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 5/10/2019 Minutes
Outcome: Passed with discussed amendments

STRUCTURING FOCUS AREAS
The group viewed Palliative Care Draft Recommendations and discussed:

- In rural areas, there may be no board certified or eligible physicians in specialty palliative care
  - Care team will often be led by a nurse or ARNP
    - Even specifying a nurse professional may be limiting
  - Group needs to accommodate individual physicians that may be starting a palliative care program
    - Under Recommendations – Specialty Palliative Care, removed “led by a board-certified or board-eligible physician”
  - Attempts to be inclusive should be aware of the risk of setting up teams that are not qualified (i.e. no specialty training)
    - Ideal still needs to be defined
    - Under Recommendations – Specialty Palliative Care, changed “includes” to “or has access to” a care coordination function
- Group discussed whether patient should have 24/7 access to care
- Very expensive to fund without a constant patient flow
- Tension between ideal and what is permitted by organizations and reimbursement
  - 24/7 access can be provided via telemedicine or consulting services
  - Consulting can lose effectiveness due to the unique complexity of each patient
  - Examples of a tele-ICU in Alaska
- Under Recommendations – Specialty Palliative Care” sentence added “Access (e.g., telemedicine) to 24/7 specialty expertise is highly recommended.”

- Group discussed recommending a centralized telemedicine resource
  - Could be seen as a revenue opportunity for telemedicine vendors
- Second bullet under Recommendations “cultural competency” changed to “cultural humility”
- Under Recommendations – Primary Care addition made to first sentence to read “…primary care and relevant sub-specialty care…”
- Group discussed whether to endorse National Consensus Project guidelines or possibly redundant
  - Can put forth as a gold standard and softening the ask

**Action Item: Ms. Weir will update language and send draft to group**

- Group discussed possible inclusion of the Seriously Ill Population Option payment model
  - Model is not in practice and much of the model is not well defined
    - How Medicare selects
  - Builds in the extra intake time along with outcome metrics
  - Good framework
  - Only example of a federal model
  - Huge breadth of services would be a big lift for most programs
    - Group agreed to include as an example
  - Payment per member per month could sound like a recommendation for a capitated model
    - George Birchfield, MD, Inpatient Hospice EvergreenHealth, recommended adding some clarification

- Anne Anderson, BSN, Seattle Children’s described the pediatric palliative care benefit for Medicaid
  - Up to 6 visits a month, includes social work and care coordination
  - Reimbursement is low
  - Is mostly adequate, but allows for an appeals process if an individual needs more visits
- Cynthia Tomik, LICSW, EvergreenHealth, described all the preparation (record gathering and review) that goes into an initial visit
- Richard Stuart, DSW, Psychologist, Swedish Medical Center – Edmonds Campus, recommended having more services provided by volunteer organization
  - Suggested recommending funding for organizing trained community support
    - Critical to making economically sustainable
  - Volunteers can provide non-clinical services that reduce the clinical burden
    - Social workers can connect with community resources
    - Role of home care workers in palliative care
  - Group discussed language that would encourage but not require volunteer inclusion
  - Under Recommendations bullet recommending per member per month benefit, “diffuse services” changed to “diverse services”

- Outcome metrics
o Bruce Smith,* MD, Providence Health and Services, stated that the group does not need to define every detail but rather the structural components of good palliative care and that outcomes should be measured

• Anne Anderson, BSN, Seattle Children’s mentioned Kaiser Permanente’s palliative care benefit
  o First private insurance to agree to concurrent benefits

NEXT STEPS AND PUBLIC COMMENTS
Dr. Robinson and Ms. Weir asked for final comments and thanked all for attending. The meeting adjourned.