Bree Collaborative | Palliative Care Workgroup
April 12th, 2019 | 10:00-11:30
Foundation for Health Care Quality

Members Present

John Robinson, MD, SM, First Choice Health (Chair)
Lydia Bartholomew,* MD, Aetna
Raleigh Bowden,* MD, Okanogan Palliative Care Team
Mary Catlin,* MPH, Honoring Choices, Washington State Hospital Association
Leslie Emerick,* Washington State Hospice and Palliative Care Organization
Ross M Hays, MD, Director, Palliative Care Program, Seattle Children's
Kerry Schaefer, MS, King County
Bruce Smith, MD, Providence Health and Services
Stephen Thielke,* MD Geriatric Psychiatry University of Washington
Cynthia Tomik, LICSW, EvergreenHealth
Gregg Vandekieft, MD, MA Medical Director for Palliative Care Providence St. Peter Hospital
Hope Wechkin, MD Medical Director, Hospice and Palliative Care EvergreenHealth

Staff and Members of the Public

Pat Justis,* MA, Executive Director, Washington State Office of Rural Health, WA State Department of Health
Alicia Parris, Bree Collaborative
Ginny Weir, MPH, Bree Collaborative
Francesca Stracke,* ARNP, MultiCare Good Samaritan Hospital

* By phone/web conference

CHAIR REPORT AND APPROVAL OF MINUTES

John Robinson, MD, SM, First Choice Health and Ginny Weir, MPH, Bree Collaborative opened the meeting and those present introduced themselves.

Motion: Approve 3/8/2019 Minutes
Outcome: Passed with unanimous support.

PRESENTATION: WASHINGTON STATE RURAL PALLIATIVE CARE

Pat Justis, MA, Executive Director, Washington State Office of Rural Health, WA State Department of Health, presented to the group on integration of palliative care into rural communities:

- People were highly engaged with the idea of providing palliative care
    - Integrating skills, culture, and paradigms of palliative care into existing services for those without the volume/resources to offer a full palliative care service
- Washington Rural Palliative Care Initiative (what is palliative care)
        - Adapted definitions and made additions to existing definitions
            - Moved upstream to diagnosis of some serious illnesses
            - Didn't limit diagnostically
            - Any stage any age
            - Intentionally did not use "surprise question" so that persons could be supported at any stage of illness
- Palliative Care Enhanced Model from University of BC
    - Shows that not everyone who receives palliative care is terminal

        - Includes survivorship and rehabilitation
- Lessons from providing rural palliative care in Minnesota
    - Asset and gap analysis
    - Form a community based team of stakeholders
    - Provide help to access to national standards
    - Structured process for development and implementation
- Developing primary palliative skills in existing teams and access to tertiary specialty care
- Variation in program structure based on resources
- Update on first cohort; initial sites
    - Program evaluation metrics
- 2019 goals

Ms. Justis took questions on the presentation from the group:

- Are there shared savings contracts that could be shared with the group?
    - There is not a complete model yet, could be a potential shared activity
- Has there been an analysis to determine who the major payers are?
    - Medicare is the major payer mostly
- What can the workgroup do that would be most synergistic
    - Collective work on fiscal sustainability
    - Spreading best practice models to employer sponsored plans
    - Nationally influencing CMS on Medicare design

DEFINING OUR POPULATION

Group discussed patient population:

- Hope Wechkin, MD Medical Director, Hospice and Palliative Care EvergreenHealth Experience asked Ms. Justis about her experience prioritizing without being diagnosis or prognosis limited. Avoiding triage impulse
    - Rural health providers are often more in tune with what resources and limitations a person has which allows them to better serve their population and determine who is most in need beyond prognosis
    - Gregg Vandekieft, MD, MA Medical Director for Palliative Care Providence St. Peter Hospital, shared in his perspective from telehealth case consulting
        - Majority of cases presented by the rural community are persons with complex comorbid conditions and often a mental health diagnosis
        - Function-limited not life-limited
    - Bruce Smith, MD, Providence Health and Services, pointed out the difficulty of operationalizing such criteria for payers without diagnostic codes
        - Finding a middle ground
        - Ms. Justis explained that their tool is an attempt to do so while still using objective and observable criteria
    - Importance of including social determinants of health (e.g. food security, transportation, care giving support)
        - Payers have no access to medical records, needs to be translated to diagnostic and utilization codes to be automated into a billing system
        - Kerry Schaefer, MS, King County, suggested using public health data on social determinants of health to enrich claims data
    - Use of predictive analytics in health care

- Ms. Weir suggested not being prescriptive for methods of determining inclusion
    - Ms. Schaefer suggested defining patient population and the desired outcome of palliative care
    - Group may explicitly state that criteria are iterative
        - Bree process includes review, recommendations may be revised as resources and knowledge grow
    - Providing eligibility criteria could help give guidance to referring providers outside of palliative care

Group viewed the *Bree Defining Serious Illness* handout consult and discussed:

- Ms. Justis commented there are benefits to defining some diagnoses as automatic triggers (e.g. Huntington's or multiple sclerosis) but not limiting to certain diagnoses
    - More subjective criteria require a provider to write letters to payers
    - Will require more training of PCPs and frontline staff on inclusion criteria and documentation etc.
    - Making it automated will increase utilization and capture more eligible patients
- Group discussed using the eligibility criteria listed from AAHPM (American Academy of Hospice and Palliative Medicine): Payment Reforms to Improve Care for Patients with Serious Illness
    - Eligibility elements included
        - having a serious illness
        - having a significant functional limitation
        - health care utilization
    - Complexity levels to help operationalize with payers
        - Higher compensation for higher complexity
    - A common ask may be more likely to be successful

Action Item: Group will consider adoption of AAHPM: Payment Reforms to Improve Care for Patients with Serious Illness eligibility criteria

NEXT STEPS AND PUBLIC COMMENTS

Dr. Robinson and Ms. Weir asked for final comments and thanked all for attending. The meeting adjourned.