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## Bree Collaborative | Palliative Care Workgroup

June 14<sup>th</sup>, 2019 | 10:00-11:30

Foundation for Health Care Quality

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### Members Present

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John Robinson, MD, SM, First Choice Health  
(Chair)

George Birchfield, MD, Inpatient Hospice  
EvergreenHealth

Raleigh Bowden,\* MD, Director, Okanogan  
Palliative Care Team

Randy Curtis,\* MD, MPH, Director, Cambia  
Palliative Care Center of Excellence,  
University of Washington Medicine

Leslie Emerick,\* Washington State Hospice and  
Palliative Care Organization

Anne Anderson, BSN for Ross M Hays, MD,  
Director, Palliative Care Program, Seattle  
Children's

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

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

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Alicia Parris, Bree Collaborative

Ginny Weir, MPH, Bree Collaborative

\* By phone/web conference

### CHAIR REPORT AND APPROVAL OF MINUTES

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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

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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

- 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
  - First private insurance to agree to concurrent benefits

#### **NEXT STEPS AND PUBLIC COMMENTS**

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