

MEETING HIGHLIGHTS

PALLIATIVE CARE TASKFORCE
Wilsonville Training Center Room 111
Wilsonville, Oregon
January 29, 2009
6:30 – 8:30 p.m.

Members Present: Paul Bascom MD; Ellen Lowe; Kevin Olson MD; Gregory Thomas MD.

Members Present by Phone: Nora Tobin MD; Dan Reese MSW; Chris Kirk, MD.

Members Absent: Eric Walsh MD, Chair; Suzanne Fournier.

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

TOPIC	ACTION	RESPONSIBILITY	DATE
Goal of Meeting/Timeline Ariel Smits reviewed the goals of the meeting which where to review the proposed Statements of Intent.	None		
Review of the Death with Dignity Statement of Intent Lowe indicated that the SOI reflected past HSC intent regarding coverage of Death with Dignity Services. The SOI was approved without change to forward to the HSC.	Death with Dignity SOI approved to forward to the HSC.		
Review of the Palliative Care Statement of Intent Discussion centered on use of palliative care in communities without palliative care teams or large amounts of palliative care resources. The intent of the group is for patients to have access to palliative care specialists and teams whenever feasible; the group understands that this may not be possible in all cases.			

<p>Review of the Palliative Care Statement of Intent (Cont'd)</p> <p>The group decided to strike paragraph 2, as the wording may be too restrictive. Several of the examples were modified for clarification of intent. The statement regarding palliation by non chemotherapy means was taken from the “Inappropriate Care” SOI and added to this SOI.</p> <p>The group debated the level of detail for this recommendation. Kirk indicated that the general recommendations of the SOI would be enough for a start. Olson indicated that in his conversations with oncologists around the state, they desire consistent answers from their local plans. Kirk indicated that the OHP medical directors technology group could work on a list of agents to cover or not cover and make more explicit recommendations to the health plans to try to make coverage more uniform.</p>	<p>Palliative Care SOI approved to forward to the HSC.</p>		
<p>Review of the “Inappropriate Care” Statement of Intent</p> <p>There was discussion surrounding the wording of who needs palliative care consultation. Should the HSC require a consult (“must”) or simply recommend one as best practice (“should”)? “Should” was determined to be the best wording.</p> <p>There was discussion about qualifying Eastern Cooperative Oncology Group (ECOG) scores. Olson felt that most studies exclude patients with ECOG score of 3 or higher, so the data does not apply to them, making it difficult to determine how well treatment will work.</p> <p>Group agreed with ECOG of 3 or higher, as these people will not have</p>			

<p>Review of the “Inappropriate Care” Statement of Intent (Cont’d) much in the way of physical reserves. However, ECOG is best applied to cancer patients. Debate around whether this SOI should be about cancer or about all terminal illnesses. Concern was raised that ECOG does not apply to other illnesses. Concern was also raised about not treating complications such as pneumonia due to ECOG score. Olson proposed changing SOI to include “of cancer.” Reese agreed, stating that this gave the benefit of limiting to cancer for clarity. The group agreed that the HSC can come back and make other SOI for other conditions in the future if a need is found.</p> <p>Experimental treatment was felt to be beyond the scope of this SOI. The group felt that if a guideline was required to address experimental treatment, then the HSC should convene another workgroup. Also, it was mentioned that a bill in legislature addresses this topic currently and the HSC should make no decisions until the outcome of that bill is known.</p>	<p>Statement of Intent on Treatment of Cancer with Little or No Benefit Provided Near the End of Life was approved as amended to forward to the HSC.</p>		
<p>Next Steps A suggestion was made to have the guideline distributed to the Medical Directors and possibly to community physicians to obtain feedback. It was agreed that Smits would distribute the draft SOIs to the OHP Medical Directors for comment, with a suggestion that they also distribute it to providers in their plans. Depending on the amount of feedback obtained, the Taskforce will comment via email or reconvene by phone or in person to discuss.</p>	<p>Distribute the SOIs to the OHP Medical Directors for comment.</p> <p>Obtain input from Task Force on any suggested changes.</p>	<p>Dr. Smits</p> <p>Mr. Coffman</p>	<p>Next 2 weeks for Medical Director’s meeting, next 1-2 months for feedback.</p>

Palliative Care Taskforce Recommendations to the Health Services Commission

Final Draft

DEATH WITH DIGNITY STATEMENT OF INTENT

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

PALLIATIVE CARE STATEMENT OF INTENT

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the patient's expected length of life, or goals for medical treatment.

Palliative Care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services:

- 1) Home hospice care for those patients with a life-threatening illness and a life expectancy of 6 months or less, where the primary goal of care is quality of life (hospice services to be defined by DMAP);
- 2) Home-based palliative care services for those patients with a life threatening/limiting illness, without regard to life expectancy, and/or who have the primary goal of prolonging life (home-based palliative care services to be defined by DMAP);
- 3) Inpatient palliative care consultation; and,
- 4) Outpatient palliative care consultation, office visits.

It is the intent of the Commission that certain palliative care *treatments* be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

1. Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life;
2. Surgical decompression for malignant bowel obstruction; and,
3. Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.

Medical equipment and supplies (such as wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Statement of Intent on Treatment of Cancer with Little or No Benefit Provided Near the End of Life.

STATEMENT OF INTENT ON TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment
- Median survival with treatment of 6-12 months when the treatment is expected to improve survival by less than 50%
- Median survival with treatment of more than 12 months when the treatment is not expected to improve survival by less than 30%
- Eastern Co-operative Oncology Group (ECOG) performance score of 3 or higher

The Health Services Commission is reluctant to place a strict \$/QALY (quality adjusted life-year) or \$/LYS (life-year saved) requirement on end-of-life treatments, as such measurement are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into

consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend \$100,000 in public resources to increase an individual's expected survival from six to nine months when hundreds of thousands of Oregonians are without any form of health insurance.

Treatment with the goal to palliate is addressed in the Palliative Care Statement of Intent.