

DRAFT  
**COMMISSION ON AFFORDABLE HEALTH CARE**  
**COPIC, Mile High Room**  
**June 8, 2015**  
**12:30 – 3:00 PM**

**Meeting Minutes**

**Commissioners Present:** Bill Lindsay (chair), Cindy Sovine-Miller (vice chair), Elisabeth Arenales, Sue Birch, Jeff Cain, Rebecca Cordes, Greg D’Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman, Dee Martinez, Marcy Morrison, Dorothy Perry, Marguerite Salazar, Chris Tholen, Jay Want, Larry Wolk  
**Staff Present:** Lorez Meinhold, Johanna Gibbs, and Kim Haller (Keystone Policy Center)

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**I) Presentations**

A) **“Importance of Consideration for End of Life Care: How Palliative Care is an Important Strategy”** – Presented by Tina Staley, Clinical Social Worker, University Health

- 1) The presentation reviewed how to improve a patient’s quality of life while improving health care costs. The presented findings are based on two research studies including late stage breast cancer patients and a 17 hospital study with 160 participants. Through end of life conversations, patients are able to face their fears, cope with illness, and communicate more effectively with physicians leading to an overall better quality of life. A short documentary clip showed that when patients had their questions answered, there were less ER visits and the subsequent health care costs diminished. Additionally, patients who were provided end of life conversation services didn’t want to go for a heroic treatment, instead they took advantage of life. This is said to be the “million dollar conversation” and Staley reviewed the importance of a better quality of life and a more cost effective system. This can happen when comprehensive care teams are formed with nurses, social workers, and physicians communicating with the patient throughout their journey. There are currently several insurance programs that are reimbursing physicians for having these conversations.
- 2) *Commission Discussion/Questions:*
  - (a) Colorado has made the decision at the state level to train physicians; however, it’s going to need more lift. Hospice has been extended to nine months but there is not much movement with physicians. The state has moved in some ways, but do you have any ideas for what else needs to be done?
    - (i) More teams need to be formed involving nurses, social workers and doctors. Many conversations need to happen, not just a 30 minute conversation.
  - (b) The culture in Grand Junction is to prepare from diagnosis. One-third of health care spending is at the end of life. It’s important to have patients living their life fully in the time that they are alive. Conversations need to happen sooner.
    - (i) Care for undocumented workers and end of life discussions are hot topics currently. Grand Junction has higher hospice rates and lower health care costs. The quality and cost discussion lies around patient empowerment, regardless of how that impacts extraordinary measures at the end of life. Insurance and government aren’t typically the most supportive.

- (c) Is there movement on the Medicare side? End of life physicians don't always want to have those conversations and sometimes the amount of time the patient has is unknown.
  - (i) Education needs to improve regarding hospice; those conversations need to begin earlier. Palliative care conversation teams are crucial in terms of providing supportive care and getting better cost outcomes. This also impacts the negative association with hospice – education is key.
- (d) There is movement in the payment world (\$150 per conversation), but is the movement in the right direction?
  - (i) It's just a first step but is certainly moving in the right direction
- (e) There could be barriers on the uptake and physicians involved, is being sued by family member and/or hospitals ever an issue?
  - (i) Doctors are afraid of being sued if they don't actually perform tests
  - (ii) Research shows that chemo only extends life an additional month
    - (i) It comes back to the patient.
    - (ii) Physicians aren't taught to talk about these issues with patients
  - (iii) There is uncertainty of talking with patients about end of life however it needs to happen in a patient-centered way and physicians need to not worry about being sued.
- (f) It's important for people to understand their choices. That being said, the choice still needs to rest with the patient. The current system is too far one way to driving every possible option; we need to find a balance.
  - (i) It's a more difficult process if patients don't have an understanding of what is to come and how to deal with their families and emotions
- (g) Our culture today and medical students should be learning how to communicate in medical school. Doctors are not ready to take this on. Residency and medical school should include this in their curriculums.
- (h) Thus far, we haven't had to worry about the government because they have chosen to ignore this. There is a struggle to gain traction due to cultural issues and family barriers. What does good look like 10 years out without barriers? Quality agenda, patient and cost agenda?
  - (i) Comfort care, not having people due in IC units hooked up to machines. Managed care with organizations like hospice. Family and patients on the same team and pain and symptoms being managed. Having a better deal with a physical and psycho-social balance before dying.
  - (i) There are two components: changing the culture of a practice and the continuity of care. The continuum of conversation around end of life conversations. Continuity of care is a great model for it.
  - (j) It's the patient's choice to determine what is most important. Choices are being made based on what the patient wants.