

Palliative Care and Quality of Life Interdisciplinary Council

July 24, 2020

9:00 AM -3:00 PM

Minutes

Members in Attendance: Elizabeth Keene, Lauren Michalakes, Terry Baker

Members Remotely: Steve D'Amato, Sarah Morrill, Kirsten Skorpen, Greg Burns, Myra Ross, Vanessa Little, Kevin Lewis, Jim VanKirk

Members Excused: Pam Brown

Convening member: Kandyce Powell (in person)

Guests: Margaret Craven (in person), Shauna McElrath, Kristina Connor, Deborah Silberstein (remotely)

Community and Provider Members: Lori Dyer, Jane Conrad (remotely)

| Time | Topic | Discussion | Action Items/Outcome |
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| 9:00-9:30 | Welcome and Introductions | | Note: Guests Krissy, Shauna and Deb to attend this afternoon |
| 9:30-10:45 | Letter from HHS: Legislative Opportunity | Letter from Health and Human Services Committee reviewed. This was composed after members of Advisory Council participate in work session for LD 1950, An Act to Advance Palliative Care in Maine. Language of directive Discussed. | Information shared, conversation followed |

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| | | <p>Our task is to research and make recommendations regarding reimbursement.</p> <p>NASHP resources discussed and reviewed. Kandyce, Lauren and Elizabeth participated in phone call with Kitty Purington, Senior Program Director of NASHP's Chronic Care and Vulnerable Populations initiatives. She shared the development of a Toolkit of resources for state Policymakers who wish to support the advancement of palliative care. The first part, dealing with helping policymakers understand what they need to know has been released. The second and third parts will be released. They deal with helping states build infrastructure to deliver palliative care, and assembling appropriate reimbursement models for this care.</p> <p>Discussion involved our particular challenges and barriers at this point. They include the continued recognized deficiencies in peoples understanding of what palliative care means. A recent article was referenced which reported that 68-71% of people had no idea what palliative care is. The remaining 30% strongly associated it with end-of-life and hospice. The fact that there is a toolkit that includes educational and informational materials to share with policymakers creates opportunity for our group.</p> | |
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| | | <p>As part of invitation to this meeting “prompt questions” were included, asking participated to consider, first, what would be appropriate for Maine need in order to make recommendations? What “levers?” The conversation included adequate education for community, providers and policymakers, and defining palliative care in a way that would be most meaningful – to consumers, providers and payers. Collaboration with PCPs was also addressed, as well as the inclusion of spiritual care and psychosocial support. Adherence to the National Consensus Project quality metrics was also discussed, as a way to align Maine’s efforts with what’s been identified as “quality” palliative care. Participants wondered what the reimbursement models might be suggesting, in terms of both services provided and a per-member-per-month payment schedule.</p> <p>The second prompt was “how can we ensure access to high quality palliative care that is available, equitable and consistent in the state of Maine?” Conversation focused on National Standards, NASHP resources and looking to what other states have done.</p> | |
| 10:45-11:00 | Break | | |
| 11:00-12:30 | | <p>Continue discussion: Lauren presented information on what other states have done with regard to Medicaid</p> | <p>Information shared. Discussion resulted in support of exploring</p> |

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| | | <p>payment models for palliative. This is summarized in the Appendix of the National Review of State Palliative Care Policies document. It appears that California is a state at the forefront, with passage of SB 1004 in 2014. Since 2017 all managed Medicaid Programs are required to provide palliative care. "Medi-Cal" MCPs must provide palliative care through relationships with palliative care provider programs that meet well-defined components, including advance care planning, completion of ACP documents, comprehensive palliative care assessments, plans of care created by interdisciplinary teams, pain and symptom management, and psychosocial and mental health supports.</p> <p>Results from a survey sent to Medi-Cal MCPs and providers discussed. This is a new service under Medi-Cal. It appears there is flexibility with regard to eligibility and services provided.</p> <p>Slides describing responses included in handout/Power Point presentation. In 2018, based on 2019 survey, California had 21 MCPs contract with 59 provider programs. Most programs were community-based with hospice availability. Eligibility was described both generally and for specific diagnosis. Many programs were new and had been providing palliative care for one year. Most programs had</p> | <p>California as a resource for our plan and set recommendations.</p> <p>Lauren and Elizabeth</p> |
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| | | <p>MDs, NPs, RNs MSWs. There was reported collaboration between MCPs and providers in care coordination, education, patient education, authorizations, various referrals. In light of how new this concept was, there seemed to be a fair amount of flexibility on both MCP and provider sides in doing what's best for the patient.</p> <p>This was a very helpful and illustrative discussion. Clearly California can be viewed as a possible model to emulate. Interestingly, NASPH will be working with California during their next grant cycle on reimbursement models to share with the rest of the states.</p> | |
| 12:30-1:00 | Lunch | | |
| 1:00-1:30 | Palliative Care Telemedicine: Experiences in Maine | <p>Krissy Connor from Maine Med, Shauna McElrath of Androscoggin Home Health and Hospice, and Jim VanKirk of Northern Light presented how their programs have been using Telemedicine to expand their palliative care activities. Apparently even before COVID, programs had been starting to explore telehealth as an option to reach patients in rural settings. But COVID has propelled the need for virtual care, not just in Maine but throughout the entire country; and not just in palliative medicine, but other specialties, as well. The three presenters described the use of telemedicine in both patients at home, for new</p> | <p>We will continue to follow the legislative updates that come from Washington regarding billing and coding.</p> <p>We will certainly include telemedicine in any recommendations we make to HHS regarding inclusion in services that might be</p> |

