
Bree Collaborative | Palliative Care Workgroup

May 10th, 2019 | 10:00-11:30

Foundation for Health Care Quality

Members Present

John Robinson, MD, SM, First Choice Health
(Chair)
George Birchfield, MD, Inpatient Hospice
EvergreenHealth
Mary Catlin,* MPH, Honoring Choices,
Washington State Hospital Association
Leslie Emerick,* Washington State Hospice and
Palliative Care Organization
Greg Malone,* MA, Mdiv, BCC, Mgr Palliative
Care Services, & Spiritual Care Provider
Swedish Medical Center

Kerry Schaefer, MS
Bruce Smith,* MD, Providence Health and
Services
Richard Stuart, DSW, Psychologist, Swedish
Medical Center – Edmonds Campus
Stephen Thielke,* MD Geriatric Psychiatry
University of Washington
Cynthia Tomik, LICSW, EvergreenHealth
Hope Wechkin,* MD Medical Director, Hospice
and Palliative Care EvergreenHealth

Staff and Members of the Public

Josh Morse,* Health Technology Assessment,
State of Washington
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 4/12/2019 Minutes

Outcome: Passed with unanimous support.

STRUCTURING FOCUS AREAS

The group viewed [Draft Recommendations](#) and discussed potential focus areas:

- Goals for the recommendations
 - Create a better understanding of palliative care statewide that can help patients with serious illness diagnoses.
 - Help clinicians with referrals
 - Financing creation and maintenance of programs
 - Discussing telemedicine
- Decisions to make
 - Whether to adopt PACSI model
 - How to define serious illness
 - Selecting metrics to evaluate effectiveness in order to justify continuation and expansion of funding
 - Including “bowtie model” from the presentation given by Pat Justis, MA, Executive Director, Washington State Office of Rural Health, Washington State
- Focus areas to include

- Access
 - Including outreach as palliative care is rarely delivered to ethnic and racial minorities
 - Access should be its own section as it is a key disparity
 - Needs to be intentional
- Symptom relief
- Interdisciplinary team
- Funding
- Advanced care planning
- Outreach
 - Richard Stuart, DSW, Psychologist, Swedish Medical Center, suggested addressing distrust of system in minority communities (e.g. African American, LGBT)
 - Ms. Schaefer suggested reaching out to public health organizations to write a protocol for how to convene their community groups in a way that can help them design successful community outreach
 - Goes far beyond linguistic translations
- Metrics
 - Will ensure care is being delivered
- Ethics
- How the National Consensus Project can fit into recommendations
 - Dr. Robinson pointed out that the group's focus areas match the NCP domains with the exception of funding as opposed to ethical/legal
 - Group discussed if they can add value or if the group should endorse the NCP guidelines
 - The additions of funding and metrics would be extremely valuable

The group discussed potential funding models and whether to endorse an existing model or to advocate for a bundle more generally:

- Dr. Robinson asked Bruce Smith, MD, Providence Health and Services, to comment on whether he feels bundled payments are the best way to fund palliative care
 - Dr. Smith agreed, providing palliative care on an incrementally billed basis is very problematic
 - May restrict access to large insurers who will be able to put together a bundle
 - But is the only mechanism currently available to ensure a successful, comprehensive palliative care program
 - Group could devise a tiered model beginning with a midrange modest reimbursement model based on a monthly fee
- Dr. Robinson asked Dr. Smith if he thought the group should endorse an existing model
 - Due to the great amount of work that have already gone into existing models, group could use an existing model as a starting point and be customized to fit Washington population
- Ms. Weir presented the two models in the defined in the [Bree: Defining Serious Illness](#) document
 - ACM (not tiered, includes surprise question)
 - PACSSI (two-tiered)
- Ms. Weir pointed out the implementation barrier to palliative care of engaging purchasers
 - Most purchasers skew towards a younger population
 - HCA as a primary adopter could be very powerful
 - Josh Morse, Health Technology Assessment, State of Washington, shared that the HCA is currently working on a policy for palliative care
- Metrics for the PACSSI model

Action Item: Dr. Smith will look into possible performance metrics for the PACSSI model

DEFINING OUR POPULATION

Group considered PACSSI inclusion criteria and discussed:

- Needs to be broad enough to serve communities without being restrictive, yet have enough structure to be funded
- Could be defined as a benefit rather than a bundle since it is not episodic as most existing bundles
- PACSSI model has a lot of exclusions, group could endorse the structure without the eligibility criteria
 - George Birchfield, MD, Inpatient Hospice, EvergreenHealth, advised it may not be possible to start with the ideal, advised including end stage cancer, stage 3 or 4 heart failure, ovarian cancer and others
 - Patients on dialysis would be important inclusion for stage 4 renal disease
 - Allowing for referral based on clinical judgement
 - Could inclusion of early stage dementia patients help them get access advanced care planning

Action Item: Group will consider inclusion of dementia

NEXT STEPS AND PUBLIC COMMENTS

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