to existing protections for providers who honor a patient's advance directive

Alzheimer's Disease and Other Dementias

Adopted November 2017



- Diagnosis,
- Ongoing care and support,
- Advance care planning and palliative care,
 - Patients, providers, family, and other caregivers have had a comprehensive advance care planning conversation in a clinical setting that has been documented in an advance directive as early as possible to maximize the patient's voice and input. This stipulates specific treatment preferences (if known and applicable to the situation), a durable power of attorney for health care that names a surrogate and indicates the amount of leeway the surrogate should have in decision-making; a written personal statement that articulates the patient's values and goals regarding end-of-life care; discussion of risks, benefits, and goals for a potential hospitalization; and Physician Orders for Life Sustaining Treatment (POLST).
 - Providers routinely consider patient's dementia diagnosis and issues of decision-making capacity when making decisions to minimize unnecessary or harmful care and discuss this with the patient and family.
 - The care team has discussed when palliative care and/or hospice might be appropriate.
 - The patient and family know who to contact if symptoms (e.g., pain) develop or worsen and feel confident in their care plan.
- Need for increased support and/or higher levels of care,
- Preparing for potential hospitalization, and
- Screening for delirium risk.

Oncology Care Adopted March 2016



- Follow the American Society of Clinical Oncology's (ASCO) Choosing Wisely recommendations:
 - Do not use PET [positron emission tomography], CT [computed tomography] and radionuclide bone scans in the staging of early prostate cancer at low risk of spreading.
 - Do not use PET, CT, and radionuclide bone scans in the staging of early breast cancer that is at low risk of spreading.
- Palliative care be offered alongside active anti-cancer care, as needed.
 - Oncology care should be aligned with a patient's individual goals and values and follow ASCO's position statement of key elements for individualized cancer care.
 - Patients should be apprised of the harms, benefits, evidence, and potential impact of chemotherapy, radiation, molecular therapy, immunotherapy, and surgery at all stages in their illness trajectory.

Oncology Care

Palliative Care Definition



- The World Health Organization (WHO) defines palliative care as *“an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”* Oncology care should be aligned with a patient’s individual goals and values. Patients should be apprised of the harms, benefits, evidence, and potential impact chemotherapy, radiation, molecular therapy, immunotherapy, and surgery at all stages in their illness trajectory. We encourage clinicians and care teams to regularly ask patients, their family members, and friends to discuss their goals of care and work with the care team to tailor care to patient goals. Symptom management should be included as a part of this type of oncology care.
- There is also a movement to use the term “supportive” rather than “palliative” care to clarify the misconception that palliative care is meant only for the end of life. Some define palliative care as a subset of supportive care, care of any kind designed to support the cancer patient and his/her family and support system in their journey with cancer. In this definition, supportive care encompasses physical, emotional, spiritual, and other identified needs and is not limited by the kind of cancer or the stage of cancer or by goals of therapy (curative, life-prolonging, or palliative).

World Health Organization. WHO Definition of Palliative Care. Available: www.who.int/cancer/palliative/definition/en/. Accessed: September 2015.

Staying alive

Why suicide is falling around the world, and how to bring it down more

Urbanisation, fewer forced marriages and more curbs on the means of self-destruction



"The remarkable recent fall in suicide among elderly Britons may have happened in part because Britain's palliative-care system is the best in the world."

Source: www.economist.com/leaders/2018/11/24/why-suicide-is-falling-around-the-world-and-how-to-bring-it-down-more

National Coalition for Hospice and Palliative Care

Clinical Practice Guidelines for Quality Palliative Care 4th edition



Palliative care focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family.

1. **Structure and Processes of Care:** The composition of an interdisciplinary team is outlined, including the professional qualifications, education, training, and support needed to deliver optimal patient- and family-centered care. Domain 1 also defines the elements of the palliative care assessment and care plan, as well as systems and processes specific to palliative care.
2. **Physical Aspects of Care:** The palliative care assessment, care planning, and treatment of physical symptoms are described, emphasizing patient- and family-directed holistic care.
3. **Psychological and Psychiatric Aspects:** The domain focuses on the processes for systematically assessing and addressing the psychological and psychiatric aspects of care in the context of serious illness.

Continued



4. Social Aspects of Care: Domain 4 outlines the palliative care approach to assessing and addressing patient and family social support needs.
5. Spiritual, Religious, and Existential Aspects of Care: The spiritual, religious, and existential aspects of care are described, including the importance of screening for unmet needs.
6. Cultural Aspects of Care: The domain outlines the ways in which culture influences both palliative care delivery and the experience of that care by the patient and family, from the time of diagnosis through death and bereavement.
7. Care of the Patient Nearing the End of Life: This domain focuses on the symptoms and situations that are common in the final days and weeks of life.
8. Ethical and Legal Aspects of Care: Content includes advance care planning, surrogate decision-making, regulatory and legal considerations, and related palliative care issues, focusing on ethical imperatives and processes to support patient autonomy.