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| | | <p>and follow up visits, but also as an opportunity to assist in the care of hospitalized patients during the days of COVID. It is clear that this innovation has changed the way this field, and others will be practiced in the future, especially in a rural state like Maine.</p> <p>There was a great deal of discussion about logistics and billing. During COVID, emergency legislation has provider waivers for Medicare patients at the federal level, and Medicaid patients at the state. We are waiting to hear whether these waivers, which allow billing and reimbursement for telemedicine visits to equal in-office visits, will be extended, and hopefully made permanent. Some in the room expressed an understanding that word from Washington was imminent.</p> | <p>made available to patients.</p> |
| 1:30-2:00 | Project ECHO | <p>Palliative Care Project ECHO is a telehealth educational platform in palliative care, that has been meeting monthly via ZOOM since January 2019. This has been a collaborative effort, as MaineHealth provides the technology and administrative support, while the Advisory Council has contributed to the broad participation from across the state.</p> <p>Deb Silberstein, Project Manager in Palliative Care from Maine, was present at the meeting, and</p> | <p>We will certainly include a need for ongoing provider education in any recommendations we make to HHS regarding increasing awareness of palliative care. Project ECHO is easily accessible, with free registration and CME,</p> |

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| | <p>provided an overview from MaineHealth’s perspective. There are many ECHOs delivered by MaineHealth, including palliative care, endocrinology, IMAT, heart failure, geriatrics, among others. Palliative care is noted for greater participation outside of MaineHealth. Lauren Michalakes serves as the Clinical Champion. She and Deb work together to create the schedule of didactics and case presentations. While getting palliative care clinicians to step up and provide didactics has not been challenging, getting “spokes” to present cases for discussion has been challenging. Ideally, we would like to have primary care physicians present these cases.</p> <p>There were suggestions from the group regarding contacts with various organizations who might represent target providers. Most were contacted at some point. It was mentioned that simply informing providers of availability does not ensure that they will tune in. All providers are under a great deal of pressure, and setting aside this time is challenging.</p> <p>The Advisory Council continues to support Project ECHO in concept, as the only state-wide educational event open to all providers, with free CME provided. It was suggested that as we make recommendations to HHS we encourage the participation in educational activities regarding palliative care, like Project ECHO.</p> | <p>and contains evidence-based didactic information, with case discussions leading to greater understanding of the palliative care skill set.</p> |
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| 2:00-2:30 | Statewide Palliative Conference | <p>Planning meetings have been on hold given COVID. Tentative conference is still slated for Fall 2021. However, it is still unclear whether it will be feasible to hold an on-site face-to-face meeting, including a community event the night before. There were discussions regarding the possibility of turning this into a virtual on-line event or perhaps a hybrid. Formal grant support and planning will likely need that distinction.</p> <p>Kandyce has been in contact with 2 individuals in from Downeast, representing the CDC in Washington and Hancock Counties who would like to collaborate. They were invited to today's meeting, but unfortunately did not attend. Their names are Al May and Maura Goss.</p> <p>The Maine Cancer Foundation has been a strong supported and potential funder for this event. In the short term, they have needed to prioritize funding day-to-day needs of cancer patients. We will continue to communicate with MCF to discuss their interest in ongoing discussions and planning.</p> <p>Kandyce will send out a notice for another planning meeting in upcoming weeks.</p> | |
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| 2:30-2:45 | Final thoughts and comments Next meeting | Margaret Craven provided information about timing. Although recommendations to HHS are to be provided to HHS on January 1, 2021, we need to be ready to present recommendations in the form of a bill by early-mid November. | <p>Work plan for further development of HHS recommendations and legislation to be discussed by Lauren, Elizabeth and Kandyce.</p> <p>Working through the required components of California's program, we will likely pull together a work group to identify similar components of Maine's program.</p> <p>We will circle back with Kitty Purington of NASHP to get her further thoughts following this meeting.</p> <p>Lauren can reach out to Torrie Fields of California. She is CAPC faculty, worked on Blue Cross and Medi-Cal benefits in California.</p> |
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| | | <p>New item presented by Jane Conrad, member of the public. She brought forward Governor's Executive Order #37 allowing remote access of health care powers of attorney/advance directives. This apparently reports that 2 remote signatures be provided for completion of Power of Attorney, one must be an attorney. Apparently, the order does not distinguish between financial or health care power of attorney. This needs more clarification.</p> <p>Next meeting: October 23, 2020 Location TBD</p> | <p>Margaret will follow-up with the Attorney General's office to see if the requirement for attorney for health care agent can be eliminated.</p> |
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