

MEETING HIGHLIGHTS

PALLIATIVE CARE TASKFORCE
Wilsonville Training Center Room 218
Wilsonville, Oregon
November 10, 2008
6:30 – 9:00 p.m.

Members Present: Eric Walsh MD, Chair; Paul Bascom MD; Suzanne Fournier; Chris Kirk MD; Ellen Lowe; Kevin Olson MD; Dan Reese, MSW; Gregory Thomas MD; Nora Tobin MD (by phone)

Staff Present: Ariel Smits, MD, MPH; Darren Coffman.

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>Goal of Meeting/Timeline Eric Walsh and Ariel Smits reviewed the goals of the meeting and timeline. The first meeting goal was mainly to determine the best strategies for moving forward on revising the HSC Comfort/Palliative Care Guideline.</p>	None		
<p>Workgroup Charge Ariel Smits read through the charge of the taskforce. The group accepted the charge without change or significant comment.</p>	Workgroup accepts charge without further questions.		
<p>Review of HSC Comfort/Palliative Care Guideline The group discussed funding for palliative care. Different funding strategies include dollar/benefit limit such as is found in private insurance, coverage of basic palliative care, but not care which does not have an adequate cost-benefit ratio. Other plans use a case-rate basis. The members generally agreed that conversations about palliative care between patients and providers are generally not reimbursed.</p> <p>The group decided to look into ways to fund palliative care services. Expensive palliative care should be covered with a prior authorization process with a requirement for a consult with a palliative care team (radiation, chemotherapy). <50% survival at time of diagnosis would be appropriate for palliative care consult. Some pilot programs have been tried, such as a program through MediCal, which look at alternative strategies for reimbursement. Such programs should be investigated.</p>	None		

TOPIC	ACTION	RESPONSIBILITY	DATE
<p>The group next discussed terminology. The group decided that “palliative care” was the best term for the type of care which occurs at the end of life. Palliative care was tentatively defined as care with relieves symptom burden/provides symptom control, encompasses assessment, maximizing QOL for as long as possible, and the establishment of realistic goals. However, and exact definition of palliative care was not finalized. The group decided to determine this definition as part of the workgroup effort (see below). The group also decided that the type of care which the HSC does not want to cover should be referred to as “medically inappropriate care.”</p> <p>After much discussion, the group determined that the current Palliative/Comfort Care Guideline should be broken into two guidelines 1) medically inappropriate care and 2) palliative care. These two new guidelines need to consider a) functional status, b) comorbidities, c) median or disease-free survival, and possibly d) a list of covered and non-covered treatments/medications. The palliative care guideline should identify specific services, and both guidelines should cover what is considered experimental.</p>			
<p>Next Steps The group agreed to form two workgroups, one to craft wording for a Palliative Care Guideline and one to craft wording for a Medically Inappropriate Care Guideline. The Palliative Care guideline should include a definition of palliative care, as well as a scope of treatments to be covered. The Medically Inappropriate Care guideline group should discuss performance scales, median survival, and treatments requiring review.</p>	<p>Dr. Smits and/or Mr. Coffman will contact Taskforce members about their interest and availability for participation in the Palliative Care and Medically Inappropriate Care Workgroups. The Workgroups will meet in early December. It is anticipated that the Workgroups will meet 1-3 times to finalize wording for the new guidelines, and then the entire Taskforce will reconvene to discuss the proposed guidelines.</p>	<p>Dr. Smits and/or Mr. Coffman</p>	<p>Next 2 weeks</p>