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Community Conversation: Outpatient Palliative Care

Northwest Life Passages Coalition

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COMMUNITY CONVERSATIONS

In 2014, a community task force wrote a [Blueprint](#) that outlines steps to make Whatcom County a community of excellence for those with serious illness or facing death and their families.

The Blueprint has five pillars: Advance Care Planning, Clinical Care, Provider Training, Community Culture and Activation and Financial Sustainability.

Many organizations are involved with implementing various aspects of the Blueprint. The Northwest Life Passages (NWLP) Coalition provides a platform for Blueprint implementation by strengthening partners' shared commitment to the vision, facilitating coordination among programs and initiatives and fostering ongoing learning and innovation.

As part of those goals, the NWLP Coalition hosts community conversations on Blueprint pillars several times a year. Our intent is to share the progress that has been made and the challenges we still face, and to listen to community members' ideas, suggestions and concerns.



COMMUNITY CONVERSATION: OUTPATIENT PALLIATIVE CARE

July 23, 2018

Health Education Center, Bellingham, WA

About 55 people participated.

WELCOME

Marie Eaton, Chair of the Northwest Life Passages Coalition and Community Champion for the Palliative Care Institute, welcomed participants, described the Northwest Life Passages Blueprint, and explained the purpose of the Community Conversations.

DEFINITION OF PALLIATIVE CARE

Dr Meg Jacobson described the meaning of "palliative care:"

Palliative care is specialized medical care for people with serious illnesses, focusing on providing relief from the symptoms, pain and stress of a serious illness. You can get palliative care at *the same time* as treatment for your disease and at any stage of your disease.

Palliative comes from the Latin word meaning "to cloak." Meaning to 'wrap' someone with those things that can provide comfort and relief from symptoms.

Quote from Shel Silverstein's *Poor Angus*.

Oh what do you wear, poor Angus,
When winds blow down the hills?
"I sew myself a warm cloak, sir,
Of hope and daffodils."

- Outpatient Palliative Care = services to help people outside of the hospital.
 - At your local doctor's office
 - In the cancer center or clinic
 - At home
- Benefits Outpatient Palliative Care and targeted populations.
 - Quality of care
 - Improved patient experience
 - Caregiver & provider experience
 - Possible reduction in cost of care from severe illness to the end of life
- Challenges of Outpatient Palliative Care
 - Reimbursement models & regulatory barriers
 - Identifying those who could benefit most
 - Inefficiencies of scale
 - Distance
 - Coordination
 - Current medical mindset around cure
- Targeted populations for initial program
 - Hospice 'no-goes' – not eligible for Hospice yet
 - Hospice 'graduates' – those who did better than expected in Hospice, but are still fragile.
 - ED 'Frequent flyer' diagnoses: COPD, Cancer, Congestive Heart Failure

LOCAL PALLIATIVE CARE

Gurpreet Dhillon – outlined PeaceHealth roll out, targeted for August 2018

- New multidisciplinary team hired
- Working to develop good screening and follow-up protocols
- Secure funding from Foundation (\$2.5 million) to get program up and running
- Will report back in January 2019 about progress.

Berdi Safford - Family Care Network

- Summarized challenges of providing outpatient services in a private group practice of family physicians.
- Stressed that palliative and end of life care is part of the family medicine skill set (birth to death care)
- Use of nurse case managers to provide support to frail patients

Chris Hawk - Lummi Tribal Health Center

- Acknowledge that the reimbursement challenges are not the same in the Tribal Health system.
- Home visits supported, and successfully keeping elders and frail community members at home.
- Building a palliative care set of documents that can provide community education and support to elders.

Elizabeth Anderson & Kate Massey - Northwest Regional Council Supportive Services

- Described a set of supportive services to help those with serious illness or facing end of life stay in their home settings, including supportive transportation, mental health services.
- Most services are targeted at Medicaid clients.

OPEN COMMENT PERIOD

About 50 minutes of open comments surfaced some of these questions and themes.

1. How can we work to ensure long term support when the supplemental funding from the grant /Foundation runs out?
 - a. Plan is to use data from the pilot project to persuade other payers to support this kind of care.
2. How can we refer patients?
 - a. Initial pilot program (PH) will be small purposefully so that it can be done well.
 - b. Eventually through PCP, Hospice and other providers
3. Acknowledgment that the loss of the Adult Day Health Program is a blow to our community.
4. Challenges of costs of care.
5. A reminder that the “Elephant in the Room” is our cultural attitude about “fighting” until the end and ‘not giving up’ which often leads to funding care that will not ever lead to cure.
6. The challenges of living spaces that don’t support aging in place.
7. Need for more clarity about the differences between Advance Care Planning and the POLST
 - a. Small sub-group is meeting to work on better training for providers so that more are on the same page about how these documents can support better end of life planning. (Hilary Walker for more information).
8. Importance of integrative therapies in this model (touch, massage, acupuncture, etc). Some insurers pay- others don’t
9. Some connections and collaborations to explore as these programs develop:
 - a. with Home Health Agencies
 - b. with Community Health Workers
 - c. Tele-Health support
 - i. Project ECHO
 - ii. Link to Tele-Health lecture on PCI’s Cedar site (<https://cedar.wvu.edu/pci>)
 - iii. Health Ministries Nurses provide significant supportive services for those in their congregations.
 - iv. Explore other ways that faith communities can be involved.
10. Serious illness and end of life care as a shared responsibility between medical profession and the community
11. Importance of cultural humility in building these programs and remembering those populations who have experience historical trauma, which may make buying into these programs more difficulty (native and black populations, LGBTQ, etc)